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DETENTION AS TREATMENT

Detention of Methamphetamine Users in Cambodia, Laos, and Thailand

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Public Health Program

DETENTION AS TREATMENT

Detention of Methamphetamine Users in Cambodia, Laos, and Thailand

March 2010

International Harm Reduction Development Program

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I would like to sincerely thank Daniel Wolfe and Roxanne Saucier from OSI for their ongoing patience and guidance in the completion of this work and their tireless efforts in bringing the issue of compulsory detention of drug users to the attention of national and international agencies in an effort to find solutions that are fundamentally grounded in human rights and evidence-based public health principles.

We apologize for the low quality of many of the photographs in this report. Few people have been able to take pictures inside these compulsory drug treatment/detention centers, and those that are taken are often captured surreptitiously, on cellphone cameras, or from a distance. Those managing the centers are reluctant for conditions inside to be captured on camera.

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Preface

The widespread availability and use of methamphetamine in Southeast Asia has been a very real concern for families, communities, and affected States. Methamphetamine and related substances can lead to a range of harms for individual users, their loved ones, and their communities. So it should not be surprising that governments in the region have attempted to respond to rising methamphetamine use, or that they have sought, and received, donor support to do so.

How have the governments of Thailand, Laos, and Cambodia responded?

As this report details, the prevailing responses have been compulsory detention—generally without medical management of detoxification. Detention in conditions that are themselves threats to health and life, has been done under the banner of "treatment" for drug use, but little or no evidence-based treatment has been available.

The voices of drug users heard here are among the first to have emerged from these Southeast Asian "compulsory drug treatment/detention centers (CDTDCs)." They will remind many readers of the accounts of mental patients from 18th or 19th century Europe—with shackles, chains, and beatings masquerading as treatment, gross overcrowding, the ever-present stench of human waste, and the always dangerous mix of locking away children and youth with adults. That men and women, adolescents and adults, are being detained across this region in dangerous and destructive environments without due process, often without trial, and based on arbitrary decisions by untrained officials, makes this all the more a cause for regional and international concern.

This report makes clear that drug treatment is not occurring in these compulsory centers, and that what is happening to thousands of (mostly young) people is a threat to public health and safety, and represents ongoing violations of a range of basic human rights. Anxiety over drug abuse leads many governments to respond with harsh and draconian measures, often to little avail. But here we see governments, and well-meaning individuals within them, attempting to address a problem with solutions that are profound failures on any measure we have. This must stop.

How can the governments of Thailand, Cambodia, and Laos respond to methamphetamine use in ways that might actually help affected citizens and their families and deal with the social and security concerns over methamphetamine use? The authors suggest several steps that should be undertaken immediately. First, halt the construction of more CDTDCs. To date, there is only

evidence of their harm. Second, invest in community-based strategies that can better address the harms of methamphetamine use. And finally, transition to community-based models of drug treatment and initiate the closing down of all CDTDCs.

The donor community, including the United Nations, has critical roles to play as well. Given the evidence of the harms of these compulsory detention facilities, and the lack of evidence for their efficacy, donors should cease and desist from financial support for these institutions. Continuing to support these centers now that we know about the kinds of abuses they are leading to, including the incarceration and sexual exploitation of minors, could be tantamount to complicity in rights violations, or at least to the perceived tolerance of those violations.

Donors could play truly positive roles by promoting, piloting, and helping to evaluate alternative approaches to compulsory detention. Normative guidelines on drug treatment based on evidence and grounded in human rights would be enormously helpful as well. Arbitrary and compulsory detention is not drug treatment. And the ways in which it is now being conducted in Thailand, Cambodia, and Laos is inhumane, ineffective, and must change.

This report sheds critical and much-needed light on hidden and neglected people who need our urgent attention. Please read it, and please act on its findings and recommendations.

Sincerely,

Chris Beyrer, MD, MPH
Director, Center for Public Health and Human Rights
Johns Hopkins Bloomberg School of Public Health

Executive Summary

This report examines the establishment and operation of centers to detain and "treat" methamphetamine users in Thailand, Cambodia, and Laos. It documents the increasing number of such compulsory drug treatment/detention centers (CDTDCs)[I], examines the policies and practices that force people into them, and explores the implications for individual health, public health, and human rights. This approach to treating methamphetamine use is implemented without evidence of effectiveness, and it places people in environments where their basic health needs are unmet and abuse is pervasive.

The core issue identified in this report is the use of law enforcement approaches to address health issues. Though drug policies in Thailand, Cambodia, and Laos have been amended in recent years to recognize that drug dependence is a health issue, the public security sectors in these three countries tend to trump the smaller and weaker health sectors. Illicit drug use remains a violation of criminal law in these countries, and people who use drugs are treated as criminals. CDTDCs are generally run by police or military personnel. Drug users are often detained using administrative rules rather than criminal laws, and in many cases, do not see a judge or have the ability to question or appeal internment.

International actors, particularly agencies of the United Nations and donor states, face a policy conflict when confronted with CDTDCs. At the same time that they advocate for evidence-based treatment, they issue grants to agencies working with these centers or to the centers themselves. The steady growth in the construction of the CDTDCs, and the lack of HIV prevention or treatment, evidence-based and effective drug treatment, or any other medical treatment, reveal the limits of the approach.

While opiate users comprise the majority of those detained in CDTDCs in countries like China and Vietnam, in many countries in Southeast Asia it is methamphetamine users who are the overwhelming majority of detainees. The production, trafficking, and use of methamphetamine in Thailand, Cambodia, and Laos pose significant challenges to both the law enforcement and health service sectors. As with other problems related to illicit drugs, finding an appropriate balance between the security needs of the community and the health needs and rights of methamphetamine users should be the ultimate goal. The current approach, however, is harmful to the health and rights of individuals, and to the health of the larger community.

Patients Not Criminals: Rhetoric versus Reality

In each of the three countries considered in this report, it is specified, either by law or Prime Ministerial Decree, that methamphetamine users are to be considered patients, not criminals. Considering the multiple and ongoing violations of human rights of methamphetamine users in Thailand, Cambodia, and Laos, it is hard to argue that detained individuals are in fact treated like patients. Placing methamphetamine users in compulsory detention is possibly the worst intervention imaginable, given their health-related risk profiles and needs. Instead they require a range of services that focus on sexual risk behaviors and drug use in their community and social networks.

These centers lack health professionals and staff are not trained in drug dependence treatment; individuals detained in these centers are not provided with pre-admission or pre-release health screenings (including mental health), or post-release support. Additionally, methods of detention are not conducive for effective treatment: these include use of chains and locking groups of people in rooms that resemble large holding cells.[2] The settings are far more basic in Laos and Cambodia, where youth and adults are confined in much smaller cells, generally with no mattresses on the concrete floors.[3] In Cambodia, the government is quite open in acknowledging the obvious pitfalls of these CDTDCs and suggests that:

> *"...due to the lack of a structural mechanism between the Ministry of Interior and the Ministry of Health there is no mechanism that would provide and make available essential medicines at this stage."*[4]

People who use drugs in Thailand, Cambodia, and Laos are breaking national laws and are therefore, in many cases, treated like criminals. This does not mean, however, that the state has a right to deprive these people of appropriate medical treatment. In fact the due process and health rights of people in detention are guaranteed under international law, particularly the International Covenant on Civil and Political Rights (ICCPR),[5] and in Article 12 of the International Covenant on Economic, Social and Cultural Rights—"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"—both of which all three countries have ratified.[6] In regard to detained persons, the United Nations Basic Principles for the Treatment of Prisoners further adds that: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[7]

Infectious Disease

Not only do detainees receive inadequate treatment in the CDTDCs[8]; they are also placed in situations where their health is put at greater jeopardy. Several studies have shown that people placed into detention settings are at significantly greater risk of contracting infectious diseases, including HIV, tuberculosis, hepatitis C, and skin infections. These health threats can follow detainees back to their home community upon release.

Risky sexual behavior, both predatory and consensual, occurs in the CDTDCs in Laos and Cambodia. In Thailand, methamphetamine users are detained in prisons prior to internment in CDTDCs. The detention of young people in CDTDCs, and in many cases the detention of juveniles with adults, poses significant risks for HIV acquisition particularly since detention increases sexual exploitation. Furthermore, other HIV risk behavior such as tattooing and body piercing are prevalent in these settings.

Arbitrary Arrest and Detention

When any person is removed from society and placed in a custodial setting, there should be proper legal safeguards and procedures to guarantee the rights of the detainee. This right is guaranteed by Article 9.4 of the ICCPR that states that any person "deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful."[9] The UN Human Rights Committee has interpreted this provision to apply to "all deprivations of liberty, whether in criminal cases or in other cases such as, for example, … drug addiction…"[10]

One means for detention, in Laos and Cambodia, appears to be a signed contract between parents or guardians of the detainee and the CDTDC in which they are detained. In most cases, young people and adults alike are rounded up by police and incarcerated at a CDTDC without any legal review of the evidence of drug use, abuse, addiction, or perceived harm of the individual to the community.

In Thailand, regulations allow for those suspected of being in possession of or using methamphetamine to be detained in prisons for up to 45 days[11] pending the case review by a committee that is both under-funded and overworked. Furthermore, many young methamphetamine users spend a significantly longer period of time in prison before being sent to a CDTDC, if they are in fact ever transferred at all.

Evidence-based and Voluntary Drug Treatment

People who use drugs should have access to voluntary treatment programs that are based on evidence of effectiveness. In many cases, methamphetamine users in CDTDCs are detained against their will for an open-ended period of time. Considering that regionally relevant research found that an acute phase of methamphetamine withdrawal usually only lasts a couple of days and a sub-acute phase between seven and 15 days,[12] detaining people for anywhere between several months and three or four years has no basis in evidence. There have been no formal evaluations as to the effectiveness of the CDTDCs in reducing return to methamphetamine use upon release. All the anecdotal evidence suggests that upon release from the CDTDCs, the relapse rates are extremely high. This means that people do not get better in these CDTDCs and in many cases, actually get worse.

Without an investment in community-based and individualized interventions, large numbers of methamphetamine users in Thailand, Cambodia, and Laos are likely to continue to move between prisons, CDTDCs, and their communities, thereby increasing their own and their sexual partners' risk for acquisition of blood-borne pathogens, sexually transmitted infections (STIs), and other communicable diseases. Furthermore, they are likely to have their human rights violated and spend a significant part of their youth behind bars.

Key Recommendations

To the Governments of Thailand, Cambodia, and Laos

- Immediately halt construction of new CDTDCs.
- Investigate ill treatment in CDTDCs, hold violators accountable, and cease all state activities and practices that perpetuate the criminalization of people who use drugs.
- Invest in community-based strategies that address the harms associated with the use of methamphetamine (such as programs to deter risky injection practices and STI prevention, screening, and treatment).
- Devise national strategies to close down all CDTDCs and transition to community-based models of treatment.
- Release all those currently detained in CDTDCs, as their detention is unjustifiable, even in the absence of viable treatment options in the community.

To the United Nations and Donor Community

- Immediately cease any financial support to the building of new CDTDCs or maintenance of existing CDTDCs in Thailand, Cambodia, and Laos. Review programs and polices inside the centers to ensure they're not furthering human rights abuses.
- Promote, pilot, and evaluate community-based alternatives to CDTDCs for the treatment of methamphetamine and the integration of associated health and social services.
- Develop regional guidelines on appropriate treatment for those that require treatment, and harm reduction approaches to methamphetamine that are both evidence-based and grounded in human rights.

Introduction

A meeting at the 18th International Harm Reduction Association conference in Warsaw in 2007 sparked the genesis of this report. At that meeting, various people from United Nations agencies and international human rights groups discussed the issue of drug treatment and the need for the promotion of evidence-based, voluntary drug treatment grounded in fundamental human rights principles. Participants felt that the UN needed to take a greater lead to ensure that rights violations in the name of drug treatment would cease. During that meeting, participants raised the issue of young methamphetamine users in CDTDCs in Thailand, Cambodia, and Laos. They expressed concerns that CDTDCs operated contrary to fundamental human rights principles and were being built at an exponential rate—in some cases, with support from UN agencies or donor nations. UN officials replied that they felt there was insufficient evidence to justify such claims and that more careful documentation was needed in order for anything to be done about the situation. With this report, and others recently published, human rights violations in CDTDCs can no longer be denied.

Methodology

Between June 2008 and October 2009, 30 interviews were conducted at various levels with government ministries, UN agencies, and nongovernmental organizations (NGOs) from Thailand, Cambodia, and Laos. Participants were selected because they either worked in ministries or departments that oversaw the compulsory drug treatment system, worked with methamphetamine users, or worked as staff at CDTDCs. Interviews focused on the source of funding for the CDTDCs, the costs of management of the CDTDCs, the centers' effectiveness in preventing recidivism to drug use, the prevalence of HIV risk behaviors in the CDTDCs, and the implications of the CDTDCs for public health and human rights. In addition, participants were asked for their ideas and suggestions for how to improve treatment for methamphetamine users. Some participants offered their insights through off-the-record conversations or through email exchanges.

During the same time period, interviews were conducted with 30 recently released detainees from CDTDCs in Thailand, Cambodia, and Laos. Interviewers had initial access to participants either through their work with research institutes and NGOs, or through their social networks. Once the initial participants were recruited, respondent-driven sampling was used to recruit further participants. A semi-structured interview guide was designed to elicit key information from participants relating to aspects of their time in CDTDCs including the circumstances of admission, the cost of being in the CDTDCs, the medical treatment provided, treatment by the center staff, the living conditions, and availability of HIV prevention. None of the people approached for this set of interviews declined to participate.

Interviews were conducted by local, trained interviewers who were familiar with the subject matter. Interviews were recorded on tape where possible, transcribed, and then translated. When it was not possible to tape interviews, extensive notes were taken that were transcribed and translated immediately following the interview. Translated interviews were discussed and checked for accuracy by two people fluent in both languages, prior to analysis. Up to ten interviews were conducted with individuals who had spent some period of time in a CDTDC in each country until saturation of information was reached.

