CHAPTER 7

SUMMARY OF MAJOR RECOMMENDATIONS AND KEY INITIATIVES

7.1 The followings are a summary of the recommendations and key initiatives in this Plan.

Part 1: Drug Treatment and Rehabilitation Work

(A) Early Identification and Intervention

(a) Families and Schools (Paragraphs 5.3-5.11)

(i) Families

7.2 We should step up our efforts in assisting parents to understand drug problems and encouraging them to make extra proactive efforts on the prevention and early identification fronts.

7.3 A district-based approach should be adopted in promoting preventive education and publicity for parents.

7.4 Mass media should be made use as a dissemination channel so that parents may receive anti-drug messages in a more effective manner.

(ii) Schools

7.5 A holistic school curriculum comprising knowledge, skills and attitudes is required to promote anti-drug education effectively in schools.

7.6 Schools should be encouraged to collaborate with suitable NGOs according to schools' needs, and apply for BDF to implement the HSP(DT).

7.7 A structured training programme for teachers should be organised to enhance their capabilities in implementing the HSP and anti-drug education in schools, and their skills in handling drug problems, and to provide teachers with hotline services manned by social workers.

(b) Outreaching Service (Paragraph 5.12)

7.8 CCPSAs and outreaching teams are encouraged to approach at-risk youths and young drug abusers through more diversified means. Co-operation on outreaching strategies and case management at district level between CCPSAs and outreaching teams should also be stepped up and cross-referrals of cases involving different service needs be made.

(c) Family Doctors (Paragraphs 5.13-5.14)

7.9 Doctors are encouraged to continue to take an active part and organise structured training programmes. We encourage organisations concerned to develop tools or protocols for screening, brief interventions and referral to treatment and promote adoption by frontline doctors.

(d) Student Health Service (Paragraph 5.15)

7.10 Health care staff of SHS on anti-drug education should be better equipped.

(e) Involvement of Other Players in Tier 1 (Paragraph 5.16)

7.11 The collaboration of these service units should be promoted in identifying people at-risk and drug abusers and providing brief interventions for occasional drug users and their families, and appropriate training.

(f) Community-based Drug Testing (Paragraph 5.17)

7.12 A consultation paper to implement drug testing at the community level should be issued to solicit views from members of the public.

(g) Surveillance of Emerging Drugs of Abuse (Paragraphs 5.18-5.20)

7.13 The Government should continue to monitor closely the local and overseas drug trend, while anti-drug sector may exchange information about emerging drugs of abuse in a timely manner so that prompt action could be taken in preventive education and publicity as well as treatment and rehabilitation.

7.14 HA is developing a chromatography-based analytical system with grants from BDF. The system will be used for surveillance of drugs abused by drug abusers and high-risk individuals so as to identify the

common and emerging drugs of abuse. Depending on the research outcome, consideration may be given to expanding efforts on this front.

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

(a) Tiered Multi-modality Framework (second edition) (Paragraph 5.22)

7.15 The tiered multi-modality framework (second edition) sets out a foundation as a reference for the Government and private/public organisations in providing a comprehensive service for drug abusers. This also allows the users have an overall understanding of services provided in different modality.

(b) Collaboration/Linkages among Service Units (Paragraphs 5.23-5.25)

7.16 Based on the foundation of tiered multi-modality framework, various service units should continue to be encouraged to establish closer linkages and co-operation on service and case management.

(c) Collaboration and Networking Models on a District/Cluster Basis (Paragraphs 5.26-5.29)

7.17 The two platforms provided by CCPSAs and DFCCs can be complementary to each other at service and district levels, enabling the district drug problem to be dealt with in greater depth and breadth.

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

(a) Drug Treatment and Rehabilitation Centres (Paragraphs 5.31-5.37)

7.18 We should continue to monitor the situation closely and seek additional resources to provide more places for female drug abusers when necessary.

7.19 Overall efficiency should be enhanced, including to strengthen assistance to rehabilitated drug abusers to reintegrate into society, to

enhance support to DTRCs so that they can better meet the medical needs of residents and to explore the provision of new services targeting abusers in their initial drug experimentation stage.

7.20 Licensing progress should be expedited. Those DTRCs which can be enhanced by in-situ upgrading/redevelopment to meet the statutory licensing requirements are encouraged to carry out improvement works as soon as practicable. For those DTRCs which require reprovisioning, the Government will continue to facilitate them in every possible way and make greater efforts to solicit local support and promote community acceptance via publicity programmes.

