

Re-Conceptualizing the International Human Right to Health: An Analysis of the Trends in Developing and Developed Countries' Responses to Substance Use Disorders

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I. INTRODUCTION

The world's opinion is progressively shifting from punitive to curative responses to drug addiction.¹ This shift emanates from the International Law and continues to trickle down into domestic legal systems, albeit at different paces.² In 2018, signaling a departure from its traditional international law enforcement approach to tackle supply, the United Nations Office on Drugs and Crime (UNODC) launched a strategy to protect public health in response to the global opioid crisis for the benefit of member states.³ Progressive countries, such as the United States, Canada, and the United Kingdom, responded by implementing a broad range of public health programs that address the opioid crisis.⁴

This Article juxtaposes addiction paradigms seen in the United States of America and Zimbabwe, two countries with diametrically dissimilar political, economic, and social systems.⁵ Thus, an insight is provided by this Article into how developing and developed countries are transitioning from punitive to curative approaches in addressing the problem of drug addiction. Positing that addiction is a health condition, this Article recognizes

1. Leonard Mukosi, Commentary, *Opioid Epidemic Provides an Unexpected Benefit? International Law Inspires a Shift from Punitive to Addiction*, NOTRE DAME INT'L & COMP. L. (2019), <https://ndjicl.org/online/2019/opioid-epidemic-provides-an-unexpected-benefit> [<https://perma.cc/WXM7-PSNS>].

2. *Id.*

3. U.N. Office on Drugs and Crimes, *Responding to the Global Opioid Crisis: UNDOC Launches Strategy to Protect Public Health* (June 26, 2018), <https://www.unodc.org/unodc/en/frontpage/2018/June/responding-to-global-opioid-crisis—unodc-launches-strategy-to-protect-public-health.html> [<https://perma.cc/U25E-MVT4>].

4. *Id.*; see Mukosi, *supra* note 1.

5. *Country Comparison, United States vs. Zimbabwe*, COUNTRYECONOMY.COM, <https://countryeconomy.com/countries/compare/usa/zimbabwe> [<https://perma.cc/R4NE-FQ48>].

the optimum realization of the addict's right to health is best met if the required international standards of health are implemented nationally to insure, treat, and evaluate addiction like other chronic illnesses.

Drug addiction is a brain disease which, like any other health problem, should be medically treated.⁶ The conventional belief that addicts are morally flawed and lack willpower fuels an overemphasized bias for punitive responses to addiction through the criminal justice system while neglecting therapeutic treatments.⁷ This stance defies empirical scientific evidence that addiction is a disease that causes severe harm to the brain.⁸

The groundbreaking scientific discoveries that revolutionized the understanding of drug addiction warrant extending the right to health to addicts. The right to health, as recognized in the International Covenant on Economic, Social and Cultural Rights (ICESCR),⁹ should protect people grappling with addiction since addicts have a medical condition that places them in a vulnerable group. This Article does not advocate for the abolishment of the criminal justice responses to addiction, but rather prescribes a harmonious coexistence between criminal justice and health care mechanisms in response to addiction.

II. UNDERSTANDING DRUG ADDICTION

Addiction is defined as “a chronic relapsing brain disease that can be characterized by compulsive drug seeking and use despite harmful consequences.”¹⁰ In 1964, a World Health Organization Expert Committee dispensed with the terms “addiction” and “habituation,” replacing them with the expansive term “dependence syndrome” in order to give a comprehensive

6. NORA D. VOLKOW, *DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION* 5 (3d ed. 2007).

7. *Id.* at 1.

8. The National Institute of Drug Abuse compares addiction to other diseases such as heart disease. Both disrupt the normal healthy functioning of the underlying organ, have serious harmful consequences and are preventable and treatable, but if left untreated can last a lifetime. *Id.* at 5.

9. The Committee on Economic, Social and Cultural Rights has on numerous occasions mentioned that the ICESCR protects vulnerable groups within society. Therefore, states are required to adopt protective measures to ensure that vulnerable groups are given priority consideration, especially where there are limited resources. *See* United Nations General Assembly Int'l Covenant on Econ. Soc. & Cultural Rights, Jan. 3, 1976, 933 U.N.T.S. 3, 6.

10. VOLKOW, *supra* note 6, at 5.

description of substance use disorders (ordinarily known as addiction).¹¹ The Committee defined dependence syndrome as “a cluster of physiological, behavioral, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value.”¹² Dependence syndrome involves the desire, which is often strong or sometimes overpowering, to take psychoactive drugs that may or not have been medically prescribed.¹³ According to the World Health Organization, “There may be evidence that returning to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.”¹⁴

While various societies view and treat addiction differently, the prominent narrative surrounding drug users in most societies is that addiction is a moral failing rather than a health problem.¹⁵ Users are often blamed for their failure to abstain from drugs and described as lacking the motivation, character, or perseverance to stop using drugs.¹⁶ Politically, addiction is treated as a moral decision and addicts are treated like criminals rather than individuals in need of medical intervention.¹⁷ This misconception forms the basis for the traditional response to addiction, which has been predominantly punitive.¹⁸

A disease is described as a condition that changes the brain’s chemistry and functions.¹⁹ Humans are wired with nerve cells called neurons that run from the brain and spinal cord throughout the body.²⁰ Chemicals known as neurotransmitters transmit signals from one neuron to the next across synapses that direct human thoughts, feelings, and behavior.²¹ Some of the most significant neurotransmitters are: acetylcholine, which

11. *Management of Substance Abuse: Dependence Syndrome*, WORLD HEALTH ORG. [WHO], https://www.who.int/substance_abuse/terminology/definition1/en/ [https://perma.cc/LG32-8EPD].

12. *Id.*

13. *Id.*

14. *Id.*

15. VOLKOW, *supra* note 6, at 1.

16. *Id.*

17. *Id.*

18. See Richard A. Rawson et al., *Addiction Science: A Rationale and Tools for a Public Health Response to Drug Abuse*, 35 PUB. HEALTH REV. 1 (2014).

19. A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284(13) J. AM. MED. ASS’N 1689, 1693 (2000).

20. Seunggu Han, *What Are Neurons*, HEALTHLINE, <https://www.healthline.com/health/neurons> [https://perma.cc/WG4A-L66Y].

21. Carl Sherman, *Impacts of Drugs on Neurotransmission*, NAT’L INST. ON DRUG ABUSE (Mar. 9, 2017), <https://www.drugabuse.gov/news-events/nida-notes/2017/03/impacts-drugs-neurotransmission> [https://perma.cc/DG46-QPGB].

is responsible for much of the stimulation of muscles; norepinephrine, which functions to bring the human nervous systems into “high alert;” and dopamine, which is associated with reward mechanisms in the brain.²²

Dopamine is the critical neurotransmitter involved in addiction.²³ The abuse of substances such as alcohol, nicotine, opiates, and cocaine increases the levels of dopamine in the body, generating powerful feelings of pleasure.²⁴ The persistent release of high levels of dopamine through drug use forces the brain to depend on the presence of dopamine to maintain normalcy.²⁵ The absence of a drug to artificially cause the release of the dopamine triggers symptoms such as depression, fatigue, and withdrawal.²⁶ In the words of the Director of the National Institute of Drug Abuse, addicts “seek out drugs because of the very potency with which they can increase dopamine in the brain, often at the expense of other pleasurable natural stimulants that do not increase dopamine so dramatically.”²⁷ Addicts often use their drug of choice to obtain relief from dopamine withdrawal symptoms, which transforms what was formerly a voluntary behavior into an involuntary behavior resulting in addiction.²⁸

However, not all people are susceptible to addiction. For some, occasional drug use quickly becomes an addiction, while others remain occasional users and do not develop an addiction.²⁹ There are biological factors that contribute to the differences in levels of vulnerability to addiction.³⁰ Some

22. The term “reward system” refers to a group of structures that are activated by rewarding or reinforcing stimuli (e.g. addictive drugs). See Cynthia M. Kuhn & Wilkie A. Wilson, *How Addiction Hijacks Our Reward System*, DANA FOUND. (Apr. 1, 2005), [https://www.dana.org/article/how-addiction-hijacks-our-reward-system/#:~:text=All%20addictive%20drugs%20activate%20the,to%20be%20a%20common%20denominator.\[https://perma.cc/D8KV-93NU\]](https://www.dana.org/article/how-addiction-hijacks-our-reward-system/#:~:text=All%20addictive%20drugs%20activate%20the,to%20be%20a%20common%20denominator.[https://perma.cc/D8KV-93NU]).

23. *Id.*

24. Butler Center for Research, *The Brain Disease Model of Addiction*, HAZELDEN BETTY FORD (Mar. 1, 2016), <https://www.hazeldenbettyford.org/education/bcr/addiction-research/brain-disease-model-ru-316> [https://perma.cc/VK2A-VZCU].

25. See Kuhn & Wilson, *supra* note 22.

26. *Id.*

27. NIDA Director Calls for Humane Response to Addiction as a Brain Disorder, NAMI SOUTH BAY (May 20, 2015), <https://namisouthbay.com/2015/05/20/nida-director-calls-for-humane-response-to-addiction-as-a-brain-disorder/> [https://perma.cc/Q2VG-B2KV].

28. See U.S. DEP’T OF HEALTH AND HUM. SERV. [HHS] OFF. OF THE SURGEON GEN., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH (2016) [hereinafter FACING ADDICTION].

29. VOLKOW, *supra* note 6, at 7.

30. *Id.* at 8.

of these factors include heredity and gender.³¹ Family studies focusing on identical twins, fraternal twins, adoptees, and siblings show that people who have relatives with substance use disorders may inherit an increased susceptibility to dependence on substances.³² Researchers have also found evidence of “complex interplay between a person’s genes and environment” that influence addiction, similar to other chronic illnesses.³³ Statistically, men tend to drink more than women and are therefore believed to be at a higher risk of alcohol and other substance use disorders.³⁴ However, investigation of gender and substance use disorders reveals that, despite having been exposed to fewer substances for a shorter period of time, women progress from initial use to a disorder at a faster rate than men.³⁵

A. Addiction Crisis in Zimbabwe

Economic challenges are the primary cause of addiction in Zimbabwe.³⁶ Due to limited career opportunities and an ever-deteriorating economic terrain, an increasing portion of the population is resorting to drugs as a way to “escape” from the stress of daily challenges. In 2015, the Voice of America, African Division, reported that the number of addicts in Zimbabwe ranged between 1 million and 1.2 million countrywide, 60% of which comprised of the youth (ages 15 to 24) who are supposed to form the core of the workforce in any vibrant economy.³⁷ The most commonly used drugs in Zimbabwe include “alcohol, cannabis, heroin, glue, and cough mixtures such as histalix and bron clear.”³⁸

31. *Id.* at 7–8.

32. See Patrick Zickler, *Twin Studies Help Define the Role of Genes in Vulnerability to Drug Abuse*, NAT’L INST. ON DRUG ABUSE (Nov. 1, 1999), <https://archives.drugabuse.gov/news-events/nida-notes/1999/11/twin-studies-help-define-role-genes-in-vulnerability-to-drug-abuse> [<https://perma.cc/8UXJ-AU4R>].

33. FACING ADDICTION, *supra* note 28.

34. See Zickler, *supra* note 32.

35. Harvard Mental Health Letter, *Addiction in Women*, HARV. MED. SCH. (Jan. 2010), https://www.health.harvard.edu/newsletter_article/addiction-in-women [<https://perma.cc/8YGB-XVAP>].

36. There are multiple factors leading to an increase in drug use among Zimbabweans. These include peer pressure, rigorous training, broken families, and sexual, emotional, and physical abuse. This Article focuses on economic challenges because it is currently the most common driver. See Jeffery Moyo, *Drowning the Unemployment Worries*, D+C (Nov. 28, 2018), <https://www.dandc.eu/en/article/context-high-unemployment-and-bleak-future-drug-and-alcohol-abuse-spreading-zimbabwe> [<https://perma.cc/NG9B-QM58>].

37. Byron Mutingwende, *Substance and Drug Abuse Rampant Among Zimbabwean Youths*, SPIKED (June 12, 2017), <https://spiked.co.zw/substance-and-drug-abuse-rampant-among-zimbabwean-youths/> [<https://perma.cc/Y5SQ-PP39>].

38. *Country Snapshot: Drugs in Zimbabwe*, GLOB. DRUG POL’Y OBSERVATORY (Mar. 20, 2014), <https://gdpo.swan.ac.uk/?p=245> [<https://perma.cc/45TQ-D3S5>].

