Transition from compulsory centres for drug users to voluntary community-based treatment and services

Discussion paper

Executive summary

With this discussion paper, the expert working group aims to build on the outcomes of the previous Regional Consultations on Compulsory Centres for Drug Users (CCDUs). It offers additional data and examples of country practices through formulating evidence-based recommendations to support the transition from CCDUs to a comprehensive system of voluntary community-based treatment and complementary health, harm reduction and social support services (referred to as "support services" in this paper). These are aligned with international guidelines and principles regarding drug dependence treatment, drug use, and human rights.

The expert working group proposes a three-step approach for transitioning from CCDUs to voluntary community-based treatment and support services that prioritizes the achievement of public health objectives at a national level. This approach can and should be followed by all countries in the region operating CCDUs – regardless of whether they are contemplating or have taken actual steps towards transition. The aim of the approach is to inform evidence that will enable human rights-based decision-making:

1. A national multi-sectoral decision-making mechanism should be established with overall responsibility for the transition. In consultation with key stakeholders from the public security, public health and community sectors, including people who use drugs, this body should be responsible for the development of a comprehensive action plan or strategy that includes objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities. This document can provide countries with a critical platform from which to coordinate the transition.
2. The development of an effective and evidence-based drug dependence treatment system is imperative. Reforms should be implemented to develop and strengthen the various mechanisms underpinning drug treatment management and operations across different sectors including justice, health and community. These reforms need to be accompanied by significant investments to support the development of sufficient expertise and workforce capacity across all relevant sectors, as well as within the communities of people who use drugs.
3. Drug policies, defined to include laws, regulations, strategies and practices for the purposes of this paper, are critical to the success of the transition to voluntary community-based treatment and support services. To promote voluntary access to

drug treatment and support services, policy approaches to drug use and drug dependence need to shift away from criminalization and punishment, to health- and rights-based drug policy measures. For example, instead of arrests, urine drug testing and detention, governments should consider adopting programmes that refer and divert people who use or are dependent on drugs to voluntary drug treatment and support services. Accordingly, national reviews to identify policies that restrict voluntary access to community-based drug dependence treatment and support services should be conducted as a critical step towards achieving an enabling policy environment for the transition.

The following recommendations are proposed for the consideration of all stakeholders involved in the CCDUs transition process, including government agencies, drug policy and drug treatment experts, as well as people who use drugs. These recommendations are in line with UNESCAP Member States' commitments to intensify efforts to eliminate HIV and AIDS in the region,[1] including deployment of national processes detailed in the *Regional Framework for Action on HIV and AIDS beyond 2015*.[2]

[1] For more details, see UNESCAP Resolutions: E/ESCAP/67/9 and E/ESCAP/66/10.
[2] UNESCAP. 2014. *Item 7: Enhancing regional cooperation to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific beyond 2015*.

Recommendations

(a) Address the current negative consequences for people detained in CCDUs as an immediate priority by:

   i. taking immediate steps to minimise human rights violations associated with existing CCDUs during the transition phase (as recommended in the UN Joint Statement on Compulsory Drug Detention and Rehabilitation Centres).[3]

(b) Take steps to initiate a national transition away from CCDUs that engages relevant stakeholders by:

   i. rapidly assessing national structures and capacities in order to identify gaps, risks, opportunities and benefits of the transition, and building on currently available infrastructure, capacities and resources to expedite the transition process;

   ii. developing national transition plans or strategies with objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities through consultation with relevant stakeholders, including government agencies from public health, drug control and public security sectors, as well as people who use drugs;

   iii. using the national transition plans and strategies as well as results of national assessments to develop costed frameworks to allocate and mobilize adequate human, technical and financial resources for each phase and component of the transition; and

   iv. providing annual updates of progress towards the transition, based on indicators included in Annex 2 as well as comprehensive performance assessments of drug dependence treatment services, and allow transparent sharing of information.

(c) Approach the provision of drug dependence treatment as a public health rather than public security issue by:

   i. adhering to human rights principles and international best practice and standards in ensuring the delivery of and voluntary access to evidenced-based drug dependence treatment and harm reduction interventions;

   ii. rapidly building the various capacities of public health, public security, the justice sector, and civil society groups and communities of people who use drugs

[3] United Nations. 2012. *Joint statement on compulsory drug detention and rehabilitation centres*.

to facilitate collaboration in delivering voluntary community-based treatment and support services for people who use drugs;

iii. meaningfully engaging and collaborating with civil society and community groups, including communities of people who use drugs, in order to reduce bottlenecks in the treatment pathway, as well as facilitating access to effective treatment and support services for people who use drugs;

iv. deploying evidence-based communication strategies to raise awareness about the need to reduce drug-related harms including drug dependence, HIV, viral hepatitis and overdose, to increase evidence-based understanding about drug use, and to inform the public about the availability of drug dependence treatment, harm reduction services and support services.

(d) Foster an enabling policy environment to ensure voluntary access to drug dependence treatment and support services by:

i. conducting a multi-sectoral and participatory review of existing legal and policy frameworks relating to drug use and dependence in order to identify and remove barriers preventing people who use drugs from accessing voluntary community-based treatment and support services, such as criminalisation and punishment (including detention and corporal punishment, whether under the criminal justice system, administrative system or other) of people caught using drugs and in possession of drugs for personal use or drug paraphernalia;

ii. replacing policies which criminalise and punish people who use drugs with measures which refer and divert them to voluntary community-based treatment, harm reduction and support services, including existing low-threshold services[4] such as drop-in centres and peer outreach programmes;

iii. building the capacity of the public health, public security and criminal justice representatives as well as civil society and communities of people who use drugs to better understand and facilitate the implementation of current and reformed/revised policies for maximum protection of the human rights of people who use drugs.

[4] Low-threshold services for people who use drugs have been defined as those that: are easily accessible; do not impose abstinence from drugs as a condition of service access; and endeavour to reduce other documented barriers to service access. For more on low-threshold services, see Islam, M. M., et al. 2013. "Defining a service for people who use drugs as 'low-threshold': What should be the criteria?" in *International Journal of Drug Policy,* 24: 220–222.

Introduction

The detention of people who use drugs remains a common response to drug use and drug dependence in many Asian countries, implemented with the aim of curing and rehabilitating people who use drugs. To date, this approach has not resulted in sustained treatment outcomes or social rehabilitation but rather has been associated with increased HIV risks, added stigma and discrimination against people who use drugs, numerous violations of human rights, and significant deviations from evidence-based best practices in drug dependence treatment. Specifically, the detention and coercive treatment of people who use or are dependent on illicit drugs is currently the dominant approach in Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Viet Nam.[5]

The United Nations (UN) issued a Joint Statement in July 2012 calling for the closure of compulsory drug detention and rehabilitation centres and, through a series of regional consultations, offered technical support to facilitate the transition to evidence-based voluntary community-based treatment and support services.[6] In this context, community-based treatment and support services refers to an integrated model of treatment in the community that facilitates access to a menu of evidence-based treatment options from which clients can choose.

In an effort to stimulate a transition towards community-based drug treatment and support services, the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), the United Nations Office on Drugs and Crime (UNODC) Regional Centre for East Asia and the Pacific, and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for Asia and the Pacific, with the support of the Australian National Council on Drugs (ANCD), organized the First and Second Regional Consultations on Compulsory Centres for Drug Users (CCDUs) in December 2010 and October 2012. The Consultations yielded the following recommendations:

(a) raising awareness and building capacity regarding community-based treatment among governmental, non-governmental and private organizations, as well as community members, health professionals, religious leaders, social workers and

[5] UNAIDS and UNODC. 2015. *Third Regional Consultation on Compulsory Centres for Drug Users in East and Southeast Asia: From Policy change to enhanced service.*

[6] United Nations. 2012. *Joint statement on compulsory drug detention and rehabilitation centres*. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf

those working in charities;

(b) initiating, as appropriate, in line with national priorities, multi-sectoral consultations and reviews of laws, policies and practices that hinder access to voluntary and effective drug dependence treatment;

(c) increasing multi-sectoral coordinated action among law enforcement, health, judiciary, drug control and other relevant sectors, as well as with affected communities;

(d) improving data collection and monitoring and evaluation of the effectiveness and cost-effectiveness of CCDUs from both a public health and a public security perspective;

(e) advocating for mobilization of greater financial and human resources as well as capacity-building support for evidence-informed, community-based drug dependence treatment services, including the development of effective responses to amphetamine-type stimulants (ATS) and inhalants;

(f) mobilizing additional human resources, including communities of people who use drugs, and enhancing specialized training for the delivery of voluntary community-based services;

(g) addressing stigma and discrimination and legal and policy barriers to universal access to prevention, care, treatment and support for people who use drugs living with and vulnerable to HIV/AIDS and hepatitis C;

(h) improving follow-up and aftercare in voluntary community-based treatment;

