HHR Health and Human Rights Journal

VIEWPOINT

Moving toward Voluntary Community-Based Treatment for Drug Use and Dependence

ROBERT ALI AND MATTHEW STEVENS

The supply of illicit drugs available in East and Southeast Asian markets is higher than ever before. Methamphetamine seizures across the region have increased yearly since 2011 due to the increased production and availability of crystal methamphetamine.[1] This has also coincided with an increase in the number of seizures from new and emerging psychostimulants, including those with opioid effects.[2] A wider scope of production and distribution of illicit drugs within the region has led authorities to establish more severe penalties for drug use in a misdirected attempt to curb the demand for drugs. These include the use of involuntary detainment approaches such as compulsory drug detention and rehabilitation centers (CDDCs).

CDDCs are part of a punitive treatment and rehabilitation system used by legal authorities to address drug use and dependence. But while many centers are designed for the purposes of treatment and rehabilitation, they are also commonly used for detainment across a range of issues beyond their scope. For example, individuals are often detained for, or under the suspicion of, a number of drug and non-drug -related behaviors, including the use or possession of illicit substances, engagement in sex work, and being (child) victims of sexual exploitation.[3] Detainment in CDDCs typically involves elements of forced labor, physical and sexual violence, inadequate provision of nutrition, and limited access to quality health care services.[4]

A fundamental pillar of the compulsory detention model is that CDDCs work by reducing the supply of and demand for illicit drugs. However, the evidence in favor of these views is lacking. On the supply side, the rates of production and use of illicit drugs in the region are higher than ever.[5] On the demand side, the high rate of relapse from involuntary treatment, and the lack of reduction in the number of people detained over the past decade seem to indicate similar failures.[6] This may be partially explained by demand inelasticity among dependent individuals. In some cases, depending on the type of drug and the availability of substitutes, dependent individuals may be more willing to pay higher prices or to engage in criminal activity to obtain illicit drugs.[7] Individual demand for illicit drugs is not likely to decrease without structured

Robert Ali, MBBS, FAChAM, FAFPHM, is an associate professor at the School of Biomedicine, University of Adelaide, Australia, as well as a member of the Australian National Advisory Council on Alcohol and Drugs, the Cochrane Alcohol and Drug Group editorial board, and the World Health Organization Expert Advisory Panel on Drug Dependence and Alcohol Problems.

Matthew Stevens, PhD, is a research fellow at the School of Biomedicine, University of Adelaide, Australia.

Please address correspondence to Robert Ali. Email: Robert.ali@adelaide.edu.au.

Competing interests: None declared.

Copyright © 2022 Ali and Stevens. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits unrestricted non-commercial use, distribution, and reproduction.

clinical interventions. Furthermore, lower prices in response to increased supply and rates of production may also contribute to sustained demand among marginal recreational users.[8]

Unless the situation changes, the call for more CDDCs is likely to continue to grow in line with the increased supply of illicit drugs in the region. Greater supply means a higher number of people detained, leading to more overcrowding and less capacity for effective service provision. The current system of forced detention, irrespective of detainees' level of dependence, has not worked and will not work in the way intended.

The hidden costs of compulsory detention and rehabilitation

There are significant financial costs associated with the compulsory treatment model. In an area where resources are extremely limited, the compulsory treatment model has been found to be costly and consumes considerable resources.[9] But an underappreciated cost burden associated with the compulsory treatment model is the productive capacity lost through detainment. The majority of individuals detained in CDDCs are young, otherwise healthy individuals of productive working age.[10] A great number of these young people are not drug dependent and are therefore not in need of intensive treatment for drug dependence. Removal of these individuals from the workplace and society, in socioeconomic terms, constitutes a loss of productivity and social capital.

