

VIRTUAL ROUNDTABLE

Compulsory Drug Treatment and Rehabilitation, Health, and Human Rights in Asia

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Claudia, Karen, and Quinten: *Thank you all for participating in this virtual roundtable. Let's get things started with a key question: Why do so many countries, including in the Asia region, continue to rely on punitive approaches to drug use and dependence when such approaches are unsupported by evidence?*

Ajeng: This is an excellent, and complex, question. The six decades-long “drug war” propaganda is a key contributor. From generation to generation, we have been falsely told that drugs are evil. I still remember seeing huge banners in Jakarta’s streets portraying two men, one in a coffin—supposedly the person who uses drugs—and the second one—who does not use drugs—in a graduation cap. We have been taught to blindly hate drugs, and to (wrongly) believe that drugs are harmful for society. The punitive approach is seen as a “course correction” for drug use, although there is no evidence of a correlation between punitive approaches and decreases in drug use and dependence.

Karyn: The lack of informed political leadership promoting failed approaches such as the criminalization of people who use drugs is a recipe for disaster in terms of promoting effective and rights-based approaches to drug-related issues in society. Until there was an organized movement of people who use drugs—who’d been through the system (forced rehabilitation, prison, detention, etc.)—to protest their “treatment” and conditions, and the inhumanity and disproportionality of punitive drug-related policies and the law, most of these approaches went unchallenged.

Governments themselves housed drug control under criminal justice rather than public health systems and remained ignorant—willfully or otherwise—of innovative approaches such as opioid substitution therapy in the 1960s and harm reduction after the 1980s. They got away with this due largely to an uninformed public, which was generally fed terrifying images of “drug addicts” blamed for criminal behavior in communities. The media was often complicit. Even people who use drugs, who had suffered so many injustices in the grip of the system, had internalized the messages that they were “garbage,” “enemies of the state,” and not worthy of equal treatment as human beings.

Claudia: *What about the broader context of these political choices?*

Judy: I think it’s important to take a longer historical view: people have been using drugs for centuries,

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and it has been a common practice across diverse cultures, societies, settings, and contexts. Drug use has been a part of religious rituals and everyday life. Yet there has always been a tendency to categorize, shame, and stigmatize that which is different, that which is not understood by the majority. Despite the fact that drugs are used widely in society, this has been used as a political tool to target and marginalize. We have seen the same strategies being deployed against certain identities and communities—whether they are women, people of color, gay and bisexual men, sex workers, transgender people, migrants, or others. These groups are demonized, dehumanized, and pathologized, sometimes in equal measure, in the name of “protecting society” from deviant and morally polluting forces.

Gloria: Understanding the historical and cultural context is important, but there is also a very simple political context: criminal justice and law enforcement institutions have become accustomed to operating with bloated budgets and do not want to see them reduced or shifted to other agencies. For governments to undo the institutionalization of drug-free ideologies and to invest in health-, harm reduction- and human rights-based response

measures to drug use and dependence, there would need to be greater incentives for them to do so.

Francis: From the perspective Gloria raises—the political and economic incentives of punitive approaches—it’s an inconvenient fact that the majority of drug use is manageable without any intervention. It’s in the interest, then, of governments to promote the idea that any drug use is immoral and deserving of punishment in the name of achieving abstinence. We have seen numerous examples of the atrocities that transpire inside compulsory centers in the name of treatment.

Apinun: I think another aspect is that decision-makers want social problems to vanish quickly, and addressing the root causes humanely requires patience and experience. Punishment provides a “quick” solution to the perceived social problem of drug use.

Quinten: *The reliance on detention in the name of drug dependence treatment in Asia is well documented.¹ In many countries in the region, people who use or are suspected of using drugs are detained involuntarily without adequate due process and le-*

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gal safeguards, allegedly for the purpose of receiving drug “treatment” or “rehabilitation.” Despite the evidence of inefficacy and harms to individuals, there has been little progress toward discontinuing compulsory and other punitive approaches to drug treatment across the Asia region. Why does this approach seem so rooted in this region?

