Country Report

Field-testing of the International Standards for the Treatment of Drug Use Disorders

Country: Thailand

Dates of data collection: 1 December 2017 - 31 January 2018

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Parts of the field testing we have taken part:

- Key informant survey data collection
- Key informant survey data analysis
- Focus group data collection
- Focus group data analysis
- Experts' review analysis
- Evaluation of services' compliance with standards

ETHICAL CLEARANCE

The field test proposal was submitted to the IRB of Faculty of Medicine, Prince of Songkla University and received the exempt ethics determination on December 7, 2017 [REC 60-460-18-1].

RESULTS OF THE FIELD TEST

(A) REPORT ON THE KEY INFORMANT SURVEY

The web-based questionnaire was translated into Thai and posted in the WHO study web site. Invitations were sent out to psychiatrists, physicians, nurses, social workers, psychologists and public health workers working in mental health and drug treatment clinics in general hospitals, psychiatric hospitals and drug treatment and rehabilitation hospitals across the country. The invitations were also sent to researchers involved in drug treatment research in universities and Ministry of Public Health and policy management officers involved in drug treatment policy in the Office of the Narcotics Control Board, Ministry of Justice.

As of February 1, 2018, 135 informants answered the questionnaire. Almost half (47.4%) of the respondents are medical doctors, including psychiatrist, addiction medicine specialists and family doctors or general practitioners, 43.7% are nurses working in addiction treatment units and other settings. The rest is psychologists, social workers, policy officers and researchers. The respondents have been working in their professions for an average of 15 years. Summary of the responses to items of the web-based questionnaire and qualitative summary of the comments to all items are presented in Appendix A.

(B) REPORT ON LOCAL EXPERTS' REVIEW

Eleven experts (male = 6, female = 5) in clinical practice and research related to treatment of drug use disorders in Thailand who have been working in the field for at least 10 years provided the reports of their opinions about The International Standards for the Treatment of Drug Use Disorders (The Standards). Out of the ten experts, six are psychiatrists, one family doctor, one is social worker, and three are nurses. Working places of the eleven experts include specialized drug treatment hospitals (n=2), psychiatric hospital (n=1), universities (n=5), army hospital (n=1) and private practice (n=1).

B1. Summary of expert comments to the Chapter 1 of the Standards (Introduction)

Regarding overall feedback of the full version of the Standards, all of the experts thought that the Standards is very comprehensive, appropriate, applicable, helpful and useful and somewhat feasible for the practice of drug abuse treatment in Thailand. It covers all levels of treatment, including principles and some details of all treatment modalities for drug use disorders. It can be used as a guide in the development of policies, drug treatment services, and human resources to support therapeutic services. They had positive feelings that the Standards could be considered as the first comprehensive international standards of service for

substance use disorder to be used internationally. They suggested though to stimulate and to encourage all stakeholders in Thailand to understand and see how important these modalities of treatment can help people suffering with drug use disorders. The policy makers should take into consideration and support these treatment modalities as a national standard for treatment of drug use disorders, provide financial support, facilitate training, man power, and so on.

The Standards provides recommendations and guidelines for effective substance use services in different settings such as outreach office, outpatient or inpatient settings in the hospital, residential setting and prison. It also provides guidelines and competency of staff for each level or setting. In addition, organizations could develop effective human resource development plan to increase staff competency by providing external or internal training according to characteristics and competency recommended in each level or setting. The Standards also recommends evidence-based practice for each setting to increase effectiveness of treatment outcome.

Work related risks such as dealing with clients with high risks for suicide or aggressive behaviors are included in this manual. Indicators of treatment outcome effectiveness are applied which would be helpful for organizations to monitor their performances on treatment outcome and review their processes in treatment to improve the quality of services for clients, family members and community.

The important topics / issues that are underrepresented include:

1) Harm reduction because even though it is not the treatment, it is closely related to treatment. A specific part on harm reduction strategy is very important to be included in the Standards. As seen in Thailand health workers in public hospitals are reluctant to provide needle exchange program because of the conflicting legal framework although it is one of the evidence-based effective service. A specific section in the Standards on harm reduction may help to raise awareness and confidence of policy makers and health providers in the setting to give such service.
2) Managements of acute problems in emergency unit, e.g. overdose, withdrawal symptoms and acute psychosis seem to be lacking or inadequately mentioned.
3) Definite practical method and clear strategies for treatment and for follow-up are not described adequately. Before getting into details of each treatment modality, there should be a part describing about the assessment and diagnostic methods to help set a guide for essential diagnostic procedures in clinical practice and in resource allocation.
4) New trends in drug use which keep changing in the new form of synthetic psychoactive substances (NPS) and patterns of drug distribution as well as adverse consequences in users.
5) The needs of effective and comprehensive strategies to handle these trends should be evidence-based practice in the field of health care system and integrated with other sectors such as justice system, cultural, social service system and community-based level. Each system or sector should have varieties of interventions to support and link with health care systems.

6) Empowerment of local communities to genuinely feel that it is the responsibility of the community to take part in all level of the process of prevention and treatment should be included.

7) Figures summarizing brain functions, mechanism of action of the drugs, and other factors on our brain and body will be helpful to provide knowledge of drug use disorders to the personnel who will use the Standards in their works on the treatment of drug addiction.

Regarding conformity of the Standards with cultural context and health/social system in Thailand, one expert said that “reducing” drug use which is one of the goals of treatment does not conform to the context of Thailand and suggested “stopping” drug use instead. In addition, cultural context, national laws and policies should be considered if the Standards would be integrated in each country. Specifically, how to adapt the Standards into Thai clinical practice in some local areas and target populations is a big challenge with the limitations regarding accessibility, availability, and quality of the services in Thailand. One expert suggested have a specific part on “kratom leaves” which is a plant-derived substances since they are highly relevant to the Thai context and the countries in Southeast Asia.

Regarding feasibility, most of the experts thought that the Standards have low to moderate feasibility in Thailand, mainly because of lack of resources. There are many obstacles such as 1) lack of specialized professional staff in addiction, 2) no naltrexone and buprenorphine availability, 3) disintegrated system between criminal justice system, social system, educational system and health care system, 4) lack of collaboration in multidisciplinary teamwork, 5) inadequacy of health personnel and budgets, 6) no outreach services for people with drug use disorders in community, and 7) social stigma. Moreover, The Standards show predominately evidence based interventions of opioid use disorder, but limited information on interventions for alcohol, nicotine, psychostimulants, cannabis, volatile inhalants, and hallucinogen use disorders is described.