Due to the sensitive nature of the information, identifying information for many of the interviewees, both officials and recently released detainees, has been omitted.

In addition to interviews, information came from an extensive literature review of published and unpublished papers and reports, and through the use of relevant internet sources. Where possible, information has been verified by at least one other source.

Background

The Continued Increase of Methamphetamine Use in Thailand, Cambodia, and Laos

Experts have linked the rise of methamphetamine production, trafficking, and use in Thailand and Southeast Asia to the Asian economic crisis of 1996,[13] the collapse of the infamous Khun Sa heroin operations in Burma,[14] ongoing internal conflicts in Burma, transnational crime syndicates, and the shifting trends of global illicit drug use. In reality, the rise of methamphetamine use in Southeast Asia is most likely the result of all of these and a host of other social and environmental factors.

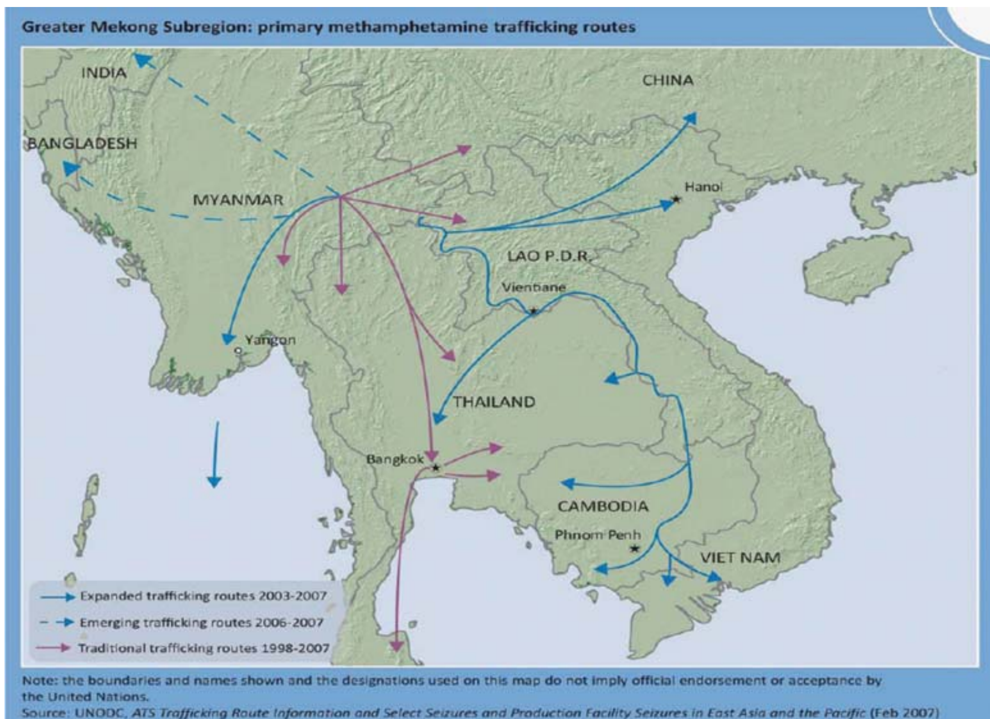
Whatever the cause, there has indeed been an exponential increase in the recreational use of methamphetamine in Thailand, Cambodia, and Laos since 1996. In fact, methamphetamine has surpassed heroin as the major drug used[15] in many parts of the Southeast Asian region. In Thailand, the first country where increases in methamphetamine use were carefully documented,[16] there has also been a documented rise in adverse health and social consequences related to methamphetamine use. This has been seen in Cambodia and Laos as well. These consequences include high rates of common STIs among methamphetamine users,[17] high rates of self-reported depression and alcohol consumption,[18] psychosis,[19] and deleterious interactions with law enforcement officials that often result in some period of incarceration in either prison, a CDTDC, or both.[20, 21]

Between 1955 and 1980, methamphetamine tablets, known in Thailand as "yaba" and in other parts of the region as "yama,"[22] were initially legally available[23] and ingested by laborers in Southeast Asia to provide additional energy for physical work.[24] Large-scale production of yaba tablets continues in the region, predominantly in Burma, but also throughout Thailand, with recent reports of production in Cambodia,[25] and anecdotal reports of production in Laos.[26] With an increased supply and deliberate marketing campaign, methamphetamine tablets became the most common recreationally used illicit drug in Thailand by 1997 and are currently the most used illicit drug in Laos and Cambodia among young people.[27] Methamphetamine tablets vary

in chemical composition, but in general contain approximately 25 percent active methamphetamine.[28] In addition, the amphetamine-type stimulant known as "ice" (a crystalline form of methamphetamine) is becoming increasingly produced, trafficked, and used in Southeast Asia.[29]

Methamphetamine and ice are typically inhaled. The tablets or crystals are often put on foil and melted from beneath. The resulting vapor is either inhaled through water or directly through a straw. The documented effects include feelings of euphoria, alertness, and confidence,[30] but these are often followed by feelings of anxiety, depression, and insomnia; in some, prolonged use leads to acute psychosis[31, 32] (see Annex 1 for more information about methamphetamine use). In 2003, Thailand's Academic Substance Abuse Network[33] estimated that 3,500,000 citizens had ever used methamphetamine.[34] Though estimates vary widely, some researchers suggest that, among the estimated 520,000 drug users in Cambodia, methamphetamine tablets are the predominant drug of abuse.[35] In Laos, there are no reliable estimates of the total number of illicit drug users, but the Laos government has said that the use of methamphetamine is the most pressing illicit drug concern in the country.[36] In 2008, a United Nations Office on Drugs and Crime (UNODC) study estimated that there were between 35,000 and 40,000 methamphetamine addicts in Laos[37] but did not specify how the term "addict" was applied.

Figure 1. Traditional, emerging, and expanding methamphetamine trafficking routes across Southeast Asia and into South Asia (2002)



Source: UNODC East Asia and the Pacific

The Thai government began criminalizing methamphetamine in 1996.[38] In 2003, the government launched a well-documented "war on drugs" that included mass arrests of those suspected of manufacturing or selling methamphetamine, as well as what human rights observers termed extrajudicial executions of more than 2,500 individuals, often following police interrogation.[39] In combination, these events led to a doubling of the number of people incarcerated in Thailand's prison system between 1996 and 2004.[40] In 2006, 75 percent of the 68,000 drug-related charges in Thailand were related to methamphetamine;[41] this number rose to 84,073 methamphetamine-related arrests in 2007.[42] Thailand's Department of Corrections' website states that offences associated with narcotics currently account for 55 percent of all incarcerations.[43] In Cambodia, more than 90 percent of people charged with drug law violations in 2005 and 2006 were charged in relation to methamphetamine tablets. In Laos, 100 percent of drug-related arrests in 2006 were attributed to methamphetamine tablets. In all three countries more than 75 percent of those arrested on drug-related charges are male.[44]

Risk Profiles of Methamphetamine Users

A recently completed five-year study investigating risk profiles and peer-based risk reduction strategies with methamphetamine users in northern Thailand[45] showed that methamphetamine users between the ages of 18 and 25 (n=1,189) had multiple risks for problems of substance use, STIs, HIV, mental illness, and criminal records. The cohort were frequent users of methamphetamine tablets; in addition, 50 percent reported alcohol abuse more than five days a week; chlamydia rates were above 30 percent; 22 percent had ever been arrested and of those, 75 percent had been arrested at least twice; condom use during the most recent sexual intercourse was only 15 percent; and many females reported unplanned pregnancies and self-induced abortions.[46]

The results of a similar study conducted in Thailand, Cambodia, and Laos were presented at the International Harm Reduction Association conference in Bangkok in April 2009.[47] Initial exploration of data from those countries suggests that the risk profiles of young methamphetamine users are fairly similar in all three countries, including high rates of STIs (three to six times higher in women than men); and high arrest rates for methamphetamine users who were not already in a CDTDC (20 percent in Laos, 40 percent in Cambodia, and 34 percent in Chiang Rai, Thailand). The primary reason for arrest was for using methamphetamine or fighting, with less than five percent arrested for selling or delivering drugs.

Methamphetamine users in this study reported similar alcohol and sexual risk profiles as in the Chiang Mai study. While the non-injecting use of methamphetamine does not carry the same risk of HIV acquisition as injecting drug use, it appears that non-injecting methamphetamine users have more risk of HIV through sexual behavior compared to other sentinel groups studied in the region[48] (see Annex 2 for more information on a peer-based intervention study conducted with methamphetamine users in northern Thailand).

Assessment, Management, and Treatment of Methamphetamine Dependence

The physical manifestations of methamphetamine use include a loss of appetite, insomnia, rapid heartbeat, jaw tension, grinding of teeth, palpitations, irritability, desire to urinate, and tremors.[49] Adverse psychological consequences of methamphetamine use are usually short-lived, typically lasting a few hours to a few days and can include mental confusion, paranoid ideation, and auditory hallucinations. In some cases, toxicity can mimic a functional psychosis such as paranoid schizophrenia.[50] Severity of adverse psychological events is dependent upon the amount used, the pattern of use, other substances used, and the presence of any pre-existing psychiatric illnesses.[51]

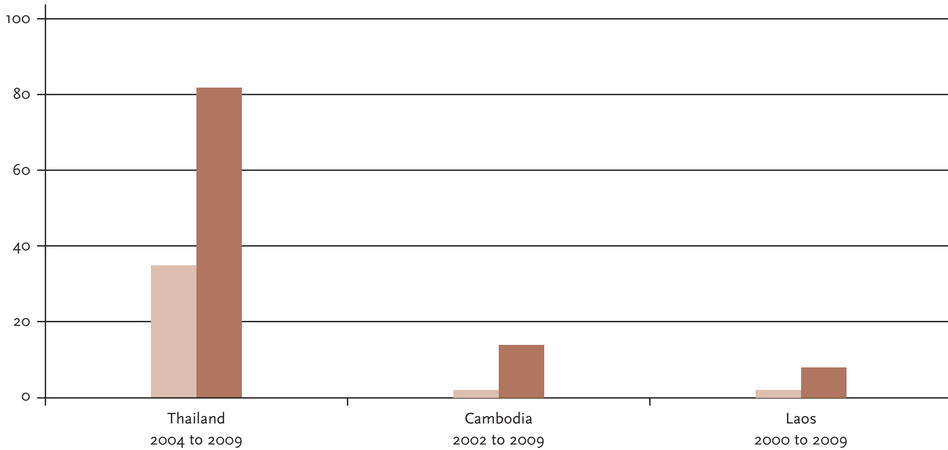
Withdrawal from methamphetamine use can induce symptoms of depression, need for seclusion, hyperphagia (abnormally increased appetite and consumption of food), and hypersomnia. Withdrawal syndromes are rarely life-threatening yet may require hospitalization, particularly in cases of severe depression.[52] Pharmacotherapies such as benzodiazepines and antipsychotics are sometimes used to aid withdrawal or reduce the symptoms of psychosis.[53] Despite ongoing research, substitution therapies for methamphetamine dependence remains unavailable.[54]

The Rise of a Compulsory Drug Treatment/Detention Center Model

The rise in methamphetamine-related arrests in the Southeast Asian region has been paralleled by increased testing for amphetamine use, including compulsory testing, and an associated demand to treat those who test positive. In Thailand, a lack of infrastructure to treat methamphetamine users and limited treatment options have resulted in increasing numbers of young methamphetamine users being sent to prisons and CDTDCs.[55] In 2004, there were 35 CDTDCs in Thailand; currently there are 84.[56] A similar approach is gaining momentum in Cambodia (from zero to 14 CDTDCs in eight years[57]) and in Laos (from zero to eight CDTDCs in ten years[58]). While some heroin and other drug users are also detained in these CDTDCs, they remain predominantly filled with methamphetamine users.[59]

The CDTDCs in Thailand, Cambodia, and Laos are predominantly managed by either the military or law enforcement sectors, and the drug treatment regimes implemented in these centers are based upon a military "boot camp" type model. Detainees are subjected to early morning wake-ups and physical exercises, and are often indoctrinated with anti-drug rhetoric. The system in Thailand is more regulated than that in Cambodia and Laos, with CDTDCs often located within military barracks. In many cases, detainees report inadequate food and shelter. Some CDTDCs in Thailand are managed by the Ministry of Interior, rather than the armed forces, and there are greater concerns as to the conditions in these centers. In Cambodia and Laos, CDTDCs are also run by military or public security personnel. Qualified health sector personnel are rarely involved in any aspects of drug treatment in the centers.

Figure 2. Proliferation of CDTDCs



International Concern about Compulsory Drug Treatment/Detention Centers

In recent years the international community, including human rights groups, UN agencies, legal and policy analysts, and drug treatment professionals have called for a review and restructuring of how the public security and public health systems in Southeast Asia implement drug treatment.[60] WHO and UNODC,[61] for example, have stated clearly that drug treatment should be evidence-based, promote prevention of HIV and other communicable disease transmission, and should not violate the human rights of detainees. Further, these agencies have outlined nine principles for guiding treatment of drug dependence. These recommendations include screening, assessment, diagnosis, and treatment planning; evidence-informed treatment; respect for human rights and dignity; and community involvement and patient participation.[62] The CDTDCs in Southeast Asia violate all of these principles.

Manfred Nowak, the UN Special Rapporteur on Torture, has also made it clear that CDTDCs violate international standards on torture and cruel, inhuman, and degrading treatment.[63] His 2009 report to the Human Rights Council details examples of situations where abuses of drug users in the name of treatment, including detention in CDTDCs, violate the Convention Against Torture, as well as the protections inherent in the International Covenant on Civil and Political Rights against the use of non-consensual medical treatment and experimentation. Professor Nowak has further suggested that the lack of access to HIV prevention options for drug users in high-risk settings; ill treatment at the hands of police; lack of judicial review in the forced detentions of drug users; and forced testing of HIV all raise significant human rights concerns.

