

Drug dependence treatment in China: A policy analysis

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Introduction

Drug use and supply have been a sensitive and high-priority issue for successive governments in China since at least the Opium Wars in the mid-19th century. China's policy response to drug use relies on punishment and coercion as central components, including compulsory detoxification, detention in labour camps or so-called 'rehabilitation' facilities, and compulsory registration with law enforcement authorities resulting in surveillance and random interrogations.

Yet, in the late-1990s, in a policy move that appeared to emphasize healthcare instead of punishment for people who inject drugs, China began implementing the world's largest scale-up provision of opioid substitution therapy (OST) and needle and syringe programmes (NSP) – two critical harm reduction measures for preventing HIV transmission.² However, the overall approach towards people who use drugs remains punitive and stigmatising in China. As drug use continues to rise and expand across a greater range of drugs (especially synthetic drugs such as methamphetamine), as well as amongst younger age groups,³ China requires a comprehensive system of evidence-based and humane drug treatment and harm reduction services capable of advancing the health and quality of life of individuals and communities.

This IDPC briefing paper provides an analysis of the current drug treatment system in China and offers recommendations for ensuring its effectiveness.

Historical context: The origins of China's drug treatment system

The beginnings of drug control: The 'Hard Strike' strategy

In the mid-19th century, the armies of China's Qing Dynasty fought and lost two successive Opium Wars against Britain and France.⁴ In 1860, at the end of the Second Opium War, China was forced to submit to a *de facto* legalisation of opium, based on the Treaty of Tianjin.⁵ For the next half-century, unprecedented amounts of opium, produced in India and domestically, became available in China, leading to a surge in its use and dependence.

At the turn of the 20th century, it was estimated that almost one in four Chinese men regularly smoked opium.⁶ In 1909, China's delegation to the International Opium Commission of Shanghai claimed that the country was then home to between 21.5 and 25 million people dependent on opium.⁷

Opium consumption remained at epidemic levels up until the founding of the People's Republic of China in 1949, following the communist revolution led by Mao Zedong. Mao's response to the opium epidemic set an important precedent for later administrations to follow. Using a combination of voluntary and compulsory 'detoxification', Mao was credited with 'curing' between 10 and 20 million people who used drugs in just three years.⁸

In 1950, the government issued the *Circular on Strict Prohibition of Opium and Drug Taking*, which criminalised the production, trafficking, and sale

of opium and other drugs, but made consumption an administrative offence. Under the new law, people using drugs were required to register at a local government office, and consent to giving up drug use within a fixed time period.⁹ Those who successfully ended their drug use would be spared punishment, whereas those who failed — or did not register — would be heavily fined or sentenced to administrative detention for ‘coercive rehabilitation’.¹⁰

Between 1950 and 1952, millions of Chinese citizens took part in Mao’s anti-drug campaign. Trade unions and other party organisations held large education forums and anti-drug rallies, where people found to be using or trafficking drugs would be publicly shamed and sentenced before an audience.¹¹ By the end of 1952, China claimed to be a ‘drug-free nation’.¹²

Subsequent propaganda has immortalised Mao’s anti-drug campaign as a ‘glorious’ chapter in Chinese history, replenishing national pride after the ‘humiliation’ of widespread ‘drug addiction’.¹³ It is no surprise, then, that Mao’s anti-drug tactics were later revived by his successor, Deng Xiaoping, whose administration witnessed the steady return of China’s illicit drug market.

Like his predecessor, Deng believed that illicit drug use posed an existential threat to Chinese society. Such fears were best articulated in Deng’s ‘social stability’ doctrine, which regarded social stability as the ‘essential pre-condition to economic development’.¹⁴ Any behaviour deemed as ‘threatening’ to social stability — even behaviours that were then not considered as criminal, such as drug use and sex work — thus became highly politicised during Deng’s premiership, and attracted ‘swift and severe’ punishment as part of the Comprehensive Management of Public Order.¹⁵

Deng’s preferred model of combating drug use and drug crime was known as the ‘Hard Strike’: a highly aggressive, periodic police crackdown, in which suspected offenders were sentenced through fast-tracked mass trials; and sentences were doubled upon each successful conviction.¹⁶ It was under the influence of the Hard Strike and the broader ‘social stability’ doctrine that a form

of detention involving forced labour, known as ‘rehabilitation through labour’ (RTL), emerged as the preferred punishment for drug use. People using and/or dependent on drugs represented the largest increase of people detained in RTL since the late 1980s; other detainees included political dissidents and those engaged in activities deemed as ‘morally unacceptable’ such as sex work and gambling.¹⁷

