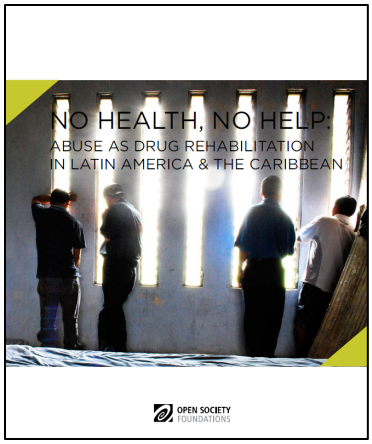
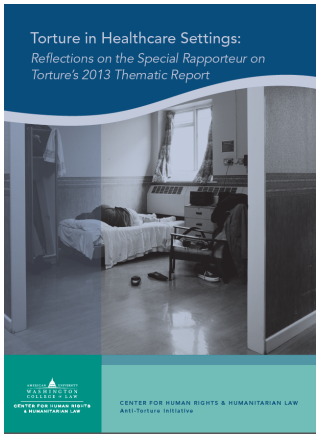
APPENDIX E: SELECT PUBLICATIONS

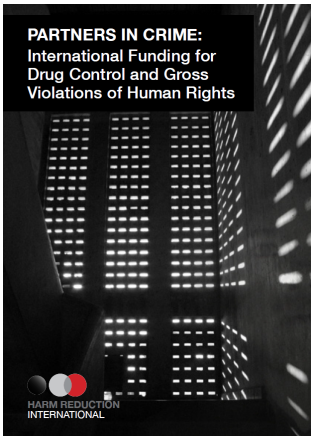
OSF Authored and Co-Authored Publications on Ending Drug Detention



2015 - “No Health, No Help: Abuse as Drug Rehabilitation in Latin America & the Caribbean”

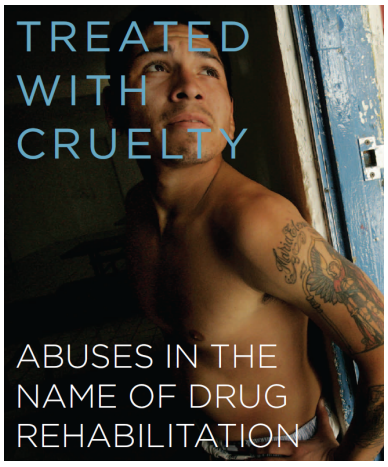


2014 - “Privatizing Cruelty — Torture, Inhumane and Degrading Treatment in Non-Governmental Drug Rehabilitation Centers,” in Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture’s 2013 Thematic Report

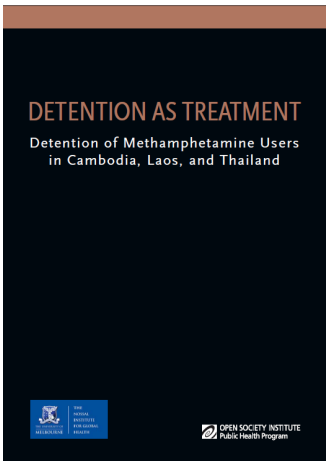


2012 - “Partners in Crime: International Funding for Drug Control and Gross Violations of Human Rights”

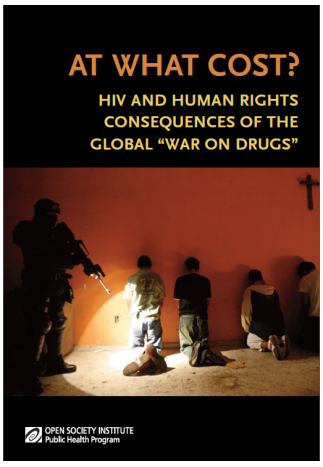
2011 - "Treatment or Torture? Applying International Human Rights Standards to Drug Detention Centers"



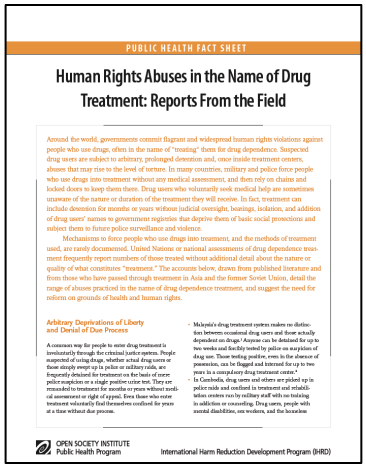
2011 - "Treated with Cruelty: Abuses in the Name of Rehabilitation"



2010 - "Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand"



2009 - "At What Cost? HIV and Human Rights Consequences of the Global War on Drugs"



2009 - "Human Rights Abuses in the Name of Drug Treatment: Reports from the Field"

Human Rights Abuses in the Name of Drug Treatment: Reports From the Field

Around the world, governments commit flagrant and widespread human rights violations against people who use drugs, often in the name of "treating" them for drug dependence. Suspected drug users are subject to arbitrary, prolonged detention and, once inside treatment centers, abuses that may rise to the level of torture. In many countries, military and police force people who use drugs into treatment without any medical assessment, and then rely on chains and locked doors to keep them there. Drug users who voluntarily seek medical help are sometimes unaware of the nature or duration of the treatment they will receive. In fact, treatment can include detention for months or years without judicial oversight, beatings, isolation, and addition of drug users' names to government registries that deprive them of basic social protections and subject them to future police surveillance and violence.