(b) Public Hospitals (Paragraphs 5.38-5.42)

7.21 SACs should be encouraged to roll out pilot scheme(s) to increase the participation of other supporting services, such as occupational therapists and clinical psychologists. Broader participation should be further considered if they are proven to be effective.

7.22 SACs should be recommended to consider adopting other approaches to provide services for DTRC residents subject to the availability of resources and on the condition that the services of the centres are not affected.

7.23 A case management approach (e.g. conducting case conferences) providing patient-centred services may be contemplated if more than one specialist treatment is involved.

7.24 Public hospitals should be encouraged to put forward more service delivery models to facilitate early identification and intervention of drug abusers.

(c) Probation Service (Paragraph 5.43)

7.25 Subject to the outcome of the review and availability of resources, the Pilot Project on Enhanced Probation Service should be continued to provide more focus, systematic and in-depth rehabilitation programmes for the probationers.

(d) Training for Anti-drug Professionals (Paragraphs 5.44-5.46)

7.26 Agencies should be encouraged to continue to organise more in-depth and structured training for anti-drug professionals to equip them

with sufficient knowledge and skills to deliver treatment and rehabilitation programmes. In the long term, the agencies should initiate to provide training according to the needs.

7.27 Training should be extended to those service units which are not specialised in handling drug abuse problem (i.e. Tier 1) to enrich their drug knowledge.

7.28 Local universities and educational institutions should be encouraged to cover and/or strengthen anti-drug topics in the curriculum of social work, education and medicine degree programmes.

(e) Services for Ethnic Minorities (Paragraph 5.47)

7.29 Anti-drug agencies should be encouraged to enhance cultural sensitivity, provide cultural training to staff and offer services that can cater for the particular needs of ethnic minorities as far as practicable.

7.30 Treatment and rehabilitation agencies should be encouraged to partner with different ethnic minority organisations in order to identify drug abusers more effectively and provide more relevant services for them.

(f) Family Support (Paragraphs 5.48-5.49)

7.31 We continue to encourage DTRCs to develop family support services and to continue to work with the existing service units dedicated to handling family cases (e.g. Integrated Family Service Centres).

(D) Reintegration into Society and Prevention of Relapse

(a) Overall – Multiple Pathways (Paragraph 5.50)

7.32 Ways to enhance information flow and facilitate better coordination among different stakeholders (bureaux, departments, agencies, etc.) to provide aftercare services and multiple pathways for rehabilitated drug abusers should be explored.

(b) Aftercare Services (Paragraph 5.51)

7.33 CCPSAs and CDCs should continue to play a prominent role in the provision and coordination of aftercare services, with involvement of

the family, school, social worker, mentor and others. A care-plan/case management approach should be considered.

(c) Education/Vocational Training in DTRCs (Paragraphs 5.52-5.54)

7.34 EDB should continue to provide subvention for the 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.

7.35 DTRC operators should be encouraged to apply for the BDF to provide vocational training and job preparation services.

(d) Arrangements after Discharge (Paragraphs 5.55-5.57)

(i) Schooling

7.36 EDB and/or SWD should continue to provide placement services for rehabilitated students to assist them to return to schools and refer students rehabilitated from drug abuse who have moderate to severe emotional and behavioural difficulties to SSDs for admission.

(ii) Vocational Training and Job Placement

7.37 DTRC operators and service providers of vocational training and job placement services should enhance communication, establish more formal linkages and maintain close partnership through regular meetings and other means.

7.38 We should continue to seek community support to facilitate drug abusers' reintegration into society and leverage the "Path Builders" initiative where appropriate.

(e) Drug Addiction Treatment Centres (Paragraph 5.58)

7.39 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 (Paragraphs 5.59-5.60)

7.40 SWD should review comprehensively the use of resources as well as the utilisation and provision of services to cater for the needs of drug abusers.

(b) Drug Treatment and Rehabilitation Centres (Paragraphs 5.61-5.62)

7.41 The SIS will be extended to all subvented DTRCs and promoted to non-subvented DTRCs for voluntary adoption following the system upgrading which is expected to be completed in 2012.

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

(c) Methadone Treatment Programme (Paragraph 5.63)

7.43 DH should conduct a review of the MTP to identify service gaps and room for improvement.

(d) Beat Drugs Fund (Paragraphs 5.64-5.65)

7.44 BDF should further improve the monitoring mechanism as far as possible, with a view to facilitating overall improvement of the treatment and rehabilitation services.

