# CHAPTER 5

# RECOMMENDATIONS (PART 1): DRUG TREATMENT AND REHABILITATION WORK

5.1 To take forward the strategies set out in Chapter 4, the following paragraphs set out the recommendations made.

## (A) Early Identification and Intervention

5.2 While the number of reported drug abusers has declined since 2009, there are signs showing that drug abuse has become increasingly hidden. The time for newly reported drug abusers to be caught by the help network since they first took drugs has increased from two years in 2009 to 3.5 years in 2011. In the meantime, the location of drug abuse has shifted from public places to homes. In 2011, 79.9% of the total number of drug abusers took drugs at their own homes or at friends' homes, and as much as 50% took drugs only at home.

### (a) Families and Schools

5.3 Families and schools play a strategic role of being in the front line of preventing and combating drug abuse. Parents, schools, teachers and student guidance personnel /social workers should stay alert to any behavioural change or deterioration of health among the young people. This would help identify those who are at risk for early intervention. Some of the details as mentioned in the following paragraphs may touch upon the areas of preventive education and publicity. They are presented here as a holistic package of strategies targeting at families and schools.

#### *(i) Families*

5.4 We should strengthen support to parents and encourage them to understand and tackle the drug abuse problems. With drug abuse becoming increasingly hidden, we recommend that training and support services to parents should continue to help them identify early children who may be prone to drug abuse or those who are already abusing drugs. This could include a district-based approach whereas parent-teacher associations and district bodies provide relevant information at workshops/seminars. There should also be trainings for social workers on how best to render assistance to parents in need. NGOs may also

provide support via, for example, telephone support service manned by social workers.

5.5 We also recommend that regional networks like the District Fight Crime Committees (DFCCs) may, on a trial basis, carry out preventive education and publicity targeting at parents. The focus could be on raising awareness and understanding to drug abuse problems at the neighbourhood level, and encouraging parents to seek help when necessary. Paragraphs 5.28 and 5.29 have more elaborations on this suggestion.

5.6 We acknowledge that many working parents have so long working hours that they cannot spare time to participate in anti-drug activities. We recommend that anti-drug messages be disseminated through the mass media to increase parents' awareness of the hidden nature of psychotropic substance abuse. The mass media can also serve as a platform for parents to obtain anti-drug information and seek help. For example, NGOs may suggest appropriate speakers at radio programmes to offer advice and follow up referrals to parents who seek help. For a more detailed discussion on the role of the mass media, please see paragraph 6.4.

*(ii) Schools*

5.7 A holistic school curriculum comprising knowledge, skills and attitudes is conducive to the effective promotion of anti-drug education in schools. With the New Senior Secondary Curriculum coming into effect in 2009/10 school year, various subjects such as "Liberal Studies" and "Health Management and Social Care" have strengthened the anti-drug education. "General Studies" at primary level has enriched anti-drug elements and the updated curriculum has been implemented since the 2011/12 school year. The learning elements to develop students' related personal and social skills as well as the values have been included in the "Life and Society" curriculum to be implemented at junior secondary level with effect from 2012/13 school year. Besides, the Curriculum Development Council has conducted a consultation on "Moral and National Education Subject", which is enriched based on the current "Moral and Civic Education Curriculum Framework" with a view to cultivating students' positive values and attitudes, covering topics such as to treasure one's health and to take responsibility for others' health. EDB promulgated a curriculum guide on "Moral and National Education Subject" for primary and secondary schools on 30 April 2012.

5.8 Schools will continue to promote anti-drug education through school curriculum as well as learning experience and activities outside the lessons (e.g. class teacher periods, visits and weekly assemblies, etc.) in order to enrich students' knowledge about psychotropic substances, to help them cultivate positive values and attitudes and to strengthen their skills to resist temptation of drugs.

5.9 Moreover, we recommend that ND and EDB should continue to promote the HSP(DT) at schools. Schools outside Tai Po District are encouraged to implement the HSP(DT) starting from the 2011/12 school year as part of the Healthy School Policy, and to holistically inculcate a drug-free culture on school campuses through voluntary drug testing, life and value education, etc. In addition to drug testing which has a deterrent effect, participating schools of the HSP(DT) will also provide specific preventive and support activities for students, parents and teachers, including skills training programmes, leadership training, and training workshops for parents and teachers etc. Both ND and EDB should continue to encourage schools to collaborate with appropriate NGOs to apply for BDF for implementation of the HSP(DT).

5.10 We also recommend that ND should continue to collaborate with EDB and to sponsor NGOs to organise structured training programmes for teachers to enhance their capabilities in implementing the HSP and anti-drug education in schools, and their skills in handling drug related problems. Furthermore, ND should continue to provide teachers with hotline services manned by social workers.

5.11 Starting from September 2011, the Government has allocated additional resources to strengthen school social work services in secondary schools by a 20% increase in manpower. The NGOs providing the services have utilised and deployed the new resources in a flexible manner, with the focus on helping schools which face bigger drug problems and providing more in-depth counselling for targeted groups according to varying backgrounds and circumstances of students (such as the degree of severity of their association with drugs). Apart from providing support to students at risk, social workers also engage the parents and help them improve their parenting skills and strengthen parent-child relationship, and enhance the motivation of these students to sustain the positive change and healthy development.

## (b) Outreaching Service

5.12 Both CCPSAs and outreaching teams proactively go out to make contact with youth who are at risk and offer them immediate intervention, counselling and referral services. CCPSAs and outreaching teams can no longer just focus on the traditional "black spots" to identify drug abusers as they increasingly hide themselves at home or private premises. We encourage them to adopt diversified means (e.g. social networking and websites popular among the youth) to identify cases. CCPSAs and outreaching teams should also strengthen cooperation in formulating outreaching strategies and case management at district level, as well as in making cross-referrals of cases with different service needs.

## (c) Family Doctors

5.13 Since the Fifth Three-year Plan, we are pleased to see more family doctors taking part in the anti-drug initiative. With the support of BDF, HKMA conducted a structured certificate course for private medical practitioner. The course contents were compiled into a professional training manual. HKMA also organised various preventive education activities under its district network to promote the importance of early intervention. We encourage HKMA to continue to organise training for doctors.

5.14 We encourage the medical sector to develop, on the existing basis, tools or protocols for screening, brief interventions and referral to treatment for use by frontline doctors. The ultimate objective is to mainstream and integrate drug abuse screening and the need of intervention into the routine practice and the healthcare setting of family doctors and the primary healthcare system.

## (d) Student Health Service

5.15 Anti-drug elements have been incorporated into the Student Health Service (SHS) by DH which includes the Adolescent Health Programme (AHP) targeting secondary school students and the Junior Health Pioneer Workshops targeting Primary Three students. We recommend that DH better equip the SHS staff for measures that would help students resist drugs and get motivated to seek professional help as early as possible.

## (e) Involvement of Other Players in Tier 1

5.16 Tier 1 of the Tiered Multi-modality Framework mainly comprises non-drug treatment and rehabilitation service units having frequent contacts with potential abusers and their families (such as family doctors, social workers in youth/children centres, nurses, teachers, etc.). They have a role to play on prevention and early intervention. To expand the network of community intervention and support, we would promote the collaboration of these service units in identifying people at-risk and drug abusers and providing brief interventions for occasional drug users and their families. Drug abusers with more serious problems could be referred to service units at other tiers for treatment. Training for enhancing awareness and knowledge of drug abuse should also be provided to the service units at Tier I. This could also boost their confidence in handling problems. Please refer to paragraphs 5.44-5.46 for detailed discussion on training.

