Applying the Convention on the Rights of the Child to Work with Young People and Drugs

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Introduction

In the field of international human rights law the UN Convention on the Rights of the Child (CRC) has been one of the most influential treaties. It was adopted by the UN General Assembly on November 20, 1989 after ten years of drafting and today this instrument has been ratified by 193 States[1]. The CRC was the first legally binding international instrument to incorporate the full range of human rights—civil, cultural, economic, political and social rights. Three Optional Protocols were added later dealing with specific issues (respectively child soldiers[2], child prostitution[3] and a complaint procedure[4]).

The CRC spells out the basic human rights that children everywhere have and sets out core principles that underpin all of these rights (non-discrimination, the best interests of the child as a primary consideration, the right to life, survival and development and respect for the views of the child). That the CRC formalises that children can express their opinions, and that these will be taken into account, was new in 1989. In the course of the 20th Century children became not only *objects of rights* to be protected but also *subjects of rights* to be exercised.

The Convention is intended to protect children's rights by setting standards in education and for legal-, civil- and social services, including health care. By agreeing to undertake the obligations of the Convention (by signing and then ratifying or acceding to it), States parties have committed themselves to respect, protect and fulfil the rights it contains. Since the CRC came into force, the implementation of children's rights in different countries can now be monitored in a systematic way, via the periodic

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[1] Only Somalia and the United States have not ratified the CRC. In 2002, the United States ratified two Optional Protocols to the Convention on the Rights of the Child-one on the involvement of children in armed conflict (child soldiers) and another on the sale of children, child prostitution and child pornography (for the OP's see note 2, 3 and 4).

[2] *Optional Protocol to the Convention on the Rights of the Child on the Involvement of children in armed conflict*, 25 May (2000), General Assembly resolution A/RES/54/263.

[3] *Optional Protocol to the Convention on the rights of the Child on the sale of children, child prostitution and child pornography*, 25 May (2000), Also adopted by General Assembly resolution A/RES/54/263.

[4] *Optional Protocol to the Convention on the Rights of the Child on a Communications Procedure (OPIC),* 19.12.2011. To learn more about the new Optional Protocol, visit: http://www2.ohchr.org/english/bodies/hrcouncil/OEWG/index.htm

reporting process, whereby States parties must report on progress to the UN Committee on the Rights of the Child every five years.[5]

From the moment of the adoption of the CRC and its widespread ratification, the CRC has led to the amendments of constitutional provisions, the introduction and revision of national laws in many countries; the development of policies across a range of issues reflecting child rights provisions; the strengthening children's protection rights and introducing participation rights; the proliferation of national ombudsmen for children[6]; and increased disaggregated data collection and gave a push to attempts to measure progress or decline with the help of child well-being indicators[7].

The 'discovery' of the importance of the CRC for the field of drug policy, however, is new[8]. This is odd as drugs are explicitly addressed in the CRC, which sets it apart from the other core UN human rights treaties. The text of this article reads as follows:

'States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties and to prevent the use of children in the illicit production and trafficking of such substances'.

During the drafting process of the CRC China had proposed the words 'preventing and prohibiting the child from using drugs'.[9] this was rejected, however, in favour of a broader protection focus[10] and the words '*to protect children from...'* were the ones making it to the final article 33. This leads to a broader reading of the provision in relation to drug use. Throughout policy discussions, however, primary prevention (i.e. stopping the uptake of drug use in the first place) dominates in relation to children and

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[5] Yanghee Lee, Introduction: Celebrating important milestones for children's and their rights, *International Journal on the Rights of the Child*, (2010) 18, No. 4, 479-482.

[6] Ombudsmen are not mentioned in the CRC, but the idea of establishing independent spokespersons for children got wind in the sails by the adoption of the CRC. The first ombudsman was appointed by the Norwegian Parliament. She described her pioneering work in: Malfrid Grude Flekkoy, *A Voice for Children; Speaking out as their ombudsman*, New York, 1991, Unicef. The European ombudsmen for children have an informative website: www.ombudsman.europa.eu

[7] Asher Ben-Arieh, The Child Indicators Movement: Past, Present and Future, *Child Indicators Research*, 1,1, (2008), 3-16. Comparing data is not an easy matter. See: Judith Ennew and Per Miljeteig, Indicators for children's rights: progress report on a project, *International Journal of Children's Rights*, (1996), 4, 213-236.

