Chapter VI

TREATMENT AND REHABILITATION

(A) Overview of Existing Efforts

6.1 Treatment and rehabilitation is an indispensable part of our drug demand reduction efforts to help unfortunate individuals who have fallen victim to drug abuse.

6.2 Broadly speaking, we adopt a multi-modality approach to cater for the different needs of drug abusers with varying backgrounds and circumstances[1]. The services can be grouped into the following five categories –

(a) counselling centres for psychotropic substance abusers (CCPSAs) subvented by SWD provide counselling services and other assistance to psychotropic substance abusers and youth at risk;

(b) Substance Abuse Clinics (SACs) run by the Hospital Authority (HA) provide medical treatment to drug abusers with psychiatric problems;

(c) methadone treatment programme (MTP) provided by DH offers both maintenance and detoxification options for opiate drug dependent persons of all ages through a network of 20 methadone clinics on an outpatient mode;

(d) 39 residential drug treatment and rehabilitation centres and halfway houses (DTRCs) run by 17 NGOs. 20 of them are subvented by DH or SWD whereas 19 are non-subvented.

[1] The different service modalities may refer to the different points of intervention, different target groups (e.g. opiate users or psychotropic substance abusers), different treatment approaches (e.g. medical-based or faith-based), different aims (e.g. detoxification, maintenance or psychiatric treatment), or other differences.

All except three are currently providing services to young drug abusers as well as adult abusers; and

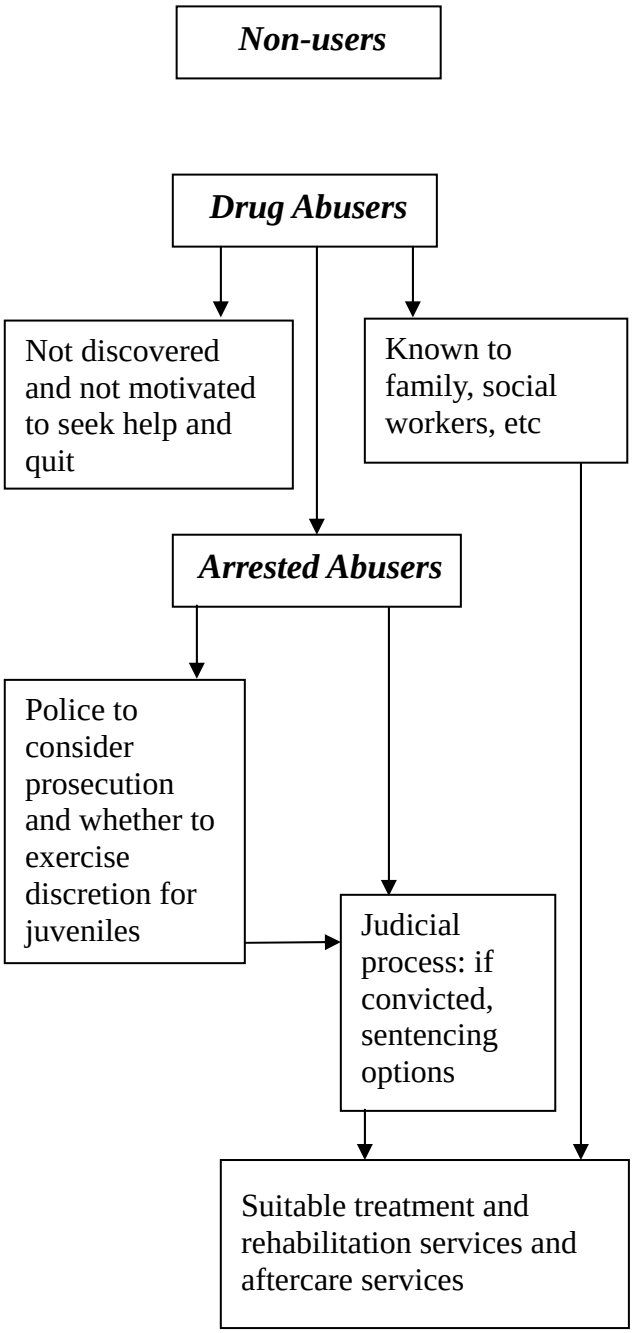
(e) compulsory drug treatment programme at drug addiction treatment centres (DATCs) operated by the Correctional Services Department for persons of 14 years old or above who are found guilty of offences punishable by imprisonment and addicted to drugs.