Currently, Zimbabwe does not have evidence-based drug policies, so drug abuse is dealt with primarily through the criminal justice system. The Zimbabwean Civil Liberties and Drug Network, a local advocacy and harm reduction organization, stated that the “Zimbabwean government is taking drug abuse as a war, a war [that] unfortunately no one is winning.”³⁹ This fuels the Zimbabwean society’s stigma towards addicts who are viewed as outcasts, criminals, or morally weak people. The absence of a treatment component in Zimbabwe’s responses to addiction has created public health issues related to drug abuse. People who use drugs are more prone to diseases such as HIV/AIDS, hepatitis C virus (HCV), and other infectious diseases.⁴⁰

1. Zimbabwe’s Substance Abuse Policy and Law

Though Zimbabwe continues to punish drug addicts by criminalizing their behavior, the Zimbabwean government addressed the injustice of depriving addicts of individual liberties based on their addict status alone. The 1981 Constitution of Zimbabwe allowed the deprivation of an individual’s liberty, “[I]f he is, or is reasonably suspected to be, of unsound mind, addicted to drugs or alcohol, or a vagrant, for the purpose of his care, treatment or rehabilitation or the protection of the community.”⁴¹ However, the new Zimbabwean Constitution enacted in 2013 omitted the aforementioned provision.⁴² While one’s status as a drug addict is no longer grounds for depriving individual liberties, the new Zimbabwean Constitution still makes no reference to rehabilitation or treatment for addicts.⁴³ As such, Zimbabwean drug laws are designed primarily to punish users and dealers rather than to prevent opioid misuse or provide treatment for addicts.⁴⁴

The criminal legislative instrument that deals with drug-related issues in Zimbabwe is the Dangerous Drugs Act of 1956.⁴⁵ This Act takes a prohibitionist approach by forbidding the use or abuse of certain drugs

39. Wilson Box, *Why Zim Needs to Review Its Drug Laws*, HERALD (July 18, 2017), <https://www.herald.co.zw/why-zim-needs-to-review-its-drug-laws/> [<https://perma.cc/VHM5-33WS>].

40. *Id.*

41. CONST. OF ZIMBABWE AMENDMENT ACT 2005, art. 13.

42. CONST. OF ZIMBABWE AMENDMENT ACT 2013, art. 20.

43. CONST. OF ZIMBABWE AMENDMENT ACT 2013.

44. See e.g., U.N. OFFICE ON DRUGS & CRIME, WORLD DRUG REPORT, U.N. Sales No. E.13.XI.6 (2013); see also GLOB. DRUG POL’Y OBSERVATORY, *supra* note 38.

45. Dangerous Drugs Act, 1956 (Act No. 28/1956) (Zim.).

and the imports and exports of drugs, such as prepared opium and Indian hemp.⁴⁶ The Act serves an entirely punitive purpose and does not make any mention of “treatment” or “rehabilitation of people with substance abuse disorders.”⁴⁷ In its preamble, the Act’s stated purpose is “to control the importation, exportation, production, possession, sale, distribution and use of dangerous drugs; and to provide for matters incidental thereto.”⁴⁸

The Criminal Law (Codification Reform) Act of 2005 (CLA) is another legislation that uses a punitive approach to deal with crimes involving drug abuse.⁴⁹

The CLA states, (1) Any person who unlawfully—

- a) acquires or possesses a dangerous drug; or
- b) ingests, smokes or otherwise consumes a dangerous drug;
- c) cultivates, produces or manufactures a dangerous drug for his or her own consumption; shall be guilty of unlawfully possessing or using a dangerous drug and, subject to subsection (2), liable to a fine not exceeding level ten or imprisonment for a period not exceeding five years or both.⁵⁰

The CLA refers to the treatment of people with substance use disorders in section 157 (2) of the Act, which states:

Where a court convicts any person of the crime of unlawfully possessing or using a dangerous drug and it is established that the person is an abuser of and addicted to a dangerous drug the court may, *additionally or alternatively* to any sentence imposable under subsection (1), impose a sentence requiring the person to undergo treatment for such addiction.⁵¹

Section 157(2) of the CLA does not make it the duty of the court to refer the addict for treatment, but provides the court with discretion to “additionally or alternatively” give an addict a sentence that allows for treatment.⁵² Essentially, in situations where a person violates the above CLA provision, the court decides whether that person should undergo treatment for an addiction. However, Zimbabwe does not have adequate government-run drug treatment centers and the few private treatment centers are costly for most citizens who continue to endure the severe economic challenges that have gripped the country.⁵³ Some Zimbabweans

46. *Id.*

47. *See id.*

48. *Id.*

49. Criminal Law (Codification and Reform) Act, 2005 (Act No. 6/2005) (Zim.).

50. *Id.*

51. *Id.* §157 (emphasis added).

52. *Id.*

53. Mugwadi v. Dube, [2014] 6913 H.C. 11 (Zim.).

prefer to seek treatment in the neighboring South Africa where drug rehabilitation facilities are cheaper and better-equipped.⁵⁴

The exclusion of drug addiction from the Zimbabwean health regime is evidenced by the omission of “substance use” or “addiction” treatment from the Public Health Act, Zimbabwe’s primary health legislation.⁵⁵ On the other hand, the Mental Health Act, which provides for the welfare of the mentally ill, authorizes the magistrate to direct the removal of a person who is excessively dependent on alcohol or illicit drugs and order the person’s detention in a mental institution.⁵⁶ Notwithstanding the existence of this provision, according to the Zimbabwe Civil Liberties and Drug Network, people suffering from substance abuse disorders are not given serious attention in Zimbabwe as drug users are left in hospital wards or prisons without proper treatment and rehabilitation.⁵⁷

The table below, based on research conducted by the World Health Organization in 2010, summarizes the current resources for the prevention and treatment of substance use disorders in Zimbabwe.⁵⁸

54. *Id.* Currently, the Zimbabwean courts have not issued a judgment mandating or recommending that an addict obtain treatment in a drug treatment center pursuant to section 157 (2) of the CLA.

55. *See* Public Health Act, 1924 (Act No. 19/1924) (Zim.).

56. Mental Health Act, 1996 (Act No. 15/1996) (Zim.).

57. ZIMBABWE CIVIL LIBERTIES AND DRUG NETWORK, SUPPORT. DON’T PUNISH CAMPAIGN. A STEP IN THE SEARCH FOR A SUSTAINABLE DRUG POLICY IN ZIMBABWE (2014), http://supportdontpunish.org/wp-content/uploads/2014/07/2014-day-of-action_Zimbabwe-2.pdf [<https://perma.cc/C3HH-DVXE>].

58. WORLD HEALTH ORG. [WHO], ATLAS OF SUBSTANCE USE DISORDERS RESOURCES FOR THE PREVENTION AND TREATMENT OF SUBSTANCE USE DISORDERS (SUD) COUNTRY PROFILE: ZIMBABWE (2010), https://www.who.int/substance_abuse/publications/atlas_report/profiles/zimbabwe.pdf?ua=1 [<https://perma.cc/87TT-GAR3>].

TABLE 1: ZIMBABWEAN SUBSTANCE ABUSE POLICY AND LAW⁵⁹

SUBSTANCE ABUSE EPIDEMIOLOGY	
NATIONAL EPIDEMIOLOGICAL DATA COLLECTION SYSTEM	
Alcohol	No data collection mechanisms
Drugs	No data collection mechanisms
Prevalence estimates for alcohol use disorders (12-month prevalence, %)	
Female (15+years) Year 2004	0.28
Male (15+years) Year 2004	2.62
Prevalence estimates for drug use disorders (12-month prevalence, %)	
Female (15+ years) Year 2004	0.03
Male (15+ years) Year 2004	0.08
Injecting Drug Users (per 100,000 inhabitants) ⁶⁰	0
SUBSTANCE ABUSE POLICY AND LAW	
Substance Abuse Policy	<p>Substance abuse is addressed within the Criminal Justice System: (Health legislation does not include addiction)</p> <ul style="list-style-type: none"> • Dangerous Drugs Act. • Criminal Law Codification and Reform Act. • Mental Health Act (no mention of addiction treatment). • Public health act no mention of addiction treatment).⁶¹
Availability of Special Legislative Provisions:	
Treatment and rehabilitation of people with SUD	No
Compulsory treatment for people with SUD	No
Presence of Drug Courts in the Country	No

59. *Id.*60. *Id.*61. *See id.* at 9–11.

Availability of programs which divert addicts from Criminal Justice system towards rehabilitation. ⁶²	Yes, a legislative provision sec 157 (2) Criminal Law act (Has not been utilized by the courts to recommend rehabilitation) ⁶³
TREATMENT SERVICES	
ADMINISTRATION AND FINANCING	
Government Unit Responsible for treatment services of SUD	No, (only for mental health which includes SUD)
MOST IMPORTANT FINANCING FOR TREATMENT SERVICES	
Alcohol.	Tax based funding.
Drugs. ⁶⁴	Tax based funding.
TREATMENT SYSTEM ORGANISATION	
Integrated with mental health care	Treatment for both alcohol and drug use disorders
Human Resources	
Alcohol use disorders	<ul style="list-style-type: none"> • General Practitioners • Psychiatrists
Drug use disorders ⁶⁵	<ul style="list-style-type: none"> • General Practitioners • Psychiatrists

B. Addiction Crisis in the United States of America

Drug addiction has been referred to as one of the most neglected diseases in America.⁶⁶ In 2015, drug overdose deaths outnumbered deaths from motor vehicle accidents, homicides, and suicides.⁶⁷ Opioid misuse and addiction

62. WORLD HEALTH ORG., *supra* note 58.

63. *See id.* at 9–10.

64. WORLD HEALTH ORG., *supra* note 58, at 2.

65. *Id.* at 3.

66. *See* Lloyd I. Sederer, *Addiction: America's Most Neglected Disease*, HUFFINGTON POST (June 26, 2012, 01:13 PM), https://www.huffpost.com/entry/casa-addiction-report_b_1622978 [<https://perma.cc/2YR6-Z7DT>].

67. Mike Stobbe, *A Grim Tally Soars: More Than 50,000 Overdose Deaths in US*, CBS NEWS (Dec. 8, 2016, 11:44 AM), <https://www.cbsnews.com/news/drug-overdose-deaths-heroin-opioid-prescription-painkillers-more-than-guns/> [<https://perma.cc/JJ45-FXYS>].

are serious public health problems in the United States.⁶⁸ In 2016, the U.S. Department of Health and Human Services (HHS) estimated that 78 people died from opioid overdoses every day in the United States, and, in 2014, opioids were attributed to a total of 25,760 overdoses.⁶⁹ Despite the public health threat posed by opioid addiction, only 1 in 5 people who need treatment for opioid use disorders actually receive such treatment.⁷⁰

While there are federal drug laws, the United States does not have a unified drug policy.⁷¹ Individual states have different laws on drugs.⁷² In 2012, the Congressional Research Service reported that the bulk of drug crimes known to U.S. law enforcement are handled through the criminal justice system at the state level.⁷³ Federal enforcement agencies often work with state law enforcement by effecting arrests for drug offenses and referring to the state for prosecution.⁷⁴ The federal government prohibits the production, distribution, and possession of many intoxicating substances that are solely intended for recreational purposes.⁷⁵

1. The American Criminal Justice System and Drug Addiction

For many years, the U.S. criminal justice system rigidly adhered to a punitive response to drug use, which contributed to the rapid increase in federal and state prison populations.⁷⁶ The Bureau of Justice Statistics recorded that the United States currently holds between 400,000 and 500,000 persons in prison for drug law violations.⁷⁷ Further, “one-half of all prisoners . . . meet the criteria for diagnosis of drug abuse or dependence,”

68. The abuse of opioids is considered the “use of a medication without a prescription, in a way other than as prescribed, or for the experience or feelings elicited.” Meanwhile, the misuse of opioids “may involve failure to follow medical instructions, but the person taking the drug is not looking to ‘get high.’” See *What Is the Difference Between Misuse and Abuse*, COAL. FOR A DRUG-FREE CLERMONT CNTY., <https://drugfreeclermont.org/difference-between-misuse-abuse/> [<https://perma.cc/8JJEJ-PLWC>]; see also *Opioid Misuse and Addiction*, MEDLINEPLUS, https://medlineplus.gov/opioid_misuseandaddiction.html [<https://perma.cc/363N-PWU6>] (explaining that opioids are a type of drug that include prescription pain relievers, heroin, opioids based in the opium plant, and other synthetic drugs).