[8] Damon Barrett and Philip Veerman, Children who use Drugs: The Need for More Clarity on state Obligations in International Law, *International Journal on Human Rights and Drug P*olicy, 2011, vol.1., pp. 63-82. And: Damon Barrett and Philip Veerman, *Commentary on the CRC article 33: Protection from the Use of Illicit Drugs*, Leiden, Brill, 2012. See also: CRIN, *Children and Drugs Fact file*, Published by Child Rights Information Network (CRIN), London , 2010. www.crin.org

[9] E/CN.4/198330Add.1.para 118).

[10] E/CN4./1986/WG.1., page 31. See also: HCHR, *Legislative History of the Convention on the Rights of the Child*, Vol.II, New York and Geneva, 2007, United Nations, 709-712.

young people[11], maybe the drafters at the Palais des Nations in Geneva found it hard to think that children can become dependent on drugs. This is important, but the CRC's protections should not be equated with it or limited to it.

The UN Committee on the Rights of the Child started only in recent years to give more attention to children and drugs in their dialogues with States parties. The "late discovery" by the Committee of the issue of drugs (although a special article was dedicated to the issue in the CRC) is perhaps a result of the comprehensive nature of the CRC, covering over forty substantive rights. Very little input has been received by the Committee from NGOs on drug-related issues, and there has been little expertise on drugs among the Committee's membership. Whatever the reason that attention to drug-related issues was weak at the Committee, the result is that the CRC's influence on drug policies at national level has been minimal. In addition, normative guidance from the Committee on the Rights of the Child on these topics is still patchy. Little appears in academic literature on drugs and the CRC, and drug policies have traditionally not been prominent concerns of mainstream child rights organisations.

So there we are: after 23 years since the CRC was adopted *children's rights and drugs* is still a new issue for the Committee on the Rights of the Child and children's rights organisations. In turn, however, those working in addiction psychology and psychiatry itself have not shown much interest in the CRC.

In the field of work with children and adolescents who are starting to experiment with drugs, misuse drugs or who have become dependent on them, the CRC has not traditionally guided how to shape these services, and seems distant from the realities practitioners face. I will try to review parts of the work with these children and adolescents and try to describe the importance of the CRC for this area of mental health work.

What are 'appropriate measures' for treatment from a child's rights perspective?

According to the CRC, States parties are legal bound to take 'all appropriate measures' to protect children from the illicit use of drugs. The questions therefore arises as to what are 'appropriate measures' from a child rights perspective?

In a previous paper with Damon Barrett[12] I have set out five tests of what might be 'appropriate':

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[11] See for example, '*Youth and Drugs: A Global Overview, Report of the Secretariat*', (UN Doc No E/CN.7/1999/8, 1999) and INCB, *Report of the International Narcotics Control Board for 2009*, (UN Doc No E/INCB/2009/1, 2009) (see especially Chapter I: Primary prevention of drug abuse).

- Such measures must be read in the light of the CRC as a whole, in particular the 'General Principles' and article 5 (evolving capacities)
- They must take into account other laws more conducive to the realisation of the rights of the child
- They must focus on patterns of vulnerability
- They must be evidence based (not arbitrary or irrational)
- They must be proportionate

These principles find support in the CRC itself and in legal concepts.

The General Principles of the CRC and the actual work in the field of addiction

To begin with, appropriate measures must be *read in the light of the remaining articles of the CRC,* in particular the General Principles of the CRC[13] and article 5 (the evolving capacities of the child).