One expert also suggested that some of the treatment options are not covered by health insurance in the country and so are perceived as controversial in term of having potential for improving coverage and/or quality of treatment for drug use disorders. Including sections on competency of different kinds of the treatment settings will help improve applicability for use of the Standards in treatment system for drug use disorders in Thailand.

B2. Summary of expert comments to the Chapter 2 (Key Principles and Standards for the Treatment of Drug Use Disorders)

All of the eleven experts think that Chapter 2 of the Standards is comprehensive, useful / helpful and somewhat feasible to continue in the practical policy and routine service in Thailand. The key principles and standards for the treatment of drug use disorders are introduced as being important for all settings of SUDs services. Most of the experts think that the comprehensiveness is perfect, however the appropriateness, utility and feasibility will need more in-depth field tests in various contexts. Regarding the comprehensiveness, the Standards include the role of accreditation for SUDs service to ensure that clients, family members and community

will be provided with standardized, professional and effective services. These standards are useful and can be served as a goal for Thai health system to move towards and it is appropriate to be used for linkage with multidisciplinary team.

Regarding important topics/issues that are underrepresented, the change of norm and attitude toward drug use should be included. In addition, the process for accreditation (how to survey for accreditation, period of accreditation) and responsible organizations (national or international auditors/surveyors) should be recommended in the relevant standards. The principle of “No single treatment is appropriate for all individuals.” should be emphasized (from U.S. National Institute on Drug Abuse. 2012; Principles of drug addiction treatment: A research-based guide) so that organizations could develop person-centered treatment plan based on client’s needs. Case manager could also play a major role in coordinating with other service providers if the organization is unable to provide some specific services such as vocational training, medical care or financial counseling. If clients are not appropriate for the service or client’s characteristics do not fit to the treatment eligibility, the referral should be made for client’s best interest. Client eligibility for treatment should be documented.

Other issues that are underrepresented in the Standards include community involvement in prevention and rehabilitation, treatment services in criminal justice setting, and treatment service in school setting. Although the prevalence of methamphetamine use disorders children and adolescents in schools and colleges are increasing, there is no standard treatment for this issue. A segment for the group of people who need specific responses is needed to be included. In addition, treatment related to relevant religious practice integrated in each country that can be integrated in all treatment modalities such as CBT, MET, CRA or CM should be included to strengthen spiritual aspects for the treatment for relapse prevention.

The challenging conformity of The Standards with cultural context and health/social care system in Thailand and/or its culture include the policy for drug surveillance in the Thai community, which community leaders have to monitor illegal drugs sale and inform policemen to arrest persons who are dealing with drugs. Some communities have social sanction with persons who are dealing with the drugs, therefore drug use disorders are considered primarily as criminal behaviors rather than health problems. Social stigma and discrimination to persons with drug use disorder are the main barriers to access treatment service in Thailand.

In addition, Principle 3, and 5 have challenging conformity with cultural context and health/social care system in Thailand. We still have ineffective coordination mechanisms among the criminal justice system, health care system and social services of people in contact with the criminal justice system.

Because of workload and resource shortage, there are no special services and treatment programs for adolescents, the elderly, women, pregnant women, children, sex workers, sexual and gender minorities, ethnic and religious minorities, individuals involved with the criminal justice system and individuals that are socially marginalized. One expert also suggests clarify more in details on in principle 4, “the specific needs of individuals”.

There are some elements perceived as controversial in terms of having potential for improving coverage and/or quality of treatment for drug use disorders such as treatment decisions, including when to start and stop treatment, and what kind of treatment, should be made by the individual, to the extent that they have capacity to do so and treatment should not be forced or against the will and autonomy of the patient. Because most of people with drug use disorders refuse treatment due to poor insight and lack of motivation for drug abstinence. If they have rights to refuse treatment, they will receive treatment late and harm themselves and their families. In addition, one expert think that principle 5, specific populations, is the most challenging issue. For example, how can we recruit and provide the standard treatment for each specific population.

Regarding components in the Standards that are perceived as difficult in terms of applicability for use in treatment system for drug use disorders, most experts suggest that the 'principle 1' (related to availability and accessibility of the essential treatment services within reach of public transport (Standards 1.3) and a wide range of opening hour (Standards 1.6) on the remote area) is difficult to follow due to geographical limitation especially on the highland where most of special population live. The poor infrastructure, transportation and insufficient staff to man the clinic are main barriers. While the experts thought that the principle 2-7 are practical and fit in the Thai context, one expert mentioned problems with following Principle 3 regarding legal status of drug users, including those who trade drugs to earn money for their use. This thus limits the effective coordination between the criminal justice system and health and social services. In addition, it seems to be some repetitive parts in the 6th and 7th principles, such as 6.1 and 7.1.

B3. Summary of expert comments to the Chapter 3 (Treatment modalities and interventions)

Recommendations and guidelines for different settings are introduced in the Chapter 3 including outreach, residential setting and recovery management. All appropriate and approved treatment modalities and interventions are already included. The variety of treatment and strategies is very helpful and complete. Most of the contents in Chapter 3 are comprehensible, appropriate and useful for planning to implement in clinical practice. The SBIRT is useful, comprehensive, appropriate, and can be implemented in the Thai context as some of an assessment tools like ASSIST and BI has been practiced in health care and community-based care for many years.

There are some important topics/issues underrepresented such as outreach service organizations whether they are managed by NGO or government or community participatory. The qualification of peer outreach workers and training system, and safety procedure for outreach service should be included. Outreach worker needs to understand about work related health conditions such as risk of respiratory infection. Dealing with clients in crisis and clients who have high risk for suicide should be introduced to outreach officers. Harm reduction strategies are used in many countries and should be included although needle exchange program in outreach service is still controversial in some countries. National laws and policies should be considered and reviewed before integrating this standard. For example, take-home naloxone for opioid overdose, naloxone administration by non-licensed individual is illegal in many

countries. Prevention of work risks including infection or dealing with violent clients should be included by introducing universal precaution such as hand hygiene or wearing masks when staff contacts with infected clients. Risks and benefits of each treatment intervention should be given to all clients as well as documents should be written. More advices/ recommended rationales for group therapy may be useful and practical in many setting in developing countries which have limited number of specialists and should be included.

