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Drug control and harm reduction in Thailand

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Introduction

In South East Asia, Thailand is lauded for its success in reversing an HIV epidemic in the 1990s, particularly amongst sex workers.[3] Thailand is also known for its success in significantly reducing opium cultivation, and implementing effective alternative development programmes for opium farmers.[4] However, other aspects of the government's response to illicit drug markets in Thailand undermine these successes and have been characterised by the exclusion and marginalisation of people who use drugs, which has fuelled on-going epidemics of HIV and hepatitis C virus (HCV) among this population.

The Thai government's response to drug use continues to be one of 'zero-tolerance', focused on eradicating drug consumption and production with the imposition of harsh punishment for drug-related crimes, ranging from compulsory detention to the death penalty. This response reflects the regional commitment to achieving a 'drug-free ASEAN by 2015'.[5] Further, while national drug laws accommodate the notion that people who use drugs are 'patients not criminals', in reality people who use drugs are frequently incarcerated and there is little understanding or consideration given to the realities of drug use and dependence, relapse to drug use or the acceptance that dependence is a chronic relapsing medical condition.[6] Within prisons and treatment/rehabilitation centres, limited or no evidence-based treatment for drug dependence is provided. In the community, people who use drugs are highly stigmatised, harassed by law enforcement officials, unlawfully tested and detained on suspicion of drug use, and excluded from accessing health, social and legal services.

The purpose of this paper is to analyse the Thai Government's policy response to drug use and drug-related risks, and to develop recommendations, on the basis of international evidence and best practice, for strengthening Thailand's policy response in this area.

Recent trends in drug supply and demand

Thailand's approach to alternative development and opium crop eradication is widely regarded as the most successful in the world and has resulted not only in a greatly diminished production of opium crops, but also improved livelihoods for farmers in their project areas.[7] Currently, heroin is not known to be produced in Thailand; but heroin supplied from South East and South West Asia is trafficked through the country.[8]

However, one of the unintended consequences of opium eradication in South East Asia has been a rise in the production and use of amphetamine-type stimulants (ATS), mainly methamphetamine. The United Nations Office on Drugs and Crime (UNODC) 2013 World Drug Report states that in 2011, seizure and arrest data related to methamphetamine reached record levels in Thailand, but that this reflects increasing manufacture and trafficking from Myanmar, Iran and West African nations rather than

domestic production.[9] Further, while a large portion of the methamphetamine smuggled into Thailand is intended for the domestic market, considerable quantities are trafficked to neighbouring countries and smaller amounts are trafficked beyond the region. Bulk quantities of precursor chemicals used in drug production (mainly preparations containing ephedrine and pseudoephedrine) are also diverted and smuggled through Thailand to manufacturing sites in Myanmar and, to a lesser extent, Cambodia.

In Thailand, there is a high degree of concern over rates of drug use, particularly the use of methamphetamines in both pill form ('yaba') and in crystalline form ('ice'). Media reporting fuels the popular belief that illicit drug use is widespread, particularly among young people, and that it threatens public health and security in Thailand.[10] A recent Bangkok poll found that 88 per cent of those surveyed felt that drug use was the most serious problem affecting Thailand.[11] In fact, the prevalence and nature of harmful drug use in Thailand is poorly understood, with few reliable data sources.

Box 1. Kratom control in Thailand

Kratom (mitragynia speciosa korth) is a tropical deciduous tree indigenous to South East Asia which acts on opioid receptors, with a stimulant effect at low doses and a sedative effect at higher doses. Traditionally in Thailand, kratom is chewed or brewed in tea and is regarded as being relatively harmless. More recently younger people in Bangkok and the South of Thailand have been drinking kratom in a cocktail called '4x100' which includes kratom tea, Coca-Cola, cough syrup and ice cubes. Kratom is a controlled substance in Thailand and has increasingly been the focus of law enforcement officials, with kratom seizures rising from 1.7 tons in 2005 to 23 tons in 2011. Similarly, the number of kratom-related arrests more than doubled between 2007 and 2011, from 5,571 to 13,134.