6.3 Efforts to engage the youth and identify those at risk include services such as the school social work service, District Youth Outreaching Social Work Teams (YOTs), and designated Integrated Children and Youth Services Centres which provide overnight outreaching service for young night drifters (YNDs). Regarding young people who have broken the law, professional intervention may be made through the Community Support Service Scheme (CSSS) for those subject to the Police Superintendent's Discretion Scheme (PSDS), and through the probation service and DATC programme, among other sentencing options, for those convicted.

6.4 A schematic diagram of the various services and programmes in different stages of drug use can be found in Chart 1.

Chart 1

Services and Programmes in Different Stages of Drug Use



1. Primary prevention - education and publicity to increase awareness.

2. Secondary/Early intervention - to identify and motivate abusers to seek treatment; and refer abusers to suitable drug treatment and rehabilitation services.
   [services include school social work service, YOTs, YND teams, CCPSAs, etc]

3. Law enforcement - For juveniles, Police to consider the PSDS; and SWD to render service under the CSSS.

4. Judicial process - Court to consider whether the person is guilty or not. If convicted, appropriate sentencing such as DATCs, probation orders, etc.

5. Tertiary intervention - to help abusers under detention and those with serious dependency.
   [services include DATCs, MTP, DTRCs, CCPSAs and SACs]

6.5 We keep our treatment and rehabilitation programmes under regular review through the cyclical formulation of a "Three-year Plan on Drug Treatment and Rehabilitation Services in Hong Kong" [2] in consultation with the anti-drug sector. We also keep in touch with anti-drug workers from subvented and non-subvented centres, youth groups, social welfare organisations, etc through various forum including ACAN and DLC.

(B) Issues

6.6 In its exchanges with the stakeholders, the Task Force has identified several major issues of concern having regard to the rising trend of psychotropic substance abuse, particularly among the youth, as follows –

(a) Many psychotropic substance abusers are "hidden" and/or are not motivated to seek help. They have remained out of reach of the existing help networks. Identification tools and outreaching programmes should be useful for seeking them out for treatment and rehabilitation. The inadequacy of early intervention has been regarded as a service gap in the anti-drug sector.

(b) The provision of downstream treatment and rehabilitation services, including counselling, medical and residential drug treatment services is considered to have fallen behind demand. In particular, the inadequacy of medical services for psychotropic substance abusers has been criticised.

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[2] The Plan maps out the future direction which drug treatment and rehabilitation services should take. Its formulation goes through a consensus building process among the stakeholders, providing a platform for all to reflect on the past years' efforts and develop complementing strategies and programmes in view of the latest drug trend. ND plays a coordinating and overseeing role in the preparation and roll -out of the Plan. The drawing up of the Fifth Three-Year Plan for 2009-11 is underway. A working group comprising anti-drug workers from drug treatment and rehabilitation agencies, counselling centres, academics, medical professionals and Government departments has been tasked to consider and advise on the objectives, scope, work plan and preparation of the Plan. Consultation sessions have been organised to gather views from the service sector direct. ACAN, its Treatment and Rehabilitation Sub-committee, and DLC will be consulted before the Plan is finalised.

(c) Whether and how more structured and focused treatment programmes may be provided to young drug abusers who fall under the criminal justice system should be considered.

(C) Strategy

6.7 To address the above concerns, the Task Force has pursued a strategy focusing on the following areas –

- early identification of youth at risk and intervention;
- enhancement of downstream programmes in terms of capacity and sophistication;
- continuum of service by different sectors/modalities;
- training for anti-drug workers;
- reintegration of abusers into society;
- sustained service improvements; and
- resource alignment;

and, accordingly, made a number of recommendations to enhance the welfare and medical services and undertake further policy measures.

