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Catherine Pilley

Usaneyya Perngparn

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Introduction to Drug Use and Treatments in Thailand

(อรรถกถาเรื่องการใช้นยาเสพติดและการบำบัดรักษาในประเทศไทย)

Catherine Pilley*

Usaney Perngarn**

บทคัดย่อ

บทความต่อไปนี้เป็นการศึกษาผลงานวิจัยที่เกี่ยวข้องกับการใช้นยาเสพติดและการรักษาในประเทศไทยนับตั้งแต่ศตวรรษที่ 20 (หรือประมาณปี พ.ศ.2500) เป็นต้นมา ประเทศไทยมีการเปลี่ยนแปลงกฎหมายหลักเกี่ยวกับการควบคุมยา/สารเสพติดในประเทศ 3 ครั้ง คือ ครั้งแรกเมื่อ พ.ศ.2502 มีพระราชบัญญัติห้ามสูบฝิ่น ครั้งที่ 2 เมื่อ พ.ศ.2518 ได้มีประกาศพระราชบัญญัติควบคุมวัตถุออกฤทธิ์ต่อจิตประสาท และครั้งสุดท้ายเมื่อ พ.ศ.2539 มีประกาศพระราชบัญญัติจัดกลุ่มสารแอมเฟตามีนและอนุพันธ์ให้เป็นสารเสพติดประเภท 1

ประเทศไทยได้ชื่อว่าเป็นส่วนหนึ่งของเครือข่ายที่ซับซ้อนในกระบวนการค้ายา/สารผิดกฎหมาย ในภูมิภาคเอเชียตะวันออกเฉียงใต้ นับตั้งแต่การค้าฝิ่นซึ่งมีมานาน จนกระทั่งเมื่อเร็ว ๆ นี้ก็มีแนวโน้มว่าจะกลายเป็นแหล่งค้าและเสพยาแอมเฟตามีน

ข้อมูลการบำบัดรักษาผู้ติดสารเสพติดในสถานพยาบาลทั่วประเทศแสดงว่าส่วนใหญ่ผู้เสพยาใช้เฮโรอีนเป็นหลัก อย่างไรก็ตามเมื่อปีที่แล้วข้อมูลรายงานว่ามีจำนวนผู้เสพยาแอมเฟตามีนมากขึ้น ส่วนในเรื่องของวิธีการบำบัดรักษาผู้เสพยาเสพติดก็มีตั้งแต่การรักษาด้วยสมุนไพร ไปจนถึงการรักษาด้วยเมธาโดน การติดตามผลดูแลหลังการบำบัดรักษาได้รับการพัฒนาน้อยกว่าการถอนพิษยา มีสถานพยาบาลจำนวน 2-3 แห่งเท่านั้นที่มีการดูแลหลังการบำบัดรักษา ซึ่งส่วนใหญ่ก็อยู่ในรูปของชุมชนบำบัด ปัญหาของการใช้สารเสพติดนี้ยังต่อเนื่องไปถึงการติดเชื้อโรคเอดส์ด้วย ในบางสถานพยาบาลพบว่าผู้ติดเชื้อโรคเอดส์ในกลุ่มเสพยานี้สูงถึงร้อยละ 33 การศึกษาวิจัยในประเทศส่วนมากจะเป็นเรื่องของลักษณะการใช้นยาเสพติด ส่วนการศึกษาในเชิงประเมินผลยังไม่ มี ซึ่งอาจจะทำให้เป็นจุดอ่อนของความรู้ที่มีอยู่ในปัจจุบันได้

* Ph.D. Student, Aberdeen University, United Kingdom.

** Researcher, Drug Dependence Research Center, Institute of Health Research, Chulalongkorn University.

INTRODUCTION

Much of the research undertaken in Thailand concerns itself with the treatment population and the convicted population (Perngporn et al 1992), both are visible groups in an otherwise invisible population. As Lee pointed out, research into illicit behaviour is notoriously difficult (Lee 1993), hence a predominance of studies on these population groups. The research is especially concerned with opiate users as treatment centres and prisons have historically dealt with a larger number of opiate users than any other type of user (Poshyachinda 1981). There are however some exceptions where researchers have tried with some success to establish a more accurate picture of overall drug use in Thailand. These studies have been conducted both at a localised level, concentrating on one geographical area (Poshyachinda 1988a), a regional level (Poshyachinda 1987) and also on specific ethnic or occupational groups within Thailand (Poshyachinda 1988, Siriwongs na Ayudyha et al 1995). Although no difference is made at a government level on dependent and non-dependent use, studies have also tried to determine the extent of these two distinct groups (Poshyachinda 1981).