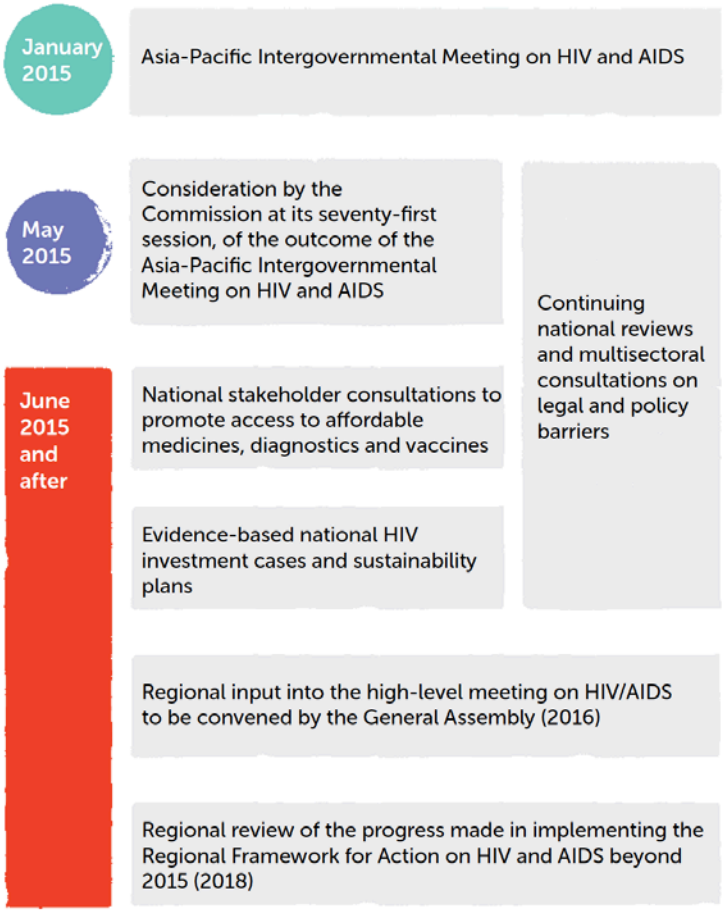
(i) undertaking a mapping of existing resources allocated to different treatment systems.

Building on and reinforcing the outcomes of these previous regional consultations on CCDUs, UNESCAP Member States have also made commitments at the regional level to implement national processes to achieve universal access to HIV prevention, treatment care and support, including for people who use drugs. The commitments detailed in the 2012 *Regional Framework for Action* included national reviews and multi-sectoral consultations on legal and policy barriers to universal access.[7] Recognising the value of such processes, and the need for ongoing and inclusive consultation to address persistent policy barriers in some areas, UNESCAP Member States committed to continue national reviews and consultations on legal and policy barriers in the *Regional*

[7] UNESCAP. 2012. *Report of the Asia-Pacific High-Level Intergovernmental Meeting on the Assessment of Progress Against Commitments in the Political Declaration on HIV/AIDS and the Millennium Development Goals*.

Framework for Action on HIV and AIDS beyond 2015.[8] Figure 1 details the various components of the 2015 regional HIV and AIDS action framework. These frameworks and high-level commitments will continue to offer opportunities for countries to operationalise recommendations developed through the previous regional consultations on CCDUs, as well as those included in this paper.

Figure 1: UNESCAP Regional Framework for Action on HIV and AIDS Beyond 2015



The aim of this discussion paper is to build on the results of the previous Regional Consultations and existing political action frameworks to offer additional data, and examples of country practices through the formulation of evidence-based recommendations to support the transition from CCDUs to a comprehensive system of voluntary community-based treatment and complementary health, harm reduction and social support services (referred to as "support services" in this paper) that are aligned with international guidelines and principles regarding drug dependence treatment, drug use and human rights.

[8] UNESCAP. 2015. *Report of the Asia-Pacific Intergovernmental Meeting on HIV and AIDS*.

The discussion paper presents a short overview of current trends in transitioning away from CCDUs, and highlighting the challenges and benefits of the transition. In addition, the paper underlines key elements and principles that are important for a successful transition to voluntary community-based treatment and support services, and proposes a model for initiating an effective transition at the national level. Where relevant, examples of country practices in terms of implementation of community-based treatment and services are highlighted.

Draft findings and recommendations of this paper were shared during the Informal Partners Consultation on CCDUs that took place in Bangkok, Thailand, on 11-12 February 2015, after which additional inputs were integrated in the paper. The final version of this paper was shared at the Third Regional Consultation on CCDUs in September 2015 in Manila, the Philippines. A summary of the paper will be published in the *Harm Reduction Journal*[9] later this year.

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[9] See www.harmreductionjournal.com.
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Situation analysis

Current and recent historical literature documenting CCDUs in Southeast Asia indicates the need for a transition towards alternative models to address drug use and dependence.[18] To date however, this evidence has not adequately articulated the range of steps that can be taken across key sectors to support such a transition. Predominantly, the evidence clearly shows that CCDUs are neither appropriate nor effective instruments to address national drug issues. Evidence shows that CCDUs are generally:

- **Ineffective**. Data and evidence indicate that CCDUs do not lead to sustained abstinence from drug use or significant gains in health or quality of life; relapse rates after release are high, as is criminal recidivism.[19] A history of detention in CCDUs has been associated with a higher risk of HIV transmission,[20] increased risk behaviours,[21] a higher risk of overdose,[22] and reduced access to health care and health-seeking behaviours.[23]
- **Unsafe for clients**. Multiple case studies and front-line reports have documented human rights violations, including arbitrary detention, denial of health care, forced labour and physical and sexual violence.[24] Such events represent significant deviations from the fundamental goals of treatment and rehabilitation of people in CCDUs and compromise potential for successfully achieving those objectives.
- **Costly**. The significant national-level investments in CCDUs in Southeast Asia over the past decade are much greater than the investments made to develop effective, comprehensive, voluntary, evidence-based treatment and support services for people

[18] Baldwin, S., Thomson, N., Dorabjee, J. and Kumar, S. 2012. *Compulsory Detention of People who Use Drugs – Looking for Alternatives*.
[19] World Health Organization. 2009. *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles*.
[20] Hayashi, K., et al. 2009. "Incarceration experiences among a community-recruited sample of injection drug users in Bangkok, Thailand" in *BMC Public Health, 9*:492.
[21] Chen, H. T., et al. 2013. "Correlations between compulsory drug abstinence treatments and HIV risk behaviors among injection drug users in a border city of South China" in *AIDS Education and Prevention. 25*(4): 336-48.
[22] Milloy, M-J., et al. 2010. "Overdose experiences among injection drug users in Bangkok, Thailand" *Harm Reduction Journal*, *7*:9.
[23] Kerr, T., et al. 2014. "The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand" in *International Journal of Drug Policy, 25*(1): 171-4.
[24] Amon, J. J., et al. 2013. "Compulsory drug detention centres in China, Cambodia, Vietnam, and Laos: Health and human rights abuses" in *Health and Human Rights*, *15*:2; Canadian HIV/AIDS Legal Network. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*; Davis, S. L. M., et al. 2009. "Survey of abuses against injecting drug users in Indonesia" in *Harm Reduction Journal*, *6*:28; Human Rights Watch. 2008. *An Unbreakable Cycle Drug Dependency Treatment, Mandatory Confinement, and HIV/AIDS in China's Guangxi Province*; Human Rights Watch. 2011. *The Rehab Archipelago Forced Labor and Other Abuses in Drug Detention Centres in Southern Vietnam*; Human Rights Watch. 2010. *"Skin on the cable" - The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia*; Human Rights Watch. 2014. *Public insecurity: Deaths in Custody and Police Brutality in Vietnam*; Open Society Institute. 2009. *At What Cost? HIV and Human Rights Consequences of the Global "War on Drugs"*; Open Society Institute. 2010. *Detention as treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*; PSI Thailand. 2011. *Rapid PEER Study to strengthen the Injecting Drug Users Quality of Life Programme.*

who use drugs, especially given the substantial capital investment associated with CCDUs. Few cost-effectiveness studies have evaluated their added value in the context of public health, but it is estimated that overall cost-effectiveness is very poor.

- **Insufficiently capacitated**. Staff that manage and implement 'drug rehabilitation' in CCDUs have been found to be lacking in basic medical and clinical capacity; national clinical guidelines and standards for treatment services and providers have often not been developed; where guidelines have been developed, they often omit key interventions that could significantly reduce harm and improve clients' quality of life but rather promote interventions that are not aligned with evidence and good practice.[25]

In addition, evidence suggests that a great number of people currently inside CCDUs are not in need of clinical treatment for drug dependence, which further contributes to the cost burden created by CCDUs. Indeed, research from Northern Thailand indicates that approximately 20% of amphetamine users require clinical treatment for drug dependence, whereas the remaining 80% are at low risk of developing substance dependence and, therefore, do not need clinical treatment.[26] Clinical treatment for drug dependence implies that clients have been assessed by a public health professional against valid criteria to confirm dependence and are provided with nothing less "than a qualified, systematic, science-based approach such as that developed to treat other chronic diseases considered untreatable some decades ago".[27] The need for clinical treatment, correlated with substance dependence rates, has been measured elsewhere and largely confirms findings from the region (see Table 1).