Gloria: There are several issues at play here. Looking back at history, in times of political upheaval, such as in China before and after the Opium Wars with Britain, government leaders have often attributed blame for economic and social problems to drug use.² People who use or are dependent on drugs are cast as social deviants who will inevitably commit crimes and cause trouble to hurt others. Given such a portrayal, governments and many members of the public then consider it an imperative to force people who use drugs to undergo measures to stop them from using drugs. Such thinking is not unique to Asia and continues to be proposed and implemented in other regions of the world. However, the degree of brutality and widespread nature in which compulsory rehabilitation has been implemented in Asia is due at least partly to the lack of transparency and accountability of governments and severe limitations to civil society advocacy.

Apinun: A culture of paternalism as well as wide socioeconomic and income gaps are two additional factors that have sustained compulsory treatment approaches in Asia.

Krisanaphong: Agreed. In most countries in Asia, the rich are normally well treated even though they might engage in harmful behaviors or even break laws. On the other hand, the poor are treated badly, including in terms of drug treatment. Therefore, people who use drugs, many of whom have a low socioeconomic status, become an easy target group for law enforcement officers, particularly when there are arrest quotas.

Sangeeth: I would like to add that historically a key policy development behind compulsory treatment approaches were the United Nations international

drug control treaties, which are fundamentally based on prohibitionist approaches to controlling drugs. In practice, prohibition has been highly unsuccessful and in fact has increased disease transmission, violence, and displacement and has denied people’s right to health. In Malaysia, there are ingrained cultural beliefs that abstinence should be the ultimate goal of treatment and rehabilitation and that this can be achieved only in high-security compulsory centers. Socially, people who use drugs are seen as not being able to contribute to the community.

Sam: I also suspect that the early approach to dealing with psychoactive drug use was based on approaches to mental illness, which historically has often involved compulsory treatment.

Karyn: Religion has also played a role. Many religions paint drug use as a sin and people who use drugs as bad people. Often, people in the general public see it as better than prison (since the “patients, not criminals” message gained traction) and better than having people who use drugs in the community. Again, this links back to the lack of political leadership and options available, as well as the lack of safe space for people who use drugs to provide alternative narratives.

Historically, it is clear that a combination of ignorance (of a harm reduction approach, and of the devastating impact of laws and policies on the lives and health of people who use drugs), apathy, and awful stereotypes perpetuated by media and others led to the constant scapegoating of people involved with drugs and produced deep-seated fear in communities that was hard to counter, especially by people who use drugs themselves, who were the only ones advocating and with few allies.

However, if you scratched beneath the surface, especially in places where drugs were so prevalent—areas near the Burma border where opium is grown, or in urban slums—so many families were affected by the drug epidemic and desperately wanting help, but shame and religious and other influences prevented them from standing up to demand or participate in more humane solutions,

none of which were being provided by the state anyway. There were exceptions, always led by people who use drugs themselves—for example, a Muslim living with HIV drug user activist in Satun Province, southern Thailand, who got the blessing of his elders to run a harm reduction-style treatment center in his community, that also provided methadone—but these types of programs were a hard sell.

At the outset of our work with the Thai AIDS Treatment Action Group, we heard many stories of people who use drugs who were arrested by the police as a result of calls made by their own parents, out of desperation to get them off drugs. This was reported to us in both Thailand and Myanmar and continues to happen. People who use drugs would also agree to be chained and fed herbal concoctions to induce vomiting for a week at a Buddhist temple so they could quit heroin, in places where there were no other options. In early 2003, many expressed “support” for Prime Minister Thaksin’s war on drugs in the hopes that a zero-tolerance approach to drugs and dealers would “work” and they could finally get off drugs, even though the campaign was ineffective in achieving this.

There were (and still are) few to no options for living as a person who used drugs without needing to assert oneself on a spectrum of detox and “rehabilitation” (i.e., boot camps run by the military consisting mainly of exercise and Buddhist prayer). There were no public conversations, and it was hard to find a sympathetic ear or support—even among fellow nongovernmental organizations, most of whom bought into the narrative that drugs are bad, people who use drugs are bad, and one should just buck up and stop using them. There was extraordinary intolerance, ignorance, and lack of compassion, as well as significant self-stigma by people who use drugs themselves, that hampered social and political progress.

