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Commentary

Compulsory drug detention centers in East and Southeast Asia

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ABSTRACT

Over the last three decades in response to a rise in substance use in the region, many countries in East and Southeast Asia responded by establishing laws and policies that allowed for compulsory detention in the name of treatment for people who use drugs. These centers have recently come under international scrutiny with a call for their closure in a Joint Statement from United Nations entities in March 2012. The UN's response was a result of concern for human rights violations, including the lack of consent for treatment and due process protections for compulsory detention, the lack of general healthcare and evidence based drug dependency treatment and in some centers, of forced labor and physical and sexual abuse (United Nations, 2012). A few countries have responded to this call with evidence of an evolving response for community-based voluntary treatment; however progress is likely going to be hampered by existing laws and policies, the lack of skilled human resource and infrastructure to rapidly establish evidence based community treatment centers in place of these detention centers, pervasive stigmatization of people who use drugs and the ongoing tensions between the abstinence-based model of treatment as compared to harm reduction approaches in many of these affected countries.

Introduction

In response to the growing epidemic of substance use, compulsory drug detention centers (CDDC) grew exponentially in the last decade throughout East and Southeast Asia (Thomson, 2010). In countries that include Burma, Cambodia, China, Laos, Malaysia, Thailand, and Vietnam, people who use drugs (PWUD) or are suspected of drug use can face compulsory detention ostensibly for the purpose of drug treatment and rehabilitation. These centers are administered through either the criminal or administrative laws and are operated by a variety of institutions depending upon country, including law enforcement authorities, the judiciary, local/municipal authorities, and the Ministry of Health and the Ministry of Social Affairs. PWUDs may be detained in police sweeps, or as a result of having a single positive urine test for drugs, and some turned over by family or community members (United Nations, Office of the High Commissioner, 2009). In most CDDCs in the countries mentioned, medical evaluation of drug dependency is not available upon entry into these centres and treatment of drug dependency and other related disorders are also often not available (International Harm Reduction Association, 2010). This questions the fundamental legal legitimacy of their detention.

In Thailand, CDDCs were created in 2002 in response to a growing methamphetamine epidemic with the government introducing a law that reclassified PWUD as patients eligible for care, rather than criminals deserving of punishment (Pearshouse, 2009a). The number of these centers grew from six in 2000 to 84 in 2008, the majority of which were run by the Royal Thai Army, Air Force or Navy (Office of the Narcotics Control Board of Thailand, 2009). In China between 1995 and 2000, the government quadrupled its capacity to provide compulsory detoxification and by 2005 it launched a National People's War on Illicit Drugs with the goal of further increasing the number of people detained (Human Rights Watch, 2010). Resolution 06/CP in 1993 in Vietnam gave rise to the 06 centers where drug users were re-educated, punished, and rehabilitated, since they were viewed as a "social evil" (Giang, Ngoc, Hoang, Mulvey, & Rawson, 2013). By 1995, the Ordinance launched by the National Assembly drove a significant increase in the number of these CDDCs resulting in 129 centres across Vietnam by June 2010 (Giang et al., 2013). Similar centers were also created in Cambodia and Laos in response to the rising use of methamphetamines in these respective countries (Open Society Institute, 2010).

Although an accurate estimate of the total number of people detained in these centers is difficult to determine, it has been reported that more than 235,000 PWUD are detained in over 1000 centres in several of these Asian countries (Open Society Institute,

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2010). The estimated number of people detained in these centres range from 2000 in Lao PDR to more than 170,000 in China in 2011 (Human Rights Watch, 2010; Office of the Narcotics Control Board of Thailand, 2011; He & Swanstrom, 2006). In Thailand, there were an estimated 170,485 people enrolled in some form of drug treatment in 2011 of which approximately 60% were detained in CDDCs (Hayashi, Small, Csete, Hattirat, & Kerr, 2013).

