

# COMPULSORY DRUG TREATMENT AND REHABILITATION IN EAST AND SOUTHEAST ASIA

## Regional Overview





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# EXPLANATORY NOTES

Consisting of three booklets, this report assesses progress towards the closure of compulsory facilities for people who use drugs in selected countries in East and Southeast Asia. It also features case examples of the transition to voluntary community-based treatment and complementary health, harm reduction and social support services. The report is structured as follows:

**Booklet 1**

summarizes the findings from the other two booklets.

**Booklet 2**

**provides a regional overview of the state of the transition from compulsory facilities for people who use drugs and towards voluntary community-based treatment, care and support services in East and Southeast Asia. The analysis is based on official data that Member States submitted to UNAIDS and UNODC through a regional questionnaire distributed in November 2019, unless indicated otherwise.**

**Booklet 3**

developed in consultation with the members of the Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs, consists of case examples of practices and policy recommendations to support the expansion of voluntary, community-based treatment, care and support services.

All uses of the word “drug” and the term “drug use” in this report refer to substances controlled under the international drug control conventions and their non-medical use, unless indicated otherwise.

All \$ currencies are United States dollars.

The following abbreviations are used in this booklet:

<b>ART</b>	antiretroviral therapy
<b>ASSIST</b>	Alcohol, Smoking and Substance Involvement Screening Test
<b>ATS</b>	amphetamine-type stimulants
<b>COVID-19</b>	coronavirus disease
<b>HIV</b>	human immunodeficiency virus
<b>NGO</b>	non-government organization
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>WHO</b>	World Health Organization

# INTRODUCTION

## Scope of the report

This report assesses progress on the closure of compulsory drug detention and rehabilitation facilities and the transition to voluntary community-based treatment and complementary health, harm reduction and social support services for people who use drugs in nine countries in East and Southeast Asia: Cambodia, China, Indonesia, the Lao People's Democratic Republic (PDR), Malaysia, Myanmar, the Philippines, Thailand and Viet Nam. Focus countries for this report were selected based on the country presence of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) and the mandates of the regional offices of the two UN entities. The findings presented are based on responses to a questionnaire that UNAIDS and UNODC crafted jointly and a complementary literature review.

The questionnaire (see the Annex) sought information on national responses to drug use and dependence. It asked about compulsory treatment and rehabilitation modalities and countries' commitment towards transitioning to voluntary community-based treatment and support services for people who use drugs, as agreed by States at the Third Regional Consultation on Compulsory Centres for People Who Use Drugs in Asia and the Pacific (2015).<sup>1</sup> The questionnaire was administered by email to relevant drug control authorities in the nine countries. Seven countries provided data: Cambodia, China, Indonesia, Malaysia, Myanmar, the Philippines and Thailand.

The literature review covered government reports and peer-reviewed journal articles referencing the nine countries that were published between January 2015 and July 2021. The report's analysis

combines the findings from the questionnaire and the literature review. It considers the status of facilities described as having elements of compulsory treatment and the conditions of treatment and rehabilitation facilities for people who use drugs. It also examines progress towards expanding voluntary community-based treatment and support services since 2015. A validation process was undertaken in May 2021, whereby the report was shared by email with the respective national authorities who provided data. An online validation meeting then followed. The draft report was also shared for comments with UNODC and UNAIDS country offices in the region.

## Definitions and guiding principles

### Compulsory facilities for people who use drugs

Many East and Southeast Asian countries operate compulsory facilities in which people who use or are suspected of using drugs are detained, along with other individuals deemed threatening to national security or public order. In some countries, these centres may also house homeless persons, sex workers and individuals with mental health conditions.<sup>2</sup> Compulsory drug treatment and rehabilitation facilities have been the subject of sustained criticism over the years due to evidence of forced labour, lack of due process, lack of adequate nutrition and sanitation, physical and sexual violence and/or denial or inadequate access to quality health care and harm reduction services.<sup>3</sup> Compulsory drug treatment is unethical, ineffective for improving health and public safety outcomes and is associated with negative impacts in relation to criminal recidivism and drug use.<sup>4</sup>

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<sup>1</sup> UNODC, ESCAP and UNAIDS, 2015.

<sup>2</sup> WHO, 2009.

<sup>3</sup> United Nations, 2020; UNAIDS, 2019; UN Human Rights Committee, 2018; ILO Committee of Experts on the Application of Conventions and Recommendations, 2015; United Nations, 2012.

<sup>4</sup> United Nations, 2012.



Programmes that employ punitive treatment modalities are called different names in different countries. Some countries do not differentiate between treatment structures that apply detention or the involuntary committal of people who use (or are suspected of using) drugs and those that allow for free and informed consent to pursue or refuse treatment. Typically, compulsory treatment and rehabilitation involves the confinement of individuals under the care and supervision of inpatient residential institutions, usually with the goal of attaining abstinence from drug use, and therefore not offering evidence-based treatment interventions. Compulsory treatment may also include involuntary committal to a drug treatment programme at the request of a person's parents or family members or by the police following arrest and without due process.

Regardless of the name or setting of the programme, the 2012 United Nations Joint Statement on Compulsory Drug Detention and Rehabilitation Centres outlines concerns related to compulsory treatment.<sup>5</sup> Compulsory treatment is country-specific, meaning a range of problematic practices in the name of drug treatment are being employed, and they differ from country to country. Although this is not an exhaustive list, States may be characterized as having compulsory drug treatment and/or rehabilitation if at least one of the following criteria, drawn from the Joint Statement, is in operation:

**i.** People who use or who are suspected of using or are dependent on drugs are admitted against their will, are not provided with a choice to consent to or refuse treatment, and/or are denied the unconditional right to refuse and/or leave the programme at any time without incurring penalties.

**ii.** The process for ordering compulsory treatment and rehabilitation lacks adequate due process protections established by international human rights treaties (detention is arbitrary and/or there is no right to a court hearing within a reasonable period of time, the right to an appeal and the right to legal representation, and/or there is absence of independent oversight of the grounds for continuing detention and conditions of detention).

**iii.** The conditions of treatment and rehabilitation violate United Nations international standards on human rights. These encompass the failure to provide evidence-based drug dependence treatment and complementary health, harm reduction and social support services consistent with the World Health Organization (WHO) and UNODC International Standards for the Treatment of Drug Use Disorders,<sup>7</sup> inadequate provision of living conditions and health care services that meet the highest attainable standard for physical and mental health and exposure to violence, abuse and forced labour.<sup>8</sup>

Based on information available to UNAIDS and UNODC,<sup>9</sup> all nine countries covered in this report are categorized as employing compulsory modalities for drug treatment and rehabilitation in state-run facilities that meet one or more elements of the above criteria. This criteria list is not exhaustive, but it provides an indication of the parameters framed by international drug dependence treatment and human rights standards. It is intended as a starting point for addressing concerns related to compulsory facilities for people who use drugs.

<sup>5</sup> United Nations, 2012.

<sup>6</sup> WHO, UNODC and UNAIDS, 2012.

<sup>7</sup> WHO and UNODC, 2017.

<sup>8</sup> According to the International Labour Organization's Forced Labour Convention, 1930 (No. 29), forced or compulsory labour comprises "all work or service which is exacted from any person under the threat of a penalty and for which the person has not offered himself or herself voluntarily".

<sup>9</sup> UNAIDS, 2016.

## Principles for an evidence- and human rights-based drug dependence treatment system

According to the World Drug Report 2018, an estimated one in nine people who use drugs experience high-risk patterns of drug use or drug dependence, while the majority does not.<sup>10</sup> For people who experiment with drug use or consume drugs episodically, long-term residential drug treatment is unnecessary and ineffective.<sup>11</sup> For people affected by drug dependence, the WHO and UNODC International Standards for the Treatment of Drug Use Disorders<sup>12</sup> outline seven principles of a quality evidence-based drug dependence treatment system:

### Principle 1.

**Treatment must be available, accessible, attractive and appropriate.** People with drug dependence should have access to a range of treatment services that address multiple needs in a variety of community settings. Services should be affordable, geographically accessible, flexible in terms of opening hours, friendly and non-discriminatory in terms of drug use, class, race or gender. And they should be responsive to the diverse needs of individuals.

### Principle 2.

**Ensuring ethical standards of care in treatment services.** Treatment interventions should comply with universal human rights standards, be voluntary, provide the highest attainable standard of health care and ensure non-discrimination. Any treatment intervention must respect personal autonomy and have the informed consent of an individual in relation to the type, start and end of treatment.

### Principle 3.

**Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services.** Drug dependence should be seen as a health care issue and be addressed by the health care system rather than the criminal justice system, with community-based treatment and support services offered as an alternative to detention and incarceration.

### Principle 4.

**Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders.** Evidence-based good practices and scientific knowledge on drug dependence should guide interventions. The presence of drug dependence should be established by trained health care practitioners using comprehensive screening and assessment tools. Individualized treatments that address the specific needs of each individual must be available.

### Principle 5.

**Responding to the needs of specific populations.** Several groups within the larger population of those affected by drug dependence require special attention, including adolescents and young people, women (including pregnant women), individuals with comorbid health conditions, sex workers, ethnic minorities and homeless people. Services should be tailored to address the unique vulnerabilities and needs of these groups while ensuring equity and non-discrimination at all stages of the care continuum.

<sup>10</sup> UNODC, 2018.

<sup>11</sup> WHO and UNODC, 2020.

<sup>12</sup> WHO and UNODC, 2017.

## Principle 6.

### **Ensuring good clinical governance of treatment services and programmes for drug use disorders.**

Good-quality and efficient treatment services have clearly defined policies, treatment protocols, programmes, procedures, definitions of professional roles and responsibilities, supervision and financial resources.

## Principle 7.

### **Treatment policies, services and procedures should support an integrated treatment approach, and links to complementary services must be constantly monitored and evaluated.**

A systematic high-level policy approach to drug dependence along with a logical, step-by-step sequence that links policy to needs assessments, treatment planning, implementation and to monitoring and evaluation is most beneficial for addressing the multifaceted needs of people with drug dependence. An effective treatment system should engage and coordinate between psychological and mental health care, social services (housing, job skills, employment, legal assistance), and specialist health care (services for HIV, hepatitis C virus, tuberculosis and other infections). Fidelity, effectiveness and quality of services should be regularly monitored through a comprehensive outcome-based monitoring and evaluation framework. In relation to the outcome of treatment for people with drug dependence, complete abstinence from drug use may not be a desirable or appropriate goal for everyone. In 2017, the International Narcotics Control Board noted: "It has been demonstrated that even without achieving complete abstinence, some people may be able to reduce the harmful consequences of their drug use and may go on to lead relatively stable and productive lives."<sup>13</sup>

The following outcomes prioritizing improved health and social functioning and reduction in high-risk drug use patterns are recommended by the WHO and UNODC *International Standards for the Treatment of Drug Use Disorders*:<sup>14</sup>

- reduce drug use and cravings for drug use;
- improve health, well-being and social functioning of the affected individual;
- prevent future harms by decreasing the risk of complications and relapse.

All people who use drugs may benefit from low-threshold, person-centred<sup>15</sup> harm reduction interventions that encourage positive change in people's lives without requiring them to stop using drugs as a precondition for accessing services. Alongside more "traditional" harm reduction strategies, such as opioid agonist treatment and needle and syringe programmes for preventing and treating blood-borne infections and overdose, complementary health and social services should be provided to address individuals' whole-person needs beyond their drug use or medical condition.<sup>16</sup> These needs are often complex, intersectional and shaped by social determinants of health, which may include assistance for housing, legal issues, employment and income.

It is important to emphasize that treatment, harm reduction and support services are most effective and responsive to individual needs when designed in close partnership with people who use drugs.<sup>17</sup> The meaningful involvement of people with lived experience of drug use in all aspects of service design, delivery, monitoring and evaluation is associated with reduced HIV incidence and prevalence, increased service access, acceptability and quality, improvements in reducing risk behaviours and reduced stigma and discrimination.<sup>18</sup>

<sup>13</sup> International Narcotics Control Board, 2017.

<sup>14</sup> WHO and UNODC, 2017.

<sup>15</sup> Low-threshold harm reduction services are easily accessible in community settings where people live, work and use drugs. They do not impose abstinence from drugs as a condition for service access, and they endeavor to reduce other documented barriers to service access. Person-centered harm reduction services refer to those organized around a person as an autonomous whole rather than focusing on their drug use or medical condition. See Islam and others, 2013; Harm Reduction International, 2021.

<sup>16</sup> UNODC, 2014a; WHO, UNAIDS and UNODC, 2012.

<sup>17</sup> Jürgens, 2008; INPUD and UNODC, 2017.

<sup>18</sup> Chang and others, 2021.

# BACKGROUND

Several key developments form the backdrop for this report. They include two United Nations Joint Statements on Compulsory Drug Detention and Rehabilitation Centres for people who use drugs (in 2012 and 2020); three regional consultations on compulsory facilities (2010–2015); and a Regional Framework for Action on Transition agreed by States participating in the Third Regional Consultation.

## 2012 United Nations Joint Statement

In March 2012, 12 United Nations entities issued a Joint Statement calling for the closure of compulsory drug detention and rehabilitation centres.<sup>19</sup> The Joint Statement observes that conditions in the centres contravene human rights and undermine the health of detainees, including by increasing vulnerability to HIV and tuberculosis infection and failing to provide effective treatment for drug dependence. The 2012 Joint Statement called on States that operate compulsory facilities to implement voluntary, evidence-informed and rights-based alternatives in communities.

