

“Patients, not criminals”?

An assessment of Thailand’s compulsory drug dependence treatment system

Since the enactment of a new law on addiction treatment in 2002, Thailand has sharply increased the number of people in compulsory drug treatment programs. This article provides an overview of the system, particularly the custodial programs. It also provides some preliminary observations on the implementation of the legislation on its own terms — namely, that people who are dependent on drugs should be “treated as patients and not criminals.” While diverting people with drug dependence from the criminal justice system is important, this stated approach is undermined in a number of ways by the law’s implementation. This article is based on a longer report released by the Canadian HIV/AIDS Legal Network in 2009.¹

Introduction

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 aimed at the same objective, the *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* (“the Act”) provides alternatives to incarceration for some drug offences:

Drug addicts [sic] 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.²

In a speech in 2004 to celebrate the U.N.’s annual “International Day Against Drug Abuse and Illicit Trafficking,” Thailand’s then-

Minister of Justice, Phongthep Thepkanjana, declared that

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.³

Methodology

During two visits to Thailand in 2008, over the course of about three weeks in total, the author met with officials in various government departments and agencies, and visited seven custodial centres run by various entities, including branches of the armed forces. 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 here was cross-checked against information provided by other officials. The author also conducted detailed, semi-structured interviews with 15 people who had been detained in Thailand’s compulsory drug treatment centres.⁴

Limitations of this research include the relatively small number of people interviewed about their experiences in compulsory treatment centres, the large number of such centres in Thailand and the different approaches towards treatment among the different agencies that run the centres. Nevertheless, this research is among the first to assess Thailand’s recent system of compulsory drug treatment. It also captures some of the experiences and opinions of people who have passed through the centres, perspectives that are all too frequently ignored.

Thailand’s drug laws and HIV risk

Despite the passage of the 2002 Act, the *Psychotropic Substances Act B.E. 2518 (1975)*, the *Narcotics Control Act B.E. 2519 (1976)* and the *Narcotics Act B.E. 2522 (1979)* remain in force. These acts prohibit and control the unauthorized production, consumption, possession and sale of a wide range of drugs, including cannabis, heroin, cocaine and amphetamine-type stimulants.

(Methamphetamine, commonly known as *ya ba* or *ya ma*, is one of the principal drugs used in Thailand.⁵)

Penalties for drug offences can range from fines of several hundred thousand Thai baht to up to 20 years in prison — and, in the case of “disposal” (i.e., trafficking), or possession for this purpose, of even the smallest amounts of certain drugs (e.g., heroin, amphetamine-type stimulants), the penalty can include life imprisonment. The death penalty may be imposed for offences involving more than 20 g of these substances.⁶

The policy that people who use drugs should be “treated as patients, not criminals” is contradicted by existing laws that continue to criminalize mere consumption.

While the 2002 Act creates a legal regime to divert people from incarceration for some drug offences, people continue to be arrested and charged for offences under the other acts, including consumption and possession of illegal drugs. 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 continue to criminalize mere consumption.

Many people who use drugs in Thailand are incarcerated at some point. From 1992 to 2000, the number of persons jailed for drug use and possession only (i.e., not traf-

ficking) more than doubled.⁷ Despite diversion into compulsory treatment, Thailand had over 100 000 people in prison on “drug-related cases,” and more than one-fifth of such cases were cases of drug consumption (as opposed to drug trafficking or other drug-related offences), as reported in 2004 by the U.N. Office on Drugs and Crimes (UNODC).⁸

Incarceration has been a known risk factor for HIV infection among people who inject drugs in Thailand for more than a decade.⁹ Illegal drugs continue to be available in some Thai correctional facilities, resulting in some people continuing to use injection drugs while incarcerated.¹⁰ Research has revealed HIV prevalence as high as 40 percent among injectors who had been jailed.¹¹

People in custody are also exposed to other infectious diseases. Tuberculosis prevalence in prisons is several times that in the population as a whole.¹² High rates of incarceration among young methamphetamine users in Thailand have been associated with a range of HIV risk behaviours, including injection drug use.¹³

Research has also found significant risks of HIV infection related to syringe-sharing in pre-trial detention facilities.¹⁴ As of the end of 2008, opioid substitution therapy for people dependent on opioids was not available in prisons in Thailand, there was no access to HIV prevention materials in Thai prisons, and community-based HIV education groups had limited access to prisons.