Other leading figures, including Anand Grover, the UN Special Rapporteur on the Right to Health, and Navanethem Pillay, the UN High Commissioner for Human Rights, have expressed

similar concerns about human rights abuses committed in the name of drug treatment.[64] International NGOs have examined the practices of CDTDCs and documented multiple rights violations committed in the name of drug treatment.[65] While the majority of these reports have focused on the forced treatment of injecting drug users, this report seeks to highlight that multiple human rights violations and negative individual and public health outcomes are also prevalent in the case of compulsory detention of primarily non-injecting methamphetamine users in Thailand, Cambodia, and Laos.

Health Implications of Compulsory Detention

Even though methamphetamine is predominantly inhaled in Thailand, Cambodia, and Laos, once inside either a prison or a CDTDC, exposure to blood-borne viruses and other infectious disease increases. Incarceration or institutionalization of drug users in custodial settings has been associated with a host of negative health outcomes including STIs and blood-borne viruses such as syphilis,[66] herpes,[67] HIV,[68] hepatitis B,[69] and hepatitis C.[70] While these infections also exist outside of closed settings, it is clear that the custodial environment exposes individuals to behaviors and events that increase negative health outcomes. In Southeast Asia, prevalent behaviors or events include tattooing, injection of drugs,[71] penile modifications,[72] unprotected sex, and rape.[73] Risk in CDTDCs is increased by the absence of HIV preventive measures. Of the three countries considered here, none makes condoms, sterile injection equipment, or tattooing paraphernalia available to detainees.

Thailand

Drug Policy, Availability, and Use

Thailand formalized a ban on opium in 1959 when Prime Minister Sarit introduced the Harmful Habit Forming Drugs Act, which outlawed the production, sale, and use of opium.[74] Several decades of alternative development in the highlands, largely supported and subsidized by the royal family of Thailand, has contributed to Thailand currently being recognized as essentially free of opium production.[75]

Thailand became a signatory to the 1961 United Nations Single Convention that year, and in 1975 signed onto the 1971 UN Convention on Psychotropic Substances, and in 2002 ratified the UN Convention against Illicit Trafficking in Narcotics.[76] In 1976, the country introduced legislation known as the Narcotic Control Act[77] and established the Office of the Narcotics Control Board (ONCB), with the Prime Minister as chair. The ONCB is the lead authority coordinating all anti-drugs efforts in Thailand. Under the terms of legal amendments and ONCB guidelines issued in 2002 and 2007, the possession and consumption of narcotics can result in fines and/or incarceration sentences of up to 10 years. Methamphetamine was criminalized in 1996; those convicted of trafficking in heroin and/or methamphetamine may be sentenced to death.[78]

In addition to national narcotics laws, Thailand is heavily engaged in regional and international drug enforcement. This includes, since 1993, cooperation in the UNODC regional Memorandum of Understanding on Drug Control and a commitment to the Association of Southeast Asian Nations (ASEAN) and China Cooperative Operations in Response to Dangerous Drugs (ACCORD) project.[79] The US government has long supported antinarcotics efforts in Thailand through the provision of law enforcement trainings[80] and the ONCB also has strong links to the US Drug Enforcement Agency.[81] The website of the ONCB claims that Thailand is consistently and actively involved in bilateral and multilateral law enforcement activities in Southeast Asia and gives full cooperation to foreign countries on matters of drugs control.[82]

Methamphetamine: Implications for Individual and Public Health

Scientific research on issues of illicit drug use and public health in Thailand has traditionally focused on HIV risk behaviors and incidence rates among cohorts of injecting heroin users.[83] As the number of heroin users tapered off in the late 1990s[84] and the numbers of methamphetamine users increased, research efforts began to explore patterns of methamphetamine use and the implications of its effect on individual and public health.

The first Thai national household survey was conducted by the Academic Committee on Substance Abuse in 2001. It estimated that 3,500,000 million Thais between the ages of 15 and 60 reported ever using methamphetamine. A second survey, in 2003, suggested that approximately 1 million people in Thailand had used methamphetamine in the previous year. The survey also found that of the 450,000 people who reported using methamphetamine within the last 30 days, 73 percent were between 12 and 24 years old.[85]

Research has shown differences between methamphetamine users and injecting opiate users. Between 1999 and 2000, researchers investigated the sociodemographic, sexual, and drug use risk factors among methamphetamine users accessing drug treatment in northern Thailand.[86] The study investigated data from 750 methamphetamine users and found that they had a higher number of sexual partners and higher rates of STIs when compared with heroin users. While HIV infection rates are higher among injecting drug users, another study confirmed that methamphetamine users are more likely to have HIV than the general Thai population.[87] Among 1,890 methamphetamine users who predominantly inhaled the drug, HIV prevalence in this population was 2.4 percent, almost double Thailand's national HIV prevalence rate.

Referral to Treatment

The Narcotic Addict Rehabilitation Act, which came into effect in 2002, states the government of Thailand's legal response to treat and rehabilitate those addicted to narcotics. A comprehensive review of the Narcotic Addict Rehabilitation Act has recently been conducted by the Canadian HIV/AIDS Legal Network and provides recommendations for improvements.[88]

The Narcotic Addict Rehabilitation Act legislates that drug users are to be considered patients and have their cases reviewed by a Narcotic Rehabilitation Act Committee (NRAC), established in every province, which reviews each arrest for drug use (in the absence of other crimes) and makes a decision about what should happen to the alleged drug user. The committee is made up of psychologists, psychiatrists, community health workers, and key community leaders.[89] The options open to the committee include: refer the person to compulsory four-month detention in a CDTDC; release the person back to the community to undertake supervised outpatient cognitive behavioral therapy; release the person back to the community with no further action; or recommend prosecuting the person in the criminal court for a potential prison sentence.

To help guide the committee, the Department of Probation, in conjunction with the arresting police officer, puts together an investigation of the particular case in question. At no stage in the investigation does the NRAC actually meet with the alleged user,[90] thereby limiting their ability to make an accurate medical assessment of the severity of dependence or the person's mental health needs. Committee members acknowledge that this results in many methamphetamine users who are not drug dependent being sent to the CDTDCs.[91] While investigation is ongoing, the individual is detained in a custodial setting, often a prison. While detention is not supposed to exceed 45 days according to policy, in practice those imprisoned may remain for as long as a year. Medical assessments are not carried out during the investigation and therefore those people who may be methamphetamine dependent receive no medical assistance to ease symptoms of withdrawal.[92]

The Department of Probation states that any individual who has a case being investigated for an NRAC hearing is to be kept separate from prisoners.[93] Those awaiting a hearing, however, are subject to the same poor prison conditions.[94] Wanchai Roujanavong, then Director-General of the Department of Probation admitted:

> *"In many cases prisons are used to detain methamphetamine users as there is no room anywhere else."*[95]

Methamphetamine withdrawal is usually completed with no trial, due process, or medical supervision,[96] and then detainees are frequently committed to involuntary detention for an additional three to four months. One methamphetamine user who had recently left a military-run CDTDC outside of Chiang Mai noted:

> *"I was arrested for two methamphetamine tablets and put in prison; I stayed there for 11 months and then one day was moved to a boot-camp. After three months in the boot-camp I was released."*[97]

The Department of Probation supports the NRAC by providing 500 baht (US$15) to each committee member per meeting attended.[98] In addition, the Department of Probation provides CDTDC management with 18,000 baht (US$540) for each person detained in a CDTDC. CDTDCs can hold between 30 and 400 people depending on their size, but the average CDTDC holds 100 people. The Department of Probation estimated that more than 10,000 people passed through these CDTDCs in 2008 in Thailand.[99] The Royal Thai Airforce, however, stated that the government expected at least 50,000 people to pass through the system in 2009.[100] The Department of Probation provides the money to CDTDC management upon receipt of quarterly reports submitted by CDTDC staff. Conversations with Department of Probation officials suggest that the budget provided to some CDTDCs, particularly those under the auspices of Ministry of Interior, is frequently unaccounted for, resulting in low morale for unpaid staff and concern about theft.[101]

Discussions with various NRACs from across Thailand[102] highlight the multiple issues facing the committees, including insufficient time to review cases, and lag times of several months in payment for committee members. A senior psychiatrist from Rajburi Province, who serves on the NRAC notes:

"We have up to 50 cases a week to hear, but we only meet for two hours once a week. It means we have only a couple of minutes to review each case and make a recommendation. It is not enough time but we have so much to do outside of the NRAC that it is the only time we can give. Our committee has not received its budget for the last four months."[103]

If the goal of the National Rehabilitation Act was to divert patients from the prison environment, this has clearly failed as a result of spikes in arrests of methamphetamine users, insufficient budgets for the NRAC, and limited alternatives to incarceration. The end result is that methamphetamine users are still likely to spend a period of time either in prison or in a CDTDC. Thailand's prison system has long been associated with overcrowding, high rates of HIV and tuberculosis infection, and inadequate staff-to-prisoner ratios.[104] Detainees, who by law are meant to be considered "patients," are therefore essentially treated like criminals and are thus sentenced both to time in prison and CDTDCs, and to negative health outcomes.

Conditions Inside the Compulsory Drug Treatment/ Detention Centers

Recent downsizing of the Thai military has led to many of the provincial military barracks being converted into CDTDCs and run by the military on behalf of the Department of Probation.[105] These CDTDCs are run like military boot-camps with an emphasis on exercise regimens, discipline, and time spent reciting anti-drug rhetoric. One recently released 23-year-old male from the camp in Chiang Dao noted:

"After waking up at 5 am we exercised until 7 am, ate breakfast, and then spent the rest of the morning listening to one of the army guys tell us about why drugs were bad."[106]

The "Jirasa Model" is the predominant program operating in the Air Force-run CDTDCs. The "Jirasa Model" is a combination of selected activities from a therapeutic community model and military principles including discipline, military drills, leadership training, and exercise.

The daily routine consists of: a 5 am wake-up call; morning prayers and meditation; jogging; cleaning living quarters; breakfast; paying respect to the national flag; muscle stretching; small group meeting with counselor; lunch; life skills; military drills and discipline; muscle strength training; sports; dinner; paying respect to the flag; prayers and meditation; paying respect to the king; checking water taps and turning off lights for an 8:30 pm bedtime.[107]

Fifty of 84 CDTDCs are implemented by military personnel.[108] Many of the CDTDCs report that visits by a qualified medical practitioner are intermittent and a nurse may visit one morning a week:

"We see the doctor about once every couple of weeks and the nurse sometimes one morning a month, and otherwise there is no health staff anywhere. The only medicines we have are paracetamol."[109]

This does not constitute medically supervised treatment as per the principles of drug dependence treatment released by UNODC and WHO.[110] The Thai Department of Mental Health is nominally in charge of the program design, but discussions with the department suggest they are actually not effectively involved at all. The Deputy Secretary General of the Department of Mental Health indicated that divisions between the Ministry of Public Health and the Department of Probation limited involvement of the Department of Mental Health in the management, evaluation, and technical support of the CDTDCs.[111]

Ten of the CDTDCs are run by the Ministry of Interior, rather than the military.[112] The Department of Probation acknowledges that the conditions in the CDTDCs that are managed by the Ministry of Interior are much harsher than those in CDTDCs run by the military,[113] with little accountability for budgets allocated for these CDTDCs. One senior official who worked in one of the CDTDCs managed by the Ministry of Interior said:

> *"It's very tough; we have no budgets, no assistance, and no idea what we are doing."*[114]

A visit to a police-run CDTDC in Udon Thani, in northeast Thailand, confirmed that conditions were poor, with patients receiving no medical checks, and being subjected to harsh discipline such as chaining and beating. When asked why a Thai male was tethered by a heavy steel chain around his neck to a concrete pillar in the middle of the center, the same senior staff member responded:

> *"He is being unsociable; we have asked the NRAC to remove him from here and send him to a hospital, as we think he has a mental illness, but they are not meeting this month; we will have to wait for another month."*[115]

Research conducted by the Canadian HIV/AIDS Legal Network uncovered allegations of physical beatings used to discipline inmates for breaches of CDTDC rules, including engaging in consensual sexual activity.

While reports have not detailed rapes in CDTDCs, such behaviors have been widely documented in Thai prisons. Despite this, the Department of Probation does not provide condoms either to those imprisoned and awaiting disposition by the NRAC, or in the CDTDCs. As of early 2010, services for voluntary counseling and testing for HIV and the provision of anti-retroviral treatment were unavailable in the CDTDCs in Thailand.[116]

Release and Recidivism

After three to four months in detention, detainees are released back to their communities with no pre-release health screening, no medical referrals, no job placement, and every chance of returning to methamphetamine use. Despite the documented need for relapse prevention efforts upon release from drug treatment, no such programs are available and return to drug use is common. As one former detainee stated:

"It is just so nice to be free after prison and then the camp. You miss your friends because the camp is generally in another province away from your family and friends; when you see [your friends] again, you don't worry about anything, and if they are smoking methamphetamine, so would I."[117]

Individuals are required to report to the provincial Department of Probation two months after release from the CDTDCs and submit to a compulsory urine test to screen for methamphetamines. This system is not monitored on a national scale, though interviews with officials suggest that some 20 percent of individuals test positive for methamphetamine within two months of release in parts of the country.[118] In one large cohort study in northern Thailand, 70 percent of those arrested for methamphetamine use were arrested and incarcerated a second time after release.[119]

Proliferation of the Compulsory Drug Treatment/ Detention Centers

In Thailand, in the year 2000, there were six CDTDCs; in 2004 there were 35 CDTDCs; by 2005 this number had increased to 49;[120] and at the close of 2008, there were 84 CDTDCs operating in military barracks in Thailand.[121] Wanchai Roujanavong, the previous Director-General of the Department of Probation stated that continued expansion of the CDTDC model was the goal, and that they would like to see another 25 CDTDCs set up (this would mean at least one CDTDC in every province of the country), as he believed that only 25 percent of people who should be sent to CDTDCs were currently being admitted.[122]

The prime minister of Thailand stated in March 2009 that the aim of Thailand's next phase of a "war on drugs" was to get 120,000 people into rehabilitation programs.[123] If this was to be done utilizing the CDTDCs, Thailand would need to build another 300 facilities. In February 2010, that call was renewed with a plan by the Deputy Prime Minister to send 300,000 drug addicts for treatment—half of those to CDTDCs—by the close of the fiscal year.[124] There has been no large-scale evaluation done in Thailand as to the effectiveness of the CDTDCs in preventing relapse to drug use.

