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First Model of One Stop Service for Drug Users in Drug Dependent Centers In Southern, Thailand

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Abstract
Preventing an epidemic of HIV among drug injectors may not have prevented an AIDS epidemic in Thailand totally, but as the risky behavior among this group has not been addressed it does consequently stand out as a major cause of continued HIV transmission. This qualitative study was done and a Rapid Situation Assessment was used in Drug Dependence Center Pattani. Fifty-six intravenous drug users (IDUs) were included in the service and all of them received service care (which was appropriate for all drug users) such as methadone maintenance, VCT/DCT testing for HIV screening, health education, TB care, ART, and Harm Reduction. Forty-five of the 56 subjects were admitted through legal channels. Sixteen of the 56 IDUs were HIV positive, and 3 of them had an opportunistic infection. Most of the subjects were satisfied with the services of the "One Stop Service". The nurses accepted that it should be built into routine care. The subjects established a "self-help group" with good cooperation from all members. Currently we have 45 cases in the project and all of them are members of a self-help club and join in the meetings regularly.
Keywords: RSA (Rapid Situation Assessment), IDUs, one stop service, drug dependence center, HIV, VCT (Voluntary Counseling and Testing)

1. Introduction

Before 1984 many people in the Thai health service .said that AIDS was not a threat to Thailand(Ainsworth et al., 2003). Many people in the public security services have said that stamping out drug use was more important than preventing an HIV epidemic; they were disastrously wrong because they never understood (Ball, 2007b, Ball, 2007a) "why they were using drugs?, and if they needed help or not". By 1995, the national HIV prevalence among Intravenous Drug Users (IDUs) was 32 percent, which then increased to 51 percent by 1999 and reached 54 percent in 2000. It has been estimated that each year 5%-10% of drug users become infected with HIV. Since the beginning of the epidemic, nearly 300,000 people have died of AIDS and it was estimated at the end of 2001. In Thailand, the HIV prevalence among injecting drug users has remained at levels around 40% since the beginning of the epidemic. In 2003-2004 the Thai government's policy "War on Drugs", which aimed to save the drug users and to jail the pushers did not, however, meet the needs of the drug users and their families. More than 43,000 drug "traffickers" have been imprisoned in Thailand and as many as 230,000 have been interned in "military-style" "treatment centers". Nearly 2,600 people were killed during the crackdown, in what human rights observers have concluded are extrajudicial murders with the tacit support of the government. Many drug users in Thailand feel that the care system for drug users is not equitable(Vongchak et al., 2005). They do believe that the establishment of a series of "Harm Reduction Clinics" throughout the country would be beneficial in helping them and others reduce their drug dependency. Some people, however, from both the government and general population sectors are not sure that this is a good idea because it is goes against the existing legal framework. In 2011, prevalence of HIV in IDUs was 26.5 %, which is still high, compared with the other group.

Preventing an epidemic of HIV among IDUs may not have totally prevented an AIDS epidemic in Thailand. Although the risk behavior in this group has not been addressed, it does, however, stand out as a major cause of continued HIV transmission in the Thailand, many of them concerned about HIV by sexual transmission and the focus of sex workers. Since the late 1990s methamphetamine was increased in use, (not only smoked but also injected), and there are at present an estimated two to three million drug users in the country. The risk groups were young adults and teenagers and while most methamphetamine is smoked or ingested, it may still facilitate an increased sexual risk and thus the potential for HIV transmission to occur.

One additional major barrier to providing healthcare and harm reduction services to IDUs stems neither from a lack of adequate funding nor from the absence of effective treatment models. Instead, it is a prevalence,

internationally, of strict anti-drug laws that punish the user rather than addressing his or her healthcare needs. In order to succeed, both donor and recipient nations, in developed and developing countries need policies that mandate or emphasize abstinence. That criminalize possession of small amounts of illicit substances and create environments in which drug users fear harassment, arrest, and incarceration ; if they are subsequently driven further underground, thus limiting their access to services they have the risk of spreading the virus. In the era of HIV and AIDS, the difference between treating drugs use as an illness or a crime is the difference between life and death(Bloom and Mahal, 1997, Aceijas et al., 2004, Glick, 2005) Thailand has 7 Drug Dependence Centers but they offer no support for drug users with HIV.

This project “one stop service” was to created to offer a service which would be appropriate to drug users (IDUs and DUs). The services for this group should be complete in only one clinic such as a Matrix program , Methadone maintenance, Voluntary counseling and testing, or Diagnostic counseling and testing for HIV screening, health education, TB care, ART, and harm reduction, and etc.