Article 5 describes the importance of the evolving capacities of the child, formulated because the drafters of the Convention recognized that growth is a gradual process and as the child's body and personality grows the child should be able to carry more responsibility and exercise greater autonomy. The perspective of article 5 (the child's evolving capacities) is crucial for the development of child rights-based and child friendly approaches in addiction psychology and psychiatry, as is the principle of 'the best interests of the child' which underpins the entire CRC and is reflected in article 3. With these principles in mind, for example, Bouman mental health[14] (where I work) opened several *special* outpatient clinics for adolescents and young adults in the Rotterdam area of the Netherlands. The furniture and interior design has been especially given a lot of thought and they are, we believe, attractive for adolescents. Also the name *Bouman mental health services* which many people in the Rotterdam area associate with 'junkies' (a terrible word which we as professionals never use) has in these locations been replaced by a more neutral brand (YOUZ), in order that parents will be less afraid when their child will come for treatment. Of course there is especially trained staff who specialize in adolescent addiction and psychopathology of adolescents.

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[12] Damon Barrett and Philip Veerman, *Commentary on the CRC article 33: Protection from the Use of Illicit Drugs*, Leiden, Brill,2012

[13] Art 2 (non-discrimination), art 3 (best interests of the child), art 6 (right to life survival and development) and art 12 (right to be heard and have views taken into account). See: Committee on the rights of the Child, Thirty-fourth session, 19 September - 3 October 2003, *General Comment No. 5, General measures of implementation of the Convention on the Rights of the Child* (arts. 4, 42 and 44, para. 6), Geneva, 2003, CRC/GC/2003/5, 27 November 2003.

[14] Bouman mental health is at present in the process of merging with Delta Psychiatric Hospital in the Rotterdam area.

Although the CRC describes the child as every human being below the age of 18 years (unless, under the law applicable to the child the, majority of obtained earlier) in order to account for continuing development and continuity of care, we found it acceptable to make outpatient clinics and clinics for minors also accessible for young adults until they reach 24.

In taking into account the general principles of the CRC for measures to be 'appropriate' they must take into account the child's opinion. When should a child or adolescent, for example, be able to enter treatment without consent of his or her parents? When can they refuse treatment? This is a matter of debate in many States and among practitioners. The Gillick case[15] in the UK has been cited in this context often. This case established that the child's full consent to examination, treatment or assessment is required if he or she 'is of sufficient understanding to make an informed decision'. In the Netherlands although a child under eighteen years of age (a 'minor') can't enter agreements without his parents approval, a child can enter a treatment agreement from 16 years of age. From 12 to 16 years of age the minor's approval is needed as well as the approval of the parents. Under age 12 only the parents can give such an approval. Although the law gives us guidance[16], how to work with parents is not an easy subject and the ''the therapist not only must maintain a shaky therapeutic alliance with the adolescent, but also must maintain one which may be even more tricky with the parents'[17].

The concept 'autonomy' has been found important for the treatment within a child rights perspective. For young people being a *subject of rights* means that they have a certain amount of autonomy. This is reflected throughout the CRC, and is directly related to the above discussion.

The concept of autonomy, we have found, is a central concept in the treatment of adolescent addiction. In the study of human motivation and personality, autonomy is, for instance, connected with the concept of self-determination[18][19]. A central aim of therapy is to restore autonomy or to achieve in the client (for the first time) a feeling of autonomy. In essence, the professional help we provide has the aim that the young person can take life again in his or her own hands.

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[15] *The Weekly Law Reports*, London (1985), 3, 831-875. Or: *The All England Law Reports*, London (1985) 1, 533-559. S. P. De Cruz, Parents, doctors and children: The Gillick case and beyond, *Journal of Social Welfare Law*, (1987) 93-108. See also: M. D. Freeman, Taking Children's Rights Seriously, *Children and Society*, 1987-1988, 4, 299-319.

[16] In the Netherlands this law is called *Wet op de Geneeskundige Behandelovereenkomst (WGBO).*

[17] John E. Meeks, *The Fragile Alliance, an orientation to the outpatient psychotherapy of the adolescent*, Huntington, N. Y, 1980, Robert E. Krieger Publishing Company.

