Caritas Lok Heep Club
and
Department of Applied Social Sciences
The Hong Kong Polytechnic University

THE HONG KONG
POLYTECHNIC UNIVERSITY
香港理工大學

Resource Package of Certificate Course in Drug Treatment & Rehabilitation 2011

Foreword

This package is produced to record the running of the Certificate Course and provide reference for future course organizers. I am grateful to all the speakers of the lectures who not only participated but agreed to let us list out the lecture materials. Apart from the contents of the lectures, the publicity pamphlet, a sample of the Certificate, the list of participants who got the certificates, as well as information on the requirements of the course are listed. It is hoped that there are other agencies which will run similar courses in the future as there is a high demand on such training.

I would like to express my heartfelt gratitude to the following parties and friends:
Beat Drugs Fund Association which provided sponsorship,
Prof Daniel Shek of Department of Applied Social Sciences, The Hong Kong Polytechnic University who co-organised the course with Lok Heep Club and delivered a lecture, Dr Rosanna Cowan who flew back from England to deliver 4 lectures, Dr Lo Chun Wai, Mr Kong Chung Yau, Dr Tse Man Li, Mr Water Lai, Miss May Ngai, Mr Eric Siu, Dr Leung Shung Pun, and representative from the Government Laboratory who delivered lectures.

David Cheung
Supervisor
27 January 2012

Content

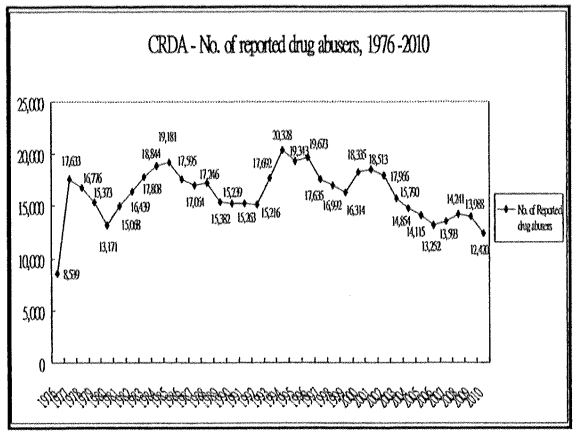
Session	Topic	Trainer	Date
1.	**吸毒的趨勢及理論** 1A：Powerpoint file by David Cheung (The Trends of Drug Abuse & Drug Policy) 1B：Powerpoint file by David Cheung (World drug trend) 1C：Powerpoint file by Dr Lo (Various Forms of Addiction) 1D：Reference	David Cheung & Dr Lo Chun Wai	8/9
2	**藥物濫用、治療及驗毒相關之法律、中國禁毒法** 2A：Powerpoint file by Mr. Kong (吸食毒品的禍害、檢測和刑事責任)	Lawyer Mr Kong Chung Yan	8/9
3.	**香港多元化的戒毒治療及匹配服務** 3A：Powerpoint file by David Cheung (The UK Models of care for treatment of adult drug misusers) 3B：Reference--香港為吸毒者而設的治療及治療服務分級多模式架構(二零一零年十二月，第一版) 3C：Reference--Treatment Outcomes Profile(TOP) 3D：Reference--持牌自願性質的住院式戒毒中心及中途宿舍名單	David Cheung	15/9
4.	**藥物濫用做成的傷害** 4A：Powerpoint file by Dr Tse Man Li (Harm of Psychotrophic Substance)	Dr Tse Man Li	15/9
5.	**British Drug Policy and Present situation in Harrow** 5A：Powerpoint file by Dr Rosanna Cowan (Review of Treatment Effectiveness and the Implication on service commissioning and development in England - A Case Study in Harrow)	Dr Rosanna Cowan	22/9
6.	**A review of the Effectiveness of drug and alcohol treatment in England** 6A：Powerpoint file by Dr Rosanna Cowan (British Drug Treatment Policy and its Implementation)	Dr Rosanna Cowan	22/9

7.	**Addiction and offender Management policy in England** 7A：Powerpoint file by Dr Rosanna Cowan (Addiction and offender Management policy in England)	Dr Rosanna Cowan	6/10
8.	**Mobilizing resources-writing Proposals** 8A：Powerpoint file by Dr Rosanna Cowan (Mobilizing Resources by Writing Funding Proposals: the Essentials)	Dr Rosanna Cowan	6/10
9.	**吸毒者家人服務及互累症** 9A：Powerpoint file by Water (吸毒者家人服務及互累症) 9B：Powerpoint file by Water (有關家人之研究) 9C：Powerpoint file by Water (互累症) 9D：Powerpoint file by Water (Satir 不同家庭角色的輔導需要) 9E：Reference--個案討論 9F：Reference--Codependency test pack	Mr Water Lai	13/10
10.	**實證為本服務及研究工作** 10A：Powerpoint file by Dr Shek (Evidence Based Practice and Research Work) 10B：Powerpoint file by Dr Shek (Quantitative vs. Qualitative Research Designs) 10C：Reference	Daniel TL Shek, PhD	20/10
11.	**預防重吸及動機式晤談法** 11A：Powerpoint file by May (Therapeutic Community) 11B：Powerpoint file by May (Relapse Prevention) 11C：Reference -- Incident sheet 11D：Reference --戴托普信條 11E：Reference -- Relapse Prevention 11F：Powerpoint file by Water (動機式晤談法訓練) 11G：Reference --Effective Elements of Brief Intervention 11H：Reference --濫用藥物境況測量表	May Ngai & Mr Water Lai	20/10

12.	**靈性治療及同輩輔導** 12A：Powerpoint file by Eric Siu (靈性治療及同輩輔導) 12B： Powerpoint file by Eric Siu (福音戒毒治療綱要) 12C：Reference --得基輔康會(恩慈之家事工點滴一、二) 12D：Reference --詩歌 (奇異恩典) 12E：Reference	Mr Eric Siu	27/10
13.	**藥物測試及藥物濫用的評估** 13A：Powerpoint file by 政府代驗所 (Forensic Drug Testing of Biological Specimens) 13B：Powerpoint file by Dr S P Leung (Assessment of drug/alcohol abusers) 13C：Reference	政府代驗所 & Dr S P Leung	3/11
14.	**改進參與治療的合作性及降低損害** 14A：Powerpoint file by David Cheung (降低損害的概念) 14B：Powerpoint file by David Cheung (提昇接受治療者的合作) 14C：Powerpoint file by David Cheung (Improving Treatment Compliance) 14D：Powerpoint file by David Cheung& May Ngai (The role of coercion in drug treatment-Probation Order maker a difference)	David Cheung	3/11

The Trends of Drug Abuse & Drug Policy

David Cheung
8 September 2011
Certificate Course in Drug Treatment Work
Caritas Lok Heep Club



Trends of Drug Abuse in HK

How to trace the trends:
Please think and suggest methods

Trends in HK: please refer to our newsletter
The Horn 40th Anniversary Issue*, centre page

Other possible means

- Census
- Multiplier: Police, treatment
- Capture – Recapture
- Others

Trends

- According to CRDA which was set up in 1972 – the overall trend

www.nd.gov.hk

- According to School Surveys, figures on students only

6 surveys from1987/88 to 2004/05, last one carried out in 2008/09

World drug trends

According to World Drug Report 2011*, UNODC (free download from the UN page)
Terms: illicit users, problem drug users
Facts:
4 types of drugs:
Cannabis; ATS; Opioids; Cocaine
Trends in 2009:
Decrease in heroin and cocaine use offset by increase in synthetic and prescription drug use

2009

HIV 17.9% among IDU (injecting drug users)
HCV 50% among IDU
Deaths: 104 ~ 263K
Production:
Poppy: Afghanistan stable; Myanmar ↑ 20%
Coca cultivation ↓ 18%
Colombia ↓ offset Peru & Bolivia ↑
ATS & Cannabis production difficult to estimate

Drug Policy in Hong Kong

1. Law Enforcement
2. Treatment and Rehabilitation
3. Preventive Education and Publicity
4. Research
5. International Cooperation

www.nd.gov.hk

~~(Harm Reduction)~~

Heroin Prices

Afghanistan	1g = US$4
West & Central Europe	US$40-100
United States	US$170-200
Australia	US$230-370

Afghanistan farmers got US$0.44 bn
While the global amount was US$68bn

Other reference

- Swiss Four Pillars Policy

1. Prevention
2. Therapy
3. Harm Reduction
4. Enforcement

(Paper available)*

- UK Drug Policy

(Dr Cowan will cover the topic)
Analysis available*

A Century of International Drug Control

- A chapter of World Drug Report 2008*

Separate ppt file
Policy trend:

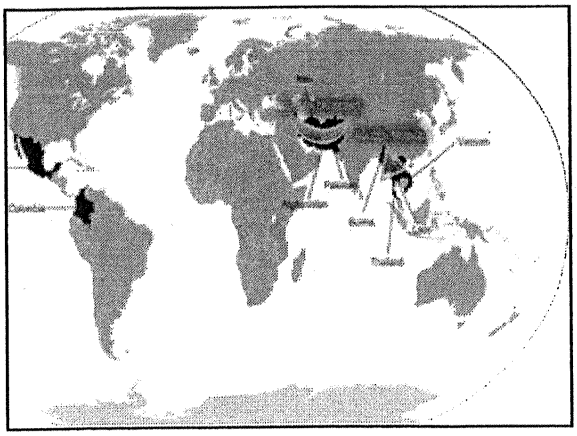
1. From Supply control in own country
2. to international cooperation in supply control
3. to demand control – treatment needs
4. To harm minimization and
5. Against money laundering and organized crime

Debate: Drug War vs Decriminalization

Reference: War on Drugs not Working*;
according to Guardian
Paper available

- The **Golden Triangle** is one of Asia's two main illicit opium-producing areas. It is an area of around 367,000 square miles (950,000 km2) that overlaps the mountains of four countries of Southeast Asia: Burma, Vietnam, Laos, and Thailand. Along with Afghanistan in the Golden Crescent and Pakistan, it has been one of the most extensive opium-producing areas of Asia and of the world since the 1920s. Most of the world's heroin came from the Golden Triangle until the early 21st century when Afghanistan became the world's largest producer.1

Source: *http://en.wikipedia.org/wiki/Golden_Triangle_(Southeast_Asia)*



World drug trend according to 2008 World Drug Report

United Nations
Office on Drugs and Crime

1961 Single Convention on Narcotic Drugs

- A major achievement in the history of intern'l efforts to control narcotics
- Today, one of 3 treaties that define the intern'l drug control system.
- The other two are the 1971 Convention on Psychotropic Substances and the 1988 UN Convention vs Illicit Traffic in Narcotic Drugs and Psychotropic Substances.
- As of March 2008, 183 parties, 95% of the 192 UN States Members

1. Trends in the World Markets

- Overview
- Opium/heroin market
- Coca/cocaine market
- Cannabis market
- Amphetamine-type stimulants (ATS) Market

1961 Single Convention on Narcotic Drugs

Consists of 51 articles, covering:

- Definitions of the substances under control;
- The framework for the operations of the intern'l drug control bodies;
- reporting obligations of States Members
- Obligations regarding the production, manufacture, trade and consumption of controlled substances
- Actions to be taken against illicit traffic and penal provisions

2. A Century of International Drug Control

- 1909 Shanghai Opium Commission
- 1961 Single Convention on Narcotic Drugs
  (1961年麻醉品單一公約)
- 1971 Convention on Psychotropic substances
  (1971年精神藥物公約)
- 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic substances
  (1988年禁止販運麻醉品和精神藥物公約)

1961 Single Convention on Narcotic Drugs

- Key Provision found in Article 4:
- The parties shall take such legislative and administrative measures ... to limit exclusively to medical and scientific purposes the production, manufacture, export, import distribution of, trade in, use and possession of drugs.

1961 Single Convention on Narcotic Drugs

3 objectives:

1. Codification of existing multilateral treaty laws into one single document;
2. Streamlining of the intern'l drug control machinery;
3. Extension of the existing controls into new areas.

1971 Convention on Psychotropic Substances

- Parties mast also take, according to Article 20,1 "measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved.

1971 Convention on Psychotropic Substances

- For the first time a no. of amphetamine type stimulants, Hallucinogens (such as LSD), sedative hypnotics and anxiolytics (benzodiazepines and barbiturates), analgesics and antidepressants are placed under control.
- A significant no. of additional substances were added in subsequent decades

It was a major step ahead for intern'l drug control

1971 Convention on Psychotropic Substances

- Introduce a system of licensing for manufacture, trade and distribution.
- Maintain a system of inspection of manufacturers, exporters, importers, wholesalers, distributors and medical and scientific institution.

1971 Convention on Psychotropic Substances

- Again, as of March 2008, 183 countries were party.
- The parties agreed that all listed substances only be supplied with a medical prescription, no advertisement to the general public.
- Appropriate cautions and warnings added on labels and leaflets.

1971 Convention on Psychotropic Substances

Schedule I: MDA, MDMA

Schedule II: amphetamine-type stimulants, including methamphetamine, amphetamine, methylphenidate and fenerylline, Phencyclidine, methaqualone and secobarbital.

Schedule III: barbiturates, flunitrazepam, buprenorphine, pentazocine

Schedule IV: diazepeam, phenobarbital

1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

- A powerful instrument in the international struggle against drug trafficking. As of March 1008, 183 parties.
- Obliges parties to make trafficking activities a "criminal offences," instead of "punishable offences" in the 1961 Convention.
- Unique in its focus on the prevention of money laundering.

4. Methodology

- SOURCES OF INFORMATION
- Sources and limitations of data on the supply side
- Sources and limitations of data on consumption

1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

- A major achievement: establishing precursor control at the intern'l level
- Tends to promote the concept of extradition
- Endorsement of "controlled deliveries"
- Addresses the concept of alternative development
- Requires Parties to adopt appropriate measures to eliminate illicit demand for narcotic drugs and psychotropic substances

Indirect methods to measure problem drug use

- *Treatment multiplier*
- *Police data multiplier*
- *Capture-recapture* models
- use of *multivariate indicators*

3. Statistical Annex

- 3.1 Production
- 3.1.1 Afghanistan
- 3.1.2 Bolivia
- 3.1.3 Colombia
- 3.1.4 Lao PDR
- 3.1.5 Myanmar
- 3.1.6 Peru
- 3.2 Seizures
- 3.3 Seizures of illicit laboratories
- 3.4 Prices
- 3.5 Consumption

2008 World Drug Report

Please spend time to read this report in full and you would find your effort well paid off!

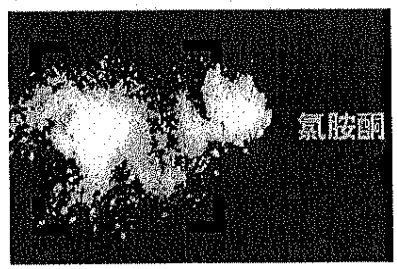
You may read this report on line or get a soft copy of it in PDF format