But once users—who are brothers, mothers, fathers, sons, and daughters—started organizing and bringing alternative solutions, and mounting stories of horrors inflicted on them in the system, slowly there became more sympathy—for example, a progressive parliamentarian over here, an

interested nongovernmental donor over there, a human rights lawyer. Thus, a movement against the criminal justice punitive approach and for harm reduction, rights-based approaches, and a public health approach began to grow. Once space for discussions and conversations could be had, change became more imminent and victories were achieved, but never without a struggle. And non-coercive, punitive measures to address drug use remains a contentious and unresolved issue in the region as users’ movements struggle for space and legitimacy.

Karen: *A few of you touched on this earlier in the conversation, but can you speak more directly to the role of the media in relation to compulsory treatment practices in the region?*

Apinun: Unfortunately, people tend to consume media stories that serve existing beliefs; it is rare for them to seek stories that expose painful, inconvenient truths. The only exception I’ve seen is when relatives or loved ones suffer from the negative impact of compulsory measures. If there are a few sustainable positive or best practices available in their areas, either from faith-based or private organizations, these could be used for changing their attitudes. A sustainable government-supported program could be a great best-practice example for advocating through the media. However, such measures often are not a high priority for the government and may not enjoy the same popularity as tough-on-drugs policies.

Francis: The media has always been very critical toward drug use and people who use drugs and has played a major role in demonizing drug use that has led to stigma, discrimination, and hatred against us within the general population. Even the smallest incidents related to drugs and drug use have been displayed as a house of horror within the mass media. Instead of generating awareness on drug use and its negative impact on the health of people who use drugs, the media has horrified drug use to such a level that has led to the general population considering drug use as akin to terrorism.

Inez: Francis is right—the media plays a significant role in the perpetuation of beliefs about people whose lives include drugs. News reports on drug-related cases tend to lack nuance, often focusing on numbers and figures devoid of context. An example in the Philippines is the barrage of news reports on the number of “graduates” from so-called community-based programs as proof of “drug-cleared barangays.” Numbers and percentages provided by government agencies are often reported by the media without details on what “achieving” this “drug-cleared barangay” status may have entailed (e.g., forcing people into treatment, arbitrary arrests, or forced drug testing). Through the constant labeling of people as “surrenderees,” “reformists,” “drug personalities,” and even “PWUDs,” the media boxes individuals into stereotypes and reinforces caricatures about drug use in people’s minds.

The rush to be the first to report, or “scoop,” an incident also makes it a challenge time-wise to do deeper investigation into an incident. During a seminar where we had the opportunity to share about harm reduction and have a nuanced discussion on drugs, I will never forget how some of the young journalists leaned back on their seats, the dilemma showing on their faces, saying how they understand the need for taking the time to investigate further in order to provide nuance and context, but how they are also pressured to be the first to publish the news report.

Karyn: It’s important to keep in mind the legal environment that inhibits freedom of the press and puts restrictions on legal registration, freedom of movement, assembly, expression, and so forth. This makes it more difficult for people who use drugs to safely open up to the press and have their stories told and to organize around their drug use in a way that allows the public to see another side to the story. Independent media outlets also don’t have access to compulsory drug detention centers to be able to report on how these centers violate rights and are failing to provide treatment.

Claudia: *What about the role of faith-based organizations and private (non-state-run) treatment*

centers in relation to compulsory treatment practices in the region?

Inez: Yes, in the Philippine context, the role of faith-based groups is critical, as well as distressing. The Catholic Church has a very strong presence and is a perceived authority by followers. It was disheartening that the church and other faith-based groups did not speak up as soon as the extrajudicial drug-related killings in the Philippines became evident in the first days and weeks of this current administration. At the time, one regular bible-study attendee even remarked: “They [the government] are only doing cleansing. Like Sodom and Gomorrah.” A review of the pronouncements of the Catholic Bishops’ Conference of the Philippines also captures how the church perceives people whose lives include drugs. For example, in a pastoral letter dated January 28, 2019, the president of the Catholic Bishops’ Conference of the Philippines stated, “We are not against the government’s efforts to fight illegal drugs. We do respect the fact that it is the government’s duty to maintain law and order and to protect its citizens from lawless elements. We have long acknowledged that illegal drugs are a menace to society and that their easier victims are the poor.”³

With regard to treatment facilities established and run by private operators, the treatment landscape is dominated by abstinence-based 12-step and therapeutic community ideologies. Many of the people working in these facilities also serve as consultants to the government and promote this approach. During one meeting with government representatives, one of these consultants insisted there was no need to develop redress mechanisms for people confined or forced into treatment. Having consultants with this ideology in the government not only demonstrates the conflict of interest reflected in the strong objection to having redress mechanisms in place but can also perpetuate a compulsory, punitive mindset in the government’s health response. This also spills over to influence societal attitudes.