Part 2: Continuum and Complementarity with Other Prongs

(A) Preventive Education and Publicity

(a) Families and Schools (Paragraph 6.3)

7.45 Please refer to paragraphs 7.2 to 7.7 for the work of families and schools.

(b) General Publicity (Paragraphs 6.4-6.5)

7.46 We recommend the good use of the mass media (including announcements of public interest) and posters should be made to disseminate the importance of seeking assistance early and to enhance community understanding for the treatment and rehabilitation facilities and rehabilitated drug abusers.

7.47 We should continue to optimise the DIC so as to facilitate better understanding of anti-drug work (including drug treatment and rehabilitation services).

(c) Roving Exhibitions (Paragraphs 6.6-6.7)

7.48 The contents of the anti-drug roving exhibitions should be enriched, including enhancing the community's knowledge of treatment and rehabilitation services and highlighting the importance of these services in helping rehabilitated drug abusers reintegrate into society.

7.49 Support of property management agencies and public transport operators should be enlisted to hold exhibitions at their properties, and also to explore making use of properties of the Government and public organisations to hold exhibitions.

(d) Social Media (Paragraph 6.8)

7.50 We should continue to explore suitable measures to reach out to hidden young drug abusers through social media.

(B) Community Mobilisation

(a) Community Participation (Paragraphs 6.9-6.10)

7.51 We should continue to appeal participation from all sectors of the community to lend drug abusers a helping hand, such as through the "Path Builders" initiative or other platforms.

(b) Community Acceptance (Paragraph 6.11)

7.52 Suitable activities should be supported to enhance the public's understanding of treatment and rehabilitation services.

<u>(c) Mutual Help in the Neighbourhood (Paragraph 6.12)</u>

7.53 Co-operation among various stakeholders at the neighbourhood level should be promoted to heighten their awareness of the drug problem as well as solicit public support for treatment and rehabilitation services and accepting rehabilitated drug abusers to reintegrate into society.

(C) Research

<u>(a) Monitoring of Drug Abuse Situation (Paragraphs 6.13-6.17)</u>

<u>(i) CRDA and Student Survey</u>

7.54 We should continue to enhance CRDA and Student Survey.

<u>(ii) Better Estimating the Drug Abusing Population</u>

7.55 Subject to the outcome and recommendations of the research, study method to supplement CRDA and other statistics currently being collected should be applied as appropriate.

<u>(iii) Studying the Drug Abuse Situation of Non-engaged Youth</u>

7.56 Subject to the outcome and recommendations of the research study, a better understanding of the drug abuse situation of these young people and their service needs will assist formulating further policies and measures.

<u>(iv) Qualitative Module of the Supplementary System</u>

7.57 Efforts should continue to be made to identify a suitable researcher, with a view to collecting more information about the drug abuse situation in Hong Kong, in addition to the quantitative information currently available.

<u>(b) Studies on the Harmful Effects and Impact of Psychotropic Substance Abuse (Paragraphs 6.18-6.19)</u>

7.58 We should continue to encourage and support further studies on the harmful effects and impact of psychotropic substance abuse. The treatment and rehabilitation sector should be constantly briefed on the

findings of the researches.

(D) Law Enforcement / International Co-operation (Paragraphs 6.20-6.21)

7.59 Law enforcement agencies continue to curb the supply of drugs and deter drug abuse behaviour, and participate in the early intervention at schools and support for juvenile offenders.

7.60 Regional cooperation and exchange of intelligence information should be enhanced in order to interdict trafficking of ketamine and control sources.

(E) Implementation and Monitoring

7.61 This Plan gives strategic direction to government departments, service agencies and NGOs in delivering drug treatment and rehabilitation services in the short to medium term. Its implementation requires joint efforts from both the Government and NGOs and various stakeholders. ND will continue to provide policy support to back up the roll out of the recommendations. Comments from ACAN and/ or its T&R Sub-committee will be sought for initiatives that require strategic input. Agencies and departments are called upon to make reference to the Plan and review their current activities, make adjustment to the service objectives or targets, if any, and contemplate deliverables to meet service needs. Service providers are welcome to carry out the initiatives individually or in partnership with others.

7.62 ND will monitor the overall implementation of the Plan and present periodic progress reports to the ACAN, its T&R Sub-committee and DLC. Related government departments and agencies in the anti-drug sector are invited to keep ND informed of their programmes and activities that support the Plan, and to provide timely feedback on the implementation progress of the Plan. Such regular inputs are important and valuable to help ND, the ACAN T&R Subcommittee and DLC to maintain an oversight, to recommend necessary fine-tuning during the three year period, and to better take stock for preparing the next Three-year Plan.