On 28th August 2013, Thailand's Minister of Justice announced that his office was considering removing criminal sanctions for kratom use. This recent debate represents the third attempt to officially decriminalise kratom since it was scheduled under the Kratom Act of 1943. The Ministry of Justice delegated the management of the consultation process to the Office of the Narcotics Control Board (ONCB). This is based on newly accepted evidence that kratom is safe, with few negative health or social side effects and does not create dependence.[12] Further, Chulalongkorn University's Department of Pharmacy has provided evidence that kratom has potential as a substitute in drug dependence and can help manage cravings and withdrawal symptoms. Concerns about the danger of kratom refer only to the 4x100 cocktail and the combination of kratom with pharmaceuticals, rather than with kratom itself. Polls of Bangkok residents indicate divided views about the decriminalisation of kratom: 52 per cent worry that it could lead to misuse, 48 per cent think of kratom as harmless traditional medicine.[13]

The ONCB uses results of the national household survey to estimate the numbers of users of different drugs.[14] In 2011, they projected that around 125,000 people in Thailand had used *yaba* at least once in the last month. They also estimated that 98,000 had used cannabis and about 400,000 people had used kratom at least once in the last month. However, while the prevalence of drug use can be used as an indicator of the extent of the drug problem in a country, these results reveal little about problems relating to drug use as they do not distinguish between dependent or recreational drug use. This misunderstanding is reflected in almost all national laws and policies, where no distinction is made between drug use and drug dependence, leading to misguided policy objectives such as requiring that all people who use drugs receive some form of drug treatment. Such policies do not appear to be guided by evidence, given the finding by UNODC that only around 10 per cent of people who use drugs are dependent on drugs.[15]

Research by the Chiang Mai University estimated that, in 2009, the number of people who injected drugs in Thailand was between 40,300 and 97,300,[16] with the lower estimate of 40,300 taken as the official figure by the Government. It is believed that methamphetamine injection is becoming more common – research in Bangkok showed that one in three people who inject drugs use methamphetamine.[17] The latest results of the Integrated Biological and Behavioural Survey (IBBS) also indicate a significant number of methamphetamine injectors (30.3 per cent of people who inject drugs surveyed in Central Thailand, 29.9 per cent in Chiang Mai and 18.1 per cent in Songklha).

Other drugs of concern include midazolam, a benzodiazepine which is frequently injected, despite the fact that it is a non-soluble pill. As with all benzodiazepines, there are therefore several health risks associated with injection, including vein damage, but also nerve and vascular injuries, dependence and withdrawal. With the decreasing availability of heroin in Thailand, service providers have noted increasing amounts of midazolam injecting, and reported daily injection of midazolam over the last six months among more than a third of people who inject drugs surveyed in Bangkok.[18]

Sentencing laws and practices for drug offences

Drug control laws in Thailand are contained in the Psychotropic Substances Act B.E. 2518 (1975), the Narcotics Control Act B.E. 2519 (1976) and the Narcotics Act B.E. 2522 (1979). Controlled psychotropic substances are listed in Schedules I to 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. According to this Act, unauthorised consumption or possession of Schedule I or Schedule II drugs is punishable by one to five years' imprisonment and/or a fine of 100,000 to 400,000 baht (USD 3,200 to USD 12,794). Unauthorised production, importation, export or sale of Schedule I and II drugs is punishable by imprisonment of five to twenty years in prison and/or a fine of 100,000 to 400,000 baht (USD 3,200 to USD 12,794).

Controlled narcotic substances are listed in Categories I-V of the Narcotics Act B.E. 2522 (1979). Category I drugs include heroin, amphetamine, methamphetamines, ecstasy and lysergic acid diethylamide (LSD). Category II drugs include the coca leaf, cocaine, codeine, morphine and methadone. Category V drugs include cannabis and kratom. Under this Act the consumption, possession (of 'smallest dosage'), disposal (i.e. trafficking), possession for the purposes of disposal, production, import and export are punishable by imprisonment and/or fines. The length of imprisonment and the fine depend on the quantity and schedule of the drug; e.g. possession for the purpose of disposal for amounts ranging from the smallest dosage of up to 20g of category I substances carries a punishment of imprisonment of four years to life and a fine of 400,000 to five million baht (USD 12,794 to USD 159,874); for amounts of more than 20g of category I substances, the punishment is life imprisonment, a fine of one million to five million baht (USD 31,976 to USD 159,874) or the death penalty. The death penalty may also be imposed for the production, importation or exportation for the purposes of disposal of category I narcotics involving amounts above the 'lowest dosage'.

These Acts also give the police and other officials wide powers of search, seizure and arrest, and authorise the police to conduct drug testing using urine samples.

The Narcotic Addict Rehabilitation Act (2002) creates a different approach to drug control, by providing alternatives to incarceration for some drug offences with the aim of diverting people charged with drug consumption (and other minor offences, as outlined in the next paragraph) into treatment programmes instead of prison. However, while the Narcotic Addict Rehabilitation Act provides a framework whereby people who use drugs are 'patients, not criminals', the consumption and possession of drugs is still illegal and

punishable under the Psychotropic Substances and Narcotic Control Acts. In addition there are no statutory provisions regarding drugs in Thailand that provides legal grounding for harm reduction services or treating people dependent on drugs as patients.

