Chapter 4

RECOMMENDED STRATEGIES

(A) Views and Discussion

4.1 In drawing up the Three-year Plan, we have collected views from different parties providing T&R services and relevant government departments. As noted in Chapter 1, between June 2014 and February 2015, ND representatives paid over 30 visits to individual CCPSAs, DTRCs, YOT/YND teams, relevant government departments and public bodies or met their representatives to hear their on-the-ground experience and views. In all these sessions, there was useful exchange on issues which form the focus of the Three-Year Plan.

4.2 The subject was also discussed at ACAN, the T&R/SC and the DLC between March and June 2015.

4.3 The HKCSS held two seminars in July and August 2014 inviting practitioners in the social services sector to discuss issues which should be considered in the context of the Plan. ND representatives attended both seminars.

(B) Strategies of the Three-year Plan (2015-2017)

4.4 The Fifth Three-year Plan covering 2009-2011 had focused primarily on expanding the capacity of services to meet the demand arising from the surge in PSAs during the period. The Sixth Three-year Plan covering 2012-2014 took one step ahead in promoting better integration among the different service modes and the trial of more innovative treatment and rehabilitation programmes.

4.5 This Seventh Three-year Plan would follow the track of the foundations laid and seek to promote further development of the services in response to the evolving drug scene. The steady decline in the number of reported drug abusers since its peak in 2008 has not resulted in a substantial decline in service demand. This could be attributed to the often long-term effects of psychotropic substances on abusers. Although we notice a general drop in service users in residential facilities, there remains a

continued solid demand for community-based services like CCPSAs and SACs. Feedback from service units also suggest an increase in cases with more complexity, in particular those showing psychiatric symptoms even when they first approached the help network. This was not the case with drug abusers using traditional opiate drugs. There is an apparent worrying sign of an increase in the number as well as proportion of PSAs abusing "Ice", which can cause hallucination, feeling of persecution and possible violent behaviour. There is a need to monitor developments closely since the more complex psychiatric cases would require more intensive care in terms of medical intervention, in addition to counselling support.

4.6 The success or otherwise of T&R programmes and continued abstinence would to varying extents be subject to at least three factors, which often are inter-dependent: the drug abuser's own motivation and efforts, relationship with his/her family, and the opportunities available to him/her after quitting drugs. Anti-drug initiatives and resources hitherto have focused primarily on services for the drug abusers individually during the treatment process, and relatively less on the support for the family, which could in turn play an important role in the treatment process, and post-treatment support for the rehabilitees. It has been argued that if there could be more focus on the family and preparing the rehabilitees for the post-treatment stage, we would be better able to ensure continued abstinence. With the more solid foundation established in different aspects of T&R services over the past few years, there is room for identifying means to further deepen existing services, with the aim of minimising service gaps. Along this thinking, the Seventh Three-year Plan would recommend initiatives in the following five major areas –

(a) <u>service enhancement</u> – the sector should continue to deepen various T&R services and to trial and adopt innovative measures to cater for the varying needs of different drug abusers;

(b) <u>promoting a better interface between different services</u> – different service modes and sectors should continue to strengthen communication and identify more room for collaboration;

(c) <u>early identification of hidden drug abusers</u> – in view of growing concern about the prolonged drug history of drug abusers before they surface in the system, the sector should continue to explore

means to facilitate the early identification of drug abusers so that they could be offered help before too late;

(d) minimising relapse and facilitating reintegration into society – the emphasis in the past has been on channelling drug abusers into the help network. As we begin to bring under control the trend of growth of drug abusers, we could better afford to make an effort to minimise relapse among those who have completed treatment and to facilitate their reintegration into society; and

(e) measures beyond T&R services – T&R services is just one arm of the five-pronged anti-drug strategy. We should at the same time continue to tackle the drug problem in a holistic manner.

I. *Service Enhancement*

General

4.7 There is a decline in drug-abusing population over the past few years, with a change in their demographic characteristics. Service providers should keep in view if their target clientele and scope of services suitably match such characteristics including age, gender and employment, etc., and where necessary, consider adjustments, refinement and reprioritisation of resources. An example is the MTP service, which is recording a gradual decline in clients against the background of a continuous decrease in the number of heroine abusers. The Government will continue to closely monitor the demand for MTP services and keep in view the feasibility of adjusting the number and service capacity of methadone clinics, service delivery ratios of staff and patients, as well as the scope for encouraging more commitment to the detoxification programme, subject to resource availability.