Compulsory treatment: legal procedures

Arrest and court

The diversion scheme established by the 2002 Act can apply to people

charged with drug consumption alone, or drug consumption plus one or more of the following charges: possession, possession for “disposal” (i.e., trafficking), or disposal.¹⁵ The amounts of drugs involved must be small in order to qualify the person for diversion (e.g. less than 100 mg of heroin or 500 mg [5 tablets] of methamphetamine).¹⁶

After a person’s arrest for one of these offences, a court determines whether to “transfer such alleged offender for the identification of narcotics consumption or narcotic addiction” to a Sub-Committee for assessment.¹⁷ In practice, this decision turns on whether the person’s urine tests positive for drugs. When the case is transferred to a Sub-Committee, the prosecution is temporarily suspended.¹⁸

Detention for assessment

The accused is then detained for an assessment of drug-dependence by Department of Probation officials.¹⁹ Assessment usually involves a urine test and a criminal record check. The probation officer might also interview the person and will often investigate the person’s relationship with family, level of education and employment, which may involve interviews with family members or employers.

The officer will also investigate the person’s medical history and history of drug treatment. If the assessment finds the person ineligible for diversion into treatment, the case is returned to the Public Prosecutor; if the person is eligible, the probation officer’s report recommends a particular form of treatment.

According to the Act, assessment should happen within 15 days, a period which can be extended by up to a maximum of 30 days where there

is necessary cause.²⁰ However, being detained for the full 45 days appears to be routine, rather than exceptional. According to people interviewed, 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. Although separated from other prisoners, those being detained for assessment of drug-dependence are subject to the same poor conditions.²¹

Despite the Act's stated purpose of diverting people from incarceration, people have been incarcerated for extended periods of time.

Sub-Committees and treatment orders

Usually Sub-Committees make decisions very quickly, such as a brief deliberation of a minute or two. Most decisions follow the recommendations contained in the probation officers' reports.

The Sub-Committees will order compulsory drug treatment in either custodial or non-custodial programs.²² Custodial programs are commonly described as either "intensive" (higher security) or "less intensive" (lower security).

According to officials, a person who uses drugs but is not dependent

is likely to be ordered into a (non-custodial) out-patient treatment program. A person who is dependent is likely to be sent to a (custodial) less intensive program. A person considered severely dependent — e.g., daily use and a prior record of compulsory treatment — is likely to be sent to a (custodial) intensive program.

According to data from the Department of Probation, in any given year between 2003 and 2008, 25 to 50 percent of people in the compulsory drug treatment system were ordered to attend custodial programs.²³ Over the same five-year period, almost 84 percent of people undergoing compulsory drug dependence treatment were methamphetamine users.²⁴

Initial treatment orders may be for up to six months, although the Sub-Committee has authority under the Act to extend treatment for further periods of up to six months at a time, to a maximum duration of three years. If the Sub-Committee determines that the outcome of treatment is "satisfactory," the person is released without further prosecution. If it deems the outcome "not satisfactory," the Public Prosecutor will revive the criminal prosecution.²⁵

Custodial treatment programs

While the system is overseen by the Department of Probation, the actual custodial centres are run by the military (the Royal Thai Army, Navy and Air Forces), the Ministry of Public Health, the Ministry of Interior, the police force and the Bangkok Metropolitan Administration.²⁶

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;²⁷ by the end

of 2008, there were 84.²⁸ There are plans for the Army to establish an additional 14 centres by 2009.²⁹

The centres run by the Army are of the less intensive variety, while the centres run by the Air Force are intensive. For its part, the Navy runs both intensive and less intensive centres. Typically, the military centres hold 100–400 patients, except the Air Force centres which hold 30–60 patients. The centres run by 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 and three intensive centres — and one centre for juveniles. 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.

The Thanyarak Institute on Drug Abuse is responsible for training the centres' personnel. The Department of Probation is responsible for assessing the centres every three years. Assessment is not compulsory; the centres themselves must request assessment.

"Patients not criminals"?

Despite the stated intention, there are a number of ways in which people in Thailand's compulsory drug treatment system are not, in practice, treated as patients rather than criminals.

Detoxification

Detoxification will often be the first phase of drug treatment programs.

According to UNODC, “[t]he main goal of detoxification programs is to achieve withdrawal in as safe and as comfortable a manner as possible.”³⁰ UNODC notes that

[d]ependent 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.³¹

The people who enter custodial treatment programs have no right to choose their treatment or have input into their treatment plan.

Methamphetamine addiction is the most common form of drug dependence among those in Thailand's compulsory treatment system. The severity of withdrawal is generally greater in people who are older, who are more dependent and who have been using methamphetamine longer.³²

Yet the current process under Thailand's compulsory drug treatment system means that most people who are drug-dependent undergo detoxification while detained for

assessment in prison, as opposed to in 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 drug-dependent people being detained for assessment. None of the people interviewed for this research had received medication to help manage withdrawal symptoms in prison.

Opioid substitution therapy — maintenance or tapering — for those dependent on opioids does not exist in Thai prisons.³³ While proper nutrition, rest and exercise are particularly important during methamphetamine withdrawal,³⁴ these conditions are not present in Thailand's prisons. 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. There is little or no attention to mental health problems that are common among people who use drugs.