Another part that should be included in the Standards, suggested by most of the experts is to include alcohol and multiple drug use disorder treatments because these are important problems and the prevalence of these disorders is quite high. Treatment of alcohol intoxication and withdrawal states and pharmacological treatment of alcohol dependence should be included as they are common problems and can cause complicated conditions. Otherwise, it should be clearly stated at the beginning of the Standards that alcohol is not covered here and the Standards are for just other illicit drugs.

Regarding the sentence 'Agreements between health and law enforcement personnel are in place and there is a mutual understanding of the benefits of outreach work', this issue is an important part of the Standards. However, how to provide treatment by health care system for the people who contact with criminal justice system is very crucial and challenging and should be included.

In the recovery management, 12-steps group or Narcotics Anonymous (NA) should be included and described in details. It will help clients to continue in the treatment program and could be adjusted or adapted to different cultures and could be well integrated with After Care activities. The Strength of evidence should be given in numbers or symbols (such as +, ++, +/-,-,- -) with interpretations for easy understanding.

Parts of The Standards that have challenging conformity with cultural context and health/social care system in Thailand and/or Thai culture and are perceived as difficult in terms of applicability for use in treatment system for drug use disorders includes some pharmacotherapies; trained specialists who can provide some specific psychosocial treatments are not available / not enough in some contexts in Thailand. There is still lack of adequate staffing in drug treatment system in Thailand and also lack of essential knowledge and skills necessary to deliver many treatment modalities described. In actual practice, the standards of treatment are still not informed and they are not well organized in the field.

Community-based outreach is limitedly feasible in Thailand. Because of some legal constraint, the needle exchange programme is hardly provided in Thailand and the outreach service is only available in a few parts of the country and mostly operated by NGOs.

In addition, the routine screening and brief intervention in non-specialized health settings is not fully available and pharmacological interventions are limited. Overdose management system is not developed. The pharmacological treatment for relapse prevention in our country is quite limit and difficult because naltrexone and buprenorphine are not available. In addition, there are limited outreach service, long-term residential treatment service and social service system for after care,

rehabilitation and recovery in Thailand. It is also difficult to evaluate the effectiveness of the recovery management as it is a life long process.

B4. Summary of expert comments to the Chapter 4 (Special Populations)

The guideline of the Standards for 'special populations' is comprehensive, appropriate and useful in Thai context. There has been no systematic approach like the Standards to the special population in place yet in Thailand. However it is somehow has low feasibility because of resource shortage.

A section about sexual minorities should be included, as they are an important special population of the drug users. In addition, for preventing unknown pregnant women from exposing to medication that can be harmful for fetus and providing appropriate care for pregnant women, pregnancy screening by history taking and/or urine test for female clients in facilities should be considered. For children and adolescents, screening and assessment tools should be specific and valid. Although the topic about 'Treatment of people with drug use disorders in contact with the criminal justice system' is beneficial for those who get involve with criminal justice system, appropriate and trained personnel in the criminal justice system should be available to provide bio-psycho-social treatment.

In addition, every part should be adapted for appropriateness to the specific context in each country. Since there are no practice guidelines for special population especially pregnant women, child and adolescence, elderly with drug use disorder in Thailand, this will be the first guideline to be used in the country. There may be some difficulties in terms of applicability for use in treatment system for drug use disorders in Thailand, especially in term of collaboration between social workers and Ministry of Human & Society Development. It is hardly feasible in Thailand to have a separate setting for child and adolescent drug users and staff specialized for pregnant women or children and adolescents. Some recommendations regarding treatments for people in criminal justice system may not be possible at all in Thailand, for example: "Treatment interventions must always be voluntary and based on the informed consent from the patient. All persons who access services, including individuals under the supervision of the criminal justice system, should have the right to refuse treatment, even if this entails other custodial or non-custodial measures."

B5. Summary of expert comments to the Chapter 5 (Characteristics of an Effective System to Deliver Services for the Treatment of Drug Use Disorders)

This chapter provides the coverage concepts of how to manage an effective national system for the treatment of drug use disorders which are useful, comprehensive, and can be partly implemented. One stop shop approach, model of community-based treatment and model of case management introduced in the Standards are very helpful for addiction professionals to integrate these concepts into real-life practice. This section will help Thailand understand the status of clinical setting and can help select what setting should have for providing service that is more relevant in the Thai context.

However, there are difficulties in term of applicability for use in treatment system for drug use disorders in Thailand because of conflicting norm, attitude, fear factor, safety and policy in Thailand. Under current limited workforce, knowledge, skills, fragmented and underfunded services, many services are not quite feasible. Treatment programmes cannot integrate all services (like the one-stop-shop approach) or coordinate comprehensive continuum of care, especially social service system and community based treatment network.

The underrepresented parts of the Standards include how to select interventions at different service levels. The strength or importance of each intervention at specific service level should be classified. In addition treatment system in prison or treatment for persons with other legal charges should be organized systematically and practically. Lastly, although treatment system organization model is also useful, it refers to the ICD-10 classification which is not compatible with the latest DSM-5 classification that are being used in many countries.

B6. Summary of any additional comments

The experts reported that overall the Standards are appropriate and comprehensive and should be translated in as many languages as possible. The Standards can be used as guideline for developing strategic plan to increase organization and staff competency. Some parts of the standards may not be suitable for Thailand such as that on providing hepatitis B vaccination by peer outreach workers as this work should be done by the health care unit. In addition, integration of these standards should comply with national laws and policies under cultural context. The Standards should also include suggestions for strategic implementation especially in resource-limited countries.

One expert concerns that there may be an issue when disseminating the Standards in Thailand. If it is called as a “standard” for treatment, it may imply that these are minimum requirements for treatment of people with drug use disorders. When an adverse or unsatisfactory event occurs, for examples death or serious condition from drug overdose or withdrawal, not getting treatment for HBV, HCV, people may claim that they do not receive standard treatment as stated in the Standards and want to sue the health care provider or the health system. This issue has been of concern in Thailand for some years and made some medical professional societies do not want to set or approve a standard or guideline for clinical practice. However, to make the Standards be widely recognized by health professionals and make full use of them, a seminar or workshop to present and discuss them should be organized. Although with this field-testing we have been able to make them known by a lot of professionals, there are many more who are not within our reach or those who have refused to participate in our field test because of their incompetence in English or busy schedule at the time.

