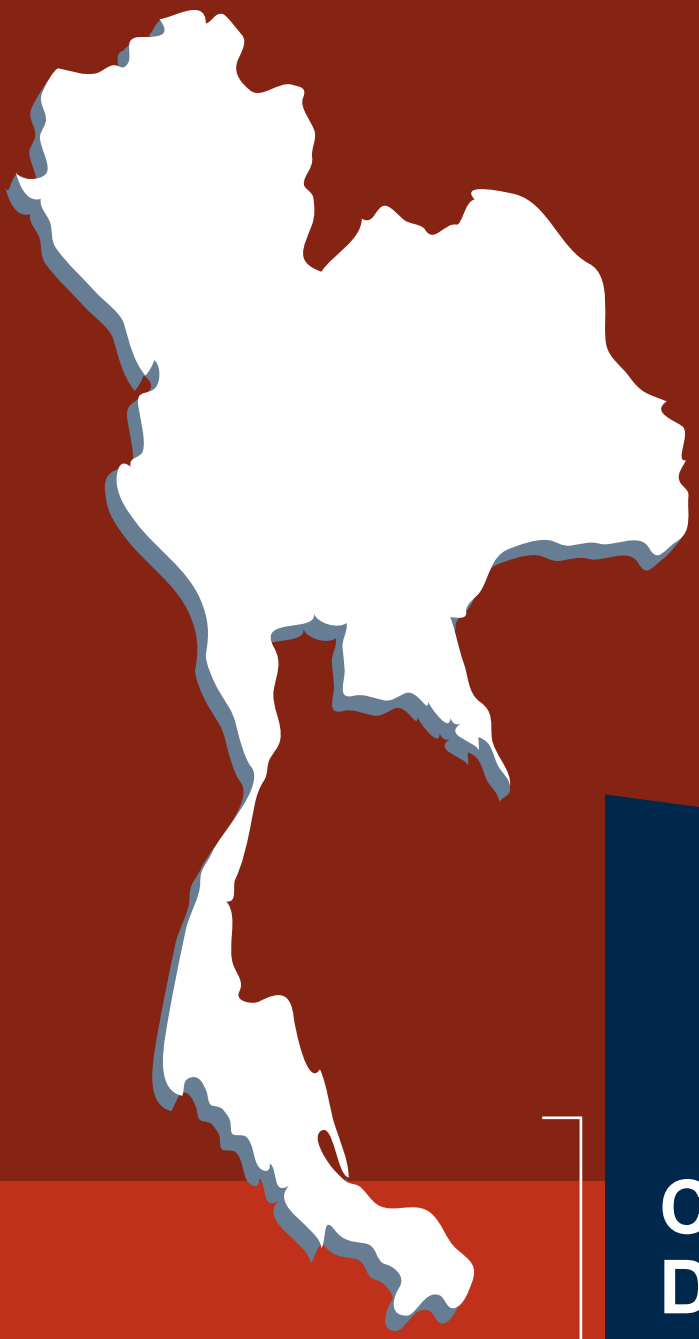

Compulsory Drug Treatment in Thailand:

Observations on the *Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

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Authorship note

This report was written by Richard Pearshouse.

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About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

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Executive summary

This paper has two main objectives. The first objective is to provide a general overview of Thailand's *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* ("the Act") and the system of diversion into compulsory drug treatment that the Act has established.[1] The second objective of this paper is to offer some preliminary observations on the implementation of the Act on its own terms — i.e., that people who are dependent on drugs should be "treated as patients and not criminals." One of the central findings of this paper is that this approach is undermined by a number of different ways the Act has been implemented.

Diverting people away from prisons and into compulsory drug treatment centres may reduce the number of people in prison. In general terms, this is advantageous to the health and human rights of people who use drugs. Of particular importance to Thailand, such an approach may reduce HIV risks associated with imprisonment. However, under the Act, before treatment programs begin people are routinely held in prison for up to 45 days awaiting the assessment of their cases. There are indications that, on occasion, people are held for longer. Thailand's prisons are poorly equipped to oversee the process of detoxification and to provide quality medical care and supervision of the symptoms of withdrawal from drug dependence. While the HIV risks associated with being held in prison while waiting for assessment have not been rigorously studied, a number of people interviewed in the course of research for this paper mentioned that HIV risk behaviour, such as injection drug use, occurred during this assessment period.

In the centres themselves, the central components of treatment are therapeutic community activities, vocational training and physical exercise. The treatment approach differs among centres and among agencies responsible for the centres.

There have been some attempts to measure the efficacy of compulsory treatment in Thailand. However, in general, the quality of the information obtained has been compromised by limitations in follow-up after people are released from compulsory treatment centres. The limited number of people interviewed for this paper revealed highly different results from, and opinions towards, their treatment.

Some officials mentioned the need to develop discipline as one objective of drug treatment. However, some of the people interviewed who had been through compulsory treatment centres mentioned forms of punishment

[1] "Treatment," as used in this paper, is defined as "the process that begins when psychoactive substance users come into contact with a health provider or other community service, and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached. Treatment and rehabilitation are defined as a comprehensive approach to identification, assistance, health care, and social integration with regards to persons presenting problems caused by the use of any psychoactive substance. These definitions include the notion that substance users are entitled to be treated with humanity and respect." (WHO Expert Committee on Drug Dependence, *Thirtieth Report: WHO Technical Report Series 873*, 1998, available at http://whqlibdoc.who.int/trs/WHO_TRS_873.pdf.) According to the *Oxford Dictionary*, to compel is to "force or oblige to do something," while to coerce is to "persuade (an unwilling person) to do something by using force or threats. (*Compact Oxford English Dictionary*, 2005). Following these definitions, the treatment system discussed in this paper should be described as "compulsory," as opposed to "coercive," as the individual does not have any choice in the matter.

that were cruel, inhuman and degrading. Such punishments are outside the legal forms of punishment permitted in the Act. Furthermore, the Act was intended to ensure that people were "treated as patients not criminals"; such forms of punishment serve no therapeutic purpose.

The need for evaluation is even more pressing given that people in the programs do not give their fully informed consent to such treatment; and given that, in the centres themselves, there is little or no adjustment of treatment to meet individual needs. Treatment is the same for all individuals at a particular centre. A rigid approach to treatment, even one that is carefully designed, will not meet the treatment needs of all individuals. Mechanisms must be found that allow people greater autonomy and meaningful choices in their treatment. Further research and innovations designed to reduce strains on the system and to improve the quality of patient care are required.

Introduction

The World Health Organization (WHO) notes that substance dependence is characterized by a strong desire to consume psychoactive substances; difficulties in controlling substance use; the continued use of psychoactive substances despite physical, mental and social problems associated with that use; increased tolerance over time; and, sometimes, withdrawal symptoms if the substance is abruptly unavailable.[2] Research has shown that substance dependence, including injection drug use, is not a failure of will or of strength of character but a chronic, relapsing medical condition with a physiological and genetic basis that could affect any human being.[3]

This paper has two main objectives. The first objective is to provide a general overview of Thailand's *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* ("the Act") and the system of diversion into compulsory drug treatment that the Act established. Following the introduction of the Act, Thailand sharply increased the number of people in compulsory drug treatment programs. However, the expansion of the system has been accompanied by relatively little attention either to how it is intended to operate or how it operates in practice. Given the large number of people dealt with under the Act, the system warrants far more detailed study than was possible in the course of research for this paper. However, it is hoped that this general overview will be useful in stimulating further research and analysis.

The second objective of this paper is to offer preliminary observations on the implementation of the Act on its own terms — i.e., that people who are dependent on drugs should be "treated as patients and not criminals." This paper attempts to reflect some of the experiences and opinions of people who have spent time in Thailand's compulsory drug treatment system. Such an approach is inherently limited, particularly given the relatively small number of people interviewed during the course of this research, the large number of compulsory treatment centres in Thailand and the different approaches towards treatment among the different agencies that run the centres.

Despite these limitations, the approach of capturing some of the experiences and opinions of people who have passed through the centres offers a key advantage of including perspectives that are all too frequently ignored in studies and discussions regarding drug policy. To a very great extent, this paper and its conclusions are guided by the experiences and opinions of some of those who have been detained in Thailand's compulsory drug treatment centres.

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[2] See ICD-10 diagnostic guidelines (at www.who.int/substance_abuse/terminology/definition1/en/). The DSM-IV definition of drug dependence is provided in American Psychiatric Association, *DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, ed. 4*, 1994, at http://allpsych.com/disorders/substance/substancedependence.html.

[3] WHO, *Neuroscience of Psychoactive Substance Use and Dependence*, 2004, at www.who.int/substance_abuse/publications/en/Neuroscience_E.pdf . See also, WHO, *Management of Substance Dependence,* fact sheet, 2003, at www.who.int/substance_abuse.

Methodology

This report is based on information collected during two visits to Thailand (in July and October/November 2008). Over the course of about three weeks in total, the author held meetings and conducted interviews. He met with officials in the Department of Probation and the Office of the Narcotics Control Board. He also visited seven custodial centres, run variously by the Royal Thai Army, the Royal Thai Navy, the Thanyarak Institute on Drug Abuse (Department of Medical Services, Ministry of Public Health) and the Department of Probation (Ministry of Justice). These centres included both intensive and less intensive centres, as well as a centre for women and a centre for juveniles. Where possible, information provided by officials cited in this paper was cross-checked against information provided by other officials.

The author also conducted detailed, semi-structured interviews with 15 people who use drugs who had been detained in Thailand's compulsory drug treatment centres. These interviews took place in Bangkok and Chiang Mai.

This field research was supplemented by additional research into the literature related to dependence on illegal drugs and treatment for that dependence, in general, and particularly in Thailand.

Overview of the system

The people who implement Thailand's drug treatment systems commonly describe the country as having "three systems" of drug treatment: the voluntary, the compulsory and the correctional (i.e. prisons-based). The voluntary system is coordinated by the Ministry of Public Health, the correctional system by the Department of Corrections (Ministry of Justice), while the compulsory system is overseen by the Department of Probation (Ministry of Justice). It is the compulsory system — the most recent addition to how Thailand approaches the issue of illegal drug use and dependence — that is the focus of this paper.

Historically, Thailand's drug policy has prioritized the criminalization and imprisonment of people who use drugs in attempts to make the country "drug free." While still intended to make Thailand drug free, the *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* incorporates a different approach to drug use and dependence by creating a legal regime to provide alternatives to incarceration for some drug offences. The essence of the Act is neatly captured in a description taken from a publication by the Department of Probation:

> Drug addicts rehabilitation has been considered as an important task in [the] criminal justice system in Thailand. Previously drug users/drug addicts used to be charged as offenders. Since March 2, 2003 onwards drug users/drug addicts has [sic] not been arrested as "offenders" but "patients." Instead of being prosecuted, they will be diverted to rehabilitation under appropriate plans. If they are successful, they will be acquitted. On the other hand, if they fail, they will finally be prosecuted in [the] criminal justice system.[4]

Prior to the introduction of the 2002 Act, the *Drug Addicts Rehabilitation Act, 1991* had languished largely unimplemented.[5] In late 2002 and early 2003, Thailand reinvigorated its drug policy. The "war on drugs" launched by then Prime Minister Thaksin received widespread condemnation because of the emphasis on harsh law enforcement, including reports of extensive extra-judicial killings.[6] However, the "war on drugs" policy also included a component on drug treatment, and compulsory treatment in particular. According to a Department of Probation publication, the government developed a policy that "drug addicts are patients [and]

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[4] Department of Probation, *Department of Probation*, 2005, p. 20 [original in English].