[18] Note, this has a very different meaning in human rights law, relating to the self-determination of peoples, a post-colonialist/imperialist concept, and central to indigenous people's rights.

[19] Richard M. Ryan, Veronika Huta and Edward L. Deci, Living Well: A Self-Determination theory Perspective on Eudaimonia, *Journal of Happiness Studies* (2008) 9, 139-170.

Stephen Arnott[20] found that an empowerment perspective, which is central to children's rights and which we find in working towards restoring autonomy 'attributes competencies to children that enable them to act autonomously in legal proceedings affecting them'[21]. Arnott concluded that 'it may be more productive to view autonomy as latent in the sense that it is present in all persons, including children, but that the capacity to exercise may be restricted'. At Bouman mental health services the concept of autonomy has been central in the treatment plan. But often in our field of work with children and drugs we find ourselves balancing autonomy rights with protection rights. While autonomy must be the aim, in order not to neglect the child, a (legal) protection decision is sometimes needed. Indeed, here there is sometimes a paradox, because hospitalisation (with detoxification) can sometimes be seen as a start of the restoration of autonomy.[22] Here the CRC has a lot to contribute in terms of safeguards and due process. The Committee on the Rights of the Child has, for instance, heavily criticised drug detention centres in Cambodia,[23] while offering more normative guidance on children's involvement (in line with their evolving capacities) in decisions about their own healthcare.[24] It has also applied juvenile justice standards to children deprived of their liberty for drug treatment.[25]

At Bouman mental health a treatment method was developed in which after a day of diagnostic screening[26] the patient will be given a treatment perspective. For young people I believe it is very much in line with a child rights approach. Advice is given after a day of diagnostic work (to understand what is in the best interests of the specific child, rather than arbitrary decisions made en masse or in policy documents – article 3 of the CRC). A treatment perspective will then be linked with the level of autonomy (articles 5 & 12). After a perspective is given the young people know what to expect, which engages them in their own treatment. At Bouman mental health we try to get to the level of restoration of autonomy which is possible to reach. According to the seriousness of the problems and the level of autonomy a 'treatment route' will then be established. For the model of the treatment perspective four levels of autonomy are described, from *temporarily diminished autonomy* till serious and *probably lasting hampered autonomy* (which one of course does not see often with adolescents or young adults, but we do see it in patients who are 40 years on heroin and other drugs). I believe that taking the level

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[20] Stephen R. Arnott, Autonomy, Standing and Children's Rights, *William Mitchell Law Review*, 4, 10(2007), 807-825.
[21] Idem, p.818.
[22] Arthur Caplan, Denying autonomy in order to create it: the paradox of forcing treatment upon addicts, *Addiction*, 103 (12) December (2008) 1919-1921.
[23] Committee on the Rights of the Child, *Concluding Observations: Cambodia* (UN Doc No CRC/C/KHM/CO/2, 2011) paras 55 & 56.
[24] Committee on the Rights of the Child, *General Comment No. 12: the right of the child to be heard*, (UN Doc No CRC/C/GC/12, 2009)
[25] Committee on the Rights of the Child, *General Comment No. 10: Children's rights in juvenile justice* (UN Doc No CRC/C/GC/10, 2007).
[26] To measure autonomy an instrument for the intaker at Bouman mental health was designed (the AOS-V) where the intaker will evaluate the person's autonomic functioning.

of autonomy as one of the starting points for treatment is very much in line with the vision of children as rights bearers in the CRC.

Patterns of vulnerability

What is important to realise is (and this is knowledge from the mental health field and the field of child development) that focused protection is required for certain *vulnerable groups.* Young people in general are to be considered a vulnerable group in relation to drugs and alcohol for multiple reasons, including in relation of physical and psychological development. In addition there are certain groups of young people even more at risk such as young people with mild intellectual disability, or young people who have a parent or parents with a history of addiction or mental health problems. When, for example, there is schizophrenia in the family cannabis use is more likely to lead to psychosis that where there is no schizophrenia in the family[27]. Young people who have experienced trauma are also more at risk.[28]

For young people from these groups the risks of drug related harms tend to be greater because irreversible damage to the still growing brain might be done.