Mechanisms to force people who use drugs into treatment, and the methods of treatment used, are rarely documented. United Nations or national assessments of drug dependence treatment frequently report numbers of those treated without additional detail about the nature or quality of what constitutes "treatment." The accounts below, drawn from published literature and from those who have passed through treatment in Asia and the former Soviet Union, detail the range of abuses practiced in the name of drug dependence treatment, and suggest the need for reform on grounds of health and human rights.

Arbitrary Deprivations of Liberty and Denial of Due Process

A common way for people to enter drug treatment is involuntarily through the criminal justice system. People suspected of using drugs, whether actual drug users or those simply swept up in police or military raids, are frequently detained for treatment on the basis of mere police suspicion or a single positive urine test. They are remanded to treatment for months or years without medical assessment or right of appeal. Even those who enter treatment voluntarily find themselves confined for years at a time without due process.

- Malaysia's drug treatment system makes no distinction between occasional drug users and those actually dependent on drugs.[1] Anyone can be detained for up to two weeks and forcibly tested by police on suspicion of drug use. Those testing positive, even in the absence of possession, can be flogged and interned for up to two years in a compulsory drug treatment center.[2]
- In Cambodia, drug users and others are picked up in police raids and confined in treatment and rehabilitation centers run by military staff with no training in addiction or counseling. Drug users, people with mental disabilities, sex workers, and the homeless

are sometimes confined together. There is no judicial supervision or process for appeal, though detainees report being able to bribe their way out of internment.[3] There is no clear criteria for release, which may depend on being able to recite the Cambodian national drug laws from memory.[4]

- Drug users in Vietnam can be committed by family members or community focal points that keep lists of known drug users, and there is no due process to appeal commitment or extension of internment.[5] In response to high rates of return to drug use (as high as 95 percent by those leaving the centers[6]) the government in some cities has extended terms of detention to as long as six years, including labor in facilities built near the treatment centers.[7,8] Between 50,000 to 100,000 drug users are now interned in Vietnam's compulsory rehabilitation centers.[9,10]
- As many as 350,000 people are in China's reeducation through labor and compulsory detoxification centers, which have recently been renamed, but which continue to intern people upon suspicion of drug use or a positive test for illicit substances.[11] The involuntary nature of treatment is revealed by one 2004 study, which found that nearly 10 percent of those apprehended by the police on suspicion of drug use swallowed nails, metal filings, or ground glass in order to obtain a medical exemption and escape internment.[12]

Abuses in Confinement

What is referred to as "treatment" in many centers in fact includes painful, unmedicated withdrawal, beatings, military drills, verbal abuse, and sometimes scientific experimentation without informed consent. Forced labor, without pay or at extremely low wages, at times in total silence, is used as "rehabilitation," with detainees punished if work quotas are not met. These abuses violate the right to be free from torture, cruel, inhuman, or degrading treatment and punishment; the right to health; and other fundamental human rights.

Physical and mental abuse

- People formerly detained in Malaysian government treatment centers describe being kicked, punched, made to crawl through animal excrement, "act like a whale" by drinking and spitting out dirty water, and being abused and caned by a religious leader while being told that they are "worse than an animal." Overcrowding forces as many as 40 inmates to sleep in one cell.[13]
- In Vietnam, detainees are punished for failing to meet work quotas by being denied baths for a month, beaten with clubs, and being chained and forced to stand on their toes for more than 24 hours. Some internees report being put in isolation for up to a week in a cell so small that they are forced to sleep, urinate, and defecate in a standing position. Several people interviewed after completing compulsory treatment said they felt "lower than animals" after serving such sentences.[14]
- In Guangxi province, China, a recent study found reports of sexual abuse of female inmates by guards. Inmates received mandatory HIV tests but were not told the results. Guards repotedly used the data to know which inmates they could sleep with without using a condom.[15]
- In Nagaland, India, drug users have been crammed into thorn-tree cages in a sitting position.[16] In Punjab, drug treatment patients are routinely tortured, and in some cases have been beaten to death.[17]
- Drug users in Nepal recount that being taken for treatment has included suspension by the arms or legs for hours, beatings on the soles of the feet, threat of rape, and verbal abuse that includes assertions that they do not belong in the "new Nepal."[18]
- Former detainees in Cambodia report being locked in cement facilities where they are forced to withdraw "cold turkey," and not allowed to use the toilet despite the diarrhea that is commonly associated with such withdrawal, subjected to sexual violence and beatings with batons and boards, and compelled to confess to unsolved criminal cases. Detainees also describe shortages of food so severe that some eat grass and leaves.[19]
- In Russia, drug users in some facilities are chained to their bed and offered "flogging therapy."[20]
- In South Africa, unregistered treatment centers are allowed to operate without government regulation or medical oversight. Former residents of one center report being kicked and beaten if they did not maintain sufficient speed during physical training, which consisted of carrying boulders on their bare backs, rolling long distances on hot pavement, or running while carrying as much as 25 liters of water and then being forced to drink it all, pausing only to vomit.[21]