69. FACING ADDICTION, *supra* note 28.

70. *Id.*

71. See LISA N. SACCO, CONG. RESEARCH SERV., R43749, DRUG ENFORCEMENT IN THE UNITED STATES: HISTORY, POLICY, AND TRENDS 16 (2014).

72. *Id.*

73. *Id.*

74. *Id.* at 17.

75. *Id.* at 1.

76. Arthur J. Lurigio, *The First 20 Years of Drug Treatment Courts: A Brief Description of Their History and Impact*, 72 FED. PROHIBITION 13, 13 (2008).

77. SEAN ROSENMERKEL ET AL., BUREAU OF JUSTICE STATISTICS, NCJ 226846, FELONY SENTENCES IN STATE COURTS, 2006 – STATISTICAL TABLES (2009).

yet 80% to 85% of these prisoners do not receive treatment for drug abuse.⁷⁸

In response to the increased imprisonment of addicts, the U.S. criminal justice system introduced Drug Treatment Courts that began to embrace the notion that “addiction is ‘as much a public health problem as a criminal justice problem,’ and drug treatment is the only long-term solution ‘to the drug crisis.’”⁷⁹ In 1997, Native American tribes also developed a customized drug court system to help drug-addicted tribal members regain sobriety using culturally sensitive practices through the Healing to Wellness Courts.⁸⁰ Presently, there are more than 2,700 drug courts throughout the United States with half of such drug courts overseeing substance use disorder treatment for adult criminal offenders.⁸¹

The introduction of Drug Treatment Courts signifies a major step towards a public health-oriented approach, rather than the traditional punitive approach, for dealing with the devastating impact of drugs and drug-related crime.⁸² Still, Drug Treatment Courts fail to incorporate medication-assisted treatment (MAT), which is considered the “best practice for treating opioid dependence” and consists of “methadone, buprenorphine, or extended-release injectable naltrexone.”⁸³

Legislatively, compulsory treatment programs for addicts are offered in prisons pursuant to 18 U.S.C.A. § 3621. This statute empowers the Bureau of Prisons to make appropriate substance abuse treatments available for each prisoner after determining whether the prisoner has a treatable condition

78. Redonna K. Chandler et al., *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301(2) J. AM. MED. ASS'N 183, 183 (2009).

79. Drug Treatment Courts use a combination of addiction treatment, sanctions, support services, and expedited case processing, which allows for nonviolent drug-addicted defendants to be placed in judicially supervised rehabilitation programs. Lurigio, *supra* note 76.

80. As sovereign entities, Native American tribes have criminal jurisdiction over tribal members for crimes committed on tribal land. Leonard Mukosi, *Odawa Cultural Practices to Treat Substance Addictions: A Tour of the Healing to Wellness Court*, 20 FOURTH WORLD J. 41, 42 (2020).

81. *Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence*, 8(1) SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 1, 1 (2014) [hereinafter SAMHSA].

82. See DRUG CTS. PROGRAM OFF., U.S. DEP'T OF JUST., DRUG COURTS PROGRAM OFFICE: ABOUT THE DRUG COURTS PROGRAM OFFICE (2000).

83. While MAT could help decrease recidivism and avert drug-related crimes, a survey revealed that in 50% of drug courts “MAT was not available under any circumstances to participants with opioid dependence.” SAMHSA, *supra* note 81.

of substance addiction or abuse.⁸⁴ According to this statute, treatment is subject to the availability of government funds and there is no guarantee that Congress will provide money for treatment in any given year.⁸⁵ Due to a shortage of resources, the prison system lacks a “treatment component” for addicts.⁸⁶ Based on the Bureau of Justice Statistics’ 2016 report, the residential drug abuse treatment programs within prisons are provided only by the Psychology Services Department and there are no drug abuse treatment specialists available.⁸⁷

The United States’ overemphasis in a punitive criminal law approach to addiction can be traced back to 1971 when President Richard Nixon described the United States’ drug problem as “a serious national threat,” and declared the notorious “war on drugs” where he labeled drug abuse as “public enemy No. 1.”⁸⁸ Together with the Drug Enforcement Administration (DEA), which was designed in 1973 to coordinate the efforts of all other agencies, these policies inaugurated an era of intense prohibition and incarceration to curtail the drug market.⁸⁹ Arguably, this approach can be said to have fostered drug abuse and trade.⁹⁰

On October 27, 1986, the U.S. Congress passed the Anti-Drug Abuse Act.⁹¹ This Act played a major role in shaping and reinforcing a punitive response to addiction through the criminal justice system, and heightened the “war on drugs.”⁹² The Act further imposed mandatory minimum sentences for drug offenses and departed from a rehabilitative federal supervised release system to a more punitive program.⁹³ The Act also imposed harsher sentences for possession of crack cocaine, a cheap drug, while offenses involving powdered cocaine, a more expensive drug, offered a lesser

84. 18 U.S.C.A. § 3621.

85. *Id.*

86. See Drug Abuse Treatment Program, 81 Fed. Reg. 80, 24484 (Apr. 26, 2016) (to be codified at 28 C.F.R. pt. 550).

87. *Id.*

88. Roger Stark, *A New Approach is Needed to Solve the Opioid Crisis*, WASH. POL’Y CTR. 3 (July 2018), <https://www.washingtonpolicy.org/library/doclib/Stark-A-New-Approach-is-needed-to-solve-the-opioid-crisis-PB.pdf> [<https://perma.cc/4MNS-A58D>].

89. DRUG ENF’T AGENCY, THE DEA YEARS 30, <https://www.dea.gov/sites/default/files/2018-07/1970-1975%20p%2030-39.pdf> [<https://perma.cc/LHC2-R64H>].

90. See Jenn S. Wenner, *America’s War on Drugs: Lawmakers, CEOs, Police Chiefs, Academics and Artists Talk About One of the Most Controversial Issues of Our Time*, ROLLING STONE MAG., Aug. 16, 2001, at 8.

91. Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207.

92. See Wenner, *supra* note 90, at 3–4.

93. See Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207.

sentence.⁹⁴ Consequently, these inconsistent sentencing standards increased racial disparities in the prison population.⁹⁵

The Illicit Drug Anti-Proliferation Act cannot escape mention as contributing to the punitive drug policy in America.⁹⁶ This Act was enacted to “combat deaths due to ‘club’ drugs.”⁹⁷ Organizers of an event where controlled substances are suspected to be present can be charged with a felony for contributing to drug use, “punishable by up to 20 years imprisonment, a fine of up to \$500,000, and can have their venue seized by law enforcement.”⁹⁸ It is argued that this penalty stands in the way of harm-reduction services for addicts, such as free water to prevent heat stroke that usually occurs after consumption of illicit drugs like ecstasy, because organizers fear federal prosecution based on suspicion of contributing to drug use.⁹⁹ This has caused an increase in the number of drug-related deaths in the night life and music communities.¹⁰⁰

2. *The American Federal Health Care System and Addiction*

As stated earlier, substance use disorders and general health care have traditionally been treated as mutually exclusive regimes in the United States, owing to the systematic exclusion of addicts from the purview of the mainstream health care system.¹⁰¹ Providing substance use disorder treatment through programs that are geographically, financially, culturally, and organizationally separate from conventional health care (especially prisons) has stigmatized addiction as different from other medical conditions.¹⁰² Therefore, substance use disorder treatment is often offered through scattered,

94. See Wenner, *supra* note 90, at 4.

95. See Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207; see also Catherine London, *Racial Impact Statements: A Proactive Approach to Addressing Racial Disparities in Prison Populations*, 29 L. & INEQ. J. THEORY & PRAC. 211, 217 (2011).

96. Illicit Drug Anti-Proliferation Act, 21 U.S.C. § 856 (2003).

97. *The Agony of Ecstasy: Amend the Illicit Drug Anti-Proliferation*, SBFPHC POL’Y ADVOC. (Mar. 4, 2016), <https://sbfphc.wordpress.com/author/ssaleem4jhmiedu/> [<https://perma.cc/N8JL-LKUE>].

98. *Id.*

99. *Id.*

100. See e.g., AMEND THE RAVE ACT, <https://amendtheraveact.org/about-shelley/> [<https://perma.cc/EE43-VSRK>] (indicating an example of a student at the University of Virginia who died of dehydration and heatstroke after consuming MDMA at a rave in Washington D.C.).

101. FACING ADDICTION, *supra* note 28, at 4–14.

102. *Id.* at V.

poorly-funded, and stand-alone clinics that do not necessarily provide evidence-based treatment and have long waiting lists.¹⁰³

The prevalence of substance abuse disorders and the proliferation of scientific evidence depicting addiction as a health problem paved way for the initial steps towards incorporating addiction into the mainstream health care system.¹⁰⁴ In 2008, the Mental Health Parity and Addiction Equity Act (MHPAEA) nullified all the restrictive financial requirements and treatment limitations imposed by health plans and insurers for substance use disorders.¹⁰⁵ Further, the act required addiction to be treated equally with other medical and surgical conditions.¹⁰⁶

The Affordable Care Act (ACA) was a monumental legal instrument towards the expansion of treatment for people with substance use disorders.¹⁰⁷ In order to merge substance use disorders into the conventional health care system, the ACA provides for the integration of primary and behavioral health at community health centers.¹⁰⁸ Community health centers are recommended to integrate primary and specialty care into one location to address all the mental and physical health needs of people with substance use disorders.¹⁰⁹ By 2014, the ACA funding had extended behavioral health coverage to 221 health centers that incorporated substance use disorders services across the United States.¹¹⁰ Most importantly, by prohibiting exclusions for pre-existing conditions, the ACA compelled insurers to extend coverage to people with substance use disorders or mental health conditions.¹¹¹

Under the ACA, a National Prevention Strategy was launched with the core purpose of preventing drug and alcohol misuse.¹¹² By 2014, with the support of the Prevention and Public Health Fund, \$50 million was devoted

103. *Id.* at 7–16.

104. *Id.*

105. Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881.

106. *Id.*

107. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2006 & Supp. IV 2010).

108. Melissa Ough, *The Affordable Care Act Expands Access to Treatment for Substance Use Disorders*, CMTY. CATALYST (Oct. 2014), https://www.communitycatalyst.org/document/publications/ACA_substance_use_disorders.pdf?1412963386 [<https://perma.cc/8B3A-K9A6>].

109. 42 U.S.C. § 2703(e) (2010) (“A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.”).

110. Ough, *supra* note 108.

111. 42 U.S.C. § 300gg-3 (2006 & Supp. IV 2010) (“[P]rohibition of preexisting condition exclusions or other discrimination based on health status.”).

112. Ough, *supra* note 108.

to recovery supports for people struggling with drug addiction problems.¹¹³ The act also eliminates costs for mental health and alcohol screenings for adults who have access to Medicaid, Medicare, and qualified health plans offered on the federal health insurance marketplaces.¹¹⁴ The Center on Budget and Policy Priorities estimated that 2.8 million people with drug addiction problems, including 220,000 with opioid disorders, had health care coverage under the ACA.¹¹⁵

Currently, the Affordable Care Act is under constant threat of repeal since President Donald Trump took office in 2016.¹¹⁶ This move would potentially leave many addicts who are currently benefiting from the act with no coverage. Foundational provisions to the ACA have already been compromised, with the most recent potentially catastrophic threat being the December 2017 tax bill passed by both chambers to eliminate the penalty for not having coverage under the ACA's individual mandate.¹¹⁷ The Congressional Budget Office predicted that at least 4 million people would lose coverage in the first year of the repeal.¹¹⁸

The Comprehensive Addiction and Recovery Act (CARA) promotes many evidence-based interventions that can potentially address opioid and heroin dependency.¹¹⁹ CARA provides for a grant program within the Department of Justice that encourages "[s]tates, local governments, and Indian tribes to develop, implement, or expand a treatment program for alternatives to incarceration."¹²⁰ This grant program also "enhance[s] collaboration between state criminal justice agencies and substance abuse

113. *Id.* at 2; VANESSA FORSBERG & CAROLINE FICHTENBERG, THE PREVENTION AND PUB. HEALTH FUND 9, 11 (Am. Pub. Health Ass'n, 2012) ("[T]he Prevention and Public Health Fund was created by Section 4002 of the Affordable Care Act. . . . [Its] purpose is to provide expanded and sustained national investment in prevention and public health programs to improve health and restrain the rate of growth in private and public healthcare costs.").

114. Ough, *supra* note 108, at 2.

115. Katherine Q. Seelve & Abby Goodnough, *Addiction Treatment Grew Under Health Law. Now What?*, N.Y. TIMES (Feb. 10, 2017), <https://www.nytimes.com/2017/02/10/health/addiction-treatment-opioids-aca-obamacare.html> [<https://perma.cc/ZQZ2-U54A>].

