

# COMPULSORY DRUG TREATMENT AND REHABILITATION IN EAST AND SOUTHEAST ASIA

## Voluntary Community-based Alternatives

Discussion Paper of the UNAIDS–UNODC Asia–Pacific Expert Advisory Group  
on Compulsory Facilities for People Who Use Drugs





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# EXPLANATORY NOTES

Consisting of three booklets, this report assesses progress towards the closure of compulsory facilities for people who use drugs in selected countries in East and Southeast Asia. It also features case examples of the transition to voluntary community-based treatment and complementary health, harm reduction and social support services. The report is structured as follows:

## Booklet 1

summarizes the findings from the other two booklets.

## Booklet 2

provides a regional overview of the state of the transition away from compulsory facilities for people who use drugs and towards voluntary community-based treatment, care and support services in East and Southeast Asia. The analysis is based on official data that Member States submitted to UNAIDS and UNODC through a regional questionnaire distributed in November 2019, unless indicated otherwise.

## Booklet 3

**developed in consultation with the members of the Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs, consists of case examples of practices and policy recommendations to support the expansion of voluntary, community-based treatment and support services.**

All uses of the word “drug” and the term “drug use” in this report refer to substances controlled under the international drug control conventions and their non-medical use, unless indicated otherwise.

All \$ currencies are United States dollars.

The following abbreviations are used in this booklet:

<b>ART</b>	antiretroviral therapy
<b>ASSIST</b>	Alcohol, Smoking and Substance Involvement Screening Test
<b>ATS</b>	amphetamine-type stimulants
<b>COVID-19</b>	coronavirus disease
<b>ESCAP</b>	United Nations Economic and Social Commission for Asia and the Pacific
<b>HIV</b>	human immunodeficiency virus
<b>MMT</b>	methadone maintenance treatment
<b>NGO</b>	non-government organization
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>WHO</b>	World Health Organization

# SCOPE OF THE PAPER

In 2022, United Nations Member States in East and Southeast Asia will review progress made on the recommendations of the 2015 Regional Consultation on Compulsory Centres for Drug Users and determine a way forward for accelerating the transition. This discussion paper aims to inform the national and regional dialogues that will lead up to the Fourth Regional Consultation on Compulsory Centres for People Who Use Drugs. With this paper, the Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs wants to build on the outcomes of previous regional consultations, including the 2015 informal Expert Working Group paper, *Transition from Compulsory Centres for Drug Users to Voluntary Community-Based Treatment and Services*,<sup>1</sup> by providing additional examples that depart from punitive approaches to drug control.

This paper (Booklet 3) begins with a discussion of the basic concepts in relation to drug use and dependence and summarizes the principles of voluntary, community-based drug dependence treatment and support services. It then documents promising practices that Member States and civil society organizations are implementing in relation to drug dependence treatment at the national level. A discussion of the barriers and facilitators that should be addressed to expedite the expansion of voluntary community-based drug dependence treatment then follows. The case studies encompass:

- the development of partnerships between law enforcement, government agencies and community-based organizations in China;
- a peer-led programme in Indonesia integrating harm reduction services, mental health support and links to primary health care for people who use methamphetamines;
- a voluntary, community-based drug dependence treatment model in the Lao People's Democratic Republic (PDR);

- provision of low-threshold, flexible dose access to opioid agonist treatment in Malaysia;
- drug policy reform in Myanmar involving participatory consultation and multisector cooperation;
- the process of reorienting the response to drug dependence in the Philippines through the development of evidence-based treatment practices, guidance and standards;
- a court diversion initiative in Thailand that implements outpatient psychosocial counselling as an alternative to incarceration for low-level drug offences; and
- national scale-up of methadone treatment in Viet Nam.

Recommendations for the case examples were obtained from members of the Expert Advisory Group, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for Asia and the Pacific and the United Nations Office on Drugs and Crime (UNODC) Regional Office for Southeast

## Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs

The Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs was established by UNAIDS and UNODC in August 2020. Comprising 11 members with a wide range of experience in academia, civil society and government, the group is tasked with informing and strengthening advocacy on the transition from compulsory treatment and rehabilitation towards voluntary, community-based drug dependence treatment, harm reduction and social support services.

<sup>1</sup>Tanguay and others, 2015.



Asia and the Pacific and their various country offices. The discussion is intended to document a cross-section of promising approaches being implemented in the region. The authors acknowledge that this is not an exhaustive selection of case examples. Other encouraging models that support an evidence-informed, harm reduction approach to drug use and dependence have been previously documented.<sup>2</sup>

## Drug use, dependence and voluntary community-based treatment and support services

### Language, perception and stigma

Language shapes how society perceives and responds to drug use and the people affected by it. Inappropriate use of terminology, such as “drug abuse” or “abuser”, “drug misuse” and “addict”, promotes misunderstanding related to the nature of drug use and dependence. It fuels stigmatization and discrimination and contributes to criminalizing laws, policies and practices. Insidious fears and misconceptions around drug use in East and Southeast Asia have contributed to a view that people who use drugs represent a “social evil”,

are morally weak, lack self-control, are incapable of making productive contributions to society and inevitably engage in criminal activities.<sup>3</sup> Even portrayals of people with drug dependence as “patients not criminals” often cast those who use drugs as socially dysfunctional outsiders who must be coerced into treatment to ensure their abstinence and, therefore, resume their social function.<sup>4</sup>

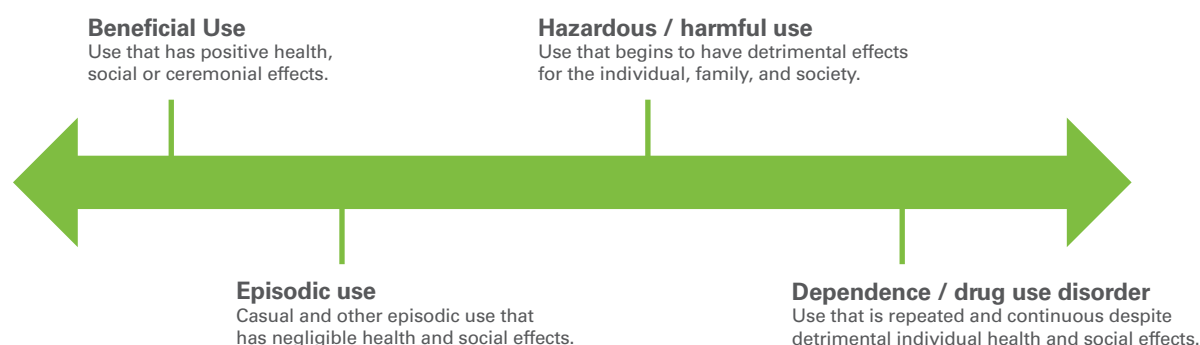
Justification for the imposition of compulsory treatment and rehabilitation is often premised on these incorrect perceptions. In many countries in East and Southeast Asia, even the one-time use of an illegal or illicit substance<sup>5</sup> may incur a criminal or administrative penalty.<sup>6</sup> Such penalties, which often include compulsory treatment and rehabilitation, are imposed by countries despite their condemnation by United Nations agencies.<sup>7</sup>

### A spectrum of drug use

Given this context, it is important to distinguish between different patterns of drug use. Based on a public health approach, drug use can be understood as being on a spectrum (figure 1).

The spectrum does not suggest a linear progression whereby periodic drug use leads to problematic

**Figure 1 Spectrum of psychoactive drug use**



Source: Adapted from Health Officers Council of British Columbia, 2005.

<sup>2</sup> See for example: [www.unodc.org/documents/southeastasiaandpacific/Publications/2015/hiv/Discussion\\_Paper\\_on\\_Transition\\_from\\_CCDUs\\_Edited\\_Final4\\_04Sept15.pdf](http://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/hiv/Discussion_Paper_on_Transition_from_CCDUs_Edited_Final4_04Sept15.pdf) and [www.hri.global/contents/1648](http://www.hri.global/contents/1648).

<sup>3</sup> Miao, 2017.


<sup>4</sup> Lai and Stoicescu, 2020.

<sup>5</sup> Illegal drugs are substances with criminal sanctions against any personal possession or use, typically referring to drugs scheduled under the three United Nations drug conventions. Illicit use refers to any non-medical use of controlled drugs. In the context of this report, the terms “drugs” and “drug use” encompass both and refer to substances scheduled under the three United Nations drug conventions and their non-medical use.

<sup>6</sup> International Narcotics Control Board, 2017.

<sup>7</sup> *ibid.*





use and dependence. According to the UNODC World Drug Report 2018, an estimated quarter of a billion people used illegal drugs, while 11.6 per cent developed high-risk patterns of use.<sup>8</sup> UNODC recognizes that “many people who have experimented with drug use do not become frequent users and many who become frequent users do not become dependent.”<sup>9</sup> An estimated 23 per cent of people who try heroin will develop harmful use patterns, while 77 per cent will not; for cannabis, and only around 9 per cent will engage in harmful use, while the majority will not. Importantly, people can find themselves at different points on the spectrum in relation to different substances at different times in their lives.<sup>10</sup>

Drug research and policy largely focus on the harms associated with drug use. An inclusive approach to drug use should consider that drug use may have physical, psychological, social and economic benefits. Examples of benefits derived from using various controlled substances include pain relief, endurance, relaxation, pleasure, spiritual or ceremonial use and wealth, job and tax revenue creation (such as with medical cannabis). Although there is a potential level of risk with any pattern of use, opportunities to reduce risk without necessarily discontinuing drug use exist at every point along the spectrum.

In line with the World Health Organization (WHO) International Classification of Diseases, 11th revision, hazardous and/or harmful use refers to “a pattern of use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals.”<sup>11</sup> Chronic dependence describes a pattern of drug use defined by a characteristic set of cognitive, physiological and psychological indications, including substance tolerance and withdrawal.<sup>12</sup> The WHO and UNODC International Standards for the Treatment of Drug Use Disorders recommend that the presence of drug dependence be indicated by evidence-based

diagnostic guidelines administered by trained health care practitioners.<sup>13</sup> Because dependence is characterized by a chronic or frequently relapsing course, it may require long-term engagement and care. Relapse during and despite treatment is typically experienced by most people with drug dependence, is “not a weakness of character or will” and should never incur punishment.<sup>14</sup>

### *Social and environmental influences on drug use*

Negative impacts to an individual and society vary widely, depending on the substance and its pharmacological effects, concentration, mode of use, circumstances of use and legal status. Although people with drug use disorders comprise a small proportion of people who use drugs, they experience disproportionate health impacts and account for a large burden of disease on society.<sup>15</sup> Detrimental impacts include higher morbidity and mortality, increased vulnerability to HIV, hepatitis C, coronary artery disease and higher levels of violence, overdose and stigma. In 2015, UNODC estimated that, globally, 28 million years of healthy life were lost as a result of drug use; of those years, 17 million were lost in relation to drug dependence, although people with drug dependence accounted for only 10 per cent of all people who use drugs.<sup>16</sup>

High-risk drug use patterns are strongly influenced by social conditions and structural forces such as economic disadvantage; discrimination based on drug use, class, race or gender; unemployment; inadequate housing; disempowerment; and criminalizing laws and policies. Crucially, the criminalization of drug possession for personal use and its enforcement, including arrest, incarceration, abusive and corrupt policing practices, the unavailability or inadequate access to harm reduction and evidence-based drug dependence treatment services and restrictions on possession

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<sup>8</sup> UNODC, 2018.

<sup>9</sup> UNODC, 2014.

<sup>10</sup> Health Officers Council of British Columbia, 2005.

<sup>11</sup> WHO, 2020.

<sup>12</sup> WHO and UNODC, 2020.