The duration of incarceration in these centres vary from country to country. For example in China, the Anti-Drug Law of 2008 stipulates that first offenders are subject to community treatment for their substance use and the use of reeducation through labor has supposedly been abolished (Jingjing, 2012). Repeat offenders are subject to two (2) years of detention in a CDDC, regular assessments within CDDC are carried out allowing for the early release or prolongation of detention by one (1) additional year, and that upon release the PWUD are subject to continuous rehabilitation in their local communities for up to three (3) years with elapses and multiple convictions being common (Liu et al., 2013).

In Vietnam in the beginning, terms of detention are as long as five years: two of "treatment" and three of labor in facilities built near the detention centres. Vietnam has since moved to two years of detention followed by an evaluation for post rehabilitation which may include an additional two years in the CDDC (National Committee for AIDS, Drugs and Prostitution Prevention and Control of Vietnam, 2014). Under Malaysia's drug control laws, any individual with a positive urine screen for substances classified as illicit by the Dangerous Drug Act (1952) and the Drug Dependence (Treatment and Rehabilitation) Act (1983) and deemed to be drug-dependent by a government medical officer can be mandated to two years of detention and two years of community supervision following release (Kamarulzaman, 2009).

Treatment of substance abuse

Although CDDCs have been established as drug treatment centres and detention is for the purposes of rehabilitation and treatment of substance use disorders rather than criminal punishment, entry and exit into these CDDCs are involuntary and frequently includes highly punitive measures in facilities operated by security officials and outside the medical system which rarely have medical personnel trained in drug dependence assessment or treatment (World Health Organization, 2009).

The two primary substances leading to detention in CDDC are opiates and amphetamine-type substances (World Health Organization, 2009). Opiate substitution therapy (OST) is not available in the CDDCs, instead "treatment" is primarily based upon forced abstinence (Amon, Pearshouse, Cohen, & Schleifer, 2013; Fu, Bazazi, Altice, Mohamed, & Kamarulzaman, 2012). In a cross-sectional study conducted in 2010 of two drug rehabilitation centers in Malaysia that house HIV positive detainees, substance use disorders were highly prevalent, with 95% meeting DSM-IV criteria for opioid dependence prior to detention and 93% reporting substantial or high addiction severity prior to detention. Current cravings for opioids and methamphetamines were reported among 86% and 58% of participants respectively despite a mean period of incarceration of 7.5 months. In these centers, treatment for substance withdrawal syndromes was not available. In the study described above, eighty-seven percent of participants reported anticipating relapsing to drug use after release (Fu et al., 2012).

High relapse rates following release from these centres have also been reported in China and Cambodia, with more than 90% of heroin users have been reported to relapse following release (United Nations Office of Drugs and Crime, 2010; Yan et al., 2013). While no formal evaluations on the effectiveness of CDDC in reducing return to drugs including methamphetamines have been conducted in East and South-East Asia, interviews with officials in one country indicate that approximately 20% of those released from CDDCs test positive for methamphetamine within two months of release (Yan et al., 2013). In another country, centre staff indicated, "about 70 per cent of centre residents have been there before" (United Nations Office of Drugs and Crime, 2010).

CDDCs have been criticized for a variety of human rights abuses including involuntary and indefinite detention, physical abuse, torture of detainees, and the denial of or inadequate provision of medical care. Interviews with formerly detained individuals indicate that the common elements of treatment are forced work regimens set within an abusive environment, grueling physical exercises, and military style training within the detention environment (Human Rights Watch, 2010). Exercise has been reported frequently as accompanied by the mantra that, "when you exercise you sweat, and when you sweat the drug substance will be removed" (Amon et al., 2013). There are also widespread reports that detainees were tied up in the sun for hours without food or water, including punishment in isolation cells (Human Rights Watch, 2010). The foundation of this kind of treatment is based upon an ideology that drug use is pure exercise of free will, that an individual must be punished for their drug use, and that punishment will serve as a deterrent to a return to use upon release. In many countries, detainees are also forced to work often in factories or sweatshops that are on site without pay or at a rate far below the prevailing wage (World Health Organization, 2009). Evidence also demonstrates a high rate of drug overdose and crime recidivism among drug dependent individuals upon release from detention (Dolan et al., 2005; Ramsay, 2003).