116. *Id.*

117. CHRISTINE EIBNER & SARAH NOWAK, THE EFFECT OF ELIMINATING THE INDIVIDUAL MANDATE PENALTY AND THE ROLE OF BEHAVIORAL FACTORS (The Commonwealth Fund, 2018).

118. SUSAN YEH BEYER ET AL., REPEALING THE INDIVIDUAL HEALTH INSURANCE MANDATE 1, 3 (John Skeen, Cong. Budget Office, 2017).

119. Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-98, § 1, 130 Stat. 695.

120. *Id.*

agencies in order to enhance efforts to combat opioid abuse; provide[s] training and resources for first responders on opioid overdose reversal drugs and devices; and enhance[s] law enforcement efforts to combat illegal distribution of opioids.”¹²¹

The notion of an “inclusive health care system,” which encompasses substance use disorders and evidently seems to be taking root at the federal level, is permeating state boundaries at a disappointingly slow pace. In 2014, the Supreme Court rendered the ACA requirement for expanding Medicaid programs optional at the state level.¹²² Therefore, not all states have elected to participate.¹²³

On October 24, 2018, President Trump signed into law the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, which aims to address the opioid crisis through the public health system.¹²⁴ The act requires state Medicaid programs to cover medication-assisted treatment (MAT), including all FDA-approved drugs, counseling services, behavioral therapy, and other health-based solutions.¹²⁵

States still have considerable freedom to determine the details of their essential health benefits for “newly eligible Medicaid enrollees and most individual and small group health plans.”¹²⁶ This elasticity often harms those with substance abuse issues because states are not required to extend Medicaid programs to addicts.

The states’ approach to addressing substance abuse disorders still favors the criminal justice approach, which overemphasizes punishing drug offenders and supports an exclusionary health care system that does not extend to addicts. Due to time and space constraints, this Article shall primarily focus on the two states that have recently recorded the highest drug overdose

121. *Id.*

122. *See* Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607, 2630 (2012) ([T]he majority of the court found the ACA’s Medicaid expansion *unconstitutionally coercive of the states*, while a different majority of the Court held that this issue was fully remedied by limiting the Health and Human Services (HHS) Secretary’s enforcement authority. The ruling left the ACA’s Medicaid expansion intact in the law, but the practical effect of the Court’s decision makes the Medicaid expansion optional for the states.) (emphasis added).

123. *Id.* at 2607.

124. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018) (enacted).

125. *Id.* § 1006 (B).

126. *The Affordable Care Act: Shaping Substance Abuse Treatment*, CARNEVALE ASSOCS. LLC (Apr. 26, 2013), <https://www.carnevaleassociates.com/our-work/policy-information-briefs.html/article/2013/04/26/the-affordable-care-act-shaping-substance-abuse-treatment> [<https://perma.cc/U8U7-LH9C>].

deaths and most plausibly mirror the drug and opioid crisis across the rest of the United States: West Virginia and Ohio.¹²⁷

3. Opioid Abuse in West Virginia

West Virginia is said to be one of the States that is experiencing very high drug rates.¹²⁸ In 2014, the Centers for Disease Control and Prevention reported that West Virginia had the highest drug rate in the United States.¹²⁹ In 2016, 884 people died from drug overdoses in West Virginia.¹³⁰ While opioids such as Codeine, Oxycodone, Morphine, and Hydrocodone are most often abused, people are increasingly turning to opioids' cheaper alternative, heroin.¹³¹ Sometimes laced with fentanyl, heroin is a more dangerous drug that accounts for the majority of drug overdose deaths.¹³²

The opioid epidemic in West Virginia can be traced back to the 1990s when a period of unregulated opioid prescription coincided with the rate of manual jobs such as coal mining, timbering, and manufacturing, which exposed many workers to injuries that led to an inevitable need for opioid prescriptions.¹³³ Moreover, a significant decrease in employment plagued West Virginia from 2001 to 2015.¹³⁴ Dr. Carl Sullivan, who runs the addiction program at West Virginia hospitals, described the dire situation created

127. *Opioid Summaries by State*, NAT'L INST. ON DRUG ABUSE (Apr. 16, 2020), <https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state> [https://perma.cc/HT6U-ZEW4].

128. *Id.*

129. Harrison Jacobs, *Here's Why the Opioid Epidemic Is So Bad in West Virginia—The State with the Highest Overdose Rate in the US*, BUS. INSIDER (May 1, 2016, 8:00 AM), <https://www.businessinsider.com/why-the-opioid-epidemic-is-so-bad-in-west-virginia-2016-4> [https://perma.cc/RBK2-2W63].

130. *2016 Drug Overdose Death Rates, Opioid Overdose*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2016.html> [https://perma.cc/6UDE-5RVF].

131. Margerate Talbort, *The Addicts Next Door*, NEW YORKER (May 29, 2017), <https://www.newyorker.com/magazine/2017/06/05/the-addicts-next-door> [https://perma.cc/E47Z-7GE4].

132. *Id.*

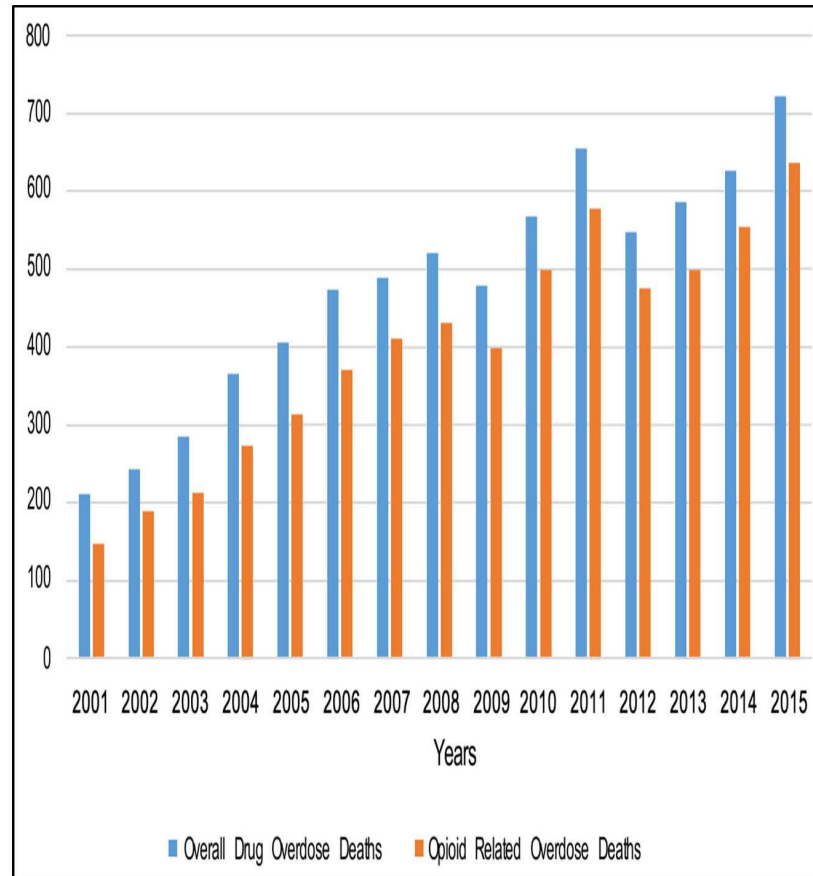
133. Jacobs, *supra* note 129.

134. *West Virginia Drug Overdose Deaths Historical Overview 2001-2015*, W. VA. HEALTH AND HUM. RES. BUREAU FOR PUB. HEALTH (Aug. 17, 2017), https://dhhr.wv.gov/oeps/disease/ob/documents/opioid/wv-drug-overdoses-2001_2015.pdf [https://perma.cc/BTV7-X66F] [hereinafter *West Virginia Overdose Overview*].

by unemployment, “With a population primed by prescriptions from work-related injuries, job loss was the gasoline on the fire.”¹³⁵

The graph below illustrates how opioids contributed to drug overdose deaths from 2001 to 2015 in West Virginia.¹³⁶

DRUG OVERDOSE DEATHS IN WEST VIRGINIA FROM 2001 TO 2015¹³⁷



135. Jacobs, *supra* note 129.

136. *West Virginia Overdose Overview*, *supra* note 134.

137. *Id.*

Drug offenses in West Virginia fall under the Uniform Controlled Substances Act (UCSA).¹³⁸ Habitual drug offenders can attract penalties up to a life sentence.¹³⁹ The UCSA states, “Any person convicted of a second or subsequent offense under this chapter may be imprisoned for a term up to twice the term otherwise authorized, fined an amount up to twice that otherwise authorized, or both.”¹⁴⁰

People with a history of prior drug offenses in West Virginia are subject to the general sentencing statute applicable to second or third felonies. In the case of *State ex rel. Daye v. McBride*, the defendant was arrested in West Virginia for possession of crack cocaine.¹⁴¹ While on probation, the defendant was arrested again in Orange County, Florida for possession of a controlled substance and sentenced to 6 months in jail.¹⁴² Based on the defendant’s admission to prior drug-related convictions, the West Virginia court ultimately sentenced him to life in prison.¹⁴³

Courts in West Virginia slightly acknowledged addicts’ right to health care in one of their judgments on drug offenses. In *State v. Broughton*, while sentencing a drug offender charged with delivering less than 15 grams of marijuana, the court considered whether the defendant was a reasonably good prospect for rehabilitation.¹⁴⁴

The West Virginia Code is the only health care instrument that mentions addiction in West Virginia.¹⁴⁵ Until 2001, the West Virginia Code unequivocally excluded substance abuse from coverage by saying that “mental health benefits do not include benefits with respect to treatment of substance abuse or chemical dependency.”¹⁴⁶ This clause was later replaced by an amendment that stated, “The insurer shall not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan.”¹⁴⁷ Since the amendment did not expressly extend coverage to people suffering from substance use disorders, whether Group Accident

138. W. VA. CODE § 60A-4-408 (1971).

139. *Id.*

140. *Id.*

141. *State ex rel. Daye v. McBride*, 222 W. Va. 17, 19 (2007).

142. *Id.* at 18–19.

143. *Id.* at 20.

144. *State v. Broughton*, 196 W. Va. 281, 286 (1996).

145. W. VA. CODE ANN. § 33-16-3a (repealed 2020).

146. *Id.*

147. W. VA. CODE ANN. § 33-16-3a (amended).

and Sickness insurance covered people with substance use disorders in West Virginia remained ambiguous until 2018.¹⁴⁸

Since 2018, the West Virginia Legislature began to overtly require insurance providers to cover substance use disorders.¹⁴⁹ Specifically, Group Accident and Sickness insurance benefits are required to “be provided to all covered persons with a diagnosis of substance use disorder.”¹⁵⁰ Similarly, in 2020, the West Virginia Legislature required, “The carrier shall . . . [n]ot apply any nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits.”¹⁵¹

In 2016, West Virginia took a giant stride towards acknowledging substance use disorders as a public health crisis by passing the Medication-Assisted Treatment Licensing Program Act.¹⁵² The Act’s main purpose is to “establish licensing and registration requirements for facilities and physicians that treat patients with substance use disorders to ensure that patients may be lawfully treated by the use of medication and drug screens, in combination with counseling and behavioral therapies.”¹⁵³ In passing this Act, the West Virginia Legislature “recognizes the problem of substance use disorders in West Virginia and the need for quality, safe treatment of substance use disorders to adequately protect the people of West Virginia.”¹⁵⁴

4. Drug Addiction Law and Policy in Ohio

The state of Ohio is regarded as the nations “overdose capital,”¹⁵⁵ with overdose deaths rising to 3,050 in 2015.¹⁵⁶ By March 2017, overdose deaths in Ohio had skyrocketed such that cold storage trailers were used as morgues.¹⁵⁷ Overdoses from heroin and opiate abuse are the most common

148. W. VA. CODE § 33-16-3cc (2018).

149. *Id.*

150. *Id.*

151. W. VA. CODE § 33-16-3ff (2020).

152. W. VA. CODE § 16-5Y-1.

153. *Id.*

154. *Id.*

155. *As Southwestern Ohio County Tops Nation in Per Capita Opioid Overdose Deaths, State Takes Action*, OHIO HOSP. FOR PSYCHIATRY, <https://www.ohiohospitalforpsychiatry.com/about/columbus-community-resources/opioid-overdose-state-takes-action/> [https://perma.cc/MZA9-5NVF].