A new ‘health’ approach to drug use

In the early 2000s, China’s leaders began to rein in the Hard Strike model, seeing it as an overused weapon in the fight for social stability. Xiao Yang, president of the State People’s Court, admitted that successive Hard Strike campaigns had brutalised minor offenders,¹⁸ through a combination of police violence, contact with more serious offenders in jail, and long stays in administrative detention, often in inhumane conditions.¹⁹

In 2006, Premier Hu Jintao inaugurated a new anti-crime doctrine to complement the Hard Strike strategy, known as the ‘socialist harmonious society’, which remains in place today. Hu’s harmonious ideal seeks to balance ‘leniency and severity’ in China’s response to crime and ‘antisocial behaviour’, as well as to impose clear checks and balances on the arbitrary use of administrative detention.²⁰ In service of this ideal, punishing people using or dependent on drugs were no longer the goal of China’s drug policy. Instead, people who use drugs were to be thought of as ‘sick’ people and ‘victims of their dependency’, and should therefore be offered medical treatment instead of being punished. This change of perception was also driven by China’s HIV epidemic among people who inject drugs which, from the late-1990s onwards, obliged policy makers to adopt a public health-oriented approach to tackling drug use and drug-related crime — including an expansion of harm reduction services such as NSPs and OST.²¹

These developments culminated in 2007 with the passing of the *Anti-Drug Law*. In June 2008, during a speech given to mark the inauguration of the new law, Hu Jintao described China’s drug war as a ‘battle’ to be fought on five fronts: prevention and education, treatment and rehabilitation, law enforcement, drug administration, and international cooperation.²²

In theory, this ‘all-round’, ‘inter-agency’ approach may be considered as a clear departure from the punitive, ‘shock and awe’ tactics of the Hard Strike era.²³ In practice, however, there are still many similarities between China’s current and former approaches to drug policy and drug dependence treatment.

Crucially, among both law enforcement officials and the general public, the impulse to punish and isolate people who use drugs from their communities — for posing a threat to ‘social stability’ — still runs strong.²⁴ This position follows the six decades prior to 2008, where China’s leaders identified drug use as a great ‘social evil’, a national ‘humiliation’ following defeat by the British in the Opium Wars, and a ‘sign of moral decay’.²⁵ Such attitudes continue to complicate efforts to expand evidence- and human rights-based drug treatment in the country.

Overview of China’s current drug treatment system

Like China’s previous drug legislation, the *Anti-Drug Law* ensures that drug use is treated as an administrative offence (instead of a criminal offence), while China’s longer standing Criminal Code outlines severe criminal penalties for trafficking, production and supply, ranging from up to 3 years imprisonment for a trafficking offence involving 10 grams or less to the death penalty for a trafficking offence involving ‘serious circumstances’ such as violence regardless of quantity.²⁶ Technically, drug use is therefore ‘decriminalised’ in China. However, the severely punitive nature of the administrative sanctions imposed render China’s model of decriminalisation inconsistent with the recommendations for decriminalisation of drug use and possession for personal use recommended by international health and human rights bodies (see also **Box 1** on additional restrictions imposed upon people who use drugs).²⁷

A hallmark of former President Hu Jintao’s ‘harmonious society’, the *Anti-Drug Law* represents China’s best efforts at implementing a more humane, compassionate, and self-proclaimed ‘scientific’ approach to drug treatment. Chinese government officials often refer to the *Anti-Drug*

Box 1 Restrictions on people who use drugs

Registration and police monitoring

The consequences of being registered on the government online database are extensive. If an individual is added to the database, their electronic national identity card will also be marked with their drug use history.²⁸ Then when the card is used — during travel to another province or when checking into a hotel — the local police will receive a notification of the cardholder’s location.²⁹

This surveillance system poses a major barrier to accessing voluntary treatment, since police are known to harass and intimidate blacklisted individuals through random interrogations and compulsory urine tests.³⁰ Although individuals may now be removed from the blacklist after two years of certified abstinence, such practices pose barriers for individuals to come forward for voluntary drug treatment.³¹

Ban on obtaining a driver’s license

A similar barrier to treatment takes the form of a blanket ban on the issuing of a driver’s licence to people certified as using drugs.³² In 2013, after less than one year of enforcing this ban, the Ministry of Public Security (MPS) revealed that it had revoked more than 10,000 driver’s licences, and rejected over 4,000 new applications, as the individuals in question were judged to be ‘drug addicts’.³³ Such restrictions deter people dependent on drugs from seeking treatment, increase stigma associated with drug use, and deny essential life opportunities to those whose ID cards are already marked with drug use. Any form of employment that involves operating a motorised vehicle, for example, will be strictly off-limits once an individual’s driver’s licence is revoked.³⁴ This is despite the fact that article 52 of the *Anti-Drug Law* states that individuals receiving drug dependence treatment ‘shall not be discriminated against in terms of enrolment in schools, employment, enjoyment of social security, etc.’