The diversion scheme applies to people charged with the following offences: drug consumption; consumption and possession; drug consumption and possession for disposal; and drug consumption and disposal. In all cases, the amount of drugs involved must be small in order to qualify for diversion.[19] After arrest, an individual's case must be sent to court for consideration within 48 hours; if the person is under 18 years, this must happen within 24 hours. Whether the accused should have their case diverted is determined by the court, which decides whether or not to issue an order referring the person to a subcommittee.[20] There are no clear criteria on the basis of which an individual's circumstances will lead a prosecutor or judge to order the person into the diversion scheme (the subcommittee). However, it appears that a significant proportion of people arrested for drug consumption are not diverted but imprisoned, representing 3 per cent of people imprisoned in Thailand in 2012 (see the section on Prisons). The subcommittee must then identify whether the person is a 'narcotics consumer or addict' within 15 days, with an additional 30 days available if needed by the subcommittee, but not exceeding 45 days. In contrast to international best practice, which would apply one or more of a range of validated measures of drug dependence, for example the WHO Addiction Severity Index, determination of whether an individual is a recreational/occasional user or drug dependent is usually made on the basis of urine test results, without assessing levels of drug use, dependence or related risk behaviours. During this time, people are detained in prison if they are over 18 years, or in Juvenile Observation and Protection Centres if they are under 18 – effectively imprisoning some patients who were meant to be diverted from the prison system.[21]

If the urine test results show prior drug use, the subcommittee will issue a treatment order that involves programmes in detention or voluntary treatment centres. Within the detention system, this may be a detention centre that is 'intensive'/'strict' (i.e. a centre from which it is very 'difficult to escape') or 'non-intensive'/'non-strict' (where there is less monitoring by guards and weekend visits home are allowed). Reportedly, those who are more frequent (or 'hard core') users will be sent to the intensive custodial centres, while those who are dependent but not 'hard core' will be sent to a custodial non-intensive centre[22] (please see the following section for a more detailed outline of the drug treatment system).

Harm reduction policies and services

For the past two decades, HIV and HCV rates amongst people who inject drugs have remained unacceptably high in Thailand. The most recent estimates found that HIV prevalence rates in people who inject drugs to be between 25.2[23] and 50 per cent.[24] The HCV prevalence rate is estimated to be at 89.8 per cent.[25] Needle and syringe programmes (NSP), opioid substitution therapy (OST) and HIV and HCV testing and treatment are proven, effective interventions for reducing the transmission of blood-borne viruses among people who inject drugs. However, political support for harm reduction and coverage of harm reduction services remain extremely low in Thailand.[26]

In 2009, the National AIDS Prevention and Alleviation Committee resolved to approve a draft policy on harm reduction for people who use drugs which had been proposed by the National AIDS Management Centre of the Department of Disease Control. The draft policy consisted of the UN recommended 'comprehensive package of services'[27] (including NSP and OST) to reduce HIV among people who inject drugs. After a parliamentary review and approval, the draft policy was reviewed by the Council of State.[28] However, in its 2011 ruling, the Council noted that the distribution of injecting equipment was in contravention with the Narcotics Act, given that 'inciting drug use' is a crime under existing laws.[29] As such, the Prime Minister at

the time did not endorse the policy, and Thailand remains without an official national harm reduction policy. In February 2013, the Law Reform Commission of Thailand (LRCT) decided to approve the creation of a Narcotics Law Reform Sub-Committee comprising representatives from relevant sectors, including civil society representatives, with the aim of working towards the official adoption of a harm reduction policy.

In November 2010, the ONCB issued a notification calling for pilot 'harm reduction services' to be set up in 10 provinces. However, the funds were used for coordination meetings and capacity-building workshops instead. In 2013, the ONCB called for the expansion of the pilot programme to another nine provinces to synchronise with the CHAMPION-IDU project (see below for a description of this project), and improvements in coordination between civil society organisations and law enforcement. The ONCB also endorsed the provision of harm reduction services in its annual operational strategy for 2014, launched in October 2013.[30]

Needle and syringe programmes

Unofficial NSPs commenced in Thailand as a small community programme in the Northern province of Chiang Rai in 1992, using left over needles and syringes intended for a vaccination programme.[31] In 2003, the Thai Drug Users Network (TDN), the Thai Treatment Action Group (TTAG), Alden House and the Raks Thai Foundation were awarded a non-Country Coordinating Mechanism (CCM) grant by the Global Fund to Fight AIDS, Tuberculosis & Malaria (GFATM) in order to implement Thailand's first peer-driven national-level harm reduction programme, paving the way for future GFATM grants. It is noteworthy that these organisations, led by people who use drugs, secured international funding for harm reduction services without the explicit support of the Thai Government. Currently, all NSPs are funded by the GFATM and endorsed by the CCM, under the CHAMPION-IDU project. The current project supports 13 drop-in centres and 10 satellite outreach networks in 19 out of Thailand's 77 provinces.