Figure 3. Detained methamphetamine users undergo military-style training at a CDTDC in Thailand in April 2009

Cambodia

Drug Policy, Availability, and Use

Cambodia, unlike neighboring Thailand, Laos, and Vietnam, had no tradition of opium cultivation[125] and was never considered part of the area of illicit opiate production known as the "Golden Triangle." The UN peacekeeping operation and the 1993 election led to foreign investment, increased trade, and the use of Cambodia as a transit point for heroin and cannabis, which were smuggled out of the country's two ports: Sihanoukville and Koh Kong. In 2001, the International Labour Organization cited a 1995 report from the *The Cambodia Daily*:

> *"Smugglers of illegal narcotics are increasingly using Cambodia as a transit point for the drugs which are heading primarily to United States and European markets … Ministry of Interior officials have pointed to Banteay Meanchey Province, on the northwestern Thai border and the coastal Koh Kong Province as the current narcotic smuggling "hot spots" … hundreds of kilograms of heroin are seized by anti-narcotic officials every month."*[126]

By 1996, Cambodia had been added to the US State Department's list of countries that needed to take greater action to control production or trafficking of illicit drugs.[127] This was a classification the Cambodian government contested, noting that they were in fact a transit country in need of greater international law enforcement support.[128] While formal assessments were not published, anecdotal reports documented increased production, trafficking, and use of methamphetamine tablets in Cambodia from the beginning of 2000. A report in the *Far East Economic Review* in 2001, cited by the International Labour Organization, notes:

> *"Thousands of poor farmers on the northwestern border with Thailand daily pop two to three pills of yama (which means horse medicine in Thai) to work longer and stave off hunger… Dealers are using Cambodia as a dumping ground for pills made in Burma that sell for just under US$1 each to an alarming number of rural labourers… Sopheap is one of thousands of Khmer Rouge fighters who defected to the army before being disbanded … He began taking yama when working for a*

Thai logging company in Cambodia for a meager but steady income. The more wood he cut, the more money he got. So he was happy to try a pill that promised to increase his productivity."[129]

By 2002, the large-scale presence of methamphetamine was officially confirmed with an estimated 81 percent increase from 2001 in the seizure of methamphetamine tablets.[130] One US State Department report said that:

> *"Cambodia has experienced a significant increase in the amount of amphetamine-type stimulants transiting from the Golden Triangle. The UNODC estimates that 100,000 methamphetamine tablets entered Cambodia each day, some 75 percent of which are thought to be exported to Thailand."*[131]

A UNODC report from 2002 noted that yama tablets[132] were so readily available in the border town of Poipet that the price of a single tablet decreased by nearly half, to 60 cents, in the past two years.[133] While much yama trafficking in border areas was attributed to the import of drugs manufactured in Burma, drug control authorities subsequently confirmed methamphetamine production within Cambodia and noted discoveries of laboratories capable of producing precursor chemicals and crystal methamphetamine powder, and seizures of precursor chemicals and tablet-pressing machinery.[134]

Methamphetamine has been ranked the most commonly abused drug in Cambodia since 2003, with abuse increasing every year between 2003 and 2006.[135] In 2007, the National Authority for Combating Drugs (NACD) stated that methamphetamine accounted for 80 percent of all illicit drug use and that more than 80 percent of users were under 25 years old.[136]

In addition to methamphetamine tablets, crystal methamphetamine (known as ice), has become increasingly available in Cambodia. In 2007, one study showed that 42 percent of street children sampled had used crystal methamphetamine.[137] Estimates of the total number of drug users in Cambodia remain unclear and differ greatly; the NACD estimated that there were 5,797 drug users in 2007 and UNAIDS estimated that there were 46,300 problematic illicit drug users for the same period.[138]

Methamphetamine: Implications for Individual and Public Health

In 2007, the National Centre for HIV, Dermatology and STIs (NCHADS) conducted a study of methamphetamine use among women in the entertainment industry in Cambodia and suggested that methamphetamine use was associated with a higher number of sex partners. The study also suggested associations between methamphetamine use and HIV infection among sex workers in Cambodia.[139] The NACD also reported HIV associated with drug use (including opiate injection) in a small sample (n=77) of injecting drug users who showed an HIV prevalence of 35 percent and another survey of 647 non-injecting drug users who showed HIV prevalence of 3.7 percent.[140] Both

figures are well above the 2007 national HIV prevalence estimated by sentinel surveillance at 0.9 percent[141] and prompted recognition of the need for a harm reduction approach to both injecting and non-injecting drug use. This has led to an authorization that currently allows one NGO to provide clean needles and syringes through outreach programs in the capital, Phnom Penh. At the time of this report, Cambodia was preparing to begin its first methadone maintenance program.[142] Methamphetamine is primarily smoked[143] and harm reduction responses to non-injecting drug use in Cambodia remain scant.

Stimulant users in Cambodia report several other behaviors that increase risk of disease or arrest. A 2008 cross-sectional study conducted among methamphetamine users in and out of CDTDCs explored STI prevalence, rates of arrest, and other individual and public health concerns.[144] The study population (n=651) was overwhelmingly male (96 percent); only 30 percent had completed high school; 46 percent of those surveyed used methamphetamine four or more times a week; and after using methamphetamine they drank alcohol (68 percent), had sex (60 percent), or engaged in fighting (33 percent). Half reported that methamphetamine use increased their sexual desire, and 60 percent reported having sex while high on methamphetamine or alcohol or both. Female users in the sample were almost nine times more likely than non-users to test positive for chlamydia (27 percent vs. 3.9 percent).

Nearly two-thirds of these methamphetamine users (61 percent) had passed through the CDTDCs previously and the median duration of stay in such a center was 90 days. Two-thirds of those surveyed (65 percent) were forced to enroll by their families, and 30 percent were forced into the CDTDCs by the authorities.[145]

Figure 4. Compulsory Drug Treatment/Detention Centers in Cambodia (2009)

Fourteen CDTDCs operated in Cambodia in 2009. There were none in operation in 2000.[146]

Source: http://www.canbypublications.com/maps/simpleprov.htm.

Referral to Treatment

Due process in cases of detention is a fundamental human right applicable "to all deprivations of liberty, including non-criminal detention for drug dependency."[147] Despite this, procedures in Cambodia mandating treatment lack the most basic protections against arbitrariness. As one detainee notes:

> *"I got arrested when I was walking with a group of friends. I was told the reason I was arrested was that I was walking with too many people at the same time (12 people). I didn't go to court or face a trial. I was told I was a yama user and therefore required treatment."*[148]

Police roundups of drug users and others in Cambodia, including sex workers, are well documented,[149] whether as part of "clean streets" campaigns prior to national holidays or elections, or in response to international or national dynamics. NGOs reported increased arrests of drug users and sex workers in 2008, for example, following the decision of the US government to downgrade Cambodia's status related to efforts to combat human trafficking.[150]

Instances of non-drug users being put in the CDTDCs have also been documented by human rights NGOs. A representative of a human rights organization commented on police roundups in Cambodia:

> *"None of these people have been charged with any crime. They are arrested because they're poor and because they're either living or working on the streets. So they may be sex workers who are working on the streets, they may be street children, they may be street families who have no houses, they may be drug users; some of the people we met said they didn't live or work on the streets, but because of the way they were dressed they were mistaken for poor people therefore they had to be homeless, so they were arrested and detained as well. So it's very indiscriminate."*[151]

The 1997 Law on the Control of Drugs in Cambodia, amended in 2005 states that people arrested and found to be dependent on illicit drugs, must appear before the court where an order may be made for them to enter CDTDCs. The expenses related to this treatment must be paid for by the state.[152] Nonetheless, multiple case reports make clear that there was no medical assessment for severity of drug dependence, no judicial process, and no rights protections afforded to detainees prior to or during their internment in CDTDCs. Of six CDTDCs visited by WHO in collaboration with a government team in 2007, only one reported any form of pre-admission assessment (which was only a basic physical examination).[153]

In addition to police roundups, many methamphetamine users are sent to the CDTDCs by their parents, who are asked to sign a contract with the center. The law requires the entire costs of "treatment" to be provided by the government, although it is not known how much money (if any at all) is actually provided to the centers to cover the costs of detention.[154] Despite government assurances that costs are covered by the state, families of drug users report that admission costs between US$100 and US$200, and relatives of detainees are expected to contribute US$50 per month.[155] The average salary in Cambodia in 2008 was US$167 per month.[156]

Conditions Inside the Compulsory Drug Treatment/ Detention Centers

Currently, CDTDCs share no common standards, though all report deficiencies in human resources, and no mechanism exists to ensure observance of minimum standards. As an assistant to the Secretary General of NACD notes:

> *"Each drug treatment center has its own regulations and all of them lack human resources. Several regimens are based on military drills and exercise, with little or no treatment and scant vocational resources."*[157]

The findings from a WHO report conducted in 2007 are consistent with the findings from this assessment. Both reports indicate that most of the CDTDCs in Cambodia do not have health professionals on staff, which severely limits their ability to provide medical assistance in the case of emergencies, or even assist with treatment of withdrawal associated with drug dependence or to provide psychological counseling.[158] The similarities in the findings from the WHO report and this assessment indicate that recommendations made to address the concerns raised in the WHO report have not been implemented. In this assessment, many former detainees report that they did not receive any health check upon admission to the CDTDCs, received no health care while they were in the CDTDCs, and relapsed back to methamphetamine use immediately upon release. WHO staff in Cambodia estimate that the lack of any qualified staff or evidence-based treatment has probably led to a relapse rate of almost 100 percent.[159] As one former detainee interviewed for this report recalled:

> *"I didn't receive any health checks or health care. There was no medication. Drug treatment consisted of a daily boot-camp regimen. Wake up, exercise, shower, salute the flag, have boot-camp, go into work groups, lock up, eat, lock up, sleep. There was no education about drugs, they just told us to stay clean. They said that if we wanted to stay off drugs we had to find a job."*[160]

Many detainees have reported beatings in the CDTDCs. Two men said:

> *"All the staff carried around a bamboo stick, and if they saw people that weren't working they would hit them across the back."*[161]

> *"I saw three staff beat a guy unconscious; they then dragged him away to another room. They also beat me once, but they put a blanket over my head so I couldn't see or defend myself."*[162]

Others mentioned the forced labor that they were assigned, including menial tasks that could not qualify as vocational training or drug treatment. These tasks were uncompensated and often seemed pointless or degrading.

> *"We had to cut the grass for one hour a day with a pair of scissors."*[163]

"We had to dig holes in the dirt. But we were not digging for any reason, they just didn't know what to do with us so they made us dig holes and then fill them in."[164]

Figure 5. Sleeping quarters in the Bavel CDTDC, Cambodia (May 2008)

Source: Patrick Duigan.

People released describe overcrowding, poor hygienic practices, the detention of people under 18 years old alongside adults, as well as the detention of people with mental illness:

"There were about 70 of us put in one room of about 20 by 30 feet. It felt very crowded, and it was filthy. There was a mix of people in there: drug users, homeless, alcoholics. The youngest person was six, and the oldest about 37."[165]

The Convention on the Rights of the Child states that detaining adults and juveniles together violates international norms, noting that juveniles should be detained with adults only as a "last resort."[166] In their fourth quarterly report in 2007, the NACD's routine analysis of data provided by government-run CDTDCs showed that 31 percent of the 357 treatment admissions were of people younger than 18 years old.[167] In the CDTDCs in Cambodia, there is no reported effort to separate adult and juvenile detainees, which is in clear violation of the Convention of the Rights of the Child.

Patrick Duigan, MD, based with the International Office on Migration in Phnom Penh, visited several CDTDCs in 2008 in an effort to understand the extent of health concerns in the CDTDCs. He visited the center in Sisophon, the capital of Banteay Meanchey Province, which opened in 2002 and is run by military police, and noted that many detainees appeared to be suffering a range of health concerns attributed to malnutrition. He also suggested that mental health problems were rife and many detainees made regular attempts to escape.[168] In the Bavel Detention Center, in Battambang Province, also run by the military police, he noted that the majority of detainees were extremely poor and that there was "absolutely no rehabilitation activity and no skills training."[169]

Figure 6. Bavel District CDTDC, Cambodia (May 2008)

Source: Patrick Duigan.

International literature widely documents that HIV risk in closed settings is increased due to consensual and non-consensual sex and the sharing of needles for either drug use or tattooing.[170] Despite this, condoms are not available in CDTDCs in Cambodia and neither are sterile implements for the purposes of tattooing. Furthermore, none of the CDTDCs visited during the WHO assessment provided STI testing or treatment, despite the known STI risk profiles of methamphetamine users in Cambodia.[171] As one recently released female noted:

> *"There was tattooing and piercing going on, and there were men who had sex with the lady boys."*[172]

Another reported:

> *"There was lots of HIV risk behavior. There was a lot of penile piercing and a lot of sex and rape between inmates and staff and inmates and inmates. Sometimes the staff would pay the prettier girls for sex but usually only 5000 Riel (US$1.20)."*[173]

In addition, there were reports of detainees being asked to perform sex work by guards who took a share of the proceeds. As a recently released female noted:

> *"The guards pimp the inmates—the ones that are sex workers—as well. They let them go out all night and get as high as they like, as long as the girls give them all the money they made in the morning. These girls are also the ones that bring yama tablets back into the center."*[174]

Penile modification has been documented in half of the male methamphetamine users in a recent study in northern Thailand[175] and the majority of those who had modified had done so while in some form of custodial setting. While studies have not detailed the extent of the practice in Cambodian prisons or CDTDCs, multiple interviews noted the prevalence of both penile modification and tattooing in the CDTDCs:

> *"Yes, I have seen it a lot. People sharpen a toothbrush and make a slit in the shaft of the penis in which to push marbles."*[176]

> *"There was tattooing, they used needles and mixed charcoal and toothpaste together to make ink. There were also people having sex."*[177]

Overcrowding and confinement in close proximity to others elevates the risk of tuberculosis transmission and infection,[178] yet none of the CDTDCs in Cambodia provide tuberculosis screening or treatment.