Although the collaboration of organizations, health and justice policies, attitude and fear factor is yet the main obstacle, one expert suggest that The Standards should remain the same as it is the “standard” of treatment. The Standards will be useful to develop practice guideline for people with drug use disorder in the future in each country. They will receive the optimum of care and achieve recovery. However, they

need important policy decision makers to plan a functional and sustainable drug dependence treatment system and allocate resources and the services offered at different levels of the health and social system. In addition, potential unintended side effects of applying the standards might be chaotic and burnout of health providers due to many interventions to do. Potential intended benefits of applying the standards are the increase of specialized personnel in addiction treatment, integrated service provision without barriers in accessibility and full range of care services for drug users in Thailand.

(C) REPORT ON FOCUS GROUPS

Characteristics of focus group participants

Groups	Participants characteristics:
Group 1 **26/12/2560 Chiang Mai** Moderator: F, 63y, Psychiatric Nurse Assistant: F, 52y, Addiction Nurse Setting: Drug Abuse Treatment Hospital, Chiang Mai Content of discussion: M1 M2 M6	Participant 1: M, 40y, Psychiatrist, Psychiatric hospital
	Participant 2: M, 69y, Ex-Social Worker, Psychiatric hospital
	Participant 3: F, 55y, Register Nurse, Psychiatric hospital
	Participant 4: F, 55y, Register Nurse, Community hospital
	Participant 5: F, 47y, Register Nurse, Community hospital
	Participant 6: F, 53y, Register Nurse, Psychiatric hospital
Group 2 **29/12/2560 Chiang Mai** Moderator: F, 63y, Psychiatric Nurse Assistant: F, 52y, Addiction Nurse Setting: Drug Abuse Treatment Hospital, Chiang Mai Content of discussion: M1 M2 M6	Participant 1: M, 36y, Physician, Drug abuse treatment hospital (Deputy director of the Hospital)
	Participant 2: M, 41y, Register Nurse, Drug abuse treatment hospital
	Participant 3: M, 55y, Public health officer, Primary care centre (Director of primary care centre)
	Participant 4: M, 42y, Public health officer, Primary care centre (Director of primary care centre)
	Participant 5: F, 48y, Register Nurse, Drug abuse treatment hospital (Head of Alcohol inpatient ward)
	Participant 6: F, 50+y, Register Nurse, Drug abuse treatment hospital (Deputy Chief of nursing department)
Group 3 **28/12/2560 Bangkok** Moderator: F,40y, Psychiatrist/Associate Professor Assistant: M,30y, Psychiatrist/Lecturer Setting: University hospital	Participant 1: M, 50+y, Psychiatrist, Army Hospital (Head of drug and alcohol department)
	Participant 2: M, 40y, Psychiatrist, University hospital
	Participant 3: F, 40+y, Lecturer, University
	Participant 4: M, 50+y Physician, Drug abuse treatment hospital
	Participant 5:

Content of discussion: M3 M4 M5	F, Psychiatrist, Psychiatric hospital Participant 6: M, Psychiatrist/Lecturer University hospital
Group 4 **29/12/2560 Bangkok** Moderator: F,40y, Psychiatrist/Associate Professor Assistant: M,30y, Psychiatrist/Lecturer Setting: University hospital Content of discussion: M3 M4 M5	Participant 1: F, Physician, Drug abuse treatment hospital Participant 2: F, Nurse, Drug abuse treatment hospital Participant 3: F, Nurse, Drug abuse treatment hospital Participant 4: F, Nurse, Drug abuse treatment hospital Participant 5: F, 40y, Associate Professor, University. Participant 6: F, 50+y, Academic officer, Office of the Narcotics Control Board
Group 5 **26/12/2560 Khon Kaen** Moderator: F,50y,Nurse/Associate Professor Assistant: F, 60y, Psychiatrist/Professor Setting: Drug Abuse Treatment Hospital Content of discussion M3 M4 M5	Participant 1: F, 55y, Register Nurse, Drug abuse treatment hospital Participant 2: M, 43y, Psychiatrist, Drug abuse treatment hospital Participant 3: F, 50y, Register Nurse, Drug abuse treatment hospital Participant 4: F, 50y, Nurse, Regional hospital Participant 5: M, 29y, Psychiatrist, Regional hospital Participant 6: F, 36y, Psychiatrist, Regional hospital
Group 6 **19/12/2560 Khon Kae** Moderator: F,50y,Nurse/Associate Professor Assistant: F, 60y, Psychiatrist/Professor Setting: Drug Abuse Treatment Hospital Content of discussion M3 M4 M5	Participant 1: M, 31y, Psychiatrist, Drug abuse treatment hospital Participant 2: F, 49y, Nurse, General Hospital Participant 3: F, 53y, Nurse, Drug abuse treatment hospital Participant 4: F, 49y, Nurse, Regional Hospital Participant 5: M, 43y, Nurse, Psychiatric Inpatient Division, University Hospital Participant 6: F, 44y, Psychologist, Regional Hospital Participant 7: F, 58y, Register Nurse, Psychiatric Outpatient Division, University Hospital
Group 7 **25/12/2560 Songkhla** Moderator: F, 62y, Assoc. Prof. Assistant: F, 60y, Psychiatric Nurse	Participant 1: F, 47y, Register Nurse, Drug abuse treatment hospital Participant 2: F, 54y. Register Nurse, Community hospital Participant 3: M, 47y, Psychiatrist, Regional Hospital

Setting: University department Content of discussion M1 M2 M6	Participant 4: F, 52y, Register Nurse, Regional Hospital,
	Participant 5: M, 46y, Register Nurse, Drug abuse treatment hospital
	Participant 6: F, 42y, Register Nurse, Community Hospital
Group 8 **29/12/2560 Songkhla** Moderator: F, 62y, Assoc. Prof. Assistant: F, 60y, Psychiatric Nurse Setting: University department Content of discussion M1 M2 M6	Participant 1: F, 47y, Register Nurse, Community Hospital
	Participant 2: F, 39y, Regional Coordinator of drop-in centre
	Participant 3: F, 36y, Drop-in Manager
	Participant 4: F, 30y, Drop-in Manager

Structured summary of the discussions related to the question stated

Content of this Chapter in general is good. The focus group (FC) participants suggested some additions in the following issues: harm reduction approach, the use of online media in the treatment, more details on management of ATS use, psychosocial treatments, the integration of treatment options with local resources, modification of treatment options to be context-appropriate, decriminalization concept (to help drawing users into treatment), human rights (need clearer explanation on this issue), management of new psychoactive substances and prescription drug use and management of some special populations, e.g. Children with ADHD and patients with psychiatric co-morbidity.