## 2020 United Nations Joint Statement

In June 2020, a renewed call for the permanent closure of compulsory drug detention and rehabilitation centres as a measure for curbing the spread of COVID-19 was endorsed by 13 United Nations agencies.<sup>20</sup> The 2020 Joint Statement highlighted that people in compulsory centres are at elevated risk of

contracting COVID-19, owing to substandard living conditions, including extreme overcrowding and related challenges to enforcing physical distancing. And it called on United Nations Member States to immediately release persons detained and support their reintegration into communities.

## Regional consultations

In 2010, the UNODC Regional Office for Southeast Asia and the Pacific, the UNAIDS Regional Support Team for Asia and the Pacific and the United Nations Economic and Social Commission for Asia and the Pacific, in partnership with the Australian National Council on Drugs, initiated consultations among the nine countries covered in this report to raise awareness and promote change in the operation of compulsory facilities for people who use drugs. The consultations offered governments in East and Southeast Asia a platform to discuss voluntary, evidence-informed and human rights-based alternatives. During the First Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific in 2010, the organizing United Nations entities adopted recommendations, calling on Member States to reconsider the legal, policy and institutional environments governing national responses to drug use and dependence, including compulsory treatment and rehabilitation.<sup>21</sup>

Two more regional consultations followed. The Second Regional Consultation (in 2012) reviewed the progress made in each participating country on the implementation of the recommendations and highlighted good practices emerging in the region at that time.<sup>22</sup> During the Third Regional Consultation (2015), countries acknowledged the need to support voluntary community-based treatment and support services for people who use drugs through the implementation of a transitional framework.

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<sup>19</sup> United Nations, 2012.

<sup>20</sup> United Nations, 2020.

<sup>21</sup> First Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific (Bangkok, 2010).

<sup>22</sup> The Second Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific (Kuala Lumpur, 2012).

Countries also recognized the need for an accelerated shift in policy approaches to drugs, away from criminalization and punishment and towards health- and rights-based approaches.<sup>23</sup>

## Regional Framework for Action on Transition

The recommendations of the Third Regional Consultation focused on supporting the expansion of voluntary community-based treatment and support services through the adoption of a transition framework consisting of three pillars:

### 1. Planning and management.

A national multisector decision-making committee should be established with overall responsibility for the transition to community-based treatment and services. This body would be responsible for the development and overall implementation of a comprehensive action plan, in consultation with stakeholders from various sectors. This action plan should include objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities and provide countries with a critical platform from which to coordinate the transition.

### 2. Fostering enabling legal and policy environments.

Drug policies, defined to include laws, regulations, strategies and practices, are recognized as critical to the success of the transition to voluntary community-based treatment and support

services for people who use drugs. A shift in policy approaches to drug use and dependence—away from criminalization and punishment and towards health- and rights-based measures—should have a central role in ensuring the effectiveness of the transition.

### 3. Health and community systems-strengthening and financing.

Bottlenecks along the pathway to voluntary community-based treatment and support services for people who use drugs are largely due to weak capacity across the public health, social affairs, law enforcement and civil society sectors. Assessments need to be conducted that involve finding potential bottlenecks and ensuring that sufficient capacity is available. The assessments can then inform the development of national capacity-building plans and technical assistance mobilization plans to fill operational gaps. Systemic reforms to establish and strengthen the various mechanisms underpinning drug treatment management and operations should be accompanied by investments to support the development of expertise and workforce capacity across relevant sectors as well as within communities.

Seven years after the Third Regional Consultation, there is a need to assess the progress on national actions towards phasing out compulsory facilities for people who use drugs and scaling up voluntary community-based approaches. The findings described here present a snapshot of the regional situation.

<sup>23</sup> UNODC, ESCAP and UNAIDS, 2015.

## REGIONAL OVERVIEW

### Compulsory facilities for people who use drugs

#### Number of compulsory facilities and persons detained in compulsory facilities

At the end of 2018, the number of compulsory facilities remained high, at more than 886 facilities in seven countries with available data (Cambodia, China, Lao PDR, Malaysia, Philippines, Thailand, Viet Nam) (table 1). Four of those countries (Cambodia, Lao

PDR, Philippines, Viet Nam) registered an increase in compulsory facilities between 2012 and 2018. There was a decline in the number of compulsory facilities in China and Thailand, while the number in Malaysia remained the same. As of 2021, no country in the region had discontinued the use of compulsory treatment and rehabilitation for people who use drugs. The total number of people detained in compulsory facilities overall increased by 1 per cent between 2012 and 2018. The number fluctuated between approximately 440,000 and 500,000 people annually throughout the seven-year period (table 2 and figure 1).<sup>24</sup> At the end of 2018, at least 478,000 people were detained in compulsory centres in seven countries.

**Table 1 Number of compulsory treatment and rehabilitation facilities in East and Southeast Asia, 2012–2018**

	2012	2013	2014	2015	2016	2017	2018
<b>Cambodia</b>	10	10	10	11	11	13	13
<b>China</b>	700	700	700 <sup>a</sup>	75 <sup>b</sup>	775 <sup>c</sup>	560	570
<b>Lao PDR<sup>d</sup></b>	9	10	11	11 <sup>e</sup>	12 <sup>f</sup>	12 <sup>g</sup>	17 <sup>h</sup>
<b>Malaysia</b>	21	21	21	21 <sup>i</sup>	20	21	21
<b>Philippines</b>	37	37	37	48	48	53	60 <sup>j</sup>
<b>Thailand<sup>k</sup></b>	87	86	86	n/a	79	92	85
<b>Viet Nam</b>	110	105	83	142 <sup>l</sup>	105 <sup>m</sup>	80 <sup>n</sup>	120 <sup>o</sup>

Source: <sup>a</sup>UNAIDS and UNODC, 2015. <sup>b</sup>China Anti-Drug Network, 2015. <sup>c</sup>China Drug Control Network, 2016. <sup>d</sup>Includes standard and non-standard treatment, rehabilitation and vocational training centres. <sup>e</sup>ASEAN-NARCO, 2015. <sup>f</sup>ASEAN-NARCO, 2016. <sup>g</sup>ASEAN-NARCO, 2017. <sup>h</sup>ASEAN-NARCO, 2018. <sup>i</sup>Includes standard and non-standard treatment, rehabilitation and vocational training centres. <sup>j</sup>Includes one new facility for women. Refers to residential facilities that admit clients through voluntary and “compulsory” pathways. <sup>k</sup>Figures for Thailand for 2015–2018 include three reported facilities for women and one facility for children. <sup>l</sup>Includes both private and government-managed drug treatment facilities, of which 123 are maintained by the Government. See UNODC, 2017b. <sup>m</sup>ASEAN-NARCO, 2016. <sup>n</sup>Includes five state-managed compulsory detoxification facilities and 75 mixed facilities that offer compulsory and voluntary treatment. See Department of Social Evils Prevention, 2017. <sup>o</sup>Includes both compulsory detoxification facilities and mixed facilities that offer compulsory and voluntary treatment. See Department of Social Evils Prevention, 2019.

Note: The reported numbers refer to the period from 1 January through 31 December of each year. Unless otherwise indicated, data reported in the table for 2015–2018 are based on country responses to the 2019 UNODC and UNAIDS questionnaire in preparation for the Fourth Regional Consultation on Compulsory Centres for People Who Use Drugs in East and Southeast Asia. Data for 2012–2014 are based on country responses to the 2012 and 2015 UNODC and UNAIDS questionnaires, as reported in Lunze and others, 2018. n/a = data not available.

<sup>23</sup> Total figures for the region exclude Indonesia and Myanmar due to the lack of disaggregated data and/or insufficient data on the number of compulsory drug treatment and rehabilitation facilities and persons enrolled in such facilities.

<sup>24</sup> Total figures for the region exclude Indonesia and Myanmar due to the lack of disaggregated data and/or insufficient data on the number of compulsory drug treatment and rehabilitation facilities and persons enrolled in such facilities.



The number of individuals in compulsory treatment and rehabilitation increased in four countries between 2012 and 2018 (up by 82.5 per cent in Cambodia, by 2.2 per cent in Lao PDR, by 98.5 per cent in the Philippines and by 4.3 per cent in Thailand). A decline in the number of people enrolled in compulsory facilities was recorded in

three countries (down by 0.6 per cent in China, by 14.8 per cent in Malaysia and by 9 per cent in Viet Nam). As of 2018, Thailand anticipated an increase in the number of compulsory facilities and the number of individuals held in compulsory treatment, while Cambodia and Malaysia anticipated no change in the number of facilities.

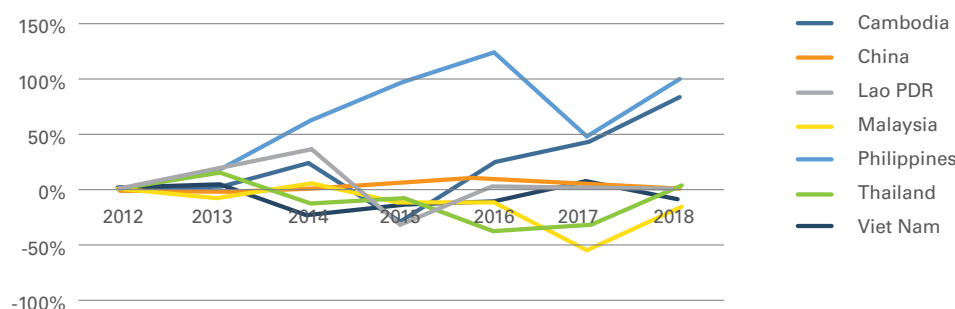
**Table 2 Number of people in compulsory treatment and rehabilitation facilities in East and Southeast Asia, 2012–2018**

	2012	2013	2014	2015	2016	2017	2018
<b>Cambodia</b>	2,600	2,713	3,249	1,852	3,243	3,751	4,746
<b>China</b>	319,000	319,000	319,000 <sup>a</sup>	340,000 <sup>b</sup>	357,000 <sup>c</sup>	337,000	317,000
<b>Lao PDR<sup>d</sup></b>	3,915	4,718	5,339	2,696 <sup>e</sup>	4,000 <sup>f</sup>	4,000 <sup>g</sup>	4,000 <sup>h</sup>
<b>Malaysia</b>	5,473	5,136	5,753	4,838	4,720	2,433	4,660
<b>Philippines</b>	2,744	3,266	4,392	5,402	6,079	4,045	5,447
<b>Thailand<sup>k</sup></b>	112,589	131,496	96,680	103,917 <sup>l</sup>	69,457	78,238	117,465 <sup>j</sup>
<b>Viet Nam</b>	27,920	29,273	21,401	24,123 <sup>k</sup>	25,484 <sup>l</sup>	30,048 <sup>m</sup>	25,400 <sup>n</sup>

Source: <sup>a</sup>UNAIDS and UNODC, 2015. <sup>b</sup>China Anti-Drug Network, 2016. <sup>c</sup>China Drug Control Network, 2016. <sup>d</sup>Figures for the Lao PDR for 2016, 2017 and 2018 represent the upper bound of the range of people in compulsory treatment facilities, reported as 3,000–4,000. <sup>e</sup>Includes only drug admissions recorded at the Somsanga Treatment and Rehabilitation Centre in Vientiane. See UNODC, 2017b. <sup>f</sup>ASEAN-NARCO, 2018. <sup>g</sup>ASEAN-NARCO, 2018. <sup>h</sup>ASEAN-NARCO, 2018. <sup>i</sup>Includes all admissions to drug dependence treatment. <sup>j</sup>Includes detention centres under the Department of Probation, Army, Royal Thai Armed Forces, Air Force, Navy, Department of Provincial Administration, Royal Thai Police, Department of Medical Services and Department of Mental Health as well as medical centres under the Ministry of Public Health. <sup>k</sup>UNODC, 2017b. <sup>l</sup>Includes people held in government drug treatment centres as well as 5,300 people held in private drug treatment facilities. See ASEAN-NARCO, 2016. <sup>m</sup>MOLISA, 2018. <sup>n</sup>ASEAN-NARCO, 2018.

Note: The reported numbers refer to the period from 1 January through 31 December of each year. Unless otherwise indicated, data reported in the table for 2015–2018 are based on country responses to the 2019 UNAIDS and UNODC questionnaire in preparation for the Fourth Regional Consultation on Compulsory Centres for People Who Use Drugs in East and Southeast Asia. Data for 2012–2014 are based on country responses to the 2012 and 2015 UNAIDS and UNODC questionnaires, as reported in Lunze and others, 2018.

**Figure 1 Percentage change in the number of people detained in compulsory facilities, 2012–2018**



Source: Percentage change since 2012 is calculated based on the figures in table 2. Unless otherwise indicated, data reported in the table for 2015–2018 are based on country responses to the 2019 UNODC and UNAIDS questionnaire in preparation for the Fourth Regional Consultation on Compulsory Centres for People Who Use Drugs in East and Southeast Asia. The reported numbers refer to the period from 1 January through 31 December of each year. Data for 2012–2014 are based on country responses to the 2012 and 2015 UNODC and UNAIDS questionnaires.

### Box 1 China's transitional measures

There has been a decline in the reported number of compulsory treatment and rehabilitation facilities in China from 700 in 2012 to 570 in 2018. As of June 2021, China has decreased the capacity in compulsory facilities by 4%. The most recent data reported by China (2019) reflects a decrease from the preceding year in the number of people in compulsory facilities by 17%. However, the number of people in compulsory treatment in China has remained nearly unchanged between 2012 and 2018.

In 2021, China reported that community-based detoxification and rehabilitation have become the main form of drug treatment for people with drug dependence. As of November 2021, there were over 280 reportedly voluntary treatment institutions and over 790 methadone treatment clinics nationwide.<sup>a</sup> While the transition from compulsory to voluntary approaches is slow, the reported data appear to indicate an expansion of voluntary treatment and harm reduction service provision in the community.