This paper will review the English language research concerned with drug use and treatment in Thailand. It will track the use of different substances. Attention will then be paid to treatment types developed to assist drug dependents. Finally, it will address the effect of the advent of HIV.

GOVERNMENT CONTROLS ON THE USE AND DISTRIBUTION OF DRUGS

Legislation Thailand has for many years been aware of the social, physical and economic problems caused by the use of illicit drugs. Historically, the use of opium has been both legal and illegal, showing the changing views of Thailand and world opinion on its harmfulness. In 1976 the Government classed drug dependence as a national priority problem and it has remained high on the political agenda ever since (Poshyachinda 1988). Drug related legislation has been as follows :

Thailand Act of BE 2502 (December 1959 AD) The use of opium was banned and all opium users were required to identify themselves to the opium addict's register.

Thailand Act of BE 2518 (1973 AD) In 1971 Thailand ratified the International Convention on Psychotropic Substances and in 1973 added extra measures to control psychopharmaceutical products at each stage of production. Measures cover registration, manufacture, import, export, storage, quality control and distribution. Since 1973 there have been further modifications to this Act, adding and moving substances to specific schedules. In all, there are 104 substances listed in the International Convention and 114 in the Thailand Act of BE 2518 (Poshyachinda 1987).

Thailand Act of BE 2539 (1996) With the rise in the use of amphetamines among a wide number of groups, legislation was introduced to attempt to curb the spread. Amphetamines were rescheduled to the same category as heroin, carrying with it the stiffest penalties for production, trafficking and use.

DISTRIBUTION NETWORKS

Measuring Availability There are various ways to estimate the use of drugs in Thailand. Much of the data on availability comes from drug seizures but there have also been some attempts to measure availability of certain drugs such as amphetamines (Poshyachinda et al 1980). Attempts have also been made to estimate availability among various population groups (Narcotic Affairs Section, Embassy of the United States 1996). These results probably only scratch the surface on what is available but it does give information on changing trends in drug use. To treat Thailand as an island in Southeast Asia when it comes to drug availability is to miss the complex interactions which go on between the bordering countries. For example Thailand is inextricably linked with the Golden Triangle which crosses three countries, Thailand, Myanmar and Laos. However, Thai production in this region is low, only 20% of the Golden Triangle is actually in Thailand, and the state has intervened on an economic and enforcement level to reduce production. However, supply from the Golden Triangle remains probably the most developed of any area in the world (National Council on Social Welfare 1994).

Smuggling From 1983 to 1992, 1 ton of opium was recovered and 2 tons of heroin (Poshyachinda 1994). Looking at convictions for smuggling, the number of foreign nationals convicted has risen consistently. In 1983 there were 148 cases involving 23 nationalities and by 1992 those figures had risen to 877 cases and 68 nationalities. The number of non-Asian couriers has been on the increase since 1989 and of those, the most dramatic increase has been among African nationals, especially Nigerian (Poshyachinda et al 1994).

Increased availability The second epidemic of heroin coincided with the Vietnam war where it was suggested CIA were indirectly involved in the production and smuggling of heroin (McCoy 1972). It is probably true to say that if production increases, availability at source becomes easier and may lead to a rise in domestic use. This appears to have been the pattern in Thailand's domestic market for heroin.

Distribution of illegal stimulants As well as networks involving the spread of opiates, there are also developed networks dealing in the sale of illegal stimulants. Initially stimulants were used by truck drivers, taxi drivers and hard labourers. Studies revealed that networks centred around petrol filling stations (Poshyachinda et al 1988). More recently, it seems production of illegal stimulants has increased and distribution networks are developing among students. Laboratories have also been discovered in Northern Thailand suggesting production is becoming a home industry (Poshyachinda 1994). In the more recent past, there has been an increase in seizures (ONCB 1997). One must strongly suspect that the use of amphetamines is becoming more widespread.

The following sections will concern themselves with substance use, the spread of HIV in the drug using population and treatment availability.