Despite the reported deaths of two teenage patients, the center still in operation.[22,23,24] Methods used to at other centers in South Africa include stranding patients in remote areas for three days, or prohibiting them from talking to, looking at, writing messages to, or touching another person while in treatment.[25]

Non-evidence-based and experimental treatment

- Malaysia's drug treatment centers are commonly run by ex-army personnel, and there are few trained paramedics or counselors.[26] Treatment is largely military-style discipline and drills in the hot sun. Methadone, a proven treatment for opioid dependence, is unavailable in most centers.[27] Condoms are also unavailable in many centers, despite accounts of sexual behavior among residents and between residents and guards.[28]
- Antiretroviral treatment is not available in most of Vietnam's treatment centers, although HIV prevalence is reported at 75 percent.[29] Some centers conduct mandatory HIV testing without informing those tested of their results.[30] Treatment of tuberculosis and other opportunistic infections is also unavailable, except through bribes, and there is no access to sterile injection equipment despite documented drug use in many centers.[31]
- Those interned in China's centers are often offered little treatment other than mandated chants such as "drugs are bad, I am bad," long hours of forced labor, and military-style drills.[32] Private and voluntary treatment methods include partial lobotomy through the insertion of heated needles clamped in place for up to a week to destroy brain tissue thought to be connected to cravings.[33] The technique is a variation of a Russian technique in which very cold, rather than heated, rods were used to destroy brain tissue.[34] This surgery is one for which families save and pay significant money, despite reports of adverse effects and widespread condemnation of such procedures as experimental and unethical.
- One treatment center in India runs on the motto "changed when chained," and shackles participants' legs together and loosens links the longer they remain drug free.[35] Some centers administer drugs that have been discontinued in Europe due to their adverse effects, while treatment with methadone or buprenorphine, both on WHO's list of essential medicines, is often not available.[36]
- Throughout Eastern Europe and Central Asia, "narcologists" charged with treating drug and alcohol addiction administer hypnoid therapies used in Soviet times, where patients have ampoules or substances injected under the skin and are told that they will explode and poison them if they drink or use drugs, or where patients are shown films with subliminal anti-addiction messages.[37] Prescription of methadone or buprenorphine, either for maintenance or detoxification, is illegal in Russia.

Forced labor

- Human rights groups assert that drug treatment centers in Vietnam are in reality forced labor camps, with inmates required to work long hours under extremely harsh conditions[38] at far below market wages. Tasks included carrying heavy buckets of water and excrement, hauling clay on their shoulders,[39] or making trinkets for market sale. Those who fail to meet work quotas are isolated and punished severely.[40]
- One study in China found that detained IDUs reported working from 7 a.m. to 2 a.m., seven days a week, performing unpaid factory labor, with the threat of punishment, including beatings, if production quotas were not met.[41]

"The Special Rapporteur wishes to recall that, from a human rights perspective, drug dependence should be treated like any other health care condition. Consequently, he would like to reiterate that denial of medical treatment and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law. Equally, subjecting persons to treatment or testing without their consent may constitute a violation of the right to physical integrity. He would also like to stress that, in this regard, States have a positive obligation to ensure the same access to prevention and treatment in places of detention as outside."

— Manfred Nowak

Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (Geneva, January 14, 2009)

Endnotes

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International Harm Reduction Development Program (IHRD)

The International Harm Reduction Development Program (IHRD), part of the Open Society Institute's Public Health Program, works to reduce HIV and other harms related to injecting drug use and to press for policies that reduce stigmatization of illicit drug users and protect their human rights. Since 1995 IHRD has supported more than 200 programs in Central and Eastern Europe and Asia, and bases its activities on the philosophy that people unable or unwilling to abstain from drug use can make positive changes to protect their health and the health of others. Since 2001, IHRD has prioritized advocacy to expand availability and quality of needle exchange, drug dependence treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the participation of people who use drugs and those living with HIV in shaping policies that affect their lives.