156. *See Drug Overdose Mortality by State*, CTDS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm [https://perma.cc/6XJQ-ACDL].

157. Kristine Phillips, *Drugs Are Killing So Many People in Ohio that Cold-Storage Trailers Are Being Used as Morgues*, WASH. POST (July 21, 2020), <https://www.washington>

types of overdose in Ohio.¹⁵⁸ Despite the grave magnitude of Ohio's drug overdose problem, law enforcement in most Ohio counties, such as Butler County, have failed to heed ongoing calls for saving addicts' lives through naloxone, an opioid overdose reversal drug that saves hundreds of lives.¹⁵⁹ This reflects Ohio's longstanding punitive approach to combatting addiction.

Chapter 2925 of the Ohio Revised Code deals with drug offenses.¹⁶⁰ This chapter makes abusing harmful intoxicants a misdemeanor of the first degree.¹⁶¹ People with prior convictions who are charged under this chapter risk fifth-degree felony convictions.¹⁶² Licensed professionals who are convicted of abusing harmful intoxicants under the same code will face criminal liability and have their professional licenses revoked.¹⁶³ Chapter 2925 states that; "If a person who is convicted of or pleads guilty to a violation of section 2925.31 is a professionally licensed person, in addition to any other sanctions imposed for the violation, the court . . . immediately shall transmit a certified copy of the judgment entry of conviction to the regulatory or licensing board or agency that has the administrative authority to suspend or revoke the offender's professional license."¹⁶⁴

Ohio's punitive approach is further exemplified by the *Kilbourn v. Henderson* case. In *Kilbourn v. Henderson*, the Ohio Court of Appeals refrained from revising a health insurance provision that limited the scope from which people with substance use disorders could obtain treatment.¹⁶⁵ In this case, an employee was denied health insurance coverage for in-patient treatment of alcoholism.¹⁶⁶ The court concluded that a health insurance policy that does not extend in-patient coverage for facilities to drug addicts does not impermissibly discriminate against persons handicapped

post.com/news/to-your-health/wp/2017/03/16/drugs-are-killing-so-many-in-this-county-that-cold-storage-trailers-are-being-used-as-morgues/ [https://perma.cc/8CPF-NKJU].

158. See *Ohio: Opioid-Involved Deaths and Related Harms*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/ohio-opioid-involved-deaths-related-harms> [https://perma.cc/56X8-3MPA].

159. See *Naloxone: The Opioid Reversal Drug that Saves Lives*, U.S. DEP'T OF HEALTH AND HUM. SERVS., <https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf> [https://perma.cc/KZ23-T2J3].

160. OHIO REV. CODE ANN. § 2925.31 (West 2015).

161. *Id.*

162. *Id.*

163. *Id.*

164. *Id.* § 2925.38.

165. *Kilbourn v. Henderson*, 577 N.E.2d 1132, 1135–36 (Ohio App.1989).

166. *Id.*

due to alcoholism even if the same insurance policy provided in-patient treatment for other illnesses.¹⁶⁷

C. *The International Law Framework and Drug Abuse*

There are three main United Nations treaties that make up the international legal framework regarding drugs,¹⁶⁸ including, the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 protocol;¹⁶⁹ the Convention on Psychotropic Substances of 1971;¹⁷⁰ and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.¹⁷¹ While these treaties generally recognize that drug abuse is a public health issue, they were primarily enacted as a punitive approach to drug use and cultivation, which departs from the non-punitive, normative nature of drug treaties negotiated by the League of Nations (predecessor to the United Nations, 1919-1946).¹⁷²

Of the three treaties, the Single Convention on Narcotic Drugs of 1961 (1961 Convention) is the only treaty that mentions the word “addiction”—though only once in its preamble.¹⁷³ International organizations, such as the Human Rights Watch, lament over the U.N. Conventions’ overemphasis on punitive responses to drug use and failure to equally focus on adequate treatment for drug users.¹⁷⁴

Notwithstanding the scope constraints precluding an extensive analysis of the circumstances which actuated the formation of the three Conventions,

167. *Id.* at 1136.

168. Amira Armenta & Martin Jelsma, *The UN Drug Control Conventions*, TRANSNAT’L INST. (Oct. 8, 2015), https://www.tni.org/files/publication-downloads/primer_unconventions_24102015.pdf [https://perma.cc/2GGS-8LQC].

169. Protocol Amending the Single Convention on Narcotic Drugs, Mar. 25, 1972, 976 U.N.T.S. 3 [hereinafter 1961 Convention].

170. Convention on Psychotropic Substances, Feb. 21, 1971, 1019 U.N.T.S. 175 [hereinafter 1971 Convention].

171. United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Dec. 20, 1988, 1582 U.N.T.S. 95 [hereinafter 1988 Convention].

172. Armenta & Jelsma, *supra* note 168; 1961 Convention, *supra* note 169, at 11 (authorizing countries to prohibit the cultivation of opium poppy or the cannabis plant for the protection of public health); 1971 Convention, *supra* note 170, 192 (allowing countries to apply strict or severe measures of control greater than those prescribed by the treaty for the protection of the public health); 1988 Convention, *supra* note 171, at 190 (“If the Board . . . finds that the volume and extent of the illicit manufacture of a narcotic drug or psychotropic substance creates serious public health problems . . . it shall communicate to the Commission.”).

173. 1961 Convention, *supra* note 169, at 106 (“Recognizing that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind.”).

174. Miguel Antonio Núñez Valadez, *Drug Use and the Right to Health: An Analysis of International Law and the Mexican Case*, 6 MEXICAN L. REV. 201, 206 (2018).

a brief overview of the how prevailing geopolitical circumstances influenced the objectives of the Convention is necessary. The 1961 Convention contained provisions designed to heavily restrict the traditional producers of the opium poppy, cocoa leaf, and cannabis.¹⁷⁵

Meanwhile, the Convention on Psychotropic Drugs of 1971 (1971 Convention) was propelled by the urgent need of manufacturing and exporting countries to limit the negative impacts to trade that were caused by the restrictive drug control regime under the 1961 Convention.¹⁷⁶ As such, the 1971 Convention created a drug control regime that was less strict in its structure.¹⁷⁷ Finally, the rise in international drug trafficking during the 1970s and 1980s intensified the need for a more restrictive drug regime, which resulted in the enactment of the Convention Against the Trafficking in Illicit Drugs and Psychotropic Substances of 1988 (1988 Convention).¹⁷⁸ This treaty required member states to establish the possession, cultivation, and purchase of narcotic drugs as a criminal offence under domestic law.¹⁷⁹

Some scholars commend these U.N. treaties as adequate sources of international law that mandate member states “to provide adequate treatment facilities for drug addicts and abusers.”¹⁸⁰ The 1961 Convention mandates member states to take measures that prevent drug abuse and provide for early treatment, education, after-care, and rehabilitation of drug users.¹⁸¹ Similarly, the 1988 Convention authorizes member states to require offenders to “undergo measures such as treatment, education, aftercare, rehabilitation or social reintegration.”¹⁸²

Both Zimbabwe and the United States are parties to all the three of the U.N. Conventions regarding drugs—by way of accession or ratification.¹⁸³ The punitive approach that some member states of the U.N. Conventions

175. See 1961 Convention, *supra* note 169.

176. Armenta & Jelsma, *supra* note 168.

177. *Id.*

178. *Id.* at 7.

179. See 1988 Convention, *supra* note 171, at 170–71.

180. Valadez, *supra* note 174.

181. 1961 Convention, *supra* note 169, at 13.

182. 1988 Convention, *supra* note 171, at 172.

183. *Chapter VI Narcotic Drugs and Psychotropic Substances*, U.N. TREATY COLLECTION, https://treaties.un.org/Pages/ViewDetails.aspx?chapter=6&clang=_en&mtdsg_no=VI-19&src=IND [<https://perma.cc/685M-LGLP>].

took towards drug use reflects the objectives of the U.N. Conventions.¹⁸⁴ Therefore, it is no exaggeration to attribute the punitive approach that characterizes drug laws in Zimbabwe and the United States to the same Conventions.

It is worth acknowledging that the comprehensive health-based approach to addiction is incorporated in resolutions passed by the Commission on Narcotic Drugs (CND)—“the main drug-policy-making organ within the United Nations.”¹⁸⁵

III. THE RIGHT TO HEALTH UNDER INTERNATIONAL HUMAN RIGHTS LAW

A. *Regional International Law*

At the regional level, Zimbabwe is a member of the African Union, a regional body consisting of 55 member states that make up the countries of the African Continent.¹⁸⁶ The African Charter on Human and Peoples’ Rights (ACHPR) is the main human rights instrument in the African Union and observes the right to the “best and attainable physical and mental health of every individual.”¹⁸⁷ The ACHPR requires member states to guarantee every person’s right to “enjoy the best attainable state of mental and physical health.”¹⁸⁸ Governments of the member states to the ACHPR are required to take “necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”¹⁸⁹

In 1985, the African Union, then called the Organization of African Union (OAU), adopted the Agreement for the Establishment of the African Rehabilitation Institute (ARI).¹⁹⁰ The ARI unifies member states’ efforts to promote the development of treatment and rehabilitation services for people with disabilities using different mechanisms, such as regional or sub-regional training and research programs.¹⁹¹

184. See generally Armenta & Jelsma, *supra* note 168 (explaining the objectives of each of the three U.N. Conventions that create the international legal framework regarding drugs).

185. Mukosi, *supra* note 1 (“[C]ountries at the 61st Session [of the Commission on Narcotic Drugs] drafted health-based resolutions to address the problem of drug addiction and pledged their commitment to implementing these resolutions domestically.”).

186. *Member States*, AFRICAN UNION (Dec. 24, 2017), <https://au.int/en/memberstates/countryprofiles2> [<https://perma.cc/XLP3-GW95>].

187. African (Banjul) Charter on Human and Peoples’ Rights, art. 16, June 27, 1981, 21 I.L.M. 58 (entered into force Oct. 21, 1986).

188. *Id.*

189. *Id.*

190. The Agreement for the Establishment of the African Rehabilitation Institute, July 17, 1985, AFRICAN UNION (entered into force Dec. 2, 1991).

191. *Id.* art. 1.

Comparably, the United States is one of the 354 participating members in the Organization of American States (OAS).¹⁹² The OAS is a regional organization whose purpose is to maintain “peace and justice, promote solidarity, [and] to strengthen the collaboration” among the Western Hemisphere states.¹⁹³

The American Declaration on the Rights and Duties of Man (American Declaration) is the principal instrument that enshrines the human rights duties for members of the OAS towards their citizens.¹⁹⁴ Article 11 of the American Declaration guarantees the right to health by providing that “[e]very person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.”¹⁹⁵

To tackle drug use and addiction in the United States, the OAS created the Inter-American Drug Abuse Control Commission (CICAD), which serves as a consultative and advisory platform for OAS member states.¹⁹⁶ The OAS member states discuss and find solutions to the drug problem at the CICAD, thereby increasing their capacity to counter the drug problem. The United States, with Assistant Secretary Kirsten Madison as its principal representative, is a member to the CICAD through the Bureau of International Narcotics and Law Enforcement Affairs.¹⁹⁷

The CICAD’s subsidiary, the Inter-American Observatory on Drugs (OID), is primarily mandated to ensure that member states can better understand, design, and implement policies and programs to confront drug abuse and addiction.¹⁹⁸ In 2018, the OID enacted the Manual for the Design, Monitoring, and Evaluation of a Drug Treatment, which acknowledges

192. *Member States*, ORG. OF AM. STATES, http://www.oas.org/en/member_states/default.asp [https://perma.cc/9M58-JGXY].

193. *Who We Are*, ORG. OF AM. STATES, http://www.oas.org/en/about/who_we_are.asp [https://perma.cc/Y2QP-6R3H].

194. American Declaration of the Rights and Duties of Man, May 2, 1948, ORG. OF AM. STATES (adopted by the Ninth International Conference of American States) [hereinafter American Declaration].

195. *Id.* art. 12.

196. *Inter-American Drug Abuse Control Commission (CICAD): About CICAD*, ORG. OF AM. STATES http://www.cicad.oas.org/Main/Template.asp?File=/Main/AboutCICAD/about_eng.asp. [https://perma.cc/WNT6-RFJL].

197. *About CICAD: Directory of Member States*, ORG. OF AM. STATES, http://www.cicad.oas.org/main/aboutcicad/dirmemberstates_eng.asp. [https://perma.cc/CGW7-WECU].