[25] Amon, J.-J. et al. 2014. "Compulsory drug detention in East and Southeast Asia: Evolving government, UN and donor responses" in *International Journal of Drug Policy*, 25: 13-20; Asian Network of People who Use Drugs. 2013. Position paper: Compulsory Detention of People who Use Drugs; Canadian HIV/AIDS Legal Network. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*; Csete, J. et al. 2011. "Compulsory drug detention centre experiences among a community-based sample of injection drug users in Bangkok, Thailand" in *BMC International Health and Human Rights*, 11:12; Open Society Foundations. 2009. *Human Rights Abuses in the Name of Drug Treatment: Reports From the Field*.

[26] Chua-nam, S., Jantip, S., Yasuwan, S., Aramrattana, A. 21-23 November 2013. "*Community-owned Comprehensive Program for Methamphetamine Users in Northern Thailand*" Abstract Presented at the 15th ISAM Annual Meeting, Kuala Lumpur, Malaysia.

[27] UNODC and WHO. 2008. *Principles of Drug Dependence Treatment.*

Table 1: Clinical dependence rates by substance[28]

Substance	Percentage of people who use drugs that develop clinical dependence
Tobacco	32%
Heroin	23%
Cocaine	17%
Alcohol	15%
ATS	11%
Cannabis	9%
Sedative-hypnotics	9%
Analgesics	9%
Psychedelics	5%
Inhalants	4%

The literature often describes CCDUs as drug control and prohibition mechanisms, used to deter drug use rather than to fulfil the mandate of treating or rehabilitating people who use drugs.[29] In many countries in the region, CCDUs are staffed, operated, managed and financed largely through public security agencies. In many CCDUs across the region, the staff's clinical knowledge on addiction, including medical knowledge relating to substance use, as well as a capacity and certification for assessing treatment needs and providing drug dependence treatment are low.[30] A growing number of political leaders and other key stakeholders are recognizing that punitive approaches to drug use, including CCDUs, criminalization and punishment, have failed to deliver the outcomes required to support the social and health needs of people dependent on drugs and people who use drugs.[31]

[28] Anthony, J. C., 2002. "Epidemiology of drug dependence" in: Davis, K. L. et al. (Eds.), *Neuropsychopharmacology: The Fifth Generation of Progress*, 1557-1574.
[29] UNODC. 2009. *From Coercion to cohesion – Treating drug dependence through healthcare, not punishment*.
[30] Research Triangle International. 2013. *Compulsory Detention of People Who Use Drugs in Asia - Looking for Alternatives*.
[31] Global Commission on Drug Policy. 2012. *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic;* Global Commission on HIV and the Law. 2012. *Risks, Rights and Health*.

Accordingly, the expert working group fully supports the initiation of a transition towards voluntary, evidence- and community-based drug dependence treatment and support services across the region, as well as the scaling-down of CCDUs. The expert working group acknowledges that many challenges will need to be addressed during the transition, including:

- National laws and policies have been documented to act as barriers to voluntary access to drug dependence treatment and support services. For example, criminal and administrative laws and policies mandate law enforcement to arrest and detain people who use drugs on the basis of suspected drug use and possession; laws and policies continue to compel urine tests despite the fact that such testing does not diagnose the need for drug dependence treatment.
- Few public health and community options – beyond CCDUs – are perceived to be available to meet the diverse needs of the growing numbers of people who use drugs in the region, especially people who use amphetamine-type stimulants (ATS).
- The overall burden of drug use and dependence is perceived as a challenge to current levels of capacity within the public health and public security sectors given that prisons and other closed institutions (including CCDUs) are overcrowded and inadequately prepared to meet the health needs of people who use drugs.
- Public health, criminal justice and community resistance. This is due to the potential need for complex structural, legislative, cultural and operational changes required to complete the transition.
- Public perceptions and expectations related to drug use. These are intimately related to public security approaches to drug-related issues and indicate a high desire to see people who use drugs forcibly rehabilitated and even punished in many Southeast Asian countries. This is despite evidence that such practices do not generate sustainable public health outcomes.
- The stigma and discrimination associated with drug use and dependence affects both clients and service providers and can reduce political willingness to prioritise the issue, thus posing difficult challenges for implementation of the transition.

However, despite these difficult challenges, a transition away from relying on CCDUs towards voluntary community-based treatment and support service options can, potentially, generate significant benefits. These include: better and more sustainable health outcomes

at the client level; improved efficiency of both public health and public security operations through harmonization and collaboration; improved community participation, ownership and cohesiveness; reduced operational costs as well as improved cost-effectiveness and sustainability across public health and public security sectors; and recognition and support from the international community for pursuing effective, human rights- and evidence-based approaches to drug dependence treatment.

Elements and principles for an effective transition

Voluntary community-based drug dependence treatment has been defined as a specific integrated approach to treatment in the community that facilitates access to a menu of treatment and support services from which clients can choose (see other key terms defined in Annex 1).[32] In this section, the paper further expands upon the definition of community-based treatment to include a range of complimentary health and social services, as well as the guiding principles and elements recommended for a successful transition at the national level. In practice, a range of community-based drug dependence treatment models can be implemented and cultivating diversity and a plurality of accessible and evidence-based health service options from which clients can choose will ultimately facilitate recovery.[33]

Principles of drug dependence treatment include:[34]

- offering multiple treatment options will better meet a client's individual needs;
- evidence-based treatment options;
- selection of treatment options by the client on a voluntary basis, without coercion or pressure;
- culturally tailored and relevant treatment options;
- respect for human rights, guarantee of ethical compliance and safeguarding clients' well-being and security;
- meaningful participation and engagement of the community (civil society, peer groups, people who use drugs);
- integration of key interventions in low-threshold health service outlets;
- multi-sectoral coordination and collaboration, especially between public health and public security.

[32] UNAIDS & UNODC. 2015. *Third Regional Consultation on Compulsory Centres for Drug Users in East and Southeast Asia: From Policy Change to Enhanced Service.*
[33] Sugarman, P., et al. 2010. "Choice in mental health: participation and recovery" in *The Psychiatrist*, *34*(1): 1-3.
[34] Based on UNODC & WHO. 2008. *Principles of Drug Dependence Treatment.*

Fundamentally, interventions and services seeking to treat and assist people who use drugs should be the purview and responsibility of public health professionals. Yet, currently, they exert limited influence over decisions related to treatment and other services for people who use drugs in the region. The international drug control apparatus formally recognizes the mandate of health experts in the context of improving overall health and quality of life for people who use drugs,[35] and the international drug control conventions make clear that "the drug issue is first and foremost a matter of public and individual health and welfare".[36]

However, with just a few exceptions, the drug treatment apparatus is often led, managed and operated by public security and law enforcement in most countries in the region.[37] Instead, public health professionals should lead and drive the response to drug dependence and use. As such, collaboration and coordination between public health and law enforcement is essential to the fundamental success of the overall response to drug-related issues, including the transition to community-based treatment and support services. In this sense, public health principles should guide national transitions to voluntary community-based treatment and support services, while acknowledging the need to integrate public security objectives.

All efforts related to the treatment of drug dependence, as well as interventions to improve the health and quality of life for people who use drugs, should be guided by the recognition that substance dependence is a "multifactorial health disorder that often follows the course of a relapsing and remitting chronic disease" that is best addressed through a biopsychosocial model and a multi-disciplinary approach centred on health.[38]

Furthermore, the primary objective of the transition should be to stimulate a more effective and cost-effective response to drug use and dependence across the region. Unfortunately, CCDUs have not generated reliable evidence of sustained treatment responses (abstinence, rehabilitation, re-integration), nor have they resulted in enhanced community safety. This is

[35] International Drug Policy Consortium and Transnational Institute. 2012. *The UN drug control conventions - The Limits of Latitude*. 9-17 March 2015. Statement by Dr Lochan Maidoo, President of the International Narcotics Control Board (INCB), Fifty-eighth session of the Commission on Narcotic Drugs Special segment on preparations for the special session of the General Assembly on the world drug problem (UNGASS) to be held in 2016 Vienna: www.incb.org/documents/Speeches/Speeches2015/Statement_INCB_President_CND_2015_UNGASS_06_03_15V_1_cl_INCB_logo.pdf.

