Compulsory drug dependence treatment centres in South and East Asia: HIV Risks and Rights

The Second Asian Consultation on the Prevention of HIV Related to Drug use
Track on Compulsory drug dependence treatment centres (CDDTCs)

Sonia Bezziccheri, HIV Associate Adviser
UNODC Regional Centre for East Asia and the Pacific

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Content

Based on UNODC literature review findings of 2009

- Problem
- Conclusions
- Recommendations

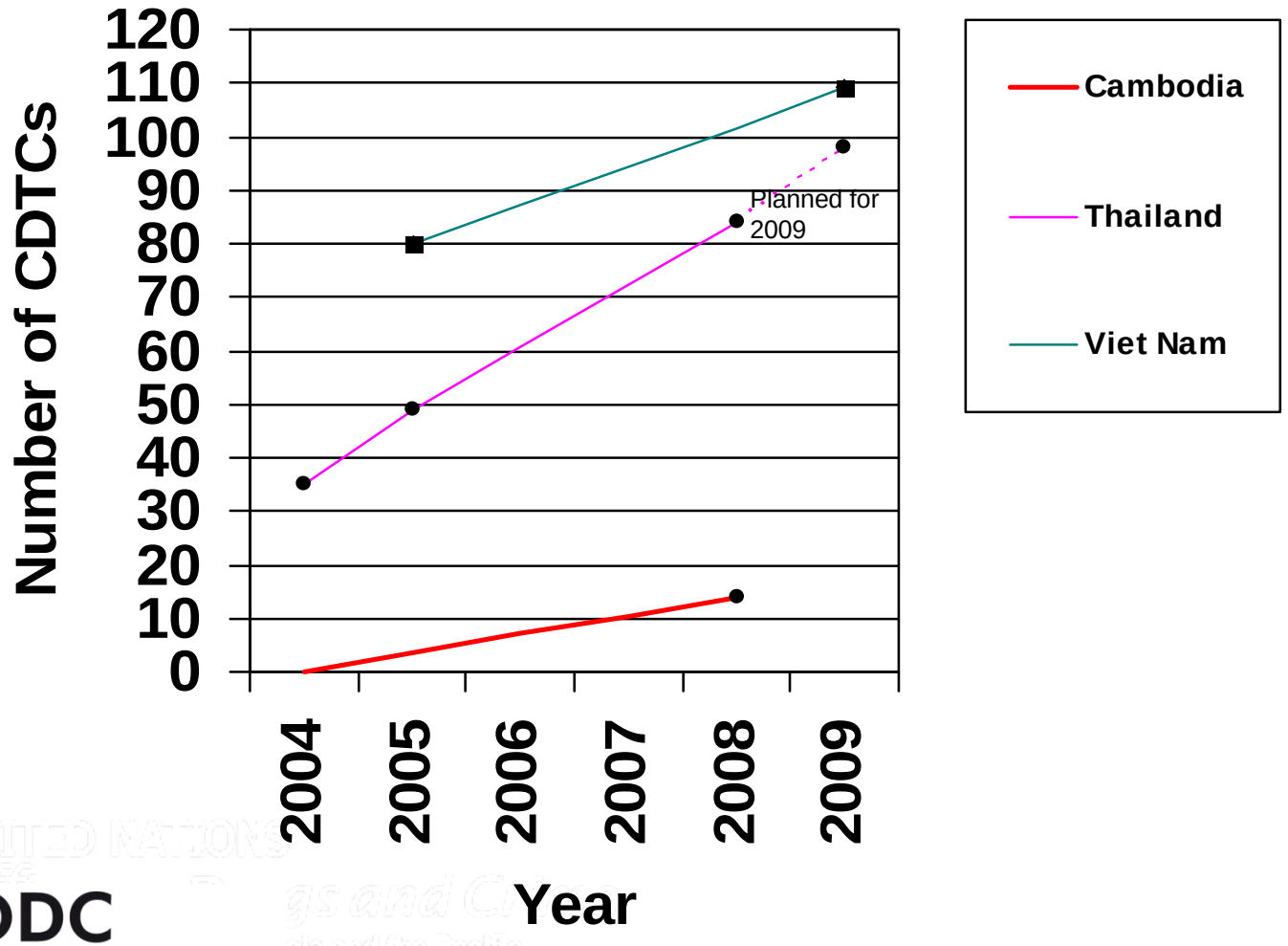
What is the CDDTCs approach?