[5] I. Pandey, *'Law on the Books' and High Risk Populations in Thailand*, 2006, p. 7, at www.temple.edu/lawschool/phrhcs/rpar/about/thai.pdf.

[6] See, e.g., Human Rights Watch, *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights*, 2004; Asian Centre for Human Rights, *Thailand: Not Smiling on Rights*, 2005.

should receive treatment [as an] alternative to incarceration."[7]

In a speech on 26 June 2004, to celebrate the U.N.'s annual "International Day Against Drug Abuse and Illicit Trafficking," Thailand's then-Minister of Justice Phongthep Thepkanjana stated:

> The Royal Thai Government fully recognizes the ominous threat posed to mankind by narcotics drugs and the paramount need to eliminate the problem. H.E. Dr. Thaksin Shinawatra, our Prime Minister declared the policy against illicit drug trafficking and abuse in order to secure the future of the Thai people from the threat of drug problem. Drug matters have been placed as the national agenda focussing on drug demand reduction in parallel with drug law enforcement with the objective to eliminate drug supply and drug demand, particularly methamphetamine problem. Drug addicts should be cured while drug traffickers should be punished….

Since the Act came into effect, Thailand's compulsory drug treatment system has expanded dramatically.

> Supply reduction, demand reduction and potential demand are three main pillars of drug control to be implemented with the conceptual framework of area approach and integrated approach. Treatment work is aimed at 3 objectives:
>
> First, there should be no new drug addicts;
>
> Second, all existing drug addicts are under a proper treatment, rehabilitation, or continuing care program;
>
> And third, communities are empowered to protect themselves against drugs.
>
> In order to achieve the aforementioned goals, the national policy on solving the problem of drug abuse and addiction is clearly stated that drug addicts are considered as "Patients", not criminals. Emphasizing the importance and effectiveness of drug treatment is one of our major strategic approaches. Drug abusers and addicts are separated from drug traffickers and dealers. They are encouraged to report themselves to the authorities for further treatment in different schemes…. The self-reporting drug abusers and addicts are sent for treatment and rehabilitation. The abolition of Drug Addicts Rehabilitation Act, 1991 and the enactment of Drug Addicts Rehabilitation Act, 2002 enable the implementation of compulsory treatment for drug addicts throughout the country from 1 October 2002 onward.[8]

Since the Act came into effect, Thailand's compulsory drug treatment system has expanded dramatically. Large numbers of people are diverted from prisons into either custodial or non-custodial treatment programs: since 2003, the number of people in both custodial and non-custodial treatment programs has increased considerably, as has the number of custodial treatment centres.

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[7] Department of Probation, *Department of Probation*, p. 22.

[8] Keynote address by H.E. Mr Phongthep Thepkanjana, Minister of Justice of Thailand, at the observance of the United Nations "International Day Against Drug Abuse and Illicit Trafficking," 28 June 2004, United Nations Conference Centre, Bangkok, at www.unodc.un.or.th/interday/2004/HE%20Phongthep_keynote.pdf.

Thailand's drug laws

There are a number of laws governing drug use currently in force in Thailand. The ones that remain central, despite that later enactment of the *Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*, are the *Psychotropic Substances Act B.E. 2518 (1975),* the *Narcotics Control Act B.E. 2519 (1976)* and the *Narcotics Act B.E. 2522 (1979)*. These Acts concentrate on banning the unauthorized production, consumption, possession and sale of a wide range of drugs:

- Controlled psychotropic substances are listed in Schedules I-IV of the *Psychotropic Substances Act B.E. 2518 (1975)*. Gamma-hydroxybutyric acid (or GHB) is found in Schedule I. Drugs such as ephedrine, midazolam, ketamine and pseudoephedrine are included in Schedule II.

- Controlled narcotic substances are enumerated in Categories I-V of the *Narcotics Act B.E. 2522 (1979)*. Category I drugs include heroin, amphetamine, methamphetamine (commonly known as *ya ba* or *ya ma*[9]), ecstasy and lysergic acid diethylamide (LSD). Category II drugs include coca leaf, cocaine, codeine, morphine and methadone. Category V drugs include cannabis and the kratom plant.

These Acts give police and other competent officials wide powers of search, seizure and arrest, and authorize police to conduct drug testing.[10]

According to the *Psychotropic Substances Act B.E. 2518 (1975),* consumption or possession of Schedule I or Schedule II drugs is punished by one to five years' imprisonment and/or a fine of 100,000 to 400,000 baht.[11] Production, importation, export or sale of Schedule I and II drugs is punished by imprisonment of five to twenty years and/or a fine of 100,000 to 400,000 baht.[12]

Under the *Narcotics Act B.E. 2522 (1979),* consumption of category I substances is punished by imprisonment of from six months to three years and/or a fine of 10,000 to 60,000 baht.[13] Possession of up to the "smallest dosage" of category I narcotics is punished by imprisonment for 1–10 years and/or a fine of 20,000 to 200,000 baht.[14] "Disposal" (i.e. trafficking) or possession for the purposes of disposal of category I substances of amounts less than the smallest dosage is punishable by a term of imprisonment from four to 15 years and a fine of 80,000 to 300,000 baht; for amounts ranging from the smallest dosage up to 20 g of category I substances, the punishment is imprisonment of four years to life and a fine of 400,000 to five million baht; for amounts more than 20 g of category I substances, the punishment is life imprisonment, a fine of one million to five

---

[9] Literally, *ya ba* means "crazy drug," referring to the limited cases when a methamphetamine consumer might display "crazy" behaviour, possibly due to a drug-induced psychosis. Literally, *ya ma* means "horse drug," referring to its effects on the consumer's energy level. The latter term is often preferred among people who consume methamphetamine as being less stigmatizing.

[10] See *Narcotics Control Act, B.E. 2519 (1976),* s. 14. The *Narcotics Act, B.E. 2522 (1979)* also permits searches (s. 49) and drug testing (s. 58(1)), while the *Psychotropic Substances Act B.E. 2518 (1975)* contains broad powers of search in s. 49. All Acts cited in this paper are from official English translations found in Office of the Narcotics Control Board, *Narcotics Laws of Thailand* (Bangkok: 2007).

[11] S. 62 and s. 106. To help understand these amounts: Thailand's National Statistical Office reports that the average monthly household income in Thailand in 2006 (the last year for which data has been published) was just under 18,000 baht. See National Statistical Office, *Statistical Yearbook Thailand 2007*, 2007, p. 39 [original in English], available via http://web.nso.go.th/eng/en/pub/pub0.htm.

[12] S. 89.

[13] S. 57 and s. 91.

[14] S. 67. The smallest dosage is established as three grams of pure substances of narcotics in category I (or, in the case of LSD, 0.75 mg of "pure substance," 15 "doses" or 300 mg of pure weight; or, in the case of amphetamine or amphetamine derivatives, 375 mg, 50 "doses" or 1.5 grams of pure weight): s. 15(3).

million baht or the death penalty.[15]

According to the *Narcotics Act B.E. 2522 (1979),* production, importation or exportation of narcotics listed in category I (e.g., heroin, amphetamine type substances) up to the smallest dosage is punished by 4-15 years of imprisonment and/or a fine of 80,000 to 300,000 baht.[16] When these acts are done "for the purpose of disposal" (i.e. trafficking) and involve amounts below the smallest dosage, then they are punishable by a term of imprisonment from four years to life and a fine of 400,000 to five million baht.[17] Production, importation or exportation of narcotics listed in category I in amounts above the smallest dosage is punishable by life imprisonment and a fine of one million to five million baht.[18] When these acts (i.e. production, importation or exportation) are "for the purposes of disposal" (i.e., trafficking) and involve amounts above the lowest dosage, the death penalty may be imposed.[19]

Many people who use drugs in Thailand are incarcerated at some point in their lives. From 1992 to 2000, the number of persons jailed for drug use and drug possession only (i.e., not trafficking) more than doubled.[20] Despite the system described in this paper, there is evidence that people who use drugs continue to be imprisoned in Thailand. The United Nations Office on Drugs and Crimes (UNODC) reported that as of 2004, Thailand had over 100,000 people in prison on "drug-related cases", over one-fifth of which involved drug consumption (as opposed to drug trafficking or other drug-related offences).[21]

Incarceration has been a known risk factor for HIV infection among injection drug users in Thailand for more than a decade.[22] There is evidence that illegal drugs continue to be available in some Thai correctional facilities, indicating continued injection drug use while incarcerated.[23] Research has revealed HIV prevalence rates as high as 40 percent among injectors who had been jailed.[24] People in custody also face a risk of exposure to other infectious diseases. For example, tuberculosis prevalence in prisons is several times the prevalence in the population as a whole.[25] High rates of incarceration among young methamphetamine users in Thailand have been associated with a range of HIV risk behaviours, including injection drug use.[26] Research

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[15] S. 66(3).

[16] S. 66(1).

[17] S. 65(4).

[18] S. 65(1).

[19] S. 65(2). Note that under the *International Covenant on Civil and Political Rights* (ICCPR), the death penalty may only be applied for the "most serious crimes." Interpretations of "most serious crimes" from human rights bodies do not include drug-related offences; consequently, the execution of offenders of drug laws violates international human rights law. See R. Lines, *The Death Penalty for Drug Offences: A Violation of International Human Rights Law*, International Harm Reduction Association, 2007.

[20] C. Beyrer *et al.* "Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand" *AIDS Behaviour* 7 (2003): 153.

[21] UNODC, *Drugs and HIV/AIDS in South East Asia: A Review of Critical Geographic Areas of HIV/AIDS Infection Among Injecting Drug Users and of National Programmme Responses in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam*, 2004, p. 42.

[22] K. Choopanya et al, "Incarceration and risk for HIV infection among injection drug users in Bangkok," *Journal of AIDS* 29(1) (2002): 86–94.

[23] Ibid.

[24] C. Beyrer et al, "Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand," *AIDS and Behavior* 7(2) (2003): 153–161; H. Thaisri et al, "HIV infection and risk factors among Bangkok prisoners," *BMC Infectious Diseases* 3 (2003): 25.

[25] See, e.g., S. Nateniyom, "Implementation of the DOTS strategy in prisons at provincial level, Thailand," *International Journal of Tuberculosis and Lung Disease* 8(7) (2004): 848–854.

