

A BROKEN SYSTEM:

Drug Control, Detention
and Treatment of People
Who Use Drugs in Sri Lanka

Ambika Satkunanathan



**HARM REDUCTION
INTERNATIONAL**

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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations programme.

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Acronyms

AG	– Attorney General
BCGR	– Bureau of Commissioner General for Rehabilitation
CBC	– Community Based Corrections
g	– gram/grams
HRCSL	– Human Rights Commission of Sri Lanka
ICCPR	– International Covenant on Civil and Political Rights
IGP	– Inspector General of Police
JSC	– Judicial Services Commission
KDC	– Kandakadu Drug Treatment Centre
mg	– milligram/milligrams
NDDCB	– National Dangerous Drugs Control Board
NSP	– Needle and Syringe Exchange Programmes
OAT	– Opioid Agonist Therapy
OHCHR	– Office of the High Commissioner for Human Rights
PNB	– Police Narcotics Bureau
UDHR	– Universal Declaration of Human Rights
UNODC	– United Nations Office on Drugs and Crime
WHO	– World Health Organisation

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1. Executive Summary

1. Executive Summary

1.1. Background

The focus of this study is the impact of drug control, detention and treatment in Sri Lanka on the protection and promotion of human rights. This report is the first comprehensive analysis of the domestic legal and policy framework on drug control and drug treatment and its implementation.

The methodology of this study is comprised of a desk review of international and national standards, laws and policies as well as interviews with relevant stakeholders, including persons who underwent drug rehabilitation in Sri Lanka, members of civil society and counsellors of the National Dangerous Drugs Control Board.

Over the past decade, the government of Sri Lanka has adopted a militarised approach to drug control and treatment, with the security forces increasingly playing a significant role in the ‘war on drugs’. This includes not only participation in countering drug trafficking, but also in drug treatment and prevention. The militarisation of drug control has accelerated since the November 2019 election of President Gotabaya Rajapaksa whose election manifesto prioritised eradication of “the drug menace”¹. Since then, the President has formalized the military’s involvement in many ways including the establishment of a special Taskforce to build a “Secure Country, Disciplined, Virtuous and Lawful Society”², comprised of mainly police and military personnel mandated to “take necessary measures for prevention from drug menace (sic), and to fully eradicate drug trafficking in the country”³. Furthermore, the National Dangerous Drugs Control Board – the national drug control authority which manages drug rehabilitation centres – has been brought within the purview of the Ministry of Defence.⁴

1. Sri Lanka Podujana Peramuna, ‘Vistas of Prosperity and Splendour’, 2019, <https://gota.lk/sri-lanka-podujana-peramuna-manifesto-english.pdf>.

2. ‘Presidential Task Force Appointed to Build a “Secure Country and a Disciplined, Virtuous, and Lawful Society”’, *NewsWire*, 03 June 2020, <https://www.newswire.lk/2020/06/03/presidential-task-force-appointed-to-build-a-secure-country-and-a-disciplined-virtuous-and-lawful-society/>.

3. Ibid.

4. Presidential Secretariat, Sri Lanka, “Ministry of Defence – Special Priorities”, Extraordinary Gazette No. 2196/27, 06 October 2020, http://www.cabinetoffice.gov.lk/cab/images/Downloads/functions_2020-10-06_E.pdf.

The media enables the government's war on drugs through the negative portrayal of people who use drugs and engages in fear-mongering about the growing "drug menace" in Sri Lanka. People who use drugs or have a drug dependency are described using pejorative terms such as "drug addicts" and "drug traffickers" and are frequently blamed for crime and other anti-social behaviours in society.

They are demonised and dehumanised and portrayed as a public threat. As they are seen as undesirable outcasts, the violation of their human rights does not generate a public outcry, and is instead almost deemed justified in order to rid the country of the 'menace of drugs'. For instance, following the emergence of a COVID-19 cluster in the Kandakadu Drug Treatment Centre in July 2020, persons held at the centre were blamed by mainstream and social media for 'spreading COVID-19' in Sri Lanka⁵.

There are several similarities between the rehabilitation process for alleged former combatants and the rehabilitation process to which people who are deemed to have a drug dependence are subjected. The similarities point to the ethos upon which the process of rehabilitation of people with drug dependence is founded, i.e. the state 'rehabilitates' a group of persons viewed as undesirables by society.

1.2. International legal framework

International human rights instruments promote a human rights-based public health approach to drug treatment, which involves community-based treatment and care, evidence-based medicines and harm reduction interventions. Consent to the treatment and the right to withdraw from treatment at any time form the core of this approach. A strategy that requires persons to undergo abstinence-based drug treatment, without any medication or harm reduction interventions to ease withdrawal symptoms, such as in Sri Lanka, can constitute torture, cruel, inhuman and degrading treatment or punishment under international human rights law.

Sri Lanka is a party to the three key international drug control conventions: The Single Convention on Narcotics Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the 1988 United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances. Sri Lanka is also a party to the Convention on Narcotic

5. Kalinga Tudor Silva, 'Stigma and Moral Panic about COVID-19 in Sri Lanka', *Humanities and Social Sciences (JHS)* 3, no. 2 (2020), [http://pgihs.ac.lk/reserch/7/3.%20Prof.%20Tudor%20Silva%20\(Final\).pdf](http://pgihs.ac.lk/reserch/7/3.%20Prof.%20Tudor%20Silva%20(Final).pdf).

Drugs and Psychotropic Substances adopted at the Fifth Summit of the South Asian Association for Regional Co-operation held in Male and signed in Male on 23 November 1990. The Outcome Document of the 2016 United Nations General Assembly Special Session on the Drug Problem (UNGASS 2016) is a landmark declaration where Member States affirmed that the interpretation of the international drug conventions must be in accordance with human rights law.

According to international human rights standards, compulsory detention and treatment violate the rights of people who use drugs against arbitrary detention, the right to be free from torture, cruel, inhuman or degrading treatment and punishment as well as the right to the highest attainable standard of healthcare and the right to be free from discrimination. To protect the rights of people who use drugs, the formulation of community-based treatment options, including harm reduction services so that individuals do not have to undergo the painful process of withdrawal, and is in line with international human rights standards is recommended.

1.3. The national approach to drug control and prevention

1.3.1. Arrest and detention of people who use drugs

The Police Department is the primary law enforcement authority responsible for conducting arrests of persons suspected of committing drug-related offences. The Police Narcotics Bureau is a specialised unit within the police that is tasked with conducting investigations into drug cases.

A number of systemic shortcomings in law and practice create space for gross misconduct and malpractices within the Police Department, which impact the rights of persons arrested for drug-related offences. For instance, according to the Sri Lankan Human Rights Commission's first national study of prisons⁶, persons in prison frequently accused the police of planting drugs to frame them. Women, in particular, reported being subjected to invasive body cavity searches by female police officers during the arrest process. The use of torture in police custody, specifically against persons arrested for drug-related offences, is a widely documented phenomenon and action is not taken against officers who perpetrate violence, thereby creating a culture of power and impunity within the Police Department.⁷

6. Human Rights Commission of Sri Lanka, 'Arrest and Detention', in *Prison Study by the Human Rights Commission of Sri Lanka*, 2020, <https://www.hrcl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

7. Report of The Human Rights Commission to The Committee Against Torture Review of The 5th Periodic Report of Sri

Further, the lack of oversight and accountability mechanisms for police create space for officers to interfere with the investigation into drug-related cases, by falsifying crucial details with regards to the timing of arrest, tamper with the chain of custody for drugs seized and intentionally cause the trial process to be delayed. This results in suspects remaining in pre-trial detention for prolonged periods of time. The findings of the study illustrate these factors result in violations of the right to due process and fair trial. It is also common for persons who have been convicted of drug offences in the past to be harassed and targeted by police officers even after their release.

In July 2020, several officers of the Police Narcotics Bureau were arrested for corruption and involvement in drug trafficking after evidence of police officers being engaged in a drug-selling network emerged.⁸ It was noted by the prosecuting counsel in court that the lack of supervision and oversight within the Police Department enabled a drug trafficking ring to operate within the Police Narcotics Bureau. This incident calls into question the integrity of past investigations conducted by the Police Narcotics Bureau and casts reasonable doubt on the integrity of the evidence upon which persons were convicted.

1.3.2 The legal framework on drug control

The Poisons, Opium and Dangerous Drugs Ordinance (the Ordinance) outlines drug-related offences in the national legislation – Section 54A criminalises import, export, trafficking and possession of a wide variety of narcotic substances including heroin, cannabis, opium and cocaine.

The maximum punishment for offences under Section 54A is death or life imprisonment and bail cannot be obtained for offences under Section 54A, except at the High Court under exceptional circumstances.

Although Section 52 of the Ordinance criminalises the offence of possession, the case is usually presented to the Magistrate under Section 78 (5) of the Ordinance, i.e. the general penalty provision for all offences under the Ordinance (except Section 54A). Section 52 is no longer used in practice. According to Section 78 (5)(a), the maximum sentence at the Magistrate's Court is a fine between Rs. 1,000 (5.1 USD) and Rs. 10,000 (51.7 USD) and/or imprisonment of up to five years. Offences to which this penalty applies are bailable at

Lanka, October 2016.

8. '18 Narcotic Bureau Officers arrested so far for operating drug trafficking ring', *News First*, 08 July 2020, <https://www.newsfirst.lk/2020/07/08/18-narcotic-bureau-officers-arrested-so-far-for-operating-drug-trafficking-ring/>.

the Magistrate's Court. The quantity of drugs involved in the case will usually determine the charge and penalty imposed on the individual.

Cases involving methamphetamines are dealt with in the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act (No. 1 of 2008).

The situation pre-2020

Prior to 2020, in cases involving heroin, if a person was arrested for possession of under 500mg gross of heroin, the facts of the case would be presented by the police to the Magistrate under Section 78 (5)(a) of the Ordinance. This practice emerged after instructions were issued by the Attorney General to the Inspector General of Police in May 2012 establishing the 500mg threshold, to reduce the wide discretion exercised by the police to charge a large number of persons under Section 54A.

Cases filed under Section 78 (5)(a) of the Ordinance would be concluded on the same day in the Magistrate's Court. Following the admission of guilt by the arrested individual, s/he would typically be sentenced to a fine, the amount of which would be at the discretion of the judge, and upon payment of the fine s/he would be released. If a person is not able to afford the fine, s/he will be imprisoned for up to six months in lieu of the fine. Six months is the maximum term of imprisonment that can be imposed by the Magistrate in lieu of a fine under Section 291 of the Criminal Procedure Code Act (No. 15 of 1979).

In instances where persons are found with a quantity of more than 500mg gross of heroin, the facts of the case will be presented under Section 54A of the Ordinance and the individual will be sent to remand prison as bail cannot be obtained at the Magistrate's Court for offences under Section 54A. The drugs found in the possession of arrested individuals will be sent to the Government Analyst Department for a report on the purity of the substances. As is commonly known, the Government Analyst Department is under-resourced, meaning it can take months or longer for the report to be issued. Individuals thus remain in remand prison for a prolonged period of time due to administrative delays within the department. This leads to severe overcrowding of remand prisons.

Once the Government Analyst report is issued, the pure quantity of drugs in the case will determine under which section persons will be charged. If the net quantity of heroin is below 500mg, then the case will be presented under Section 78 (5)(a) and will be concluded at the Magistrate's Court, with the imposition of a fine as a penalty. Where the net quantity of

heroin is above 500mg, the case file will be sent to the Attorney General's Department for a decision on whether to indict the individual under Section 54A. The death penalty or life imprisonment can be imposed in cases involving more than 2g of pure heroin, as outlined in the Third Schedule of the Poisons, Opium and Dangerous Drugs Ordinance.

The situation post-2020

The large number of persons being sent to prison for drug-related offences has led to the severe overcrowding of all prisons in Sri Lanka. Findings of the Human Rights Commission's national study of prisons affirmed that prisoners suffer inhuman conditions of detention and degrading treatment and punishment.⁹

Since the onset of the pandemic, due to the outbreak of COVID-19 in prisons, the government has taken measures to reduce the prison population. A large number of convicted persons imprisoned for the non-payment of fines and minor offences were released, and persons held in pre-trial detention for minor offences were released on bail.¹⁰ To reduce the number of persons being sent to prison for drug offences, the Attorney General issued guidelines to the Inspector General of Police in November 2020. According to the instructions, in instances where persons are found in possession of less than 2g gross heroin, or the net weight of heroin involved in the case is less than 1000mg, provided there is no evidence of drug trafficking, or prior offences and pending cases involving more than 1g of heroin, the case should be filed under Section 78 (5)(a) rather than Section 54A and concluded in the Magistrate's Court.

Guidelines were also issued in January 2021 to State Counsels instructing them not to object to bail in cases involving not more than 10g gross heroin if the person has been in remand for over six months and investigations have been concluded, there are no pending cases or previous offences against them, and there is no evidence of heroin trafficking/money laundering. However, the study found that in practice since the conditions described above are broad and arbitrary it allows State Counsels to object to bail. As a result, the award of bail in drug-related cases has reportedly been restricted. Furthermore, the requirement to spend at least six months in remand prison before bail can be awarded appears to be a penalty that has to be fulfilled to qualify for bail and will also have limited impact on reducing prison overcrowding.

9. Human Rights Commission of Sri Lanka, *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

10. '25,224 inmates released from prison to ease overcrowding', *Dinamina*, 1 April 2021. (Translation of Sinhala article)

In May 2021, the Attorney General issued additional instructions and introduced a new category of “between 2g and 4g” (gross quantity) in relation to heroin which increased the threshold eligible for bail and enabled a person who has been in remand for three months to be granted bail. In such situations, to enable the granting of bail, facts must be reported to Court under section 78 (5)(a) of the Ordinance. This will enable the conclusion of the case on the same day with a payment of a fine. The Attorney General states the instructions are based on data provided by the Government Analyst Department that the average percentage of pure heroin contained in the amount of heroin seized, i.e. 2g to 4g would be less than 1g net. Hence, the instructions purportedly aim to prevent those who have a drug dependency from being imprisoned.

An analysis of the laws on drug offences in Sri Lanka reveals that the legal framework is not equipped to address current issues of drug control and contains contradictory provisions that result in arbitrary and disproportionate outcomes. Furthermore, as the study illustrates, instead of instituting legal reform, laws are overridden through administrative circulars and instructions in an ad-hoc manner which undermines legal certainty and transparency.

1.3.3 The legal framework on compulsory drug treatment

The Drug Dependant Persons (Treatment and Rehabilitation) Act (No. 54 of 2007) governs the legal framework for drug rehabilitation in Sri Lanka. Section 10 of the Act empowers police officers to send any person suspected of consuming drugs for a medical assessment, and thereafter produce the person before a Magistrate. Section 10 (4) allows a Magistrate to send the person for compulsory drug rehabilitation, either on the basis of the medical assessment conducted by a medical officer who assesses the person to be “drug-dependent”, or as a punishment for an offence under the Poisons, Opium and Dangerous Drugs Ordinance. Section 10 allows the police to arrest without evidence, arbitrarily detain a person, ultimately leading to the person being sentenced to compulsory drug rehabilitation.

The Community Based Corrections Act provides alternatives to incarceration, whereby a non-custodial sanction can be imposed on persons convicted for minor offences for which imprisonment is not a mandatory penalty and for offences for which the penalty is less than two years’ imprisonment. However, when persons are arrested for drug-related offences and have a history of drug use or prior offences, the judge may require the individual to undergo mandatory drug treatment as part of the conditions of the Community Based Corrections order. Although the Act requires the individual to consent to the Community

Based on the Community Based Corrections order¹¹, the consent will not be free of duress as the alternative to mandatory treatment is a prison sentence. The lack of awareness of the Community Based Corrections Act has also resulted in its limited implementation.

Compulsory drug treatment and rehabilitation is contrary to international human rights standards and constitutes arbitrary detention, as well as a violation of the right to the highest attainable standard of healthcare. Since the onset of the pandemic, key members of the government and the President have announced they propose to send persons convicted for drug offences to rehabilitation instead of prison, to reduce overcrowding in prisons.¹² This approach has the potential to be an extension of the militarised approach to drug eradication, under the guise of rehabilitation. Furthermore, it is likely that people who use drugs will be targeted under this mechanism and diverted to mandatory drug rehabilitation without their consent, which will be administered by the Ministries of Defence and Justice, rather than the Ministry of Health.

1.4 Compulsory drug rehabilitation in Sri Lanka

There are both state-administered and private drug rehabilitation and treatment centres in Sri Lanka. Individuals may voluntarily participate in drug treatment programmes at public centres run by the National Dangerous Drugs Control Board by paying a nominal fee.

Persons can also be required to undergo mandatory drug rehabilitation and treatment via a court order at a National Dangerous Drugs Control Board centre or at the Kandakadu Drug Treatment Centre and Senapura Vocational Training Centre. The centres at Kandakadu and Senapura, which were formerly used by the military to 'rehabilitate' alleged ex-combatants following the conclusion of the armed conflict in 2009, are now used for mandatory drug treatment and rehabilitation.¹³ Although the two centres are within the purview of the State Ministry of Prison Reform and Prisoners Rehabilitation, they are operated by the military. Alternatively, persons can obtain treatment at private fee-levying centres.

11. Community Based Corrections Act (No. 46 of 1999), Section 7

12. 'Mandatory Rehabilitation for Drug Addicts: Minister', *News First*, 05 January 2021, <https://www.newsfirst.lk/2021/01/05/mandatory-rehabilitation-for-drug-addicts-minister/>.

13. 'Preliminary Findings from its visit to Sri Lanka' Working Group on Arbitrary Detention, (4 to 15 December 2017), 2017, *OHCHR*, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22541>.

The majority of state centres designated for drug rehabilitation and treatment are for men, and there is only one centre in the country run by the National Dangerous Drugs Control Board that contains a ward for women. The only other known state centre for women is within the purview of the Department of Social Services.

Private drug rehabilitation centres are regulated by the National Dangerous Drugs Control Board which is mandated to issue a license for a private facility to operate. The Drug Dependents (Treatment and Rehabilitation) Act requires the National Dangerous Drugs Control Board to appoint a Director of Treatment Centres who is empowered to visit any detention centre licensed under the Act for the purposes of inspecting and ascertaining whether the provisions of this Act are being complied with. However, it is not uncommon to find private, fee-levying drug treatment centres functioning without the approval of the National Dangerous Drugs Control Board. The monitoring of private centres by the National Dangerous Drugs Control Board is inadequate.

All rehabilitation programmes at both state and private centres are abstinence-based and no harm reduction services are provided. In this regard, it has to be noted that the UN Special Rapporteur on Torture has highlighted that by denying persons access to substitution therapies, states are subjecting “a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence”.¹⁴

The findings of this study demonstrated shortcomings in the rehabilitation programmes administered by both state and private drug treatment centres. While programmes were not evidence-based nor health-focused, the common use of violence is one of the most egregious violations found in both state and private centres. In particular, persons who had been sentenced to compulsory treatment at the Kandakadu and Senapura centres spoke of the everyday nature of violence to which they were subjected from the point of admission. Rehabilitees said they often did not know the reason they were beaten and that the use of collective punishment was common.

Compulsory rehabilitation was identified as a problem by all interviewees for reasons ranging from the fact that it is ineffective to the fact that it drives persons to relapse and is a human

14. 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' (UN Human Rights Council, 1 February 2013), <https://www.refworld.org/docid/51136ae62.html>.

rights violation. Those interviewed and who had been sent for compulsory rehabilitation had relapsed more than once, illustrating the ineffective nature of compulsory drug treatment.

There is also little post-release support or after-care to support effective reintegration into society. This is evidenced in the narratives of the interviewees who have been to more than one rehabilitation centre. They report facing stigma, which hinders social and reintegration and livelihood opportunities, as well as harassment by the police. The need for community support, particularly to secure a livelihood, was reiterated by all interviewees. Those who had received treatment for drug dependency pointed out that stigma and harassment are key reasons that lead to relapse.

Although private centres are supposed to be voluntary, in practice, families forcibly send persons to these centres and even those who enter voluntarily may not always be allowed to leave when they wish. Drug treatment centres run by priests of the Buddhist and Christian faiths are also commonly found in Sri Lanka.

In prison, there is extremely limited access to drug treatment that is not evidence-based. Imprisonment without access to medicines to mitigate withdrawal symptoms can lead to dire health consequences and even death. It should be noted that most persons who are imprisoned for drug offences and who may have dependency are remand prisoners, and their inability to access any medical intervention places their health and lives at risk¹⁵.

15. Human Rights Commission of Sri Lanka, 'Deaths in Prison', in *Prison Study by the Human Rights Commission of Sri Lanka*, 2020, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

2. Introduction

2. Introduction

2.1. Background and aims of the study

This study aims to provide a comprehensive analysis of drug control, detention, treatment and rehabilitation¹⁶ of people who use drugs in Sri Lanka.

The study takes note of the increasing role played by the military in the incarceration and rehabilitation of people who use drugs. Therefore, the analysis will be undertaken within the context of the 'War on Drugs' rhetoric employed by the state. The state's militarised response to drug control and drug use is a continuum of the rehabilitation programme administered by the Ministry of Defence for alleged former combatants, following the conclusion of the armed conflict in Sri Lanka in 2009.¹⁷ As such, the overall framework of the strategy of the state is the same, causing concerns ranging from the treatment of persons undergoing rehabilitation and conditions in which the rehabilitation is conducted, to the impact of the present approach on low-income communities in which drug use may be prevalent. Due to the lack of external monitoring of and reporting on drug rehabilitation centres, very little information exists in the public domain on the conditions at drug treatment centres and the content of drug treatment and rehabilitation programmes.

The study is informed by the fact that the criminal justice system in Sri Lanka has long viewed retributive policies, which are believed to act as deterrents, as the primary means of dealing with persons in conflict with the law. Retributive policies also garner public support.¹⁸ As a result of this, the inhuman treatment of persons, such as prisoners and persons arrested for drug offences, does not elicit public outrage as these persons are viewed as undesirables and outcasts and not worthy of being treated humanely. Therefore, the systemic use of torture within correctional institutions to discipline and punish continues with impunity because it is validated by both state structures as well as the public, resulting in its normalisation and entrenchment. Within this environment, particular persons, such as people who use drugs and those detained for drug offences, are thought to be more deserving than other offenders of severe punitive sanctions, including violence.

16. It must be highlighted at the onset that where the report mentions drug rehabilitation, it does not necessarily refer to an evidence-based approach as recognised by international standards, but rather the approach to rehabilitation in the context of the Sri Lankan national drug policy.

17. Ambika Satkunanathan, 'The Treatment of Former Combatants in Post-War Sri Lanka: A Form of Arbitrary Detention or Rehabilitation?', in *Routledge Handbook of Human Rights in Asia* (Routledge, 2018).

18. Human Rights Commission of Sri Lanka, 'Prisoners on Death Row', 'Early Release Measures' in *Prison Study by the Human Rights Commission of Sri Lanka*, 2020, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

To justify its war on drugs, the government is constructing a narrative that blames individuals such as prisoners engaging in illegal activities, mainly drug offences, while being in prison,¹⁹ for the dysfunctional state of the penal system in Sri Lanka, and ignores systemic, structural and social factors that cause crime.²⁰ This is captured in Secretary, Ministry of Defence, General (Retd) Kamal Gunaratne's statement that "(I)t's no secret that prisons in this country had become sanctuaries for drug lords and underworld criminals over the years".²¹ Hence, those who are arrested or imprisoned for drug offences occupy the lowest rung as the newest group of undesirables, joining those arrested and imprisoned for terror offences. This too impacts the treatment by state and society of people who use drugs and will be discussed in this study.

The purpose of this study is to gain a deeper insight into:

1. The legal regime for drug control in Sri Lanka and whether it adheres to international human rights standards.
2. The process by which people who use drugs are sentenced to compulsory treatment and rehabilitation, the conditions of detention at treatment centres and content of the treatment programme, including the impact of the treatment programme on the person, and available post-release support.
3. The ways in which the COVID-19 pandemic has affected people held in drug treatment centres and the measures that have been taken, if any, to prevent the spread of COVID-19 in these institutions.

19. 'Sri Lanka Might Execute Drug Traffickers Caught Dealing from Prison', *Reuters*, 11 July 2018, <https://www.reuters.com/article/uk-sri-lanka-drugs-idUKKBN1K11UW>.

20. Ambika Satkunanathan, 'Militarisation of Prisons: Quick Fixes over Long Term Change?', *Daily FT*, 23 July 2020, <https://www.ft.lk/columns/Militarising-prisons-Quick-fixes-over-long-term-change/4-703539>.

21. 'Sri Lanka Will Be a Just and Safe Country for all Communities to Live, Defence Secretary Assures', *ColomboPage*, 16 June 2020, http://www.colombopage.com/archive_20A/Jun16_1592308914CH.php.

2.2. Methodology

The methodology consisted of the following:

1. Review of international standards and relevant international treaties which Sri Lanka has ratified, as well as applicable national laws and policies, academic articles and comparative policies on drug treatment and rehabilitation policies.
2. Review of all relevant information on drug treatment centres in Sri Lanka available in the public domain, such as newspaper articles, government websites, reports by civil society organisations and international bodies (eg: Report of the UN Working Group on Arbitrary Detention).
3. Interviews with persons who have undergone the rehabilitation process at treatment centres, officers of the National Dangerous Drugs Control Board (NDDCB), lawyers and members of civil society. All interviews, except for the interview with the UN representative, who agreed to be quoted, have been anonymised due to concerns of interviewees about stigma and possible reprisals.

In total, 19 persons were interviewed:

- Seven persons who have received treatment for drug dependence²²
- Two lawyers
- Five past and current NDDCB officers
- Four civil society activists
- One UN representative

2.3. Limitations of the study

A key limitation of the study was the difficulty in locating persons who have received treatment for drug dependence due to their unwillingness to divulge information, because of stigma or possible reprisals for disclosing information about rights violations. For these reasons, all interviews, except one, have been anonymised and are devoid of any identifying elements. Minimal information and empirical research published on drug treatment in Sri Lanka, particularly using a human rights lens, also posed a challenge in finding secondary data. The lack of access to treatment centres to conduct first-hand inspections of the treatment facilities means the data collection has been restricted to qualitative interviews.

²². Names of these interviewees mentioned in the report were changed to protect their identities.

3. Context

3. Context

3.1. The militarised war on drugs

During the Good Governance regime from 2015-2019, the pace of post-war militarisation had somewhat reduced. Following the Presidential election in November 2019 it resumed with vigour.²³ The militarisation of civilian space has been justified by Prime Minister Mahinda Rajapaksa, one of the brothers of the current President, who criticised political opponents for creating an “artificial social dichotomy between ‘military’ and ‘civilian’”²⁴ and stated that “whenever we happen to be in power, there will always be former members of the armed forces and police holding various positions in the government.”²⁵

The role of the military in drug control has increased rapidly during the last decade, especially after the conclusion of the armed conflict in Sri Lanka in 2009. The security forces’ engagement ranges from making drug-related arrests to conducting awareness programs in schools about drug use.²⁶ For instance, the media frequently report instances of the Sri Lanka Navy seizing and arresting persons with significant quantities of narcotic substances^{27,28}.

In 2019, former President Maithripala Sirisena initiated a ‘War on Drugs’, inspired by President Rodrigo Duterte of the Philippines,²⁹ to combat drug trafficking in Sri Lanka, and

23. Ambika Satkunanathan, “Securitisation and militarisation in Sri Lanka: A Continuum”, *The Daily FT*, 20 January 2021, <https://www.ft.lk/columns/Securitisation-and-militarisation-in-Sri-Lanka-A-continuum/4-711827>.

24. ‘Sri Lanka Will Not Tolerate Targeting of War Heroes: Gotabaya Rajapaksa’, *The Hindu*, 19 May 2020, <https://www.thehindu.com/news/international/sri-lanka-will-not-tolerate-targeting-of-war-heroes-gotabaya-rajapaksa/article31626767.ece>.

25. Ibid

26. ‘Tri Forces Play Active Role in the Fight against Drugs’, *Ministry of Defence*, 08 March 2019, http://www.defence.lk/Article/view_article/219.

27. ‘Over 200kg Kerala Cannabis Seized by Sri Lanka Navy in Mannar’, *News First*, 18 October 2020, <https://www.newsfirst.lk/2020/10/18/over-200kg-kerala-cannabis-seized-by-sri-lanka-navy-in-mannar/>.

28. “While conducting a record-breaking number of drug-bust operations in known history, the Navy has seized 718kg of heroin, 797kg of crystal methamphetamine, 581kg of ketamine and 2,475kg of cannabis in the first three and half months of year 2020. The street value of these mammoth consignments of drugs is estimated to be over Rs. 21 billion.” - ‘Vessel Seized by Navy in High Seas While Carrying a Stock of Heroin and Crystal Methamphetamine Escorted to Dikkowita Fisheries Harbour’, *Sri Lanka Navy*, 15 April 2020, <https://news.navy.lk/lead-story/2020/04/15/202004151746/>.

29. “Example to the World’: Sri Lanka President Plans to Copy Duterte’s War on Drugs’, *The Guardian*, 18 January 2019, <https://www.theguardian.com/world/2019/jan/18/example-to-the-world-sri-lanka-president-plans-to-copy-dutertes-war-on-drugs>.

proposed the resumption of executions of persons sentenced to death for drug trafficking. President Sirisena also expanded the role of security forces in drug control.³⁰ This trend has intensified since November 2019 with the election of President Gotabaya Rajapaksa, who has adopted a hyper-militarised approach towards combating the use and sale of narcotics. In his inaugural speech, President Rajapaksa promised to “take all necessary steps to make our motherland a safe country free of terrorism, extremism, underworld activities, theft and robbery, extortionists, the drug menace, disruptors of public order, and the abuse of women and children.”³¹ Extraordinary Gazette number 2196/27 of 2020, which outlines the functions and special priorities of each Ministry, states that a special priority for the Ministry of Defence is the:

“Creation of a country free from drugs by working jointly with the relevant Presidential Task Force for prevention of the influx of drugs into the country, control of the drug menace, prevention from falling prey to drugs, rehabilitation of those addicted to drugs.”³²

In line with the stated objective, in June 2020 the President established an ad-hoc Task force mainly comprised of police and military personnel to build “a Secure Country, Disciplined, Virtuous and Lawful Society.”³³ This entity is mandated to “take necessary measures for prevention from drug menace, prevent entry of drugs from abroad through ports and airports and to fully eradicate drug trafficking in the country and to prevent other social illnesses caused by drug abuse.”³⁴

Statements by members of the present government, particularly the President, Commander of the Army and Secretary of Defence, have consistently equated the ‘fight against drugs’ with the ‘fight against terrorism’, and drug eradication is often discussed as an issue of national security. Winning the war against terror, which the government has used as a badge of honour to deflect any criticism of its actions, has been replaced by the war against drugs. This is illustrated by the statement of Commander of the Sri Lanka Army, General Shavendra Silva that:

30. “War on Drugs ‘Identical to How We Finished Off LTTE’ Warns Sri Lankan Commander”, *Tamil Guardian*, 28 March 2019, <https://www.tamilguardian.com/content/war-drugs-%E2%80%99identical-how-we-finished-ltte%E2%80%99-warns-sri-lankan-commander>.

31. ‘Utmost priority for National Security’, *Daily News*, 18 November 2020, <https://www.dailynews.lk/2020/11/18/supplement/233815/utmost-priority-national-security>.

32. Presidential Secretariat, Sri Lanka, “*Ministry of Defence – Special Priorities*”, Extraordinary Gazette No. 2196/27, 06 October 2020, http://www.cabinetoffice.gov.lk/cab/images/Downloads/functions_2020-10-06_E.pdf.

33. ‘Presidential Task Force Appointed to Build a “Secure Country and a Disciplined, Virtuous, and Lawful Society”’, *News Wire*, June 3, 2020, <https://www.newswire.lk/2020/06/03/presidential-task-force-appointed-to-build-a-secure-country-and-a-disciplined-virtuous-and-lawful-society/>.

34. *Ibid.*

“The security forces, which eradicated terrorism in the country 10 years ago, have been given a new task – to combat drug trafficking. We have given instructions to all Security Forces commanders, especially the SF HQ Wann, to take speedy measures to nab drug smugglers”.³⁵

Likewise, the treatment of persons with³⁶ drug dependence is equated with the rehabilitation of former LTTE combatants. For instance, in the 2020 progress report of the State Ministry of Prison Reform and Prisoners Rehabilitation, the Secretary to the Ministry, when discussing the role of the Bureau for Commissioner General of Rehabilitation, states:

“On the back of successful rehabilitation process of misguided combatants, the task of rehabilitating drug addicts and reintegrating them into society as productive citizens has been assigned to the Bureau of the Commissioner General of rehabilitation as drug addiction has become a burning social issue.”³⁷

The militarised approach has extended to bringing the National Dangerous Drugs Control Board (NDDCB), the principal national drug control and monitoring authority in Sri Lanka, within the purview of the Ministry of Defence.³⁸ Further, two compulsory drug treatment centres, Kandakadu Drug Treatment Centre (KDC) and Senapura Vocational Training Centres, are managed by the military³⁹ although they are within the purview of the State Ministry of Prison Management and Prisoners’ Rehabilitation, which is under the purview of the Ministry of Justice.⁴⁰ The Secretary of Defence and Commander of the Army are also frequently reported to be discussing and deciding on policy related to drug treatment and launching new drug prevention initiatives of the NDDCB. For example, at the inaugural ceremony of the new Nawadiganthaya (Treatment and Rehabilitation Centre),⁴¹ the Secretary

35. “Police, Navy and Army Intensify Fight Against Drug Smuggling”. *Ministry of Defence*. 29 February 2020. https://www.defence.lk/Article/view_article/897

36. ‘Presidential Task Force Appointed to Build a “Secure Country and a Disciplined, Virtuous, and Lawful Society”’, *News Wire*, June 3, 2020, <https://www.newswire.lk/2020/06/03/presidential-task-force-appointed-to-build-a-secure-country-and-a-disciplined-virtuous-and-lawful-society/>.

37. State Ministry of Prison Reforms and Prisoners’ Rehabilitation, ‘Progress Report - 2020’, 2021, <http://www.prison-min.gov.lk/web/images/pdf/progress-report-2020.pdf>.

38. Presidential Secretariat, Sri Lanka, “*Ministry of Defence* - Related Institutional and Legal Framework”, Extraordinary Gazette No. 2196/27, 06 October 2020, http://www.cabinetoffice.gov.lk/cab/images/Downloads/functions_2020-10-06_E.pdf

39. ‘Preliminary Findings from its visit to Sri Lanka’ Working Group on Arbitrary Detention, (4 to 15 December 2017), 2017, *OHCHR*. <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=22541&LangID=E>.

40. Presidential Secretariat, Sri Lanka, ‘Extraordinary Gazette No. 2187/27’ (2020), http://documents.gov.lk/files/eg-z/2020/8/2187-27_E.pdf.

41. ‘Legal Reforms to Deal with Drug Related Issues - Defence Secretary’, *Ministry of Defence*, 30 January 2021, http://www.defence.lk/Article/view_article/2965.

of Defence presented the proposed plan to build eight such rehabilitation centres staffed by the armed forces.

By equating drug use, treatment and trafficking with terrorism and thereby creating the impression of an existential threat to society, which only the armed forces are capable of combating, the activities and functions of the armed forces in drug control and treatment are legitimised in the public domain. In this context, the lack of transparency regarding the control and disposal of narcotics seized by the armed forces, evidence of gross inefficiency and misuse and abuse of public funds,⁴² and reported instances of members of security forces being arrested for drug trafficking⁴³ are not subject to public scrutiny or inquiry.

3.2. The state's approach to drug treatment

The National Dangerous Drugs Control Board's (NDDCB) approach to drug treatment and rehabilitation involves abstinence-based detoxification, combined with physical labour and psychological programmes. As outlined in the NDDCB Performance Report of 2016 submitted to Parliament, the treatment programme undertaken in the NDDCB-run centres include "individual and family counselling. It consists of detoxification treatment, physical exercises, mental relaxation, indoor and outdoor activities, psychotherapy, education, vocational training in coping with skills (sic) and motivation to develop healthy lifestyles".⁴⁴ The NDDCB Chairman's statement below, setting out the purported causes of drug dependence, is illustrative of the government's approach to drug use and its lack of scientific basis. He is reported to have said:

'Factors connected to drug addiction include unemployment, relationship issues such as divorce and extra-marital affairs, the high usage of mobile phones and the internet, having less time for recreational activities and there being few recreational activities to engage in, and increased foreign tourism.'⁴⁵

42. National Audit Office "Sri Lanka Army – Head 222.", "Sri Lanka Navy – Head 223.", "Sri Lanka Air Force – Head 224." 2019.

43. 'Two Army Personnel Arrested for Drug Trafficking', *Daily FT*. 26 February 2021, <http://www.ft.lk/news/Two-Army-personnel-arrested-for-drug-trafficking/56-713853>.

44. National Dangerous Drugs Control Board, 'National Dangerous Drugs Control Board – Annual Report and Accounts 2015', 2016, <https://www.parliament.lk/uploads/documents/paperspresented/annual-report-national-dangerous-drugs-control-board-2015.pdf>.

45. 'Drug Addiction up 400% Since 2010'. *The Morning*, 19 January 2021, <http://www.themorning.lk/drug-addiction-up-400-since-2010/>.