198. *CICAD: Inter-American Observatory on Drugs*, ORG. OF AM. STATES, http://www.cicad.oas.org/Main/Template.asp?File=/oid/aboutus_eng.asp [https://perma.cc/PQ6M-DJN4].

the need for member states to establish specialized units that provide treatment to people diagnosed with psycho-active substance use disorders.¹⁹⁹

B. United Nations and the Right to Health

The Universal Declaration of Human Rights (Declaration) acknowledges a person's right to "a standard of living adequate for the health and well-being . . . including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond . . . control."²⁰⁰ At the time of its adoption by the U.N. General Assembly, the Declaration did not have binding effect.²⁰¹ However, principles that are initially considered to be merely goals and aspirations at the international level can develop into binding norms and elevate to the status of customary international law if the principles are widespread and carried out in an obligatory way (*opinio juris*).²⁰² Similarly, the Declaration is regarded by many scholars as having attained the status of customary international law for the reasons explained below.

To determine the existence of a customary norm of international law, many sources can be considered, including diplomatic correspondence, policy statements, and press releases. Additionally, normative value has attached to resolutions of international organizations, including the General Assembly whose resolutions were said to be *opinio juris* in the *Nicaragua* case.²⁰³ The court reasoned that the creation of the General Assembly's resolution "itself testifies" to the attitude of states who adopted such resolutions "as a matter of customary international law."²⁰⁴ To elaborate, there is evidentiary conduct that signifies the existence of *opinio juris*. This evidence includes the "incorporation of human rights provisions in many national constitutions and laws," condemnations by international bodies of particular actions as constituting violations of international law, and official statements denouncing other states for human rights violations.²⁰⁵

Additionally, the attitude of many states and international bodies towards the Declaration increasingly demonstrates somewhat compulsory adherence.

199. INTER-AM. DRUG ABUSE CONTROL COMM'N, OEA/Ser.L/XIV.6.50, MANUAL FOR THE DESIGN, MONITORING, AND EVALUATION OF A DRUG TREATMENT INFORMATION SYSTEM: GENERATING INFORMATION 21–22 (2018).

200. G.A. Res. 217 (III), art. 25 (Dec. 10, 1948).

201. See generally *id.* at 1–2 (showing no binding language).

202. See OSCAR SCHACHTER, INTERNATIONAL LAW IN THEORY AND PRACTICE 336 (1991).

203. Military and Paramilitary Activities in and Against Nicaragua (Nicar. v. U.S.), Judgment, 1986 I.C.J. 14, ¶ 191 (June 27, 1986).

204. *Id.* ¶ 193.

205. SCHACHTER, *supra* note 202, at 336.

For example, more than one Latin American country concurs with the assertion that the Declaration constitutes customary law.²⁰⁶ In 1994, the International Law Association concluded that the Declaration “is universally regarded as an authoritative elaboration of the human rights provisions of the United Nations Charter.”²⁰⁷ It also stated that “many if not all of the rights elaborated in the . . . Declaration . . . are widely recognized as constituting rules of customary international law.”²⁰⁸ While the Declaration was initially non-binding, it has become part of the customary laws of nations due to the multiplicity of occasions it has been invoked at both the domestic and international level.²⁰⁹ Many scholars, to include one of the Declaration’s key drafters, reinforce this notion.²¹⁰ Accordingly, it can be argued that the Universal Declaration of Human Rights is an authoritative international source from which the right to health can be derived.

The right to health is further enshrined in the Convention on the Elimination of All Forms of Racial Discrimination, which recognizes the “right to public health, medical care, social security and social services.”²¹¹ Both the United States and Zimbabwe ratified this Convention in 1994 and 1991, respectively.²¹² These countries are obligated to recognize the right to health as provided by the Convention on the Elimination of All Forms of Racial Discrimination.²¹³ However, in 1995, the United States only signed, but did not ratify, the Convention on the Rights of the Child, which mandates states parties to recognize the right of the child to the

206. See *id.*; Hurst Hannum, *The Status of the Universal Declaration of Human Rights in National and International Law*, 25 GA. J. INT'L & COMP. L. 327 (1996) (noting that Uruguay’s foreign minister stated that the international obligation to guarantee and protect human rights is derived not only from international treaties, but also from the Declaration). The Presidents of Colombia and Venezuela also referred to the Declaration when they denounced human rights violations in Nicaragua. *Id.* Additionally, a statement made on behalf of Denmark, Finland, Iceland, Norway, and Sweden during the 40th anniversary of the Declaration explained, “The Declaration is generally recognized as having already become a part of universal international law. Therefore, the implementation of the principles of the Declaration is the responsibility of all Member States of the United Nations.” *Id.*

207. Int’l Law Ass’n, *Report of the Sixty-Sixth Conference*, at 29 (Aug. 20, 1994).

208. *Id.*

209. *Id.* at 539.

210. *Id.*

211. International Convention on the Elimination of All Forms of Racial Discrimination, art. 5, Mar. 7, 1966, 660 U.N.T.S. 195.

212. International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195.

213. *Id.*

enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.²¹⁴ Meanwhile, Zimbabwe ratified the Convention on the Rights of the Child in 1990.²¹⁵ Whether the United States is bound by this Convention will be elucidated later in this Article where the implications of a state's signature to a treaty is explored.

At the regional level, the African Charter on Human and Peoples' Rights (ACHPR) observes the right to "the best and attainable physical and mental health of every individual."²¹⁶ ACHPR requires member states to take the "necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."²¹⁷ Further, in the preamble of the World Health Organization's Constitution, every human being has the right to enjoy the highest attainable standard of health without distinction of race.²¹⁸ Both the United States and Zimbabwe are parties to the World Health Organization's Constitution.²¹⁹

The importance of the right to health is further supported by the inclusion of health in the Sustainable Development Goals as adopted through a resolution by the United Nations General Assembly in September 2015.²²⁰ Among the 17 goals listed, Sustainable Development Goal 3 is meant "[t]o ensure healthy lives and promote well-being for all at all ages."²²¹ Most importantly, Sustainable Development Goal 3 explicitly includes strengthening "the prevention and treatment of substance abuse, including narcotic drug abuse."²²² Both Zimbabwe and the United States pledged their commitment to these goals.²²³

1. International Covenant on Economic, Social and Cultural Rights

The most comprehensive international instrument that guarantees the right to health is Article 12 of the International Covenant on Economic,

214. Convention on the Rights of the Child, art. 24, Nov. 20, 1989, 1577 U.N.T.S. 3.

215. See *Chapter IV, Human Rights Convention on the Rights of the Child*, U.N. TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-11&chapter=4&clang=en [<https://perma.cc/BB76-8W27>].

216. African (Banjul) Charter on Human and Peoples' Rights, art. 16, June 27, 1981, 21 I.L.M. 58 (entered into force Oct. 21, 1986).

217. *Id.*

218. Constitution of the World Health Organization, Apr. 7, 1948, 14 U.N.T.S. 186.

219. See *Alphabetical List of WHO Member States*, WORLD HEALTH ORG. [WHO], https://www.who.int/choice/demography/by_country/en/ [<https://perma.cc/76D3-HKGW>].

220. G.A. Res. 70/1 at 14 (Sept. 25, 2015).

221. *Id.*

222. See *id.* at 16.

223. See *Sustainable Development Goals Officially Adopted by 193 Countries*, U.N. IN CHINA (Sept. 27), <http://www.un.org.cn/info/6/620.html> [<https://perma.cc/FB8E-VJLR>] (noting that all U.N. countries, including Zimbabwe and the United States, signed onto the goals).

Social and Cultural Rights (ICESCR).²²⁴ The ICESCR mandates states parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.²²⁵ While Zimbabwe ratified the key instruments that guarantee the right to health, both at the regional level (the ACHPR ratified in 1986) and United Nations level (the Convention on the Rights of the Child ratified in 1990 and the ICESCR ratified in 1991), the United States failed to ratify both the Convention on the Rights of the Child and the ICESCR.²²⁶

Technically, this may mean that the United States is not fully bound by the ICESCR and the Convention on the Rights of the Child until it ratifies. However, the Vienna Convention on the Law of Treaties places upon signatory states the obligation not to defeat the object and purpose of a treaty prior to its entry into force.²²⁷ Therefore, it is important to assess whether the United States is bound by the ICESCR, and if so, the extent of such an obligation.

The Vienna Convention on the Law of Treaties (Vienna Convention) requires states to desist from acts that would defeat the object and purpose of a treaty when a state has: (1) signed the treaty or has exchanged instruments constituting the treaty subject to ratification, acceptance or approval, until it shall have made its intention clear not to become a party to the treaty or (2) expressed its consent to be bound by the treaty, pending the treaty's entry into force and provided that such entry into force is not unduly delayed.²²⁸ The object of Article 18 of the Vienna Convention is to safeguard the member states' legitimate expectation that during the treaty-making process a state that has accepted a treaty, even in non-binding form, would not work against the object of its acceptance.²²⁹

224. International Covenant on Economic, Social and Cultural Rights, art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].

225. *Id.*

226. See Martha F. Davis, *Bringing It Home: Human Rights Treaties and Economic, Social, and Cultural Rights in the United States*, AM. B. ASS'N (Apr. 1, 2015), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/2015-vol-41-vol-41-no-2-human-rights-at-home/bringing-it-home-human-rights-treaties-and-economic-social-an/ [https://perma.cc/K3TS-5C57].

227. VIENNA CONVENTION ON THE LAW OF TREATIES: A COMMENTARY 383 (Olivier Corten et al. eds., 2011).

228. Vienna Convention on the Law of Treaties, art. 18, May 23, 1969, 1155 U.N.T.S. 331.

229. See VIENNA CONVENTION ON THE LAW OF TREATIES: A COMMENTARY 379 (Olivier Corten et al. eds., 2011).

In 1926, the Permanent Court of International Justice in the Case concerning Certain German interests in Polish Upper Silesia laid down the custom, which was later codified as Article 18 of the Vienna Convention, when it stated that a signatory state's misuse of its rights prior to ratification may amount to a violation of the treaty obligations.²³⁰ Similarly, in the case of *Öcalan v. Turkey*, the European Court of Human Rights upheld the same notion when it ruled that Turkey complied with its interim obligation pursuant to Article 18 by suspending the implementation of capital sentences after signing Protocol No. 6 to the European Court of Human Rights.²³¹

Therefore, rule against defeating the object and purpose of a treaty is regarded as customary international law as later codified in Article 18 of the Vienna Convention on the Law of Treaties. It is on these grounds that the United States is bound, as some scholars would say, by means of reduced obligation to uphold the very essence of the ICESCR, thus, not to render its entry into force de facto meaningless.²³²

Economic, social, and cultural rights create both negative and positive duties for states. The Committee on ESCR lists three obligations that states are expected to discharge in respect to the right to health including the obligation to *respect*, obligation to *protect*, and obligation to *fulfil*.²³³ The African Commission agrees with these obligations in the realization of socioeconomic rights and recognizes an additional duty to *promote*.²³⁴ The details and possible ways in which these obligations can be extended towards people with substance use disorders will be explored later in this Article.

Violations of the above obligations can occur through failure to honor the above obligations by acts of commission or omission. Acts of commission usually occur when a state enacts retrogressive policies that are incompatible with the core obligations under the right to health or policies that are manifestly inconsistent with pre-existing domestic or international legal obligations regarding the right to health.²³⁵ On the other hand, violations that occur by acts of omission include the failure to take appropriate steps

230. Case concerning Certain German interests in Polish Upper Silesia (Ger. v. Pol.), Judgment, 1926 P.C.I.J. (ser. A) No. 7, at 40 (May 25).

231. *Öcalan v. Turkey*, App. No. 46221/99, (May 12, 2015), <http://hudoc.echr.coe.int/eng?i=001-69022>.

232. See VIENNA CONVENTION ON THE LAW OF TREATIES: A COMMENTARY 397 (Olivier Corten et al. eds., 2011).

233. Comm. on Econ., Soc. and Cultural Rts, Rep. on Its Twenty-Second Session, U.N. Doc. E/C.12/2000/4, at ¶ 33 (2000).

234. See African (Banjul) Charter on Human and People's Rights, June 27, 1981, 21 I.L.M. 58 (entered into force Oct. 21, 1986).