## (f) Community-based Drug Testing

5.17 The hidden nature of psychotropic substance abuse and the shift in locality of abuse make it increasingly difficult to reach drug abusers. Despite the fact that drug consumption is an offence, there is currently no legal basis in Hong Kong to mandate suspected drug abusers to undergo drug testing. To enable more effective identification of those endangered by drugs, hence early intervention with the necessary assistance, the Government is considering whether to introduce legislation to implement drug testing at the community level, empowering law enforcement officers to require a person reasonably suspected of having consumed drugs to undergo drug test. This was one of the proposals by the Task Force on Youth Drug Abuse led by the Secretary for Justice. The issue needs a thorough deliberation as it involves many complex legal, human rights and implementation issues as well as support of downstream services, resource implications and implementation details. The Government adopts an open attitude and would solicit views from the public through a consultation exercise before a final decision.

## (g) Surveillance of Emerging Drugs of Abuse

5.18 An inter-departmental working group consisting of ND, the Police, the Customs and Excise Department, the Government Laboratory and DH is in operation to monitor the emergence of new drugs in the local and overseas context and recommend legislative control if necessary.

As a preventive measure, the Government has taken pre-emptive efforts to list the derivatives of piperazine (e.g. trifluoromethylphenylpiperazine) as dangerous drugs in April 2011 through legislative means on the recommendations of the working group. To make the surveillance work more effective, consistent and extensive, we recommend that the Government continue to closely monitor the local and overseas drug trend and consider tasking relevant departments to liaise with professional bodies in other sectors.

5.19 On the other hand, HA is developing a chromatography-based analytical system with grants from BDF. The system will be used to identify the common and emerging drugs of abuse. Depending on the research outcome, consideration may be given to expanding efforts on this front.

5.20 Apart from surveillance, we recommend that the anti-drug sector share intelligence about emerging drugs of abuse in a timely manner, so that prompt response could be made on the fronts of preventive education and publicity as well as treatment and rehabilitation. We also encourage anti-drug agencies to provide the Government with information about emerging drugs of abuse gathered from time to time to enable joint efforts in early surveillance and prevention.

**(B) Collaboration across and Continuum of Service by Different Sectors/Modalities**

5.21 Drug abuse is often a manifestation of more deep-rooted family or growth problems and the harms caused are multifarious. This is especially so with psychotropic substances which are more prevalent in recent years. More often than not, we have to deal with not only detoxification, but also the damage on bodily functions caused by drugs. Drug abusers are becoming younger, and it is important to assist them in schooling and employment, as well as to support their families. Drug treatment and rehabilitation services should be people-oriented. To provide a seamless service to drug abusers, service providers should adopt a multi-disciplinary and holistic approach to engage different sectors (e.g. social welfare organisations, medical organisations, criminal justice setting, schools, as well as family members, etc.) as appropriate. They should also ensure smooth case referral and cooperation among service units at different stages.

## (a) Tiered Multi-modality Framework (Second Edition)

5.22 The first edition of a tiered multi-modality framework of treatment and rehabilitation services for drug abusers was published in December 2010. It sets out the main functions and positioning of various services in a more structured manner and highlights the importance of continuum of service at different stages and the synergy effect produced by diverse professional services. With further comments from the anti-drug sector since its publication, ND has prepared the second edition of the framework which is attached at the end of this chapter.

## (b) Collaboration/Linkages among Service Units

5.23 When the Fifth Three-year Plan came out, the Government, in the first instance, promoted the linkage between CCPSAs and SACs and coordinated an overall collaboration meeting for the operators. The Government then facilitated the collaboration among other service units. For example, CCPSAs has been provided with recurrent resources for OSMSS since October 2009, which bring together service centres and general practitioners and nurses. Moreover, the Government has organised tours and visits to enable drug treatment agencies and general welfare service units to get to know each other and encourage case referrals and cooperation.

5.24 The tiered multi-modality framework enables us to understand systematically the current and potential linkage among various services. We would like to have not only more service units but also a better communication, collaboration and networking among themselves. Currently we already see close cooperation through a systematic case referral mechanism among service units with a view to responding to the varying needs of each drug abuser. Looking ahead, we hope to continue to refine what we are doing now for delivering a seamless treatment programme for drug abusers. Where necessary, service units may work together to work out the best treatment and rehabilitation plan for a drug abuser at a multi-disciplinary meeting. We may contemplate how to promote a better linkage of the following services -

(a) from generic welfare services to specific community-based drug treatment and rehabilitation services, or even linking directly to voluntary residential treatment and rehabilitation services;

(b) from community-based drug treatment and rehabilitation services to voluntary residential treatment and rehabilitation services;

(c) from MTP to services within and beyond the tier;

(d) from community-based medical service units to specialty units in a hospital;

(e) networking among various departments in a hospital; and

(f) from voluntary and compulsory residential drug treatment and rehabilitation services to aftercare and generic employment/ vocational training services.

5.25 The Government will continue to promote understanding and linkages among units through different platforms, e.g. collaboration meetings and visits, and encourage service units to trial some innovative schemes that involve cross-sector partnership. Moreover, making available a clear listing of service units in different tiers can be considered so as to facilitate one to decide what service to take. However, we should avoid imposing any rigid service paradigm upon individual service providers, acknowledging that different modalities or service units adopt different service approaches and philosophies. The resources they each have also vary. The people who go to seek help from service units largely come forward on voluntary basis.

**(c) Collaboration and Networking Models on a District/Cluster Basis**

5.26 Demographic structures of the 18 districts in Hong Kong are heterogeneous. Inevitably, the core of drug problem of each district varies from one another. We should encourage more targeted efforts at the district level.

5.27 With additional resources from the Government, the number of CCPSAs has increased to 11 since October 2010, corresponding to the 11 administrative districts of SWD. CCPSAs play a greater role as the first stop in the community for handling the problem of psychotropic substance abuse. They provide more focused services, hence a better understanding of the drug situation at different localities, in the districts CCPSAs may share expertise, best practices and intelligence on drug scene with counterparts on the front of social welfare, medical, educational and even law enforcement.

5.28 We also recommend building up district-based anti-drug networks, bringing in multi-disciplinary collaboration and mutual help in the neighbourhood, thereby raising community awareness of the drug problem. We also hope to solicit public support for establishing treatment and rehabilitation service and facilities in districts.

5.29 In practice, DFCCs are a case in point. DFCCs gather the relevant government departments and local leaders to disseminate anti-crime messages and encourage residents to be part of the fighting crime in their own districts. They focus on not just anti-drug work but the overall law and order situation of the districts. They can deal with drug abuse problems and the related law and order and social issues from a more comprehensive angle. They can also effectively engage agencies or personalities of different sectors, including using district-based network to enhance parents' understanding of drug abuse problems.

## (C) Enhancement of Downstream Programmes in terms of Capacity and Sophistication

5.30 The Government has injected substantial new resources in the past three years (an annual additional recurrent provision amounting to $140 million) to implement the recommendations of the Task Force on Youth Drug Abuse and take forward the anti-drug campaign spearheaded by the CE. This has satisfied the demand for various major services. However, the demand for certain specialised services continues and there may be a need to increase their capacity. In response to the latest drug trend, certain services could also be made more sophisticated. This would also be in line with the long-term strategy.