A report published by NDDCB and the National STD/AIDS Control Programme in 2018 states that harm reduction policies are not utilised in the national approach to drug treatment in Sri Lanka.⁴⁶ This is also highlighted in a report published by Harm Reduction International in 2020⁴⁷ on harm reduction policies and practices worldwide, which states that harm reduction approaches to drug treatment and rehabilitation, including opioid agonist therapy (OAT), needle and syringe exchange programmes (NSP) and peer distribution of naloxone, are not available or utilised in Sri Lanka. Notably, these have been widely recognised as evidence-based, effective approaches to drug use recommended by WHO, UNODC and OHCHR (among others) as well as essential components of the right to health.⁴⁸

In its recommendations, the 2018 NDDCB and National STD/AIDS Control Programme report highlights the need for “urgent and strong advocacy measures for initiating evidence-based treatment for drug dependence (Opioid Substitution Treatment) and harm-reduction interventions (including access to clean injecting equipment) for people who usedrugs.”⁴⁹ The report also highlights the current ‘misconceptions’ in Sri Lanka surrounding harm reduction policies. It quotes a Medical Officer and law enforcement official who express their discomfort with harm reduction policies, and claim that a policy of providing access to sterile injecting equipment would legitimise the usage of narcotic substances and cause the number of people who inject drugs, as well as the rate of crime, in Sri Lanka to rise.⁵⁰ As stated in the report:

“Treatment facilities appear to rely largely upon ‘counselling’ instead of evidence-based medical treatment. In the words of a doctor, “We don’t give medicine to heroin addicts. We give medicine to people who are addicted to alcohol and cigarettes. If we give medicine treatment (sic) to heroin consumers, they get addicted to that”.

46. ‘Rapid Assessment of Drug Use Patterns (RADUP) In Sri Lanka to Inform Risk Reduction Interventions for People Who Use / Inject Drugs (PWUD/PWID)’ (National Dangerous Drugs Control Board and the National STD/AIDS Control Programme, 2018), https://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/Rapid-Assessment-of-Drug-Use-Patterns-in-Sri-Lanka.pdf.

47. ‘The Global State of Harm Reduction 2020’ (Harm Reduction International, 2020), https://www.hri.global/files/2020/10/26/Global_State_HRI_2020_BOOK_FA.pdf.

48. ‘International Standards for the Treatment of Drug use disorders’ (World Health Organization and United Nations Office on Drugs and Crime, 2020), <https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders>.

49. ‘Rapid Assessment of Drug Use Patterns (RADUP) In Sri Lanka to Inform Risk Reduction Interventions for People Who Use / Inject Drugs (PWUD/PWID)’ (National Dangerous Drugs Control Board and the National STD/AIDS Control Programme, 2018), https://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/Rapid-Assessment-of-Drug-Use-Patterns-in-Sri-Lanka.pdf.

50. Ibid

3.3. State and media portrayal of people who use drugs

Both the government and the media portray people who use drugs and those with drug dependence issues as “evil” and “a danger to society”.

The government's militarised war on drugs is aided by the media, particularly regime-affiliated media, which portray the “drug menace” as the biggest threat to social order and well-being. It is not uncommon for reports of large hauls of drugs being seized by police to be published in newspapers of all three languages with several articles appearing each day, and reports being televised at least a few times a week. News reports mention the details of individual arrests, the arresting entity and the amount of drugs found in the possession of the individual as well as the location of the arrest. They also refer to arrested persons as “drug addicts”⁵¹, “addicts” or “drug traffickers”⁵², conflating people who use drugs with those who engage in trafficking. News reports, particularly in Sinhala media, also mention the names of persons who are arrested and of those released on bail, thereby affecting the presumption of innocence enjoyed by all persons.⁵³

Such reports have the effect of creating the impression amongst the public of the existence of a ‘drug problem’ that has pervaded society and is a threat to national security. This serves as a justification for the increased militarisation of drug control; drugs are presented as an issue of national security, which only the armed forces are suited to address. Furthermore, such a narrative increases the stigma suffered by people who use drugs and creates barriers to accessing treatment. For instance, in a May 2021 article in a national newspaper, the police cautioned the public to safeguard their belongings in public spaces “as around 8,000 drug addicts are roaming in the busy areas of Colombo city”.⁵⁴ The article further stated that “drug addicts will be looking for valuables, such as mobile phones, ladies’ handbags, jewellery and men’s wallets for easy money” as they have “come to the Colombo city to target the shoppers who throng in the city prior to the upcoming festival season”.⁵⁵ Similar statements were widely circulated through WhatsApp messages around Colombo city, and persons were asked to beware of “druggies” roaming around in Colombo city who will try to break

51. ‘97,000 Heroin Addicts in Sri Lanka: National Dangerous Drugs Control Board’, *News First*, 11 June 2020, <https://www.newsfirst.lk/2020/06/11/97000-heroin-addicts-in-sri-lanka-national-dangerous-drugs-control-board/>.

52. ‘Drug Dealer Arrested with Rs. 1 Million Worth ‘Ice’ and heroin’, *Colombo Page*, 24 December 2020, http://www.colombopage.com/archive_20B/Dec24_1608793200CH.php.

53. ‘Bail for Woman Who Sold Drugs Hidden in Her Bra’, *Divaina*, 04 May 2021. (translation of Sinhala article)

54. ‘Public cautioned; Colombo Witnesses nearly 8,000 Drug Addicts roaming: Police’, *Daily News*, 16 March 2021, http://www.dailymirror.lk/breaking_news/Public-cautioned-Colombo-witnesses-nearly-8-000-drug-addicts-roaming-Police/108-208666.

55. *Ibid.*

into homes.⁵⁶ In another news report, the Ministry of Public Security is quoted saying that “individuals who are engaged in drug use are responsible for 40% of all criminal activities in Sri Lanka, with most of the drug addicts becoming criminals while in prison.”⁵⁷

The demonization of people who use drugs creates an environment in which discrimination against an already stigmatised group becomes normalised. An example is a reported plan to deny driving licenses to persons identified as having a drug dependence. The headline of the 2020 article titled “No Driver’s License For Drug Addicts”⁵⁸ quotes the State Minister of Vehicle Regulation, who describes the proposed program to conduct “medical examinations to determine if an individual attempting to obtain a license for the first time or a renewal of their license has used drugs in the past year.” If there is confirmation of drug use in the previous year, the license will not be issued to them. The denial of a driving license to a person who uses drugs or with drug dependence is discriminatory.

Women are largely absent from the discourse on drug policies although they are amongst the groups most affected by punitive drug laws. In 2020, the Human Rights Commission of Sri Lanka (HRCSL) reported that 24% of convicted women were in prison for drug offences, while 62% of female remandees were held for drug offences.⁵⁹ It is not known how many women are detained for personal drug use as opposed to those involved in trafficking. Women who use drugs are subject to stereotyped, discriminatory, and demeaning portrayals in the media, which mirrors the discrimination they are subject to in society and the legal process. This has been documented in the HRCSL national study of prisons.⁶⁰ When women are arrested for drug-related offences during raids, news reports specifically mention that women were arrested.⁶¹ Further, articles describing the use of drugs by women are replete with judgmental statements unsubstantiated by evidence, which increases the stigmatisation of women who use drugs. As reported in an article titled “The disturbing new trend of female drug users”, the former Chairman of NDDCB is quoted stating:⁶²

56. Messages received via different WhatsApp chat groups.

57. ‘Drug Users Responsible for 40% of Criminal activities’, *The Morning*, 10 May 2021, <https://www.themorning.lk/drug-users-responsible-for-40-of-criminal-activities/>.

58. ‘No Drivers’ License for Drug Addicts from 2021’, *News First*, 28 December 2020, <https://www.newsfirst.lk/2020/12/28/no-drivers-license-for-drug-addicts-from-2021/>.

59. Human Rights Commission of Sri Lanka, ‘Women’, in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

60. Ibid

61. ‘Three Including a Woman Arrested with over Rs. 1.5 Million Worth Drugs’, *Colombo Page*, 09 August 2020, http://www.colombopage.com/archive_20B/Aug09_1596955387CH.php.

62. ‘Female Drug Users, a Disturbing New Trend in Sri Lanka’, *Sunday Observer*, 13 September 2020, <http://www.sundayobserver.lk/2020/09/13/health/female-drug-users-disturbing-new-trend-sri-lanka>.

“Women face unique issues when it comes to substance use, in part influenced by firstly sex (differences based on biology) and secondly, gender (differences based on culturally defined roles for men and women). According to scientists who study substance use, women who use drugs can have issues related to hormones, menstrual cycle, fertility, pregnancy, breastfeeding, and menopause. Most women we have seen have revealed that the reasons for using drugs, included controlling weight, fighting exhaustion, coping with pain, and attempts to self-treat mental health problems, reasons which are unique to women.”

Such statements reflect the state’s opinion of people who use drugs and the role played by the police and media in enabling their stigmatisation. This is affirmed by the report by the NDDCB and National STD/AIDS Control Program, which describes the stigma faced by people who use drugs:

“(A) Significant amount of stigma and discrimination is faced by persons who use drugs in Sri Lanka. This begins from the family and involves the neighbourhood and the entire society. Persons who use drugs reported their own families “treating them like thieves and not looking after them”. Spouses of persons who use drugs reported facing embarrassment in the neighbourhood. The wife of a person who uses drugs reported that she “doesn’t like to attend any wedding or funeral (sic) because of her husband’s drug use”. Even children of PWUD [persons who use drugs] were reported to face discrimination in the society on account of their father’s drug use.”⁶³

3.4 Deaths in custody and extra-judicial killings

In recent years, a notable increase is observed in deaths in police custody or deaths of persons arrested for drug-related offences and organised crime.⁶⁴ Many deaths in police custody of persons arrested for drug offences follow a similar pattern. The most common is where persons are taken by the police to recover weapons/evidence, during which the

63. ‘Rapid Assessment of Drug Use Patterns (RADUP) In Sri Lanka to Inform Risk Reduction Interventions for People Who Use / Inject Drugs (PWUD/PWID)’ (National Dangerous Drugs Control Board and the National STD/AIDS Control Programme, 2018), https://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/Rapid-Assessment-of-Drug-Use-Patterns-in-Sri-Lanka.pdf.

64. Ambika Satkunanathan, ‘Connecting the Dots: The Death of a Drug Trafficker and the State of Democracy’, *Sri Lanka Brief*, 11 November 2020, <https://srilankabrief.org/connecting-the-dots-the-death-of-a-drug-trafficker-and-the-state-of-democracy-ambika-sathkumamathan/>.

detainee reportedly tries to escape and/or attacks police officers. Or they are waylaid by accomplices, resulting in the police using lethal force.⁶⁵ There is no information in the public domain on whether the police investigate such deaths and if so, the outcomes of the investigations and any follow-up action taken.

For instance, in May 2021, a person in police custody named Mabulage Dineth Melan Mabula, alias Uru Juwa, who was reportedly involved in organised crime, was shot dead by police. He had been taken to a specific location where a shooting incident allegedly occurred. The same day, the mother of another person in custody – Dharmakeerthilage Tharaka Wijesekara alias Kosgoda Tharaka – who was being held in police custody under a Detention Order under the Prevention of Terrorism Act wrote to the Inspector General of Police (IGP) and the Human Rights Commission of Sri Lanka. She pleaded with the authorities to protect her son's life because he was suddenly taken to the Peliyagoda Special Crimes Investigation Unit and she feared he would be killed in custody like other persons who were shot by police. Less than 24 hours later, it was reported that Kosgoda Tharaka was shot and killed by police when he had been taken out of detention to "Rendapola for a 'special operation' [...] once there, an incident had occurred which compelled police officers to use force."⁶⁶

A lawyer interviewed for this study described the pattern thus: "Before 2019, police arrested people with heroin and produced them in the Magistrate's Court. Since 2019, it is not persons that are produced in court, but bodies. The Magistrate just conducts the inquest". Despite numerous such cases with elements that indicate extra-legal action and the unjustified use of lethal force by the authorities, no independent inquiry into these cases has been conducted.

The HRCSL report of the national study of prisons also found a pattern of deaths of persons who were remanded for drug-related offences.⁶⁷ These persons would reportedly become distressed, agitated or violent due to withdrawal symptoms they were likely experiencing. Instead of providing them access to medical treatment to deal with withdrawal symptoms, prison officers, who are accustomed to using violence to maintain order and discipline in prison,⁶⁸ would subject the person to physical assault or even tie them up or use restraints and isolate them to subdue them. The HRCSL prison study reports of such action resulting in death.⁶⁹

65. For examples, 'Drug Kingpin Makandure Madush shot dead', *Daily FT*, 21 October 2020, <http://www.ft.lk/news/Drug-kingpin-Makandure-Madush-shot-dead/56-707829%C2%A0>. Also below.

66. "Kosgoda Tharaka Shot Dead by Police", *Ada Derana*, 13 May 2021. <http://www.adaderana.lk/news/73799/kosgoda-tharaka-shot-dead-by-police>.

67. Human Rights Commission of Sri Lanka, 'Death in Prison', in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

68. Ibid – Chapter 14: Discipline and Punishment.

69. Ibid – Chapter 15: Death in Prison.

The Convention Against Torture Act (No. 22 of 1994), which gives effect to the Convention Against Torture, criminalises torture committed by public officers. During the 5th periodic review of Sri Lanka by the UN Committee Against Torture in 2016, the government reported that since 2012, 17 cases were filed under the Convention Against Torture Act against 36 police officers. At the time of reporting, 9 cases were concluded as a result of which “4 police officers involved in 2 of the cases had been convicted and sentenced to imprisonment.”⁷⁰ The total number of cases initiated under the act and the total number of convictions to date remains unreported.

3.5. Involvement of police in drug trafficking offences

In July 2020, multiple officers from the Police Narcotics Bureau were arrested for corruption and involvement in drug trafficking, after evidence of police officers being engaged in a drug selling ring emerged. The officers were also allegedly connected to international drug trafficking rings, possessed illegal firearms, printed fake currency, and even conducted fake raids. An investigation into the assets of these officers revealed they owned multiple luxury properties and cars. It was noted in court that the lack of supervision and oversight within the Police Department enabled such a drug trafficking ring to operate within the Police Narcotics Bureau (PNB).⁷¹ These officers continue to be held in remand as of May 2021.⁷² Senior Deputy Inspector General of Police (Legal) Mr Ajith Rohana stated in a media briefing that the Police Department intends to “push hard for an expeditious conclusion of the ongoing investigations” and also requested the Attorney General to request the death penalty for officers who are found guilty.⁷³ It should be noted that Sri Lanka has a moratorium on the implementation of the death penalty since 1976, despite which persons continue to be sentenced to death resulting in around 1500 persons to date languishing on death row. There is no publicly available official data on the exact number of persons on death row for drug offences as of May 2021.

70. Response of the Government of Sri Lanka to the List of Issues raised by the UN Committee Against Torture - Sri Lanka's 5th Periodic Review by the Committee Against Torture, 15-16 November 2016.

71. '18 Narcotic Bureau Officers Arrested So Far for Operating Drug Trafficking Ring', *News First*, 08 July 2020, <https://www.newsfirst.lk/2020/07/08/18-narcotic-bureau-officers-arrested-so-far-for-operating-drug-trafficking-ring/>.

72. 'Drug Trafficking PNB Officers Further Remanded', *News First*, 03 May 2021, <https://www.newsfirst.lk/2021/05/03/drug-trafficking-pnb-officers-further-remanded-3/>.

73. 'Police Seek Death Penalty for PNB Officers Colluded with Drug Traffickers', *Colombo Page*, 11 July 2020, http://www.colombopage.com/archive_20B/Jul11_1594465962CH.php.

The aforementioned cases are illustrative of the embedded nature of corruption within the Police Department and validate the allegations made by several prisoners during the prison study conducted by the HRCSL that the police planted evidence to frame them for drug offences.⁷⁴ Furthermore, these arrests raise questions regarding the integrity of investigations conducted by the PNB. More importantly, they highlight the inequitable nature of the carceral approach, which targets and penalises mainly those who use drugs, while the illegal drug trade continues with the aid of persons within state structures.

3.6. Drug use profile in Sri Lanka

According to statistics gathered by the NDDCB⁷⁵ on the national prevalence of drug use in 2019, there are 301,898 persons above the age of fourteen who use cannabis in Sri Lanka, with at least 178,643 persons reportedly ‘regular users’⁷⁶. Cannabis appears to be the most prevalent substance used in Sri Lanka.⁷⁷ An estimated 92,540 persons consume heroin in Sri Lanka, of which 77% are reportedly ‘regular users’. Around 24,211 consume pharmaceutical drugs while 115,324 use ‘other’ drugs. The prevalence of drug use is highest in Colombo in the Western Province, and available data suggest that people who use drugs are overwhelmingly male.

According to a Rapid Assessment of Drug Use Patterns study conducted in 2019 by the NDDCB and the National STD/AIDS Control Programme⁷⁸ of people who use drugs and persons who inject drugs in Sri Lanka, almost all persons from both groups used multiple substances. Two-thirds of respondents in both groups reported using cannabis. While 93% of people who used drugs stated they used heroin, and 91% of persons who injected drugs stated they used heroin, with heroin being the most commonly injected drug. The report further states that the number of persons in Sri Lanka who inject drugs remains small compared to the number of people who use drugs, which is estimated to be 218 ‘on a usual day’ and increases to 423 ‘on a peak day’.

74. Human Rights Commission of Sri Lanka, ‘Arrest and Detention’, in *Prison Study by the Human Rights Commission of Sri Lanka*, 2020, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

75. ‘National Prevalence Survey on Drug Use 2019’ (National Dangerous Drugs Control Board, 2020), <http://www.nddcb.gov.lk/Docs/research/National%20P%20New.pdf>.

76. The report defines “regular use” as daily consumption of heroin.

77. ‘Over 50% of 530,000 Drug Addicts on Cannabis’, *The Morning*, 03 September 2020, <https://www.themorning.lk/over-50-of-530000-drug-addicts-on-cannabis/>.

78. ‘Rapid Assessment of Drug Use Patterns (RADUP) In Sri Lanka to Inform Risk Reduction Interventions for People Who Use / Inject Drugs (PWUD/PWID)’ (National Dangerous Drugs Control Board and the National STD/AIDS Control Programme, 2018), https://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/Rapid-Assessment-of-Drug-Use-Patterns-in-Sri-Lanka.pdf.

Based on the arrests, the police spokesperson is reported to have stated that there has been a 40% increase in the use of synthetic substances, such as methamphetamine, which is commonly referred to as 'ice' in Sri Lanka.⁷⁹ This was confirmed by a lawyer. Police raids involving ice are also frequently reported in the media. The increasing popularity of ice across all socio-economic classes of drug users is attributed to its easy accessibility. Furthermore, according to many interviewees, ice is cheaper than heroin. As one interviewee stated, "It is possible to purchase 5g of ice for Rs. 10,000 (in November 2020), while the price of 1g of heroin is Rs 10,000 (50.47 USD). Further, while 1g of heroin can be used by only one or two persons at once, 5g of ice can be used by a few people or by one or two people for several days as reportedly ice tends to have a higher level of purity than most heroin currently on the market."⁸⁰

Interviewees also reported that people who use drugs are combining opioids with ice, which is cause for concern since heroin is a depressant and ice is a stimulant. Consequently, the combination of the two can cause several serious health issues. It is, however, not possible to ascertain the number of deaths due to drug overdoses in Sri Lanka as they are seldom reported as such. Instead, these deaths are commonly recorded as cardiac arrests, making it challenging to monitor trends and patterns, particularly concerning the health impact of the new trend of combining these drugs.

Although cocaine is consumed in Sri Lanka, it is considered to be a 'drug of the wealthy' and it is mostly accessible to persons with high levels of disposable income. This is reflected in the price of cocaine. According to an interviewee who stated in November 2020, "The price of cocaine a few months ago for 1g was Rs. 22,000 (111 USD). Yesterday, it became Rs. 42,000 (212 USD). If you have a kilo of cocaine, you can sell it within one hour because cocaine is the wealthy people's drug." The increase in price may be due to the trafficking and supply of drugs being disrupted because of the pandemic.

79. 'Synthetic Drugs Usage up 40% in WP', *The Morning*, 15 March 2021, <https://www.themorning.lk/synthetic-drugs-usage-up-40-in-wp/>.

80. 'Handbook of Drug Abuse Information' (National Dangerous Drugs Control Board, 2020), https://drive.google.com/file/d/1khkVbSG8jniHPsgjP7PR23tlaFKOyD_F.

3.7. Statistical information on drug treatment and drug-related detention

3.7.1. Statistics on persons who have received drug treatment

The total number of reported drug users who had received treatment from state and private drug treatment facilities for the year 2019, as per the NDDCB annual report, was 3,613. In comparison to the number of individuals who received drug treatment in 2018, this shows a decrease of 19%. Of the total number of reported drug users who received treatment, 32% received treatment at NDDCB treatment and rehabilitation centres, 19% from prisons drug treatment and rehabilitation programmes, 20% in NGO-run facilities, and 29% at the KDC – which is within the purview of the Bureau of the Commissioner General of Rehabilitation (BCGR).⁸¹

Gender

99% of the persons receiving treatment were male, with only 19 females reported to have received treatment in 2019.⁸²

Age

The distribution of persons receiving drug treatment according to age is as follows: 51% (1,867) were between the ages of twenty and twenty-nine, 15.5% (559) were aged between thirty and thirty-four, 11% (381) were aged between thirty-five and thirty-nine, 9% (347) were aged between forty and forty-nine years, while 4% were aged fifty and above. 8.2% were between the ages of fifteen and nineteen, and six persons admitted for treatment reportedly fell within the category of one to fourteen years.⁸³

Education

The NDDCB report further mentions that 50% (1,788) of people who received treatment had completed up to Grade 10 of their secondary schooling, 35% (1270) had completed Ordinary Level examinations and 12% (438) had completed Advanced Level examinations. 29 persons had pursued higher education and 6 persons had completed professional qualifications. 41 people had received no schooling.⁸⁴

81. Drug Abuse Monitoring System, 'Statistical Report on Drug Dependents Reported from Treatment Agencies', Volume 115 (Research Division, National Dangerous Drugs Control Board, 2019), https://drive.google.com/file/d/1ksJLa9p-N9g6jjwiMjZDeL1pg8JYIXs_x/view.

82. Ibid, page 7

83. Ibid, page 8

84. Ibid, page 9

Voluntary vs. Court referral

According to the NDDCB report, 1,735 or 48% of persons had reportedly voluntarily sought drug rehabilitation and treatment while 1,564 or 43% were referred to mandatory treatment by a court order. The statistics mention 9% of persons under the category of other; it is not stated to what this category refers.⁸⁵

Employment

The statistics on the employment status of the people who received treatment indicate that 600 were engaged in manual labour, 453 were drivers or transportation workers, 382 were self-employed and 202 were businessmen. 296 persons were reportedly unemployed.⁸⁶

3.7.2. Statistics on people convicted for drug offences

According to the Department of Prisons 2021 Statistics Report,⁸⁷ of the total number of 19,856 direct admissions of convicted prisoners in 2020, persons convicted for drug offences constituted 9,336. Forty-five persons were sentenced to death for offences related to drug trafficking, while the number of persons sentenced to life imprisonment for drug offences is 21. 1,984 persons were sentenced to less than one-month imprisonment, 6,504 offenders were sentenced to one to six months imprisonment, 487 were sentenced to six months to one year, and 295 for a year and longer.⁸⁸

The total number of convicted persons and the percentage convicted for drug offences has sharply decreased in the year 2020, compared to the previous year. According to the Department of Prisons 2020 Statistics Report,⁸⁹ the total number of direct admissions of convicted persons in 2019 was 29,164, of which 15,123 were convicted of drug offences. The decrease in the number of cases can presumably be a result of the measures taken by the government to reduce the number of persons being imprisoned for drug-related offences, to curb overcrowding in prison due to the risks associated with the COVID-19 pandemic.⁹⁰

85. Ibid, page 5

86. Ibid, page 10

87. 'Prison Statistics of Sri Lanka 2021' (Statistics Division, Department of Prisons, 2021), <http://prisons.gov.lk/web/wp-content/uploads/2021/05/prison-statistics-2021.pdf>.

88. Ibid, page 92

89. 'Prison Statistics of Sri Lanka 2020' (Statistics Division, Department of Prisons, 2020), <http://prisons.gov.lk/web/wp-content/uploads/2020/08/prison-statistics-2020.pdf>.

90. These measures are elaborated further in Section 5.10. Legal measures taken during the COVID-19 pandemic.

As highlighted above, in 2020, 8,488 people were sentenced to a term of imprisonment of between 1 to 6 months and 487 were sentenced to 6 months to one year, which constitutes 96% of the total number of persons convicted for drug offences. Therefore, it can be assumed that nearly 96% of people convicted for drug offences who were sentenced to imprisonment for offences related to drug possession were eligible to pay a fine as a penalty and avoid imprisonment.⁹¹ Their inability to pay the fine illustrates that they are from economically marginalised groups and were likely to be people who use drugs and had small quantities in their possession. Imprisoning such persons will lead to criminalizing them and undermining any life chances they have, thereby pushing them into exploitative and precarious income generation activities upon release.

The statistics also highlight that at least 45.5% of offenders were first time offenders, while 33.8% were convicted for the second time and 20.7% offenders were previously convicted more than twice.⁹²

Age

The median age range for people convicted for drug offences is twenty-two to thirty years, with 3,413 persons falling within this category, while 2,556 persons fall within the category of thirty to forty years.⁹³

Education

The majority of people convicted for drug offences (i.e. 3,957 persons) had completed grade 5, while 2,792 persons had completed Ordinary Level and Advanced Level examinations. 492 persons had not received any schooling.⁹⁴

3.8. Drug treatment during COVID-19

Due to the COVID-19 pandemic, persons held in closed settings like drug rehabilitation centres are at higher risk of contracting the virus.⁹⁵ In this context, those with pre-existing health conditions are more vulnerable, particularly where access to health care may be limited.⁹⁶

91. For more details, please refer Section 5.2 in Chapter 5: National legal framework on drug control and treatment in Sri Lanka.

92. 'Prison Statistics of Sri Lanka 2021' (Statistics Division, Department of Prisons, 2021), <http://prisons.gov.lk/web/wp-content/uploads/2021/05/prison-statistics-2021.pdf>.

93. Ibid, page 90

94. Ibid, page 90

95. "Joint statement on COVID-19 in prisons and other closed settings", UNODC, WHO, UNAIDS and OHCHR, 13 May 2020, <https://www.who.int/news/item/13-05-2020-unodc-who-unaid-and-ohchr-joint-statement-on-covid-19-in-prisons-and-other-closed-settings>.

96. Dainius Pras, "Statement by the UN expert on the right to health on the protection of people who use drugs during the COVID-19 pandemic", *OHCHR*, 16 April 2020, <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25797&LangID=E>.

It was reported by NDDCB counsellors interviewed for this study that following the onset of the pandemic, the number of persons sentenced to drug rehabilitation by court has decreased. As a precaution, persons who are admitted to the NDDCB centres have to first undergo a PCR test and are admitted only if their test is negative. Further, new entrants are separated from other detainees to minimise the risk of an outbreak. It was also reported that when the country was placed in an island-wide lockdown in March 2020, no new entrants were admitted to the centres and persons already held at the centres were not allowed to leave until the NDDCB was provided with access to PCR testing to ensure those who were released were not infected.

3.8.1 COVID-19 cluster at the Kandakadu Drug Treatment Centre

In July 2020, a cluster of COVID-19 cases was discovered at KDC when a person who had been at the centre for three months was transferred to the Welikada Prison in Colombo and subjected to a PCR test. The test result was positive and this sparked concern because this case had been detected from outside the COVID-19 clusters that existed at the time. Subsequently, two counsellors who had visited the KDC also tested positive.⁹⁷ PCR tests were conducted on detainees, staff members at KDC and the Senapura Centre and their families. Close contacts were sent to quarantine facilities or were quarantined at home. A total of 650 confirmed cases emerged from this cluster.⁹⁸

The source of this cluster was suspected to be individuals who had been repatriated from prisons in the Middle East and were subsequently sent to KDC for drug rehabilitation.⁹⁹ The process by which these individuals had been detained at KDC was not reported.

The emergence of this cluster revealed the perception of the public towards people who use drugs. For instance, information provided by the government on this cluster referred to individuals held at KDC as “addicts”. In response to a question from the media about why detainees from KDC were not being treated at public hospitals but were instead being treated at an army-run quarantine centre that had been converted into a hospital, the Army

97. ‘252 Patients Identified at Kandakadu Rehabilitation Centre’, *Roar Media*, 10 July 2020, <https://roar.media/english/news/covid19/new-covid-19-cluster>.

98. ‘All 650 people at the Kandakadu Rehabilitation Centre Fully Recovered; NOCPCO’, *News First*, 06 October 2020, [https://www.newsfirst.lk/2020/10/06/all-650-people-at-the-kandakadu-rehabilitation-centre-fully-recovered-nocpco/](https://www.newsfirst.lk/2020/10/06/all-650-people-at-the-kandakadu-rehabilitation-centre-fully-recovered-nocpc/).

99. ‘New COVID 19 Cluster May Be Emerging at the Kandakadu Rehabilitation Centre in Polonnaruwa’, *Economy Next*, 09 July 2020, <https://economynext.com/new-covid-19-cluster-may-be-emerging-at-the-kandakadu-rehabilitation-centre-in-polonnaruwa-71788/>.

Commander Major Shavendra Silva, who is the head of the National Operation Centre for Prevention of COVID-19 Outbreak (NOCPOC), stated there were issues in “treating inmates at the rehabilitation centre at a common hospital with common patients.”¹⁰⁰ The article further reports:

“The inmates at the centre are subject to special daily treatment and often show abnormal behaviour. They need special attention in addition to normal treatment given to any other person with COVID -19. That is why the decision was taken to convert the quarantine centre into a hospital to exclusively treat these inmates,” he explained adding that with their behaviour it is difficult to maintain one-metre social distance and this could put other patients at risk if put in general wards.”¹⁰¹

In another instance, the Police Media Spokesperson Deputy Inspector General (DIG) Ajith Rohana, when discussing COVID-19 patients who had escaped quarantine facilities and hospitals where they were being held, stated that, “drug addiction is the main reason behind quarantine centre and hospital escapes”, and said that police will be paying “special attention to potential escapees, who are mostly persons addicted to drugs. All thirteen escapes reported so far were due to drug addiction.” While the KDC cluster was active, public perception as observed on social media blamed persons held in KDC for ‘spreading COVID-19’.¹⁰²

These statements indicate stigmatisation by the government of people who use drugs or are detained on drug-related offences, which permeates through to society and impacts even those undergoing treatment for dependence. Such statements are also indicative of the barriers faced by persons who have a drug dependence in accessing treatment as well as barriers to reintegrating into society after being released from treatment centres.

100. ‘The Kandakadu COVID cluster’, *Ceylon Today*, 09 July 2020, <https://ceylontoday.lk/news/the-kandakadu-covid-cluster>.

101. Ibid.

102. Kalinga Tudor Silva, ‘Stigma and Moral Panic about COVID-19 in Sri Lanka’, *Humanities and Social Sciences (JHS)* 3, no. 2 (2020), [http://pgihs.ac.lk/research/7/3.%20Prof.%20Tudor%20Silva%20\(Final\).pdf](http://pgihs.ac.lk/research/7/3.%20Prof.%20Tudor%20Silva%20(Final).pdf).

4. International human rights standards

4. International human rights standards

Sri Lanka is a party to the three key international drug control conventions: The Single Convention on Narcotics Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the 1988 United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances. Sri Lanka is also a party to the Convention on Narcotic Drugs and Psychotropic Substances adopted at the Fifth Summit of the South Asian Association for Regional Co-operation held in Male and signed in Male on 23 November 1990.

Article 38 of the 1961 Convention requires parties to “give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.” However, the provisions of the treaty must be interpreted in line with and cannot be in contravention of international human rights standards and the Universal Declaration of Human Rights (UDHR). This was confirmed by the Ministers and government representatives at the 62nd Session of the UN Commission of Narcotic Drugs where they stated, in the adopted Ministerial Declaration:

“We also reaffirm our commitment to effectively addressing and countering the world drug problem in full conformity with the purposes and principles of the Charter of the United Nations, international law and the Universal Declaration of Human Rights, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States, all human rights, fundamental freedoms, the inherent dignity of all individuals and the principles of equal rights and mutual respect among States.”

Similarly, in the Outcome Document of the 2016 United Nations General Assembly Special Session on the Drug Problem (UNGASS 2016), States committed to “ensuring that all aspects of demand reduction and related measures, supply reduction and related measures, and international cooperation are addressed in full conformity with the purposes and principles of the Charter of the United Nations, international law and the Universal Declaration of Human Rights.”

The provision of treatment for people who use drugs must therefore be compliant with human rights standards. Further commentary provided by the UNODC on the international drug conventions with regards to compulsory treatment measures states:

'The 1961 Convention never states that conviction or punishment can or should be offered as treatment. In this sense, presenting detention centres for drug users and drug dependent patients as education, treatment and rehabilitation is inappropriate. Education, treatment, rehabilitation and social reintegration should be offered as opportunities and alternatives to prison for drug users and drug dependent individuals. These interventions should not be imposed. The legislation in many States Parties and international medical standards require that all medical treatment be provided with the free "consent" of the patient. The goals of the detoxification/recovery process are not social exclusion, segregation in detention centres or application of coercive measures. Rather the aims of the Conventions are to restore citizenship and empowerment, strengthen social cohesion and promote a sense of bonding to the community. Rehabilitation steps cannot be imposed on a patient, and the process requires patience and long-term commitment.'¹⁰³

In March 2020, UNODC and WHO released a report on International Standards for the Treatment of Drug Use Disorders in line with their objectives to "support Member States in their efforts to develop and expand effective, evidence-based and ethical treatment for drug use disorders."¹⁰⁴ The standards outline the following key principles to be observed when providing treatment for drug use disorders:

- **Principle 1** - Treatment should be available, accessible, attractive, and appropriate
- **Principle 2** - Ensuring ethical standards of care in treatment services
- **Principle 3** - Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services
- **Principle 4** - Treatment should be based on scientific evidence and respond to the specific needs of individuals with drug use disorders
- **Principle 5** - Responding to the special treatment and care needs of population groups.
- **Principle 6** - Ensuring good clinical governance of treatment services and programmes for drug use disorders
- **Principle 7** - Treatment services, policies and procedures should support an integrated treatment approach, and linkages to complementary services require constant monitoring and evaluation.

103. 'Drug Policy Provisions from The International Drug Control Conventions' (UNODC, 2014), https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_57/E-CN7-2014-CRP05_V1400819_E.pdf.

104. 'International Standards for the Treatment of Drug Use Disorders' (World Health Organization (WHO) and United Nations Office on Drugs and Crime (UNODC), 2020), <https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders>.

These principles, along with the international human rights standards outlined below, will constitute the framework of analysis for drug rehabilitation and treatment in Sri Lanka.

4.1. Human rights aspects of involuntary treatment

Compulsory drug rehabilitation and treatment have been condemned by UN agencies for violating the rights of people who use drugs.¹⁰⁵

Evidence gathered from compulsory drug rehabilitation centres around the world indicates that there is no independent medical assessment conducted to affirm the need for treatment, and the period of detention is often not authorised or periodically reviewed by a judicial authority.¹⁰⁶ In many cases, persons have been detained without due process and do not have access to legal representation or means to challenge the detention. The living conditions and treatment of people at the centres can amount to inhuman living conditions due to overcrowding and lack of basic facilities, such as sanitation. The lack of oversight and independent monitoring enables the use of violence to discipline and punish people at these centres with impunity.¹⁰⁷ The treatment is often abstinence-based, with centres being run by military and police personnel rather than staff trained in drug treatment who could assist people suffering withdrawal symptoms.¹⁰⁸

For these reasons, UN agencies and international human rights organisations and mechanisms have called upon governments to close mandatory drug detention centres and establish community-based voluntary treatment measures. One of the most important developments in this regard is the joint statement issued by several UN agencies in 2012 which states that:

105. 'JOINT STATEMENT: Compulsory Drug Detention and Rehabilitation Centres', March 2012, https://unaids-test.unaids.org/sites/default/files/unaidstest/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf. International Labour Organisation; Office of the High Commissioner for Human Rights; United Nations Development Programme; United Nations Educational, Scientific and Cultural Organisation; United Nations Population Fund; United Nations High Commissioner for Refugees; United Nations Children's Fund; United Nations Office on Drugs and Crime; United Nations Entity for Gender Equality and the Empowerment of Women; World Food Programme; World Health Organisation; and Joint United Nations Programme on HIV/AIDS.

106. Joseph J Amon, Richard Pearshouse, Jane E Cohen, Rebecca Schleifer, 'Compulsory Drug Detention in East and Southeast Asia: Evolving Government, UN and Donor Responses', *International Journal of Drug Policy* 25, no. 1 (January 2014): 13–20.

107. 'Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and Lao PDR' (*Human Rights Watch*, 2012), <https://www.hrw.org/report/2012/07/24/torture-name-treatment/human-rights-abuses-vietnam-china-cambodia-and-lao-pdr>.

108. 'Human Rights and Drug Policy: A Paradigm Shift' (*Amnesty International*, 2019), <https://www.amnesty.org/download/Documents/POL3011302019ENGLISH.pdf>.