Drug Abusers at Work

4.8 More specifically, our efforts in tackling youth drug abuse in the past few years have begun to bear fruit, and a growing proportion of newly reported drug abusers is now in young adulthood (aged 21 to 30) or older. Unlike drug-abusing youth who may require more support in education,

drug abusers in their young adulthood would need help in respect of job skills to prepare them for leading a normal life after completing the T&R programmes. In addition, many of them may have also formed their own families. This points to the need for T&R programmes to take into account the way that family circumstances may impact on the individual.

4.9 Indeed, many service providers, with the support of BDF, are experimenting with different means to reach out to working drug abusers and to offer programmes that may cater for their specific needs. For example, some NGOs approached employers of certain trades and offered seminars/workshops for their employees so as to alert them to the harm of drug abuse and encourage those with drug problems to seek help. Some have also stepped up efforts in providing adult drug abusers with vocational training, job placement opportunities and job counselling, as part of the T&R programmes. We encourage the sector to continue to explore ways to better target these adult drug abusers.

4.10 Residential drug treatment programmes mostly last from three months to one year. The duration of such programmes is usually considered too long and it would not be practical to expect the drug abusers to get away for months without quitting their jobs. There are comments that there have been difficulties for drug abusers who are in employment to quit their jobs in order to join residential programmes in DTRCs, even when that is indeed what is warranted after assessment by social workers or healthcare professionals.

4.11 While acknowledging that programmes with longer duration would enable residents to go through a process of self-reflection and life re-building, we encourage service providers to explore on a pilot basis the feasibility of programmes with more flexible terms for those PSAs who can only afford a shorter break from their routine. We understand that, at present, individual DTRCs are already offering shorter programmes lasting for four weeks. In addition, the Enlighten Centre of the Evangelical Lutheran Church of Hong Kong (ELCHK) had, as part of its BDF funded project, lined up with a DTRC a five-day camp for their cases to experience short-term residential care. The objective was not to demand the participants to completely abstain from drugs immediately after this camp but rather to provide crisis intervention and create a safe environment for them to reflect on the way ahead. Such experience was also intended to sow the seed in their minds such that one day when the

time is ripe, they may awake to the option of a more comprehensive residential programme. Currently, the North District Hospital, with the support of BDF, has launched a five-day residential programme in the hospital setting to provide crisis intervention and T&R services. It is found that the use of brief intervention under this programme is effective in reducing drug consumption by patients and in strengthening their resolve to quit drugs.

4.12 We believe that pilot projects funded under the BDF to test the efficacy of new ideas are of great value. Data and questionnaires could be collected during the project period to assess the effectiveness of the programmes. We encourage service providers to continue to pioneer new T&R models, which may involve cross-sector and cross-agency collaboration. We also invite service providers to consider incorporating successful experiences into the service setting.

Female Drug Abusers

4.13 We note there are some concerns over the service for female drug abusers, including the availability of residential facilities. At present, about 15% of the DTRC places are allocated to females, while another 15% of the total can flexibly serve either males or females. Female drug abusers account for about 18% of the overall drug-abusing population throughout the past few years. While the average occupancy of the female DTRCs is higher than that of the male (around 70% vs around 60% in 2014), the current capacity of female places can meet the demand in general.

4.14 That said, some cases concerning female drug abusers are more complicated and require additional efforts of service providers. CCPSAs have reported that some drug abusers seeking help are pregnant. Pregnancy is considered as an effective intervention point as prospective mothers are observed to be more willing to quit drugs at this stage of life for the healthy development of their foetus. However, they would need help in dealing with the practical issues during pregnancy and after giving birth to their babies. The Rainbow Lutheran Centre of the Hong Kong Lutheran Social Service (HKLSS), with the support of the BDF, has launched a project targeting pregnant women with drug problems, as well as their family members (including partners). Under the project, the Centre collaborates with the medical sector including hospitals, and

maternal and child health centres (MCHCs) under DH, to provide comprehensive services for pregnant drug abusers and their newborns. The services cover T&R programmes for the mothers, and pre- and post-natal medical care and assistance in baby nursing. Feedback on the project so far is positive. We encourage relevant sectors to continue to explore best means to help pregnant drug abusers.