Although HIV rates are unknown, reported sexual and drug use histories of methamphetamine users suggest many people detained are at risk of or infected with HIV. None of the CDTDCs currently offers voluntary HIV counseling and testing or antiretroviral treatment, nor referral to such services even when they are available near the center.[179]

Release and Recidivism

Not only is admission to detention in the CDTDCs in Cambodia arbitrary, but so too are the circumstances of release. The assistant to the Secretary General of NACD explained:

> *"It is not very clear how patients are released but most likely doctors will decide if someone can go or not. Some people could stay four or five years."*[180]

A recent study showed that most people are released after a median detention time of three months.[181] The release criteria are unclear but informal discussions with staff suggest one of the criteria for release includes a detainee's demonstrated ability to recite the Cambodian National

Drug Laws from memory. Recitation of the laws forms part of the daily routine of detainees in the CDTDCs in Cambodia.[182]

No formal evaluations have yet been conducted to assess the effectiveness of the CDTDCs in preventing relapse to methamphetamine use upon release, although experts working in Cambodia estimate that the relapse rate is close to 100 percent.[183] WHO reports that they plan to assist the government of Cambodia to undertake evaluation in the near future.[184]

Proliferation of the Compulsory Drug Treatment/ Detention Centers

In an interview with *The Cambodia Daily* in 2004, the Cambodian government announced plans to build its first drug rehabilitation center, with 300 beds, in Phnom Penh. On October 23, 2006, the Prime Minister of Cambodia, Hun Sen, released *The Implementation of Education, Treatment and Rehabilitation Measures for Drug Addicts*. The instruction called upon all concerned ministries, agencies, and provincial and municipal authorities to implement several strategies without delay, including finding one location in each province to organize a "drug addict treatment and rehabilitation center."[185] The instruction recommended that the Ministry of Health "create a drug addict treatment unit at the national level in Phnom Penh, arrange consultation services at provincial-municipal and district referral hospitals to advise and cure drug addicts sent to the hospitals by their parents, develop technical standards to control drug addict treatment services in communities' drug treatment and rehabilitation centers, and eliminate treatment places that are not authorized by the Ministry of Health." The Prime Minister also called on communities, families, and former drug addicts to create model drug-free communities.[186]

There are currently 14 CDTDCs nationwide, run by government ministries, plus at least four NGO-run centers.[187] In a recent interview, Prum Sokha, Secretary of State at the Ministry of Interior, called the CDTDCs:

> *"...ad hoc accidental creations, which do not really offer treatment. What we need is not a technical solution but a comprehensive one bringing together education, drug users' families, and the community—this is very important."*[188]

None of the 14 state-managed CDTDCs are currently operated by the Ministry of Health. Instead, the CDTDCs are predominately operated by the Military Police of the Royal Cambodian Armed Forces, which is a component of the Ministry of National Defense. Some CDTDCs are run by police (overseen by the Ministry of Interior), and a small number of CDTDCs are run by the Ministry of Social Affairs, Veterans and Youth Rehabilitation.[189] According to staff at the Ministry of Health, H.E. Dr. Mam Bun Heng, Secretary of State for the Ministry of Health, is reported to have stated in mid-2008 that all such CDTDCs operate outside of the official mandate of the Ministry of Health and that his ministry had no jurisdiction to intervene in such premises.[190]

In 2010, the Deputy Prime Minister announced a plan to reduce the number of centers to one by 2015. However, the proposed center would hold as many people as the other centers com-

bined. In addition, this center would be run by the NACD rather than the Ministry of Health.[191] As this report went to print, the UN Country Team in Cambodia issued a statement welcoming the government plan to scale down to one center; the statement, however, stops short of calling for the closure of all CDTDCs in Cambodia (see Annex 3). In fact, the UN Country Team agrees to provide assistance to the centers, provided certain conditions are met, an agreement that risks sounding like an endorsement of the CDTDC model. Subsequent to the UN Country Team statement, Michel Sidibé, the director of UNAIDS, issued a directive clearly calling for the closure of all Cambodia's CDTDCs, saying "I am asking relevant partners to join me in intensifying UN system support toward: the earliest possible closure of detention centres, which do not meet minimum standards in Cambodia and other countries. [192]

Laos

Drug Policy, Availability, and Use

Drug production and use in Laos has traditionally centered on the cultivation of opium; in fact, since the 1950s, Laos has been one of the world's major opium producers.[193] Much of the opium has been consumed in a traditional cultural context.[194] It has been used for both medicinal and social purposes and indeed is also grown as a cash crop. Opium was so central to the fundamental economy and culture of many of the ethnic groups living in the highlands of Laos that it struck many Laotians as strange that it would ever be considered illegal. Soubanh Srithirath, who was both the deputy foreign minister and the chairman of the Lao Commission for Drug Control and Supervision (LCDC), made a speech in November 1995 in which he urged westerners to be more understanding of opium as part of the "Lao Soung" way of life. Apparently aiming his remarks at some westerners who thought Laos was not doing enough to eradicate opium cultivation, Srithirath explained that for many people in the highlands "smoking opium is no different from the way you in the West drink wine."[195]

Between 1975 and 1990, Laos was sustained by Soviet aid. Despite the presence of a US Embassy in Vientiane, the US Drug Enforcement Agency was unable to implement its war on drugs strategy throughout the period of the Cold War.[196] However, as communism began to collapse, western aid moved in to fill the gap left by the Soviet Union. It was at this juncture that the US Government—in particular, the US Drug Enforcement Agency through its main international ally, the United Nations Drug Control Program (now the United Nations Office on Drugs and Crime[197])—stepped up pressure on the government of Laos to eradicate opium. In May 1999, an agreement was made between the president of Laos and the UN to eliminate opium production in the region within six years through alternative development, demand reduction, and law enforcement.[198]

In 2000, the UNDCP promised US$80 million to expedite opium elimination, and in December 2000, the prime minister issued Decree 14 mandating the total elimination of opium by 2006.[199]

In 1989, opium cultivation peaked at an estimated 380 tons, and by 2007, Laos had only an estimated 9 tons of cultivated opium. This was heralded as a success by the UN, though observers noted that eradication efforts had consequences, including social dislocation, economic hardship, increased poverty,[200] and large numbers of untreated opium-dependent people. Some observers also believe opium eradication contributed to the large-scale uptake of methamphetamine.[201]

At the beginning of the new millennium, at the same time as UNODC and western embassies in Laos were pressuring the government to crack down on opium cultivation, methamphetamine tablets started to make their way across the Mekong River from Thailand and circulate among unemployed youth, sex workers, and nightclub goers in Vientiane.[202] The first documented seizure of methamphetamine tablets was reported in 1997, and by 1999 the Vientiane prefecture reported that 2.5 percent of youth between the ages of 13 and 30 in the capital Vientiane used yaba. Similar figures were reported from Savanakhet (3.5 percent) and Oudomxay (2.8 percent).[203] Thailand's well documented "war on drugs" in 2003 was also believed to have contributed to a change in the trafficking routes of methamphetamine tablets. UNODC noted in 2006 that methamphetamine tablet trafficking moved to less policed and more vulnerable states such as Laos.[204]

The alarming spread of methamphetamine tablets by 2003 caught authorities unaware, and caused some diplomats to question whether too much attention had been placed on opium. The Australian Ambassador at the time expressed serious misgivings, stating:

> *"The international community has put too much focus on getting rid of opium, but this yaba problem is much worse, and we should be focused on that instead."*[205]

The Laos authorities became increasingly concerned about the widespread use of methamphetamine when it became apparent that the smuggling of methamphetamine tablets from Nong Khai, Thailand across the Mekong into Vientiane was affecting youth, including scions of the influential communist party and government officials.[206] Despite the emergence of methamphetamine, the donor community continued to devote resources to opium eradication, although only about 10% of the US $80 million pledged to the Laos government was ever received.[207] Opium, which can be readily converted into heroin, was long a concern of the US and western countries, whereas methamphetamine tablets remained a domestic drug threat.

Methamphetamine: Implications for Individual and Public Health

Despite methamphetamine tablets being the most widely used illicit drug in Laos, there is a dearth of information on their implications for individual and public health. In 1999, UNODC, in conjunction with the Laos government, conducted a survey among students from 13 schools in Vientiane. It found that 4.8 percent of students between 12 and 21 years old (n=2631) in the survey reported using yaba and 11 percent of those had injected it.[208] In the second round national

HIV surveillance conducted in 2004, 15 percent of sex workers in Luang Namtha reported ever using amphetamines and 11 percent of those had injected in the last 12 months,[209] although it is not clear what they injected.

By 2005, the Asia and Pacific Amphetamine-Type Stimulants Information Center (APAIC) reported that methamphetamine was the most widely used illicit drug in Laos, that 4.6 million tablets were seized that year, and that national drug arrest and seizure data showed that 90 percent of drug-related arrests were related to methamphetamine. Males accounted for 72 percent of those arrested.[210]

A 2005 UNODC report stated that methamphetamine was increasingly available and used by different segments of society including laborers, school students, married men, and farm workers.[211] Participants in the survey commented that methamphetamine was being marketed as a drug that could help alleviate symptoms of opiate withdrawal. The report found that public perception and understanding of the health and societal impacts of methamphetamine use were low. Many people who used methamphetamine reported doing so to increase energy or make them stronger, and because they thought the drug could be used as a painkiller or opiate substitute. Participants interviewed for the report did note that methamphetamine use was associated with increased alcohol and tobacco use and increased sexual risk behavior. Individual and public health interventions were deemed non-existent. Participants noted that those who used methamphetamine were also likely to be arrested, incarcerated for a period of time in police cells without any form of psychological or medical treatment, and that they return to using methamphetamine upon release.[212]

In 2006, the LCDC estimated that there were 5,000 methamphetamine users in Vientiane and 5,780 methamphetamine users in surrounding Vientiane Province.[213] A study conducted between 2006 and 2007 with funding from AusAID's Illicit Drugs Initiative aimed to explore the individual and public health implications of methamphetamine use among young people in Vientiane and Vientiane Province, including its implications for STIs, sexual risk behavior, and rates of arrest and incarceration. The 443 methamphetamine users interviewed were between the ages of 15 and 25, were predominantly male (90 percent), and used yaba at least once a week (46 percent). More than a third (38 percent) reported that methamphetamine increased sexual desire, and 54 percent of people reported drinking alcohol after taking methamphetamine. A high proportion of males reported having been drunk or high on methamphetamine while having sex. In addition, a high percentage of males reported frequenting female sex workers while either using methamphetamine (55 percent) or while drunk on alcohol (97 percent). Overall, 13.6 percent of participants screened positive for chlamydia; 32 percent of all females tested positive compared to 12 percent of males.[214, 215]

In 2008, the UNODC Laos country office estimated that there were 35,000 to 40,000 amphetamine-type stimulant addicts in the country.[216] It is not clear how they arrived at this estimate or how the notion of drug dependence and measurements of addiction were applied. A rapid escalation in the construction and use of CDTDCs, built with funds from international donors, has accompanied reports of increasing methamphetamine use.

Referral to Treatment

Health personnel with limited training[217] and communities and families of yaba users often turn to law enforcement for assistance in managing problematic methamphetamine users:

> *"Sometimes the family could not treat their children anymore so they ask the police to send their children to the rehabilitation center. Thus the methamphetamine user will be arrested and kept at the village office until working hours, when the head [of the] village, police, and parents come together and identify who are the yaba users and who are the dealers. The users will be sent to a rehabilitation center, and the dealers will have their case formally investigated by the police."*[218]

In Laos, issues arising in a community are often dealt with by village mediation units. The village mediation units are a traditional platform for mediating adult disputes at a community level, and therefore obviate the need for involvement of state-based public security.[219] Methamphetamine users are often accused of disturbing the peace and therefore find themselves before village mediation units where they will typically be warned and asked to stop using methamphetamine. After several transgressions of community-set conditions, they may find themselves being taken to a CDTDC by their own family, members of the community, or local police. As shown in Cambodia, activities after using methamphetamine include drinking and fighting. These activities often result in arrest and incarceration in a CDTDC or a prison, particularly for those unable to pay fines:

> *"Some of my friends used to fight after using yaba, and the police arrested them and called the parents to mediate, and the parents paid a fine of 500,000 kip (50 USD)."*[220]

Methamphetamine users also report that police use them as spies and informants:

> *"After being arrested, I was put in jail and they asked me where I had got the yaba. They asked me if I wanted to be a spy and communicate with the dealers. The police left me in prison for a week then gave me 500,000 kip (50 USD) and 10 yaba tablets. If they didn't keep me in prison for 10 days, the dealers would be suspicious and beat me."*[221]

In many cases, methamphetamine users are rounded up by the police and incarcerated in a CDTDC without any legal review of the person's status of drug dependence or of the perceived danger to the community that the detained person poses.[222] Detention is also effected through a contract signed between parents of the detainee and the administrators of the CDTDCs, despite the fact that such documents have no legal validity for adults. The contract stipulates that treatment at the CDTDC will be for a period of at least six months and if the detainee runs away, the parents have the responsibility to return the person.