(D) Enhancing Welfare Services

6.8 The Task Force considers that the welfare services should be enhanced to strengthen early identification, timely intervention, and remedial counselling and treatment for potential, occasional and habitual young drug abusers, as well as compulsory supervision and counselling for convicted drug offenders.

(a) School social work service

6.9 The Administration has maintained the policy of "one school social worker for each secondary school" since September 2000. SWD provides subventions to 34 NGOs which deliver the school social work service in collaboration with school personnel and other welfare service units/stakeholders in the community. In the 2007-08 school year, there are some 490 secondary schools each served by a school social worker pitched at the rank of Assistant Social Work Officer (ASWO).

6.10 Apart from conducting programmes to promote the positive development of secondary school students from adolescence to adulthood, the school social work service has played a pivotal role in the early intervention of problem students with a view to preventing them from becoming hardcore youth at risk. School social workers provide the necessary professional support to tackle the student drug abuse problems, among other psychosocial and behavioural problems. This includes initial engagement, motivational counselling to the needy students and their families, and subsequent referral to drug treatment and rehabilitation programmes upon consent.

6.11 The secondary school platform is always an important one to prevent and combat youth drug abuse. As set out in Chapter V, upon the recommendation of the Task Force, EDB is implementing a healthy school policy with an anti-drug element. In support, school social workers should play an important role, as part of the school guidance team, in early identification of vulnerable and problem students, organising preventive and education programmes, and providing them counselling and referral services.

Recommendation 6.1

The Task Force recommends that, subject to availability of resources, the school social work service should be strengthened to complement the overall enhancement of

anti-drug efforts in the school sector following progressive implementation of the healthy school policy.

(b) Day and overnight outreaching service

6.12 The outreaching service plays an important part of our early intervention strategy, by seeking out and engaging young people, in particular those who do not normally participate in conventional social or youth activities, and are vulnerable to negative influence including drug abuse. There are at present 16 YOTs providing a day service and 18 YND teams providing an overnight service, all operated by NGOs on subvention.

6.13 The outreaching service has demonstrated effectiveness in the early identification of potential or occasional young drug abusers who are non-engaged in study or employment. Through on-the-spot contacts and immediate intervention, social workers can establish trustful relationship with youngsters through rapport building which is in turn crucial in cultivating and maintaining their motivation to abstain from drugs.

6.14 The Task Force recognises that the rising number of young psychotropic substance abusers has created increasingly heavy workloads for the outreaching service.

Recommendation 6.2

The Task Force recommends the strengthening of the manpower of the outreaching service to meet an acute service need.

Measures taken thus far

Starting from 2008-09, one additional Social Work Assistant has been approved for each of the 16 district-based YOTs and

18 YND teams and the enhanced service has started since October 2008.

Recommendation 6.3

The Task Force also recommends that, in the longer term and taking into account the service demand, the outreaching service should be further strengthened to enhance early identification and engagement of youth at risk, in particular young drug abusers, to render immediate intervention and to strengthen collaboration with CCPSAs on referral of needy cases.

(c) CCPSAs

6.15 CCPSAs are cluster-based, designated units providing preventive education services and community-based treatment and rehabilitation support to psychotropic substance abusers.

6.16 At present, there are five CCPSAs operated by NGOs on subvention serving the whole territory. Each centre covers three to five districts in their respective region, i.e. Hong Kong Island, Kowloon West, Kowloon East, New Territories East and New Territories West.

6.17 The Task Force observes an increasing caseload due to the prevalence of psychotropic substance abuse, and service limitations due to the wide geographical coverage of a given centre and that drug abusers are generally less motivated to seek help. Given the increasing community awareness of the youth drug problem, enhanced upstream efforts to seek out abusers and the gradual surfacing of health problems due to psychotropic substance abuse, further surges in the downstream service demand is anticipated in the longer run.