Certificate Course on Drug Treatment and Rehabilitation

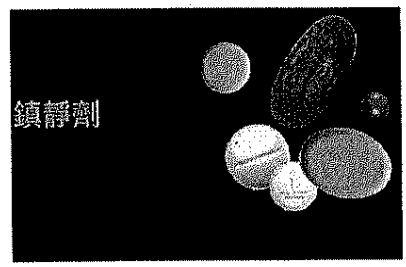
吸食毒品的禍害、檢測和刑事責任

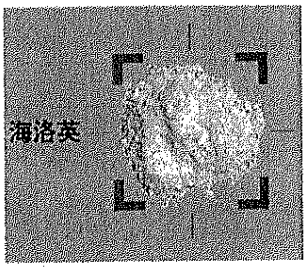
明愛樂協會
香港理工大學
合辦

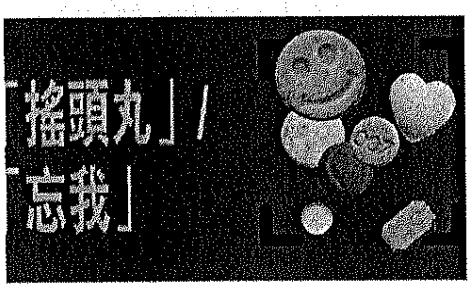
江仲有律師
9月8日

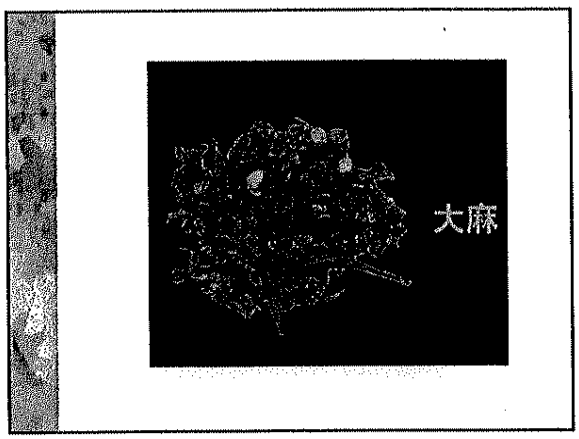


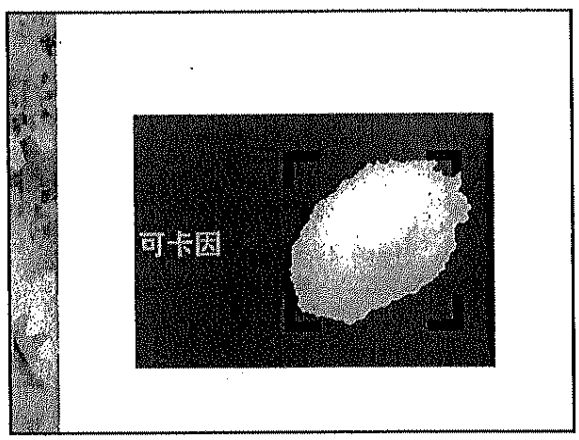
常被吸食的毒品種類

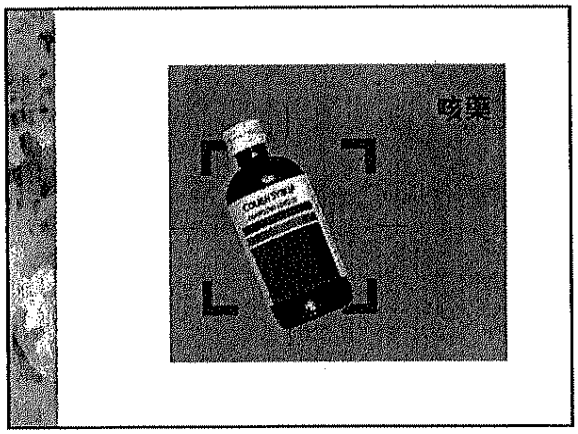


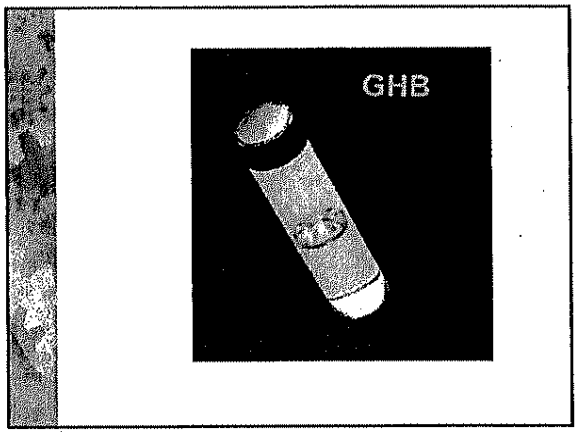


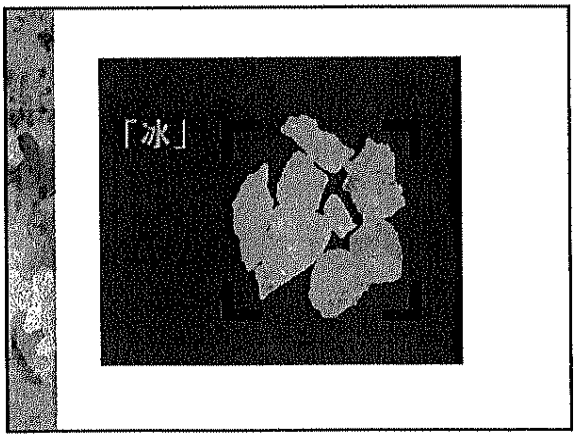


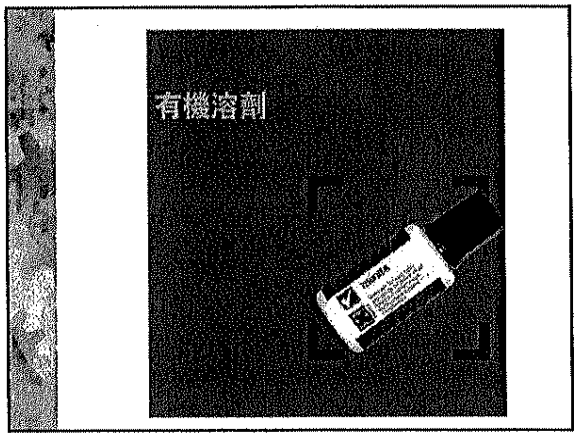

大麻


可卡因


咳藥


GHB


「冰」


有機溶劑

青少年首次吸食毒品原因

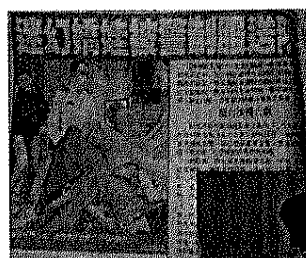
毒品類別 / 原因	海洛英	危害精神毒品
好奇	21.4%	34.9%
朋友影響	10.0%	15.4%
尋求刺激	12.0%	14.0%
逃避不開心	9.3%	10.4%
減輕壓力	3.4%	6.4%
提神	11.0%	2.7%
炫耀	6.2%	1.6%

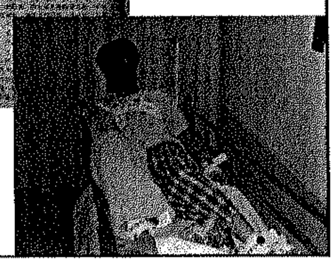
資料來源：
保安局禁毒處(2005)委託香港浸會大學：《二零零四年學生服用藥物情況調查》

吸食危害精神毒品的禍害

- 危害精神毒品會損害身體其他器官的功能，例如：氯胺酮或會對多項重要的身體機能產生不良影響，包括心血管、呼吸、神經肌肉、腸胃、生殖和免疫系統15。
- 經常吸食氯胺酮可導致嚴重的膀胱機能失調和腎功能受損，以致要不停上廁所，頻密程度可以是每15分鐘一次。
- 危害精神毒品可以令人上癮，造成生理依賴和心理依賴。
- 生理依賴可見於中斷吸食時所出現的斷癮症狀。
- 心理依賴則指無法控制吸食某毒品，以致要不斷和過量吸食。

吸食危害精神毒品的禍害





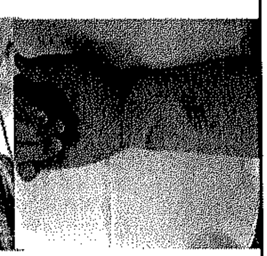
當你神志不清，

行為失控…

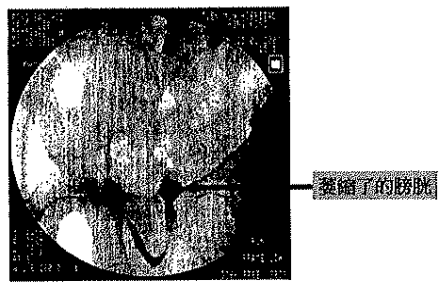
吸食危害精神毒品的禍害

- 吸食危害精神毒品對個人健康、家庭、社交生活、學業和工作表現均會造成很多不良影響。
- 危害精神毒品影響個人心智和精神健康，禍害可包括注意力不足、記憶力衰退、行動障礙、認知能力受損、抑鬱和產生幻覺等，也可能引致嚴重精神病。智力受損時，或會更易遇到意外和行為失常，不但危及自身的安全，其他人的安全也會受到威脅。

在自己的身體亂挖……



嚴重尿頻，因膀胱出現不能逆轉的纖維化



販運看來是危險藥物的物質
《危險藥物條例》第4A條

- (1) 任何人不得為其本人或代表不論是否在香港的其他人士—
- (a) 販運其表示或顯示為危險藥物，但事實上並非危險藥物的物質；
  (b) 提出販運其表示或顯示為危險藥物，但事實上並非危險藥物的物質；或
  (c) 作出或提出作出任何作為，以準備販運或目的是販運其表示或顯示為危險藥物，但事實上並非危險藥物的物質。

涉及毒品的法律、法規

除向獲授權或獲發許可證管有危險藥物的人供應外，不得供應危險藥物
《危險藥物條例》第5條

- (1) 任何人不得在香港向他人供應或為他人獲取，或提出向他人供應或為他人獲取危險藥物，除非—
- (a) 該他人根據本條例獲授權或獲發許可證管有該危險藥物；
  (b) 該危險藥物乃按照本條例供應或獲取者；及
  (c) 該人乃根據本條例獲發許可證管有危險藥物，而危險藥物乃按照其許可證的條件而供應或獲取者。

《危險藥物條例》Cap 134
第4條　危險藥物的販運

- (1) 除根據及按照本條例，或根據及按照署長根據本條例而發出的許可證外，任何人不得為其本人或代表不 論是否在香港的其他人士—
  - (a) 販運危險藥物；
    (b) 提出販運危險藥物或提出販運他相信為危險藥物的物質；或
    (c) 作出或提出作出任何作為，以準備販運或目的是販運危險藥物或他相信為危險藥物的物質。
- (2) 不論危險藥物是否在香港，或將進口入香港，或是否核確定、據有或存在，第(1)款均適用。
- (3) 任何人違反第(1)款的任何規定，即屬犯罪。

《危險藥物條例》第6條
危險藥物的製造

- (1) 除非根據及按照本條例，或根據及按照署長根據本條例而發出的許可證，並在該許可證所指明的處所內進行，否則任何人不得—
  - (a) 製造危險藥物；或
    (b) 作出或提出作出準備製造或目的是製造危險藥物的作為。

《危險藥物條例》第9條
大麻植物及鴉片罌粟的栽植及經營

- (1) 任何人不得栽植任何大麻屬植物或鴉片罌粟，但本款的規定並不妨礙政府化驗師為擔任其受僱職務的需要及以其職位的身分栽植大麻屬植物。（由1994年第62號第3條修訂）
- (2) 任何人不得為其本人或代表不論是否在香港的其他人士—
  - (a) 供應或獲取，或提出供應或獲取任何大麻屬植物或鴉片罌粟；
  (b) 以任何方式經營或處理，或提出或宣稱經營或處理任何大麻屬植物或鴉片罌粟；或
  (c) 將任何大麻屬植物或鴉片罌粟進口入香港或從香港出口，或作出任何作為，以準備該等進出口，或目的是該等進出口，不論該等大麻屬植物或鴉片罌粟是否在香港，或是否被確定、據有或存在。
- (3) 任何人不得管有任何大麻屬植物或鴉片罌粟，除非該大麻屬植物或鴉片罌粟是在過境途

《危險藥物條例》第40條
虛假陳述，及相應法律所訂罪行的協助、教唆等

- (1) 任何人如—
  - (a) 為著替本人或他人根據本條例獲發給或續發許可證或證明書，而作出在要項上屬虛假的聲明或陳述；
  (b) 明知而講述、出示或使用任何該等聲明或陳述或載有該等聲明或陳述的文件；或
  (c) 協助、教唆、慫使或促致在香港以外犯有根據當地有效的相應法律可懲處的罪行，或作出準備進行或推動進行一項行為的作為，而該項行為如在香港進行即構成第4或6條所訂的罪行，
- 即屬犯罪。

《危險藥物條例》第35 條
經營煙窟

- (1) 任何人不得開設、經營、管理或協助管理煙窟，即—
  - (a) 在煙窟中出售危險藥物以供人在其內吸食、吸服、服食或注射；
  (b) 就在其內吸食、吸服、服食或注射危險藥物收取費用或相等的價值；或
  (c) 該人由於他人在其內吸食、吸服、服食或注射危險藥物而直接或間接從中獲得任何利益或好處。

販毒(追討得益)條例
第405章第25條
處理已知道或相信為代表販毒得益的財產

- (1) 除第25A條另有規定外，如有人知道或有合理理由相信任何財產全部或部分、直接或間接代表任何人的販毒得益而仍處理該財產，即屬犯罪。

《危險藥物條例》第37條
擁有人、租客等的責任

- (1) 任何人不得—
  - (a) 身為任何場所或處所的擁有人、租客、佔用人或管理人，准許或容受該場所或處所或其任何部分，開設、經營或使用作為煙窟，或作非法販運或非法製造或儲存危險藥物之用；或
  (b) 明知該場所或處所或其任何部分將開設、經營或使用作為煙窟，或將作非法販運或非法製造或儲存危險藥物之用，而以主事人或代理人身分出租或同意出租該場所或處所。

罪行	說明*	罰則
《危險藥物條例》(第134章)第4(1)條	販賣毒品	(a) 經公訴程序定罪後，可處罰款$5000000及終身監禁；及 (b) 循簡易程序定罪後，可處罰款$500000及監禁3年。
《危險藥物條例》(第134章)第4A條	販運看來是危險藥物的物質	(a) 經公訴程序定罪後，可處罰款$500000及監禁7年；及 (b) 循簡易程序定罪後，可處罰款$100000及監禁1年。
《危險藥物條例》(第134章)第5(1)條	向非獲授權人供應或為其採辦危險藥物	(a) 經公訴程序定罪後，可處罰款$100000及監禁15年；及 (b) 循簡易程序定罪後，可處罰款$10000及監禁3年。

罪行	說明*	罰則
《危險藥物條例》(第134章)第6(1)條	製造毒品	循公訴程序定罪後，可處罰款$5000000及終身監禁。
《危險藥物條例》(第134章)第9(1)、(2)及(3)條	種植、供應、採辦、經營、輸入、輸出或藏有大麻屬植物或鴉片罌粟	5) 任何人違反本條的任何條文，即屬犯罪，循公訴程序定罪後，可處罰款$100000及監禁15年。
《危險藥物條例》(第134章)第35條	開設或經營煙格作吸毒用途	(a) 循公訴程序定罪後，可處罰款$5000000及監禁15年；及 (b) 循簡易程序定罪後，可處罰款$500000及監禁3年。

《藥劑業及毒藥條例》第138章第33條　罪行

- (1) 任何人違反第21、23、26、27或28條，即屬犯罪。
  (2) 如因僱員銷售、為出售而展出或供應毒藥或就僱員銷售、為出售而展出或供應毒藥而根據本條例對任何人提起法律程序，則—
  - (a) 不得以僱員未經僱主授權而行事作為免責辯護；及
  - (b) 僱員知道的任何重要事實須當作為僱主已知道者。

罪行	說明*	罰則
《危險藥物條例》(第134章)第37條	容許房產用作非法販賣、製造或貯存毒品用途	(a) 循公訴程序定罪後，可處罰款$5000000及監禁15年；及 (b) 循簡易程序定罪後，可處罰款$500000及監禁3年。
《危險藥物條例》(第134章)第40(1)(c)條	虛假陳述，及相應法律所訂罪行的協助、教唆等	2) 任何人如犯有第(1)(a)或(b)款所訂的罪行，經定罪後，可處罰款$10000及監禁3年。 (3) 任何人如犯有第(1)(c)款所訂的罪行，可處以下罰則— (a) 循公訴程序定罪後，可處罰款$100000及監禁15年；及 (b) 循簡易程序定罪後，可處罰款$10000及監禁3年。
《販毒(追討得益)條例》(第405章)第25條	處理已知道或相信為代表販毒得益的財產	(a) 循公訴程序定罪，可處罰款$5000000及監禁14年；或 (b) 循簡易程序定罪，可處罰款$500000及監禁3年。

其他毒品

- 雖然吸服溶劑或易揮發物品不屬違法，但若引致人身傷害或犯罪行為時，則警方有權干預。

《藥劑業及毒藥條例》第138章第34條　罰則

- 有些咳藥有第一類毒藥，如非法管有，均屬違法。
- 任何人犯本條例所訂的任何罪行，除非另有明文規定的罰則，否則一經定罪，可處罰款$100000及監禁2年。

中國《刑法》第347條

走私、販賣、運輸、製造毒品，有下列情形之一的，處十五年有期徒刑、無期徒刑或者死刑，並處沒收財產：

（一）走私、販賣、運輸、製造鴉片一千克以上、海洛因或者甲基苯丙胺五十克以上或者其他毒品數量大的；

（二）走私、販賣、運輸、製造毒品集團的首要分子；

（三）武裝掩護走私、販賣、運輸、製造毒品的；

（四）以暴力抗拒檢查、拘留、逮捕，情節嚴重的；

（五）參與有組織的國際販毒活動的。

走私、販賣、運輸、製造鴉片二百克以上不滿一千克、海洛因或者甲基苯丙胺十克以上不滿五十克或者其他毒品數量較大的，處七年以上有期徒刑，並處罰金。

中國《刑 法》第347條

- 走私、販賣、運輸、製造鴉片不滿二百克、海洛因或者甲基苯丙胺不滿十克或者其他少量毒品的，處三年以下有期徒刑、拘役或者管制，並處罰金；情節嚴重的，處三年以上七年以下有期徒刑，並處罰金。
- 單位犯第二款、第三款、第四款罪的，對單位判處罰金，並對其直接負責的主管人員和其他直接責任人員，依照各該款的規定處罰。
- 利用、教唆未成年人走私、販賣、運輸、製造毒品，或者向未成年人出售毒品的，從重處罰。
- 對多次走私、販賣、運輸、製造毒品，未經處理的，毒品數量累計計算。

香港特別行政區
刑事上訴案件
2006年第96號

中國《刑 法》第357條

- 本法所稱的毒品，是指鴉片、海洛因、甲基苯丙胺（冰毒）、嗎啡、大麻、可卡因以及國家規定管制的其他能夠使人形成癮癖的麻醉藥品和精神藥品。
- 毒品的數量以查證屬實的走私、販賣、運輸、製造、非法持有毒品的數量計算，*不以純度折算*。

香港特別行政區
訴
JARHIA KULDEEP SINGH
"SINGH"

一些司法案例/指引

案情

- SINGH藏有6.82克毒品"冰"
- 價值約HK$2,200

起點:
- 12-18個月監禁 十

潛著風險:
- 12個月

女皇
訴
羅耀生("羅")

判:

- 15+12(起點+潛著風險)
  =27個月監禁
- 認罪扣減1/3刑期
- 最後判18月監禁

案情:

警察突擊搜查廟街一家餐廳之宿舍，發現羅在吸毒，並有3條鎖匙及一份租約。

香港特別行政區
刑事上訴案件
1989年第600號

- 羅承認3條鎖匙是他的。
- 按租約上的地址，用了3條鎖匙開了門，發現正在製造毒品。

- 羅承認:-

1. 現場之毒品是他的;
2. 他住在該住所約6個月;及
3. 有6-7磅"3仔"及17磅"4仔"在牀下

香港特別行政區
刑事覆核案件
2006年第7號

上訴理由:

羅之律師稱羅只是看管場所不是製造人，24年刑期太長。

律政司
訴
許守城(“許”)

結果:

羅所犯之罪行極為嚴重，雖然他不是主腦，仍不獲減刑。

案情:

- 許於2007年因販運1.64公斤毒品"K仔"被判入獄7年4個月
- 律政司不服量刑指引過輕，提出覆核刑期，並要求上訴庭就毒品"K仔"及"搖頭丸"案件訂出新量刑指引

覆核理由:

- 據外國專家的分析，本港青少年吸食K仔的人數，在世界居「領先地位」
- 4名醫學專家證明服用K仔及搖頭丸會成癮及對身體構成損害，甚至導致死亡
- 自2004年至2007年初，已有19人因吸食K仔及搖頭丸導致死亡。當中年紀最輕只有13歲
- 1998年上訴庭基於搖頭丸不會上癮所作的判刑指引已不合時宜，必須作出修改

香港特別行政區 訴 吳 寶 林
及
香港特別行政區 訴 HONG Chang Chi

- 判決指引
  - 偷運毒品（ 不論數量多寡） 入境和出境應列為*加重刑罰*的因素， 以遏止毒販經常從內地偷運小量毒品入境的活動

結果:

上訴庭接納數據分析，決定就K仔和搖頭丸定下同一判刑指引，讓販運 1克或以上K仔和搖頭丸的毒販都必須判囚。

The Queen v Lau Chi Sing

- 律政司要求上訴法庭澄清：

"Whether I was correct in law in ruling that a person taking drugs out of Hong Kong with him for his own consumption is not trafficking in drugs within the meaning of Section 2 and 4 of the Dangerous Drugs Ordinance?"