### (a) Drug Treatment and Rehabilitation Centres

5.31 DTRCs are operated by NGOs and their services are broadly classified as medical and non-medical models (such as gospel affiliation). DTRCs take in drug abusers who wish to seek voluntary residential treatment and rehabilitation, and those who have been placed under a probation order. In the past three years, the Government has increased the capacity of DTRCs and improved the uneven utilisation among DTRCs. Coupling with measures such as sharing of information, the waiting time for DTRC admission has continuously been shortened. Between December 2010 and end-December 2011, about 77% of the probationers only waited for two weeks or less before admission to the

centres. Noting that the demand for female places is relatively higher, we shall continue to closely monitor the situation. We shall seek to provide more female places with additional resources where it deems necessary.

5.32 On the whole, considerations may be given to strengthening the voluntary residential services and adding new elements to enhance overall efficiency along several directions. We recommend that more assistance be given to rehabilitated residents in reintegrating into society (such as education, vocational training, pre-employment counselling and job placement) so long as the core services of the centres are not affected. Such services can be provided by drug treatment agencies direct or through cooperation with other service providers. The programmes may go beyond the residential period and continue after the rehabilitants are discharged. We encourage centres to build up partnership with agencies providing education, vocational training, job placement, etc., so that the rehabilitates may have a clearer idea of what to do upon discharge. Part D below elaborate on this idea.

5.33 We recommend enhancing the support to DTRCs for addressing the medical needs of residents. Some centres reveal that psychotropic substance abusers usually suffer more complications than abusers of traditional drugs, e.g. bladder dysfunction and psychiatric issues. Some residents would need to attend consultations in hospitals not only regularly but also frequently. Centres are under pressure to deploy staff to take residents to doctors, and staff is also under pressure to provide first aid for residents in case of emergency. We recommend that as a first step, some basic medical training be made available to staff of DTRCs to help them cope with the daily medical needs of residents. We also encourage DTRCs to collaborate with healthcare institutions and initiate projects on a trial basis that may support DTRCs in this respect.

5.34 DTRCs could offer an environment for drug abusers to distant themselves from the peers and break away from the vicious cycle of drug-taking. However, “novice” drug abusers are less likely to seek help from DTRCs as the bodily harm have yet to become apparent. For this group of drug absuers, we encourage DTRCs to initiate some services which would cause much disruption to their normal work or schooling. This could increase drug abusers’ motivation to seek assistance. DTRCs interested in providing such services may cooperate with the service providers at Tier 1.

5.35 The Drug Dependent Persons Treatment and Rehabilitation

Centres (Licensing) Ordinance (Cap. 566) came into operation in 2002 requiring DTRCs to meet the safety and management standards Eight DTRCs have successfully obtained licences over the past three years, bringing the number of licensed centres to more than half of the total. The remaining DTRCs, constrained by geographical and environmental reasons, would have to deal with the challenging issues in relation to land, construction and sentiment of the local community.

5.36 The Government should expedite the licensing of DTRCs by working together with those that are still operating on Certificate of Exemption. DTRCs that can meet the statutory licensing requirements by in-situ upgrading/redevelopment should carry out improvement works as soon as possible. The Government would facilitate DTRCs to commence the works projects. In particular, the maximum amount of funding under the SFS of BDF has been substantially raised to $50 million since May 2011 and the claimable expenses have been expanded to cover, for example, feasibility study and recruitment of project coordinators. The Licensing Office of SWD and relevant departments would continue to give advice on the procedures of obtaining a licence. DTRC operators should, in their roles as proponents and implementers, seek to commence the projects early.

5.37 Some DTRCs would need to move away from their current location and search land for reprovisioning. The Government would continue to assist them in identifying land and soliciting support from local community. The Government would continue to promote community acceptance of treatment facilities through publicity programmes. DTRC operators, as project proponents, could be more proactive in the neighbourhood and make themselves known by the local community. In fact, community liaison work is listed as a fundable item under SFS of BDF. Relevant government departments would also provide expertise and support in the community liaison work.

**(b) Public Hospitals**

5.38 A growing number of research studies and clinical cases show that psychotropic substances (such as ketamine) damage not only the brain and urinary tract but also other organs. Moreover, as drug abuse has become increasingly hidden, serious or even permanent damage has already been inflicted when the drug abuser's problems surface and require specialised treatment. Specialist services of HA, therefore, must take on a more significant role.

5.39 SACs treat drug abusers with psychiatric problems with consultations by psychiatrists and supporting services by occupational therapists and clinical psychologists. Some frontline staff are of the view that the supporting services can greatly facilitate one's treatment and rehabilitation. For instance, occupational therapists can employ professional assessment tools on drug abusers and counsel them on the types of work that they can take having regard to their bodily harm. This would help them find jobs and lead a normal work life as soon as possible. We recommend that some projects with the involvement of these supporting services could be implemented as pilot schemes to prove their effectiveness, with a view to assessing whether there is a case to allocate recurrent resources in the long run. For example, with the support of BDF, HA will launch a trial scheme in 2012 to introduce occupational therapy service to DTRCs for helping drug abusers.

5.40 Some residents of DTRCs still have to go to SACs for regular medical follow-ups. The process of attending SAC follow-ups could be tough for some as they have to travel long distance while suffering from damaged urological system. Besides, this also exerts somer pressure on DTRC's manpower deployment as staff need to accompany the residents to the medical sessions. In view of this, we recommend that SACs consider different ways to help DTRC residents, so long as resources are available and the services of SACs are not affected (please also see paragraph 5.33).

5.41 Many psychotropic substance abusers suffer complex bodily damage. It is widely known that ketamine abuse causes urological problems. HA should closely monitor the service demand and enhance the capacity of various services if necessary and when resources are available. A case management approach (e.g. conducting case conferences) providing patient-centred services may be contemplated if more than one specialist treatment is involved.

5.42 The General Out-patient Department and the Accident and Emergency Department in a public hospital, as well as specialised medical service such as the Psychiatric Department and the Urology Department, would have access to drug abusers. We recommend that public hospitals develop a continuum of services to facilitate early identification, hence offering help to drug abusers. For example, with BDF's support, the North District Hospital will launch a short-term residential programme for hidden young drug abusers in 2012, providing crisis intervention (e.g. accident and emergency services) and community treatment and rehabilitation services. Drug abusers are given a chance

to disengage themselves from their peers for some time and to tackle seriously the bodily harms caused by drug abuse, thereby enhancing their resolve to stay away from drugs. We recommend that HA provide regular funding if the models are proven to be effective and resources permit.

**(c) Probation Service**

5.43 In October 2009, SWD launched a Pilot Project on Enhanced Probation Service in the probation offices serving two Magistrates' Courts. The Pilot Project provides more focused, structured and intensive treatment programmes for young offenders aged below 21 and convicted of drug-related offences. SWD in a preliminary evaluation conducted in mid 2011 indicated that the closer supervision under the Pilot Project had helped probation officers build up a better working relationship with parents. Feedback from the participating magistrates, parents and probation officers has been positive. The Project was extended for a year in 2012-13. SWD is conducting a final review and expects to complete it in 2012-13. Subject to the outcome of the review and resources, the Pilot Project should be continued and refined as appropriate, so as to provide more suitable rehabilitation programmes for the probationers.