Coverage of NSP remains low in Thailand, in part due to the legal ambiguity surrounding the provision of needles and/or syringes in Thailand. Since July 2009, fewer than 1,5 million needles and syringes have been distributed against a target of approximately 5 million. National data indicates that less than 1 per cent of people who inject drugs access NSPs, with less than one sterile needles and/or syringe available for each person who injects drugs per year.[32] For 2012, UNAIDS data showed that 12 syringes were distributed per person who injects drugs per year by NSP – a very low figure given that the WHO and UNODC guidelines advise that 100 or less syringes or less per person who injects drugs per year is already considered a low level of distribution.[33] A study of people who inject drugs in Bangkok found that 30 per cent had borrowed a used syringe in the past six months and 65 per cent of these individuals reported multiple borrowing events. Study participants reported that the main difficulties in accessing needles and syringes were that they lived too far from outlets, pharmacies were closed at the time they needed a syringe, and they were refused needles and syringes at pharmacies.[34] Under the CHAMPION-IDU project, a network of private-sector pharmacies also support the distribution of safe injecting equipment, but despite multiple distribution channels and strategies, CHAMPION-IDU needle and syringe distribution remain constrained by legal barriers to the provision of NSP and police harassment of both clients and staff. Outreach staff and their clients reported police beatings,[35] the police planting drugs,[36] forced urine testing[37] and other inhumane treatment.

Methadone maintenance treatment

Methadone maintenance treatment (MMT)[38] is well recognised as an effective therapy for opioid dependence and the provision of methadone as a form of OST is associated with decreases in illicit drug use and reduced rates of HIV sero-conversion.[39] Methadone has been available in Thailand for detoxification since 1979 and approved for MMT since 2000.[40] It is included on the Essential Medicines list, and clinical guidelines for its use are available. Since 2008, costs have been covered by the National Health Security Office (NHSO) and, in theory,

methadone as a maintenance therapy should be available at all provincial and district hospitals. However, enrolment into MMT programmes remains low among people who use heroin. While the World Health Organisation (WHO) recommends at least 40 per cent coverage of OST among people who use heroin in order to have an impact on HIV prevention, in Thailand only an estimated 7 per cent of people who inject drugs are enrolled in OST programmes, and drop-out rates are high.[41]

There are several issues related to the provision of MMT in Thailand, creating barriers and reducing treatment adherence and effectiveness. While national guidelines promote MMT, in reality few services provide it continuously, and most people enrolled in these programmes are reportedly receiving a prolonged detoxification for around 45 to 90 days with tapered doses of methadone.[42] In some programmes, eligibility for long-term MMT can only be reached after three 'failed' attempts at methadone detoxification.[43] The daily methadone doses given are reportedly too low – an average of 45-50mg per day – and dosing practices are poor with both rapidly decreasing tapers or 'saw-tooth' dosing (i.e. where patients are provided increasing methadone doses until they no longer experience withdrawal, they are then perceived as 'cured', at which time the dose will be rapidly decreased with an aim for detoxification, only to be increased again when withdrawal symptoms reappear).[44] None of these approaches are consistent with either international guidelines on provision of MMT, or evidence for drug treatment or HIV prevention.

18 of the Kingdom's 108 MMT programmes are located in Bangkok, and are largely operated by the Bangkok Metropolitan Authority (BMA). While they are free – or at least relatively cheap – in Bangkok, and are provided by the majority of public sector health service providers across the country, access is constrained by the many conditions imposed on people who use drugs. Dispensation from private clinics is expensive. Many patients are deterred from enrolling in a MMT programme because of the travel distance to the clinics, particularly for people who live in hillside and remote regions. Compounding this, few – if any – programmes offer take-away doses of methadone and those that allow weekly 'carries' dispense a maximum 350 mg per week (as per the Food and Drug Administration (FDA) notification) which does not ensure an adequate management of withdrawal symptoms for the majority of people dependent on opioids.[45]

The costs of MMT are covered by the NHSO, but this excludes people who are employed and covered by the social security system. In addition, clinics continue to charge patients for 'clinic costs' even though the medication is free. Outside of Bangkok, few patients receive free treatment in practice. For those clients referred to MMT through a compulsory treatment order, tapered doses are provided free of charge, but long-term maintenance is not subsidised.[46] Finally, there have been limited coordinated efforts to train health personnel to provide MMT, little monitoring of MMT programmes and no follow-up of patients who leave the programme.