If a treatment manual is to be developed for use in Thailand, the FC participants suggested that it should be made specific to level of practitioners and added details related to screening, assessment and supports for drug users. Thailand has several limitations in the management of people who use drugs as there are limited numbers of specialized drug abuse treatment hospitals and psychiatric hospitals. Most community hospitals and general hospitals have no specialist in addiction medicine and no in-patient facility and the national and hospital policies do not give much value on drug abuse treatment. In addition, the drug use is common in the community while treatment and care resources are so limited.

(M1) COMMUNITY-BASED OUTREACH

M1. Comprehensiveness

Overall, the Module covers most important points in providing outreach service in a community. It suggests the use of local people in the community to do this work. The outreach work targets individuals with harmful use of drugs and/or dependence who are not currently receiving treatment as well as individuals who are affected by the drug use of others (e.g. sexual partners, needle-sharing partners, etc.). The followings are some points raised by focus group (FC) participants to be covered

in the module.

1. The outreach workers should be trained and audited to make sure that they can do the work up to the standard practice in the country, have good attitudes towards drug users and this kind of work and be accepted by the community. Some knowledge about laws related to drug abuse, symptoms and signs of drug use and its complications and psychiatric co-morbidity should be taught.
2. Issues about stigma of drug use, safety of the outreach workers and precaution regarding the use of an ex-drug user as a worker should be discussed in the Module.
3. How to make people in the community and family members accept drug users who still use drug but are in harm reduction service should be included in the Module.
4. The Introduction part should include some overview about significance of this work, including the benefits and losses of the community if implementing or not implementing the work, who are involved in providing the service and who are targets of the service.
5. The target population of the service should include not only those who are not currently receiving treatment but also those who have dropped out from treatment or do not attend treatment programme regularly, those who could not stop their drug use but are not currently in the harm reduction programme and those at low-risk for drug use problem.
6. Description of the intervention should be specific to the target group, type of drug used and clinical symptoms. For example, the harm reduction interventions should be described differently for methamphetamine, heroin or alcohol users.
7. In addition to HIV/HCV testing and counseling, TB and STI screening should be included in the service.
8. Issues on community empowerment and social environment manipulation to reduce drug use and community health promotion strategies should be added in the Module.
9. The community outreach work needs collaboration between stakeholders of various parts of the society, e.g. public health, justice system, police and administrative officers of the community as well as participation of local people, these people therefore should be educated to understand the principles and philosophy of this approach and have positive attitudes towards harm reduction approach and outreach work. This point should be stated in the Standards.
10. There should be some discussion about outreach workers' manner, personality, dressing and grooming, communication skill, rapport making skill and technique in approaching the clients included in the Module.

M1. Appropriateness

A concern was raised by FC participants on the conformity of some harm reduction services with the laws. In Thailand, providing needle and/or syringe to drug users is interpreted as helping/promoting them to use drug and is considered a wrong

conduct in Thai law. Needle/syringe programme is thus not widely available in the country. Furthermore, there has been no law to support the injection of naloxone by layperson to overdose individual. There should be an emphasis in the Module that the implementation of such work needs to be applicable with the law of that country.

Another point is about the use of ex-users as outreach workers. In some community it may not be appropriate to use ex-drug users as outreach workers as they may be induced to return to drug use.

Community leaders are key person in the community to engage people into treatment. They should understand the concept of outreach work and co-operate with the service providers. However, in Thailand it is still a top-down operation in many places and the drug users are compulsorily engaged into treatment. Success of outreach work is thus low.

In some parts of the country there are ethnic minority groups who speak different languages, for examples hill-tribe people in the northern mountainous areas and migrant workers from neighboring countries in the border areas. This is raised as a challenge.

As the drug of most common use in Thailand is kratom (mitragynine speciosa, a local narcotic plant), a specific section on this drug should be included if the Standards are to be used in Thailand.

The coverage of outreach service, drop-in centre and treatment centre in all parts of the country is another challenge. Sub-district health centres (so-called sub-district health promotion hospitals) are in fact located in all areas of the country, they could be supported to provide outreach service if there is a policy.

The referral system from community to treatment centre should be improved. At present because of inadequate staff both in terms of time and competence, some drug users are not engaged into treatment or to continue treatment.

Different drugs create different concerns to people, for example people are kind of accepting the use of tobacco and alcohol but not methamphetamine. The work to reduce methamphetamine problem in the community is thus receiving more cooperation than that for alcohol or tobacco, which may be used by community leaders themselves.

In Thailand, district health system (DHS) is considered as the best system because it draws people from different fields of work, including police, health and social welfare for example to work together as a community committee. However, in some areas people have not yet understood the concept and cannot implement the system effectively. Outreach service for drug abuse can be one issue integrated in the DHS work.

Up to present there has not been a system to link records of drug users receiving any of the 11 outreach services with the main treatment system. Data linkage system and confidentiality of the data should be prepared.

M1. Utility

The outreach service described in the Standards is useful to be applied in a community. It can be used as a guide for community workers in developing such

service. The FC participants were aware of the utility of community-based outreach work in terms of new case finding, reducing consequences of drug use to others, such as spouse, partner and family member. They suggested a full training workshop for outreach workers and other stakeholders in the community about drug use and related problems, concept, benefits and precautions of outreach and harm reduction services,

M1. Feasibility

Cost of medicines and services in the outreach package, e.g. HIV/HCV testing, NSP and referral is a big concern for FC participants. In Thailand, hospitals have to bear some unreimbursed cost by themselves, for example the cost of treatment for illegal migrants. In case of referring patients with drug use problem from an outreach worker to a hospital, some hospitals do not want to accept these patients as hospitals sometimes cannot get reimbursement from the government or the National Health Security Board.

Another concern is about the staff, who can take blood sample. As outreach workers are only trained to be counselor, they cannot do blood sample collection. A system is needed for referral of suspected individuals to a health centre and training of all related staff in the health system is thus very important.