**(d) Training for Anti-drug Professionals**

5.44 Against the ever-changing drug scene and the specialisation and variety of drug treatment and rehabilitation services, it is essential to provide continuous professional training to anti-drug workers to keep them updated of the trend of drug abuse, needs of drug abusers and effective intervention methods. We encourage different agencies to continue organising more in-depth and structured training for anti-drug professionals to equip them for delivering treatment and rehabilitation programmes. In the long term, the anti-drug agencies should initiate regular trainings for their own staff having regard to the needs and characteristics of their target clients.

5.45 The training targets should not be confined to professional anti-drug workers. We recommend that service units that are not specialised in handling drug abuse problems (i.e. Tier 1) could be given training in identifying the characteristics of drug abusers; and getting to know the features of different professional treatment and rehabilitation services to facilitate referrals when necessary. Family doctors have made encouraging progress in this regard over the past three years.

They may serve as an example to other sectors.

5.46 Furthermore, we encourage local universities and educational institutions to continue to cover and strengthen anti-drug topics in the curricula of social work, education and medicine degree programmes. Seminars or sharing sessions could be organised for curriculum planners and/or lecturers to update them on the latest drug scene and service demand and thus to develop suitable course contents for students.

**(e) Services for Ethnic Minorities**

5.47 There are no specific guidelines or rules to bind how the agencies should provide treatment and rehabilitation services for ethnic minorities. We recommend that service units which have contact with ethnic minorities should enhance cultural sensitivity, and where practicable, provide services that would take into account their specific needs. In 2012, ND produced anti-drug posters in Nepali, Hindi and Urdu. Also, BDF will continue to consider projects catering for ethnic minorities in the light of the drug trend. Agencies could train their staff in understanding the cultural characteristics of ethnic minorities. Agencies could also make use of the existing social resources by partnering with ethnic minority organisations in identifying and helping drug abusers.

**(f) Family Support**

5.48 Family plays a pivotal role in fighting against drugs. Family support is necessary for drug abusers at all ages and through the whole rehabilitation process from prevention, identification, motivating drug abusers to be treated, to finally relapse prevention. Families should therefore be involved during the treatment and rehabilitation process. Timely family support may also help prevent inter-generational drug abuse.

5.49 We encourage drug treatment and rehabilitation agencies to continue developing family support services. Possible directions include assisting drug abusers in building a closer relationship with families, enhancing family involvement in the treatment process and strengthening support among different families. Agencies could also work with service units specialised in handling family cases (e.g. integrated family service centres). Such a cooperation makes the best use of existing resources and is conducive to making available a holistic service for drug abusers. For examples, a family service unit may encounter cases at risk or drug abuse cases. These cases could be referred to CCPSAs or CDCs

for counselling or even residential services. In return, CCPSAs or CDCs can let family service units tackle the family issues of drug abusers. The objective is to make the treatment services more comprehensive. Moreover, DTRCs or CCPSAs may join hands with family service units in the aftercare programme for those rehabilitants who have been discharged from DTRCs.

## (D) Reintegration into Society and Prevention of Relapse

### (a) Overall – Multiple Pathways

5.50 Appropriate aftercare services and clear pathways help drug abusers turn over a new leaf. The tiered multi-modality framework describes the work at this stage, highlighting the multiple pathways available for rehabilitants, including education, vocational training and job placement in which different service units can take part. Many dedicated vocational training and job placement services are available for rehabilitated drug abusers. We should enhance information flow and facilitate better coordination among different stakeholders and make full use of the existing social resources rehabilitant in the provision of aftercare services and pathways leading to returning to school, attending vocational training/education or joining the workforce.

### (b) Aftercare Services

5.51 CCPSAs have been providing aftercare services to rehabilitants discharged from non-subvented DTRCs since October 2010. CCPSAs and CDCs, as community-based dedicated treatment and rehabilitation units, can continue to play a prominent role in the provision and coordination of aftercare services, with involvement of families, schools, social workers, and mentors. If circumstances permit, a care-plan/case management approach may be considered for coordinating various relevant services.

### (c) Education/Vocational Training in DTRCs

5.52 Education and vocational training provided by DTRCs serve a dual purpose. On one hand, it can, as part of the treatment and rehabilitation process, enhance the discipline, confidence and initiative of residents. On the other, it sets the pathways for residents after treatment from the centres. Drug abusers undergoing rehabilitation require different types of training as their ages, interests, skills, career

orientations and durations of treatment are different. Moreover, the contents and levels of the courses offered also vary because of different missions of the centres and other circumstantial factors (e.g. centre capacity, space and funding).

5.53 Against this background, we encourage DTRCs to continue to develop different types of education, vocational training and job preparation programmes taking into account the needs of abusers. As mentioned in paragraph 5.32, the training does not have to be provided by drug treatment agencies alone or completed before the discharge of the residents. There are certain constraints in providing education or job training for short-term treatment programmes. These centres should seek cooperation with other training institutions to better prepare residents for receiving education and vocational training upon discharge.

5.54 In terms of resources, EDB will continue to provide subvention for educational programmes operated by DTRCs and review on a regular basis the programme operation in order to meet the changing needs of young drug abusers. DTRC operators can also apply for the BDF to provide vocational training and job preparation services.

**(d) Arrangements after Discharge**

*(i) Schooling*

5.55 We encourage rehabilitated youths (such as those who have completed the voluntary treatment programmes) to return to schools. They may encounter difficulties when applying for re-admission to mainstream schools. The Regional Education Offices and Non-attendance Cases Team of EDB should continue to provide placement services to ensure that rehabilitated students aged 15 or below attend schools and to assist those above 15, if they so wish, in seeking suitable school places.

5.56 Although the service of Schools for Social Development (SSDs) is not aimed for students with drug abuse problems, students who have rehabilitated from drug abuse but have moderate to severe emotional and behavioural difficulties can be referred to SSDs for admission through the Central Co-ordinating Referral Mechanism co-managed by SWD and EDB. SSDs aim to provide intensive counselling and educational guidance for the students with a view to helping them tide over their transient development difficulties and strengthening their life skills. Students with marked improvements will be arranged for re-integration

into mainstream schools as soon as possible. At present, there are seven SSDs subvented by EDB, providing about 1 200 school places. 657 subvented residential places are also provided by SWD for the students of six SSDs. Under the current referral mechanism, social workers, student guidance personnel, educational psychologists and psychiatrists will refer students rehabilitated from drug abuse who have moderate to severe emotional and behavioural difficulties to SSDs for intensive counselling to help them tide over their transient development difficulties. SWD and EDB will continue to monitor the service demand for SSD.

*(ii) Vocational Training and Job Placement*

5.57 DTRC operators and service providers of vocational training and job placement services should enhance communication, establish linkages and maintain close partnership through regular meetings and other means, in order to strengthen pre-employment preparation and possible job matching for ex-drug abusers. We should also continue to encourage DTRCs to explore different ways to collaborate with corporations and the community in offering job opportunities for rehabilitants who are ready to take employment, so as to assist their reintegration into society.