An ongoing concern is the requirement for individuals partaking in voluntary treatment and methadone providers to register client details with the government's online database.<sup>25</sup> Database registration, which targets a wide range of individuals considered threatening to national security or public order, including persons using drugs, religious minorities and criminal offenders, poses limits on rights and freedoms, including a permanent record of drug use history on an individual's national identity card and restrictions on freedom of movement.

Source: <sup>a</sup>UNAIDS and UNODC, 2019.

In Indonesia, there were 16,009 persons in 923 facilities combining voluntary and mandatory treatment under the National Narcotics Board, the Ministry of Health, the Ministry of Social Affairs and the National Police as of March 2019.<sup>26</sup> Due to insufficient data in relation to the nature of inpatient facilities under different government agencies, it was not possible to determine the number of individuals detained within the conditions outlined in the United Nations Joint Statement (2012).

In Myanmar, there are 11 compulsory rehabilitation centres under the supervision of the Ministry of Social Welfare, Relief and Resettlement for people who have already undergone drug dependence treatment. They

are located in Yangon, Mandalay, Myitkyina, Lashio, Kyaing Tong and Tachileik.<sup>27</sup> The Central Committee for Drug Abuse Control also operates three youth drug treatment and rehabilitation centres for young people who use drugs who are serving prison sentences.<sup>28</sup> The number of people detained in rehabilitation centres in Myanmar is not known.

### Detention duration

In the four countries with available data on detention duration, the average initial length of stay varied widely, with reported detention times ranging from three to 24 months (table 3).

**Table 3 Average length of stay in compulsory treatment in countries reporting data, 2018**

Country	Months
Cambodia	6
China	24 <sup>a</sup>
Malaysia	14
Myanmar	3 <sup>b</sup>
Philippines	10

Source: UNAIDS and UNODC estimates, based on responses to the regional questionnaire, 2019.

Note: <sup>a</sup>The 2008 Anti-Drug Law of the People's Republic of China and the 2011 Regulation on Drug Rehabilitation stipulate that the period for compulsory isolation for drug rehabilitation is two years. <sup>b</sup>Section 9, subsection g of the revised Drug Law 2018 establishes that a three- to five-month rehabilitation period can be imposed on individuals who fail to undertake treatment following a court's decision.

<sup>25</sup> Chin and Zhang, 2015.

<sup>26</sup> National Narcotics Board, 2019.

<sup>27</sup> ASEAN Inter-Parliamentary Assembly Advisory Council on Dangerous Drugs, 2020.

<sup>28</sup> ASEAN-NARCO, 2018.



## Substances associated with admission to treatment

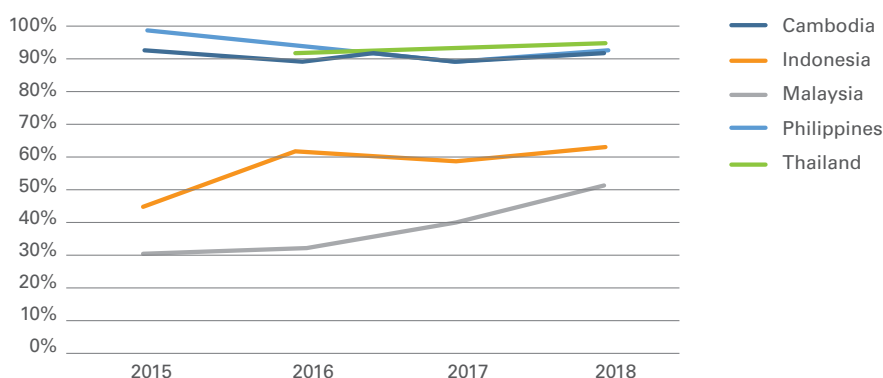
Amphetamine-type stimulants (ATS), particularly methamphetamine, were most frequently cited in relation to admissions to compulsory treatment in the countries that provided data (Cambodia, China, Indonesia, Malaysia, Philippines, Thailand). In 2018, methamphetamine in either tablet or crystalline form accounted for 51–97 per cent of treatment admissions in Cambodia, Indonesia, Malaysia, the Philippines and Thailand (figure 2). This reflects a consistent trend since 2012, associated with ATS becoming increasingly widespread throughout the region.<sup>29</sup>

In China in 2018, synthetic drugs, such as methamphetamine, accounted for approximately 46 per cent of admissions to compulsory treatment, followed by opioids (heroin), at 43 per cent, and ketamine, at 2 per cent.

A shift was observed in Malaysia, with methamphetamine surpassing opiates as the substance most commonly associated with admission to treatment in 2017 and 2018.

Heroin remains a significant concern in Myanmar, the Lao PDR and Viet Nam.<sup>30</sup> For instance, heroin accounted for 78–90 per cent of admissions to drug dependence treatment in drug treatment centres under the Ministry of Health and Sports in Myanmar during 2015–2018.<sup>31</sup>

**Figure 2 Methamphetamine use as a percentage of admissions to compulsory facilities in countries reporting data, 2015–2018**



Source: UNAIDS and UNODC estimates, based on responses to the regional questionnaire, 2019.

<sup>29</sup> UNODC, 2019.

<sup>30</sup> ASEAN Inter-Parliamentary Assembly Advisory Council on Dangerous Drugs, 2019.

<sup>31</sup> UNAIDS and UNODC, 2019.

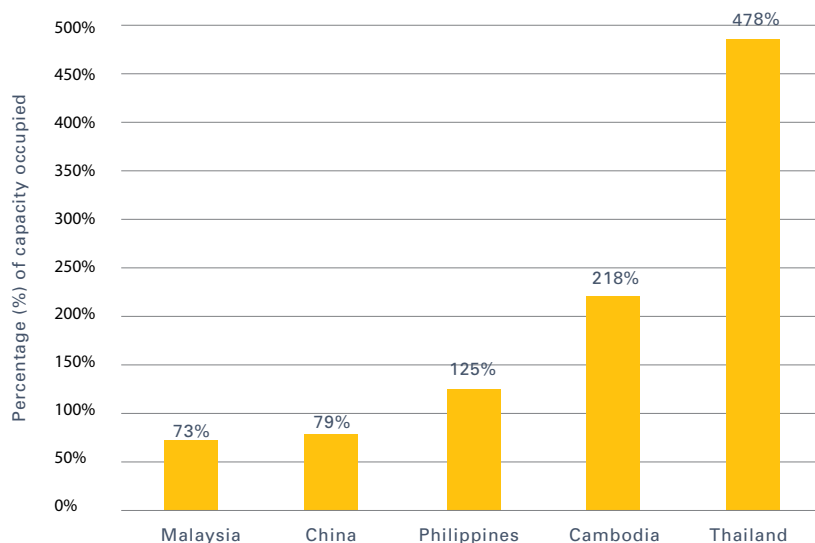
## Health and human rights in compulsory facilities

### Living conditions

Government data on levels of capacity and occupancy suggest that conditions inside compulsory facilities in many countries remain substandard. Among the five countries that reported capacity data (Cambodia, China, Malaysia, Philippines, Thailand), only facilities in China and Malaysia operated below their capacity, at 79 per cent and 73 per cent, respectively, at the end of 2018 (figure 3). Thailand had the most overcrowded compulsory treatment system,


with its capacity stretched to 478 per cent. Compulsory facilities in Cambodia operated at 218 per cent of their capacity. Built to house 4,345 individuals as of 2018, facilities in the Philippines accommodated 5,447 people, at 125 per cent of their capacity. Although precise data for Viet Nam were unavailable, in June 2019, the Minister of Labour, Invalids and Social Affairs stated that compulsory centres operated up to four times beyond their capacity. Overcrowding increases vulnerability to tuberculosis and COVID-19, in addition to creating challenges related to sanitation, physical distancing and adequate ventilation.

**Figure 3** Occupancy rate in compulsory facilities for people who use drugs in countries reporting data, 2018



Source: UNAIDS and UNODC estimates, based on responses to the regional questionnaire, 2019.

Note: The occupancy rate is presented as the total number of individuals in compulsory drug treatment as a percentage of the official reported capacity of the compulsory treatment system. Capacity is measured by the total number of beds available across compulsory facilities during the period from 1 January through 31 December 2018.



Since 2015, documentation by the United Nations, academic researchers and civil society has added to the existing body of evidence linking compulsory treatment and rehabilitation to human rights violations.<sup>34</sup> In 2018, the United Nations Human Rights Council documented allegations of arbitrary arrest and detention without due process as well as punishment amounting to torture and ill-treatment, including severe beatings of detainees, in drug detention centres in the Lao PDR.<sup>35</sup> In a 2018 qualitative study, former compulsory centre detainees in Bangkok, Thailand, reported being subjected to long hours of forced labour and physical exercise, verbal abuse and violence.<sup>36</sup>

## Drug dependence treatment and related services

### *Assessment for drug dependence*

The WHO and UNODC International Standards for the Treatment of Drug Use Disorders recommend that drug dependence treatment programmes distinguish between drug use and dependence and that clients are provided with a range of health services and treatment options to choose from, based on their individual needs.<sup>37</sup> In all nine countries considered in this assessment, individuals continued to be involuntarily admitted to treatment, at the request of their family or simply upon arrest. In most cases, they were denied the opportunity to decline the treatment or choose the type of health intervention they receive.

In practice, compulsory detention in the name of drug treatment may be imposed based solely on a positive urine drug test, which is not a reliable indicator of drug dependence or of drug use over a longer retrospective period.<sup>38</sup> In China,<sup>39</sup> Myanmar,<sup>40</sup> Thailand<sup>41</sup> and Viet Nam,<sup>42</sup> assessments of drug use and dependency leading to detention in compulsory facilities may be performed by law enforcement officers outside of health care settings and without training in drug dependence assessment or treatment. These practices contravene the WHO and UNODC international standards, which state that only qualified medical professionals should be permitted to conduct clinical diagnoses.<sup>43</sup>

The use of internationally accepted standardized screening and assessment tools for drug dependence upon entry to a compulsory facility remains uneven across the region. Six countries (Cambodia, Indonesia, Malaysia, Myanmar, Philippines, Thailand) reported using standardized and valid diagnostic instruments, specifically the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) or the Addiction Severity Index (ASI), to screen substance use severity among persons admitted to treatment.<sup>44</sup> China reported using a tool issued jointly by the Public Security, Justice and Health Departments, the Measure for Diagnosis and Assessment of Compulsory Isolation for Drug Rehabilitation, to screen and assess drug dependence in compulsory facilities.

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<sup>34</sup> Amnesty International, 2020; UN Human Rights Committee, 2018; UN Human Rights Council, 2015.

<sup>35</sup> UN Human Rights Committee, 2018.

<sup>36</sup> Kerr and others, 2018.

<sup>37</sup> WHO and UNODC, 2017.

<sup>38</sup> UNODC, 2014b.

<sup>39</sup> Government of China, 2008.

<sup>40</sup> Myanmar's amended Drug Law (2018) allows for the police to "screen" and "send" any "person suspected of using narcotic drugs" to a drug treatment centre, regardless of whether the person has committed a criminal offence and without clear indicated criteria for drug dependence. See DPAG Myanmar, 2017.

<sup>41</sup> UNODC, 2010.

<sup>42</sup> In Viet Nam, the police typically monitor people who use drugs post-detoxification as they reintegrate into the community, including determining the success or failure of these individuals in their legal requirement of abstinence (Luong and others, 2020).

<sup>43</sup> WHO and UNODC, 2017.

<sup>44</sup> WHO, 2010.

## Drug dependence treatment

By and large, compulsory facilities have failed to provide comprehensive drug dependence treatment as outlined by the WHO and UNODC<sup>45</sup> international standards and the principles for the treatment of drug use disorders, also defined by the WHO and UNODC. Opioid agonist treatment for persons with opioid dependence remains unavailable in compulsory facilities regionwide.<sup>46</sup> Pharmacological detoxification and medically supervised withdrawal management were available at the end of 2018 in compulsory treatment facilities in Cambodia, China, Indonesia, Malaysia and Myanmar.<sup>47</sup> In Thailand, medically assisted detoxification and withdrawal management for persons detained in compulsory facilities can be provided by referral,<sup>48</sup> but the conditions under which such a referral may be granted are unclear.

Beyond detoxification, the range of interventions employed by compulsory facilities in the name of drug treatment and rehabilitation varied between countries and among facilities within countries. This

is further complicated by the absence of independent accountability mechanisms in relation to drug dependence treatment in all countries.

Facilities in Cambodia,<sup>49</sup> China,<sup>50</sup> Malaysia,<sup>51</sup> Myanmar,<sup>52</sup> the Philippines<sup>53</sup> and Thailand<sup>54</sup> have been documented to employ physical exercise drills as part of the treatment and rehabilitation process, despite physical exercise lacking scientific basis as a component of treatment for drug dependence.

There is evidence that compulsory facilities in Cambodia,<sup>55</sup> China,<sup>56</sup> Lao PDR,<sup>57</sup> Thailand<sup>58</sup> and Viet Nam<sup>59</sup> retained a strict disciplinary regime, as well as forced labour, as part of the detoxification process. The imposition of labour as treatment for drug dependence is not supported by scientific evidence.<sup>60</sup> It also constitutes a violation of international human rights law, as specified in Article 4 of the Universal Declaration of Human Rights stating that “No one shall be held in slavery or servitude”<sup>61</sup> and Article 8 of the International Covenant on Civil and Political Rights, according to which “No one shall be required to perform forced or compulsory labour.”<sup>62</sup>

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<sup>45</sup> UNODC and WHO, 2008.

<sup>46</sup> UNAIDS and UNODC, 2019.

<sup>47</sup> *ibid.*

<sup>48</sup> *ibid.*

<sup>49</sup> Kamarulzaman and McBrayer, 2015.