Governments must also consider other significant economic and social costs associated with the spread of blood-borne illnesses such as HIV, as well as viral hepatitis. Given that the spread of HIV and other communicable diseases, including COVID-19, is higher in CDDCs than in voluntary community-based services, this represents another opportunity cost for governments.[11] Evidence from Indonesia suggests that governments can save an estimated US$7,000 for each averted case of HIV, indicating that these resources could be better deployed elsewhere.[12] It is time to stop the cycle of compulsory detention and move to a culturally adapted evidence-based system of voluntary community-based treatment that is less costly, more effective, and rights based.

Voluntary community-based treatments: A better alternative for all

There is mounting evidence that CDDCs are ineffective in the treatment of substance use disorders and dependence. In fact, on balance, CDDCs may actually contribute more harm than benefit to the health of both individuals and public.[13] Several United Nations entities released a joint statement in 2012 calling for the closure of CDDCs, citing numerous health and human rights concerns.[14] Since then, a number of calls have been made to transition from CDDCs to voluntary community-based treatment services.[15] Recently, another joint statement was released by UN entities reiterating calls for the closure of CDDCs in light of the spread of COVID-19 and the risk it poses to people in prisons and other closed settings.[16]

There are several issues of concern relating to CDDCs, including higher rates of relapse compared to voluntary community-based treatment services; avoidance of health care in response to stigma and shame; higher rates of infectious disease and blood-borne virus transmission due to overcrowding; and inadequate medication and staffing.[17] The last point is of particular concern in light of COVID-19 and the risk it poses to the community.

On the other hand, voluntary community-based treatment services present an effective, viable alternative. Voluntary community-based services are more cost-effective and more likely to lead to better drug-related outcomes, including sustained abstinence.[18] They have also been shown to be more effective from a public health perspective in that they are less stigmatizing and discriminatory, lead to more prosocial behavior, and lead to a reduction in the spread of infectious diseases.[19]

Despite evidence in favor of the socioeconomic advantage of voluntary approaches, some jurisdictions continue to object to community-based

treatments, citing a lack of evidence. Proponents of the compulsory treatment model might argue that voluntary approaches have been shown to be effective only for sedative and opioid-type drugs, and in the absence of effective medicines to treat dependence on stimulant-type drugs the perception is that there is no alternative option for public security and safety other than retaining the centers to detain the drug user. Once again, however, the evidence to support such a claim is unfounded. Community-based psychosocial interventions for methamphetamine dependence have been shown to work and have good acceptability.[20] The absence of safe and effective medication to treat methamphetamine dependence is no justification for preventing the introduction and scaling-up of evidence-based psychosocial interventions in community-based settings.

Concluding remarks

Given the arguments in favor of voluntary community-based approaches, the natural question becomes, What is stopping governments from moving in that direction? The answer is less clear and requires a change in perspective.

First, moving to a community-based model requires a shift in paradigm away from viewing drug dependence as a moral failing toward viewing it as a treatable condition that can be addressed through evidence-informed, community-based treatment approaches. CDDCs operate within the moralistic view that drug use is a character flaw that can be "cured" through various forms of therapy. The CDDC model typically uses religious education, physical exercise, forced labor, and even unmedicated withdrawal as a form of punishment to coerce individuals into future abstinence. This is highly problematic given that CDDCs are often staffed with workers who have no formal training in treating substance use disorders. Also, the frequent lack of medical personnel means that staff are ill-equipped to supervise persons going through withdrawal.[21]

Aside from the commonly held view among government authorities regarding the "need" for CDDCs to cope with growing rate of methamphetamine use in the region, it has also been argued that there are limited financial, human, and technical resources available to aid transition.[22] But these and other key issues have been considered and rebutted. Most notably, in 2015, an expert advisory group at the United Nations Office on Drugs and Crime laid out its vision of a roadmap to enable a transition toward voluntary community-based treatment approaches.[23]

A final challenge preventing the move toward voluntary community-based approaches is the need for continuing support for recovery. Rehabilitation programs require continuing support to help individuals transition back into society following release. Employment, housing, and social connectedness with non-drug-using family and friends are key components to reduce the risk of relapse.[24] Unfortunately, the reality is that CDDCs are not providing meaningful treatment, and due to the stigma and shame associated with drug detention, many detainees struggle to assimilate back into the community, often ending up back in detention following relapse. The absence of a community support system greatly increases that risk.