‘There is no evidence that these centres represent a favourable or effective environment for the treatment of drug dependence... The UN entities which have signed on to this statement call on States that operate compulsory drug detention and rehabilitation centres to close them without delay and to release the individuals detained. Upon release, appropriate health care services should be provided to those in need of such services, on a voluntary basis, at community level. These services should include evidence-informed drug dependence treatment; HIV and TB prevention, treatment, care and support; as well as health, legal and social services to address physical and sexual violence and enable reintegration.’¹⁰⁹

The International Narcotics Control Board in its 2017 report highlighted the need for treatment and rehabilitation as a significant component of reducing the demand for drugs. It also stated that access to drug rehabilitation should be considered a human right. Furthermore, the report affirmed that delivery of drug rehabilitation services should be undertaken in a manner compliant with human rights standards and principles observed in other areas of health-services. Thus reiterating “the right to autonomy and self-determination for patients and the principles of beneficence, non-maleficence and confidentiality on the part of care providers”.¹¹⁰

In September 2018, at the 39th session of the Human Rights Council, the Office of the High Commissioner for Human Rights submitted a report on the “Implementation of the joint commitment to effectively addressing and countering the world drug problem with regard to human rights” pursuant to Human Rights Council resolution 37/42. The report highlighted that at the 30th special session, the General Assembly recognised that “drug dependence can be prevented and treated through, inter alia, effective scientific evidence-based drug treatment, care and rehabilitation programmes and encouraged the voluntary participation of individuals with drug use disorders in treatment programmes, with informed consent”.¹¹¹

109. ‘JOINT STATEMENT: Compulsory Drug Detention and Rehabilitation Centres’, March 2012, https://unaids-test.unaids.org/sites/default/files/unaidstestorg/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf.

110. ‘Chapter I: Treatment, Rehabilitation and Social Reintegration for Drug Use Disorders: Essential Components of Drug Demand Reduction’, in *Report of the International Narcotics Control Board for 2017* (International Narcotics Control Board), https://www.incb.org/documents/Publications/AnnualReports/AR2017/Annual_Report_chapters/Chapter_1_2017.pdf.

111. ‘Implementation of the Joint Commitment to Effectively Addressing and Countering the World Drug Problem with Regard to Human Rights’, Report of the Office of the United Nations High Commissioner for Human Rights (OHCHR) A/HRC/39/39, 14 September 2018, <https://www.ohchr.org/EN/HRBodies/HRC/Pages/WorldDrugProblemHRC39.aspx>.

Several key human rights concerns related to compulsory drug treatment were highlighted by the UN High Commissioner for Human Rights in her statement at the Harm Reduction International Conference in 2019. She pointed out that:¹¹²

“People who use drugs are also frequently subjected to arbitrary detention or related abuses by law enforcement agencies. Compulsory drug detention centres are inconsistent with human rights law, often involving multiple forms of human rights abuse, and they require comprehensive review and replacement with voluntary services in the community. People do not lose their human rights because they use drugs. They have the same rights as all of us: to health and to life; to non-discrimination; to freedom from arbitrary arrest and detention; and to freedom from torture and other forms of ill treatment, among others.”

In June 2020, a joint statement was released by UN agencies highlighting that persons held in compulsory drug and rehabilitation centres are particularly at risk of contracting COVID-19 due to overcrowding and associated difficulties that prevent effective implementation of social distancing measures. The statement also notes reports of “forced labour, lack of adequate nutrition, physical and sexual violence, and denial or comparatively lower access to and quality of healthcare services” at such centres. It reiterated its call to Member States to “permanently close compulsory drug detention and rehabilitation centres and to transition to an evidence-informed system of voluntary community-based treatment”¹¹³ in line with international human rights standards.

Drug treatment with legal safeguards, including due process, the right consent to the treatment and to choose treatment options, as well independent monitoring of treatment centres have “been found to be more effective than imprisonment in encouraging recovery from drug dependence and reducing drug-related crime. It can be provided in ways that do not violate the rights of the patients, provided that the decision to refuse treatment remains in the hands of the drug user and the patient’s autonomy and human rights are respected.”¹¹⁴ Rights violations as a result of compulsory drug rehabilitation constitute those set out below.

112. ‘Statement by UN High Commissioner for Human Rights Michelle Bachelet’, *OHCHR*, 2019, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24529>.

113. “Joint Statement Compulsory Drug Detention and Rehabilitation Centres in Asia and The Pacific in The Context of COVID-19, June 1, 2020 - World”. 2020. Reliefweb. Accessed September 7. <https://www.who.int/news/item/01-06-2020-compulsory-drug-detention-and-rehabilitation-centres>

114. “From Coercion to Cohesion: Treating Drug Dependence through Health Care, Not Punishment’, *Discussion Paper* (UNODC, 2010), https://www.unodc.org/docs/treatment/Coercion/From_coercion_to_cohesion.pdf.

4.1.1. Arbitrary detention

The International Covenant on Civil and Political Rights (ICCPR), to which Sri Lanka is a state party, affirms the right against arbitrary deprivation of liberty of all persons.¹¹⁵ In instances where persons are deprived of their liberty, the following safeguards must be in place to ensure the detention is not unlawful or arbitrary. Article 10 of the ICCPR requires that all persons deprived of their liberty are treated with humanity and respect for the inherent dignity of the human person.

Primarily, the deprivation of liberty must be in accordance with procedure established by law. This is further elaborated in General Comment No. 35 of the UN Human Rights Committee on Article 9 — the right to liberty and security — which states that the purpose of detention may be enacted by statute but may still be arbitrary based on elements of “reasonableness, necessity and proportionality”¹¹⁶. The detention period must also be subject to a periodic judicial re-evaluation of the justification for continuing detention,¹¹⁷ and victims of unlawful detention shall have the enforceable right to compensation.¹¹⁸ The General Comment specifies that these standards must be applied to all detention by official action or pursuant to an official authorisation, including “detention for drug addiction and other forms of administrative detention”¹¹⁹.

General Comment 35 affirms that extended periods of detention could constitute arbitrary detention and pre-trial detention should be used only in exceptional circumstances and should not be the norm. This is relevant with regard to pre-trial detention of people who use drugs as the General Comment states:

“It should not be the general practice to subject defendants to pretrial detention. Detention pending trial must be based on an individualized determination that it is reasonable and necessary taking into account all the circumstances, for such purposes as to prevent flight, interference with evidence or the recurrence of crime. The relevant factors should be specified in law and should not include vague and expansive standards such as “public security”. Pretrial detention should not be mandatory for

115. Article 9, ICCPR

116. General Comment No.35 - Article 9: Liberty and Security of Person, *Human Rights Committee*, 2014, <https://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC35-Article9LibertyandSecurityofperson.aspx>.

117. Ibid

118. Article 9 (5), ICCPR

119. General Comment No.35 - Article 9: Liberty and Security of Person, *Human Rights Committee*, 2014, <https://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC35-Article9LibertyandSecurityofperson.aspx>.

all defendants charged with a particular crime, without regard to individual circumstances. Neither should pretrial detention be ordered for a period based on the potential sentence for the crime charged, rather than on a determination of necessity.”¹²⁰

In its 2015 Annual Report, the UN Working Group on Arbitrary Detention affirmed that drug consumption is not sufficient justification for detention and described compulsory drug treatment thus:

“This translates into administrative drug detention justified on the basis of health grounds, which can lead to involuntary commitment or compulsory drug treatment that is unsupported by either international drug control conventions or international human rights law. It has been established that detention and forced labour are not scientifically valid means to treat drug dependence. Compulsory detention regimes for purposes of drug “rehabilitation” through confinement or forced labour are contrary to scientific evidence and inherently arbitrary. Drug consumption or dependence is not sufficient justification for detention. Involuntary confinement of those who use or are suspected of using drugs should be avoided.”¹²¹

The standards on involuntary hospitalisation on the basis of medical grounds, which is not absolutely prohibited under international law, but is allowed in very limited circumstances and with strict safeguards, would also be relevant when discussing involuntary treatment. In this regard, the Human Rights Committee, in General Comment No. 35 states that community-based alternatives to confinement should be available for persons with ‘psychosocial disabilities’. In relation to deprivation of liberty for purposes of medical treatment, the General Comments further highlights that:

“It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual. The individuals must be assisted in obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to prevent conditions of detention incompatible with the Covenant.”¹²²

120. Ibid.

121. ‘Report of the Working Group on Arbitrary Detention’ (UN Human Rights Council, 10 July 2015), <https://www.ref-world.org/docid/55f7d5844.html>. Emphasis added.

122. General Comment No.35 - Article 9: Liberty and Security of Person, Human Rights Committee, 2014, <https://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC35-Article9LibertyandSecurityofperson.aspx>.

4.1.2. Torture and ill-treatment

Freedom from torture is guaranteed by the UDHR, Article 7 of the ICCPR and the Convention Against Torture (CAT), which declares the right of all persons not to be subject to torture, inhuman, degrading treatment and punishment as absolute and not subject to any limitations or derogations. The right against torture is also considered a *jus cogens* norm in international law, and therefore applicable to all states, irrespective of whether they have ratified a convention in that regard.

The UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment has highlighted that “forcible testing of people who use drugs without respecting their autonomy and their right to informed consent may constitute degrading treatment, especially in detention settings. States are obliged to respect the enjoyment of the right to health, including by refraining from using coercive medical treatment. The requirement of informed consent, including the right to refuse treatment, should be observed in administering any treatment for drug dependence”.¹²³

The Special Rapporteur further stated that detention for the purpose of drug rehabilitation, and measures such as forced labour, may constitute inhuman treatment, particularly where evidence-based and effective treatment options are denied to persons who are dependent on drugs. He said that:

“Compulsory treatment programmes that consist primarily of physical disciplinary exercises, often including military-style drills, disregard medical evidence (A/65/255, paras. 31, 34). According to the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC), “neither detention nor forced labour have been recognized by science as treatment for drug use disorders”. Such detention – frequently without medical evaluation, judicial review or right of appeal – offers no evidence-based or effective treatment. Detention and forced labour programmes, therefore, violate international human rights law and are illegitimate substitutes for evidence-based measures, such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent (A/65/255, para. 31). The evidence shows that this

123. ‘Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment’ (UN Human Rights Council, 1 February 2013), <https://www.refworld.org/docid/51136ae62.html>.

arbitrary and unjustified detention is frequently accompanied by – and is the setting for – egregious physical and mental abuse.

A particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment, including as a way of eliciting criminal confessions through inducing painful withdrawal symptoms (A/HRC/10/44 and Corr.1, para. 57). The denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances (*ibid.*, para. 71). By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependence and of the scientific evidence pointing to the ineffectiveness of punitive measures.”¹²⁴

4.1.3. Right to health

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is ensured by Article 12 of the International Convention on Economic, Cultural and Social Rights, of which Sri Lanka is a state party. This is further elaborated by General Comment No. 14 of the Committee on Economic, Social and Cultural Rights on Article 12, which affirms that the right to health also includes the right to be free from non-consensual medical treatment, i.e. the right to refuse healthcare. The right against coercive medical treatment can be restricted only on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases.

The UN Special Rapporteur on the Right to Health, in a submission to the UN Committee Against Torture,¹²⁵ while emphasising the need to view drug dependence as a medical condition, affirmed the rights of people who use drugs to the same ethical standards for medical treatment as persons with other health conditions. This includes the patient’s right to autonomy and self-determination and the treating staff’s obligations of beneficence and non-maleficence. In his submission, the Special Rapporteur further stated:

124. *Ibid*

125. ‘Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health’ (OHCHR, 2012). <https://www.ohchr.org/Documents/Issues/Health/drugPolicyLaw.pdf>.

“Incarceration and/or compulsory treatment is often imposed on people regardless of their drug-dependent medical and health condition. Forced labour, solitary confinement and experimental treatment administered without consent may violate international human rights law, including the right to health and the right to be free from torture, and cruel, inhuman or degrading treatment or punishment. These are illegitimate substitutes for evidence-based measures such as substitution therapy, psychological interventions and other forms of treatment administered with full, informed consent.”¹²⁶

Similarly, the International Guidelines on Human Rights and Drug Policy reiterate that the state obligation to “Ensure that voluntary, informed consent is a precondition for any medical treatment or preventive or diagnostic intervention and that drug use or dependence alone are not grounds to deprive someone of the right to withhold consent” stem from the right to health.¹²⁷

A discussion paper published by UNODC in September 2015 on “Transition from compulsory centres to voluntary community-based treatment and services”¹²⁸ succinctly summarises the entitlement of persons, including people who use drugs, to the highest standard of attainable healthcare:

“Fundamentally, for any treatment to be considered ethical, it must minimize the risks of unnecessary harm to the client and be in the best interests of the client, including considerations such as freedom from arbitrary detention, torture, and other forms of cruel, inhuman or degrading procedures. As noted above, compulsory centres for drug users have at times been associated with significant ethical violations. Finally, clinical ethics require providers to maintain confidentiality and safeguard the privacy of clients. Compliance with human rights instruments will also increase the potential to achieve positive results in advancing the welfare and quality of life of people who use drugs.”¹²⁹

126. Ibid

127. ‘International Guidelines on Human Rights and Drug Policy’ (International Centre on Human Rights and Drug Policy, United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the World Health Organization (WHO), March 2019), https://www.humanrights-drugpolicy.org/site/assets/files/1640/hrdp_guidelines_2020_english.pdf.

128. ‘Transition from compulsory centers for drug users to voluntary community-based treatment and services’, (UN-ODC, 2015), https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/hiv/Discussion_Paper_on_Transition_from_CCDUs_Edited_Final4_04Sept15.pdf.

129. Ibid.

Conclusion

According to international human rights standards, compulsory detention and treatment violate multiple rights of people who use drugs. These include the right against arbitrary detention, the right to be free from torture, cruel, inhuman or degrading treatment or punishment, as well as the right to the highest attainable standard of health, and the right to be free from discrimination. To protect the rights of people who use drugs, the provision of community-based options, including harm reduction services where individuals do not have to undergo the painful process of abstinence and suffering induced by withdrawal, in line with international human rights standards, is recommended as an effective public health strategy. The International Standards for Drug Abuse Disorders, while affirming the need for community-based treatment options, highlights the following standards to be followed with regards to the treatment of drug dependence:

“Treatment of drug use disorders should be based on the universal ethical standards – respect for human rights and dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being, ensuring non-discrimination, and removing stigma. The choice to start treatment should be left to the individual. Treatment should not be forced or against the will and autonomy of the patient. The consent of the patient should be obtained before any treatment intervention. Accurate and up to date medical records should be maintained and the confidentiality of treatment records should be guaranteed. Punitive, humiliating or degrading interventions should be avoided. The individual affected should be recognized as a person suffering with a health problem and deserving treatment similar to patients with other psychiatric or medical problems.”¹³⁰

130. ‘International Standards for the Treatment of Drug Use Disorders’ (WHO and UNODC, 2020), <https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders>.

5. National legal framework on drug control and treatment in Sri Lanka

5. National legal framework on drug control and treatment in Sri Lanka

This section will review the national legal framework on drug offences and its implementation. The domestic legal and policy framework related to drug treatment will also be examined to evaluate whether they adhere to international and national human rights standards.

5.1. Arrest and detention for drug offences

As highlighted in previous chapters, illicit drugs have become a political tool the government uses to justify the increased militarisation of the law and order apparatus, particularly drug control, drug-related incarceration and compulsory rehabilitation.

The PNB is the primary law enforcement entity responsible for drug-related arrests and detention as well as conducting criminal investigations into drug cases. According to lawyers who work on drug-related cases who were interviewed for this study, there are three main ways in which the police conduct arrests of persons suspected to have committed drug offences:

- 1) Stop and search persons suspected of carrying drugs and arrest them pursuant to the laws discussed below if they are found in possession of narcotics;
- 2) Conduct a police raid of premises, vehicles, etc. when they receive a tip about a supply of drugs, and arrest persons found in possession of drugs; or
- 3) Purchase narcotics undercover and apprehend the dealer in the act.

The Police Department publishes periodic statistics on the number of arrests and raids conducted, as well as the number of arrests for drugs. Raids conducted by the police as well as the haul of drugs seized are reported by media outlets and widely publicised.

In practice, several systemic and socio-political elements render the arrest and detention process vulnerable to abuse and corruption. For instance, prisoners interviewed by the HRCSL reported malpractice and misconduct by police during arrest and detention.¹³¹ Persons who were arrested on drug-related charges stated they were beaten by the police during arrest and detention. Women, in particular, alleged they were subjected to invasive

131. Human Rights Commission of Sri Lanka, 'Arrest and Detention', in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

body cavity searches by female police officers during the arrest process. A common allegation was that the police plant drugs to frame persons. Those interviewed for the HRCSL prison study stated that when they were arrested with small quantities of heroin, which did not meet the requisite quantity threshold to be charged under Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance, the police added to the quantity of drugs to increase the weight of the drugs. If facts are reported to court under Section 54, which is a non-bailable provision, the person would have to spend many months in remand (discussed in detail below).

Allegations of misconduct were also reported by two leading lawyers interviewed for this study, who described the shortcomings in the manner in which police raids are conducted. According to them, each police station maintains three or four “information books” in which police officers are required to record details of arrests and detention of suspects. One information book is reserved for police raids, and police officers are required to attach an arrest note outlining details of the raid when they return to the police station. However, many officers reportedly do not follow this procedure. Instead, months later, when details of the raid are required for judicial proceedings, police officers reportedly complete the note with inaccurate information and present it in court. This makes it difficult to trace the sequence of events and determine, for instance, the time the police returned to the station after the raid.

The PNB has a similar book, the “Police Narcotics Book”, which is required to have a copy of all notes related to drug-related arrests and raids, but reportedly officers do not complete this task on time. Once again, it was said there are instances when information is added to the book only when it is required for court proceedings. A lawyer interviewed for this study narrated a personal experience of going to the police station to consult the crime notebook to check the details of an arrest that occurred in 2012, only to find that the notebook in which the officer had recorded the details was printed in 2013. The particular book which contained details of the arrest had not even been printed at the time the arrest occurred. As a result, the accused in the case was acquitted and the prosecuting counsel did not call the police to the witness box to address the discrepancy.

This pattern is validated by both HRCSL recommendations on complaints regarding police action as well as the judgments. For instance, in May 2021, in a drug-related case, a judge discharged the defendant, who was held in remand prison for three years and seven months, without even hearing the arguments of the defence because the evidence presented by the police could not be corroborated for numerous reasons, including the lack of a proper police

report after the raid was conducted.¹³² Recommendations issued by the HRCSL regarding complaints of torture and arbitrary arrest and detention also indicate discrepancies and irregularities in the records maintained by the police. For example, there have been instances when the time of arrest in the testimony provided by the police officer contradicted the time of arrest in the police records, and the reason for arrest mentioned in the police record contradicted the reason mentioned in the B report¹³³ submitted to the court.¹³⁴

An interviewee described the entire process as follows: “The way the police conduct raids is very primitive. All the police need is a pen and paper and they can make a good raid note and good inward entry and outward entry – then it becomes difficult to convince the judge that the person is innocent”.

Sri Lanka’s approach to drug control has become increasingly punitive, leading to arrests consistently increasing annually. For example, the Auditor General’s report for the Police Department states that in 2019 the number of “persons arrested in relation to heroin offences increased by 8,672” in comparison to 2018.¹³⁵ Since 2019, when the government intensified the war on drugs rhetoric, it has been reported that drug-related arrests and police raids have increased.¹³⁶ As an interviewee described:

“In the news at least 20-30% of the coverage is about drug offences and the underworld. That gives other police officers incentive to conduct more raids or even fake raids to impress the government. To impress their senior officers. Police officers refer to the list of people who have pending cases or previous convictions, and they go and search for those persons, and arrest them again and frame them to impress their seniors.”

The law too incentivises police to conduct more arrests. For instance, Section 78 A of the Poisons, Opium and Dangerous Drugs Ordinance states that “there shall be paid to the Police Reward Fund established under Section 73 of the Police Ordinance one-third of each and every fine recovered for any offence committed under this Ordinance.”

132. ‘Person from Gampola with Drug Related Charges Acquitted’, *Divaina*, 13 May 2021 (Translation of Sinhala article.

133. A ‘B report’, as outlined in Section 136 (b) of the Code of Criminal Procedure refers to a written report issued by the police to initiate proceedings in a Magistrate’s Court which outlines details of the reasons for an individual’s arrest.

134. HRC/K/08/16; HRC/2868/14

135. National Audit Office, “Head 225 - Sri Lanka Police”, 2019, http://www.auditorgeneral.gov.lk/web/images/audit-reports/upload/2019/mindept_19/1-XXI/Head225SriLankaPoliceE.pdf.

136. ‘Over 75,000 Arrested in Drug Related Offences’, *The Morning*, 26 February 2021, <http://www.themorning.lk/over-75000-arrested-in-drug-related-offences/>; ‘Prisons Resources Fully Stretched’, *The Morning*, 06 September 2020, <https://www.themorning.lk/prisons-resources-fully-stretched/>.

Reportedly, the police hierarchy decides the officers to whom rewards should be given. Therefore, the police may be inclined to conduct more arrests of persons who possess drugs to receive rewards for their service in ‘eradicating the drug menace’.

These examples illustrate the lack of accountability and oversight of the functions of the Police Department, which not only creates space for corruption and malpractice but also compromises the integrity of the criminal justice process. In this context, the allegations by persons that they were framed for drug offences appear credible. Moreover, the arrests of several PNB officers for engaging in drug-related illegal activities call into question the integrity of all past investigations conducted by the PNB and casts reasonable doubt on the integrity of the evidence upon which persons were convicted. There is no publicly available information on whether the Attorney General’s Department has reviewed the evidence provided by these officers in cases where indictments are yet to be issued or have been issued and trials have not begun.

Many interviewees said that it is not uncommon for people who are known to use drugs to become targets of the police for arrests. An interviewee with a history of drug use noted, “You can’t even walk on the street without them (the police) checking you. Wherever they see you, they take you. You don’t need to have anything in your possession”. In this manner, people who use drugs are criminalised, stigmatised and targeted when the state adopts a punitive law-and-order approach to drug treatment and prevention.

5.2. Poisons, Opium and Dangerous Drugs Ordinance (No. 13 of 1984)

The Poisons, Opium and Dangerous Drugs Ordinance (No. 13 of 1984) is the principal law on the classification and regulation of drugs and narcotic substances. The Poisons, Opium and Dangerous Drugs Ordinance was enacted nearly forty years ago when drug use and trafficking patterns in Sri Lanka were vastly different to today. Therefore, its provisions are not suited to address current issues related to drug control. Further, certain provisions criminalise and contribute to the incarceration of people who use drugs and those with drug dependence, which adversely impacts their rights as well as their ability to voluntarily access treatment.

The following provisions of the Ordinance are key sections that are applicable in the national framework for drug-related offences.

Section 52	Criminalises unauthorised possession and consumption of dangerous drugs outlined in the Ordinance.
Section 54	Criminalises unauthorised administering, selling, supplying, or procuring any dangerous drug.
Section 54A	Possession, trafficking, import and export of narcotic substances set out in Column II Part III of the Third Schedule to the Act is an offence punishable by death or life imprisonment.
Section 78 (5)	General penalty for all offences under the Ordinance (except Section 54A) (a) on summary conviction by a Magistrate, a fine not less than Rs. 1,000 (5.1 USD) and not exceeding Rs. 10,000 (51.7 USD) or to imprisonment for a period not exceeding five years or to both such fine and imprisonment; (b) on conviction before the High Court, a fine not less than Rs. 10,000 (51.7 USD) and not exceeding Rs. 25,000 (126.2 USD) or to imprisonment for a period not less than six months and not exceeding seven years, or to both such fine and imprisonment.
Section 83	Persons suspected or accused of an offence under Section 54A cannot be released on bail, except by the High Court under exceptional circumstances.
Third Schedule	Punishment of death or life punishment can be imposed for offences involving: morphine (more than 3g), heroin (more than 2g), cocaine (more than 2g) and opium (more than 500g).
	A quantity of more than 5kg of cannabis is punishable by a fine between Rs. 25,000 (126.2 USD) and Rs. 50,000 (252.4 USD) and/or a term of imprisonment between two to five years.

While Section 52 and 54A both contain offences related to the possession of drugs, in practice, according to lawyers, Section 52 is no longer used. Section 54 of the Act sets out the offences of selling, supplying or procuring, or offering to undertake any of the aforementioned three acts. Yet, in practice this section is also reportedly not used.

An important point to note is that Section 78 (5) is the penalty provision for all offences in the Ordinance, except offences under Section 54A. Hence, Section 78 (5) does not set out any offences. However, in practice, if a B report is not filed under Section 54A, the

person is sentenced to penalties stipulated in Section 78 (5). In instances of possession, the sentencing order does not mention the specific offence/the section under which the person pleaded guilty, but mentions only that the person is declared guilty, the fine amount and that information was reported under Section 78 (5).

In 2012, the Attorney General issued instructions to the police on instituting legal proceedings regarding offences related to heroin, cannabis, and other drugs. Prior to the issuance of these instructions, the police's decision under which law to file charges, i.e. under 78 (5) or Section 54A, was reportedly arbitrary.

In instances where the police filed charges under Section 54A, even if the net weight turned out to be a negligible amount, the case file would have to be sent to the Attorney General's Department because the B report was filed under Section 54A. This increased the workload of the Department. The aim of the circular was therefore reportedly to reduce the discretion of the police in relation to deciding under which law the case was to be filed, as well as reduce the workload of the Attorney General's Department.

5.2.1. Attorney General's instructions, May 2012

According to the Attorney General's instructions issued in May 2012, if the Government Analyst report states that the net weight is more than 500mg of heroin, the person will be indicted under Section 54A. In instances where the net weight is less than 500mg but there is 'clear evidence of trafficking' or the person has similar prior convictions or three or more pending cases and is "not an addict", the person will be indicted under Section 54A. If found in possession of cannabis of less than 1kg net weight but more than 500g net weight and there is 'clear evidence of trafficking' or the person has three prior convictions or pending cases the person will be indicted under the aforementioned provision.

In the instructions, the Attorney General states that a distinction should be made between trafficking and selling and that "it is appropriate to consider small scale selling of a few packets of drugs to be "selling". The distinction was reportedly made due to all cases being construed as trafficking and being filed under Section 54A resulting in a large number of files being sent to the Attorney General's Department for indictment. Therefore, the instructions were issued to divert some cases to Magistrate's Court in order to avoid long trials.

Following the issuance of these instructions, in practice, in instances where the gross quantity of heroin found in an individual's possession was more than 500mg, the police would file a B report under Section 54A. When the B Report is filed under Section 54A, the evidence (i.e. the drugs found) is sent to the Government Analyst's Department to determine the purity of the narcotic substance.

If the Government Analyst finds the net weight of heroin to be less than 500mg, the file will be sent to the Magistrate's Court and the person will be charged under Section 78 (5)(a) of the Ordinance. The maximum penalty that can be awarded is a fine of Rs. 10,000 (51.7 USD) and/or imprisonment for up to five years. Often, once the person pleads guilty to the charge, the judge may award a fine and allow the person to be released upon payment of the fine. Thus, a person would have spent many months or even a year in remand, only to be released with a fine. If the gross quantity is over 500mg but under 1g then it is possible to obtain bail via the Release of Remand Prisoners Act; this will be discussed in section 4.5 on bail for drug offences.

A factor that is not stipulated in the instructions but in practice reportedly influences the decision regarding the section under which the case will be filed, is how the person was apprehended. If the person was arrested on a tip off during a raid, or an informer/decoy was used to purchase narcotics from the suspect and they were arrested during a drug deal, the case against the suspect may be filed as an offence of sale or trafficking.

According to a lawyer who represents persons charged with drug offences, in practice, when persons are found in possession of less than 500mg gross police usually present the facts of the case to the Magistrate under Section 78 (5) of the Ordinance.

In such cases, the charges would be filed and upon admission of guilt by the person, a fine would be imposed by the Magistrate as a penalty and the person would be released the same day. Although the section stipulates that the Magistrate may impose a fine or term of imprisonment or both, it is reportedly very rare that the Magistrate imposes a sentence of imprisonment on the person when the person pleads guilty. This is because the person pleads guilty based on the understanding that the court will impose a fine and/or imprisonment but the sentence is suspended for a number of years at the discretion of the Magistrate. The amount payable as fine is at the discretion of the Magistrate, but factors such as past convictions will be taken into consideration and a higher fine may be awarded in that regard, up to a maximum of Rs. 10,000 (51.7 USD).

If the Magistrate suspends the sentence for a stipulated period, for example, for five years, the term of imprisonment will be suspended for five years on the condition that the s/he does not commit a criminal offence, as outlined in Section 303 of the Code of Criminal Procedure.¹³⁷ The case of *Kumara v Attorney General* which was heard in the Court of Appeal held that where persons plead guilty and s/he has no previous convictions, these factors should be considered as mitigating factors in sentencing and a suspended sentence should be considered. The Court held that:

“Suspended sentence with its connotation of punishment and pardon is supposed to have integrative powers. The offender is shown that he has violated the tenets of society and provoked its wrath, but is immediately forgiven and permitted to continue to live in society with the hope that he would not indulge in that form of behaviour again.”¹³⁸

If the person commits another offence within five years, s/he is at the risk of being sentenced to imprisonment for the new offence as well as being required to serve the imprisonment for the previous offence.

As reported by a lawyer, it very unlikely that persons would plead not guilty to the charge, even if they have not committed the offence, because the admission of guilt is highly incentivised by systemic factors within the legal process. Firstly, Magistrate’s Courts around the country are overburdened – especially courts in the Western Province where the number of drug-related cases are highest. As pointed out by this lawyer, around 70% of cases each day in Magistrate’s Courts in Colombo are related to drugs, and each day there may be around 500 to 600 cases being heard in court within five hours. In such an environment, pleading guilty is the quickest and most attractive option as the suspect may be released immediately upon the payment of a fine and the case can be concluded within minutes.

On the other hand, if a person pleads ‘not guilty’ after facts are reported under Section 78 (5), the Magistrate may order a fingerprint report of the suspect to be undertaken and call for the Government Analyst report on the pure quantity of the drug. Due to the administrative delays in the Police Department and the Government Analyst Department,

137. Section 303 of Code of Criminal Procedure

138. *Kumara v Attorney General*, CA 50/2001

the case may continue for months. The person even runs the risk of being detained in remand prison for at least seven days if the judge refuses to grant bail. Therefore, no person would be willing to be detained when they can be released the same day upon the payment of a fine. Over time, the Magistrate's Court has illustrated through practice that for small quantities of heroin, pleading guilty would result in a fine and/or suspended sentence and would result in the case being concluded immediately, whereas pleading not guilty would result in the case being prolonged for several months.

5.2.2. Impact of penalties imposed under Section 78 (5)

If a person is unable to pay the fine imposed under Section 78 (5), they are liable to be imprisoned for up to 6 months in lieu of the fine, which is the maximum period for which imprisonment can be imposed in lieu of non-payment of fines as per Section 291 of the Criminal Procedure Code Act (No. 15 of 1979). In such cases, the person will be sent to prison and the term of imprisonment will come to an end if the fine is subsequently paid or the sentence period will have to be served.

It must be highlighted that in cases where the person is imprisoned in lieu of payment of the fine, Section 291(4) of the Code of Criminal Procedure allows the court to:

- Allow time for the payment of the said fine;
- Direct payment to be made of the said fine by instalments; or
- Direct that the person liable to pay the said fine shall be at liberty to give to the satisfaction of the court a bond, with or without a surety or sureties, for the payment of the said fine or any instalment thereof, and such bond may be given and enforced in a manner provided by this Code.

Despite this provision, as reported by the Department of Prisons, in 2020 nearly 73.8% of prisoners were convicted for non-payment of fines. According to the report of the HRCSL study of prisons, judges may be disinclined to use the abovementioned provisions as that would result in the case file being kept open for longer, whereas imprisoning an offender in lieu of the fine would result in a swift conclusion of the case.¹³⁹ This is also contrary to

139. Human Rights Commission of Sri Lanka, 'Legal and Judicial Proceedings', in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

the judgement of the Court of Appeal in *Kumara v Attorney General* referred to above, where the court held that ‘no offender should be confined to in a prison unless there is no alternative available for the protection of the community and to reform the individual’¹⁴⁰.

In cases filed under Section 78 (5), the Magistrate also has the power to sentence the person for compulsory drug rehabilitation under Section 10 of the Drug Dependents (Treatment and Rehabilitation) Act, or for drug rehabilitation under the Community Based Corrections Act (discussed in detail below). Compulsory drug rehabilitation can be imposed at the discretion of the Magistrate or upon the request of the family. The person himself can also request to undergo rehabilitation. However, as stated by a lawyer interviewed for this study, “only people who don’t have a single cent in their hands request for rehabilitation.” Even in these cases, the treatment cannot be construed as ‘voluntary’ as when a person feels compelled to undergo drug rehabilitation because they cannot pay the fine and wishes to avoid a prison sentence, the consent cannot be deemed to be free and without duress. Therefore, the treatment still amounts to compulsory rehabilitation.

5.2.3. Post-indictment under Section 54A

Where persons are indicted at the High Court under Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance, the trial will commence. A noted feature of the criminal justice process in Sri Lanka is that criminal cases continue for years before they are concluded,¹⁴¹ and persons may have to spend the entirety of this period in remand prison if they are not able to obtain bail.

The penalties for an offence under Section 54A are outlined in Schedule Three of the Poisons, Opium and Dangerous Drugs Ordinance, which stipulates the sentence of death or life for cases involving net amounts of 2g or more of heroin, 2g or more of cocaine, 3g or more of morphine and 500g or more of opium. As highlighted by the lawyer who represents persons arrested for drug offences, 2g of heroin was considered a large amount in 1986 when Section 54A of the Act came into force and the death penalty was prescribed as punishment. However, since then, heroin has become more accessible and the use of drugs in society has also increased. In the present context, 2g of heroin can be considered a ‘user quantity’ but a person found in the possession of more than 2g net of heroin, even if it is for their personal use rather than trafficking, runs the risk of being sentenced to death.

140. CA 50/2001

141. Human Rights Commission of Sri Lanka, ‘Legal and Judicial Proceedings’, in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

5.3. The Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act (No. 1 of 2008)

During the last ten to fifteen years, the drug use profile in Sri Lanka has increasingly shifted towards the use of synthetic drugs, such as methamphetamines or meth, often referred to by its street name 'ice'. The price of ice is cheaper than heroin and less ice is required in quantity, compared to heroin, to reach levels of intoxication.

The Poisons, Opium and Dangerous Drugs Ordinance does not include offences involving synthetic drugs. To address this gap and to give effect to the 1988 Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances and the SAARC Convention, the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act (No. 1 of 2008) was enacted in 2008. The offences set out in the Act are as follows:

2. (1) Any person who, whether in or outside Sri Lanka, and whether he is a citizen of Sri Lanka or not, intentionally—

(a) produces, manufactures, extracts, prepares, offers, offers for sale, distributes, sells, delivers, acts as broker for the supply of, dispatches, dispatches in transit, transports, imports or exports or traffics any narcotic drugs or psychotropic substances;

(b) cultivates opium poppy, coca bush or the cannabis plant, for the purposes of the production of any narcotic drug;

(c) possesses or purchases any narcotic drug or psychotropic substance, for any of the purposes described in paragraph (a);

(d) procures, manufactures, stores, transports, sells, delivers or distributes any equipment, material or any substance, set out in Table I or Table II of the First Schedule to this Act, knowing that it is to be used in, or for, the unlawful cultivation, production or manufacture of, any narcotic drug or psychotropic substance;

The offences of organising or financing the commission of offences under the Act carry a sentence of imprisonment to a term not less than ten years and not exceeding fifteen years.

The offence of trafficking, while included in the English translation of the statute in Section 2(a), is not mentioned in the Sinhala version of the statute, and as per Section 32 of the Act, in cases where there is any inconsistency between translations of the Acts, the Sinhala version will prevail. Therefore, the 2008 Act does not stipulate trafficking as an offence, and according to a lawyer representing persons arrested for drug offences, persons arrested for trafficking may instead be charged with the offence of possession or aiding and abetting in the commission of an offence.

Although the Act requires the offence of possession outlined in subsection (c) to be for any of the purposes described in subsection (a), in practice, persons who are found in the possession of synthetic substances even for their own use, will be charged under this Act. Until the decision of the Court of Appeal in case No. 87/2019 was issued, in practice, the police were charging persons in possession of synthetic drugs under Section 54A of the Poisons, Opium and Dangerous Drugs Act, instead of the Convention Against Illicit Traffic in Narcotics Drugs Act. Following a challenge to the Court of Appeal in 2019 by a person who was charged under the wrong law, the police reportedly no longer charge persons in possession of synthetic narcotic substances under the Poisons, Opium and Dangerous Drugs Act.¹⁴²

Section 4 of the Act enshrines the rights of persons who are not citizens of Sri Lanka to be able to communicate without delay with representatives of their respective countries and to be visited by these representatives. This is an important protection for foreign nationals who are arrested under the Act, particularly because, foreign nationals arrested in Sri Lanka often report delays in being able to access their consular representatives.¹⁴³

Although the Act does not stipulate quantities in relation to the offences or penalties, according to the 2012 Attorney General's instructions, when the net weight of amphetamine or methamphetamine is higher than 100g, it must be reported to Court that the accused had committed an offence under Section 2 of the Conventions Against Illicit Traffic in

142. In the aforementioned case, the suspect was a foreign national who was found in possession of 500g of ice and the case was filed under Section 54A of the Poisons, Opium and Dangerous Drugs Act. As a result of this, he was held in remand prison for several months because bail cannot be granted by the Magistrate's Court under Section 54A. He appealed to the Magistrate, who stated he had no power to direct the police to file it under a specific act. The appeal reached the Court of Appeal where the judge and prosecuting officer both agreed that the case should be filed under the provisions of Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act under which the Magistrate has the jurisdiction to grant bail. Case reference: CA (PHC) APN: 87/2019

143. Human Rights Commission of Sri Lanka, 'Foreign Nationals', in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

Narcotic Drugs and Psychotropic Substances Act as well as under the Poisons, Opium and Dangerous Drugs Ordinance, and proceedings must be instituted in the High Court under the Convention Against Illicit Traffic in Narcotic Drugs. Bail for offences in the Traffic in Illicit Narcotics Act will be discussed in section 5.4 on bail for drug offences.