Prevention and treatment of HIV in CDDC

Given the lack of effective HIV prevention programs for PWUDs until recently, many of the countries with CDDC face high rates of HIV and hepatitis C infections among PWUDs detained in these centres. In Malaysia, for example, HIV prevalence in CDDCs is estimated to be 10%, nearly two-fold higher than in prisons and more than 20-fold higher than in the community (Ministry of Health of Malaysia, 2008). In many instances, those living with HIV or AIDS and other related co-morbidities do not have access to treatment for any of the related infections (Gore et al., 1995; Jurgens & Betteridge, 2005). In addition there are reports of unsafe sex, unsafe drug use, and sex for drugs within CDDCs (Human Rights Watch, 2010; Open Society Institute, 2010; Jurgens, Nowak, & Day, 2011). Most CDDCs lack any form of HIV prevention programs including condoms and clean needles and syringes (Open Society Institute, 2009). In most centres, the only HIV prevention measures available are information, education, and communication (IEC) materials. The major barriers towards the provision of HIV prevention include the lack of financial resource and qualified staff and a general negative attitude towards those infected with HIV (Bezziccheri & Vumbaca, 2007).

Mandatory HIV testing is commonly carried out in many of these centres throughout the region with detainees rarely told of their results or linked to HIV care upon diagnosis (Cohen & Amon, 2008; Wolfe, 2010). In the study on the health status of 100 HIV positive detainees in Malaysia, only 9% were reported to have received antiretroviral therapy (ART) despite having been diagnosed with HIV for a median of 5.8 years (Fu et al., 2012).

The negative impact on health extends beyond the period of incarceration. In a cross-sectional study of 435 Thai drug users, it was reported that PWUD who had been exposed to CDDCs were more likely to report avoiding healthcare (Kerr et al., 2013). In Vietnam where there has been a recent rapid and massive scale up of ART, nearly half of all PLHIV across the nation continue to present late and initiate ART with CD4 counts less than100 cells/mm^3.

History of detention or incarceration and history of injecting drug use were significant risk factors associated with delayed entry into treatment and care (Rangarajan et al., 2014). Possible reasons for avoiding healthcare centres include the fear of loss of confidentiality in the clinic setting including the possibility of health records being shared between healthcare providers and police increasing the risk for an arrest and readmission to drug detention, and fear of stigma or discrimination in the community (Kerr et al., 2013).

Challenges faced by PWUD who have undergone detention upon re-entry into the community are exacerbated by deep drug-related and HIV-related stigma and discrimination in most of these countries. In a recent study in Vietnam of male PWUD released within the past two (2) years from "06 centers" in Hanoi, Vietnam, persistent stigma and discrimination hindered employment, increased participants' social isolation and exacerbated their struggles with addiction (Tomori et al., 2014).

Evolving response and ongoing challenges

In Malaysia, PWUDs are sent to such detention facilities (locally known as PUSPEN) for a mandatory two-year sentence since its establishment in 1983 (Gill, 2010). These centers are operated by the Malaysian National Anti-Drug Agency under the Ministry of Home Affairs. Up until three years ago, the programs conducted in these centres mirrored those of other countries with an emphasis on forced work regimens, grueling physical exercises, and military style training (Pearshouse, 2009b; Human Rights Watch, 2010; Fu et al., 2012).

In 2005 in response to the increasing HIV epidemic driven by injecting drug use, the Malaysian government began implementing harm reduction programs that included needle syringe and methadone maintenance treatment (MMT) programs across the country and began reducing its reliance on detention and forced rehabilitation (Wan Mahmood, 2008). As of 2013, more than 65,000 PWUDs are receiving MMT provided through government hospitals and clinics, private healthcare practitioners and prisons throughout the country (Ministry of Health of Malaysia, 2014).