Law as ‘people-oriented’, or adhering to a ‘human-centred principle’, stressing that local communities are capable of ‘curing’ people dependent on drugs – who are characterised as ‘patients’ and ‘victims’ – without the need for the heavy hand of the state.³⁵

The law makes it clear, however, that under certain conditions government authorities may order the detention of a ‘seriously addicted’ individual for the purpose of ‘treatment’ and ‘rehabilitation’, without a criminal conviction or trial, or a right of appeal by the individual.

As a result, China has adopted a drug treatment and rehabilitation system with four stages:

1. Voluntary treatment (自愿戒毒)
2. Community-based treatment (社区戒毒)
3. Compulsory isolated treatment (CIT) (强制隔离戒毒), and
4. Community-based rehabilitation (社区康复)

These types of treatment form a graduated scale: from least to most coercive, and from least to most custodial.

Despite the objective of the *Anti-Drug Law* to apply a ‘human-centred’ approach to drug use and dependence, the law does not adhere to the humane and ‘scientific’ method it claims to respect. Indeed, the *Anti-Drug Law* continues to rely heavily on forced rehabilitation in detention – which has no basis in science or any evidence of effectiveness, and constitutes violations of human rights (see Box 2).

Voluntary treatment (自愿戒毒)

Voluntary treatment under the 2008 *Anti-Drug Law*

Voluntary treatment has long been offered by private clinics in China, but unofficially and in a largely unregulated form. With the passing of the 2008 *Anti-Drug Law*, however, voluntary treatment was for the first time officially acknowledged as part of China’s national drug policy.³⁶

The *Anti-Drug Law* does not explicitly endorse or prioritise voluntary treatment over other

Box 2 Voluntary vs coercive treatment: Evidence of effectiveness

According to drug dependence experts – including those at the World Health Organisation (WHO) Expert Committee on Drug Dependence – drug treatment is most effective when conducted *voluntarily*, with the full and informed consent of the client.³⁷ Any departure from this basic principle not only contravenes scientific evidence, but is also a step towards serious violations of an individual’s rights.³⁸

In establishing processes and facilities for detaining individuals for compulsory isolated treatment, the *Anti-Drug Law* sanctions the arbitrary deprivation of liberty without the assurance of a free and fair trial and in violation of article 9 of the *Universal Declaration of Human Rights*, and article 9(1) of the *International Covenant on Civil and Political Rights*, to both of which China is a signatory.³⁹ For the same reasons, the *Anti-Drug Law* is also inconsistent with the UN’s 2012 *Joint Statement on Compulsory Drug Detention and Rehabilitation Centres*, which calls on all member states to end the compulsory detention of people who use drugs for the purpose of ‘treatment’ and ‘rehabilitation’.⁴⁰

more coercive (and less effective) alternatives, but it ensures that individuals who partake in voluntary treatment are protected from arrest and administrative sanction, as outlined in article 62:

‘If a drug user goes to the public security organ for registration on his own initiative or goes to a qualified medical institution to receive treatment of drug addiction, he shall be dispensed from any penalty.’

Methods of voluntary treatment

The *Anti-Drug Law* is comprised of 71 articles in total, but makes only a few passing references to voluntary treatment. With this being so, the description of what voluntary treatment should consist of is included in the 2011 *Drug Treatment Regulation*.

Article 10 of the *Regulation* states that voluntary drug treatment should be based upon a ‘treatment agreement’, signed by both the person who uses drugs or his/her parent or ‘guardian’,⁴¹ – which raises concerns as to whether the treatment involves the fully informed consent of the patient – and a qualified, medical practitioner. The agreement should state the ‘method’ and ‘duration’ of treatment, and also explain any ‘rules’ and ‘regulations’. Government clinics, for example, are supposed to maintain a zero-tolerance policy toward concurrent drug use during treatment,⁴² although studies have shown that these rules are rarely enforced by treatment providers, and that expelled clients are permitted to re-enrol – a practice that rightly acknowledges the chronic relapsing nature of drug dependence.⁴³

Elsewhere in the *Regulation*, articles 7 and 12 stipulate that treatment agreements are to be kept confidential,⁴⁴ unless the client is either 1) receiving methadone maintenance therapy (MMT);⁴⁵ or 2) relapses during treatment.⁴⁶ In any of these two scenarios, the treatment provider must report the individual’s name, personal details, and drug use history to the police, who will then add the person to the government’s online drug user database.⁴⁷

