



## Short report

## Police interference with methadone treatment in Bangkok, Thailand



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## Introduction

Methadone maintenance therapy is an evidence-based pharmacotherapy to treat opioid dependence (World Health Organization [WHO], United Nations Office on Drugs and Crime, & Joint United Nations Programme on HIV/AIDS, 2012). The WHO and other United Nations agencies recommend it as part of essential services for the prevention, treatment and care of human immunodeficiency virus (HIV) infection among people who inject drugs (IDU) as it has been demonstrated to reduce HIV risk behaviour and improve access and adherence to HIV treatment among this population (WHO et al., 2012). Despite the proven therapeutic benefits, methadone is not always readily accessible to those in need in many settings (Wolfe, Carrieri, & Shepard, 2010).

In Thailand, a country contending with a longstanding dual epidemic of opioid use and HIV among IDU (Assanangkornchai et al., 2008; National AIDS Prevention and Alleviation Committee [NAPAC], 2010; Reid & Costigan, 2002), methadone was approved for opioid substitution therapy in 2000, although having been provided as tapered detoxification regimens rather than as a maintenance therapy (Tyndall, 2011). In 2008, methadone was added to the universal healthcare coverage scheme (NAPAC, 2010). In Bangkok, methadone treatment is primarily provided by the Bangkok Metropolitan Authority (BMA) through its 17 public health centers, two hospitals and one stand-alone clinic (Tyndall, 2011).

The Thai government has for many years implemented aggressive drug prohibition approaches (Hayashi, Small, Csete, Hattirat, & Kerr, 2013a). A recent qualitative study of IDU in Bangkok has highlighted that the police often conduct surveillance of people accessing methadone clinics; harass methadone patients with extortion and urine drug testing; and arrest patients who test positive for an illicit drug (Hayashi et al., 2013a). In response, some

interviewees reported feeling discouraged from continuing their methadone treatment (Hayashi et al., 2013a). While these reports are consistent with international literature indicating that aggressive policing can impede IDU's access to healthcare (Kerr, Small, & Wood, 2005), few studies have quantitatively evaluated the impact of policing around health service sites. Therefore, we sought to examine the prevalence and correlates of noticing police presence around methadone clinics among methadone-treated IDU in Bangkok.

## Methods

Data were derived from the Mitsampan Community Research Project (MSCRP), a collaborative research effort involving the Mitsampan Harm Reduction Center (MSHRC; a drug user-run drop-in centre in Bangkok, Thailand), Thai AIDS Treatment Action Group (Bangkok, Thailand), Chulalongkorn University (Bangkok, Thailand), and the British Columbia Centre for Excellence in HIV/AIDS/University of British Columbia (Vancouver, Canada). This serial cross-sectional study aims to investigate drug-using behaviour, healthcare access, and other drug-related harms among IDU in Bangkok. Between July and October 2011, 440 IDU in Bangkok were surveyed. Potential 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. Recruitment criteria included adults residing in Bangkok or in adjacent provinces who had injected drug(s) in the past six months. The recruitment methods and the sample characteristics have been described in detail previously (Hayashi et al., 2012). All participants provided informed consent and completed an interviewer-administered questionnaire eliciting a range of information, including demographic characteristics, drug use patterns, and experiences with drug law enforcement and accessing healthcare. Upon completion of the questionnaire, 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.

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Participants who reported having received methadone treatment during the previous six months and who had complete data were included in this study. The primary outcome of interest was noticing police presence near methadone clinics during the previous six months, defined as answering “Yes” to a question: “In the last six months, have you noticed police presence where you obtain methadone?” Explanatory variables included: younger age; male gender; daily heroin injection; daily midazolam (a short-acting benzodiazepine) injection; daily methamphetamine injection; binge drug use; rushed injection; syringe sharing; HIV serostatus (positive vs. negative or unknown); non-fatal overdose; and avoiding healthcare. Drug-using behaviours referred to the previous six months. Consistent with our previous MSCRP study (Kerr et al., 2014), avoiding healthcare was defined as answering “Yes” to a question: “Do you sometimes avoid healthcare because you are a drug user?”

To examine bivariate associations between each explanatory variable and the outcome, we used the Pearson  $\chi^2$  test. Fisher’s exact test was used when one or more of the cells contained values less than or equal to five. Next, we fit a multivariate logistic regression model including all variables that were significantly associated with the outcome at the  $p < 0.05$  level in bivariate analyses. All  $p$ -values were two-sided.

In a sub-analysis, we also asked participants if they have been harassed by police after receiving methadone, if they had stopped methadone treatment anytime during the past six months, and the reasons for stopping treatment (participants could provide more than one response). We used the Pearson  $\chi^2$  test to determine if there was an association between methadone discontinuation and noticing police presence near methadone clinics.