"任何人帶毒品(自用)離境，並 構成販運毒品罪?"

- 判決指引："否定"（2對1決定）

販運K仔及搖頭丸的新舊量刑指引	
舊指引	
*販運毒品份量	判刑指引
25克或以下	沒有判刑指引
25克或以上至400克	監禁2至4年
400克至800克	監禁4至8年
800克以上	監禁8年或以上
新指引	
*販運毒品份量	判刑指引
1克或以下	沒有判刑指引
1克以上至10克	監禁2至4年
10克至50克	監禁4至6年
50克至300克	監禁6至9年
300克至600克	監禁9至12年
600克至1000克	監禁12至14年
1000克以上	監禁14年以上

內地現行毒品測試以及強制戒毒措施

現行毒品測試以及強制戒毒措施

- 在內地，《禁毒法》授權當局可要求涉嫌吸毒者提供尿液樣本作測試用途。若該人拒絕這項要求，當局可執行強制毒品測試。對毒品試劑呈陽性反應者，會被判罰款人民幣2,000 元和行政拘留10至15 天。
- 《禁毒法》並指明三種適用於吸毒者的戒毒措施，即自願戒毒、社區戒毒，以及強制隔離戒毒。
- 後二者均屬強制性質，公安機關可根據情況下令執行。

《禁毒法》第三十八條

- 吸毒成癮人員有下列情形之一的，由縣級以上人民政府公安機關作出強制隔離戒毒的決定：

（一）拒絕接受社區戒毒的；
（二）在社區戒毒期間吸食、注射毒品的；
（三）嚴重違反社區戒毒協議的；
（四）經社區戒毒、強制隔離戒毒後再次吸食、注射毒品的。

對於吸毒成癮嚴重，通過社區戒毒難以戒除毒癮的人員，公安機關可以直接作出強制隔離戒毒的決定。

吸毒成癮人員自願接受強制隔離戒毒的，經公安機關同意，可以進入強制隔離戒毒場所戒毒。

《禁毒法》第三十二條

- 公安機關可以對涉嫌吸毒的人員進行必要的檢測，被檢測人員應當予以配合；對拒絕接受檢測的，經縣級以上人民政府公安機關或者其派出機構負責人批準，可以強制檢測。

公安機關應當對吸毒人員進行登記。

香港現行毒品測試以及強制戒毒措施

《禁毒法》第三十三條

- 對吸毒成癮人員，公安機關可以責令其接受社區戒毒，同時通知吸毒人員戶籍所在地或者現居住地的城市街道辦事處、鄉鎮人民政府。社區戒毒的期限為三年。

戒毒人員應當在戶籍所在地接受社區戒毒；在戶籍所在地以外的現居住地有固定住所的，可以在現居住地接受社區戒毒。

《警隊條例》第232 章 第59C條

- 獲授權的警務人員可從觸犯*嚴重可逮捕罪行*（包括吸食危險藥物）的疑犯身上收取非體內樣本（例如指甲、唾液和毛髮）。

《危險藥物條例》第134章 第54AA條

- 獲授權的警務人員和海關人員，可從*觸犯嚴重可逮捕罪行*（包括吸食危險藥物）的疑犯身上收取尿液樣本，但必須取得疑犯同意（如疑犯未成年，則須取得其父母或監護人同意），並須獲得法庭授權。

強制毒品測試的局限

- 強制毒品測試亦可能會被指：
  - 侵犯人權， 特別是私隱權， 包括維護人格尊嚴和保持身體不受侵犯的權利（例如拒絕治療的權利）。
  - 令執法機關（或執行測試的其他機構）擁有過大權力，會導致公民自由受到侵犯，尤其是處境無助的青少年，他們需要特別保護，以免成為濫權的對象。
  - 會破壞校園內教職員與學生之間應有的信任， 繼而對其他方面的青少年教育工作，包括禁毒教育，造成負面影響。
  - 造成標籤效應。

強制戒毒措施

- 如某人被控並被判罪名成立，法庭可要求有關方面提交報告，以考慮各種判刑選擇。在擬備這些報告時，有關方面可為已定罪的犯人進行毒品測試。對於據報有吸毒行為的罪犯，法庭可酌情判處含戒毒治療元素的刑罰，特別是判入由懲教署管理的戒毒所， 或判接受感化，規定進入戒毒治療中心或參加戒毒治療計劃。

藥物倚賴者治療康復中心(發牌)條例 第566章 第四條 對營辦治療中心的限制

- (1) 任何人不得營辦治療中心或對治療中心的管理行使控制權，但如該人為該中心的指明營辦者，則屬例外。
  (2) 除非就有關治療中心有在當其時有效的—
- (a) 牌照；或
  (b) 豁免證明書，
- 否則任何人不得參與該中心的管理。
  (3) 任何人違反第(1)款，即屬犯罪—
- (a) 如屬首次定罪，可處第6級罰款及監禁6個月，並可就該罪行持續的每一日，另處罰款$5000；
  (b) 如屬其後的定罪，可處第6級罰款及監禁1年，並可就該罪行持續的每一日，另處罰款$10000。

建議強制毒品測試

- 由於香港現時沒有授權執法機關無須徵得涉嫌人士同意而進行強制毒品測試，以確定他曾否吸毒。因此，在預防偵察青少年吸毒方面，家長、學校、社工亦無法在早期甄別和辨識潛匿的青少年吸毒者方法。
- 因此，香港特區府在2008年《青少年毒品問題專責小組報告》中建議引入新法例以賦權執法人員要求被合理懷疑吸毒者接受毒品測試等措施。

藥物倚賴者治療康復中心(發牌)條例 第566章 第五條 牌照或豁免證明書條件遭違反

- (1) 如署長已就任何治療中心發給牌照或豁免證明書，而該中心在違反牌照或豁免證明書條件的情況下營辦，則該中心的指明營辦者及任何其他對該中心的管理行使控制權的人，均屬犯罪。
  (2) 在不影響第(3)款的原則下，任何被控犯了第(1)款所訂罪行的人如能證明下述情況，即可以此為免責辯護—
- (a) 他既不知道亦無理由懷疑有導致有關違反事件的情況存在；及
  (b) 他即使有作出合理的監管及努力，亦不能避免該等情況出現。
- (3) 如就第(1)款所訂罪行而針對某指明營辦者提起法律程序，則在該等程序中，控方無須證明該營辦者知道構成該罪行的該項違反所涉的牌照或豁免證明書條件。
  (4) 任何人犯本條所訂罪行，可處第6級罰款及監禁6個月，並可就該罪行持續的每一日，另處罰款$5000。

藥物倚賴者治療康復中心(發牌)條例 第566章
第六條　牌照的申請及發出

- (1) 任何人就治療中心申請牌照，須按署長指明的格式及方式向署長提出申請。
  (4) 署長如覺得有以下情況，可拒絕發出牌照予申請人—
- (a) (i) (如申請人屬個人)申請人並非適當人士；
- (ii) (如申請人屬法人團體)該法人團體的任何董事並非適當人士；
  (iii) (如申請人屬合夥)該合夥的任何合夥人並非適當人士；
- (b) 擬用作有關治療中心的地方，因面積、人手或設備方面的理由，不適合用作治療中心；
  (c) 擬用作有關治療中心的地方不符合在—
- (i) 《建築物條例》(第123章)的條文；
  (ii) 消防處處長根據《建築物條例》(第123章)第16(1)(b)條公布的實務守則；
  (iii) 署長根據第25條發出的實務守則；

題問時間

多謝各位垂聽

藥物倚賴者治療康復中心(發牌)條例 第566章
第七條　不得視為適當人士的人

- 符合以下說明的人士並非適當人士—
- (a) 該人是或曾是藥物倚賴者，但第(2)款適用者除外；
  (b) 該人在緊接署長考慮有關事項之日之前10年內，曾在香港被裁定犯了《有組織及嚴重罪行條例》(第455章)附表1所指明的罪行並被判處監禁；或
  (c) 該人在該期間內，曾在其他地方被裁定犯了某項罪行並被判處監禁，而構成該項罪行的作為或不作為假若是在香港作出，即會構成《有組織及嚴重罪行條例》(第455章)附表1所指明的罪行。
- (2) 如某人曾是藥物倚賴者，而該人能令署長信納他在緊接署長考慮有關事項之日之前連續7年內一直不再是藥物倚賴者，則署長可認為他是適當人士。

江仲有律師

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藥物倚賴者治療康復中心(發牌)條例 第566章
第十條　在申請過程中作出虛假陳述等

- 任何人如在根據本條例提出的申請中，或在與該等申請有關連的情況下，作出任何陳述(不論是口頭或書面陳述)，或提供任何資料，而—
- (a) 該等陳述或資料在要項上屬虛假或具誤導性；及
  (b) 他知道或理應知道該等陳述或資料在該要項上屬虛假或具誤導性，
- 該人即屬犯罪，可處第6級罰款及監禁6個月。

- 資歷
  - 澳洲新南爾斯、昆士蘭、維多利亞最高法院律師；
  - 澳洲聯邦最高法院律師；
  - 英國最高法院律師；
  - 香港最高法院律師；
  - 香港工程師學會會員；
  - 英國仲裁師學會資深會員；
  - 香港調解會認可專業調解員(一般、家事)；
  - 香港律師會會認可專業調解員；
  - 香港家事法庭認可家事調解員；
  - 香港土地審裁認可家事調解員；
  - 深圳、廣州、天津、克拉瑪依仲裁委員會仲裁員；
  - 中國國際經濟貿易仲裁委員會仲裁員；
  - 香港婚姻監禮人。
  - 深圳市僑界法律顧問團顧問律師。

江仲有律師 學歷

- 澳洲新南爾斯大學土木工程學學士；
- 澳洲悉尼科技大學政務工程深造文憑；
- 澳洲麥哥爾大學法學學士；
- 澳洲悉尼科技大學法律實務深造文憑；
- 香港城市大學仲裁及爭議解決學文學碩士；
- 香港國際仲裁中心、香港律師會聯合主辦之家事調解基礎及高級訓練文憑；
- 香港國際仲裁中心主辦之商事調解基礎及高級訓練文憑。

參考書

- 《青少年毒品問題專責小組報告》，香港特別行政區政府，政府物流服務署印，二零零八年十一月。

Caritas Lok Heep Club & Hong Kong Polytechnic University
Certificate Course in Treatment of Drug Abuse

The UK Models of care for treatment of adult drug misusers; The Hong Kong Tiered approach; & Matching clients to treatment

David Cheung
15 September 2011

The UK Models of Care

- Provides the framework required to achieve equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in England.
- Advocates a systems approach to meeting the multiple needs of drug and alcohol misusers.
- Reflects professional consensus of 'what works best' for drug misusers, resulting from an extensive consultative process.
- Based upon current evidence, guidance, quality standards and good practice in drug treatment in England.

The Four-tiered framework for commissioning drug treatment

- To provide a conceptual framework and be applied to local areas with flexibility.
- has enabled a better articulation of provision of treatment
- It is not a rigid blueprint for provision
- The tiers refer to the level of the interventions provided and do not refer to the provider organisations

Definition of Treatment

- *This term describes a range of interventions that are intended to remedy an identified drug-related problem or condition relating to a person's physical, psychological or social (including legal) well-being.*
- *Structured drug treatment follows assessment and is delivered according to a care plan, with clear goals, which is regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions.*

Good quality treatment is highly effective in reducing:

- Illegal drug misuse
- Improving the health of drug misusers,
- Reducing drug related offending,
- Reducing the risk of death due to overdose,
- Reducing the risk of death due to infections, and
- Improving social functioning

Tier 1 Interventions: Drug-related information and advice, screening and referral by generic services

- Include provision of drug-related information and advice, screening and referral to specialised drug treatment
- In the context of general healthcare settings, or social care, education or criminal justice settings (e.g. probation, courts, prison reception) where the main focus in not drug treatment
- Staff require competence to screen and identify drug misuse and refer to local specialized drug treatment systems

Tier 2 Interventions
Open access, non-care-planned drug-specific interventions

- Provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions(including needle exchange) and aftercare
- May be delivered separately from Tier 3 but will often also be delivered with Tier 3 interventions, through outreach, in pharmacy settings, criminal justice settings, or in prison
- Require competent drug and alcohol speicalist workers

Tier 3 interventions:
Structured, care-planned drug treatment

- Provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison

Interventions include:

- Comprehensive drug misuse assessment
- Care-planning, coordination and review for all in structured treatment
- Community care assessment
- Harm reduction activities integral to care-planned treatment

Tier 3 interventions(continued):
Structured, care-planned drug treatment

- A range of prescribing interventions
- A range of structured evidence-based psychosocial interventions
- Structured day programmes and care-planned day care
- Liaison services fro acute medical and psychiatric health services
- Liaison services for care services
- A range of the above interventions for drug misusing offenders

Tier 3 interventions:
Structured, care-planned drug treatment

Settings: normally delivered in specialised drug treatment services with their own premises in the community or hospital sites

- May based in primary setting or in prison
- Require competent drug and alcohol specialised practitioners and medical staff will require different levels of competence

Tier 4 interventions:
Drug specialist inpatient treatment and residential rehabilitation

Provision of residential specialised drug treatment, which is care planned and care coordinated to ensure continuity of care and aftercare.

Tier 4 interventions include:

- Inpatient specialist drug and alcohol assessment, stabilisation, and detoxification/assisted withdrawal services
- A range of drug and alcohol residential rehabilitation units
- A range of half way houses
- Residential drug and alcohol crisis intervention units
- Inpatient detoxification/assisted withdrawal provision

Tier 4 interventions (continued):
Drug specialist inpatient treatment and residential rehabilitation

- Provision for special groups for which a need is identified (e.g. drug-using pregnant women)
- A range of the above interventions for drug-misusing offenders

Ideal settings: specialised dedicated inpatient or residential substance misuse units or wards

Continuity of care is essential for preserving gains achieved in residential treatments.

Can be found within prisons, specialist detoxification units, therapeutic communities and some 12-Step programmes

Require normally medical staff with specialised substance misuse competency

All staff working in all residential setting sare advised to demonstrate specific competence level

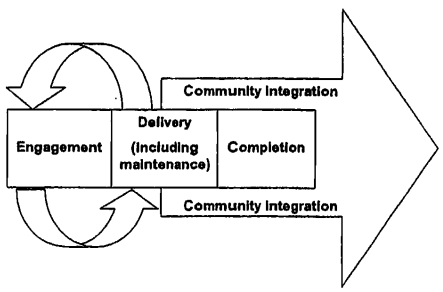
Points to note:

- Providers spanning tiers – Many community based specialised providers provide a range of interventions spanning Tier 2 and Tier 3.
- Tier 1 service may not be generic, Tier 4b in 2002 redesignated as Tier 1.
- Tier 2 interventions should include :
  - Interventions to engage people to drug treatment
  - Interventions to support people prior to structured treatment
  - Interventions to help retain people in the treatment system
  - A range of drug misuse harm reduction interventions
  - Interventions to support active drug users who may not want or need intensive structured drug treatment at that point in their live.

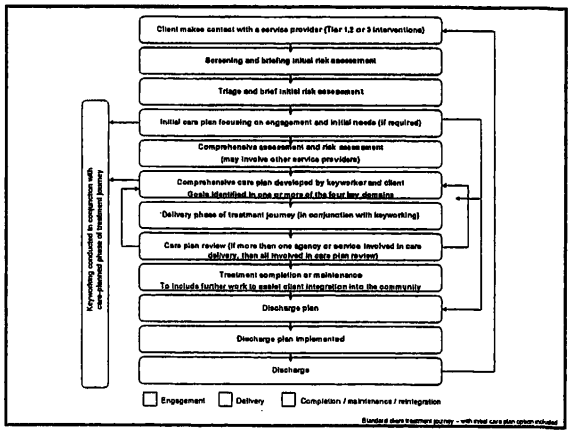
Points to note:

- Tier 2 interventions do not focus only on those who are still actively using illegal drugs, but also to those who are drug–free
- Tier 2 interventions can be a component of aftercare
- Tier 2 vs Tier 3 interventions may be very similar and difficult to decide. The main difference between the two is that Tier 3 refers to the provision of care-planned interventions that meet the threshold for structured drug treatment, determined following comprehensive assessment.
- All substitute prescribing interventions are Tier 3

The Client's journey



Models of care for treatment of adult drug misusers Update 2006



Standard open treatment journey – with initial care plan option included

Various emphases

- Assessment – screening, triage, initial care plan, comprehensive, risk
- Various competence level required for workers
- Care planning
- Keyworking
- Integrated care pathways
- Quality criteria and improvement reviews
- Performance monitoring and management

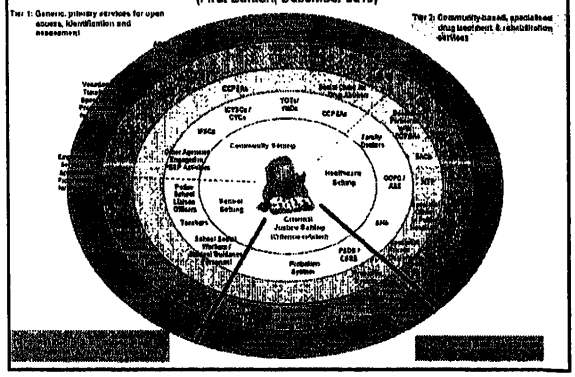
Drug treatment interventions are part of a local treatment system which include:

- Advice and information
- Harm reduction interventions
- Community prescribing interventions
- Structured day programmes
- Structured psychosocial interventions
- Other structured treatment
- Inpatient drug treatment
- Residential rehabilitation
- Aftercare

Source:

National Treatment Agency for Substance Misuse(2006), Models of care of treatment of adult drug misusers, update 2006

A Tiered, Multi-modality Approach of Treatment and Rehabilitation Services for Drug Abusers in Hong Kong
(First Edition, December 2010)



- **Abbreviations**
  - A&E: Accident and Emergency Unit
  - CCPSA: Counselling Centre for Psychotropic Substance Abusers
  - CSSS: Community Support Service Scheme
  - CYC: Children and Youth Centre
  - DATC: Drug Addiction Treatment Centre
  - DTRC: Drug Treatment & 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 Drifter
  - YOT: District Youth Outreaching Social Work Service

Comments on the proposed Tiered Approach

- Good initiative
- Unclear objectives
- Unclear definitions which lead to inclusion of unclassified services, failing to include existing interventions, failing to note the difference between compulsory and voluntary services, putting rehabilitation service into the highest tier, and focusing on the youth sometimes
- Failing to consult the key players

UK Drug Demand Reduction Task Force Review Report 1992

"Many of the Drug Abuse Treatment and Rehabilitation Services in Hong Kong have been pioneers in the field, and are internationally known and highly regarded. There are many experts and that Hong Kong is a leader in the field in Asia, and a source of information and advice for many countries in the area ..."