235. Comm. on Econ., Soc., & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4, ¶ 48 (Aug. 11, 2000) [hereinafter General Comment No. 14].

towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health.²³⁶

Before a state's conduct qualifies as a violation of the ICESCR, a distinction must be made between a state's inability to guarantee the right to health and its unwillingness to do so. While such inability may be the result of a lack of resources, a state's unwillingness to maximize its resources or take steps towards the realization of economic, social, and cultural rights may be a violation of its human rights obligations.²³⁷

The ICESCR implicitly acknowledges that, in some instances, limited resources may hamper the immediate and full realization of human rights. Under Article 2(1), member states should take steps "to the maximum of its available resources with a view to achieving progressively the full realization of the rights recognized."²³⁸ This means that a government must do all that it can to mobilize resources within the country in order to have funds available to progressively realize economic, social, and cultural rights. Similarly, the concept of progressive realization was also adopted by the African Commission on Human and Peoples' Rights in Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights when it placed the obligation on states to progressively and constantly move towards the full realization of economic, social, and cultural rights within the resources available.²³⁹

The elasticity provided by the principle of progressive realization is neither absolute nor does it give states unfettered discretion to decide when and how a right recognized at the international level should be implemented at the domestic level. There are instances when immediate realization is required instead of progressive realization. This is particularly so with some aspects of the right to health.²⁴⁰ The Committee on ECSR explains, "States parties have immediate obligations in relation to the right to health,"

236. *Id.* ¶ 49.

237. *Id.* ¶ 47.

238. ICESCR, *supra* note 224, art. 2, ¶ 1.

239. African Comm'n on Hum. and Peoples' Rts., *Principles and Guidelines on the Implementation of Economic, Social, and Cultural Rights in the African Charter on Human and Peoples' Rights*, ¶ 13 (May 26, 2010) (emphasis added), https://www.achpr.org/public/Document/file/English/achpr_instr_guide_draft_esc_rights_eng.pdf [<https://perma.cc/X797-6GWJ>].

240. See General Comment No. 14, *supra* note 235, at ¶ 30.

to ensure that it “is exercised without discrimination of any kind,” and “the obligation to take steps . . . towards the full realization of Article 12.”²⁴¹

Accordingly, this implies that if the right of addicts to health care is operationalized at the international level, extending this right to people with substance abuse disorders at the domestic level in Zimbabwe and the United States would not be subject to the countries’ discretion but is mandatory, since failure to do so would discriminate the addicts thereby violating the immediate obligation imposed on states.²⁴²

IV. EXTENDING THE STATES’ OBLIGATIONS TO COVER DRUG ADDICTION

A. *The Obligation to Respect*

The obligation to respect, as included in the ICESCR, requires states to ensure everyone’s equal access to their socioeconomic rights.²⁴³ This obligation also includes a state’s obligation to desist from prohibiting or impeding traditional preventive care, healing practices, and medicines.²⁴⁴ The obligation to respect coincides with Article 2 (2) of the ICESCR, which requires member states to guarantee socioeconomic rights “without discrimination.”²⁴⁵ States discharge the obligation to respect by ensuring that socioeconomic rights are extended to all persons without discrimination. In the context of the right to health, states should be expected to indiscriminately extend preventive, curative, and palliative health services to all persons without discrimination.²⁴⁶

The ICESCR requires states to guarantee that the rights enshrined in the “Covenant will be exercised *without discrimination* of any kind as to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”²⁴⁷ The Committee on Economic, Social and Cultural Rights prohibits “any discrimination in access to health care and underlying determinants of health.”²⁴⁸ It further includes “health status” as prohibited grounds of discrimination.²⁴⁹ Furthermore, the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights state that the grounds of discrimination listed

241. *Id.*

242. *See id.*

243. ICESCR, *supra* note 224, art. 3.

244. General Comment No. 14, *supra* note 235, ¶ 34.

245. ICESCR, *supra* note 224, art. 2, ¶ 2.

246. General Comment No. 14, *supra* note 235.

247. ICESCR, *supra* note 224, art. 2, ¶ 2.

248. General Comment No. 14, *supra* note 235, ¶ 18.

249. *Id.*

above are not exhaustive.²⁵⁰ Similarly, the African Charter prohibits any discrimination in the enjoyment of the protected rights on the following non-exhaustive grounds including race, ethnic group, color, sex/gender, language, religion, political or any other opinion, national and social origin, economic status and birth.²⁵¹

The open-endedness of the grounds for discrimination serves the purpose of promoting the equal enjoyment or exercise of the right to health. This leaves room for the incorporation of substance use disorders or addiction into the category of health statuses to which discrimination is prohibited by both the ACHPR and ICESCR.²⁵² For this to be done, a preliminary question that must be addressed is whether addiction is a health status.

Over the years, neuroscience and behavioral science research have demonstrated how drug use has well-known, severe negative consequences for mental and physical health.²⁵³ In the United States, the National Institute on Drug Abuse, the U.S. Substance Abuse and Mental Health Services Administration, and the Clinical Trials Network through collaborative efforts have promoted the perspective that addiction is a treatable medical condition.²⁵⁴ Through research, these organizations revealed that brain structures and brain chemistry levels can be altered by drug use and addiction.²⁵⁵ Consequently, “the cognitive, decision-making, memory, and impulse-control capabilities of addicted individuals [are] impaired and their brains [become] ‘injured.’”²⁵⁶

Considering the disseminated science that has unearthed addiction as a disease, it is important to adopt an innovative interpretation of the ICESCR that would allow people with substance use disorders to be treated within the public health system without discrimination. This is consistent with the Committee on ECSR’s requirement that member states “adopt and

250. U.N. Econ. & Soc. Council, Comm’n on Hum. Rts., The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, ¶ 36, U.N. Doc. E/CN.4/1987/17 (Jan. 8, 1987) [hereinafter Limburg Principles].

251. See African (Banjul) Charter on Human and People’s Rights, June 27, 1981, 21 I.L.M. 58 (entered into force Oct. 21, 1986).

252. Paul Hunt et al., *Neglected Diseases: A Human Rights Analysis*, WORLD HEALTH ORG. [WHO] 8 (2007), https://apps.who.int/iris/bitstream/handle/10665/43696/9789241563420_eng.pdf?sequence=1&isAllowed=y.

253. Alan I. Leshner, *Addiction is a Brain Disease, and it Matters*, 278 SCIENCE 45, 45 (1997).

254. Rawson et al., *supra* note 18, at 3.

255. *Id.* at 5.

256. *Id.*

implement national public health strategies founded upon epidemiological evidence, addressing the health concerns of the whole population.”²⁵⁷

Along the same line, the Limburg Principles further call for “special measures to be taken for the sole purpose of advancing the interests of certain groups and to ensure that these groups enjoy economic, social and cultural rights.”²⁵⁸ Eliminating the traditional discrimination against drug addicts by including substance abuse as a health status, to be addressed in the health system without discrimination, could be interpreted as a “special measure” that is “taken for the sole purpose of securing adequate advancement of a certain group.”²⁵⁹ Still, this is in concord with the obligation to respect the right to health.

The Vienna Convention on the Law of Treaties requires treaties to be “interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose.”²⁶⁰ Classifying drug users as a vulnerable group entitled to the right to health without discrimination, therefore, realizes the object and purpose of the treaty, which is to respect the right to health by refraining from denying or limiting equal access for all persons, including addicts, to health services.²⁶¹

B. The Obligation to Protect

Under the obligation to protect, states are required to take positive measures to ensure that third parties do not violate economic, social, and cultural rights.²⁶² The state can play a regulatory role in the conduct of non-state actors whose operations affect people’s access to and equal enjoyment of economic, social, and cultural right by ensuring the effective implementation of relevant legislation and programs, and providing remedies for such violations.²⁶³ The Committee on the ESCR identified failure by the state to discourage the production, marketing, and consumption of tobacco, narcotics, and other harmful substances as a violation of the obligation to protect.²⁶⁴

257. See General Comment No. 14, *supra* note 235.

258. See Limburg Principles, *supra* note 250, at 127.

259. *Id.*

260. Vienna Convention on the Law of Treaties, art. 31, May 23, 1969, 1151 U.N.T.S. 331.

261. See ICESCR, *supra* note 224.

262. See General Comment No. 14, *supra* note 235, ¶ 51.

263. See African (Banjul) Charter on Human and People’s Rights, art. 1, June 27, 1981, 21 I.L.M. 58 (entered into force Oct. 21, 1986).

264. See General Comment No. 14, *supra* note 235.

The discharge of the obligation to protect is commendably exemplified by the United States through its efforts aimed at reducing the problem of opioid abuse. In recognition of the opioid epidemic's devastating effects on American lives, families, and communities, the Centers for Disease Control and Prevention (CDC) developed guidelines regarding opioid prescriptions for chronic pain.²⁶⁵ The guidelines provide recommendations to improve patient care and safety as follows: (1) "Non-opioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care;" (2) "Clinicians should always exercise caution when prescribing opioids and monitor all patients closely;" (3) "When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose."²⁶⁶

Other ways in which the obligation to protect can be executed by the government is through the formation of mechanisms that ensure drug companies include information on drug labels and provide medication guides describing how patients can safely use the drug.²⁶⁷ Comparably, the U.S. Food and Drug Administration (FDA) could limit the opioid marketing for situations where risks of use outweigh potential benefits.²⁶⁸ States aligned with the obligation to protect should also ensure that health insurance provided by third parties is accessible to everyone, including addicts. However, one problem is that much of the responsibility for drugs and health falls to individual states in the United States.

Meanwhile in Zimbabwe, the Concluding Observations of the Committee on Economic, Social and Cultural Rights indicate that the country did not provide any written answers to the Committee's questions relating to the

265. *CDC Guideline for Prescribing Opioids for Chronic Pain*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-a.pdf [<https://perma.cc/6DM5-SDVC>] [hereinafter *CDC Guidelines*]. The CDC is a United States federal agency under the Department of Health and Human Services. *About CDC 24-7: CDC Organization*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/about/organization/cio.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fabout%2Forganization%2Findex.html [<https://perma.cc/GW6L-9Y45>].

266. *CDC Guidelines*, *supra* note 265.

267. *See, e.g., Guide to Drug Safety Terms at FDA*, U.S. FOOD AND DRUG ADMIN., Nov. 2017, at 2, <https://www.fda.gov/media/74382/download> [<https://perma.cc/7MZA-78XT>].

268. *See* German Lopez, *How to Stop the Deadliest Drug Overdose Crisis in American History*, VOX (Dec. 21, 2017), <https://www.vox.com/science-and-health/2017/8/1/15746780/opioid-epidemic-end> [<https://perma.cc/NM5A-EADW>].

implementation of Article 12 of the ICESCR.²⁶⁹ The Committee further observed that the ICESCR could not be invoked directly before Zimbabwean courts.²⁷⁰ Contrary to the United States, where measures such as the ACA ensure equal treatment of addicts, Zimbabwe lacks a comprehensive public health provision or other legislative measures that ensure addicts are equally treated.²⁷¹ This could be grounds for concluding that Zimbabwe, by omission, violated the obligation to protect by failing to take appropriate steps towards addicts' full realization of the right to the enjoyment of the highest attainable standard of physical and mental health as required by Article 12 (1) of the ICESCR.²⁷²

C. *Obligation to Fulfil*

The obligation to fulfil economic, social, and cultural rights is a “positive expectation” that requires member states to take steps to advance the realization of these rights.²⁷³ The obligation to fulfil is ongoing in nature since it requires states to continually aim at improving the range of individuals, communities, and groups who have access to the relevant rights as well as the quality of enjoyment.²⁷⁴ Under this obligation, states are mandated to take measures to ensure that each person within its jurisdiction may obtain basic economic, social, and cultural rights. Generally, States are required “to take legislative, administrative, budgetary, judicial and other measures that contribute towards the full realization of rights, including by means of international assistance and cooperation.”²⁷⁵

With respect to the right to health, the obligation to fulfil requires states to take steps that help individuals and communities enjoy the right to health. These steps, which should maintain and restore the health of the population, include: (1) spreading the awareness of factors that foster positive health results (e.g., research and provision of information); (2) training healthcare staff to identify and respond to the specific needs of vulnerable or marginalized

269. Comm. on Econ., Soc. and Cultural Rts., Concluding Observations of the Committee on Economic, Social and Cultural Rights, ¶ 9, U.N. Doc. E/C.12/1/Add.12 (May 20, 1997).

270. *Id.*

271. *Id.*

272. *Id.* ¶ 9, at 2.