## Results

In total, 190 IDU who accessed methadone treatment during the previous six months participated in this study, including 29 (15.3%) women. The median age was 38 years (interquartile range: 34–48). In total, 109 (57.4%) individuals reported having noticed police presence near methadone clinics in the previous six months. Of these, 42 (38.5%) reported having been harassed by police after receiving methadone.

Table 1 shows the results of bivariate and multivariate logistic regression analysis. As shown, in the multivariate analysis, factors independently and positively associated with the outcome included daily midazolam injection (adjusted odds ratio [AOR]: 2.33; 95% confidence interval [CI]: 1.26–4.32) and avoiding healthcare (AOR: 2.20; 95% CI: 1.02–4.74).

In the sub-analysis, 39 (20.5%) of the entire sample reported having stopped methadone treatment during the previous six months. There was no significant difference in the proportion of methadone discontinuation between those who did and did not notice police presence near methadone clinics ( $p = 0.62$ ). Among 190 individuals who noticed police presence, 21 (19.3%) reported methadone discontinuation, and the primary reasons for stopping treatment were: incarceration (33.3%); difficulty accessing clinics (19.0%); and did not want to take methadone any more (14.3%). In contrast, 18 (22.2%) of 81 participants who did not notice police presence reported methadone discontinuation, and the primary reasons included: did not want to take methadone any more (42.1%); incarceration (22.2%); and too many side effects (11.1%).

## Discussion

We found that more than half of a sample of methadone-treated IDU in Bangkok noticed police presence near methadone clinics in the previous six months. Patients who injected midazolam daily

and avoided accessing healthcare were more likely to have witnessed police officers near clinics. Approximately 40% of those who had noticed police presence also experienced police harassment and 20% stopped methadone treatment primarily due to incarceration and difficulty accessing clinics.

While rates of methadone discontinuation did not differ between those who did and did not notice police presence, the primary reasons for stopping methadone appeared to differ between the two groups. Specifically, difficulty-accessing clinics was referred to only among those who noticed police presence. Further, incarceration appeared to be more commonly reported among this group, which may suggest that patients who saw police officers near clinics may have been subsequently arrested by these police officers, detained, incarcerated and taken off methadone. These findings corroborate previous qualitative studies indicating that Thai police often conduct targeted surveillance and arrests of drug offenders around methadone clinics in Bangkok (Hayashi et al., 2013a). It has also been reported that drug policing in this setting generally involves various forms of police misconduct and violence (Hayashi et al., 2013a). Given the aggressiveness of policing practices in this setting, it may be that policing activities around methadone clinics have created a climate of fear among methadone patients and deterred some patients from accessing treatment. Such impacts of policing have also been indicated in the international literature (Meng & Burris, 2013).

The independent association between daily midazolam injection and noticing police presence near clinics may indicate a potential consequence of compromised access to methadone treatment. A previous study in this setting has shown that the majority of midazolam injectors use midazolam as a legal substitute for heroin due to the low price and its potential to alleviate heroin withdrawal symptoms (Hayashi et al., 2013b). In light of these reports, our findings may suggest that methadone patients who noticed police presence may have skipped some methadone doses to avoid a future encounter with police near clinics, and they may have resorted to injecting midazolam to diminish the symptoms of opioid withdrawal. High rates of midazolam misuse are concerning as there is no proven pharmacotherapy to treat benzodiazepine dependence (WHO-SEARO, 2008), and frequent midazolam injection is linked to serious venous disease and injuries (Hayashi et al., 2013b). An alternative explanation for our findings is that midazolam injectors are more likely to generate police attention. Future research should seek to unpack the association between policing and midazolam injecting among Thai IDU accessing methadone treatment.

We also found that IDU who reported avoiding healthcare were more likely to report witnessing police officers near clinics. In Bangkok, methadone clinics are typically housed within the BMA public health centers and hospitals that provide general healthcare services (Tyndall, 2011). Therefore, it may be that policing around methadone clinics may not only interfere with methadone treatment but also impede methadone patients’ access to healthcare more generally. Alternatively, individuals who actively avoid healthcare due to their drug use may be more cautious about police presence.

Collectively, these findings raise concern that policing around methadone clinics may be undermining the potential benefits of including methadone treatment in the universal healthcare scheme. Efforts to ensure that policing practices do not interfere with the essential health service for IDU are urgently needed in this setting. A recent report has indicated that harm reduction services, including methadone treatment, are poorly understood by the police and are not part of the police curriculum in Thailand, although a plan for a pilot harm reduction training program for police officers is underway (Macdonald & Nacapew, 2013). There is a clear need for the prompt implementation,

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