

ORIGINAL ARTICLE

Stakeholder's Narrative Experiences in Methamphetamine Rehabilitation: A Case Study of the FAST-Model

Nanta Chaiphichitphan¹ and Kanvee Viwatpanich²

¹ Ph.D. Candidate, Department of Community and Family Medicine, Faculty of Medicine, Thammasat University, Thailand.

² Dr.rer.nat. Chulabhorn International Collage of Medicine, Thammasat University, Thailand.

Corresponding author: Nanta Chaipichitpan Email: nan_0308@yahoo.com

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Abstract

Chaiphichitphan N. and Viwatpanich K.

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Methamphetamine is the most commonly abused drug in Thailand. The FAST model for rehabilitation had been implemented for decades. In this research, the benefits and limitations of using the FAST model were investigated for future development. A qualitative approach was used as the main tool for data collection. The key informants were selected based on purposive sampling, which consisted of health professionals (n=13), patients (n=10), and their family members (N=9). Focus Group Discussions and in-depth interviews were conducted at a drug addiction treatment Center in Pathum Thani. Content analysis was used for data conclusion. The findings indicated that the FAST model gave direct benefit to the patient. Due to the FAST model is a great teamwork, great process of learning, humanizing, and successful changes in patient behavior. Limitations in the FAST model relied on lack of patients' needs assessment and health screening, limiting personal resources and skills, lack of family participation, and human rights.

From this narrative study, the two domains for development are suggested include (1) patient-family management to in achieve success in the rehabilitation process (2) medical services improvement for health care provider and multidisciplinary teams.

Keywords: methamphetamine, rehabilitation, FAST model

ประสบการณ์ของผู้มีส่วนได้เสียในการบำบัดฟื้นฟูสมรรถภาพ ผู้ป่วยเสพติดยาบ้า: กรณีศึกษา FAST Model

นันทา ชัยพิชิตพันธ์¹ และกัณฑ์วีร์ วิวัฒน์พาณิชย์²

¹ Ph.D.Candidate สาขาเวชศาสตร์ชุมชน และเวชศาสตร์ครอบครัว คณะแพทยศาสตร์ มหาวิทยาลัยธรรมศาสตร์ ประเทศไทย

² Dr.rer.nat วิทยาลัยแพทยศาสตร์นานาชาติจุฬาภรณ์ มหาวิทยาลัยธรรมศาสตร์ ประเทศไทย

บทคัดย่อ

นันทา ชัยพิชิตพันธ์ และกัณฑ์วีร์ วิวัฒน์พาณิชย์

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ว สาธารณสุขและการพัฒนา. 2558;13(3):35-49

ยาบ้าเป็นยาเสพติดที่แพร่ระบาดในประเทศไทย การบำบัดฟื้นฟูสมรรถภาพผู้ป่วยเสพติดในรูปแบบ FAST Model เป็นรูปแบบที่ใช้มานานหลายทศวรรษ งานวิจัยนี้ศึกษาถึงข้อดี และโอกาสพัฒนาของการบำบัดฟื้นฟู รูปแบบนี้ ซึ่งจะนำผลลัพธ์ไปพัฒนารูปแบบการบำบัดฟื้นฟู ให้สอดคล้องกับความต้องการของผู้ป่วยเสพติดในอนาคต การศึกษานี้ใช้ระเบียบวิธีวิจัยเชิงคุณภาพ เก็บรวบรวมข้อมูลโดยการสัมภาษณ์เชิงลึก และการสนทนากลุ่ม กลุ่มตัวอย่างคัดเลือกแบบเจาะจง ตามเกณฑ์กำหนด ประกอบด้วย บุคลากรทางสุขภาพ 13 คน ผู้ป่วยเสพติดยา 10 คน และญาติผู้ป่วย 9 คน ดำเนินการ ณ สถาบันบำบัดรักษาเสพติดแห่งหนึ่งในจังหวัดปทุมธานี วิเคราะห์ข้อมูลด้วยเทคนิค Content Analysis ผลการศึกษาพบว่า รูปแบบการบำบัดแบบ FAST Model มีประโยชน์ต่อผู้ป่วย เนื่องจาก FAST Model มีการทำงานเป็นทีมที่ดี มีกระบวนการสอนให้เกิดการเรียนรู้ที่คืนผู้ป่วยสามารถปรับเปลี่ยนพฤติกรรมของตนเองได้ และมีระบบการดูแลผู้ป่วยด้วยหัวใจแห่งความเป็นมนุษย์ ในส่วนข้อจำกัดของการบำบัดแบบ FAST Model นี้พบว่า ยังขาดการประเมินคัดกรองด้านร่างกาย และจิตใจของผู้ป่วย ขาดการประเมินความต้องการของผู้ป่วย จำนวนบุคลากรไม่เพียงพอกับภาระงาน บุคลากรขาดทักษะที่สำคัญ และยังพร่องด้านการพิทักษ์สิทธิผู้ป่วยด้วย จากการศึกษาเมื่อนำข้อมูลเบื้องต้นทั้ง 2 ส่วนมาสังเคราะห์และสรุปสิ่งที่ได้เรียนรู้พบข้อเสนอแนะที่สำคัญ ดังนี้ (1) ควรนำครอบครัวเข้ามามีส่วนร่วมในการบำบัด เพื่อช่วยให้กระบวนการบำบัดฟื้นฟู ประสบความสำเร็จ และ (2) ควรปรับปรุงระบบบริการทางการแพทย์ เพื่อสนับสนุนการทำงานของทีมบำบัดและทีมสหสาขาวิชาชีพ