[26] N. Thomson et al, "Correlates of incarceration among young methamphetamine users in Chiang Mai, Thailand," *American Journal of Public Health*, 2008 (in publication).

has also found significant risks of HIV infection related to syringe-sharing in pre-trial detention facilities.[27]

Some prisons in Thailand provide some forms of drug treatment. Where it does exist, drug treatment usually consists of the operation of therapeutic communities. Opioid substitution therapy for those dependent on opioids is not available in prisons. As of the end of 2008, there is no access to HIV prevention materials in Thai prisons and there is limited access to prisons by community-based HIV education groups. According to the finding of one study, "HIV prevention and drug treatment are urgently needed in Thai prisons."[28] According to another study:

> The main HIV risk factors of Bangkok inmates were those related to drug injection. Harm reduction measures and HIV intervention strategies should be implemented to prevent more spread of HIV among the inmates and into the community.[29]

The policy that people who use drugs or are dependent on drugs should be "treated as patients, not criminals" is contradicted by existing laws that establish criminal liability for mere consumption of drugs.

Narcotic Addict Rehabilitation Act B.E. 2545 (2002)

Arrest and court

The *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* incorporates a different approach from the laws identified above by creating a legal regime to divert people from incarceration for some drug offences.[30] However, it should be noted that the previous laws remain in force and people continue to be arrested and charged for offences under those Acts. As noted above, consumption and possession of illegal drugs are criminal offences. Thus the policy that people who use drugs or are dependent on drugs should be "treated as patients, not criminals" is contradicted by existing laws that establish criminal liability for mere consumption of drugs.[31]

The diversion scheme established by the Act can apply to people charged with the following four offences when they involve certain illegal drugs in quantities less than the limit prescribed by a Ministerial Regulation:

- drug consumption;
- drug consumption and possession;

[27] See, e.g., A. Buavirat et al, "Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: case-control study," *British Medical Journal* 326 (2003): 308–326; K. Choopanya et al.

[28] C. Beyrer et al.

[29] H. Thaisri et al.

[30] Note, however, that acts adopted before the *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* also contain certain provisions compelling people who have committed some offences under these acts to undergo drug dependence treatment in certain circumstances: see, e.g., *Psychotropic Substances Act B.E. 2518 (1975)*, s. 88; *Narcotics Act, B.E. 2522 (1979),* ss. 94 and 98.

[31] Thailand is a party to the three U.N. drug control conventions. While these conventions require states to impose controls on various substances (including the use of criminal law in some instances), they also contain various flexibilities. There is no strict requirement to make consumption or possession of drugs for personal use a criminal offence under domestic law.

- drug consumption and possession for disposal; and
- drug consumption and disposal.[32]

The amounts of drugs involved in the offences above must be small in order to qualify the person for diversion under the Act:

Drugs in Category I:

- Heroin: not more than 100 mg;
- Methamphetamine: not more than five useable units, or total weight not more than 500 mg;
- Amphetamine: not more than five useable units, or total weight not more than 500 mg;
- 3,4-methylenedioxyamphetamine (MDA): not more than five useable units, or total weight not more than 1200 mg;
- Methylenedioxymethamphetamine (MDMA): not more than five useable units, or total weight not more than 1200 mg;
- N-methyl-D-aspartate (NMDA or MDE): not more than five useable units, or total weight not more than 1.25 g;

Drugs in Category II:

- Cocaine: pure weight not more than 200 mg;
- Opiate: pure weight not more than 5 g;

Drugs in Category V:

- Marijuana: pure weight not more than 5 g.[33]

After arrest, an individual's case must be sent to court for consideration within 48 hours and, in the case of a minor under 18 years of age, within 24 hours.[34] The accused does not decide whether his or her case is to be diverted: this is determined by a court.[35]

There is no determination of innocence or guilt by the court at this stage (indeed, the law continues to refer to the person as an "alleged offender"). According to the Act, the court's role is "to consider and issue the court order to transfer such alleged offender for the identification of narcotics consumption or narcotic addiction" to a Sub-Committee.[36]

According to the Act, in determining whether or not to transfer the accused to a Sub-Committee, the court

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[32] S. 19.

[33] Ministry of Justice Regulation, 2003. Cited in S. Eiamanupong, "PPT Presentation to delegates and representatives of the eleventh United Nation [sic] Congress on Crime Prevention and Criminal Justice on April 21–22, 2005," Power-Point presentation [original in English], on file with the author.

[34] S. 19.

[35] The treatment provided in the centres is compulsory treatment — i.e., without voluntary, fully informed consent. According to UNODC and WHO: "As any other medical procedure, in general conditions drug dependence treatment, be it psychosocial or pharmacological, should not be forced on patients. Only in exceptional crisis situations of high risk to self or others, compulsory treatment should be mandated for specific conditions and periods of time as specified by law. When the use and possession of drugs results in state imposed penal sanctions, the offer of treatment as an alternative to imprisonment or other penal sanction presents a choice to the patient/offender, and although it entails a degree of coercion to treatment, the patient is entitled to reject treatment and choose the penal sanction instead." (UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion paper*, 2008, p. 10.)

[36] S. 19.

should consider the age, gender and "individual specific character" of the accused.[37] In practice, the court's determination will turn on whether or not the individual has used drugs, which will be established by whether the person's urine tests positive for drugs. Should the court decide to transfer the case to the Sub-Committee for investigation (as outlined below) then the Public Prosecutor is advised of the fact. The Public Prosecutor issues an order that temporarily suspends the prosecution of the case.[38]

Detained for assessment

The accused is then detained for assessment of whether he or she is a user of drugs or dependent on drugs and, if dependent, the nature of that dependency. According to the Act, the assessment should take place within 15 days of being transferred to a locality for detention, with an extra 30 days available where there is necessary cause. [39] According to the Act, the total period should not exceed 45 days.

People detained for assessment may apply for bail. Rather than being covered by the Act, bail applications are governed by a Ministry of Justice Regulation, which provides that bail should be granted when conditional release would not present a danger to evidence, there is no flight risk by the person charged, the person charged would not represent a danger to society, and the person charged has a place of permanent residence. In the course of research for this paper, officials explained that the majority of people who apply for bail receive it, although they clarified that only a minority of individuals applies for bail. Officials explained this fact as a function of many people not being able to enlist relatives to help them post money for bail or guarantee a place to stay, as well as some people not having rights to bail (e.g., because they had been arrested for a second time.)[40]

In practice the question of whether the person is a person who merely *uses* drugs or whether the person is also *dependent* on drugs is determined by an investigation process performed by officials from the Department of Probation. During the assessment period, the Department of Probation will assign an officer to investigate each individual case. A Department of Probation publication clarifies that the process of assessment includes assessing "biological domains" (a physical examination and urine testing), "psychological domains" (motivation, attitude, self-awareness, guilt and anti-social behaviour) and "social domains" (family history, education, occupation, economy, personality, relationship, environment, criminal record, drug usage history, problems from drug use and past drug treatment).[41]

In practice the investigation will usually involve a urine test and a criminal record check of the accused. The probation officer might also interview the person. The probation officer will often investigate the accused's relationship with his or her family, level of education and employment. This may involve a visit to the person's community and interviews with family members or employers. The probation officer will also investigate the person's medical history and history of drug treatment.

On the basis of this investigation, the probation officer will draw up a brief report outlining the details of the individual case and recommending a particular form of treatment.[42] If the investigation finds that the person

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[37] Ibid.

[38] Ibid.

[39] S. 21: "The identification shall be conducted within fifteen days from the date … [on which] such alleged offender [was accepted] into the locality for [identification], except [where] there is a necessary cause, the sub-committee of [the] Narcotic Addict Treatment [Act] may order to extend that time [by a period] not exceeding thirty days."

[40] Note that according to the ICCPR, "It shall not be the general rule that persons awaiting trial shall be detained in custody": Article 9(3). The U.N. Human Rights Committee has stated that "[p]re-trial detention should be an exception and as short as possible": General Comment 8: Article 9, U.N. Doc. HRI/GEN/1/Rev.1 at 8 (1994).

[41] Department of Probation, *Department of Probation & The Compulsory Drug Rehabilitation System in Thailand*, undated [original in English], on file with the author.

[42] Note that the probation officers undertaking the assessment (on which treatment decisions are based) are not trained medical

does not use drugs, then the person will not be eligible for diversion into treatment and the case is returned to the Public Prosecutor (as the person might face standard criminal prosecution for a drug offence other than consumption). As discussed in more detail below, if the investigation finds the person does use drugs, then some sort of treatment order will be issued.

A number of officials mentioned the high case load of probation officers responsible for these assessments. For example, in some regions, an individual probation officer at any given time may be responsible for the assessment of 40–50 cases.

Being detained for 45 days appears to be routine, rather than exceptional. According to people interviewed in the course of this research, on occasion some people are detained for longer than 45 days. During this period, individuals are held in prison. Thus, despite the Act's stated purpose of diverting people from incarceration, people dealt with under the Act are effectively incarcerated for extended periods of time. Officials explained that budget restrictions prevented people being detained elsewhere, such as health care facilities.

None of the people interviewed in the course of this research had received medication to help manage withdrawal symptoms in prison.

The prison facilities will separate people being detained for assessment from other prisoners. Nevertheless, they are subject to the same poor conditions as the prison system as a whole.[43] Some prison facilities employed to detain people during the assessment period are crowded, while others are less so.[44] The crowding and poor conditions were confirmed in interviews with people who had been detained in prison for assessment. According to L.V. (male, from Bangkok), who had been detained in Lad Yao prison (a large prison in Bangkok):

> I was playing cards in the middle of the *soi* [side street] and the police came in the vehicle and arrested me and tested me. The result was purple [i.e. positive for drugs]. So I was kept at the police station for one day and then [went] to Lad Yao for 47 days, then to [a military camp].
>
> The conditions [in Lad Yao] were very crowded: no mosquito nets, not enough food, a lot of mosquitoes. You sleep on a cement floor. You have to sleep on your side. The food was bought in from another compound. They only gave [food] once: if it's finished, no more…. Sometimes the guard would hit persons if there was a fight or if they found people using drugs.

O.N. (male, from Bangkok) said he had been kept in Lad Yao prison for longer than the 45 days permitted under the Act:

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professionals. The extent to which they apply standardized assessment tools to assess the severity of addiction (such as the *Addiction Severity Index* [ASI]) is unknown. They would appear to have limited training to assess mental health co-morbidities common among people who use drugs. There is, therefore, a risk that the process of decision-making about whether a person be subject to compulsory treatment, and for what period, is not clinically driven.

[43] Note that, according to Article 10(1) of the ICCPR, "All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."

[44] According to some officials, facilities in Bangkok and in nearby provinces, such as Samut Prakan and Chonburi, were particularly crowded.

> I was there for 80 days, 85 days. Most [people] were there for 45 days. I don't know why I was there for longer. Others were there for longer than 45 days, but not many.

Q.U. (male, from Bangkok) explained that he had been held in Lad Yao prison for "about two months" while being assessed. He described the conditions thus:

> It's crowded. The room was small. In one room there were more than one hundred people. Some people had to sleep while sitting or on their sides.… [The food is] like leftover food. There was not enough. We had to compete with each other for food. There were many quarrels to compete for food.
>
> In Lad Yao, prisoners control prisoners. There are gangs of prisoners. Those who have many people control others. So we didn't get the stuff bought by [our] visitors, it was taken. If we didn't give them this, there was trouble. There was violence, beatings.