**(e) Drug Addiction Treatment Centres**

5.58 CSD has increased the number of treatment places for young drug addicts and incorporated structured counselling and psychological programmes into the daily DATC programme by redeployment of resources and re-organisation of institutional regime in 2010. CSD should continue to monitor critically the demand for DATC services and improve its programmes, in particular vocational training, to enhance the competitiveness of the inmates in the employment market.

**(E) Sustained Service Improvement**

**(a) Community-based Counselling Services**

5.59 SWD will conduct a review of the funding and service agreement with the CCPSAs in 2013. SWD and NGOs concerned will review comprehensively the use of resources as well as the utilisation and provision of services. In particular, the review should also cover how CCPSAs, after addition of four service units in 2010, has strengthened their functions of being the first line in the community to identify, provide counselling and referrals for drug abusers as well as coordinating and

supporting other relevant units. The review will also follow up on the evaluation of OSMSS conducted by SWD in the fourth quarter of 2011 concerning the types and sophistication of medical support services, the support of nursing staff as well as partnership with medical practitioners.

5.60 Following consultation with SWD, the two social clubs had their services enhanced in April 2011 and renamed as CDCs in August 2011 with OSMSS implemented at the same time. Services provided by CDCs are specifically for drug abusers, ex-drug abusers and their families. CDCs also organise preventive education and publicity programmes for workers of the service sector and employers in need. We encourage CDCs to continue their services along this direction and duly review on their direction and position.

**(b) Drug Treatment and Rehabilitation Centres**

5.61 A review on the pilot scheme of the Service Information System (SIS) was completed by ND in 2011. ND is proceeding with upgrading the system, with a view to extending the SIS to all subvented DTRCs and promoted to non-subvented DTRCs for voluntary adoption in the second half of 2012. ND has set up a working group to solicit views from players on the future development of SIS. We hope that NGOs can actively participate in the new information system to streamline the procedures on collecting information and increase transparency so as to enhance the service quality of the whole sector.

5.62 Separately, ND, SWD and DH should continue to monitor critically the demand for DTRC services. The NGO operators should continuously adapt their service programmes to meet the evolving needs of drug abusers.

**(c) Methadone Treatment Programme**

5.63 The last comprehensive review of MTP was conducted in 2000, which is more than ten years ago. The Programme is subject to greater constraints and challenges at present. For example, there is continuous pressure from local communities for closure of existing clinics while it is difficult to establish new MTP clinics in new development areas, rendering the maintenance of accessible services increasingly difficult. While moving towards a holistic care approach, not only should an abuser's drug dependence be stopped, his or her psychosocial needs also be addressed. In the meantime, the number of reported heroin abusers has been decreasing. Having regard to the above factors and the need

for providing more suitable and comprehensive services for the clients, DH is going to review the MTP in 2012 to identify service gaps and room for improvement.

**(d) Beat Drugs Fund**

5.64 With the capital injection of $3 billion in 2010, BDF is better endowed to support different types of anti-drug projects. On such basis, BDF expanded the amount of funding for the improvement works of DTRCs and began to subsidise school's HSP(DT) projects in 2011. Also, BDF introduced in 2010 a new mechanism for evaluating the effectiveness of the projects applying for funding. In the 2011 BDF Funding Exercise, priority has been given to projects relating to treatment and rehabilitation services.

5.65 Looking forward to the next three years, BDF should further improve the monitoring mechanism as far as possible. Appropriate adjustment should be made to the funding priority of the regular funding exercises in the light of the prevailing drug situation. Moreover, BDF should proactively follow up on the utilisation of the new arrangements of funding for the enhance work of DTRCs and make appropriate adjustments as far as practicable and when necessary.

## A Tiered, Multi-modality Approach of Treatment and Rehabilitation Services for Drug Abusers in Hong Kong

## (Second Edition)

## Introduction

The tiered, multi-modality framework (the table below and the schematic representation attached) is to conceptualise and articulate the treatment and rehabilitation services in Hong Kong in a more structured manner as a reference for relevant service sectors, the service users and the public. The framework is **not** intended to be prescriptive in nature to cast service or resource boundaries. The first edition of the framework was published in December 2010.

2. The framework embodies a continuum of services from identification, treatment, rehabilitation to reintegration, and highlights the complementary roles of social welfare, healthcare, education, and aftercare services. With unique expertise and strengths, services at each tier make distinctive contribution to the treatment and rehabilitation of drug abusers.

3. As far the Government and service providers in public and private sectors are concerned, the framework can, among other things, increase understanding of organisational interface, facilitate networking and collaboration between parties, and help oversee current provision and identify possible gaps. More importantly, it sets out a common basis for all concerned parties to work together to achieve the collective goal of a holistic service.

4. The users can have a pan picture of service offered for people of varying needs and at different stages of a treatment and rehabilitation process.

**Tier 1 – Generic, primary services for open access, identification and assessment**

**Outline description** This Tier describes the frontline of service delivery which is the first response to the drug abusers and their families. They are primary services and directly accessible by drug abusers in general and their families. By virtue of their contact with the drug abusers and their immediate support network (e.g. parents and spouse) in their own environment, they are best placed to identify people at-risk and drug abusers and provide brief interventions for occasional drug abusers and their families. More serious drug abusers should be referred to other Tiers if necessary. Although frontline service personnel may not have in-depth knowledge in drug issues, appropriate training could equip them with skills to identify drug abusers and enhance their understanding on existing drug treatment and rehabilitation services (i.e. services amongst Tier 2 and Tier 3), which could greatly help them to make necessary referrals.

**Aim/Purpose** To ensure universal access and continuity of care to all generic services with a view to reducing risks and vulnerabilities and encourage them to face the problem and seek suitable rehabilitation services at early stage, particularly for those who are early drug abusers, in mainstream services.

**Target population** All in particular those vulnerable to drug abuse or already having problems with drug abuse.

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[8] | Source of funding |
|---|---|---|---|---|
| **A. Voluntary programmes** | | | | |
| a. Community setting | | | | |
| (i) District Youth Outreaching Social Work Teams | To seek out and engage people vulnerable to drug abuse, in particular those who do not normally participate in conventional social or youth activities, and are vulnerable to negative influence including drug abuse. | NGOs | LWB/SWD | Subvention |

[8] Envelope holders/Controlling officers, as applicable.