50 years ago, there were

- Only one primitive gospel treatment centre
- Another experimental compulsory treatment centre run by the Prisons Department

in Hong Kong

Four main modalities of Treatment and Rehabilitation Services

A. Compulsory Treatment

B. Voluntary Residential Drug Treatment

C. Outpatient Clinics

D. Counseling Centres

Level of care D<C<A~B

香港的多元化戒毒治療 及 康復服務

A. 強制治療 (CSD)

B. 自願性質住院戒毒
   1. 有醫護輔助的 (由DH資助)
   2. 福音戒毒 (自資或SWD買位)

C. 門診
   1. 美沙酮診所 (DH)
   2. 物質誤用診所 (HA)

D. 輔導中心
   1. 樂協會 (SWD)
   2. CCPSAs (SWD)

Compulsory Treatment (Drug Addiction Treatment Centre, DATC)

- Operated by Correctional Services Department (Government), called Prisons Dept. before 1982
- Started since 1958
- Targets: drug dependents who had committed offences and are considered suitable for compulsory treatment
- Duration: 2 to 12 months
- Plus 12 months aftercare and half way houses for selected persons
- Contents: medical services, work therapy, physical education, recreational activities, spiritual service and counseling services

Compulsory Treatment(DATC)

- At present: 3 centres on Heiling Chau Island
- Heiling Chau DATC: 688 beds for male adult
- Lai Sun DATC: 182 beds for young male
- Nei Kwu DATC: 236 beds for female
- A total of 1,106 beds

- In 2009, total number of admissions was 1,572 and number of dischargees 1,461. At the end of 2009, there were 691 under treatment and 1,304 receiving aftercare service

Voluntary Residential Drug Treatment Centres

1. Subvented by Department of Health with medical service
2. Gospel Treatment run by Christian agencies

As at November 2010, there were a total of 1,378 beds at the 27 centres operated by 15 NGOs

Voluntary Residential Drug Treatment Centres with medical unit

1. Subvented by the Government through the Department of Health and have medical support

a. The Society for the Aid and Rehabilitation of Drug Abusers(SARDA, since 1963) runs four centres, 316+20+24+42 beds, plus 5 half way houses
   admitted 1,908 males and 171 females in 2009
   clients need not pay fees

b. Caritas Wong Yiu Nam Centre (since 1999) for young male, 28 beds, admitted 92 in 2009
   A client pays $3,200 monthly treatment fee

c. Christian Service Lodge of Rising Sun (since 2003) for young male, 30 beds, admitted 60 in 2009, daily treatment fee : $100

Voluntary Residential Drug Treatment Centres with medical unit

- Contents: medically assisted detoxification, counseling, group work services plus other supportive services, including half way houses and aftercare support
- Treatment duration: from 3 weeks to one year, majority within six months
- The six centres are operated by three NGOs. SARDA serve mainly opioid abusers and 3 of her 4 centres adopt the Therapeutic Community model.
- Wong Yiu Nam Centre uses buprenorphine for opioid detoxification but nowadays very few clients are opioid abusers.
- Lodge of Rising Sun runs an outpatient unit

Gospel Treatment

1. Since 1956, operated by Christian agencies with self finance, many charge clients fees at welfare assistance level. Since 1997, Government buys beds from 4 agencies
2. At present, 12 agencies run 21 such centres with a total of 918 beds, 823 for male and 95 for female
3. Contents: Bible study, devotional time, regular and simple daily routine life with discipline. Emphasis on conversion of clients to Christians
4. Duration: usually long, may exceed 3 years

Gospel Treatment

- Some agencies still stress no drugs are used
- Many were set up between 1984 to 2002.
- With the implementation of the Drug Dependent Persons Treatment & Rehabilitation Centre (Licencing) Ordinance in April 2002, no new centres have evolved
- Some of these agencies run half way houses to facilitate the rehabilitation of their recovering clients

Gospel Treatment

A list the Christian agencies providing gospel treatment services (year started):

- Operation Dawn(1968)
- St Stephen's Society(1974)
- Wu Oi Christian Centre(1974)
- Barnabas Charitable Service Association(1981)
- Finnish Evangelical Lutheran Mission(1984)
- Christian Zheng Sheng Association(1985)
- Drug Addiction Counseling & Rehabilitation Services(1988)
- Christian New Being Fellowship(1989)
- Perfect Fellowship(1990)
- Remar Association(1998)
- Glorious Praise Fellowship(1999)
- Christian New Life Association(2001)

Outpatient Clinics

1. Methadone clinics operated by the Government(Department of Health) since 1972, there are 20 clinics now. In 2009, total attendance was 2,352,766, equaling 6,446 daily.
2. Substance Abuse Clinics operated by the Government (Hospital Authority) since 1994, at present 7 SACs. In 2009, 814 new cases, total attendance was 15,417.

Methadone Clinics

- Pioneered by an NGO in late 1960s
- Started by Government as a trial in 1972
- For opioid dependents
- $1 per dose since then
- 2 schemes: Maintenance vs Detoxification, majority joining the Maintenance Scheme.
- In 2009, 203 registered for detoxification against an average of 8,457 cases
- Demand shrinking, with peak in 1987 when there were 25 clinics, a total attendance of 3,411,313, equaling a daily average of 9,349

Substance Abuse Clinics(SACs)

- Second generation of outpatient clinic service
- For psychotropic substance abusers mainly
- Contents: assessment, drug treatment, counseling, in some cases inpatient treatment
- At Kowloon Hospital, Eastern Hospital, Prince of Wales Hospital, Queen Mary Hospital, Kwai Chung Hospital, Castle Peak Hospital, and United Christian Hospital
- $100 fee for first consultation session and $60 each for subsequent sessions

Counseling Centres

1. Caritas Lok Heep Club since 1968, the club has two centres serving more than 900 cases in 2009, subvented by Government (SWD)
2. Counseling Centres for Psychotropic Substance Abusers(CCPSAs) since 1988. They are PS33(since 1988), HUGS(1996), Cheer Centre(1998), Evergreen Centre(2002), CROSS Centre(2002), Neo-Horizon (2008) and Enlighten Centre(2008). They had 509 male and 366 female admissions in the year 2009. 4 new CCPSAs started service in October 2010. All CCPSAs are subvented by SWD.

Caritas Lok Heep Club

- Lok: Happiness; Heep: mutual assistance
- Serving drug/ex-drug abusers of opioids and psychotropic substances and their family members
- Casework, group work plus other peripheral services such as drug tests
- Playing a bridging role by matching clients to relevant services
- Clients receive services for free
- Organized a Certificate Course in Treatment of Alcohol and Drug Abuse with CUHK in 2009

CCPSAs

- Second generation of service, for psychotropic substance abusers
- Started in 1988 with PS33
- As a focal point for drug abusers to receive relevant information, timely counseling, and treatment and rehabilitation.
- As information and resource centres
- Regionally based with connection with SACs
- Serving mainly the youths, clients do not need to pay for service
- 4 new CCPSAs added in October 2010, giving a total of 11 units

Others T&R Services

a. Half Way Houses, 7 agencies running 12 houses with 220 beds
b. Service for Alcoholics, AA
c. Mobile Acute Drug Rehabilitation Team of Haven of Hope Hospital, for drug dependents with other illnesses
d. Self help association called Pui Hong Self-help Association started in 1967
e. Private practitioners including general practitioners and psychiatrists

Observations and discussions

1. Most services rely on Government funding. Services started in response to high drug abuse figures. In general there have been two generations of services.
2. NGOs play an important role, especially gospel treatment services. No new residential centres have been set up since 2002 except one subvented centre.
3. Lack of overall or Long term policy to coordinate service to generate concerted effort. Existing 3-year plan of little reference value for service development.

Observations and discussions

4. Limited choices to users: lack of service information such as walt time, completion rate, success rate because of no standard set and loose control.
5. No accurate figures on drug abuse magnitude, no central Service Information Systems, little matching of services, and more researches needed, especially on evidence based practice.
6. Lack of training and exchange activities for drug workers.

Observations and discussions

7. Reengineering needed in many centres to meet changing needs. Alcoholic problem deserves attention and efforts.
8. With the new wave of drug abuse, more resources are input by the Government in 2010. New services like very short term(one to two weeks) residential treatment and drug tests are advocated. Emphasis are put on the outpatient and counseling services. Whether the tactics work is to be observed.

Matching Clients to treatment

Caritas Lok Heep Club
David Cheung

The 13 NIDA Treatment Principles

1. **No single treatment is appropriate for all individuals.**
2. **Treatment needs to be readily available.**
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.**

The 13 NIDA Treatment Principles

4. **At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation, and social and legal services.**
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.**
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.**

The 13 NIDA Treatment Principles

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.**
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.**

The 13 NIDA Treatment Principles

10. Treatment does not need to be voluntary to be effective.

11. Possible drug use during treatment must be monitored continuously.

The 13 NIDA Treatment Principles

12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.

13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Standard Regime 1970s & 1980s

In-patient detoxification
followed by
After-care

Treatment matching variables (American Psychiatric Association)

Identified by epidemiological studies

- Demographic features(age, gender, ethnicity)
- Addiciton features(topology & severity)
- Intra personal characteristics
- Interpersonal function

Clinical guidelines

- Patient placement criteria 2, Separate guidelines for both adults and adolescents.
- 5 levels of service: (Later changed 4 levels)

1. Early intervention
2. Out-patient service
3. Intensive out-patient/partial hospitalization service
4. residential/in-patient services
5. Medically managed intensive in-patient services

(American Society of Addiction Medicine, ASAM)

Source

- M N Gourevitch, P A Selwyn and P G O'connor, Patient assessment, pp 192-213,

In R Robertson, Management of Drug users in the Community, a Practical Handbook, New York, Arnold, 1998.

Top 10 Questions to Ask

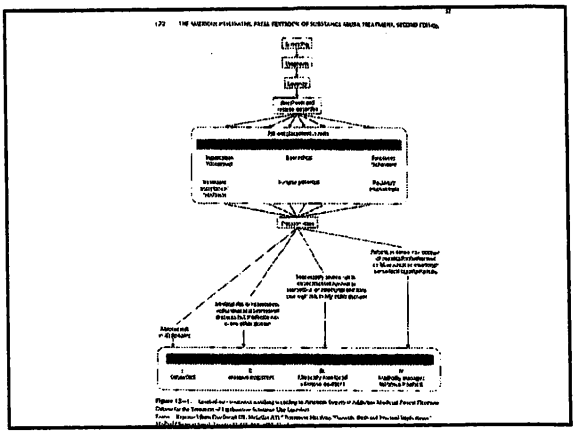
- Are you state licenced?
- Are you accredited?
- What is your patient-complaint procedure?
- What is the role of confrontation or 'breaking denial' in your treatment?
- When do you use medications?

Top 10 Questions to Ask

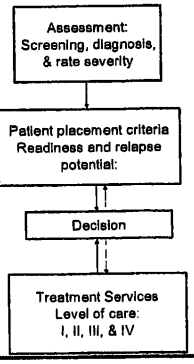
- What is the cause of relapse, and how do you deal with it?
- What is your position on 12-step programs?
- What do you provide in terms of aftercare?
- How do you deal with (special issues)?
- What research is your treatment based on, and has it been evaluated by outside researchers?

Source

- J Volpicelli and M Szalavitz, Recovery Options, the Complete Guide, New York, Wiley, 2000, P 98.



Simplified ASAM Model



Client placement factors

- Intoxication, Withdrawal
- Biomedical
- Emotional, Behavioral
- Treatment Acceptance/resistance
- Relapse potential
- Recovery Environment

Level of care

Level	Description of Service
I	Outpatient
II	Intensive outpatient
III	Medically monitored intensive outpatient
IV	Medically managed intensive outpatient

How to choose treatment?

- Step 1: Complete Assessment
- Choose what's right for the stage of change
- Maintenance vs Abstinence focused
- Inpatient vs outpatient
- Drugs of abuse

Criteria

Check licence

Complaint procedure

Talk to treatment graduate

Find out the Centre's beliefs about relapse and the nature of addiction

Find out the Centre's beliefs about research and outside evaluation

Ask about medication use

Special concerns

- Dual Diagnosis
- Women
- Sexual orientation
- Race
- Ask about the daily routine
- Find out about family involvement

Source

- J Volpicelli and M Szalavitz, Recovery Options, the Complete Guide, New York, Wiley, 2000, P 98.

香港為吸毒者而設的治療及康復服務分級多模式架構

(二零一零年十二月，第一版)

引言

1. 這架構(載列於下表及附圖)，是當局首次嘗試以更有系統的方式，將本港為吸毒者提供的戒毒治療及康復服務的種種概念，加以整合，並透過一個分級多模式架構，勾劃出來。架構體現了由辨識、戒毒治療、康復以至重返社會階段各項服務的連貫性，同時突顯社會福利、醫護、教育和續顧服務所發揮的相輔相成作用。

2. 對政府和公私營機構的服務提供者來說，架構可加深大家對機構之間的服務連接點的了解、促進各方的聯繫和合作，以及協助監察現時服務的提供情況和找出服務不足之處。更重要的是，架構定出一個共同基礎，讓有關各方.策.力，務求達到提供全面服務的整體目標。

3. 至於對服務的最終使用者來說，則可透過這個架構，綜覽在不同模式下照顧處於不同療程及康復階段的人士的不同需要的各項服務。

4. 為免生疑問，這個架構並非一個用作訂定資源或服務地域範圍的規範性的架構。

5. 當局現發表香港為吸毒者而設的治療及康復服務分級多模式架構第一版，供有關服務界別、服務使用者和公眾參考。禁毒處作為政策統籌部門，會繼續與相關各方合作，力求改善服務。我們歡迎大家就此架構提出意見。我們在二零一一年.手擬備香港戒毒治療和康復服務第六個三年計劃(二零一二至一四年)時，會就分級架構連同其他現行措施，一併作出檢討。

保安局
禁毒處
二零一零年十二月

第 1 級 - 初步接觸、辨識及評估的一般基本服務

概要

這一級所述的是前線服務。該等服務往往是因應吸毒者及其家人的需要而給予的最先回應。第 1 級服務是一般基
本服務，一般來說，吸毒者及其家人均可直接獲提供有關服務。服務提供者對毒品問題不一定有深入認識，但由
於他們在本身所處環境經常與吸毒者及其直接支援網絡(例如父母和配偶)接觸，因而最易於辨識高危人士和吸毒
者，並對間歇吸毒者及其家人作出初步介入。如有需要，他們亦須轉介較嚴重的吸毒者至其他級別。

目的

確保所有吸毒者均可獲提供各項一般服務，並持續得到照顧，以期減少他們吸毒的風險和經不起誘惑的情況，並
鼓勵他們重投社會，務使這些吸毒者，特別是早期吸毒者，繼續接受主流服務。

對象

任何人士，特別是易受毒品危害或有吸毒問題的人士。

服務／服務提供者	目的及服務	機構	決策局／部門 (掌管營運開支封套人員／ 管制人員， 視乎情況而定)	經費來源
A. 自願計劃				
a. 社區				
(i) 地區青少年外展服務隊	找出並接觸易受毒品危害的人士，特別是通常不大參與傳統社交或青少年活動，而又易受不良影響(包括吸毒)的人士。	非政府機構	勞福局／社署	資助
(ii) 青少年深宵外展服務		非政府機構	勞福局／社署	資助
(iii) 濫用精神藥物者輔導中心(濫藥者輔導中心)		非政府機構	保安局／社署	資助
(iv) 綜合青少年服務中心／兒童及青年中心	辨識並接觸會踏足中心及／或參與中心活動而又易受不良影響(包括吸毒)的青少年。	非政府機構	勞福局／社署	資助
(v) 綜合家庭服務中心	提高家長對潛在的子女吸毒問題的警覺，並視乎需要向子女有吸毒問題的家庭提供支援。	非政府機構／社署	勞福局／社署	資助／政府
(vi) 舉辦預防教育和宣傳活動的機構	提高各界對毒品問題的警覺，並在碰到吸毒者時，提供初步接觸／轉介服務。	非政府機構	—	社區／來自多方面的計劃撥款

b. 學校				
(i) 教師和其他教職員(包括學生輔導人員)	辨識和初步接觸高危學生，進行動機式輔導，以及處理與毒品有關的個案。	學校	教育局	政府／資助／私人
(ii) 學校社工	初步接觸有需要的學生及其家人，進行動機式輔導，並在.得同意後轉介參與戒毒治療及康復計劃。	非政府機構	勞福局／社署	資助
(iii) 警察學校聯絡主任	協助學校及早辨識青少年犯罪行為，預防和處理學生參與犯罪和非法活動的問題。 以小組或個別形式，會見學校辨識到的問題學生，協助他們建立正面的價值觀和遵守紀律。	警務處	保安局／警務處	政府
c. 醫護機構				
(i) 公立醫院				
— 普通科門診診所	辨識吸毒者，並在適當情況下作出轉介。	醫管局	食衛局	資助
— 急症室	辨識吸毒者，並在適當情況下作出轉介。	醫管局	食衛局	資助
(ii) 衛生署的服務				
— 學生健康服務	向中小學學生推廣禁毒教育。	衛生署	食衛局／衛生署	政府