คำสำคัญ: ยาบ้า, การบำบัดฟื้นฟูสมรรถภาพ, FAST Model

Introduction

Drug addiction creates several medical, social, and economic problems. During the year 2010, approximately 230 million adults worldwide were estimated to have used any illicit drug. Moreover, UNODC reported that 99,000 to 253,000 people died in 2010 as a result of drug use.¹ The negative impacts occurred at individual, family, community, national, and international levels and is a major problem in Thailand. In the year 2012, about 1.4 to 1.7 million incidents of drug use and addiction were officially reported in Thailand.²

Methamphetamine (MA) is the most commonly abused drug in Thailand and it's difficult to estimate the real size of the problem. McCoy³ reported approximately 257,000 Thai low-wage workers used methamphetamine regularly to increase working hours. During the year 2014, 98.6 million tablets of methamphetamine were officially confiscated, that is about 2.6 times higher than the number reported in 2004.²

In Thailand, "Return to society as good people" is an important concept in political changes to drug policy.⁴ According to this policy, drug addiction is interpreted as an illness, and rehabilitation is officially required.⁵ The Drug Addiction Treatment Center (the first and largest treatment center for drug dependence in Thailand – established since 1959), Department of Medical Services, Ministry of Public Health, provides classical treatment for those patients. The process of treatment consists of (1) pre-admission (2) detoxification (3) rehabilitation and (4) follow up and after care.⁶ During the year 1986, the concept of a Therapeutic Community (TC) was applied and developed as the supplementary treatment. However, there are limitations in classical treatment and TC.

There are long periods for treatment (approximately 18-24 months), long time to monitor, and difficulties in follow up and after care.⁷ Consequently, FAST model was developed, not only to decrease the duration of rehabilitation, but also to increase social and family participation in the rehabilitation process.

FAST Model is the assimilation of (1) *family participation* in the rehabilitation process including knowledge empowerment of family members to accept the situation and more understanding of the patient's situation by family education, family counseling, and family therapy (2) *alternative activities* designed to increase meaning and quality of life such as sports, education, volunteering activities, social responsibility activities, etc. (3) *Self help* is also applied as personal cognitive development is encouraged so that the patient can find answers to their problems and difficulties on their own (4) *therapeutic community* (TC) is another principal strategy to promote patient development that focus on social, psychological and behavioral dimensions to support the attitudes and values of healthy living by using family and community approaches.

The FAST model has been implemented in Thai society for decades and was apparently effective.⁸⁻⁹ Even though the duration of treatment was decreased from 24 months to 4 months,⁷ about 75% of the patients reported that they could return to their normal lives, living in the community with happiness, continue their education and jobs. Family members were highly satisfied.⁸⁻⁹

The limitations of the FAST model have been mentioned by several scientists. Even though the rehabilitation period was eventually reduced, the drop-out rate was 85%. Family engagement was

irregular because family member's lives were so busy. Only 30% reported they were able to join and support in the rehabilitation process. Finally, approximately 53.9% indicated that the patient-family relationship after returning home was not well established.⁸⁻⁹ The data based from Drug Addiction Treatment Center also found that during the year 2008-2012, around 70% of the participants dropped out and relapsed. Moreover, 49% of the participants had been more than two times in treatment during year 2010-2012.¹⁰ The FAST model needed more investigation and development. Thus, the aims of this study were; (1) to explore personal experiences among stakeholders including patients, families, and health care providers toward the FAST model, (2) to identify problematic issues in the FAST model under emic point of views as a strategic model for more development in future step.