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Editorial

In rehabilitation's name? Ending institutionalised cruelty and degrading treatment of people who use drugs

The UN's World Drug Day on June 26th is also the UN International Day in Support of Victims of Torture. While coincidental, the conjunction is unfortunately apt. Across the world, whether the result of police apprehension, diversion to treatment as an alternative to incarceration, or involuntary commitment under health statutes or at the request of family members, people who use drugs are subjected to cruel, inhuman, or degrading practices, many of which rise to the level of torture. These breaches of international law are often conducted in the name of law enforcement or in facilities run by police or military personnel; this highlights the difficulty, and importance, of protecting the rights of criminalised groups in state custody, of whom drug users are almost always the most numerous. Because the so-called health services are so often abusive detention by another name, honest examination of what has been allowed to pass as drug treatment requires that we challenge the notion of "treatment failure," examining treatment systems more closely rather than unreflectively attributing blame to the individuals within them.

The prohibition against torture in international law is "non-derogable," meaning that it is binding for all states (UN Committee Against Torture, 2007). Even those countries that have not signed international conventions prohibiting torture are bound to respect international norms and to take immediate action to end torture (United Nations General Assembly, 1984). International instruments prohibiting torture, cruel, inhuman, and degrading treatment and punishment include the Universal Declaration of Human Rights (article 5), the International Covenant on Civil and Political Rights (article 7), and the Convention Against Torture (United Nations General Assembly, 1948; United Nations General Assembly, 1966; United Nations General Assembly, 1984).

In the era of Abu Ghraib and Guantanamo, complaints about torture or ill-treatment of drug users in health care settings may sound trivial. United Nations authorities, however, after considering documentation from countries as varied as Nepal, India, Cambodia, and Sweden, have been clear that abuses committed in the name of drug treatment are rights violations and cruel, inhuman, degrading, or torturous and that treatment-related abuses merit moral and legal scrutiny. Manfred Nowak (Human Rights Council, 2009), Special Rapporteur on torture, has noted that "from a human rights perspective, drug dependence should be treated like any other health care condition," and declared that "denial of medical treatment and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law" (p. 23). Navanethem Pillay, the UN High Commissioner for Human Rights (Office of the United Nations High Commissioner for Human Rights, 2009) recently affirmed that "individuals who use drugs do not forfeit their human rights" and noted that "too often, drug users suffer discrimination, are forced to accept treatment, are marginalised and often harmed by approaches which over-emphasise criminalisation and punishment."

Despite these bold statements, the UN response to cruel treatment and torture of drug users is largely a tale of two cities. While UNAIDS, the Office of the High Commissioner for Human Rights, and other Geneva-based agencies and human rights bodies have expressed concern (Sidibé, 2009a; Office of the United Nations High Commissioner for Human Rights, 2009; Mandate of the Special Rapporteur on the question of torture and Mandate of the Special Rapporteur on the right to everyone to the highest attainable standard of physical and mental health, 2008), two of the three Vienna-based UN drug control entities, the International Narcotics Control Board and the Commission on Narcotic Drugs, have yet to affirm the human rights of people who use drugs. The UN Office on Drugs and Crime (UNODC) in Vienna, at once responsible for HIV prevention among injecting drug users and for advising countries on strengthening their drug control laws, remains poised uncomfortably in between. Antonio Maria Costa, the agency's executive director, routinely mentions human rights in his speeches (see for example Costa, 2009), and Gilberto Gerra, chief of the health and human development section, publicly affirms that forced labour is not treatment and calls for approaches based in peer-reviewed evidence. Regional UNODC offices have also highlighted human rights concerns (Bezziccheri, 2009). Still, unlike UNAIDS or the World Health Organization, UNODC has no dedicated staff to examine human rights issues, and no human rights guidelines to follow when carrying out its mandate. UNODC's annual *World Drugs Report* uncritically reproduces country estimates of the number of people in treatment, while doing little to illuminate the alarming conditions that often lie behind these figures (United Nations Office on Drugs and Crime, 2009).

Torture as "treatment"

Health and criminal justice advocates have encouraged efforts to divert drug users to treatment rather than to penal institutions. These arguments have gained favour in settings as varied as New York, which recently reformed the mandatory minimum sentences known as the Rockefeller Drug laws, and in Indonesia, where the Supreme Court in March 2009 encouraged judges to send drug users to rehabilitation centres rather than to prison

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(Ketua Mahkamah Agung Republik Indonesia, 2009). However, rather than alleviating suffering, treatment for drug dependence is often incarceration by another name, with less due process rights or safeguards than would be found in prison systems. Even when drug users enter voluntarily, they are sometimes unaware of the "treatment" they will receive.