(iii) 家庭醫生／普通科醫生	提高醫護專業人員在日常工作中對吸毒問題的意識，並制定和發布及早辨識和轉介吸毒者指引。	私家醫生／醫院及醫療專業團體	食衛局／衛生署	私人
B. 刑事司法制度				
a. 警司警誡計劃及社區支援服務計劃	辨識有吸毒傾向的年輕罪犯，提供警誡後及續顧服務。	警務處／非政府機構	保安局／警務處	政府／資助
b. 由感化主任在司法監察制度下執行的感化制度	按法院規定進行判刑前社會背景調查，並就犯事者是否適合接受感化監管提出建議，作為取代扣押刑罰的介入措施。在這過程中，或可把吸毒者辨識出來。 如罪犯被判接受感化令，感化主任須依據感化令所訂條件，對罪犯(即受感化者)進行法定監管。 一項針對青少年吸毒者的加強制度正在試行中。	社署／司法機構	勞福局／社署／司法機構	政府

同級之間／與其他各級的聯繫

- 為提供全面且以受助人為本的治療服務，每名在不同環境辨識到的吸毒者均應有一名主要工作人員跟進。有關的主要工作人員應視乎需要，當場作出初步評估和介入。必要時，應轉介吸毒者及其家人接受其他級別的服務。主要工作人員的角色，可以由學校社工、學生輔導人員、外展社工、綜合青少年服務中心、兒童及青年中心、綜合家庭服務中心、感化主任和家庭醫生／普通科醫生擔任。

- 我們非常鼓勵跨專業團隊合作模式。在學校方面，處理校園吸毒個案需要有教師、學校社工、警察學校聯絡主任等參與的跨專業隊伍互相合作。教育局、禁毒處、社署和警方正徵詢學界和福利界的意見，協力加強學校的禁毒指引，以處理涉及高危或有吸毒問題的學生。至於醫護機構，私家醫生、醫院和社工可視乎需要和按個別情況，攜手成立支援青少年
吸毒者的網絡。

- 第 1 級與第 2 級和第 3 級之間，應確保有清晰的轉介途徑和聯繫。凡不能單靠當場處理的個案須轉介至第 2 級的濫藥者輔導中心。不過，第 1 級和第 2 級的服務仍可同時提供。舉例來說，學校社工和濫藥者輔導中心可為吸毒者提供輔導，但後者應在治療計劃中擔當主要工作人員的角色。

- 濫藥者輔導中心除接收轉介或自行轉介個案外，還在第 1 級提供外展服務，以辨識和接觸目標吸毒者，又在第 2 級提供治療輔導和實地醫療支援，幫助吸毒者戒除毒癖，以及在第 4 級為有需要的人士提供續顧服務，使他們得以重投社會繼續生活。在第 1 級的日間和深宵外展社會工作隊應致力接觸和辨識吸毒者，並在推動和鼓勵他們接受指定的戒毒治療及康復服務的過程中，提供深入輔導。

- 感化制度是一個服務單元，也是連接其餘各級服務的途徑。作為主要工作人員，感化主任須按照法庭指令，定期匯報受感化者的進展，或就受感化者未如理想的表現，擬備進度報告。若有違反感化令的情況，則把受感化者送交法庭處理感化主任除向受感化者提供輔導和小組活動外，也會轉介受感化者參加由其他專業人士或非政府機構所辦的適當計劃(例如濫藥者輔導中心、戒毒治療及康復中心等)。

- 自二零零九年十月一日起，兩間裁判法院推行為期兩年的先導計劃，為 21 歲以下被判接受感化的被定罪青少年毒犯提供更聚焦、有系統和深入的戒毒治療計劃。

- 至於情況較嚴重的個案，尋求治療者可無須經第 2 級便獲直接轉介接受第 3 級的服務，例如入院接受深入治療，或入住戒毒治療及康復中心，並獲提供跟進服務。

第 2 級 - 社區為本戒毒治療及康復專門服務

概要

這一級所述的是第一線戒毒治療專門服務。介入措施包括提供以社區為本的吸毒評估專門服務，以及經協調的護理計劃戒毒治療。護理計劃應.重在有關功能領域(例如教育、違規、精神健康及其他醫學專科)取得成效。一般而言，介入措施會在社區層面進行。

目的

提供有系統的心理社會介入和醫療服務，以協助吸毒者遠離毒品，並鼓勵他們參加社區所提供的戒毒治療。

對象

有吸毒問題的人，特別是需要有系統的心理社會和醫療服務的間歇／慣性吸毒者。

服務／服務提供者	目的及服務	機構	決策局／部門 (掌管營運開支封套人員／ 管制人員， 視乎情況而定)	經費來源
A. 自願計劃				
a. 社區和醫護機構				
(i) 11 間濫藥者輔導中心	為吸毒者提供輔導和實地基本醫療支援，使他們不再吸食危害精神毒品。	非政府機構	保安局／社署	資助
(ii) 2 間為吸毒者而設的交誼會所	向吸毒者、戒毒康復者及其家人提供輔導和其他支援服務。	非政府機構	保安局／社署	資助

(iii)與濫藥者輔導中心合作的普通科醫生	為吸毒者診症，此乃濫藥者輔導中心提供的實地基本醫療服務的其中一環。	濫藥者輔導中心及私家醫生	保安局／社署	資助
(iv) 7 間物質誤用診所	在指定時段以門診形式，為患有精神病併發症的吸毒者提供專科醫療和戒毒治療服務。	醫管局	食衛局	資助
(v) 公立醫院專科診所	為患有其他併發症的吸毒者提供專科(例如泌尿科)治療。	醫管局	食衛局	資助
(vi) 私人執業的專科醫療專業人員	吸毒者可向私人執業的精神科醫生和其他專業人士尋求協助。	私家醫生	食衛局	私人
(vii) 美沙酮治療計劃	透過轄下 20 間美沙酮診所的門診網絡，為吸食鴉片類毒品人士提供代用和戒毒兩類療法，以及向受助人提供輔導服務。	衛生署／非政府機構	保安局／衛生署	政府／資助
B. 刑事司法制度				
a. 感化服務	感化主任向受感化者提供輔導和小組活動，並轉介受感化者參加由其他專業人士和非政府機構所辦的適當計劃。 一項針對青少年吸毒者的加強制度正在試行中。	社署／司法機構	勞福局／社署／司法機構	政府

同級之間／與其他各級的聯繫

- 作為社區內提供戒毒治療及康復服務的第一站，濫藥者輔導中心社工可擔當主要處於第 2 級的受助人的主要工作人員。主要工作人員應與醫護界別人士(例如與濫藥者輔導中心合作的普通科醫生，或物質誤用診所的精神科醫生)作出協調。

- 應確保第 2 級與第 1 級和第 3 級之間有清晰的轉介途徑和聯繫。

- 第 2 級介入可與第 3 級介入同時進行，舉例說，入住住院戒毒治療及康復中心的吸毒者如有需要，可到公立醫院接受物質誤用診所提供的精神科治療，以及其他專科治療。

- 物質誤用診所與其他專科部門互相協調十分重要，使公共醫護制度得以提供全面和以病人為本的服務。

- 物質誤用診所為濫藥者輔導中心和非政府機構內須處理吸食危害精神毒品人士的前線人員，提供教育和培訓。濫藥者輔導中心和為吸毒者而設的交誼會所亦為專職人員(例如教師、醫護專業人員、警務人員和社工等)提供專業培訓，以便他們為吸毒者提供協助。

第 3 級 - 住院式及更專門的戒毒治療及康復服務

概要

這一級所述的是專門服務，用以輔助第 1 級和第 2 級服務，並用於進行特別介入或重點介入工作及／或臨時性質
的服務。

目的

在特定時間，為特定用途提供專門介入服務和環境，以輔助和支援其他兩級服務。

對象

涉及複雜吸毒問題而需針對性介入服務的人。

服務／服務提供者	目的及服務	機構	決策局／部門 (掌管營運開支封套人員／管制人員，視乎情況而定)	經費來源
A. 自願計劃				
a. 28 間戒毒治療及康復 中心	為自願尋求住院治療及由感化主任轉介的吸毒者提供不同年期和性質的住院戒毒治療及康復計劃 (請同時參閱下文第 B(c) 項)。 此外，還設立了 12 間中途宿舍，為戒毒康復者提供續顧服務(請參閱第 R 級)	非政府機構	保安局／社署／衞生署	資助及自資
b. 戒毒治療及康復中心為青少年吸毒者開辦的教育課程	為學齡戒毒者開辦教育課程。	非政府機構	教育局	資助及自資

c. 公立醫院	透過專用或非專用病房住院服務，為患有較嚴重精神病併發症和同時患有其他疾病的吸毒者，提供專科治療及戒毒治療。	醫管局	食衞局	資助
d. 私家醫院	吸毒者可向私人執業的精神科醫生和其他專業人士尋求協助。	私家醫生	食衞局	私人
B. 刑事司法制度				
a. 戒毒所	為 14 歲或以上被裁定犯了可處監禁罪行並有毒癮人士提供強迫住院戒毒治療。	懲教署	保安局／懲教署	政府
b. 其他院所，包括更生中心、勞教中心和教導所，以及年輕罪犯監獄	為青少年犯提供懲教服務。	懲教署	保安局／懲教署	政府
c. 感化服務	可把正接受感化的毒犯轉介接受住院治療及康復服務(例如入住戒毒治療及康復中心)。有關的感化主任會定期探訪受感化者，監察其進展。 一項針對青少年吸毒者的加強制度正在試行中。	社署／司法機構	勞福局／社署／司法機構	政府

同級之間／與其他各級的聯繫

- 住院照顧服務應減至最少，以盡量避免導致失去工作和造成社會隔膜問題。為確保受助人持續得到照顧，第 1 級和第 2 級的工作人員繼續參與有關工作，十分重要。

- 在特定處所(例如戒毒治療及康復中心、戒毒所和醫院)接受治療的吸毒者的治療計劃，由營辦服務機構負責統籌。

第 R 級 - 重返社會及續顧

概要

這一級所述的是續顧服務，主要是跟進第 2 級和第 3 級的專門戒毒治療及康復計劃。有關服務可協助戒毒康復者重
新融入社會。部分服務(尤其是有關教育、職業訓練和就業援助的服務)屬人皆可得的一般服務。不過，吸毒者如因
行為問題或學習困難而有特別需要，當局會按情況加強支援。

目的

加入保護因素，減低戒毒康復者重返社會時再次吸毒的可能，幫助他們改過自新。

對象

完成戒毒治療及康復計劃的戒毒康復者。

服務／服務提供者	目的及服務	機構	決策局／部門 (掌管營運開支封套人員／ 管制人員， 視乎情況而定)	經費來源
A. 自願計劃				
a. 戒毒治療及康復中心營辦機構	透過設立中途宿舍(共 12 間)，為戒毒康復者提供續顧服務。 如有需要並可行，將跟進有家人、學校、負責轉介的社工、督導感化主任、師友和其他人等參與為戒毒康復者制訂的續顧計劃。	非政府機構	保安局／社署／衛生署	資助及自資

b. 濫藥者輔導中心及為吸毒者而設的交誼會所	如有需要並可行，將跟進有家人、學校、負責轉介的社工、督導感化主任、師友和其他人等參與為戒毒康復者制訂的續顧計劃。	非政府機構	保安局／社署	資助
c. 美沙酮治療計劃的續顧服務	為已完成戒毒計劃的吸食鴉片康復者提供續顧服務。	衞生署／非政府機構	保安局／衞生署	政府／資助
d. 為青少年而設的就業服務和特定計劃	為15至29歲青少年提供職業輔導、職業介紹、培訓及自僱支援服務。	勞工處／非政府機構	勞福局／勞工處	政府／資助
e. 主流學校	學齡戒毒康復者在完成戒毒治療及康復計劃後，可在教育局／非政府機構／主要工作人員協助下，申請入讀主流學校，繼續學業。其後還會獲提供支援服務。	公營學校／非政府機構	教育局／社署	資助
f. 7所群育學校	學齡戒毒康復者在完成戒毒治療及康復計劃後，如仍有嚴重行為／情緒問題，可申請入讀.育學校。.育學校旨在為學童提供加強輔導和教育指導，以幫助他們克服在成長階段中短暫出現的適應困難，以及提升他們的生活技能，使他們得以盡快重返校園。申請會由教育局及社署轄下的中央統籌轉介系統考慮，並連同其他經主流學校轉介申請入讀群育學校的個案，一併批核。	資助學校	教育局／社署	資助

g. 為青少年而設的職業訓練和特定計劃	戒毒康復者在完成戒毒治療及康復中心的治療計劃後，可在非政府機構／主要工作人員／教育局協助下，申請參加職業訓練／職前訓練計劃。	職訓局／僱員再培訓局	教育局／勞福局	資助及僱員再培訓基金
B. 刑事司法制度				
a. 感化服務	離開戒毒治療及康復中心後，在社區層面進行監管，直至感化期完結為止。	社署／司法機構	勞福局／社署／司法機構	政府
b. 出院後的法定監管	實行出院後的法定監管。	懲教署	保安局／懲教署	政府

同級之間／與其他各級的聯繫

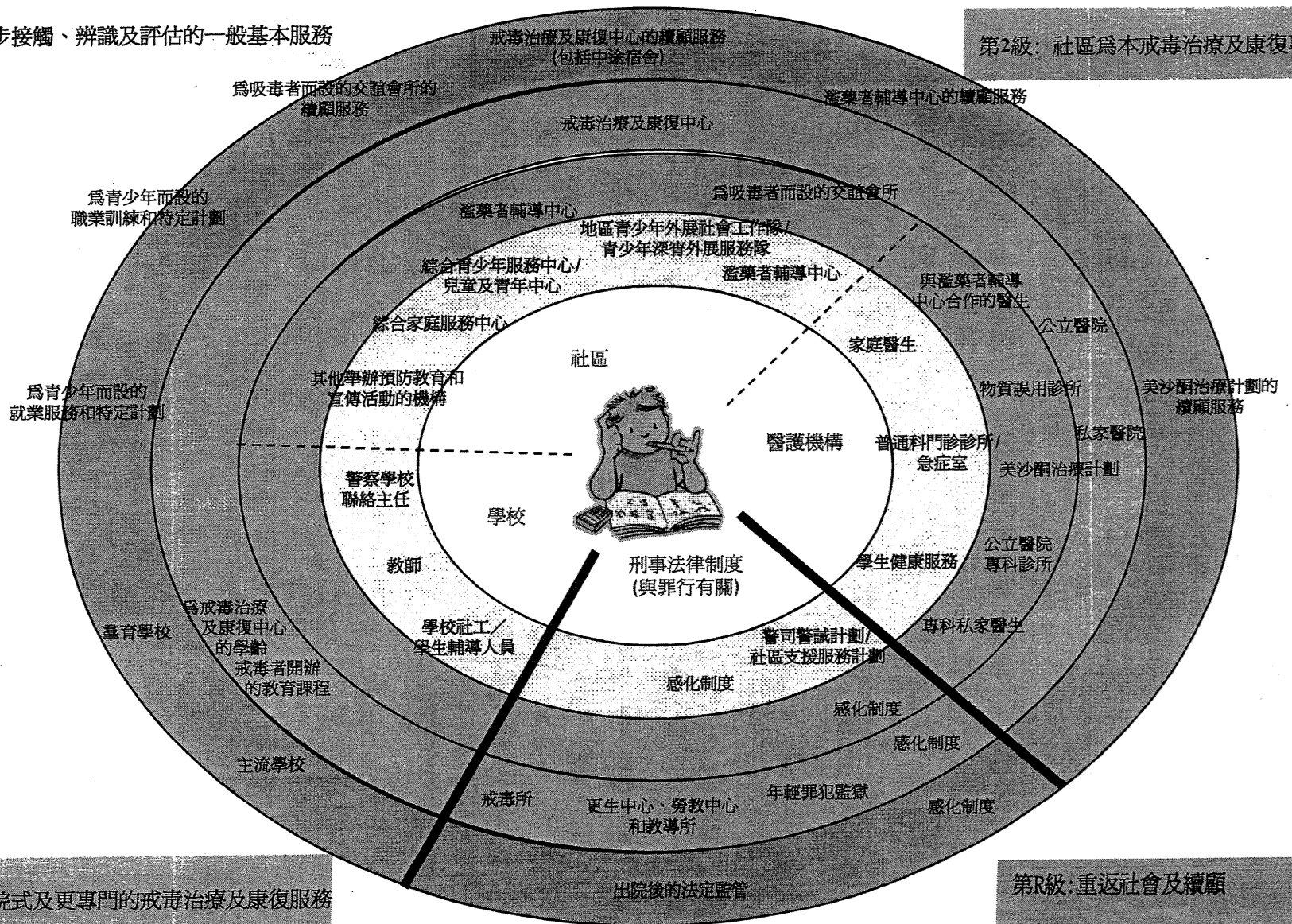
- 部分戒毒治療及康復中心營辦機構現已在社區提供續顧服務。受感化者在完成戒毒治療及康復中心的計劃後，也會得到督導感化主任的照顧。

- 濫藥者輔導中心可擔當輔助角色，為在不設續顧計劃的中心接受治療，或不方便前往中心的人士，提供協助。就此，濫藥者輔導中心的社工會擔任主要工作人員，統籌推行包含其他範疇的計劃元素的跟進計劃。

- 區域教育服務處和教育局的缺課個案專責小組一直合力為有關學生安排學位，以確保 15 歲或以下學生有學可上，並協助 15 歲以上學生(如他們願意)尋找合適的學位。

香港爲吸毒者而設的治療及康復服務分級多模式架構

(二零一零年十二月，第一版)



Treatment Outcomes Profile

Client ID | D.O.B. (dd/mm/yyyy) | Name of keyworker

TOP interview date (dd/mm/yyyy) | **Gender:** M ☐ F ☐ | **Treatment stage:** Treatment start ☐ Review ☐ Treatment exit ☐ Post-treatment exit ☐

Section 1: Substance use

(Please use NA only if information is not disclosed or not answered.)