<sup>13</sup> *ibid.*

<sup>14</sup> WHO, UNODC and UNAIDS, 2004.

<sup>15</sup> International Narcotics Control Board, 2017. Studies have shown that individual and societal harms attributed to currently legal substances, such as alcohol and tobacco, are greater than the burdens attributed to illegal drugs overall. In a 2007 breakthrough study in *The Lancet* that categorized drugs according to multiple criteria, such as individual physical harm (acute, chronic, intravenous harm) and psychological and social harms (health care costs), alcohol emerged as the most harmful substance, overtaking heroin and amphetamines. See also Nutt, and others, 2007, pp. 1047–1053.

<sup>16</sup> UNODC, 2017.

of drug use paraphernalia, exacerbate poor health outcomes among people who use drugs.<sup>17</sup> Harm Reduction International estimates that \$100 billion is spent on global drug law enforcement every year without seeing major reductions in the use or sale of drugs,<sup>18</sup> proving that focusing solely on supply reduction without efforts to shift the social and structural environments shaping drug use will not solve the complex issues that governments face.

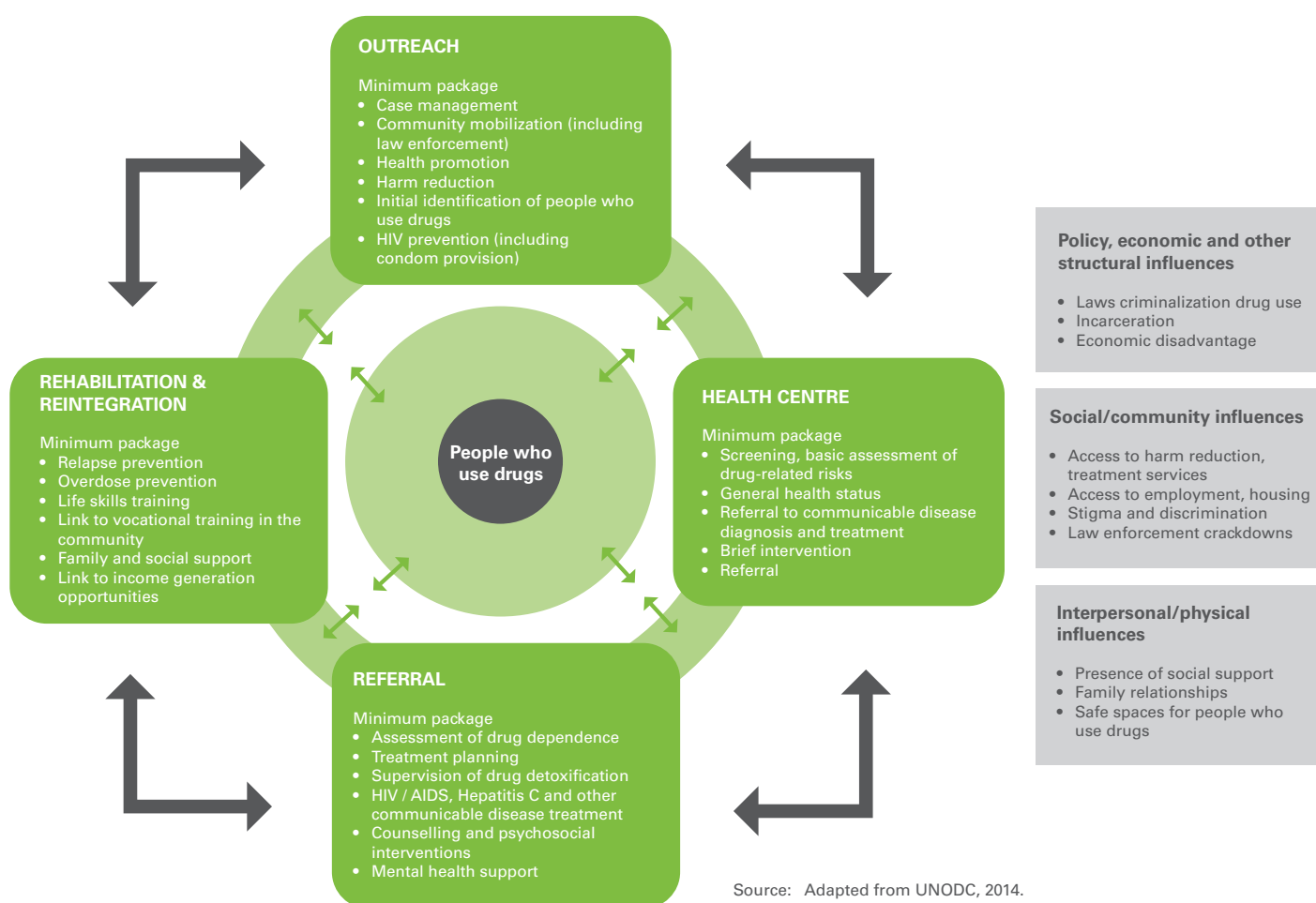
### Principles of community-based treatment and support services

Recognizing the nature of drug use and dependence and taking into account the socio-structural influences on drug-related risks are critical to developing

effective and equitable approaches to treatment and support. No single treatment approach is workable for all persons affected by drug dependence. As informed by the WHO and UNODC International Standards for the Treatment of Drug Use Disorders<sup>19</sup> and reflected in the UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia,<sup>20</sup> a model for service provision in the community must comprise a range of options—from residential inpatient rehabilitation to psychosocial support and opioid agonist treatment—to address the spectrum of issues that individuals may face (figure 2).

The model reflects a continuum of services from informal care in the community, outreach services,

**Figure 2 Model of community-based treatment and care for people who are affected by drug use and dependence**



<sup>17</sup> United Nations System Coordination Task Team, 2019; DeBeck and others, 2017; Degenhardt and others, 2017; Baker and others, 2020.

<sup>18</sup> Harm Reduction International, 2021.

<sup>19</sup> WHO and UNODC, 2017

<sup>20</sup> UNODC, 2014.



brief interventions and psychosocial counselling to rehabilitation and social reintegration support. Because the most typical pattern of illegal drug use is episodic and non-problematic, the bulk of services provided as part of a continuum of care should prioritize community outreach and non-custodial, low-threshold services focused on health promotion and harm reduction. Rather than exclusively focusing on abstinence from drug use, the aims of the treatment and support services continuum should be to reduce high-risk drug use patterns and to support social reintegration by facilitating assistance for social welfare, housing and employment.

While no single treatment approach is effective for all persons, the UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia highlights the following principles that should be at the core of an integrated approach to treatment in the community:<sup>21</sup>

- Continuum of care, from outreach, basic support and harm reduction to social reintegration.
- Delivery of services in the community, as close as possible to where people affected by drug use and dependence live.
- Minimal disruption of social links and employment.
- Integration of drug dependence treatment into existing health and social services.
- Involvement of and building on community resources, including families.
- Participation of people who are affected by drug use and dependence, their families and the community-at-large in service planning and delivery.
- Comprehensive approaches, considering health, family, education, employment and housing.
- Close collaboration between civil society, law enforcement and the health sector.
- Provision of evidence-based interventions.

- Informed and voluntary participation in treatment.
- Respect for human rights and dignity, including confidentiality.
- Acceptance that relapse is part of the treatment process and will not limit access to services.

An evidence-informed, voluntary community-based drug dependence treatment and support system can decrease harmful drug use patterns, minimize negative health effects to an individual and reduce secondary impacts to society, including crime, violence, corruption and excess medical and criminal justice costs. The case examples presented here offer options and lessons towards achieving these aims in diverse country settings and circumstances.

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<sup>21</sup> UNODC, 2014.

# CASE EXAMPLES SUPPORTING THE TRANSITION

The following section highlights policy and programmatic approaches from China, Indonesia, the Lao PDR, Myanmar, Malaysia, the Philippines, Thailand and Viet Nam. They provide helpful indications for expanding the reach and scope of alternatives to compulsory treatment and rehabilitation. Each case example features a brief description of the country context and practical details on key components and/or activities. The examples also note achievements and challenges encountered during implementation and lessons learned from each approach.

## CHINA

### Forging a partnership between law enforcement, government and community

The Ping An (Peace Harbor) Centre No. 1 in China's Yuxi City in Yunnan Province is an example of effective collaboration between the police, the health department and people who use drugs. The Ping An Centre No. 1 and its satellite facility, Chunhui Home, located in Daying village, provide opioid agonist treatment in the form of methadone as part of an integrated community-based drug treatment service.

#### Background

China implements the world's largest methadone maintenance treatment (MMT) programme, consisting of over 790 community MMT clinics across all 31 provinces, which were accessed by 91,000 clients as of November 2021.<sup>22</sup> However, access to and effectiveness of voluntary MMT services are hindered by the need for daily clinic visits, which

leave little time for employment and other activities; fear of arrest in and around MMT clinics; pervasive stigma against people who use drugs; and drug law enforcement practices such as mandatory registration for people accessing methadone, regular monitoring and urine drug testing by the police.<sup>23</sup>

#### Activities

Established in 2014 by the non-government organization AIDS Care China, in collaboration with Hongta District Centre for Disease Control and Prevention, the Ping An Centre No. 1 provides integrated drug dependence treatment and support services under one roof. Services include MMT, medical examinations, treatment referrals, naloxone for overdose prevention, social and educational activities, home visits, vocational training, legal aid, psychological counselling, HIV and hepatitis C testing and treatment, as well as facilities for cooking, laundry and showering. The centre operates on an outpatient basis and is run by six staff members, including a coordinator, two case managers, a nurse, an administration and finance officer and a technical assistant affiliated with the district Center for Disease Control and Prevention, whose main role is to monitor clinic operations.

The Ping An model was informed by a comprehensive needs assessment with people affected by drug dependence, their families, drug treatment workers and government officials who identified gaps and needs around drug treatment services. Flexible MMT dosing was a primary need cited by people accessing the service. Following a lengthy period of advocacy, harm reduction training workshops for police officers, collaborative trial runs with the Yunnan Institute for Drug Abuse, the Health Department and the police, AIDS Care China, in collaboration with the Hongta District Center for Disease Control and Prevention, initiated the country's first take-home MMT pilot programme in 2013.<sup>24</sup> Clients may take home two to six daily doses of methadone per week, depending on their prior MMT adherence record. Preliminary results showed improved retention in treatment, reduced relapse rates and enhanced police confidence in non-compulsory approaches to drug use.<sup>25</sup>

<sup>22</sup> UNAIDS and UNODC, 2019.

<sup>23</sup> Ma and others, 2016, p. 20879; Meng and Burris, 2013, pp. 25–34

<sup>24</sup> *ibid.*

<sup>25</sup> Yan and others, 2015.



“

**Ping An Centre No. 1, particularly its take-home methadone programme, exemplifies a promising model of collaboration among non-governmental organizations, community, law enforcement and government stakeholders towards the shared goal of enhancing health and psychosocial outcomes for people who use drugs.**

”

In 2016, based on Ping An’s positive outcomes, AIDS Care China established the Chunhui Home satellite community-based treatment centre in Daying village, in collaboration with the local Public Security Bureau and the Hongta District Center for Disease Control and Prevention. A referral and feedback mechanism between the police, local compulsory detoxification facility and the Ping An and Chunhui Centre staff facilitates the diversion of persons who use drugs (who may otherwise be incarcerated or ordered to compulsory detoxification) to the Chunhui Home community-based alternative. Ongoing coordination is facilitated by a joint working group comprising governmental, community and law enforcement representatives.