According to T.X. (male, from Bangkok), who was detained in a different facility:

> It was very difficult to stay in Minburi [an assessment facility in Bangkok]. When you're sleeping, one person's head is up, another person's head is down. There was little meat to eat, it was mainly vegetables…. There were two rooms holding 300 people. I couldn't lie on my back, I had to sleep on my side.... It was very crowded.

B.L. (female, from Bangkok), who was detained for assessment at Klong Ha Krueng (a facility for assessment of women in Thanya Buri municipality, close to Bangkok), stated:

> Before [a period in an army camp] I stayed in an assessment centre in Klong Ha Krueng. I stayed there 45 days, waiting for a decision [from the Sub-Committee]. Some [others] were released. There was no medical treatment. It was very difficult to stay there…. [It was] very crowded, not enough water. This place could accommodate 150 people but when I was there, there were 300. They did not know where to put the people. People had to sleep on their sides. If I moved [during the night], I would lose my space.

T.Q. (male, from Chiang Mai) who had been held in a prison in Chiang Mai during the assessment process, explained:

> Last time I stayed there the full course of 45 days. They told me, "You have been here so many times, haven't you learnt? This time you need to stay the whole 45 days."
>
> I slept in the treatment section [of the prison], [with a] mattress on the floor. There is enough space, it's not crowded. The food is O.K., [it's the] same type of food as offered to other criminals. You're not allowed cigarettes, so people secretly smoke. If they see you smoking cigarettes you have to stand up and sit down 500 times [i.e., as punishment].

Given the current implementation of the Act, people who are dependent on drugs will undergo detoxification and experience withdrawal symptoms in prison. None of the people interviewed in the course of this research had received medication to help manage withdrawal symptoms in prison. This issue is explored in greater detail below.

Relapse to drug use is common during detoxification and withdrawal. A number of people interviewed in the course of this research mentioned that drug use occurred in prison facilities while waiting for assessment. This drug use was related to a high risk of HIV transmission because of an absence of HIV prevention materials, such as sterile syringes and condoms, in prison.

According to Q.Q. (male, from Bangkok), who spent his assessment period in Lad Yao prison, "During the 44 days, I injected once and smoked [illegal drugs] once. I illegally ordered the needle from the Lad Yao hospital: [The hospital] did not know this." Q.U. (male, from Bangkok), who had also spent his assessment

period in Lad Yao prison, stated "I knew people injected. I didn't see the actual injections but I saw people had sharpened the tip of a pen to inject."

U.T. (male, from Chiang Mai), who had spent the assessment period in Chiang Mai prison, stated:

> Sometimes they do have heroin [in the prison's assessment facilities]. They blow it through a tube connected to a needle into a vein. I did this sometimes. I can do that only when my relatives visit me quite often and I have some money. There was no drug use in the military camp. [This is] because people have only a few months to go [before they are released]. They don't want to spoil the occasion.

The research showing strong associations between injection in prison and HIV transmission has been mentioned above. Other research from Thailand has identified time spent *before* incarceration in prison as a period of particular high risk for HIV infection. For example, Buavirat and colleagues have shown that detention in police holding cells in Thailand is a period in which needle-sharing is particularly prevalent.

> Sharing needles while in the police holding cell was an independent risk factor for prevalent HIV infection. Although previous studies have indicated that sharing injecting equipment while incarcerated is a key risk factor for HIV infection in Thailand, the exact time of infection could not be determined in these studies. To our knowledge, our study is the first to pinpoint excess risk during the holding period before incarceration. This finding confirms our hypothesis that high risk exposures such as borrowing needles and injecting drugs with multiple partners in the holding cell are probably attempts to alleviate the severe symptoms of drug withdrawal. A possible confounding factor is that prisoners in holding cells in Bangkok may have more opportunity to inject owing to lower security at this stage of their remand.[45]

Sub-Committees and treatment orders

The Act provides for the establishment of Narcotic Addict Rehabilitation Act Sub-Committees.[46] Among other powers, the Sub-Committees may:

- determine whether a person is dependent on drugs, a (non-dependent) consumer or otherwise;
- consider granting conditional release, either during the period of investigation (i.e., bail) or the period of treatment;
- supervise the person's period of detention;
- supervise the person's treatment plan;
- consider the transfer of persons between treatment centres; and
- consider the results of treatment.

These Sub-Committees are made up (on average) of seven people: a representative of the Ministry of Justice (often a Public Prosecutor, usually the chairperson of the Committee), a representative of the Department of Probation (who is usually the secretary of the Committee) as well as a medical doctor, a psychologist, a social worker and experts in drug treatment. They will often meet once or twice a week to process cases.

According to the Act, the Sub-Committees may order treatment of three types:

[45] Buavirat et al.

[46] These are commonly referred to as Provincial Sub-Committees, although there are 76 provinces in Thailand (if Bangkok is counted as a province) and 98 such Sub-Committees.

- detention in a treatment centre which has "the detention system to prevent … escape";
- detention in a treatment centre which requires "the person … committed for treatment to stay within the area … required during treatment"; or,
- where detention is unnecessary, a requirement of the person committed for treatment to comply "with any other procedure under the [supervision] of [a] probation official."[47]

In other words, the Sub-Committees will order compulsory drug treatment in either custodial or non-custodial programs. Non-custodial programs commonly involve out-patient programs that are run by a variety of entities including government hospitals, the Thanyarak Institute on Drug Abuse (under the Department of Medical Services, Ministry of Public Health), or the Department of Probation. In certain circumstances, non-custodial programs may actually be in-patient, such as where it involves brief periods (such as five days) at treatment centres.

A number of people interviewed in the course of this research mentioned that drug use occurred in prison facilities while waiting for assessment. This drug use was related to a high risk of HIV transmission because of an absence of HIV prevention materials, such as sterile syringes and condoms, in prison.

Custodial programs are commonly described (by those working in the system) as either "intensive" or "less intensive." An intensive program takes place at a centre that has higher security designed to reduce the likelihood of escape. A less intensive program occurs at a centre with less security.

According to officials, if the person is only a drug user, then he or she is likely to be ordered into a (non-custodial) out-patient treatment program. If the person is dependent on drugs, he or she is likely to be sent to a (custodial) less intensive program (e.g., a centre run by the Royal Thai Army.) If the person is considered severely dependent on drugs, commonly referred to by officials in the system as being a "hardcore addict," then he or she is likely to be sent to a (custodial) intensive program (i.e., in the Royal Thai Air Force or Royal Thai Navy centres). A hardcore addict is considered to be someone who uses drugs every day and that has a prior record of compulsory treatment.

The decisions of the Sub-Committees are based on the assessment reports of probation officers. The reports — whether regarding bail applications, treatment orders or evaluations of treatment — contain standardized background information and a recommendation. The decision-making process of the Sub-Committees is usually very rapid: it might take a decision after a brief deliberation of a minute or two. Most decisions follow the recommendations contained in the probation officers' reports although, on occasion, the Sub-Committees may order differently.[48]

In practice, the decisions of the Sub-Committees are also influenced by the available space in custodial centres. Sometimes the Sub-Committee will make a determination relatively early in the 45-day period that the person should be sent for custodial treatment. However if the centres are full, the Sub-Committee will order that person to attend a non-custodial program. In such a case, the Sub-Committee will sometimes release the person immediately to attend a non-custodial program (because it foresees no available space in a centre.)

[47] S. 23.

[48] Note that, according to the ICCPR, "In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.... " (Article 14(1).)

However in other cases, the Sub-Committees will delay ordering the person to attend a non-custodial program until the expiry of the 45 day period, despite the fact that it foresees no space available in a centre.

T.X. (male, from Bangkok) described the process in the following terms:

> I was sent to Minburi to wait [for assessment]. I was with the other drug users, not the prisoners.… [I was there] 45 days waiting to be sent to the military centres … [then] I was released. Some others were sent to centres. It's not certain [why I was released]. Some of the people were arrested many times and sent to the centres, and many centres were full. I was released. I had to go to a probation office once a month. I had urine testing for one year.

According to the Act, initial treatment orders may be for up to six months. The Act states:

> In the case where it appears that the result of the treatment is unsatisfactory, the sub-committee of [the] Narcotic Addict Treatment [Act] shall consider to extend the duration of treatment.[49]

The Sub-Committee has authority under the Act to extend treatment for periods of up to six months at a time, but the total duration in treatment cannot extend past three years. If, at the end of the period of treatment, the Sub-Committee determines that the treatment is "satisfactory," then the person is released. The Public Prosecutor is notified accordingly and there are no further steps in the prosecution process. The individual does not have a criminal record. If, at the end of the extended treatment process, the Sub-Committee determines that treatment is "not satisfactory," then the Sub-Committee reports this fact to the Public Prosecutor and the individual will be prosecuted.[50]

The Department of Probation has published the data on "drug abusers/addicts under the compulsory drug rehabilitation system" from 2003 to 2008.[51] These figures show that while the majority of people are ordered into non-custodial treatment, 25–50 percent of people, depending on the year, are ordered to attend custodial treatment programs:

Year	2003	2004	2005	2006	2007	2008
Custodial rehabilitation program	**3019**	**9343**	**10 481**	**10 618**	**14 591**	**10 023**
– Intensive	1053	2098	2643	2428	2562	1363
– Non-Intensive	1966	7245	7838	8191	12 029	8660
Non-custodial rehabilitation program	**3261**	**8639**	**21 037**	**31 814**	**34 304**	**30 657**
– Outpatient	1720	5323	13 318	15 821	16 009	16 761
– Inpatient	174	469	522	409	326	138
– Probation-based program	1367	2847	7197	15584	17 969	13 758

The Department of Probation reports that between 2003 and 2008, the vast majority of people within the compulsory drug treatment system were charged with "consumption" or "consumption and possession" of illegal drugs: Around 90 percent of those under investigation (and a similar percentage of those under treatment) were charged with consumption, while eight percent of those under investigation were charged

[49] S. 25. Note that the Act does not specify the meaning of "satisfactory" or "unsatisfactory."

[50] S. 33.

[51] Department of Probation, *Department of Probation & the Compulsory Drug Treatment System in Thailand*. As periods in custodial treatment generally last for four months, an approximate number of people in custodial treatment at any one time can be derived by dividing by three the figures shown here for people in custodial treatment per year (although, as noted in the main text, some people will spend more than the initial four-month period in custodial treatment.)

with consumption and possession.[52] The numbers of people charged with "consumption and possession for disposal" and "consumption and disposal" were both under one percent of the total charged.

The following table from the Department of Probation reports the number of people in compulsory drug treatment (both custodial and non-custodial) between 2003 and 2008 divided by type of drug used.[53]

Type of drug				
	Methamphetamine	**Amphetamine**	**Marijuana**	**Others**
No. of people in compulsory drug treatment	157 693	13 370	11 871	4850
Percentage	83.97	7.12	6.32	2.59

Appeals

Technically, the Act provides for appeals from decisions of a Sub-Committee in respect of three types of determinations:

- a determination that the person consumed drugs or is addicted to drugs;
- a decision to deny conditional release, either from detention for assessment (i.e., bail) or detention for compulsory treatment;
- a decision to extend compulsory treatment by up to six months at a time.[54]

No other types of determinations can be appealed. For example, a person cannot appeal the type of treatment program (whether custodial or non-custodial, or whether intensive or non-intensive) or the initial length of the treatment program.