Methods

To explore the experiences toward FAST model, a qualitative approach including focus group discussions and in-depth interviews were used as the main tools for data collection. In case of FGDs, the respondents consisting of three population groups: (1) health personels who had long experience in the FAST model (N=13), (2) patients who were in the process of rehabilitation at the time of the data collection and also patients who had completed the FAST Model (N=10), and (3) family members of patients in the second group (N=9). Due to the limitation in number of the cases, in-depth interviews were instead performed with 4 administrators. All key informants were purposively selected and were conducted at one health care facility in Pathum Thani province during February-April, 2014.

Before data collection, the objectives and informed consents were explained and provided, to ensure that all personal information would be protected and presented as anonymous. During a 120-minute interviews, either FGDs or IDIs – the respondents were asked in the same question guidelines such as what do you think about the FAST model? From your experiences what are advantages and disadvantages of the FAST model? The FAST model was applied for Methamphetamine rehabilitation for years, there are any ideas to improve and develop? The participants were free to explain their experiences, feelings, and developmental viewpoints about the FAST model. Their answers were recorded and summarized as well as grouped to explain the contexts involved in the rehabilitation process. Significant quotations by key informants were also presented. Suggestion model was provided relied on their needs under emic point of views. This research was approved by the ethical committee, Faculty of Medicine, Thammasat University.

Results

1) Characteristic of key informants

The key informants were demographically diverse: 46.9% male and 53.1% female. The majorities were the patients and their family (59.4%), the Health professionals (Multidisciplinary team and medical/nurse administrators) were 40.6%. The median age was 45.7 years (64 years maximum and 20 years minimum) about half (49% and 50%) reported their age in the range of 41-60 years old and were married. The majority graduated from secondary school (34.4%) and only 12.5% reported that they were unemployed during the time of data collection. (Table 1)

Table 1 Demographical characteristics of the key informants

Background	Demographical characteristic							
	Health Personel		Patient		Family Member		Total	
	n=13	%	n=10	%	n=9	%	n=32	%
Gender								
Female	11	84.6	-	-	6	66.7	17	53.1
Male	2	15.4	10	100.0	3	33.3	15	46.9
Age								
Younger than 21 years old	-	-	2	20.0	-	-	2	6.3
21-40 years old	4	30.8	8	80.0	-	-	11	34.3
41-60 years old	9	63.2	-	-	6	66.7	16	49.0
older than 60 years old	-	-	-	-	3	33.3	3	9.4
Marital status								
Married	8	61.5	2	20.0	6	66.7	16	50.0
Single	3	23.1	8	80.2	-	-	11	34.4
Divorced	-	-	-	-	3	33.3	3	9.3
Widowed	2	15.4	-	-	-	-	2	6.3
Educational level								
Primary school	-	-	1	10.0	3	33.3	4	12.5
Secondary school	-	-	8	80.0	3	33.3	11	34.4
Certificate level	-	-	1	10.0	1	11.1	2	6.3
Bachelor degree	5	38.5	-	-	2	22.2	7	21.8
Master degree or higher	8	61.5	-	-	-	-	8	25.0
Occupation								
Government sector	12	93.3	-	-	2	22.2	14	43.8
Personal business	-	-	3	30.0	5	55.6	8	25.0
Employee	1	7.7	5	50.0	-	-	6	18.7
No job	-	-	2	20.0	2	22.2	4	12.5

2) FAST model: The positive viewpoints

This part describes the positive experiences from all stakeholders engaged in the FAST model. The findings indicated that the positive viewpoints could be categorized into four main patterns including;

2.1 FAST is a team: Providing care, giving treatment, and empowering the patients were impossible to perform by one's self, it should be participated in a team. Teamwork in the FAST model is not the medical health care providers; instead it consists of family members, health psychologists, occupational therapists, social workers, and recreational therapists. This holistic teamwork is a platform to support the patients, provide health information, and create health and social activities. Moreover, individual care also benefits from the referral system, especially when the special care, specialists, and special support are required. The meaning of teamwork is not limited in the Drug Addiction Treatment Center circumstance. The teamwork mentioned in this research is also related to ASOD (ASEAN senior officials on drug matters), the international organization which plays an important role in supporting new ideas, exchanging knowledge and experiences, being a mentor for peer review.