<sup>50</sup> Chin and Zhang, 2015.

<sup>51</sup> Kamarulzaman and McBrayer, 2015.

<sup>52</sup> UNAIDS, 2016.

<sup>53</sup> Health Facilities and Services Regulatory Bureau, 2018.

<sup>54</sup> Kerr and others, 2018.

<sup>55</sup> ILO Committee of Experts on the Application of Conventions and Recommendations, 2015.

<sup>56</sup> Zhang and others, 2015.

<sup>57</sup> UN Human Rights Committee, 2018.

<sup>58</sup> Kerr and others, 2018.

<sup>59</sup> UN Human Rights Committee, 2019.

<sup>60</sup> WHO and UNODC, 2017.

<sup>61</sup> United Nations General Assembly, 1948.

<sup>62</sup> United Nations General Assembly, 1946.

## Box 2 Arbitrary detention relating to drug policies

In July 2021, the Working Group on Arbitrary Detention, composed of five independent experts appointed by the United Nations Human Rights Council, published a study detailing how drug policies can result in human rights violations relating to arbitrary detention.<sup>a</sup> According to the study, state-run compulsory drug detention facilities operate in Cambodia, China, Indonesia, Lao PDR, Malaysia, Philippines, Singapore, Sri Lanka, Thailand and Viet Nam. The report documented ongoing health and human rights violations in these facilities, including “painful unmedicated withdrawal, beatings, military drills, verbal abuse and sometimes scientific experimentation without informed consent”, “forced labour, without pay or at extremely low wages ... with detainees punished if work quotas are not met” and, in some cases, “deaths ... due to severe beatings”. The report noted that for even minor infractions of the rules, detainees could be subject to “severe beatings, solitary confinement and other harsh punishments”.

The report called on States to “close without delay state-run compulsory drug detention centres and private treatment facilities that hold persons against their will”, “institute moratoria on further admissions awaiting reform” and “make available voluntary, evidence-informed and rights-based health and social services in the community” as an alternative to compulsory facilities. These recommendations are aligned with the findings of the present report and reflect the commitment of the United Nations system to support States to design and implement “national drug control programmes, strategies and policies ... in accordance with their human rights obligations.”<sup>b</sup>

Source: <sup>a</sup>OHCHR Working Group on Arbitrary Detention, 2021; <sup>b</sup>United Nations System Coordination Task Team, 2019.

## Psychosocial support

Mental health challenges were commonly cited concerns among detainees in compulsory treatment. Cambodia, China, Indonesia, Malaysia and Myanmar<sup>63</sup> reported offering some form of drug dependence and/or psychological counselling in government-run compulsory facilities.<sup>64</sup>

Psychiatric, psychosocial and counselling interventions employed in compulsory facilities differed across the region and were not uniformly applied across facilities within countries. In several countries (Malaysia,<sup>65</sup> Myanmar,<sup>66</sup> Indonesia,<sup>67</sup> Philippines<sup>68</sup>), psychosocial support in compulsory facilities commonly involved spiritual or religious components.

Lido, one of Indonesia’s largest inpatient residential treatment centres managed by the National Narcotics Board, provides individual counselling, cognitive behavioural therapy, motivational interviewing and family support groups guided by the therapeutic community method.<sup>69</sup> Elsewhere in the country, rehabilitation services under the Ministry of Social Affairs included case management, self-help groups and religious and spiritual counselling, while medical rehabilitation programmes under the Ministry of Health also offer drug dependence counselling.<sup>70</sup> Some of the therapies endorsed by the different sets of guidelines and agencies’ standard operating procedures, including spiritual and religious components, are inconsistent with the WHO and UNODC international standards.

<sup>63</sup> Psychosocial support is offered in major drug treatment centres under the Ministry of Health and Sports; it is not known whether such interventions are available in rehabilitation centres.

<sup>64</sup> UNAIDS and UNODC, 2019.

<sup>65</sup> Mohamed and Marican, 2017.

<sup>66</sup> Gooch, 2016.

<sup>67</sup> Larasati, Christian and Misero, 2017.

<sup>68</sup> Health Facilities and Services Regulatory Bureau, 2018.

<sup>69</sup> According to the WHO and UNODC International Standards (2017), therapeutic community is a long-term abstinence-based treatment model that uses active participation in drug-free community living and activities to support the attainment of individual therapeutic goals. The International Standards note that the evidence on the effectiveness of this model is limited. The Cochrane review on therapeutic communities, for example, found evidence to support its efficacy only in prison settings. But there is no specific WHO guidance on it. See Badan Narkotika Nasional, 2019.

<sup>70</sup> Larasati, Christian and Misero, 2017.

There is limited information on the availability of treatment modalities specifically designed to treat ATS dependence in compulsory facilities. In the absence of integrated evidence-based pharmacological interventions for ATS, what exists consists mainly of behavioural interventions for psychostimulant dependence as well as psychosocial and medical support for stimulant-induced psychosis and other comorbidities.<sup>71</sup> In 2017, Myanmar introduced national guidelines for ATS treatment,<sup>72</sup> but it is unclear to what extent they have been applied in practice.

### **Drug use cessation and relapse**

Across the region, countries continue to rely on abstinence as the main indicator of successful drug dependence treatment, typically using therapeutic community approaches enforced through mandatory urine testing. All countries that provided data reported conducting regular urine drug testing inside their compulsory facilities.

#### **Box 3 A need to move beyond abstinence-based measures**

Abstinence is not an appropriate measure of effective drug dependence treatment for everyone. The WHO and UNODC International Standards for the Treatment of Drug Use Disorders call for a range of biological, behavioural, socioeconomic, structural and quality-of-life components linked to an individual's personal social determinants of health to be taken into account when assessing the attainment of individual treatment goals.<sup>a</sup> The UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia states that individual treatment goals may include a combination of reduction in drug use, abstinence, improved physical and mental health, improved social adjustment and functioning, reduction in criminal behaviour and other goals according to each person's unique and complex needs.<sup>b</sup> Recognizing that abstinence is not a desirable or realistic goal for everyone allows services to focus on reducing harms and providing more effective person-centred care.

Source: <sup>a</sup>WHO and UNODC, 2017; <sup>b</sup>UNODC, 2014a.

Accounts from four countries documented high levels of relapse to drug use,<sup>73</sup> ranging from 33 per cent in Malaysia to 60 per cent in Indonesia (table 4). Only Malaysia and Thailand reported empirically tracking drug relapse rates post-release from compulsory detention. Although Thailand's Department of

Probation registered a 1.6 per cent relapse rate among persons released from compulsory centres in 2018, it is likely to be a sizeable underestimation and reflects retainer bias because the figures included only individuals who voluntarily attended follow-up sessions after release.<sup>74</sup>

<sup>71</sup> UNODC, 2017c.

<sup>72</sup> Department of Medical Services, MOHS and WHO, 2017.

<sup>73</sup> The WHO defines relapse as return drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms.

<sup>74</sup> Pearshouse, 2002.

Although relapse to drug use often takes place in the weeks following release from a compulsory facility,<sup>75</sup> none of the countries providing data reported offering relapse prevention, comprehensive medical check-ups or referrals to specialized health and social support

services post-release from compulsory treatment. China, Thailand and Indonesia confirmed tracking individuals for up to six months post-release but did not document relapse rates.

**Table 4 Relapse rates post-release from compulsory facilities in countries reporting data, 2018**

Country	Estimated relapse rate
Cambodia	>50%
Indonesia	60%
Malaysia	33%

Source: UNAIDS and UNODC estimates, based on responses to the regional questionnaire, 2019.

Note: Figures for Cambodia and Indonesia (2019) are based on approximate expert estimates. The estimate for Indonesia includes only drug treatment centres managed by the National Narcotics Board. Figures for Malaysia (2019) are based on empirical data.

#### Box 4 Relapse and compulsory treatment

The UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia recognizes that “relapse is part of the treatment process” and should not incur punishment.<sup>a</sup> There is no evidence that compulsory treatment and rehabilitation result in sustained positive impacts on drug use.<sup>b</sup> Recent studies of former detainees of compulsory facilities in Malaysia and Thailand further substantiate existing evidence showing that compulsory drug detention is associated with short-term drug cessation and high rates of relapse.<sup>c</sup> For example, a prospective observational study in Malaysia found that individuals enrolled in a voluntary methadone programme had a seven-fold decreased risk of relapse to opioids and any illicit drugs following treatment, compared with similarly matched individuals released from compulsory drug detention centres.<sup>d</sup> This is in contrast to the significantly lower risk of relapse and reduced drug use reported by individuals who voluntarily took part in a methadone treatment programme.<sup>e</sup> High relapse rates may also mean potential multiple terms in compulsory facilities for repeat offenders who are sent back to them.<sup>f</sup>

Source: <sup>a</sup>UNODC, 2014a; <sup>b</sup>Werb and others, 2016; <sup>c</sup>Wegman and others, 2017; Fairbairn and others, 2015; <sup>d</sup>Wegman and others, 2017; <sup>e</sup>ibid.; <sup>f</sup>Edington, 2016.

### Overdose prevention and reversal

People who use drugs are at increased risk of overdose after their release from detention,<sup>76</sup> with the risk of overdose being highest in the days and weeks immediately after release.<sup>77</sup> Only China and Malaysia reported providing some form of overdose prevention services in compulsory facilities. None of the countries that provided data (Cambodia, China, Indonesia, Malaysia, Myanmar, Philippines, Thailand) have offered peer-led naloxone distribution in compulsory facilities or after release.

Overdose prevention and management strategies supported by scientific evidence include opioid agonist treatment; overdose prevention and reversal training for staff and detainees; peer distribution of naloxone to reverse the symptoms of opioid overdose; and continuity of care, including via pre-release assessments and referrals to treatment in community settings, reintegration programmes and adequate follow-up post-release.<sup>78</sup>

<sup>75</sup> Wegman and others, 2017.

<sup>76</sup> Kamarulzaman and McBrayer, 2015.

<sup>77</sup> WHO, 2014.

<sup>78</sup> Wenger and others, 2019; WHO, 2014.



## Prevention, treatment and care for HIV and other communicable diseases

The most commonly cited risk factor for HIV inside compulsory facilities in Cambodia, Indonesia, Malaysia, Myanmar, Philippines, and Thailand was vaginal or anal sex without a condom. This was followed by violence-related blood splatters and the sharing of unsterile equipment for piercings, self-scarring and hair clipping.

Typical health problems among detainees in compulsory treatment in the countries that provided data (Cambodia, China, Indonesia, Malaysia, Myanmar, Philippines, Thailand) included cardiovascular diseases, tuberculosis and other communicable diseases with epidemic potential, such as acute respiratory infections and scabies.<sup>79</sup>

Detention in compulsory centres has been associated with elevated risk of acquiring HIV and not receiving antiretroviral therapy,<sup>80</sup> with repeat detainment associated with greater risk of HIV infection.<sup>81</sup> Free condoms and sterile injecting equipment were unavailable inside compulsory facilities in all the countries. Among the seven countries with available data, China, Indonesia and Malaysia reported that HIV screening was available in compulsory treatment facilities, but only Indonesia and Malaysia reported that referral to or continuation of antiretroviral therapy was provided for people living with HIV in such facilities. A 2015 study in Guangxi Province found that practices surrounding HIV service provision in compulsory isolation centres were at odds with international guidance<sup>82</sup> due to the lack of pre- and post-test

counselling by a qualified medical professional, failure to disclose results to the persons tested, breaches of confidentiality and inadequate access to antiretroviral therapy.<sup>83</sup>

Prevention, treatment and care for HIV, hepatitis C virus and tuberculosis were unavailable in compulsory centres in Cambodia and Thailand.<sup>84</sup> Thai authorities reported that screening for and referral to treatment for HIV, viral hepatitis (hepatitis B and C), and tuberculosis was typically conducted by a health professional prior to detention. In Yangon, Myanmar, individuals eligible for opioid agonist treatment with methadone may be screened for HIV and hepatitis B and C at drug treatment centres under the Ministry of Health and Sports,<sup>85</sup> but information on the availability of these services in compulsory rehabilitation centres was not available.

## Staff composition

Compulsory facilities in East and Southeast Asia continued to be overwhelmingly managed by the criminal justice system. Typically, facilities were supervised by custodial personnel, with few non-custodial staff, such as doctors, nurses, counsellors and substance-use specialists, on site. Cambodia reported 381 custodial staff (comprising 75 per cent of all staff) and 23 non-custodial staff (5 per cent of all staff) working across its 13 compulsory facilities (figure 4). Malaysia's 31 compulsory centres for people who use drugs employed 921 non-custodial staff (37 per cent of all staff) and 1,274 custodial staff (50 per cent of all staff).

<sup>79</sup> UNAIDS and UNODC, 2019.

<sup>80</sup> Hayashi and others, 2015.

<sup>81</sup> Zhang and others, 2015.

<sup>82</sup> WHO, 2016.