OPIATE USE

Opium

Opium Smokers Register The ban, in BE 2502 (1959 AD), on opium was effected with a notice that all opium smokers should register within six months of the new legislation in order to receive treatment. The opium smokers register gives the first tangible record of who smoked opium. At this time, there were many foreign residents, mainly Chinese, who were not Thai citizens, so all information collected was divided into Thai and non-Thai. The number of people who registered in the initial period was 70,958. 52.7% of those registered lived in Bangkok or Dhonburi which is now classed as Greater Bangkok. The rest lived in the provinces. 61% were foreign residents, mainly Chinese and 98.6% of all those registered were male. Female smokers were very rare but when they did register, they were mainly from Bangkok or Dhonburi and of Thai nationality (Poshyachinda 1982a). Of those registered, only around 2,000 sought treatment in the first year. Interviews in 1982 with four people from the original registration list gave interesting insight into the views of opium smokers at the time. These interviews as well as pointing out the suspicion with which the register was viewed, also indicated that, soon after the ban, opium had not disappeared and could still be obtained relatively easily on the black market. So for those people who did not want to stop using, there was a continued supply (Poshyachinda 1982a).

Use by Northern Hilltribes More recently, opium smoking has become a much more localised tradition. Treatment population data shows most opium smokers come from the North where opium poppies have traditionally been cultivated (Poshyachinda et al 1994). Studies on opium use have been conducted amongst the ethnic hilltribes in North and Northeastern Thailand.

Not all studies have included all ethnic groups. It seems likely that selection was often based on geography, not on racial groups so the area studied, determined which ethnic groups were included (Poshyachinda 1981 and 1988). In data from treatment centres, all ethnic groups are taken together under the title of “ethnic Thais” or “Hilltribe.” Two major surveys have attempted to study all ethnic groups, one from December 1965 to

March 1966 (Poshyachinda 1981) and a second from 1979 to 1980 (Poshyachinda 1981). All Studies held in common, that they were trying to determine rates of dependency.

In the 1965-66 study, rates of dependency were 9.55% among Hmong, 11.7% among Lahu and 15.9% among Yao. A study of the Akha people in April 1976 which had a sample group of 1,028 people or 10.9% of the total Akha population at that time, found dependency rates of 10.9% on average (Poshyachinda 1981). A study in 1976-77 of 9 hilltribe villages showed a mean rate of dependency of 9.6% (Poshyachinda 1981). Among the regional studies in 1976-78, was a study of 253 villages and 6 tribes in the North, Northeast and Central regions. Total population studied was 5,400 people, where a dependency rate of 1.5 to 29.6% was found among different villages (Poshyachinda 1988). A major study of all ethnic groups was undertaken in 1979-1980 by the Narcotics Control Division, Office of the Narcotics Control Board to look at cultivation and dependency. Rates of dependency were:- Karen 7.2%, Hmong 4.8% Yao 11.2% Lisu 6.1% Lahu 11.4% and Akha 9.5% (Poshyachinda 1981). The most recent study conducted in 1981 in Amphoe Mae Cham and Chiangmai Province surveyed 33 hilltribe villages and 2,983 people, of whom 1,525 were men and 1,458 were women. They discovered 104 male opium dependents and 15 women. Overall rates of dependence were 4.3%, although one large village showed no dependency at all (Poshyachinda 1981).

It is clear from these studies that opium dependency exists at relatively high levels among the hilltribe communities. Whether this use is problematic is a matter of opinion to some extent but, dependency, as opposed to use, is generally seen as having some problems for the individual and community. There are no recent studies in drug dependency among hilltribes which may reflect the priority focus shifting to the study of HIV in recent years. It may also reflect changes in agricultural practices. Since 1963 legislation has been introduced to develop hilltribes economically in a bid to reduce opium cultivation. Most of the aid has been in the form of crop substitution programmes but has also included drug treatment programmes for opium users. A mark of the success of these interventions is the reduction in production from hundreds of tons in the 1960s to around 25-60 tons from 1983 to 1991 (Poshyachinda et al 1994).

Since the ban on opium, opium users have been in the minority, accounting for an estimated 10% of the total opiate dependent population. The next section will look in greater detail at the emergence of heroin use in Thailand.