(M2) SCREENING, BRIEF INTERVENTIONS, AND REFERRAL TO TREATMENT (SBIRT)

Overall, FC participants agreed that the Module is good and comprehensive and it suggests a screening instrument (ASSIST) for use in the service centre. However, they suggested the Standards include some details about brief intervention method. And in the real practice, issues on patients' rights to participate in or refuse the screening, which also depend on the type of drug used and legal context of the country must be considered. Furthermore, in real practice, there may not be a need to screen all cases, thus a short prescreen question may be used to indicate at risk individuals for full-scale screening.

M2. Comprehensiveness

The FC participants agreed that the Module covers all issues in the process of SBIRT and they agreed with all suggested methods of providing the services. Nevertheless, they would like to see more details on the brief intervention process. They also suggested that the Module should cover SBI in patients with physical illnesses, including those who come to the hospital with NCDs, hemorrhage and abdominal pains and people in the justice system. Training of staff for all process of the SBI should be emphasized as well.

M2. Appropriateness

Several issues were raised by FC participants with regards to the implementation of SBIRT in real clinical practice in Thailand as follows:

1. It should be clearly defined who and which department should do screening and BI and these staff need prior training. Implementing SBI in various departments of the hospital or health centre can be a problem. Some patients

who come to the hospital with physical illness may refuse screening and the nurses or other health personnel in some departments may also refuse to do the screening and BI. This then will put the load on psychiatric nurses who are expected to do such work despite being full-handed with other work.

2. Each level of service centre needs to modify the SBIRT service to be suitable to their level of care.
3. The ASSIST has not been widely used in Thailand and there are many versions of ASSIST or similar instruments used in the country. There should be a consensus to use a standard version in the country. And the linkage between referring and referral centres should be established
4. The screening for drug use should be extended to non-health systems, e.g. school, social welfare, workplace and justice systems. In health system, screening should also be done in several departments, e.g. ER (where frequented by alcohol drinkers and benzodiazepine users), NCD clinics (where frequented by alcohol, tobacco users).
5. In justice system in Thailand, SBI has been used with some arrestees who are suspected of doing drug. Special training for those staff should be conducted. Furthermore, there should be some guides on when the screening for drug use should be done with people who are released from prison.
6. The issues of stigmatization and cultural and legal contexts are also concerned. In some families whose children are arrested because of drug use, they keep this as a secret. Thus, screening for drug use is a sensitive issue.
7. Skill and competence of staff, who provide screening and BI are very important. They should be trained to do screening with appropriate manner in a suitable atmosphere and private place. Training of such personnel is needed.
8. Referral system is not functioning so well in Thailand. There should be a clear policy on this so all centres can do the same. The patient's security scheme should be identified and agreed upon by referring and referral hospitals.

M2. Utility

The FC participants all agreed that it would be useful for their settings and patients if they could follow the SBIRT described in the Standards. The recommendations can be used to improve the coverage and quality of treatment for drug use disorders in Thailand. However, the work to be done and the health personnel to do such work in each level of care should be specified. For example, the clinical staff in general out-patient clinic may only do brief pre-screening with simple questions and refer the positive pre-screens for more detailed screening and brief intervention to the mental health staff. The proportion of patients with more serious screening results who received formal assessment and referral to treatment, and proportion of patients referred to treatment who initiated treatment may not be well used as indicators of programme completion and effectiveness as it also depends on the patients, referral system between hospitals, security scheme and supporting policy of the hospital and the national health system (which has yet seen the importance of the SBI).

M2. Feasibility

Overloaded work and time constraint are major problems impeding SBI in health centres in Thailand. However, if there is clear policy that it has to be done in all hospitals and the hospital executives see the importance of this service, these will not be a problem. Each setting needs to identify its own process and service point for implementing SBI, e.g. in ER, inpatient ward or OPD. In some hospital it may be better to do brief pre-screening first and follow with ASSIST and brief advice for some cases before referring the patients to mental health clinic.

(M3) SHORT-TERM IN-PATIENT OR RESIDENTIAL TREATMENT

M3. Comprehensiveness

The FC participants expressed that there is a lack of a section, which links all treatment modalities together, e.g. the linkage between managements of drug users who are identified by outreach programme or receive harm reduction programme in the community and do not need in-patient treatment with other sectors of the treatment programme. There are also lacks of content on eligibility criteria for individuals who should receive short-term, outpatient or in-patient treatment, treatment of those with poly-drug use. They suggested add more contents on:

- warning signs that the subject needs in-patient treatment;
- management of alcohol and cannabis use;
- standard for case record forms, treatment planning and managed care;
- risk and safety management;
- treatment of common co-occurring diseases;
- compulsory treatment approach and approach for those who refuse treatment;
- modification of treatment options to suit local context and
- how to engage family to participate in the treatment of drug users.

M3. Appropriateness

The content of this Module seems to focus on opioid treatment so it does not fit very well with Thai context where ATS use is more common. The linkage between system and referral system recommended in this Module is not so appropriate in Thailand because in our country integrated treatment approach is not well received. Drug treatment settings, psychiatric hospitals and general hospitals work independently and do not co-operate well, making referral between hospitals very difficult. Patients or their relatives have to refer themselves to other hospital when need it. The FC participants discussed about a need of having a central referring centre to manage referrals between hospitals.

The content related to voluntary treatment concepts and principles may not be appropriate to Thai setting. If a drug user has committed a crime such as trading drug to get money for his/her own use, the individual has to go to compulsory treatment

scheme regardless of his/her voluntariness so this is conflicting with the principle that treatment should not be imposed on individuals against their will.

In some areas of Thailand there are specific problems, for example kratom (mitragynine) use and unrest situation in southern Thailand. The Standards do not cover these points well.

M3. Utility

The Module comprises all necessary subsections, making it easy to see the whole picture of treatment and care of drug users in out-, in-patients and residential care settings. It is quite useful for clinicians to use as a guide to review their own practice to see if it is complying with what written in the Standards or not. There should be a version of the Standards for general practitioners too. The criteria for treatment completion are very useful and the Module can be used as a guide for improvement of treatment system of drug users in Thailand.

M3. Feasibility

It is difficult to allow take-home medicine as it is very difficult to prevent patients in MMT programme to redistribute their methadone to other people. It is likely not possible to adopt the treatment standards and recommendations into practice in community hospitals where there are limited resources and personnel.