And because of the common narrative that has been perpetuated about drugs, punitive acts become a logical response. So much so that there are

government officials who seem to genuinely believe that such acts are appropriate, especially when the heads and staff of treatment programs display the same punitive, authoritative mindset in providing their services. We thus need to also look into how the health and treatment response itself may be perpetuating this public narrative so that this may be understood, addressed, and rectified.

Priya: At the Working Group on Arbitrary Detention, we found that private drug treatment centers exist on a significant scale in Asian countries, including Bangladesh, India, Indonesia, and Nepal. In these facilities, there are serious human rights violations, resulting in the beating, shackling, and sometimes death of people who use drugs. People are involuntarily brought to private facilities by law enforcement officials, family members, or staff of the centers. Staff at private facilities try to intimidate people into signing consent forms by threatening them or their families if they refuse to do so. In our research, we also found that private drug treatment facilities may have a financial conflict of interest since they benefit from payment from the state for cases referred by drug courts or regular courts, providing a financial reason for the continued detention of people in their facilities beyond what may be strictly necessary. Noting this, it is perhaps unsurprising that the working group has described private drug treatment centers as a “disturbing development,” has called on states to investigate and take appropriate action, and in fact has called for their closure as well.⁴

Ajeng: I agree completely with Priya and the findings of the working group. Let’s also note that many of these facilities implement non-evidence-based and ineffective treatment modalities.

Karen: *Recent reports on the state of the transition from compulsory treatment in Asia paint a bleak picture of cautious, slow progress toward expanding evidence- and human rights-based approaches to drug use and dependence, including harm reduction. Over the past decade, there have been several rhetorical commitments made by states in the region*

aimed at effectively moving forward on this issue, but little has changed in practice. What needs to be done to meaningfully engage states and keep them accountable when it comes to transitioning from compulsory treatment toward voluntary community-based approaches?

Priya: It is important to hold countries accountable to their international human rights obligations. To this end, the United Nations Working Group on Arbitrary Detention conducts country visits. During these visits, we have observed the negative effects of punitive approaches adopted by countries vis-à-vis drug use and dependence. For example, during the working group’s 2017 visit to Sri Lanka, we noted that “almost 50 per cent of the persons deprived of their liberty in the criminal justice system have allegedly committed non-violent crimes related to drugs, which is a very high percentage.”⁵ During the group’s 2019 visit to Bhutan, we also noted that “drug and alcohol addiction is a serious and growing concern across Bhutan” and recommended that Bhutan “avoid criminalization of consumption and detention of substance consumers.”⁶

We also completed a study on arbitrary detention relating to drug policies in 2021 and presented it to the Human Rights Council in July 2021. In this study, we found that people who use drugs are particularly at risk of arbitrary detention, and noted with concern a continuation of what was already reported in 2015: “increasing instances of arbitrary detention as a consequence of drug control laws and policies.”⁷ As a result of this study, we emphasized that the absolute prohibition of arbitrary deprivation of liberty and the safeguards to prevent such instances apply to everyone, including those who are arrested, detained, or charged with drug-related offenses and those undergoing rehabilitation for drug dependence, in accordance with international human rights obligations. There is a need for all drug policies to serve a necessary, proportionate, and legitimate aim. Imprisonment for drug-related offenses should be a last resort and in principle should be used only for serious offenses, with diversion or a decision not to prosecute used most often for lesser offenses.

The threat of imprisonment should not be used as a coercive tool to incentivize people into drug treatment. While some defendants, when given a choice, have refused drug treatment and accepted a prison sentence as an outcome, the measure of coercion involved in such a choice is too great and is an unacceptable infringement on the right to choose one's treatment freely, to refuse treatment, or to discontinue it at any time.⁸ Courts should also not order compulsory or forced drug treatment. Drug treatment should always be voluntary, based on informed consent, and left exclusively to health professionals. There should be no court supervision or monitoring of the process, which should rest exclusively with trained medical professionals.