As a matter of effective policy it is wise to aim at reducing the initiation of drug use among children. It is not possible to prevent all drug use – either immediately or even in the long term. The CRC, however, allows for the 'progressive realisation' of rights. The State must, therefore, take measures to progressively reduce the numbers of young people initiating drug use. This is both measureable and outcomes based. The question then comes back to 'appropriate measures' to achieve this. A focus on vulnerability would address the root causes of that vulnerability, which in turn draws on rights protections in the CRC (e.g. freedom from neglect or abuse, article 19). And an evidence-based approach would rule out arbitrary or failed measures such as random school drug testing or 'just say no' general prevention messaging, which are a waste of the taxpayers money.

Within the category of young people, it should be noted, age is important (again in line with evolving capacities). Use of cannabis at an early age, for example, is connected with depression spells[29] and

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[27] Bossong, M.G.; Niesink, R.J.M, Adolescent brain maturation, the endogenous cannabinoid system and he neurobiology of cannabis-induced schizophrenia, *Prog. Neurobiology*, (2010) ,92, (3) 370-385.

[28] Winters, K. C., Latimer, W. W., & Stinchfield, R. W. (2001). Assessing adolescent substance use. In E. Wagner & H. B. Waldron (Eds) *Innovations in adolescent substance abuse interventions*, Amsterdam, Pergamon Elsevier Science, 1-29; . Deykin, E. Y., and Buka, S. L. Prevalence and risk factors for posttraumatic stress disorder among chemically dependent adolescents. *Am J Psychiatry*, (1997)154(6), 752-7.

[29] Graaf, R. De, Radovanovic, M,; Laar, M. Van, Fairman, B., Degenhardt, L., Aguilar-Gaxiola, S.; Bruffaerts, R , De Girolamo, G., Fayyad, J., Early cannabis use and estimated risk of later onset of depression spells: epidemiological

some intensive drug use may lead to cognitive deterioration[30] such as memory loss[31]. Delaying initiation into drug use is therefore important, even if it is not prevented entirely.

Evidence based: Protecting children and adolescents who are currently using drugs

If a child is using drugs then protecting a child from drugs (as required by the CRC) must involve also policies and interventions to protect them from the negative health, education and social harms associated with such use. This relates closely to the child's right to health under article 24 (the child's right to health and health services) of the Convention. As noted above, in order for measures to protect children to be 'appropriate' they must be evidence based (non-arbitrary, not irrational).

Harm reduction is important, and in my view entirely in line with a child protection approach and services delivered in the best interests of the child. As recommended by the Committee on the Rights of the Child in the context of Ukraine recently: 'the State party, in partnership with non-governmental organizations, [should] develop a comprehensive strategy for addressing the alarming situation of drug abuse among children and youth and undertake a broad range of evidence-based measures in line with the Convention, and to develop specialised and youth-friendly drug dependence treatment and harm reduction services for children and young people (...)'[32]. Here the implementation CRC can give a push to establish better quality services.

Harm reduction may involve a reduction in the amount of drugs consumed even if the young person does not cease use entirely. In Australia there is experience with two short interventions to reduce cannabis use in relatively unmotivated young cannabis users or 'non treatment seekers'. Their findings are that some cannabis users will seek treatment without being coerced. Two 60 minute motivational enhancement therapy sessions have shown in Australia that entailing assessment and feedback can

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evidence from the population-based World Health Organization World Mental Health Survey Initiative, in: *American Journal of Epidemiology* (2010), :172, 149-159.

[30] Ersche K. D., Jones PS, Williams G. B., Robbins T. W., Bullmore E.T. (2012), "Cocaine dependence: A fast-track for brain ageing?" *Molecular Psychiatry* E-pub 25 April 2012.

[31] Robbins T. W., Ersche K .D., Everitt B.J. (2008), "Drug addiction and the memory systems of the brain" *New York Academy of Science* 1141:1-21.