Recently, the WHO, the Thanyarak Institute for Drug Abuse (under the Ministry of Health), the NHSO, the public sector hospital network of Thailand and several civil society groups have agreed to scale up MMT, improve the quality of services, strengthen guidelines, and allocate national resources to support these initiatives in order to improve access for people who use drugs.

Other treatment services for people who use drugs

While Thailand has a relatively high coverage of antiretroviral treatment (ART) for eligible patients (60 to 79 per cent of them are receiving ART), only 2 per cent of people who inject drugs and living with HIV receive ART.[47] In Bangkok, HIV testing rates among people who inject drugs are relatively high at around 70 per cent,[48] with HCV testing rates of about 30 per cent.[49] There are no integrated services for people who use drugs, with methadone, HIV and HCV treatment provided at separate sites.

Under the National Health Security System, hepatitis C treatment is currently provided for HCV genotypes 2 and 3 only and does not include co-infections or lab investigations. The Health and Intervention Technology Assessment Programme (HITAP) investigated hepatitis C treatment and proposed that the NHSO extend therapeutic benefits to cover co-infections and genotype 6, as well as lab investigations. Since then, the NHSO requested further studies to assist with developing a budget for extending HCV services, including a cost-benefit study. This research will be finished by the end of 2013 and if the cost-benefit is demonstrated, the expanded hepatitis C benefits should then be included in the National Health Security System by October 2014.

Community-based research found that about 30 per cent of people who inject drugs in a Bangkok sample had experienced non-fatal overdose, mainly associated with heroin use; 68 per cent had witnessed an overdose with few people being able to identify the correct ways to manage overdose.[50] Naloxone is an opioid receptor antagonist, which can be used to counter the effects of opioid overdose and prevent overdose deaths.[51] Naloxone is not a scheduled drug under the Narcotics Control Act, but its availability in Thailand is regulated by the FDA. The FDA classifies naloxone as a 'dangerous drug' which can only be administered by a medical professional. This limits the usage of naloxone and means that community-based naloxone programmes – shown in other settings to have been effective in reducing morbidity associated with illicit drug use – cannot legally be implemented in Thailand.

Civil society engagement

Since 2002, people who use drugs have organised for advocacy purposes under the umbrella of TDN. In 2008, TDN along with its civil society allies – mainly HIV/AIDS advocates – formed a coalition of 12 organisations to advocate on harm reduction services and supportive drug policies under the name of the '12D' network.[52] Currently, the CHAMPION-IDU project is the best resourced consortium of organisations working with people who use drugs and is implemented by Population Services International (PSI) as a principal recipient under a GFATM Round 8 grant. As well as providing all NSP services in the country, the role of PSI and their partners[53] is to enter into policy dialogue with community and religious leaders, and drug control and prison officials in order to support service delivery; conduct national-level advocacy through civil society mobilisation, specifically with the aim of adopting a national harm reduction policy; address the policy barriers to naloxone distribution; liaise with law enforcement agencies and officials to minimise the negative impact of law enforcement activities on people who use drugs; and conduct sensitisation activities at community level. However there is still relatively little civil society engagement in advocacy relating to harm reduction and drug policy due to a lack of financial resources for such activities, and the fact that discussions about drug use are still difficult to have in Thailand due to social taboos.

Box 2. Support. Don't Punish: A campaign to promote harm reduction in Thailand

On 26th June 2013, the International Day against Drug Abuse and Illicit Trafficking, 12D organised a day of action as part of the global 'Support. Don't Punish' campaign.[54] During the rally the ONCB Secretary-General met with 12D and received a letter from them which called for the support of harm reduction services and other evidence-based policies; increased financial resources for the provision of services for people who use drugs; an end to the criminalisation of drug use; voluntary and human-rights based treatment and rehabilitation; and more opportunities for Thai civil society and drug user networks to participate in policy making processes. He agreed to meet with 12D representatives following the rally, and further meetings with the ONCB resulted in their agreements to work to end police obstruction of peer educators working to provide

services under the CHAMPION-IDU programme, and to expand the ONCB's harm reduction programme to another nine provinces. This represented a considerable and positive shift in the ONCB's dealings with civil society groups on the issue of drug use.