### **Challenges**

Challenges include limited government funding, which threatens the long-term sustainability and scalability of the model; the persistence of punitive and stigmatizing attitudes among local police and health officials towards people who use drugs; mutual distrust between people who use drugs and the police; and conflicting performance targets related to drug-related arrest and treatment within the police (arrest quotas) and health department (treatment quotas).

## **Results and accomplishments**

### **Access to integrated treatment and support services**

As of October 2020:

- A total of 443 individuals had accessed community-based drug treatment and support services.
- A total of 358 individuals had accessed MMT, including 152 clients who had accessed take-home doses. The MMT programme has official backing from the Chinese Center for Disease Control and Prevention and the Public Security Bureau, which subsequently took over implementation of take-home dosing.
- Over the past six years, Ping An distributed 2,546 naloxone kits to 862 individuals, with 23 lives saved through the peer distribution of naloxone.
- A total of 580 people accessed free HIV and hepatitis C virus counselling and testing services, with 348 people subsequently linked to treatment.
- 109 people found employment via Ping An’s vocational support services.

### **Multisector links**

As a result of the multisector collaboration between law enforcement, government stakeholders and community facilitated by AIDS Care China, law enforcement authorities have adopted less punitive approaches. Notably, a regular feedback mechanism between Ping An and the police station has resulted in the removal of persons who had completed their treatment programme from the compulsory registration database maintained by the police. Furthermore, individuals on MMT who are caught by police and test positive on a urine drug test are now given a “warning” but are able to remain on MMT, instead of the prior practice of being sent to compulsory isolated treatment.

### **Lessons learned**

Ping An Centre No. 1, particularly its take-home MMT programme, exemplifies a promising model of collaboration among NGO, community, law enforcement and government stakeholders towards the shared goal of enhancing health and psychosocial outcomes for people who use drugs, improving public safety in communities and reducing criminality. Regular multisector meetings, negotiations and advocacy with senior government



officials, study visits for officials to explore non-compulsory alternatives for addressing drug use and dependence and harm reduction training for the police have been integral components for developing a successful multisector partnership and securing official support for the initiative. In a national context in which the response to drug use relies on compulsory reporting, detention and surveillance, the Ping An Centre No. 1 demonstrates that it is possible to develop workable models of community-based treatment by building partnerships outside of the health sector.

## INDONESIA

### Reducing methamphetamine-related harms through community-led service delivery and links to primary health care

Karitas Sani Mandani (Karisma) Foundation collaborates with community health centres (*puskesmas*) under the Ministry of Health to distribute harm reduction and education for people who use methamphetamines, provide peer-to-peer mental health support in community settings and establish linkages with primary health services.

#### Background

In recent years, rising trends in methamphetamine use have found harm reduction and drug dependence treatment services in Indonesia unprepared.<sup>26</sup> By 2018, crystal methamphetamine surpassed heroin as the drug of choice in the archipelago, accounting for 62 per cent of admissions to drug treatment.<sup>27</sup> A 2017 study in six Indonesian cities found high prevalence of HIV (at 10.2 per cent) and hepatitis C virus (at 14.2 per cent) among people who use crystal methamphetamine.<sup>28</sup> Yet, despite national increases in methamphetamine use, the focus of existing services, policies and donor funding has remained on opiates while evidence-based interventions addressing methamphetamines are underdeveloped.

#### Activities

In 2017 and with funding from the Mainline Foundation and technical assistance by Atma Jaya University's AIDS Research Centre, Karisma piloted the first harm reduction programme for people who use crystal methamphetamine in Indonesia. Initially implemented in two Jakarta districts with elevated levels of crystal methamphetamine use and HIV, the programme was scaled up to the Greater Jakarta area and to Makassar City in Sulawesi in 2018. The intervention consists of outreach activities, peer-led screening, brief interventions for mental health and distribution of tailored information and education

materials. It also includes provision of harm reduction materials, such as condoms, lubricant and safer-smoking kits (containing a glass pipe, foil and matches) via community outreach in an effort to discourage pipe sharing and prevent the oral transmission of hepatitis C.<sup>29</sup>

Supporting community-led mental health responses is a key component of the programme. Outreach workers are equipped to provide peer-to-peer mental health support through a series of trainings on mental health screening using standard diagnostic tools and conducting brief interventions with techniques such as motivational interviewing and behaviour change communication. In collaboration with the Jakarta Provincial Health Office, Karisma facilitated trainings for *puskesmas* staff on the management of people who use crystal methamphetamine, specifically on the provision of mental health care.

Community-based responses on mental health conducted by outreach workers include:

- **Outreach.** Getting in touch with people who use crystal methamphetamine and building trusting relationships involved engaging peer educators to support the outreach team to access new "hotspots", hiring outreach staff with lived experience of crystal meth use, including female staff, and involving researchers from Atma Jaya University to document the process and better understand and respond to the experiences and needs of the community.<sup>30</sup>
- **Disseminating harm reduction materials.** This includes safer-smoking kits and information and education materials, including online resources, on how to use safely (eat, sleep, drink, repeat) and thus prevent transmission of HIV, hepatitis C virus and sexually transmitted infections (STIs).
- **Screening for drug dependence severity and mental health challenges.** Every six months, outreach workers support people who use crystal methamphetamine to carry out a formal self-assessment using The Drug Abuse Screening Test to assess their drug dependence risk, individual risk assessment to evaluate HIV risk and a self-reporting questionnaire to screen their mental health.

<sup>26</sup> Praptoraharjo and others, 2017; Neverndorff and Praptoraharjo, 2015.

<sup>27</sup> UNAIDS and UNODC, 2020.

<sup>28</sup> Praptoraharjo and others, 2017.

<sup>29</sup> Farrell and others, 2019, pp. 1652–1667; Strike, Elton-Marshall and Rehm, 2019, pp. 1189–1190.

<sup>30</sup> Rigoni, Woods and Breeksema, 2019.

- **Screening for additional health challenges.** During face-to-face meetings and field visits, the outreach workers carry out additional informal risk assessments to monitor clients' state of health.
- **Provision of brief counselling interventions.** Based on individual assessment results, the outreach workers provide mental health counselling support and brief interventions. They are also trained to lead activities to help clients cope with panic and anxiety attacks.
- **Referral to community health centres.** Risk assessment results form the basis for determining follow-up action on referrals to health and support services, including voluntary counselling and testing for HIV, tuberculosis, hepatitis C and STIs, as well as follow-up mental health care for severe cases.

A service referral infrastructure involving the *puskesmas*, which provide primary care services at the subdistrict level, was developed to facilitate service linkage. Since early 2019, Karisma has supported the *puskesmas* to enhance provision of mental health care. In response to mobility restrictions and limited access to *puskesmas* due to the COVID-19 pandemic, Karisma established satellites with seven peer educators in the five districts of Greater Jakarta. The satellites deliver health information and education, provide legal aid and distribute prevention materials, including mobile needle and syringe programmes, in their immediate communities.<sup>31</sup> The work carried out by the satellite peer workers has helped bridge gaps in access during the COVID-19 pandemic and reduced the workload of the *puskesmas*.

## Challenges

Law enforcement activities focused on eradication of drug use, including raids, mandatory urine testing and detention by National Narcotics Board officials, police confiscation of harm reduction materials and even the arrest of outreach workers, have undermined access to services and increased distrust of authorities among people who use crystal methamphetamine. Strengthened human resources management, monitoring and evaluation frameworks and additional support and capacity-

building for outreach staff and for the *puskesmas* workers are necessary to maintain service quality. Innovative sources of funding must be identified to ensure programme sustainability and expansion sufficient to address a growing population of people who use stimulants.

## Results and accomplishments

### Service uptake and scale up

According to the Department of Health, outreach services implemented by Karisma had a positive impact on service uptake at the *puskesmas* by people who use crystal methamphetamine, with more individuals accessing more services as a result of referral than prior to the start of the intervention.<sup>32</sup> Overall:

- In 2018, the intervention reached 1,645 people who use crystal methamphetamine (70 per cent male, 20 per cent female, 1 per cent transgender) in Jakarta.
- In 2019, 1,116 information and education leaflets were distributed. The most common prevention materials distributed were condoms and matches, followed by glass pipes.
- In 2019 and based on individual needs identified through risk assessments, 651 people who use crystal methamphetamine were referred to HIV testing and counselling, 487 to hepatitis C virus testing, 356 to tuberculosis screening, 173 to mental health care, 140 to antiretroviral therapy (ART) services, 133 to a support group, 94 to STI testing and 15 to legal assistance.

Following the promising results in Jakarta, the intervention was scaled up to Makassar in Sulawesi Province, where it is implemented by the Makassar Drug Users Organization. Between April 2018 and October 2020, the programme in Makassar reached 1,524 people who use crystal methamphetamine.

<sup>31</sup> Atma Jaya University AIDS Research Centre, 2020a.

<sup>32</sup> *ibid.*



### **Health care integration**

Karisma's programme enjoys strong support from the health sector. Karisma established a memorandum of understanding (MOU) with 42 puskesmas across Jakarta that committed them to becoming a referral facility, with 14 health centres also providing mental health services tailored for people who use crystal methamphetamine. The outreach workers are appreciated by the community health clinics because they act as a bridge between the methamphetamine-using community and the public health system while reducing the Department of Health's financial burden and workload.

### **Increased primary health service capacity to address methamphetamine use and dependence**

Health clinic staff reported that the trainings facilitated by Karisma helped them gain a deeper understanding of crystal methamphetamine use and potential mental health challenges. It also enhanced their competence around supporting people who use crystal methamphetamine. Building on this work, in 2020 Atma Jaya University's AIDS Research Centre and Karisma developed guidelines for health workers on providing mental health support for people who use methamphetamines.<sup>33</sup>

### **Lessons learned**

This model shows that integration of mental health and psychosocial support services in the primary health system for people who use crystal methamphetamines is feasible and acceptable, both to users and to the health sector. In a context in which mental health remains a taboo topic, low-threshold, peer-led service delivery contributes significantly in filling a gap in mental health services to affected individuals and offers a crucial entry point into formal health care services.

Karisma's work underscores the need to acknowledge that people who use crystal methamphetamine have needs different from people who use opioids and require tailored approaches. Thus, harm reduction and drug treatment infrastructure must be adjusted accordingly. More attention should be given to reaching populations using peer-led methods, building relationships with affected communities

<sup>33</sup> Atma Jaya University AIDS Research Centre, 2020b.

<sup>34</sup> Rigoni, Woods and Breeksema, 2019.

<sup>35</sup> UNODC, 2014.

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**Integration of mental health and psychosocial support services in the primary health system for people who use crystal methamphetamines is feasible and acceptable.**

**More attention should be given to reaching populations using peer-led methods, building relationships with affected communities and providing person-centred services.**

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and providing person-centred services. The meaningful involvement of people with lived experience was essential in the development and evaluation of outreach work as well as the adaptation of information and education materials and safer-smoking kits to the local context.<sup>34</sup>

If the programme is to succeed in the long term, common goals that recognize harm reduction as an integral part of a continuum of voluntary, community-based treatment and support services<sup>35</sup> must be agreed by law enforcement and health agencies.

## LAO PDR

### Community-based drug dependence treatment at Sisattanak Community Hospital

The Sisattanak Community Hospital in Vientiane integrates person-centred psychosocial services for amphetamine-type stimulant (ATS) dependence into primary health care.