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[8] | Source of funding |
|---|---|---|---|---|
| (ii) Overnight Outreaching Service for Young Night Drifters | | NGOs | LWB/SWD | Subvention |
| (iii) Counselling centres for psychotropic substance abusers (CCPSAs) | | NGOs | SB/SWD | Subvention |
| (iv) Integrated Children and Youth Services Centres (ICYSCs)/ Children and Youth Centre (CYCs) | To identify and engage young people who would drop in and/or participate in the activities of the centres, and are vulnerable to negative influence including drug abuse. | NGOs | LWB/SWD | Subvention |
| (v) Integrated Family Service Centres (IFSCs) | To raise parents' awareness of potential drug issues of children and to provide support for such families as and where appropriate. | NGOs/SWD | LWB/SWD | Subvention/ Government |
| (vi) Other agencies | To raise the awareness of drug issues in various sectors through preventive education and publicity activities and other anti-drug works; and provide initial engagement / referral in coming into contact with drug abusers | NGOs | - | Community/ project funding from various sources |
| b. School setting | | | | |
| (i) Teachers and other school personnel including student guidance personnel | To identify, provide initial engagement and motivational counselling for at-risk students and handle drug-related cases. | Schools | EDB | Government/ Subvention/ Private |

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[8] | Source of funding |
|---|---|---|---|---|
| (ii) School social workers | To provide initial engagement, motivational counselling to the students in need and their families, and subsequent referral to drug treatment and rehabilitation programmes upon consent. | NGOs | LWB/SWD | Subvention |
| (iii) Police School Liaison Officers | To assist schools in identifying early juvenile delinquency, preventing and tackling students' involvement in crime and illegal activities.<br><br>To interview problematic students identified by schools on a small group or individual basis to assist them in building up positive values and observing discipline. | Police | SB/Police | Government |
| c. Healthcare setting | | | | |
| (i) Public hospital | | | | |
| - General Outpatient Clinics | To help identify drug abusers and in appropriate circumstances make necessary referrals. | HA | FHB | Subvention |
| - Accident and Emergency Units | To help identify drug abusers and in appropriate circumstances make necessary referrals. | HA | FHB | Subvention |
| (ii) DH's services | | | | |
| - Student Health Service | To promote anti-drug education for primary and secondary school students. | DH | FHB/ DH | Government |

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[8] | Source of funding |
|---|---|---|---|---|
| (iii) Family doctors/general practitioners | To promote awareness of drug abuse among healthcare professionals in everyday practice and develop and promulgate guidelines for early identification and referral. | Private practitioners/ hospitals and medical professional bodies | FHB /DH | Private |
| **B. Criminal justice setting** | | | | |
| a. Police Superintendents' Discretion Scheme and Community Support Service Scheme | To identify young offenders prone to drug abuse, provide post-caution and aftercare services. | Police NGOs | SB/Police LWB/SWD | Government/ Subvention |
| b. Probation system administered by probation officers and under judicial oversight | As required by the Court, to conduct a pre-sentence social enquiry with recommendation on the suitability of an offender for probation supervision, as an intervention measure in lieu of a custodial sentence. Drug abusers may be identified in the process.<br><br>For an offender who has been placed under a probation order, a probation officer (PO) renders statutory supervision to the offender (i.e. the probationer) pursuant to the conditions stipulated in the Probation Order. | SWD/ Judiciary | LWB/SWD/ Judiciary | Government |

**Linkages within the tier / with other tiers**

- To provide holistic and client-centred treatment, there should be a key worker for each drug abuser identified. The key worker should provide an initial assessment and intervention on the site as and when necessary. He or she should refer the drug abuser and their families to other tiers of services if necessary. The role of key worker can be played by school social workers, student guidance personnel, social workers in outreaching teams, ICYSCs, CYCs, IFSCs, probation officers and family doctors/general practitioners.

- A multi-disciplinary team work approach is most encouraged. At the school setting, the handling of drug abuse cases at schools should involve cross-discipline team work involving teachers, student guidance personnel, school social workers, police school liaison officers, etc. EDB, ND, SWD and the Police are, in consultation with the school and welfare sectors, jointly working in helping schools to revised school guidelines on anti-drug measures timely, in order to handle cases involving at-risk students and those with drug abuse problems. As for healthcare settings, private practitioners, hospitals and social workers may join hands to form a collaboration network for young drug abusers on a need and individual case basis.

- Tier 1 should ensure clear referral pathways and links with Tiers 2 and 3. For cases which cannot be handled by the services at Tier 1, they should be referred to CCPSAs or Centres for Drug Counselling (CDCs) at Tier 2. That said, Tier 1 services may still be delivered alongside Tier 2 services. For instance, a school social worker and a CCPSA may provide counselling to a drug abuser, but the CCPSA should play the role as a key worker of the treatment plan.

- CCPSAs undertake some outreaching work in Tier 1 to identify and engage target drug abusers apart from receipt of referrals or self-referrals, provide therapeutic counselling and on-site medical support service (OSMSS) in Tier 2 targeted for drug abstinence, and deliver aftercare services in Tier 4 for needy cases to sustain and achieve social re-integration. The day and night outreaching social work teams in Tier 1 should outreach and identify drug abuse cases and render in-depth counselling in the course of engaging and motivating them to receive designated drug treatment and rehabilitation services.

- The probation system serves as a service unit and a pathway linking to services in other tiers. As a key worker, a probation officer (PO) is required to report the probationer's progress at regular intervals as directed by the court, or may initiate progress reports on the probationer's unsatisfactory performance and bring the probationer to the court in dealing with a breach of the Order. A PO not only provides counselling and group activities to the probationer, but also refers probationers to suitable programmes (e.g. CCPSA, DTRC) run by other professionals or NGOs.

- Since 1 October 2009, SWD has implemented a two-year Pilot Project on Enhanced Probation Service in the two Probation Offices serving the Kowloon City Magistrates' Courts and Kwun Tong Magistrates' Courts respectively. The project aims to provide more focused, structured and intensive treatment and counselling services for young offenders aged below 21 and convicted of drug-related offences, who are put on probation pursuant to the Probation of Offenders Ordinance (Cap 298), and helps them to stay clear from drugs and turn a new leaf.

- For more serious cases, drug abusers may be admitted to hospitals for in-depth treatment or DTRCs at Tier 3 and follow up without going through Tier 2.

**Tier 2 – Community-based specialised drug treatment and rehabilitation services**

| | |
|---|---|
| **Outline description** | This Tier describes the first line of drug-specific services. The interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment. A care plan should be concerned with outcomes across relevant domains of functioning (e.g. education, offending, mental health and other medical specialities). Commonly, interventions take place in community settings. |
| **Aim/Purpose** | To provide structured psychosocial interventions and medical services with a view to assisting drug abusers to abstain from drugs and motivating them into treatment systems within the community. |
| **Target population** | People with drug abuse problems, particularly occasional/habitual drug abusers, who require structured psychosocial and medical services. |

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[9] | Source of funding |
|---|---|---|---|---|
| **A. Voluntary programmes** | | | | |
| a. Community and healthcare settings | | | | |
| (i) CCPSAs | To provide counselling and OSMSS to drug abusers with a view to assisting them to abstain from abusing psychotropic substance. | NGOs | SB/SWD | Subvention |
| (ii) CDCs | To provide counselling and other support services to drug abusers, ex-drug abusers and their family members. | NGO | SB/SWD | Subvention |
| (iii) General practitioners in partnership with CCPSAs and CDCs | To provide medical consultation service to drug abusers as part of the OSMSS by CCPSAs and CDCs. | CCPSAs, CDCs & private practitioners | SB/SWD | Subvention |

[9] Envelope holders/Controlling officers, as applicable.