Article 11 of the *Drug Treatment Regulation* sets out the treatment method, stating that voluntary treatment should include psychological counselling, behavioural therapy, information on voluntary abstinence, and information on HIV/AIDS and other infectious diseases. Beyond these few instructions, however, the *Drug Treatment Regulation* stipulates no other essential features of a standard, voluntary treatment programme – and does not provide minimum quality standards the programme should adhere to.⁴⁸

Community-based treatment (社区康复)

Community-based treatment under the 2008 Anti-Drug Law

Community-based treatment is a creation of the *Anti-Drug Law*, and a clear reflection of Hu Jintao’s ‘harmonious society’ doctrine. The *Anti-Drug Law* explicitly calls for ‘all sectors of the society’ to partake in the ‘fight’ against ‘drug

abuse’, characterising drug dependence treatment as a shared burden of the entire community, not merely the preserve of law enforcement or medical professionals. As such, community-based treatment attempts to marshal a wide range of existing social resources toward the goal of rehabilitating people dependent on drugs, without them having to suffer incarceration, stigma or social exclusion.⁴⁹

As noted above, however, this harmonious ideal is plainly contradicted by the fact that community-based treatment is *compulsory*, and relies on a system of threats and coercion. Community-based treatment naturally takes the appearance of a punitive and stigmatising intervention, drawing on the very same tools and institutions that are more commonly used to fight against crime and protect the public from ‘dangerous’ individuals.

According to the *Anti-Drug Law*, community-based treatment can be imposed on any person who is arrested for drug use and who has not enrolled in voluntary treatment. In minor cases of drug possession – in which the offender tests negative for drug use – he/she may be spared community-based treatment, made to pay a fine of up to RMB 2,000 (US\$ 314), and held in administrative detention for up to 15 days.

In the event that an arrested individual tests positive for drug use, the police are responsible for assessing the individual’s drug dependence. The *Anti-Drug Law* does not provide any health-based criteria by which to perform such an assessment; instead, the police are permitted to make clinical diagnoses purely on the basis of the individual’s appearance, his/her criminal record (if any), and his/her drug use history (if any). This conflicts with internationally accepted standards of assessing drug dependence – such as the Addiction Severity Index (ASI) approved by the WHO – which call for a wide range of biological, behavioural and psychological components be taken into account.⁵⁰ Additionally, the WHO recommends that only qualified medical professionals, as opposed to law enforcement officials, should be permitted to conduct clinical diagnoses of drug dependence.⁵¹

Article 38 of the *Anti-Drug Law* states that all community-based treatment orders shall be

effective for three years, with no possibility of early termination for good behaviour or continued abstinence. At the end of the three-year period, local police will then decide — again, without professional medical assessment — whether an individual has made a full recovery, or is in need of further treatment. If the former, the individual's community order is discontinued. If the latter, the individual will be sentenced to up to three years' incarceration at a CIT centre. Once again, *the Anti-Drug Law* fails to outline any explicit criteria by which to establish whether an individual has succeeded or failed community-based treatment. In reality, it is simply up to the local police to decide whether an individual shall be released from the treatment order or enter CIT.

Methods of community-based treatment

The *Anti-Drug Law* entrusts the local government with the task of formulating community-based treatment programmes; it does not, however, stipulate that the local government must deliver the 'treatment'. Instead, the local government is expected to act as an intermediary, delegating treatment provision to other local organisations. According to article 34 of the *Anti-Drug Law*, the local government may 'designate the relevant grassroots organizations to sign agreements on treatment of drug addiction in the communities', while the local police, justice department, department of health, and the department of civil affairs shall 'provide guidance and assistance with respect to treatment of drug addiction in the communities'. The law makes no attempt to explain what makes a grassroots organisation 'relevant' to provide drug dependence treatment, and it is unclear whether such organisations should follow standards for the provision of drug treatment services.

Article 34 also states that the local government must provide 'the necessary vocational training in skills, and employment guidance and aid to the persons receiving treatment of drug addiction who are jobless and are unable to find jobs' (see Box 3).

Unfortunately, most community-based treatment programmes are nowhere near as well-organised or well-funded as the Sunshine Project (whose budget totalled US\$ 21 million in 2012). Less

Box 3 Vocational training for people undergoing community-based treatment

For those receiving community-based treatment, article 34 of the *Anti-Drug Law* puts more emphasis on paid employment as a means of 'rehabilitation', and less emphasis on evidence-based clinical treatment. It is worth noting that this stipulation is not found in any of the *Anti-Drug Law's* references to voluntary treatment.