In summary, not only is involuntary detention ineffective in the treatment of drug dependence, but there are more cost-effective and socially beneficial programs available. Drug dependence is not a moral failing, and moving toward a person-centered approach that views drug dependence as a treatable chronic relapsing disorder using interventions that are grounded in evidence and embrace a rights-based approach to health is the way forward. Ultimately, CDDCs are the enduring legacy of a system of coercive abstinence-based treatment that has been shown, time and again, to be both costly and ineffective—and more importantly, harmful. Governments that want to enable improvements in public health outcomes for their jurisdictions must move to close all CDDCs immediately and scale up voluntary community-based treatment. This is particularly important in light of the COVID-19 pandemic, in which overcrowding continues to represent a significant risk to both individuals and the community.

Funding

Both authors are funded by a grant awarded by the Australian Government Department of Health for the prevention of substance use disorders.

References

1. United Nations Office on Drugs and Crime, *Synthetic drugs in East and Southeast Asia: Latest developments and challenges* (Bangkok: United Nations Office on Drugs and Crime, 2021).
2. Ibid.
3. World Health Organization Western Pacific Region, *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles* (Manila: World Health Organization Pacific Regional Office, 2009); United Nations, *Joint statement on compulsory drug detention and rehabilitation centres in Asia and the Pacific in the context of COVID-19* (2020). Available at https://unaidsapnew.files.wordpress.com/2020/05/unjointstatement1june2020.pdf; United Nations, *Joint statement: Compulsory drug detention and rehabilitation centres* (2012). Available at https://unaids-test.unaids.org/sites/default/files/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf.
4. World Health Organization Western Pacific Region (see note 3)
5. United Nations Office on Drugs and Crime (see note 1).
6. United Nations Office on Drugs and Crime Regional Office for Southeast Asia and the Pacific and Joint United Nations Programme on HIV/AIDS Regional Support Team for Asia and the Pacific, *Booklet 2: Regional overview of compulsory drug treatment and rehabilitation in East and Southeast Asia* (Bangkok: United Nations Office on Drugs and Crime, 2022).
7. D. Deitch, I. Koutsenok, and A. Ruiz, "The relationship between crime and drugs: What we have learned in recent decades," *Journal of Psychoactive Drugs* 32/4 (2000), pp. 391–397; C. A. Gallet, "Can price get the monkey off our back? A meta-analysis of illicit drug demand," *Health Economics* 23/1 (2014), pp. 55–68.
8. United Nations Office on Drugs and Crime (see note 1).
9. United Nations Office on Drugs and Crime Regional Office for Southeast Asia and the Pacific and Joint United Nations Programme on HIV/AIDS Regional Support Team for Asia and the Pacific (see note 6); C. Cook, J. Bridge, S. Susie McLean, et al., *The funding crisis for harm reduction: donor retreat, government neglect and the way forward* (London: Harm Reduction International, 2014).
10. United Nations Office on Drugs and Crime, *Synthetic drugs in East and Southeast Asia: Trends and patterns of amphetamine-type stimulants and new psychoactive substances* (Bangkok: United Nations Office on Drugs and Crime, 2019).
11. United Nations (2020, see note 3); K. DeBeck, T. Cheng, J. S. Montaner, et al., "HIV and the criminalisation of drug use among people who inject drugs: A systematic review," *Lancet HIV* 4/8 (2017); K. Hayashi, M. J. Milloy, N. Fairbairn, et al., "Incarceration experiences among a community-recruited sample of injection drug users in Bangkok, Thailand," *BMC Public Health* 9/1 (2009), pp. 1–7.
12. J. J. Wammes, A. Y. Siregar, T. Hidayat, et al., "Cost-effectiveness of methadone maintenance therapy as HIV prevention in an Indonesian high-prevalence setting: A mathematical modeling study," *International Journal of Drug Policy* 23/5 (2012), pp. 358–364.
13. D. Werb, A. Kamarulzaman, M. C. Meacham, et al., "The effectiveness of compulsory drug treatment: A systematic review," *International Journal of Drug Policy* 28 (2016), pp. 1–9.
14. United Nations (2012, see note 3).
15. A. Bergenstrom and G. Vumbaca, "Compulsory drug detention centres: Time to questions their continued use?," *Lancet Global Health* (2017), pp. e123–e124; C. Stoicescu, Q. Lataire, K. Peters, et al., "End compulsory drug treatment in the Asia-Pacific region," *Lancet* 399/10323 (2022), pp. 419–421; P. Tanguay, A. Kamarulzaman, A. Aramrattana, et al., "Facilitating a transition from compulsory detention of people who use drugs towards voluntary community-based drug dependence treatment and support services in Asia," *Harm Reduction Journal* 12/1 (2015), pp. 1–5.
16. United Nations (2020, see note 3).
17. Ibid.; T. Kerr, K. Hayashi, L. Ti, et al., "The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand," *International Journal of Drug Policy* 25/1 (2014), pp. 171–174; J. J. Fu, A. R. Bazazi, F. L. Altice, et al., "Absence of antiretroviral therapy and other risk factors for morbidity and mortality in Malaysian compulsory drug detention and rehabilitation centers," *PLOS One* 8/2 (2012); M. P. Wegman, F. L. Altice, S. Kaur, et al., "Relapse to opioid use in opioid-dependent individuals released from compulsory drug detention centres compared with those from voluntary methadone treatment centres in Malaysia: A two-arm, prospective observational study," *Lancet Global Health* (2017).
18. T. Vuong, M. Shanahan, N. Nguyen, et al., "Cost-effectiveness of center-based compulsory rehabilitation compared to community-based voluntary methadone maintenance treatment in Hai Phong City, Vietnam," *Drug and Alcohol Dependence* 168 (2016), pp. 147–155.
19. T. Vuong, A. Ritter, M. Shanahan, et al., "Outcomes of compulsory detention compared to community-based voluntary methadone maintenance treatment in Vietnam," *Journal of Substance Abuse Treatment* 87 (2018), pp. 9–15.
20. F. De Crescenzo, M. Ciabattini, G. L. D'Alò, et al.,

"Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis," *PLoS Medicine* 15/12 (2018).

21. J. J. Amon, R. Pearshouse, J. E. Cohen, and R. Schleifer, "Compulsory drug detention in East and Southeast Asia: Evolving government, UN and donor responses," *International Journal of Drug Policy* 25/1 (2014), pp. 13–20; R. Pearshouse, *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)* (Toronto: Canadian HIV/AIDS Legal Network, 2009); J. Csete, K. Kaplan, K. Hayashi, et al., "Compulsory drug detention centre experiences among a community-based sample of injection drug users in Bangkok, Thailand," *BMC International Health and Human Rights* (2001); World Health Organization Western Pacific Region, *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles* (Geneva: World Health Organization, 2009).

22. United Nations Office on Drugs and Crime, *Transition from compulsory drug detention centers for drug users to voluntary community-based treatments and services* (Bangkok: United Nations Office on Drugs and Crime, 2015).

23. Ibid.

24. I. A. Binswanger, C. Nowels, K. F. Corsi, et al., "'From the prison door right to the sidewalk, everything went downhill': A qualitative study of the health experiences of recently released inmates," *International Journal of Law and Psychiatry* 34/4 (2011), pp. 249–255; I. A. Binswanger, C. Nowels, K. F. Corsi, et al., "Return to drug use and overdose after release from prison: A qualitative study of risk and protective factors," *Addiction Science and Clinical Practice* 7/1 (2012), pp. 1–9; J. Van Olphen, N. Freudenberg, P. Fortin, and S. Galea, "Community reentry: Perceptions of people with substance use problems returning home from New York City jails," *Journal of Urban Health* 83/3 (2006), pp. 372–381.