The 2012 instructions issued by the Attorney General state that in cases where the weight of amphetamine or methamphetamine is less than 100g, proceedings should be instituted in the Magistrate's Court under Poisons, Opium and Dangerous Drugs Ordinance as amended by Act No. 13 of 1984, i.e. Section 78 (5).

Interviewees also reported that the police do not file cases involving heroin, cocaine and cannabis under the Convention on Illicit Traffic in Narcotic Drugs Act, although the Act applies to offences involving the aforementioned three drugs as well because it is less punitive – i.e. suspects may be able to obtain bail from the Magistrate's Court. For instance, under the Poisons, Opium and Dangerous Drugs Ordinance a person in possession of 2g of heroin runs the risk of being sentenced to death.¹⁴⁴ Whereas according to the Convention on the Illicit Traffic in Narcotic Drugs, a person found with several hundred kilograms of synthetic drugs can be awarded a maximum of fifteen years imprisonment as punishment. This can lead to arbitrary and disproportionate outcomes. In March 2021, there were reports that the government is considering a legislative amendment to include the death penalty as a punishment for trafficking ice since more persons have reportedly begun trafficking ice due to the comparatively less severe sentence.¹⁴⁵

It should be stressed that the death penalty for drug offences or offences involving drug trafficking is in contravention of international human rights standards as well as the international drug control conventions, which have concerns for the health and welfare of mankind at their core and stipulate that national drug control laws and policies must be in line with international standards.¹⁴⁶

144. Schedule 3, Poisons, Opium and Dangerous Drugs Ordinance.

145. 'The Gallows for "Ice"', *Divaina*, 14 March 2021. (Translation of Sinhala Article)

146. 'International Guidelines on Human Rights and Drug Policy' (International Centre on Human Rights and Drug Policy, United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the World Health Organization (WHO), March 2019), https://www.humanrights-drugpolicy.org/site/assets/files/1640/hrdp_guidelines_2020_english.pdf.

5.4. Bail for drug offences

5.4.1. Poisons, Opium and Dangerous Drugs Ordinance

When the case is filed under Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance, a person cannot obtain bail at the Magistrate's Court since bail can only be awarded by the High Court under exceptional circumstances according to the Act. Thus, the section under which the police initially report facts to court is crucial, because when cases are filed under Section 54A, the person may spend several months or years in remand until they are granted bail by the High Court.

Although the primary factor which determines whether the police file the case under Section 54A or 78 (5) of the Ordinance is the quantity of narcotics found in the possession of the person, the decision about which section to use is discretionary and arbitrary and can lead to discriminatory practices and corruption. For instance, those who have the financial means could possibly bribe to be charged under the law with less harsh penalties, while the poor and marginalised would be charged under the harsher law. An interviewee for this study cited one instance where a case involving 100g of heroin was filed under Section 78 (5) by the police, resulting in the Magistrate granting bail to the suspect. It is not known whether the police thereafter filed the case under Section 54A. Although such instances are rare, they indicate a lack of consistency in practice.

Persons who are charged under Section 54A with less than 1g of heroin or less than 5kg of cannabis may be released on bail after three months in remand prison per Section 3(2) of the Release of Remand Prisoners Act. This Section states: "where a person to whom this Act applies has been in remand for a period of three months from the date of the order of remand, the Superintendent of the Prison in which such person is remanded, shall on the expiration of the three months, produce such person before the court, and the court, shall, if no proceedings have been instituted against such person at the time he is so produced, release such person on his executing a bond without sureties for his appearance in court." Section 16 of the Schedule of the Act, which sets out the offences to which this Act is applicable includes persons charged under Section 54A with less than 1g of heroin and less than 5kg of cannabis.

Persons with more than the aforementioned amounts of cannabis and heroin in their possession will have to apply for bail at the High Court. However, the probability of the suspect obtaining bail at the High Court can be low since Section 54A stipulates that bail can only be awarded in 'exceptional circumstances'. However, there are no guidelines as to what constitutes exceptional circumstances. In HCBA 862/2017 decided by the High Court of Colombo, the court held that the following factors would *not* be considered exceptional circumstances in the consideration of bail:

1. The suspect is married and has children;
2. The suspect is the breadwinner of the family;
3. Children's education would be hindered and other family matters would be neglected;
4. The suspect is engaged in an occupation;
5. The suspect has no prior offences or ongoing cases;
6. The suspect's relatives are in bad health;
7. The suspect's bad health, except in circumstances where medical certificates have been produced to confirm that further remand will result in threats to life due to bad health;
8. The time spent for the trial once the charge sheet is presented.

In determining the factors that would constitute exceptional circumstances, the court stated that (although the Bail Act is not applicable to a Section 54A offence) the time spent by the person in remand prison can be considered as an exceptional circumstance because even the Bail Act stipulates the maximum period a person can be generally held in remand as twelve months and another twelve months in special situations.¹⁴⁷ Therefore, according to the court, the time spent in remand without being charged can be considered an exceptional circumstance in determining whether bail should be awarded. The court also cited the Release of Remand Prisoners Act, which states that persons found in the possession of less than 1g of heroin and 5kg of cannabis, against whom charges have not been filed despite the person having spent at least three months in remand, may be released on bail by the court. The court, therefore, placed emphasis on the time spent in remand without charges being filed and the quantity of drugs involved in the case as factors to be considered to determine whether there are exceptional circumstances that would justify granting bail.

147. Bail Act (No. 30 of 1997) – Section 17: Notwithstanding the provisions of section 16, on application made in that behalf by the Attorney General at, the High Court in any zone or a High Court established under Article 154P of the Constitution may, for good and sufficient reasons that shall be recorded, order that a person who has not been convicted and sentenced by a court, be detained in custody for a period in excess of twelve months: Provided that the period of detention ordered under this section, shall not in any case exceed three months at a time and twelve months in the aggregate.

The guidelines issued by the court are in respect of cases where the indictment has been presented, and as highlighted above, the time spent in prison after indictment cannot be considered an exceptional circumstance. Thus, persons charged under Section 54A may spend many months or years in remand, until their cases are concluded because they were not granted bail at the High Court. In one instance reported by an interviewee, a suspect charged under Section 54A has reportedly been in remand prison for 9 years awaiting the conclusion of their trial.

The Attorney General can issue instructions to the police on the legal provisions to be used to charge suspects, which would determine whether the person is eligible for bail. The Attorney General can also issue instructions on whether State Counsels should object to bail being granted in High Court for cases filed under Section 54A. Prima facie, these directions do not appear to be formulated according to objective criteria and hence can be arbitrary. For instance, in February 2019, the Attorney General issued the following instructions regarding whether prosecuting officers should object to bail at the High Court for cases involving, heroin, cannabis, cocaine and morphine:

Nature of offence	Pure quantities	Period in remand	Whether bail should be objected to
Heroin/Cocaine	Less than 1g	More than 6 months	No objection
	Between 1-2g	1 year and over	No objection
	Between 2-10g	Over 3 years in remand	No objection
	Over 10g	Irrelevant	Object to bail
Morphine	Less than 1g	More than 6 months	No objection
	Between 1-3g	1 year and over	No objection
	Between 2-10g	Over 3 years in remand	No objection
	Over 10g	Irrelevant	Object to bail
Cannabis/Hashish	Between 5-10kg	6 months and more	No objection
	Between 11-25 kg	More than 1 year	No objection
	Above 50kg	Irrelevant	Object to bail
Opium	500g and above	Irrelevant	Object to bail

Furthermore, the instructions state that officers should object to bail being granted in cases involving 5 to 25kg of cannabis/hashish or 1 to 10g of heroin, where there is a previous conviction for drugs involving a “trafficking quantity and not a user quantity.” Since it is not specified in law what constitutes a trafficking quantity or a user quantity, the determination is subjective and is dependent on the judge. Arbitrary outcomes due to the lack of certainty and clarity were confirmed by a lawyer interviewed for this study.

It is clear that the award of bail depends on the quantity of drugs found and the time spent by a person in remand, rather than relevant individual factors of the case. This is contrary to international human rights standards including the right to liberty and security enshrined in Article 9 of the ICCPR. General Comment 35 on Article 9 of the Human Rights Committee states, with regards to pre-trial detention that:

“It should not be the general practice to subject defendants to pretrial detention. Detention pending trial must be based on an individualized determination that it is reasonable and necessary taking into account all the circumstances, for such purposes as to prevent flight, interference with evidence or the recurrence of crime. The relevant factors should be specified in law and should not include vague and expansive standards such as “public security”. Pretrial detention should not be mandatory for all defendants charged with a particular crime, without regard to individual circumstances. Neither should pretrial detention be ordered for a period based on the potential sentence for the crime charged, rather than on a determination of necessity.”

On the flipside, in certain instances, the Attorney General has used this power to issue progressive instructions, such as addressing over-incarceration and the overcrowding of prisons during the COVID-19 pandemic.

5.4.2. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act 2008

The Act stipulates that offences under this statute are non-bailable.¹⁴⁸ However, in practice, according to lawyers who appear for persons arrested for drug offences, Magistrates are likely to release persons arrested under the Act on bail. This is because although the offences in the statute are stipulated as non-bailable, this Act does not explicitly exclude the application of Section 403 of the Code of Criminal Procedure to cases filed under this Act.

Section 403 states that “a Magistrate or a Judge of the High Court, at any stage of any inquiry or trial, may in his discretion release on bail any person accused of any nonbailable offence”, except where the case involves certain offences in the Penal Code, such as the offence of murder. Additionally, Section 5 of the Bail Act (No. 30 of 1997) stipulates that a person suspected of committing non-bailable offences may be released on bail at the discretion of the court.

This is unlike the Poisons, Opium and Dangerous Drugs Ordinance, which explicitly excludes the application of Section 403 of the Code of Criminal Procedure to charges filed under the Act. Therefore, this statute is distinguished from the Poisons, Opium and Dangerous Drugs Ordinance which denies bail via Section 83 of the Ordinance, except by the High Court due to exceptional circumstances.

5.5. Delays in the issuance of the Government Analyst report

As outlined in section 4.3.1, facts are reported to court under Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance when persons are found in the possession of heroin above 500mg gross quantity. As bail can only be obtained in the High Court for this offence, such persons are held in remand prison until they receive the report from the Government Analyst Department on the pure quantity of the drug found in their possession.

The Government Analyst Department is underfunded, under-resourced and does not have an adequate number of competent officers to tackle the large volume of cases it receives daily.¹⁴⁹ The report of the Auditor General for 2019 states that during the year under review the Department could not meet 2484 requests by courts for reports and the inability to

148. Section 8, Conventions Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act (No. 1 of 2008)

149. Human Rights Commission of Sri Lanka, ‘Legal and Judicial Proceedings’, in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

provide reports had increased by 18% in comparison to the previous year.¹⁵⁰ Therefore, it can take up to one year for the Government Analyst to issue a report on the pure quantity of drugs involved in a case.¹⁵¹ The structural shortcomings in the department can also result in incorrect reports being issued. A lawyer interviewed for this study stated that in one of his cases involving 5g gross of heroin, the Government Analyst report declared that the pure quantity of heroin to be 7.5g.

During the time taken to issue the report, persons involved in the case languish in remand. In this context, it should also be noted that the heroin purchased illicitly in Sri Lanka generally is of very low purity. As mentioned in a letter dated 6 April 2020 by the Government Analyst, it is 'very rare' that a gross quantity of heroin of up to 10g would contain pure heroin of up to 1 or 2g. Thus, persons may spend months in remand prison waiting for the Government Analyst report to be issued, to learn that the quantity of drugs in their possession only contained traces of heroin and will thereafter be released upon payment of a fine.

An interviewee with a history of drug use described how he was once arrested by the police when he had drugs in his possession and was held in remand prison for two years and two months. The gross quantity of heroin in his possession was about 2g and the Government Analyst report on the purity of the drugs stated it contained only traces or a few milligrams of heroin. He was therefore released by court upon paying a fine after spending two years in remand prison. Notably, prolonged pre-trial detention for small quantities of drugs as a result of administrative delays in the system constitutes arbitrary detention as it does not meet the threshold of reasonableness, necessity and proportionality.¹⁵²

Delays in the investigation process can also be caused by the police. For instance, it is the police that is responsible for sending the drugs to the Government Analyst Department, but there is no oversight or accountability mechanism to ensure the police officer does in fact send the drugs to the Government Analyst in a timely manner. If the police were to tamper with the evidence in their possession, for instance by opening the packet of drugs, there would be no mechanism in place for such issues to be identified. Additionally, the Police Department is not compelled by law to send the drugs to the Government Analyst without delay. In one case, one of the lawyers interviewed reported that the police had

150. National Audit Office, "Head 233 – Department of Government Analyst" 2019.http://www.auditorgeneral.gov.lk/web/images/audit-reports/upload/2019/mindept_19/1_VII/Head233Dept.ofGovernmentAnalystE.pdf.

151. 'Backlog of 9,000 Drug Samples Government Analyst's Department', *The Morning*, 28 September 2020, <http://www.themorning.lk/backlog-of-9000-drug-samples-government-analysts-department/>.

152. 'Arbitrary Detention Relating to Drug Policies', *Working Group on Arbitrary Detention*, 18 May 2021.

delayed sending the drugs to the Government Analyst for up to eight months as it had been misplaced at the police station, while the suspect remained in remand prison without being charged. In this case, the Magistrate called for an inquiry and despite adequate evidence that the chain of custody had been broken to cause reasonable doubt, the Magistrate convicted the person. As the lawyer stated:

“No one is willing to take the risk. Anyone who wants to release drug offenders will think twice because they don’t want to get a bad reputation or fall into trouble for it. At the end of the day, they are doing a government job and get paid by the government. Nobody wants to lose a job because of a case, to do the correct thing.”

These issues illustrate the systemic injustices that persons arrested on drug-related charges can be subjected to due to the nature of the allegations against them and the stigma surrounding drug use, fuelled by government rhetoric that seeks to portray people who use drugs as undesirable and dangerous.

The need to expedite the issuance of reports by the Government Analyst Department has been affirmed by the 2020 progress report of the State Ministry of Prison Reforms and Prisoners’ Rehabilitation which states that:

“Discussions are in progress with the Department of Police on exploring the possibility of constituting legal action under Section 78 instead of Section 54 of the Poisons, Opium and Dangerous Drugs (Amendment) Act No. 13 of 1984 when arresting and initiating legal action against drug addicts. If this method can be successfully implemented, it will be possible to direct most of the drug addicts for rehabilitation and treatments. This will also offer a solution to the overcrowding of prisons which has been a long-standing problem.”¹⁵³

153. State Ministry of Prison Reforms and Prisoners’ Rehabilitation, ‘Progress Report - 2020’, 2021, <http://www.prison-min.gov.lk/web/images/pdf/progress-report-2020.pdf>.

5.6. Disposal of evidence

The disposal of evidence is done upon the issuance of an order by the Magistrate. This is enshrined in Section 77A (4) of the Poisons, Dangerous Drugs and Opium Ordinance.¹⁵⁴

The quantity of narcotics seized by the police must be produced in court. When the case is filed under Section 54A of the Poisons, Dangerous Drugs and Opium Ordinance, the Police can send the evidence to the Government Analyst Department either directly or via court.¹⁵⁵ Empowering the police to send the evidence directly to the Government Analyst creates room for corruption as there is no oversight to prevent tampering or pilfering. This has been illustrated by the arrests of numerous officers of the PNB in 2020, who were able to pilfer part of the confiscated drugs and re-sell them. From the Government Analyst, the evidence will be sent to court and will be stored in the record room until the conclusion of the appealable period or the conclusion of the case at the court of final appeal, whichever is relevant. After that, the drugs will be destroyed upon the order of the Magistrate.

In instances where persons are produced in Magistrate's Court under Section 78 (5) of the Poisons, Opium and Dangerous Drugs Ordinance, a judge who adjudicates drug-related cases stated that until the substances are produced in court, he does not allow the police to file a case. Practitioners however stated that often the police would not produce the drugs on the same day, but would bring them to court on another day. When they submit it to the record room, it would be in an envelope, often sealed with sticky tape. The production keeper accepting the evidence reportedly does not check the contents of the package, nor weighs it to ensure that the weight corresponds with the weight stated in the charge sheet. This too creates room for corruption and enables the police to maintain supplies in their custody and engage in trafficking themselves as evidenced by the arrests of PNB officers in 2020. In the words of one of the lawyers interviewed for this study:

“The government and the legal process almost encourage the police to sell drugs. If I was a police officer, I would easily be tempted to sell drugs. They are paid the worst salaries. The system encourages police to get involved in the drugs business.”

154. Section 77A - (4) The Government Analyst to whom any drug, substance, article, preparation or any portion or sample thereof had been submitted for examination under subsection (1) shall, after submitting his report thereon under subsection (2), send such drug, substance, article, preparation or the portion or sample thereof to the Police Narcotics Bureau, which shall upon an order issued by the Magistrate for its destruction, forthwith cause such drug, substance, article, preparation or portion or sample thereof to be destroyed

155. 77A (1) Notwithstanding anything to the contrary in section 116 of the Code of Criminal Procedure Act, a police officer may submit any drug, substance, article or preparation seized by him or any portion thereof or any sample taken by him in relation to an offence committed under Chapter III or Chapter V of this Ordinance to the Government Analyst for examination.

5.7. The National Dangerous Drugs Control Board

The NDDCB was established by the National Dangerous Drugs Control Board Act (No. 11 of 1984) and is tasked with the “formulation and review of a national policy relating to the prevention, control, treatment and rehabilitation of drug abusers.” The NDDCB, which was within the purview of the Ministry of Law and Order since 2015, was brought once again under the purview of the Ministry of Defence in 2019.¹⁵⁶

Section 7 of the NDDCB Act outlines the powers of the Board which include inter alia to “promote treatment and rehabilitation measures for drug dependent persons and conduct national drug abuse and preventive educational programmes for children and adults.” The main functions of the NDDCB are enshrined in different legislation and are as follows:

- Establishing and operating national drug rehabilitation and treatment centres.¹⁵⁷
- Issuing licenses for private drug rehabilitation centres to be established.¹⁵⁸
- Conducting primary research to produce statistics related to substance abuse in Sri Lanka, including on national prevalence, the demographic of people who use drugs, as well as the numbers of persons receiving treatment at state and non-state centres.¹⁵⁹
- Monitoring private centres for their compliance with NDDCB standards for rehabilitation centres, and recommend the closure of centres that do not comply with these standards.¹⁶⁰
- Recommending to the Minister the designation of any place or building as a treatment and rehabilitation centre for drug rehabilitation.¹⁶¹

156. Presidential Secretariat, Sri Lanka, “*Ministry of Defence – Special Priorities*”, Extraordinary Gazette No. 2196/27, 06 October 2020, http://www.cabinetoffice.gov.lk/cab/images/Downloads/functions_2020-10-06_E.pdf.

157. Section 7 (e) National Dangerous Drugs Control Board Act (No. 11 of 1984)

158. Section 3 Drug Dependiant Persons (Treatment and Rehabilitation) Act (No. 54 of 2007)

159. Section 7 (f) National Dangerous Drugs Control Board Act (No. 11 of 1984)

160. Section 12 Drug Dependiant Persons (Treatment and Rehabilitation) Act, (No. 54 of 2007)

161. Ibid, Section 2

5.8. The Drug Dependant Persons (Treatment and Rehabilitation) Act (No. 54 of 2007)

This section will focus on the legal provisions related to compulsory drug treatment, while compulsory treatment in practice and its human rights dimensions will be discussed in section 6 of the report.

The Drug Dependant Persons (Treatment and Rehabilitation) Act contains provisions that allow the state to administer compulsory treatment to persons identified as “drug dependent”, and sets out the manner in which drug rehabilitation centres in Sri Lanka have to function. The Act is applicable to both voluntary and compulsory treatment and state-administered and private centres and sets out the process of establishing and licensing treatment centres and the role of the relevant ministry, which is at present the Ministry of Defence,¹⁶² in this regard.

Section 10 of the Act requires an Officer-in-Charge of a police station, upon receiving information (from anyone) that “any person is a habitual user of dangerous drugs and has since become a drug dependant person”, to take steps to present the person for a medical examination to a Medical Officer. In practice, this means that any person can be arbitrarily arrested and detained based on unverified information received by the said police officer. The Act requires the Medical Officer to state “the reasons for his observations that such person is or is not a drug dependent, and details as to the extent of such person’s drug dependence”. It requires the report of the medical examination to be submitted to the police station, and if the report states the person has a drug dependence, s/he must be produced before a Magistrate.¹⁶³ The Magistrate shall then order the individual concerned to be sent for compulsory treatment and rehabilitation at any drug treatment centre licensed by the Act.¹⁶⁴

Empowering law enforcement agencies to apprehend and detain persons they suspect ‘have become drug dependent’, equates to providing the police with the power to arbitrarily deprive persons of liberty without due process. Further, it empowers law enforcement to make determinations on a person’s health condition, which they are not qualified to do. Police ordering persons to undergo a medical assessment could constitute arbitrary arrest and detention, as well as a violation of the person’s right to privacy and right to health, which includes the right to consent or refuse medical examination or treatment. The provision does not stipulate whether the person is to be arrested in order to be sent

162. The Act does not specify which Ministry, so the responsible Ministry would depend on which one the NDDCB is within the purview of.

163. Drug Dependant Persons (Treatment and Rehabilitation) Act. 2007. Section 10 (2)

164. Ibid. Section 10 (3)

for medical examination, the period within which the person should be sent for medical examination, nor the period within which the report has to be submitted or whether the person continues to be in police custody while the report is being prepared. Therefore, there is room for grave abuse of power by police personnel. Law enforcement authorities thus take action in what is essentially a public health issue, which will lead to the criminalisation and incarceration of people who use drugs, with a particularly dire impact on marginalised communities.

Police officers can take any person to the Medical Officer for a medical assessment, and the medical assessment that is conducted is basic, for instance inquiring from the patient about their medical history and past drug use. No urine test or toxicology screening is conducted to ascertain the presence of drugs in the body, as was confirmed in an interview with an officer of the NDDCB. It is critical to note that there is no medical test that can 'prove' drug dependence. Through the aforementioned test, persons who may be using/ have used drugs recreationally are likely to be sent for compulsory drug rehabilitation. It should be reiterated that even those that have a drug dependence should not be sent to compulsory treatment as that violates human rights standards, as explained in Chapter 4. According to a former NDDCB officer, it may not be possible to implement Section 10 (3) as the Medical Officer may be reluctant to issue such a report in respect of the person being examined. Sometimes the Medical Officer may not even be aware of the Act and the referral mechanism in Section 10 (3), all of which illustrate the limited role played by the health sector in drug treatment and rehabilitation.

Section 10 (4) of the Act stipulates that a Magistrate may send any person convicted and sentenced for an offence under the Poisons, Opium and Dangerous Drugs Ordinance for compulsory treatment and rehabilitation for a period of time as determined by the Court taking into consideration the degree of dependence, "if it is satisfied by evidence on oath led before such Court that such person is a drug dependant person."¹⁶⁵ The specific evidence on which basis the Magistrate, who does not have the expertise to make assessments of a person's health status, determines the existence of drug dependence is not stipulated in the Act. In practice, the evidence could be prior drug-related offences of possession of small quantities of narcotics (which the Court would construe to be evidence of drug use), personal testimonies, or requests by family to order the person to treatment. Unlike Section 10 (1), this provision does not require a medical assessment to

165. Ibid. Section 10 (4)

be conducted. Section 13 (2) of the Act does, however, state that no order shall be made by a Magistrate only upon facts communicated by others.¹⁶⁶

It was reported by several interviewees that it is quite common for the police to misuse the provisions outlined in Section 10 and produce persons who do not use drugs, let alone have a drug dependence, before the Magistrate for rehabilitation as a result of personal vendettas or upon the requests of family members. The person would thus be produced in the Magistrate's Court and sentenced to rehabilitation by the court following the direction of the police and would be required to spend a certain number of months in a treatment centre.

An example of such an instance was highlighted in the report of the prison study conducted by the HRCSL, where a person stated that he did not know the reason he was produced in court but assumed it was because he had an altercation with his father, who had reported him to the police. He proceeded to plead guilty and only later realised that he had pleaded guilty to a drug-related offence and was being sentenced to rehabilitation at the request of his father, who had enlisted the assistance of the police to admit him to a drug rehabilitation centre.¹⁶⁷

If a person is ordered to compulsory drug rehabilitation as part of their sentence for an offence committed under the Poisons, Opium and Dangerous Drugs Act, it is the Commissioner-General of Prisons that has to take the necessary steps to transfer the person to the designated treatment centre as stipulated in Section 10 (5). This results in people who are sentenced to compulsory treatment spending up to a maximum of six days in a prison until the Superintendent of the prison organises the transfer of the individual to the designated rehabilitation centre.¹⁶⁸

The Act allows the Minister, under whose purview NDDCB is placed, to make regulations on the standards to which treatment centres must adhere. By virtue of Extraordinary Gazette number 1653/19 in 2010,¹⁶⁹ the Minister at the time who was also the President,¹⁷⁰ enacted

166. Drug Dependant Persons (Treatment and Rehabilitation) Act. 2007, Section 13 (1) 'A medical practitioner who signs a medical certificate supporting any application or committal to be made under this Act or for any other purpose provided in this Act shall specify therein, the facts upon which he has formed his opinion that the person to whom the certificate relates is a drug dependant person. He shall also set out in detail the circumstances as perceived by him, and the facts communicated to him by others.' (2) 'No Order shall be made by a Magistrate under this Act upon a certificate which purports to be founded only upon facts communicated by others.'

167. Human Rights Commission of Sri Lanka, 'Legal and Judicial Proceedings', in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

168. This phenomenon was discovered during the national study of prisons conducted by the Human Rights Commission of Sri Lanka.

169. Presidential Secretariat, Sri Lanka, Extraordinary Gazette No. 1653/19, 12 May 2010. http://documents.gov.lk/files/egz/2010/5/1653-19_E.pdf.

170. The gazette was issued by the President at the time, Mr Mahinda Rajapaksa, as he was also the Minister of Defence and the NDDCB was within the purview of the *Ministry of Defence* in 2010.

a set of regulations outlining minimum standards that private treatment centres must maintain to qualify for a license to operate. However, it must be pointed out that although it is Section 21 of the Act that empowers the Minister to make regulations regarding the standards at treatment centres, the gazette issued by the Minister refers to Section 3 of the Act, which describes the power of the NDDCB to grant licenses to private treatment centres if they have met the necessary conditions proposed by the NDDCB.

Section 10 of the form outlines the minimum specifications for the premises, including adequate living spaces, outdoor spaces, and separate facilities for counselling and educational programs as well as spaces for staff.

Furthermore, Section 11 outlines the designated personnel required to operate the centre including, Director, Counsellor, Assistant Counsellor, Counselling Assistants, Nurse and Vocational Instructors. Section 12 sets out the minimum qualifications that each designated officer in Section 10 should possess. Section 13 and 14 set out the type of treatment model that the centre proposes to follow and the services that will be available at the centre.

5.8.1. The role of the Assessment Panel in admission and release

The Act requires the Minister to establish Assessment Panels comprising of not more than ten persons from amongst those “who have gained eminence or experience in the fields of law or persons having experience or knowledge in the fields of physiological or social problems connected with drug dependence.”¹⁷¹ Additionally, regulations issued under the Act¹⁷² state that the NDDCB can nominate persons from amongst the aforementioned ten persons appointed by the Minister to be part of Assessment Panels consisting of no more than three persons. The panels would be established whenever it becomes necessary to evaluate persons seeking admission to, and any person undergoing treatment for drug dependence at any treatment centre licensed by the Act and to evaluate future rehabilitation

171. Drug Dependand Persons (Treatment and Rehabilitation) Act. 2007, Section 7 (1) ‘The Minister shall appoint Assessment Panels consisting of not more than ten persons from amongst persons who have gained eminence or experience in the fields of law or persons having experience or knowledge in the Fields of physiological or social problems connected with drug dependence.’ (2) Assessment Panels consisting of not more than three persons shall be nominated by the NDDCB whenever it becomes necessary to — (a) assess persons seeking admission in terms of this Act, to Treatment Centres designated or licensed under this Act; or (b) assess persons presently undergoing treatment for drug dependence, and to evaluate future rehabilitation programmes.’

172. Presidential Secretariat, Sri Lanka, Extraordinary Gazette No. 1653/19, 12 May 2010. http://documents.gov.lk/files/egz/2010/5/1653-19_E.pdf.

programmes.¹⁷³ Section 7 (1) of the Act sets out the criteria for selection of members of the Assessment Panel “possessing appropriate qualifications and experience, in the fields of law or persons having experience or knowledge in the fields of physiological or social problems connected with drug dependence.”

The Assessment Panels cannot be considered independent bodies as they are appointed at the discretion of the Minister. Hence, the continued detention of persons is subject to the decision and recommendation of a non-judicial authority, which is appointed based on broad criteria through a non-transparent process.

The regulations elaborate on the monitoring and reporting functions and powers of the Assessment Panel, including the power to enter any treatment centre without prior notice, examine any new or existing rehabilitee at a centre as well as any documents held at the centre and interview family members of any person at the centre.

In instances where a person voluntarily seeks admission to a rehabilitation centre for drug dependence treatment, the Act states that admission shall be subject to an assessment by the Panel, and the person shall not leave the treatment centre until the Assessment Panel and Medical Officer in charge at the centre are of the opinion that s/he may be discharged, subject to conditions stipulated by the centre.¹⁷⁴ The release of persons could be subject to conditions imposed by the NDDCB, a non-judicial body that exercises broad discretion and the drug detainee would have no recourse to challenge or appeal the conditions imposed by the NDDCB for release.

When persons are required to undergo compulsory rehabilitation under a court order, the court may authorise the release of the person upon the Director's recommendation following consultations with the Assessment Panel, under conditions specified by the court.¹⁷⁵

The Director of the treatment centre can also make a request to the court for an extension of the treatment period.¹⁷⁶

In practice, Assessment Panels are not appointed, as was reported by officers of the NDDCB and an assessment of the client is conducted by the staff at NDDCB centres. Therefore,

173. Ibid

174. Drug Dependant Persons (Treatment and Rehabilitation) Act. 2007. Section 11 (1)

175. Ibid. Section 11 (2)

176. Ibid. Section 10 (4)

although there is no separate panel, an internal panel comprising the counsellor, counselling assistant and assistant counsellor appointed for each case file are tasked with making a decision, with the approval of the manager at the centre. Furthermore, it was reported that the staff of the centre do not stipulate conditions for release. Instead, the details of released clients are shared with the relevant outreach officer in the area where the client resides, who will then monitor their progress. The NDDCB officer stated that the monitoring process includes monthly house visits, and reports of the visits are sent to the treatment centre where the client was held. The relevant treatment also includes follow-up calls.

According to an officer from the NDDCB interviewed for this study, the NDDCB has introduced vocational training for released clients in collaboration with a youth training group. This enables released persons to follow a three-month vocational training course after their release from the centre, for which they will be awarded a certificate.

5.8.2. Use of force against people in rehabilitation centres

The Act empowers employees of the centre “to use all such means, including such degree of force, as may reasonably be necessary to compel obedience to any lawful directions” to maintain discipline and order amongst persons detained at the centre.¹⁷⁷ Further, Section 18 stipulates that any person who ‘obstructs’ the duties of an employee of a treatment centre shall be guilty of an offence, which carries a fine of Rs. 5,000 (25.2 USD) and/or imprisonment for up to eighteen months as a penalty. There is no definition of what constitutes an ‘obstruction’ of the duties of persons employed at the centre.

At the same time, the Act states that striking, wounding, ill-treating or wilfully neglecting ‘without reasonable cause’¹⁷⁸ any person receiving treatment at the centre shall constitute an offence. The penalty for this is a fine not exceeding Rs. 5,000 (25.2 USD) and/or imprisonment of either description for a period not exceeding eighteen months, following a trial in the Magistrate’s Court.¹⁷⁹ These provisions are applicable to personnel from both private and state-administered detention centres. This provision does not preclude action being taken under the Penal Code in the event a police complaint is made about the use of force by staff, which rarely happens in practice.

177. Ibid. Section 19 (2)

178. Ibid. Section 17

179. Ibid. Section 20

It must be highlighted that the absolute right against torture, cruel inhuman degrading treatment or punishment is enshrined in the Constitution of Sri Lanka. Further, the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment Act (No. 22 of 1994) criminalises torture and states that “any person who attempts to commit, aids and abets to commit or conspires to commit torture” can be punished with a term of imprisonment between seven to ten years and a fine between Rs. 10,000 (50.5 USD) and Rs. 50,000 (252.4 USD)¹⁸⁰.

Furthermore, Section 19 (1) of the Drug Dependant Persons Act empowers the police to apprehend and return ‘escaped’ detainees to the centre.¹⁸¹ Enabling the police to apprehend persons who have ‘escaped’ from the centres, and return them to the centre is a violation of their right to withdraw from treatment. It also allows the police to bypass due process safeguards and the judicial process to return an individual to the custody of the rehabilitation centre. This creates a severe imbalance of power, especially where persons who voluntarily sought drug treatment are concerned because they would be deprived of their liberty by a non-judicial body, without access to legal representation or a judicial body to monitor the interests of the detainee, as a result of which the voluntary participation of the individual ceases to become voluntary and begins to constitute arbitrary detention.

5.8.3. Official visitors to treatment centres

Section 8 of the Act allows the Minister, on the recommendation of the NDDCB, to “nominate one or more fit and proper persons to be official visitors to any treatment centre”¹⁸² for a period of two years. The visitor has the power to visit a treatment centre at any time and is tasked with making inquiries or examinations. The Act further states that “it shall be the duty of such visitors to visit such Treatment Centres from time to time and submit periodic reports to the NDDCB in accordance with such guidelines or regulations as may be issued in this regard”.¹⁸³ There is no procedure set out as to how the visitors would conduct such inquiries, the issues that are within their purview of inquiry, and how the findings of such inquiries will be used.

180. Section 2 of the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment Act (No. 22 of 1994)

181. Section 19 (1) of the Drug Dependant Persons (Treatment and Rehabilitation) Act. 2007.

182. Ibid. Section 8 (1)

183. Ibid. Section 8 (2)

Although on the face of it, this appears to be a monitoring and oversight mechanism, it has many shortcomings. Firstly, there are no qualifications stipulated for those who are eligible to be appointed as Official Visitors except that they are 'fit and proper'- a subjective assessment that is at the discretion of the NDDCB and the Minister. Furthermore, while the NDDCB's administration and regulation of private and public treatment centres should be monitored, in the absence of an enforcement mechanism to ensure the implementation of any recommendations issued, the monitoring mechanism will not fulfil its purpose. According to interviewees, this provision is not implemented.

5.9. The Community Based Corrections Act

The only alternative to incarceration in the Sri Lankan penal system is set out in the Community Based Corrections (CBC) Act.¹⁸⁴

CBC orders can be issued to persons convicted of any offence, including drug offences, for which imprisonment is not a mandatory penalty and the penalty is less than two years imprisonment.¹⁸⁵ The conditions of the order will be stipulated based on the pre-sentence report of the offender, submitted by the Department of CBC, which must include inter alia social history, background, details of dependents, educational/employment history and special needs of the offender, and courses of programmes which s/he could attend and benefit from.¹⁸⁶ The Act sets out the type of conditions that may be imposed as part of the CBC order and include, but are not limited to, unpaid community work, completion of an education or vocational training programme, treatment for alcohol or drug dependence and/or to submit for alcohol or drug use testing as required.¹⁸⁷ The type of conditions attached to the CBC order would therefore be determined by the judge after considering factors such as the background report, the offence for which the person is convicted, and history of offences.

Therefore, a CBC order may be issued in respect of a person convicted of drug offences if the pre-sentence report and history indicate they may have used drugs and they would be required to undergo drug treatment as part of the conditions of the order, in lieu of imprisonment. The consent of the person is required for the CBC order to come into effect and the Act requires that the purpose of the order and the conditions are explained to the individual, as well as the consequences of failing to complete the conditions or potential

184. Community Based Corrections Act (No. 46 of 1999).

185. Ibid. Section 5

186. Ibid. Section 6

187. Ibid. Section 9 (2)(iv)-(v)

to change the conditions of the order.¹⁸⁸ However, it is highly likely that in such a situation, the individual concerned may have little choice but to consent to the order for treatment, as the alternative is likely to be imprisonment. Thus, the consent of the individual to drug treatment may be given under duress and coercion, and would not constitute informed consent. Moreover, such “consent” given under duress would be in contravention of medical ethics and international standards for healthcare, which acknowledge the right of all persons to refuse treatment.

Furthermore, since a condition of the CBC order is to refrain from consuming substances, any person with drug dependence may be at the threat of imprisonment when s/he relapses. Returning to drug use is a common part of reported experiences with drugs, in particular drug dependence. Accordingly, a common experience is essentially criminalised through this Act.

According to the 2020 progress report of the State Ministry of Prison Reform and Prisoners Rehabilitation, under the purview of which the CBC Department falls, between 1 January 2010 and 30 September 2020, of the 7,731 total CBC orders that were issued, 2,778 were issued in respect of cases involving heroin and 1,111 were issued for cases involving cannabis.¹⁸⁹

The same report, which states that one of its goals for the future is “converting drug addict offenders into good citizen” (sic), also highlights that when persons who committed drug offences are referred to treatment as per a CBC order, an initial screening and counselling session is conducted by Medical Officers to determine whether the individual requires residential care or out-patient treatment for drug dependence. Detention in residential centres for drug treatment, after ‘consenting’ under duress or coercion to avoid imprisonment, constitutes arbitrary detention and violates the right to the highest attainable standards of healthcare, of which informed consent and the right to refuse treatment are necessary components.

