

COMPULSORY DRUG TREATMENT AND REHABILITATION IN EAST AND SOUTHEAST ASIA

Executive Summary



PREFACE

Seven years have passed since delegations from nine countries in East and Southeast Asia gathered in the Philippines for a strategic consultation on the development of a roadmap for transitioning from compulsory drug treatment to voluntary community-based treatment. The question this report seeks to understand is, what has changed since?

Compulsory facilities for people who use drugs are a form of custodial confinement in which those perceived or known to be using drugs are placed to undergo abstinence and 'treatment' for a pre-determined period of time – the duration depends on the country and can vary significantly. Administered through criminal law, administrative law or government policy, these centres are operated by different government agencies including the military, the police, national drug control authorities, and in some places ministries of health or social affairs. Typically aiming for a so-called 'drug-free environment', the approach taken is typically abstinence-based and focussed on detoxification, is rarely medically supervised, and little or no evidence-based treatment, harm reduction or counselling services are offered after.

The United Nations Office on Drugs and Crime (UNODC) Regional Office for Southeast Asia and the Pacific and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for Asia and the Pacific, have compiled this report to understand the status of compulsory treatment and related trends. In some countries conditions for people who use drugs have deteriorated since 2015, while in others policies and laws have changed, and overall the situation for people who use drugs has largely remained the same. Notably, in 2021, Thailand reformed and updated the national drug law and has indicated that compulsory treatment will end. In reality though, unless legal and policy reforms are coupled with a change process and concrete steps – including measures to ensure harm reduction and counselling services administered by health authorities are available– then not much will change.

Drug seizure, arrest and other data in the region continue to indicate a strong upward trend in production, trafficking and use, particularly of synthetic drugs like methamphetamine, and it is clear that focussing almost solely on trying to stop the supply has not had much of an impact. The region needs a balanced approach to drug policy that invests both human and financial resources in real change, including for the scaling-up of voluntary community-based alternatives that are discussed in this report. Further time should not be lost, and East and Southeast Asia should come together for a health and human-rights based response to drugs.

We trust that the data and case examples highlighted in this report prove helpful, particularly so the region can consider, discuss and debate the situation, but most importantly for formulating policy and operational responses. UNODC and UNAIDS will continue to advocate for, and support, a balanced approach to drug policy, including evidence-informed and human-rights based approaches in-line with the recommendations of the 2016 United Nations General Assembly Special Session on the World Drug Problem and the United Nations Common Position on drug-related matters.



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EXECUTIVE SUMMARY

Overview

Despite the high financial and human costs, mounting evidence of human rights violations, and failure to produce sustained public health outcomes, compulsory detention in the name of drug treatment remains a steadfast practice across East and Southeast Asia.

International consensus has shifted to the need for a comprehensive and integrated continuum of voluntary services implemented in the community that are person-centred and encompass drug dependence treatment, harm reduction and social support services. These must be informed by universal human rights obligations and scientific evidence that demonstrates what works and what does not. This approach is considered keystone for addressing drug use and dependence and has shown positive effects on public safety and health.

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Compulsory treatment and rehabilitation is unethical, ineffective for improving health and public safety outcomes and linked to negative impacts on criminal recidivism and drug use.

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United Nations agencies have recognized the negative impacts of compulsory drug treatment on the health and human rights of people affected by drug use and dependence. The United Nations issued two Joint Statements, in March 2012 and June 2020,

calling for the permanent closure of compulsory facilities for people who use drugs. The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) also convened regional consultations in 2010, 2012 and 2015. These forums led to political commitments by Member States to implement national processes to accelerate the transition away from compulsory treatment and rehabilitation towards voluntary community-based drug dependence treatment services.

These commitments are supported by the United Nations System Common Position on drug-related matters, adopted in 2018 by the United Nations System Chief Executives Board for Coordination, which represents 31 United Nations agencies, including UNAIDS and UNODC. The United Nations Common Position promotes the reform and repeal of “laws, policies and practices that threaten the health and human rights of people”, including in relation to compulsory treatment and rehabilitation, by decriminalizing possession and use of scheduled substances, applying the principle of proportionality and providing legal guarantees and due process safeguards in criminal justice proceedings.