“Advantage of FAST model is teamwork, the therapists take care the patient individually in all problems. This system supports the patient directly and holistically, because we have multidisciplinary team in the treatment process”

(Female-general ward head nurse, 55 years old)

“There is a process to prepare the patient. Family, staffs, and other teams also participate in the treatment process”

(Female-nurse administrator, 58 years old)

“It can be said that process of treatment is appropriate and responding to our situation and global trend. This evidence also accepted by the meeting of ASOD (ASEAN senior officials on drug matters) that means the content of our rehabilitation process and other member countries were found in the same direction that all are trying hard to develop the pattern of care and rehabilitation process, such as time reduction in treatment process or searching or including the other new ways to combine in the treatment, all activities that we applied in FAST model, I think it helpful and appropriate”

(Male-medical administrator, 52 years old)

2.2 FAST is a process of learning: key informants explained that the FAST model provides an opportunity for learning, to develop new ideas about life, to create social skills to develop personal cognitive functions, and to promote appropriate lifestyles. The findings indicated that the patients had to cross old borders overcome things that they had never done before. The process of learning provided space and time to create a new life. Self-help and the group dynamics provided in the FAST model was also reported as a significant factor in shaping their cognitive functions as explain in the quotations below.

“For the patients they are also learnt...learnt how to learn by participation until they felt strong enough to express and exchange their ideas to each others. The senior who had learnt before also being as a model for the junior, the junior follows the ways that senior had done before”

(Female-nurse administrator, 56 years old)

“At the beginning I thought it (FAST model) would not works at me and I will relapse again likes always. But not so long I realized that I got a great progress and development, I mean my way of thinking was changed because the teaching way of nurses and other staffs. Teaching medias were also good not only VCD but also the others things to support the patients”

(Male-patient, 32 years old)

“They trained us to accept what we dislike. In the beginning I said why I have to accept. I asked myself so many times but I was afraid to say so. I tried to communicate them (nurse), but not in the direct way that I did not like the things that you forced me to do. The answer I got and realized was sometimes we could not select the things we want, but we should try to accept and stay with something that we hate... Ah ha, I see, they wanted to inform me how to behave when I had to confront with the things I dislike, that what I got from FAST”

(Male-patient, 22 years old)

“Nurses feed us information day by day continuously, just like slowly reduction of our bad habits and filled in the good things instead. Such activities, health educations, self helps, group works, all groups, every group is really important to me”

(Male-patient, 28 years old)

2.3 FAST is humanizing: drug treatment is often perceived as being forceful and even violent. This is not the case in the FAST model. FAST is a harmonized process in treatment. Friendliness, and caring by means of moving forward together, creates a positive experience and feedback. This is rewarding for patient parents. The happiness of a mother or father when saw her/his child developing and progressing in a good way without any force increases family participation in the rehabilitation process. A nice atmosphere encourages family members to make more visits. Increasing the frequency of visits creates a chance for family participation, and this is a benefit to the patients.

“I really love the pattern of treatment here and I think it is better than the other centers. No chain here, other centers sometime the patients were chained and controlled them not to be mad or aggressive. But here, so many activities, I asked him (son) “are you able stay here?”, and he said to me, of course and he will stay until the doctor says okay, back home”

(Female-family caregiver, 60 years old)

“Really great approach with a good care, for example, my brother has congenital disease, and sometimes I totally forgot to bring him pills. But the nurse was calling me and said your brother’s medications nearly finished Na Ka (very polite). I think this is a great standpoint in the treatment.

(Male-family caregiver, 42 years old)

“In my way of thinking, it is a really good model because it was modified and developed from TC (Therapeutic Community), therefore, we tried to make it short and appropriate to Thai people and cultural context”

(Female-nurse administrator, 58 years old)

“He said he did not want me to come and visit so often, coz he did not want to disturb me as I live in the city... but I said I really want to come to see you my child. You know, I really proud on him that he asked me in this way”

(Female-family caregiver, 55 years old)

2.4 FAST can change patient behavior: family members explained that the patients often changed inappropriate or antisocial behavior into socially appropriate behavior. This change included such things as living without any aggression, increased emotional control, increased responsibility, social skills, self-confidence and showing respect to others. All of these attributes are signs of social maturity.