It should be noted that only persons who are charged under Section 78 (5) of the Poisons, Opium and Dangerous Drugs Ordinance at the Magistrate’s Court can request a CBC order to be issued. As reported by a lawyer who appears for persons charged for drug offences, of the 100-200 cases involving minor drug offences at the Magistrate’s Court, only one or two persons may ask for a CBC order to be issued since the penalty for an offence under Section 78 (5) of the Ordinance is usually a fine. Therefore, it may only be persons who cannot afford the fine and wish to avoid imprisonment for non-payment of the fine, who would request a CBC order.

188. Ibid. Section 7

189. State Ministry of Prison Reforms and Prisoners’ Rehabilitation, ‘Progress Report - 2020’, 2021, <http://www.prison-min.gov.lk/web/images/pdf/progress-report-2020.pdf>.

5.10. Legal measures taken during the COVID-19 pandemic

In 2020, during the COVID-19 pandemic, the criminal justice system attempted to reduce the growing number of persons being held in overcrowded prisons, in particular those held for drug offences.

A series of measures were announced, including the release on bail of prisoners held in remand prison for minor drug offences as well as the release of persons imprisoned for the non-payment of fines.¹⁹⁰ It was reported that nearly 25,224 prisoners were released by the Department of Prisons during the period December 2020 to March 2021. This included 3,364 convicted prisoners and 21,360 remand prisoners.¹⁹¹

Measures were also announced by the Attorney General's Department by way of instructions issued to the (acting) IGP to reduce the number of persons arrested for minor drug offences being remanded. These are discussed below.

5.10.1. Instructions issued by the Attorney General, April 2020

The Secretary to the President, in a letter to the Attorney General dated 8 April 2020, highlighted the need to curb the population of remandees to prevent the risk of COVID-19 spreading in prisons. The letter recommended that persons who have spent a long period of time in remand awaiting trial should be released on bail, after an assessment of the seriousness of the charges against them.

Following this letter, the Attorney General wrote to the (acting) IGP on 9 April 2020 highlighting that nearly 8,000 of the 13,000 persons in remand are in prison for drug-related offences and due to the COVID-19 pandemic, overcrowding poses a risk to the health of people in detention. In response, the Attorney General issued instructions in relation to remandees whose cases fell within the following categories stipulating that facts should be presented to the Magistrate under Section 78 instead of Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance. This would allow the person to apply for bail at the Magistrate's Court and avoid being detained in remand prison for many months, as Section 54A of the Ordinance explicitly provides that bail can only be obtained at the High Court under exceptional circumstances.

190. 'Thousands of Drug Offenders to be Released from Prisons Due to Overcrowding', *Economy Next*, 09 April 2020, <https://economynext.com/thousands-of-drug-offenders-to-be-released-from-prisons-due-to-overcrowding-64811/>.

191. '25,224 inmates released from prison to ease overcrowding', *Dinamina*, 01 April 2021 (Translation of Sinhala article).

The rationale for this decision was based upon a letter issued by the Government Analyst Department dated 6 April 2020, which confirmed that it was very rare for quantities of 2g to 10g (gross) of heroin to contain 2g of pure heroin – which is the minimum threshold quantity for a sentence of life or death under the Poisons, Opium and Dangerous Drugs Ordinance. Therefore, using Section 78 of the Ordinance would allow the person to be released on bail, thus reducing the level of overcrowding in remand prisons.

The following categories of cases were applicable to this guideline:

1.1 Gross weight of heroin between 10-20g	If the gross weight of heroin seized is between 10-20g, where the Government Analyst's Report has not been issued, persons who have been in remand prison for 3 months or longer.
1.2 Gross weight of heroin between 5-10g	Where the Government Analyst's Report has not been issued, persons who have been in remand prison for longer than 1 month.
1.3 Gross weight of heroin less than 5g	Where the Government Analyst's Report has not been issued, time spent in prison is irrelevant.
1.4 Net weight of heroin between 1-2g	Where time period spent in remand prison is longer than 3 months.
1.5 Net weight of heroin less than 1g	Where time period spent in remand prison is longer than 1 month.
1.6 Cannabis	More than 5kg: Where time period spent in prison is longer than 1 month.
	Less than 5kg: Time period spent in prison is irrelevant.

It must be highlighted that in practice, the report of the Government Analyst would have to be issued to ascertain the amount of pure heroin, i.e. the net weight, which due to backlog usually takes several months. Hence, in practice, the thresholds of three months and one month set out in sections 1.4 and 1.5 of the instructions are irrelevant since a detainee will have spent many months in remand prison until the Government Analyst Report is issued confirming the net quantity of drugs.

In a letter dated 14 April 2020 addressed to all police districts, the Acting IGP stated that the guidelines issued by the Attorney General, which were relayed to the police via telephone

message were “invalidated with immediate effect” and there was no need to take further action in this regard. No explanation was provided by the IGP as to why the AG’s instructions were invalidated, particularly given its purpose, i.e. to prevent the spread of COVID-19 in prisons. Therefore, the April instructions issued by the Attorney General were not implemented.

According to a lawyer, since the instructions of the Attorney General limit the powers of the police to file cases against suspects under Section 54A and send them to remand prison, the police were disinclined to follow them. In fact, a large number of arrests of persons found in possession of small quantities of drugs were made under Section 54A during the pandemic, which further contributed to overcrowding in prison, in contravention of the aim of the Attorney General’s instructions. Especially when considering the letter of the Government Analyst, which states that small quantities of gross heroin contain only negligible amounts of pure heroin. The pre-trial detention of a large number of persons in remand prison until their Government Analyst Report is issued would seem completely unnecessary under normal circumstances. During a pandemic, it could constitute criminal negligence.

According to a criminal lawyer, despite the fact the police were not following the guidelines of the Attorney General issued in April 2020 and persons were not able to obtain bail in the Magistrate’s Court, judges of the High Court released persons in drug-related cases according to standards set by the judges themselves with respect to the quantities of drugs involved in the case. The judges cited the April 2020 instructions of the Attorney General as an indication of the less restrictive position of the Attorney General’s Department on releasing persons on bail. For instance, if the case involved less than 5g gross quantity of heroin and there were no prior offences and no evidence of trafficking or money laundering, some judges would grant bail, even when the State Counsel objected to bail. The interviewee also reported that where prior offences were concerned, if the quantity involved in the prior offence was a ‘user quantity’ i.e. less than 1g of heroin, judges often released persons on bail.

5.10.2 Instructions issued by the Attorney General, May 2020

Instructions were issued by the Attorney General to the IGP in May 2020 regarding cases involving heroin that were required to be forwarded to the Attorney General’s Department for indictment. The Attorney General cited the letter of the Government Analyst which stated that considerable time, labour and resources are required to analyse samples of heroin of less than 1g, and due to the large volume of such cases, the process of administration of justice is delayed. To rectify this problem, the instructions stated that:

1. Where the net weight is 500mg or more, according to the Government Analyst's Report, the cases shall be forwarded to the Attorney General to consider all such cases for indictment before the High Court.
2. The police shall take steps to institute proceedings against suspects under Section 78 (5)(a) of the Poisons, Opium and Dangerous Drugs Ordinance in the following instances:
 - i. Where the net weight is less than 500mg according to the Government Analyst's Report and,
 - ii. Where the gross weight of the substance suspected to be heroin in possession of the person arrested is less than 1g even if the Government Analyst has not conducted a quantitative analysis as to the net weight, if the Government Analyst's Report states that such sample contains heroin.

In cases where the net weight is less than 500mg the person would likely have already spent time in remand until the Government Analyst issued a report on the pure quantity of heroin found in the seized substance. However, as stated in 2 (ii), if the person is arrested with less than 1g gross heroin the Government Analyst is not required to conduct an analysis to ascertain the net weight. Instead, the Government Analyst is only required to confirm whether the sample contains heroin, which is reportedly done via a rapid test. Hence, it is possible in such instances, since the case can be filed under Section 78 (5)(a), that the case can be concluded on the same day and a person may be released upon the payment of a fine. Alternatively, since the case is filed under Section 78 (5)(a) bail can be granted until the report is issued, thereby reducing the number of persons remanded in prison.

5.10.3. Instructions issued by the Attorney General, November 2020

In November 2020, the Attorney General wrote to the Acting IGP and restated the need to curb the population of remand prisoners due to the risk of a COVID-19 outbreak in prisons, and reiterated that previously issued guidelines were to be followed with the amendments below.

The instructions are on filing cases under Section 78 (5)(a) of the Poisons, Opium and Dangerous Drugs Ordinance instead of Section 54A or 78 (5)(b) to enable cases to be concluded in the Magistrate's Court without the file being sent to the Attorney General's Department. As per the November 2020 guidelines:

“Filing cases relating to Diacetylmorphine/Heroin

1. For the purpose of considering presenting the indictment to the High Court it is advised to forward to the Attorney General the completed investigation files in which, according to the Government Analyst’s report, the net weight is 1000mgs (1g) or more.
2. In the following instances it is not necessary to forward the completed investigation files to the Attorney General. Instead, the Police must take steps to present facts to the relevant Magistrate’s Court and file cases against the suspects under Section 78 (5)(a) of the Poisons, Opium and Dangerous Drugs Act No 13 of 1984, as amended.
 - (i) If, according to the Government Analyst’s report, the net weight of Heroin is less than 1000mg (1g) and if the suspect is a first offender;
 - (ii) In instances where the gross weight of the relevant substance, arrested on suspicion of Heroin, is less than 2g. (A copy of the letter of the opinion of the Government Analyst’s on this matter is attached herewith as ‘Annex 2’)

However, in relation to 2(i) and 2(ii), even if the net weight of Heroin is less than 1000mg (1g), if the matter falls under the following circumstances [or conditions], to consider filing an indictment in the High Court the completed investigation file must be forwarded to the Attorney General.

- (a) Clear evidence of Drug trafficking and/or
- (b) Previous drug-related offences and/or
- (c) Persons having three or more existing [pending] cases relating to drugs

The prior offences and/or pending cases in relation to conditions (a) and (c), as mentioned above, should not be relevant to user quantities but should be relevant to the substantive quantities, that is, instances in which the net weight of heroin is 1g or more.

Filing cases relating to cannabis:

It is not necessary to forward the completed investigation file to the Attorney General if the amount of Cannabis apprehended is less than 5kgs. Instead, under Section 78 (5)(a) of the Poisons, Opium and Dangerous Drugs Act No 13 of 1984, as amended, the Police should take steps to file cases in the relevant Magistrate's Court.

However, in the circumstances if the apprehended amount of Cannabis exceeds 5kgs, or where it is less than 5kg but falls within the scope of conditions (a), (b) and (c), as mentioned above, completed investigation files should be submitted to the Attorney General for the purpose of considering whether to file indictments in the High Court.”

The instructions also cite a letter from the Government Analyst Department dated 9 November 2020, which states that samples of heroin of gross weight of up to 2g have only about a 5% chance of containing pure heroin that exceeds 500mg, and there is less than 1% chance that the amount of pure heroin contained in the sample would exceed 1000mg.

In response to the Attorney General's instructions, the IGP issued Circular No. 2693/202 to be disseminated to all police officers requiring the guidelines issued by the Attorney General to be followed across all police stations.

While the April 2020 instructions were regarding releasing persons on bail to reduce prison overcrowding due to the pandemic, the November 2020 instructions concern changing the quantity threshold to enable filing cases under Section 78 (5)(a) instead of Section 54A. Section 2(i) of the instructions states that if the report of the Government Analyst finds a net quantity of less than 1000mg (1g), cases can be filed under Section 78 (5)(a). This means that a person will still have to spend considerable time in remand while the Government Analyst Department issues a report on the pure quantity of drugs involved in the case. However, the pre-2020 quantity threshold for filing charges under Section 54A, i.e. over 500mg, has been increased to over 1000mg.

Furthermore, as described in Section 2(ii), if a person is arrested with less than 2g gross of heroin, or 5 kg of cannabis, the police have been instructed to file the case under Section 78 (5)(a) of the Ordinance, which will allow the detainee to be released the same day upon payment of a fine. These instructions thus give effect to the letters issued by

the Government Analyst Department, dated 6 April 2020 and 9 November 2020, which state that between 10g and 2g gross of heroin would contain a very limited amount of pure heroin, that would not reach the required threshold of 1g, where a minimum sentence of three years imprisonment becomes applicable under the Third Schedule of the Ordinance. Therefore, persons arrested with less than gross 2g of heroin will not have to languish in remand for many months until the Government Analyst Report is issued and instead can be released on the same day by the Magistrate's Court upon the payment of a fine.

Furthermore, the guidelines expressly require that there must be evidence of trafficking or previous offences if the case is to be forwarded to the Attorney General for indictment, and previous cases too should not concern 'user quantities' i.e. 1g of heroin. Hence, while it appears that the criminal justice system is moving away from criminalizing and penalizing those with 'user quantities', it is being done in an arbitrary manner by the Attorney General through ad-hoc guidelines and instructions that the police are not bound to follow, rather than an enactment in law to clearly indicate a progressive human rights and health-based approach.

According to an interviewee who represents persons arrested for drug offences, since the November 2020 guidelines were issued and the IGP issued a follow up circular instructing all police to adhere to the instruction of the Attorney General, cases involving up to 1000mg net are filed under Section 78 (5)(a) and persons are able to secure their release in the Magistrate's Court upon the payment of fines. As a result, nearly 6000 persons were able to leave remand prisons because charges were filed against them under Section 78 (5)(a) and they were released upon payment of fines.¹⁹² However, although this results in the release of persons, it still constitutes criminalising the person who is compelled to plead guilty in order to secure their release.

192. 'Legal Action Instituted Against Drug Addicts as per Instructions of AG', *News First*, 09 December 2020, <https://www.newsfirst.lk/2020/12/09/legal-action-instituted-against-drug-addicts-as-per-instructions-of-ag/>.

5.10.4. Instructions to the Counsel issued by the Attorney General, January 2021

In January 2021, the Attorney General issued circular No. 6 of 2021 to all prosecuting counsel in High Courts, instructing they should not object to bail in cases that involve not more than 10g gross quantity of heroin if the following conditions are met:

- i. The suspect has been in remand for over six months, investigations have been concluded.
- ii. There are no pending cases or previous offences for related cases (however if pending cases/previous convictions involve less than 1g of heroin, they may be disregarded)
- iii. There is no evidence of heroin trafficking/money laundering.

It was also stated that this circular will prevail over all others issued in this regard.

This circular effectively fulfils the recommendations outlined in the letters issued by the Government Analyst Department in April and November 2020, which affirm that gross quantities between 2g and 10g of heroin rarely contain up to 2g of pure heroin, which is the quantity of pure heroin where the punishment of death would become applicable. Thus, the instructions of the Attorney General to prosecuting counsel not to object to bail when the suspect has been in remand for more than six months, where there is no evidence of heroin trafficking or money laundering and there are no previous convictions involving more than 1g heroin, will allow persons to be released on bail at the High Court. Although this circular is a step in the right direction, persons still have to spend a minimum of six months in prison before these instructions can be applied.

As reported by practising attorneys, despite the January 2021 instructions by the Attorney General not to object to bail where there is no evidence of drug trafficking or money laundering, some State Counsels have reportedly continued to object to bail and judges have acceded to their demands. This is because the conditions stipulated in the instructions require State Counsels not to object to bail only where there is no evidence of drug trafficking or money laundering. Previous instructions of the Attorney General to State Counsels, such as those issued in February 2019, only required the quantity of drugs involved in the case, the time spent in remand and previous convictions to be taken into account when considering whether bail should be objected to. However, the new instructions also require that there should be no evidence of trafficking or money laundering. As these conditions are difficult to satisfy, State Counsels are now more restrictive when not objecting to bail.

In one case, involving 4g of a gross quantity of heroin, where the suspect had spent six months in remand, and the B report did not allege money laundering and there was no evidence of trafficking (for instance no weight scales or small packets to pack narcotics were found in the defendant's possession or premises, which suggest the possession may have been for their own use) the State Counsel objected to bail on the basis that it could “potentially” be used for trafficking. In the words of the person's attorney, State Counsels have been given “a stick to use at their convenience and they are going on an absolute wild ride. [...] The State Counsels have been given more liberty to object to bail.”

5.10.5. Instructions issued by the Attorney General, May 2021

In May 2021, the Attorney General issued further instructions to the Inspector General of Police, in response to the request made by the Commissioner General of Prisons to the Secretary of the Ministry of Justice to consider non-custodial measures to curb overcrowding due to the third wave of COVID-19 and an increase of infections in prisons.

With the objective of taking ‘positive steps to ensure the safety of the inmates held in prisons’, the Attorney General introduced a new category of “between 2g and 4g” in relation to the “heroin” categories set out in instructions issued via the letter dated 9 November 2020. These instructions, therefore, increase the threshold of 2g gross heroin mentioned in the November 2020 guidelines to 4g gross heroin.

The Attorney General states that the primary objective “is to avoid reporting facts to Court under Section 54A of the Poisons, Opium and Dangerous Drugs Act (No.13 of 1984) where the case is regarding addiction to heroin, or the gross weight of heroin is such that the net weight is less than 1g.” The Attorney General stated that this is because “according to data of the Government Analyst's Department, the average percentage of pure heroin contained in the amount of heroin seized is 15%.” Therefore, “by reporting facts under Section 78 (5)(a) of the same Act, sending persons addicted to drugs to prison in these problematic times can be avoided.”

The Attorney General further instructs that if the person has been in remand for three months there should be no objections to granting bail if the gross weight of heroin is between 2g and 4g. In such situations, to enable the granting of bail, facts must be reported to Court under Section 78 (5)(a) of the aforementioned Act. It should be noted

that the Attorney General could have instructed that facts should be reported under the Conventions Against Traffic in Illicit Narcotics Act, which includes heroin as a banned substance and allows bail to be granted by the Magistrate. It is likely this was not done in case the net quantity turns out to be a quantity for which the death penalty would be applicable, and if reported under the Conventions Against Traffic in Illicit Narcotics Act the person would be subject to a less harsh penalty.

An analysis of recent newspaper reports on drug-related cases in the table below illustrates whether the abovementioned guidelines are being followed in practice.

Instructions of Attorney General:	Cases reported in 2021:
<p>November 2020 Instructions of Attorney General:</p> <p>The Police must take steps to present facts to the relevant Magistrate Court and file charges against the suspects under Section 78 (5)(a) of the Poisons, Opium and Dangerous Drugs Act:</p> <p>(i) If, according to the Government Analyst's report, the net weight of Heroin is less than 1000mgs (1g) and if the person is a first offender;</p> <p>(ii) In instances where the gross weight of the relevant substance, arrested on suspicion of heroin, is less than 2g.</p>	<p>Reported on 1 April 2021:¹⁹³ eight persons were released upon the payment of a fine of Rs. 10,000 (50.5 USD) each after they were arrested for the possession of quantities of heroin amounting to 40mg, 60mg, 280mg and 475mg.</p> <p>Reported on 1 April 2021¹⁹⁴: fines were imposed on two persons who pleaded guilty after being arrested in the possession of 30mg and 35mg of heroin. The fines imposed amounted to Rs. 100,000 (504.7 USD) per defendant.</p>

193. '8 people who possessed heroin fined', *Divaina*, 01 April 2021 (Translation of Sinhala article)

194. '2 People Who Possessed Heroin Plead Guilty', *Divaina*, 01 April 2021. (Translation of Sinhala article)

<p>November 2020 instructions of the Attorney General:</p> <p>It is not necessary to forward the completed investigation file to the Attorney General if the amount of cannabis apprehended is less than 5kgs. Instead, the Police should take steps to file cases under Section 78 (5)(a) of the Poisons, Opium and Dangerous Drugs Act No. 13 of 1984 in the relevant Magistrate's Court.</p>	<p>Reported on 26 March 2021: an individual who was arrested in possession of 1 kg of cannabis was sentenced to six months imprisonment, suspended for five years and imposed a fine of Rs. 10,000 (50.5 USD).¹⁹⁵</p>
<p>January 2021 instructions of the Attorney General (circular No. 6 of 2021) to all prosecuting counsel in High Courts: Bail should not be objected to in cases which involve not more than 10g gross of heroin, the person has been in remand for over six months and investigations have concluded.</p>	<p>Reported on 23 March 2021: a person was granted bail after spending about one year in remand prison for a case involving 8000mg of heroin. The conditions of bail included a cash bail of Rs. 25,000 (126.2 USD) and two personal bails of Rs. 500,000 (2523.7 USD) each. The article mentions that the defendant was arrested "while trafficking".¹⁹⁶</p> <p>Reported on 26 March 2021: an individual was awarded bail after spending five months in remand prison for a case involving 2200mg of heroin. Conditions of bail included a cash bail of Rs. 25,000 (126.2 USD) and two personal bails of Rs. 500,000 (2523.7 USD) each.¹⁹⁷</p>

Although a positive step in the correct direction, these new policies are being formulated in an ad-hoc and arbitrary manner at the discretion of the Attorney General. Without amending the national laws on drug offences and criminal procedure, the changes in policy will not be consistently adopted and applied by all police, judges, and State Counsel. Moreover, it appears that time spent in remand is required in certain instances to grant bail. This gives the appearance that pre-trial incarceration is deemed mandatory to qualify for bail, though no such requirement is stipulated in the law. This could constitute arbitrary detention in certain instances and violates the presumption of innocence.

195. 'A Fine of Rs. 10,000/- and Suspended Imprisonment (imposed on person) Caught with Cannabis,' *Mawbima*, 16 March 2021. (Translation of Sinhala article)

196. 'Bail Granted to a Heroin Trafficker of "Waggawwa" after 1 year'. *Divaina*. March 23, 2021. (Translation of Sinhala article)

197. 'Bail Granted to Trafficker at Awarakotuwa', *Divaina*, 26 March 2021. (Translation of Sinhala article)

5.10.6. Instructions issued by the Judicial Services Commission, May 2021

The Judicial Services Commission (JSC), a body which was established under Article 112 of the Constitution of Sri Lanka and is chaired by the Chief Justice, is responsible for the appointment, transfer, dismissal and disciplinary control of judicial officers.¹⁹⁸

In May 2021, the JSC issued a letter to all High Court judges and judicial officers, outlining guidelines aimed at minimising the spread of COVID:

- I. “Strict adherence to Section 3 (1) of the Release of Remand Prisoners Act No. 8 of 1991 is expected from all Magistrates and Additional Magistrates.
- II. All judges are reminded the (sic) importance of adhering to the guiding principles relating to granting of bail embodied in Section 2 of the Bail Act.
- III. In instances:
 - a) Where a person is languishing in remand custody
 - or
 - b) Where a person is likely to be remanded due to his/her inability to furnish bail, despite bail having been granted by a competent court, Magistrate and High Court Judges may exercise their discretion and order that such bail be furnished within a specific time period and until such time may consider the release of such person upon entering into a bond without sureties.”

Although such guidelines are aimed at curbing the number of pre-trial detainees held in prison, it must be highlighted that the above-mentioned guidelines have limited impact in curbing the population of persons remanded under the Poisons, Opium and Dangerous Drugs Ordinance, as bail cannot be awarded by the Magistrate’s Court for offences under Section 54A. Furthermore, as discussed above in Section 4.5 on Bail for drug offences, the provisions under Section 3 of the Release of Remand Prisoners Act are only applicable to persons found in possession of less than 1g gross heroin.

198. Article 114 of the Constitution of Sri Lanka

Conclusion

The analysis of the legal framework governing drug use, drug dependence and drug offences illustrates that Sri Lanka adopts a punitive approach than a human rights-based, public health-centred approach to drug use. This has led to the criminalisation, stigmatisation and over-incarceration of people who use drugs. This in turn has resulted in the overcrowding of prisons, which has made prisoners (and connected communities) more exposed to COVID-19, resulting in nearly 5,000 cases in prison¹⁹⁹ and ten deaths²⁰⁰ as of March 2021.

The review also highlights how Sri Lankan laws on drug control contain numerous provisions that allow arbitrary decision-making, and/or are applied arbitrarily. For example, as discussed in this section, police are empowered to arbitrarily decide based on unverified information that a person has to be sent for a medical examination to determine if the person is drug dependent. Police decisions on under which law to charge a person are sometimes dependent not on the kind or quantity of the drug but on the penalties in each law and whether bail can be granted.

Decisions regarding the extension of compulsory treatment at a NDDCB centre, which is deprivation of liberty, is made by a non-judicial entity. Further, various aspects of the laws governing drug control, such as provisions allowing compulsory rehabilitation do not adhere to international human rights laws and standards. Judicial decisions regarding sentencing persons to compulsory drug treatment are arbitrary and are not based on objective criteria. Further, persons convicted of minor drug offences and are subjected to fines may be sent to prison if they are unable to afford the fine, effectively criminalising the poorest among those in conflict with the law. All of these factors result in the criminalisation and over-incarceration of people who use drugs, particularly those from marginalised socioeconomic backgrounds.

Although during the COVID-19 pandemic the Attorney General issued instructions to the police to facilitate the granting of bail for drug offences to reduce prison overcrowding, these guidelines present several shortcomings (illustrated in the previous paragraphs). Further, the government has announced its intention to address prison overcrowding by sending persons deemed to have a drug dependence to compulsory rehabilitation instead of prisons, thus merely 'shifting' them from one overcrowded and unsanitary environment to another.

199. 'COVID-19: Prisons Cluster Nears 5000', *Ceylon Today*, 06 March 2021, <https://ceylontoday.lk/news/covid-19-prisons-cluster>.

200. '11 COVID Positive Cases from the Prison Cluster', *Ceylon Today*, 06 February 2021, <https://ceylontoday.lk/news/more-prison-cluster-associates-test-positive-for-covid>.

6. Drug treatment and rehabilitation in Sri Lanka

6. Drug treatment and rehabilitation in Sri Lanka

*“They were referred to as ‘kuddo’ [drug addicts].
They were treated as lesser human beings”²⁰¹*

Drug rehabilitation and treatment centres in Sri Lanka are state-administered or private. Individuals may voluntarily participate in drug treatment programmes at public centres run by the NDDCB by paying a nominal fee. Or they can be required to undergo mandatory drug rehabilitation and treatment via a court order at either a NDDCB centre or KDC and Senapura, which are centres under the purview of the Ministry of Justice but managed by the military. Alternatively, persons can obtain treatment at private fee-levying centres. Both public and private centres will be discussed in this chapter, as well as drug treatment that is available in prisons.

The majority of state centres designated for drug rehabilitation and treatment are for men, and there is only one centre in the country run by the NDDCB that contains a ward for women. The only other known state centre for women is under the purview of the Department of Social Services.

All rehabilitation programmes, at both state and private centres, are abstinence-based. In this regard, as discussed in section 4, it has to be noted that the UN Special Rapporteur on Torture has highlighted that by denying persons access to substitution therapies, states are subjecting “a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence.”²⁰²

In 2020, the government announced its intention to divert persons charged with drug offences from prisons to rehabilitation centres as part of its attempt to reduce prison overcrowding, following an outbreak of COVID-19 in prisons in Sri Lanka.²⁰³ On 3 December 2020, the Minister of Justice stated in Parliament that imprisonment is not the solution for “drug-addicted convicts”, mentioning that nearly 52% of the prison population was comprised of persons imprisoned for drug-related offences. He further stated that the prospects of sending such persons for drug rehabilitation would be explored as

201. As stated by an interviewee who had a drug dependence.

202. ‘Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment’ (UN Human Rights Council, 1 February 2013), Paragraph 73 <https://www.refworld.org/docid/51136ae62.html>.

203. ‘Inmates Charged with Drug Offences should be Rehabilitated: President’, *News First*, 10 December, 2020, <https://www.newsfirst.lk/2020/12/10/inmates-charged-with-drug-offences-should-be-rehabilitated-president/>.

imprisonment is not a long-term solution.²⁰⁴ Similar sentiments have repeatedly been expressed by the Minister of Public Security, an ex-senior Naval officer, who has stated that a mandatory rehabilitation program of one year would be more effective than a sentence of imprisonment for persons arrested for drug-related offences.²⁰⁵

The language used by the government demonstrates that its approach to drug treatment will simply be an extension of the militarised and punitive approach to drug control. Mandatory rehabilitation is in contravention of international human rights standards, and detention for a one-year drug rehabilitation program would constitute arbitrary detention. Furthermore, it is likely that this program will be used to target people who use drugs and do not consent to being subject to the treatment program, and all persons imprisoned for minor drug offences will be diverted to “rehabilitation”. The means of diverting to rehabilitation is cause for concern given the statement of the Minister of Public Security that the “police will move to direct drug abusers to rehabilitation centres where they can be treated and not seek to prosecute them in court”.²⁰⁶ This indicates that the government might make extensive use of the arbitrary power in the Drug Dependant Persons (Treatment and Rehabilitation) Act or an alternative means that does not require persons to be subjected to a judicial process before they are sent to treatment centres.

According to the instructions of the Attorney General discussed in Chapter 5, cases of persons arrested in possession of less than 1g of pure heroin or between 2g – 4g of gross heroin can be presented before the Magistrate under Section 78 (5) of the Poisons, Opium and Dangerous Drugs Ordinance and therefore eligible to be released upon the payment of a fine. Hence, it is likely that persons sentenced to imprisonment due to the non-payment of fines, or with previous drug convictions, would be diverted to rehabilitation centres to ease prison overcrowding. Therefore, it is predominantly persons from marginalised socioeconomic backgrounds that will be sent to rehabilitation.

Due to the limited research conducted on drug rehabilitation centres in Sri Lanka and the effectiveness of such programmes, very little information on drug treatment is available in the public domain. Where information does exist, there may be concerns with regard to its

204. ‘Imprisonment Not The Solution for Drug-addicted Convicts – Ali Sabry’, *Ada Derana*, 03 December 2020, <http://www.adaderana.lk/news/69663/imprisonment-not-the-solution-for-drug-addicted-convicts-ali-sabry>.

205. ‘Mandatory Rehabilitation for Drug Addicts: Minister’, *News First*, 05 January 2021, <https://www.newsfirst.lk/2021/01/05/mandatory-rehabilitation-for-drug-addicts-minister/>.

206. ‘Policy Reform on Drug Users Soon: Minister’, *Daily FT*, 18 February 2021, <http://www.ft.lk/news/Policy-reform-on-drug-users-soon-Minister/56-713411>.

accuracy. The NDDCB is the exclusive national authority that conducts primary research and publishes facts and figures related to drug use in Sri Lanka and the number of persons receiving treatment.

The NDDCB reports contain many inconsistencies. For instance, according to the statistics released by the NDDCB, 37,978 persons were arrested in 2019 for drug-related offences.²⁰⁷ Another report released by the NDDCB however, quotes the total number of arrests as 89,321 for drug-related offences in the year 2019.²⁰⁸

Where research conducted by the NDDCB is concerned, the reports do not highlight the standards or benchmarks used for analysis. For instance, the NDDCB Performance Report submitted to Parliament in 2015, highlights a study on the effectiveness of NDDCB treatment centres by quoting that 31% of persons who had received treatment at NDDCB centres were 'leading a successful life'.²⁰⁹ It is unclear what factors constitute a 'successful life' and how the benchmark was established. Furthermore, a report by the NDDCB released in 2021 on the effectiveness of its treatment programs, as reported by people in the centre themselves measures effectiveness in a broad and general manner that provides little information on the substance and quality of the programmes. For instance, people who underwent treatment describe their experiences as follows:

“When inquired on the quality of the rehabilitation given to the drug users, it was revealed that 100 (58.8%) said “Very Good” on the welcome that they received at their first arrival at the center, 99 (58.2%) said “Very Good” on the friendliness of the officers at the treatment center, 77 (45.3%) said “Very Good” on the cooperation given to them with regard to identification of hidden talents of them (drug users) by the officers at the center. And furthermore, 102 (60%) said “Very Good” on the relationship between the officers of the treatment centers and the drug users.”²¹⁰

207. Drug Abuse Monitoring System, 'Statistical Report on Drug Related Arrests in Sri Lanka' (Research Division, National Dangerous Drugs Control Board, December 2019), https://drive.google.com/file/d/1aFijuo_R2bfa4dU-FIAM1sLF1QAtyX3M4/view.

208. 'Handbook of Drug Abuse Information' (National Dangerous Drugs Control Board, 2020), https://drive.google.com/file/d/1khkVbSG8jniHPsgjP7PR23tlaFKOyD_F.

209. 'Annual Report 2015' (Research Unit, National Dangerous Drugs Control Board, 2016), <http://www.nddcb.gov.lk/Docs/research/Annual%20Report%202015.pdf>.

210. 'Quick Survey on the Effectiveness of the Treatment Process and Identifying Relevant Factors Affecting the Relapse of Drug for Clients Treated for Drug Abuse Disorders' (National Dangerous Drugs Control Board, 2021), <http://www.nddcb.gov.lk/Docs/research/Quick%20survey%20on%20the%20effectiveness%20of%20the.pdf>.

6.1. Centres within the purview of National Dangerous Drugs Control Board

There are four drug rehabilitation centres under the purview of the NDDCB, located in Thalangama, Galle, Nittambuwa and Kandy.²¹¹ The latter is reserved for persons below the age of 18 while the other three are reserved for adults. These centres provide voluntary treatment and accept persons sentenced to treatment by a court. According to the NDDCB performance report of 2018, these centres also function as non-residential outreach centres for persons who have a drug dependence, where they can receive 'day counselling' as part of the treatment for drug dependence, and potentially be referred to residential treatment if they request to do so, or if the outreach officer deems it necessary. This section will first discuss general issues relevant to the NDDCB centres and thereafter focus on specific centres.

According to the NDDCB website, the programme is for more than a year and consists of a two-month residential treatment followed by enrolment in the relapse prevention programme. There is no information provided on the content or duration of the relapse prevention programme. The website states that a two-week fee-paying residential programme is also available. The treatment at the centre involves counselling, behavioural therapy, vocational training, indoor and outdoor recreational activities, with harm reduction and evidence-based individualised treatment notably absent in the programme. Daily activities at the centre as per the website include:

- Educational programme
- Psycho education programme
- Music Therapy, Art Therapy
- Entertainment programme
- Stress Management (physical exercises, meditation, yoga)
- In-door & Out-door recreational activities
- Vocational Training programme
- After Care programme
- Follow-up meeting, Family meeting
- Health Awareness programme
- Agriculture Activities
- Spiritual programme

211. Thalangama Prevention, Treatment & Rehabilitation Centre (Sethsevana); Kandy Youth Prevention, Treatment & Rehabilitation Centre (Handessa); Galle Youth Prevention, Treatment & Rehabilitation Centre; Nawadiganthaya Youth Prevention, Treatment & Rehabilitation Centre (Nittambuwa).

Residents at the centre are supposedly allowed to meet with their parents or guardians once a month. Personnel at the centre are said to include a resident manager, counsellor and assistant counsellors, as well as members of 'treatment staff'.²¹²

6.1.1. Findings

Admission process

Although a NDDCB officer stated that a drug use screening test (DUST) is administered upon admission, according to counsellors interviewed, this does not normally take place in practice. Usually, during admission at the NDDCB centres, basic personal information is collected, together with information on any specific medical condition or medications the person is taking and the person's drug use history. No psychological evaluation is conducted upon admission.

According to a NDDCB officer, based on this information the centre decides on the individualised treatment plan. The assessment of a person's need for treatment is based solely on the information provided by the person. In the case of voluntary rehabilitees, the centre obtains information from the family as well. It should be noted that at times families send persons to these centres through coercion and hence there would be no informed consent, although the person would be deemed by the centre to have consented to treatment.

In cases of compulsory rehabilitation, the period of rehabilitation is most often decided by the court solely on the basis of the amount of drugs in possession of the person, i.e. the amount for which the person was sentenced. Further, NDDCB personnel are not provided with any background information on persons who are sent to the centres via court order and hence they have no knowledge if they have a criminal record, dependents, or complex health needs since the centre is sent only a piece of paper with the information on the rehabilitation period to which the person has been sentenced.

After registration, body checking is conducted by a counselling assistant with the assistance of a security officer, and any visible wounds or marks are documented. Some people reportedly try to bring things such as tobacco, which is prohibited, into the centre. This would be confiscated during the body check. The person's bags and belongings are also checked to ensure that they have brought the required personal items, such as toothpaste, a brush, clothes, slippers, and more.

212. 'Treatment Programme', Treatment and Rehabilitation Division, National Dangerous Drugs Control Board, Accessed September 17, 2020, <http://www.nddcb.gov.lk/treatment-and-rehabilitation-division.php>

The rehabilitation process

According to NDDCB counsellors, during the withdrawal period, doctors are summoned if persons experience health complications that require medical treatment, but as per normal practice, no substitution or other medication is provided to ease the symptoms. A counsellor stated that on average a person has withdrawal symptoms for about two days, and therefore although they try to include the person in the activities, they do not compel the person to participate. If the person experiences severe withdrawal symptoms they reportedly allow the person to remain in the dormitory or sit in the space where the activities are being conducted without participating. As the UN Special Rapporteur on Torture has stated, withdrawal symptoms “can cause severe pain and suffering if not alleviated by appropriate medical treatment” and denying medical treatment “or absence of access to medical care in custodial situations” to deal with such symptoms “may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law.”²¹³

Each person at the centre is said to be monitored by three persons – the counselling assistant, assistant counsellor and counsellor – during their stay at the centre. Reportedly, the centre prepares an individual treatment plan for each person based on which they participate in common activities, such as individual counselling, spiritual programmes, meditation, music, drama, handicraft and art activities. In practice, the individualised treatment plan appears to include only one-on-one counselling and no other specific activities tailored to each person’s needs.