Support to Family Members

4.15 As mentioned in paragraph 4.6, family relation is one of the three main factors which may impact on the success or otherwise of the rehabilitation of the drug abuser. The survey mentioned in paragraph 3.15 of Chapter 3 also highlighted that around 50% of drug abusers have been identified by their family members/friends within half a year after they started taking drugs, and around 45% of drug abusers were first identified by their family members.

4.16 Indeed, the support of family members is important throughout the process from identification, treatment, rehabilitation to finally relapse minimisation. Currently, there are quite some programmes, including PE&P programmes, aiming at equipping parents, and sometimes spouses or partners, with the knowledge of drug abuse and skills to motivate their drug-abusing family members to seek help. Many service providers have also made the involvement of family members part and parcel of their T&R programmes, placing emphasis on how to foster closer relationship and give mutual support. Certain service providers have reflected that the support given to family members may at times help them to establish a dialogue with the drug abusers, who might be reluctant to receive any form of help initially.

4.17 We encourage service providers to continue along this direction. To recognise the importance of various family work, SWD has since October 2013 counted such activities in the caseload under the Funding and Service Agreement (FSAs) of CCPSAs. We welcome the sector to continue to provide feedback on their observation and experience, which may be taken into account in future reviews of the FSAs.

Vocational Training for Drug Abusers

4.18 Both community-based and residential T&R services engage drug abusers who have successfully quitted drugs to work as peer counsellors. In many cases, these peer counsellors could make valuable contributions to the T&R process as they had walked the path and very often are considered by drug abusers to be better able to empathise with them. Through helping others, peer counsellors could also build up their own confidence and strengthen their own resolve to continue to stay away from drugs. While there has been positive feedback on the work of peer counsellors and the important role they could play in the rehabilitation process of PSAs, there has been no systematic training hitherto for them.

4.19 The ELCHK, in collaboration with the Employee Retraining Board, has recently developed a new course entitled "Foundation Certificate in Peer Counsellor Training", providing 200 hours of training in counselling skills, activity organisation, emergency handling, personal growth, as well as internships in anti-drug agencies. In 2015, two classes of 18 students each will be run. It is expected that the anti-drug sector should be able to absorb all the graduates. The first class started in late May 2015. We encourage the organiser and other relevant agencies to monitor feedback on the course and its outcome in considering the needs for peer counsellors' training, and the possible development of services by peer counsellors in the longer term.

4.20 Apart from peer counsellor training, service providers should continue to develop and implement other types of vocational training, job placement programmes and job counselling services for their clients. These kinds of programmes and services can, not only equip rehabilitees with various knowledge and skills, but also help them to identify their goals and facilitate their reintegration into society.

Drug Abusers of Ethnic Minorities

4.21 Ethnic minorities usually have their specific cultural characteristics, including language, customs and sometimes communities. In Hong Kong, some NGOs provide support services for certain ethnic minority groups. Some of these organisations also provide services for those who are drug abusers. In general, service providers should have the cultural sensitivity

in serving ethnic minority clients, and may also seek funding support from the BDF, where appropriate. The Government and the anti-drug sector can explore closer partnership with organisations which have more contact with ethnic minorities in preventive anti-drug work at the district level.

II. *Promoting a Better Interface between Different Services*

4.22 Having regard to the increased prevalence of psychotropic substances and the changes in the demographic characteristics of drug abusers over the past few years, the sector in general agree that service needs of drug abusers have become more multifarious and complex. Drug abusers now have a longer drug history when they first surface in the help network, meaning that they may already be suffering from serious or even irreversible bodily and brain damage when the T&R services start to reach them. In addition, the increase in the proportion of PSAs in their young adulthood also suggests that more service users would have their own families and children, and may have a job which they need to preserve. Their drug-taking behaviour for sure will have taken its toll on the families involved, and may be more difficult to tackle because of the problem in staying away from work for long. Many frontline workers are facing the challenge of not just handling their clients' physical discomfort or bodily dysfunction but also, very often, the psychiatric symptoms such as hallucination, depression, paranoid delusions and mania. Such cases invariably call for multi-disciplinary intervention, involving different T&R services and medical professionals.