(M4) OUTPATIENT TREATMENT

M4. Comprehensiveness

The followings are some points suggested by the FC participants to add in the Module:

- Supporting roles and systems in the society, community and family
- Clear structure and core of outpatient treatment
- More details on psychosocial interventions, including other evidence-based interventions such as CRA and 12-step facilitation (which were not covered in the current version), case management, physical health support
- Treatment of alcohol use and poly-drug use disorders, management in emergency and critical cases
- Indications for out- or in-patient treatment and for choosing each type of psychosocial treatment
- Management of patients with high suicidal risk among cases of opioid overdose
- In the part of naloxone administration for opioid overdose, it should be emphasized that in case of methadone overdose, naloxone may be needed for several doses as methadone has long half-life
- How to assess patient in each visit, frequency of follow-ups and cost-effectiveness of follow-up visits
- Methadone treatment in psychiatric patients who are more difficult to treat

than pure drug using patients.

M4. Appropriateness

When administering any interventions it should be modified to suit context and skill of clinicians. For example, general nurses can be trained to provide MI or MET but some other interventions e.g. CBT, family therapy and marital therapy may need more specialized training and skills so it may not be appropriate for staff in district or province level hospitals to do such interventions.

In methadone maintenance treatment, an agreement should be made with the patients with regard to the management strategies if they violate the rules or regulations, for example if they illicitly sell their prescribed medication.

There are some challenges in providing outpatient treatments for drug using patients. The main point is because of the limited knowledge and understanding of patients and their caregivers or relatives. Therefore, safety for take-home medicine is a big concern. This may be partly overcome by having healthcare staff in the area to pay home visit to help advise and monitor medication of the patients. However, this should be done with high caution, especially with regard to confidentiality of the patients.

M4. Utility

The Module is useful in helping clinicians to check if what they have been involved in the outpatient treatment process is complying to the standards endorsed by international experts in the filed or not.

M4. Feasibility

It is feasible to provide outpatient treatment according to the Standards in addiction treatment centre and regional hospital, where specialized staff are available. However, there are several limitations in practice in community-level or lower level of hospitals, with regards to skill and number of staff and availability of medicines and other resources. Methadone storage needs high safeguard as it can be stolen for illicit sale; this is thus a limitation for MMT in some areas.

(M5) LONG-TERM RESIDENTIAL TREATMENT

M5. Comprehensiveness

Overall, the Module is comprehensive and presenting all dimensions of therapeutic community. However, the FC participants suggested some additional points in the Module to make it more complete as follows:

- Health education and skill training to family and role of family in long-term care of drug users
- Other therapeutic programmes for long-term treatment (apart from the TC) for general drug users and the specific one for those with comorbid mental illness
- Physical structure of a TC
- Selection criteria for patients eligible for long-term residential care

M5. Appropriateness

The content of this Module with regard to Therapeutic community is not so appropriate to Thai setting as there is a very limited number of settings which can provide such treatment.

M5. Utility

The Module is useful as it covers essential dimensions of care. The FC participants discussed more on some points which they thought are important and can be applied to the real practice, including the importance of taking individual lifestyle into consideration when making a treatment plan and signing an agreement between patient and clinician. They also mentioned that it would be more useful for practice if the Module provides more concrete approaches of this treatment modality.

M5. Feasibility

It is feasible to provide long-term residential care only in large setting, which has multi-disciplinary staff. In other settings, there are several limitations in terms of limited number and capacity of staff, budget and resources. Medical insurance is an issue of concern as the long-term care will not be covered by the Universal Coverage scheme or Social Security Scheme. It would be more feasible if the clients in the long-term care can do some income-earning work. Furthermore, it is quite feasible to develop such treatment in prison for prisoners with drug use problem or in military setting. However, Thai people prefer medication treatment to psychosocial treatment so they do not pay much attention on long-term and continuous treatment.

(M6) RECOVERY MANAGEMENT

The FC participants all saw the importance of recovery management in helping drug users to return to their normal lives in the society after treatment or to prevent relapse to drug use. They emphasized that the patients should be empowered and enhanced their self-efficacy. Psychological support, occupational support, life skill and skill in living with other people in the society and medical coverage are main issues to be taken care of in this stage of care. Community should be drawn to participate in this process, which will help in reducing stigma towards drug users. The community may also help in providing some financial support and spaces for useful activities. The importance of community collaboration in this stage of care should be thus emphasized in the Introduction part of the Module. In addition, there should be an emphasis on the use of the aftercare methods, which are already available in the country. For example, in Thailand there are spiritual recovery groups, the Family Club and AA available in some part of the country and such groups are well accepted in the community.

M6. Comprehensiveness

The FC participants found that the following issues do not get enough attention or are not well covered in the Module.

1. Medication to reduce craving and prevent relapse;
2. Bringing community to take part in the aftercare process;
3. Structure, format and duration of the recovery service for specific type of

drugs;

4. Timing for boostering the intervention to improve the recovery outcome;
5. De-stigmatization of drug users who are discharged from treatment.

M6. Appropriateness

In Thailand, collaboration of people from all parts of the community in helping drug users to reintegrate into their society and to be drug-free is currently promoted to be the main part of aftercare process of drug users. Community education relating to care and health promotion of drug users who have passed the treatment course and changing people's attitude towards relapse is promoted. Service providers and patients are made to understand that the intensity of treatment in aftercare process is less than that in the main treatment course. The community is encouraged to be active in managing drug abuse problem in their community by themselves with only minor support from outside organization. Natural leaders in the community, especially spiritual leaders play an important role in helping drug users to remain drug-free after treatment. Therefore, it can be said that the recovery management described in the Standards is appropriate for Thailand as it focuses on long-term management of patients within the network of community-based supports and services.

The FC participants discussed that there should be some guide about who or which organization should take main responsibility in each stage of the recovery management. Furthermore, description of rehabilitation programme specific to each level of service centre, which is easy to follow in real practice should be included in the Module.

M6. Utility

The principles of recovery management can be used in Thailand to improve the quality of aftercare as they are based on the same approach being promoted in the country. However, the treatment activities described in the Module are rather limited, there needs to be some modifications to suit the context of each community. The FC participants would like to see more emphasis on how to maintain self-help group to make it sustainable, self-care, social support including caregiver support and how to obtain policy support for the recovery management.