[36] Statement by Dr Lochan Naidoo, President, International Narcotics Control Board (INCB), Fifty-eighth session of the Commission on Narcotic Drugs Special segment on preparations for the special session of the General Assembly on the world drug problem (UNGASS) held in 2016 (Vienna, 9 March 2015). See https://www.incb.org/documents/Speeches/Speeches2015/Statement_INCB_President_CND_2015_UNGASS_06_03_15V_1_cl_INCB_logo.pdf.

[37] Research Triangle International. 2013. *Compulsory Detention of People Who Use Drugs in Asia - Looking for Alternatives.*

[38] UNODC and WHO. 2008. *Principles of Drug Dependence Treatment*.

principally due to them not influencing the prevalence of drug use nor leading to a reduction in crime, despite the significant investments that have been made to support an expanding infrastructure. In order to develop the responses that can potentially better meet the individual needs of clients and generate sustained positive outcomes, a better understanding of drugs, including dependence and use, and the roles of law enforcement and public health should be fostered. For example, only a small proportion of ATS users will require clinical treatment; therefore, such treatment should be offered only to those who have been clinically assessed and diagnosed as substance-dependent rather than simply those who test positive after a urine test. Services aimed at reducing the risks associated with drug use, such as overdose prevention, opioid substitution therapy (OST), sterile injecting equipment, and factual information about the potential effects of using various drugs are also relevant for people who use drugs.

Drug dependence treatment and support service options should be based on evidence of clinical and cost effectiveness, as well as being easily accessible on a voluntary basis. Though treatment options should be selected by the individual client, this paper recognizes the need to supervise and monitor treatment, especially when treatment is legally mandated and clinically warranted. In essence, no single treatment option will be able to meet the needs of every individual who decides to enter into drug dependence treatment.

In that respect, supervision and monitoring of people who use drugs undergoing drug dependence treatment can be done in health and community settings – outside CCDUs. This would present an opportunity for synergies with community groups that will improve overall clinical and cost effectiveness. The one-size-fits-all approach that underpins the assumption that all drug use can be ‘cured’ or eliminated through CCDUs should be discarded in favour of cultivating a multiplicity of options for those who are in clinical need of treatment.

Additional opportunities for synergies will be available where community representatives, civil society organizations and peer groups are meaningfully involved. Their engagement in the transition process enhances the potential for multi-sectoral collaboration and coordination, as well as programmatic and structural integration across national systems. In parallel, working with community groups can generate better insights and information about the needs of people who use drugs and inform tailored responses. In turn, those opportunities can translate into further significant gains in clinical and cost effectiveness.

A range of various principles should guide any transition towards voluntary community-based treatment and support services, including ethics, human rights and client safety, as well as good governance, transparency and accountability. Compliance with these various principles of good practice will ensure that governments undertaking the transition will minimize any potential unintended negative consequences of the transition and maximize the probability of achieving positive sustainable results.

Fundamentally, for any treatment to be considered ethical, it must minimize the risks of unnecessary harm to the client and be in the best interests of the client, including considerations such as freedom from arbitrary detention, torture, and other forms of cruel, inhuman or degrading procedures. As noted above, CCDUs have at times been associated with significant ethical violations. Finally, clinical ethics require providers to maintain confidentiality and safeguard the privacy of clients. Compliance with human rights instruments will also increase the potential to achieve positive results in advancing the welfare and quality of life of people who use drugs.

Remaining mindful of ethics and human rights principles will also compel those initiating the transition to consider improving transparency to ensure that results can be measured, assessed, and compared. In parallel, as decision-making about drug dependence treatment becomes more transparent, those undertaking the transition will need to strengthen accountability and governance in order to ensure that breaches in principles, policies, guidelines and protocols are quickly identified and appropriately addressed. It is also important to ensure that those providing drug dependence treatment services are competent to do so and, where possible, professionally accredited.

In essence, the probability of a successful transition from CCDUs to voluntary community-based treatment and support services will be higher if it is underpinned by national consensus on the ineffectiveness of CCDUs and an understanding of the benefits of voluntary, evidence-based approaches, guided by a genuine, broad-based high-level commitment to protect patients' health, human rights and quality of life, and managed and operated by public health experts. Indeed, it will be critical to mobilize both political will and multi-sectoral leadership for a successful transition to voluntary, effective drug dependence treatment practices.

Effective community-based treatment and services supporting transition in Southeast Asia

Despite the absence of official transition frameworks at the national level, components of community-based drug dependence treatment and support services are being implemented in the region. This section will highlight a handful of examples of community-based drug dependence treatment and support services from Cambodia, China, Indonesia, Malaysia, and Thailand. Where possible, project descriptions will include information on the key project components, the motivation behind the transition, and the impact of such interventions.

Cambodia

In 2010, the Government of Cambodia approved the Community-Based Drug Prevention and Treatment pilot programme, following the First Regional Consultation on CCDUs. The project has been implemented by the National Authority for Combating Drugs (NACD) with support from UNODC and the World Health Organisation (WHO) and in partnership with CSO, including the Khmer HIV/AIDS Alliance (KHANA), Family Health International (FHI), Friends International (FI), Mith Samlanh, the Social Environment Agricultural Development Organisation (SEADO), the Khmer Buddhist Association (KBA), the Cambodian Women for Peace and Development (CWPD), and the Rural Economic Development Association (REDA).

Community-based drug dependence treatment services were initiated in 2011 in Banteay Meanchey province and, in 2012, efforts were scaled up to cover Battambang and Stung Treng provinces. Over 1,200 people who use drugs affected by drug dependence are currently voluntarily accessing services based on the UNODC-WHO Principles of Drug Dependence Treatment, and hundreds of health service providers from government and civil society sectors have been trained. Notably, standards of care and standard operating procedures have been developed to enshrine the principles and provide guidance to key stakeholders involved in community-based drug dependence treatment. All clients are assessed using the WHO ASSIST tool in order to develop a tailored treatment plan and response.

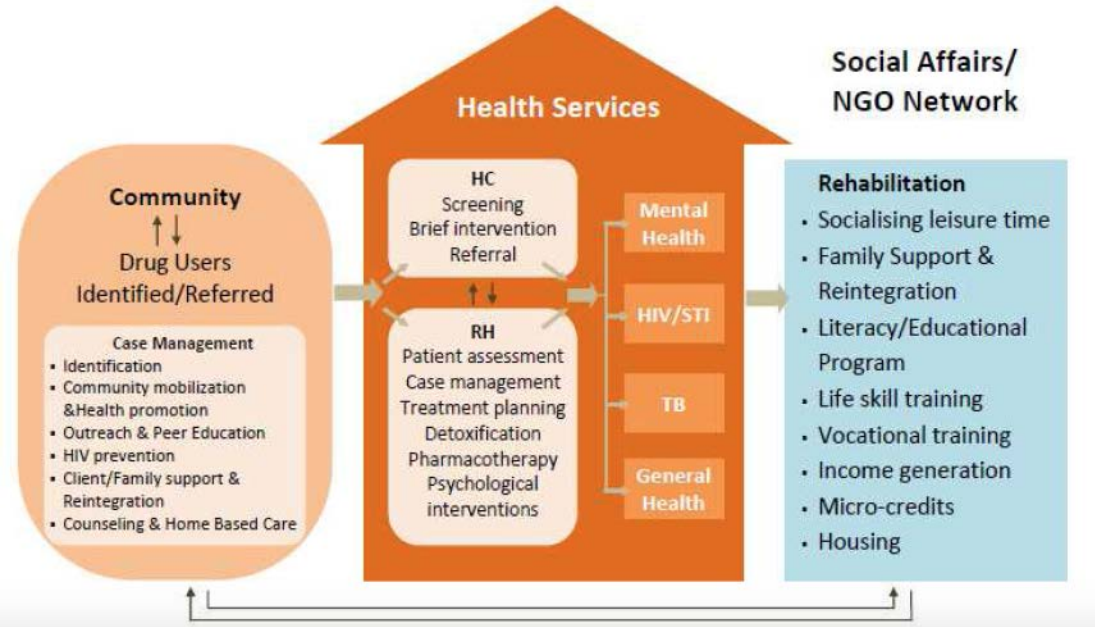
The principles underlying the new approach include the following:

- continuum of care, including outreach, harm reduction, early and brief interventions, drug dependence treatment, provision of health and social care services, and social reintegration;
- delivery of services in the community, as close as possible to where the client lives;
- maximize the client's social links and employment;
- integration into existing health and social services, including referrals;
- involvement and development of community resources, including families, NGOs and health service providers;
- holistic approach to drug dependence that takes into account clients' different needs (health, family, education, employment, housing, etc.);
- informed and voluntary participation and involvement of the client in treatment;
- respect for human rights and dignity;
- acceptance that relapsing and remitting is part of the treatment process.