Heroin

Reasons for increase in the use of heroin There are probably many reasons for the emergence of heroin but several are of great significance to its rapid spread. In the initial stages, the authorities were unaware of the existence of heroin. At this time, opium had just been made illegal so efforts were concentrated in enforcing the new law (Poshyachinda 1982a). It may be that, as a result, opium became scarce and users, afraid of coming into contact with the police, saw heroin as a good substitute. Heroin was easier to conceal as the quantities used for one dose were smaller. Thus heroin was introduced at a time when a large number of people already dependent on opium were in need of an alternative. Heroin substitution may be the reason why so few people presented for treatment. This possibility is further reinforced by treatment figures for 1960 where 70.7% of cases presenting for treatment were opium users who had switched to taking heroin after the opium ban was introduced (Poshyachinda 1982a). A further indicator on the spread of heroin use is the the number of new heroin users who appeared in the second year of treatment. 16.2% of the treatment cases were new heroin users and, unlike opium users, they were more likely to be Thai, only 5.2% of this group were Chinese (Poshyachinda 1982a).

Treatment population Detailed statistics on treatment populations have been collected since 1978 (Poshyachinda 1981). From 1978, there have also been records kept on those convicted of drug offences (Poshyachinda 1981). It is possible to estimate the known user population from these figures but there are some inaccuracies which cannot easily be eliminated. Double counting may occur where one person has appeared on several different records in a twelve month period. Each of these instances will give one case which is not then linked back to the individual.

Bearing these limitations in mind, from 1978 to 1980, there were between 12,277 and 15,415 treatment cases and 8,065 and 9,216 convicted drug cases. It was estimated at this time that the known user population, through these figures and smaller supplementary research, was 20,000 heroin users and 2,000 opium users (Poshyachinda 1981). In 1992, researchers calculated how many individuals were treated as opposed to cases and found that 38,864 individuals accounted for 65,000 treatment cases. Of this group, 80% had used heroin or opium over the previous 30 days (Poshyachinda et al 1994).

Morphine

Morphine is probably the least used opiate in Thailand although it has made sporadic appearances over the years. In 1970 to 1971, Thanyarak Hospital saw an increase in admissions which peaked at 37% of total admissions. In 1978 Suranaree Hospital in the Northeast saw morphine admissions rise to 71.1% of total admissions for the year. However, these are isolated figures which go unexplained and have never been sustained over a long period of time (Poshyachinda 1982a).

Methadone

In more recent times, methadone has been used in the treatment of opium dependency and despite stringent control mechanisms, some has inevitably found its way onto the illegal market. It is postulated the leakages come from private clinics and patients at treatment centres but it appears to be confined to Bangkok and constitutes relatively small amounts (Poshyachinda 1988). Legal consumption of methadone has increased over the years from 28.3kg in 1983 to 45.5kg in 1985 (Poshyachinda 1988). Recent figures are much higher than this as treatment populations rise and the use of methadone becomes standard treatment practice. As methadone became the favoured treatment in the 1980s, further legislation was issued to limit its use, presumably in a bid to keep control on prescribing of methadone, given its dependency inducing potential. Legislation was particularly stringent on controlling its use in private clinics and gave most flexibility to government run drug treatment centres (Poshyachinda 1988). These limits do not appear

to be rigidly adhered to at the present time with more flexible options available on an experimental level.

AMPHETAMINE USE

User Population A study in 1974 of amphetamine use among students in Chiang Mai, Nakhon Ratchassima and Bangkok showed that of the 23% of students who had ever used an illicit drug, only 1% had ever used amphetamines (Poshyachinda 1988a). Other studies confirmed a similar low level of use, in fact, prior to 1971 there were no records of anyone in treatment for amphetamine use (Poshyachinda 1988a). The first recorded treatment cases were in Thanyarak hospital and Khon Kaen hospital in 1972. From October 1976 to May 1979 Khon Kaen had the highest recorded proportion of amphetamine cases in the country which accounted for 7.1% of their total admissions. The first intravenous use of amphetamines was recorded in 1979 (Poshyachinda 1982a).

Recent treatment figures show a dramatic change in treatment of amphetamine users. The number of new cases with amphetamine as principle drug of use has risen from 2.69% in 1995 to 10.6% in 1996 (Ministry of Public Health 1995, and 1996). Reasons for these rapid changes are unclear at the present time and require further investigation.