#### Background

Prior to 2014, the response to drug use and dependence in the Lao PDR relied on centre-based compulsory detention and incarceration.<sup>36</sup> As the Lao PDR's policy response to drugs began shifting towards health-focused approaches, the Government worked with development partners to expand voluntary community-based treatment services. In 2016, the Government adopted the Drug Control Master Plan 2016–2020, which includes among its nine priorities the scale-up of community-based drug treatment for people who use drugs.<sup>37</sup>

#### Approach

In January 2015, Sisattanak Community Hospital, a primary health care hospital in Vientiane, opened the first voluntary community-based treatment programme in the country. Informed by a pilot project in Sisavath village in 2012,<sup>38</sup> the model offers health and psychosocial services for people affected by drug dependence on an outpatient basis, with the goal of reducing the need and demand for centre-based and custodial options. The initiative is funded by the United States Government and implemented in collaboration with the UNODC and WHO Drug Dependence Treatment and Care Project, the Vientiane Committee for Drug Control under the Ministry of Health and the Drug Control Bureau under the Ministry of Public Security. UNODC contributed technical assistance, including training 76 practitioners on evidence-based drug treatment methods and brief interventions for addressing ATS.<sup>39</sup>

To reduce the stigma associated with accessing specialized drug dependence services, individuals who access community-based treatment at Sisattanak Hospital are treated as typical patients in primary health care. Upon arrival, prospective clients consult with a doctor and receive a general medical check-up, after which they are offered HIV and hepatitis B and C virus testing, tuberculosis screening and an assessment for drug dependence using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) diagnostic tool. A personalized treatment plan that considers each person's drug use history, including frequency and duration of use, is developed with the individual. Based on their needs, individuals may integrate symptomatic treatment (pain relief medication, mental health medication, vitamins and others), counselling, motivational interviewing, cognitive behavioural therapy and group counselling into their treatment plan. The treatment model also offers individuals the option of engaging their family in the counselling process. Follow-up case management is conducted weekly for the first two months and every one to two months thereafter. The hospital also provides free ART and treatment for tuberculosis.

To raise awareness about the community-based treatment programme, Sisattanak Community Hospital, in collaboration with the provincial and district government authorities, spearheaded an informational campaign in 37 surrounding villages. The campaign raised awareness about the drug laws, drug-related harms and availability of community-based treatment and engaged with village leaders to encourage affected persons to seek health and support services without fear of arrest or detention. Based on a cross-section of 100 individuals accessing services at Sisattanak Hospital in 2017, 95 per cent were male, the largest proportion (42 per cent) were 26–35 years old and approximately 95 per cent used stimulants, specifically methamphetamine tablets (yaba).<sup>40</sup> In 2019, with assistance from UNODC, Sisattanak Hospital expanded its treatment centre's counselling facilities to offer clients greater privacy and support.<sup>41</sup>

<sup>36</sup> AIPA, 2019.

<sup>37</sup> Government of Lao PDR, 2016.

<sup>38</sup> Burns and Tanguay, 2018.

<sup>39</sup> UNODC, 2016c.

<sup>40</sup> Souliyaseng and others, 2017.

<sup>41</sup> UNODC, 2019.

## Challenges

In 2016, the Lao Government amended its Law on Narcotics and Penal Code to impose stricter punishments against drug offences, including lowering thresholds for methamphetamines for personal consumption (currently set at 300 mg, amounting to approximately three pills).<sup>42</sup> The country's continued reliance on custodial measures as the principal approach to drug use and dependence makes people who use drugs reluctant to come forward due to fear of arrest. The lack of updated and reliable data collection on drug use and dependence in the Lao PDR complicates intervention planning. Limited resources, capacity and competency of local health care professionals outside of Vientiane for evidence-based treatment and care further deter scaling up the programme. In the Lao PDR, community-based treatment over-relies on external donors; adequate government support and investment are needed to ensure long-term sustainability.

## Results and accomplishments

### Expansion of voluntary services in the community

In the first five years after its inception, 382 individuals accessed treatment services at Sisattanak Community Hospital.<sup>43</sup> The success of the Sisattanak model informed the establishment of an additional 28 outpatient community-based treatment programmes at district hospitals in six provinces, enrolling a cumulative total of 2,737 individuals between 2015 and 2018.

### Reduced frequency and severity of drug use

According to a 2017 cross-sectional study, six months after completing treatment at Sisattanak, all clients showed reductions in the frequency and severity of drug use, based on improved ASSIST scores, and 47 per cent of clients had stopped using drugs altogether.<sup>44</sup> Following treatment, several individuals were able to take up employment or study.

### Client satisfaction

In evaluation findings, 54 per cent of clients reported that they were very satisfied with the care services from doctors and nurses, while 73 per cent were satisfied with the counselling services.<sup>45</sup>

## Increased awareness and willingness to access voluntary community-based treatment

The village awareness-raising initiative resulted in an increased number of individuals voluntarily seeking community-based treatment. Attractive features include the ability to access drug treatment services as part of the primary health care services, including using the same registration system and waiting room as other hospital patients. Most individuals at Sisattanak access the programme voluntarily, but the facility also accepts family admissions and referrals from public security, health and social welfare officers.

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**Focusing on individual treatment needs through comprehensive case management and on restoring relationships with family and other social networks allows people to prioritize elements important to their personal recovery.**

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## Lessons learned

The Sisattanak Community Hospital's community-based treatment model shows that it is not only possible but also desirable to integrate evidence-based drug dependence treatment into primary health care. The ability to access treatment as part of primary health care contributes to the normalization of drug dependence as a health issue and reduces

<sup>42</sup>AIPA, 2019.

<sup>43</sup>Personal communication with Dr Noy Souliyaseng, 12 February 2021.

<sup>44</sup>Souliyaseng and others, 2017.

<sup>45</sup>ibid.



societal stigma associated with drug use and dependence. Focusing on individual treatment needs through comprehensive case management and on restoring relationships with family and other social networks allows people to prioritize elements important to their personal recovery, thus creating a supportive environment and mitigating social factors that may put them at risk of developing problematic drug use.<sup>46</sup> Community outreach to surrounding villages to raise awareness about community-based treatment should be more widely implemented in remote areas outside of Vientiane.

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<sup>46</sup> UNODC, 2019.

## MALAYSIA

### Low-threshold methadone treatment at Harapan Community Health Clinic

The Harapan Community Health Clinic in Kuala Lumpur is an example of low-threshold, flexible-dose methadone provision for people who use opioids in a supportive community setting.

#### Background

Between 2010 and 2015, Malaysia's endorsement of evidence-based, voluntary responses to drug use and dependence was accompanied by consistent political and financial commitment.<sup>47</sup> During this period, Malaysia spearheaded a shift towards a more balanced response to drug use and dependence in Southeast Asia by promoting such harm reduction interventions as opioid agonist treatment and needle and syringe programmes (since 2005)<sup>48</sup> and by transforming several compulsory treatment centres into voluntary facilities.<sup>49</sup> However, since 2015, the number of compulsory facilities for people who use drugs has remained unchanged, at 21, while the number of voluntary centres decreased.

The Harapan Community Health Clinic was established in 2011 as part of the voluntary Kerinchi Cure and Care Service Centre in Kuala Lumpur, through collaboration between the University of Malaya's Centre of Excellence for Research in AIDS (CERiA), the National Anti-Drugs Agency (NADA) and the Ministry of Health. In December 2020, the Kerinchi facility was shut down as part of broader anti-drug measures targeting voluntary treatment facilities. To ensure the continuity of its operations, the Harapan Clinic shifted its operations to a new site in the Kampung Baru District of Kuala Lumpur, in partnership with the private non-profit clinic Polyklinik Insaf Murni and the Ministry of Health.

#### Activities and approach

The Harapan Community Health Clinic provides voluntary, low-threshold access to opioid agonist treatment using methadone alongside a range of pharmacological and psychosocial interventions. As of 2021 the clinic offers the following services.

- To mitigate the impact of COVID-19 mobility restrictions, Harapan provides larger takeaway doses of methadone for up to two weeks to eligible clients with stable health status and employment.
- A digitized slot-scheduling system for methadone dispensing to enable individuals to select suitable time visits, thus reducing waiting times and overcrowding at the clinic.
- Monitoring for ART adherence for clients living with HIV.
- HIV, hepatitis C virus and tuberculosis screening and testing and onward referral to public hospitals for treatment and adherence support.
- Biannual liver function monitoring for clients with hepatitis C virus.
- On-call telemedicine services.
- Psychosocial support, including brief interventions provided in person and via mobile device applications and relapse prevention workshops.
- Home visits to check on clients and deliver methadone to persons who cannot come to the clinic due to the COVID-19 travel restrictions.
- Educational talks on drugs and health and recreational activities (sports, hiking).

The clinic is operated by five full-time staff members, including a doctor, pharmacist and psychiatrist. The three research assistants affiliated with CERiA support the clinic operations and data management systems, compile monitoring reports and provide referrals to medical and social services. The research assistants are additionally trained to provide counselling and brief interventions. The clinic is funded by CERiA, while procurement of methadone

<sup>47</sup> Tanguay and others, 2015, p. 31.

<sup>48</sup> Kamarulzaman, 2009.

<sup>49</sup> UNAIDS and UNODC, 2019.

is financially supported by the Ministry of Health. Staff strive to provide non-judgmental care informed by a harm reduction approach. The project is regularly evaluated. Clients are approached for feedback on the accessibility and quality of services, which is taken into consideration when designing programming.

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**The use of a harm reduction approach that does not punish people for relapsing enables them to develop trusting therapeutic relationships with staff and be supported to remain in the programme and achieve their treatment goals.**

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### **Challenges**

Structurally, the greatest barrier to programme scalability is Malaysia's recent political regression towards punitive and penal approaches to drug use. Since 2015, the Government has downsized voluntary community-based responses, despite overwhelming evidence of effectiveness of such approaches in decreasing risk of relapse<sup>50</sup> and drug use frequency and severity<sup>51</sup> and of cost-effectiveness as compared to incarceration or detention.<sup>52</sup> Another challenge relates to funding sustainability, with current funding support for Harapan largely provided by United States government research

grants via CERiA. Enduring perceptions around the superiority of a zero-tolerance approach to drugs<sup>53</sup> and continued use of law enforcement performance metrics linked to arrest and detention<sup>54</sup> contribute to societal stigma and discrimination against people who use drugs and place Harapan clients at ongoing risk of arrest.

### **Results and accomplishments**

#### **High retention in MMT**

Since the clinic's inception, more than 1,000 people who use opioids have registered for MMT. As of 2019, 96 individuals were actively enrolled on MMT. Despite moving locations from Kerinchi to Kampung Baru, retention was 96 per cent, with 92 of the 96 active individuals on treatment remaining in the programme.

#### **Flexible-dose strategies**

Clients have access to flexible methadone dosing, including takeaway doses for up to two weeks. Methadone dosage ranges from 20 mg to 250 mg daily, based on individual need and ongoing monitoring, in line with evidence showing that flexible doses and dosing strategies are associated with greater retention than the fixed-dose approach.<sup>55</sup> Based on client feedback, the clinic created a joint WhatsApp group for clients and staff to share updated information regarding clinic operations, which has provided individuals with additional flexibility in relation to dispensing schedules and appointments.

#### **Improved health, quality of life and social functioning outcomes**

A main goal of the MMT programme at the Harapan Community Clinic is to improve individuals' quality of life and social functioning. The clients reported that MMT had helped them discontinue or reduce their drug use by decreasing their cravings and symptoms of withdrawal. While on MMT, approximately 89 per cent of clients at Harapan had stable employment over the previous six months. Among those living with HIV, ART adherence was 100 per cent.

<sup>50</sup> Wegman and others, 2017.

<sup>51</sup> Khan and others, 2018.

<sup>52</sup> Osornprasop, Dahlui and Kamarulzaman, 2014.

<sup>53</sup> Wegman and others, 2017.

<sup>54</sup> Wegman and others, 2016.

<sup>55</sup> Bao and others, 2009.