Consisting of three booklets, this report documents progress and case examples pertaining to the transition from compulsory facilities for people who use drugs and towards voluntary community-based treatment and services in East and Southeast Asia. The report is structured as follows:

Booklet 1

summarizes findings and messages from the other two booklets.

Booklet 2

provides a regional overview of the state of the transition in selected countries in East and Southeast Asia.

Analysis contained in Booklet 2 is based on the official data submitted by Member States to UNAIDS and UNODC through a regional questionnaire (Booklet 2 Annex distributed in November 2019, unless indicated otherwise).

Booklet 3

developed in consultation with the members of the UNAIDS-UNODC Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs,

documents promising case examples that support the transition from criminalizing policies and compulsory treatment systems and offers lessons and recommendations to expedite the expansion of

voluntary community-based treatment. The examples include:

- development of partnerships between law enforcement, government agencies and community-based organizations in China;
- a peer-led programme in Indonesia integrating harm reduction services, mental health support and links with primary health care for people who use methamphetamines;
- a voluntary, community-based drug dependence treatment model in the Lao People's Democratic Republic (PDR);
- provision of low-threshold, flexible-dose access to opioid agonist treatment in Malaysia;
- drug policy reform in Myanmar involving participatory consultation and multisector cooperation;
- a process of reorienting the response to drug dependence in the Philippines through development of evidence-based treatment practices, guidance and standards;
- a court diversion initiative in Thailand that offers outpatient psychosocial counselling as an alternative to incarceration for drug use offences; and
- national scaling up of methadone treatment in Viet Nam.

The report is intended as a resource for governments, service providers, civil society organizations and communities of people who use drugs. It provides lessons and guidance that countries can adopt to develop legal, policy and programmatic approaches that achieve better public health and safety outcomes by shifting away from compulsory treatment and accelerating voluntary public health- and human-rights based approaches to drug use and dependence.

The number of people in compulsory drug treatment and rehabilitation facilities has stayed the same or increased in most countries since 2012.

440,000 – 500,000
people were detained annually in compulsory facilities in seven countries between 2012 and 2018.

Summary of key findings

The overall number of people detained in compulsory facilities stayed the same or increased in most countries between 2012 and 2018.

- From 440,000 to 500,000 people were detained annually in compulsory facilities in seven countries.
- People were held in compulsory facilities for varying durations, ranging from an average length of three months in Myanmar to 24 months in China.

The number of compulsory facilities for people who use drugs remains high.

- At the end of 2018, there were at least 886 compulsory facilities for people who use drugs in seven countries (Cambodia, China, Lao PDR, Malaysia, Philippines, Thailand and Viet Nam).
- The number of compulsory facilities increased in the majority of those countries between 2012 and 2018.

Punitive practices that contravene human rights, including substandard living conditions and overcrowding, persist in compulsory facilities for people who use drugs.

- Overcrowding, with capacity levels of more than 400 per cent in some compulsory facilities in the region, is a serious concern that exacerbates the risk of HIV, tuberculosis and now COVID-19 transmission.
- Compulsory facilities continue to be run primarily by custodial, military or police personnel rather than medical specialists trained in drug dependence assessment, treatment and mental health services, which results in insufficient provision of evidence-based drug dependence treatment inside these facilities.
- Forced labour, forced unmedicated withdrawal, physical and sexual violence, denial of medical services and other abuses continue to occur in the context of compulsory treatment and rehabilitation in several countries.

Provision of evidence-based drug dependence treatment and complementary health, harm reduction and social support services in the context of compulsory treatment and rehabilitation is inadequate.

- Urine testing as an assessment of drug use is often performed by the police at the point of arrest. A positive urine drug test may lead to

legal procedures and may result in involuntary committal without due process.

- Non-evidence-based interventions including physical exercise, religious instruction and forced labour as “therapy” continue in compulsory treatment systems in the region, in violation of international human rights standards and principles and minimum drug treatment standards.
- There is minimal to no provision of harm reduction services in compulsory facilities.

