



Short report

The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand



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ABSTRACT

Background: Although Thailand has relied on the use of compulsory drug detention centres as a strategy to try to address problematic drug use, little is known about the effects of exposure to these centres on people who inject drugs (IDU). Therefore, we undertook this study to explore whether exposure to compulsory drug detention was associated with avoiding healthcare among Thai IDU.

Methods: Using Poisson regression analyses, we examined the relationship between compulsory drug detention exposure and avoiding healthcare among participants in the Mitsampan Community Research Project based in Bangkok.

Results: 435 IDU participated in this study, including 111 (25.5%) participants who reported avoiding healthcare. In multivariate analyses, avoiding healthcare was positively associated with exposure to compulsory drug detention (adjusted prevalence ratio [APR] = 1.60; 95% confidence interval [CI]: 1.16–2.21), having been refused healthcare (APR = 3.46; 95% CI: 2.61–4.60), and experiencing shame associated with one's drug use (APR = 1.93; 95% CI: 1.21–3.09).

Conclusion: Exposure to compulsory drug detention was associated with avoiding healthcare among Thai IDU, suggesting that this system of detention may be contributing to the burden of preventable morbidity among IDU in this setting. Although further research is needed to confirm these findings, the results of this study reinforce previous calls to replace the system of compulsory drug detention with evidence-based public health interventions for IDU.

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Introduction

Thailand has long experienced related epidemics of injection drug use and HIV infection (Csete et al., 2011). It has been estimated that there are between 16,000 and 270,000 people who inject drugs (IDU) in Thailand (Canadian HIV/AIDS Legal Network, 2009), and the prevalence of HIV infection among Thai IDU is estimated to be as high as 50% (Thai Bureau of Epidemiology, 2011). The primary response to these problems has been aggressive law enforcement (Human Rights Watch, 2004). However, in 2002, the Thai government introduced a law that reclassified people who use illicit drugs as “patients” eligible for care, rather than criminals deserving of punishment (Pearsehouse, 2009). This resulted in the creation of a system of compulsory drug detention centres (referred

to as *bangkap bambat* or “forced treatment”) (Pearsehouse, 2009). The majority of drug detention centres are run by the Royal Thai Army, Air Force or Navy, and according to the Office of the Narcotics Control Board (ONCB), there were approximately 73,000 individuals in drug detention in Thailand in 2010 (ONCB, 2010). In 2011, the Thai government established a target of admitting 400,000 Thai drug users into “treatment” (ONCB, 2011), and based on past estimates it is anticipated that over 60% (240,000) of these individuals would be placed in drug detention centres (ONCB, 2010).

Past reports have indicated that there is a lack of evidence-based addiction treatment within drug detention centres, as emphasis is placed on intensive physical exercise akin to that found in military “boot camps,” group work common among therapeutic communities, and vocational training (Pearsehouse, 2009). There have also been reports of human rights abuses within Thai drug detention centres (Pearsehouse, 2009). In March 2012, 13 United Nations (UN) agencies issued a joint statement calling for the closure of all drug detention centres, noting that “[t]here is no evidence that these centres represent a favourable or effective environment for the treatment of drug dependence” (United Nations, 2012). This

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observation is consistent with previous work demonstrating high rates of relapse to drug use among those admitted to drug detention (Cohen and Amon, 2008; Csete et al., 2011).

Given the lack of empirical data specific to drug detention centres, and the fact that little is known about the impact of exposure to drug detention on the health behaviours of IDU, we undertook this study to assess whether exposure to compulsory detention was associated with avoiding healthcare among Thai IDU.

Methods

Study design

Data for this study were derived from the Mitsampan Community Research Project, a collaborative research effort involving the Mitsampan Harm Reduction Center (MSHRC), a drug user – run drop-in centre in Bangkok, Thailand, the Thai AIDS Treatment Action Group (Bangkok, Thailand), Chulalongkorn University (Bangkok, Thailand), the British Columbia Centre for Excellence in HIV/AIDS (Vancouver, Canada), and the University of British Columbia (Vancouver, Canada). This serial cross-sectional study aims to investigate drug-using behaviour, healthcare access, and drug-related harms among IDU in Bangkok. The specific methods employed have been described in detail elsewhere (Hayashi et al., 2012). In brief, between July and October of 2011, 440 IDU were recruited and surveyed. Participants were recruited through peer outreach efforts and word of mouth, and were invited to attend the MSHRC or O-Zone House (another drop-in centre in Bangkok) to enrol in the study. Adults residing in Bangkok or in adjacent provinces who had injected drugs in the past six months were eligible. All participants provided informed consent and completed an interviewer-administered questionnaire eliciting a range of information, including socio-demographic characteristics, drug use patterns, and experiences with drug law enforcement and healthcare utilization. Upon completion, participants received a stipend of 350 Thai baht (approximately US\$12). The study was approved by the research ethics boards at Chulalongkorn University and the University of British Columbia.