Ajeng: To add to what Priya said, one sector that we need to engage better in this advocacy is national human rights institutions and other bodies whose task it is to monitor the government (such as ombuds offices). Compulsory treatment is a clear human rights violation. National human rights institutions must play a bigger role in calling out the state to stop compulsory treatment practices, including by carrying out research on compulsory treatment practices and requesting government accountability. They can also document and monitor the situation of compulsory treatment practices in their country as part of the Universal Periodic Review process. Ombuds offices can also encourage people to submit complaints against state-run compulsory treatment programs. These bodies can keep calling for the necessary transition to voluntary community-based treatment as part of their reports and recommendations.

I also believe that we need to continue providing evidence of the benefits of redirecting funding from compulsory detention (in fact, from the punitive approach as a whole) to voluntary community-based treatment and harm reduction. Harm Reduction International's *Divest. Redirect. Invest* study reports that "decriminalising drug use and closing compulsory drug detention centres could dramatically reduce the number of people detained in prisons and detention centres, save

governments money and help prevent public health emergencies."⁹

Judy: I agree and I'd like to expand on Ajeng's point. Successful advocacy depends on legitimacy, and that legitimacy rests with communities that are most directly impacted by an issue. This time around, we need to be directly resourcing drug user-led networks, if not nationally then regionally to push for the shift from compulsory drug detention and treatment to voluntary community-based harm reduction services that put people at the center, with no compromise. Drug user-led networks should be supported by United Nations agencies, and they should work together to set measurable targets and accountability frameworks that can be used on the ground.

Sam: We also need practical examples of alternatives that can be easily adopted and scaled up, many of which are offered by peer-led organizations. For example, in 2010, I established Rumah Singgah PEKA in Bogor, Indonesia, because I wanted to provide a new drug treatment option for people who use drugs that integrated a harm reduction approach and did not require individuals to be abstinent to improve their quality of life. The Rumah Singgah PEKA model has been adopted in four cities (Bandung, Bogor, Cirebon, and Medan) in Indonesia by other community-based organizations.

Judy: When the 2012 joint United Nations paper on compulsory drug detention centers was published, civil society celebrated and saw this as a potential turning point that would lead to their eventual closure. Sadly, 10 years on, less progress than we had hoped has been made. As we reflect on this lost opportunity, renewed efforts need to be made. Successful efforts to close compulsory drug detention centers depends on clear, realistic, and time-bound targets and stronger accountability mechanisms from United Nations agencies; but most importantly, it requires engaged community and civil society who are motivated and have the necessary financial, technical, and political resources to both hold

governments to account for global commitments and targets and create a political cost of inaction.

Krisanaphong: Policy makers have a major role to play here. The Royal Thai Police, for instance, is under the Prime Minister's Office. The prime minister has absolute authority to reform policies away from arresting people who use drugs toward voluntary and evidence-based drug treatment and health services. However, stigma and public attitudes toward people who use drugs are likely to be a key concern for policy adjustment.

Sangeeth: There must be political will and commitment in order for anything to change. As was outlined in the transitional framework recommended by the regional expert advisory group, a national task force should be formed with all relevant stakeholders, including the Ministry of Health, Ministry of Home Affairs, and the community of people who use drugs. There should be separate committees to review and amend current drug laws. The Ministry of Health needs to be committed to improving health care services and scaling up harm reduction and voluntary community-based treatment services. This means that there should be continued dialogue and involvement of the community in developing a comprehensive national drug policy.

Francis: Right, Sangeeth, ultimately the decision to stop or reduce drug use is an individual choice that must happen organically and never by force. Pitying and humiliating us for using drugs will never work. Compulsory drug treatment approaches prevent an individual from being able to access health care or other therapeutic modalities according to their needs, their choice of drugs, the results of medical assessment of their drug use, and with informed consent. We need to educate and empower individuals to reduce drug-use-related harms and to make informed decisions while respecting their human rights and dignity. Voluntary drug treatment approaches ensure better outcomes and a whole-person recovery with little chance of a relapse.

Quinten: *What are the main barriers to scaling up voluntary evidence- and rights-based approaches to drug use and dependence?*

Apinun: I agree with what was mentioned by Karyn earlier. The main barriers I see are a lack of strong leadership on this issue in the region.