According to the Act, appeals are heard by the Narcotic Addict Rehabilitation Act Committee. This Committee is national-level committee of government functionaries and is also responsible for such matters as submitting recommendations for ministerial regulations, appointing and dismissing members of the Sub-Committees, and issuing rules prescribing the process of investigation of individual cases.[55] Decisions of the Committee concerning decisions of a Sub-Committee are final.[56]

Despite the existence of these provisions, officials clarified that, in practice, there are few appeals from Sub-Committees' decisions.

Non-custodial treatment programs

As noted above, according to Department of Probation data, the majority of people in compulsory drug treatment are in non-custodial treatment programs. Non-custodial programs are commonly run by a variety of entities, including government hospitals, the Thanyarak Institute on Drug Abuse (under the Department of Medical Services, Ministry of Public Health), or the Department of Probation.

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[52] Department of Probation, *Department of Probation & the Compulsory Drug Treatment System in Thailand.* Note that the Department of Probation refers to the charge of "addiction" while the *Narcotics Act* refers to "consumption."

[53] Ibid.

[54] S. 38.

[55] S. 7.

[56] S. 38.

Non-custodial treatment programs frequently involve people completing the Matrix program. The Matrix program is an out-patient treatment program for stimulant use and dependence developed by the Matrix Institute on Addictions, based in the U.S.[57] Often, the program is structured in sessions that take place approximately two hours a day, two or three times a week, over four months. The intervention consists of individual sessions and group sessions that cover relapse prevention, education on drugs, social support as well as individual counselling and drug education for family members. Patients are regularly monitored for drug use by urine testing.[58] This four-month period is followed by a two-month "re-entry" period.

Other forms of non-custodial programs may involve vocational training or treatment through Buddhism-inspired programs. As noted above, some non-custodial programs may actually be in-patient (such as short periods at drug treatment centres). The two-month "re-entry" period that follows a period in custodial treatment is also considered a non-custodial program.

Custodial treatment programs

While the system of compulsory drug treatment is overseen by the Department of Probation, the actual treatment centres are run by a number of different government entities. According to the Department of Probation:

> In order to effectively rehabilitate drug abusers/addicts, the Department of Probation has collaborated with various agencies to conduct treatment programs. This multi-agency collaboration makes it possible for the Department to cope with high number of drug abusers/addicts admitted to the compulsory system. The collaborating agencies do not only provide facilities for rehabilitation but also provide staff and conduct treatment programs for drug abusers/addicts. These agencies are the Royal Thai Army, the Royal Thai Navy, the Royal Thai Air Force, Ministry of Public Health, Ministry of Interior, and Bangkok Metropolitan Administration.[59]

Since the Act was adopted, the number of compulsory drug treatment centres has been expanding rapidly: in 2004, there were 35 centres; by 2005, there were 49;[60] by the end of 2008, there were 84.[61]

Of the 84 compulsory drug treatment centres in Thailand at the end of 2008:

- 31 were run by the Royal Thai Army;
- 12 were run by the Royal Thai Air Force;
- 4 were run by the Royal Thai Navy;
- 3 were run by the Royal Thai Armed Forces Supreme Command;
- 7 were run by the Thanyarak Institute on Drug Abuse;[62]

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[57] For an overview of the Matrix program, see R. Rawson and M. McCann, *The Matrix Model of Intensive Outpatient Treatment: A Guideline Developed for the Behavioural Health Recovery Management Project*, 2006, at www.bhrm.org/guidelines/The_Matrix_Model_Of_Intensive_Outpatient_Treatment.pdf.

[58] The Matrix program approach became accepted in Thailand following a knowledge exchange initiative between Thai treatment officials and the Matrix Institute in 2001. See J. Obert et al, "Exporting methamphetamine treatment to Thailand: a large scale technology transfer project," Abstract number 25620, 21 October 2001, presentation at the 129th Annual Meeting of American Public Health Association (APHA), Atlanta, U.S., 21–25 October 2001.

[59] Department of Probation, *Department of Probation & the Compulsory Drug Treatment System in Thailand.*

[60] See UNODC, *HIV/AIDS and Custodial Settings in South East Asia: An Exploratory Review into the Issue of HIV/AIDS in Custodial Settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam*, 2006, p. 46.

[61] Personal communication by the author with the Department of Probation, December 2008.

[62] These centres will also offer voluntary drug treatment programs, on either an in-patient or out-patient model.

- 1 was run by the Department of Probation itself (at Ladlumkoew);
- 10 were run by the Ministry of the Interior;[63]
- 13 were run by Department of Mental Health (under the Ministry of Public Health); and
- 2 were run by the police and one by the Department of Corrections.

There are plans for an additional 14 centres to be established under the auspices of the Royal Thai Army by 2009.[64]

The centres run by the Royal Thai Army are considered "less intensive," while the centres run by the Royal Thai Air Force are "intensive." For its part, the Royal Thai Navy runs both intensive and less intensive centres.[65]

Typically, the military centres hold 100–400 patients, except that the centres run by the Royal Thai Air Force hold 30–60 patients. The centres run under the auspices of the Ministry of the Interior are also smaller (30–50 patients).

Included in these figures are a number of centres for women and for juveniles. As of the end of 2008, there were 11 centres for women — eight less intensive centres (one run by the Royal Thai Army and seven run by the Thanyarak Institute on Drug Abuse) and three intensive centres (two run by the Royal Thai Air Force and one run by the Department of Probation) — and one centre for juveniles (run by the Royal Thai Air Force). These centres follow the general treatment approach of other centres, but with some adaptations. For example, a centre for juveniles might have general education classes each morning. A centre for women might have less vigorous physical exercises and different types of vocational training.

Oversight by the Department of Probation

The Department of Probation is responsible for assessing the centres. Assessment of the centres is scheduled to occur every three years, although officials clarified that assessment is not compulsory and that the centres themselves must request assessment. The process is carried out by a small assessment team, formed primarily of staff from the Department of Probation and the Thanyarak Institute on Drug Abuse, and may take place over one or two visits by the team to the centre. A particular centre will be assessed on a standardized set of categories:

- mission of the centre
- organizational structure
- human resources
- supplementary training
- policy and practices
- physical environment of facilities
- equipment and materials

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[63] Many centres under the auspices of the Ministry of the Interior are run by Thailand's Volunteer Defence Corps, commonly called the *Or Sor*, Thailand's largest armed paramilitary organisation. For a description of the Or Sor's role in the war on drugs, see D. Ball and D. Mathieson, *Militia Redux: Or Sor and the Revival of Paramilitarism in Thailand*, 2007, pp. 134–143.

[64] Personal communication by the author with the Department of Probation, December 2008.

[65] The intensive centres run by the Navy include three in Sattahip, in Chonburi province.

- treatment process
- evaluation and monitoring

The Thanyarak Institute on Drug Abuse is responsible for training the personnel of the different entities which operate the centres. While large numbers of people required training following the introduction of the Act, trainings have become less necessary in recent years. The training typically last 1–2 weeks for each person and might include a visit to another centre to observe operations there.

Some military officials consider that the country is involved in a less-traditional war (i.e., the war on drugs) and that their duty is to contribute to the fight against the country's drug problems. Other military officials simply consider that their professional duty requires them to faithfully execute orders (in this case, the order to oversee drug treatment).

One challenge mentioned by officials was the high rates of staff turnover among personnel of some entities — particularly the centres run by the armed forces and the Ministry of the Interior. The centres run by the Thanyarak Institute on Drug Abuse or the Department of Probation do not appear to have the same high rates of staff turnover.

"Patients not criminals"

1. Detoxification

As noted above, the current structure of Thailand's compulsory drug treatment system means that most people who are drug dependent must undergo detoxification in prison as opposed to a health care setting. Thailand's prisons are poorly equipped and poorly resourced to supervise the process of detoxification and manage the complicated symptoms of withdrawal. There is little or no medical supervision or medication available to these people while being detained for assessment in prison.[66] Opioid substitution therapy — maintenance or tapering — for those dependent on opioids does not exist in the prisons.[67] No psychosocial interventions (such as counselling) were available to the people who went through detoxification in prison and who were interviewed in the course of this research.[68] There is little or no attention to mental health problems that are common among people who use drugs.[69] While proper nutrition, rest and exercise are particularly important during methamphetamine withdrawal, these conditions are not present in Thailand's prisons.

Detoxification will often be the first phase of drug treatment programs. According to the UNODC, "[t]he main goal of detoxification programs is to achieve withdrawal in as safe and as comfortable a manner as possible."[70]

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[66] It is worth noting that, in one case, the European Court of Human Rights held in 2003 that the failure of prison health facilities to provide adequate medical care to a prisoner undergoing heroin withdrawal, who subsequently died, constituted inhuman or degrading treatment in violation of Article 3 of the *European Convention on Human Rights*: *McGlinchey and Others v. United Kingdom*, European Court of Human Rights, Application No.50390/99, Final Judgment, 29 April 2003.

[67] Forced, abrupt opioid withdrawal can cause profound mental and physical pain and may be considered a violation of human rights obligations to protect detainees from inhuman or degrading treatment: R. Bruce and R. Schleifer, "Ethical and human rights imperatives to ensure medication-assisted treatment for opioid dependence in prisons and pre-trial detention," *International Journal of Drug Policy*, 19 (2008): 17–23.

[68] Research shows that beginning psychosocial interventions (such as counselling) with patients during the detoxification stage is an important factor in the eventual effectiveness of treatment: [U.S.] Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, *Detoxification and Substance Abuse Treatment,* Treatment Improvement Protocol (TIP) Series 45, 2006, pp. 4–5.

[69] See A. Palepu et al, "Factors associated with the response to antiretroviral therapy among HIV-infected patients with and without a history of injection drug use," *AIDS* 5 (2001): 423–424.

[70] UNODC, *Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide*, 2003, p. IV.2, at www.unodc.org/pdf/report_2003-07-17_1.pdf.

UNODC summarizes the need for medically supervised detoxification in the following terms:

> A withdrawal syndrome that can develop after stopping the use of a drug will vary according to the type of drug the person was using. Common general features can include craving for the substance, anxiety, restlessness, irritability, insomnia and impaired attention.
>
> Dependent users of psychostimulants, in particular amphetamines and cocaine, may also require medical supervision during the acute withdrawal phase following cessation of use. While there may be no direct physical withdrawal effects (and no prescribing of an agonist to minimize discomfort), the individual may have severe psychological problems (including induced psychosis) and sleep disturbance that may be managed by prescribing suitable medication.
>
> … Various medications have been shown to be effective in opioid detoxification, including true analogues or agonists such as methadone, partial agonists such as buprenorphine and other non-opioid drugs that are called α2-adrenergic agonists (lofexidine or clonidine). Some inpatient programmes use opioid antagonists under sedation or general anaesthesia (so-called ultra-rapid detoxification). In some countries, opiate products (including tincture of opium) are used as a detoxification agent. Withdrawal from benzodiazepines is usually achieved via use of a long-acting benzodiazepine (for example, diazepam).[71]

The current structure of Thailand's compulsory drug treatment system means that most people who are drug dependent must undergo detoxification in prison as opposed to a health care setting. . . . There is little or no medical supervision or medication available to these people while being detained for assessment in prison.