There is ongoing financial support for compulsory treatment and rehabilitation despite political commitments to phase out such facilities.

- Although information on compulsory treatment expenditure by governments is limited, available data suggests some countries may spend up to 77 per cent of the national annual allocated budget for drug dependence treatment on compulsory facilities.
- The reported cost per person in a compulsory facility per year ranged from \$412 to \$4,000.

Voluntary community-based drug treatment and complementary health, harm reduction and social support services, particularly responses to amphetamine-type stimulant use and dependence, remain insufficiently available.

- Implementation of voluntary alternatives to compulsory detention in the region has been slow.
- No country has established a national multisector committee or action plan with responsibility for the transition.
- Examples of positive changes that could serve as evidence for the feasibility of replacing the compulsory treatment infrastructure and accelerating the transition are being implemented in the region, with several examples highlighted in Booklet 3.

The criminalization of use and possession of scheduled substances is the most significant barrier to the transition and is counterproductive to implementing health-centred and human-rights based programmes.

- No country in the region has fully removed criminal penalties for the use and possession of drugs despite United Nations system guidance endorsing decriminalization.
- Several countries have adopted alternatives to incarceration and diversion mechanisms that work to avoid the criminal justice system and direct people who use drugs towards health and social

services. But the potential impact of such initiatives to promote public health and safety is constrained by contradicting drug legislation.

- Countries continue to implement administrative sanctions and other punitive measures for drug use, including mandatory urine drug testing and compulsory registration. These measures act as a link to compulsory system infrastructure, stoke stigma and fear among people who use drugs and hinder access to health and social services.

Summary of lessons learned

Booklet 3 provides examples of possible pathways and lessons for accelerating the transition to voluntary community-based treatment, harm reduction and social support services. Promising strategies prioritize the following areas for critical action that support a shift away from compulsory and criminalizing approaches.

1. Strategies such as decriminalization of drug possession and related offences and diversion mechanisms that lead people who use drugs away from the criminal justice system are important steps towards accomplishing a **supportive legal and policy** environment that acknowledges the vital influence of the social determinants of health and drug use.

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The estimated number of compulsory facilities for people who use drugs in seven countries. The number of compulsory facilities increased in the majority of countries between 2012 and 2018.

2. **Putting the well-being of people at the centre** of drug policies and interventions by understanding the specific and unique needs of individuals and the challenges they face when seeking drug dependence treatment services promotes social inclusion and fights stigma and discrimination.
3. **Commitment to harm reduction** as an integral approach to delivering drug dependence treatment meets people “where they are at” in relation to their personal health and treatment goals and accepts that not all persons may be willing or ready to stop using drugs.
4. **Commitment to evidence and international drug dependence and human rights standards and principles** is used in the assessment of drug dependence and the provision of evidence-based interventions that fulfil the highest attainable standard of physical and mental health.
5. **Community empowerment that emphasizes agency and community-building for people who use drugs** prioritizes the meaningful participation of individuals with lived experience in programme design, implementation, oversight and policy decisions.
6. **The recognition of the value of rehabilitation and social reintegration, including housing, employment and family and social relationships**, sustains lasting change in the lives of people with drug dependence and helps counter the stigma associated with using drugs and having a criminal record.
7. **Partnership with law enforcement**, which strengthens the common understanding of the need to facilitate health-based approaches to drug use and dependence, increases accountability between the police and communities and decreases the potential for corruption and abuse.
8. **Multisector collaboration** is a critical requisite to facilitate a shift from punishment towards a health-based approach to drug use and to scaling up voluntary community-based drug treatment services.

The evidence-informed initiatives presented in this report unfortunately remain the exception in the region, while criminalizing policies and practices that support compulsory treatment are too often the norm. To expedite the transition, the report highlights several challenges that must be addressed in three

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International consensus supports the provision of a comprehensive and integrated continuum of voluntary services implemented in the community that are person-centred and encompass drug dependence treatment, health, harm reduction and social support services. These must be informed by universal human rights obligations and scientific evidence.