During the counselling session, each person is called upon to share their experience during the programme. A former NDDCB counsellor stated that counsellors often teach the detainees what to say during these sessions as they want only positive comments to be made. Sometimes, according to the interviewee, counsellors withhold food if the person does not say what was taught to them. Once each person completes sharing their thoughts, the counsellors prepare a report. “Everything is fake, the speech is fake, the report is fake. It is like a ‘Tom and Jerry show,’” described a former employee, speaking about the process. The interviewee said that although he made attempts to change the process, he was unsuccessful due to hostility from other staff.

213. ‘Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment’ (UN Human Rights Council, 14 January 2009), <https://undocs.org/A/HRC/10/44>.

A NDDCB report states that part of the rehabilitation process is “strengthening the individual personality” to address what they have identified as one of the reasons for the dependence on drugs, meaning “weaknesses in the individual personality”, which is attributed to factors such as “birth inabilities, nature of family, society, environment and economic factors.”²¹⁴ The report states that relapse can be avoided “if the individual personality is powerful.” This is illustrative of NDDCB’s non-scientific approach to treatment that is not evidence-based.

Court-ordered rehabilitation can be extended after the stipulated period only upon the recommendation of the Director of the centre. According to a former officer of the NDDCB, the centre will usually agree to the extension of the period of rehabilitation because the person will not be considered to have been ‘rehabilitated’ – the centre would be reluctant to refuse an extension because they do not want to be blamed if the person relapses.

However, according to current NDDCB officers, due to the limitation of space, the period of rehabilitation might not be extended even if deemed necessary. According to a counsellor, although during the years 2013/2014 judges often sentenced persons for six months, presently the centre keeps the person for two to three months, after which they “write to court saying the rehabilitation period is over and to take appropriate action.” This is reportedly because there is a long waiting list and “when [the person] is kept for six months the opportunity for another person to enter the centre is reduced.” Detainees are therefore released after three months to enable the centre to allow more new intakes.

Family visits

Family visits are allowed once a month after the first month, usually on weekends. During visits, the family is not allowed to give provisions such as food to the person undergoing ‘treatment’. The reason according to counsellors is because “during the first month the client has urges to return home due to withdrawals”. A counsellor stated that although withdrawal symptoms “usually last about a week, it varies from person to person, and it can take up to a month for the person to stabilize”. Therefore, according to counsellors if the family visits during this period, “as soon as family members visit the person says, ‘I want to leave’”. According to a NDDCB officer, the number of visits allowed is decided by the counselling assistant, assistant counsellor, and counsellor monitoring each person. Such denial of visits that are based on unscientific justifications contravene the person’s right to family life and can hinder successful reintegration post-treatment.

214. ‘Quick Survey on the Effectiveness of the Treatment Process and Identifying Relevant Factors Affecting the Relapse of Drug for Clients Treated for Drug Abuse Disorders’ (National Dangerous Drugs Control Board, 2021), <http://www.nddcb.gov.lk/Docs/research/Quick%20survey%20on%20the%20effectiveness%20of%20the.pdf>.

Closer to the release date, the centre holds family counselling sessions to enable smooth social reintegration upon release. The number of counselling sessions is decided taking into consideration factors such as the person's health condition, the risk of relapse and obstacles to reintegration the person is likely to face when released. If the person has a close relationship with their family, they are invited to visit often. A former detainee's experience of family visits was however different; he said that officers would become annoyed and shout at his mother for regularly visiting him. If the person has no close family, a friend is invited to visit. A counsellor stated that if the person shares a problem that will have an impact on the person's recovery it may be necessary to enlist the family's immediate intervention, and in such instances, the family is invited to the centre outside the planned schedule.

Access to medical care

Before 2013, it was reportedly common for doctors to regularly visit the centres but at present doctors were said to visit the centre only when required. The extent of the involvement of medical personnel in the formulation of individual treatment plans and the provision of regular counselling appears to be non-existent as they visit to address only specific medical needs as and when required.

The counsellor stated that all NDDCB centres are close to hospitals and hence the lack of regular visits by the doctor does not pose a problem.²¹⁵ The officer also said they prefer not to have doctors visit the centres or maintain a dispensary at the centre because when "people are addicted to pharmaceutical drugs and they do not have access to drugs, they want any kind of tablet. So, they even lie and try to get anything. When the doctor comes it is difficult for us to control them." The officer stated that as soon as someone develops symptoms of an illness they are immediately taken to hospital, and to date they have not faced any problems due to doctors not visiting the centres. The perspective of the officer is based on problematic generalisations and illustrates little regard for the health needs or rights of people at the NDDCB centres.

215. The Thalagalama centre is close to the Thalagalama Hospital; the Nittabuwa centre is very close to the Wathupitiwala Hospital and the Galle centre is next to the Unawatuna Hospital. Although the Kandy centre is a bit far from a hospital, the officer said it is close enough to access quickly in an emergency.

A former counsellor pointed out the high incidence of self-harm at treatment centres because persons have no access to mental health counselling. The interviewee also said that due to lack of hygiene and overcrowding, if a detainee contracts a skin ailment it tends to spread quickly amongst the population at the centre. Reportedly, when there is a rash epidemic, none of the counsellors attend to the detainees and they are locked in their wards until they recover.

Post-release support

The 'relapse prevention programme' is said to entail an outreach officer following up with the person for a maximum period of around three months post-release. This is done via home visits and reports of the visits are sent to the treatment centre. According to a counsellor, if the client is deemed to be 'not doing well' or needing support then they will be referred to day counselling at a treatment centre. According to a NDDCB study, post-release follow-up was undertaken only for 45% of clients in the study sample.²¹⁶

The recovery rate, which is defined by the NDDCB as 'not relapsing', is 25%-30% according to counsellors. Hence, 70% of those that receive treatment reportedly use drugs after release. Although there is no public data on the rate of relapse of all persons who receive treatment at state-run facilities, this is in line with the findings of the aforementioned NDDCB study.²¹⁷

216. 'Quick Survey on the Effectiveness of the Treatment Process and Identifying Relevant Factors Affecting the Relapse of Drug for Clients Treated for Drug Abuse Disorders' (National Dangerous Drugs Control Board, 2021), <http://www.nddcb.gov.lk/Docs/research/Quick%20survey%20on%20the%20effectiveness%20of%20the.pdf>.

217. Ibid, page 34

Snapshot: NDDCB Centre in Thalangama

Ranil, a thirty-year-old man who has been to several drug treatment centres, stated that in 2011 his mother took him to the NDDCB Koswatta centre, where he spent nearly 2.5 months until he was issued a visa to go abroad to work. Ranil stated that although prior to admission a full strip search was conducted, it was still possible to smuggle contraband and drugs inside the centre.

According to Ranil, the centre was housed in a building with three floors. The office and staff space were on the ground floor and those in the centre – both the voluntary rehabilitees and the court-ordered – were housed on the first floor. Those experiencing withdrawal symptoms occupied the second floor.

At the time, those seeking voluntary treatment were charged around Rs. 7,500 (37.9 USD) and were kept at the centre for fourteen days. Reportedly, if the voluntary rehabilitee acted in a belligerent manner or became agitated, they would discharge the person because the majority of staff were women who would become scared. At the time, the staff consisted of fifteen women and three men.

During what Ranil referred to as the “sick period”, i.e. the initial period of withdrawal symptoms, they were given generic medicines such as painkillers. Contrary to what a current NDDCB officer said, according to Ranil, those experiencing withdrawal symptoms had to follow the same routine as everyone else. They began the day with physical exercises, which Ranil referred to as “quite useless because it was conducted by ladies wearing sarees and therefore it mostly involved stretching and light exercise”. The centre had a separate section for women and physical exercises were conducted together for men and women. There was no interaction between men and women apart from this. Films would be shown or a song and dance session would be held in the evening. According to the NDDCB officer, the food was provided as per the regulations, and rice and curries with fruit and yoghurt were served.

There is reportedly natural segregation amongst the voluntary rehabilitees and the court-ordered rehabilitees, with the court-ordered persons segregated and stigmatised, and the voluntary rehabilitees discouraged by centre staff from talking to them. Ranil mentioned, for instance, that the court-ordered rehabilitees would receive food of lesser quality.

COVID-19

Due to COVID-19, the NDDCB centres did not admit persons during the initial months of the pandemic and thereafter began admitting only if the person produced a negative PCR test. During the same period, people who were due to be discharged were not discharged until PCR tests were conducted.

Challenges and proposed initiatives

One of the challenges identified by current and former NDDCB staff members was the lack of human resources, which, according to current NDDCB officers, is reportedly being addressed as the NDDCB is said to be expanding its cadre. NDDCB officers also pointed out that the rehabilitation facilities need to be expanded, for which the assistance of the UN Office of Drug and Crime (UNODC) has reportedly been enlisted. The other challenge identified is the lack of adequate training.

According to an NDDCB officer, NDDCB is reportedly in the process of implementing the following initiatives:

- Establishing a referral mechanism for persons outside of Colombo who wish to receive treatment for drug dependency, but do not have a way to be referred to a centre. District level state officers will be trained to identify 'drug users' and refer them to relevant care. Development Officers will also send information to District level officers about those needing assistance. The persons would be referred to the district office counsellor, undergo day counselling and be sent to a psychiatric ward or a NDDCB centre. The process through which persons would be identified as 'drug users' was not mentioned.
- NDDCB has introduced a 24-hour hotline to provide information to families of drug dependent persons. It is reported that the 1927 hotline service operates 24 hours every day in English, Sinhala and Tamil languages²¹⁸ to provide counselling and information on intervention services to persons who are drug dependent and their families.²¹⁹ The purpose of introducing the hotline was to address the difficulties posed by the COVID-19 pandemic, which prevented persons from accessing such services in person.

218. 'Advice through Telephones to Save from Drugs', *Mawbima*, 07 December 2020. (Translated from Sinhala)

219. 'Emergency hotline 1927 for counselling for drug addicts: NDDCB', *News First*, 14 November 2020, <https://www.newsfirst.lk/2020/11/14/emergency-hotline-1927-for-counselling-for-drug-addicts-nddcb/>.

- A ‘substance use disorder’ ward will be established at every district hospital with a consultant psychologist, counsellor and nurse. It will have counselling, follow up and reporting on the client who will be monitored. If there is a need to admit persons to a centre, they will be referred to treatment centres.
- The screening of people who use drugs and urine testing at prisons and at the community level, based on which persons will be directed to a centre. It is not known whether the testing will be mandatory or random.

The proposed initiatives are cause for concern, particularly in the context of a militarised approach to drugs which is based on demonising, criminalising, and stigmatising people who use drugs. Once a person is classified as using or being dependent on drugs by the authorities, it is not clear whether the state officer will coerce the person to rehabilitation against the person’s wishes. For instance, the district level officers could enlist the assistance of police officers and use Section 10 of the Drug Dependents (Rehabilitation) Act to send a person for compulsory rehabilitation. Secondly, there are serious concerns whether the confidentiality of the data gathered through this process at the district level will be maintained, and if the privacy of individuals will be protected. Moreover, mandatory urine testing of persons is coercive and is not evidence of drug dependence as it only shows the existence of drugs in a person’s system at the time the test was conducted.

6.2. Centres within the purview of the Bureau of the Commissioner General for Rehabilitation

There are two centres that are within the purview of the Bureau of Commissioner General Rehabilitation (BCGR): Kandakadu Drug Treatment Centre (KDC) and Senapura Vocational Training Centre. BCGR is under the purview of the State Ministry of Prison Management and Prisoners’ Rehabilitation, which is under the purview of the Ministry of Justice. Both centres were used to rehabilitate alleged former combatants of the Liberation Tigers of Tamil Eelam (LTTE) following the conclusion of the internal armed conflict in Sri Lanka in 2009. At the time, it was administered by the Sri Lanka Army, with the Commissioner General of Rehabilitation position being occupied by a senior army officer. The centre was converted to a drug rehabilitation centre in 2013 and continues to be administered by military personnel.

Persons who are sentenced to compulsory drug rehabilitation for one year by a court as an alternative to imprisonment for drug offences are admitted to KDC for six months. They are thereafter sent to the military-run Senapura Vocational Training Centre for another six months to follow a vocational training programme.

Information about KDC in the public domain is limited and mostly found only in a few news reports.²²⁰ A 2018 newspaper report, which describes a visit to KDC and interviews with personnel and persons held at the centre, states the programme at KDC reportedly involves spiritual training, counselling, therapy and meditation.

The facility is said to be kept secure using a double fence around the perimeter with multiple entry points so that “there is no possibility for anyone to escape.” According to the military personnel administering the centre that were interviewed for the article, persons are required to follow ‘military rules’ and their daily schedule is planned accordingly. The daily routine is as follows:

- Hoisting of the national flag followed by physical training/aerobics from 6.00 am to 7.00 am.
- Tidying up their living areas/breakfast.
- Cognitive therapy and other personality and self-confidence-building exercises from 9.00 am to 10.30 am.
- Tea break from 10.30 am to 11.00 am.
- Leadership skills, personal development and soft skills development from 11.00 am to 12.30 pm
- Lunch from 12.30 pm to 2.30 pm
- Activities such as music & collective recreational activities until 4.00 pm.
- Sports such as volleyball, football, cricket, badminton or gym for physical fitness from 4.00 pm to 6.00 pm.
- Headcount and dinner at 6.00 pm.
- Watching television or reading newspapers after 7.00 pm (on Wednesdays they are allowed to watch musical programmes/movies)
- Lights off at 10.00 pm.

220. ‘Rehab And The Addict’, *Daily News*, November 13, 2018, <https://www.dailynews.lk/2018/11/13/features/168292/rehab-and-addict>.

The article further mentions that the centre is managed by around 70 staff members, including seven counsellors; at the time, there were 1,066 persons at the centre. Staff members at KDC are from the National Cadet Corps who have undergone training in counselling conducted by the NDDCB for one year, while two visiting NDDCB counsellors conduct individual and group counselling sessions. The article highlights that “their military background also helps them instil discipline in the lives of the rehabilitees, who are required to have neat haircuts and shave, clip their nails and keep themselves clean, neat and tidy.”²²¹ Provisions such as clothing and toiletries are reportedly provided by the centre.

With regards to contact with family members, persons held at KDC are reportedly not permitted to meet their families during their first three months at the centre, after which visitors are permitted twice a month. Contact by telephone is said to be allowed once a week using the phone services provided at the centre, while personal mobile phones are not permitted.

The article highlights that during their initial months at the centre, persons are required to undergo “agro-therapy” i.e. farming and agricultural activities. According to a member of the military staff this “is believed to be helpful in breaking their drug habit. When they engage in agriculture and see the results of their efforts and the plants bearing fruit by the time they leave the facility, these rehabilitants get great mental satisfaction”. The initial period of rehabilitation also involves a “ten-day Vipassana meditation programme” during which persons are not permitted to speak to anyone and are required to engage in “meditation and reflection”. The article states that this programme is conducted by a Buddhist monk and is aimed at “curing their minds”.

The article reports a success rate of 50% but the standards by which success is measured are not described.

According to the 2020 progress report of the State Ministry of Prison Reform and Prisoners’ Rehabilitation,²²² the vocational training and rehabilitation programmes undertaken by the BCGR for persons undergoing the drug rehabilitation programme include courses involving manual labour such as welding, carpentry and masonry and a computer course. The centre also reportedly conducts religious and spiritual programs involving meditation and yoga as well as sporting activities and handicraft making, alongside counselling and leadership/mentoring training. The statistics of those enrolled at KDC and those reintegrated from the BCGR website are set out in the tables below.

221. Ibid

222. State Ministry of Prison Reforms and Prisoners’ Rehabilitation, ‘Progress Report - 2020’, 2021, <http://www.prison-min.gov.lk/web/images/pdf/progress-report-2020.pdf>.

Summary of enrolment of persons as at 12 February 2020²²³

Year	Month												Number of persons enrolled
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2013	-	-	-	-	-	-	-	77	58	70	47	43	295
2014	70	82	88	54	61	112	84	62	76	72	49	5	815
2015	19	36	49	25	55	41	49	47	41	27	37	32	458
2016	25	27	13	14	38	22	51	29	33	55	35	29	371
2017	23	25	26	40	48	60	65	42	69	109	61	71	639
2018	63	72	76	92	133	138	172	164	256	249	232	201	1,848
2019	162	269	372	-	22	8	15	20	62	38	77	120	1,165
2020	126	82											208
Total													5,799

Summary of “reintegrated” persons as at 12 February 2020²²⁴

Year	Month												Number “Re-integrated”
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2013	-	-	-	-	-	-	-	-	-	6	3	1	10
2014	5	13	13	21	28	22	11	16	29	36	15	76	285
2015	26	22	37	32	44	50	109	44	101	73	50	32	620
2016	80	43	43	53	67	56	46	51	59	38	52	37	625
2017	28	26	16	20	32	23	45	34	34	52	37	30	377
2018	24	32	26	38	51	54	75	44	96	92	66	64	662
2019	74	68	80	86	134	150	161	162	228	250	214	171	1,781
2020	162	87											249
Total													4609

In its statement at the conclusion of its visit to Sri Lanka in 2017, the UN Working Group on Arbitrary Detention expressed concern regarding the involvement of military personnel in drug treatment and rehabilitation. It pointed out that strenuous physical exercise was the core component of compulsory drug treatment, while there is a lack of trained professionals to monitor the health of people in detention. Furthermore, the statement highlighted the irregularities in the judicial process by which persons were sent to the centre without a medical assessment being carried out.²²⁵

223. ‘Summary of Enrolment of Drug Addicts as at 12.02.2020’, Bureau of Commissioner General for Rehabilitation, Accessed 16 June 2021, <https://www.bcgr.gov.lk/drug-addict-summary>.

224. ‘Summary of Reintegrated Drug Addicts - as at 12.02.2020’, Bureau of Commissioner General for Rehabilitation, Accessed 16 June 2021, <https://www.bcgr.gov.lk/drug-addict-summary>.

225. ‘Preliminary Findings from its visit to Sri Lanka’ Working Group on Arbitrary Detention, (4 to 15 December 2017), 2017, OHCHR, <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=22541&LangID=E>.

6.2.1. Findings – Kandakadu Drug Treatment Centre

Three persons who were sentenced to rehabilitation at KDC – Sarath, Kumara and Ranil²²⁶ – were interviewed about the conditions at KDC. All three relapsed upon release and thereafter entered private rehabilitation programmes.

Sarath was at KDC twice. The first time was during 2014-2015 and thereafter during 2017-2018. The first time he was sent to KDC upon his family's request to court that he be rehabilitated. The second time his mother requested that he be sent to the NDDCB centre in Unawatuna, but he was sent to KDC. In 2020, he was imprisoned for three months for the possession of drugs and was released after paying a fine. He continued using drugs while in prison. Thereafter, he voluntarily entered a private rehabilitation centre. Kumara went to KDC when he was 22, in 2018. Ranil was sent to KDC in November 2018.

The process reportedly followed to send a person to KDC after they are sentenced is in line with the findings of the HRCSL national prisons study. Sarath said that following his conviction, he was sent to Negombo Prison for 14 days and from there to Welikada Prison for seven days, and thereafter to Polonnaruwa Prison for a day. From Polonnaruwa Prison he was sent to KDC. He said he experienced withdrawal symptoms when he was being transferred to KDC, which he had to manage without any assistance. Kumara too was sent to Negombo Prison for three days, thereafter to Welikada Prison for a week, following which he was transferred to the Polonnaruwa Prison, where he was held for a night before being transferred to KDC.

Ranil was initially held at Mahara Prison for a week in a ward with all remandees, during which period his wife was allowed to visit him. He was then taken to Welikada Prison and kept there for a week in the I1 ward, which is the ward in which persons are held as soon as they are admitted to prison and before they are assigned to a ward. From Welikada he was taken to a lock up in Kurunegala, where he was given meals, and then taken to Polonnaruwa Prison, where he was kept overnight. The following morning, after being provided breakfast, he was taken to KDC. During their transportation to KDC, Ranil said he was handcuffed with others and held together by a long chain and during this period no one was allowed to use sanitation facilities.

226. Pseudonyms.

Since Welikada Prison held only convicted persons in 2018, Ranil would have been held with convicted persons for a week. The reason he says he was held at Welikada Prison for a week is because the prison authorities would transport persons to KDC only when there were about fifteen to twenty persons. According to the findings of the report of the HRCSL national prison study, persons are transported to KDC every Saturday from Welikada Prison. Therefore, those who are sentenced to rehabilitation on Monday will be held at Welikada Prison until Saturday to be transported to KDC.²²⁷

Those being sent for compulsory rehabilitation at KDC are therefore criminalised and treated like sentenced or remanded persons as they are transferred via the prison system and have to spend a few days in prison both to and from the centre.

Entrance process

Ranil stated that after admission to KDC their hair was cut and all new detainees were instructed to shave. Following that they were registered and were checked for identifiable marks on their bodies. He said new detainees were beaten during admission. According to him all new entrants are beaten using wires, hose pipes or sticks and subjected to verbal abuse. For instance, he narrated the incident of a person with a tattoo of his daughter's name being verbally abused and screamed at by officers who asked the person why he took drugs if he loved his daughter. According to Ranil those who are sent to KDC a second time are asked if they have come to "eat Rs. 200,000 again". The phrase 'eating' also describes wastage in Sinhala. Since Rs. 200,000 (1,009.5 USD) is the supposed cost of maintaining each person they were chastising Ranil for wasting state funds.

All new entrants were lined up in three rows and each person was subjected to a full body search for which they had to strip in front of each other. Thereafter, they had to squat naked and spread their legs and pass faeces, which was done to check if they were trying to smuggle contraband inside the Centre. After the search was complete, they took their set of clothes (uniform), which included four t-shirts, two pairs of shorts, two PT shorts, a pair of shoes, a toothbrush and razor and walked to the billet (the accommodation unit), which held around 40 people.

227. Human Rights Commission of Sri Lanka, 'Rehabilitation of Prisoners', in *Prison Study by the Human Rights Commission of Sri Lanka*, 2020, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

Kumara's experience of the entrance process was similar to Ranil's. He said their handcuffs were removed in the bus after they arrived at KDC, following which they were instructed to change their clothes, wash themselves and were given a towel along with two shirts, two shorts, a PT kit and canvas shoes. They were told to shave daily and were provided with two razors and two pieces of soap, but no shaving cream.

Kumara said that before all new detainees were taken to the billet they were taken to the main office where they were assigned numbers, a form was completed, and their photos were taken. They were also given a punishment of two beatings on the back with a big cable, which he said was painful. Thereafter, a full body search was done during which he was instructed to strip naked. He reported being body-searched alone.

All interviewees said no medical check-up was conducted during admission – they were asked for information such as their national ID number and household information.

Conditions of detention

In the billet, each person was assigned a bed with two bed sheets, a pillow and a locker. Kumara said they were not informed of the rules of the centre during admission, but were expected to act according to the rules – new entrants observed how others behaved and emulated their behaviour.

There is no categorisation of detainees at KDC in the billet according to Ranil, and they are assigned billets based on the availability of space. Sarath said that when he was sent to KDC the first time he was given a mattress to sleep and there were around 50 persons in each billet. The second time he was provided a bed. He stated that when the centre is overcrowded the beds are assigned to the 'seniors'.

Ranil however was provided only with sheets and pillows and since the cement floor had a rough texture, he said it was uncomfortable to sleep on. The billets are covered with aluminium sheets, and there were gaps between the floor and the walls through which insects crawled inside.

Water is reportedly inadequate, and the tanks inside the billet were meant to be used only for washing up in the morning and not for showering. From the tank, each person was allocated one bucket of water to wash in the morning and shower after 4 pm using the showers outside. The process of showering is similar to that followed in some prisons: persons are allocated 60 seconds to shower, due to which he said they applied soap even before they stood under the shower. According to Ranil, if the officer was kind people might be allowed

some extra time to wash but this was supposedly not common. He explains that usually, officers shout and tell them to hurry up. On Sundays, each person was allowed two buckets to wash their clothes and bedding. Soap was provided to them every month.

There is a volleyball court, cricket ground and a fully equipped gym at the centre.

Daily schedule

A class is formed by all those who were admitted on a particular day of a month. For example, all those who were admitted on Sundays during the month of December are assigned to one class. Each class had around 200 persons.

Sarath mentioned a monitor is appointed to each billet, often the most senior rehabilitee, i.e. the person who has been there the longest. According to him, "As long as you aren't mentally insane, if you are the most senior you are appointed". It was the monitor's responsibility to ensure everyone woke up on time and attended all activities.

People at the centre were woken up at 5 am and provided with a bucket of water each. Next, polling (the counting of rehabilitees) was done, after which they assembled for the hoisting of the national flag and the singing of the national anthem. Following this, they had PT and even older detainees were expected to participate in various army drills, running and other physical exercises. All interviewees said everyone had to participate, and if a person said they were sick, the officers would check if the person was lying. Those who did not perform well, such as those experiencing withdrawals, would be punished, and punishments included push-ups, squats, and other physical exercises.

According to Ranil, after the exercise session, which would take about an hour, people were not allowed to shower but were provided with a bucket of water to wash themselves. Kumara's experience was similar as he said that there were about 25 shower stalls and they were given time to only wash off the sweat. Despite this, he said: "By the time you go for meals, the canvas shoes you wore for PT were expected to be clean even though no water or cloth was provided to clean it. You have to look presentable when you go to eat".

For breakfast, they were served red rice and dhal with pol sambol (spicy coconut sambol) or chickpeas with pol sambol. For lunch, they were served rice and chicken, with around 3-4 curries around noon. They showered at 4.30 pm and a count was taken at 5.30 pm. A dinner of rice and curry was served at 7 pm. Once or twice a week they were given bread. All interviewees said they had no complaints about the food.

The next activity on their daily schedule was classes conducted by army officers. During these classes the officers would talk about the consequences of drugs and the impact it has on the families of detainees. These programmes do not appear to be evidence-based or adhere to internationally recognised and recommended standards of treatment.

During the first month, detainees were also expected to engage in agricultural work. Ranil pointed out that this was during the withdrawal period making it difficult for many persons. Kumara, who was given a small shovel and asked to dig a small lake/waterway, said that “If you do something you are not supposed to do, first you are warned and if you repeat it you are punished. That punishment is beating your back while you are in a push-up position.” Ranil reported that if they refused to work they would be beaten, “so you have to do the work”. Ranil felt they force the people undergoing ‘treatment’ to engage in strenuous agricultural work/manual labour during the withdrawal period because they think it will help them overcome/replace the craving.

Classes in the second month were conducted by NDDCB officers who are stationed at the centre for a few weeks at a time. During class, the purpose of which reportedly was to prevent detainees from re-using, the officers would inquire about the reasons detainees used heroin and show videos and photos of the impact of heroin, which they assumed would act as a deterrent to re-using. The activities during the third month were also the same but the classes were conducted by army officers. During classes, the officers spoke of the impact of heroin on the lives of detainees and their families and how they have “wasted their lives by becoming dependent on heroin”. Although there was a question-and-answer session after each class, interviewees said that usually no one asked questions.

Sarath said that as someone who had consumed drugs for a long time, he had more experience and knowledge than the army officers of the impact of drug use. Kumara echoed these sentiments as he said the military officers could not relate to the people at the centre because they knew nothing about the experiences of people who use drugs. In the fifth month, external counsellors visited the centre. In the sixth month, there were no classes as seniors are tasked with supervising the others.

Reportedly, there are about 20 to 30 counsellors²²⁸ who are very young, and according to

228. The counsellors would have had some form of training but the content and quality of training would depend on the entity from which they had received training.

Kumara, 'They don't know how to counsel.' Counselling sessions were usually for around 20 minutes and around 20 persons participated in each session. Those who came to counsel reportedly asked the person undergoing 'treatment' to relate their life stories and the counsellor wrote it down but rarely said anything. He said: "The counsellors learn from the inmates rather than inmates learning from them." A counsellor had told him that if he felt an urge to use drugs, he must immediately start playing his guitar. Kumara pointed out that this is not a successful strategy and queried, "What will I do if the urge comes back after playing the guitar?"

One-on-one counselling was also conducted, usually by army officers. It is not known if these officers are specifically trained to be counsellors. According to Sarath, "It was more like a class and did not take place often", and he said he was not willing to share his private thoughts with a group of people. Ranil said he found it difficult to answer the questions posed by the counsellors as he was very angry and upset that he had missed birth of his child. The counsellor had reportedly responded by scolding him and pointing out that he missed it because of his heroin habit.

In the evening, they were allowed to watch television in the TV room and read newspapers or books. Although the centre had a small library, it opened only once a month because books often went missing or were not returned. Reportedly, there was only one newspaper that was circulated amongst all people at the centre and by the time it reached the last person, it was in tatters. Every Saturday was designated the cleaning day. Apart from cleaning, during the weekend, they had no other activities and were allowed to watch films.

According to the interviewees, those who were at KDC a second time were not included in classes and had to only work/complete chores. They did not receive "treatment". This illustrates that the centre believed that either those who relapsed could not be helped, or were treating relapse as an offence and were addressing it through hard physical labour and/or punishment.

Favouritism

Sarath said that during his stay at KDC the first time and during the first six months of his second stay he did not consume any drugs. However, during his second stay he consumed tobacco, which he obtained from the military officers, which he said was possible if one had cordial relations with the officers on guard duty (“fit eke hitiyoth”). He said he also saw mobile phones being used inside the centre. As he said, “If you have the means, you can get things done”.

Kumara too mentioned the existence of favouritism at KDC but said they did not complain about it for fear of being punished. Some apparently received food from their families although they were not allowed to.

Ranil too validated this and said that those from influential families were treated better. For instance, they were often sent to work in the office or work for the officers/‘Sirs’ in the corporal or sergeants mess. Older detainees who had a good relationship with officers would request their friends to be assigned to work in the office. Influential persons being assigned office work was also observed during the HRCSL’s national study of prisons.²²⁹

Violence and ill-treatment

The violence described in this section constitutes torture and cruel, inhuman and degrading treatment or punishment, not only according to international human rights law and standards but also Sri Lankan law. Article 11 of the Constitution of Sri Lanka prohibits torture, while the Convention Against Torture Act 1994 criminalises torture.

Alleged violence at KDC is commonly discussed amongst those arrested for drug offences. A number of persons who had been sentenced to drug rehabilitation at KDC and were interviewed during the HRCSL’s national study of prison inquired from the Commission, with fear in their voices, if the stories of violence at KDC were true. An interviewee who had functioned as an external counsellor at KDC said of the violence, “They run the centre like a military camp, with the use of physical punishments to enforce discipline”. Other people at the centre reportedly requested the counsellor to intervene on their behalf with the army officers and pleaded not to be punished.

229. Human Rights Commission of Sri Lanka, ‘Inmate-Officer Relationship’, in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

All interviewees spoke of the everyday nature of violence at KDC. Ranil reported that “there is a lot of violence”, and that of 365 days you may escape violence for about five. Those who relapse and return to KDC are beaten, which is similar to a pattern in prison where repeat offenders are beaten. Ranil said that, like in prisons, at KDC too everyone receives a ‘welcome beating’ or a ‘welcome slap’, as it is referred to in prisons.

According to Sarath, officers hit detainees with wires or their hands, or sometimes with 33,000 [volts] power cables. He said he “does not even know the reason why they beat sometimes. If you happen to be there you get hit”. According to Sarath, detainees are asked to kneel for no reason and are sometimes beaten even at 1 or 2 am. Sarath narrated one such experience of an officer instructing him to fetch some fruits and vegetables from the kitchen and when he went to the kitchen, another officer in the kitchen had beaten him. He said, “You can’t escape from KDC. They will break your legs. You get used to a routine. The body gets used to punishments and beating”.

He narrated another experience of being handcuffed to a tree for three days, during which he had to remain standing the entire time, and was released only to eat and use the bathroom. Food and water were brought to him and he was not allowed to sleep. This severe ill-treatment was framed as punishment for being involved in a fight.

Ranil highlighted the use of collective punishment: “If one person makes a mistake, everyone is beaten”. He narrated an instance where a few detainees were singing, and everyone in the class was beaten because there was a line in the song which the instructor thought was used to ridicule him. The ‘mistakes’ for which people at the centre are punished can include (among others) being late for polling, trying to get food a second time by joining the line again, or engaging in same-sex acts with others. The use of collective punishment was confirmed by the interviewee who worked as an external counsellor at KDC.

The punishments include making detainees remain in the push-up position and beating them with a hose or stick. If they try to take food twice, they reportedly make the person roll on the ground until the person vomits. People undergoing ‘treatment’ are said to be beaten even during classes because army officers remain in the class while NDDCB officers conduct classes. The NDDCB counsellors apparently do not intervene when this happens.

Punishment is also meted out if the billet is not spotless, which according to Sarath is impossible because the nature of the building and the environment is such that there was

always dust and dirt. Officers supposedly checked under cupboards and beds and would declare the floor was not clean. Punishment would consequently be imposed, in the form of beatings while in a push-up position, being ordered to do push-ups, or lying on the floor under the bed for a certain period of time. If the billet was dirty, all people detained in that billet were supposedly punished.

Sarath described the anger the people undergoing 'treatment' felt throughout their time at KDC and pointed out that the failure to deal with drug dependence in a holistic and health-based approach results in them using drugs when they are released. He said, he "didn't last two hours" when he was released, and his main goal while at KDC was to "just put up with it and get out, without getting into any trouble. You feel so physically drained". Kumara echoed this and said because of the pressure he suffered at KDC, he started using drugs as soon as he was released.

Medical

According to interviewees, there is an army dispenser who issues medicine at the dispensary, and a doctor from the Polonnaruwa hospital visits the centre once a week. If someone fell ill at night, they were taken to the Polonnaruwa hospital. If the illness was not deemed serious, an assessment was made by the officers and the person was given painkillers. As the interviewees said, "Panadol is given for headache or chest pain."

According to Ranil, when medical personnel obtained blood samples of detainees, they were not informed of the reason for procuring the sample nor received a report of any tests that are done. Kumara however said that he was provided with a report on his cholesterol and blood sugar levels as well the results of his HIV test.

During Ranil's rehabilitation period, one person reportedly died of a heart attack, another person collapsed after polling and was declared dead, and two persons committed suicide at KDC and Senapura.

Family visits

Sarath said that family visits were not allowed at KDC during the first three months. During that period the person is allowed to communicate with their family mainly through letters, which are read by an officer before they are posted. Paper is provided by KDC but the families have to provide the stamps. Every Sunday people at the centre were allowed to receive phone calls from their families for about 7 - 8 minutes, but no outgoing calls were allowed. Reportedly, there aren't an adequate number of phones – hence each person was able to speak only for about 4 - 7 minutes.

After the initial three months, visits were permitted on the first and third Saturday of every month. Usually visiting hours are from morning to around 3 pm and visit times are limited based on the number of visitors.

Ranil, however, said that visits were allowed after the first month, stating that two visits per month were allowed. Each visit lasted for about thirty minutes and people were allowed to sit in the visiting area with their visitors. Like in prisons, interviewees stated that the officers at KDC requested the phone numbers of the women who visited, mainly female relatives of detainees, and thereafter harassed them.

6.2.2. Findings - Senapura Vocational Training Centre

After spending six months at KDC, people were sent to Senapura for six months of vocational training. At Senapura, the detainees were allowed to select the course they wished to follow, with choices including computer hardware, carpentry, welding, wiring, cooking etc. Upon completion of the course, they were provided with an NVQ²³⁰ Level 3 certificate. Kumara said he chose the computer hardware course and there were only around ten computers for thirty persons who followed the course, and hence each computer was shared by two persons. He felt the course was not particularly useful and the students did not learn much. Ranil said he chose the cooking course because he had a background in hospitality but did not find the course useful as he already knew everything that was being taught. Therefore, the instructor enlisted Ranil to assist him.

230. 'The National Vocational Qualifications (NVQ) Framework is a seven level qualification framework for vocational training. A Qualification is generally a package of competency units to suit requirements in a particular position in the labour market.' – https://www.tvec.gov.lk/?page_id=140

At Senapura, persons were subject to comparatively more violence, which the interviewees referred to as “punishment.” The interviewees attributed this to the fact that after spending six months at KDC they were deemed to be ‘rehabilitated’ and hence higher standards were used to assess their behaviour. For instance, even if their shirts were untucked, if their shoes were dirty or if they didn’t stand in line for lunch, they were hit with an iron rod or handcuffed to a tree for 24 hours – handcuffs were removed only to allow the use of sanitation facilities or to eat.

Ranil confirmed these practices and said that the violence was worse at Senapura, where punishments included being hung up by the wrists for 24 hours. These punishments, which are considered severe, were meted out for escape attempts and being found with contraband like tobacco. Ranil said, “At KDC, an officer might give you a chance sometimes but never at Senapura”. Due to such punishments, Kumara said they were all petrified and would avoid doing anything that could result in punishment, though they had no idea what that might be. Punishments were always carried out in view of others, much like in prison, since the purpose was to create a sense of fear in others.

Kumara said that tobacco was available in Senapura, which he also smoked. He further said he had seen psychiatric drugs being given to others by non-medical personnel not as medication but as contraband, and assumed they had been brought inside the centre by the officers. Ranil said it was possible to “obtain anti-psychotic medicine and even tobacco is smuggled inside”. Kumara said that at KDC and Senapura he learnt, what he calls, “a lot of bad stuff” from the older detainees, who would talk about their experiences experimenting with drugs. After hearing that he too reportedly experimented with drugs after his release.