273. General Comment No. 14, *supra* note 235, ¶ 36–37.

274. *See id.*

275. Int'l Comm'n of Jurists, *State Obligations Stemming from International Law*, <https://www.icj.org/chapter-2-esc-rights-under-international-law-and-the-role-of-judicial-and-quasi-judicial-bodies-2/2-3-identifying-breaches-of-international-obligations-of-states-pertaining-to-esc-rights/2-3-1-state-obligations-stemming-from-international-law/> [https://perma.cc/65X7-6DW7].

groups; and (3) ensuring that the state meets its obligations in the dissemination of appropriate information relating to healthy lifestyles.²⁷⁶

As demonstrated earlier, treatment of addiction as a brain disease is still a new and often contested hypothesis. The obligation to fulfil could be a viable medium through which the urgently needed research and infrastructure can be achieved for the purposes of transforming substance abuse treatment systems. This is mostly required in Zimbabwe where drug abuse and addiction are largely still addressed through the criminal justice system as depicted in Table 1. Pursuant to the obligation to fulfil, research and dissemination of information by the state, based on a belief in and respect for the right to health for addicts, can be used to create a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use.²⁷⁷

The evidence-based approach adopted in Lebanon in response to drug addiction exemplifies the efficiency of using research and dissemination of science in honor of the obligation to fulfil to come up with an effective medication to addiction.²⁷⁸ Following a devastating rise in opioid addiction, the Lebanese government funded research to decide whether to introduce buprenorphine into Lebanon because no medication-assisted treatment had been available.²⁷⁹ The research analyzed the results associated with methadone and buprenorphine in Europe and the United States.²⁸⁰ Evidence of buprenorphine's flexibility in administration and service delivery made it the preferable agonist medication to introduce into Lebanon.²⁸¹ Subsequently, the Lebanese government approved the use of buprenorphine.²⁸² This was followed by a groundbreaking increase in the number of patients who recovered from addiction and an unprecedented expansion of treatment services for addicts.²⁸³

276. General Comment No. 14, *supra* note 235, ¶ 37.

277. *See id.*

278. *See* Rawson et al., *supra* note 18, at 13.

279. *See id.* at 11–13.

280. *See id.* at 5.

281. *Id.* at 10.

282. *Id.*

283. *See id.* at 12–13.

D. The Duty to Promote (Under the ACHPR)

The African Commission on Human and Peoples' Rights places the fourth duty on states to promote economic, social, and cultural rights.²⁸⁴ Under this duty, states are required to adopt measures to promote people's awareness of their rights and to provide access to information regarding the programs and institutions adopted to realize these rights.²⁸⁵ This aligns with Article 25 of the African Charter which explicitly obligates member states "to promote and ensure through teaching, education and publication, the respect of the rights and freedoms contained in the present Charter and to see to it that these freedoms and rights as well as corresponding obligations and duties are understood."²⁸⁶ The obligation to promote further encompasses training the judiciary and administrative officials on economic, social, and cultural rights.²⁸⁷

Judicial involvement in protecting socioeconomic rights is a possible way to carry out the duty to promote socioeconomic rights, which includes the right to health. This is particularly relevant to Zimbabwe where such rights are not justiciable. While other rights, such as freedoms of speech and religion, create an absolute duty on the government to ensure protection for everyone who needs them. Socioeconomic rights, including the right to health in Zimbabwe, were not subject to judicial enforcement until 2013. In order to address the historical anomaly of neglecting socioeconomic rights, Zimbabwe expressly protects socioeconomic rights as justiciable rights in their Bill of Rights in its new constitution adopted in 2013.²⁸⁸

In the few cases involving socioeconomic rights, the Zimbabwean courts have displayed indifference to the historical absence of judicial mechanisms to safeguard socioeconomic rights, including the right to health.²⁸⁹ In the landmark case, *Soobramoney v. Minister of Health, KwaZulu-Natal*, the Constitutional Court of South Africa demonstrated its promotion of the right to health through the judiciary's enforcement.²⁹⁰ In *Soobramoney*,

284. African Comm'n on Hum. and Peoples' Rts., *supra* note 239, at 11.

285. *Id.*

286. *Id.* art. 25.

287. *See id.*

288. *See* Constitution of Zimbabwe Amendment (No. 20) Act, 2013, ch. 4.

289. *See* Elaine Sullivan, *Zimbabwe Lawyers for Human Rights*, SILO.TIPS (Nov. 4, 2016), <https://silo.tips/download/zimbabwe-lawyers-for-human-rights> [<https://perma.cc/5HYA-68RN>] (explaining the court's holding in the case of *Dare Remusha Cooperative v. The Minister of Local Government, Public Works, and Urban Development* where the court dismissed an injunction application to stop the continued violent destruction of homes because the public policy considerations in eviction and the destruction of homes far outweighed the interests of the terms of their leases and manner of settlement).

290. *Soobramoney v. Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC) (S. Afr.).

the court held that in all the open and democratic societies based upon dignity, freedom, and equality (which the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with) it is the state's duty to effectuate a human rights approach to health care. The State can execute this duty by managing its limited resources in order to address the right to health.²⁹¹ If Zimbabwe adopts this approach, the courts can be instrumental in promoting the right to health of addicts through judgments that are not only punitive, but also enforce the right to health for people with substance use disorders.²⁹²

V. THE CONVENTION ON THE RIGHTS OF A CHILD AND OPIOID ADDICTION

The Convention on the Rights of the Child (CRC) is another source that affirms the right to health.²⁹³ Under the CRC, member states are required to recognize the right of the child to enjoy the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health.²⁹⁴ Measures that a state is expected to fulfill under the CRC include diminishing infant and child mortality and ensuring that mothers receive appropriate pre-natal and post-natal health care.²⁹⁵ Additionally, member states are required to protect every child's inherent right to life and ensure the survival and development of the child to the maximum extent possible.²⁹⁶

The Committee on the Rights of the Child recognized the need to prevent high infant mortality rates during the neonatal period as caused by mothers' poor health before and during pregnancy.²⁹⁷ The Committee further stated that children's health is majorly impacted by the health and health-related behaviors of parents and other significant adults.²⁹⁸ Accordingly, this calls

291. *Id.* ¶ 52.

292. *See* NTANDOKAYISE NDHLOVU, PROTECTION OF SOCIO-ECONOMIC RIGHTS IN ZIMBABWE, A CRITICAL ASSESSMENT OF THE DOMESTIC FRAMEWORK UNDER THE 2013 CONSTITUTION OF ZIMBABWE 19–20 (2016).

293. United Nations Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3.

294. *Id.* art. 24.

295. *Id.* art. 24 (2)(d).

296. *Id.* art. 6.

297. *See* U.N. Committee on the Rights of the Child, General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, art. 24, CRC/C/GC/15 (Apr. 17, 2013) [hereinafter General Comment No. 15].

298. *Id.*

for the realization of the mother's right to health and the role of parents and other caregivers.

The above comment from the Committee speaks directly to the situation in the United States where mothers who use opioids during pregnancy usually give birth to drug dependent babies. Experts call this "neonatal abstinence syndrome" (NAS), a condition where a newborn suffers from withdrawal symptoms due to prenatal exposure to drugs.²⁹⁹ The symptoms include excessive crying, sweating, tremors, and frequent yawning.³⁰⁰ The National Institute on Drug Abuse reported that at least one baby is born every 15 minutes suffering from NAS.³⁰¹ Further, in 2012, an estimated 22,000 infants were born affected by NAS.³⁰²

At Cabell Huntington Hospital in West Virginia, 1 in 5 newborns has been exposed to opioids in the womb.³⁰³ A related study conducted in Ireland revealed that parents who struggle with opioid addiction cannot provide adequate parental support and care for the child both physically or emotionally.³⁰⁴ This is caused by the parents' preoccupation with the supply and acquisition of drugs, the consequences of intoxication, withdrawal syndrome, and instability of moods.³⁰⁵ The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."³⁰⁶ Therefore, the inability of parents to provide physical and emotional care to their children affects the child's social wellbeing which is detrimental to the child's health.

299. *Neonatal Abstinence Syndrome (NAS)*, BOSTON CHILDREN'S HOSPITAL, <http://www.childrenshospital.org/conditions-and-treatments/conditions/n/neonatal-abstinence-syndrome-nas#:~:text=What%20is%20neonatal%20abstinence%20syndrome,and%20area%20of%20the%20country> [https://perma.cc/KE9L-2Q7N].

300. *Testing & Diagnosis for Neonatal Abstinence Syndrome (NAS) in Children*, BOSTON CHILDREN'S HOSPITAL, <http://www.childrenshospital.org/conditions-and-treatments/conditions/n/neonatal-abstinence-syndrome-nas/testing-and-diagnosis> [https://perma.cc/NYU2-RYQV].

301. *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome*, NAT'L INST. ON DRUG ABUSE (Jan. 22, 2019), <https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome> [https://perma.cc/RA2P-E6BD].

302. *Advancing Research of Effect of Maternal Opioid Exposure on Developing Brain*, NAT'L INST. ON DRUG ABUSE (Oct. 24, 2017), <https://www.drugabuse.gov/about-nida/organization/cross-cutting-research-teams-workgroups-interest-groups-consortia/brain-development-research-consortium-0/advancing-research-effect-maternal-opioid-exposure-developing-brain> [https://perma.cc/45PH-BHD8].

303. Laura Santhanam, *Saving the Babies of the Opioid Epidemic*, PBS NEWS HOUR (Oct. 2, 2017), <https://www.pbs.org/newshour/nation/saving-babies-opioid-epidemic> [https://perma.cc/RA2P-E6BD].

304. U.N. Office on Drugs and Crime, *World Drug Report*, 68; Sales No. E.16.XI.7 (2016).

305. *Id.*

306. Constitution of the World Health Organization, Apr. 7, 1948, 14 U.N.T.S. 186.

A survey by the University of Montana revealed that addicted women have the best chance of getting off drugs during pregnancy, but addicted women are often discouraged from seeking help out of fear that their babies will be taken away.³⁰⁷ Without necessary medical support, weaning off drugs is often not possible. For most medical practitioners, providing care for addicts is not very lucrative, so very few doctors are committed to treating pregnant women who struggle with addictions.³⁰⁸ Moreover, few places offer health care for addicted mothers, and most mothers end up in jail when their children are taken away from them after birth.³⁰⁹

In order to combat NAS incidences in the United States, lessons can be drawn from Tennessee where adopted measures aim to curb both the consequences of opioid abuse and NAS. In Tennessee, awareness of incidence among neonatal providers increased due to the introduction of the Tennessee Prescription Safety Act of 2012, which requires prescribers to register with the Controlled Substances Monitoring Database.³¹⁰ Additionally, the NAS Subcabinet Working Group was introduced with members comprised of the Public Health Department, Children's Services, and Human Services.³¹¹ The Subcabinet Working Group takes a supportive rather than punitive approach.³¹² Focus is placed on preventive methods such as limitations on the available quantity of prescription drugs, prevention of drug addiction during pregnancy, and the requirement for counseling as part of prior authorization to access opioids and secondary preventive methods that include minimizing complications for addicted women and their neonates.³¹³

VI. CONCLUSION

The central hypothesis posited in this Article is that substance addiction is a disease of the brain, yet the global response to this public health crisis

307. Clare Menehan, *UM Investigates Pregnancy and Opioid Use in Montana*, MONT. PUB. RADIO (Dec. 27, 2017), <https://www.mtpr.org/post/um-investigates-pregnancy-and-opioid-use-montana> [<https://perma.cc/AE36-QJYF>].

308. *Id.*

309. *Id.*

310. Tennessee Prescription Safety Act of 2012, 2012 Tenn. Pub. Acts 880; Michael Warren, *Reducing Neonatal Abstinence Syndrome: Tennessee's Experience*, CHILDREN'S SAFETY NETWORK (Nov. 26, 2012), <https://www.childrenssafetynetwork.org/sites/childrenssafetynetwork.org/files/NeonatalAbstinence112612.pdf> [<https://perma.cc/724W-YLMD>].

311. *Id.*

312. *Id.*

313. *Id.*

is primarily rooted in the criminal justice system, which is vastly punitive to addicts. Through groundbreaking scientific evidence, the global attitude towards drug addiction has been revolutionized to address addiction as a public health issue rather than a criminal justice problem addressed through a punitive approach. Accordingly, developing and developed countries continue to depart from purely punitive approaches and instead adopt curative responses to addiction—although at different paces as exemplified by Zimbabwe and the United States of America. Key United Nations and regional human rights instruments mandate that countries protect, promote, fulfil, and respect every citizens' right to health. This right to health presupposes people suffering from any known diseases, including substance use disorders. As such, countries must effectively develop their legal instruments to extend and safeguard the fundamental human right to health for those suffering from substance use disorders.