Sangeeth: The main barrier is the archaic punitive laws that need to be reviewed and amended. But corruption is another major barrier.

Sam: In my experience, the main barrier is lack of commitment from donors and governments to support promising approaches.

Inez: Another is the blind obsession with a drug-free goal—drug-free Philippines, drug-free society, drug-cleared barangays—giving tacit permission for the different actors to do whatever it takes to be able to demonstrate this status. A striking conversation with a high-level government official representing a primary agency in the drug response captures this. He had been in a seminar on HIV where harm reduction was discussed. During one meeting, he said he feels for the people at risk for or who may be living with HIV, and understands how harm reduction may be helpful—but, he added, the fact remains that we are supposed to be going for drug free, and that was not what harm reduction was going for. Where health and abstinence collide, the latter still wins where programs and policies are concerned.

Gloria: The lack of expertise and willingness among government agencies is a barrier, as is the shortage of experts who may advise them on how to develop and implement effective approaches to drug use and dependence that are genuinely voluntary and evidence- and rights-based. It is the result of decades of investment in punitive approaches enforcing abstinence. Overcoming this barrier requires adequate investment, and of course time, to attain the capacity to scale up improved measures responding to drug use and dependence.

Claudia: *What has been the impact of COVID-19 on efforts to transition away from compulsory centers toward voluntary community-based approaches in Asia?*

Apinun: In Thailand, the COVID-19 pandemic appears to have reduced compulsory treatment admissions. However, it has not automatically led to an increase in voluntary community-based treatment.

Sam: The situation is different in Indonesia. COVID-19 contributed to even more punitive than voluntary based approaches (e.g., more people who used drugs arrested and sentenced to prison).

Sangeeth: COVID-19 has had a big impact on community-based programs because it has prevented many people who use drugs from accessing harm reduction services in the community and has increased law enforcement's access to health care services.

Francis: Related to this, COVID-19 lockdowns led to severe casualties among people who use drugs who were, out of desperation, trying newer combinations of substances that resulted in many overdose-related deaths. Like the absence of drugs, there was an absence of life-saving drugs, such as naloxone.

Krisanaphong: The pandemic has also been linked to a worsening of mental health and an increase in substance use.

Inez: The assumption of this question is that there were efforts to transition away from compulsory centers. At least where we are at in the Philippines, there were no such efforts or initiatives. In fact, after 2016, more funds were poured into constructing additional compulsory rehab detention facilities. Sure, there were limits and restrictions imposed, especially during the peak of COVID-19, limiting the number of people entering facilities, but that was in no way because of an intent to transition. Because once restrictions were lifted, people continued to be brought to the facilities. Many in jails

who had availed of plea bargains and were court mandated to attend "treatment and rehabilitation programs" still ended up attending these programs within the confines of overcrowded jails or rehab detention facilities.

Ajeng: Let me, for once, focus on the positives rather than the negatives. A key finding from Harm Reduction International's study on the impact of COVID-19 on harm reduction services in seven Asian countries is that harm reduction services adapted quickly and made innovations to improve their processes to respond to COVID-19 conditions.¹⁰ Moreover, people who use drugs have played an important role in providing critical harm reduction interventions during the pandemic. This shows that voluntary treatment, especially that delivered by peers, can adapt to diverse situations.

Gloria: The COVID-19 pandemic shifted health resources away from other health issues, so I think any transition efforts would have slowed down in the past two years. There is advocacy in countries such as Malaysia that appear to call for non-punitive responses to drug use, but the alternative to imprisonment proposed is placing people into drug rehabilitation centers—quite possibly compulsory rehabilitation centers.¹¹ This brings up another concern around proposals made by various well-meaning advocates for reforming punitive responses to drug use: the alternatives proposed are also punitive (e.g., compulsory drug rehabilitation programs).

Claudia: *Are there promising responses in the Asia region that we can look to for renewed hope?*

Karyn: Yes. Though underfunded and generally small scale, there are many projects across the region trying to promote access to justice and generally establish community-based harm reduction services, including outreach and education, needle and syringe programs, naloxone distribution, HIV and hepatitis C testing and treatment support, and other services (such as takeaway methadone and methadone in prison, and work with youth, eth-

nic minorities, trans people, and women-specific groups addressing sexual and reproductive health and rights). But sadly, they are often one-off or not nationally scaled, as well as underdocumented, so support for these models is currently inadequate to meet the need.