Social service sector and medical professionals

4.23 Over the past few years, CCPSAs, YOTs, YNDs and SACs have already established closer linkage for cross-referral of cases. The continuous prevalence of psychotropic substances and the increasing popularity of "Ice" abuse among PSAs suggest that the social services sector and SACs/psychiatric departments in hospitals/clinical psychologists need to work more closely together in the next three years. Service providers should enhance communications with SACs and other relevant agencies to project caseloads, conduct better resource planning, and streamline the

work flow in order to provide comprehensive services for drug abusers with psychiatric disorders.

4.24 We have seen close collaboration between the social services sector and the medical professionals, such as between CCPSAs and SACs, or between DTRCs and SACs, in dealing with the health issues arising from psychotropic substance abuse. Within the system of HA, SACs have been providing one-stop service to help refer patients with other health problems to specialist departments (e.g. urological department), if needed. We encourage continuous collaboration in this respect.

4.25 Some medical professionals have pointed out that because of the prevalence of psychotropic substance abuse, especially "Ice", a higher proportion of drug abusers were observed to have symptoms of psychiatric disorders and were in need to be hospitalised. The Accident and Emergency (A&E) departments of the public hospitals may increasingly become the first point of contact with cases suffering from acute drug-induced symptoms.

4.26 Currently, when someone with drug history is admitted to the A&E department and presents psychiatric symptoms that warrant intervention, doctors in the A&E department would consult the respective psychiatric consultation liaison team in the hospital. The team would provide support including making referrals to SACs or inpatient service. For urgent psychotic cases, the team would give immediate treatment and arrange follow-up as necessary, e.g. admission to the hospitals. However, many patients are known to have low incentive to seek further help after the brief treatment at the A&E department where their acute pain may have been relieved. We encourage relevant parties to further explore new cooperation modes which would enable drug abusers who have surfaced in the A&E departments to be linked up with the help network, including SACs, CCPSAs or where appropriate, YOT/YND teams, and be followed up as early as possible. We also encourage relevant parties to try out pilot projects for the provision of psychiatric assessment to those with known drug-abusing history but not showing psychiatric symptoms upon admission to the A&E departments.

4.27 For the OSMSS provided in CCPSAs, we are mindful that some CCPSAs have experienced genuine difficulties in recruiting Registered Nurse (Psychiatric) (RN(Psy)) to deliver the services due to the limited supply

of RN(Psy) in the job market and the relatively less attractive prospect for a single RN(Psy) working in an NGO setting. On the premise that the quality of OSMSS is not adversely affected, SWD has given and will continue to allow greater flexibility for CCPSAs to deal with the recruitment difficulties encountered. In the event that RN(Psy) cannot be recruited, we encourage the CCPSAs concerned to seek training from SACs or other relevant medical professionals for their staff where necessary.

Community-based and residential drug treatment services

4.28 The collaboration between community-based and residential drug treatment services is of equal importance. In particular, community-based services including CCPSAs and YOT/YND teams should continue to encourage their cases to receive more intensive T&R services in residential settings when the circumstances are appropriate. Similarly, the residential services could also work together with the community-based service units which could provide aftercare service when the cases have completed the residential T&R programme. We will continue to provide suitable platforms for experience sharing and exploring ideas on collaboration. We also encourage service providers to maintain other effective communication channels and networks of their own.