A form of restriction of an individual's personal freedom in which those drug users or those suspected of drug use **who do not voluntarily opt for rehabilitation** and treatment are **forced to undergo these practices for a determined period of time.**

General characteristics

- CDTCs are present across the GMS countries and Malaysia
- CDTCs are established through **either criminal or administrative law.**
- CDTCs are often **under law enforcement authorities**; or the judiciary, the Ministry of Health and/or the Ministry of Social Affairs.
- Considered essential to meet the **goal of a Drug Free ASEAN by 2015**
- Often established under a Prime Ministerial Decree to treat drug users as **'patients' rather than 'criminals'**
- Often a **result of the decriminalisation of drug use** (under administrative law)
- **Lacking sufficient funding/health staffing**
- **High relapse rates post discharge**
- **Contribute to stigma and discrimination of drug users**
- **Contribute to burden public health/ increase HIV risks**
- **Concern for human rights bodies**, UN Special Rapporteurs

Problem: CDDTCs increasing despite lack of evidence on (cost and treatment) effectiveness



Problem

Lack of evidence based drug dependence treatment

1. Treatment generally based on forced abstinence only – not medically supervised
2. ATS and occasional/recreational users – treatment inappropriate
4. Unqualified and untrained staff
5. No tailoring to individual needs – lack of assessment per client basis
6. Lack of aftercare services
7. Not in line with UNODC/WHO *Principles of Drug Dependence Treatment*

Problem cont'

Treatment outcomes/relapse rate:

China:

- China National Surveillance (2005): 62% relapse after 3 days; 20% relapse after 30 days
- WHO (2002): 80% relapse after 2 weeks; 95% relapse after 6 months.
- Liu et al. concluded that there is '**no correlation between confinement at a drug detoxification centre and drug use** (that is ongoing abstinence from drug use) … detoxification and Rehabilitation through Labour Centres offer at best only a period of abstinence from drug use.'

Viet Nam:

- WHO (2009) found: 95% relapse

Problem cont'
HIV high risk behaviours in CDDTCs reported by every country:

- Injecting drug use - sharing of needles and diluents
- Unprotected sex
- Tattooing
- Penile modification
- Blood splatters (via rape and other violence)
- Use of others' razor/toothbrush

Problem cont'

HIV Prevalence

- **Viet Nam:** study in 6 of the 06 Centres show HIV prevelence ranged from **30 to 65%** (Martin G et al 2005)

- **China:**
  - *National HIV prevalence in the Rehabilitation through Labour Centres **5%** (Bureau of RE-education Administration 2006)*
  - *HIV prevalence amongst IDUs in CDTC in Cai Yuan City, China, was estimated at **42%** (Dolan et al., 2004)*

UNODC Review

Problem cont'

Lack of HIV Services for PWID

1. Only 1 (IEC) out of 9 intervention for HIV prevention for injecting drug users advocated by UNODC/WHO/UNAIDS on offer in most countries in CDDTCs
2. No access to Oral substitution therapy and **disruption of MMT**
3. No access to condoms
4. No access to syringes
5. Poor general health care / access
6. Limited access to ARV / **disruption of ARV treatment**

However, controlling the transmission of HIV as well as hepatitis and tuberculosis, were prioritised by the GMS countries in a UNODC regional review, as the most important health risks which needed to be addressed in CDDTCs.