“Health and behavior of my son is getting better and not aggressive”

(Female-family caregiver, 60 years old)

“His responsibility has increased more after being here”

(Female-family caregiver, 58 years old)

“I have seen their personal adaptation, especially public speech, increasing a sign of social adulthood, can express their feeling, and support the others”

(Female-nurse administrator, 56 years old)

“It enough to play with my life, sometime I’m homesick, but since participate in group activities, I learnt a lot, step by step, it automatically changed which is I could not recognized, since when.

(Male-patient, 28 years old)

“My behavior was totally changed, absolutely. I became more reasonable and flexible that never ever happened at me in the past, now it so easy for me to say hey its okay, hey its all right”

(Male-patient, 32 years old)

“Normally my child neither says hi nor respect me, but since here, when I came he pay respect to me, when I back he pay respect again”

(Female-family caregiver, 55 years old)

3. FAST Model: some remarks that need to be developed

The FAST model, has been a beneficial process for many patient's rehabilitation, but they have been reports of several limitations that need to be rethought and revised. The narrative experiences and suggestions were mostly explained by medical and nurse administrators as well as the multidisciplinary team. Negative experiences from family members or patients were found but limited. The details are explained as below.

3.1 Knowing the patient's limitations and assessing their needs: health care providers especially nurse practitioners and administrators affirmed that to achieve the goal of the FAST model, screening the patients should be strictly implemented. Presently, anyone with drug addiction is perceived as a patient and can take part in the rehabilitation process. Unfortunately, the FAST model does not work for everyone. The patients with cognitive limitations and mental disorder can't participate in group activities. They lack the learning processes, especially during self-help activities where cognitive and transformative ways of thought are really needed for their improvement. Thus, lack of screening or identifying the patients is huge barrier for the rehabilitation process. This is true not only for the patient but also the whole group. The details are explained as below.

"Screening the patient into FAST model, this we did not do. Sometimes the patients had psychological problem or severe health problems, if this happened we should treat them first, but they (Out Patient Department & Detoxification) send them immediately for rehabilitation, just only the reason that they are

voluntarily patients. But in fact, if the patient has cognitive impairment, this case could not be possible for FAST model rehabilitation.

(Female-general ward head nurse, 48 years old)

"Activity needs assessment is, perhaps, not well planned and organized, if we could not evaluate the patient's efficacy or we did not know what they needs, this could be a problem. But if we know what is a real condition of the patient, if we know their efficacy, then we can develop and manage it very well and it could be surfed to their needs. I think Addiction Severity Index (ASI) should be applied to solve this problem"

(Male-medical administrator, 52 years old)

**Addiction Severity Index (ASI): A professional health team tool for screening addicted patient.*

3.2 Limiting personal resources and increasing personal skills: staff to patient ratio is a problem in FAST rehabilitation. Due to long-term nature of rehabilitation and treatment, the number of staff should be sufficient and appropriated to number of the patients. Limitation of staff results in staff rotations, and can cause a lack of continuing care. Moreover, new staff needs time to train or improve their skills. Reorganization is mentioned as a key point affecting rehabilitation. To learn new duties or experience increased workloads can reduce patient's care.

"Staff to patient ratios are inappropriate and inefficient, think about it approximately 50-60 patients for a building, but only 5 nurses, sometimes during anti-drug policy can be reached 70-80, with the same

number of nurses. I think it not sufficient for giving care”

(Female-nurse practitioner, 38 years old)

“Staff rotation is also a limitation in rehabilitation process, because we need specific skills and specialty, we trained them until they know their duties very well... then they moved ... and of course the gap is emerged and effect the process of treatment”

(Female-clinical psychologist, 42 years old)

“Re-organization, lack of number of health care providers, as well as the patients are also increased, something which is really important for rehabilitation was gone or dismissed”

(Female-nurse practitioner, 38 years old)

“How to motivate the patients this is a question too, reward is needed to support and encourage their life situation and behavioral changes. Case management, angry management also important in rehabilitation process”

(Female-general ward head nurse, 49 years old)

“I think, in the past, TC was really effective. Meeting among working team occurred very so often, at least one time a week, I am occupational therapist I was involved in evaluation process and I knew the patients, but now I think, it gone.