In Malaysia, for example, detainees in government treatment centres have reported that their orientation included being caned by religious teachers, beaten with bricks, kicked, punched, made to crawl through animal excrement and swallow dirty water. In Vietnam, between 50,000 and 100,000 drug users remain detained in so-called "06" centres (Hammett et al., 2007; World Health Organization, Regional Office for the Western Pacific, 2009). Here treatment can include forced labour at far below market wages, beatings for those who fail to meet quotas, and punishment by such methods as isolation in cells, where patients are required to remain vertical, and defecating where they stand (International Harm Reduction Development Program, 2009). In China, where the "Wind and Thunder Sweeping Narcotics" campaign allows police to arrest and urine-test suspected drug users (Cohen & Amon, 2008), more than 330,000 are currently detained for up to two years in compulsory detoxification centres run by the Public Security Bureau (Ministry of Public Security of the People's Republic of China, 2008). Conditions include long hours of forced labour, beatings, withholding of food, and sleep deprivation. Guards get around a national law prohibiting them from physically punishing detainees by getting more senior detainees, called "Big Brothers" or "Big Sisters" to do the dirty work of performing the beatings, while they stand aside and watch (International Harm Reduction Development Program, in press). In Cambodia, detainees report beatings, custodial deaths, sexual abuse, and shortages of food so severe that those detained are forced to eat grass and leaves to survive (International Harm Reduction Development Program, 2009).

The limits of these facilities are further reflected in the absence of HIV or addiction treatment, and by the fact that police, security services, or the military oversee the services delivered. In Vietnam, despite detention terms of three years or more and high rates of HIV among inmates (Department for Social Evil Prevention et al., 2009), centres run by the division of social evils prevention in the Ministry of Labor, Invalids, and Social Affairs rarely offer condoms or HIV treatment, and provide no clean needles to detainees. Those tested for HIV are frequently not told their status until they become too sick to work and are released (International Harm Reduction Development Program, 2009). In China, those detained for drug use in the centres run by Public Security, report that forced HIV testing is common, though detainees are rarely told their results. Instead, according to one guard (Cohen & Amon, 2008), the guards used HIV testing data "to know which female inmates they could sleep with without using a condom" (p. 1685). In Thailand, suspected drug users are frequently kept in prison with convicted criminals until a commission can evaluate their case, and most are consigned to compulsory treatment and housed in centres run by the military (Pearshouse, 2009). In Cambodia, compulsory treatment centres frequently lack any trained medical personnel, and are staffed by police or poorly trained guards wielding sticks and electric batons (Human Rights Watch, 2010).

The Convention Against Torture (Article 2) binds governments not only to ensure that state officials do not commit torture, but also to take action to prevent torture in any territory under their jurisdiction (United Nations General Assembly, 1984) (see also: UN Committee Against Torture, 2007). Many states are remiss in this duty, since privately run drug dependence facilities commit abuses including chaining, beatings, humiliations, and custodial deaths. In Russia, one of the best known private treatment centres chains patients to beds during withdrawal, while others offer "flogging therapy" (International Harm Reduction Development Program, 2009). Footage aired on the BBC from a Serbian religious facility showed treatment to include being beaten with a paddle in front of a religious icon (BBC, 2009). A recent communication from a former patient at the Noupoort Christian Care Centre in South Africa described abuse including anal rape with a broomstick and demands that detainees eat their own feces (Citizen, 2009). While the claims have not yet been independently verified, the Centre is one where custodial deaths were reported in 2001 (Anonymous, 2001).

Abuses are not limited to African, Asian, or post-Soviet countries. Indeed, the break-them-down, build-them-up model used as treatment in Asia finds its origins in a therapeutic community approach supported by Daytop, Inc., a U.S. drug treatment provider that the U.S. State Department has engaged to offer training in Cambodia, Vietnam, and other countries. While stressing the therapeutic value of support provided by drug-free peers, Datyop's philosophy regards active users as "alone as in death" (Daytop Inc.). This invocation of death in association with drug use, and the refusal to recognise existing social networks as in any way meaningful, echoes what some analysts of slavery and abuses in health care settings have termed "social death". This is the process by which individuals are regarded as alien to any network of family or friends, and so reduced to objects to be acted upon rather than subjects deserving a voice or authority of their own (Patterson, 1982; Sweeting & Gilhooly, 1991). In returning people who use drugs from this state of social death to healthy life, extraordinary measures—including those that scourge the body or mind—are deemed justified.

Harm reduction, decriminalisation and beyond

Increasingly, these punitive approaches to drug treatment exist in tension with other, evidence-based efforts to prevent HIV and other drug-related harms. Malaysia, Vietnam, and China are all countries where evidence-based, harm reduction approaches such as methadone or buprenorphine treatment have been implemented and scaled up, often with the assistance of UNODC or international donors. China, for example, is appropriately recognised for remarkable commitment to scale-up of methadone treatment: since the medication was introduced by the government in 2004, more than 178,000 patients have received treatment (Jian, 2009). Vietnam launched two pilot methadone programmes in 2008, with the support of the U.S. and UK governments. Malaysia is noteworthy for its move to increase methadone treatment and to decrease the numbers of those remanded to compulsory treatment centres run by ministries of interior or police, and also for its willingness to use government funds to do so (Chawarski, Mazlan, & Schottenfeld, 2006). Nonetheless, as quickly as such responses by health authorities grow, those in the punitive drug-free centres continues to exceed, exponentially, the number receiving evidence-based treatment for drug dependence (World Health Organization, Regional Office for the Western Pacific, 2009). In many countries, the compulsory approach is growing, rather than declining: in Thailand, for example, where there were six compulsory treatment centres in 2000, there are now 84. The number of centres in Cambodia and Laos has increased tenfold in less than a decade (Thomson, in press).