Counselling was initiated at Senapura in 2018. It is conducted by NDDCB and is a combination of one-on-one counselling and group sessions, depending on the number of persons. During these sessions, like at the sessions at KDC, the counsellors apparently mainly obtained information from the detainees, wrote it down and said little.

At Senapura, visits were allowed from the fourth month of ‘treatment’ and took place during the first and last week of the month. Visits took place in a huge billet and chairs were grouped together to enable the person to sit with their family. The parents, siblings, or guardian in lieu of parents were also allowed to visit, but at the time of admission, the person had to inform the centre of the persons they expected to visit them. Visits took place from 9 am until about 2 or 3 pm and lunch was provided.

Where internal grievance mechanisms are concerned, Kumara said he was instructed to inform the officer in charge of his class if he faced any problems and the officer would inform the Director. If the officer did not take any action, then the problem would not be solved. He said if they attempted to meet the Director they would be punished.

During the last two months of 'rehabilitation', Kumara was not required to attend any classes as he was assigned a leadership role because he was considered a senior. In practice, when one has completed ten months, the person is reportedly entitled to a leadership position.

Upon the completion of six months, some detainees are released from Senapura while others are taken to court and released from court. The basis on which the place of release is determined is not known. The process of release reportedly begins when the court sends a letter to the centre stipulating the date on which the person has to be released, which is usually received a few days prior to the release but could also be delayed by a few days. In instances of delay, the person would spend a few days more than the legally stipulated, court-ordered period of detention. Those being released from Senapura, would reportedly receive a lecture from the 'loku sir' [Director] before being released by noon. Kumara was taken to the Director's office, the Director signed his release form and said that he was released. When leaving he received a shirt, shorts, shoes and a certificate for the course he followed. Generally, the family or guardian come to the centre and the person is released into their care. If no one comes to receive the person, the person is provided money for transport and released.

Ranil, however, was handed to the custody of the Polonnaruwa Prison. From there he was sent to Welikada Prison and from Welikada to Mahara Prison. Persons at the rehabilitation centre are handed over to the Department of Prisons because generally persons sentenced to detention or protection in a state institution are transported to their destination by the Department of Prisons. On the third day after being admitted to Mahara Prison, Ranil was sent to court and released. In instances when a person is not released from the Senapura Centre but is transferred on the day of release from the centre to various prisons prior to being released via court, the time the person spends in the various prisons is additional to the legally stipulated court-ordered period of detention.

Follow-up

Sarath mentioned that after his release from Senapura he received no follow-up visits, although the officers at KDC had said they would check on him. There is no known policy of follow-up or post-release support. Since NDDCB is not involved in the rehabilitation process at KDC and Senapura, except to provide counsellors when requested, NDDCB also does no outreach for those who are sentenced to treatment at these centres. There was also no family counselling at KDC or Senapura, like at the NDDCB centres, to enable post-release reintegration.

There are several similarities between the rehabilitation process for alleged former combatants and the rehabilitation process to which people who are deemed to have a drug dependence are subjected. The similarities point to the ethos upon which the process of rehabilitation of people with drug dependence is founded, i.e. the state 'rehabilitates' a group of persons viewed as undesirables by society. People who use drugs, like persons deemed to be former combatants before them, are demonised, dehumanised and portrayed as causing harm to society, ignoring the socio-economic conditions which cause a person to come into conflict with the law. Instead, a hyper-militarised approach is taken to 'rehabilitate' these individuals for the supposed greater good of society at the cost of impinging upon their human rights. As in the case of rehabilitation for alleged former combatants, the lack of external monitoring by an independent or judicial authority creates space for the rights of persons detained for drug rehabilitation to be subjected to rights violations.

6.3. Drug rehabilitation in prison

Rehabilitation conducted by the Department of Prisons

In 2004, circular No. 3/2004, was issued to all Superintendents of Prisons, informing them of new guidelines for prisoners who use drugs as part of the rehabilitation program to rehabilitate 'drug addicts' in collaboration with the NDDCB. The circular required all persons imprisoned for drug-related offences to be interviewed and among them, those found to be 'drug addicts' to be sent to a specific prison based on the length of their sentence and whether they had any previous offences.²³¹ The circular does not mention the method used to determine a person is an 'addict', which means it would depend on arbitrary, subjective, non-evidence-based criteria.

In 2010, as outlined in Extraordinary Gazette 1653/19, eight institutions²³² were designated as treatment and rehabilitation centres by then President Mahinda Rajapaksa by virtue of Section 2 of the Drug Dependant Persons (Treatment and Rehabilitation) Act on the recommendation of the National Dangerous Drug Control Board, "for the care and rehabilitation to drug dependant persons"²³³. Similar gazettes were issued in subsequent years, for instance in respect of the Kalutara Prison (2011),²³⁴ KDC (2014),²³⁵ and once again for Weerawila Rehabilitation Centre (2019)²³⁶ by former President Maithripala Sirisena.

However, it is unclear whether all these institutions are currently operating as drug rehabilitation centres. For instance, the 2018 performance report of the National Dangerous Drugs Control Board that was presented to Parliament in 2020, highlights ten designated centres²³⁷ being a part of the 'Prisoner Diversion Scheme' where prisoners receive treatment for drug dependence. The report highlights that counselling officers from NDDCB have been appointed to conduct rehabilitation programs and counselling at these centres for prisoners every day.

231. Welikada Prison, Anuradhapura Prison, Mahara Prison, Boossa, Homagama Work Camp, Thaldena Prison, Dalupotha, Weerawila Work Camp, Pallekele Open Prison Camp, Kuruwita Prison (for women)

232. Pallekele, Wataraka, Thaldena, Weerawila, Anuradhapura, Pallensena, Kandhawatta, Meethirigala.

233. Presidential Secretariat, Sri Lanka, Extra Gazette No. 1653/19, 12 May 2010.

234. Presidential Secretariat, Sri Lanka, Extra Gazette No. 1723/34, 16 September 2011.

235. Presidential Secretariat, Sri Lanka, Extra Gazette No. 1849/33, 13 February 2014.

236. Presidential Secretariat, Sri Lanka, Extra Gazette No. 2141/7, 16 September 2019.

237. Pallekele, Wataraka, Thaldena, Weerawila, Anuradhapura, Pallensena, Kandhawatta, Meethirigala, Kandakadu, Ambepussa.

Furthermore, the 2019 annual report of the NDDCB mentions that the Prisoner Diversion Scheme was ‘changed’ in 2011 following the enactment of the Drug Dependents (Treatment and Rehabilitation) Act, which “implemented compulsory treatment facilities in Sri Lanka and an exclusive treatment programme has been designed for prisons for drug-related offenders”.²³⁸ This was also confirmed by an interviewee from the NDDCB, who reported that ten institutions that are under the Department of Prisons are termed designated treatment centres where persons imprisoned for drug offences, as well as other offenders who may be dependent on drugs, could be sent to for rehabilitation. Persons who are convicted of drug offences may be transferred to one of these institutions for compulsory drug treatment by the court or at the discretion of the Superintendent of Prisons of the institution at which they are held if the Superintendent is of the view that a prisoner is dependent on drugs and requires treatment.

However, the statistics reports issued by the Department of Prisons in 2019, 2020 and 2021 only describe four institutions²³⁹ as centres used for ‘drug rehabilitation operations’. Additionally, the Department of Prisons Circular No. 4/2010 issued in 2010, requires Superintendents to transfer persons imprisoned for drug offences to prisons as per the classifications in circular 3/2004 as this was not being done efficiently. It also requires persons convicted of drug offences to be sent to work camps in Weerawila, Pallekele and Thaldena that are managed by the Department of Prisons, after they are subjected to interviews. Only persons serving sentences for the first or second time, and those sentenced for more than six months and less than three years can be transferred to these centres, other trials, if any, they are involved in are concluded.

The Department of Prisons Circular No. 22/2016 dated 05.09.2016 issued by the Commissioner General of Prisons directs the Superintendents of all prisons to send offenders sentenced for a term of imprisonment between three months and one year for offences involving drug consumption to the Ambepussa Paboda Meth Sewana Treatment and Rehabilitation Centre, which is under the purview of the Department of Prisons.

The HRCSL prison study report mentions that a drug rehabilitation programme was in place at the Weerawila Work Camp, Anuradhapura Remand Prison and Welikada Prison where NDDCB officers visited the prison and conducted group and individual counselling sessions as well as drug awareness programmes.²⁴⁰ A counsellor from the NDDCB is

238. ‘Annual Report 2019’ (Research Unit, National Dangerous Drugs Control Board, 2020).

239. Thaldena Correctional Centre for Youth Offenders (open camp), Weerawila Work Camp, Ambepussa Work Camp and Pallekele Open Prison Camp – Department of Prison Statistics, 2019, 2020, 2021.

240. Human Rights Commission of Sri Lanka, ‘Rehabilitation of Prisoners’, in *Prison Study by the Human Rights Commis-*

also assigned to the Pallekele Open Prison Camp, as per the prison report. However, drug rehabilitation programmes were not found at the Wataraka Work Camp, which is a designated centre. The Commission did not visit the other designated centres in Thaldena, Kandhawatta, Meethirigala, Kandakadu and Ambepussa as part of the study.

Circular no 3/2004 mentioned above requires a prison officer to conduct an interview of all persons imprisoned for drug offences to determine who amongst them are 'drug addicts', before transferring them to the relevant prison for drug rehabilitation. It does not mention the factors used by the prison officer to determine that the person has a drug dependence. Notably, this constitutes a prison official, rather than a judicial authority altering the conditions of the sentence of a person convicted for a drug offence, which is not subject to judicial or other review or appeal. Further, the programme is mandatory and the person is not given the choice of not participating in it.

Although work and open camps are less crowded than closed prisons²⁴¹, have minimal security and are spread over a large open space in a rural area²⁴², persons at work camps are required to engage in forced manual labour. The imprisonment of persons for minor drug offences, people who use drugs or have a drug dependence contravenes a human rights-based public health approach towards drug prevention and treatment.²⁴³

Furthermore, imprisonment without any access to harm reduction services and medical support to mitigate withdrawal symptoms can lead to dire health consequences and even death. For instance, in 2020 it was reported in the media that two remand prisoners who had drug dependence died by suicide as they had no medical intervention to assist them to cope with being deprived of access to drugs.²⁴⁴ It should be noted that most persons who are imprisoned for drug offences and who may have dependence are remand prisoners, and their inability to access any medical intervention places their health and lives at risk. Further, it can create a market for drugs within prison, as illustrated by reports of various interceptions by the authorities of drugs that were being smuggled into prisons.²⁴⁵

sion of Sri Lanka, 2020, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

241. Closed Prisons refer to prisons that contain a perimeter wall and hold prisoners under conditions of maximum security. (Human Rights Commission of Sri Lanka, 'Introduction to the prison system', in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.)

242. Ibid

243. 'UN System Common Position Supporting the Implementation of the International Drug Control Policy Through Effective Inter-Agency Collaboration', CEB/2018/2, pp. 12-14, <https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf>.

244. 'Three Inmates Commit Suicide Over Zero Access to Drugs', *Daily Mirror*, 26 August 2020, http://www.dailymirror.lk/top_story/Three-inmates-commit-suicide-over-zero-access-to-drugs/155-194572.

245. 'Heroin Inside the Mouth of a Prison Inmate', *Hiru News*, 07 April 2021; 'Jaffna Prison Guard Arrested with 45g of Heroin', *Hiru News*, 21 March 2021; 'Parcel Thrown over Kalutara Prison Wall Found', *Hiru News*, 10 February 2021.

Moreover, as HRCSL's national study of prisons found, prison authorities have no training or knowledge to deal with those experiencing withdrawal symptoms and resort to force as the primary means of managing it, which leads to injury and even death.²⁴⁶ As reported by the National STD/AIDS Control Programme:

“All the interviewees who used drugs who had been to jail, relapsed to using drugs again after their jail terms. In the words of a law enforcement official “Most of them are jailed for possession and only few are convicted for selling drugs.” Other officials reported that “...most of the arrested people only have about 1 or 2 grams of heroin on them” or “major challenge is arresting drug dealers. Arresting drug consumers is not a challenge”. Thus, it appears that the law enforcement response is heavily skewed towards arresting the people who USE drugs. However, even the law enforcers seem to concede that this approach is not likely to be effective. As per a law enforcement officer, “Some people are repeated offenders and have been jailed for the same offence more than a half a dozen times. But if they are still committing the same offence then something is wrong”.²⁴⁷

6.4. Proposed new centres

In 2020, the government announced plans to build three new drug rehabilitation centres.

The first is to be built in Nawadiganthaya with assistance from the United Nations Office of Drugs and Crime (UNODC), the foundation for which was laid in June 2020.²⁴⁸ The proposed centre will be within the purview of the NDDCB. The fact that NDDCB continues to be under the purview of the Ministry of Defence and the presence of high-level representatives from the Ministry of Defence, including the Sri Lanka Navy, Police and State Intelligence Service at the opening ceremony indicates that the new centre is not likely to adopt a public health approach to drug rehabilitation, but will follow the same punitive and militarised approach to rehabilitation.

246. Human Rights Commission of Sri Lanka, 'Death in Prison', in *Prison Study by the Human Rights Commission of Sri Lanka*, 2020, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

247. 'Rapid Assessment of Drug Use Patterns (RADUP) in Sri Lanka to Inform Risk Reduction Interventions for People Who Use/Inject Drugs (PWUD/PWID)' (National Dangerous Drugs Control Board and the National STD/AIDS Control Programme, 2018).
https://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/Rapid-Assessment-of-Drug-Use-Patterns-in-Sri-Lanka.pdf.

248. 'Sri Lanka: Ground-breaking of New Voluntary Drug Rehabilitation Centre', *UNODC*, 26 June 2020, <https://www.unodc.org/southasia/en/frontpage/2020/May/ground-breaking-of-new-voluntary-drug-rehabilitation-centre-in-sri-lanka.html>.

UNODC has reiterated that treatment should be voluntary as opposed to compulsory. However, despite vague statements about the need to provide rehabilitation to those with a drug dependence instead of imprisoning them, the government, to date, has made no formal commitment to transitioning to voluntary rehabilitation nor illustrated its commitment through meaningful action, such as legal reform or demilitarisation of the drug control and treatment process. On the contrary, the militarisation of drug control has heightened. In this context, UNODC's provision of support to a centre²⁴⁹ is cause for deep concern, particularly as it is contrary to the UN Common Position on Drugs²⁵⁰.

The centre proposes to “divert drug users away from prisons, reduce prison populations and strengthen the response capacity and capability to prevent and combat the spread of COVID-19 in the prison sector, contributing to the overall Government strategy to address the pandemic”. It has not been announced how persons would access the centre. Further, although the stated aim is to reduce overcrowding in prison by diverting persons imprisoned for drug offences away from the prison system and towards treatment, it is not known whether and how they will distinguish a person who uses drugs from those engaged in offences such as drug trafficking. Diverting people who use drugs to a treatment centre, as an alternative to imprisonment rather than allowing them to be released upon the payment of fines or considering decriminalising minor drug offences is a punitive response to drug use that is neither proportionate nor effective, and can constitute a form of arbitrary deprivation of liberty. Furthermore, mandatory treatment instead of imprisonment does not constitute voluntary treatment as the person has essentially no choice but to consent.

The second plan is to convert the Weerawila Open Prison Camp, which is within the purview of the Department of Prisons, into a treatment centre to hold persons convicted of drug offences and sentenced to less than five years. The centre will supposedly house about 2000 persons imprisoned for drug offences in an attempt to separate ‘minor drug offenders’ from ‘hard criminals’ with the aim of preventing the breeding of criminality in prison. The centre will conduct rehabilitation programmes for these persons.²⁵¹

249. ‘UNODC Pledges Further Support for Rehabilitation of Drug Addicts’, *Ministry of Defence*, 11 December 2020, http://www.defence.lk/Article/view_article/2720.

250. ‘UN system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration’, CEB/2018/2, pp. 12-14, <https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf>

251. State Ministry of Prison Reforms and Prisoners’ Rehabilitation, ‘Progress Report - 2020’, 2021, <http://www.prison-min.gov.lk/web/images/pdf/progress-report-2020.pdf>.

The third proposed centre was announced by the Defence Secretary Kamal Gunaratne in February 2021. Gunaratne highlighted the need for a separate centre where children arrested for drug offences can be held, as they are presently being held in adult facilities which has created the risk of “breeding crime.” Reportedly, the centre will have the capacity to ‘treat’ sixty children at a time and at least seven such centres were proposed to be built. The age of the children who will be held at this centre is not known, nor is the ‘treatment’ that will be provided. In his speech, the Defence Secretary described combatting the sale and use of narcotics as a “battle” for which they have “already commenced battles on a few battlefronts.”²⁵²

The detention of minors is highly discouraged in international human rights law and must only be done as a last resort after all non-custodial mechanisms have been explored.²⁵³ The detention of minors for minor drug offences cannot be considered necessary, proportionate and reasonable and the negative social and psychological costs of imprisonment – including the stigma, estrangement from family and the trauma of detention – cannot outweigh any proposed benefit derived from detaining minors. This is evidenced by the report of HRCSL’s national study of prisons which found high levels of mental distress and self-harm amongst the young offenders held at the Wataraka Youth Training School where young persons convicted of minor offences are held for at least two years. The UN Committee on the Rights of the Child (CRC) has consistently recommended against criminalising children linked to drug use.²⁵⁴

All three proposed centres mentioned above are an extension of the punitive and militarised approach to drug rehabilitation that ignores a human rights-based public health approach. With the aim of reducing overcrowding in prisons, the government is proposing to build new centres to hold persons for treatment, thereby replacing prisons with detention centres that operate as de facto prisons. Rather than investing in new centres, the government should use voluntary, community-based measures to respond to drug dependence. Moreover, the decriminalisation of drug use and possession for personal use will result in the reduction of the prison population, and resources could instead be allocated to awareness programmes as well as community-based voluntary treatment programmes.

252. ‘We Are Not Ready to Allow Children who are Drug Addicts to Languish in Prisons’, *Mawbima*, 02 February 2021. (Translation of Sinhala Article)

253. Rule 2, United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules). 1990; General Comment No.35 - Article 9: Liberty and Security of Person, 2014, *Human Rights Committee*, Accessed 07 September 2020, <https://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC35-Article9LibertyandSecurityofperson.aspx>.

254. ‘General Comment No. 20 (2016) on the Implementation of the Rights of the Child During Adolescence’, *Committee on Rights of the Child*, *CRC/C/GC/20*, 06 December 2016, <https://undocs.org/en/CRC/C/GC/20>, para 64; *CRC/C/AFG/CO/1*, para 52; *CRC/C/DNK/CO/3* para 55.

6.5. Private drug rehabilitation centres

Private drug rehabilitation centres are regulated by the NDDCB, which is mandated to issue a license for a private facility to operate. The Drug Dependants (Treatment and Rehabilitation) Act²⁵⁵ requires the NDDCB to appoint a Director of Treatment Centres who is empowered to visit any detention centre licensed under the Act for the purposes of inspecting and ascertaining whether the provisions of this Act are being complied with. The Director is required to produce reports on the number of persons receiving treatment at the centres and the effectiveness of the rehabilitation programmes.²⁵⁶ As reported by interviewees, investigation officers from NDDCB also reportedly conduct periodic visits to private drug treatment centres to monitor and report on the conditions at the centres.

Reports produced by the NDDCB on visits to private rehabilitation centres are not accessible to the public. Statistics on the number of people receiving treatment at private drug rehabilitation centres are also submitted by centres to NDDCB, which includes them in its reports. A list of private centres operating in Sri Lanka is in the NDDCB performance report of 2018²⁵⁷ which was published in 2020, but it is unclear if this list is updated/exhaustive.²⁵⁸

Although the Drug Dependant Persons (Treatment and Rehabilitation) Act allows persons to be sent for mandatory treatment²⁵⁹ at any facility that is designated as a treatment centre or licensed as a drug treatment centre by the NDDCB, court-ordered rehabilitees are primarily sent to state detention centres for mandatory treatment, unless they make specific requests to be sent to private centres. Private centres usually admit persons voluntarily for treatment, and may typically require the payment of a fee.

There are a number of centres founded and managed by religious figures whose programmes contain significant religious content. This is a common factor that has been

255. Section 4, Drug Dependant Persons (Treatment and Rehabilitation) Act (No. 54 of 2007). 2007. Sri Lanka.

256. Ibid, Section 4 (3)

257. National Dangerous Drugs Control Board, 'National Dangerous Drugs Control Board – Annual Report and Accounts 2015', 2016, page 44, <https://www.parliament.lk/uploads/documents/paperspresented/annual-report-national-dangerous-drugs-control-board-2015.pdf>.

258. Sumithrayo Drug Demand Reduction Centre, Power House Treatment Centre, AI – Ano Club Treatment Centre, Adurin Alokaya Treatment Centre, Senehasa Treatment Centre, Nisansala Treatment Centre, Nawajeewana Amadyapa Hada Sewaya Treatment Centre, Nethra Treatment Centre, Petuma Treatment Centre, Yawwana Kithu Maga Treatment Centre, Nidahasasa Treatment Centre, Karunawe Niwasa Treatment Centre, Meduma Treatment Centre, Mithuru – Mithuro Drugs Rehabilitation Center, Jayawiru Samadhi Niwahana Treatment Centre, Jayawiru Samadhi Niwahana Treatment Centre, Bethesda Treatment Centre, Yauwana Sahana Sewaya Treatment Centre, Promise Land Treatment Centre, Wimochana Treatment Centre, Bosco Treatment Centre, Mithra Rehabilitation Center, Rehabilitation Center, Mattakkuliya, Mithuru Mithuro Treatment Centre.

259. For a detailed discussion, please refer Section 4 – *National Standards*.

found in rehabilitation programmes in Sri Lanka since the inception of such programmes. Two examples are a centre run by a Buddhist monk, and another based on Christian values, i.e. the Mithuru–Mithuro Drugs Rehabilitation Centre²⁶⁰ and the Bethesda Reincarnation Centre²⁶¹ respectively.

Speaking about the quality of available drug treatment programmes, a medical professional pointed out that, “There is no great difference between ‘voluntary’ and ‘mandatory’ rehabilitation centres. The main difference is that compulsory is free of charge; when it’s voluntary, you are paying for poor service.” According to him, it is easy to obtain a license to operate a private drug rehabilitation centre as there is no proper assessment or monitoring conducted by NDDCB. According to a NDDCB officer, NDDCB has a unit that monitors private centres but the officer admitted that there are institutions that have not been registered yet. The officer also acknowledged that it is not always possible to find unregistered centres and hence it is possible for unregistered drug treatment centres to function for years without being identified. Validating this, an interviewee alleged that NDDCB does not take any action regarding complaints about private centres, especially ones that have political patronage. There is considerable room for abuse and exploitation at private centres since it is often the owner of the centre who decides the period a person would be held at the centre. As an interviewee described it, “The more you can pay, the longer they want to keep you.” This is a violation of the government’s responsibility to ensure all centres adhere to health and human rights standards.

6.5.1. Faith-based rehabilitation centres

Buddhist fee-paying centre

This fee-paying centre in the Sabaragamuwa Province was founded and is managed by a member of the Buddhist clergy who is allegedly politically well connected. The majority of persons interviewed for this study knew of the centre well and alleged that violence was commonly used at the centre, such as tying up persons and beating them during withdrawal.

260. ‘Mithuru Mithuro’, *Mithuru Mithuro Movement – Facebook page*, Accessed 19 September 2020, <https://www.facebook.com/mithurumithuromovement/>.

261. ‘Bethesda Reincarnation Centre’ *Bethesda Reincarnation Centre*, Accessed 19 September 2020, <http://bethesdareincarnationcentre.lk/index.html>.

Ranil was sent to this centre by his family in 2010 when they had charged Rs. 30,000 (151.4 USD) for admission for the first time and then Rs. 15,000 (75.7 USD) each month. In addition, the person is required to bring various things such as Rs. 5,000 (25.2 USD) worth rations such as sugar, rice etc. Despite this, Ranil complained they were not provided proper and adequate meals. They were served small quantities of mostly dhal and rice or chickpeas and rice or rice and pol sambol for breakfast.

Ranil said that soon after he was admitted he was kept in chains for a month and beaten because they thought he would escape as he complained. He was made to remain inside the cell at all times; even the toilet was inside the cell. Even when the chains were removed, he was made to remain inside all the time and engage in cleaning.

According to Ranil, there is a step-by-step process of rehabilitation that is followed each month. During the first month one has to work in the kitchen, and the next month the person is rotated to another work station. The activities at the centre were mostly religious in nature, which he said he found difficult to concentrate on because when one is in withdrawal, “one does not feel inclined to go to the temple”. Activities also included singing songs and discussing their meaning and team competitions. Each person also had to share their stories with the others. Ranil said he tried to escape from that centre because he did not want to stay as “there was no freedom of the mind. If you talk, you get a punishment. You can’t talk to anyone there”. According to him, for ten months he could not talk freely to people. Each day around 4 pm, they are allowed to go out for outside for some time.

Punishments at the centre included having to balance a brick on your thighs and remaining in that position, i.e. the stress position, for a long time. Ranil called it a “punishment for small offences”. Small offences constituted smiling or eating when you were not supposed to. Serious offences included trying to escape, conspiring to escape and being playful/being disruptive. Ranil said there are five levels of punishment with the lowest level consisting of doing extra chores, like washing all dishes. A variation of this punishment is called the ‘Fish Bowl punishment’, which entails having to scrub huge dishes until they go back to their original colour. The toilet punishment is cleaning the toilet with your fingers without a brush. Jungle punishment is cleaning the garden while wearing torn clothes with no water provided until the task is completed at the end of the day.

Reportedly, when one is being punished no one is allowed to talk to the person until the person is released from the punishment. Ranil said that even if he needed something, he would have to “wait for them to ask me with my hand raised. I could not talk to anyone directly otherwise. The staff could talk to me but I could not talk to them”. According to Ranil, even when not under punishment, there were set times to talk to staff and other persons at the centre. He described it thus, “even to get [painkillers] you have to go through so many people because you have to wait for specific times to talk to counsellors.”

According to Ranil, the system at the centre to maintain order and discipline was to ensure that each person was afraid of the other because when they were afraid, people would complain about each other to the officers. If someone did something that was considered wrong, the person was expected to admit to it and they were taught a chant about confessing one’s wrongdoings. For example, if someone did not clean the toilet, at the morning meeting the group leaders would mention the wrongdoing but would not mention the name of the person who did it. The supposed offender would then have to confess. If the person did not confess, someone else might point them out and then the matter will be sent to the Director as a complaint. Ranil concluded, “That’s a wrong system, it does not work. That’s not how it should function. It is too strict and too stressful”. He said he was very unhappy at the centre because of the pressure. He pointed out that although the method might have enabled the maintenance of discipline it did not help the treatment process.

As he was unable to bear the conditions at the centre, Ranil escaped. Six days after his escape, his mother contacted the centre and requested them to take him away again. The centre agreed and demanded that she pay Rs. 14,000 (70.7 USD). When the centre officers arrived to take him away he began shouting and created a scene and they left him alone. However, his mother was not refunded the Rs. 14,000 (70.7 USD). A month later, his mother gave him sleeping pills so he was tired and disoriented and called the centre officers who were able to take him. They held him in a cell as punishment for escaping and beat him using a cricket stump.

Three months later, he escaped again because he could not bear to stay there. He relapsed again despite the fact that he had tried to follow the programme while at the centre and had attended meetings with priests and had family counselling. When his family came to visit, the counsellor/priest would tell the family “Do not take him home yet, let him stay here a little longer, if you take him home, his addiction will cause problems for you”. Yet, they did not provide any explanations or advice on how to deal with dependence or how to support him after release.

Christian free of charge centre

This centre in the Western Province, which claims to be non-fee levying and voluntary is, however, not voluntary as evidenced by the statement of Gamini, the founder/manager, who has a history of drug use himself. He said, “Here we don’t let them leave if they try to leave without getting to a proper stable level of recovery. Otherwise, they will easily relapse”. The person hence has no freedom to leave when they wish, which makes the treatment compulsory. The means used to bring persons to the centre can also be coercive as illustrated by Sarath whose family used the police to bring him to the centre. The families allegedly pay the policeman or request a police officer who is a friend or relative to do a favour by forcibly bringing the person to the centre. The people undergoing ‘treatment’ too appeared to be conditioned into accepting that they will not be allowed to leave until they are ‘ready’ as demonstrated by Ranil who said, “Gamini knows that if I go home, I will try to get my hands on heroin, so he does not allow me to go home. There are good brothers here. We have not done anything wrong – we only did heroin”.

During the admission process Gamini said they obtain a person’s personal identification documents, which are maintained in a file that is opened for each person. These documents should include a letter from the Grama Sevaka (local village officer) and the church/mosque, a request letter from the family and the details of the guardian. Gamini admitted that families sometimes have difficulties obtaining these documents from state authorities who refuse to provide them, which Gamini finds ridiculous. He says,

“They would rather send them to prison for rehabilitation. They don’t want to help people who have a determination to change their lives. Over here, rehabilitees would rather come here after relapsing even ten times. No one wants to go back to prison or KDC. They always prefer this place”.

The centre is open and there is no security. Gamini is the only staff member and claims that he does this alone without any support from either individuals or institutions. The rehabilitees engage in the tasks required to run the centre and are made to feel part of it, unlike he says, “In those places, (where) there is police and security with guns and people try to escape. No one tries to escape from here”.

Every evening, prayer meetings are conducted and Gamini believes the only way in which people change is through their own motivation. Reportedly, since 2018 around 250 people have undergone the programme to date.

Gamini pointed out that many think that people who use drugs deserve to be treated badly and should be disrespected. He reiterated the need to remove the stigma attached to drug use. He said his philosophy is to treat people with dignity and respect and that they cannot be treated as if they are inferior. He emphasised that everyone is required to be polite to each other at the centre. For instance, no one is allowed to say 'umba' (informal form of 'you'). Ranil affirmed this through his statement that, "Over here, we mostly talk about the Bible and other good things. We do not talk about dirty things – we do not say words like Kudu Kara (druggie), we do not even want to talk about those things." Sarath stated that the centre was much better than KDC and is "ahasata polowa wage" (the difference between KDC and the centre is like the difference between the sky and the earth). Nevertheless, during the first month he said he experienced withdrawal symptoms and wanted to leave but could not.

Kumara said that when he was released from KDC he was still craving drugs and continued consuming heroin. His uncle was an Officer-in-Charge of the local police station and at his parents' request, his uncle sent a police escort that brought him to the Christian Centre. During the withdrawal period he was given no medicine, and he slept in a separate room where he was given a mattress and remained there for about three days until his withdrawal symptoms subsided. During that period, he could not eat rice, meat or anything heavy and would only eat a few biscuits or Samaposha²⁶² and was sometimes force-fed as he would not eat anything. He shouted at the group leaders at the centre who soothed him and told him he would feel better soon.

Kumara was born a Catholic and said he believed in God but said it was after coming to the centre that he began praying non-stop. He said he feels a "shocking change" as if he has a "new character". During the first month he said he wanted to escape but then step by step he improved by praying for strength. Now he does not want to leave the centre but wants to stay and help others.

Their daily schedule involves waking up at 6 am, completing morning ablutions following which they have a sing-song at 7 am. Then the rehabilitees have Bible study until lunchtime, after which everyone gets involved in different chores, like cleaning and washing clothes. They are provided breakfast, lunch and dinner. They spend the afternoon and evening singing and praying. Sarath mentioned that the hour of worship twice a day followed by

262. Samaposha is a pre-cooked, cereal based nutritional supplement food made of soya, rice, green gram and corn.

'sharing the word' soothed him and that he was not at peace until he came to the centre. The use of cigarettes and alcohol is prohibited at the centre.

According to Gamini, "he gives them advice using God's words". He said they use 'psychological methods' too to give counselling but "God's word is what helps people change. Apart from that, I do not have anything else to give". He stated that is how he was able to change himself and can only show them what he has been able to do himself.

Family meetings are conducted at the centre, usually every Sunday, to help families learn how to listen, cope and respond to the rehabilitees' concerns and needs. When they are released, people are told to contact Gamini if they face any problems. His system for the follow-up work is to request the pastor/church/Christian organisation in the area to 'keep an eye' on the person so that someone in the area is informed and responsible for checking on the person.

At the centre, visits can take place at any time and people are able to call their families at any time. Sarath said at this centre "there is time for them to think. To remember where they went wrong, whom they hurt etc. It is not a military schedule like KDC. There is a lot of free time". He said the reason he trusts Gamini is because he has been through the same experience, which was echoed by the others as well. Former rehabilitees visit the centre which the interviewees said was inspiring as they could learn about their progress post-release.

People usually stay at the centre for six months and the release depends entirely on Gamini. Hence, the decision to extend their period of treatment or to release them is dependent on one man, who makes the decision based on unknown and subjective factors and likely without any medical assessment or informed consent of the person.

While on the surface people who underwent 'treatment' at the centre had positive comments about the centre and its impact on their journey to deal with drug dependence, the treatment is not voluntary as persons are sometimes coerced or tricked into entering the centre and thereafter do not have the freedom to leave when they wish. The decision regarding extension of treatment period as well as release is dependent on one man who makes decisions based on unknown, arbitrary and subjective criteria. They are provided no medical treatment during the withdrawal period and there is no counsellor or staff other than Gamini. Further, its overwhelming religious content and the dependence on religion as the main means of treatment is cause for concern as it is not an evidence-based treatment.

Christian fee levying centre

A pattern that has been observed in private centres is that often former clients function as staff members or establish new centres after release. For instance, an interviewee, Dinesh²⁶³, went to a centre run by a man who had received treatment at Mithuru Mithuruo, where he had initially worked as a counsellor after his treatment. Thereafter, he worked as a counsellor at another Christian religious centre in Kuruwita and following that established his own centre in Nugegoda in the Western Province.

The average duration of the program at this centre was eight months, although the interviewee remained there for thirteen months. Persons were required to pay Rs. 4,000 (20.2 USD) each month for the treatment program along with a separate admission fee. Even if a person was discharged by their family before the eight-months period was completed, the balance payment for the remaining months had to be paid.

Dinesh, a lawyer based in the Western Province who represents persons arrested for drug offences, and who himself underwent drug treatment, reported that as soon as persons were admitted to the centre, for the first few weeks they were not allowed to speak to anyone except with certain senior rehabilitees, to prevent newly admitted persons from influencing and conspiring to escape with those that had been in recovery for a certain amount of time. Dinesh stated that regardless of whether one was still experiencing withdrawal symptoms, the centre staff would “come down on you hard”. This would often result in people experiencing suicidal tendencies and engaging in self-harm because of the mental distress they felt. The staff reportedly would respond by rubbing chilli powder as a punishment on the injuries inflicted to deter others from engaging in similar behaviour. If the injuries were serious, they would be taken to the hospital for treatment.

The process of rehabilitation involved abstinence, along with certain spiritual and religious exercises and group activities. For instance, the day would begin with a morning meeting, where people were required to write the faults/misdeeds committed by their fellow rehabilitees in a book. Then, after advising the person who committed the misdemeanour, the entry in the book would be erased. The purpose of this activity was to “fortify yourself by advising others”. The daily routine also included morning cleaning chores.

263. Pseudonym

Another activity involved people undergoing 'treatment' being required to write "confessions" and read them out aloud in front of a mirror, an exercise that was meant to operate as a "healing tool". They were also required to recite certain songs and quotes and analyse and question the deeper meaning of the recitations. Evening activities labelled 'family time' entailed everyone gathering for song and drama performances before dinner.

However, as this was a faith-based centre, Dinesh reported that there was always a degree of pressure to adopt evangelical Christian beliefs. For instance, all were said to have been forced to participate in singing Christian songs, and the staff at the centre would try to force detainees to engage in prayer, often punishing them if they failed to do so. Counselling was not conducted, but faith leaders and preachers would speak to the people undergoing 'rehabilitation' from time to time.

The centre had a system of punishments in place and the severity of the offence would match the severity of the punishment. For instance, people who committed the least severe offences would be required to sit at the back of the room, face the wall and reflect on their actions, after which they were allowed to return to the ward, and the ward-mates would scold the person by mentioning his faults.

The second level of sanctions were referred to as "shot down", where a person would be considered "shot down from the community" as a result of the misdemeanour they had committed. At this level of punishment, the person would be required to engage in all the chores at the centre, such as cleaning plates and washing toilets, and at other times would be required to sit facing a wall and think about their actions. The punishments would typically continue for a few days and wrongdoers would be "advised" or "scolded" by other people at the centre.

Normally, for the first offence, a person would only be required to sit in front of the wall for a few hours, and then three or four fellow rehabilitees would advise him on how to improve his behaviour. If the person is considered to have committed a severe offence, the punishment would continue for a few days. As the interviewee described it, although the methods were used as disciplinary tools, it was an 'unpleasant experience' to be scolded by others or to face the wall the whole day. The punishments were thought to deter persons from committing misdemeanours. These punishments constitute ill-treatment and are neither evidence-based nor effective.

Violence was often used to control and discipline people at this centre too. The interviewee reported that if a new entrant to the centre broke the rule of not speaking to others undergoing 'treatment', he would be slapped. If they told their family members during family visits that they wanted to go home, they would be beaten after their family left. Most people completed the stay of eight months at the centre, but the staff at the centre would convince the family to continue their stay for an additional two months because the person needed to 'correct themselves'. Since Dinesh's mother was inclined to listen to the centre staff, he remained at the centre for thirteen months. In instances the family members did not listen to the centre staff, they released the person after eight months. Although most people stayed for eight months, there were also those that left the program early, for example, if their families insisted on discharging them.