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critical areas: (i) planning and management; (ii) enabling legal and policy environments; and (iii) strengthening and financing of health and community systems.

Planning and management

- **Fidelity in the practice of voluntary community-based treatment programmes is inconsistent.** Purported community-based treatment programmes operate in many countries across the region, but their practical implementation often strays from international and regional standards. Many programmes retain punitive elements and



omit important principles of drug dependence treatment found in the UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia and the World Health Organization and UNODC International Standards on Drug Dependence Treatment.

- **Substandard accountability, transparency and independent oversight related to the drug dependence treatment infrastructure.** This reality poses barriers to assessing progress and identifying bottlenecks in the transition. In relation to drug dependence treatment services, there is an overreliance on the monitoring process (enrolment, activities and outputs) rather than outcomes (whether a programme has achieved its goals). Comprehensive outcome-based evaluation frameworks are a requisite to tailoring responses and monitoring service quality, effectiveness and implementation fidelity.
- **Resistance from law enforcement and judiciary counterparts to permanently close compulsory facilities and shift to voluntary options in the community.** This is a major barrier across the region. Increased collaboration with and engagement of the judiciary and law enforcement authorities around service design and delivery, accompanied by structural and legislative reforms, are required to ensure an enabling environment in which services can operate and people who use drugs can access them without fear of intimidation, arrest or reprisal.
- **Inadequate involvement of people with lived experience of drug use and dependence.** Effective programmes emphasize the role of people with lived experience as active and empowered participants in the design, delivery and monitoring of services as a critical factor in their success. Yet, across the region, the expertise and agency of people who use drugs remains largely unrecognized and undervalued in policy systems and processes, while spaces in the political sphere where people can openly discuss their drug use and needs without fear of legal or social consequences remain few and far between.

Fostering enabling legal and policy environment

- **National laws and policies that criminalize drug use and possession for personal use.** Criminalizing drug use and possession for personal use undermines efforts to prevent HIV, viral hepatitis and other communicable diseases and hinders scaling up of voluntary alternatives. It increases stigma and discrimination, high-risk drug use patterns and risk of overdose while limiting opportunities to access housing, education and employment.
- **Legal and policy incoherence.** Governments in the region are starting to acknowledge the shortcomings of a zero-tolerance approach to drug use and possession for personal use. Yet, tensions remain between public health and public security approaches to drug use and dependence, which continue to coexist and block progress towards the expansion of voluntary evidence-based practices.
- **Stigma and discrimination against people who use drugs are major barriers.** Both impede health care access for people across the region and are often related to misconceptions around drug use and the lack of differentiation between drug use and dependence.
- **Overreliance on abstinence-based indicators.** This is a critical challenge in both compulsory and community-based settings. Urine tests cannot identify whether a person is experiencing problematic drug use nor if they have a drug use disorder. There are more effective measures for determining positive treatment outcomes. Improvements in the quality of life, health outcomes and social functioning as well as reductions in high-risk drug use patterns and crime represent more meaningful and desirable outcomes for people who use drugs.



Health and community systems strengthening and financing

- **Inconsistent dissemination and implementation of existing guidance, policies and standards.** Even in countries that have taken concrete steps towards promoting greater access to voluntary community-based treatment, dissemination, capacity-building and oversight related to implementing these measures remain weak or non-existent, contributing to the delayed operationalization of a complete transition to these measures.
- **Inadequate resources for voluntary community-based approaches.** Several of the case examples in Booklet 3, illustrate human, technical and financial resource gaps that are hindering the expansion of promising interventions. This highlights the need for improved tracking systems and transparency of government investment and their allocation of resources away from a compulsory system and towards voluntary community-based treatment.
- **Insufficient attention to developing interventions for people who use stimulants.** Stimulants comprise the most widely used group of substances in most countries in the region. Yet, effective behavioural interventions for psychostimulant use disorders and psychosocial and scientific medical support for stimulant-induced psychosis and other comorbidities have been insufficiently implemented across the region. Community-led safer-use and mental health interventions show promising results.