Authorities at the United Nations have begun to consider more directly the human rights implications of the schizophrenic approach to treatment of drug users. In a 2008 discussion paper on drug dependence treatment, UNODC and WHO note that human rights violations are unacceptable (United Nations Office on Drugs and Crime and World Health Organization, 2008). A companion document to WHO's recently released guidelines on pharmacotherapy for opiate dependence, outlined what the authors termed "practical ethical issues" for drug dependence treatment, including

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individualised, safe, and flexible treatment, free and fully informed consent, patient autonomy, and accurate information about the risks of detoxification without medication (Carter & Hall, 2007).

These injunctions and recommendations, however, are routinely ignored. WHO and UNODC should develop clear guidelines that detail not only good treatment practice, but that also make explicit that such practices as chaining, flogging, and forced labour do not constitute drug treatment. The International Narcotics Control Board, as the body that advises national governments on responses to illicit drugs, should take a strong stance against abuses committed in the name of drug treatment, and the Commission on Narcotic Drugs should devote attention to the topic at their annual meetings.

Ensuring compliance with prohibitions against torture need not be the sole province of international bodies. Donors, too, should articulate ethical guidelines for engagement with punitive drug treatment regimes, and consider cessation of funding in the case of flagrant rights violations. In the U.S., for example, the so-called Leahy laws,[1] prohibit military assistance to foreign military units that violate human rights. The United States also decertifies countries whose drug trafficking is deemed uncontrolled, with decertification accompanied by cuts in most U.S. foreign assistance (US Department of State). However, the United States has no provisions to prohibit funding to compulsory drug treatment centres that violate human rights. Decertification may be needed not just for drug trafficking or transit, but for those countries whose drug treatment practices subject participants to torture. Donors should also ensure support for greater operational research into outpatient treatment and harm reduction, particularly for stimulant users, who are the majority of those interned in compulsory treatment centres in many southeast Asian countries (Thomson, in press).

Removing police from health care settings, and ensuring that drug users in need of treatment are regarded as patients, is also likely to require removal of drug users from the category of the criminal. Increasingly, leaders in the global response to HIV have highlighted the adverse effects of punitive laws and policies on health promotion, with the UN Secretary-General, the executive director of UNAIDS, and the executive director of the Global Fund calling for decriminalisation of possession of drugs for personal use (O'Hara, 2009; Sidibé, 2009b; United Nations General Assembly, 2009). In Portugal, a policy change decriminalising possession of illicit substances without intent to traffic, and promotion of voluntary drug treatment, has resulted in improved treatment—both in terms of numbers of drug users seeking treatment and in the funding available for treatment services (Greenwald, 2009). While changes in criminal law are unlikely to resolve all problems related to police or public security, for the detention of people who use drugs—those detained in China and Vietnam, for example, are held in administrative grounds, and never appear before a judge—police are likely to remain their primary point of contact as long as criminal penalties for petty drug use remain in force. The results are seen in the high rates of HIV infection, less than universal access to HIV treatment, and near universal return to drug use following release among those institutionalised in the name of treatment.

Next June 26, rather than the usual bonfires of seized drugs and executions of alleged traffickers, countries should remember that the day is also the one on which the Convention Against Torture came into force. The catalogue of abuses conducted in the name of health suggests that it is not drug users who must be broken down, but rather the systems that arbitrarily detain hundreds of thousands of drug users and subject them to cruel, inhuman, and degrading practices unjustified by law or the most basic moral, ethical, or evidentiary standards.

[1] There are actually two so-called Leahy laws, one attached to the Foreign Operations Appropriations Act and one attached to the Defense Appropriations Act. Both are named after Patrick Leahy, the Vermont Senator who was the principal sponsor of the laws. The full text of both laws is available at http://leahy.senate.gov/issues/humanrights/law.html.

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Conflict of interest statement

The authors declare that they have no conflicts of interest.

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Mandate of the Special Rapporteur on the question of torture and Mandate of the Special Rapporteur on the right to everyone to the highest attainable standard

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VOICES

Navigating a Rotten Compromise

April 12, 2010 | by Daniel Wolfe

Last week, the Open Society Institute hosted a meeting in Washington to bring together U.S. government officials and aid organizations providing HIV services in Asia. We wanted to call attention to the fact that U.S. funds (particularly through the U.S. President's Emergency Plan for AIDS Relief) are being used to support work in and around detention centers where people who use drugs are routinely abused. There are more than 400,000 people in these places—ostensibly compulsory drug rehabilitation centers, though, as I have blogged previously, they are operated by the police and the detainees are held there without trial, appeal, or medical evaluation.