Sangeeth: As Karyn mentioned, some of the promising responses are harm reduction interventions, including needle and syringe programs and opioid agonist therapy, which have been adopted successfully in many countries in the region and have contributed to successfully reducing HIV transmission among people who use drugs. The pandemic highlighted the issue of overcrowding in prisons, where almost 60% of inmates are people who use drugs with minor drug-related offenses. There has been a positive initiative to reduce overcrowding by studying alternatives to drug-related offenses. We have seen some progress in establishing dialogue regarding the death penalty and legalizing medical marijuana in Malaysia.

Apinun: In Thailand, there are a few non-punitive community-based responses to drugs. The new drug law puts more emphasis on engaging people who use drugs in voluntary community-based treatment and long-term health and social care. But we need to have a proper framework for scaling up these best practices. These small-scale practices should be implemented across the region in order to be ready to expand once a more enabling political environment is possible.

Sam: Rumah Singgah PEKA, the harm reduction-focused treatment center I founded in Bogor, which is free for everyone, is an example of such an initiative. Every client makes their own decision to participate voluntarily. But what makes us different from government treatment centers is that clients are not required to pursue abstinence in order to join our program and improve their lives. We see our relationship with clients as a partnership. We offer a broad range of harm reduction interventions, including outreach, needle and syringe programs,

links to methadone services, addiction counseling, and case management. We take a client-centered approach to drug treatment, so each person's treatment plan and goals look quite different. What they have in common is a desire to improve the quality of their lives.¹² Unlike most drug treatment programs in Indonesia, clients are free to leave anytime they want, but the overwhelming majority stay and complete their goals. It's the first rehab program that takes this approach in Indonesia.

Inez: In the Philippines, there are pockets of hope and existing programs that were in place long before 2016 but which were not perceived as "community-based programs" for drug-related concerns. One example of a remarkable community-based, community-led program is IDUCare, which is led by peers who understand the challenges of seeking and accessing the appropriate treatment and support. This includes the provision of physical and psychological spaces that are accessible and safe; outreach services (unlike most "community-based programs," which wait for individuals to come in); and an array of health and support services (including for HIV, hepatitis C, and other health related concerns). IDUCare also employs a "two expert" model whereby the individuals accessing the services play an active role in the design of the services they receive.

There are also existing services provided by nongovernmental organizations whose work is in communities where drugs are present but whose primary mission is not about being a "community-based treatment program." For instance, this might mean a religious-run program working with women (including those engaged in sex work) that provides a place for rest, shower, food, other basic needs, and social support services and which does not let a woman's continued use of drugs constitute an obstacle to receiving services and support. It might also mean a child rights organization that works with families, helping them, for example, with housing concerns, legal assistance, and rights protection, again recognizing that abstinence from drugs is not a precondition to receiving support nor

the be-all and end-all of any response.

A major need is to navigate and address the still deeply embedded belief that a person has to be abstinent or “drug free.” Another need is to address the fact that drug use and related acts continue to be criminalized and that our current drug law in the Philippines penalizes those perceived to be knowledgeable of continued drug-related acts and not reporting them.

Judy: Reflecting on what Inez shared and in my observations, I am concerned about the lack of a shared understanding—and by extension, standards on voluntary community-based harm reduction services. Very often, these services are also experienced as punitive by people who use drugs, in the name of control and “care.” Too many harm reduction programs put strict time limits on how long people can stay on methadone or buprenorphine, require supervised urine testing, and ban take-home doses. In no other health service or program is there so much social control, denial of agency, ability to voluntarily enroll and dismiss, and marginalization of people’s voices, choices, and perspectives on what they need to enhance their quality of life. The principles of agency, rights, and dignity need to be centered in all discussions on the health and rights of people who use drugs—not just in the Asia-Pacific but worldwide.