### *Lessons learned*

A key contributing factor to high client retention and satisfaction is the non-judgmental environment at Harapan Community Health Clinic. The use of a harm reduction approach that does not punish people for relapsing enables them to develop trusting therapeutic relationships with staff and be supported to remain in the programme and achieve their treatment goals. In line with existing international guidance,<sup>56</sup> this example confirms that MMT provision is most effective when complemented by other services that address clients' holistic needs as part of a one-stop shop approach to health care. The early multisector partnership between academics at CERiA and government agencies focused on drug control and public health ensured that each agency's strengths were optimized in relation to programme design, management, financing and operations.

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<sup>56</sup> UNODC, 2014.

## MYANMAR

### Developing a health-focused drug policy through participatory consultation and multisector cooperation

#### Background

Myanmar is a major source of illicit drug production trafficking in Southeast Asia and the world's second-largest producer of opium, after Afghanistan.<sup>57</sup> Rates of methamphetamine and heroin use are high, with people who inject drugs facing the greatest burden of HIV among key populations, at 35 per cent.<sup>58</sup> As in other countries in the region, drug use was conventionally regarded as a public security issue, with compulsory registration, incarceration and detention as hallmarks of the response. A shift towards a health-focused strategy for drug control was signalled in 2018 with the introduction of significant reforms to Myanmar's legal and policy framework on drugs. Heralding this shift was Myanmar's first National Drug Control Policy, launched in February 2018.<sup>59</sup>

However, post-2018 the implementation of Myanmar's National Drug Control Policy faced mounting challenges. Following the February 2021 military coup, there is no evidence to suggest that it will be realized. This case study focuses on the process leading up to launch of the new drug policy. It highlights what can be achieved when participatory consultation and multisector cooperation are prioritized.

#### Activities and approach

Civil society organizations, community networks and United Nations agencies have long advocated for evidence-based policies that prioritize health and human rights in Myanmar.<sup>60</sup> During the democratic transition between 2011 and 2015 different stakeholders, including civil society, communities of

people who use drugs and subsistence opium poppy producers, initiated advocacy efforts to redirect drug policies and laws in an evidence-based, humane direction. These efforts contributed substantially to drug law and policy reform discussions in 2015 and 2016.

The 2016 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem and outcome document were key enabling factors supporting drug policy reform in Myanmar. A rebalancing of the country's approach to drugs began after the 2016 UNGASS, with the Government formally requesting financial and technical support from UNODC to design a new drug policy.<sup>61</sup>

The development of the new drug policy was underpinned by an extensive two-year consultation process.<sup>62</sup> The consultation process, led by the Central Committee for Drug Abuse Control, included meetings and workshops with government ministries and departments (law enforcement, health, social welfare, education and others), United Nations agencies, NGOs providing health and harm reduction services, civil society and affected community networks. Later stages of the consultation also involved a national expert advisory group working to further develop the five priority areas outlined by the new drug policy. The consultation was complemented by a comprehensive review of existing drug laws.

The resulting policy "aims to build safe and healthy communities by minimizing health, social and economic harm"<sup>63</sup> Demand and harm reduction, including adequate drug dependence treatment, are among its five priority areas, while human rights is a cross-cutting issue. Crucially, the document makes explicit recommendations to decriminalize drug use and phase out compulsory treatment in favour of voluntary health and support services. A five-year national Strategic Plan (2020–2024) was developed to guide the implementation of the new policy and was due to be released in March 2020, but its launch was delayed by COVID-19.

<sup>57</sup> UNODC, 2020.

<sup>58</sup> Ministry of Health and Sports, Myanmar, 2019.

<sup>59</sup> Central Committee for Drug Abuse Control, 2018.

<sup>60</sup> Drug Policy Advocacy Group Myanmar, 2017; Transnational Institute, 2017; UNODC 2015.

<sup>61</sup> UNODC, 2018.

<sup>62</sup> UNODC. Myanmar drug policy c 2016.

<sup>63</sup> Central Committee for Drug Abuse Control, 2018.



## Challenges

Three main challenges to reshaping Myanmar's drug control system persist. The first was a parallel amendment of the country's 1993 Narcotic Drugs and Psychotropic Substances Law, which retained harsh punishments for drug use. While the Drug Control Policy embraces a public health and sustainable development approach to drugs, the amended drug law, enacted by parliament in February 2018, continues to favour the use of repression, compulsory treatment and incarceration.<sup>64</sup> For instance, although the law eliminates penalties associated with mandatory registration requirements for people who use drugs, it retains court-ordered involuntary detention in the name of drug treatment and imposes imprisonment for individuals who are caught with small quantities of drugs for their personal use.

The second challenge was the tepid political commitment to implement the drug policy from the start. This was rooted in a misunderstanding of what decriminalization of drug use comprises and evidenced by continued crackdowns on people who use drugs. There is no indication, following the military coup of February 2021, that this will change for the better.

The third obstacle was a lack of human and financial resources to operationalize the new drug policy, especially in relation to expanding voluntary alternatives to compulsory detention and incarceration.<sup>65</sup> The services promoted by the policy have not yet materialized in practice, and in the current political context it is unlikely that they will. Despite the shift in national discourse and a national policy that was supportive of voluntary treatment and harm reduction, facilities offering evidence-based drug dependence treatment in Myanmar remained vastly under resourced, especially outside Yangon.<sup>66</sup>

## Results and accomplishments

### **Balanced, evidence-based drug policy that prioritizes health**

The new Drug Control Policy focuses on public health and development, indicating a decisive shift away from the country's official stance on

drug control, which is characterized by repressive approaches. With the introduction of the amended drug policy, Myanmar is the first country to adopt the UNGASS 2016 framework<sup>67</sup> at a national level. Notable features of the policy include:

- Inclusion of harm reduction for the first time in a strategic policy document by the Central Committee for Drug Abuse Control.
- Explicit recommendations to decriminalize drug use and eradicate the compulsory treatment system in favour of voluntary community-based alternatives for people with drug dependence.
- Promotion of alternative development programmes in opium-growing areas.
- Reaffirmation that people who use drugs shall not be treated as criminals, and endorsement of sentencing proportionality, including the suggestion to "repeal the death sentence for drug-related offences".

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**The transition towards voluntary, community-based approaches would be better supported by greater policy and legal coherence.**

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### **Participatory consultative process**

The policy was guided by an inclusive and transparent consultative process involving diverse stakeholders. The participatory dimension of the consultation involved candid discussions that challenged dominant beliefs on drug control. Participatory multisector engagement is in itself an achievement and is consistent with the 2016 UNGASS outcome document, which asserts that "affected populations and representatives of civil society entities ... should be enabled to play a participatory role in the formulation, implementation and ... evaluation of drug control policies and programmes".<sup>68</sup>

<sup>64</sup> AIPA, 2019.

<sup>65</sup> Sao Mon, 2019.

<sup>66</sup> Drug Policy Advocacy Group Myanmar, 2017.

<sup>67</sup> UNODC, 2016a.

<sup>68</sup> *ibid.*



### ***Multisector cooperation***

In 2017, the consultative process was facilitated by the Central Committee for Drug Abuse Control, the Myanmar Police Force and the Ministry of Home Affairs, with support from UNODC and UNAIDS and with the involvement of civil society.<sup>69</sup> Years of prior cooperation between the partners and across sectors contributed to the success of the consultation.

### ***Lessons learned***

A comprehensive consultation process, enabled by multisector cooperation across the health, criminal justice and law enforcement sectors, was essential to the enactment of the National Drug Control Policy. The consultative process brought about an explicit acknowledgement by government authorities of the shortcomings of zero-tolerance approaches to drug control.<sup>70</sup> In promoting evidence-based approaches to mitigate the harmful effects of drug production, trafficking and dependence, the policy provides a strong basis to advocate for voluntary, community-based models of drug treatment and advance the national discourse on decriminalization. The leadership of Myanmar's Central Committee for Drug Abuse Control in the consultation process, with support from UNODC, UNAIDS and the WHO, was crucial. The contributions of harm reduction organizations and community networks in the consultation process were essential to the development of a drug policy reflective of international standards and local community needs. However, Myanmar's parallel drug law reform favours a punishing approach to drug control. The transition towards voluntary, community-based approaches would be better supported by greater policy and legal coherence. This implies political, economic and social stability.

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<sup>69</sup> UNODC, 2016b.

<sup>70</sup> UNODC, 2018.

## PHILIPPINES

### Reorienting the response to drug dependence treatment through the development of evidence-based treatment practices, guidance and standards

#### Background

Following the presidential election in June 2016, the Philippines launched an unprecedented anti-drug campaign that involved street-level sweeps, placing persons suspected of engaging in drug-related activities on police watch lists and household visits to urge suspects to “voluntarily surrender and receive treatment.”<sup>71</sup> In the first six months of the campaign, more than 1.18 million persons were forced to “surrender” to authorities out of fear for their safety,<sup>72</sup> 53,025 were arrested and 5,601 perished in extrajudicial killings by the police.<sup>73</sup>

The record numbers of persons coerced to report to authorities overwhelmed the detention centres and prisons which were already operating above capacity.<sup>74</sup> This precipitous demand led to a rapid expansion of both compulsory rehabilitation centres and community-based treatment centres managed by local government units.<sup>75</sup> Treatment options in these facilities varied, with most relying on abstinence-based 12-step and therapeutic community approaches, alongside religious instruction and aerobics.<sup>76</sup>

#### Activities

Efforts to recalibrate the Philippines’ response to drug use away from punitive measures and towards voluntary, health-based services started prior to the 2016 election. In 2015, a localized version of regional guidance, the *Guidance Document for*

*Community-based Treatment and Care Services for People Affected by Drug Use and Dependence in the Philippines*, was adopted by the Department of Health and Dangerous Drugs Board, with plans to pilot test it at multiple sites.<sup>77</sup>

In response to the heightened demand for alternatives to criminal sanctions in the wake of the Government’s anti-drug campaign, the Dangerous Drugs Board issued Board Regulation No. 4 in September 2016, following a consultation with the Department of Health, medical associations, WHO Philippines and treatment practitioners from residential, private and faith-based facilities.<sup>78</sup> The regulation introduced the “client flow”, a set of guidelines on conducting drug dependence screening, risk identification and assessment and referral pathways to drug treatment and rehabilitation for persons targeted by law enforcement authorities. Despite its recognition of drug dependence as a health issue and its inclusion of options for undergoing treatment in community-based programmes, the client flow had significant shortcomings. These include limited referral options (no referral to specialized services, such as mental health care), requirement to undergo treatment for pre-set periods and inadequate differentiation between levels of drug dependence severity, which resulted in persons who were deemed to be “low” and “moderate” risk mandated to undergo lengthy periods of rehabilitation and aftercare.

In 2019, a technical working group composed of a broader range of government agencies (the Department of the Interior and Local Government, the Department of Social Welfare and Development, the Department of Education), academic institutions, professional associations, development partners such as the United States Agency for International Development, practitioners and civil society organizations was convened by the Dangerous Drugs Board, the Department of Health, UNODC and the WHO. The working group’s responsibility was to revise, consolidate and update policies on the client flow and related interventions. For the first time, deliberations also engaged a harm reduction advocacy organization, NoBox Philippines. The resulting guidance, the *New Client Flow for Wellness and Recovery from Substance-Related Issues* (detailed in the Dangerous Drugs Board Regulation No. 7, 2019), addresses several of its predecessor’s shortcomings:

<sup>71</sup> Simbulan and others, 2019.

<sup>72</sup> Raymundo, 2017.

<sup>73</sup> Bueza, 2017.

<sup>74</sup> Simbulan and others, 2019.