An updated Regional Framework for Action on Transition

Booklet 3 provides practical recommendations for governments to accelerate the transition away from the detention of people who use drugs in compulsory facilities to voluntary community-based treatment, harm reduction and social support services.

At the Third Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific in 2015, States adopted a landmark road map for initiating the transition at the national level—the Regional Framework for Action on Transition. Building on this framework, the UNAIDS-UNODC Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs proposes an updated set of recommendations to address key challenges and accelerate the transition by (i) establishing a multisector transition committee and action plan to instigate the transition; (ii) reforming drug laws to foster an enabling policy environment and (iii) strengthening resilience of, building up capacity within and adequately resourcing health systems.

1. PLANNING AND MANAGEMENT



1.1 Establish and strengthen a multisector decision-making committee, with participation of civil society and communities of people who use drugs.

1.2 Develop national transition plans with objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities through consultation with relevant stakeholders, including government agencies from the public health, social affairs, drug control and public security sectors as well as people who use drugs.

1.3 Develop costed implementation frameworks to allocate and mobilize adequate human, technical and financial resources for each phase and component of the transition.

1.4 Annually update progress towards the transition, based on a unified monitoring tool that will be developed by the United Nations.

1.5 Strengthen multisector and interagency coordination and cooperation for implementing action plans and activities related to drug dependence treatment.

2. FOSTERING ENABLING LEGAL AND POLICY ENVIRONMENTS



2.1 Decriminalize the use, possession for personal use and paraphernalia related to scheduled substances as the first step towards reducing stigma and discrimination that hampers access to health care, harm reduction and voluntary community-based drug dependence treatment services.

2.2 Where drugs remain illegal, apply the principle of proportionality for drug-related crimes and implement non-coercive public health-based diversion initiatives.

2.3 Conduct a multisector and participatory review of existing legal and policy frameworks relating to drug use and dependence, with the aim of identifying the barriers that prevent people who use drugs from accessing voluntary community-based treatment and services.

2.4 Develop, promote and implement an action plan based on that review to create enabling environments that facilitate the transition.

2.5 Strengthen the capacity of the public health, social affairs, public security, justice, judiciary and civil society sectors along with communities of people who use drugs and other relevant sectors to better understand and facilitate the implementation of current and reformed or revised policies for the maximum protection of the human rights of people who use drugs.

3. HEALTH AND COMMUNITY SYSTEMS-STRENGTHENING AND FINANCING



3.1 Rebalance national budgets related to drug control to reallocate sufficient funding away from compulsory treatment modalities and towards voluntary, community-based treatment and support services, including harm reduction.

3.2 Conduct a capacity and systems assessment of sectors involved in the transition process (public health, social affairs, public security, justice and civil society groups and communities of people who use drugs).

3.3 Develop or update community-based treatment and services strategies, including establishing a minimum standard of care and governance framework modelled on regional community-based treatment guidance and international standards, which encompass elements of capacity-building and systems-strengthening.

3.4 Implement and scale up a comprehensive menu of voluntary community-based treatment and services for people who use drugs, including harm reduction and HIV services, such as needle and syringe programmes, opioid agonist therapy, safer-use kits for persons who use methamphetamines and peer distribution of naloxone, in partnership with communities and relevant service providers.

3.5 Build up the capacity of public health, social affairs, public security and the justice sectors, civil society organizations and communities of people who use drugs to facilitate collaboration in delivering voluntary community-based treatment services.

3.6 Engage and collaborate with civil society and community groups, including communities of people who use drugs, at the national and subnational levels, to reduce bottlenecks in the treatment pathway and to facilitate access to effective voluntary community-based treatment and services for people who use drugs.

3.7 Implement evidence-based communication strategies to raise awareness about the need to reduce drug-related harms, including drug dependence, HIV and viral hepatitis infection and overdose. These service promotion activities must aim to increase the evidence-based understanding of drug use and to inform the public about the availability of drug dependence treatment and harm reduction services.

3.8 Conduct an assessment of current funding (domestic and international) with a view to develop a transitional financing plan for voluntary community-based treatment and services.



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