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[9] | Source of funding |
|---|---|---|---|---|
| (iv) Substance Abuse Clinics (SACs) | To provide specialist interventions and treatment to abusers with psychiatric complications through out-patient services in designated sessions. | HA | FHB | Subvention |
| (v) Specialist clinics in public hospitals | To provide specialist treatment e.g. in urology to abusers with other complications. | HA | FHB | Subvention |
| (vi) Specialist medical professionals in private practice | Drug abusers may seek help from psychiatrists and other professionals who are in private practice. | Private practitioners | FHB | Private |
| (vii) Methadone Treatment Programme (MTP) | To offer both maintenance and detoxification options for opiate drug dependent persons through a network of 20 methadone clinics on an outpatient mode; counselling services are provided for clients. | DH/NGO | SB/DH | Government/ subvention |
| **B. Criminal justice setting** | | | | |
| a. Probation services | A PO provides counselling and group activities to the probationer, and also refers the probationer to suitable programmes run by other professionals and NGOs.<br><br>An enhanced system targeting young drug abusers is being tried out. | SWD/ Judiciary | LWB/SWD/ Judiciary | Government |

**Linkages within the tier / with other tiers**

- As a first stop for drug-specific treatment and rehabilitation service in the community, social workers in CCPSAs and CDCs can serve as key workers for clients who mainly stay in Tier 2. The key worker should coordinate with elements from healthcare disciplines (e.g. general practitioners in partnership with CCPSAs and CDCs, or psychiatrists in SACs).

- Tier 2 should ensure clear referral pathways and links with Tier 1 and Tier 3.

- Tier 2 interventions may be delivered alongside Tier 3 interventions according to the needs of drug abusers. For example, a drug abuser who stays in a residential drug treatment and rehabilitation centre may visit public hospital to receive specialist psychiatric care by SAC and other specialist care if they suffer physical and mental damage. Some drug abusers need residential services but cannot leave their jobs for a long period of time for certain reasons. In this case, service units at Tier 2 and 3 can assist these drug abusers to develop a treatment programme which enable them to complete the treatment even if they remain in the community.

- Coordination among SAC and other specialty units is important to provide a holistic, patient-centred service in the public health system.

- SACs provide education and training to frontline staff of CCPSAs, CDCs and NGOs who need to work with psychotropic substance abusers (PSAs). CCPSAs and and CDCs also provide professional training sessions for allied professionals such as teachers, healthcare professionals, polices and social workers, with a view of facilitating their assistance to drug abusers.

**Tier 3 – Residential, specialised treatment & rehabilitation and related services**

| | |
|---|---|
| **Outline description** | This Tier describes specialised services targeted for more serious drug abusers, as an adjunct to Tier 1 and Tier 2 and used for particular interventions or focused work and/or temporary periods. This tier also include other related services which arise from residential treatment and help rehabilitants lead a new life |
| **Aim/Purpose** | To provide specialised interventions and setting for a particular period of time and for a specific function, as an adjunct to and a backstop for the services of the other two tiers. |
| **Target population** | People with complicated drug abuse problems requiring specific interventions |

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[10] | Source of funding |
|---|---|---|---|---|
| **A. Voluntary programmes** | | | | |
| a. DTRCs | To provide residential treatment and rehabilitation programmes of various lengths and natures to drug abusers who wish to seek residential treatment voluntarily and those who are referred by Probation Officers. (see also B(c) below)<br><br>There are also halfway houses which provide aftercare services to rehabilitated abuser (see Tier R) | NGOs | SB/ SWD /DH | Subvention & self-financed |
| b. Educational programmes for young drug abusers in DTRCs | To run educational programmes for school-aged DTRC residents. | NGOs | EDB | Subvention & self-financed |

[10] Envelope holders/Controlling officers, as applicable.

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[10] | Source of funding |
|---|---|---|---|---|
| c. Public hospitals | To provide specialist interventions and treatment to abusers with more severe psychiatric complications and other co-morbidity through in-patient services in dedicated or non-dedicated wards. | HA | FHB | Subvention |
| d. Private hospitals | Drug abusers may seek help from psychiatrists and other professionals who are in private practice. | Private practitioners | FHB | Private |
| **B. Criminal justice setting** | | | | |
| a. Drug Addiction Treatment Centre (DATC) | To provide compulsory residential treatment for persons of 14 years old or above who are convicted of offences punishable by imprisonment and addicted to drugs. | CSD | SB/CSD | Government |
| b. Other institutions including Rehabilitation, Detention and Training Centres and Correctional Institutions for young offenders | To provide correctional services to young offenders. | CSD | SB/CSD | Government |
| c. Probation services | A drug offender on probation may be referred to residential treatment and rehabilitation services, such as DTRCs. The probation officer concerned would visit the probationer at regular interval to monitor his/her progress.<br><br>An enhanced system targeting young drug abusers is being tried out. | SWD/ Judiciary | LWB/SWD/ Judiciary | Government |

**Linkages within the tier / with other tiers**

- To ensure service continuity, service providers in the Tier 1 and Tier 2 should continue to participate in the treatment process if needed.

- DTRCs should provide appropriate residential treatment programme according to the circumstances and needs of a drug abuser. Meanwhile, DTRCs should closely connect with Tier R in order to assist rehabilitants in completing their treatment and ensure smooth reintegration into society.

- For drug abusers who stay in particular settings, such as DTRCs, DATCs and hospitals, their treatment plan would be coordinated by the operating agencies.

**Tier R – Reintegration and aftercare**

| | |
|---|---|
| **Outline description** | This Tier describes aftercare services, mainly as a follow up to specialised treatment and rehabilitation programmes (particularly residential service in Tier 3). The services serve as a bridge to help rehabilitated drug abusers reintegrate into society. Some of the services, particularly those related to education, vocational training and employment assistance, are openly accessible and generic services, though enhanced support would be given as appropriate to help drug abusers if they have special needs as a result of behavioural problems or learning difficulties. |
| **Aim/Purpose** | To build in protective factors so as to reduce the chance of relapse as rehabilitated drug abusers return to the community and to help them turn a new leaf. |
| **Target population** | Rehabilitated drug abusers who have completed a drug treatment and rehabilitation programme |

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[11] | Source of funding |
|---|---|---|---|---|
| **A. Voluntary programmes** | | | | |
| a. DTRC operators | To provide aftercare service to rehabilitated abusers through their halfway houses.<br><br>To follow through the aftercare plan of a rehabilitated drug abuser with involvement of their family members, school, referring social workers, supervising probation officers, mentor and others as and where necessary and feasible. | NGOs | SB/ SWD /DH | Subvention & self-financed |
| b. CCPSAs | To provide counselling, support and aftercare services for dischargees from non-subvented DTRCs without such provision. | NGOs | SB/SWD | Subvention |

[11] Envelope holders/Controlling officers, as applicable.