These principles are articulated in the model of care and depicted in Figure 2. The success generated to date by the project has been attributed to strong leadership and national commitment, meaningful engagement of people who use drugs, community participation, NGO engagement, as well as multi-sectoral collaboration and coordination between public health, public security and CSO sectors.[39]

[39] UNODC. 2015. *Supporting Access for Drug Users to Health and Social Care in Cambodia - Case studies of community-based services in Banteay Meanchey, Battambang and Stung Treng provinces*.

Figure 2: Community-based drug dependence treatment model in Cambodia



China

Though China's legal and policy framework allows for community-based drug dependence treatment, the vast majority of services for people who use drugs are offered through CCDUs. However, in May 2014, the Ping An No. 1 Centre was established by AIDS Care China and other NGOs in Yuxi city, Yunnan, with the involvement of people who use drugs, to provide community-based drug dependence treatment and support services. The Ping An No. 1 Centre offers OST, overdose prevention with naloxone, primary care (including food, medical consultations and referrals), employment referrals, psychological counselling, and family support.

In the setup phase, collaboration was secured from law enforcement, public health and community leaders in the following roles:

- The police department diverts people who use drugs to the centre instead of arrest and reduces tensions between police and community.
- Health service providers offer take-home methadone and naloxone and facilitate referrals to treatment and care.

- The Civil Affairs department provides financial subsides to clients in need and identifies suitable job opportunities.

Future plans include scaling-up the Ping An model, mobilizing local government funding, and linking law enforcement measures of success with public health objectives.

Indonesia

The community-based NGO Rumah Singgah *Perkumpulan Komunitas Pemulihan Adiksi* (PEKA) was established in 2010 as a halfway house to provide community-based drug dependence treatment and support services to people who use drugs in Bogor, largely in response to the closure of several rehabilitation centres in the provinces around the city. Supported by the Australian Government Overseas Aid Program, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Indonesian Partnership Fund for HIV/AIDS, the International HIV/AIDS Alliance and UNODC, as well as the Ministry of Social Affairs, the National AIDS Commission and the National Narcotics Board, PEKA is the first community-based organization providing drug dependence treatment services to be mostly comprised of people who have recovered from using drugs.

All of PEKA's clients voluntarily access services that are tailored to meet their individual needs and range from abstinence-based approaches to harm reduction, including behavioural, cognitive and clinical approaches. It is up to the client, with support from professionals and peers, to select which treatment intervention will best suit their needs.

The team working at PEKA considers that a key measure of success is improving clients' quality of life, as measured with WHO instruments.[40] Additional measures – including progress against the Addiction Severity Index[41] – shows that PEKA's approach is generating positive treatment outcomes and the organization has been recognized and acknowledged for excellence and innovation in the field.

Overall, PEKA has provided community-based drug dependence treatment and support services to 95 people who use drugs. However, PEKA has reached many more people who use drugs through outreach and other services and influenced their behaviours and attitudes. A survey conducted in a sample of 260 of PEKA's clients found that almost 45 per

[40] See www.who.int/mental_health/publications/whoqol/en.
[41] See www.who.int/substance_abuse/research_tools/addictionseverity/en.

cent show positive progress against the Addiction Severity Index. A similar survey among 290 clients showed positive progress for almost 48 per cent of clients against the WHO Quality of Life Index. The majority of clients reported feeling more comfortable with PEKA's services than with government-operated CCDUs.

Malaysia

In 2010, the Malaysian government initiated the conversion of CCDUs into Cure and Care (CNC) centres, which offer voluntary access to a comprehensive package of health and support services for people who use drugs. Recent publications describe evaluations of CNC centres, both in terms of treatment outcomes as well as in terms of client satisfaction.[42]

Overall, CNC clients expressed satisfaction with treatment outcomes and identified diminished withdrawal symptoms and craving for drugs as important personal successes. Analyses of participant interviews identified four CNC services that contributed significantly to these positive results: methadone treatment; psychological counselling; religious instruction; and recreation. An open environment with strong and trusting relationships among peers and staff contributed to improved programme adherence. Participants felt that their access to health care greatly benefited their overall health.

Specifically, the majority of people who use drugs found CNC services helpful or very helpful in securing employment, accessing welfare and government services, accessing formal education, improving relationships with family and friends, finding a place to live, assisting with drug problems, staying out of prisons and CCDUs, accessing health services, including HIV prevention and OST, and accessing legal aid.

In another study comparing CNC with CCDUs in Malaysia, it was found that half of clients coming out of CCDUs relapsed within 32 days of release, compared with 429 days for CNC clients.[43]

[42] Ghani, M. A. 2015. "An exploratory qualitative assessment of self-reported treatment outcomes and satisfaction among patients accessing an innovative voluntary drug treatment centre in Malaysia" in *International Journal of Drug Policy* Volume 26, Issue 2: 175–182*;* Kamarulzaman, A. & McBrayer, J. L. 2015. "Compulsory drug detention centers in East and Southeast Asia" in *International Journal of Drug Policy*, *26*: S33–S37.

[43] Ghani, M. A. 2015. "An exploratory qualitative assessment of self-reported treatment outcomes and satisfaction among patients accessing an innovative voluntary drug treatment centre in Malaysia" in *International Journal of Drug Policy* .

Thailand

The "Community-owned Comprehensive Program for Methamphetamine Users in Northern Thailand" was initiated in 2007 in Kuanpahk, Chiang Mai, to address the rising number of ATS users in the area. At the outset, the project focused on community justice through recruiting and training peer volunteers who worked under the guidance of a community advisory committee to conduct community- and school-based awareness-raising campaigns focused on alcohol use. In 2009, the project expanded to cover ATS users through a similar format, as well as through community-based outreach. Under this component, ATS users are treated through a community-based model that reduces the involvement of law enforcement (and accompanying criminal justice implications) while encouraging family engagement and spiritual/religious guidance in the context of a health approach. All clients have now been assessed for drug use and dependence using the ASSIST tool and results show that only a minority of ATS users actually require clinical treatment. This project demonstrates that people who use drugs can effectively be treated in the community in a non-coercive manner.[44]

In addition, Ozone, a local NGO, is dispensing community-based peer-led methadone in the mountains of Chiang Rai, in partnership with the government hospital. In an effort to overcome significant access barriers, due to the distance from hilltop villages to the hospital at the foot of the mountains, Ozone negotiated a partnership with the provincial hospital to collect, manage and distribute methadone to registered clients. Over 70 clients are currently accessing methadone through this innovative community-based drug dependence treatment intervention initiated and operated by civil society. The programme has been operating for approximately 18 months under the CHAMPION-IDU project, and was supported by the Global Fund until January 2015.

Facilitating the transition to voluntary community-based treatment and services

Initiation of the transition to voluntary community-based treatment and support services in the region will need to be sensitive to cultural factors and national laws within each country,

[44] PSI Thailand. 2015. *CHAMPION-IDU - Innovations, best practices and lessons learned - Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*; PSI Thailand. 2015. *Providing Community Level Methadone Maintenance Therapy: An Evidence-Based Report on Effective and Sustaining Treatment for Opioid Substance Users.*

while acknowledging that this transition is a process, and not a single step. Indeed, in some countries, the transition has already begun and progress towards developing voluntary community-based drug dependence treatment options has been made. However, as part of the transition process, and in order to maximize opportunities for successful transition, key agencies will have to commit to adhering to scientific evidence, especially when such evidence shows that CCDUs are ineffective and, in some cases, harmful. In addition, commitment from leaders from multiple sectors to review and change laws and policies that impede the transition will need to become a significant component of the transition itself.

Meanwhile, identification of existing options for voluntary community-based treatment and support services should always underpin any effort to scale-down CCDUs. During the period of transition, countries should implement the recommendations for immediate action detailed in the 2012 United Nations Joint Statement on Compulsory Drug Detention and Rehabilitation Centres[45] in order to minimize the human rights violations associated with existing centres. Recommended steps include ensuring due process for those who are detained (and release of those who should not be detained), review of policies and conditions in the CCDUs (including access to health care and cessation of torture, inhuman and degrading treatment and forced labour), implementing judicial and other independent methods of oversight and reporting, and moratoria on further admissions.

In this respect, the expert working group has crafted three broad recommendations for governments in the region to consider, adapt and apply as necessary within their national contexts. The recommendations focus on building leadership consensus through: planning and management; developing a more enabling legal and policy environment; and strengthening health and social services systems and overall national capacity to implement and manage voluntary community-based treatment services (see Figure 3 below). The recommendations are designed to be applicable to all countries in the region, whether or not progress towards transition has already been achieved.

The recommendations are consistent with approaches recognised as effective by Member States at the 2015 Asia-Pacific Intergovernmental Meeting on HIV and AIDS, including: promoting harm reduction for people who inject drugs; implementation of non-discriminatory legal frameworks; adoption of multi-sectoral, multi-level and multi-stakeholder approaches, including strategic partnerships with civil society organisations and

[45] United Nations. 2012. *Joint statement on compulsory drug detention and rehabilitation centres*.

communities; and regional cooperation (e.g. technology transfer, sharing of lessons and promotion of good practices) as both necessary and complementary to national efforts.[46] This section of the paper will also describe each of those components and explore their relevance in the context of the transition towards voluntary community-based treatment and support services.