<sup>75</sup> Dangerous Drugs Board, 2016b.

<sup>76</sup> Health Facilities and Services Regulatory Bureau, 2018.

<sup>77</sup> UNODC, Department of Health and Dangerous Drugs Board, 2016.

<sup>78</sup> Dangerous Drugs Board, 2016a.



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**Efforts to develop a continuum of services aligned with community-based treatment guidance and with international human rights standards requires, in the first instance, greater meaningful participation of civil society and persons with lived experience of drug use in policy-making processes and service design.**

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- recognizes the 12 principles of community-based treatment;
- provides clearer guidance around risk assessment and drug dependence severity screening; the former may be conducted by any health workers, while the latter may only be undertaken by Department of Health-accredited physicians using standardized screening tools (ASSIST, WHO Self Reporting Questionnaire)
- acknowledges that people require individualized treatment plans;
- provides distinct intervention referral pathways based on level of risk and drug dependence severity, including referral to outpatient and community-based programmes for people who use drugs assessed to have low to moderate risk of drug dependence and related health risks, and removal of mandated aftercare for persons deemed low risk;

- emphasizes the maintenance of confidential medical records and observation of patients' rights, privacy and confidentiality; and
- recognizes an array of social support services beyond education and employment, such as legal, financial and health support.

### **Challenges**

Most community-based programmes in the Philippines are mandatory in practice, and none have been independently evaluated. Gaps remain in relation to policy coherence around the definition of voluntary services for people who use drugs and implementation of existing guidance.<sup>79</sup> Barriers include limited local budgets for community-based treatment; shortage of trained practitioners to staff these facilities; concerns around confidentiality and access to client data by authorities; dominance of zero-tolerance approaches that fail to recognize relapse as a common part of the recovery process; and the absence of harm reduction interventions as alternatives for referral within the new client flow guidance.<sup>80</sup> Two of the immediate challenges are overcoming the perception that successful treatment outcomes are related to abstinence and educating treatment providers and local governments on what voluntary, community-based approaches entail. Current moves to amend the drug law to increase sanctions related to drug offences threaten to undermine existing efforts to develop a health-centred response to drugs.

### **Results and accomplishments**

The recognition of health-focused alternatives via the new client flow is a noteworthy development, given that prior to 2016 the response relied exclusively on court-ordered compulsory detention or incarceration.<sup>81</sup> The new client flow minimizes challenges associated with an overburdened drug dependence treatment system by addressing the issue of treatment centre overflow due to large numbers of people being forced to report to authorities and standardizing non-custodial pathways to health and social services. The adoption of the new client flow benefited from civil society voices promoting more engaged consultation

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<sup>79</sup> NoBox Philippines, 2021.

<sup>80</sup> Antonio and others, 2018.

<sup>81</sup> NoBox Philippines, 2018.



on drug-related guidance, and the subsequent inclusion in the 2019 revision of the client flow of a wider range of experts.

### ***Lessons learned***

A cautious shift from punitive, custodial measures towards the acceptance of voluntary community-based treatment is transpiring in the Philippines, as evidenced by the promulgation of guidance on the assessment of and interventions for drug dependence. This incremental process has been facilitated by multisector collaboration and ongoing advocacy efforts by emerging civil society groups promoting evidence-based drug dependence treatment and harm reduction. Efforts to develop a continuum of services aligned with the new guidance and with international human rights standards requires, in the first instance, greater meaningful participation of civil society and persons with lived experience of drug use in policy-making processes and service design.

## THAILAND

### Court diversion integrating psychosocial counselling into the criminal justice system

#### Background

In 2002, Thailand's Narcotic Addict Rehabilitation Act reclassified people who use drugs as "patients" rather than "criminals"; but the consumption and possession of drugs remained illegal and punishable.<sup>82</sup> Since the Narcotic Act went into effect, the incidence of drug use, drug-related incarceration and detainment in compulsory treatment have continued to increase. Thailand has the sixth-largest prison population in the world, mostly related to drug offences related to personal use and possession.<sup>83</sup> With prison capacity at 330 per cent,<sup>84</sup> overcrowding is a grave concern, exacerbating vulnerability to HIV, viral hepatitis and communicable diseases such as COVID-19.

In 2009, in an attempt to address Thailand's severe prison overcrowding and the high costs associated with incarceration, the Thonburi Criminal Court in Bangkok initiated a programme to divert persons charged with drug use offences to outpatient psychosocial counselling instead of incarceration.<sup>85</sup> The programme has since expanded to 25 courts (two criminal, seven provincial, one municipal and 15 juvenile or family courts) in 17 provinces (four in Bangkok and 18 in other provinces), supported by a partnership among the justice, judicial and health sectors and the Thai Health Promotion Foundation.

#### Activities and approach

Psychosocial counselling clinics are located on the premises of the court and staffed by psychologists, social workers and volunteers trained to assess substance use severity and provide counselling, psychosocial support services and onward health care referrals. In addition, training for judges is

conducted to raise awareness about and expand the use of the diversion scheme. The diversion process works as follows:<sup>86</sup>

1. Individuals with use, possession for personal use and other related drug offences may be diverted as part of temporary release during the pre-sentence trial period or during the post-trial period. Post-trial a judge may suspend a sentence and refer the person to undertake supervised outpatient counselling as an alternative to probation or other custodial punishment.
2. During the initial session, counsellors assess substance dependence severity using the ASSIST tool.<sup>87</sup> Individuals with medium to high severity scores are referred to drug dependence treatment in a hospital setting, while persons with low drug dependence risk undergo counselling.
3. Counselling services involve brief interventions, such as motivational interviewing and cognitive behavioural therapy. The focus is on enhancing a client's life skills, supporting personal development and promoting social support, with family members often involved in the counselling process. During pre-sentencing or pretrial detention, an individual may receive three to four counselling sessions of 45–60 minutes each and 12 days apart. Post-sentencing, a person receives four counselling sessions of 45–60 minutes each, one to three months apart throughout their probation period.
4. Counsellors may refer persons to health services in the public health system based on their needs.
5. Throughout the programme, the counsellor provides periodical progress reports to the judge. Successful completion of the counselling programme is measured through non-recidivism and self-reported abstinence from drug use. Programme interruption or failure to comply

<sup>82</sup> ONCB, 2011.

<sup>83</sup> Thailand Institute of Justice and UNODC, 2021.

<sup>84</sup> Thailand Institute of Justice and UNODC, 2021.

<sup>85</sup> Northern Substance Abuse Center, 2021.

<sup>86</sup> Southeast Asia HIV Addiction Technology Transfer Center, 2019.

<sup>87</sup> Ali and others, 2013.

with court conditions may lead to such sanctions as termination from the counselling programme or cancellation of non-monetary pre-trial release or bail.

Following the Thonburi Court's success in diverting approximately 20 per cent of defendants away from prison and into counselling between 2012 and 2015, the Office of the Narcotics Control Board established MOUs with several agencies across the judiciary and the Ministry of Health to facilitate interagency collaboration and conduct further pilot studies. The Thai Health Promotion Foundation funded research and development in cooperation with the Mental Health Promotion Program under the Department of Mental Health. As a result of the MOUs, psychosocial clinic services were piloted in five additional courts, while an additional six courts initiated psychosocial clinics using their own funds. Hundreds of volunteers were trained and certified as counsellors as part of the initiative.<sup>88</sup>

Between 2016 and 2019, additional partnerships were established with the aim of scaling up the court diversion programme. Chiang Mai University's Southeast Asia HIV-Addiction Technology Transfer Center and the Galya Rajanagarindra Institute, a forensic psychiatric facility, were funded by the United States' Substance Abuse and Mental Health Services Administration to support the expansion of the programme through academic research, development and evaluation.<sup>89</sup>

### Challenges

A key weakness of the initiative is that diversion and sentencing depend on a judge's prerogative. Because not all judges are supportive of the counselling programme, ongoing training and advocacy targeting judges are needed to ensure programme longevity and expansion. An additional challenge is the need to identify sustainable funding. There continues to be pushback from the judiciary

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**A range of agencies spanning the behavioural health field, the judicial arena and academia have been involved in a partnership to implement a court diversion programme in Thailand. In the courts where it operates, the outpatient psychosocial counselling model has helped promote a public health approach to drug use and dependence among judges and other legal counsel.**

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around funding the national scaling up of the court counselling model because it is not viewed as a primary objective of the court system.<sup>90</sup> Additionally, the court diversion programme faces deficiencies in relation to monitoring and evaluation, which do not clearly assess improvements to individuals' quality of life.<sup>91</sup>

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<sup>88</sup> Northern Substance Abuse Center, 2021.

<sup>89</sup> Robertson, 2019.

<sup>90</sup> *ibid.*

<sup>91</sup> *ibid.*

## Results and accomplishments

### *Health-based alternative to incarceration and detention*

Between 2016 and 2019, approximately 9,650 persons were diverted into the counselling programme instead of given a prison sentence.<sup>92</sup> Referral to specialized drug use and mental health counselling forms an integral part of the programme beyond the initial psychosocial counselling service. For instance, clients are provided cognitive and behavioural health interventions and motivational interviewing as well as access to a nurse, social worker and legal assistance as part of the counselling process.<sup>93</sup>

### *Reductions in drug use and recidivism*

After more than a decade of operation, more than 90 per cent of defendants completed the programme.<sup>94</sup> Among persons assisted by the diversion initiative, the recidivism rate was nearly 1.4 per cent,<sup>95</sup> a relatively low figure when compared with national trends showing that around one third of prisoners released from Thai prisons are reincarcerated within three years.<sup>96</sup>

### *Cooperation between the criminal justice and health care sectors*

Over the past decade, a range of agencies spanning the behavioural health field, the judicial arena and academia have been involved in a partnership to implement and scale up the court diversion programme. In the courts where it operates, the psychosocial counselling model has helped promote a public health approach to drug use and dependence among judges and other legal counsel.<sup>97</sup>

### *Staff training and capacity building*

There is a strong focus on case management and counselling skills-building for programme volunteers. For instance, the 28 counsellors at the

Thonburi Criminal Court psychosocial clinic must pass a certification exam. Training consists of four training modules (on basic psychosocial counselling, management of substance use, family counselling and group counselling) as well as advanced courses on behavioural therapies, totalling 48 hours of training over eight days.<sup>98</sup> Case supervision training is provided to support counsellors to provide effective case management. To assist the national expansion of the model in criminal courts, a training of trainers was conducted in 2020 for 62 mental health nurses and psychologists to be qualified trainers under the Department of Mental Health.

### *Lessons learned*

The counselling diversion programme within the Thai criminal court system is an innovative example of multiagency cooperation that prioritizes health-focused outpatient interventions for drug use and dependence. The involvement of both the judiciary and the Department of Mental Health has been critical to achieving a high programme completion rate and to promoting non-custodial approaches in the judicial arena. Resistance from some courts and judges may be tempered by a clearer demonstration of cost savings to the State due to diverting individuals away from prison and detention and towards community-based health care services.<sup>99</sup> Thailand's new Narcotics Code, which went into effect on 9 December 2021, allows *inter alia* for discretion to be applied by the judiciary in relation to sentencing and diversion. Independent evaluations that involve broader outcomes than abstinence and recidivism and measure improvements in quality of life and health status are needed to accurately measure programme performance and support the national expansion of the model.

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<sup>92</sup> Kanato and others, 2020.

<sup>93</sup> Robertson, 2019.

<sup>94</sup> Northern Substance Abuse Center, 2021. Although abstinence is encouraged, the programme does not utilize urine drug testing. This choice is intentional so as to avoid conflicting with existing drug laws that require persons who test positive for illicit drugs to be incarcerated or ordered to compulsory treatment.