Better integration of services and division of labour

4.29 There is room to examine if the role of each service can be more clearly delineated. For example, we note comments that the outreaching services of CCPSAs may, to a certain extent, overlap with the services provided by the YOT/YND teams in the same district. We understand that in some districts the CCPSAs and the YOT/YND teams have joined hands in identifying potential drug users and we encourage such cooperation where possible. We also note comments that the preventive education by CCPSAs at schools could be further adjusted[5] as the Government has in

[5] For preventive education work, CCPSAs have already been allowed flexibility in deploying the resources in serving secondary school students to provide PE&P programmes for PSAs at work sites in the last FSA review in 2013. CCPSA is required to serve 80% of the total number of schools in their catchment area. If a CCPSA has attained 70% of the school served, it can replace the remaining 10% of schools with an equivalent number of work site served with drug preventive programme(s).

general strengthened preventive education and publicity in the past years, in particular, those targeting schools, e.g. through school talks by NGOs, the HSP(DT) and interactive drama (on pilot). CCPSAs have the expertise in dealing with complex drug cases and they should be allowed to focus more of their energy and manpower in this respect. We would take these comments into account in future reviews of the FSAs of CCPSAs.

4.30 With an increasing proportion of drug abusers falling into the age of young adulthood (21 to 30 years old) or older, as well as the decline in the number of young people in Hong Kong in general, some have commented that the service range provided by YOT/YND teams should be reviewed. According to the prevailing FSAs, the clientele of YOT/YND teams cover children and youth aged 24 or below. Many of the cases of the YOT/YND teams were handled when the clients were below 24. However, some of them have now grown beyond the age of 24, hence outside the service scope of these teams. We encourage service units to refer cases to, say CCPSAs, and/or to consider other follow-up mechanisms to promote a continuum of services for this kind of clients. Relevant service providers are encouraged to further explore the most effective ways to handle these cases that would be in clients' best interest.

<u>Social service sector and law enforcement agencies (LEAs)</u>

4.31 For young offenders of drug-related offences, additional resources have been provided since 2013 to extend the EPS to the seven Magistracies throughout the territory for three years till 2016. We will consider the way forward of the EPS in view of the availability of resources and the experience gathered in these few years.

4.32 In addition to the EPS and CSSS, some police districts have established referral mechanisms to introduce young suspects/delinquent youth to social workers. The aftercare services provided by the relevant agency can help improve the behaviour of these young people and minimise relapse and reconviction. We are mindful that many social workers may want to distance themselves from police enforcement action in order to maintain a neutral position before their clients. However, there should be room for LEAs and social workers to forge collaboration and develop suitable workflow so that both can effectively perform their functions.

We encourage the sector to continue to explore means to build up trust and foster closer collaboration with LEAs.

III. *Early Identification of Hidden Drug Abusers*

4.33 The Government has stepped up publicity to promote help seeking by hidden drug abusers and enhanced the 24-hour "186 186" helpline service and the instant messaging service of "98 186 186". We encourage the sector to continue to explore ways to identify and reach out to hidden drug abusers. As previously noted, support to family members of drug abusers has been found to be effective in the identification of drug abusers. Service providers should continue to support and empower family members to stay alert to drug-abusing behaviour around them and also help to impart in them skills for motivating the drug-abusing family member to seek help. Some frontline outreach social workers have also encouraged clients to bring along their drug-abusing friends to attend some group activities ("peer snowballing") so that the social workers can come into contact with them and offer assistance, if needed.

4.34 Some service agencies are conducting trial home visits with a view to identifying drug abusers in the community or running trial schemes for support groups for parents of those drug abusers who refuse help of any form. For example, with BDF's support, the HKLSS has launched a project to enhance community awareness of the drug abuse problem, including conducting home visits to provide counselling service for family members of drug abusers and enhance their skills to tackle the drug abuse problems in their families. Some have also expressed the view that home visits by medical professionals (e.g. nurses), together with social workers, could be explored to assist drug abusers with physical or mental health issues. We encourage more service agencies to pilot on home visits so that more data could be gathered for assessing their effectiveness.

4.35 The Government will also continue with the study on the RDT as an additional tool to tackle the hidden drug abuse problem. In particular, we are examining the possible triggering and follow-up mechanisms which could effectively balance giving a chance of non-prosecution to the drug abuser but mandating counselling and treatment. We are fully aware that

during the first-stage public consultation, some stakeholders had raised concerns about the possible infringement of human rights and civil liberties arising from the drug testing process. We are also conscious that some stakeholders have been keen to see the Government's proposal for aftercare service for those identified to have abused drugs in the event of introducing the RDT. We will continue to engage stakeholders, including those in the anti-drug sector and professional bodies, in ongoing discussions and identify ways to address their concerns. In addition, we are working on the development and validation of test kits for rapid oral fluid test, which could give an instant objective indication of drug testing results on the spot.