Record the average amount on a using day and number of days substances used in each of past four weeks

		Average		Week 4		Week 3		Week 2		Week 1		Total	
a	Alcohol		units/day		0–7		0–7		0–7		0–7		0–28
b	Opiates		g/day		0–7		0–7		0–7		0–7		0–28
c	Crack		g/day		0–7		0–7		0–7		0–7		0–28
d	Cocaine		g/day		0–7		0–7		0–7		0–7		0–28
e	Amphetamines		g/day		0–7		0–7		0–7		0–7		0–28
f	Cannabis		spliff/day		0–7		0–7		0–7		0–7		0–28
g	Other problem substance?		g/day		0–7		0–7		0–7		0–7		0–28

Name.....

Section 2: Injecting risk behaviour

(Please use NA only if information is not disclosed or not answered.)

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and 'N', and go to section 3)

		Week 4		Week 3		Week 2		Week 1		Total	
a	Injected		0–7		0–7		0–7		0–7		0–28

b	Inject with needle or syringe used by someone else?	Yes ☐	No ☐		Enter 'Y' if any yes, otherwise 'N'
c	Inject using a spoon, water or filter used by someone else?	Yes ☐	No ☐		

Section 3: Crime

(Please use NA only if information is not disclosed or not answered.)

Record days of shoplifting, drug selling and other categories committed in past four weeks

		Week 4		Week 3		Week 2		Week 1		Total	
a	Shoplifting		0–7		0–7		0–7		0–7		0–28
b	Drug selling		0–7		0–7		0–7		0–7		0–28

c	Theft from or of a vehicle	Yes ☐	No ☐		Enter 'Y' if any yes, otherwise 'N'
d	Other property theft or burglary	Yes ☐	No ☐		
e	Fraud, forgery and handling stolen goods	Yes ☐	No ☐		
f	Committing assault or violence	Yes ☐	No ☐		Enter 'Y' or 'N'

Section 4: Health and social functioning

(Please use NA only if information is not disclosed or not answered.)

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0–20

Record days worked and at college or school for the past four weeks

		Week 4		Week 3		Week 2		Week 1		Total	
b	Days paid work		0–7		0–7		0–7		0–7		0–28
c	Days attended college or school		0–7		0–7		0–7		0–7		0–28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0–20

Record accommodation items for the past four weeks

e	Acute housing problem	Yes ☐	No ☐		Enter 'Y' or 'N'
f	At risk of eviction	Yes ☐	No ☐		Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0–20

Treatment Outcomes Profile (TOP)

NHS

National Treatment Agency for Substance Misuse

About the TOP

The Treatment Outcomes Profile (TOP) is a new drug treatment outcome monitoring tool that has been developed by the NTA in partnership with drug treatment providers in over 70 sites across England. It is applicable for use in all of the structured treatment modalities as defined by Models of Care for Treatment of Adult Drug Misusers: Update 2006. For the first time, service users, clinicians, service managers and commissioners will be able to obtain objective and comparable data about real improvements in service users' lives that will be able to inform and improve practice on both an individual and strategic level.

The TOP is a simple set of questions that will improve clinical practice by enhancing assessment and care plan reviews for clients. The data it provides will improve performance monitoring. Data will be reported into the National Drug Treatment Monitoring System (NDTMS) from October 2007 and results fed back to providers and commissioners from March 2008. There will also be monthly exception reports from NDTMS on non-returns and multiple submissions.

The TOP should be completed at the start of each client's treatment journey to record a baseline of behaviour in the month leading up to starting a new treatment journey. Follow up scores should be recorded every three months during treatment (usually at the same time as a care plan review) to capture changes in behaviour. It should also be completed at discharge and may be used by some services to measure post-discharge outcomes. Note: when services are introducing TOP, existing clients (as well as new presentations) should also have TOP forms completed with them as part of the care plan review process.

How to complete the TOP

Start by entering:

- Name and identifiers of your client (date of birth and gender)
- Your name
- Date of assessment
- The stage at which the TOP is being completed – modality start, care plan review, discharge or post-discharge.

Types of responses:

- Timeline – invite the client to recall the number of days in each of the past four weeks on which they did something – for example, the number of days they used heroin. You then add these to create a total for the past four weeks in the blue NDTMS box
- Yes and no – a simple tick for yes or no, then a "Y" or "N" in the blue NDTMS box
- Rating scale – a 20-point scale from poor to good. Together with the client, mark the scale in an appropriate place and then write the equivalent score in the blue NDTMS box.

You should aim to ask and complete every question. Do not leave any of the blue boxes blank. Enter "NA" if the client refuses to answer a question or, after prompting, cannot recall.

(See TOP keyworker guidance for more detailed information: www.nta.nhs.uk/TOP)

Alcohol units converter

Drink	%ABV	Units
Pint ordinary strength lager, beer or cider	3.5	2
Pint strong lager, beer or cider	5	3
440ml can ordinary strength lager	3.5	1.5
440ml can strong lager, beer or cider	5	2
440ml can super strength lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9

Drink	%ABV	Units
Glass of wine (175ml)	12	2
Large glass of wine (250ml)	12	3
Bottle of wine (750ml)	12	9
Single measure of spirits (25ml)	40	1
Bottle of spirits (750ml)	40	30
275ml bottle alcopops	5	1.5

Thank you for your contribution to the TOP

明愛樂協會 ☎2893 8060

持牌自願性質的住院式戒毒中心及中途宿舍名單

甲. 受衞生署資助的自願戒毒治療中心 - 共6間中心，5間持牌照，1間持豁免証書

△ 牌照(L) / 豁免証書(C)	中心名稱	服務對象	容額 (男性)	容額 (女性)	居住期 (按月計算)	地區
L	明愛黃耀南中心	30歲以下	28		1至6個月	西貢
L	香港基督教服務處賽馬會日出山莊	30歲以下	32		3至6個月	屯門
L	香港戒毒會凹頭青少年中心	25歲以下	20		2至6個月	元朗
L	香港戒毒會成年婦女康復中心	30歲以上		24	3至6個月	沙田
C	香港戒毒會石鼓洲康復中心		316		7至26週	離島
L	香港戒毒會區貴雅修女紀念婦女康復中心	29歲或以下		42	3至12個月	北區
	[redacted]		[redacted]	[redacted]		
	床位總數				462	

△ L : 持有戒毒所牌照
C : 持有豁免証書

乙. 福音戒毒中心 - 共22間， 4間持牌照，18間持豁免証書

△ 牌照(L) / 豁免証書(C)	中心名稱	服務對象	容額 (男性)	容額 (女性)	居住期 (按月計算)	地區
C	基督教巴拿巴愛心服務團南丫島訓練之家	40歲以下		26	3 至 12個月	南丫島
C	基督教新生協會		40		6個月	元朗
C	基督教正生會馥澗男性青少年戒毒及康復中心	21歲以下	50		24 至 36個月	大嶼山
C	基督教正生會馥澗女性青少年戒毒及康復中心			14	24 至 36個月	大嶼山
C	基督教正生會長洲男性青少年訓練中心	21歲以下	40		24 至 36個月	長洲
C	基督教正生會長洲女性訓練中心			20	24 至 36個月	長洲
C	基督教正生會梅窩男性成人訓練中心	21歲以上	24		24個月	大嶼山
L	基督教正生會大澳狗伸地男性成人戒毒及康復中心		18		12 至 24個月	大嶼山
C	得基輔康會恩慈之家		24		9至 12個月	北區
C	榮頌團契		30		12個月	屯明
C	方舟行動元朗中心 (由基督教新生協會營辦)		20		6個月	元朗
C	香港晨曦會有限公司晨曦島福音戒毒所		50		9個月	晨曦島
L	香港晨曦會有限公司姊妹之家			12	12個月	葵青
C	全備團契古洞康復中心		20		12個月	元朗
C	Remar Association (Hong Kong)	18歲以上	20		無時間限制	元朗
C	聖士提反會屯門家庭			13	12個月或以上	屯門
L	聖士提反會城門之源		318*		12個月或以上	沙田
C	基督教得生團契訓練村 #	28歲以下	93		9 至 12個月	西貢
L	基督教信義會芬蘭差會靈愛蛋家灣中心		40		12個月	大埔
C	基督教互愛中心浪茄男性訓練中心	21歲或以上	50		12個月	西貢
C	基督教互愛中心大尾篤女性訓練中心			12	12個月	大埔
C	基督教互愛中心青洲青少年訓練中心	21歲以下	20			中西區青洲
	[redacted]		[redacted]	[redacted]		
	床位總數				954	

另有12個中途宿舍床位。現時正進行工程，稍後會加戒毒床位。
* 沒有固定男女床位比例，爲方便統計一律算爲男性床位

丙. 戒毒康復中途宿舍 - 共12間，10間有牌照，2間豁免証書

△ 牌照(L) / 豁免証書(C)	中途宿舍名稱	男宿位	女宿位	居住期 (按月計算)	地區
L	基督教巴拿巴愛心服務團馬鞍山中途宿舍		27	3 至 12個月	馬鞍山
L	香港晨曦會黃大仙中心	16		3個月	黃大仙
C	基督教得生團契中途宿舍	12		3 至 6個月	西貢
L	基督教信義會芬蘭差會靈愛中心	34		3個月	葵涌
L	香港戒毒會白普理康青中心	18		3個月	灣仔
L	香港戒毒會白普理培青中心	19		3個月	九龍城
L	香港戒毒會九龍宿舍	20		3個月	九龍城
L	香港戒毒會聯青中心	20		3個月	九龍城
L	香港戒毒會婦女宿舍		16	3個月	灣仔
L	香港善導會白普理綠洲宿舍	16		3 至 6個月	旺角
L	香港善導會香港女宿舍		10	3個月	灣仔
C	基督教互愛中心順天中途宿舍	20		12個月	觀塘
[redacted]					
	床位總數			228	

共計40個牌照或豁免証書
當中19個牌照
21個豁免証書

2011年6月8日

Harm of Psychotrophic Substance

Dr Tse Man Li
Consultant and Deputy Director
Hong Kong Poison Information centre
Hospital Authority

Use of Psychoactive Substance: The Background

Ethanol Use

- Beer was consumed since >3500BC
- 1500 BC Egypt
- Harm of being drunk

- Peyotism
- Peyote Lophophora
- Ritual by some Native American tribes
- >3000 BC ago
- No evidence of harm

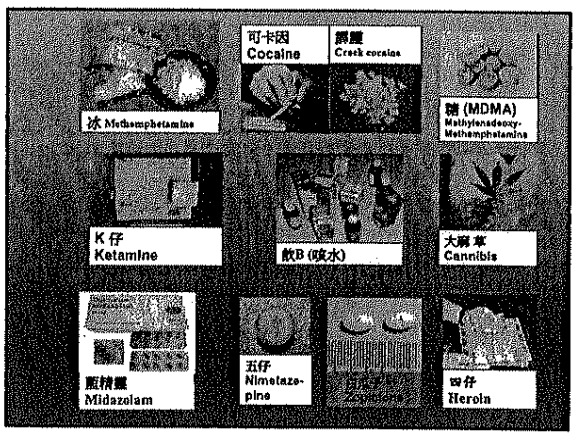
Context

- Religious
- Therapeutic
- Performance enhancement
- Social
- Recreational

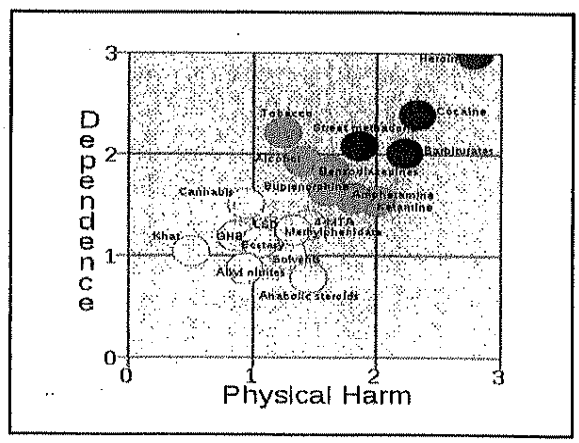
- Drugs = Poisons
- Side-effect is expected

- Plants
- Chemicals or drugs
  - Reliability
  - Easy to use
  - Cheap
- Designer drugs
  - New experience
  - Beat the Law
  - Illegalized typically in 1 year after popularized
  - New chemicals with similar effect created

危害精神毒品
Psychotropic Substance Classification

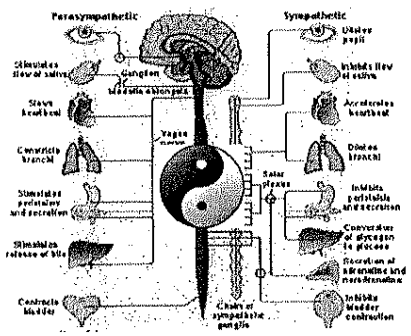


Harm of Psychotrophic Substance



Toxicities of Stimulant 興奮劑

Autonomic Nervous System



AUTONOMIC NERVES

- Sympathetic System "Wake up calls"
- "Fire Alarms"

- Parasympathetic System
- "At ease"
- "All clear"

- Pupils dilate
- Blood pressure
- Pulse
- Activate sweat glands

- Pupils constrict
- Blood pressure
- Pulse
- Deactivate sweat glands

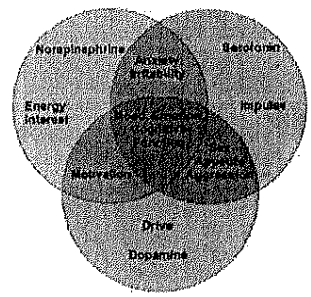
- "Gas Pedal"
- 陽

- "Brake Pedal"
- 陰

NEUROTRANSMITTERS

- Chemical secreted at the ends of nerves

- Acetylcholine (Ach)
- Glutamate (Glu)
- Gamma Amino Butyric Acid (GABA)
- Dopamine (DA)
- Serotonin (5 HT)
- Norepinephrine (NE)
- Endorphins
- etc

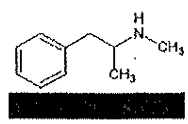


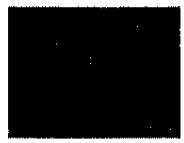
Cocaine - blocks dopamine (DA) re-uptake

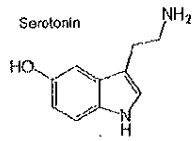
- Most addictive
- Also ↑NE and 5-HT

- *RUSH*
- *CRAVE*

The cousins







MDMA

- blocks (reverse) serotonin transporter
- ↑5 HT
- Empathogen
  Enactogens

Methamphetamine

- Release NE
- Excitation
- Energy
- Anxious

Stimulant Toxicity

跳掣 – Acute Delirium精神錯亂

- Paranoid delusion
- Violence

跳掣 – Acute delirium精神錯亂

- 想性妄, 迫害性幻覺
- 傷人, 自毀傾向

Heat Stroke 中暑

Stroke中風-Acute Brain Injury
急性腦損害

Leakage- haemorrhage

Acute Cardiac Damage急性心臟病

Rhabdomyolysis 橫紋肌溶解

磨牙- MDMA

Meth Face

Meth Bug 冰虫

Injuries and Trauma

Sleep鎮抑劑

- (白)瓜子
  - Zopiclone
  - Triazolam
- 5仔
  - Nimetazapine
- Often mixed use with other drugs

Main Harm

- ***Dependence***

- Severe withdrawal symptoms
  - Insomia, somatic symptoms
  - Anxiety, panic attacks
  - Confusion
  - Seizure

Zopiclone 白瓜子
Methaemoglobinaemia
正鉄紅血球蛋白症

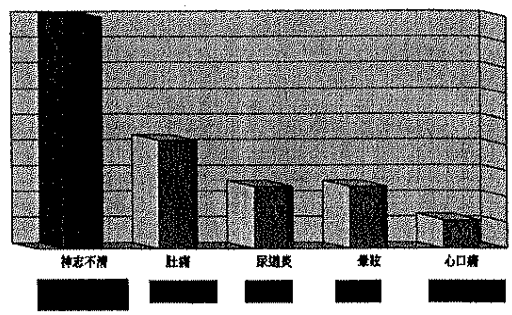
Long Term Use

- Tolerance
- Withdrawal
- Depression
- Anxiety

All Arounders

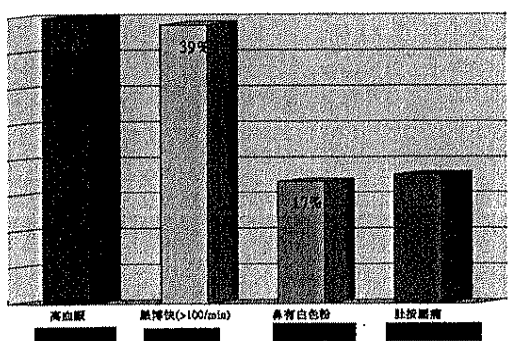
Ketamine

233 confirmed ketamine abuse A&E cases



Hong Kong Med J 2010;16:6-11

N=233



Hong Kong Med J 2010;16:6-11

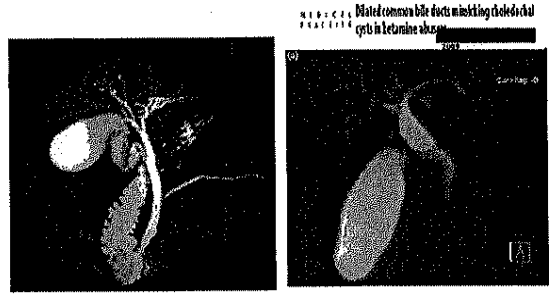
Drowsiness 爆

Nystamus in acute Intoxication

Ketamine associated Upper Abdominal Pain

- ~30% of CCPSA clients
- Onset a few hours after ketamine use
- Last x hrs to a few days
- Liver enzymes raised
- Resolved in a few weeks after cessation

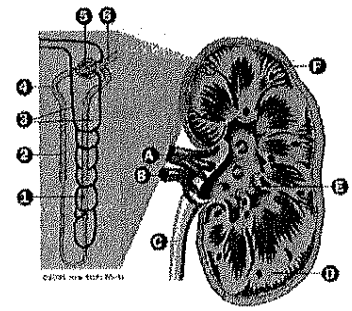
Ketamine Abuse - Biliary Obstruction



Ketamine Abuse Associated Lower Urinary Tract Destruction

- Chemical cystitis
- Use >3 times / week
- Dysuria
- Frequency
- Haematuria
- Lower abdominal pain
- Renal failure

Kidney腎臟



Ketamine Induced Urinary Tract Damage

Cystoscopy膀肛鏡

Normal 正常	K abuse 4 years 索K四年	K abuse 7 years 索K七年

ML Tse © Dr Peggy Chu TMH

Urinary Bladder Re-construction
迴腸道膀肛擴大手術

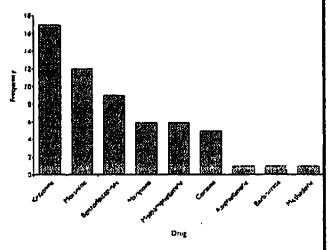
Nose damage

- Blocked nose 鼻塞
- Anosmia失去嗅覺
- Nose Bleeding流鼻血
- Sinusitis 鼻炎
- Septal perforation

More

Drug Driving

- 10% tested +ve



Hong Kong Med J 2010;16 246-51

The Overlooked All-arounders

Inhalants
Cough Mixtures

Inhalant Abuse – Cheap high

- Sniffing
- Huffing
- Bagging

Solvent Abuse

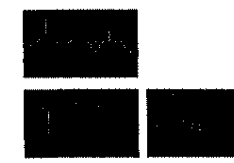
- Young adolescents
- Organic solvents, fuel, glue, duster, mothball .....
- Sudden sniffing death syndrome 55% all deaths
- Suffocation, Aspiration 15%
- Injury
- Chronic damage to brain, nerve, kidney, lung, liver

- Computer cleaning duster
  - Not simple gas
  - Fluoroethanes, Freon etc
- Cold damage to the throat, suffocation from laryngeal spasm

Nitrous Oxide

- Nitrous Oxide
- Brain damage
- Injury

Poppers



- Alkyl nitrites
- Since 60s
- Once a party drug
- Facilitate sex
- Relax sphinters
- Homosexual at risk

Known harm

- Low Blood Pressure
- Higher risk with Viagra
- Fatal
- Methaemoglobinaemia
- Hemolysis
- G6PD deficiency at risk (1in 20 male in HK)
- Brain damage in long term?