Civil society members are represented on the GFATM CCM and the National AIDS Committee. They were also vocal participants in conferences and meetings such as the 8th Thailand National Conference on Substance Abuse, held in Chiang Mai in 2013, and the seminar co-hosted by the Thailand Ministry of Justice Rights and Liberties Protection Department, the Transnational Institute (TNI) and the International Drug Policy Consortium (IDPC), to discuss legal frameworks for responding to drug-related activities.[55]

In September 2013, a coalition of NGOs, including TDN and the Foundation for AIDS Rights and led by PSI-Thailand, mobilised approximately 20 civil society and drug user representatives to present a set of recommendations and evidence to the Ministry of Health and the FDA regarding the legal status of Kratom. This coalition asked the government to decriminalise kratom and support more research into its pharmacology and its potential as a substitute in the treatment of methamphetamine dependence.

Drug treatment system and operations

There are three treatment and rehabilitation systems for people who use drugs in Thailand:

1. Voluntary system (Narcotics Act B.E. 2522) – Coordinated by the Ministry of Public Health
2. Compulsory system (Narcotic Addict Rehabilitation Act B.E. 2545) – Coordinated by the Department of Probation (Ministry of Justice)
3. Correctional system – Coordinated by the Department of Corrections (Ministry of Justice).

The Narcotics Act B.E. 2522, under Section 94, allows people who have consumed, possessed or trafficked drugs (within the quantity thresholds prescribed in Ministerial Regulations) and voluntarily enters a treatment programme, before their offence is discovered by a law enforcement official, to be excluded from arrest and a criminal record.

Table 1. Number of registered people who use drugs by type of treatment centre, 1st October 2011 to 30th September 2012[56]

Treatment system	Number of people registered
Voluntary	
Community-based therapy	213,552
Therapy under Measure 315 (an ONCB initiative in the Bangkok area to help reach the national target, e.g. door-to-door urine testing)	6164
School/university student camps	7,439
Psychosocial support in schools	17,219
Residential treatment centre	147,819
Total voluntary	392,163
Compulsory	148,026
Correctional	19,857
TOTAL	**560,046**

As of February 2012, there were reportedly 1,278 drug treatment and rehabilitation facilities in Thailand – 1,008 were voluntary[57] consisting of both residential/in-patient and out-patient services, community- and school-based programmes (see Table 1); 91 were compulsory residential centres (16 'strict' detention centres[58] and 75 'non-strict' detention centres[59]) and 179 were correctional centres.[60]

For 2012, the national target number of people who use drugs to be treated and rehabilitated was 400,000. In the period of 1st October 2011 until 30th September 2012, 560,046 people who use drugs were registered in the treatment system in Thailand – a number well exceeding the target (see Table 1).

In the compulsory system, treatment programmes usually involve four months of treatment and a two-month re-entry programme, that is, six months' detention in total. OST is not available in the centres. The treatment provided is usually a sort of 'therapeutic community', involving group work, work therapy, vocational training and physical education, with no input from the patient about the structure and nature of their treatment programme. There is no valid assessment of their drug use or whether they are in fact drug dependent (although a recent trial initiative was developed to employ the ASSIST tool[61] at the centres). All patients, regardless of their drug use, psychological and clinical history, participate in the same treatment programme.[62] There is little evidence to support the effectiveness of this treatment approach. Follow-up of patients is rare and the rate of relapse after release from the centres is unknown. In addition, there have been reports of physical and psychological abuse within the treatment centres.[63]

Prisons

About two out of every three people incarcerated in Thailand's overcrowded prisons were arrested for drug-related offences, and about a quarter of these are people who use drugs or user-dealers (i.e. people who use drugs who also sell small amounts of drugs to fund their own drug use), rather than large-scale drug producers or traffickers.

In 2013, Thailand had 287,335 people in prison, of which 50 per cent (143,068) were charged, convicted or detained for drug offences.[64] Of these, 65.05 per cent were imprisoned for offences relating to methamphetamines in pill form (yaba), 8.84 per cent in crystalline form (ice), 2.34 per cent for amphetamine, 0.75 per cent to heroin and 0.28 per cent to cannabis. About one in five prisoners arrested for drug offences were arrested for illicit consumption and/or possession without intent to supply to others. A study among a group of people who inject drugs in Bangkok found that 78 per cent had been imprisoned at least once[65] and about 48 per cent had experienced police planting drugs on them.[66] This indicates that it is a common experience among low-level dealers and people who use drugs to be imprisoned (see Table 2).