6.18 The Task Force also observes that CCPSAs have established networks with district social welfare offices, SACs, district-based outreaching teams, CSSS, and other service units and stakeholders within their service clusters. The operation of CCPSAs should be gradually enhanced –

(a) to enable CCPSAs to enhance collaboration with the aforesaid services in the community as appropriate;

(b) to strengthen preventive programmes in secondary schools (Chapter V) and for parents (Chapter IV);

(c) to receive referral of needy cases from schools, following the adoption of the healthy school policy with an anti-drug element (Chapter V);

(d) to provide on-site medical support (paragraphs 6.28 - 6.29 below); and

(e) to provide more outreaching service to the boundary areas and intensive follow-up services for drug abusers and their family members, following the stepping up of efforts to tackle the cross boundary drug abuse problem (Chapter X).

6.19 The Task Force considers that a total of seven CCPSAs, each serviced by seven frontline social workers on average, would not be adequate to rise up to the anticipated challenges in the longer term.

Recommendation 6.4

The Task Force recommends that CCPSAs should enhance collaboration with relevant services in the community for anti-drug preventive education as well as treatment and rehabilitation and two additional CCPSAs should be set up as soon as possible.

Measures taken thus far

Additional resources have been approved starting from 2008-09. Two new centres are expected to start operation in end 2008 in Yuen Long and Shatin, subject to identification of suitable premises and local consultation.

Recommendation 6.5

The Task Force also recommends that, in the longer term and taking into account the service demand, the CCPSAs should be further strengthened in terms of both the human resources provision in each centre and the number of centres in the territory.

(d) DTRCs

6.20 DTRCs are operated by NGOs to cater for the needs of those drug abusers who wish to seek residential treatment voluntarily, rehabilitation and social reintegration through a medical or non-medical model (such as gospel affiliation). DTRCs also provide aftercare service to rehabilitated abusers through their halfway houses with specific service objectives, including abstinence from taking drugs, reintegration into the community and developing a new direction in life and positive change in behaviour. This is another immediate pressure point due to the enhanced upstream measures.

Recommendation 6.6

The Task Force recommends that additional places should be provided at SWD-subvented DTRCs to meet the anticipated increase in the residential service demand downstream.

Measures taken thus far

New resources for 101 places have been approved starting from 2008-09.

(e) Medical social services at SACs

6.21 Overseas reports have estimated that among people with drug abuse, at least 53% also suffer from at least one other mental disorder. As a result of their mental health problems and residual incapability, drug abusers and their families may encounter problems of family relationship, household finances, etc.

6.22 The provision of medical social services (MSS) has, over the years, played an increasing role in promoting the rehabilitation and well-being of these patients and their families. Medical social workers of SWD serving in SACs of HA have been liaising closely with healthcare professionals to render more holistic assessment, treatment and psychosocial intervention conducive to early rehabilitation of drug abusers with mental health problems. According to the service statistics in 2007-08, the overall uptake rate of MSS cases in respect of the total number of psychiatric attendances registered under HA was about 10%.

6.23 Following the enhanced upstream efforts, corresponding increased referrals from the CCPSAs and other youth service units, and the opening up of two new SACs in 2008, it is anticipated that psychiatric attendances will continue to increase. There is also a case to consider in the longer term more intensive and comprehensive services to the abusers

and their families, and collaboration with other anti-drug units such as CCPSAs. Support services including parents' education, group services, life skills and resilience enhancement programmes, etc could be stepped up.

Recommendation 6.7

The Task Force recommends the provision of designated medical social workers at SACs to service the rising number of psychiatric attendances by drug abusers.

Measures taken thus far

Four medical social workers have been approved and started work since October 2008.

Recommendation 6.8

The Task Force also recommends that, in the longer term and taking into account evolving service needs, the capacity and support service provided by psychiatric MSS at SACs should be further strengthened.