Beginning July 2011, in addition to the community-based (MMT) program provided by the Ministry of Health and private practitioners, the National Anti-Drugs Agency underwent a transformation that saw a shift away from compulsory detention by converting the CDDCs into Cure & Care Centres which provide voluntary comprehensive client centered treatment and support services including MMT (Degenhardt et al., 2014). The aim is to convert 18 of these 28 CDDCs into voluntary treatment centres by 2015 (Kaur, 2013). To date more than 36,000 PWUD have accessed these services; with a total of 6500 people currently receiving MMT (Kaur, 2013). In addition to the core clinical services, some centers include after-care housing assistance and vocational training, as well as religious or spiritual programs. A recent explorative qualitative study was undertaken to explore patient perspectives and satisfaction regarding treatment and services at the Cure and Care centre in Kota Bharu, Malaysia. In this semi-structured in depth interview with 20 participants methadone treatment, psychosocial programs, religious instruction, and recreational activities were identified as important factors contributing to treatment success for addressing both health and addiction needs. Though many had previously been in a CDDC, adherence to treatment in the C&C centre was perceived to be facilitated by the degree of social support and the voluntary nature of the programs (Ghani et al., 2014).

In a quantitative survey of ninety-six (96) participants from the same C&C centre in Kota Bharu where methamphetamine use is high, there was a significant decrease in the mean duration of days where participants were not using amphetamine or heroin upon enrolment at the C&C compared to prior experience. Among the participants who reported using amphetamines (88.5%), there was a statistically significant decrease in the mean number of days over a 30 day time period in which amphetamines were used from 9.24 days in the 30 days before enrolling in treatment at the C&C to 0.84 days in the 30 days prior to study enrollment ($p < 0.001$). Similarly, among participants who reported using opioids, opioid use decreased significantly from 20.24 days in the 30 days before enrolling in treatment at the C&C to 0.84 days in the 30 days prior to study enrollment ($p < 0.001$).

Malaysia's approach in response to the call for the closure of the CDDC is novel by utilizing elements of existing infrastructure and doing this within the existing legal framework. What has been accomplished is both important and demonstrative of how it is possible to utilize existing scarce resources and limited infrastructure in changing the entire foundation by implementing both evidence-based drug dependence treatment and harm reduction in voluntary setting.

Similar to Malaysia, in 2004 Vietnam implemented the National Strategy for Prevention and Control of HIV/AIDS that provided support for syringe exchange and condom distribution programs for high-risk groups, and in 2006, the Law on HIV/AIDS Prevention and Control (HIV law) officially approved harm reduction programs (Giang et al., 2013). In 2009, drug use behavior was removed from the Penal code under the influence of the international community and civil society (Giang et al., 2013). The continued policy shift in Vietnam as documented in the "Renovation Plan on Drug Treatment" aims to reduce the number of PWUD detained in CDDC from 63% in 2013 to 6% by 2020 (Oanh, 2014). Despite these marked changes that have taken place in Vietnam including amendments to decriminalize drug use under the Ordinance on Administrative Violations, drug use still remains an administrative violation, with users subject to administrative detention for up to two years. In addition, a number of new legal obstacles have surfaced which may affect the ability of HIV programmes to reach key populations at higher risk of HIV infection. Decree 94/2009/ND-CP, which guides the implementation of the Law on Drugs following the 2009/21 Directive, threatens to create a more punitive legal environment for PWUD (National Committee for AIDS, Drugs and Prostitution Prevention and Control of Vietnam, 2012). Under this new legislation, repeat drug offenders are subject to an additional period of 'post-detoxification management' for between one and two years (National Committee for AIDS, Drugs and Prostitution Prevention and Control of Vietnam, 2012). Nonetheless the progress on drug treatment reform on the basis of scaling up voluntary, community-based treatment and care was approved by the Vietnamese government in December 2013 (Decision 2596/QD-TTg), where 80 of the 107 centers will be reformed to provide voluntary and friendly detoxification with possible MMT service provision (National Committee for AIDS, Drugs and Prostitution Prevention and Control of Vietnam, 2014). With these changes, the harm reduction program in Vietnam continues to expand with MMT services being provided to 15,542 patients in a total of 30 provinces in 2013 (National Committee for AIDS, Drugs and Prostitution Prevention and Control of Vietnam, 2014).