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 outside the centre.

The treatment provided in the treatment centres is a modified therapeutic community, involving a highly-structured residential environment with group psychotherapy and practical activities.³⁵

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).

In the intensive treatment centres, the Royal Thai Air Force employs a similar treatment approach (called *jirasa*), which places greater emphasis on discipline and physical activities (such as military drills) and a focus on Buddhist morality and practice.

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

- an “inception period” for the first month, during which the emphasis is on building motivation to stop drug use and preventing relapse;
- a “treatment period” for the second and third months, with an emphasis on group work, work therapy (e.g., cooking and cleaning the centre) and vocational training (e.g., agricultural work, mechanics and woodworking for men; hair-dressing, making artificial flowers or silk-screening for women); and
- a pre-release “re-entry” period for the fourth month, intended to prepare people to go back into the community and involving activities outside the centre (e.g., field trips or community service such as street cleaning).³⁶

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.

Some people who were interviewed over the course of this research said that their time in treatment centres was generally better than their experiences waiting for assessment in prison, noting that the centres had such things as scheduled activities and better food. Other people interviewed were more critical of the treatment in the centres, explaining that they were bored during their time in the centres and that the treatment was ineffective.

The people who enter custodial treatment programs have no right to choose their treatment or have input into their treatment plan, although this is both an ethical requirement and improves treatment outcomes, according to the World Health Organization (WHO) and UNODC.³⁷

Discipline

The treatment centres follow a standardized approach, though the rules can vary from one centre to another. These rules are explained to the patients on entry into the camp and are 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

According to the Act, a director has the power to punish a person who fails to follow the rules of a treatment centre by imposing probation; suspending visiting or communication rights for up to three months; or imposing solitary confinement for up to 15 days at a time.³⁸

Some interviewees who had been detained in the centres reported instances of cruel, inhuman and degrading forms of punishment, such as beatings or being made to roll on gravel.³⁹ These forms of punishment are not permissible under the Act.⁴⁰

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Follow-up

Although not required by the Act, the Department of Probation attempts to undertake follow-up one year after treatment is completed. It may involve an appointment to see a Department of Probation officer or staff at the Thanyarak Institute. 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.

Some people who had been in the compulsory drug treatment system

reported completing the requirement of follow-up visits. However, according to both officials and people who had been through the centres, for a considerable number of people follow-up is not possible. Given that drug consumption itself is illegal in Thailand, it is not surprising that some people will avoid follow-up, as this may reveal their continued drug use to authorities.

Evaluating treatment efficacy

The Act does not require an assessment of the efficacy of compulsory treatment programs. Both officials and people who have been in such programs frequently said that 70 percent of people who go through the system will not relapse, which suggests that the other 30 percent will use drugs again. 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."⁴¹

Attempts to assess drug treatment programs are inherently difficult. The task of evaluating efficacy is complicated by the fact that considerable numbers of people do not attend follow-up appointments. Thus, the statement that roughly 70 percent 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.⁴² Some officials expressed frustration

at not being able to evaluate the efficacy of treatment using more reliable data.

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.⁴³ However, key distinguishing characteristics 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.

Not all forms of compulsory treatment will be effective. Some research from outside Thailand indicates that external motivators (such as being legally mandated into treatment) may increase internal motivation or interact with it to produce better outcomes.⁴⁴ However, this has been contradicted by other research that suggests that a lack of internal client motivation in treatment may undermine positive outcomes.⁴⁵

Thailand is not alone in not basing its system on rigorous evidence. Research has highlighted that, in many cases, there is a lack of proper evaluation of the efficacy of compulsory drug dependence treatment.⁴⁶ 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.⁴⁷

The people interviewed revealed a wide variety of perspectives on the quality of treatment. Some people had remained abstinent following

compulsory treatment. Some interviewees were appreciative of the treatment they received in the treatment centres, while noting that they did not remain abstinent after being released. Other interviewees were more critical of the effectiveness of the compulsory treatment system, noting that it is up to the individual whether to give up drugs or not.

Recommendations

To realize better the intention of the Act, namely that people with drug dependence be treated as patients, not criminals, action is needed to:

- minimize use of pre-treatment detention, including in prisons;
- develop and enforce minimum standards of care for drug dependence treatment;
- create mechanisms for patient input into programs and into measures to address any abuses; and
- accurately evaluate the efficacy of compulsory drug treatment, while expanding access to voluntary treatment services.

— Richard Pearshouse

Richard Pearshouse (rpearshouse@hrw.org) is former Director of Research and Policy at the Canadian HIV/AIDS Legal Network and author of the research report on which this article is based.

¹ R. Pearshouse, *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*, Canadian HIV/AIDS Legal Network, 2009, online via www.aidslaw.ca/drugpolicy.

² Department of Probation, *Department of Probation*, 2005, p. 20 [original in English].