(f) CSSS

6.24 Currently, five CSSS teams operated by NGOs on subvention provide support services to young offenders cautioned under the PSDS. These teams assist the offenders in reintegrating into the community, eliminating their deviant behaviour, and reducing their likelihood of law infringement. CSSS team staff also participate in the Family Conference which brings together family members of a cautioned juvenile with professionals from relevant Government departments and agencies to assess his or her needs and tailor-make a follow-up plan.

6.25 Following enhancement of law enforcement efforts to combat youth drug abuse, it is anticipated that the number of cautioned juveniles will increase. The CSSS teams should also play a critical, proactive role in following up and providing services.

Recommendation 6.9

The Task Force recommends strengthening the CSSS teams to ensure adequate support services to assist juvenile offenders in reintegrating into the community.

Measures taken thus far

Additional provisions for one additional ASWO have been approved for each of the five CSSS teams and the enhanced service has started since October 2008.

(g) Probation service

6.26 For offenders with drug abuse problems who fall under the criminal justice system, probation service is one of the sentencing options by which they are subject to supervision pursuant to the conditions stipulated in a court order.

Recommendation 6.10

The Task Force recommends a two-year pilot project on an enhanced probation service to provide more focused, structured and intensive treatment programmes for young drug offenders pursuant to the Probation of Offenders Ordinance (Cap. 298), having regard to overseas drug court practices. Details are set out in Chapter VIII.

(E) Enhancing Medical Services

6.27 Drug abuse can cause complex disorders in the biological mechanism and severe harms to the brain. There is a high prevalence of mental disorders among drug abusers, and there is also a high degree of co-morbidity between various mental disorders, which would require specialist treatment. On the other hand, a distinguishing feature of psychotropic substances is that, unlike heroin, the addictiveness and serious harm often surface gradually after a few years. The different stages of abuse may call for different kinds of medical intervention in its own right and in support of some more general efforts.

(a) On-site medical support for CCPSAs

6.28 At present, CCPSAs are only manned by social workers. Experience tells that the effectiveness of early intervention efforts could be enhanced by appropriate and timely medical support. For potential and occasional drug users, advice by medical practitioners on the potential harms of drug abuse or any signs of health deterioration arising from drug use can deter drug abuse behaviour or heighten abusers' awareness to seek treatment early. As for those who are in the early stage of developing psychiatric problems, timely medical intervention could help change the drug abusing behaviour, which could help reduce the demand for further specialist treatment in SACs later on.

6.29 The Task Force sees merit in introducing medical support services at CCPSAs ranging from body checks, drug tests, motivational interviews, to drug-related consultation. This can help identify and motivate drug abusers for seeking early rehabilitation services, assess their health conditions, help abusers stay with the treatment programme, and make timely referrals of needy cases to SACs. This would make CCPSAs service more comprehensive as a first stop in the community, among other existing healthcare units, to handle psychotropic substance abusers.

Recommendation 6.11

The Task Force recommends that medical support services should be provided at CCPSAs to enable timely and early medical intervention to drug abusers who require elementary but not yet specialist medical treatment at SACs. This may encompass procurement of medical consultation service from the community and provision of appropriate nursing staff as part of the centre complement.

(b) Immediate enhancement of SAC services

6.30 SACs are set up by HA to provide specialist medical intervention for substance abusers who have developed psychiatric complications and/or co-morbidity[3]. They provide treatment services to both psychotropic substance and opiate abusers. They each operate a triage system which screens all new cases and accord priority to urgent ones. Youth drug abusers account for about 14.6% of the new cases in 2007.

6.31 SACs operate designated sessions within the psychiatric specialist out-patient departments (SOPD) of hospitals. Treatment is provided by a psychiatrist experienced in substance abuse service to patients referred from various sources such as CCPSAs, general practitioners or related NGOs. The social support and aftercare services of SACs are largely provided by CCPSAs to complement MSS.