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[11] | Source of funding |
|---|---|---|---|---|
| c. CDCs | To provide counselling and supportive services to rehabilitated drug abusers to maintain abstinence and to enhance their integration into the community. | NGOs | SB/SWD | Subvention |
| d. Aftercare service of Methadone Treatment Programme | To offer aftercare service to rehabilitated opioid dependent persons who have completed detoxification programme | DH /NGO | SB/DH | Government/ Subvention |
| e. Other agencies (e.g. rehabilitated abusers self-help organisations) | To assist rehabilitated abusers to reintegrate into society through activities like social gatherings, sharing sessions, voluntary services, etc. | NGOs | -- | Community/ Funding from various levels |
| f. Other non-specialised programmes providing related education, vocational training and employment services | | | | |
| (i) Employment services and specialised programmes for the youth | To provide career counselling, job referral, training and self-employment support services to young people aged 15-29. | LD, NGOs | LWB/LD | Government/ Subvention |
| (ii) Mainstream schools | After completion of a DTRC programme, rehabilitated school-aged drug abusers may, with the assistance of EDB / NGOs / key workers, apply for admission to mainstream schools to continue education. Support services may follow. | Public sector schools, NGOs | EDB/SWD | Subvention |
| (iii) Schools for Social Development (SSD) | After completion of a DTRC programme, rehabilitated students who still display moderate to severe behavioural/emotional difficulties may apply for | Aided schools | EDB/SWD | Subvention |

| Service/Service providers | Services for Drug Abusers and Objectives | Agencies | B/Ds[11] | Source of funding |
|---|---|---|---|---|
| | admission to SSD which provides intensive support for the students with a view to helping them tide over their transient adaptation problems in the course of development and strengthening their learning motivation and life skills so that they can resume the mainstream education as soon as possible. All applications will be considered by the Vetting Committee under the Central Co-ordinating Referral Mechanism co-managed by EDB and SWD for vetting and arrangement of appropriate services. | | | |
| (iv) Vocational training and specialised programmes for the youth | After completion of a DTRC programme, rehabilitated drug abusers may with the assistance of NGOs / key workers apply for vocational training /pre-employment training programmes. | VTC, ERB | LWB | Subvention and Employees Retraining Fund |
| **B. Criminal justice setting** | | | | |
| a. Probation services | To provide supervision in the community after discharge from DTRCs until completion of the probation period | SWD/ Judiciary | LWB/ SWD/ Judiciary | Government |
| b. Post-institutional statutory supervision | To provide post-release statutory supervision. | CSD | SB/CSD | Government |

**Linkages within the tier / with other tiers**

- Some DTRC operators have already provided aftercare services in the community. During statutory supervision, probationers are also taken care of by supervising probation officers when they finish a programme in DTRCs.

- CCPSAs play a supplementary role to help those who are discharged from non-subvented DTRCs without aftercare programme. In this regard, CCPSA social workers can serve as key workers to coordinate an aftercare plan.

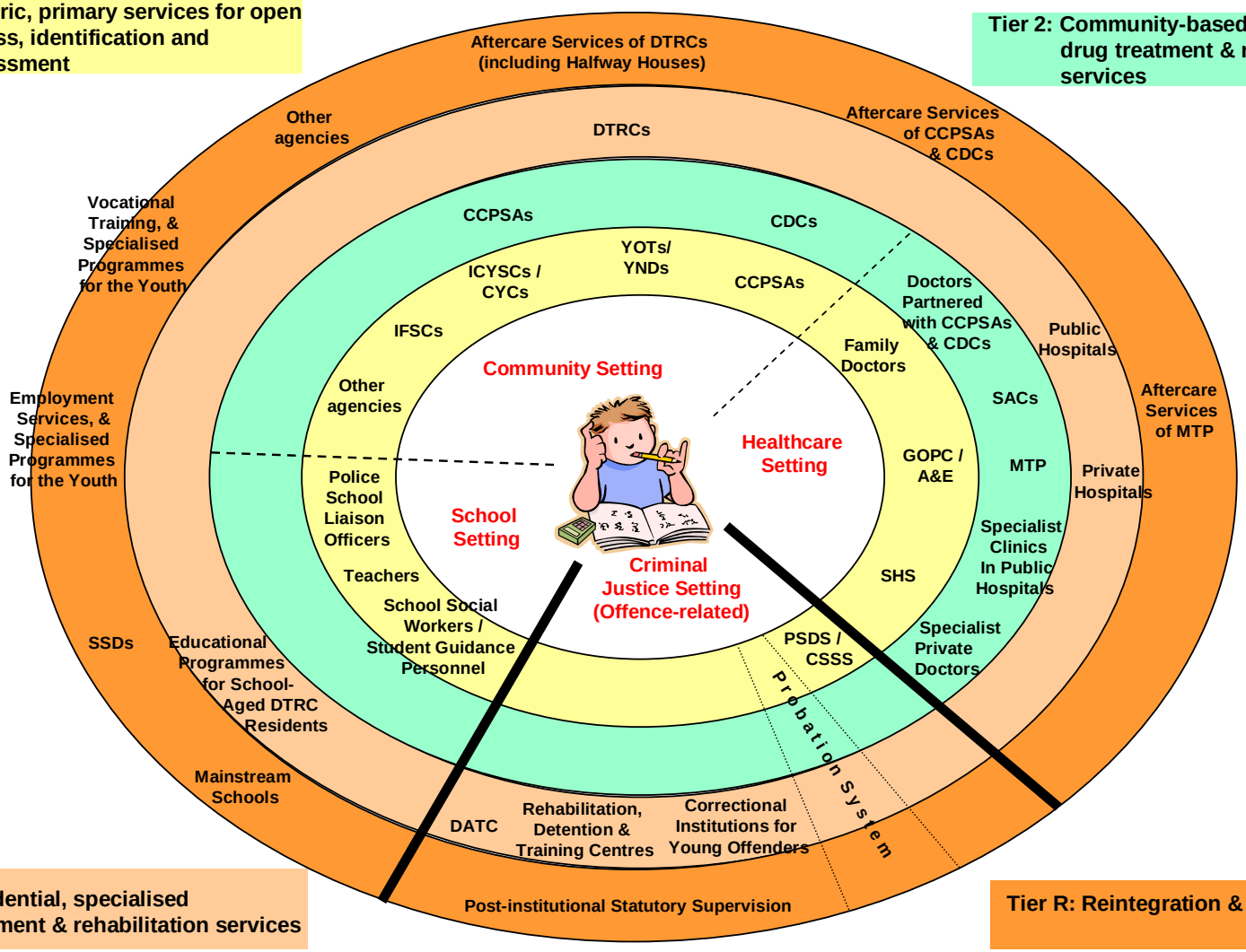
- Through concerted efforts, the Regional Education Offices and Non-Attendance Cases Team of EDB have been providing placement services to students in question to ensure that those aged 15 and below attend schools and to assist those above 15 who wish to return to school in seeking suitable school places.

# A Tiered, Multi-modality Approach of Treatment and Rehabilitation Services for Drug Abusers in Hong Kong

## (Second Edition)

**Tier 1: Generic, primary services for open access, identification and assessment**

**Tier 2: Community-based, specialised drug treatment & rehabilitation services**




**Tier 3: Residential, specialised treatment & rehabilitation services**

**Tier R: Reintegration & aftercare**

## Abbreviations

| | |
|---|---|
| A&E: | Accident and Emergency Unit |
| CCPSA: | Counselling Centre for Psychotropic Substance Abusers |
| CDCs: | Centres for Drug Counselling |
| CSSS: | Community Support Service Scheme |
| CYC: | Children and Youth Centre |
| DATC: | Drug Addiction Treatment Centre |
| DTRC: | Drug Treatment and Rehabilitation Centre |
| GOPC: | General Outpatient Clinic |
| ICYSC: | Integrated Children and Youth Services Centres |
| IFSC: | Integrated Family Service Centres |
| MTP: | Methadone Treatment Programme |
| PE&P: | Preventive Education and Publicity |
| PSDS: | Police Superintendents' Discretion Scheme |
| SAC: | Substance Abuse Clinic |
| SHS: | Student Health Service |
| SSD: | School of Social Development |
| YND: | Overnight Outreaching Service for Youth Night Drifters |
| YOT: | District Youth Outreaching Social Work Teams |