In China, Vietnam, and Cambodia, detainees in these centers report being beaten by guards, sexually abused, and starved. In China and Vietnam, they are forced to work without pay, often in the service of private companies that contract for slave labor with the centers, with severe beatings if you don't meet your work quota. Even if you enter voluntarily you are beaten within an inch of your life if you try to escape before the end of your term, and terms have been progressively extended. Now, China interns you for up to two years for a positive urine test, and in Vietnam it can be up to four.

Every center in Vietnam has a "punishment room"—by law. Infractions like smoking a cigarette or drinking tea may land you in this room for weeks at a time. In here, you may be forced to hang for hours by one or both arms, made to kneel for hours on sharp objects, forced to squat in water in a room that is too small to stand up in, or just left alone for weeks in a one meter by one meter room that is too small to lie down in.

Funders and those who implement their programs are left with a very real ethical and programmatic conundrum. If people are starving in a concentration camp, do you go in and serve them food? How about medicines for those with HIV? If you do decide to go in, how do you talk and think about it to ensure that you're not just working to perpetuate a system that is illegal, immoral, and in fact only impedes the public health goals you are supposed to be supporting? As one of the ethicists at the meeting described, you want

to avoid what philosopher Avishai Margolit calls the “rotten compromise”—working to reach common understanding with a system so fundamentally organized around humiliation or degradation that a collaboration is ethically unworkable.

The U.S. government-funded implementers working in or around the organizations have been relatively loose with their thinking and descriptions—one, in China, says it works “in partnership” with the public security bureau. Another, in Cambodia, announced that it looked forward to working with one of the centers to make it a “model of excellence.” This was a place that tasered and starved detainees. After criticism, the plan was shelved, but there is still no clear policy about when or how to engage. HIV experts have not gotten bogged down by the forced labor or human rights issues. They see their job as getting HIV services to people in need, and meeting their targets. In Vietnam and China, where the HIV epidemics are driven by injecting drug use, these centers are where the HIV is.

At our meeting, representatives from international humanitarian organizations talked about how they grapple with work in prisons, where people are also often treated badly, by making sure that they have unlimited access to all patients/prisoners, reporting abuses to authorities, and being ready to leave if they don’t feel like they’re making substantive change. It was clear that there are more questions than answers when it comes to current work in Cambodia, China, and Vietnam. It was also clear that most agencies working in these centers or on laws related to them, had not been given guidance on how to deal with the hard questions. One HIV program implementer said there were no reported abuses in the centers they worked in—but then acknowledged that they had never asked.

The meeting was a great start, and we hope the U.S. Global AIDS Coordinator will issue formal guidance on the centers and call for their closure. Since the U.S. government is a many-splendored thing, even understanding who needs to be at the table to develop a guidance note is complicated: the drug control branch of the state department, known colloquially as “drugs and thugs” and more formally as the Bureau of International Narcotics and Law Enforcement Affairs, funds training in these centers. The question of forced labor may be of interest as the U.S. engages in trade negotiations with Vietnam. We also met with Congressional and National Security Council staff, who we hope will investigate the question of how much the U.S. government is spending on work in or around these kind of centers and how abuses could be curtailed.

For closed and semi-closed societies, these kinds of ethical measures of benefit vs.

harm are not restricted to detention centers. Urging NGOs to engage with marginalized populations in facilities or countries where the moral dilemmas are stark means that all of us—donors, health implementers, and advocates—need to keep asking ourselves the hard ethical questions as we navigate the “rotten compromise.”

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Asia, Drug Policy Reform, Health, Public Health Program, Rights & Justice, Rights & Justice in the United States, Southeast Asia, United States

VOICES

Following the Money in Asian Drug War Abuses, and Finding U.S. Aid

August 30, 2012 | by Daniel Wolfe

The United Nations, AIDS advocates, and drug treatment specialists have increasingly criticized detention centers—run by governments in Asia and private actors in Latin America and elsewhere—where those suspected of using illegal drugs are held under lock and key, beaten, humiliated, and forced to work in the name of treatment and rehabilitation. Now a Bloomberg editorial has asked the U.S., Australia, the European Union, and other donors to explain why they would use development aid to pay for abusive centers that all experts agree should be shut down.

Recent reports by Harm Reduction International and Human Rights Watch make it clear: to really see the disconnect between the rhetoric of drug control assistance and the reality of the international drug war, just follow the money. In Laos, a massive "drug treatment" center in the capital holds people who do not need drug treatment at all, including casual users, street children, and the mentally ill. Shockingly, the U.S. government—despite multiple earlier reports of problems in the center—helped to build and strengthen the facility, and held press conferences and embassy events to brag about it.