Cough Mixture 飲B

Cough Mixture

- Cough mixture
  - Proprietary
  - Pharmacy store mixed
  - Typically 3 ingredients:
    - Codeine
    - Sympathomimetic
    - Anti-cholinergic
  - Mixed effect of the three: euphoria + stimulatory + confusional
- 咳丸: 黃豆仔 /R仔/ O仔
  - Dextromethorphan
  - Synthetic opioid with mixed effect

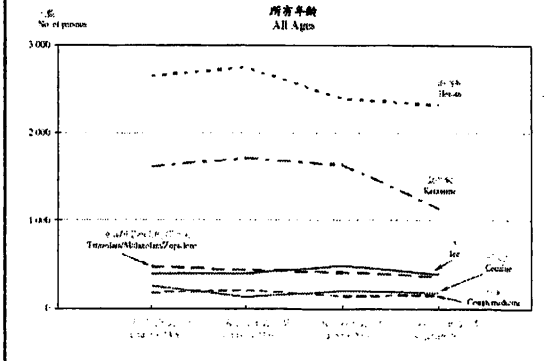
Toxicities

1. A mixture of effects + Insomia 失眠
   - Constipation便秘
   - Wt gain 体重增加
   - Dental caries
   - Vit B6 and B12 vdeficiencies: Numbness,weakness, unsteadiness (nuropathies + cerebellar degeneration), anaemia

2. **A mixture of withdrawal symptom (opioid predominates)**
   - Insomia 失眠
   - Bone pain骨"撩"
   - Runny nose流鼻水
   - Abdominal pain肚痛,diarrhoea肚疴
   - Poor concentration

3. Psychiatric
   - Personality damage
   - Psychiatric symptoms

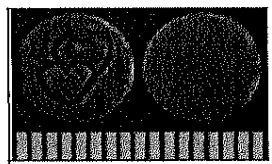
Emerging DOA



In Search of
the next
KETAMINE

New Uppers

Piperazines:
BZP / TFMPP



731

Monthly Drug Bulletin

Forensic Science Division

Government Laboratory

Piperazine Designer Drugs

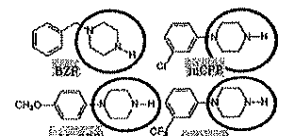
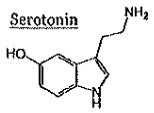


Fig. 1. The chemical structures of (A) 1-benzylpiperazine; (B) 1-(3-chlorophenyl) piperazine; (C) 1-(4-methoxyphenyl) piperazine; (D) 1-(3-trifluoromethylphenyl)-piperazine.



- 1-aryl-piperazines vs serotonin
- Can be made more specific with appropriate substituents

D. de Boer et al. / Forensic Science International 121 (2001) 47–56

A Long List

Recreational Drugs

- 4-Bromo-2,5-dimethoxy-1-benzylpiperazine (2C-B-BZP)
- 1-Benzylpiperazine (BZP)
- 2,3-Dichlorophenylpiperazine (DCPP)
- 1,4-Dibenzylpiperazine (DBZP)
- 4-Methyl-1-benzylpiperazine (MBZP)
- 3-Chlorophenylpiperazine (mCPP)
- 3,4-Methylenedioxy-1-benzylpiperazine (MDBZP)
- 4-Methoxyphenylpiperazine (MeOPP)
- 4-Chlorophenylpiperazine (pCPP)
- 4-Fluorophenylpiperazine (pFPP)
- 3-Trifluoromethylphenylpiperazine (TFMPP)

Most Famous

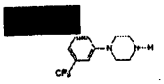


Fig. 2 Molecular structure of TFMPP.

Molecular formula C11-H13-F3-N2.

Molecular weight 230.23 Daltons (anhydrous), 266.69 (HCl).

CAS number 15532-75-9 (anhydrous), 16015-69-3 (HCl).

Fig. 3 Molecular Structure of BZP.

Molecular formula $C_{11}H_{14}N_2$.

Molecular weight 176.26 Daltons (base) 249.19 Daltons (2HCl).

CAS numbers 2759-28-6 (base), 5321-63-1 (2HCl).

Pharmacodynamics

- TFMPP
  - 5HT1 5HT2 agonist
  - LSD like effect
  - Often mixed with BZP outside HK
- BZP
  - ↑DA, 5HT, NE
  - d-Amphetamine like
  - 10 x potency

Collapse, reported seizure—and an unexpected pill

- F/18
- 5 tablets in a nightclub (thought to be Ecstasy or amphetamines)
- Collapsed and seizure x 10 mins
- Agitated, dilated pupils (8mm), HR 156 bpm, BP 160/51 mmHg, afebrile
- 6 other with similar presentations that night
- Serum and drug sample by GCMS: BZP

Death Reported

[Fatal brain edema after ingestion of ecstasy and benzylpiperazine]. [German]

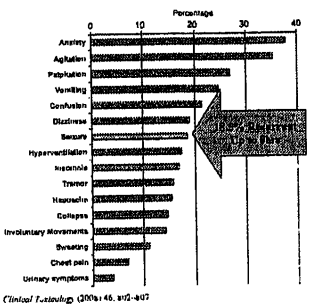
Balmelli C, Kupferschmidt H, Rentsch K, Schneemann M.

Deutsche Medizinische Wochenschrift. 126(28-29):809-11, 2001 Jul 13.
[Case Reports, English Abstract, Journal Article]

UI: 11499162

HISTORY AND ADMISSION FINDINGS: A 23-year-old woman was hospitalized with headache, malaise and somnolence 11 hours after ingestion of 3,4 (benzylpiperazine), 2 hours after ingestion of ecstasy (MDMA), and large volume of fluids. On admission she had bradycardia (heart rate 48/min), hypertension (blood pressure 154/95 mm Hg), and reduced consciousness with diminished tendon reflexes and non-reacting pupils (Glasgow Coma Score 6). INVESTIGATIONS: Serum sodium was markedly decreased (115 mmol/l (normal 135-145)) with low plasma osmolality (246 mosm/kg (normal 280-300)). Other laboratory findings were within normal limits. TREATMENT AND COURSE: The patient had severe hypervolaemic hypotonic hyponatraemia. 40 minutes after admission she seized twice and was intubated. Brain CT scan showed massive cerebral oedema with beginning tonsillar herniation. Serum sodium concentration returned to normal within 36 hours, but the patient deteriorated neurologically with increasing tonsillar herniation detected in a second brain CT scan. The patient died 57 hours after admission. CONCLUSION: 13 cases of MDMA-associated severe hyponatraemia are reported. Intake of fluids after MDMA ingestion may lead to potentially fatal hypervolaemic hypotonic hyponatraemia with cerebral oedema. Symptoms appear about 8 hours (range 4-18) after MDMA ingestion. Even low doses of MDMA and fluids may lead to a serious outcome. The only risk factor is female gender. Measurement of serum sodium and brain CT scan is recommended in all patients with altered mental status after MDMA consumption.

Clinical Effects



Clinical Toxicology (2006) 44, 415–417

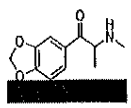
- Average 3.89 pills taken
- Many symptoms persisted > 24 hrs
- 2 patients with severe sympathomimetic toxicity reversible multiple organ failure
- 2 seizures with profound metabolic acidosis

Bath Salts
"Not for human consumption"

- Mephedrone
- MDPV
- Methylone

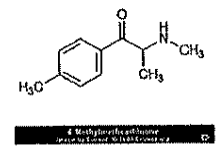
Methylone (3,4-methylenedioxy-N-methylcathinone)

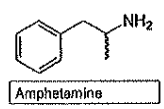
- MDMA like
- Less "magical"
- Not getting very popular

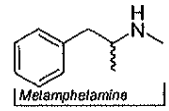


Mephedrone
喵喵

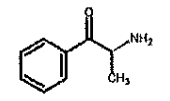
Mephedrone喵喵

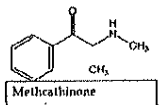




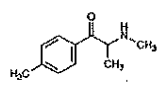


Cathinone, methcathinone, mephedrone





Methcathinone
(Ephedrone, Cat, Jeff, Mulka)



4-Methyl-methcathinone
(4-MMC)
METHyl-EPHEDRONE

- Other cathinone derivatives:
  - Methedrone (4-methoxymethcathinone)
  - Methylone (cathinone analogue of MDMA)

Synonyms

- 喵喵Meow (Meow),
- plant food, plant feeder
- Bath salt
- Miaow (Miaow), meph, m-cat,, plant growth inhibitor, bubbleluv, bubbles, drone, MD3, MMCat, Moonshine, Neo drones, roxy, rush, S.C. spirit, sub coca I, top cat, white magic
- Not For Human Use

Route of use

- ***Oral*** (powder wrapped in cigarette paper and bombed, capsule / pill form, diluted in water – whizzy water, juice drink)
- ***Nasal***
- ***Rectally*** (uncommon, diluted in water by using a syringe)
- ***Injection***

www.crew2000.org.uk / Toxbase

Mephedrone pharmacology

- Effects similar to MDMA
- ~ ½ potency
- Duration of effects (oral, from Erowid)
  - Onset 15-45 mins
  - Come up 15-30 mins
  - Plateau 15-30 mins
  - Comedown 30-90 mins
- After effects 2-4 hrs

mixmag MixMag Drug survey 2010 (UK)

41.7% had tried mephedrone
(cannabis 93%, ecstasy 91%, Salvia 29.2%, 2CB 18%, Spice 12.7%, methylone 10.8%)

www.mixmag.net/mephedrone

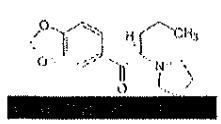
Data from 215 reports for mephedrone, methdrone and methcathinone

- Tachycardia, palpitations
- Hypertension
- Anxiety, agitation, headache
- *Excessive sweating (sometimes with a chemical smell)*
- Nausea
- *Convulsions,*
- hallucinations, raised CK, chest pain, skin rash and *peripheral vasoconstriction*
- Nasal irritation and epistaxis may occur after nasal insufflation

MDPV

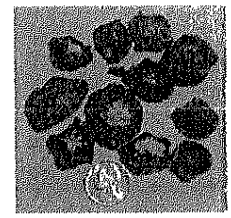
MDPV (Bath salt / Super coke / Magic)

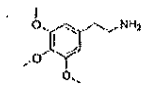
- NE and Dopamine reuptake inhibitor
- Cocaine Substitute



烏羽玉 Peyote

Peyote Button





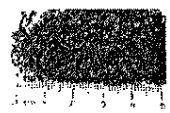
Mescaline

All Arounders

鼠尾草 Salvia (Magic Mint)

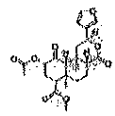
The "Youtube Drug" 13000 records

[2]



[3]

[2] Picture from Wikipedia of a Salvia divinorum plant.



Kappa opioid receptor agonist

Salvinorina A

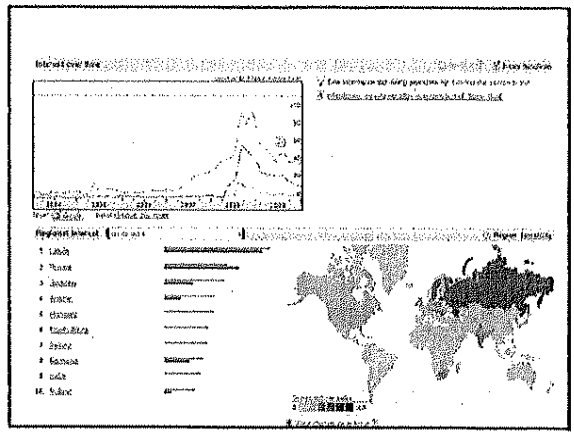
Salvia

Use

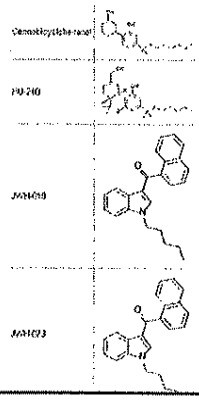
Smoke with pipe

Quid (chewing)

Synthetic
Cannibinoid Receptor Agonist:
Spice / K2



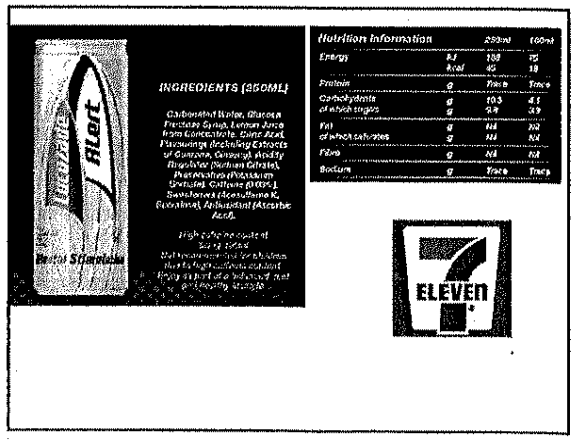
- Plant (usually Salvia) laced with synthetic cannabinoid receptor agonist
- Acute psychosis
- Newer ones are coming K3, K4?



A Legal Drug

Caffeinated energy drinks

- USA –
  - fastest growing beverage market,
  - 50% market consists of age < 25 years old
  - 30-50% adolescents and young adults reported consumion



Drink	Ounces	Caffeine	mg/oz
Starbucks Grande	16	300	20.6
Cocaine Energy	8.4	280	33.3
Starbucks Tall	12	260	21.7
McDonald's Large	16	145	9.1
Red Bull	8.46	80	9.5
Coffee (Expresso)	1.5	77	51.3
Coffee (Instant)	8	57	7.1
Tea (Brewed, Iced)	8	47	5.9
Pepsi-Cola	12	38	3.2
Coca Cola (Classic)	12	35	2.9
Green Tea	8	25	3.1

USA

http://www.energyfiend.com/the-caffeine-database

5150 Semi Sweet Energy Mix

Fixx Extreme - Caffeine Content

ALRI Hypershot - Caffeine Content

Energy Mix, Energy Shots

Caffeine + Alcohol

- **Alcoholic energy drinks**
- Alcohol 6%-9.9% + caffeine 80 to 400 mg
- ↓ drowsy feeling but not functional impairment
- ↑ alcohol consumption

Serious toxicities from energy drinks

- Poison Centre Data from Germany, Ireland and New Zealand
- Seizures
- Psychotic conditions
- Rhabdomyolysis
- MI
- Dysrhythmias
- Deaths

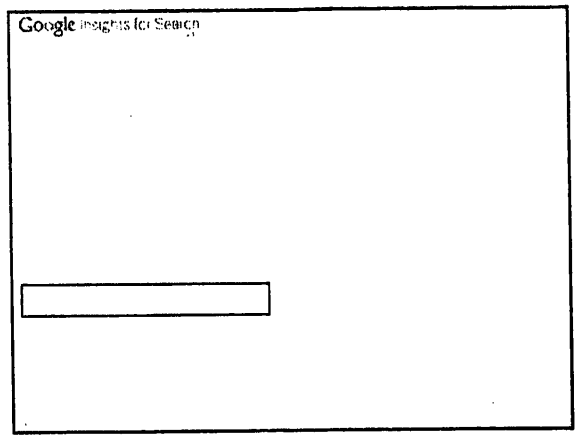
http://www.beveragedaily.com/Markets/Energy-drinks-safety-questioned-by-German-agency

Regulations?