Figure 3: Elements of transitional frameworks

Planning and management

In order to successfully transition from CCDUs to voluntary community-based treatment and support services and maximize the potential benefits to both clients and countries, governments are encouraged to develop an official national action plan and/or strategy to map out the steps in their transition and anticipated national needs for implementing the transition. Such an official document could be akin the national HIV/AIDS strategies adopted by the majority of governments in the region.

A national multi-sectoral high-level committee led by health sector representatives in close collaboration with public security stakeholders should take on overall responsibility for developing, implementing, and providing oversight over action plans related to voluntary community-based treatment and support services to ensure the success of the transition. Ideally, an existing committee can operationalize the development of the transition plan within existing structures. In turn, this committee should call for an assessment of public

[46] UNESCAP. 2015. *Report of the Asia-Pacific Intergovernmental Meeting on HIV and AIDS*.

health and public security capacity, structures and policies, as well as the current illicit drug situation across the country, in order to inform an evidence-based response.

In order to maximise the potential success of the transition, particular efforts should be made by the transition committee to solicit input and feedback from key stakeholders from multiple sectors, including public health, public security and civil society. In addition, representatives from social welfare departments should be invited to contribute to plans and strategies where they can play a significant support role. Similarly, the involvement of representatives from the educational and labour sectors, will also ensure that the multiple aspects of drug treatment and rehabilitation are taken into consideration. Similarly, governments in the region are encouraged to make use of existing regional mechanisms, such as the Association of Southeast Asian Nations (ASEAN), to mobilize support and exchange knowledge and capacity to support national level efforts.

The development of effective national transition plans will ideally be led by members of the national committee who will be further informed of the various perspectives and options through national consultations. Successful national planning will be particularly sensitive and attentive to feedback from community representatives, members of affected populations and civil society groups, as well as officials from other sectors beyond public health and public security such as education, social affairs and labour. When relevant stakeholders combine their efforts and expertise and find consensus on the assessed evidence, planning for the transition to voluntary community-based treatment and support services will be more effective.

Successful national transition plans will also ideally include clear objectives and expected outcomes, as well as representative indicators and measurable targets with proposed timelines. The development of such objective performance frameworks will facilitate data collection and assessment of the transition (and performance of both CCDUs and community-based models) as well as of the impact of voluntary community-based treatment and support services.

Countries are encouraged to regularly monitor and provide annual updates to UNODC and UNAIDS of relevant data to show progress in the transition from CCDUs to community-based drug dependence treatment and support services. The indicators included in Annex 2 have been previously used by UNODC (2010–2015). Public dissemination of such data on a regular basis would further promote regional cooperation and transparency.

Effective national transition plans will ideally detail a number of activities to respond to drug dependence in the community. Meanwhile, successful transition to voluntary community-based treatment and support services will also compel those countries that initiate it to assign responsibility for each activity to designated officials and representatives with the power and influence to carry out the work. Costing of activities related to the transition and scale-up of voluntary community-based treatment and support services is also considered to be a key element of successful transition plans.

Successful transition plans will also require significant investments in terms of human, technical and financial resources. Indeed, resources will need to be re-allocated from national and local budgets (currently dedicated to CCDUs) and mobilized to support the roll-out of planned activities. In parallel, high-level political commitment and endorsement will ensure stability of the transition, attract support and ensure clear public messaging to inform the general population. Finally, technical support will need to be mobilized to support critical capacity gaps that prevent progress in the transition and rapid scale-up of voluntary community-based treatment and support services.

Ultimately, governments in the region that develop national transition plans will be in a better position to effectively and efficiently respond to drug-related issues. In this respect, the initial phase of planning at the national level could pave the way to the establishment of pilot projects in designated areas to assess feasibility, cost and effectiveness on a small scale. Based on initial results, the national committee could then formulate longer-term plans with recommendations for consideration by national authorities.

Addressing legal and policy barriers

Addressing legal and policy barriers has been identified as a key element in the sustainable scale-up of voluntary access to drug dependence treatment and support services by people who use drugs. Where drug use and possession of drugs for personal use are crimes subject to arrest, prosecution, multiple forms of detention and punitive measures (e.g. mandatory urine drug testing, compulsory registration with law enforcement or drug control agencies, and corporal punishment), people who use or who are dependent on drugs are less likely to voluntarily seek treatment and support services. In many cases, such policy frameworks explicitly prevent people from accessing voluntary community-based treatment and support services. To increase access, a thorough review and assessment of laws and policies that restrict or prevent access to voluntary community-based treatment and support services is

recommended. Such reviews and assessments should inform the development and implementation of time-bound action plans for the creation of a more enabling national legal and policy environment[47] to support the transition.

Legal and policy assessments and review processes should be planned and conducted under the guidance of a multi-sectoral and inclusive working group comprising relevant government sectors (ministries of justice, health, interior/home affairs, welfare, education and labour), technical experts on drug use and access to justice, and community representatives – including people who use drugs.[48] In identifying effective and appropriate legal and policy reform measures to adopt, a range of policies already successfully implemented in other countries may be considered:[49]

(a) Decriminalisation of drug use, as recommended by WHO[50] and UNAIDS.[51] This includes removing criminal penalties for drug use and possession for personal use, and for possession of drug paraphernalia.

(b) Depenalization. Reducing the severity of penalties relating to drug use, for example by increasing the threshold amounts for legal possession of drugs for personal use, reducing the length of sentences and amount of fines. In the UK, for example, a person arrested for drug possession for personal use may be given a warning rather than being arrested, prosecuted or imprisoned.

(c) Diversion. Redirecting an offender away from the criminal justice or public security system, including arrest, prosecution, sentencing and imprisonment, and referring them to voluntary community-based treatment and support services. Diversion can occur at the point of arrest by a law enforcement officer, at the point of prosecution by prosecutorial staff, or at the point of sentencing by a judge. In the context of this paper, diversion involves the referral of individuals suspected of drug use, possession of drugs for personal use, or minor, non-violent offences associated with

[47] WHO. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*.
[48] This is in line with the commitment of UNESCAP Members to conduct national, multi-sectoral reviews and consultation on legal and policy barriers to universal access to HIV services in the Regional Framework for Action on HIV and AIDS beyond 2015 (E/ESCAP/HIV/IGM.2/5), adopted in January 2015. For further guidance, see UNDP, UNESCAP, & UNAIDS. 2013. *Creating Enabling Legal Environments: Conducting National Reviews and Multi-Sector Consultations on Legal and Policy Barriers to HIV Services* www.asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/hiv_aids/rbap-hhd-2013-creating-enabling-legal-environments.pdf.
[49] International Drug Policy Consortium. 2012. *Drug Policy Guide*: Chapter 2.3 provides further details explaining these policy reform options and examples of effective implementation around the world.
[50] WHO. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*.
[51] UNAIDS. 2014. *The GAP Report*.

drug use away from the criminal justice system towards community-based treatment and support services.

Developing laws, policies and practices relating to drug use and dependence that are focused on achieving public health objectives is essential for establishing an enabling environment for voluntary access to drug dependence treatment and support services. Such laws and policies could authorize and promote referrals to voluntary community-based treatment and support services, and at the same time build confidence amongst all workers involved in the process that their work is fully endorsed by national laws.

However, not all policy change requires reform of national laws. Reforming police policies, quotas and standard operating procedures (SOPs) to accommodate and prioritize diversion to voluntary community-based treatment and support services is often possible under existing legal frameworks. Changing the culture and policies that determine the interface between law enforcement and people who use drugs is a significant part of creating environments that enable access to community-based treatment and support services. Specific support to police to develop blueprints for institutional responses that support the outcomes/recommendations of national legal reviews should be considered, along with multi-sectoral coordinating mechanisms (including police, judiciary and people who use drugs) to identify challenges and solutions to transition away from drug policies that are built on punitive approaches, including CCDUs. Ensuring timely access to legal services for people who use drugs can also minimise the impact of legal and policy barriers to access to voluntary, community-based treatment and support services.

In addition to considering policy reforms, national transition committees should also consider the need to invest in improved strategic information to inform efforts to remove legal and policy barriers to community-based treatment and support services. This may include the generation and analysis of data on the impact of stigma and discrimination experienced by people who use drugs, the cost of punitive approaches compared with providing community-based treatment and support services, and monitoring and measuring the impact of legal and policy reforms on public security/safety and community health.