IV. *Minimising Relapse and Facilitating Reintegration into Society*

4.36 The road to abstinence is very often lengthy and arduous and relapse is widely known to be a challenge to T&R services. The anti-drug sector should continue to explore and adopt effective measures to deepen services to sustain the effects of T&R programmes, minimise relapse and facilitate the reintegration into society of those who have successfully completed the T&R programmes. There is the added complication that PSAs who have suffered brain damage may need life-skill training by occupational therapists, on top of vocational training. In addition to counselling and treatment services, many service providers have developed and offered various kinds of educational and vocational training programmes to equip rehabilitees with the necessary tools for making a living after quitting drugs. Those who could be engaged in meaningful activities like employment or studying are better able to stay away from drugs although this is not the single determinant. We encourage service providers to continue along the direction of relapse minimisation, including exploring cross-agency partnership involving professional support such as occupational therapists as experimented in some BDF projects. We also encourage partnership with agencies providing education and/or vocational training services, as well as collaboration with trade associations and enterprises to offer job placement opportunities for rehabilitees.

V. *Other Support Measures*

4.37 Other support measures of equal importance include assistance to family members of drug abusers, training opportunities for anti-drug workers, as well as data collection and researches for monitoring the drug scene and drug trends by.

Family

4.38 Family members may suffer from distress and feel disoriented about handling the drug abuse problems of their loved ones. In recent years, many service providers are stepping up efforts in supporting family members of drug abusers, including offering counselling services, workshops as well as sharing sessions to foster mutual support among different families with similar background and problems. We encourage the sector to further explore opportunities for possible collaboration with other service units dedicated to family services, like IFSCs, ISCs or Integrated Community Centres for Mental Wellness (ICCMWs). If the emotional needs of family members can be taken care of, they can be in a better position to face and resolve the drug abuse problems in their families.

4.39 Family support services are also important for protecting the welfare of children of drug-abusing parents and preventing them from becoming victims of their parents' behaviour. We encourage anti-drug workers to offer more counselling to the parents to help relieve emotional distress and enhance parenting skills with a view to minimising the chance of inter-generational drug abuse problems.

4.40 Multidisciplinary intervention is necessary. We encourage anti-drug workers to establish closer linkage with relevant service units, e.g. public hospitals, Maternal and Child Health Centres (MCHCs), for monitoring the growth and development of the children of drug-abusing parents. This enables early detection of any problems and timely intervention by the professionals.

Residential Drug Treatment Centres

4.41 Residential drug treatment centres constitute an important component of T&R services. At present, 15 out of 39 DTRCs have yet to obtain licences under the Drug Treatment and Rehabilitation Centres (Licensing) Ordinance (the Ordinance) and are operating on certificates of exemption. Many of the DTRCs in question are non-subvented and had been established before the Ordinance came into effect. In an effort to fully meet the design and safety standards, DTRCs in general would attempt to seek in-situ upgrading or redevelopment. Some would require relocation to new sites due to insurmountable difficulties at the existing sites, such as land use planning issues, unclear land titles or problem in securing continued use of the site with land owners. In addition to funding support through BDF, the Government will continue to assist DTRCs which need in-situ upgrading or relocation in areas such as identifying new sites, going through local consultation and/or project planning.

Training and Experience Sharing

4.42 Feedback from many frontline social workers and doctors suggests increasing difficulties to handle cases with drug-induced psychiatric symptoms. For example, some outreach workers of YOT/YND teams have shared that they had occasionally experienced difficulties in light of the complexity of the cases. Some social workers from CCPSAs have also revealed that they need to devote more time and energy to each case, as more and more of their clients are beginning to experience complex health problems and display psychiatric symptoms. We encourage more sharing among social workers and anti-drug workers, especially by those who have more experience in handling PSA cases. This would be an effective way of equipping frontline workers with the relevant knowledge and skills in tackling such cases. We also encourage more experience sharing between anti-drug workers and those in the other streams of social services, such as IFSCs, ISCs, ICCMWs and MCHCs, to help foster a better understanding of the needs of clients with drug problems.