In Thailand's case, methamphetamine addiction is the most common form of drug dependence among those in the compulsory treatment system. Withdrawal from methamphetamine addiction has been divided into two phases: an acute phase that occurs during the first week following cessation of use, and a sub-acute phase lasting at least a further two weeks. The severity of withdrawal is generally greater in people who are older, who are more dependent and who have been using methamphetamine longer.[72] According to research by McGregor and colleagues:

> The methamphetamine withdrawal syndrome was characterized principally by increases in sleeping and appetite. A cluster of depression-related symptoms including inactivity, fatigue, anhedonia and dysphoria were marked during the first week, but had largely resolved by the end of the acute phase of abstinence. Less severe symptoms of withdrawal included anxiety, motor retardation, agitation, vivid dreams, craving, poor concentration, irritability and tension. Of the withdrawal symptoms measured, most had reduced towards comparison group levels by the end of the first week of abstinence. Exceptions included the sleep and appetite-related symptoms that persisted through weeks 2 and 3 of abstinence (the subacute phase).[73]

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[71] UNODC, *Drug Abuse Treatment and Rehabilitation*, pp. IV.2-IV.3. As noted by UNODC, withdrawal may induce psychosis. It should be noted that induced psychosis may, in its most severe and rather rare cases, threaten the somatic health or even life of the ill person and those around him or her. It should also be noted that because of the risks inherent in anaesthesia, the approach of "ultra-rapid detoxification" is controversial.

[72] C. McGregor et al., "The nature, time course and severity of methamphetamine withdrawal," *Addiction* 100(9) (2005): 1320–1329.

[73] Ibid., p. 1327. Adhedonia is a psychological condition characterized by an inability to feel pleasure from normally pleasurable

According to the researchers who played a central role in developing the Matrix model:

> After long runs of meth use, in which there is substantial sleep deprivation, failure to eat, and frequently substantial musculoskeletal strain from extended drug use postures, the person is simply worn out. The needed intervention is a proper diet, rest and exercise.[74]

2. Drug Treatment

Following the period of detention for assessment, custodial treatment programs initially involve four months in treatment centres, followed by a two-month "re-entry" program. Opioid substitution treatment (OST) is not available for patients dependent on opioids in treatment centres.[75] At present, there is no proven, effective substitution treatment for non-opioid drug dependence. The treatment provided in the treatment centres is a modified therapeutic community.[76] The approach involves a highly-structured residential environment with group psychotherapy and practical activities. The therapeutic community approach to treatment has been described by the [U.S.] National Institute on Drug Abuse in the following terms:

> The therapeutic community (TC) for the treatment of drug abuse and addiction has existed for about 40 years. In general, TCs are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills. TCs differ from other treatment approaches principally in their use of the community, comprising treatment staff and those in recovery, as key agents of change. This approach is often referred to as "community as method." TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use.[77]

For custodial treatment, the centres run by the Royal Thai Army, the Royal Thai Navy, the Department of Probation and the centres under the Ministry of Public Health employ the FAST model of drug treatment, a variant of the therapeutic community approach developed by the Thanyarak Institute on Drug Abuse. FAST is an acronym that stands for Family (e.g., family visits, activities for family members), Alternative activities (e.g., group activities such as music or gardening), Self help (e.g., physical training) and Therapeutic community work (e.g., group work, group evaluation).

The Royal Thai Air Force is responsible for running intensive treatment centres. They employ a treatment

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events such as eating or sex; dysphoria is a psychological condition characterized by a depressed mood, anxiety or restlessness.

[74] J. Obert et al, *A Physician's Guide to Methamphetamine: Developed from Matrix Institute & UCLA Integrated Substance Abuse Programmes*, 2005.

[75] OST has been recognized by WHO, UNODC and UNAIDS as an effective, safe and cost-effective means of managing opioid dependence and as an essential HIV/AIDS prevention measure: WHO, UNODC, UNAIDS, *Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*, 2004, p. 32. Thailand has provided methadone since the 1970s. According to a new policy of the Thai government, methadone maintenance treatment will become available in the community under Thailand's universal health care scheme. Thus, while the Act is intended to treat people with opioid dependence as patients not criminals, such people are effectively denied an established form of treatment available outside the centres, which is a matter of human rights concern.

[76] One established form of treatment for stimulant addiction that is not available in the centres is contingency management. According to one study, "[c]ontingency management is a behavioural technique based on the systematic application of principles of positive reinforcement. It most often involves the delivery of vouchers, exchangeable for money or desired commodities, contingent upon some desired behaviour (e.g., a drug-free urine sample)." See N. Lee, "A systematic review of cognitive and behavioural therapies for methamphetamine dependence," *Drug and Alcohol Review* 27(3) (2008): 309–317; J. Roll, "Contingency management: an evidence-based component of methamphetamine use disorder treatments," *Addiction* 102 (Suppl 1) (2007): 114–120.

[77] [U.S.] National Institute on Drug Abuse, *Research Report Series: Therapeutic Community*, 2002, p. 1.

approach that is unique to the Air Force, called *Jirasa*.[78] The *Jirasa* approach seems to be similar to the FAST model, but with a greater emphasis on discipline and physical activities (such as military drills) and a focus on Buddhist morality and practice. Officials explained that there were four bases of the *Jirasa* system: moral, physical, spiritual and disciplinary.

A typical four-month period in a centre might be divided into:

- an "inception period" (that might last the first month). At this stage, the emphasis is on building motivation to stop drug use and preventing relapse. The people are given information on the centre and its rules;
- a "treatment period" (that might last the second and third month). In this period, the emphasis will be on group work, work therapy and vocational training. Groups will encourage people to change and to provide support and criticism to other members. Work therapy might involve maintenance of the centre, cooking and cleaning. Vocational training might involve agricultural work (such as growing crops or making organic fertilizer), farming (such as raising ducks or fish), mechanics and woodwork. For women, the vocational training might include hair-dressing, making artificial flowers or silk-screening; and
- a "re-entry" period (that might last the fourth month).[79] This period is intended to prepare the people to go back into the community. It may involve activities outside the centre in the community, such as when the patients undertake field trips or forms of community service (e.g., street cleaning).

The following is an example of a daily schedule provided by a centre for women run by the Royal Thai Air Force:

05.00 – 09.00 hrs	Get up, say morning prayers, personal activities in wash room, exercise, breakfast
08.00 – 09.00 hrs	Pay homage to national flag, attend group meeting
09.00 – 12.00 hrs	Activities as set in the curriculum or program
12.00 – 13.00 hrs	Have lunch and take a rest
13.00 – 16.00 hrs	Supplementary (additional) activities
16.00 – 17.00 hrs	Exercise, vocational training (continued)
17.00 – 18.00 hrs	Personal activities in wash room, pay homage to national flag, dinner and rest
19.00 – 20.00 hrs	Small group meeting, problem-solving exercises, review the documents or the skills acquired, group meeting with mentors or teachers
20.00 – 21.00 hrs	Rest, religious activities, evening prayers, bed

[78] According to one document from the Royal Thai Air Force: "*Jirasa* is a new term recently defined by combining two words together, '*Jira'* and '*arsa.'* The term means 'helping each other voluntarily with a full scale of willingness and on a sustainable basis.' Therefore, the term is used as the name of the prevention and treatment approach for drug addicts, in which successful methods from overseas are applied appropriately for the context of Thai society (which includes the family institution, culture, tradition and the characters of Thai people)." See Royal Thai Air Force, *Drug Addicts Rehabilitation Centre*, undated [unofficial translation], on file with the author.

[79] This period should not to be confused with the non-custodial 're-entry period' of two months on completion of custodial treatment.

According to a number of people interviewed in the course of this research, the central components of the daily routine in the centres are group work, vocational training and physical exercise. Q.U. (male, from Bangkok) described his period in a centre run by the Thanyarak Institute on Drug Abuse in the following terms:

> It was the same every day: group activities to share feelings. We shared with our friends. After sharing, if you said something was not so good, someone would say something to boost our feelings and try to make us tolerate it and stay longer. The group activity starts at 8 [a.m.] and lasts one and a half hours. It goes on every day for four months. There are other activities: social workers and psychologists visited us. They arranged us into groups of ten and let us share and then evaluated us. The psychologist came once a week.

Q.Q. (male, from Bangkok) recalled:

> There is a schedule for me every day: what time and what I have to do.… There are activities to do every day so people didn't have to think about drugs. I did exercise, group work, group dynamics.… About four or five p.m. was the time to rest.

While the intention behind the Act is that people who use drugs or people who are dependent on drugs are "treated as patients not criminals," there are a number of ways in which people in the centres are not, in practice, treated as patients.

L.V. (male, from Bangkok) who spent four months in a centre run by the Royal Thai Army stated:

> I woke up at five to exercise: jogging, running around the camp. After that I took a bath, had breakfast at eight, then [sung] the national anthem. After that there were group activities. When I was there, there were five groups altogether. We rotated.… Today, I grow green vegetables, on another day I did something else. The routine activities were to grow vegetables and cleaning. The other activities changed every day.

According to E.O. (male, from Chiang Mai) who spent four months in a treatment centre run by the Royal Thai Air Force in Chiang Mai:

> We have to do everything together, like brother and sister. I woke up at 4:30 am for running, then taking a bath, have breakfast and pay homage to the national flag then sit down in groups to discuss things, [such as] planning and stuff. I made a pledge I will not use drugs when I leave this place.

The patients might be assessed by staff of the centres twice during the four-month period (usually after 90 days and then again after 120 days in the centre). They are assessed on the basis of their cooperation with the system and their development in self-care skills and psychological well-being. Urine testing for drug use may be carried out in the centres.

In many centres, medical care is typically available from a medical officer who visits on a regular basis (usually once or twice a week). Information on HIV prevention is included in group sessions. In many centres, family visits are allowed on a regular basis (once or twice a month) after an initial period of 15 or 30 days.

Among people who were interviewed over the course of this research, opinions of their time in treatment centres were generally more favorable than the experiences waiting for assessment in prison. According to

Q.Q. (male, from Bangkok):

> It was good at Petchaburi [treatment centre], it was like [an] older brother taking care of [a] younger brother, but at Lad Yao [prison] it was like I was controlled.… I think the schedule of activities [at Petchaburi treatment centre] was fine. At the beginning I could not stand the place because it was far from home. During the first two weeks, I missed drugs as well. After two weeks, I could not think of drugs because I was thinking of the next activities.