[3] While the exact scope of services, set-up, staffing support and mode of operation vary among the SACs, in general they cover the following key services – (a) treatment of psychiatric co-morbidity of psychotropic substance abusers (e.g. depression, conduct or personality disorder); (b) treatment of psychiatric complication of psychotropic substance abusers (e.g. drug-induced psychosis, cognitive impairment); and (c) provision of detoxification services on a very limited basis to those abusers assessed with specific needs (mainly opioid detoxification). The SAC in the Castle Peak Hospital also deals with patients with alcohol dependence and abuse.

6.32 When the Task Force looked into SAC operations in end 2007, there were only five SACs[4] in the whole territory. In the two clusters without an SAC i.e. Hong Kong West and Kowloon East, psychiatry services were provided to drug patients in the SOPD of the Queen Mary Hospital (QMH)[5] and the United Christian Hospital (UCH) respectively without designated sessions. The Task Force also noted that while four CCPSAs[6] had set up informal linkages with the SACs in operation in their respective clusters (thus providing principal support for cases receiving specialist medical intervention), the remaining CCPSA in Kowloon East, namely the Evergreen Lutheran Centre, was left with no SAC support in its cluster. The situation is very undesirable.

Recommendation 6.12

The Task Force recommends that the SAC at QMH should be re-opened; and a new SAC should be set up at UCH to meet an imminent service need and to better collaborate with CCPSAs and anti-drug agencies in the relevant clusters.

Measures taken thus far

The SACs at QMH and UCH have come into operation since July and October 2008 respectively.

(c) Further enhancement of service capacity of SACs

6.33 The demand for services of SACs has been on the rise and the total SAC attendances have increased from 6 116 in 2001 to 12 606 in 2007. The average number of new cases referred from CCPSAs to SACs was

[4] Pamela Youde Nethersole Eastern Hospital in the Hong Kong East Cluster; Kwai Chung Hospital in the Kowloon West Cluster; Kowloon Hospital in the Kowloon Central Cluster; Prince of Wales Hospital in the New Territories East Cluster; and Castle Peak Hospital in the New Territories West Cluster.

[5] In 2005, the SAC in QMH was closed as a part of the re-organisation of services within the hospital.

[6] TWGHs CROSS Centre in Hong Kong, PS33 in Kowloon West/Central, Cheer Lutheran Centre in New Territories East and Caritas HUGS Centre in New Territories West.

around 80 cases per month in the past years, with some 50 put on the waiting list. The average waiting time for the first appointment has been lengthening over the years, which could now be as long as 10 to 15 weeks in some SACs.

6.34 Following the enhanced upstream efforts and the opening of two additional CCPSAs in end 2008, it is anticipated that referrals from CCPSAs and anti-drug NGOs will further increase.

6.35 Another major service area of SACs is the provision of education and training to frontline staff of CCPSAs and NGOs who need to work with psychotropic substance abusers. The purpose is to assist these staff to identify abusers with early signs of mental disorders for early referral.

Recommendation 6.13

The Task Force recommends that HA should, subject to availability of resources, further strengthen the service capacity of SACs and their support in education and training to frontline staff in anti-drug agencies to cope with the anticipated increase in demand for services.

(d) Improvement of the service delivery model of SACs

6.36 At present, SACs' clinical services are mainly provided through out-patient services in designated sessions. In-patient services are only available in the Castle Peak Hospital, Kwai Chung Hospital (KCH) and Kowloon Hospital, for treatment of serious psychiatric complications and/or co-morbidity and detoxification where necessary. There are no designated in-patient beds for psychotropic substance abusers in these hospitals and the patients are admitted to the psychiatric wards for treatment. The SAC in KCH is the only one with day hospital services, providing detoxification, individual and group therapy, occupational

therapy, and relapse prevention programme. The exact scope of services and mode of operation indeed vary among the SACs.

Recommendation 6.14

The Task Force recommends that the service delivery model of the SACs should be reviewed to enhance the effectiveness of specialist medical intervention. For example, regarding the day-time detoxification service currently provided by the SAC in KCH, HA should review the need for day-time detoxification currently available only in the SAC in KCH, its effectiveness and consider whether the service should be extended to other SACs, covering also psychotropic substance abusers.