(Male-occupational therapist, 41 years old)

“Group dynamic or group process is not easy, the staffs sometime did not understand the original idea

and objective, group process is not just only come and let the patient do, but skills and experiences are the most significant. Patient is diverse; we could not expect or plan what will be happened. Staffs should have professional skills and can be applied their knowledge and skills for the patient, individually”

(Female-nurse administrator, 56 years old)

3.3 Increasing family participation: Even though family participation plays a key role in the FAST model, there are problems that reduce family engagement in the rehabilitation process. For example, family or visiting days are limited to office hours. Some people cannot come during these hours. Moreover, family phone calls are allowed only once a week. Some health care providers mentioned that sense of family was changed from informal relations to a hierarchical and bureaucratic system. That means the atmosphere of family relations was decreased.

“My mother is living and working far away from here. She is a government officer. Family visiting was absolutely impossible for her, because it was setting up only on Wednesday. My suggestion is why not let it happened during the weekend or holiday, that sometime my family could be able to take part. I mean, just think for the governmental family. I know here is also governmental office that is also closed in the weekend as well. But for the family who living so far and both of my parents are governmental officer and they want to join, but if reserved only in working day, it is a barrier for my family”

(Male-patient, 26 years old)

“Disappointment here is home calling that limited only 1 time a week. In my way, I think this regulation should be rethink or at least flexible, especially for emergency case like educational purposes”

(Male-patient, 32 years old)

“Nowadays, meaning of family in FAST is changed; we might think that family is only family members of the patient. But it is not; family can also means as we are all living together like a family! In the past, we called in-patient ward as home, we called nurses as sister or aunty, not boss like we use now for this moment. The emotion and feeling are different and the sense of family can be decreased”

(Female-clinical psychologist, 42 years old)

3.4 Concerning in human and patient rights: Staff-patient relationship play an important factor in the treatment process, dropout rate, withdrawal, abstinence, and relapse. Negative impact might not be appropriated in changing transformative of thought; giving rewards and everything flexible can be cause of relapse. Thus, the balancing between the two worlds should be planned and more developed, especially within the paradigm of the 21st century in which humanistic medicine, human rights, and health rights are of major importance.

“Human rights is everywhere, we should concern and adapt ourselves into this point too. Punishment and rewards should be appropriately managed. We should respect patient’s rights and thinking how to balance the situations”

(Male-medical administrator, 52 years old)

Conclusion and discussion

The FAST model was originally established based on a Therapeutic Community point of view (TC), and has existed in Thailand for decades. The natural characteristic of the FAST model is a holistic approach, consisting of family participation, alternative activities, self-help, and the therapeutic community itself.

Medical and nurse administrators as well as health care providers indicate that “screening the patient into FAST rehabilitation” was clinically managed and practiced. This was not only to identify and prepare the patients for cognitive changes and rehabilitation, but also to understand patient’s health status. In fact, patient with mental health should be separated and treated. After psychological health is improved, participation in FAST is easier and more effective. Cognitive function, self-recognition, self-help, and the group process are the main activities used to introduce new lifestyles. Lack in cognitive function affects learning and the group process, which harms the patient and is a barrier to other patients as well as health care providers. This finding also mentioned in several previous researches such as Yullayanon et al (2000)¹¹, Hundee et al (2006)⁹, Bradizza et al (2007)¹², Solo et al (2011),¹³ Dean et al (2013).¹⁴

Qualitative finding demonstrated high patient satisfaction and they reported that FAST rehabilitation was a good process and a great chance to develop a new healthy lifestyle. Some patients felt that FAST rehabilitation changed their way of thinking. They had a more sympathetic and empathetic way of thinking which allowed them to accept and understand unwanted situations which happened in life. Moreover, abusive

treatment was less than in other organizations and resulted in full voluntarily participation during the time of rehabilitation process. Infringement of human rights in treatment and rehabilitation did not support any changed in a patient's life.¹⁵ Thus, the kind of humanistic therapy and treatment of the FAST model in a Thai cultural context should be continued.

Family members were also happy. The behavior of their kids has changed in a positive ways. They liked the freedom and humanistic treatment. However, the bureaucratic process under governmental regulations sometimes resulted in family exclusion, such as visiting days or family phone calls being limited and performed only during working hours. Management and family participation should be discussed and search for a middle way suitable to both sides. As mentioned in several researches, family is really important in rehabilitation drug abuse and addiction.¹⁵⁻¹⁸

Religion and spirituality is not mentioned in this research, but plays a key role in substance abuse treatment in Geppert's study (2007).¹⁹ Moreover, the lesson learnt from American heroin-cocaine patients, who believed in supernatural power was that they could succeed in long-term abstinence (5 years) and could managed their behavior, two times higher than those who did not believe in a higher power.²⁰ Thus, this issue might also be applied into a Thai cultural context as well, not only for psychological well-being, but also to increase holistic rehabilitation.