According to D.C. (female, from Bangkok), "In Thanyarak [treatment centre] it was good, in Lad Yao it was very hard and tough." B.L. (female, from Bangkok), who had spent four months in the Thanyarak Institute on Drug Abuse centre in Bangkok and (later, on a separate occasion) four months in a centre run by the Royal Thai Army, commented:

> They took good care of us. You couldn't call us prisoners but patients…. It was fun in the army centre, not stressful. I woke up, [went] jogging, had food then group dynamic activities.… At the beginning, I wanted to escape, [but] after a while I had fun. In Thanyarak, there was vocational training, sewing, cooking, and every Tuesday they allowed us to dance.

Other people interviewed in the course of this research were more critical of the treatment in the centres. According to O.N. (male, from Bangkok), who had been ordered to undergo four months of treatment in the centre run by the Thanyarak Institute on Drug Abuse in Bangkok:

> I escaped. I followed my friends, they didn't want to stay there. I've gone through the TC therapy already and the TC there [Thanyarak Institute on Drug Abuse centre] was about the same. I wanted to go back home. I went over the fence. I went back home and was arrested once again. I was sent once again to Lad Yao, for 45 days. Then the police came and I went to court for escaping. I had to pay a fine.

According to Q.U. (male, from Bangkok) who had also been ordered to undergo four months of treatment in the centre run by the Thanyarak Institute on Drug Abuse in Bangkok:

> I felt bored. I escaped through the window at 1 a.m. I went over the wall and walked through the swamp. I swam across the canal and called a taxi and returned home… I was arrested after almost a year.

While the intention behind the Act is that people who use drugs or people who are dependent on drugs are "treated as patients not criminals," there are a number of ways in which people in the centres are not, in practice, treated as patients. As noted above, the people who enter custodial treatment programs have no right to choose their treatment or have input into their treatment plan. The treatment will be essentially the same for all people detained in the same centre. There will be minimal or no adjustment of the treatment to fit the individual. WHO and UNODC note that

> [t]he same standards of ethical treatment should apply to the treatment of drug dependence as other health care conditions. These include the right to autonomy, and self determination on the part of the patient, and the obligation for beneficence and non maleficence [i.e. do good/do no harm] on behalf of treating staff.[80]

The same document goes on to note that "there is evidence that matching response and interventions to client needs following a serious diagnostic process and extensive assessment improves the treatment outcomes."[81]

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[80] UNODC, WHO, *Principles of Drug Dependence Treatment: Discussion Paper*, p. 9.

[81] Ibid., p. 5. According to the [U.S.] National Institute of Drug Abuse:

> **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

3. Discipline

Some officials talked of the need to develop discipline as a key objective of treatment. Physical exercise and following a centre's rules were both approaches to achieving this objective.

The Act itself does not specify the rules of the treatment programs, however it does establish the punishments that are to be used by directors of the centres. According to the Act, a director has the power to punish a person who fails to follow the rules of a treatment centre by:

- probation;
- suspension of visitation or communication rights, but for no longer than three months; or
- solitary confinement not exceeding fifteen days for each confinement.[82]

In practice, the rules will depend on each centre, but follow a standardized approach. These rules will be explained to the patients on entry into the camp and will be displayed prominently around the centre. They typically comprise the following:

- No possessing or consuming drugs
- No escaping
- No stubbornness
- No stealing
- No quarrelling
- No sexual relationships
- No unauthorized possessions

U.T. (male, from Chiang Mai), who had spent six months in a centre run by the Thanyarak Institute on Drug Abuse, noted, "It's not so strict but we are advised to talk nicely." T.L. (male, from Chiang Mai), who had spent a period in a centre run by the army, stated that the rules were "similar to prison but much better." L.V. (male, from Bangkok), who had spent four months in an army centre, said, "It [i.e. my time in the centre] was a little bit hard because we had to follow their rules. [There was] no drug use inside the camp, even smoking [was] prohibited."

Officials explained that in practice people who broke minor centre rules might be disciplined by a "pull up" (a group activity described below), or that a group might decide on a punishment such as extra cleaning.

B.L. (female, from Bangkok) described this "pull up" process in the following terms:

> We could not say impolite words. If people there did something wrong, friends in the group would comment on their behaviour. For those trying to escape and failing, there would be a "house meeting," meaning they would stand in the middle and they [i.e., the group] would blame him.… People would shout at him "Why did you have to escape? Improve yourself. Don't do it like that

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An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery.

([U.S.] National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide,* 1999, at: www.nida.nih.gov/PODAT/PODATIndex.html.)

[82] S. 32.

[i.e., try to escape]."

Some interviewees who had been detained in the centres reported instances of cruel, inhuman and degrading forms of punishment.[83] Q.Q. (male, from Bangkok) reported that physical exercise was used as a form of punishment: "If someone tried to escape, [they were] punished by four to five hours of continuous exercise." E.O. (male, from Chiang Mai) reported:

> If rules [of the centre] are broken, first they got a warning. If they still disobey, they will be beaten with a wooden stick. It happened to those who had stayed there a long time. I saw this two or three times over four months [that I was in the centre].

"They were punished by [being forced to] lie down on the gravel ground and roll over it. That's for the first time [a person broke a rule]. For the second time, there would be hitting and kicking . . . . On the third time, the hitting or the kicking would be more severe."

L.V. (male, from Bangkok), who had spent four months in a centre run by the Royal Thai Army, described the following punishments for those who broke that centre's rules:

> For those who stayed in [the] camps and didn't violate their rules, there were no problems. If you violated the rules you were hit. [The rules included] no sexual relationships, no smoking — but these things happened. They were punished by [being forced to] lie down on the gravel ground and roll over it. That's for the first time [a person broke a rule]. For the second time, there would be hitting and kicking. If this happened the rest [of the camp's detainees] would be scared. On the third time [a person broke a rule], the hitting or the kicking would be more severe. Mainly the violators would be smoking traditional cigarettes. [There were] sexual relationships with others, but it was less common. When I was there for four months I encountered this [i.e., witnessed punishment for consensual sexual relationships] only once. The punishment was severe hitting or kicking.

The forms of punishment identified above are not permissible under the Act.[84]

4. Follow-up

There is no requirement in the Act itself for follow-up of people who have been in treatment programs. The Department of Probation attempts to undertake follow-up one year after the completion of treatment. It may involve an appointment to see a Department of Probation officer or staff at the Thanyarak Institute on Drug Abuse. It might also involve a home visit, if there is sufficient staff to carry this out. Alternatively, it might also involve indirect follow-up, such as a telephone call or a questionnaire sent by mail.

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[83] The U.N.'s Standard Minimum Rules for the Treatment of Prisoners states that "[c]orporal punishment … and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences": see U.N., *United Nations Standard Minimum Rules for the Treatment of Prisoners*, 1955, U.N. Doc. E/5988 (1977), para 31. Note that according to the ICCPR, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment" (art. 7). This right is absolute and non-derogable. WHO and UNODC note that "[i]nhumane and degrading practices and punishment should never be part of treatment of drug dependence." (UNODC, WHO, *Principles of drug dependence treatment: Discussion Paper*, 2008, p. 9.)

[84] The UN's Standard Minimum Rules for the Treatment of Prisoners state that punishment must always be determined "by the law or by the regulation of the competent administrative authority" and that "no prisoner shall be punished except in accordance with the terms of such law or regulation…." (paras. 29–30).

Some people who had been in the compulsory drug treatment system reported completing the requirement of follow-up visits. According to U.T. (male, from Chiang Mai), "For follow-up, I had to report once a month for one year. I completed 12 reports. A report includes a urine test, this is all."

However, according to both officials and people who had been through the compulsory drug treatment centres, for a considerable number of people follow-up is not possible. It is not surprising that some people will avoid follow-up that might reveal their continued drug use to authorities, given that drug consumption itself is illegal in Thailand. This was confirmed by a number of people interviewed in the course of this research. According to Q.U. (male, from Bangkok), "I was told to report myself but I didn't go.… I continue using drugs, so if I report they will find out." D.C. (female, from Bangkok) stated:

> [As follow-up] I must present myself, they have urine testing. If the result is positive I have to be sent back again. I reported myself only once, because I'm using drugs now, so I would be caught.

B.L. (female, from Bangkok), who had been recently released from a centre run by the army stated:

> The Department of Probation told us we had to report to the probation officer. I was meant to go four times and I went once. If they arrest me, I'll have to be sent to a centre again.

Evaluating the efficacy of treatment

The Act does not require an assessment of the efficacy of compulsory treatment programs. In the course of research for this paper, both officials and people who have been in such programs frequently cited the figure that 70 percent of people who go through the system will not relapse, which suggests that the other 30 percent will use drugs again. Indeed, the Department of Probation's publication notes that between 2003 and 2008, among all those who underwent compulsory drug treatment, the result was satisfactory in 75 percent of cases and unsatisfactory for 15 percent, with 10 percent categorized as "others."[85]

Even if the efficacy of treatment is measured through rates of relapse into drug use, attempts to assess drug treatment programs are inherently difficult. In the case of Thailand's compulsory drug treatment system, the task of evaluating the efficacy of compulsory drug treatment is complicated by the fact that considerable numbers of people do not attend follow-up appointments. Thus, the statement that 70 percent (or thereabouts) of people who go through the system will not relapse is unreliable. The approach to assessing "success" in treatment is biased: it includes those who voluntarily return for an appointment, but ignores the many who do not, including those that do not return for follow-up because they fear the consequences of reporting ongoing drug use.[86] Some officials expressed frustration at not being able to evaluate the efficacy of treatment using more reliable data.

Thailand's compulsory drug treatment system has expanded rapidly since the introduction of the Act, both in terms of the number of people in compulsory treatment and the number of compulsory treatment centres. However, there is a clear need to rigorously evaluate the efficacy of this system in all its complexity and heterogeneity. It is notable that there has been no research into the comparative efficacy of the different forms of treatment offered by different custodial centres.

There is robust research from outside Thailand showing strong associations between periods of treatment in therapeutic communities and subsequent reductions of drug use.[87] However, key distinguishing characteristics

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[85] Department of Probation, *Department of Probation & The Compulsory Drug Rehabilitation System in Thailand.*

[86] Similar methodological challenges are present in other assessments of drug dependence in Thailand. For example, see V. Verachai et al, "The results of drug dependence treatment by therapeutic community in Thanyarak Institute on Drug Abuse," *Journal of the Medical Association of Thailand* (*Chotmaihet thangphaet*) 86(5) (2003): 407–414 [original in English]. The study reports that "[a]fter they completed the program, the clients were followed-up for five years. 203 cases (73.0%) were abstinent from drugs." However, the data is based on the 278 cases that *completed* the program of drug dependence treatment by therapeutic community from 1986 to 2000, not the 2881 cases that *joined* the therapeutic community during this period.

[87] See, e.g., S. Wilson, "The effect of treatment in a therapeutic community on intravenous drug use," *Addiction* 73(4) (2006):

of Thailand's system — such as its compulsory nature, or that it is delivered through a diverse collection of entities including those with a military and law enforcement background — call into question whether such findings extend to Thailand's system.