<sup>95</sup> Kanato and others, 2020.

<sup>96</sup> Thailand Institute of Justice and UNODC, 2021.

<sup>97</sup> Robertson, 2019.

<sup>98</sup> *ibid.*

<sup>99</sup> Robertson, 2019.



## VIET NAM

### National scale-up of methadone treatment

#### Background

In 2008, an estimated 206,000 people in Viet Nam injected drugs, 80 per cent of whom used opiates.<sup>100</sup> Injecting drug use accounted for the majority of all HIV diagnoses in the country. In response to interrelated HIV and heroin epidemics, Viet Nam gradually adopted harm reduction interventions, including needle and syringe programmes and opioid agonist treatment with methadone.

#### Activities and approach

After a successful pilot initiated by the Ministry of Health at six clinics in Hai Phong and Ho Chi Minh cities in 2008,<sup>101</sup> MMT was expanded nationwide in 2010. Decree 96/2012<sup>102</sup> on MMT appointed the Viet Nam Administration of HIV/AIDS Control, under the Ministry of Health, as the central agency responsible for MMT programming. At the provincial level, the People's Council and People's Committee oversee MMT delivery, which the provincial departments of health directly manage.<sup>103</sup> Methadone management is regulated by national technical and clinical guidelines, a training curriculum for service providers and regular monitoring and evaluation to assess compliance with national guidelines.<sup>104</sup>

Prior to 2015, MMT services were delivered via district hospitals and provincial AIDS Centres that streamlined methadone with HIV counselling, testing and treatment services and required co-payment by the user.<sup>105</sup> Since 2016, MMT has been free of charge, with 63.8 per cent of costs sourced from international donors, primarily the United

States President's Emergency Plan For AIDS Relief and The Global Fund to Fight HIV, Tuberculosis and Malaria, and 36.2 per cent from domestic budgets, including 21.9 per cent from the central Government and 14.3 per cent from provincial budgets.<sup>106</sup>

Since 2015, Viet Nam has decentralized MMT implementation to community-based health care settings (at commune health centres).<sup>107</sup> As of 2018, the majority of clients (93.4 per cent) accessed methadone via the health sector. To receive MMT, individuals must visit the clinic daily. Distance poses a challenge for those who live far away from dispensing points and has been associated with low adherence and high drop-out rates, especially in remote and mountainous areas.<sup>108</sup>

In May 2020, Viet Nam announced a pilot programme in three provinces to allow for take-home methadone.<sup>109</sup> Take-home doses are expected to greatly improve the reach and efficacy of the programme.<sup>110</sup> Eliminating transportation costs and commute time associated with in-person visits to clinics, especially in the context of the COVID-19 pandemic, is expected to enhance many individuals' quality of life and social functioning and retain more people in treatment.

#### Challenges

Despite embracing harm reduction, Viet Nam's legal framework simultaneously sustains punitive responses to drug use, which risks undermining existing gains. For example, Decree 90/2016 requires MMT clients with two positive urine tests for heroin or one positive test for another illicit drug to be dropped from the programme and committed to a compulsory facility known as an "06 centre".<sup>111</sup> The primary barrier to MMT access and retention is ongoing tension with law enforcement.<sup>112</sup> Police

<sup>100</sup> Ministry of Health, 2018.

<sup>101</sup> Hoang and others, 2015.

<sup>102</sup> Nguyen and others, 2012.

<sup>103</sup> *ibid.*

<sup>104</sup> Ministry of Health, 2018.

<sup>105</sup> Duong, 2017.

<sup>106</sup> Ministry of Health, 2018.

<sup>107</sup> Nguyen, 2020.

<sup>108</sup> Dao and others, 2018; Nguyen and others, 2017.

<sup>109</sup> Ministry of Health (Viet Nam), 2020.

<sup>110</sup> UNODC, 2021

<sup>111</sup> Government of Viet Nam, 2016.

<sup>112</sup> Luong and others, 2019.

interactions with people who use drugs tend to focus on arrest rather than facilitating access to health interventions. This approach is perpetuated by the lack of inclusion of harm reduction models in police training curricula, absence of police guidelines or protocols on harm reduction implementation,<sup>113</sup> pervasive stigmatization of people who use drugs and enduring perceptions of drug<sup>114</sup> use as a “social evil” deserving punishment.<sup>115</sup>

## Results and accomplishments

### Nationwide expansion

Since the introduction of the first pilot clinics in April 2008 that provided MMT to 946 individuals, the Vietnamese Government has scaled up the delivery of these programmes nationwide as a core component of its HIV prevention strategy.<sup>116</sup> In September 2019, 52,200 individuals accessed methadone at 335 sites in all of the nation’s 63 provinces and cities.<sup>117</sup> Viet Nam is only one of three countries in East and Southeast Asia to implement MMT in prisons and closed settings (the others are Indonesia and Malaysia), but the provision in such settings is limited.<sup>118</sup>

### Effective in reducing crime and improving health outcomes

Research points to numerous benefits derived from MMT, including reductions in crime, family violence, safety and security, economic vulnerability and unemployment.<sup>119</sup> In relation to health outcomes, studies in Viet Nam indicate that MMT clients’ health outcomes and quality of life is comparable to those of the general population.<sup>120</sup> MMT was found to be effective across delivery settings, including in mountainous regions, with the concurrent provision of mental health services reported as key to the programme’s success.<sup>121</sup> Compared with compulsory drug treatment, MMT provision has

been associated with greater reductions in heroin use, HIV risk behaviours, drug-related crime and monthly drug spending.<sup>122</sup>

### Cost-effectiveness

The Ministry of Health estimates that, since its inception in 2008, the MMT programme has saved the Vietnamese Government approximately 22,870 billion dong, which is equivalent to more than \$1 billion.<sup>123</sup> A 2015 independent economic evaluation showed that MMT was less costly than centre-based compulsory treatment.<sup>124</sup> Providing treatment for one detainee in compulsory centres over one year costs the Government 19,670,000 dong (\$845)—2.5 times more than the 7,880,000 dong (\$339) associated with one person accessing MMT over the same period.

### Political endorsement of take-home methadone

The Government’s approval in late 2020 of a pilot programme offering take-home methadone came after more than one year of advocacy by a multistakeholder task force led by the Viet Nam Administration of HIV/AIDS Control and involving academics from Hanoi Medical and Ho Chi Min universities, the Center for Supporting Community Development Initiatives, SAMHSA Viet Nam, UNODC and UNAIDS. The first take-home methadone dose was dispensed on 5 April 2021, with more than 200 clients enrolled in the programme by the end of that month.<sup>125</sup>

### Lessons learned

Government backing and investment were essential to Viet Nam’s successful national scale-up of MMT.<sup>126</sup> The promulgation of national technical guidelines and enabling policies to guide methadone delivery have subsequently been crucial to programme

<sup>113</sup> Vuong and others, 2017.

<sup>114</sup> AFP, 2017.

<sup>115</sup> Luong and others, 2020.

<sup>116</sup> Nguyen and others, 2012.

<sup>117</sup> Department of HIV/AIDS Prevention and Control, 2020.

<sup>118</sup> Ministry of Health, 2018.

<sup>119</sup> *ibid.*

<sup>120</sup> Tran and others, 2021; Tran and others, 2016.

<sup>121</sup> Tran and others, 2018.

<sup>122</sup> Vuong and others, 2018.

<sup>123</sup> Ministry of Health, 2018.

<sup>124</sup> Vuong and others, 2016; Vuong and others, 2015.

<sup>125</sup> Personal communication with Nguyen Minh Trang, SCDI, 8 March 2021.

<sup>126</sup> UNODC, 2016e.



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**Government backing and investment were essential to Viet Nam’s successful national scale-up of methadone maintenance treatment.**

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effectiveness. Ongoing monitoring and evaluation of MMT services built into the programme design, including a recent comprehensive review that took stock of a decade of MMT implementation,<sup>127</sup> have been crucial for distilling best practices and identifying shortcomings in Viet Nam’s decentralized model. Integrating MMT provision into primary

health care and connecting provision with the HIV response has maximized the use of existing health system infrastructure and lowered costs.<sup>128</sup> Further investment in institutional and technical support, as well as greater harmonization of drug laws and policies, are necessary if MMT integration with primary health care is to be optimized, especially in remote regions and closed settings.

The recent government backing of take-home methadone was facilitated by effective long-term collaboration among diverse stakeholders, including government agencies, academic institutions, civil society organizations, people who use drugs and United Nations organizations. Facilitating continuing access to methadone despite pandemic-related restrictions was a catalyst for mobilizing political support for the approval of take-home services.<sup>129</sup> Continued multisector collaboration will be vital for ensuring the future success of this initiative.

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<sup>127</sup> Ministry of Health, 2018.

<sup>128</sup> *ibid.*

<sup>129</sup> UNODC, 2021.

# LESSONS FOR SUCCESSFUL APPROACHES

## Critical elements supporting a shift away from compulsory treatment

As illustrated by these case examples, there is no one-size-fits-all blueprint when it comes to shifting away from criminalization and punishment and towards voluntary community-based approaches to drug use and dependence. The examples described in this paper have been built on an understanding of the importance of addressing drug use from a public health and human rights lens. To achieve this, successful strategies for minimizing harms associated with drug dependence and improving public safety and health tend to prioritize:

1. **A supportive legal and policy environment** that acknowledges the vital influence of social determinants (criminalization, poverty, housing, unemployment, disempowerment) of health and drug use. Decriminalization, which refers to the removal of criminal penalties for drug law violations such as possession for personal use, provides the greatest benefits for public safety and health.<sup>130</sup> No country in the region has fully eliminated criminal provisions for drug use and personal possession. However, some jurisdictions that have removed legal and administrative barriers and manage drug dependence as a health rather than criminal issue have achieved positive impacts, such as reduced high-risk drug use, minimized negative health effects to individuals and limited secondary harms to society (crime, socioeconomic costs, community safety).<sup>131</sup>

2. **Putting the well-being of people at the centre** of drug policies, strategies and interventions by understanding the specific and unique needs of individuals and the challenges they face when seeking drug dependence treatment

services. Person-centred approaches work to overcome stigma and discrimination and emphasize individual agency and choice in relation to seeking treatment and determining treatment goals.

3. **Commitment to harm reduction principles** by meeting people “where they are at” in relation to their personal health and treatment goals while accepting that not all persons who use drugs may be willing or ready to stop using drugs. Harm reduction approaches can be applied anywhere along the continuum of evidence-based integrated services that is imperative to address the complex needs of people who use drugs.
4. **Commitment to evidence.** This is a common feature of the case examples and implies that promising interventions are informed by scientific evidence and aligned with international standards on drug dependence treatment and human rights; that practices involve the use of standardized instruments, such as ASSIST, to assess drug dependence; and that programme outcomes are regularly and independently monitored and evaluated.
5. **Community empowerment that emphasizes agency and community-building for people who use drugs.** The case example from Indonesia cites peer-driven mentoring, education, counselling and capacity-building as essential elements for success. Community empowerment also facilitates the meaningful participation of communities with lived experience in programme design, implementation and monitoring and in the policy decisions that pertain to them.
6. **Recognition of the value of rehabilitation and social reintegration (housing, employment, family and social relationships) for sustaining lasting change in the lives of people with drug dependence.** This recognition leads to programmes that provide assistance towards social reintegration, support improvements in personal health and social functioning and reduce the stigma associated with using drugs and having a criminal record limits people’s economic and social opportunities.

<sup>130</sup> United Nations System Coordination Task Team, 2019.

<sup>131</sup> See United Nations System Coordination Task Team, 2019; UNAIDS, 2019.