³ Keynote address by H.E. Mr Phongthep Thepkanjana, Minister of Justice of Thailand, 26 June 2004, U.N. Conference Centre, Bangkok.

⁴ Excerpts from those interviews can be found in the full Legal Network report.

⁵ 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, while *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.

⁶ *Narcotics Act B.E. 2522 (1979)*, s. 66(3).

⁷ C. Beyrer et al., "Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand," *AIDS Behaviour* 7 (2003): 153–161.

⁸ 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 Programme Responses in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam*, 2004, p. 42.

⁹ K. Choopanya et al., "Incarceration and risk for HIV infection among injection drug users in Bangkok," *Journal of AIDS* 29(1) (2002): 86–94.

¹⁰ *Ibid.*

¹¹ C. Beyrer et al.; H. Thaisri et al., "HIV infection and risk factors among Bangkok prisoners," *BMC Infectious Diseases* 3 (2003): 25.

¹² 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.

¹³ N. Thomson et al., "Correlates of incarceration among young methamphetamine users in Chiang Mai, Thailand," *American Journal of Public Health*, 2008 (in publication).

¹⁴ 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.

¹⁵ *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* (hereinafter in these notes, "2002 Act"), s. 19.

¹⁶ For more details, see the full report by the Legal Network.

¹⁷ 2002 Act, s. 19.

¹⁸ *Ibid.*

¹⁹ Department of Probation, *Department of Probation & The Compulsory Drug Rehabilitation System in Thailand*, undated [original in English], on file with the author: Probation officers undertaking the assessment (on which treatment decisions are based) are not trained medical professionals, nor is it clear whether they apply established assessment tools to assess the severity of addiction (such as the *Addiction Severity Index [ASI]*). There is, therefore, a risk that the process of decision-making about whether a person is to be subject to compulsory treatment, and for what period, is not clinically driven.

²⁰ 2002 Act, s. 21.

²¹ 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."

²² 2002 Act, s. 23.

²³ Department of Probation, *Department of Probation & the Compulsory Drug Treatment System in Thailand*.

²⁴ *Ibid.*

²⁵ 2002 Act, s. 33.

²⁶ Department of Probation, *Department of Probation & the Compulsory Drug Treatment System in Thailand*.

²⁷ 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.

²⁸ Personal communication by the author with the Department of Probation, December 2008.

²⁹ Ibid.

³⁰ UNODC, *Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide*, 2003, p. IV.2, online at www.unodc.org/pdf/report_2003-07-17_1.pdf.

³¹ UNODC, *Drug Abuse Treatment and Rehabilitation*, pp. IV.2–IV.3.

³² C. McGregor et al., "The nature, time course and severity of methamphetamine withdrawal," *Addiction* 100(9) (2005): 1320–1329.

³³ 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.

³⁴ J. Obert et al., *A Physician's Guide to Methamphetamine: Developed from Matrix Institute & UCLA Integrated Substance Abuse Programmes*, 2005.

³⁵ [U.S.] National Institute on Drug Abuse, *Research Report Series: Therapeutic Community*, 2002, p. 1. Opioid substitution treatment is not available for patients dependent on opioids in treatment centres, yet a new policy of the Thai government is that such 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, they are effectively denied an established form of treatment available outside the centres.

³⁶ This period should not be confused with the non-custodial 're-entry period' of an additional two months following completion of custodial treatment.

³⁷ UNODC, WHO, *Principles of Drug Dependence Treatment: Discussion Paper*, pp. 5, 9. See also: [U.S.] National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide*, 1999, online at www.nida.nih.gov/PODAT/PODATIndex.html.

³⁸ 2002 Act, s. 32.

³⁹ U.N. standards state that "[c]orporal punishment ... and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences"; *United Nations Standard Minimum Rules for the Treatment of Prisoners*, 1955, U.N. Doc. E/5988 (1977), para. 31. Note that according to Article 7 of the ICCPR: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." 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.)

⁴⁰ Punishment must always be determined "by the law or by the regulation of the competent administrative authority" and "no prisoner shall be punished except in accordance with the terms of such law or regulation...": *United Nations Standard Minimum Rules*, paras. 29–30.

⁴¹ Department of Probation, *Department of Probation & The Compulsory Drug Rehabilitation System in Thailand*.

⁴² 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 thangkaet)* 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.

⁴³ See, e.g., S. Wilson, "The effect of treatment in a therapeutic community on intravenous drug use," *Addiction* 73(4) (2006): 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.

⁴⁴ 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. Note that whether involuntary treatment complies with human rights requirements is a separate matter from its effectiveness.

⁴⁵ 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.

⁴⁶ T. Wild et al., "Compulsory substance abuse treatment: an overview of recent findings and issues," *European Addiction Research* 8 (2002): 84–93.

⁴⁷ 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.