Under the principle of 'equivalence of care', and under Thai legislation, any prisoner (except non-Thai citizens) must have access to health services and benefits at the same level as those provided under the National Health Security System. In reality, there are very limited health services available in prisons. Prisons do not offer sterile needle/syringes or medical supplies. OST is generally unavailable, although there is one pilot MMT project in Fang prison in Chiang Mai province in which four clients are enrolled.[67]

Table 2. Nature of offences for which people are imprisoned in Thailand, 2013[68]

	Number	% of total prisoners
Total number of prisoners (including those convicted, charged and in pre-trial detention	287,335	
Total number of prisoners arrested for drug offences	143,068	49.79
Total number of convicted prisoners	210,744	73.34
	Number	**% of drug offences**
Drug of use		
Methamphetamine (pill form)	93,070	65.05
Methamphetamine (crystalline form)	12,646	8.84
Amphetamine	3,343	2.43
Heroin	1,074	0.75
Cannabis	395	0.28
Case type		
Disposal	48,656	34.01
Possession with intent to dispose	61,004	42,64
Import, export, production	4,975	3.48
Consumption	4,364	6.05
Possession	8,021	5.61
Consumption and possession	16,048	11.22

Law enforcement policies and practices

In 2003, the then Prime Minister Thaksin Shinawatra's 'war on drugs' became a turning point for drug control and law enforcement in Thailand. With the objective of achieving a massive reduction in drug use and availability, Thaksin talked of banishing drugs in 'every square inch' of Thailand within four months. This was to be achieved through tough enforcement including extra-judicial action by the police and other law enforcement agencies.[69] Human Rights Watch reported human rights violations, including 'government promotion of violence against drug suspects, extra-judicial executions, blacklisting of drug suspects without due process, intimidation of human rights defenders, and violence and other breaches of due process by the Royal Thai Police'.[70] An estimated 2,800 people in Thailand were killed, and 7,000 injured.[71] At the time, the war on drugs received much popular support despite the grave human rights violations committed.

The 'stamping out' of drug problems, which aimed to reduce crime and 'bring peace to society and communities' continues to be a popular Government policy, despite increasing volumes of drug seizures (particularly methamphetamine pills), which suggests no abatement in the supply and use of drugs.[72] In 2011, Prime Minister Yingluck Shinawatra publicly declared that 400,000 people who use drugs would be targeted for treatment, although there is little understanding of how this target was reached and no known evidence of the effectiveness of the current approach in reducing demand for drugs. Indeed, there has been no government assessment of the quality of treatment and rehabilitation services in Thailand. However research from a Bangkok-based sample of people who use drugs found no changes in rates of illicit drug use following release from compulsory detention centres.[73]

In order to achieve the target number of people who use, or are dependent on, drugs receiving treatment, the police have increased efforts to identify people who use drugs. Urine testing is common and occurs at police roadblocks, schools, universities and

entertainment places, with the ONCB recently introducing door-to-door urine testing. These practices do not comply with legislation or regulations regarding urine testing, resulting in infringements of personal rights, violence and unlawful arrests, searches and imprisonment on a large scale. People have been told to urinate on sidewalks, behind trees and other open spaces. A positive ('purple') urine test will lead to pre-trial detention – without charge – in prison for a period of 15 to 45 days (see Sentencing laws and practice section above).

Given the deep, widespread social stigma against people who use drugs and a firm belief that public security is threatened by their presence in the community, some parents ask the police to come and arrest their children, with the expectation that after being arrested and 'treated', their children will be cured with no chance of relapse. Such practices demonstrate a lack of understanding about drug dependence as a chronic, relapsing medical condition, and about drug use in general which has rarely been known to lead to threats to public security.

Harm reduction is poorly understood by law enforcement officials and is not currently part of the police curriculum. However, a 2012 agreement between the Royal Thai police, the United Nations Development Programme (UNDP), the FAR and the Department of Rights and Liberties Protection of the Ministry of Justice established an activity targeting 10,000 junior Thai police officers per year in order to provide education about HIV/AIDS stigma and discrimination towards key affected populations, including people who use drugs. The programme, entitled the 'Thai police as key change agents: The innovative learning programme on HIV and human rights in the context of law enforcement' was recently scaled up to include training of higher-level police officers.[74] In addition, commencing in 2013, the UNODC Regional Office in East Asia and the Pacific will implement a demonstration site in Northern Thailand and a training programme targeting law enforcement officers in Thailand to sensitise them on harm reduction and drug use.[75]

It is concerning, however, that the ONCB, in collaboration with the Central Institute of Forensic Science, plans to develop a drug crime database which will include the personal information of people who use drugs in prisons and in treatment centres, under the Narcotic Addict Rehabilitation Act B.E. 2545. This database is to be used to monitor, investigate and search drug offenders, with a target of 60,000 persons listed in the database. It is not clear what this information will be used for and whether people's names will ever be removed from the database.