[32] Committee on the Rights of the Child, *Concluding Observations: Ukraine*, Geneva, 3.2. 2011, CRC/C/UKR/ CO/3-4.

effectively reduce cannabis use[33]. Personal feedback, possibly in combination with motivational interviewing[34], seems to be an effective intervention in an early stage[35].

'Accurate and objective' information is a consistent recommendation of the Committee on the Rights of the Child about Drugs. While the Committee has not addressed it specifically, it seems consistent that information (to which the child has an explicit right in the CRC) is needed about the different drugs (cannabis, cocaine, crack and base coke, speed, GHB, heroine, poppers etc.), their effects and side effects. Non-judgmental testing to check what you have bought is important for adolescents because what they bought can be dangerous or not what they expected – both increasing the risks. This will not be new to many in the drugs field, but my contention is that it is wholly appropriate within an approach focused on the best interests of the child, to protect them from drugs, and to fulfil their right to health. Testing is available at Bouman mental health without getting in trouble with the police and should be made possible in other places[36] (contact with the criminal justice system, from a child's rights perspective, is to be avoided wherever possible and the focus on healthcare is preferred).

Evidence based approaches for addressing drug dependency are also required by the CRC. Quality outpatient clinics (which should offer cognitive behavioural therapy)[37] and residential treatment possibilities (after detox) should be available for those dependent on drugs. Cognitive behavioural therapy, for example, has emerged as effective and some therapies started to be carried out on the basis of protocols. For the work with children specifically, empirically supported psychological interventions were also reported[38] and in some therapies were especially developed for adolescents with drug dependency problems. Multi-Dimensional Family Therapy (MDFT)[39] which provides an

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[33] Martin, G., & Copeland, J. , The Adolescent cannabis check-up: Randomized trial of a brief intervention for young cannabis users. *Journal of Substance Abuse Treatment*, (2008)34, 407-414

[34] Grenard, J. L., Ames, S.L., Pentz, M. A., & Sussman, S. , Motivational interviewing with adolescents and young adults for drug-related problems. *International Journal of Adolescent Medicine & Health*, (2006) 18, 53-67. See also: Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York: The Guilford Press.

[35] Denise S. van Deursen, Elske Salemink, Jeroen Lammers en Reinout W. Wiers, Selectieve en geïndiceerde preventie van problematisch middelengebruik bij jongeren, *Kind en adolescent*, 31 (2010), nr. 4, p. 234–246 [in Dutch].

[36] Several organisations for treatment of addiction in the Netherlands provide this service as well.

[37] Copeland, J.; Swift, W.; Roffman, R.; Stephens, R. (2001). "A randomized controlled trial of brief cognitive behavioural interventions for cannabis use disorder". *Journal of Substance Abuse Treatment* 21 (2): 55. A method often used is Community Reinforcement Approach (CRA): See H. G. Roozen, et al, A systematic review of the effectiveness of the CRA in alcohol, cocaine and opioid addiction, *Drug and Alcohol Dependence*, (2004) 74, 1-13. R

[38] Chambless, D.L. and Ollendick, T. H., Empirically supported psychological interventions, Controversies and evidence, *Annual Review of Psychology* (12001), 52, 685-716. Waldron, H. B., & Turner, C.W. Evidence-based psychological treatment for adolescent substance abuse. *Journal of Clinical Child & Adolescent Psychology*, (2008) 37, 238-261.

[39] Liddle, H. A., Dakof, G. A., Rowe, C., Henderson, C., Colon, L., Kanzki, E., Marchena, J., Alberga, L., & Gonzalez, J. C. (2004, August). Is an in-home alternative to residential treatment viable? In: H. Liddle (Chair), *Family-based treatment for adolescent drug abuse: New findings* presented at *Treatment for adolescent drug abuse: New findings*. Symposium conducted at the annual conference of the American Psychological Association, Honolulu, Hawaii. See also: www.med.miami.edu/ctrada

alternative for residential treatment, is such an evidence based therapy. For adolescents who live on the street or are in very difficult situations, the approach of an ACT team ('Assertive Community Treatment') is often only what we can offer. The approach is assertive, because we let ourselves not be scared away from aggressive and rejecting behaviour and we do not give up. We cooperate with the family, social services, housing organisations, health care authorities and the police.