In China, at least at present, the reliance on an idealistic, harmonious community model is problematic since the social stigma associated with people who use drugs means that very few institutions are willing to assist in their rehabilitation amongst the community.

In recent years, the public security authorities in some provinces have been attempting to overcome such prejudices by offering financial incentives to local employers if they agree to take on people dependent on drugs as staff while they undergo community-based treatment. Guizhou, home of the *Sunshine Project*, is one of the provinces where this model appears to have achieved some success.

Organised and funded by the provincial police, the *Sunshine Project* has managed to secure paid employment for hundreds of people who use drugs undergoing community-based treatment, by offering tax breaks to local businesses willing to employ a person arrested for drug use. In 2012, *The Economist* published a positive report of the *Sunshine Project*, featuring, among other things, a packaging plant in Zunyi city, where employees under MMT were permitted to take their daily dose of methadone during lunch break before returning to work.⁵²

developed provinces not only lack public-private partnerships such as those enjoyed by Sunshine, but also suffer from a severe lack of medical expertise, and regressive social attitudes toward drug use. This means that local institutions are either unable or unwilling to participate in the shared responsibility of providing community-

Box 4 Compulsory reporting under community-based treatment

People receiving community-based treatment must report for 12 prescheduled urine tests within the first year of treatment, and will then be subjected to at least 16 random urine tests during the second and third year of treatment.⁵³

An unexplained failure to take a prescheduled test, or refusal to comply with subsequent tests, is considered to be a serious breach of the ‘community treatment agreement’, and may result in the individual being transferred to CIT.

based treatment. Community-based treatment usually consists of little more than a regimen of compulsory urine testing and restrictions on an individual’s freedom of movement (see Box 4) – both of which are enforced by the local police.

‘Dynamic management’ of people who use drugs by the police

Individuals receiving community-based treatment must confine themselves to the administrative area where they reside (either a city or district) for the entire duration of their three-year treatment order. Travelling outside of one’s designated treatment community carries a penalty. If they wish to leave this area, they must apply for a written permission from the local police. As explained in article 19 of the *Drug Treatment Regulation*, if an individual travels outside of his/her community three times without permission, or travels outside of his/her community for more than 30 days without permission, it is considered a serious breach of the community-based treatment agreement.

It is worth noting that almost identical restrictions are applied to criminal suspects during the pre-trial phase, although these measures are then referred to as ‘bail’ (取保候审) and ‘residential surveillance’ (监视居住). For suspects on bail, failure to comply with residential surveillance may result in re-arrest and transfer to pre-trial

detention, as breaking one’s bail poses a threat to public order and the safety of the community. In a similar vein, the *Anti-Drug Law* seems to imply that a person receiving community-based treatment would pose some imminent threat to social order if the person were to be permitted freedom of movement. When referring to residential surveillance for individuals undergoing community-based treatment, China’s police prefer the more technical term of ‘dynamic management’ (动态控制).⁵⁴ Whatever term is being used, this process certainly does not align with the *Anti-Drug Law*’s characterisation of people who use drugs as ‘victims’ and ‘patients’.

As noted earlier, the impulse to coercively isolate people dependent on drugs from their communities still runs strong among China’s law enforcement officials. Granted, this impulse has been tempered in recent years with the introduction of the *Anti-Drug Law*. Nevertheless, the social and legal context is such that a person who uses drugs continues to be just a few steps away from being detained without trial for up to three years.

Compulsory isolated treatment

Entering a compulsory isolated treatment programme

According to article 38 of the *Anti-Drug Law* and article 25 of the *Drug Treatment Regulation*, an individual must be sentenced to community-based treatment *before* he/she is eligible to be incarcerated for CIT – and the police are not permitted to sentence an individual to CIT *unless* he/she has failed community-based treatment, or has already spent one previous stint in CIT.⁵⁵

Under article 38 of the *Anti-Drug Law*, there are four offences which can result in a community offender being transferred to CIT:

1. refusing to receive treatment for drug dependence in the community;
2. using drugs during the period of drug treatment in the community;
3. seriously violating the agreement on drug treatment in the community; or
4. relapsing into drug use after drug treatment in the community, or after CIT.

If an individual is arrested for breaking a community treatment order, the police will then have 24 hours to decide whether the breach of conduct is serious enough to warrant CIT. If the police decide that CIT is required, then they must report the decision to the individual's family, place of residence and local police station as soon as possible, before transferring the offender to CIT.