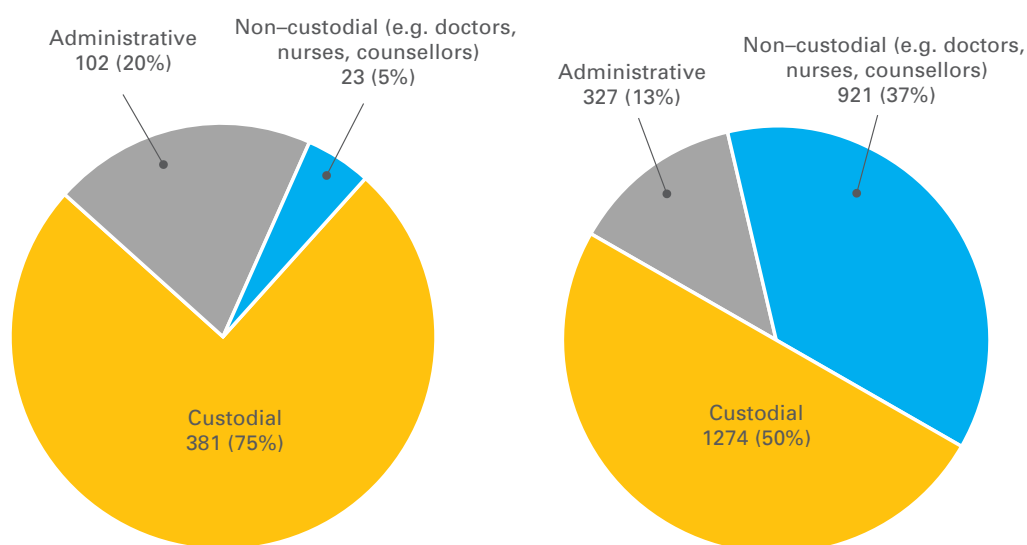
<sup>83</sup> Zhang and others, 2015.

<sup>84</sup> UNAIDS and UNODC, 2019.

<sup>85</sup> Aye and others, 2018.



**Figure 4 Staffing in compulsory treatment facilities in Cambodia (left) and Malaysia (right), 2018**



Source: UNAIDS and UNODC estimates, based on responses to the regional questionnaire, 2019.

### Costs associated with compulsory treatment and rehabilitation

Reliable data on government spending related to compulsory treatment and rehabilitation were challenging to source, either due to a lack of transparency or effective tracking systems. In most cases, governments were not forthcoming in sharing information on expenditure and budgets related to compulsory facilities and the redirection of funds towards voluntary, community-based drug treatment services. Among the three countries that provided data (Cambodia, Malaysia, Thailand), Malaysia reported the highest operational cost for compulsory centres, at \$3,935 (16,425 ringgit) per person per year.<sup>86</sup> In

2018, Malaysia spent nearly \$70.8 million (295,490,229 ringgit) on operational costs for compulsory centres.

Cambodia spends \$897 per person per year in relation to compulsory centres.<sup>87</sup> In 2018, Cambodia spent more than \$4.2 million to keep 4,746 persons in compulsory centres, representing approximately 77 per cent of the total budget for drug dependence treatment allocated that year. Thailand spends \$412–\$983 (12,450 baht–29,700 baht) per person per year.<sup>88</sup> Thailand's allocated drug dependence treatment budget for 2019 totalled more than \$55.4 million (1,675,454,700 baht), but it is not known what proportion of that amount was spent on operating compulsory facilities for people who use drugs.

<sup>86</sup> The currency exchange rate is approximate and based on monthly average rates for December 2018. See UNAIDS and UNODC, 2019.

<sup>87</sup> Figures for Cambodia refer to cost per person per treatment episode. Duration of stay in compulsory facilities varies depending on treatment plan (intensive versus non-intensive).

<sup>88</sup> The currency exchange rate is approximate and based on monthly average rates for December 2019. See UNAIDS and UNODC, 2019.

## Voluntary community-based drug dependence treatment and support services

At the Third Regional Consultation (2015), countries pledged to implement the recommendations of the Regional Framework for Action on Transition from compulsory facilities towards voluntary community-based approaches.<sup>89</sup> The recommendations focused on supporting the transition through the adoption of a national transition framework consisting of three elements: (i) planning and management; (ii) enabling legal and policy environment; and (iii) health and community systems-strengthening and financing.

The shift towards voluntary community-based services for people who use drugs continues to stall in most countries. While some countries have taken incremental steps towards phasing out compulsory treatment facilities, progress towards scaling up voluntary community-based approaches has been slow (table 5).

### Planning and management

Of the seven countries that provided data (Cambodia, China, Indonesia, Malaysia, Myanmar, Philippines, Thailand), none had established a national multisector

decision-making committee with responsibility for the transition to community-based treatment. Nor had they developed a comprehensive action plan to coordinate the transition, as defined in the Regional Framework for Action on Transition (table 5).

Few countries had evaluated the performance of their national compulsory treatment infrastructure since 2015, and none had done so via independent evaluations.<sup>90</sup> Among the seven countries reporting data, China, Indonesia, Malaysia and Thailand reported having evaluated their drug dependence treatment system. But in all cases, these evaluations typically sought to determine whether protocols had been implemented in accordance with internal standard operating procedures and objectives rather than whether these centres reflected international standards for drug dependence treatment and human rights.

### Voluntary community-based alternatives to compulsory treatment and rehabilitation

Overall, voluntary community-based drug dependence treatment approaches remained small in scale and insufficiently available in the region. Where they exist, these programmes have been implemented alongside rather than as a replacement to compulsory facilities.

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<sup>89</sup> UNODC, ESCAP and UNAIDS, 2015.

<sup>90</sup> UNDP, 2016.

**Table 5 Status of the outcomes of the Regional Framework for Action on Transition, 2019**

	Cambodia	China	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Thailand	Viet Nam
<b>Element 1: Planning and management</b>									
Multisector committee on transition	✗	n/a	✗	n/a	✗	n/a	n/a	✗	n/a
National action plan on transition	✗	n/a	✗	n/a	✗	n/a	n/a	✗	n/a
<b>Element 2: Fostering enabling legal and policy environments</b>									
Programmes with judiciary, legal service providers and law enforcement	✓	✓	✓	n/a	✗	✗	n/a	✓	n/a
Alternatives to incarceration for drug use and related offences	✓	✗	✓	n/a	✓	✗	n/a	✓	n/a
Depenalization (reduction in the level of penalties for drug use and/or possession)	✗	✗	✗	n/a	✗	✗	n/a	✓*	n/a
Decriminalization of drug use and the possession, purchase and cultivation of controlled substances for personal consumption	✗	✗	✗	n/a	✗	✗	n/a	✗	n/a
Diversion towards health and social services at the point of arrest, prosecution and sentencing	✓	✗	✗	n/a	✓	✗	n/a	✓	n/a
Legal regulation, for certain types of drugs	✗	✗	✗	n/a	✗	✗	n/a	✓	n/a
Removal of arrest quotas	✗	✓	✗	n/a	✗	✗	n/a	✗	n/a
<b>Element 3: Health and community systems-strengthening and financing</b>									
Comprehensive assessment of national systems and capacity across different sectors	✗	n/a	✗	n/a	✓	n/a	n/a	✗	n/a
Specialized training for the delivery of voluntary community-based services	✓	✓	✓	n/a	✓	✓	n/a	✗	n/a
Awareness-raising and capacity-building regarding community-based treatment	✓	✓	✓	n/a	✓	✓	n/a	✓	n/a
Mapping of resources allocated to different treatment systems	✓	n/a	✓	n/a	✓	n/a	n/a	✓	n/a
Cost-effectiveness studies comparing compulsory facilities for people who use drugs and voluntary community-based approaches	✗	n/a	✗	n/a	✗	✗	n/a	✗	n/a
Reallocation of human and financial resources from compulsory facilities for people who use drugs to voluntary community-based treatment	✓	n/a	✗	n/a	✗	n/a	n/a	✗	n/a
Increase in government investments for voluntary community-based treatment	✓	✓	✓	n/a	✓	✗	n/a	✓	n/a

Source: UNAIDS and UNODC data, based on responses to the regional questionnaire, 2019; n/a indicates non-response.

Note: \* As of 9 December 2021, Thailand enacted a new Narcotics Code that consolidates prior legislation regulating narcotics and psychotropic substances.

Since 2015, several countries have developed localized versions of community-based treatment. These programmes vary widely, both operationally and ideologically. The following provides a brief update on the status of voluntary community-based approaches.

### Cambodia

Community-based treatment and care services are provided in 451 health centres across the country.<sup>91</sup> These services are based on a community-based treatment and care programme focused on ATS that launched in Phnom Penh in 2014 after a UNODC-backed pilot programme was completed in Banteay Meanchey, Battambang and Stung Treng provinces.<sup>92</sup> The programme is guided by standard operating procedures and supported by training provided to health centres to allow for evidence-based drug dependence assessment using standardized tools (ASSIST, for example), individualized treatment planning, counselling techniques, pharmacotherapy and referrals to methadone treatment.<sup>93</sup>

### China

Voluntary treatment is provided by government and private clinics, with government clinics generally implementing a zero-tolerance policy towards drug use.<sup>94</sup> Because no minimum quality standards for voluntary services are stipulated,<sup>95</sup> treatment modalities vary. China also implements an extensive government-backed network of methadone clinics. By November 2021, at least 790 methadone maintenance treatment clinics provided methadone to 91,000 people in 31 provinces.<sup>96</sup>

Under the 2008 Anti-Drug Law, community-based treatment can be arbitrarily imposed by the police on any person suspected of drug use who is not enrolled in voluntary treatment.<sup>97</sup> As of 2018, there were 242,000 people in community-based treatment, representing a 78 per cent increase from the 136,000 people in 2012.<sup>98</sup> National treatment regulations specify that counselling, skills training and employment should be provided as part of the treatment regime.<sup>99</sup> Interventions provided as part of community-based treatment have been reported to involve compulsory prescheduled and random urine testing and restrictions to individual freedom of movement, both of which the police enforce.<sup>100</sup>

### Indonesia

Mandatory and voluntary drug treatment and rehabilitation programmes are offered by a variety of government, NGO, faith-based and private facilities. Examples of voluntary, community-based approaches that provide a menu of treatment options based on individual needs, including access to harm reduction services, and that are aligned with the WHO and UNODC international standards have been documented (Rumah Singgah Peka, for example).<sup>101</sup> As of 2021, however, these programmes continue to be implemented on a small scale by NGOs. As of 2018, opioid agonist treatment was provided at 92 sites across 18 provinces, including 44 community health centres, 29 public hospitals, 9 psychiatric hospitals and 10 prisons.<sup>102</sup>

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<sup>91</sup> Chheng, 2020.

<sup>92</sup> UNODC, 2017a.

<sup>93</sup> Tanguay and others, 2015.

<sup>94</sup> Tibke, 2017.

<sup>95</sup> Government of China, 2011 and 2008.

<sup>96</sup> UNAIDS and UNODC, 2019.

<sup>97</sup> Government of China, 2008.

<sup>98</sup> LSE International Drug Policy Unit, 2018.

<sup>99</sup> Government of China, 2011.

<sup>100</sup> Tibke, 2017.

<sup>101</sup> Simon, 2019; Stoicescu and others, 2015; Tanguay and others, 2015.

<sup>102</sup> Kementrian Hukum dan Hak Asasi Manusia, 2018; Wulansari and Makful, 2018.

## Lao PDR

Community-based drug treatment was initiated in 2012 with two pilot sites in Vientiane. As of 2018, there were 28 outpatient community-based treatment programmes at district hospitals that had enrolled a cumulative total of 2,737 people since 2015.<sup>103</sup> The programme, targeted towards people who use ATS, included screening using ASSIST, personalized treatment plans, counselling and access to symptomatic medical treatment based on need. In 2018, the Government expressed its intention to scale up counselling services for ATS users.<sup>104</sup> The services remain concentrated in the capital, however.

## Malaysia

Despite a substantial body of evidence demonstrating the effectiveness of voluntary approaches on individuals' drug use, health and social outcomes in Malaysia,<sup>105</sup> only about one third of compulsory facilities that were operational in 2010 have been transformed into voluntary Cure and Care facilities across the country. Among the services offered at the Cure and Care clinics were inpatient and/or outpatient methadone treatment services, medical care, psychosocial interventions, recreational activities (group games, hiking trips, artistic activities, dance and musical therapy) as well as group and individual vocational training.<sup>106</sup> The Government reported in 2019 that additional options have been added to the menu of services offered at the Cure and Care clinics and service centres, including vocational training, job placement and modules addressing ATS use and dependence.<sup>107</sup>

By 2015, there were 59 voluntary Cure and Care clinics and outpatient service centres operating in Malaysia, overseen by the National Anti-Drugs Agency.<sup>108</sup> However, by June 2021, four voluntary Cure and Care service centres had been shut down by the National Anti-Drugs Agency,<sup>109</sup> with further closures planned for 2022 and beyond.<sup>110</sup> Since 2015, there has been no diversion of resources away from compulsory to voluntary treatment.<sup>111</sup>

## Myanmar

In 2019, 10,346 people who use drugs accessed drug treatment services at 29 major and 56 minor drug treatment centres attached to hospitals under the Ministry of Health and Sports.<sup>112</sup> Specialized treatment facilities and capacity to deliver services remained limited, especially outside of Yangon.<sup>113</sup> In 2016–2017, trainings were conducted by UNODC in partnership with the Central Committee for Drug Abuse Control, the Ministry of Home Affairs, the National Drug Abuse Control Programme and the Ministry of Health and Sports to increase the capacity of the service providers of community-based services for people who use drugs.<sup>114</sup>

Myanmar also implements a national methadone treatment programme in partnership with United Nations agencies, the National AIDS Program and NGOs.<sup>115</sup> In 2019, 20,028 individuals (7,614 newly enrolled) accessed methadone at 71 clinics across Yangon Region, Mandalay, Sagaing Region, Shan State and Kachin State.<sup>116</sup>

<sup>103</sup> ASEAN-NARCO, 2018.

<sup>104</sup> *ibid.*

<sup>105</sup> Khan and others, 2018; Mohamed and Marican, 2017; Wegman and others 2017; Krishnan and other 2016; Ghani, 2015.

<sup>106</sup> Shanmugam, 2020.

<sup>107</sup> UNAIDS and UNODC, 2019.