In China, in an effort to address the HIV epidemic, China's Ministry of Health launched a national MMT program to provide community methadone programs with the first eight MMT clinics in southwestern China in 2004 (Yan et al., 2013). The program has since expanded with more than 210,000 reported to be receiving methadone throughout the country in 2013 (Li & Li, 2013). However, detoxification in detention centers governed by the Ministry of Public Security continue in China with 227,000 drug users in compulsory detoxification and another 36,000 in mandatory treatment in the community reported in 2013 (Yan et al., 2013; Li & Li, 2013).

Three years after the call for closure of CDDCs many of these centres remain throughout the region. The transformation that has taken place in Malaysia and Vietnam are examples of changes that can be undertaken. However, following decades of reliance on enforcement and the criminal justice system, countries will face many challenges in transitioning to voluntary community-based drug dependence treatment services not least because of existing laws in several of these countries which provide for mandatory detention of people who use drugs in CDDCs. Along with a review of these laws and policies, greater financial investment in harm reduction compared to supply and demand reduction will need to take place. An additional challenge for most of the affected countries is the limited in-country technical capacity in substance use prevention, treatment, care and support for which capacity building in a broad range of areas will need to take place to transition treatment into voluntary community based settings (Nguyen, Nguyen, Pham, Vu, & Mulvey, 2012). A significant barrier to progress is the difficulty in convincing policy makers of the need for the immediate closure of the CDDCs in the absence of adequate resources and facilities providing evidence-based treatment in the community and the continued focus on abstinence-based model of treatment as compared to harm reduction approaches in many of these affected countries. Finally the ongoing tensions between the public health imperative and public security concerns result in ongoing detention of PWUDs even in countries which have adopted evidence-informed and rights-based health and social services in the community.

Conclusion

Despite the lack of evidence of its effectiveness and an international call for closure of the CDDCs, these centers continue to operate in many countries in East and Southeast Asian countries subjecting people who use drugs to continuous and ongoing human rights abuses, including lack of access to healthcare. Punitive drug laws and policies and an ongoing focus and reliance on abstinence-based model of drug dependence treatment remain potent barriers to access to prevention and treatment for HIV and related illnesses. Evidence-informed medical interventions are often absent in these centers despite a high proportion of the detainees being HIV positive or are at very high risk for infection. Models are emerging from several countries that have successfully transformed these centres into voluntary centres providing comprehensive evidence informed treatment and support services. We urge the international community in particular the United Nations entities to monitor the progress of the call for closure of the CDDCs made in 2012 and to ensure the immediate implementation of voluntary, evidence-informed and rights-based health and social services for people who use drugs in the community. The contents and conclusions of the paper reflect a broad consensus among social and clinical scientists participating in a UNODC Scientific Consultation on HIV/AIDS (UNODC, Scientific Statement, March 11, 2014).

Conclusion statements

- Despite a call for their closure, CDDCs continue to operate in many countries in the Asian region.
- Measures that are undertaken to treat people who use drugs within these centers run counter to accepted norms and evidence-based practices and often times violate human rights principles.
- Access to HIV prevention and treatment are often absent in these centers where a high proportion of the detainees are either HIV positive or are very high risk for infection.
- Models are emerging from several countries that have successfully transformed these centres into voluntary centres providing comprehensive evidence-informed and rights-based health and social services in the community for people who use drugs.
- There is an urgent need to review existing laws and policies and to reallocate resources to ensure that the CDDCs in its current form no longer operate in countries in the East and SouthEast Asian regions.

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Conflict of interest statement

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