For the present analysis, the primary outcome was reporting avoidance of healthcare by responding “yes” to the question: “Do you sometimes avoid healthcare because you are a drug user?” We hypothesize that the system of drug detention may promote the avoidance of healthcare. These centres, although characterized as settings for rehabilitation, typically involve participation in military training drills or other intense physical exercise, and offer little in the way of evidence-based treatment. Previous reports have also suggested that human rights violations are common within such centres (Pearsehouse, 2009). Further, given that police are known to harass drug users outside of healthcare services (e.g., methadone clinics) in Bangkok, we expect that some IDU may be reluctant to access healthcare following release from drug detention centres as this could increase the risk of being exposed as drug users and being returned to a drug detention centre. In other words, we hypothesize that the pairing of criminal justice and rehabilitation interventions in this setting may have the perverse effect of prompting IDU to avoid healthcare.

The primary explanatory variable of interest was a history of drug detention exposure (yes vs. no). We also considered other variables that might confound the relationship between the primary explanatory variable and the outcome, which included: median age (≥ 38 years vs. < 38 years); gender (male vs. female); HIV serostatus (positive vs. negative or unknown); prohibited income generation (includes drug dealing, theft, sex work, and panhandling; yes vs. no); heroin injecting ($>$ weekly vs. \leq weekly), methamphetamine (“yaba” or “ice”) injecting ($>$ weekly vs. \leq weekly), midazolam

injecting ($>$ weekly vs. \leq weekly); binge drug use (yes vs. no); addiction treatment use (yes vs. no); a history of incarceration (yes vs. no); a history of being refused healthcare (yes vs. no); and experiencing shame related to one’s drug use (yes vs. no). Behavioural variables referred to the previous six months, unless otherwise stated.

For the bivariate analyses, the prevalence ratio was used as a measure of association, rather than the odds ratio, as the frequency of the outcome exceeded 10% (McNutt, Wu, Xue, & Hafner, 2003). First, we used the simple binomial regression with a log link function to examine bivariate associations between reports of avoiding healthcare and explanatory variables, which gave us unadjusted prevalence ratios with corresponding 95% confidence intervals. To fit the multivariate model, we employed a conservative backward selection approach. Beginning with a full model with all covariates included regardless of the strength of their association with the dependent variable, secondary explanatory variables were dropped one at a time, using the relative change in the regression coefficient for the variable related to drug detention exposure as a criterion, until the smallest relative change in the coefficient for compulsory drug detention exposure from the full model exceeded 5%. We then fitted a final model including drug detention exposure and all remaining covariates as terms in the regression equation. However, because the full multivariate log-binomial regression model did not converge, consistent with recommended practice, Poisson regression with the robust variance was used to obtain adjusted prevalence ratios and 95% confidence intervals (McNutt et al., 2003). All *p*-values were two-sided.

Results

In total, 435 IDU, including 85 (19.5%) females, were included in this analysis. The median age of participants was 38 years (interquartile range: 34–48 years). In total, 111 (25.5%) participants reported that they had avoided healthcare because they were drug users. In bivariate analyses, factors positively associated with avoiding healthcare included having been exposed to drug detention (prevalence ratio [PR] = 1.74, 95% confidence interval [CI]: 1.25–2.43), having been refused healthcare (PR = 3.76, 95% CI: 2.89–4.89), and experiencing shame related to one’s drug use (PR = 2.24, 95% CI: 1.38–3.63). Greater than weekly heroin injection (PR = 1.41, 95% CI: 0.99–1.99) was marginally associated with avoiding healthcare. As indicated in Table 1, in multivariate analyses, drug detention exposure remained positively associated with avoiding healthcare (adjusted prevalence ratio [APR] = 1.60; 95% CI: 1.16–2.21), as did having been denied healthcare (APR = 3.46; 95% CI: 2.61–4.60) and experiencing shame related to one’s drug use (APR = 1.93; 95% CI: 1.21–3.09).

Discussion

In the present analysis, we found that approximately 25% of a community-recruited sample of IDU in Bangkok had reported avoiding healthcare. In multivariate analyses, exposure to a compulsory drug detention centre remained positively associated with avoiding healthcare, even after adjustment for a range of potential confounders. Other factors positively associated with avoiding healthcare included having previously been denied healthcare and experiencing shame in relation to one’s drug use.

Our findings are consistent with a large body of literature demonstrating negative impacts of criminal justice interventions on access to prevention, care and treatment programmes among IDU (Kerr and Wood, 2005). However, this may be the first study to demonstrate an association between exposure to drug detention and avoidance of healthcare among IDU. While the cross-sectional

Table 1
Multivariate Poisson regression analysis of factors associated with avoiding healthcare among Thai IDU ($n = 435$).