2. Purpose of study

- To develop the treatment and prevention services model for drug users living with and without HIV/AIDS.

3. Design and Methods : This is a qualitative study. The units of analysis were 56 IDUs that were admitted and 62 health providers from the Department of Drug Dependence Treatment in Pattani Province. The RSA (Rapid situation Assessment) was used in a focus group discussion to conclude the problems and modify the model of comprehensive care for IDUs such as VCT (Voluntary Counseling and Testing) and Harm Reduction Program.

4. Context of the Pattani Drug Dependence Treatment Center, Thailand

The Pattani Drug Dependency Treatment Center is located in the town of Pattani in Pattani Province. It is the only place for Drug Dependence Treatment for the 3 Provinces in lower Southern Thailand. This center has been established since 1994 and is under the supervision of the Department of Medical Service, Ministry of Public Health. There are 60 beds, the same as a community hospital with two main services; those of IPD and OPD cases. There are two physicians, 30 Registered Nurses and one pharmacist. Another health team is comprised of a technician, social worker, and psychologist. Most of the patients (80%) were admitted through legal channels while some (20%) were volunteers. The number of lost cases found at the OPD was 40%. More than 50% were lost in follow up. The IDUs came here for Codeine Treatment and detoxification of heroine and amphetamine dependence.

5. Results

This project attempted to establish a model for a care system for IDUs and DUs in Pattani. The subjects were 9 IDUs and 47 DUs. Forty-five of the 56 subjects were admitted through legal channels. Sixteen of the 56 IDUs were HIV positive, and 3 of them had an opportunistic infection (table 1 and 2). From this project we found patients that were accepted by health providers for both IDUs and DUs. Most of subjects were satisfied with services of the “One Stop Service” such as the VCT, blood for HIV/AIDS, cd4, TB screening and physical examination. The nurses accepted that it should be built into routine care. The health team was created for extra care as follows:

- Physical exam as usual and treatment and care
- referral care system
- home care and home visit
- cooperative for DUs and IDUs
- hot line

The subjects established a “self-help group” with good cooperation from all the members. Most of the health team accepted that this project should be built into routine care because it is good for the patient to know their health status (figure 1).

Before the Start of the program, we found that most of health providers did not want to deal with drug users directly because they were scared with the dwellers in the community, and that they also be hurt by the drug users. Many service providers believe that drug use is not only illegal, but also wrong, bad, and immoral. By extension that means that drug users are bad and even immoral people. In some cases that attitude translates into a license to openly judge drug users and their behavior in a negative way, to mistreat them, to be derogatory, and even be hostile and punitive. Unfortunately, many drug users are very sensitive to people and the verbal and nonverbal cues that are given off. If health providers hold negative attitudes about them, drug users will

certainly pick up on that message even if staff do not openly mistreat or degrade them. And many drug users will respond by becoming defensive, angry, and difficult to deal with.

After implementation of this model, the health team knew about their risks because they work with people at risk, and have to take precautions. The project created good relationships with the subjects. The subjects had more choices of activities in the center.

"It's good for the subjects because many of them get sick when they stay for a long period."

"I think I would ask someone because I always used heroin injection and tattoos also, I'm very happy that the result was negative, thank you."

"I think we have to do this for the subjects as they should receive universal coverage just the same as others Thais."

"In my opinion It's very important for our patients, it does not overload the routine work and it is good for the patients, they know that health providers in this center care about their health status."

"The opinion from the director of Pattani Drug Dependence Center about this project and plan for a future.".

"I think this is a good idea for my colleagues because it makes them understand the disease related to drug problems."

"We have no budget to run this program because the budget from Department of Medical Service did not provide for these activities : HIV and TB screening, and also National Health Policy did not cover these groups"

"I heard that your PI tried to negotiate with the National Health Policy for supporting this program"

"We are limited) in ART care, I think my colleagues can do only VCT. We have 2 physicians and we have to learn more."