Health and community systems: Strengthening and capacity building

As noted earlier, significant potential bottlenecks along the pathway to voluntary community-based treatment and support services may limit clients' access, largely due to low capacity across the public health, law enforcement and civil society sectors. As such,

assessment efforts should include mapping those pathways, identifying potential bottlenecks and ensuring that sufficient capacity is available.

Such an assessment can provide evidence to inform the development of national capacity building plans as well as technical assistance mobilization plans in order to fill operational gaps. In addition, the results of the assessment can also be used to leverage support to develop national evidence-based guidelines for the clinical treatment of drug dependence that will also incorporate community-based treatment and support service components.

Meanwhile, successful transitions can also be supported by changes and reforms to systems and structures that may have previously limited or compromised access to voluntary community-based treatment and support services. As for any other health condition, the development and strengthening of national referral systems is likely to facilitate client flow, especially where information management is integrated and accessible across public health and public security sectors. In that sense, national surveillance systems may have to be reinforced and modified to track progress against transition objectives and accurately measure the impact of voluntary community-based treatment and support services. For example, in Queensland, Australia, the State Government has deployed an integrated data management system – called SupportLink[52] – that allows simultaneous real-time case management support from law enforcement, public health and social services sectors to be effectively delivered to clients in need.

Finally, successful transitions have been integrated into other national health systems, as well as other structures. Indeed, across the region, opportunities for integrating voluntary community-based treatment and support services are available, especially where low-threshold health and support services are already being delivered to people who use drugs. For example, in countries that have invested in harm reduction and the scaling-up of comprehensive HIV prevention, treatment, care and support services, a number of drug dependence treatment interventions can be integrated at existing service delivery outlets to maximize uptake and increase demand.

In the end, addressing capacity and system gaps will support a transition to voluntary community-based treatment and support services at national levels and including such issues in the national transition plan will increase the likelihood of a successful transition.

[52] See www.supportlink.com.au.

Conclusion

Current evidence does not support the continued implementation or scale-up of CCDUs and more effective alternatives are already available in the region, albeit on a small scale. In fact, evidence supports the scale-up of a multiplicity of evidence-based drug treatment and support service models in which people who use drugs can voluntarily enrol, depending on their individual needs. At present, vast majority of people inside CCDUs may not actually require clinical treatment, highlighting the significant waste of resources inherent in this approach.

Members of the informal expert working group have prepared this discussion paper in order to support the Third Regional Consultation on CCDUs, as well as to stimulate and encourage relevant stakeholders to accelerate the transition towards voluntary community-based treatment and support services at national levels. In this context, the paper was developed to take stock of the current situation and review the benefits and challenges associated with the transition. In addition, the paper reviewed key guiding principles and elements that may increase the likelihood of successful transition.

The expert working group has proposed a three-step approach for transitioning from CCDUs that prioritizes the achievement of public health objectives at the national level. This approach can and should be followed by all countries in the region with CCDUs, regardless of whether or not they are contemplating or have taken steps towards transition. This will enable and inform decisions based on sound evidence and human rights:

1. A national multi-sectoral decision-making mechanism should be established with overall responsibility for the transition. This body should be responsible for the development, in consultation with key stakeholders from the public security, public health and community sectors (including people who use drugs), of a comprehensive action plan or strategy that includes objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities. This document can provide countries with a critical platform from which to coordinate the transition.

2. The development of an effective and evidence-based drug dependence treatment system is imperative. Reforms should be implemented to develop and strengthen the various mechanisms underpinning drug treatment management

and operations across different sectors including justice, health and community. These reforms need to be accompanied by significant investments to support the development of sufficient expertise and workforce capacity across all relevant sectors, as well as within the communities of people who use drugs.

3. Drug policies, which include laws, regulations, strategies and practices for the purpose of this paper, are critical to the success of the transition to voluntary community-based treatment and support services. To promote voluntary access to drug treatment and support services, policy approaches to drug use and drug dependence need to shift away from criminalization and punishment to health- and rights-based drug policy measures. For example, instead of arresting, urine drug testing and detaining drug users, governments should consider adopting programmes that refer people who use and are dependent on drugs to voluntary drug treatment and support services. Accordingly, national reviews to identify policies that restrict voluntary access to community-based drug dependence treatment and support services should be conducted as a critical step towards achieving an enabling policy environment for the transition.

The following recommendations have been developed for the consideration of all stakeholders involved in the CCDU transition process across the region, including government agencies, drug policy and drug treatment experts, as well as people who use drugs. Again, these recommendations are in line with the processes outlined in the UNESCAP Regional Framework for Action on HIV and AIDS Beyond 2015.

Recommendations

(a) Address the current negative consequences for people detained in CCDUs as an immediate priority by:

   i. taking immediate steps to minimise human rights violations associated with existing CCDUs during the transition phase (as recommended in the UN Joint Statement on Compulsory Drug Detention and Rehabilitation Centres).[53]

(b) Take steps to initiate a national transition from CCDUs that engages relevant stakeholders by:

[53] United Nations. 2012. *Joint Statement on Compulsory Drug Detention and Rehabilitation Centres*.

i. rapidly assessing national structures and capacity in order to identify gaps, risks, opportunities and benefits of the transition and build on currently available infrastructure, capacity and resources to expedite the transition process;

ii. developing national transition plans or strategies with objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities through consultation with relevant stakeholders, including government agencies from public health, drug control and public security sectors, as well as people who use drugs;

iii. using the national transition plans and strategies, as well as results of national assessments, to develop costed frameworks to allocate and mobilize adequate human, technical and financial resources for each phase and component of the transition;

iv. providing annual updates to UNODC and UNAIDS of progress towards the transition, based on indicators included in Annex 2 as well as comprehensive performance assessments of drug dependence treatment services, and allow transparent sharing of information.

(c) Approach the provision of drug dependence treatment as a public health, rather than public security issue by:

i. adhering to human rights principles and international best practice and standards in ensuring the delivery of and voluntary access to evidenced-based drug dependence treatment and harm reduction interventions;

ii. rapidly building the capacities of public health, public security, the justice sector, civil society groups, and communities of people who use drugs to facilitate collaboration in delivering voluntary community-based treatment and support services for people who use drugs;

iii. meaningfully engaging and collaborating with civil society and community groups, including communities of people who use drugs, in order to reduce bottlenecks in the treatment pathway, as well as facilitate access to effective treatment and support services for people who use drugs;

iv. deploying evidence-based communication strategies to raise awareness about the need to reduce drug-related harms including drug dependence, HIV, viral hepatitis and overdose, to increase evidence-based understanding about drug use, and to inform the public about the availability of drug dependence treatment, harm reduction and support services.

(d) Foster an enabling policy environment to ensure voluntary access to drug dependence treatment and support services by:

i. conducting a multi-sectoral and participatory review of existing legal and policy frameworks relating to drug use and dependence in order to identify and remove barriers preventing people who use drugs from accessing voluntary community-based treatment and support services, such as criminalisation and punishment (including detention and corporal punishment, whether under the criminal justice system, administrative system or other) of people caught using drugs and in possession of drugs for personal use or drug paraphernalia;

ii. replacing policies which criminalise and punish people who use drugs with measures that refer them to voluntary community-based treatment, harm reduction and support services, including existing low-threshold services, such as drop-in centres and peer outreach programmes;

iii. building the capacities of public health, public security and criminal justice representatives, as well as civil society and communities of people who use drugs, to better understand and facilitate the implementation of current and reformed/revised policies for maximum protection of the human rights of people who use drugs.

Annex 1: Definitions and descriptions of terms

Term	Definition
Alternative sentencing	Alternative sentencing refers to a range of sentencing options available to a judicial system that results in offenders being diverted away from prisons. In the context of this paper, alternative sentencing could refer to the dropping of all charges, the use of reprimand, placing people on a good behaviour bond or releasing people into a complimentary health and social service system.
Coercion	Coercion is defined as the practice of forcing someone to behave in a certain way by use of threats, sanctions or some other form of pressure. In the case of drug treatment, a coerced choice often offered to a person between undergoing evidenced based treatment or to receive punishment for a crime they have committed. Ethical parameters limit coercion.
Community-based services	Community-based services refer to the availability of and access to high quality health and social services that can assist people to address health and social aspects of drug use within the community. Community-based services are non-restraining, allowing people to stay in their community where they can also access other formal and informal community support mechanisms.
Compulsory rehabilitation; compulsory drug treatment; compulsory detention	The terms compulsory rehabilitation, compulsory drug treatment or compulsory detention refer to a circumstance where an individual is forced either by law or a law enforcement or administrative ruling into a custodial setting for the purposes of “rehabilitation”, “drug treatment” or “detention” to bring about a cessation in drug use.