Problem cont': Overlap with prison

Pre-trial detention conditions in Thailand (pre-assessment period of 45 days in prison prior to CDDTCs)

1) Restricted health care access
2) Poor living conditions
3) Forced withdrawal – not medically supervised
4) HIV infection risk high in prison (IDU, MSM, violence, penile modification)

Problem cont'

A cost effective approach?

Recent Viet Nam study says 'No'

	USD
Unit costs per resident in centers	
Rural	$225
Urban	$641
Unit cost of interventions	
VCT*	$23.6
Needle & Syringe programs	$15-21
per clean needle	$0.10
Drug substitution treatment	$292-$587

* VCT includes ELISA test, distribution of condoms, IEC materials and consultancy

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Courtesy PPT by Martin G et al 'Does Rehabilitation in closed settings work in Viet Nam? IHRA 2009 UNODC/OSI Major Session on CDTCs

Human Rights Intl. Standards, Norms

Current CDDCTs approach of confinement of drug users is not aligned with:

1. International Covenant on Economic, Social and Cultural Rights: The Right to the Highest Standard of Physical and Mental Health
2. International Covenant on Civil and Political Rights
3. Convention on the Rights of the Child
4. Convention against Torture and other Cruel, Inhumane and Degrading Treatment or Punishment
5. WHO/UNODC *Principles of Drug Dependence Treatment* Discussion Paper
6. Alternatives to Imprisonment: UNODC guidelines for developing non-custodial sentencing approaches for drug dependent people who engage in petty drug related offences.

Conclusions

The CDDTCs approach:

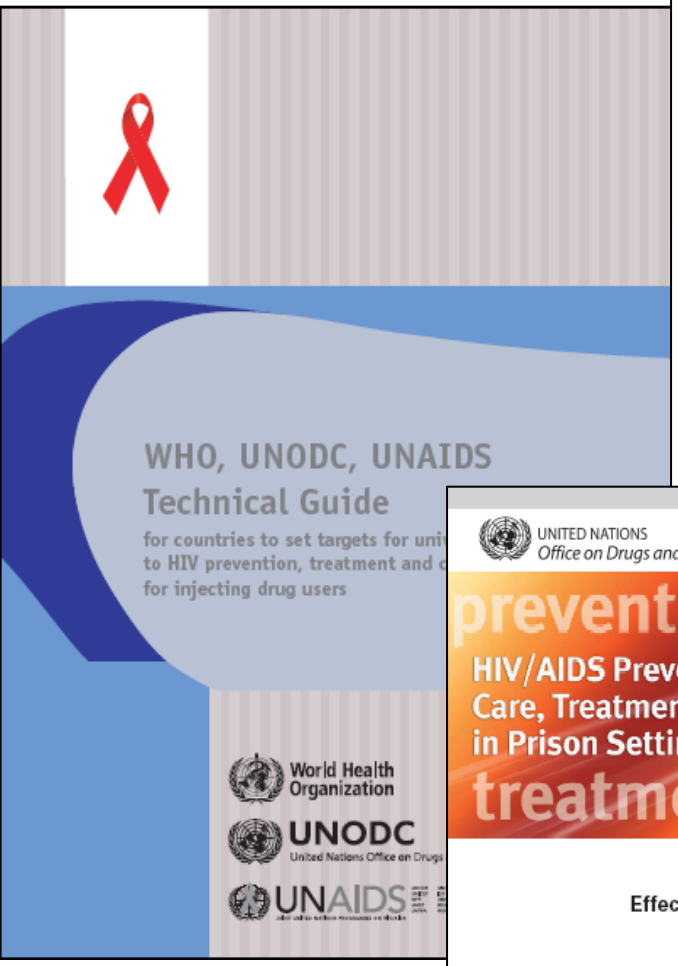
1. **Is an ineffective response**: it fails in its primary objective of supporting drug dependent people to achieve abstinence
2. **Does not provide evidence based drug dependence treatment**:
   - No clinical assessment/diagnosis to establish drug dependence
   - No individualized treatment for drug dependence
   - Only one form of 'treatment' available: abstinence
3. **Addresses drug dependence as a criminal or administrative offence rather than a chronic relapsing health condition with the result of involuntary confinement and 'treatment'**
4. **Is an inefficient investment** in drug dependence treatment
   - cost ineffective
5. **Raises issues of human rights of drug users and of HIV affected populations**
6. **Is not recognised as an 'alternative to imprisonment'**
7. **Increases HIV risks and stigma for everyone who is confined**:
   - Higher prevalence of HIV and increased HIV risk
   - Does not provide the comprehensive package recommended by UNODC/WHO/UNAIDS
   - Disrupts HIV treatments and MMT
   - CDDTCs do not meet international guidance for the provision of HIV services for PWID and programmes in closed settings, consistent with WHO principle of equivalence (1993)