"If the Department of Medical Service does not accept, I can do nothing"

NA(Narcotic Anonymous) Club was established by 7 IDUs and 2 DUs who came for drug dependence treatment at the OPD(Out Patient Department) , they plan the activities of teams and members as follows::

- self help group
- occupational therapy : agriculture such as planting bean sprouts and fertilizer, and fishery,
- to establish cooperative nursery, drop in center, and day care
- Networking in communities

6. Discussion and Conclusion

All groups in our study accepted that holistic care was needed for the drug users but it was very hard to start these activities(Donoghoe et al., 2008a, Donoghoe, 2006, Vongchak et al., 2005, Donoghoe et al., 2008b) . The big problem was that the Drug policies did not get along with Health policies and the patients needs. The national health security showed that drug users were a small group when compared with the whole population. The outreach activities such as home visits and follow up in communities could not be done properly because most of the health teams in the communities were scared of the criminals, and influential persons(Bat-Chava et al., 2005). Some of IDUs and DUs were underground with high risks transmission. Some of them were infected with HIV, TB, and Hepatitis C and they could be infected. (Qian et al., 2006) suggested that two factors protected against HIV sero-conversion: having stopped sharing of injection equipment in response to the acquired immunodeficiency syndrome (AIDS) and having a regular sexual partner. IDUs must be informed about these additional risk behaviors (Aggleton et al., 2005, Bankole et al., 2007).

The policy did not include diseases related with drugs such as HIV, TB, and hepatitis, so when the drugs users were admitted they never received other types of care, just only for drug treatment. From this project, we found that the IDUs were happy after they were registered in this program, they received a VCT screening test, occupational therapy, self help group, cooperation of NA, and continued care. We must extend this model to community hospitals and other Drug Dependence Treatment Centers. Major features of a public health-centered harm reduction model are listed according to conceptual, practical, and policy levels. Harm reduction is also discussed in relation to drug legalization, methadone maintenance, the supply side of the drug war, AIDS, prenatal drug use, and alcohol-related harm (Ball, 2007a).

7. Useful lessons learned

We learned that:

- In Thailand, there are many departments which have programs for drug users and they have different standards applied, such as those of the Department of Drug Dependency Treatment

Center, the Department of Probation, and the hospitals.

- Drug Policy in terms of treatment never goes hand in glove with the Law.
- Although we tried to cooperate with the government officers (such as policemen), the drug users always felt uncomfortable.
- Universal Coverage does not include drug related problems and when drug users who were admitted to a Drug Dependence Treatment Center they had trouble paying.
- It is very challenging to continue this program by building it into routine work.
- It is very challenging to encourage health providers in Drug Dependence Treatment Centers and hospitals to accept drug users as patients not as criminals.
- Drug users in the south want to have a Self-support Club and start to improve their lives, especially by trying to improve their health through drug dependency treatments, and HIV prevention and treatment services.
- Health teams that work in communities do not want to discuss drug problems with people in the communities.
- Health volunteers want to help their communities but they have no authority and capacity to do it effectively.
- Health teams find it difficult to negotiate with drug users on sensitive and difficult problems; such as drugs and HIV prevention and care in the community setting. However, if negotiations are conducted in meeting rooms with core groups, it may not work as effectively.

8. Suggestion for Policies

- Drug Dependence Treatment Centers and Drug User Clinics should be concerned with HIV, TB, Hepatitis B and C and infectious disease control (One Stop Service)
- The National Health policies should cover care costs in Drug Dependency Treatment Centers
- Standard care for Methadone treatment
- Establish practice guideline for HIV/AIDS and TB for the care of IDUs and DUs
- Encourage greater efficiency of care teams with outreach care, home health care and home visits.
- Harm reduction should be absorbed into drugs policies (Ball, 2007a)
- Extend the "One Stop Service" to the other Drug Dependency Treatment Centers and in general hospitals
- TB clinics should be concerned with DCT for HIV/AIDS and also the history of illicit drug use(Aggleton et al,2005)
- Policies for the broadcasting of IDU and DU issues should adopt a more positive approach (Erickson et al., 1997)
- To adapt a service which meets the unique needs of the drug user. In effect, if anyone or anything must change in order for the service delivery to work, it must be the service provider rather than the recipient. To insist otherwise all but guarantees that people most in need of life saving and lifesustaining services will receive them