There was also favouritism whereby the owner of the institution would give certain people better food, etc., in return for information about others. He assumed this was done because the owner had to protect himself since the centre's inhabitants were mostly persons who had engaged in criminal activities.

6.5.2. Other centres

Rehabilitation programme conducted by a civil society organisation

Another interviewee reported staying at a residential abstinence-based treatment centre that was operated by a non-governmental organisation that engages in drug prevention awareness raising for two weeks.

According to the interviewee, the daily schedule at the centre involved waking up early and having breakfast, which was prepared by the occupants of the centre themselves. There was no structured rehabilitation program or counselling that was undertaken routinely. In his words, sitting idly during this period of time was an issue, because of the mind's tendency to wander. The interviewee attended meetings held by a religious pastor at the centre.

He stated that due to the withdrawal symptoms, it was not possible to sleep or consume proper meals during this period and he recalled experiencing body pains, for which there was no support or medical assistance provided to him. Others would smoke cigarettes and consume alcohol to deal with withdrawal symptoms and it was also possible for heroin to be smuggled into the centre. Although he did not consume any heroin while he stayed at the centre, he did smoke cigarettes and consume alcohol for some time as it was the only way to cope with the withdrawal symptoms.

The staff at the centre consisted of a team of counsellors from the civil society organisation who gave people undergoing 'treatment' advice on how to improve their lives. At that time, there were ten counsellors at the centre and most of them were people who had used drugs in the past and were now helping others. The interviewee highlighted the importance of someone who has already been through the experience of recovery advising others. During that fourteen-day period of withdrawal, the interviewee said it was difficult for him to retain the advice he received because he did not even feel like talking. He stated that fourteen days was not adequate because it is only after fourteen days that one might feel like talking again. He reported being the only person at the centre who did not consume heroin during those two weeks, stating he was able to do it "with the help of God".

According to him, the counsellors at the centre were aware that people were consuming drugs and alcohol but were not inclined to take any action. The interviewee attributed this to the fact they were only salaried officers and their primary concern was to ensure that the group completed the fourteen-day course.

Private fee levying centre

Before coming to Gamini's centre, Kumara reported being forcefully sent by his family to another private rehabilitation centre in Gampaha in the Western Province where they were required to pay a fee of Rs. 10,000 (50.5 USD) as admission and Rs 30,000 each month. The duration of the treatment program was about three to six months, but people could only leave the centre upon the request of their families or if they escaped. Kumara spent one month at the centre.

The centre was housed in a big building, with adequate space for about 100 occupants although it held about 110-150 occupants. The quality of food served was worse than those served at a national centre such as KDC. People were allowed to call their families after the first fourteen days at the centre were completed and visits were allowed for half an hour.

The Director and managers at the centre themselves had a history of drug use and had previously been dependent on drugs. Persons were provided with medication to deal with the withdrawal symptoms but some reportedly took the medication in excess. Tobacco and other tablets were also smuggled into this centre. Similar to other centres about which interviewees spoke, here too violence was used routinely to punish people undergoing 'treatment'. For instance, the Director would beat the rehabilitees on the legs using a pole if he smelt tobacco on them.

According to Kumara, people were not provided counselling during the treatment program. Lectures were conducted infrequently and there were yoga sessions from time to time, but people mostly only ate and slept during their time at the centre. He reported feeling aimless at the centre and spent his time “doing what he would have done if he was at home”. Whenever he craved drugs, he would call his family and speak to them.

6.6 Impact of treatment programmes

“People engaged in rehabilitation need to have the passion to do the work, the NDDCB people do not have that. The army does not have that. Beating will not work. They do not understand that at Kandakadu.”²⁶⁴

All drug treatment programmes in Sri Lanka are abstinence-based and do not provide any harm reduction services nor medical intervention to treat dependence. Dependence is not viewed as a medical condition that requires treatment that has to be voluntary, but as a social evil that must be eradicated via changing mind-sets through activities such as religious instruction, personality development and yoga. The only acceptable outcome of treatment expected is the person “becoming free from the usage of drugs.”²⁶⁵ Very little information is available in the public domain on the impact of the drug rehabilitation and treatment programmes in Sri Lanka, and the rate of relapse or return of persons to treatment centres.

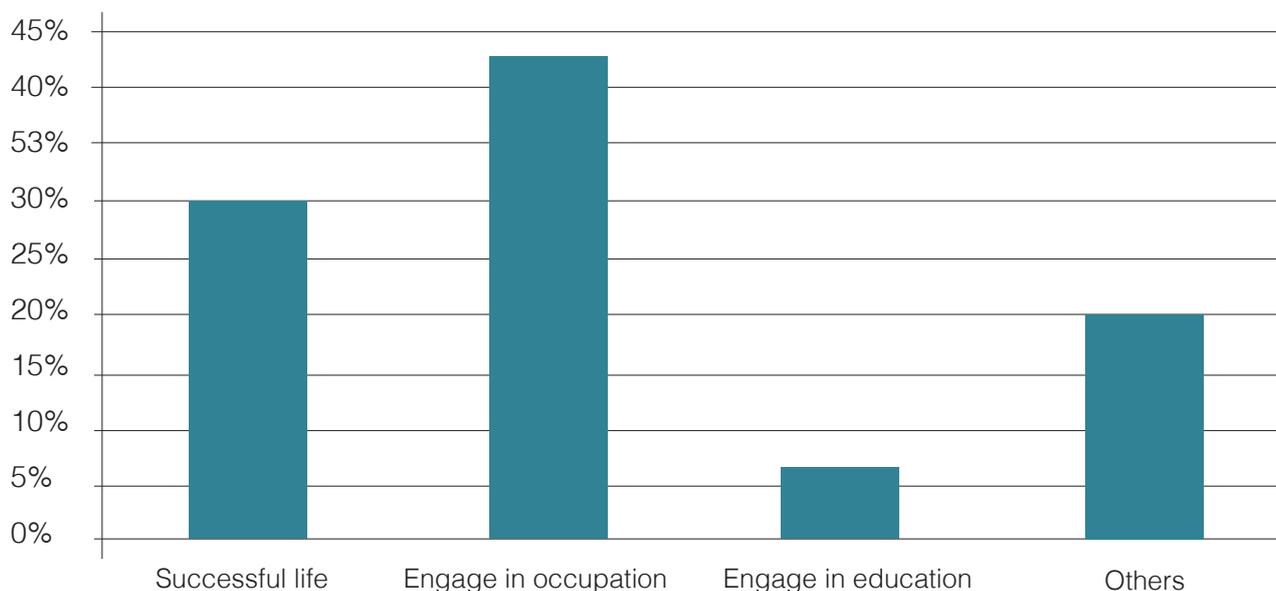
A study conducted by the NDDCB on the effectiveness of treatment centres in 2015²⁶⁶ highlights that 36% of the sample (comprising one hundred persons who completed the NDDCB drug treatment programme in 2013) “were released from drugs.” While this implies that around 64% of the sample group resumed consuming drugs following the conclusion of the treatment programme, which indicates a high rate of relapse, there is inadequate information available on the methodology of the study to arrive at such a conclusion. The results of the study further mention that 43% of the sample were engaged in a job, 31% were leading a successful life, 6% were engaged in education, and 20% fell within the ‘other’ category, as outlined below. The standards used to measure a ‘successful’ life are not stated.

264. As stated by an interviewee who was a former drug dependent.

265. ‘Quick Survey on the Effectiveness of the Treatment Process and Identifying Relevant Factors Affecting the Relapse of Drug for Clients Treated for Drug Abuse Disorders’ (*National Dangerous Drugs Control Board, 2021*), <http://www.nddcb.gov.lk/Docs/research/Quick%20survey%20on%20the%20effectiveness%20of%20the.pdf>

266. “National Dangerous Drugs Control Board – Annual Report and Accounts 2015”. 2016. *Parliament.lk*, 25 <https://www.parliament.lk/uploads/documents/paperspresented/annual-report-national-dangerous-drugs-control-board-2015.pdf>.

Current situation of the sample



Source: NDDCB

A NDDCB report of a study conducted in 2017-2018 found that of the 170 persons interviewed, 123 began re-using drugs after state-mandated compulsory treatment. Where the time taken to relapse is concerned, 72 of the 170 had begun re-using heroin – 25 had started re-using within 1-6 months of release, 12 persons within 2-4 weeks and 11 persons within a week. 16 persons had begun re-using ice of whom 5 had started within 2-4 weeks.²⁶⁷ According to a NDDCB officer, based on internal data the 'recovery rate' is around 25%-30%.

6.6.1. Challenges to reintegration

The lack of post-release support to reintegrate is evidenced in the narratives of the interviewees who have been to more than one rehabilitation centre. These persons face stigma, which hinders social reintegration and livelihood opportunities, as well as harassment by the police. This was a theme that was noted in all interviews. For instance, a medical professional who has extensive experience working with peer educators with a history of personal drug use, said persons who received drug treatment continue to be

267. 'Quick Survey on the Effectiveness of the Treatment Process and Identifying Relevant Factors Affecting the Relapse of Drug for Clients Treated for Drug Abuse Disorders' (National Dangerous Drugs Control Board, 2021), <http://www.nddcb.gov.lk/Docs/research/Quick%20survey%20on%20the%20effectiveness%20of%20the.pdf>.

harassed on the street by the police who stop and search them, even after five years. He said, “They want them to die junkies.” A person with a history of drug use who now works for a civil society organisation described it as follows:

“In our country, if you take heroin users when they are using heroin – they are called users. When they stop, they are ex-users. When you stop, they keep reminding you that you are an ex-user. There is a lot of stigma.”

All interviewees bemoaned the fact that people who use drugs do not have family support nor any other form of assistance. Gamini said, ““Everyone kicks you out – society, friends and family put you aside.” As he had no one else, he spent time with some tourists. He had some money but nothing to do in life and was always afraid of the police. An interviewee who has functioned as an external counsellor at KDC said that when he does group sessions at KDC, he asks them to raise their hands if they began using heroin again because of the stigma and the way society treated them, even after they had stopped, and often many people raise their hands. This illustrates how the lack of a supportive environment creates multiple challenges even for those who seek treatment.

Social stigma undermines and denies life opportunities to people who use drugs. A former officer of the NDDCB stated that generally during the period of end-March to mid-April, i.e. around Sinhala and Tamil New Year, families tend to send their family members who use drugs for rehabilitation. He attributed this to the fact during festivals families wish to maintain a facade of respectability in the eyes of their relatives that visit, and hence want to have any family members with drug dependence ‘out of the way’.

Gamini said that although he wanted to sit for the Ordinary Level exams, his school did not allow him and even prevented him from continuing school because of his drug use. With much regret in his voice, he said that they should have given him the opportunity to sit for his Ordinary Levels because he was interested in studying, was smart, and had a thirst to learn. As they did not give him the chance, he said he consumed more heroin.

Dinesh, a lawyer who had received treatment for drug dependence, recalled that his old friends continued to look at him as the person he was before he went to treatment for many years – a person with a history of drug use. This, he said, is the biggest challenge to overcome because you then become alone and have no one to talk to. He described it thus:

“You have lost your old friends and even new friends are difficult to make when they learn of your past. Ultimately, we are also human and need interaction. How long can you talk to your mother and father? So then eventually you look for company, and the company waiting for you is the people doing it.”

Even four years later when he sat at his social club, he said he would hear whispers about him. As he had to re-start his legal career, he began practising with a good friend, and others would joke that he was starting again at the bottom of the profession as a junior. However, he said the rehabilitation process had “toughened him” and he viewed it as a step in the right direction. He began to receive more work and his friends began engaging with him again when they realised he was “stable again”, and he slowly began to be invited to social gatherings. It took him four years. During this period, he feels his friends watched him until they were confident that he had recovered. As he pointed out, “That time frame is difficult for someone to stomach”.

The need for community support, particularly to secure a livelihood, was reiterated by all interviewees. Those who had received treatment for drug dependence pointed out that this is one of the key reasons that lead to relapse. The other urgent need is to provide support to families to support the person, because as Ranil said, “Our treatment is tied to whether our families are doing well”. This was echoed by a NDDCB officer who said, “It is aftercare that needs most change. When we are in the centre it is easy for us to take care of them. Besides, we can instruct the parents to do this and do that but after they go into the community, if they have no protection in the community, they relapse”. The officer explained it thus, “What we do as a centre is change the person’s mind and show him the methods to stay away from this but continuing it lies with the community”.

A NDDCB officer acknowledged that in some communities where there is a high prevalence of dependence or lack of familial support, they have witnessed higher rates of relapse. The officer also pointed out recent bullying and negative portrayal by the media of people who use drugs, which the officer said adversely impact persons attempting to deal with dependence. The impact of social stigmatisation and criminalisation of people who use drugs undermine their life chances. The officer described it as thus: “If a person who uses drugs has no value, if he doesn’t have any value in the community he lives in, then no one is ready to give him a job. When children in his family go to school even the teachers don’t show them any respect”.

Dinesh explained the importance of a supportive environment to deal with drug dependence as follows:

“There is no point going to rehabilitation and then going back to what you came from and to the same people. You must have a system where there is a support system, and they must not highlight themselves as anything to do with rehabilitation, but you need people. There must be a community with whom you can be friends and just have a chat. They need to have someone to talk to and good human contact. After you are rehabilitated, you want to go back to society so this system must be from society itself. He points out that while hotlines can help, ‘There is no point coming for one hour, and talking to a stranger is no good. The person who comes out must have a community for himself.’”

Where alternate approaches are concerned, a medical professional stated that when he had attempted to pilot harm reduction in 2009 he was asked for evidence that it would work. In response he invited WHO experts to visit Sri Lanka and meet with the authorities but felt the authorities were prejudiced and stigmatised harm reduction despite the fact research has shown otherwise.²⁶⁸

6.6.2. Gender dimension

Thalangama is the only centre of the four centres under the purview of NDDCB to have a ward where up to ten women can be accommodated for drug treatment. Additionally, a state detention centre within the purview of the Western Province Department of Social Services, which is used to house women including women arrested for offences under the Vagrants Ordinance and women who are suffering mental health and psychological illnesses, is also used to house women who are reportedly dependent on drugs.²⁶⁹ People are sent to the centre through a court order, but a number of due process safeguards, including judicial review of the detention²⁷⁰, are not adhered to and many women are held at the centre in violation of their right against arbitrary detention.²⁷¹ Children of some of the detainees may also be held at this centre.

268. ‘Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment’ (UN Human Rights Council, 1 February 2013), <https://www.refworld.org/docid/51136ae62.html>.

269. ‘Human Rights Report: Methsevena State House of Detention, Gangodawila’ (Monitoring & Review Division, Human Rights Commission of Sri Lanka, 2004), <http://www.janasansadaya.org/uploads/files/Methsevena.pdf>.

270. ‘Preliminary Findings from its visit to Sri Lanka’ Working Group on Arbitrary Detention, (4 to 15 December 2017), 2017, *OHCHR*, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22541>.

271. ‘Human Rights Report: Methsevena State House of Detention, Gangodawila’ (Monitoring & Review Division, Human Rights Commission of Sri Lanka, 2004), <http://www.janasansadaya.org/uploads/files/Methsevena.pdf>.

A NDDCB officer stated that in the officer's experience, women who use drugs are treated by their families and the community thus:

“When a boy or a man uses drugs and goes back the family welcomes him. They somehow welcome him. Either he's wanted as the husband, or he's lovingly welcomed as the son, somehow they do it. But when a girl gets out of it, even if she was not a sex worker, when she's labelled that way, she doesn't have a good marriage, parents don't care about her. When the pressure at home becomes too much they run away somewhere. When they go like that, that's it... And labelling happens so much more to women than it does to men in this setting. So, society itself has curtailed their scope to recover.”

The officer said that women who seek protection try to find places where other women who have had similar experiences gather. Without support, they can be pushed into sex work. The officer explained that men often have support to navigate the legal process if they are incarcerated for a drug offence, while women often have none. This is in line with the findings of the HRCSL's national study of prisons which found that many women became involved in drug trafficking due to their male family members or partners. Thereafter when they were arrested and incarcerated they had little to no support financially, and could not even retain competent legal counsel.²⁷²

Where employment is concerned, a man with a history of drug use is more likely to be employed than a woman because the NDDCB officer explained,

“When a woman gets a label as a woman who takes drugs, she won't be given a job by any place. Or she gets cleaning service work. However knowledgeable she is, however educated she is, she has to go to either a cleaning service or some hired work. To get something better than that she has to be from the highest class.”

The officer said they have informally documented around thirty-five women who were abandoned by their families.

272. Human Rights Commission of Sri Lanka, 'Women', in *Prison Study by the Human Rights Commission of Sri Lanka, 2020*, <https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf>.

6.6.3. Effectiveness of compulsory vs. voluntary treatment

“You can’t free people through compulsory court-ordered rehabilitation. Even people who went to KDC have come here afterwards.”²⁷³

Compulsory rehabilitation was identified as a problem by all interviewees for reasons ranging from the fact it is ineffective, to the fact that it drives persons to relapse due to the pressures to which they are subjected. Further, as discussed in section 4, compulsory treatment is a human rights violation. As a person with a history of drug use who now works for a civil society organisation that advocates on drug dependence issues stated,

“That’s why they say it’s better to keep them at home and administer treatment – community-based treatment. They became addicted within that environment so they have to recover from within that environment as well. When they are kept at KDC and government centres, it seems like they have recovered, and are doing better and well. But he is doing better because there are no drugs at the centre. Once they return to their home town, they will relapse because they have access.”

Many studies have found that compulsory treatment leads to faster relapse. A study in Thailand found the relapse rate after compulsory treatment to be 96%, while another study found that compulsory treatment only resulted in a ‘temporary cessation’ of drug use.²⁷⁴ As a study in Malaysia found, opioid-dependent persons that have been released from compulsory drug detention centres relapsed six times faster than those from voluntary drug treatment centres.²⁷⁵

The high possibility of relapsing is evidenced by all three interviewees at the Christian free of charge rehabilitation centre who had previously been sent to KDC. Sarath, for instance, was sent twice to KDC. Following his release from Kandakadu the second time Sarath had spent a month each at two rehabilitation centres before coming to Gamini’s Christian centre. In one instance he had escaped and in the other, he had promised his mother that he would be ‘good’ if she secured his release.

273. As stated by an interviewee who was drug dependent.

274. Nadia Fairbairn, Kanna Hayashi, Lianping Ti, Karyn Kaplan, Paisan Suwannawong, Evan Wood, Thomas Kerr, ‘Compulsory Drug Detention and Injection Drug Use Cessation and Relapse in Bangkok, Thailand’, *Drug and Alcohol Review* 34 (2015), <https://pubmed.ncbi.nlm.nih.gov/25302711/>.

275. Martin P Wegman, Frederick L Altice, Sangeeth Kaur, Vanesa Rajandaran, Sutayut Osornprasop, David Wilson, David P Wilson, Adeeba Kamarulzaman, ‘Relapse to Opioid Use in Opioid-Dependent Individuals Released from Compulsory Drug Detention Centres Compared with Those from Voluntary Methadone Treatment Centres in Malaysia: A Two-Arm, Prospective Observational Study’, *Lancet Glob Health*, 2017.

Kumara stated that when he went home, his family was happy to see him looking healthy and doing well. Yet, the pressure because of the hardship he experienced at KDC lingered in his mind and he was furious with his family because of what they had done to him. While he was at Senapura he was smoking tobacco and upon his release, he went searching for tobacco. Then he craved something stronger than tobacco, which is when he went searching for heroin. Within a month of his release he started using heroin again.

Dinesh described the problems with residential programmes by pointing to a well-known NGO which had a residential programme that was discontinued because the organisation realized it does not work as the person has to return to the community where the person faces challenges reintegrating. The NGO therefore, began non-residential programmes that persons follow while living in the community.

Current rehabilitation processes, whether residential or community-based, seem to deny the person dignity and criminalise them to some extent. This is illustrated by the comment of an interviewee about the strip search to which persons are subjected before participating in the community-based programme of the aforementioned NGO. Although he stated they conduct searches for the safety of the organisation and those that visit the centre, the process can be demeaning and is a form of criminalising and humiliating the person. He said he stopped visiting the centre because he could not bear being strip-searched daily by young counsellors.

The acceptance by people with drug dependence as well as their families that the process of dealing with drug dependence is one in which the person will be stripped of their dignity and that before treatment they are not 'normal' is reflected in Dinesh's statement below.

"Anyway when you go through a drug program you might lose some dignity, but then once you have gone through 8-10 months, your mind has changed. You think you have got your dignity back because now you are a normal person and you want to do good. After about four to five months there is a huge phase of guilt because you have done not so good things and hurt some people. So if you stay 8-9 months, you overcome that also. And you get suicidal tendencies also. When you come outside and you are treated like that, naturally there is no comfort zone. And the comfort zone is drugs."

As a medical professional and human rights activists stated, people with drug dependence are not given the opportunity to decide what they want since the

programs are prescriptive. They play no part in the decision-making process and no regard is given to their human rights, right to consent and right to health. This was also attributed to the lack of awareness and knowledge amongst policymakers and those working on dealing with drug use and drug dependence about new research on drug treatment. As an interviewee stated, “the knowledge that the whole world is using has not been transferred here”.

The importance of voluntarily seeking assistance to deal with drug dependence is reiterated by Ranil who said that after he returned from KDC he was tempted to take heroin again so he started thinking about coming to the Christian Centre because he knew if he remained at home he would relapse. The complexity of drug dependence and the need for a health-based empathetic approach is highlighted by Ranil who said,

“It is not like addicts are happy to be addicted. They need to be treated with love and kindness. If those places adopted that approach the service can be improved a lot. But each person has to have their own determination to be better – they cannot force anyone. It is not like heroin comes after us, we go after it ourselves.”

He succinctly explained that,

“Rehabilitation is not for a few weeks or months; it is for one’s whole life. The state doesn’t realise or know this. They think sending addicts to prison will fix it but they come out double addicts (more addicted than before). If you go to prison, your wife is likely to leave you. Your family breaks down. Then you leave prison and come back to no family and have no support system. The problem with KDC is that despite being a rehabilitation programme, after being released from Senapura you are sent back to prison for a few days. There you have to start at the bottom and sleep in the toilet because you are new. So, the stress of that makes you want to take tobacco or drugs available in prison. The whole year is useless if you are sent to prison after release. The whole year is undone within a day in prison. So, there is no point to the rehabilitation programme. It is better to give that money to other organisations that are actually able to help people. They cannot stop drugs coming into Sri Lanka so they need to give people treatment but their treatment methods do not work. They think that by working hard, manual labour, the addiction will leave your body.”

7. The role of the United Nations Office on Drugs and Crime in drug rehabilitation in Sri Lanka

7. The role of the United Nations Office on Drugs and Crime in drug rehabilitation in Sri Lanka

7.1 Activities of the United Nations Office on Drugs and Crime (UNODC) in Sri Lanka

The UNODC office in Sri Lanka was interviewed for this study, to gain insight into the programs being implemented in Sri Lanka.

One of the primary functions of the UNODC is to advise the government and the NDDCB on matters of national policy with regards to drugs and crime. The UNODC undertakes assessments of the patterns in the use of drugs and available drug use prevention and treatment programmes to develop the action plan to implement drug policies. UNODC is reportedly currently providing the government with technical and substantive support to conduct a comprehensive review of existing drug legislations and policies to develop a gender-sensitive drug control action plan/strategy.

The UNODC is also working with the government to implement two key programs in Sri Lanka that target drug prevention and rehabilitation. It does not appear that the programme was formulated in a transparent and inclusive manner through consultation with stakeholders, such as civil society organisations and people who use drugs.

7.2. Families United Programme²⁷⁶

One of the programs that UNODC is presently undertaking in Sri Lanka is the Families United, which is a strategy for drug prevention that focuses on developing family skills to improve family functioning. The program targets developing skills, through group interactive training, such as proper communication, promoting positive mental health, bonding, age-appropriate discipline/supervision and monitoring and other essential skills “that avail resilience in the family preventing not only substance use but also violence (including youth violence or violence against children) and crime.” This program is said to be conducted in line with the objectives of the UNODC WHO International Standards for Drug Use Prevention.

The UNODC received financial assistance from Japan to introduce the family skills program in Sri Lanka in 2020, but the initiative to train facilitators to train families was hampered due to

276. 'Family United', *UNODC*, 2020, <https://www.unodc.org/documents/listenfirst/covid19/Family-UNited-leaflet-20200218.pdf>.

the COVID-19 pandemic. UNODC has also prepared leaflets on parenting under COVID19 for initial dissemination and is planning to introduce this modality to national counterparts.

7.3. UNODC Treatnet Family²⁷⁷

This program, “an evidence-based intervention aimed at reduction of drug use, violence and delinquency”, is reportedly being piloted and scaled up in Sri Lanka after its success in South and Southeast Asia.

According to the UNODC Senior Program Manager, Treatnet Family is part of UNODC’s Treatnet initiative that aims to provide psychosocial treatment and recovery support for young people who use drugs/with drug dependence and their family members’ behaviour. The family environment can reportedly be a determinant of drug initiation and continuation. The Treatnet approach reportedly focuses on a holistic model to treatment, rather than an individual model, to improve family relationships and communication “to prevent further drug use, improve mental health of family members and relevant problematic behaviours such as violence, delinquency etc.”

In Sri Lanka, UNODC is reportedly working to train facilitators who will eventually build the capacity of national practitioners and assist them with using those skills through mentoring, supervision, data collection and analysis as well as monitoring and evaluation. The UNODC also plans to conduct a feasibility study in Sri Lanka. The first round of training of practitioners was conducted virtually.

7.4. Compulsory drug rehabilitation

UNODC stated it provides support to NDDCB to expand the capacity of the drug rehabilitation centres within the purview of the NDDCB. In 2020, the UNODC supported the NDDCB with building materials to expand the capacity of the Navadiganthaya Drug Rehabilitation Centre²⁷⁸, from its present capacity of 60 beds to 200 beds, as well as to develop areas for vocational training, healthcare and education.²⁷⁹

277. ‘Training Materials on Elements of Family Therapy for the Treatment of Adolescents with Dug and Other Substance Use Disorders including Adolescents in Contact with or at Risk of Contact with the Criminal Justice System’, *UNODC and Treatnet*, 2018.

278. ‘Sri Lanka: Ground-breaking of New Voluntary Drug Rehabilitation Centre’, *UNODC*, 26 June 2020, <https://www.unodc.org/southasia/en/frontpage/2020/May/ground-breaking-of-new-voluntary-drug-rehabilitation-centre-in-sri-lanka.html>.

279. Interview with UNODC Senior Program Manager.

According to the UNODC Senior Program Manager, the UNODC promotes evidence-based, ethical and voluntary treatment in line with international standards and UN principles. However, the UNODC office states that while persons are referred to the Navadiganthaya Centre “voluntarily by 1927 Hotline of NDDCB, from Outreach Officers of the NDDCB in the field, Development Officers attached to Divisional Secretariats, some of them are also referred mandatory by courts”.

In the context of the continued implementation of Section 10 of the Drug Dependant Persons (Treatment and Rehabilitation) Act which empowers courts to sentence persons to treatment, this is cause for serious concern. The UNODC reports that it has requested the government to abolish Section 10, but whether the government will shift to voluntary treatment remains unclear. In this context, UNODC should be mindful it does not become complicit in rights violation, albeit unwittingly, when providing technical and financial assistance.

7.5. Reducing prison population

One of the long-term objectives of UNODC is to assist the government to reduce prison overcrowding as the Department of Prisons has “recognised the importance of moving people with drug use or drug use disorders from prisons to voluntary treatment and rehabilitation facilities.”²⁸⁰

UNODC claims it can support the government to “identify and distinguish prisoners who are suited for voluntary rehabilitation outside of the prison setting as well as training of staff to identify drug use amongst prisoners”²⁸¹. The Department of Prisons and the Minister of Justice have proposed to send persons who are dependent on drugs for rehabilitation, which implies that rehabilitation would operate as an alternative to imprisonment and consequently would remain compulsory. In this context, the support of UNODC to the government is cause for serious concern as the UN would be supporting an act that is in contravention of the UN Common Position on Drugs and constitutes a human rights violation.

It is imperative to adopt a rights-based approach to drug rehabilitation in collaboration with multiple agencies with OHCHR playing a key role.

280. Ibid

281. Ibid

8. Recommendations

8. Recommendations

8.1. To the government

1. Immediately end the involvement of security forces in drug prevention and drug treatment activities. As part of this, the NDDCB should be moved from the purview of the Ministry of Defence and placed under the purview of the Ministry of Health.
2. In line with the 2012 and 2020 Joint UN Statements on Compulsory Drug Detention and Rehabilitation Centres, take immediate steps to close compulsory drug rehabilitation centres, such as KDC and Senapura, and implement voluntary and evidence and health-based treatment options. Government action should include a moratorium on further admission to compulsory drug rehabilitation centres.
3. Ensure adherence to a zero tolerance policy on torture, investigate any complaints of torture at state-run rehabilitation centres and hold those responsible accountable.
4. Review existing laws related to drug offences and undertake reform to ensure all laws are in line with human rights standards as well as Sri Lanka's international obligations. This should include:
 - a. Abolishing the death penalty for offences under Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance and implementing a maximum sentence of fifteen years imprisonment, as in the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act. Sentences of all persons on death row should be commuted to a fixed term of imprisonment immediately. Moreover, the fixed-term sentences should be evaluated periodically to enable the early release of persons.
 - b. Decriminalising drug use and possession for personal use to address the over-incarceration of people who use or are otherwise engaged with drugs, which leads to prison overcrowding as well as the criminalization of marginalized and disadvantaged populations.

- c. Repealing Section 10 of the Drugs Dependant Persons (Treatment and Rehabilitation) Act, which empowers a policeman to forcibly produce a person for medical assessment and produce the person before a magistrate for compulsory drug rehabilitation.
 - d. Amending the Poisons, Opium and Dangerous Drugs Ordinance to ensure that the distinction between the offence of possession and trafficking is not based solely on the quantity of drugs.
 - e. Consolidating the law on drug offences so there is certainty, consistency and fairness in outcomes. Similar to bail being granted at the Magistrate's Court for offences under the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, offences under the Poisons, Opium and Dangerous Drugs Ordinance too should be eligible for bail at the Magistrate's Court.
5. Formulate a national drug policy that is centred on an evidence-based public health approach to drug treatment and prevention. This should ensure that people who use drugs are able to exercise choice, from the right to consent to treatment as well as the right to withdraw from the programme at any time.
 6. Move towards the provision of community-based treatments to enable people with drug dependence to access their chosen rehabilitation and treatment from centres in their locality while living at home.
 7. Enlist expertise, including from the World Health Organisation, to explore the provision of harm reduction services. In this regard, the recommendations provided by the NDDCB/National STD control in their report on the Rapid Assessment of Drug Use Patterns in Sri Lanka to Inform Risk Reduction Interventions for People Who Use/Inject Drugs (PWUD/PWID) should be followed.
 8. Residential treatment and temporary shelters should be provided for persons who have been abandoned by their families or are in situations of homelessness. Such persons should have access to vocational training, educational and employment opportunities and aftercare monitoring based on their free and informed consent so they can reintegrate into society upon recovery.

9. Ensure that licenses are issued to private rehabilitation centres in accordance with strict standards and there is adequate official monitoring of these centres to ensure they adhere to these standards.
10. Ensure that qualified psychologists, psychiatrists and counsellors from the Ministry of Health are also included in the cadre and work as full-time NDDCB staff.
11. Consult with civil society, experts, and people who use drugs (while ensuring they are protected from negative repercussions) in the formulation of policies and processes to move away from compulsory drug treatment to voluntary community-based treatment.
12. Establish a system of referral with civil society to identify those who wish to access treatment for drug dependence and help them access the system.
13. Conduct training in treatment for drug dependence as well as evidence-based training on drug use and drug-related stigma and discrimination, and evidence-based, rights-based approaches to drug policy for public officers at the community level, such as Development Officers and Child Protection Officers. Thereafter include them in the process of aftercare so they are able to provide assistance and support to persons who are dependent on drugs.
14. Ensure that women who use drugs have equal access to voluntary, community-based treatment and psycho-social services and the specific needs of women are accommodated. For instance, the needs of women who have children that need to be cared for or require counselling for the gender-based violence they have experienced should be addressed.
15. Provide assistance and support to families of people who use drugs who may be subject to discrimination or suffer a loss of livelihood while their drug-dependent family member receives treatment.

8.2. To the National Dangerous Drugs Control Board

1. Ensure a stronger monitoring and reporting mechanism of private centres so there is adequate oversight and accountability of private centres. All private centres should be inspected at least twice a year and the findings of inspections conducted should be made available to the public.
 - a. Centres operating without the NDDCB license should be provided with assistance to obtain the license.
 - b. If the centre is not able to comply with the standards required by NDDCB after a stipulated amount of time has elapsed, the centre should be closed.
2. Establish a grievance mechanism for persons to lodge complaints against private treatment centres with the NDDCB in a simple, safe, timely and confidential manner.
 - a. Where a private centre is found to be operating in contravention of the NDDCB standards or causing harm to people undergoing 'treatment', the license of the centre should be considered for permanent or temporary suspension, depending on the misconduct.
3. Ensure strict standards are maintained regarding the voluntary participation of an individual in the drug rehabilitation program and that the informed consent of all new entrants is acquired and maintained during the duration of their stay at the centre.
4. Ensure that both state and private rehabilitation centres maintain strict standards of privacy and confidentiality with regards to the personal information of persons that access their services. Data protection and the right to privacy of the persons accessing the services should be ensured.
5. Establish a centralised electronic database to store information on persons who are admitted for drug treatment, to generate data and information on the rate of relapse to measure the success of the treatment programmes.
 - a. Individualise treatment based on the data gathered.

6. Strengthen the Research Division of the NDDCB both in terms of technical expertise and human resources. Use international standards for data analysis and advanced software to monitor trends and patterns so that statistics produced by the NDDCB have greater accuracy.
7. Introduce measures to monitor and analyse the outreach services undertaken by the NDDCB to learn from the successes and identify and address shortcomings.
8. Engage social workers and psychologists to support people with drug dependence during the aftercare process.
9. State officers working at the community level such as the Child Protection Officer, the Development Officer, the Grama Sevaka and NDDCB officers should be connected. These officers should also be made aware of the rehabilitation process and should be equipped to assist a person who relapses. This would also enable the family to be provided adequate support and create a post-release environment that is conducive for effective social reintegration.
10. Enlist the expertise of people with a history of drug use to be part of providing treatment to drug dependents.

8.3. To the Attorney General's Department

1. Ensure that persons are only indicted under Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance where there is strong evidence of trafficking, and persons found with drugs for personal consumption are not indicted under Section 54A, irrespective of the quantity.
2. In cases where defendants allege that police officers have framed them/planted drugs on them, undertake inquiries into the allegations.
3. Initiate action against police officers against whom there are allegations of perpetrating torture under the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment Act.

8.4. To the Department of Police

1. A systems overhaul of the Department of Police that addresses the structural and systemic dysfunctionalities such as the normalization of violence, corruption and disregard of due process rights, should be undertaken.
2. Increase the accountability and oversight mechanisms for police officers. For instance, introduce protocols that require officers to complete the Information Books and send evidence to the Government Analyst Department without delay. This can include establishing a separate and independent oversight body for the Department.
3. Install CCTV cameras at police stations and footage should be regularly monitored by an independent oversight body.
4. Digitise the process by which the Police Department collects, monitors, and makes publicly available quantitative data on the number of arrests made each year to ensure the accuracy of the statistics published.

8.5. To the Judicial Services Commission

1. Ensure the utilisation of legal provisions that allow fines to be paid by defendants in instalments, to avoid persons being imprisoned for the non-payment of fines.
 2. Until the KDC and Senapura Centres are closed, initiate a process of regular visitation by judges to the two centres, akin to the duty to visit prisons set out in Section 5 of the Release of Remand Prisoners Act.
1. In the interim, while efforts are made to decriminalise personal drug use, ensure that cases filed by the police under Section 54A of the Poisons, Opium and Dangerous Drugs Ordinance, where there is no evidence of drug trafficking, are directed to be filed under Section 78 (5) of the Poisons, Opium and Dangerous Drugs Ordinance instead.
 2. In instances the instructions issued by the Attorney General to the police regarding cases to be filed under Section 78 (5) of the Poisons, Opium and Dangerous Drugs Ordinance are not followed in practice by the police, ensure that officers are directed to do so.

8.6. Recommendations to the Human Rights Commission of Sri Lanka

1. Conduct regular inspections of state-run rehabilitation centres to ensure they adhere to human rights standards.
2. Publish reports of such visits.
3. Make interventions, including conducting suo motu inquiries, to address gaps and shortcomings identified during inspection visits.

8.7. To civil society

1. Call for the closure of militarised and compulsory drug rehabilitation and encourage the move towards community-based treatment for drug dependents.
2. Educate communities and young persons on evidence and health-based approaches to drug prevention, drug use, and drug dependence.
3. Advocate for the rights of people who use drugs to equal protection before the law and enjoyment of human rights, including the right to be free from arbitrary detention and torture and access to the highest standards of healthcare.
4. Create awareness on harm reduction and the benefits to society of evidence-based public health approaches to drugs.
5. Destigmatise drug use so that drug use and drug dependence are viewed as a public health issue rather than a crime.
6. Provide assistance and support to families of persons who have a drug dependency who may be subject to discrimination or suffer a loss of livelihood while their drug-dependent family member receives treatment.