4.43 We also encourage local universities and education institutions to continuously 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.

Monitoring of Drug Scene

4.44 We need to continue to monitor the drug scene and drug trends in Hong Kong to support evidence-based policy formulation. The CRDA has since 1972 been keeping statistics of drug abusers. The system remains the most comprehensive source of data of its kind and is the only source of statistics capable of reflecting the general trends of drug abuse in Hong Kong over the years. It provides a useful reference for the Government and for the anti-drug sector as to where to focus anti-drug strategies, resources and initiatives. Some agencies have opted not to report the information to the CRDA on the ground of safeguarding client identity and privacy. We wish to emphasise that personal data in the CRDA is protected by law and there are stringent security measures to prevent disclosure to third parties. We appeal to service providers for their timely and accurate report of data to the CRDA. ND will continue to organise briefings/seminars to familiarise reporting agencies, including their frontline workers, with the use of the CRDA and advise them of the safeguards which have been built into the system to protect the privacy of reported drug abusers. We also encourage service units to continue to use the SIS to collect more comprehensive data on their own cases for more effective monitoring of their progress.

VI. ***Measures Beyond T&R Services***

4.45 T&R as one of the five-pronged anti-drug strategies should work in complementarity with the other four prongs, namely researches; preventive education and publicity; law enforcement; and international cooperation. The Government undertakes to continue to combat drug abuse in a holistic manner.

Researches

4.46 Apart from data collection and analysis, we will continue to sponsor, through the BDF, researches on drug-related issues and intervention modalities. We suggest focusing on the following three areas in the coming three years. First, we should continue to promote researches on the characteristics of psychotropic substance abuse to gain more understanding about the drug harms and to identify suitable treatment methods. In particular, we encourage research studies looking into the nature and harmful effects of psychotropic drugs which have gained prevalence in Hong Kong. Secondly, we encourage researches on the behavioural patterns, including relapse patterns, of different groups of drug abusers (e.g. female drug abusers, pregnant drug abusers, working drug abusers, drug abusers of ethnic minorities, etc.). Thirdly, we encourage researches on the social return of the various anti-drug services and programmes, as well as the social costs of drug abuse (e.g. the differential in social costs between early intervention by the help network and intervention at a substantially later stage). The findings from these researches, if available, could shed light on the priorities of our anti-drug measures.

4.47 Undoubtedly, the ultimate goal of all T&R services should be the drug abusers' complete abstinence from drugs. Many drug abusers, however, have low incentive to seek help or even consider that drug taking is a matter of personal choice. Instead of demanding the immediate quitting of drugs, some anti-drug workers point out that it is necessary to adopt harm reduction means to engage and establish rapport with clients. While we recognise that harm reduction can be an effective tool to engage drug abusers when the social workers first come into contact with the cases, thereby providing an avenue for enhancing their clients' awareness of drug harms and ultimately working out the drug quitting plans, harm reduction should not be regarded as the ultimate goal of T&R programmes. We believe that anti-drug workers should work towards the goal of helping the drug abusers to completely quit drugs.

4.48 There are comments that the Government should be more tolerant of the concept of harm reduction in our anti-drug policy, and promote the wider adoption of harm reduction in T&R. We need to point out that harm reduction is not a new concept. It has long been practised, the best example being the MTP. MTP is a treatment programme for opioid

abusers, aiming to provide them with a legal, affordable, safe and effective way to break their addiction to the opioid, and lead a normal life. Methadone has been proven to be effective in controlling the withdrawal symptoms induced by opioid, hence removing their need to use heroin. However, on psychotropic substance abuse, there is still a lack of accepted international practice. Neither are there proven safe substitutes to the many psychotropic substances which, on the contrary, have been proven to have their toll on the health of abusers. We should be very cautious in considering harm reduction in the context of tackling psychotropic substance abuse.