Dr. Chantravady, one of only a few psychiatrists in Laos, laments the lack of preadmission health screening, particularly as it relates to diagnosis of mental health conditions, in a CDTDC on the outskirts of Vientiane, stating:

"I keep telling the directors of Somsagna Drug Rehabilitation Center the importance of screening and testing, but they still don't do it. Without good screening and testing of new admissions, inmates who are suffering from mental health problems may be wrongly treated for drug problems."[223]

Detention of Juveniles

The extent of compulsory detention of juveniles in Laos was initially uncovered by a government investigation conducted in conjunction with UNICEF in 2003.[224] The UNICEF-sponsored investigation visited 11 centers, both CDTDC and prisons,[225] in seven provinces and found that as many as 150 detainees (the total numbers of people in all 11 centers was not given) were less than 18 years old. The overwhelming majority of juveniles (88 percent) in the CDTDCs were incarcerated due to narcotics-related offenses, but the CDTDCs were also used to detain other juveniles accused of petty crimes.[226] Many youth were unsure about the charges on which they were detained. The report detailed shortcomings of the detention system, including multiple violations of the Convention on the Rights of the Child. Few of the detainees had been formally sentenced. Eight percent of juveniles in the survey were under 15 and had been taken to the CDTDCs by their families or guardians. Less than 2 percent of crimes were considered of a serious enough nature under Lao law for detention, and conditions in the places of detention visited failed to meet basic requirements of international regulations, which include the provision of educational services, appropriate nutrition, and adequate health care. Nearly all juveniles were being detained with adults despite reporting abuses[227] and a desire to be detained separately.[228] Not one of the "treatment" facilities in which they were detained had provided comprehensive drug rehabilitation services, nor did the CDTDCs employ any staff who had been trained in counseling techniques or treatment of drug-dependent children.[229]

While the government of Laos has been reluctant to allow outside groups to monitor conditions inside the CDTDCs, in 2006, UNICEF did begin to monitor the numbers of children in detention. The Laos government stopped this activity shortly after it had begun. At that time, UNICEF had counted more than 600 child detainees in various detention facilities across the country.[230]

Conditions Inside the Compulsory Drug Treatment/ Detention Centers

Today there are eight CDTDCs at various stages of operation in Laos. The Somsagna Drug Rehabilitation Center was the first; it was opened just outside of Vientiane in 1999 for 214 patients, under the control of the police. It had no facilities for any form of drug rehabilitation or treatment. In 2002, the management of Somsagna Drug Rehabilitation Center was taken out of the hands of police and put under the control of a board of directors under the supervision of the mayor of Vientiane.[231]

But even after the change in control, there were still problems with the center. It was one of the CDTDCs criticized in the 2003 UNICEF report. Several other investigations also highlighted the unacceptable conditions prevailing in Somsagna and confirmed the findings of the initial investigation. A 2004 WHO report noted that the admission and discharge criteria were unclear, funds for food inadequate, and medical withdrawal from methamphetamine with pharmacotherapy available but sporadic in its administration. In addition, detainees experienced high rates of common skin infections, beriberi (thiamine deficiency), and STIs. About 30 percent of those detained were under the age of 18, but were detained with adults.[232]

By 2004, 2,658 detainees were in the Somsagna Drug Rehabilitation Center—more than ten times the number of detainees in 1999. By 2007, in the wake of repeated reports[233] of abuses and appalling conditions, the number had decreased to 1,222.[234] There are no facilities with which to diagnose or treat HIV, tuberculosis, or STIs, though in 2003, the Somsagna Drug Rehabilitation Center referred 120 detainees to the STI clinic within the Vientiane Youth Center.[235] Despite a UNODC recommendation to conduct comprehensive health assessments upon admission into the CDTDCs,[236] the lack of facilities, diagnostic instruments, and trained staff continues to limit the implementation of pre-admission health screening. In addition, reports from recently released detainees suggest that conditions have not improved:

> *"Each morning we got two scoops of rice soup and at lunch a handful of sticky rice and a bowl of soup that's made from pork bones with very little meat. Maybe some soup, a handful of rice, and some vegetables for dinner. There is not enough water for drinking, showering, and washing. The toilets are filthy, and there are bags with shit lying around. We all eat and sleep in the same room, so that's dirty too. Each room is about seven by five meters, and there are about 35 to 40 people in each room."*[237]

Rules outlining procedures and regulations for those in the Somsagna Drug Rehabilitation Center were drawn up by the director, Sisouphan Boupha, and specified the need for detainees to be reeducated in the drug laws of Laos and to receive party indoctrination.[238] Other rules, which are still in effect today, include prohibitions against sexual activity, tattooing, or piercing.[239] These prohibitions are not effective, as one staff member notes:

> *"When you have many males locked up in a small space at night it is difficult to know what goes on, but I have seen evidence that some of them do have sex, do participate in tattooing and penile modifications."*[240]

Despite the fact that sexual activity is forbidden, interviews with people who have recently been released from the Somsagna Drug Rehabilitation Center highlight that sexual activity, both consensual and nonconsensual, is highly prevalent and that condoms remain unavailable:

> *"Yes, I saw a lot of unsafe sex going on inside the center, particularly older boys forcing younger boys to have sex with them. There were no condoms available; it's mainly unprotected sex. I also saw a lot of sex happening between gay men and gay men, gay men and straight men, and straight men with younger boys, and straight men with lady boys."*[241]

Accounts of rape seem to be linked to older detainees forcing themselves on younger detainees. It appears that longer-term residents are often put in positions of power to enforce CDTDC rules and regulations, but the position of power is clearly abused:

> *"The supervisors—people that have been in the center as residents a long time—control the sleeping room and often force the younger boys to have sex with them. I saw the supervisors rape boys between the ages of 10 and 14."*[242]

In addition to allegations of rape, there were also references to the various forms of punishment for infractions of CDTDC rules (including attempting to escape) and also to "calm" people who were undergoing withdrawal from drug use. Punishments were meted out by both guards and by supervisors:

> *"They always hit the people who are going through drug withdrawal, generally a group of ten 'supervisors' will hit and kick the person until they became scared and weak and calm down. If you go down quickly you won't get beaten as badly, but if you take time to go down, they beat you until you bleed."*[243]

> *"They would attack anyone who tried to be strong or tried to escape. Ten men or so would beat them, kick them. The guards would use their shoes to beat them. I also saw the guards make people jump up and down like a frog until they were exhausted, became weak, and fell down."*[244]

Treatment for drug use also appears absent or insufficient:

> *"Basically, unless your family pays 600,000 kip every 45 days [US$70] you will not receive any medication at all. If you are sick with a fever or anything, you have to write a letter to the guard, and the guard will decide if you can wait in the queue to see the health center. If you are really sick with clear signs of infection they may send you to the hospital or try and find your family and tell them to take care of you."*[245]

In 2007, a US State Department report noted that the government of Laos refused multiple requests from the International Committee of the Red Cross to establish a presence in Laos and monitor prison conditions; it has, however, provided the UN and some NGOs with access to some prisons and CDTDCs, but this access is strictly limited.[246] The US State Department report goes on to say that while it is generally believed that the conditions of CDTDCs are better than conditions in prison, "the conditions are nevertheless spartan, lengths of detention indefinite and the government does not permit regular independent monitoring."[247]

The head of the UNODC mission in Laos, Leik Boonwaat, said:

> *"My own observation is that compared to a few years back, the authorities in the drug treatment centers in Laos are becoming more open and transparent, and this is mainly due to quiet diplomatic efforts including repeated visits and participation by treatment staff in various training and study visits organized by UNODC and other partners."*[248]

Accounts from those recently released, however, indicate that the CDTDCs have far to go.

Release and Recidivism

As in Thailand and Cambodia, there remain serious concerns about the effectiveness of the CDTDCs in Laos to treat, rehabilitate, and prevent recidivism among methamphetamine users.

A staff member from Somsagna Drug Rehabilitation Center notes that "about 70 percent of the people in Somsagna Drug Rehabilitation Center have been in here before; most of them relapse."[249] More formal evaluation of relapse either has not been done or has not been documented. While UNODC has worked with the government to improve data and information collection about narcotics seizures and arrests,[250] this has not yet developed into improved data on effectiveness of CDTDCs, with staff noting that rates of relapse are difficult to track.[251] It is clear that the government has responded to treatment failure by extending terms of detention: an individual admitted to Somsagna Drug Rehabilitation Center for a second time will spend at least one year in detention (initial terms are six months) and, upon a third admittance, the period will be extended to two years.[252] Dr. Chantravady is adamant that the CDTDCs in Laos have to improve:

> *"They need to follow up, and there needs to be a community network to help them after a release."*[253]

Those recently released from Somsagna Drug Rehabilitation Center commented that the center acted as a barrier to drug use because it removed people from a drug-using environment, but as soon as people left, they would return to their old social environments and would use methamphetamine again.

> *"The treatment is ineffective. All they do is try and make you not want to come back to the center. It doesn't stop you using drugs because as soon as you return to your outside environment you will use again. They don't deal with your addiction, and they don't help you change your behavior."*[254]

Proliferation of the Compulsory Drug Treatment/ Detention Centers

In ongoing efforts to appeal to the international community for assistance in dealing with its country's methamphetamine use, Minister Srithirath stated that Laos has reached a critical tipping point, and that the assistance of international donors is needed to ensure that the balance moves in the right direction.[255] It is unclear what sort of balance or the direction to which Minister Srithirath refers, but the international donor community has responded to his calls for assistance and as a result, Laos has eight CDTDCs all built with bilateral donations. Despite enormous international funding for ongoing opium eradication, alternative development and the construction of CDTDCs, Minister Srithirath continues to ask the international donor community for further assistance:

> *"We are concerned at the lack of resources to address the problem of methamphetamine and heroin abuse and alarmed at the emerging problem of injecting drug users in certain border areas."*[256]

The international bilateral donor community active in funding projects to combat illicit drugs in Laos is spearheaded by the Mini Dublin Group.[257] In Laos, the Mini Dublin Group is very active: the embassies of Australia and Japan share a rotating chairmanship and ambassadors from the US, Germany, Japan, Australia, Singapore, and Swedish Charges d'Affairs are involved in regular meetings and site visits in Laos. The meetings and site visits are often organized and facilitated by UNODC and LCDC.

Despite the concerns of academics, NGOs, individual ambassadors, and other observers of the government's drug policy, the Mini Dublin Group continues to strike a positive tone: "The Mini Dublin Group was very impressed with progress. They saw for themselves how appropriate technology was providing a sustainable alternative to opium production and improving livelihoods."[258] Concerns about the lack of evidence-based drug treatment, implications for the spread of infectious diseases, poor sanitary and hygienic conditions, lack of trained staff, and allegations of food shortages and human rights abuses have not been reflected in the work of the group. But in fact they and other countries continue to give bilateral donations to build more CDTDCs.

In 2001, the then Chairman of the LCDC gave a speech to the Vientiane Mini Dublin Group in which he was pleased to inform that "with UNDCP assistance the construction of the first Detoxification Center for amphetamine-type stimulant addicts has already started and expected to be completed in the first half of next year."[259] The US Embassy in Laos contributed to the renovation of Somsagna Drug Rehabilitation Center in 2001, and they recently spent US$32,000 on renovating and furnishing a new women's rehabilitation facility in the same grounds. The US Embassy in Laos anticipates that this will afford young, female methamphetamine users the opportunity to complete their full rehabilitation, lasting up to six months, in a secure residential environment.[260] In dedicating the new facility, the US ambassador remarked that:

> *"Those of you who are receiving treatment are the fortunate ones. You have the chance to resume and rebuild your lives. The purpose of building this center was not just to improve living conditions. The real purpose is to help you—the patients—be better prepared to regain the control of your own lives that yaa baa took away from you. As you know, this women's rehabilitation center will allow you to return to your homes and communities with skills you will need for success: to acquire new job skills."*[261]

At this stage, the effectiveness of the program at the women's facility in Somsagna Drug Rehabilitation Center has not been evaluated, nor have the living conditions or vocational training programs.

The US has also provided financial support for the construction of other centers. In February 2005, the US Embassy's bilateral counter-narcotics program provided US$600,000 for the construction of a new 100-bed CDTDC in Savanakhet Province. A US State Department report notes that the center demonstrates the outstanding cooperation between the governments of Laos and the United States on demand reduction, and that the CDTDC is a model for future facilities and stands as an example of what cooperation between the two countries can achieve.[262] The purpose of the CDTDC is to "treat drug addicts, especially those addicted to yaabaa." The US Embassy said

it would work with UNODC to provide training to provincial medical staff of the CDTDC.[263] In addition, the US Embassy is preparing to finance a smaller CDTDC in Vientiane Province, about 70 kilometers from the capital.[264]

Linthong Phetsavan, Head of the Permanent Secretariat of LCDC, acknowledged the international support and financing of the CDTDCs at the 26th Meeting of the ASEAN Senior Officials on Drug Matters (ASOD) held in Singapore in September 2005:

> *"The construction of other Treatment and Rehabilitation Centers in Savanakhet and Champasak respectively, as part of assistance from the government of Thailand and the United States of America, is nearly completed. Hopefully the handover ceremony of the center will be held later this year. I am also pleased to inform you that China has agreed to provide financial support for the construction of Treatment and Rehabilitation Center in Oudomxay Province whereby Vietnam will provide financial support for the construction of another center in Vientiane City."*[265]

In December 2005, Thailand co-chaired the handover ceremony for the "Treatment and Rehabilitation Center" located 21 km out of Pakse in Champasak Province, for which it had contributed about US$650,000 for construction and medical supplies;[266] the center officially opened in 2007. Thailand's ONCB notes that the CDTDC was "to be ... the symbol ...of the 55th anniversary of Thai-Laos Diplomatic Protocol as well as the cooperation on drugs control between the two countries."[267]

China funded the redesign of a CDTDC in Oudomxay in 2007. This new design was built to allow for its multipurpose functioning: it serves as the office of the Provincial Commission for Drug Control in Oudomxay, as a CDTDC, and as an office for a joint project between UNODC and United Nations Industrial Development Organization.[268] In 2007, the government of Brunei contributed to the construction of two smaller CDTDCs in Sayaburi.[269] Some of these CDTDCs operate under the provincial health authorities and some are under the Minister of Interior.