Compulsory detention centre; compulsory rehabilitation centre.	Compulsory detention centre or compulsory rehabilitation centre refer to the building where individuals are sent to undergo a period of “rehabilitation”, “drug treatment” or “detention” in the context of a state-sanctioned response to drug use.
Diversion	In the context of criminal law, diversion refers to diverting a defendant out if the criminal justice system by having them complete a diversion programme rather than be incarcerated or serve another alternative sentence. Criminal charges are typically dropped when a defendant successfully completes a diversion programme. The defendant therefore avoids the stigma of a criminal conviction. In the context of this paper, diversion refers to referring those individuals on drug use charges or minor drug use related crime away from the criminal justice system and into community based services if required.
Drug policy	Definitions of a drug policy range from ‘all activities related to illicit drugs’ to ‘a set of principles or an ideology’ that directs public action in this field. It may include a system of laws, regulatory measures, courses of action and funding priorities concerning (illicit) psychoactive drugs and promulgated by a governmental entity or its representatives.
Drug treatment service system	A drug treatment service system refers to an interconnected system that provides access and referral to drug treatment and other necessary health and social services that people who use drugs may require.
Human rights	Human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, nationality or ethnic origin, colour, religion, language, or any other status. These rights are all interrelated, interdependent and indivisible.

	Universal human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law. International human rights law lays down obligations of governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups. Examples of human rights include the right to be free from torture, and cruel, inhuman or degrading treatment, the right to a fair trial, the right to be free from arbitrary arrest and detention, and the right to the highest attainable standard of physical and mental health.
Illicit drugs	In this document the term "illicit drugs" is used to describe drugs that are under international control (and which may or may not have licit medical purposes) but which are produced, trafficked and/or consumed illicitly.

Adapted from: Baldwin, S., Thomson, N., Dorabjee, J. and Kumar, S. 2012. *Compulsory Detention of People who Use Drugs – Looking for Alternatives*.

Annex 2: SAMPLE- Proposed minimum indicators for annual reporting

From UNODC, UNAIDS questionnaire

Section1: General Information

1. Please specify the total number of compulsory centres for drug users (CCDUs), the number of clients in CCDUs, and the average length of stay of each client (within a 12 month period).
2. Average of length of stay of each client.
3. Please list the three most frequent drugs associated with admission to CCDUs.

Year	Name of drug	Admission

Section 2: Legal framework, policies and responsibilities

4. Please describe the national legal framework governing CCDUs, including responsibilities of different government departments and agencies in these procedures (i.e. police, health and other ministries etc.) Please name the relevant acts or documents.
5. Please indicate the overall goal and objectives of CCDUs in your country:

Section 3: Health situation, intervention and staffing

6. What are the major health concerns in the CCDUs?
7. Do you consider the transmission of HIV and other blood-borne viruses (e.g. hepatitis C) in CCDUs as a major health issue?

   If "Yes", what do you believe are the major risk factors for the transmission of HIV inside CCDUs? Please rank them in order of importance (1 = most important, 7 = least importance)

   Unsafe (without a condom) sex between men who have sex with men, or between men and women ☐
   Unsterile tattooing ☐
   Unsterile hair clippers ☐
   Blood splatters (violence) ☐
   Injecting drug use/drug use ☐
   Penile modification ☐
   Piercing, self-scarring, etc. ☐
   Other, please specify: ..... ☐

8. From the following health-care services, please indicate those that are provided in CCDUs:

   (a) General health

   Medical check at admission ☐
   Periodic medical checks ☐

Primary health care on site ☐
Access to essential medicines ☐
Health-care referral (including to a specialized department for women) ☐
Mental health services (e.g. psychiatric/psychological/counselling services) ☐
Pre-release medical checks, advice, treatment, referrals ☐
Other, please specify: ..... ☐

(b) Drug dependence treatment and related services

Assessment for drug dependence ☐
Detoxification ☐
- Medication for withdrawal management ☐
- Non-medicated detoxification ☐

Opioid substitution treatment (e.g. methadone, buprenorphine) ☐
Drug counselling:
- Individual ☐
- Group ☐

Access to self-help groups (e.g. Alcoholics Anonymous, Narcotics Anonymous) ☐
Vocational training ☐
Pre-release assessment, advice and referral to treatment ☐
Follow-up after release (e.g. 6 months post-release) ☐
Re-integration back into the community ☐
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 (ARP) ☐
Diagnosis and treatment of sexually transmitted infections ☐
Access to condoms ☐
Information, education and communication material (IEC) ☐
Vaccination, diagnosis and treatment of viral hepatitis ☐
Prevention, diagnosis and treatment of tuberculosis[2] ☐
Peer education (either by external organizations or groups or internal) ☐
Support group for people living with HIV ☐
Counselling (individual/group) ☐
Early release for advanced AIDS cases ☐
Other, please specify: ..... ☐

9. Please indicate in the table below the prevalence of HIV, hepatitis C and tuberculosis in CCDUs.

	Prevalence of HIV (%)	Prevalence of Hepatitis C (%)	Prevalence of tuberculosis (%)
Centre for men			
Centre for women, if any			
Centre for children, if			

any			

10. If known, please provide the relapse rate following release from CCDUs. ..... %

Section 4: Human resources, budget and planning

11. Please indicate the approximate number of staff working in CCDUs in YEAR or YEAR in below table:

Type of centre	No. of non-custodial staff (doctors, nurses, counsellors)	No. of custodial/ security staff	No. of administration staff
Centre for men			
Centre for women, if any			
Centre for children, if any			
Total			

12. What is the approximate most recent total national budget for:
    a. Drug use prevention
       Budget .....
       Year .....
    b. Drug dependence treatment
       Budget .....
       Year .....
    c. Operating CCDUs
       Budget .....
       Year .....
13. Please indicate (or estimate) the total budget cost for keeping one drug user in a CCDU for one year.
14. Has the CCDU system been evaluated in your country?
    Yes ☐
    No ☐
15. Does your country anticipate (over the next two years):
    An increase in the number of CCDUs? ☐
    A decrease in the number of CCDUs? ☐
    No change? ☐

16. Does your country anticipate (over the next two years):
    An increase in the number of persons in CCDUs? ☐
    A decrease in the number of person in CCDUs? ☐
    No change? ☐
17. How high would you estimate the recidivism rate of drug users after they receive treatment in the CCDUs?
    Very high ☐ High ☐ Low ☐ Very low ☐
    Don't know ☐
18. Please share any other comments that you may have about the centres (optional).

Section 5. Implementation of the recommendations adopted by the Second Regional Consultation

The following questions related to the recommendations adopted by the Second Regional Consultation on Compulsory Centres for Drug Users in East and Southeast Asia, held from 1 to 3 October 2012 in Kuala Lumpur. The Consultation adopted the following recommendations. Countries should consider:

(a) initiating, as appropriate, in line with national priorities, multi-sectoral consultations and reviews of the laws, policies and practices that hinder access to voluntary and effective drug dependence treatment;

(b) undertaking cost-effectiveness studies comparing CCDUs and voluntary community-based treatment;

(c) improving follow-up and aftercare in voluntary community-based treatment;

(d) undertaking a mapping of existing resources allocated to different treatment systems;

(e) mobilize additional human resources, including involvement of affected populations, such as recovering drug users, and enhancing specialized training for the delivery of voluntary community-based services;

(f) reallocating human and financial resources from CCDUs to voluntary community-based treatment, in accordance with national laws and policies;

(g) increasing government investments for voluntary community-based treatment;

(h) raising awareness and building capacity regarding community-based treatment among governmental, non-governmental and private organizations, as well as community members, health professionals, religious leaders, social workers and those working in charities.

19. Did your country initiate, in line with national priorities, multi-sectoral consultations and reviews of laws, policies and practices that hinder access to voluntary and effective drug dependence treatment?

    Yes ☐
    No ☐

    If "yes", please specify which laws, policies and practices had been reviewed.

20. Did your country undertake cost-effectiveness studies to compare CCDUs with voluntary community-based treatment?

    Yes ☐
    No ☐

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

22. Did your country undertake a mapping of existing resources allocated to a different treatment system?

    Yes ☐

No ☐

If “Yes”, please provide details about the mapping structure.

……

……

23. Did your country mobilize additional human resources, including the involvement of affected populations such as recovering drug users, and enhanced specialized training for the delivery of voluntary community-based treatment?

    Yes ☐

    No ☐

    If “Yes”, please provide details about the involvement of affected populations and the enhanced training procedures of voluntary community-based services.

24. Did your country reallocate human and financial resources from CCDUs to voluntary community-based treatment?

    Yes ☐

    No ☐

    If “Yes”, please specify which steps your country takes to enforce specialized training for voluntary community-based treatment.

25. Did your country increase government investments for voluntary community-based treatment?

    Yes ☐

    No ☐

    If “Yes”, please specify the increase in investments since year 2012.

26. 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 care professionals, religious leaders, social workers or those working in charities?

    Yes ☐

    No ☐

    If “Yes”, please specify which steps your country has taken to improve awareness raising regarding community-based treatment for drug users.