In this work, it should be noted, we regularly face dilemmas in relation to rights. An adolescent in the YOUZ clinic was admitted after becoming psychotic. That happened after use of GHB. He developed after this episode a Panic Disorder with Agoraphobia. Should our course of action have been forced hospitalisation in our clinic so he could stay longer in order to prevent the development of these complaints? A patient with cannabis dependence came eventually to our youth clinic because the judge gave him a choice: to go to the clinic on his own free will, but with the suspended sentence hanging over his head if he would not go he would have to go to an institute for juvenile offenders. That otherwise the juvenile judge would have send him to a closed residential setting for juvenile offenders was what he did not want at all. After a month (being abstinent in the clinic and having therapy) he saw that he became much more energetic and wants himself now not to fall back to an earlier pattern[40] and wants, when he will goes home, to stop with cannabis and started to make plans for his future. Without the' 'threat' by the juvenile judge this would not have happened. Another dilemma is that if an adolescent wants to leave the clinic but we know that in the outside world he will not yet make it and we share that concern with him, how often should we be ready to readmit the patient? I do not intend to address these dilemmas here, but suggest that the principles of the CRC offer a path through tough decisions making processes if applied well.

The origins of two different approaches (children's rights Convention and drugs Conventions)

The origins of the CRC are very different than the origins of the Drugs Conventions. In 1924 the founder of the save the Children Fund Eglantyne Jebb scored an important achievement with her Declaration on the Rights of the Child, which became known as the '*Declaration of Geneva'* because

[40] Wayne Hall et all point out that treatment for cannabis abuse and dependence in adolescence that there are high rates of relapse to cannabis after treatment and low rates in sustained abstinence. "The modest outcomes reflect the special challenges in treating cannabis-dependent adolescents, namely the high rates of co-morbid mental disorders (the presence of more than one disorder in a person) especially socially disruptive and antisocial behaviour, and the low interest in and motivation for treatment among many young males who are legally coerced into seeing treatment". Wayne Hall, Louisa Degenhardt and George Patton, ''Cannabis Abuse and Dependence'', p.140, in: Cecilia A. Essau, editor, *Adolescent Addiction: Epidemiology, Assessment and treatment*, Amsterdam, Boston, New York, 2008,Elsevier/Academic Press.

the League of Nations adopted it. In 1922 she had already pleaded for a 'Code for Children' which should be 'not a piece of legislation, but rather a document defining the duties of adults towards children (...)' . The United Nations adopted its own '*Declaration on the Rights of the Child'* on November 20, 1959. This UN Declaration concentrated on the particular needs and rights of children as distinguished from adults. The present UN drugs conventions stem from a complete different tradition, of which the Hague Opium Convention adopted now just more than 100 years ago on January 23, 1912 was the first of such Conventions trying to solve a social problem in a treaty. It was not a very influential treaty,. but because the at the end of the first World War the Americans demanded it should be part of the Peace Treaty, it came into force globally in 1919 when it was incorporated into the Treaty of Versailles. An article of the Treaty of Versailles states that 'those of the High Contracting Parties who have not yet signed, or who have signed but not yet ratified the Opium Convention signed at The Hague on January 23, 1912, agree to bring the said Convention into force, and for this purpose States have to enact the necessary legislation without delay and in any case within a period of twelve months from the coming into force of the present Treaty'. According to de Kort the Hague Conference, was about orders 'as to the regulation of the production and trade in opiates, cannabis and coca(ine) (...) The contracting countries committed themselves to produce laws and regulations, allowing production and selling of narcotics only for medical purposes'. While the CRC has its origins in pioneers of children's rights who wanted to give more respect to the child, the drug control treaties has its roots in the prohibition philosophy. Shall the twain ever meet? The drug control treaties coming after this Hague Opium Convention all had different concerns than human rights of children. The UN human rights system and the UN drug control system are not only physically in two places (respectively Geneva and Vienna) buy are two 'different worlds' of focus and this shows how the UN system is compartmentalized. I believe that children's rights could be a first 'experiment' to try to find a more common language. But we should be realistic as well.