<sup>108</sup> Tanguay, Stoicescu and Cook, 2015.

<sup>109</sup> The four facilities that were closed were Kerinchi, Kulim, Kampar and Sri Aman. Three were converted into Agensi Antidadah Kebangsaan district offices and one was permanently shut down.

<sup>110</sup> Personal communication with Yaner Lim, Centre of Excellence for Research in AIDS, and Cik Nur Izzati bt Naim, Community Rehabilitation Division AADK, 27 April 2021.

<sup>111</sup> UNAIDS and UNODC, 2019; Tanguay and others, 2015.

<sup>112</sup> ASEAN-NARCO, 2019.

<sup>113</sup> DPAG Myanmar, 2017.

<sup>114</sup> UNODC, 2017a.

<sup>115</sup> Ministry of Health and Sports, 2017.

<sup>116</sup> ASEAN-NARCO, 2019.

## Philippines

Various iterations of community-based treatment are implemented by local government units, the Philippine Drug Enforcement Agency, the National Police as well as NGOs and private centres.<sup>117</sup> The majority promote abstinence, enforced through mandatory regular urine drug testing, and many operate via outpatient services. Models highlighted on the Dangerous Drugs Board online community-based treatment and care portal range from faith-based programmes with substantial religious components, educational seminars and community service (such as

cleaning and tree planting)<sup>118</sup> to the popular Resilience Against Drugs model in Quezon City, which offers individualized counselling and modules on adaptive coping and life skills.<sup>119</sup> An especially promising example promoted by that the Department of Health and supported by the WHO and UNODC Philippines are Recovery Clinics, voluntary outpatient facilities that employ client-centred treatment plans informed by community-based treatment guidance. As of June 2021, Recovery Clinics were piloted at six sites around the country.<sup>120</sup>

### Box 5 Community-based treatment guidance in the Philippines

The development of policy and guidance documents to strengthen the provision of community-based treatment in the Philippines has accelerated rapidly since 2016. This includes the publication by the Department of Health of an adapted version of the UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia (2017)<sup>121</sup> and the issuance of Dangerous Drugs Board Regulation No. 4, 2016 (later amended by Dangerous Drugs Board Regulation No. 7, 2019), which provided guidance on implementing community-based drug treatment and conducting related drug dependence screening, risk identification and assessment and referral for persons targeted by or forced to surrender to authorities. The promotion of community-based treatment and care in policy documents is promising, but their dissemination and practice must be strengthened.

## Thailand

The National Drug Control strategy has recognized voluntary access to treatment since 2016 and is officially overseen by the Ministry of Public Health.<sup>122</sup> The Government reported that targeted resources have been allocated towards community-based treatment since 2019, and a community-based treatment handbook and guidelines have been developed.<sup>123</sup> In practice, interventions differ substantially

among providers. A mix of outpatient and inpatient services are offered through hospitals in the general health care system, but most are privately operated.<sup>124</sup> Military camps, temples and mosques are also used as alternative drug treatment and rehabilitation centres.<sup>125</sup>

Drug treatment procedures under the public health system include screening of drug use or severity

<sup>117</sup> Dangerous Drugs Board, 2016.

<sup>118</sup> Hechanova, 2019.

<sup>119</sup> See [www.ddb.gov.ph/sidebar/301-community-based-treatment-and-rehabilitation-resources](http://www.ddb.gov.ph/sidebar/301-community-based-treatment-and-rehabilitation-resources); also see Hechanova and others, 2018.

<sup>120</sup> Department of Health, 2020.


<sup>121</sup> Department of Health, 2017.

<sup>122</sup> UNAIDS and UNODC, 2019.

<sup>123</sup> *ibid.*

<sup>124</sup> Saingam, 2018.

<sup>125</sup> Saingam, 2018; Kaewkham and others, 2019.



using a Ministry of Public Health-adapted ASSIST tool; provision of brief interventions to people who use drugs and who are deemed to be at low to moderate risk; and treatment, rehabilitation and relapse prevention with an emphasis on psychosocial interventions modelled on the FAST<sup>126</sup> model of drug treatment. People who use drugs with psychiatric comorbidities are referred to psychiatric hospitals.<sup>127</sup> A variety of treatment modalities are also offered by private centres, including therapeutic community, faith-based, spirituality teaching (such as the Twelve Steps of Buddhism adapted from the 12-step model),<sup>128</sup> vocational training and relapse-prevention counselling.<sup>129</sup> Promising community-based options are being increasingly implemented outside of detention settings. These include the community-owned Comprehensive Program for Methamphetamine in northern Thailand, which was documented in the 2015 Expert Working Group discussion paper,<sup>130</sup> and the Matrix outpatient treatment programme for ATS use and dependence.<sup>131</sup>

## Viet Nam

Voluntary treatment is provided through community- or home-based outpatient programmes, including methadone clinics for people who use opiates. In 2018, 6,043 people were in voluntary treatment in public establishments, 22,937 people were in home-based treatment.<sup>132</sup> As of September 2019, 52,200 people had accessed methadone maintenance treatment at 335 sites across Viet Nam's 63 provinces and cities.<sup>133</sup>

Because ATS use has surged in Viet Nam,<sup>134</sup> a notable gap has opened in relation to voluntary evidence-based interventions for ATS use and dependence.<sup>135</sup> The standard treatment approach for ATS is referral to a psychiatric hospital. Although ATS harm reduction models are being developed by NGOs,<sup>136</sup> they remain small in scale.

## Drug policy reform supporting public health and human rights

### *Decriminalization of drug use and possession for personal use*

Decriminalization refers to the removal or non-enforcement of criminal penalties for drug law violations, such as drug use and possession for personal use of illegal and controlled drugs. In relation to compulsory treatment and rehabilitation, decriminalizing possession along with investment in voluntary community-based treatment and harm reduction services would significantly reduce the harms associated with drugs and criminalizing policies while improving public safety and public health.<sup>137</sup>

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<sup>126</sup> The FAST model is a variant of the therapeutic community approach developed by the Thanyarak Institute on Drug Abuse. FAST is an acronym that refers to family, alternative activities, self-help and therapeutic community work.

<sup>127</sup> Saingam, 2018.

<sup>128</sup> Saengchanchai, Netrakhom and Heerhunwiwatgul, 2006.

<sup>129</sup> Tanguay and Ngamdee, 2018.

<sup>130</sup> Tanguay and others, 2015.

<sup>131</sup> Tanguay and Ngamdee, 2018.

<sup>132</sup> ASEAN-NARCO, 2018.

<sup>133</sup> Department of HIV/AIDS Prevention and Control, 2020.

<sup>134</sup> *ibid.*

<sup>135</sup> Hammett and others, 2018.

<sup>136</sup> Mainline Foundation, 2020; Hammett and others, 2018.

<sup>137</sup> United Nations System Coordination Task Team, 2019.



## Box 6 Decriminalization and the United Nations Common Position on drugs

In November 2018, the United Nations System Chief Executives Board for Coordination adopted a Common Position to guide efforts on drug-related matters across the United Nations system and articulate shared principles on drug policy that put “people, health and human rights at the centre”.<sup>a</sup> The Common Position calls for reforming and repealing “laws, policies and practices that threaten the health and human rights of people” in favour of alternatives to conviction, detention and punishment. The adoption of the Common Position means that for the first time, 31 United Nations entities, including UNAIDS and UNODC, “speak with one voice” to unequivocally endorse decriminalization of drug use and possession for personal use.

In March 2019, the Task Team on the Implementation of the Common Position, led by UNODC, published its first major report on lessons learned by the United Nations system over the previous decade. The report stated that “a major obstacle to accessibility of treatment is the criminalization of personal use and possession of drugs for purposes other than medical and scientific” and noted that criminalization leads to an “increased risk of illness among people who use drugs and a negative effect on HIV prevention and treatment”, and fuels “stigma and discrimination, police harassment and arbitrary arrests”.<sup>b</sup> This conclusion follows from the United Nations Common Position in recognition that “concern for the health and welfare of humankind underpins the three international drug control conventions” and clarifies that the existing drug control framework and norms provide sufficient flexibility for countries to decriminalize drug use and possession for personal use.<sup>c</sup>

Source: <sup>a</sup>United Nations System Chief Executives Board of Coordination, 2019; <sup>b</sup>United Nations System Coordination Task Team, 2019; <sup>c</sup>United Nations System Chief Executives Board of Coordination, 2019.

As of 2021, none of the countries included in this report had fully removed criminal provisions for drug use and possession for personal use. In recent years, national debates on proposals for decriminalizing drug use and possession occurred in Myanmar<sup>138</sup> and Thailand.<sup>139</sup> In 2019, Malaysia announced it was considering minimizing criminal penalties for drug

use, while maintaining its compulsory drug treatment system and criminal sanctions for drug possession.<sup>140</sup> If approved, this proposal could have implications for the health and well-being of marginalized communities, including allowing people who use drugs to voluntarily seek health and support services without fear of criminal sanction.

<sup>138</sup> Cachia, 2018.

<sup>139</sup> Patcharavalan and Prin, 2018.

<sup>140</sup> UNAIDS, 2021.



## Box 7 A new Narcotics Code in Thailand

On 9 December 2021, Thailand enacted a new Narcotics Code that consolidates bills regulating narcotics and psychotropic substances that were previously managed by different agencies.<sup>a</sup> The new legislation emphasizes prevention and drug dependence treatment and less punishment for the offences of drug use and possession for personal use. The legislation also abolishes minimum sentences for personal use offences and allows discretion for courts to account for socioeconomic factors in sentencing for drug-related cases. The Ministry of Health has a more prominent role under the new drug regulatory regime, having been tasked with setting quantity benchmarks to inform sentence range and presumption of motives for individuals charged with “possession for consumption” and leading on the provision of drug dependence treatment.

Among the reforms introduced by the Narcotics Code are the removal of mandatory treatment and rehabilitation for people who use drugs and the repeal of criminal and administrative penalties for persons who leave a treatment programme. Under the new legislation, a law enforcement officer who comes into contact with a person suspected of using, using or in possession of a controlled substance under a certain threshold (e.g. heroin, opium, methamphetamine, cocaine) is to refer the person to a medical facility for treatment. In addition, the law stipulates that social rehabilitation centres aimed at supporting people who have completed drug treatment to access social services and temporary accommodation will be established.

The Narcotics Code stops short of decriminalizing drug use and possession, but the proposed changes are a positive step towards a more evidence-based response to drugs. A notable limitation of the new legislation is that it does not apply retrospectively to persons currently held in compulsory treatment centres. It will be important to independently monitor the implementation of the new legislation and assess the extent to which reductions in prison overcrowding and the discontinuation of compulsory treatment are being achieved.

Source: <sup>a</sup>Government of Thailand, 2021.

The Myanmar Narcotic Drugs and Psychotropic Substances Law was amended in 2018 to reflect a policy shift towards managing drug use as a health issue. The amendments eliminated prison penalties of three to five years for not complying with mandatory requirements for people who use drugs to register with the Ministry of Health and Sports and undergo medical treatment.<sup>141</sup> Despite this positive development, the 2018 amendments allow for drug treatment to be imposed by a court on any individual caught using drugs and prescribe five to ten years of incarceration for people who are caught with small quantities of drugs for their personal use. Because no threshold quantities were established, the police and judges have wide discretion to distinguish between users and dealers.<sup>142</sup>

In the past five years, Viet Nam introduced several decrees and regulations that appear to backtrack on commitments to diversify drug dependence treatment models and scale up voluntary approaches outlined in the Drug Rehabilitation Renovation Plan 2013–2020.<sup>143</sup> For example, Decree 90 (2016) requires that individuals on methadone treatment with two positive urine tests for heroin or one positive test for another illicit drug to be dropped from the programme and committed to a compulsory centre.<sup>144</sup> In 2017, Viet Nam revised its Penal Code, which came into effect in January 2018. The 2017 Penal Code abolishes the death penalty for drug possession but retains the death penalty for trafficking or transporting quantities of drugs beyond a specified amount (more than 100 grams of heroin or methamphetamine, for instance).

<sup>141</sup> DPAG Myanmar, 2017.

<sup>142</sup> Cachia, 2018.

<sup>143</sup> Prime Minister of Vietnam, 2014.

<sup>144</sup> Government of Vietnam, 2016.

In March 2021, Viet Nam amended its drug law legislation by passing the Law on Drug Prevention and Control (Law No. 73/2021/QH14). Compulsory drug treatment remains a central element of the new legislation. This includes detention from six months to one year, including for children as young as 12 years.

### **Administrative sanctions and punishments**

All nine countries uphold administrative sanctions for drug use, including mandatory urine testing and compulsory registration of people caught using or suspected of using drugs, which are often linked to compulsory drug detention (table 6).<sup>145</sup> These punishments contravene human rights to health, liberty and privacy. In Cambodia, China, Indonesia, the Philippines and Viet Nam, the families of people who use drugs, the public and, in some cases, treatment providers (as in China)<sup>146</sup> are required,

or strongly encouraged, to report people who use drugs to the authorities.<sup>147</sup> Because law enforcement agencies may use these registries to target people suspected of using drugs for interrogation, arrest or compulsory treatment,<sup>148</sup> these practices pose a strong disincentive for accessing health and social services. In several countries, failure to complete compulsory treatment imposed by a court, violating the terms of a treatment or rehabilitation programme and relapsing while undergoing treatment are also subject to administrative sanctions. In Myanmar, community service of 140–240 hours can be imposed as a sanction for persons “convicted of violation of the disciplines of a rehabilitation centre” under section 15 of the 2018 Drug Law, but legal provisions are unclear on what constitutes such violations.<sup>150</sup> In China, persons accessing treatment voluntarily who relapse during treatment are to be reported to the police and added to a government surveillance database.<sup>151</sup>

**Table 6 Punitive measures and administrative sanctions for drug use in East and Southeast Asia, 2021**

	<b>Forced urine testing for drug use</b>	<b>Compulsory registration for people who use drugs</b>	<b>Obligation to report drug use to authorities</b>
<b>Cambodia</b>	●	●	●
<b>China</b>	●	●	●
<b>Indonesia</b>	●	●	●
<b>Lao PDR</b>	●	●	
<b>Malaysia</b>	●	●	
<b>Myanmar</b>	●	●	
<b>Philippines</b>	●		●
<b>Thailand</b>	●		
<b>Viet Nam</b>	●		●

Source: UNAIDS and UNODC data, based on responses to the regional questionnaire, 2019 and the literature review.