According to the provincial chief of the LCDC in Luang Prabang, Bounheuang Bulyaphol, the Japan International Cooperation Agency recently contributed US$86,000 to build two new buildings and a new 3-meter-high by 1.5-km-square wall in a redevelopment of an opium detoxification center in Luang Prabang. He was however skeptical about whether the new facility would be big enough:

> *"There are an estimated 5,000 yaba users in Luang Prabang, we do not have enough resources, and this drug treatment center can only accommodate 150 users per year, 50 inmates at any one time."*[270]

Table 1. International financial support for CDTDCs in Laos 2001–2008

Year	*Location*	*International Support*	*USD amount*
2001	Vientiane	UNDCP supports the first detoxification center for amphetamine-type stimulants users in Laos	Unknown
2001	Vientiane	US Embassy contributes to renovation of Somsagna	Unknown
2005	Savanakhet	US Embassy funds building of CDTDC	US$600,000
2005	Pakse	Government of Thailand funds building of "Treatment and Rehabilitation" center	US$650,000
2007	Oudomxay	China funds redesign of a former opium detoxification center	Unknown
2007	Sayaburi	Government of Brunei funds constructiuon of two small centers	Unknown
2008	Luang Prabang	Japan International Cooperation Agency funds renovations to center	US$86,000

As of 2009, the expansion of the Somsagna Drug Rehabilitation Center model across the country has resulted in eight CDTDCs at various stages of completion, operation, and utilization.

Figure 7. The new Provincial Commission for Drug Control/UNODC/United Nations Industrial Development Organization project office and CDTDC in Oudomxay (Laos)

Source: UNODC Laos country office.

Figure 8. Map of Laos showing eight CDTDCs, year 2009. There were none in 2000.

Source: http://www.mapsofworld.com/laos/laos-political-map.html

The government of Laos and its foreign partners continue to fund and promote this compulsory drug treatment system despite the fact that the effectiveness, either in terms of the long-term benefits to the individual methamphetamine users detained in these settings, or to the wider community, has not been scientifically assessed. A US State Department report released in 2008 states, “Most existing treatment facilities are notably deficient in staff proficiency and effective vocational training.”[271] Michael Hahn, the former UNAIDS country representative in Laos adds that:

> *“At the moment, on a country-wide level, the centers are operating well below capacity and lack training, equipment, medical supplies, or developed vocational training tools to adequately rehabilitate methamphetamine users.”*[272]

Leik Boonwaat notes

> *“There are currently only four fully operational centers: The Somsagna Treatment and Rehabilitation Center with 800 patients, The Champasak Drug Treatment Center with about 20–30 patients, The Savanakhet Drug Treatment and Rehabilitation Center with about 20–30 patients, and the Oudomxay Drug Treatment and Rehabilitation Center with about 20–30 patients. The treatment*

facilities in Luang Prabang, Sayaburi and Phong Sali are not operational. Except for Somsagna all other centers are very much under-utilized and have the capacity to treat up to 200 patients each."[273]

The capacity of the centers to provide appropriate treatment has not been evaluated at this stage. In addition, Boonwaat acknowledges that,

"Drug addicts who have committed a criminal offence would be put in the criminal justice correctional facilities to which we [UNODC] have no access."

Of significant concern is the fact that rapid expansion of other CDTDCs is being based on the Somsagna Drug Rehabilitation Center model and as one UNODC official commented:

"Somsagna and Pakse compulsory drug treatment centers with all their defects and limitations are far ahead of the rest of the country in trained staff and treatment. Somsagna is viewed as a model for other centers, but the legitimate criticisms of various stakeholders already indicates that it is at best, a deeply-flawed model."[274]

Michael Hahn, also said:

"Our government counterparts in [Laos] are well aware of the limitations of the centers, but are not aware at this stage of any real alternatives. What we need are well thought out, evidence-based, culturally relevant alternatives to the centers. If we can all work at providing these options, I am sure the [government of Laos] will consider community-based alternatives to these drug treatment centers. UNAIDS in Laos remains concerned by the operation of these centers both from the lack of any evidence-based drug treatment perspective and because of the implications for HIV transmission of keeping large numbers of people in a closed space, particularly since there are no condoms available."[275]

The LCDC and the government of Laos in general are increasingly aware of the need for a more effective approach and have indicated that they would like to develop different strategies that would better rehabilitate and reintegrate drug users. In fact the Laos government has stopped requesting donor money to build more centers as many of the centers built are empty.[276] As in Thailand and Cambodia though, a punitive approach to detaining alleged drug users continues to thwart effective approaches.

Figure 9. Somsagna Drug Rehabilitation Center

Source: Somsagna staff member.

Annex 1: An Overview of Methamphetamine Abuse and Treatment in the International Literature

Trends in Methamphetamine Abuse

Methamphetamine abuse remains a significant problem worldwide. The 2008 World Drug Report by the United Nations Office on Drugs and Crime (UNODC) estimated that 24.7 million persons currently abuse amphetamine-type stimulants.[277] The 2009 World Drug Report estimated that somewhere between 16 million and 51 million people aged between 15 and 64 used some form of amphetamine-type stimulant in 2007.[278] Methamphetamine constitutes the most frequently abused amphetamine-type stimulant,[279] accounting for approximately 65 percent of the total or nearly 16 million individuals, which equals or exceeds the number using cocaine or opiates.[280] Southeast and East Asia currently represent the epicenter for methamphetamine production, trafficking, and consumption.

The methamphetamine epidemic began in the late 1990s and peaked in 2000–2001. Recent evidence suggests increases in trafficking and use in the Mekong Region, along with increases in large-scale production in Cambodia, Indonesia, Malaysia, and elsewhere.[281]

Data collected by the Drug Abuse Information Network for Asia and the Pacific (DAINAP) reveals methamphetamine as among the top three most common drugs of abuse in 12 of 13 countries surveyed, while six (including Thailand, Laos, and Cambodia) ranked methamphetamine as the leading drug of abuse.[282] While some Southeast Asian countries, such as Thailand, have reported stabilization or a decrease in rates of methamphetamine consumption, the overall prevalence is among the highest in the region. There has also been an increase in the use of the crystalline form of methamphetamine known as "ice." Laos and Cambodia have reported increases in overall consumption of methamphetamine as well as a small but increasing prevalence of the use of ice.[283]

Implications of Methamphetamine Use on Individual Health and Social Outcomes

Methamphetamine is easily synthesized, has high central nervous system penetration due to its lipophilic chemical structure, and produces both an immediate and lasting euphoric high, owing to its relatively long half-life. Such factors combine to make methamphetamine widely available, abused, and highly addictive. Methamphetamine abuse has short- and long-term health consequences, some of which are unique to methamphetamine compared with other amphetamine-type stimulants, such as cocaine, and other commonly abused drugs in the region, such as opiates. Research suggests that methamphetamine users are more likely than abusers of other substances to encounter law enforcement officers.[284, 285] Indeed, more than 75 percent of drug-related arrests in Thailand, Cambodia, and Laos involved methamphetamine.[286] From a public health perspective, the high coincidence of methamphetamine abuse and law enforcement involvement necessitates a firm understanding of the health effects of methamphetamine abuse, their acute management, and long-term treatment by health providers, community-based organizations working with methamphetamine users, and law enforcement officials.

Short-term Effects of Methamphetamine Abuse

Research in animal models suggests that the biochemical target of methamphetamine is presynaptic dopaminergic transporters in the brain.[287] Amphetamine-type stimulants promote increased release, and to a lesser extent, decreased reuptake of dopamine as well as other neurotransmitters.[288] The overall effect is a marked sympathetic ("fight or flight") response with increases in heart rate, respiratory rate, body temperature, papillary dilation, and excessive sweating. In addition to physiologic changes, methamphetamine-induced release of neurotransmitters produces euphoria, which, unlike the shorter-lasting high of cocaine, can persist from eight to 12 hours and is accompanied by feelings of increased energy, curiosity, and interest in the surrounding environment; increased sexuality and desire; heightened attentiveness; and decreased anxiety.[289]

Methamphetamine tolerance develops gradually through various hypothesized neurotoxic[290] and immunologic[291] mechanisms that deplete neurotransmitters and shorten the duration of euphoric effects. During this period users typically engage in progressive dose-escalation, switch to more rapid routes of administration (e.g. inhalation or intravenous) and begin binging, characterized by repeated administration in response to drastic changes in mood ("binge-crash" cycle) that can last up to several days.[292] Dose-escalation has important medical consequences, as most acute complications of methamphetamine abuse are dose-dependent and the transition to injectable forms of methamphetamine increases the risk of blood-borne infections such as HIV, hepatitis C, and sepsis.

Although the physiologic effects of methamphetamine intoxication can produce marked cardiovascular, neurological, and metabolic effects, potentially causing myocardial infarction, cere-

bral hemorrhage, aortic dissection, arrhythmias, seizures, and hyperthermia, the incidence of such complications is rare and lower relative to those caused by cocaine use.[293] Studies in US and Australian emergency departments indicate methamphetamine users are more likely to present with psychological disturbances including agitated delirium or acute psychosis, suicidal ideation, and injury or assault related to methamphetamine use.[294, 295, 296] In addition, a majority of cases were deemed to be of high acuity and one-third required sedation, but only a small proportion required admission for severe psychiatric or medical problems and overnight observation/sedation was sufficient for an additional one-third of patients studied.[297]

Methamphetamine-induced acute psychosis is a recognized complication of methamphetamine intoxication. While research involving prisoners and psychiatric inpatients reveals prevalence rates of psychotic symptoms to be between 20 to 30 percent[298, 299] studies in outpatient and emergency room populations suggest rates closer to 12 to 13 percent.[300] One study found pre-existing psychiatric comorbidities to be 10 times that of the general population, but methamphetamine users remained three times more likely to experience psychotic episodes after adjusting for pre-existing illness. Furthermore, methamphetamine users are much more likely to experience psychotic symptoms relative to cocaine users[301] and one-quarter of those with such symptoms also exhibit violent or hostile behaviors.[302] Importantly, research not only indicates low prevalence of acute psychosis in community settings, but also that occurrence of such symptoms is associated primarily with heavy or chronic methamphetamine use and generally resolves spontaneously within hours or days.[303]

Long-term Effects of Methamphetamine Abuse

In addition to physical changes including a marked aging effect, weight-loss, and severe tooth decay ("meth mouth"), chronic methamphetamine abuse can lead to increased risk of psychiatric illness and neurocognitive deficits.[304, 305] Recent research in animal models and methamphetamine patients has focused on biochemical changes observed in the brain, particularly dopamine depletion associated with chronic use. Studies have linked reductions in dopamine transporters with decreased performance in tests of cognitive and motor function.[306] Functional imaging studies in the brains of former methamphetamine users demonstrate regrowth of these transporters; however, despite one to three years of abstinence, testing revealed persistent psychomotor impairments.[307] Other studies have shown prolonged deficits among abstaining methamphetamine users with respect to social-cognitive functioning including depression, motivation, aggression, social isolation, and decreased prospective memory formation.[308, 309] The presence of such long-term deficits not only highlights the importance of early intervention with new methamphetamine users but also has implications for rehabilitative services designed for those suffering from methamphetamine dependence.

Methamphetamine Withdrawal Syndrome

Much of what is known about withdrawal from methamphetamine is based on research involving patients recovering from cocaine addiction. Only a few prospective studies specific to methamphetamine withdrawal have been performed to-date. However, evidence suggests methamphetamine withdrawal differs from cocaine withdrawal in that the anergia and dysphoria is more severe. Unlike the marked physical symptoms associated with alcohol or opiate withdrawal, methamphetamine withdrawal syndrome is largely psychological, consisting of dysphoria, irritability, poor concentration, and sleep disturbance.[310] The most comprehensive study of the natural history of methamphetamine withdrawal found a biphasic course: severe depressive symptoms peaked within the first 24 hours of abstinence and returned to control levels by day seven; less severe symptoms of hypersomnolence, hyperphagia, anxiety, irritability, agitation, psychomotor retardation, poor concentration, tension, vivid dreams, and drug craving persisted throughout the second and third weeks of abstinence.[311] Although limited, relevant regional research[312] describes a relatively mild withdrawal syndrome, consisting primarily of depressive psychological symptoms, with the most severe symptoms occurring during the first hours of abstinence and largely resolving within one week.

Treatment of Methamphetamine Dependence

Similar to studies of methamphetamine withdrawal syndrome, little randomized, controlled data exists evaluating the various treatment approaches to methamphetamine dependence. The most widely studied are cognitive-behavioral therapy, contingency management or contracting, multifaceted programs such as the Matrix Model, case management, Stepped-Approach, and group-tailored strategies.[313, 314, 315, 316, 317] Emerging research seeks to develop pharmacologic interventions to replace or supplement psychological-behavioral treatment strategies. Several medications including antidepressants and stimulants have been tested in clinical trials with the goals of decreasing cravings, improving treatment retention rates, substituting amphetamine, and increasing abstinence. Findings are preliminary, but bupropion, mirtazapine, baclofen, topiramate, and D-amphetamine have shown some benefit in augmenting psychosocial outpatient therapy.[318, 319, 320, 321]

Annex 2: A Peer-based Network Trial with Methamphetamine Users in Chiang Mai, Northern Thailand

A Chiang Mai University and Johns Hopkins School of Public Health collaborative National Institute on Drug Abuse research project explored methods of reducing harm associated with methamphetamine use.[322] The phase III randomized control trial was designed to assess the efficacy of a network-orientated peer intervention for methamphetamine use reduction and STI/HIV prevention among young methamphetamine users and their drug-using and sexual networks. The intervention arm of the trial received risk reduction counseling plus seven two-hour network-orientated peer-educator sessions and a booster session. The control arm received risk reduction counseling and seven two-hour group sessions on life-skills training.