M6. Feasibility

The FC participants reported that recovery management as described in the Module has already existed in some parts of Thailand. However, it is quite difficult to make it work in every area of the country, as it needs collaboration between different parties of the community. At present, drug abuse problem is not an issue of most interest in the health assembly of the province. To make aftercare fully work, it is necessary to make stakeholders understand various aspects about this treatment modality, for example, concept of the recovery management and collaboration between all departments in the community (e.g. public health, justice, social welfare and education systems and religious organizations). The aftercare staff should also be all-rounded as the drug users at this stage may have several problems in their lives, including legal, health and financial problems. A case manager should be assigned to take main responsibility in caring the drug user and link supports between different organizations. This person should be involved in the care since the time of discharge planning and a network of supports is needed.

(D) REPORT ON EVALUATION OF SERVICES' COMPLIANCE WITH STANDARDS

Ten service centres were visited in four provinces; i.e. Bangkok, Chiang Mai, Khon Kaen and Songkhla in four different regions of Thailand. These include four specialized drug treatment centres, one general hospital, one psychiatric hospitals, three community hospitals and one outreach/Drop-in centre all over the country.

Service centres visited by the research team

1. Chiangmai Thanyarak Drug Treatment and Rehabilitation Hospital	Specialised drug treatment hospital	Chiang Mai (North)	M1 - M5, S &P
2. Sansai Community Hospital	Community hospital	Chiang Mai (North)	M2, M4, M6, S&P
3. Thanyarak Addiction Institute	Specialised drug treatment hospital	Bangkok	M2, M3, M4, S&P
4. Pramongkutkhlao Army Hospital	General hospital	Bangkok	M2, M3, M4, S&P
5. Ozone Foundation	Drop in Center	Songkhla	M1
6. Cha-na Community Hospital	Community hospital	Songkhla	M1, M2
7. Songkhla Rajanagarindra Psychiatric Hospital	Psychiatric Hospital	Songkhla	M2, M3
8. Songkhla Thanyarak Drug Treatment and Rehabilitation Hospital	Specialised drug treatment hospital	Songkhla	M1- M6
9. Khon Kaen Thanyarak Drug Treatment and Rehabilitation Hospital	Specialised drug treatment hospital	Khon Kaen	M3, M4, M5
10. Prayearn Community Hospital	Community hospital	Khon Kaen	M2

Usage of the Standards for service evaluation

Overall, it is not so easy to use the Checklist for evaluating the service centre as it is quite long and too much detailed. We have some comments to improve the structure and content of the Checklist as follows:

1. It is not clear if Parts S and P are to be used for evaluating a service centre. It seems that those parts are for the whole health care system of the country, which has only one system. Therefore, we think that the checklist should be separated into two documents:

a. One for the evaluation of M1 to M6 treatment modalities. This form can be used to specifically evaluate each service setting.

b. Another form is for the evaluation of the whole health care system of the country and includes only Parts S and P as these two parts ask about the whole health care system and the principles of the system of the country, which has only one system. We feel that these parts are not specific to each service centre. Therefore, they should not be used to rate each centre. However, if they are meant to be used with each centre, it should be defined clearly at the beginning.

2. When using M1-M6 parts to evaluate a service centre, it is better to choose only items specific to the main function of that centre. Evaluating all treatment modalities in one setting can confuse the evaluator. In Thailand there are various levels of service centres, e.g. community hospital, general hospital and specialized addiction centre. Each level has specific context and provides specific level of care. If we use the same measure for evaluating all levels of care the results may not be so valid. For examples:

    a. M2 (SBIRT): the specialized addiction centre does not mainly provide this service. The screening and brief intervention are just parts of the assessment of patients who visit the centre. Items M2.1, M2.2, and M2.3 are thus not so relevant to the context of the addiction centre.

    b. M4 (Outpatient service): this treatment modality can be provided in both general hospital and specialized addiction centre levels. However, opioid treatment is not available in all hospitals, depending on the prevalence of the problem and necessity of the service. There should be an item at the beginning checking if the service is available or not in the setting and skipped questions for the whole part if it is not available in that setting, e.g. items M4.14 & M4.15. We feel that to answer “not met” when there is no such service in the setting conveys the sense that the setting is not adequately functioning in providing the treatment when in fact there is no necessary demand for such service in the setting. Likewise, some forms of psychosocial treatment cannot be provided, e.g. family therapy and community reinforcement therapy because of limited resources.

    c. M4.21 - M4.24 –Outpatient treatment (Treatment for Co-morbid Medical Conditions) should include co-morbidities with other drugs as well, not only opioid patients as seen in the current version.

    d. M5 (Long term residential care): because of limited resources (beds, places, personnel, budgets), they can provide only 4 months of hospitalization for those compulsorily recruited from justice system. A full scale of TC system cannot be provided.

3. It is not so appropriate to use the same set of questions with all modalities. Some questions should be specific to level of care. For examples, the same items about staffing can be used with M3, M4 and M5, which are specialized care but not so applicable for M2, which is provided by general practitioners.

4. There are replicated items: M4.15 - M4.17 with M4.18 - M4.20.
5. Item S16 about “One Stop Service approach” is conflicting with the principle of “Integrated care”, which seems to be the principle of the Standards.
6. M4.15: Pharmacological treatment: buprenorphine is not available in Thailand. The item should read as “Pharmacological treatment options should consist of *either* methadone *or* buprenorphine… (not both methadone and buprenorphine).
7. There should be parts on evaluations of alcohol and nicotine treatment modalities as they are usually included in the same service setting as other drugs.

CONCLUSION

The field-testing of the International Standards for the Treatment of Drug Use Disorders has been conducted in four regions of Thailand in December 2017 to January 2018. Data collection includes web-based survey, focus group discussions, experts’ reviews and service site visits. Overall, it was found that the Standards are comprehensive as they provide almost all principles, descriptions of the treatment modalities and recommendations for planning, implementation and evaluations of treatment services for individuals with drug use disorders in community and clinical settings. The Standards are appropriate and useful to be used in Thailand as they can be modified to suit the Thai treatment system and cultural context and can also be used as a guideline in developing treatment standard and improving treatment quality and staff capabilities. The main issue of concern is the feasibility of the some principles and recommendations in the Thai context. Limited resources in terms of specially trained staff, number of staff, budget and time constrain are main barriers. In addition, the conformity of the principles suggested in the Standards to the Thai laws is an important offset, especially in terms of harm reduction service and rights of drug users in criminal justice system.

In sum, the experts, clinicians and policy officers involved in the test of the Standards are optimistic with the use of the Standards in Thai treatment system for drug use disorders and look forward to the improvement of the system.