Gloria: At the end of 2021, legislative reforms in Thailand indicated a further move away from compulsory rehabilitation; however, it remains to be seen whether drug treatment and rehabilitation programs will become genuinely voluntary and human rights-based. The reforms to legalize cannabis use for medical purposes in Thailand can also foster greater acceptance of the idea that drug use is not inherently “bad” or “evil” and that a policy response grounded in the principles of harm reduction and human rights is far better than punishment. Last but not least, communities of people who use drugs, who have borne the brunt of punitive drug policies, continue to work for the betterment of the lives of their peers and surround-

ing communities, such as by supporting their basic livelihoods, health, and social needs.

Karen and Quinten: *The International Guidelines on Human Rights and Drug Policy outline potentially eight human rights violations linked to compulsory treatment.*¹³ *How do you see the situation of compulsory facilities for people who use drugs in Asia a decade from now?*

Ajeng: I am not convinced that we will have zero compulsory treatment in Asia a decade from now. But I am hopeful we will be able to make progress for the following reasons: The community of people who use drugs is more and more aware of their rights and has taken part in claiming their rights. Civil society and community-based organizations continue to provide evidence to show the effectiveness of voluntary community-based treatment and call for rights-based drug policies—including an end to compulsory treatment. Various United Nations bodies and Special Procedures have also been condemning compulsory treatment and recommending that countries provide voluntary community-based treatment, as shared by Priya regarding the study of the Working Group on Arbitrary Detention.

But this is not enough. Governments continue to fiercely advocate and defend punitive approaches to drug policy, and with funding for harm reduction services at only 5% of what is needed, civil society, media, United Nations bodies, and donors all need to work hand in hand to make a case for a shift away from punitive approaches and toward voluntary community-based treatment.¹⁴

Sangeeth: In a decade, compulsory facilities for people who use drugs will continue to exist; however, I do not see an increase in the number of compulsory detention centers. We will continue to see an increase in community-based centers and an increase in the awareness and acceptance that drug dependence is a bio-psycho-social problem and is a chronic relapsing disease that needs medical attention and can be treated in the community.

Apinun: In the past, politicians enjoyed popularity by appealing to tough approaches to drugs. After several years of such policies, the public is slowly and painfully learning of the negative impacts of such policies. There has been increasing resistance to zero-tolerance policies on drugs. With strong leadership and proper technical support and coordination, in the next decade I see many best practices sustained and scaled up. I believe that when there are better choices available for their communities, people will be less supportive of compulsory and punitive approaches.

Karyn: It's largely fallen off the radar as a high-level political issue. Not only do we need new allies, but the current expert advocates already working on the issue need urgent and adequate support.

Gloria: More people are seeing the devastating harms of compulsory rehabilitation facilities and are understanding better the need to pursue harm reduction responses to drug use, including drug policy reforms to end the criminalization of and punishment against people who use drugs.¹⁵ There have been decades of advocacy from nongovernment organizations, civil society, and affected communities for voluntary and harm reduction-focused responses to drug use and dependence. As this advocacy continues, I think support will grow incrementally for humane and progressive measures.

Judy: To see change, we need United Nations agencies to act, and donors to get behind funding civil society and community action.

Additionally, we need to be funding sociological research on the topic of compulsory drug detention and compulsory treatment in order to better understand and identify levers of change, from culturally informed perspectives. The need for this is greater than ever before, as countries that support compulsory drug detention, such as China, seek to export this model to other regions.

Without focused attention and resources that aim to equip civil society and communities with the necessary tools and political, technical, and social

capital, we don't know whether we will be back here 10 years from now making the same arguments, on an endless feedback loop.

Inez: There's a lot of work that still needs to be done to disrupt dominant discourse around drugs. In the Philippines, there has been an increase in statements referring to drugs as a "health issue" (as opposed to a criminal issue) and an increase in "community-based programs," which, on the surface, sounds like positive change. Unfortunately, this supposed shift still comes with the same punitive mindset and pejorative perception of people who use drugs.

Because of the very strong drug-free mindset of those currently involved in the design and implementation of "community-based drug treatment programs" and policies, one potential pathway that seems worth exploring is engaging with groups and organizations who already work in the community (e.g., women's groups, child rights groups, etc.) but that were not set up specifically for the purpose of providing "drug treatment." It is then a matter of integrating the principles of harm reduction and ethical provision of or referral to treatment and support services. In that work, we need to create more empowering and liberating spaces for people whose lives include drugs.

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