(F) Policy Measures

6.37 From a policy coordination perspective, the Task Force also recommends a number of further measures.

(a) Multi-disciplinary approach

6.38 It is recognised that youth drug abuse problem is a manifestation of deeper family or youth development problems. To treat and rehabilitate a drug abuser, it should be most effective if a patient-centred, holistic approach can be adopted involving social workers, medical professionals, educationalists, family members, etc as appropriate. In particular, abstinence from drugs on a long-term basis cannot be achieved without an attitude change on the part of the abuser, family and peer support, provision of services such as vocational training and job hunting, as well as rebuilding one's identity and sense of worthiness.

6.39 Under the multi-modality approach of treatment and rehabilitation services as explained in paragraph 6.2 above, at the case management level, service providers of each modality already seek professional input from outside and involve other stakeholders to provide a comprehensive treatment programme. At the agency level, there are some informal linkages, for example, between SACs and CCPSAs, which work in collaboration to provide targeted services for early intervention and referral to specialist medical intervention. We have also, more systematically, sought to draw together social workers and medical practitioners to provide early intervention and motivational interview services to drug abusers in a pilot scheme launched in June 2008[7].

6.40 There is a case to further develop the multi-disciplinary approach. Notably, the Administration should explore enhancement of collaboration between CCPSAs and SACs as well as other relevant agencies on a cluster basis. An appropriate arrangement straddling different sectors should facilitate exchange of information to enhance case management, improve coordination of service delivery, complement service deliverables, and ensure a more effective use of community resources and the provision of a continuum of medical and social services that are holistic and patient-centred for youth drug abusers. This should be part of the role of CCPSAs in enhancing collaboration with relevant services in the community (paragraph 6.18 et seq) and take into account the evaluation of the effectiveness of the pilot scheme mentioned above (paragraph 6.39).

Recommendation 6.15

The Task Force recommends that, in the context of preparing the Fifth Three-year Plan for 2009-11, the Administration should continue to pursue the multi-disciplinary approach in a pragmatic manner with a view to developing appropriate

[7] Following the advice of ACAN, a two-year pilot collaboration scheme was launched in June 2008 to provide early intervention to young psychotropic substance abusers. The scheme involves social workers referring abusers to designated medical practitioners who provide body check service and motivational interviews. The aim is to alert the abusers of any signs of health deterioration as a result of drug use and to heighten their awareness to seek treatment early.

cooperation and networking models on a cluster basis.

Measure taken thus far

Formulation of the Fifth Three-year Plan for 2009-11 is underway for publication in early 2009.

(b) Professional training for anti-drug workers

6.41 Relevant short-term training programmes for anti-drug workers have been launched, including one on the Protocol on Screening and Assessment of Poly-drug Abusers in 2005, and a Workshop on Practical Skills in Handling Psychotropic Substance Abusers in 2007. ND also commissioned in 2006 the first structured training programme for frontline anti-drug workers and peer counsellors to enrich their drug knowledge and enhance their professionalism.

6.42 In view of the changing drug scene, there is a continuing need to equip anti-drug workers in a systematic and structured manner, with the necessary knowledge and skills to deliver treatment intervention effectively. This should cover not only social workers, but also others in contact with vulnerable youth and abusers in one way or the other, such as general medical practitioners who see thousands of patients a day.

Recommendation 6.16

The Task Force recommends that training should be provided to private medical practitioners to enhance their awareness and knowledge of the youth drug abuse problem, so that they can provide medical advice and treatment, and if necessary, referral services.

Measure taken thus far

ND is now inviting proposals for launching the training programme in 2009.

Recommendation 6.17

The Task Force also recommends that, in the context of preparing the Fifth Three-year Plan for 2009-11, the Administration should consider whether and how best further structured training programmes for anti-drug workers should be pursued and recognised in the light of demand and the changing drug scene.

Measure taken thus far

Formulation of the Fifth Three-year Plan for 2009-11 is underway for publication in early 2009.