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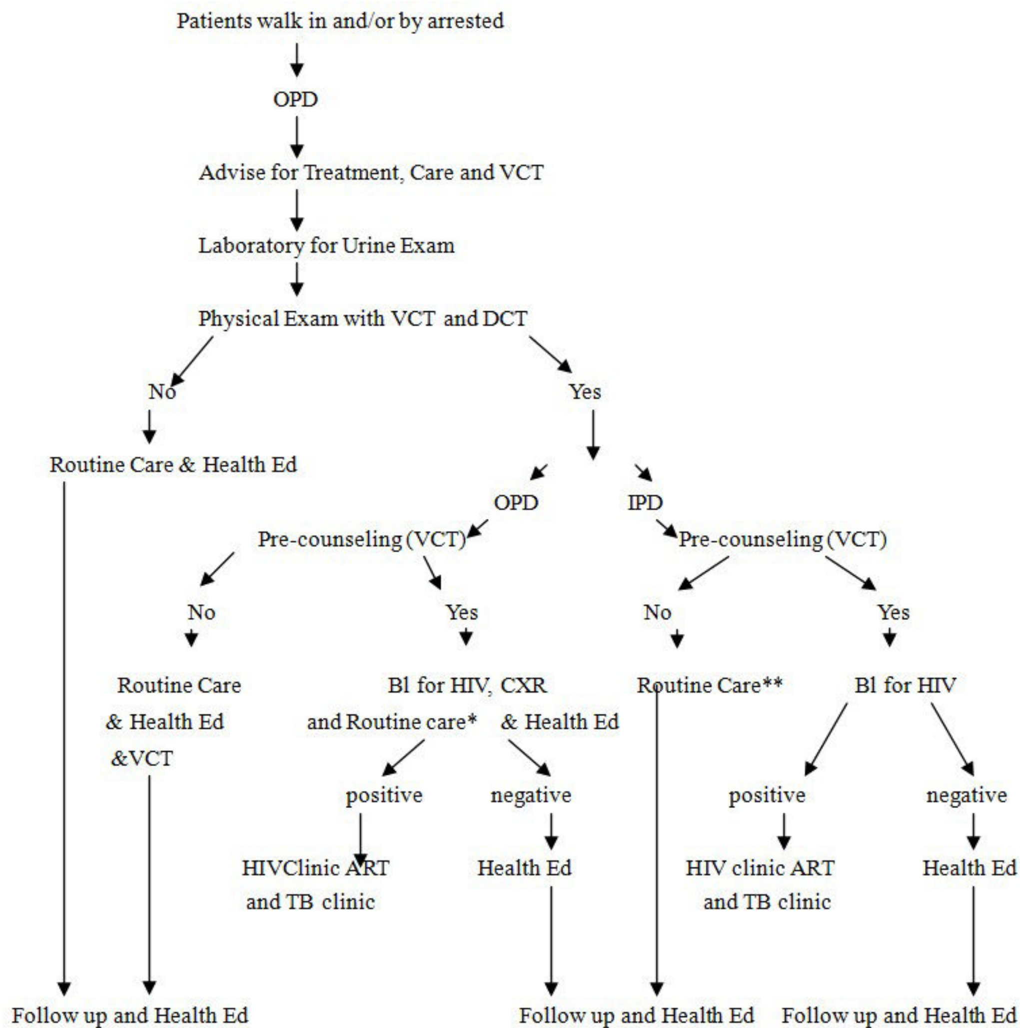

*Routine care at OPD: Matrix program, psychological support
**Routine care at IPD: detoxification, rehabilitation, occupational therapy, group therapy
Figure 1 Model development of Pattani Drug Dependence Treatment Center

Table 1 Demographics of Drug Users

Variables	Numbers (n=56)	Percent
Sex		
Male	55	98.7
Female	1	1.3
Education		
Literate	5	8.9
Primary school	28	50.0
Secondary school	13	23.2
High school	6	10.7
Vocation	4	7.1
Occupation		
Unemployed	10	18.5
Employee	33	6.1
Agriculture	12	18.5
Fishing	1	1.9
Type of drug		
Heroin	10	17.8
Methamphetamine	18	32.1
Opiate	0	0.0
Marijuana	9	16.1
Kratom	2	3.6
Other and mixed	15	26.8
Prison/Juvenile Correction Institution		
No	20	35.7
Yes	36	64.3
History of Treatment		
Never	8	14.3
Frequent/Always	48	85.7
Blood Test for HIV in IDU (9)		
Positive	6	66.6
Negative	3	33.3
Blood Test for HIV in DU		
Positive	0	0.0
Negative	47	100.0
Chest X – rays		
Positive(old TB)	1	20.0
Negative	4	80.0

Table 2 Opinions of the Drug Users Concerning the Project

variables	Numbers (n=56)	Percent
Cause to register in the project		
I'm a risk person	15	26.8
Pursued by Health team	36	64.3
Pursued by My friends	5	8.9
Satisfaction with project		
Satisfied	0	0.0
Unsatisfied	56	100.0
Establish in other centers		
Agree	0	0.0
Not agree	56	100.0

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