Throughout this process, there is no requirement for the police to consult with medical personnel before pronouncing an individual as 'seriously addicted' to drugs – and therefore deemed to be needing CIT. Likewise, if the individual is 'dissatisfied' with their CIT order, then they may invoke Article 40 of the *Anti-Drug Law* to launch an appeal, but the appeal will be directed to an administrative court judge, rather than a medical institution. In addition, the person must find some way to launch the appeal from the confinement of either a police cell or a CIT centre, as the appeals process does not allow for the postponement of CIT.⁵⁶

Moving from rehabilitation-through-labour to a compulsory isolated treatment model⁵⁷

Prior to the 2008 *Anti-Drug Law*, people caught using drugs were liable to be sentenced to RTL camps for between one and three years, or forced to undergo compulsory detoxification at a police detention facility for three to six months.⁵⁸ The *Anti-Drug Law* removed people who use drugs from the scope of RTL, and abolished compulsory detoxification in police detention.⁵⁹ Both of these penalties were then replaced by a new form of administrative detention known as CIT.⁶⁰

The *Anti-Drug Law* led to a rapid reduction in the number of offenders sent to RTL. In 2008, according to the Ministry of Justice, around 160,000 people were detained for RTL at 350 sites nationwide.⁶¹ Independent experts found the figure to be much higher, however, arguing that at its peak RTL would have held some 300,000 people⁶² (or 500,000, if we include those sentenced to compulsory detoxification in police detention).⁶³ Between 2008 and 2013, as the government readied itself for the long overdue abolition of RTL, many RTL camps were simply converted into CIT centres. By the end of 2012, the RTL population had shrunk to

60,000.⁶⁴ In December 2013, when RTL was finally abolished by President Xi Jinping, thousands of detainees — mostly sex workers and political prisoners — were suddenly released.⁶⁵

People detained for drug use, however, were mostly transferred to CIT centres, or continued to be detained at a RTL camp converted into a CIT centre. This was the case, for example, with the RTL/CIT centre Shanghai No. 3. At the end of 2012, around 200,000 people were reported to be held at CIT centres.⁶⁶

It is unclear whether the police were authorised to allow the early release of people detained for drug use following the abolition of RTL. The case of Guangdong province has been studied in some detail in this regard. In early 2013, Guangdong authorities stopped receiving new inmates for RTL; but by the end of 2013, 80% of Guangdong's labour camp population had been transferred to CIT, making it unlikely that any people detained for drug use had been released.⁶⁷

Despite the name change, CIT centres continue to operate much like RTL camps, although in 2013, the National Narcotics Control Commission attempted to clarify the nature of the new centres. A spokesperson said that CIT centres were 'in line with scientific principles and time requirements about drug treatment', and that the centres did 'guarantee legally the three necessary stages in drug treatment: 1) physical detoxification, 2) mental rehabilitation and 3) social reintegration'.⁶⁸

What to expect in compulsory isolated treatment

CIT is a form of administrative detention, and can be imposed on an individual without due process. CIT is initially imposed for a mandatory two years, but can be reduced to one year or extended to three years depending on how the individual responds to the so-called 'treatment'.

Life at a CIT centre consists mainly of forced labour — which is sometimes unpaid or usually paid below market rates — as well as rigorous physical exercise, military drill, chanting of anti-drug slogans, and 'group discussions' mostly featuring 'self-criticism'.⁶⁹ Former detainees interviewed by Human Rights Watch in 2009 reported having

to work up to 18 hours per day in ‘wretched conditions’ for no pay; many also reported experiencing physical abuse and frequent beatings at the hands of CIT staff.⁷⁰

Article 69 of the *Anti-Drug Law* states that any CIT staff member found to be ‘subjecting persons receiving treatment of drug addiction to corporal punishment, maltreatment, humiliation, etc.’ should be ‘investigated for criminal responsibility according to the law’. In reality, however, CIT staff have been accused of systematically covering up cases of physical abuse against detainees, including cases that resulted in the death of a detainee. The 2010 Human Rights Watch report cites one case in which a detainee was, by all accounts, beaten to death by CIT staff members, but the victim’s family was informed that their child had died of an ‘illness’ in detention. When the victim’s family pressed for a formal investigation, they were offered a bribe by CIT staff to stay quiet, and were physically threatened.⁷¹

Despite requirements stipulated under the *Anti-Drug Law*, individuals detained for CIT are consistently denied access to medical care and evidence-based drug treatment. Researchers who visited CIT centres reported that even where the centres have an on-site physician — as required by Article 45 of the *Anti-Drug Law* — counselling services such as cognitive behavioural therapy are not available.⁷² Likewise, despite the proven efficacy of OST in improving the quality of life of people dependent on opioids, as well as on reducing relapse, injecting drug use and the spread of blood-borne infections such as HIV and hepatitis C,⁷³ substitution therapy is not known to be prescribed during CIT. This is despite the fact that article 45 of the *Anti-Drug Law* explicitly authorises CIT physicians to ‘administer narcotic or psychotropic substances’ to people receiving drug treatment. Instead, CIT detainees are subjected to forced detoxification, and suffer the full force of their withdrawal symptoms.