(c) Reintegration into society

6.43 Any treatment and rehabilitation programme must target at drug abusers' reintegration into society and seek to prevent relapse. This would require not only a proper design of the programme to change attitudes, build up skills and provide aftercare services, but also community and family support for rehabilitated abusers.

Recommendation 6.18

The Task Force recommends educating the public about accepting rehabilitated drug abusers and appealing to different sectors of the community for support.

Measure taken thus far

Such educational and appeal efforts are part of the territory-wide campaign launched in June 2008 and the *Path Builders* initiative launched in September 2008.

Recommendation 6.19

The Task Force also recommends that, in the context of preparing the Fifth Three-year Plan for 2009-11, further measures should be explored to enhance the reintegration elements of the treatment and rehabilitation programmes and to promote and solicit community and family support.

Measure taken thus far

Formulation of the Fifth Three-year Plan for 2009-11 is underway for publication in early 2009.

(d) Sustained service improvements

6.44 As psychotropic substances have become popular drugs of choice in the recent years, drug treatment agencies are encouraged to re-engineer their opiate-oriented treatment and rehabilitation programmes to match the needs of psychotropic substance abusers. All four subvented non-medical drug treatment agencies and two of the three subvented medical drug treatment agencies, have extended their services to cater for the specific needs of psychotropic substance and occasional drug abusers since end 2003.

6.45 To understand how our treatment and rehabilitation programmes are doing, we have been collecting relevant information and statistics from service providers and making research efforts on service effectiveness. Details are set out in Chapter XI.

Recommendation 6.20

The Task Force also recommends that, to meet the increasing needs of psychotropic substance abusers, ND should, through ongoing statistics collection and research efforts, closely monitor the re-engineering pace of the drug treatment and rehabilitation programmes and work with SWD and DH, as the Controlling Officers, which would discuss with subvented agencies in updating their programmes and performance targets as appropriate.

(e) Resource and service demand

6.46 Currently a significant proportion of anti-drug resources is allocated to heroin-oriented treatment and rehabilitation services. 16% of the anti-drug expenditure was spent on programmes that supported both heroin and psychotropic substance abusers, whereas 67% was spent on programmes for heroin abusers. 17% was spent on programmes for psychotropic substance abusers[8].

6.47 Although the number of heroin abusers still remains at a high level[9] and residential treatment service for heroin abusers is more expensive than non-residential services for psychotropic substance abusers (such as CCPSAs and SACs), there is a continuing need to ensure appropriate resource allocation to meet the changing demand.

6.48 Looking forward, the enhancement of the Administration's efforts to raise public awareness and to train stakeholders (including teachers, school social workers, general medical practitioners and parents) to identify drug abusers, coupled with the enhanced efforts by outreaching

[8] Support services such as youth outreaching teams, overnight outreaching service, etc rendered to youth and youth at risk, including those who have drug abuse problems, are under general welfare provision and not covered by the allocation.

[9] There were 7 390 reported heroin abusers recorded in the Central Registry of Drug Abuse in 2007.

and anti-drug workers, will likely unearth demand for more downstream services.

Recommendation 6.21

The Task Force recommends that the Administration should ensure that anti-drug resource allocation meets the changing demand, including the review of the resources spent on MTP[10] (with an annual allocation of around $35 million) targeting heroin abusers, and the subvention allocation to the Society for the Aid and Rehabilitation of Drug Abusers (with an annual allocation of around $72 million) which only handle opiate abusers.

Recommendation 6.22

The Task Force also recommends that the Administration should continue to critically monitor the demand for downstream services for psychotropic substance abusers over time, seek appropriate provision for efficient and effective programmes, and encourage the development of non-subvented services that are of good quality.

[10] We observe that the demand for MTP services has been falling over the years. Any resource review of the MTP should not only take into account the continuing demand from heroin abusers (a large number remaining), but also the need to maintain the safety net and the role of MTP in preventing crime and transmission of important infections like viral hepatitis and HIV infection.