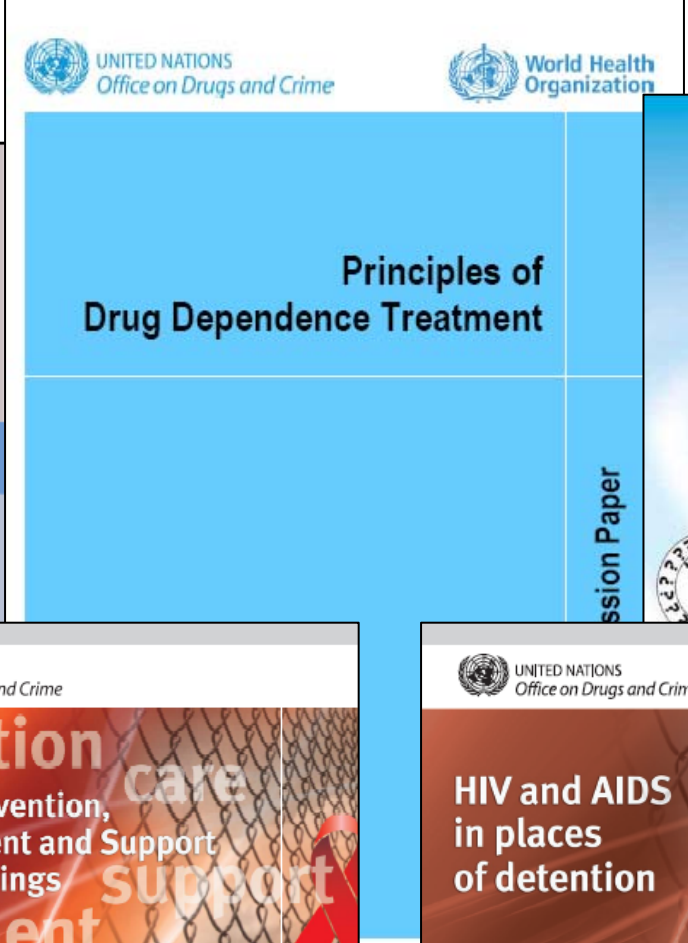
Recommendations

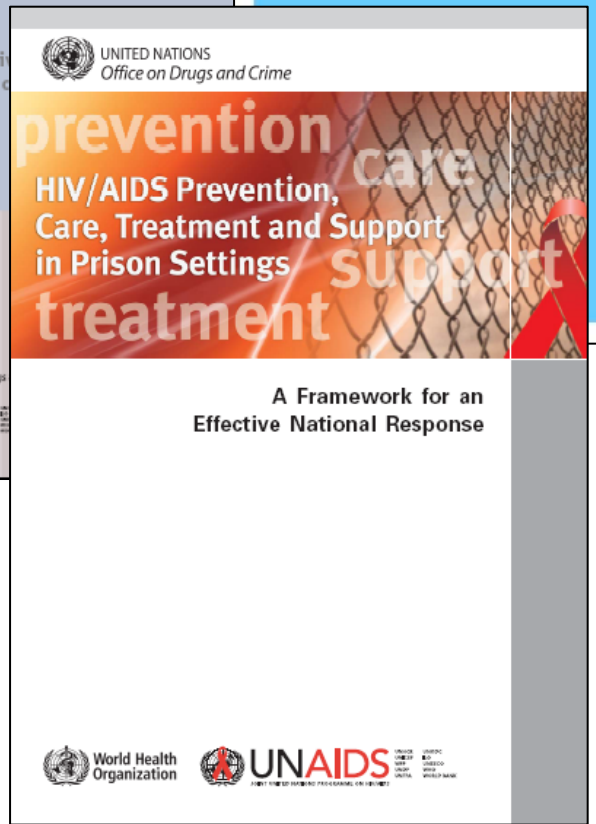
1. Drug dependence should be seen as chronic relapsing health condition
2. Further evaluation/review of cost and treatment effectiveness of CDDTCs is required
3. HIV comprehensive package (9 interventions) offered voluntarily in the community + in all closed establishments (i.e. CDTCs) based on WHO Principle of Equivalence
4. Increase investment in effective/evidence based, community and voluntary, outpatient drug dependence treatment options
5. Cease long period of detention without trial/access to health care
6. Full respect for human rights of drug dependent people/occasional users
7. Involve NGOs/civil society/families/affected community in the research; design, and implementation of responses

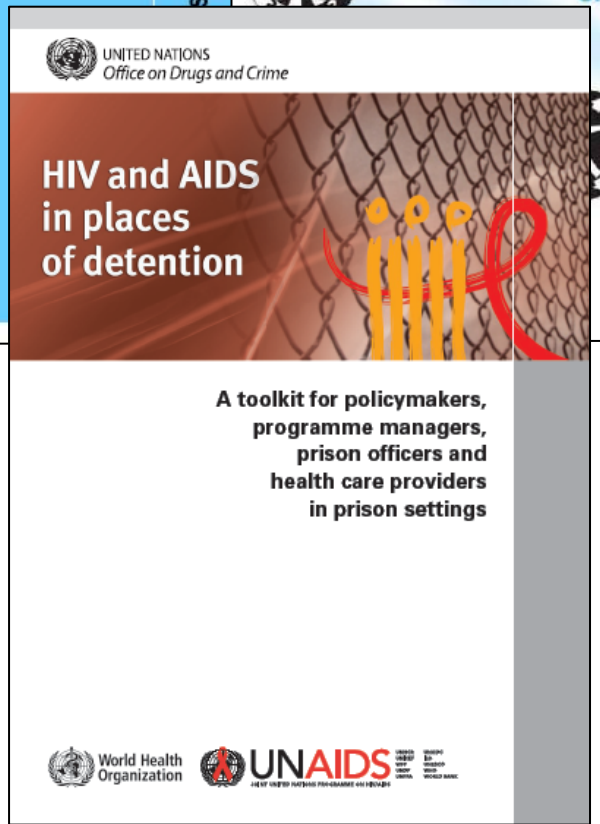
Thank you

Tools to adapt:









Example of success: Iran's experience

- 1980s CDTC approach under State Social Welfare
- CDTC was experimental, not evidence based
- 1983: plan to scale up CDTC in all 30 provinces; but reached only 13 centres
- Relapse rate: > 90%

Courtesy Dr Parviz Afshar, Senior Advisor for Minister of Welfare and Social Insurance

Iran's experience cont'd

Comprehensive HIV package for people who inject drugs in the community and in prisons

- 1996: HIV outbreak in CDTCs
- 2002: A comprehensive HIV/AIDS package for injecting drug users implemented with triangular clinic model in community and in prisons, including comprehensive aftercare
- 2002-2006: rapid scale up; and decreased HIV infections, re-incarceration, relapse rates
- 2007: CDTC approach declared ineffective and abandoned

Courtesy Dr Parviz Afshar, Senior Advisor for Minister of Welfare and Social Insurance