ELECTIVE (SSC5a) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Objective 1: Describe the pattern of addiction in the Horizon Rehabilitation population, and contextualise this from a global health standpoint

Horizon Rehab center caters to a variety of different substance and behavioural addictions. This includes alcohol, methamphetamines, cannabis, cocaine, video gaming, sex and porn. By far the most prevalent I have seen is alcohol, followed by methamphetamines. The age demographic ranges from as young as 16 to 55, with a broad spectrum of addiction durations.

According to the WHO, "Alcohol consumption contributes to 3 million deaths each year globally as well as to the disabilities and poor health of millions of people. Overall, harmful use of alcohol is responsible for 5.1% of the global burden of disease." Additionally, alcohol is the number one risk factor for premature mortality and disability in the 15-49 age group, responsible for 10% of all deaths here.

The addiction patterns observed at Horizon Rehabilitation provide a microcosm of global trends in substance and behavioral addiction. With alcohol addiction ranking as the most prevalent, followed closely by methamphetamine abuse, the center's clientele mirrors the widespread challenges seen worldwide. The inclusion of various substance and behavioural addictions, such as cannabis, cocaine, video gaming, sex, and porn, reflects a comprehensive approach to addressing addictive behaviors. Moreover, the wide age range, spanning from 16 to 55, underscores the universal nature of addiction, affecting individuals across different stages of life. Similarly, the broad spectrum of addiction durations highlights the chronic nature of these disorders, stressing the need for sustained support and interventions. Horizon's holistic approach aligns with global efforts to address the complex and evolving landscape of addiction, acknowledging the diverse needs of individuals seeking recovery and emphasising the importance of tailored interventions across demographics and addiction types.

That being said, when we look at the addiction make-up in Thailand as a whole, we see some marked differences. According to my supervisor, Methamphetamines account for up to 60% of the addiction burden in the country, followed by Alcohol at 20%, and Opiates at 5%. The remaining percentages are made up of Cannabis, Mephedrone, and other substances. It is possible that the international status of the rehab center tends its clientele's predilections towards the global standard.

Objective 2: Describe the pattern of addiction detoxification and rehabilitation in Thailand, in relation to the UK

Detoxification as a practice in Thailand bears some similarities to its UK counterparts. From a pharmacological standpoint, the medications used to induce detoxification are one and the same. Alcoholics receive Benzodiazepines and B vitamins, and Opiate users receive Methadone or Buprenorphine for substitution. Duration of treatment is individualized in both countries – my observations so far are that Thai detox can take anywhere between 1-2 weeks.

Looking at the differences, Thailand prefers to incorporate Eastern practices into their detoxification process to supplement Western medical efforts. Kratom and Ya-Hom are used sparingly, but frequently enough for me to have seen them administered. Moreover, holistic approaches feature to a greater degree (to include massages, acupuncture, and yoga, as well as CBT). In contrast, the UK leans towards empirical psychological interventions such as CBT and counselling almost exclusively, often foregoing holistic approaches in the public sector.

I should caveat my next point by saying my experience has been limited to a few detoxification facilities, and that this may not be enough to accurately generalise the de facto detoxification setting in Thailand or the UK. In short, Thailand seems to place more emphasis on comfort and luxury during the detoxification process, whereas the UK keeps their environment clinical.

Objective 3: To analyse public health strategies and campaigns in Thailand aimed at addiction prevention and awareness

The predominant public health strategy in Thailand links drug-users to detoxification and rehabilitation through the criminal system. It is well known that Thailand (and Asia as a whole) adopt a more conservative view on drug use, but this is paired with an authoritarian push to get drug addicts into a rehabilitation facility (many of which are free of charge at the point-of-access). If a Thai local is caught using illicit drugs, and their presentation suggests that they are not a dealer/supplier, then they are mandated to enter a treatment facility. The removal of choice contrasts from other rehabilitation-focused initiatives (see Portugal for example), but the principle seems to be the same – a focus on rehabilitation over punishment. When it comes to public awareness, most of the advertising around medical interventions in Bangkok is cosmetic – campaigns targeting drug users directly are few and far between.

Objective 4: Describe the benefits and drawbacks of an abstinence-based model of addiction treatment, and contrast this to the harm-reduction model commonly used in the UK

Abstinence-based models of addiction treatment advocate complete cessation of substance use as the primary goal. This approach is rooted in the belief that addiction is a chronic, relapsing condition best managed by complete abstinence. One of the key benefits of this model is its clarity and simplicity: for individuals struggling with addiction, a clear goal of abstaining from substance use can provide a sense of direction and purpose. Moreover, abstinence-based programs often promote a holistic approach to recovery, addressing not only substance use but also underlying psychological, social, and spiritual aspects of addiction.

However, abstinence-based models also have several drawbacks. One challenge is the high rate of relapse associated with addiction. For some individuals, the pressure to achieve and maintain total abstinence can be overwhelming, leading to feelings of shame, guilt, and failure when relapse occurs. Additionally, the strict adherence to abstinence may deter individuals who are not yet ready or willing to commit to complete cessation of substance use, potentially limiting their access to treatment and support services.

In contrast, harm reduction models of addiction treatment focus on minimizing the negative consequences associated with substance use, rather than insisting on complete abstinence. This approach recognizes that for some individuals, achieving total abstinence may be unrealistic or undesirable in the short term. Instead, harm reduction strategies aim to reduce the harms associated with substance use by providing access to resources such as clean needles, naloxone kits for opioid overdose reversal, and supervised consumption sites.

One of the primary benefits of the harm reduction model is its pragmatic approach to addressing the complex realities of addiction. By meeting individuals where they are and focusing on reducing immediate risks and harms, harm reduction programs can engage individuals who might otherwise be hesitant to seek help. Moreover, harm reduction approaches have been shown to effectively reduce rates of infectious diseases, overdose deaths, and other adverse outcomes associated with substance use.

However, the harm reduction model is not without its challenges. Critics argue that by tolerating continued substance use, harm reduction strategies may inadvertently enable addictive behaviors and undermine efforts to promote long-term recovery. Furthermore, there is a concern that prioritizing harm reduction measures may divert resources away from efforts to support abstinence-based treatment and recovery programs.

In the United Kingdom, harm reduction approaches are commonly used in addiction treatment and public health initiatives. This reflects a broader shift towards a more pragmatic, evidence-based approach to addressing addiction, which acknowledges the need for a range of interventions tailored to the diverse needs of individuals struggling with substance use disorders.

In conclusion, both abstinence-based and harm reduction models of addiction treatment have their own strengths and limitations. While abstinence-based approaches provide clarity and focus, harm reduction strategies offer practical solutions for reducing immediate risks and harms associated with substance use.