Characteristic	Adjusted prevalence ratio (APR)	95% confidence interval (CI)	<i>p</i> -Value
Ever in compulsory drug detention (yes vs. no)	1.60	(1.16–2.21)	0.004
Ever refused healthcare (yes vs. no)	3.46	(2.61–4.60)	<0.001
Shame related to drug use (yes vs. no)	1.93	(1.21–3.09)	0.006
Prohibited income generation ^a (yes vs. no)	1.38	(0.88–2.15)	0.160

^a Activities in the past six months.

study design limits any interpretation of temporal relationships, given the punitive nature of drug detention, the lack of evidence-based addiction treatment within such settings (Pearsehouse, 2009), and the documented human rights abuses that may take place in them (Cohen and Amon, 2008; Pearsehouse, 2009), it is understandable why IDU may avoid health services in the wake of time spent in drug detention. Previous reports have noted that, within Thailand, information pertaining to one's drug-using status is often shared between healthcare providers and police (Human Rights Watch and Thai AIDS Treatment Action Group, 2007), and therefore future contact with healthcare settings could be perceived to increase risk for an arrest and readmission to drug detention. As well, previous accounts have described how Thai police often harass IDU outside of health services, including those designed especially for drug users (e.g., methadone clinics) (Human Rights Watch, 2004). Therefore, accessing healthcare could heighten risk of confrontations with police and being readmitted to the drug detention system.

We also found that having been refused healthcare access was associated with avoiding healthcare. This raises concern regarding discriminatory practices within healthcare settings. Past studies have revealed negative attitudes towards drug users among Thai nursing students (Chan, Stooze, Sringeriyuang, & Reidpath, 2008), and discrimination towards IDU in healthcare settings, including refusal of treatment, has been observed in several Asia-Pacific countries (Paxton et al., 2005). Regarding the observed association between experiencing shame in relation to one's drug use and avoiding healthcare, it is well known that the current emphasis on punishment for drug use serves to fuel negative public opinions, but also perceived stigma among individuals who use drugs (Human Rights Watch & Thai AIDS Treatment Action Group, 2007). Pervasive stigma may render IDU less likely to access healthcare, as exposing oneself as a drug user in this context may result in further stigma and discrimination, as well as arrest.

Previous research suggests that drug detention centres are failing to reduce drug use and that human rights violations, including physical abuse and violence, are common within such centres (Cohen and Amon, 2008; Csete et al., 2011; Pearsehouse, 2009). Further, these centres offer little in the way of evidence-based addiction treatment. Given these findings and the results of the present study, there appears to be a need for policy and programme reform in Thailand, as well as a need for further research on the potential negative impacts in other countries, such as China, Vietnam, Laos and Cambodia, where drug detention centres are present (Thomson, Saucier, & Wolfe, 2010). First, we believe that the Thai government should respond to calls by key UN and international agencies to close all drug detention centres (United Nations, 2012). Second, the Thai government should implement an evidence-based approach to drug policy that is consistent with international guidance documents (WHO, UNODC, UNAIDS, 2012). Third, educational and social marketing strategies should also be implemented to counter the stigma towards drug users in Thailand. This should include efforts that specifically target healthcare professionals.

This study has limitations. First, the study sample was not randomly selected and therefore may not be representative of all local IDU. However, given that no accessible official registries of IDU exist in this setting, deriving a random sample was not possible.

Second, the study relied on self-reported data, which may be subject to response biases. Third, the study was cross-sectional in nature, and therefore we were unable to determine temporal relationships between the outcome and explanatory variables considered. Specifically, we do not know if the tendency to avoid healthcare preceded exposures to drug detention. Fourth, IDU in Thailand may have different ideas about what constitutes healthcare, and this may have affected our estimates of healthcare avoidance. Fifth, we recognize that other unmeasured factors may confound the relationship between healthcare avoidance and drug detention exposure. Lastly, we recognize that our dependent variable does not directly measure healthcare access. However, we feel that a strength of our dependent variable is that it captures more directly avoidance of healthcare in general as opposed to self-reported access to one particular health service, which could be explained by an array of factors other than avoidance (e.g., eligibility, financial barriers).

In summary, we found that Thai IDU who had been exposed to compulsory drug detention centres were more likely to report avoiding healthcare. These findings contribute to a growing international body of evidence pointing to the failure of the compulsory drug detention system to meaningfully address problematic drug use. Accordingly, efforts should be made to replace this system of drug detention with evidence-based addiction programming.

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Conflict of interest: The authors have no conflicts of interest to declare.

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