For people who have been dependent on drugs for a long time, entering withdrawal in this way can be extremely painful, traumatic, and in some cases even fatal. A 2015 study of three CIT centres in Guangxi Autonomous Region found that, from a sample group of 755 inmates — 97.8% of whom

reported heroin use — almost one third of the respondents were receiving MMT before being sentenced to CIT, but had their treatment cut-off indefinitely during incarceration.⁷⁴

HIV-related services in compulsory isolated treatment centres

HIV testing at CIT centres has been described as ‘almost universal’. However, HIV testing practices are not in line with international best practice. Indeed, upon arrival at a CIT centre, all detainees must undergo a mandatory blood test, which includes a test for HIV, although detainees are generally not informed of what they are being tested for. Those who are HIV positive are required to be informed of their test result, and offered further treatment, but most detainees are simply never informed of their result. Similarly, antiretroviral therapy (ART) should in theory be prescribed to those who test HIV positive, but studies indicate that provision of ART within the CIT system is inconsistent and inadequate.⁷⁵

The 2015 study in Guangxi mentioned above found that 96% of CIT inmates reported having received a blood test at the beginning of treatment, but only 68% of them thought that this included a test for HIV. 61 detainees self-reported that they were HIV-positive; of this group, 87% were receiving post-HIV test education at the time of the survey, but only 25% were receiving ART. Disturbingly, 78% of respondents who took a mandatory HIV test were never informed of their test results. 16% of respondents reported feelings of distress for not knowing their HIV status. For those who did receive their test results, 72.7% were informed by the CIT doctor, while 19% were informed by CIT staff — even though the WHO recommends that only qualified medical personnel should be permitted to perform pre- and post-HIV test counselling (see Box 5).⁷⁶

Community-based rehabilitation: Follow up on compulsory isolated treatment

Upon release from CIT, an individual must then undergo a mandatory further three years of *community-based rehabilitation*. Community-based rehabilitation is almost identical to community-based treatment. It is compulsory, lasts for three years, and should include counselling,

Box 5 International standards on the provision of healthcare and HIV-related prevention, treatment and care in places of detention

The *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules) set out basic principles on ensuring adequate standards of sanitation, hygiene, food and healthcare for people held in prison facilities.⁷⁷ Rule 24.2 in particular states that '[h]ealth-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence'.

The UNODC, WHO, UNAIDS, International Labour Organisation and the UN Development Programme recommend a package of 15 comprehensive interventions for the HIV prevention, treatment and care for people held in places of detention. They include the prevention of sexual violence, 'easy access to voluntary HIV testing and counselling programmes at any time during', and the recommendation that 'all forms of coercion must be avoided and testing must always be done with informed consent, pre-test information, post-test counselling protection of confidentiality and access to services that include appropriate follow-up antiretroviral therapy and other treatment as needed'. In addition, the UNODC and WHO recommend ensuring access to condoms, sterilised injecting equipment and other harm reduction services, such as OST, for detainees.⁷⁸

skills training and/or paid employment. If an individual breaches the terms of his/her order to attend community-based rehabilitation, he/she may be transferred back to CIT. According to the 2011 *Drug Treatment Regulation*, the only substantial difference between community-based rehabilitation and community-based treatment is that, if an individual is judged to have made a quick recovery during community-based rehabilitation, then his/her order may be revoked at any time.

It is important to highlight the extremely high

relapse rates that have so far been recorded among former CIT detainees. Prior to the 2008 *Anti-Drug Law*, a 2004 follow-up study among people who use drugs released from RTL camps found that over 90% of respondents relapsed into drug use upon returning to their communities. Similarly, a 2011 study of Yulu Shequ – a community-based rehabilitation facility twinned with an adjacent CIT centre – found that relapse rates at the compulsory centre in 2007 were 97%, compared with 60% at the community-based facility. The 2015 Guangxi study also noted that one in two respondents had been incarcerated at a CIT centre at least once prior to the study, and that 27.7% of respondents had spent two or more stints in RTL before its abolition in 2013. China's CIT centres therefore appear to be repeatedly detaining the same people, with little hope of a successful 'treatment' outcome – whether that success is measured in terms of abstinence, or improved quality of life and health.⁷⁹

Conclusion and recommendations

Based upon the analysis above, people who use drugs in China are liable to endure up to nine years of continuous, coercive 'drug treatment': up to three years in community-based treatment, up to three years in a CIT and up to three years in community-based rehabilitation. Along with compulsory registration and a driving license ban for people with a record of drug use, such requirements lead to high levels of stigma and discrimination and can significantly hinder an individual from pursuing essential life opportunities such as employment, education and travel. Such an approach may therefore deter people dependent on drugs from accessing drug dependence treatment programmes in the first place, as this would have a serious long-term impact on their lives. Being punitive in nature, these measures may eventually cause more harm to the individual than could be caused by drug use itself.