SOLVENTS AND INHALANTS USE

Solvent use has a relatively recent history in Thailand and is seen as a new problem (Poshyachinda 1994). The first recorded treatment cases in Thanyarak hospital were in 1974 (Poshyachinda 1988a). There has been very little research in this area but one study of Bang Sue Slum in 1982-84 found 67 users in a population of 2,500. All used furniture lacquer and were aged 15-25 either unemployed or in temporary employment (Poshyachinda 1988a).

Users In 1992, data from treatment centres was used to look at regional variations in treatment populations. It was discovered that the greatest rate of increase in any substance used among new adolescent treatment cases was in the use of organic

solvents. This increase was present in all regions but was most marked in the Northeast where an increase of 50.99% and 21.4% was found over the 1980's among early and late adolescents respectively (Perngparn et al 1992).

BENZODIAZEPINE USE

Use Benzodiazepine use until recently has been limited to prescribed medication. However, there is a suggestion that as benzodiazepines become a part of treatment options, so drug dependents come to rely on them, thus increasing their retail value on the streets. Currently this is a hypothesis rather than a statement of fact (Poshyachinda 1994). A study in Surin indicated some illicit use but only at a low level (Poshyachinda 1987).

CANNABIS USE

Cannabis or "Ganja" as it is called locally is still cultivated and exported in large quantities. Annual seizures have risen to around 200 tons (Poshyachinda et al 1994). There is evidence of chemical refining with the confiscation of cannabis oil but as yet no laboratories have been found. Production is quite recent and appears to have started around the 1980's (Poshyachinda et al 1994).

ALCOHOL USE

Alcohol use is also on the increase. Consumption per capita went up from 6.81 litres per year in 1987 to 12.5 litres per year in 1992 (Poshyachinda 1994). These figures take no account of illegally brewed white spirit, which is common, nor does it cover tonic wines or herbal remedies which are prepared with a base of white spirit. A study in Surin in 1989 and 1992 found the use and sale of these remedies was widespread and estimated the number of clients per day to be between 2,000 and 3,000 (Dinprasert et al 1993).

The following section will explore methods of treatment from the traditional herbal medicines to the more recent developments in the use of methadone and the introduction of therapeutic communities (TCs).

DRUG TREATMENT

Herbal Treatment Worldwide, Thailand is probably most famous for its herbal treatments for opiate addiction. There has been recurrent interest in its efficacy in the treatment of drug dependence. Detailed records of systematic study date back to the reign of King Rama V in the 19th Century (Perngparn et al 1994). The herbal medicines often contained opium dross. Three main advantages were noted from these studies. First, the treatment was suitable for all opium users regardless of length of use, provided the user did not suffer from tuberculosis or fever. Second, the user was not only free of cravings but also was repulsed by the smell of opium smoke. Third, because of the repulsion, relapse could only occur through determined effort, not because of cravings. Another remedy tested at this time was known as "Japanese Medicine" but it was quickly realised it had dependence forming potential so was not seen as an effective treatment for withdrawal (Poshyachinda 1982). A more recent study in 1978 tested a herbal medicine made from *Datura Metel* Linn, a plant which contains hyoscyamine, hyoscyne and atropine. The first two constituent alkaloids have a psychotropic effect and can induce unconsciousness and hallucinations (Poshyachinda 1982). After the earlier experiments in 1908-1909, interest waned, except for the occasional experiment. It was only in the 1960s when a few Buddhist temples took up the call to provide treatment centres for opium dependents following the ban on opium that interest was rekindled.

Temple Treatments Temples are an integral part of Thai family life, most sons enter priesthood for a period before marrying. Parents also believe in the reforming nature of the temple and it is not unusual for them to send their delinquent child to be ordained in the belief that the life of the temple will reform their behaviour (Perngparn et al 1994). Indeed, both the Council of Social Welfare and the Office of Narcotics Control Board have been involved in an ordination programme for ex-drug users since 1987 (Poshyachinda 1993). It is therefore clear to see that temples taking on the treatment of drug users was acceptable to a large sector of Thai society who had a strong faith in the abilities of the temple. Furthermore, one of the five principle codes of Buddhism is to refrain from intoxication, making temples an even more obvious choice to treat drug users.

Although temples began treatment in the 1960s, it was from the end of the 1970s, that the ordination of drug users and drug offenders became more accepted. 5 main temples have provided various treatments. The temples are Wat Sri Soda and Wat Pah Pang in Chiang Mai Province, Wat Tam Talu in Ratchaburi Province, Wat Tam Kraborg in Saraburi Province and Wat Thaa Shee Srisumungklaram in Roi Et Province. In general terms, the temples offer a combination of religious rites, herbal medicine, moral counselling, religious teaching and vocational training (Perngparn et al 1994).