The UN also supports the center. In one particularly ugly effort to prettify the realities of this institution, this year the UN Office on Drugs and Crime (UNODC) sponsored a fashion show to raise money for the center. Models walking the runway were no doubt unaware that those detained there for months suffer physical abuse or that suicide attempts by detainees are common. The UN and the U.S. Embassy can have no such excuse.

As *Partners in Crime*, the searing report by Harm Reduction International, makes clear, international aid is also used to facilitate extradition leading to executions in the name of drug control, "capacity building" in Vietnamese slave labor centers where drug users are

beaten and tortured, and drafting of laws that enable detention without due process or right of appeal.

Use of international aid for drug detention is what philosopher Avishai Margolit calls a "rotten compromise"—assisting a system so fundamentally flawed that humanitarian support may inadvertently hurt in the name of help. One hopes that the U.S. government, which now says it is committed to moving to a public health approach to the drugs problems, can take a hard look at how good intentions have led to immoral investments in detention centers that are some of the worst relics of the drug war.

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VOICES

Extreme Abuse in the Name of Drug "Treatment"

March 13, 2014 | by Roxanne Saucier

If a group of men grab you off the street, call you a danger to society, and lock you in a "treatment" facility where you are beaten for trying to escape, who should protect you? This is one of the many troubling questions raised in a new report edited by the UN Special Rapporteur on Torture and funded by the Open Society Foundations.

Though human rights groups have criticized government-run drug detention centers for practices including forced labor and torture in countries in East and Southeast Asia, private centers—often run by vigilante groups or religious institutions—can be just as abusive. Accounts of life in these centers have also emerged from Russia and Serbia.

Even countries throughout Latin America—a region of the world has lately lauded for its increasingly progressive stance on drugs—allow these punitive institutions. Governments in these countries at best turn a blind eye, and at worst are complicit.

Here are four ways that these private detention centers violate individual rights in Latin America:

- **Admission is often forced or coerced.** Families often don't know the bleak reality of conditions in the center, or see no other alternative for treatment. As one family member in Mexico said, "We took him there with the hope of rehabilitation, and that he would stop using drugs. We didn't send him to get beaten up; that was never our aim." In other cases, centers send volunteers out on "hunting parties" to essentially kidnap people on the streets who appear intoxicated. In some instances, police participate in roundups. When the "patients" arrive at the center, staff or volunteers from the centers often physically

force them inside against their will.

- **"Patients" are held against their will.** People describe steel bars, razor wire, concrete walls topped with glass shards, and guards tasked with keeping them inside the centers. Adequate medical care may even be restricted due to worries about escape. Family visits are usually monitored and terms of "treatment" can be extended arbitrarily. One detainee in Guatemala complained, "My family brought me here. And, from what I know, the pastor has to tell my family that I'm ready to go. I don't know [if] they will find a reason to keep me here, and every time I think I am ready, they change the game."
- **Torture passes for treatment.** One detainee described the routine in the center where he was being held: "The head guy would put shoes on, tell us to lie down, and then run on top of us. Back and forth. Back and forth. After he would beat us, he would make us sleep on the stairs, in boxers. He called it discipline." Detainees also report physical punishment for complaining about conditions or other behavioral infractions. In a Guatemalan center, for example, those who say, "I don't like it," are punished with 1,000 squats, as are those who "fail to love the Bible." Swearing is punished with 1,000 squats per letter, "including the spaces." Escape attempts are punished with 5,000 squats a day for eight days.
- **People are dying in detention.** In Peru, two fires in religious centers claimed the lives of those placed there for "rehabilitation"; detainees struggled against locked doors as they burned to death. In an account from Mexico, a sister described her brother's death from the physical abuse he received by center personnel. There are likely many other similar cases that haven't received widespread attention.

Even though many of these centers are run by private entities, it is the responsibility of governments to monitor them to ensure that abuses don't happen. Unfortunately, governments are doing very little to prevent human rights violations in private centers, to sanction the facilities, or to punish those responsible.

In fact, many such centers are not even officially registered with government entities. For example the Peruvian agency responsible for drug prevention and treatment noted that of 222 "rehabilitation" facilities in the country, only 20 percent have all the necessary licenses and required medical staff. There are an estimated 700 "treatment" slots in registered facilities for an estimated 100,000 people in need. In Guatemala, there is reportedly one government worker responsible for visiting the hundreds of drug rehabilitation centers and accrediting them.

The United States is among those governments offering training to staff and assessment

of drug treatment centers in an effort to improve conditions. But these efforts sidestep the critical issue that many people in these centers don't actually need to be there. Many of them do not have a problematic dependence on drugs and are not clinically in need of treatment, or they are from other "socially undesirable" groups like homeless people, or those with disabilities, and shouldn't be detained in the first place.

The answer isn't to improve centers that hold people against their will. Instead, governments need to make evidence-based, voluntary treatment in their communities more available—and make sure that centers that repeatedly violate human rights are closed for good.

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