Recommendations

From this study, it can be said that the FAST model is an effective process in Amphetamines rehabilitation, but some limitations are also found and mentioned by the participants. The suggestions are explained below and summarized as the framework.

To increase the opportunities for successful outcomes, mental health screening, activity needs assessment by using ASI (*Addiction Severity Index*) should be added and performed to the patient individually before the rehabilitation program starts. The benefit is not only for the patient, but also for the multidisciplinary team that they know what to do? and how to manage the patients?

To gain more family participation in rehabilitation process, the flexibilities and opportunities in family visiting should be increased and not limited only in working hours, but flexible during the weekend and holiday. Moreover, the world of communication has changed; family contact via phone call and other social medias are also possible?

The suggestions for multidisciplinary team rely on their professional and applicable skills in rehabilitation process. Treatment plan and case management should be strictly performed and monitored. Training is a key activity that needs to be developed, especially the specific medical knowledge in long-term care setting such as contingency management, cognitive behavioral therapy, continuing care, and angry management. Moreover, respect in human rights and patient's rights, even it reported as a good performance, but should be more attentive, concerned, and protected for all stakeholders.

Finally, goes to the administrators that the high volume workloads and insufficient staffs were mentioned and play a huge barrier in rehabilitation

services. How to maintain the staffs for long-term working? Special motivation rewards and payments can be applied for this case.

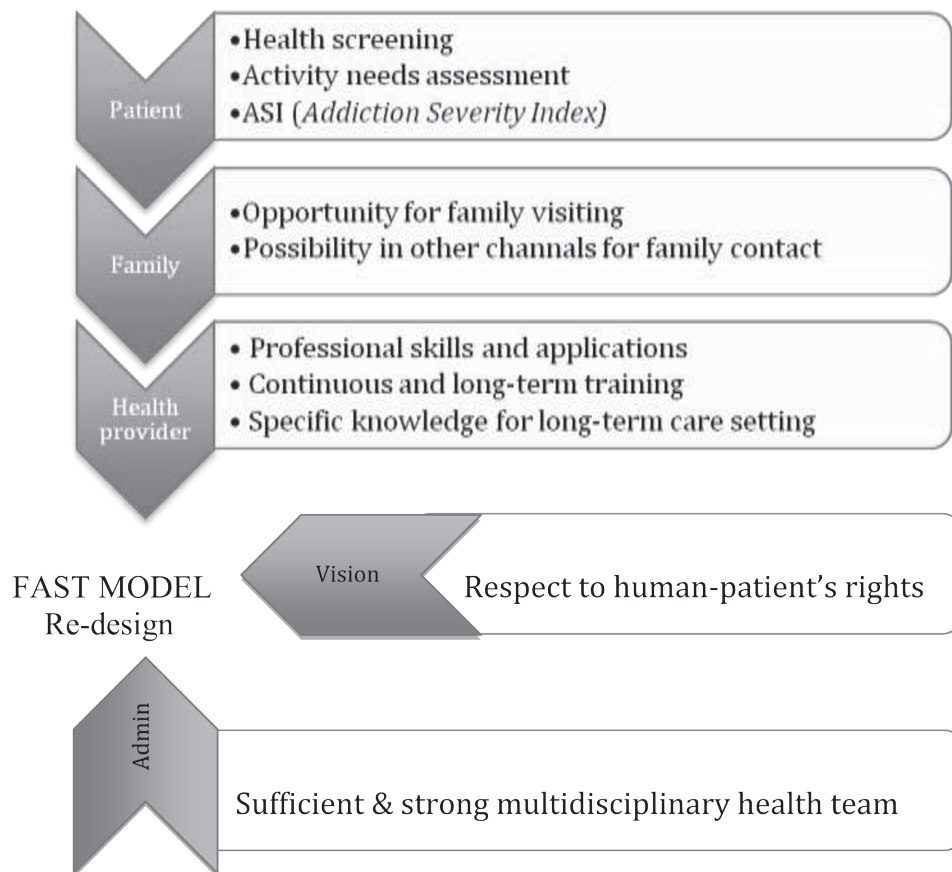


Figure 1 Model Development

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