<sup>145</sup> Stoicescu and Lasco, 2019.

<sup>146</sup> According to China’s 2011 Treatment Regulations, individuals partaking in voluntary treatment are obliged to register their personal details and drug use history in the Government’s online database (methadone treatment providers are required to report the information of clients). See Government of China, 2011.

<sup>147</sup> International Drug Policy Consortium, 2018.

<sup>148</sup> Mendez, 2013.

<sup>149</sup> UNAIDS, 2019b.

<sup>150</sup> DPAG Myanmar, 2017.

<sup>151</sup> Government of China, 2011.

## ***Diversion towards health and social services***

Among the seven countries that reported data, Cambodia, China, Indonesia and Thailand reported implementing since 2015 at least one training programme to sensitize law enforcement or legal service providers on community-based treatment approaches, including diversion towards health and social services at the point of arrest, prosecution or sentencing.<sup>152</sup> Five countries (Cambodia, Indonesia, Malaysia, Myanmar, Thailand) reported adopting alternatives to incarceration for drug use and possession offences. Even in countries that have taken tangible steps towards providing diversion measures to promote greater access to health care for people who use drugs, they have been unevenly enforced. This is partly due to inconsistencies in the legal framework, including in Cambodia, China, Indonesia, Myanmar and Viet Nam, where the offence of drug use is eligible for diversion to treatment instead of criminal prosecution, but drug possession for personal

use remains punishable with imprisonment. Because guidance on threshold quantities warranting criminal punishment is either absent or ambiguous, law enforcement officers have wide discretion to determine which suspects receive treatment referrals and what form this treatment takes.<sup>153</sup>

Diversion of people charged with drug use and possession for personal use offences to health and social services at the point of arrest is influenced by police practices. Such practices are, in turn, tied to performance targets, such as quotas for arresting and sending a certain number of people who use or are suspected of using drugs to rehabilitation centres. This has been documented in Cambodia, China, Indonesia, Malaysia, Thailand and Viet Nam.<sup>154</sup> Systems of rewards that incentivize the police to target people who use drugs undermine the effectiveness of voluntary community-based treatment programmes and promote stigmatizing attitudes towards drug use.

### **Box 8 New guidelines for prosecutors in Indonesia emphasize rehabilitation over incarceration**

As of December 2021, Indonesian prisons were operating at 336 per cent overcapacity, with 46 per cent of the 272,217 prisoners across the archipelago detained for drug use offences.<sup>a</sup> To address the high level of overcrowding in prisons, the attorney general of Indonesia issued new guidelines for prosecutors to prioritize drug treatment and rehabilitation instead of incarceration for drug-related cases.


The guidelines, which went into effect on 1 November 2021, are a welcome development towards reorienting drug policy on health-based approaches. However, the document is constrained by important limitations. Among these is the lack of clear differentiation between people who use drugs and those with clinically determined drug dependence. Second, the conditions for imposing treatment and rehabilitation orders are unclear. For example, the guidelines stipulate that if a person fails to undergo rehabilitation “without a valid reason” or “not in accordance with the stipulation”, the prosecutor may take “coercive measures”. By retaining a focus on coercion, the guidelines uphold Indonesia’s extensive mandatory drug treatment and rehabilitation system and open new pathways for abuse against people who use drugs by criminal justice system authorities.

Source: <sup>a</sup>Directorate General of Corrections, 2021; <sup>b</sup>Institute for Criminal Justice Reform, 2021.

<sup>152</sup> UNAIDS and UNODC, 2019.

<sup>153</sup> DPAG Myanmar, 2017; Larasati, Christian and Misero, 2017; Tuot and others, 2017; Chheng and others, 2012.

<sup>154</sup> Godwin, 2016; Ma and others, 2016; Rahman and others, 2014.



Research from China has shown that distrust of the police and the threat of arrest actively discourage people who use drugs from coming forward to access voluntary health services.<sup>155</sup>

In February 2019, the Hanoi People's Committee issued a pilot police-assisted diversion initiative involving the Government and civil society organizations.<sup>156</sup> The project, introduced initially in two districts, aimed to support public health-orientated approaches to drug use by having the police refer people who use drugs to health, social and legal services rather than arresting or sending them to compulsory facilities known as "06 centres". Although encouraging, such initiatives remain small scale.

### **Health and community systems-strengthening and financing**

Common challenges in the shift towards voluntary community-based approaches for people who use drugs are often attributed to weak capacity and poor resource allocation across the public health, social affairs, law enforcement and civil society sectors.<sup>157</sup> All countries reported taking steps towards building capacity across relevant sectors and mobilizing technical assistance to address operational gaps in the transition. Yet, in virtually all cases, these efforts stopped short of systemic reforms to transform drug dependence management and operations. Predominantly, capacity-strengthening, specialized training and awareness-raising in

relation to community-based approaches have been implemented in an ad hoc manner.

An effective and evidence-informed drug dependence treatment system necessitates adequate investment to support the development of expertise and workforce capacity. While most countries reported mapping resources allocated to different treatment systems, none had conducted cost-effectiveness studies comparing compulsory and voluntary community-based approaches (table 5). A 2015 independent economic evaluation comparing Viet Nam's centre-based compulsory rehabilitation approach and its community-based voluntary methadone treatment programme in Hai Phong city found conclusive evidence that compulsory detention was less effective for a range of health, criminality and quality-of-life outcomes. And it was more costly.<sup>158</sup> The study showed that providing treatment for one compulsory centre detainee for one year cost the Government 19,670,000 dong (\$845)—which was 2.5 times more than covering the costs of one methadone client during the same period, or 7,880,000 dong (\$339).

Virtually all countries that provided data, apart for Myanmar, indicated an increase in government investments for voluntary community-based treatment between 2015 and 2020 (table 5). However, these investments did not constitute a reallocation of human and financial resources from compulsory to voluntary community-based drug dependence treatment.

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<sup>155</sup> Ma and others, 2016.

<sup>156</sup> Luong and others, 2020.

<sup>157</sup> UNODC, ESCAP and UNAIDS, 2015.

<sup>158</sup> Vuong and others, 2015.

# CONCLUSION

## Accelerating the transition, in line with the 2030 Agenda for Sustainable Development and the United Nations Common Position on drug-related matters

The past decade has seen uneven progress in efforts to end compulsory treatment and rehabilitation in East and Southeast Asia. Despite international calls for the closure of compulsory treatment centres in 2012 and 2020 and several high-level consultations aimed at expediting the transition towards voluntary human rights-based approaches, no country has abolished compulsory facilities for people who use drugs. Since the release of the 2012 United Nations Joint Statement highlighting serious health and human rights concerns and calling for the immediate closure of compulsory treatment and rehabilitation centres, nearly half a million people continue to be detained in such facilities annually. As illustrated in this report, the majority of countries that reported data registered an increase in the number of compulsory centres and/or detainees between 2012 and 2018.

At the same time, voluntary community-level treatment interventions for people who use drugs remain insufficiently available regionwide. Promising efforts to explore alternatives to compulsory detention in the region, including several that are documented in Booklet 3 of this publication, have not resulted in the replacement of compulsory facilities with voluntary models. None of the countries has implemented a comprehensive national action plan on transition, as agreed by States at the Third Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific in 2015.

The 2030 Agenda for Sustainable Development and the United Nations System Common Position on drugs present important opportunities to revitalize responses to drug use and dependence in East and Southeast Asia. The Sustainable Development Goals


highlight the interconnections between various aspects of sustainable development, including poverty, access to health care, promotion of equality and justice, violence reduction, ending AIDS and the protection of the human rights of the most marginalized communities. These goals will not be attained unless efforts are strengthened to improve the health and human rights of people who use drugs and people with drug dependence.

In support of the 2030 Agenda for Sustainable Development, the United Nations Common Position on drugs calls for reforming and repealing “laws, policies and practices that threaten the health and human rights of people” in favour of alternatives to conviction, detention and punishment. Through the Common Position, the United Nations system speaks with one voice in unequivocally calling for the decriminalization of possession and use of scheduled drugs, the principle of proportionality and due process safeguards (such as timely access to legal aid and the right to a fair trial) pertaining to criminal justice proceedings. Such reforms are a requisite for the sustainable expansion of voluntary, evidence- and human rights-based drug dependence treatment, harm reduction and social support services in the region.

The Regional Framework for Action on Transition adopted by countries at the Third Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific in 2015 includes recommendations for initiating an effective transition at the national level.<sup>159</sup> The framework provides a road map for action by countries to reduce the harms associated with drug use and accelerate the transition

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<sup>159</sup> UNODC, ESCAP and UNAIDS, 2015.



by reforming drug laws to foster an enabling policy environment, establishing a multisector transition committee and action plan to instigate the transition and strengthening resilience of health systems by building up their capacity and providing adequate resources. In relation to the Regional Framework for Action on Transition, the Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs, established in 2020 by UNAIDS and UNODC, made the following updated recommendations to strengthen the framework:


- Strengthen multisector and interagency coordination and cooperation for implementing action plans and activities related to drug dependence treatment.
- Decriminalize the use, possession of 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.
- Where drugs remain illegal, apply the principle of proportionality for drug-related crimes, and implement non-coercive public health-based diversion initiatives.
- 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 treatment, safer-smoking kits for persons who use methamphetamines and peer distribution of

naloxone, in partnership with communities and relevant service providers.

- 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.

UNODC and UNAIDS stand ready to support Member States to take action to end compulsory treatment and rehabilitation in East and Southeast Asia. This comprises improving the current negative consequences for people detained in compulsory facilities as a matter of priority and promoting evidence- and human rights-based responses to drug dependence, including by the following proposed actions.

1. Supporting countries to accelerate their implementation of the updated Regional Framework on Action on Transition (booklet 3), in line with the 2030 Sustainable Development Agenda and the recommendations of the United Nations Common Position. This would involve conducting comprehensive national assessments of the legal, policy, political and operational barriers to ending compulsory drug and rehabilitation and scaling up voluntary community-based approaches. It would also involve providing evidence and technical assistance towards achieving the decriminalization of drug use and the possession, purchase or cultivation of controlled substances for personal use.

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2. Countering stigmatizing narratives related to drug use and dependence by encouraging governments and practitioners to approach the provision of drug dependence treatment as a public health rather than public security issue. This includes emphasizing that treatment and rehabilitation services should not focus exclusively on drug use cessation but on facilitating improvements in health and social functioning and reductions in high-risk consumption patterns and practices, as outlined in the WHO and UNODC international standards.
  3. Collaborating with relevant stakeholders, including governments, civil society and networks of people who use drugs, to devise agreed monitoring and outcome indicators for the transition, against which countries can report progress based on the updated Regional Framework for Action on Transition.
  4. Establishing a consolidated regional reporting system to allow the transparent sharing of information and to facilitate routine updates by countries on their progress towards the transition, including but not limited to data on conditions inside compulsory facilities and expenditure budgets related to those facilities.
  5. Supporting the production of national-level research evidence to compare the effectiveness and cost-effectiveness of different treatment models.
  6. Facilitating an inclusive regional consultative process, including governments, civil society and communities of people who use drugs, to promote and foster consensus on the definition of compulsory facilities for people who use drugs as well as on essential elements of voluntary community-based treatment.
  7. Building the capacity of governments to enhance health systems and infrastructure for health care, which in turn supports the effective implementation of drug dependence treatment services that are compliant with international human rights instruments and with the WHO and UNODC International Standards for the Treatment of Drug Use Disorders.




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# ANNEX: QUESTIONNAIRE



United Nations Office on Drugs and Crime (UNODC)  
Joint United Nations Programme on HIV/AIDS (UNAIDS)

## **Questionnaire in preparation for the Fourth Regional Consultation on Compulsory Centres for People Who Use Drugs in East and Southeast Asia 2019**

### **Background**

In 2010, the United Nations Office on Drugs and Crime (UNODC) Regional Office for Southeast Asia and the Pacific, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for Asia and the Pacific and the United Nations Economic and Social Commission for Asia and the Pacific, in partnership with the Australian National Council on Drugs, initiated consultations among nine countries.<sup>160</sup>

in the East and Southeast Asian region. The purpose was to raise awareness and promote change in the operation of compulsory facilities for people who use drugs and to offer governments a platform to discuss voluntary and evidence-informed treatment programmes that adhere to internationally accepted principles of drug dependence treatment and human rights.

The First Regional Consultation on Compulsory Centres for People Who Use Drugs was in Bangkok from 2 to 3 September 2010. The Second Regional Consultation was organized from 1 to 3 October 2012 in Kuala Lumpur, and the Third Regional Consultation was in Manila from 21 to 23 September 2016.

Similar to the procedure followed in the previous regional consultations, a questionnaire is being distributed to countries to obtain information on national responses to drug use and dependence and to assess the progress made in the implementation of the Regional Framework for Action on Transition from compulsory facilities to voluntary community-based approaches, as detailed in the report of the Third Regional Consultation.

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<sup>160</sup> Cambodia, China, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Thailand and Viet Nam.