The [U.S.] National Institute of Drug Abuse considers that "treatment does not need to be voluntary to be effective.[88] Some research indicates that external motivators (such as being legally mandated into treatment) may increase internal motivation or interact with it to produce better outcomes.[89] However, not all forms of compulsory treatment will be effective. Other research suggests that a lack of internal client motivation in treatment may undermine positive outcomes.[90] Some research has highlighted that, in many cases, there is a lack of proper evaluation of the efficacy of compulsory drug dependence treatment.[91]

Specifically with relation to treatment for methamphetamine dependence, some research has shown that compulsory treatment has been associated with higher rates of relapse than voluntary treatment. A recent study comparing the outcomes of treatment between voluntary patients and those who reported legal pressure to enter treatment found that:

> Outcomes (treatment completion, relapse within 6 months, time to relapse, and percentage of days with MA [methamphetamine] use in 24 months following treatment) did not differ significantly in simple comparisons between the pressured and nonpressured groups; however, when client and treatment characteristics were controlled, the short term outcome of relapse within 6 months was worse for those reporting legal pressure.[92]

The interviews carried out in the course of research for this paper revealed a wide variety of perspectives on the quality of treatment people had received. Some people had remained abstinent following compulsory treatment. T.X. (male, from Bangkok) said, "I'm glad that I stopped using drugs. Now, I only drink. I stopped because I was arrested several times and I'd had enough." Q.Q. (male, from Bangkok), who had spent both involuntary and voluntary periods in Bangkok's Thanyarak Institute on Drug Abuse centre, said "I stopped using drugs because I don't want to be arrested and sent for treatment again."

Other interviewees were appreciative of the treatment they received in the treatment centres, while noting that they did not remain abstinent after being released. D.C. (female, from Bangkok) stated, "I think it is good, but it's up to the individual if they can give up drugs or not." L.V. (male, from Bangkok), who had spent four months in an army centre said:

> It was good [treatment]. We could stop taking drugs. Within these four months even smoking was prohibited. We were trained like soldiers. I think it worked because some of [my] friends could stop using drugs.

407–411; J.-R. Fernández-Hermida et al, "Effectiveness of a therapeutic community treatment in Spain: a long-term follow-up study," *European Addiction Research* 8(1) (2002); 22–29.

[88] See [U.S.] National Institute of Drug Abuse, *Principles of Drug Addiction Treatment.* Whether involuntary treatment complies with human rights requirements is a separate matter from its effectiveness.

[89] See, e.g., G. De Leon et al, "Circumstances, motivation, readiness and suitability (the CMRS scales): predicting retention in therapeutic community treatment," *American Journal of Drug Abuse,* 20(4) (1993): 495–515; G. Joe et al, "Retention and patient engagement models for different treatment modalities in DATOS," *Drug & Alcohol Dependence* 57 (1999): 113–125.

[90] T Wild et al, "Perceived coercion among clients entering substance abuse treatment: structural and psychological determinants," *Addictive Behaviours* 23(1) (1998): 81–95; J. Platt et al, "The prospects and limitations of compulsory treatment of drug addiction," *Journal of Drug Issues* 18(4) (1988): 505–525; A. Stevens et al, "Quasi-compulsory treatment of drug dependent offenders: an international literature review," *Substance Use and Misuse* 40 (2005): 269–283.

[91] T. Wild et al, "Compulsory substance abuse treatment: an overview of recent findings and issues," *European Addiction Research* 8 (2002): 84–93.

[92] M.-L. Brecht et al, "Coerced treatment for methamphetamine abuse: differential patient characteristics and outcomes," *The American Journal of Drug and Alcohol Abuse* 31 (2005): 337–356.

O.N. (male, from Bangkok) stated:

> It [treatment] is good because it helped me be responsible, there is also time management [i.e., a subject covered in group sessions]. After I was released, I could stop for some time, but after I met my old friends I started again. TC is good, it is applicable. If I had a job and don't see the old environment, it would work well.

However, other interviewees were more critical of the effectiveness of the compulsory treatment system. O.L. (male, from Chiang Mai) stated:

> No, it [i.e., compulsory drug treatment] doesn't work. It [i.e., abstinence] essentially relies on the individual. Some people, they [are] afraid of the regulations and officers so they become obedient. But that's only five percent. Ninety-five percent do not fear the regulations. If people want to stop [using drugs] they will stop by following their heart, either by themselves or [with] their family. Some people stop when they have children. The main point is that the individuals have to decide, by their own will.

U.T. (male, from Chiang Mai) stated:

> I was quite addicted and I'm still young, so I use with friends. So, I have been through the prison, so I know how it is. It's not that difficult, I have no fear of imprisonment.

D.C. (female, from Bangkok) who had been detained in Thanyarak Institute on Drug Abuse for four months stated:

> I like drugs, that's why I still take [them]. I think the treatment is good but it's up to the individual if they can give up drugs or not.

Recommendations

One of the central findings of this paper is that the approach that people who use drugs or people who are dependent on drugs be "treated as patients not criminals" is undermined by the way the Act has been implemented. There are a number of concrete steps that could be taken to better realize the positive intention of the Act.

Minimize use of pre-treatment detention, including in prisons

The fact that the current system necessitates extended periods of detention in prison requires urgent attention. There are indications that people have been, on occasion, detained for assessment for longer than the extended period permitted by the Act. The intention of the Act is undermined by this arrangement. Prisons are poorly equipped to provide the necessary medical attention and supervision of detoxification and the management of withdrawal that would meet widely acknowledged scientific standards. Indeed, crowded prison conditions and poor nutrition may be exacerbating the pain and suffering often involved in detoxification. This paper also suggests that there is evidence of HIV risk behaviour while being detained for assessment in prison.

Alternatives to the current arrangement must be found. It is unclear why people need to be held in prison during this time. Officials cited resource restraints, but the system of treatment centres has expanded rapidly over the last few years and continues to do so. Such resources could be used to ensure that people are detained in health care facilities, rather than prison, while awaiting assessment.

Improved case-management processes by probation officers hold great promise for reducing the time taken in assessment (and hence the number of people in prison). Some officials explained that they had been able to reduce the average time for assessment to 18 days: Such efforts should be evaluated and expanded. The use of bail pending assessment, in appropriate cases, could also reduce the numbers of people being held in prison. There seems to be no clear reason why people could not spend the *assessment* time in their communities, given that a large percentage of them spend their *treatment* time in their communities.

The Department of Probation should revisit the current practice of holding people in prison for the full 45-day duration when there is no available place in custodial centres. When implementing a decision to impose a custodial treatment program will not be possible, people might as well be released into non-custodial treatment earlier. To do otherwise invites the conclusion that the 45-day period of detention in prison is operating, in effect, as a form of punishment for an alleged drug offence, even though there has been no finding of guilt and the stated objective is to treat people with drug dependence as patients, not criminals.

Develop and enforce minimum standards of care for drug treatment

More generally, there is a need to develop minimum standards of care across Thailand's drug treatment service providers, a need heightened by the fact that such treatment is compulsory for thousands of people. Approaches to treatment differ between centres and between the entities that run them. As recommended by UNODC and WHO:

> To ensure quality in the drug treatment network, a system of clinical governance should be developed with clear lines of clinical accountability, continuous monitoring of patient well being, adverse events and intermittent external evaluation.[93]

The officials consulted over the course of this research were highly professional and appeared motivated by good intentions towards those in their care. However, a number of people interviewed who had been through the centres mentioned forms of punishment, including physical violence, that were cruel, inhuman and degrading. The Act was intended to ensure that people were "treated as patients not criminals," but such forms of punishment serve no treatment or rehabilitative purpose. They are outside the legal forms of punishment permitted in the Act, and run contrary to stated government policy as well as international human rights law. As a matter of urgency, forms of cruel and inhumane treatment must be proscribed so that any disciplinary

[93] UNODC and WHO, *Principles of Drug Dependence Treatment,* p. 20.

action, where absolutely necessary, is of a form permissible under the Act and consistent with basic human rights standards.

Create mechanisms for patient input into programs and for addressing any abuses

On an ongoing basis, efforts to improve treatment should be explored. As noted above, treatment needs will differ among patients and over time. The current approach involves an initial assessment of individuals by probation officials which is usually endorsed by the Sub-Committees. In effect, assessment and diagnosis occurs only once, and is undertaken by people who are not addiction specialists, nor even trained health care professionals.

Actual treatment will be the same for all individuals at a particular centre. A rigid approach to treatment, even one that is carefully designed, will not meet the treatment needs of all individuals. Mechanisms must be found that allow the people greater autonomy and meaningful choices in their treatment.

There is a need to develop minimum standards of care across Thailand's drug treatment service providers, a need heightened by the fact that such treatment is compulsory for thousands of people.

Alternative forms of treatment programs should be explored. One innovation that was mentioned in the course of this research was a pilot program of five-day residential treatment. The costs and benefits of this approach, compared to four-month custodial treatment programs, should be assessed. This five-day residential treatment approach would appear to offer a key benefit of reducing the numbers of people in the system, and might still provide effective treatment.

There is no formal mechanism by which people who have spent time in the centres can provide input into the policies of drug dependence treatment programs. One approach adopted in one centre run by the Royal Thai army was a questionnaire that allowed people who had been through the camp to evaluate their treatment. This approach holds out the possibility of improving treatment. Similar creative thinking with respect to ways in which people can play a greater role in determining their own treatment should be encouraged.

UNODC and WHO identify the approach to treatment that should be followed. They recommend that drug dependence treatment systems ensure, *inter alia*, that:

- service procedures require staff to adequately inform patients of treatment processes and procedures, develop individual care plans jointly with the patient, obtain informed consent from the patient before initiating interventions, and guarantee the option to withdraw from treatment at any time….; and
- staff are properly trained in the provision of treatment in full compliance with ethical standards, and show respectful and non-stigmatizing attitudes….[94]

There is currently no mechanism in Thailand's compulsory drug treatment system by which a person can report any instances of suspected abuse, neglect or exploitation of people in the program. There is no grievance and appeal process. While people can appeal to the Sub-Committees who issued the treatment order, they can

[94] UNODC and WHO, *Principles of Drug Dependence Treatment*, p. 9.

do so on a very limited set of issues. An independent complaints mechanism to handle allegations of rights violations is necessary.

Evaluate efficacy of compulsory drug treatment, expand access to voluntary treatment

The efficacy of Thailand's compulsory drug treatment requires rigorous, independent evaluation. Some research from outside Thailand calls into question the efficacy of compulsory treatment. However, in Thailand, compulsory treatment has been introduced on an unprecedented scale and over a relatively short period of time. Rigorous evaluation of the efficacy of the system is, therefore, of utmost importance in achieving the stated objective of ensuring that, as "patients not criminals," people who use drugs have access to treatment that is effective in addressing their health needs. At the same time, given the recognition by the Thai government that drug dependence is a serious health issue facing the country, expanded access to affordable, evidence-based treatment that is voluntary should be prioritized. As noted by UNODC and WHO:

> The nature of drug use and related problems in a community will change over time, and in consequence services will need to adapt and reorient their programs in order to respond to their clients' evolving needs. Services will also need to build on feed-back from patients, their relatives and the community, as well as on monitoring and evaluation results with a view to improving their quality and performance.[95]

[95] Ibid., p. 18.