Taking stock of the design and implementation of drug treatment in China, the following key issues are highlighted for consideration by policy makers seeking to strengthen the Chinese drug treatment system.

Recommendations on improving the drug treatment system

1. Establish an evidence-based, voluntary and humane drug treatment model:
 - Transition away from compulsory treatment and detention, and towards evidence-based, voluntary treatment and harm reduction services, in accordance with the recommendations agreed at the *Third Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific* in 2015, in relation to enabling legal and policy environments and strengthening and financing health, social and community systems.⁸⁰
 - Adopt new patient-centred objectives for drug dependence treatment – the primary objective should be to enable individuals to improve their quality of life and health. Although abstinence may be a worthy goal, it should not be forced upon all people who use drugs, who should be able to remain under MMT as long as they deem it to be necessary.
 - Improve the availability of a comprehensive menu of evidence-based treatment and harm reduction services – including NSPs, OST, psychosocial support, counselling, social support services – to ensure that each person seeking treatment is able to access the most appropriate service to tackle their specific needs.
 - Establish, support and collaborate with community-based drug treatment services that are voluntary, humane and effective; and share experiences of best practice around voluntary treatment with other service providers.
 - Ensure availability and access to the package of 15 comprehensive interventions for HIV prevention, treatment and care recommended by UN agencies for people who use drugs in detention facilities, including OST, NSPs and the prevention of sexual violence.
 - Gather data on changing patterns of drug use, and scientific evidence on the risks and impacts associated with their use as well as on effective treatment and harm reduction responses.
- Continually monitor and evaluate the effectiveness of drug treatment and harm reduction services, in terms of achievement of improved outcomes in the health and welfare of people who use drugs and their communities, in consultation with affected communities including people who use drugs and service providers.
2. Develop a medically-trained workforce:
 - Employ and train medical personnel, rather than security or law enforcement officers, to conduct clinical diagnoses of an individual's drug dependence to ensure the provision of harm reduction and treatment services that meet each person's needs, while acknowledging that only people who are dependent on drugs can benefit from drug treatment – according to the United Nations, only about 1 in 10 people who use drugs become dependent and could benefit from treatment.⁸¹
 - Employ and train qualified drug treatment providers, including trained psychologists and counsellors, at all treatment sites.
3. Train law enforcement authorities to be supportive of a voluntary and humane drug treatment system:
 - Remove incentives for police to arrest people who use drugs (e.g. arrest quotas) – the threat of police arrest significantly discourages people from seeking drug treatment, harm reduction and the other health and social services they may need. On the contrary, the police can provide invaluable support to inform people who use drugs of treatment options at their disposal, and where to find them. The police should therefore be adequately trained on drug use, dependence, harm reduction and treatment, as well as on available harm reduction and treatment services available to refer people to such services.⁸²
4. Develop treatment and harm reduction services for methamphetamine use:
 - Conduct evidence-based research into treatment and harm reduction options for methamphetamine dependence, in order to increase and improve public education about methamphetamine

use and dependence and appropriate responses.⁸³

- Consider implementing appropriate treatment and harm reduction services for people who use amphetamine-type stimulants (ATS), in light of data showing rapid increases in people using synthetic drugs such as ATS.

Recommendations relating to drug policy reform

5. Shift away from punishment towards health by removing, or gradually reducing, measures which punish people for drug use, to ensure a model of decriminalisation that achieves improved quality of life and health outcomes for people who use drugs, including:

- compulsory registration of people who use drugs on the online drug user control system, along with surveillance, random interrogation and forced urine testing
- ban on people who use drugs obtaining a driver's licence; and
- police arrest of people seeking to access drug treatment and harm reduction services, including the use of quotas for police arrest of people who use drugs. Instead, police can play a role in enhancing the security and health of communities, by referring people who use drugs to voluntary, evidence-based treatment and harm reduction services.⁸⁴

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Notes:

About this policy briefing

This IDPC briefing paper provides an analysis of the current drug treatment system in China and offers recommendations for ensuring its effectiveness.

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The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

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