Methadone detoxification Government treatments offer, almost exclusively, methadone detoxification although some of the Northern clinics do provide tincture of opium for hilltribe opium smokers (Poshyachinda 1988). The programme is largely the same across the country. Detoxification lasts 4 to 6 weeks and methadone is consumed on the premises. Around 60% of drug users leave treatment after 4 weeks when levels of methadone dispensed have dropped to low levels (Poshyachinda 1988). A study in 1982 showed 40% of clients completed the 45 day detoxification programme, although the average stay was 30 days which coincided with the end of methadone prescribing. It is believed that only 10% of those attending go on to follow-up and aftercare so there is possibly a high rate of recidivism (Poshyachinda 1988). More recent figures show that length between onset of taking drugs and seeking treatment has increased, especially among the over 30s group (Poshyachinda et al 1994).

Therapeutic Community In recent years there has been an increasing interest in the therapeutic community model to aid a permanent change to a drug free lifestyle. The first TC was set up in Ratchaburi Province by a Non Government Organisation (NGO) and was soon followed by Thanyarak Hospital on the outskirts of Bangkok. More recently, TCs have been set up by the Ministry of Public Health in Southern Thailand and Northern Thailand. Both these facilities draw on the expertise from Thanyarak. Most programmes last up to two years, requiring a significant commitment from the ex-drug user. The method appears to be successful with a small number of ex-users but is not a choice taken by the majority. Little research exists on the use of TC's in Thailand but it is considered

by many to be one of the most effective treatments available (Asian Federation of Therapeutic Communities 1994).

Recent Developments The Ministry of Public Health has recently started to look at the efficacy of harm minimisation strategies in the treatment of drug users. Such interventions might include methadone maintenance and harm reduction messages in attempts to reduce the instances of drink driving (Annop 1996).

Problems It is true to say that currently there is a lack of alternatives to meet the needs of different clients. There is also a feeling that siting drug services in general health care clinics is not the best place for them. Services need staff who are specifically trained in providing detoxification and rehabilitation to this ever growing population (Poshyachinda et al 1994).

The final section will briefly outline the rise of HIV and its effect on drug users in Thailand.

HIV DISEASE

HIV has caused great concern in Thailand. The first case of HIV was identified in the mid 1980s with the first intravenous drug user identified as HIV positive coming later that decade (Poshyachinda 1992). At the end of 1987, it was estimated in one treatment population in Bangkok that 1% of IVDUs were HIV+ but 8 months later that figure had risen to 33%. A similar pattern was noted in the South but with a delay of 8 months on the Bangkok timings (Poshyachinda 1994). HIV became a priority communicable disease on 1st May 1985 (Poshyachinda et al 1989). The Communicable Diseases Centre (CDC) conducted enzyme-linked immunosorbent assay (ELISA) tests among target groups and up to 15th May 1988, 784 cases were reported, of whom 89.5% were drug users. Drug users have the highest rates of infection of any high risk group which in 1988 was 4.5% in treatment population as against just 0.1% among female prostitutes who were considered to be the second highest risk group following IVDUs (Poshyachinda et al 1989).

CONCLUSION

Thailand has seen rapid expansion in those using drugs and a move to polydrug use for which there are few services. It is clear that there are limited facilities to deal with either the numbers needing treatment or the range of different approaches needed to attract users to attend. Treatment has been concentrated on methadone substitution which, although important, constitutes only part of the treatment spectrum. Less attention has been paid to developing other treatment options such as drug-free rehabilitation. Drug users require, not only substitution therapy but also a way out of drug use back into mainstream society.

Research has tended to be of a descriptive nature, concentrating on patterns of drug use. Little research exists on treatment programmes, leaving important questions on the appropriateness of different methods unanswered.

The advent of HIV, has added further problems to the whole issue of drug use. As well as the problems of transmission through the sharing of injecting equipment, stress is a known factor in accelerating the suppression of the immune system. Thus treatment programmes receive a double challenge, to help drug users reduce their risk of contracting HIV and, at the same time, assuring programmes do not increase stress levels for those drug users who are already HIV positive.

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