4.49 Through previous researches and trials, some treatment protocols have already been proven to be effective in handling drug-induced problems. For example, some clinical studies have evaluated and verified the effectiveness of certain medication or treatment protocols for patients with ketamine-induced urological problems. Other studies have proven that abstinence from ketamine is essential for more effective treatment and better recovery of bladder functions. We encourage research/project teams to publicise, share and promote the wider adoption of their proven methods in the anti-drug field. They can also organise experience sharing sessions for peer agencies.

4.50 ND will continue to provide suitable platforms (e.g. through the DLC, thematic seminars, exhibitions, etc.) for the sharing of useful research findings and best practices among service providers. We welcome views from the sector on any other means to share such research findings and best practices. We have also uploaded the findings of BDF-funded research projects to our website for reference by interested parties. Where appropriate, ND will share the relevant research findings with policy makers (including HA).

Preventive Education and Publicity (PE&P)

4.51 T&R and the other fronts under the five-pronged anti-drug strategy (i.e. preventive education and publicity, legislation and law enforcement, external co-operation and research) are complementary to each other and mutually reinforcing. For example, preventive education and publicity can complement the work of T&R by enhancing the community's vigilance against the drug problem, reducing potential drug abuse cases

and helping to promote early help seeking by drug abusers, hence facilitating more timely intervention, and reducing pressure on downstream T&R services.

4.52 Our upcoming PE&P campaign will continue to promote public awareness of the drug abuse problems, in particular, facilitating early identification of drug abusers. This will include encouraging drug abusers to seek help through the 24-hour helpline "186 186", and instant message service "98 186 186". The Government would also continue to promote community acceptance of treatment facilities through our publicity efforts.

4.53 Young people being exploited in drug trafficking activities remains a major concern in light of the potentially serious consequences. While LEAs will continue to guard closely any such activities, there is a need to continue to step up efforts on the PE&P front to correct misguided beliefs that young people are less criminally culpable than adults when involved in drug-related offences.

4.54 The school is an equally important platform for drug prevention work among young people. The Government will continue to arrange suitable anti-drug training for teachers and students. We will also continue to promote the HSP(DT) as a school-based PE&P initiative aiming at fostering a drug-free culture in schools. Efforts to progressively roll out the HSP(DT) to more secondary schools will continue. We are also planning to conduct an independent evaluation research in the 2015/16 school year to assess the overall effectiveness of such programme and identify areas for improvement.

4.55 We will also continue to involve the community in programmes, such as the ACAB, in promoting community awareness of drug-related issues, in particular, in facilitating early identification of drug abusers.

Law Enforcement

4.56 Similarly, law enforcement can effectively curb the supply of drugs and deter drug abuse behaviour. Effective law enforcement is an important key to combating drug trafficking activities. LEAs will continue the strategy of targeting drug supply at source through stemming illegal

import of dangerous drugs, strengthening the patrol of targeted drug abuse black spots and adopting vigorous control measure at various control points to curb transnational drug trafficking activities.

4.57 LEAs will also reinforce their liaison and intelligence exchange with Mainland and international counterparts, and carry out joint operations as and when appropriate.

International Cooperation

4.58 The growing predominance of psychotropic substance abuse and the continuous emergence of new synthetic drugs pose new challenges to legislative control and law enforcement globally. We will remain vigilant in closely monitoring the drug trends both overseas and locally and will take timely action to bring new drugs under legislative control. We will endeavour to keep drug-related crimes under control, as well as to prevent a resurgence of the drug problem, which brings major social, economic and personal costs.

VII. *Concluding Remarks*

4.59 The T&R services involve many different service modes catering for the varying needs of drug abusers, as well as that of their families. The formulation of the Three-year Plans has provided us with a valuable opportunity to be in extensive engagement and dialogue with different service providers and stakeholders, as well as drug abusers. The Three-year Plans are the fruit of this consensus-building process. We deeply appreciate our partnership with the anti-drug sector and the relevant parties all along.

4.60 This Seventh Three-year Plan sets out the strategic direction of the T&R services in the coming three years, and service providers can review and develop their action plans and programmes accordingly. We would like to thank all parties again for candidly sharing their experience and views. We look forward to continuous close collaboration in future.