**7. Engaging with law enforcement** is essential for programme success, as indicated by several of the case examples, including in China and Thailand. Partnership between law enforcement and programmes serving the needs of people who use drugs strengthens the common understanding of the need to facilitate health-based approaches to drug use and dependence, increases accountability between the police and communities and decreases the potential for corruption and abuse.

**8. Multisector collaboration** was mentioned in all the case examples as a critical requisite to facilitating policy shifts away from punishment and towards a health-based approach to drugs and has been essential to scaling up voluntary community-based treatment. Successful initiatives have engaged with the health, social welfare, education and law enforcement sectors among a range of stakeholders, including civil society and people who use drugs.

These elements are aligned with the principles of evidence-based drug dependence treatment as outlined by the *UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia and the WHO and UNODC International Standards for the Treatment of Drug Use Disorders* and international human rights commitments. And they reflect the priorities of the 2030 Agenda for Sustainable Development around improving living conditions, addressing vulnerabilities and protecting the human rights of individuals and communities.

## Challenges to the transition

The case examples included in this booklet highlight common challenges encountered in the process of facilitating the transition to voluntary community-based treatment:

### *Challenges related to planning and management*

- **Fidelity in the practice of voluntary, community-based treatment programmes is inconsistent.** Fidelity is the degree to which a programme or intervention adheres to specific model standards.<sup>132</sup> So-called community-based treatment programmes operate in many countries, but their practical implementation often strays from international standards. Some programmes retain punitive elements (such as abstinence enforced through mandatory urine testing) and omit important principles of drug dependence treatment emphasized in the *UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia and the WHO and UNODC International Standards for the Treatment of Drug Use Disorders* (around non-coercive treatment access).
- **Accountability, transparency and independent monitoring and evaluation** related to the drug dependence treatment infrastructure remains substandard, posing barriers to assessing progress and identifying bottlenecks in the transition. In relation to drug dependence treatment services, there is an overreliance on monitoring process (enrolment, activities, outputs) rather than outcomes (whether a programme has achieved its goals). Appropriate, comprehensive outcome-based evaluation frameworks are a requisite to tailoring responses and monitoring service quality, effectiveness and implementation fidelity.
- **Resistance from law enforcement and judiciary counterparts in permanently closing compulsory facilities.** This was common across the case example contexts. Increased collaboration with and engagement of the judiciary and law enforcement authorities around service design and delivery,

<sup>132</sup> Bond and Drake, 2020.

accompanied by structural and legislative reforms, are required to ensure an enabling environment in which services can operate and people who use drugs can access them without fear of intimidation, arrest or reprisal.

- Inadequate involvement of people with lived experience of drug use and dependence. Several case examples mentioned the role of people with lived experience as active participants in the design, delivery and monitoring of services as a key factor in the success of the treatment approach. Yet, in most contexts across the region, the expertise and agency of people who use drugs remains largely unrecognized and undervalued in policy systems and processes, while spaces in the political sphere where individuals can openly discuss their drug use and share their experiences and needs without fear of legal or social consequences remain few and far between.

### **Challenges related to fostering enabling legal and policy environments**

- **National laws that criminalize use and possession of drugs for personal use** pose the greatest barrier to ending compulsory treatment and rehabilitation and scaling up voluntary alternatives. Despite their popular appeal, criminalizing policies and punishments do not enhance public safety and security. Criminalization of drug use and possession is associated with numerous harms, overcrowding in prison and places of detention, perpetuation of stigma and discrimination, criminal records that limit opportunities to access housing, education and employment, high-risk drug consumption patterns, overdosing and the transmission of blood-borne diseases.<sup>133</sup> Truly voluntary access can only be achieved if people who use drugs are free from the threat of arrest, detention and other forms of punishment.
- **Stigma and discrimination against people who use drugs** are linked with decreased health care access across a range of countries. Stigma relates to a lack of public understanding around the nature of drug use and dependence and is influenced by public security approaches to drug-related issues that promote coerced rehabilitation and punishment in many Asian countries. Women


in particular are disproportionately affected by this factor because they stand to lose not only access to health and social services but oftentimes access to their children if they are found to be using drugs.

- **Overreliance on abstinence-based indicators is commonly enforced through mandatory urine drug tests, and relapse to drug use is subjected to punishment or administrative sanctions.** The understanding of the differentiation between drug use and drug dependence remains limited even in community-based settings, as does formal acknowledgement in policies, guidelines and practices that relapse is common. Indicators of treatment success need to change. Improvements in the quality of life, health outcomes and social functioning and the reduction in high-risk drug use patterns and crime represent more meaningful and desirable outcomes for people who use drugs.
- **Laws and policies remain incoherent.** This is particularly evident in the drug policy and law reforms in Myanmar and promulgation of guidelines, standards and non-custodial pathways for drug dependence treatment in the Philippines. Across the region, tensions remain between public health and public security approaches to drug use and dependence, which block progress towards the expansion of voluntary, evidence-based practices.

### **Challenges related to health and community systems-strengthening and financing**

- **Inconsistent dissemination and practical application of existing policies, guidance and standards.** In countries that have taken concrete steps towards issuing policies, guidelines and standards to promote greater access to voluntary community-based treatment and support services, such as Myanmar and the Philippines, dissemination, capacity-building and independent oversight related to implementing these measures remains weak or non-existent. This then contributes to the delayed operationalization of the transition towards voluntary drug treatment options.

<sup>133</sup> See United Nations System Coordination Task Team, 2019; DeBeck and others, 2017.

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- **Inadequate resources for voluntary community-based approaches.** All of the case examples highlight human, technical and financial resource gaps that are hindering the scale up of promising interventions. Funding must be urgently reallocated away from compulsory facilities and towards expanding voluntary community-based treatment and complementary health, harm reduction and social support services.
  - **Insufficient attention to developing interventions for people who use stimulants.** Stimulants, particularly methamphetamine, account for a majority of all drug-related treatment admissions in the region. At this time, there are no evidence-based safe and effective medications or pharmacological substitutes available to clinically alleviate symptoms of stimulant withdrawal or to maintain abstinence following withdrawal. However, there are effective behavioural interventions for psychostimulant use disorders as well as psychosocial and medical support for stimulant-induced psychosis and other comorbidities that have not been culturally adapted and implemented across the region.<sup>134</sup> Community-led safer-use and mental health interventions in Indonesia and the outpatient hospital-based drug treatment in the Lao PDR show promising results. Because financial support for addressing stimulant use and dependence remains suboptimal, inclusion of people who use stimulants in national HIV strategies and major funding proposals would be an important first step in scaling up the response.

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<sup>134</sup> UNODC, 2017.



## CONCLUSION

Responses to drug use and dependence should, first and foremost, safeguard the health and well-being of all persons who use drugs while respecting their human rights and dignity. This aim is backed by a growing international consensus that drug policies and practices striving for a “drug-free” society have not only failed to deter drug use and related harms but have resulted in costly and disastrous consequences for individuals and communities.<sup>135</sup>

As shown in this report, few countries have lived up to previous political commitments to eliminate reliance on compulsory facilities and replace them with a continuum of voluntary community-based treatment and complementary health, harm reduction and social support measures that focus on achieving sustained positive health outcomes for people who use drugs. As countries in the region reflect on progress made towards the transition since 2015, the Asia-Pacific Expert Advisory Group on Compulsory Facilities for People Who Use Drugs calls for a reinvigorated public health- and human rights-based approach to drug use and dependence.

Past recommendations are being steadily implemented, but, as the case examples in this report illustrate, major challenges remain. Building on the past recommendations agreed at the Third Regional Consultation,<sup>136</sup> the Expert Advisory Group urges governments to adopt an updated Regional Framework for Action on Transition. As the examples presented here have shown, it is important to recognize that opportunities to fulfil different elements of the transitional framework may vary in different political, social and economic contexts. Although recommendations may be implemented simultaneously, the updates propose priority areas and actions for addressing shared barriers to the transition process (additions in italics in the following table).

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<sup>135</sup> UNAIDS, 2019; Global Commission on Drug Policy, 2016; UNHCHR, 2015.

<sup>136</sup> UNODC, ESCAP and UNAIDS, 2015.



## 1. PLANNING AND MANAGEMENT



**1.1** Establish and strengthen a multisector decision-making committee, with participation of civil society and communities of people who use drugs.

**1.2** Develop national transition plans with objectives, activities, outcomes, indicators, targets, budgets, timelines and responsibilities through consultation with relevant stakeholders, including government agencies from the public health, social affairs, drug control and public security sectors as well as people who use drugs.

**1.3** Develop costed implementation frameworks to allocate and mobilize adequate human, technical and financial resources for each phase and component of the transition.

**1.4** Annually update progress towards the transition, based on a unified monitoring tool that will be developed by the United Nations.

**1.5** *Strengthen multisector and interagency coordination and cooperation for implementing action plans and activities related to drug dependence treatment.*

## 2. FOSTERING ENABLING LEGAL AND POLICY ENVIRONMENTS



**2.1** *Decriminalize the use, possession for personal use and paraphernalia related to scheduled substances as the first step towards reducing stigma and discrimination that hampers access to health care, harm reduction and voluntary community-based drug dependence treatment services.*

**2.2** *Where drugs remain illegal, apply the principle of proportionality for drug-related crimes and implement non-coercive public health-based diversion initiatives.*

**2.3** Conduct a multisector and participatory review of existing legal and policy frameworks relating to drug use and dependence, with the aim of identifying the barriers that prevent people who use drugs from accessing voluntary community-based treatment and services.

**2.4** Develop, promote and implement an action plan based on that review to create enabling environments that facilitate the transition.

**2.5** Strengthen the capacity of the public health, social affairs, public security, justice, judiciary and civil society sectors along with communities of people who use drugs and other relevant sectors to better understand and facilitate the implementation of current and reformed or revised policies for the maximum protection of the human rights of people who use drugs.

## 3. HEALTH AND COMMUNITY SYSTEMS-STRENGTHENING AND FINANCING



**3.1** *Rebalance national budgets related to drug control to reallocate sufficient funding away from compulsory treatment modalities and towards voluntary, community-based treatment and support services, including harm reduction.*

**3.2** Conduct a capacity and systems assessment of sectors involved in the transition process (public health, social affairs, public security, justice and civil society groups and communities of people who use drugs).

**3.3** Develop or update community-based treatment and services strategies, including establishing a minimum standard of care and governance framework modelled on regional community-based treatment guidance and international standards, which encompass elements of capacity-building and systems-strengthening.

**3.4** Implement and scale up a *comprehensive menu of voluntary* community-based treatment and services for people who use drugs, including harm reduction and HIV services, such as needle and syringe programmes, opioid agonist therapy, safer-use kits for persons who use methamphetamines and peer distribution of naloxone, in partnership with communities and relevant service providers.

**3.5** Build up the capacity of public health, social affairs, public security and the justice sectors, civil society organizations and communities of people who use drugs to facilitate collaboration in delivering voluntary community-based treatment services.

**3.6** Engage and collaborate with civil society and community groups, including communities of people who use drugs, at the national and subnational levels, to reduce bottlenecks in the treatment pathway and to facilitate access to effective voluntary community-based treatment and services for people who use drugs.

**3.7** Implement evidence-based communication strategies to raise awareness about the need to reduce drug-related harms, including drug dependence, HIV and viral hepatitis infection and overdose. These service promotion activities must aim to increase the evidence-based understanding of drug use and to inform the public about the availability of drug dependence treatment and harm reduction services.

**3.8** Conduct an assessment of current funding (domestic and international) with a view to develop a transitional financing plan for voluntary community-based treatment and services.

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