## Importance of your government's response

Your government's response to this questionnaire will form the basis for a regional overview report on the status of compulsory facilities for people who use drugs and the progress made in the transition to voluntary community-based treatment and care for drug use and dependence. The regional overview report will be considered by participants and will provide the basis for discussions during the next regional consultation on compulsory facilities for people who use drugs in East and Southeast Asia.

## Instructions

Please answer the following questions with reference to your country. Kindly send your response, together with relevant attachments, by email before 15 December 2019 to: [ccdu@unaids.org](mailto:ccdu@unaids.org)

## Section 1: General information

1. Please specify total number of compulsory facilities for people who use drugs,<sup>161</sup> clients in these facilities, and the average length of stay of each client (over the period of 12 months).

Country	1 Jan to 31 Dec 2015	1 Jan to 31 Dec 2016	1 Jan to 31 Dec 2017	1 Jan to 31 Dec 2018
Number of facilities (in total)				
Number of facilities for men				
Number of facilities for women, if any				
Number of facilities for children,* if any				
Number of clients (in total)				
Capacity (beds) in facilities for men				
Capacity (beds) in facilities for women, if any				
Capacity (beds) in facilities for children,* if any				
Average length of stay of each client, in months or years				

Note: \*According to the United Nations Convention on the Rights of the Child, a child is "every human being below the age of 18"

2. Please list the three illicit substances most frequently associated with admission to compulsory facilities for people who use drugs.

Year	Name of substance	Percentage of admissions
2015	1.	
	2.	
	3.	

<sup>161</sup> In different countries government-run facilities that employ compulsory treatment modalities are also known by different names. Certain countries might not differentiate between centres that are compulsory in nature and those that are voluntary. Regardless of the name of the centre, [the United Nations Joint Statement outlines](#) some of the concerns related to compulsory detoxification and treatment.



Year	Name of substance	Percentage of admissions
2016	1.	
	2.	
	3.	
2017	1.	
	2.	
	3.	
2018	1.	
	2.	
	3.	

## Section 2: Legal framework, policies and responsibilities

**3. Please describe major developments since 2015 in terms of the national legal and policy framework governing compulsory facilities for people who use drugs. In your response, please include the following information:**

(a) Name relevant legal and policy changes in relation to compulsory facilities for people who use drugs, including relevant acts, policies or strategies, and indicate when each was introduced.

.....  
(b) Clarify the scope of the legal and policy changes above.

.....  
(c) Explain the responsibilities of different government departments and agencies (police, ministry of health and other relevant ministries and agencies) in these procedures.

**4. What are the specific objectives of compulsory facilities for people who use drugs in your country? Please consider in your response that objectives must be specific, measurable, achievable and time-bound.**

## Section 3: Health situation, interventions and staffing

**5. What are the major health concerns among clients in compulsory facilities for people who use drugs?**

1. ....

2. ....

3. ....



**6. Do you track the prevalence of each of the following among clients in the compulsory facilities for people who use drugs? (check all that apply)**

- Human immunodeficiency virus (HIV)
- Hepatitis B virus
- Hepatitis C virus
- Tuberculosis (TB)
- Other common health concerns (please specify: ..... )

**7. Please indicate in the table the prevalence of HIV, hepatitis B virus, hepatitis C virus and tuberculosis in compulsory facilities for people who use drugs, based on the latest data available. Please provide sources for the data reported and indicate the year the data were collected.**

Country	Prevalence of HIV (%)	Source/ year	Prevalence of hepatitis C (%)	Source/ year	Prevalence of tuberculosis (%)	Source/ year
Mixed facilities (men and women)						
Facilities for men						
Facilities for women, if any						
Facilities for children, if any						

**8. (a) What are the major risk factors for the transmission of HIV inside compulsory facilities for people who use drugs in your country? (check all that apply)**

- Vaginal and/or anal sex without a condom
- Unsterile tattooing
- Unsterile hair clippers
- Blood splatters (violence)
- Injecting drug use or drug use
- Penile modification
- Piercings, self-scarring, etc.

(b) Are there other risk factors for the transmission of HIV inside compulsory facilities for people who use drugs in your country that are not mentioned in question 8 (a)? Please specify.

.....

**9 From the following health care services, please indicate those that are provided to clients in the compulsory facilities for people who use drugs. (check all that apply)**

**a. General health**

- Medical check at admission
- Urine drug test
- Human immunodeficiency virus (HIV)
- Hepatitis B virus
- Hepatitis C virus
- Tuberculosis (TB)



- Access to medical personnel (doctors and nurses) on site
- Referral to primary health care services
- Referral to specialized health and social services
- Pre-release medical checks, advice, treatments, referrals
- Other, please specify: .....


**b. Drug dependence treatment and related services**

- Assessment for drug dependence
- Please list the tools used for the screening and assessment of substance use: .....
- Pharmacological detoxification
- Medication for withdrawal management
- Non-medicated detoxification
- Opioid substitution treatment (e.g. methadone, buprenorphine)
- Access to self-help group (e.g. Alcoholics Anonymous, Narcotics Anonymous)
- Mental health services (e.g. psychiatric, psychological, counselling)
- Vocational training
- Pre-release assessment, advice and referral to treatment
- Follow-up after release (e.g. six months post-release)
- Re-integration back into the community post-release
- Overdose prevention services
- Other, please specify: .....


**c. Prevention, treatment and care for HIV and other communicable diseases**

- Access to sterile injecting equipment
- Voluntary counselling and testing (VCT)  
If no VCT is available, please give details of any other HIV testing procedures that are carried out: .....
- Antiretroviral therapy (ART)
- Diagnosis and treatment of sexually transmitted infections
- Free condom provision
- Information, education and communication material related to HIV prevention
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of TB<sup>162</sup>
- Peer education (by external organizations or groups or internal)
- Support groups for people living with HIV
- Counselling (individual or group)
- Early release for advanced AIDS cases
- Other, please describe: .....


<sup>162</sup> The nine interventions of the comprehensive HIV prevention package for injecting drug users are recommended by WHO, UNODC and UNAIDS to be implemented simultaneously to be most effective, as outlined in: WHO, UNODC and UNAIDS, Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, 2009



## Section 4: Human resources, budget and planning

10. Please indicate the approximate number of the equivalent of full-time staff in compulsory facilities for people who use drugs in 2018 in the table below:

Type of centre	Number of non-custodial staff (doctors, nurses, counsellors)	Number of custodial/ security staff	Administration
Mixed facilities (men and women)			
Facilities for men			
Facilities for women, if any			
Facilities for children, if any			
<b>Total</b>			

11. What is the approximate most recent total national budget for each of the categories below. Where national data is not available, please indicate the relevant budget of the government ministry or agency for whom you are filling out this survey.

a. Drug use prevention

Budget ..... Year .....

b. Drug dependence treatment

Budget ..... Year .....

c. Operating compulsory centres for drug users or compulsory facilities for people who use drugs

Budget ..... Year .....

12. Please indicate (or estimate) the total budget cost for keeping one person in a compulsory facility for people who use drugs for one year.

.....

.....

.....

.....





**13. Has the compulsory treatment facility system been evaluated in your country?**

Yes  No

If yes, please provide details on the type (internal, external, independent) and key findings of the latest evaluation:

.....  
.....  
.....

**14. Does your country anticipate (over the next two years):**

An increase in the number of compulsory facilities for people who use drugs   
A decrease in the number of compulsory facilities for people who use drugs   
No change

**15. Does your country anticipate (over the next two years):**

An increase in the number of persons in compulsory facilities for people who use drugs   
A decrease in the number of persons in compulsory facilities for people who use drugs   
No change

**16. Do you track the relapse rate of drug users after they received treatment in compulsory facilities for people who use drugs?**

Yes  No

If yes, what is the relapse rate of drug users after they received treatment in the compulsory facilities? In your response, please provide the latest information available.

..... per cent (source: ..... Year: ..... )

If no, please estimate the relapse rate after a person using drugs received treatment in a compulsory facility?

..... per cent

**17. Please share any other comments that you may have about compulsory facilities for people who use drugs. (optional)**

.....  
.....  
.....

## Section 5. Implementation of the recommendations adopted by the Third Regional Consultation

The following questions relate to the recommendations adopted by the Third Regional Consultation on compulsory facilities for people who use drugs in East and Southeast Asia, from 21 to 23 September 2015 in Manila. The Consultation adopted the following recommendations as part of the Regional Framework for Action on transition from compulsory facilities towards voluntary community-based treatment and care services. The recommendations specifically focused on supporting the transition through the adoption of a national transition framework consisting of three elements that countries should consider:

### Element 1: Planning and management

A national multisector decision-making committee should be established with overall responsibility for the transition to community-based treatment and services. This body should be responsible for the development and overall implementation, in consultation with key stakeholders from various sectors, of a comprehensive action plan. This action plan should include objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities and will provide countries with a critical platform from which to coordinate the transition.

### Element 2: Fostering enabling legal and policy environments

Drug policies, defined to include laws, regulations, strategies and practices, are recognized as critical to the success of the transition to voluntary community-based treatment and services for people who use drugs. A shift in policy approaches to drug use and dependence away from criminalization and punishment and towards health- and rights-based measures, should have a central role in ensuring the effectiveness of the transition.

### Element 3: Health and community systems-strengthening and financing

Bottlenecks along the pathway to voluntary community-based treatment and services for people who use drugs are largely due to weak capacity across the public health, social affairs, law enforcement and civil society sectors. Assessments need to be conducted that involve mapping those pathways, identifying the bottlenecks and ensuring sufficient capacity. The assessments will provide evidence to inform the development of national capacity-building plans as well as technical assistance mobilization plans to fill operational gaps. The development of an effective and evidence-informed drug dependence treatment system requires systemic reforms to establish and strengthen the various mechanisms underpinning drug treatment management and operations. These reforms will be accompanied by investments to support development of expertise and workforce capacity across all relevant sectors as well as within the communities of people who use drugs.



**18. Has your country established a national multi-sectoral committee to oversee the transition from compulsory centres for drug users to community-based treatment and services?**

Yes  No

If “yes”, please provide details on the year the committee was established, participating agencies and sectors:

.....  
.....  
.....

**19. Does your country have a comprehensive action plan to coordinate the transition from compulsory centres for drug users to community-based treatment and services?**

Yes  No

If “yes”, please provide details on the process for developing the action plan, including consultations held with stakeholders, comprehensive assessments undertaken to inform the process, and components of the action plan (consider in your response whether the national action plan includes objectives, activities, outcomes, indicators, targets, budgets, timelines and division of responsibilities):

.....  
.....  
.....  
.....  
.....  
.....

**20. Did your country initiate, in line with national priorities, multisector consultations and reviews of laws, policies and practices that hinder access to voluntary and effective drug dependence treatment since 2015?**

Yes  No

If “yes”, please specify which laws, policies and practices had been reviewed:

.....  
.....  
.....



**21. Did your country implement, in line with national priorities, drug policy interventions and reforms since 2015?**

Yes  No

If "yes", please specify whether your country has implemented the following drug policy interventions and/or reforms since 2015 (check all that apply):

- Programmes with judiciary, legal service providers and law enforcement
  - Alternatives to incarceration for low-level, nonviolent offences associated with drug use
  - Depenalization
  - Decriminalization
  - Diversion towards health and social services at the point of arrest/prosecution/sentencing
  - Legal regulation, such as for certain types of drugs
  - Removing arrest quotas
- Please give details of the specific interventions and/or reforms implemented in your country:

.....

.....

.....

**22. Did your country conduct a comprehensive assessment of national systems and capacity across different sectors (health, public security, social and labour) since 2015?**

Yes  No

If "yes", please provide details on the scope and key findings of the assessment:

.....

.....

.....

**23. Did your country undertake capacity strengthening across different sectors (health, public security, social and labour) in relation to evidence-informed and community-based treatment, since 2015?**

Yes  No

If "yes", please describe the scope of the capacity-strengthening, and specify which steps your country has taken to undertake capacity strengthening across different sectors since 2015:

.....

.....

.....



**24. Did your country undertake cost-effectiveness studies comparing compulsory facilities for people who use drugs and voluntary community-based treatment?**

Yes  No

If "yes", please provide details on key findings from the cost-effectiveness studies and provide sources to the relevant documents and/or publications:

.....

.....

.....

**25. Which measures has your country taken to improve follow-up and aftercare in voluntary community-based treatment?**

.....

.....

.....

**26. Did your country undertake a mapping of existing resources allocated to different treatment systems?**

Yes  No

If "yes", please provide details about the mapping structure:

.....

.....

.....

**27. Did your country mobilize additional human resources, including the involvement of affected populations, such as people who use drugs, and enhanced specialized training for the delivery of voluntary community-based services since 2015?**

Yes  No

If "yes", please provide details about the involvement of affected populations and the enhanced training procedures of voluntary community-based services:

.....

.....

.....



**28. Did your country reallocate human and financial resources from compulsory facilities for people who use drugs to voluntary community-based treatment since 2015?**

Yes  No

If "yes"; please specify which steps your country has taken to enforce specialized training for voluntary community-based treatment since 2015:

.....

.....

.....

**29. Did your country increase government investments for voluntary community-based treatment since 2015?**

Yes  No

If "yes"; please specify the increase in investments since year 2015:

.....

.....

.....

**30. Regarding community-based treatment, did your country undertake awareness raising and capacity-building regarding community-based treatment among governmental, non-governmental and private organizations, community members, health professionals, religious leaders, social workers and those working in charities since 2015?**

Yes  No

If "yes"; please specify which steps your country has taken to improve awareness raising regarding community-based treatment since 2015:

.....

.....

.....

Thank you for completing the questionnaire.