While the study did not show a significant difference between the control and intervention arms of the study, participants in both arms of the study received information about the physiological and psychological effects of methamphetamine; harm reduction strategies; and STI information, testing, and treatment services. Both arms showed a significant reduction in methamphetamine use (Figure I) and an increase in condom use (Figure II) over time.[323]

Outreach

The outreach team was composed of young adults who were well versed in community issues, understood the culture of methamphetamine use, and could interact with both community leaders and methamphetamine users alike. The outreach team was well funded, supportive, friendly, nonjudgmental, peer orientated, adaptable, and able to engage and interact with networks of methamphetamine users around the city.

Service Provision

Both the intervention and control arms of the trial received equal access to services tailored to methamphetamine users. Both the intervention and control incorporated many aspects of harm reduction and were directly designed to address issues of harm associated with methamphetamine use, and were tailored toward issues that methamphetamine users themselves spoke of during the ethnographic phase. Aspects of service provision that both aimed to reduce harm associated with methamphetamine use and provide primary health care services included:

- Information regarding the pharmacological and physiological effects of methamphetamine use;
- Methods to assist in the reduction of methamphetamine use and in reducing risk behaviors associated with its use;
- In-depth information about prevention, treatment, and care of HIV/AIDS and other common STIs;
- Free STI testing through urine and vaginal sample analysis for trichomoniasis, gonorrhea, and chlamydia, and free treatment for positive STI cases; and
- Free and optional voluntary counseling and testing for HIV.

Community Integration and Stigma Reduction

The study worked with methamphetamine users and community leadership structures to reduce aspects of stigma and discrimination. The team facilitated sessions between methamphetamine users and the community and discussed the feasibility of conducting small community projects that would be undertaken by people in the study. Such projects were often simple but symbolic in supporting community strength and unity; for example, the young users would help garden the local grounds of the temple.

Partnerships with Law Enforcement

The study fostered cooperation with local law enforcement agencies. The relationship was carefully built by senior members of the research team and included regular discussions about the purpose and progress of the study and an in-principle agreement that no study participants would face interactions with law enforcement as a direct result of participating in the study. This included the "safe house" intervention site being given a permission to run activities with methamphetamine users without any interference from police. Furthermore, senior police were invited to community advisory board meetings. A strong partnership between the police and the research team was a feature of the study.

Figure 10. Mean proportion using methamphetamine at baseline and at 3-, 6-, 9-, and 12-month follow-ups by intervention assignment. Brackets at each time point show 95% confidence intervals for the mean.

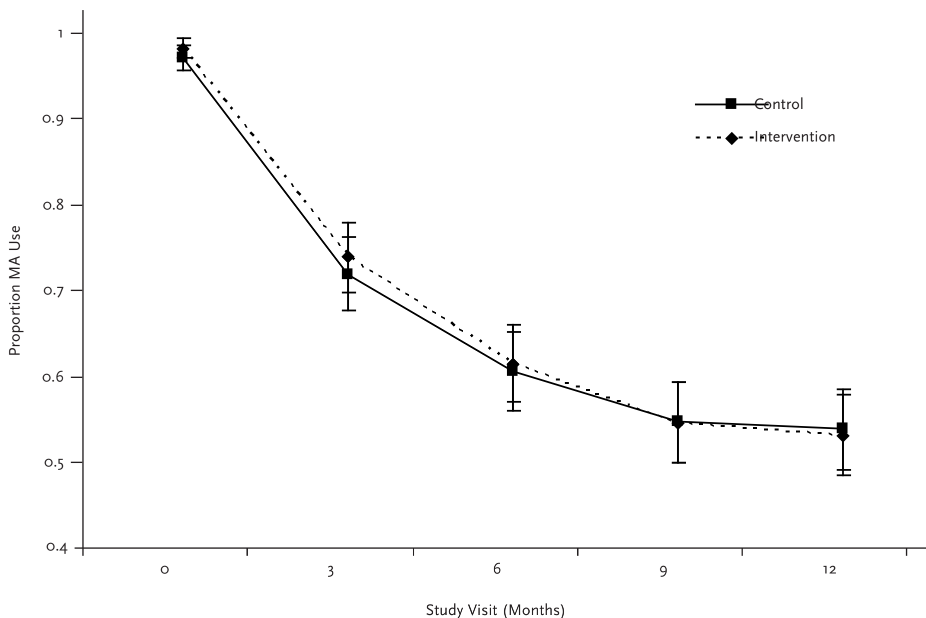
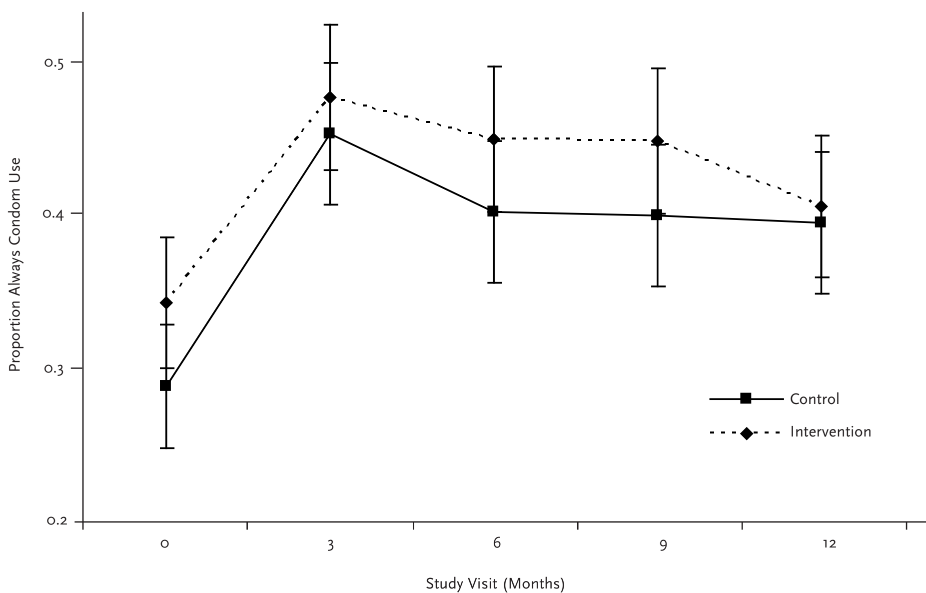


Figure 11. Mean proportion always using condoms at baseline and at 3-, 6-, 9-, and 12-month follow-ups by intervention assignment. Brackets at each time point show 95% confidence intervals for the mean.



Annex 3: UN Country Team Position on Drug Dependence Treatment and Support to the Royal Government of Cambodia

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United Nations in Cambodia

UN Country Team
Position on Drug Dependence Treatment and
Support to the Royal Government of Cambodia
16 February 2010

1. Drug dependence is a preventable and treatable disease, and effective prevention and treatment interventions are available. The best results are achieved when a comprehensive multidisciplinary approach, which includes diversified pharmacological and psychosocial interventions, is available to respond to different needs.

2. The UN in Cambodia Country Team's (UNCT) position and action on drug dependence treatment is guided by the UNODC-WHO Principles of Drug Dependence Treatment, published in March 2008. These Principles have been used in discussions with governments worldwide since their release.

3. Principles 3 and 4 are particularly relevant to the current situation in Cambodia. **Principle 3**: Evidence-informed drug dependence treatment. "Evidence-based good practice and accumulated scientific knowledge on the nature of drug dependence should guide interventions and investments in drug dependence treatment. The high quality of standards required for approval of pharmacological or psychosocial interventions in all the other medical disciplines should be applied to the field of drug dependence".

4. **Principle 4**: Drug dependence treatment, human rights and patient dignity. "Drug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes responding to the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination". Among the components in that principle, we would like to highlight two:
    a. As is the case with any other medical procedure, in general conditions drug dependence treatment, be it psychosocial or pharmacological, should not be forced on patients. Only in exceptional crisis situations of high risk to self or others should compulsory treatment be mandated for specific conditions and periods of time as specified by the law.
    b. When the use and possession of drugs results in state imposed penal sanctions, the option of treatment is presented to the patient/offender as an alternative to imprisonment or other penal sanction. The choice lies with the patient/offender.

5. **Principle 5:** Targeting special subgroups and conditions. In line with the principles, a targeted and differentiated approach is recommended when addressing the specific needs of subpopulations such as children, youth and women.

6. In March 2009 UNODC, jointly with WHO, launched a Joint Programme on Drug Dependence Treatment and Care with a vision of effective and humane treatment for all people with drug-related problems – nothing less than would be expected for any other disease.

7. The UNODC/WHO Joint Programme promotes policies that strike the right balance between the reduction of drug supply and drug demand, and incorporates evidence-based drug prevention and dependence treatment. It promotes services that provide a recovery-oriented continuum of care, matching the needs of dependent drug users in all social, motivational and clinical stages.

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8. Under the overall umbrella of the Joint Programme, in 2008 UNODC launched a global project, TREATNET. The regional component, which includes Cambodia, started in 2009. The mission of TREATNET in Southeast Asia is to demonstrate effective community-based drug dependence treatment services. This will build on prior UNODC community mobilisation efforts and serve as the basis for the larger UN coordinated support expected to be provided through a proposal currently under development.

9. The Royal Government of Cambodia (RGC) has requested that the UNCT support the provision of humanitarian/health assistance to compulsory treatment centres, to which the team has agreed. Provision of such assistance needs to be matched by a clear commitment on behalf of the RGC to abide by fundamental human rights provisions as enshrined in the Cambodian constitution and RGC obligations under international law:
   a. Ensure that there is no illegal and arbitrary detention;
   b. Ensure respect of minimum standards of humanitarian care and avoidance of inhuman and degrading treatments;
   c. Ensure that the confinement of people in drug centres can only be voluntary or, if coerced, should be the result of a court decision; and
   d. Ensure that the centres are subject to judicial oversight and open to other independent monitoring and reporting.

10. The UNCT has been informed of the RGC's intention to scale down the number of compulsory treatment centres to one by 2015. The UNCT welcomes a shift to an evidence- and community-based model in line with a rights-based approach. The UNCT hopes that the reduction in the number of centres will be mirrored by a significant reduction of the number of clients as they progressively become served by a developing community-based drug dependence treatment system with standards of care in line with international best practices and which are linked to the nine interventions of the harm reduction package recommended by the UN – a chance for Cambodia to lead the way for other countries.

11. The UNCT, at the request of the RGC, has agreed to develop a proposal for the provision of community-based drug dependence treatment services in 350 communes in Cambodia.

12. The UNCT is working to develop the proposal, integrating other ongoing and RGC-supported initiatives. These include:
   a. the community-centred outreach and counselling activities piloted by UNODC's project H83;
   b. the soon-to-be implemented WHO-supported methadone maintenance pilot;
   c. the demonstration of community-based services planned through UNODC's TREATNET programme; and
   d. the development of a strategic plan for mental health and substance use interventions.

13. Once the proposal is finalised and approved by the RGC, a concerted donor response will be required.

Notes

1. In Thailand, Cambodia, and Laos there exist a wide variety of terms and definitions that describe locations where the state detains drug users in the name of drug treatment: military boot-camps, detoxification centers, treatment and rehabilitation centers, drug treatment detention centers, detention centers for the treatment and rehabilitation of drug users. The reality, however, is that people are being detained against their will in places where they do not receive effective evidence-based drug treatment. Considering the wide variety of terms used to describe these centers, the authors have settled on the term compulsory drug treatment/detention centers, hereafter "CDTDCs."
2. In the Thai camps, detainees sleep in one room, which is locked at night and sleeps up to 100 males side by side.
3. Several visits by this author and multiple other independent observers confirm these conditions are the norm in Cambodia and Laos.
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248. Personal communication conducted between Mr. Leik Boonwaat, head of UNODC mission in Laos, and Tom Fawthrop, August 2008. Notes on file with the author.

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251. Email communications with Leik Boonwaat, country coordinator of UNODC in Laos, August 2008. Notes on file with the author.

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273. Personal communication with UNODC Laos country office, February 2010. Notes on file with the author.

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Public Health Program

The Open Society Institute's Public Health Program aims to build societies committed to inclusion, human rights, and justice, in which health-related laws, policies, and practices are evidence-based and reflect these values. The program works to advance the health and human rights of marginalized people by building the capacity of civil society leaders and organizations, and by advocating for greater accountability and transparency in health policy and practice. The Public Health Program engages in five core strategies to advance its mission and goals: grantmaking, capacity building, advocacy, strategic convening, and mobilizing and leveraging funding. The Public Health Program works in Central and Eastern Europe, Southern and Eastern Africa, Southeast Asia, and China.

International Harm Reduction Development Program

The International Harm Reduction Development Program (IHRD), part of the Open Society Institute's Public Health Program, works to advance the health and human rights of people who use drugs. Through grantmaking, capacity building, and advocacy, IHRD works to reduce HIV, fatal overdose and other drug-related harms; to decrease abuse by police and in places of detention; and to improve the quality of health services. IHRD supports community monitoring and advocacy, legal empowerment, and strategic litigation. Our work is based on the understanding that people unwilling or unable to abstain from illicit drug use can make positive changes to protect their health and that of their families and communities.

Methamphetamine use is a serious public health concern in Cambodia, Laos, and Thailand. Despite having policies that recognize addiction as a health problem, these governments are increasingly using law enforcement approaches that treat drug users as criminals rather than patients. This report examines the growing use of detention as “treatment” for methamphetamine users in the three countries. It examines the policies and practices that force people into detention centers, documents abuses and human rights violations occurring in the centers, and discusses the overall implications for individual and public health.

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