Policy recommendations

Review and amend laws criminalising people who use drugs

Policy makers and advocates on drug issues, including Parliamentarians, the Ministry of Justice, the ONCB, the Ministry of Public Health, the National Human Rights Commission and the Law Reform Commission, should focus on ensuring:

- The removal of criminal penalties, including imprisonment and pre-trial detention while awaiting a urine test, for the consumption of drugs and possession of drugs for personal consumption, in the Narcotics Control law so that it is consistent with the Narcotics Addict Rehabilitation Act and the implementation of harm reduction measures.
- The revision of the sentencing frameworks – so that people who use drugs and user-dealers are no longer the primary targets of the criminal justice system dealing with drug offences – by replacing criminal penalties with a fine or community service order and/or other alternatives to imprisonment.

Adopt humane and evidence-based drug treatment methods

Government agencies with responsibility for policy making and implementation of services relating to drug treatment should work on ensuring:

- The adoption of valid tools for assessing drug dependence, including by the subcommittee which determines treatment orders for people who use drugs diverted from prison.
- The provision of HIV prevention and other health services, including medically managed drug withdrawal, for people who use or are dependent on drugs in closed settings and the community.
- The development of drug treatment options and support services for people who use drugs, including establishing minimum standards of care for all drug treatment providers that are appropriate, effective and based on evidence, in order to establish a drug treatment system capable of meeting the diverse health needs of people who use drugs.
- The abolition of policies setting national targets for people to be sent to treatment. This particularly includes policies that mandate measures such as random urine testing, as they often lead to human rights violations by the police.

Abolish compulsory detention centres for people who use drugs

Government agencies responsible for developing and implementing policies requiring the compulsory detention of people who use drugs should work to ensure:

- The abolition of the compulsory treatment system as it is a social and financial burden and constitutes a mechanism that does not implement effective, humane, evidence-based and appropriate treatment services. This has been recognised by the United Nations in a joint statement, released in March 2012, calling for the closure of drug detention and rehabilitation centres.[76] Furthermore, it deprives people who use drugs of liberty and access to essential health services. It also leaves them with an official record that prevents them from accessing work and educational opportunities, thereby increasing already high levels of stigma and discrimination, as well as rights violations against people who use drugs.
- The transparency and accountability of organisations operating the detention and other treatment centres, so that cases and allegations of physical and psychological abuse against people who use drugs are immediately addressed and greater consistency with human rights standards are achieved.

Endorse and support the provision of harm reduction services

The National AIDS Committee and the Ministry of Public Health should work to ensure:

- The deployment and implementation of a national harm reduction policy to facilitate the harmonisation of drug control and public health approaches, including supporting the provision of NSPs and putting an end to police harassment of both clients and staff of harm reduction services.
- The scaling up of MMT and the establishment of monitoring standards to increase the coverage and quality of services. This includes training clinicians to provide maintenance doses based on international standards, allowing take-away doses and the participation of people who use drugs and NGOs in the provision of services.

Improve information about drugs and drug use to strengthen policymaking on drugs

Government agencies and academic institutions working on drug issues should:

- Conduct research to understand the extent and nature of problematic drug use, harms associated with drug use, and barriers to harm reduction and other health services. This research can help ensure that updated and valid data is being used to inform the development of more effective and appropriate approaches to managing drug

use which, in particular, clearly distinguish between occasional/recreational drug use and drug dependence.

Parliamentarians, senators and policy makers should:

- Make use of evidence and international best practice in determining effective and appropriate policy responses to drug use.
- Include the participation of civil society organisations, including representatives of people who use drugs, in developing drug strategies and policies.

Improve awareness and practices of law enforcement officers relating to people who use drugs

Agencies responsible for police and law enforcement officers, including the ONCB and the Royal Thai Police, should ensure:

- The reinforcement of legal accountability mechanisms that allow victims of police abuse to access judicial services and reparation.
- The establishment of mechanisms to monitor and investigate the practices of drug control officers, including 24-hour complaint units to respond to reports of unlawful practices (such as ensuring the imposition of swift and serious measures involving disciplinary punishment).
- The training of law enforcement officers, judges and prosecutors at central and provincial levels, on effective approaches to drug use, drug dependence and harm reduction, in an effort to end unlawful testing, searches and detention of people who use drugs.

Civil society organisations and advocates should also work on:

- Campaigns to educate people who use drugs on their rights, processes and protocols with regards to urine testing, searches, arrests, detention, inquiries as well as suspects or defendants' rights in criminal justice procedures.

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[20] These subcommittees are made up of seven people (on average): 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

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[60] Correctional centres: 85 under the Department of Correction; 94 under the Department of Juvenile Observation and Protection

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