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Commentary

Compulsory drug detention centers in East and Southeast Asia

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ABSTRACT

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

Introduction

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

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

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

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

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

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

Treatment of substance abuse

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

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

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

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

Prevention and treatment of HIV in CDDC

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

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

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