A proposal to create a new group ('article 33') to mobilize input to the Committee in Geneva

The Committee on the Rights of the Child in Geneva (this summer having its 60th session) is only now discovering its own role in answering the questions relating to directing national law and policy on drugs and assisting with some very real dilemmas on the ground. With new technologies (neuro-imaging, for instance the CT-scan) came insights from medical science. Thanks to these new technologies we now know much more about the influence of stress in pregnancy, drinking, smoking nicotine and drug use during pregnancy and how this may have an influence on the child's development, for instance on depression in later life and even antisocial behaviour. From the world of neurosciences, addiction

psychiatry and addiction psychology new knowledge about human development and mental disorders has been published and the UN Committee on the Rights of the Child should take that into account. Here, civil society briefings to the UN Committee on the Rights of the Child are relevant. Information by States parties should be reviewed by the Committee on the Rights of the Child with this new knowledge in mind. There is therefore a role for the NGO Group for the Rights of the Child in Geneva and international children's rights organisations to feed the Committee members with relevant information before they review a report of a State Party to the Committee and scan it on the issue of drugs. But to develop expertise and to get a constant flow of information to the Committee, I propose, even a place for *a small special NGO* to take upon itself this task (could be called *article 33 f*ollowing the example of organisations like article 19, which takes its name from article 19 of the ICCPR and addresses freedom of expression). Such a group can ascertain the input of psychologists and psychiatrists in the field. Now, in the field of addiction psychology and psychiatry a UN Committee in Geneva seems totally not relevant for the work. Mental health organisations treating and caring addicted young people are often not in touch with children's rights organisations coordinating a NGO report on the implementation of the CRC in a country. Drug use of minors often do not enter a NGO report and if they do it is not an issue of major concern for the other organisations contributing to such a NGO Report. Without adequate feeding of the Committee and the committee member who is writing the draft *Concluding Observations* on a certain country, there is no hope that the Committee will be more effective on the issue of children and drugs.

Conclusion

Within drug policy discussions, some tend to place article 33 alongside the three international drug conventions, as if it is part of the same system of control (an unusual role for a human rights treaty). Basic principles of the CRC (respect for the child's opinion, non-discrimination, the best interests of the child as a primary consideration, rights to survival and development) and the evolving capacities of the child, however, can give a frame of reference to look anew at some aspects of the drug conventions. But article 33 of the CRC was drafted when many drugs which minors use now were not yet in existence, other addiction issues (like alcohol use, abuse and dependence and tobacco use and dependence) did not even make it into the CRC text. New addictions or that have similarity with drug addiction like gaming, gambling on line or internet and video-game addiction where when the CRC was

drafted also not even in existence, so the text of the article itself is for modern times also not ideal[41]. Only the last two or three years article 33 of the CRC starts to get some real attention, it was until now not high on the priority list of children's rights NGO's, UNICEF and the Committee on the Rights of the Child itself. For addiction psychologists, psychiatrists and MD's, mental health nurses and social workers treating children and adolescents with drug dependency problems and those involved in designing prevention programs, the CRC and its article 33 was until recently something from another planet, while the UN drugs conventions have had significant impacts on national policies. This article is intended to show the relevance the potential influence of the CRC on policy and even in the provision of treatment for young people who use drugs. In turn, there are many, many issues I have not discussed for which the CRC has direct relevance, including parental drug use, pregnancy of addicted women and children's involvement in the drug trade. All important issues which I will try to address in separate articles in the future.

[41] Philip E. Veerman, The Ageing of the United Nations Convention on the Rights of the Child, *International Journal of Children's Rights*, (2010) 18, issue 4, 61-80.