- Only a few countries have bans / explicit restriction
  - Denmark – prohibits energy drinks entirely
  - France – bans Red Bull until 2008
  - Australia – bans some energy drinks with caffeine > 320 mg/L
  - Canada – requires warning labels, max daily consumption
  - Norway – only sold in pharmacies
  - Sweden – Sales < 15 yr old banned
  - Most other countries considering warning labels / special labels (avoid confused with alcoholic drinks)
- States of Kentucky, Louisiana, Maine, Michigan introduced legislation on ban but defeated
- Germany issued a ban but lifted by EC

DOA intelligence site

Erowid.com



Psychonaut Projects +

Thank You

Review of Treatment Effectiveness and the Implication on service commissioning and development in England – A Case Study in Harrow

Certificate Course on Drug Treatment and Rehabilitation in Hong Kong
22rd Sept 2011
Rosanna Cowan

Objectives

- Understand the Process of Needs Assessment in Harrow
- Understand the client/treatment match via screening, assessment, brief interventions and specialist treatment
- Highlight best treatment approaches and interventions for people with problems of alcohol misuse and dependence

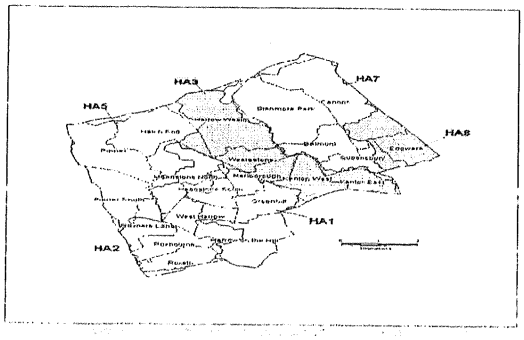
Outlines of the Presentation

- About Harrow
- Needs Assessment – Prevalence and Treatment Population
- Alcohol related harms and their cost
- Broaden the base of treatment & intervention
- Recent Evidence on Treatment Effectiveness
- A&E Project – Screening & Brief Interventions
- Detoxification & pharmacological enhancements to Treatment
- Family Interventions
- Prevention – Community Engagement

NTA Treatment Business Plan
5 Major Strands

- **Improving outcomes**, using the TOP and data warehouse project
- **Better value for money**, providing comparative unit cost data and allocating funding to incentivise achievement
- **Championing abstinence-focused treatment**, with new clinical protocols on substitute prescribing to prevent unplanned drift into long-term maintenance
- **Commissioning a rebalanced treatment system**, developing patient placement criteria to ensure a transparent approach to commissioning community and residential rehabilitation, and new services for new problems such as legal highs
- **Rehabilitating offenders**, working with MoJ and Offender Health to promote abstinence-focused treatment in CJ settings

London Borough of Harrow
First Part of Postcode Areas
to Wards



About Harrow

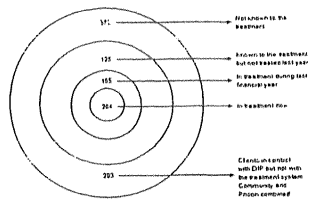
- Population: 214,800 (2007), forecasting 6% increase by 2016
- High proportion for those over 65s and 5-15 years old
- An increase in all other age groups, except the age group of 15-24 years old
- Ninth most ethnically diverse local authority
- 41 ethnic groups, people from 137 countries. 41% BMEG
- White British 50%, White Irish & other 9%,
- Asian Indian 22%, Asian Pakistani 2%, Asian Bangladeshi 0.5%, Asian other 5%
- Black Caribbean 3%, Black African 2 7%, and Black Other 0.5%
- Transient population for school children and over 50% from different countries

- Inequalities Deprivation in Harrow
- Deprived areas: Roxbourne, Stanmore Park, Wealdstone, Rayners Lane (coincide with Council Estates)
- High % of home-owners, and lower housing stocks in comparison to London as a whole
- The "at risk" group are older people, people from lower SES and or an Asian background, A8 nationals
- A record of 9,300 refugees and asylum-seekers in 2004, from Somalia, Afghanistan, Yugoslavia Kosovo, Iran, Iraq and Sri Lanka These vulnerable groups pose challenges to the statutory and voluntary organizations.

A Comparison between Asian and Black Population (Harrow JSNA 2008)

Social indicators	Asian or Asian British	Black or Black British
Socio-economic Status	Those with Indian Origin with higher SES than those in other parts of London	Black Caribbean & Black Others as an upwardly mobile groups
Family Structure	Highest married couple households	Highest on lone parent households
Education/ Employment	High achiever/ high employment rate	More likely than White & some other ethnic groups to continue education & training More unemployed status for young people
Children in Need	Under-represented	Over-presented when compared to White
Areas of concern	Involvement in unsafe sex, self harm, & increasing use of drugs	Unemployed, children in needs, mental health
Criminal Activity	Under-represented	Over-represented (Young Black men)

Harrow Bullseye 2009/10



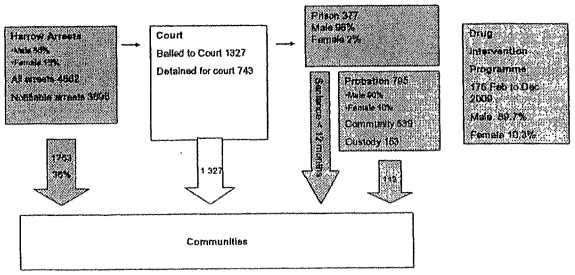
Problematic Drug Users Comparison

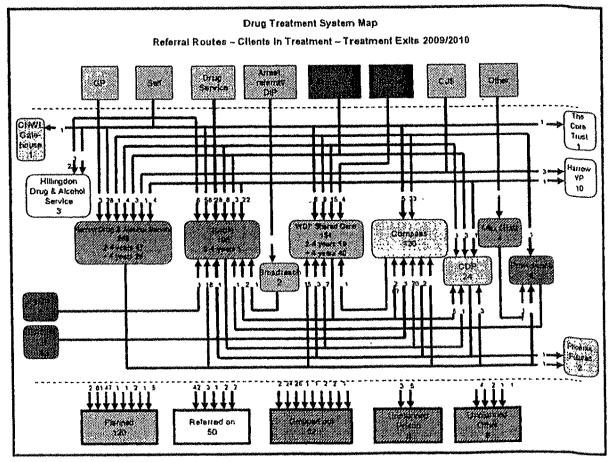
	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010
In Treatment	352	331	282	335	264
In Treatment during last financial year	41	47	132	124	155
Known to the treatment but not treated last year	103	64	76	110	125
Clients in contact with DIP but not with the treatment system Community and Prison combined	3	77	33	209	203
Not known to the treatment	443	386	402	320	580
Prevalence Estimate (Glasgow University)	939	742	889	889	1124

Link between Drugs and Crime

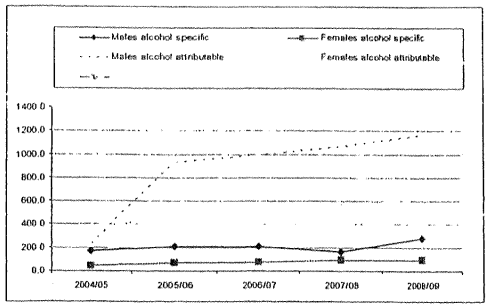
- Possession – personal use and supply
- Violence and Intimidation
- Acquisitive Crime
- Estimates suggest that drug misusers commit acquisitive crime

Harrow Criminal Justice Pathway Data 2009-2010



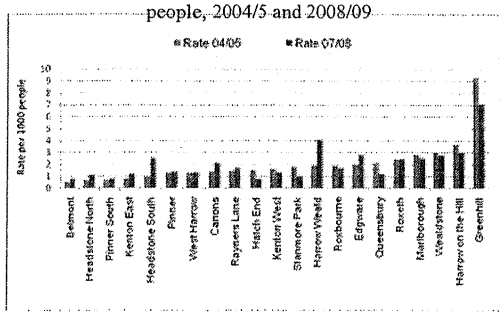


Harrow: trends in alcohol-specific and alcohol attributable hospital admissions 2004/5 - 2008/09

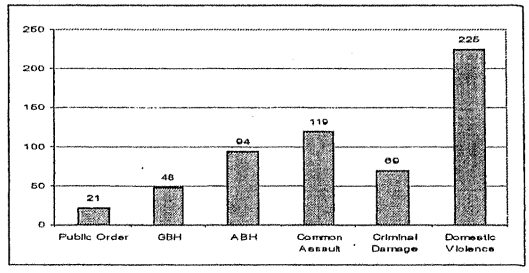


		2004-05	2005-06	2006-07	2007-8	2008/09
Males	alcohol specific	175.7	209.7	214.1	166.7	251.4
Females	alcohol specific	46.7	72	76.8	98.5	98.2
Males	alcohol attributable	724.5	931.5	997.4	1083.5	1150.9
Females	alcohol attributable	355.3	476.9	499.1	569.9	619.7
Alcohol related DSR rates		536	930	1091	1184	1311
% change - alcohol related (DSR)		25%	33%	13%	10%	13%
Number alc-related admissions		1604	2165	2479	2732	3161
% change in alc-related numbers		27%	35%	15%	10%	16%

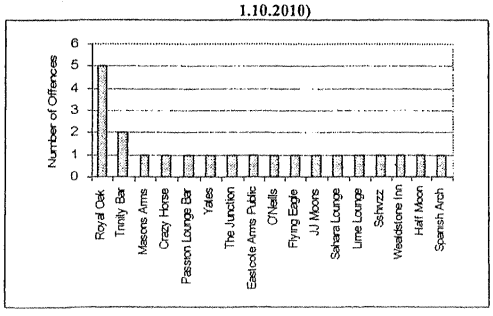
Alcohol-related ambulance call-outs in Harrow, rate per 1,000 people, 2004/5 and 2008/09



Frequency of 2009/10 (tax year) alcohol related crimes in Harrow – by offence



No of crimes where 'alcohol' or 'intoxicant' or 'drunk' was tagged to the offence, and the venue was a licensed premise (1.4.2010 to 1.10.2010)



Service Gaps/ Unmet Needs

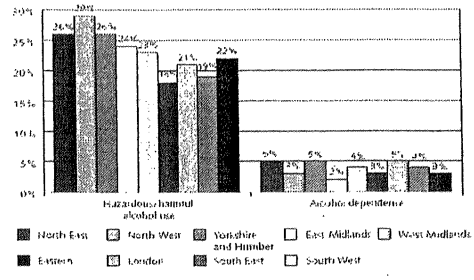
- Referrals from DIP to Structured Treatment Programme
- Group programme (i.e., stimulant)
- Abstinence-focused treatment
- Assertive Outreach
- Housing/ Education/ Training/ Employment
- Tier 4 funding

Service Improvement

- Integrated Care Management
- Community Alcohol Recovery Programme
- Rehabilitation, Recovery and Reintegration
- Volunteer/Education/Training/Employment Assessment and Pathways
- Single Data Collection System
- Personalized Care and Enablement
- Service Users and Carers Engagement
- Prevention and Community Engagement
- Value for Money

The Problem-England

Alcohol Needs Assessment Research Project (2005)



Drummond 2005

Categories of alcohol misuse

- International Classification of Mental & Behavioural Disorders (ICD-10)
- Dependence is defined as "a cluster of physiological, behavioural and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours".

Categories of Alcohol Misuse

- Strong desire or sense of compulsion to use
- Difficulties in controlling substance use
- A physiological withdrawal state
- Evidence of tolerance
- Progressive neglect of social activities
- Continued substance use in the face of overtly harmful consequences

Definitions

- **Hazardous drinker**
  - Heavy or binge drinkers with drinking patterns that pose a considerable risk to their own and others' health.
- **Harmful drinker**
  - Clear evidence that alcohol use is responsible for (or substantially contributes to) physical or psychological harm, which may lead to disability or have adverse consequences for interpersonal relationships.

Definitions

- **Moderately Dependent Drinking**
  - Individuals recognize that they have a problem with drinking, may experience a raised level of tolerance, symptoms of alcohol withdrawal and impaired control over drinking.
- **Severely Dependent Drinking**
  - Chronic alcoholics
  - Have serious and longstanding problems, have experienced withdrawal fits or delirium tremens
  - Formed the habit of drinking to counter or avoid incipient withdrawal symptoms.

A Spectrum of Responses to Alcohol Problems

None	Hazardous Drinking	Harmful Drinking	Moderately dependent drinking	Severely dependent drinking
Primary Prevention	Brief Intervention	Extended Brief Intervention	Less-intensive treatment	Structured Treatment
Public Health Programmes	Generalist setting	Generalist setting	Generalist/ Specialist setting	Specialist Setting

Broaden the base of treatment

- **Aware of Different Categories**
- **Individual Treatment Goal and Plan**
- **Including family and friends in treatment**
- **Service User Choice or self matching**
- **Equitable access to treatment**
- **Stepped Care**
  - Allow many episodes/ lapses/ relapse
  - Level of interventions/ Intensity of care/ Aspirations

Recent Evidence on Treatment Effectiveness

A. Measurements of Effectiveness

- Pre-treatment Motivation (Change Model)
- Therapist Effect – 9 to 40% variance
- Shared Ingredients – social behaviour & support network
- Matching- "weak" with exception for those with high emotional state (passion)
- Post Treatment Events – positive/ negative

Recent Evidence

The Mesa Grande Project (William R Miller et al.)

- Systematic reviews of outcome research studies
- Measure the relative quantities of research evidence rather than the degree of effectiveness
- Ranks of Treatment Modalities:
  1. Brief Intervention
  2. Motivational Enhancement
  3. Acamprosate
  4. Community Reinforcement/ Self-change Manual

Recent Evidence . . .

B. Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity, U.S.), 9 sites, Findings:

- Psychiatric Severity (low better in TSF , outset)
- Network Support for drinking (AA setting)
- Client anger (outpatient, matching MET, persist in days of abstinence, 1 to 3-yr follow-up)
- Alcohol Dependence (low with CBT, high with TSF)

Recent Evidence . . .

C. UKATT (United Kingdom Alcohol Treatment Trial, in Leeds, Birmingham & Cardiff, 5 Tx sites).

- Motivational Enhancement Therapy (MET) – three 50-minute session over 8 weeks
- Social behaviour & network therapy (SBNT) – eight weekly 50-minute sessions
- Cost effectiveness – £1 investment, £5 saving

A&E project: Definition of Alcohol-Related Attendances

- Under the influence of alcohol (n=1734; **88.8%**)
- A "medical" complication related to excess alcohol (n=427; **21.9%**)
- Trauma as a result of alcohol ingestion (n=651; **33.4%**)
- Trauma to a third party as a result of excess alcohol (n=533; **27.3%**)

Alcohol-Related Attendances

A snapshot in Liverpool Hospital
Total number of patients = 1952

- A & E Department, **n=1915**, 98.1%
- Total number of A & E attendances **n=15,931**
- Average daily attendance which was alcohol-related

Reasons for Detecting Heavy Drinking

- **Failure to detect may lead**
  - Unnecessary investigations
  - Alcohol withdrawal syndrome
  - Recurrent harm (end-organ damage)
  - Recurrent hospital attendance

Alcohol Specialist Role

- Increase Detection & Screening
- Provide treatment and intervention choice
- Provide alternative pathways for GP referral
- Reduce inappropriate attendance / admission
- Provide timely discharge
- Optimise medical management

Investigation: The Ideal Test

- High sensitivity
- High specificity
- Discriminate between safe drinking and hazardous drinking
- Should distinguish between non-alcoholic liver disease and alcohol-related damage
- Non-invasive
- Cost-effective

Screening Questionnaires

- Paddington Alcohol Test (PAT)
- The Michigan Alcohol Screening Test (MAST)
- The CAGE Questionnaire (CAGE)
- The Alcohol Use Disorders Identification Test (AUDIT)

Screening Questionnaires

- The Michigan Alcohol Screening Test (MAST)
  - Exists in 3 versions
  - Original has sensitivity of 98%
  - Used in a wide variety of settings
  - More sensitive than routine history taking

Screening Questionnaires

- **The CAGE Questionnaire (CAGE)**
  - 4 questions
  - More sensitive than routine laboratory markers (93% vs 16% for GGT)
  - insensitive to milder hazardous drinking
  - high false positive rate

Screening Questionnaires

- **The Alcohol Use Disorders Identification Test (AUDIT)**
  - 10 item questionnaire
  - 10 minutes to complete
  - A score >8 highest sensitivity
  - Identifies hazardous drinking earlier and with greater sensitivity than
    - MAST/CAGE questionnaires
    - Routine history taking

Detoxification & Pharmacological enhancements

- Medications for detoxification (Natrexone, 13%, Disulfiram-Antabuse%, antidepressants 46%, Benzodiazepine 11%)
- Relapse prevention medications (e.g.,sensitising agents- Antabuse, anti-craving agents- Naltrexone, acamprosate)
- Nutritional supplements- adequate thiamine

Non-alcohol-focused Specialist Treatment

- Social Skills Training (interpersonal & intrapersonal skills)
- Counselling (person-centre, psycho-dynamic)
- Self-esteem and complementary therapies
- Self-help manuals (based on CBT is more effective)
- Computer & internet-based self-help
- Collective Mutual Aid (AA, 12-step, peer-led support)
- Education/ Training/ Employment

Family Interventions

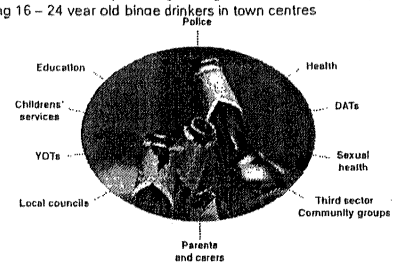
- Identify the barriers for family support and treatment
- Service to be sensitive to the socio-cultural context
- Reduction in stigma and shame (women & elderly)
- Establish more open and trusting relationship
- Create a child-friendly environment
- Clear guidelines for confidentiality

Stepwise approach to counsel relatives of problem drinkers in generic services

- Listen, reassure, explore concerns
- Provide relevant information
- Counsel about coping
- Counsel about social support
- Discuss needs for other sources of specialist help

Alcohol

Developing social marketing interventions on behalf of Lancashire LAA to reduce levels of risky drinking among those who are underage and among 16 – 24 year old binge drinkers in town centres



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- Website: Adfam, Alcohol Concern

British Drug Treatment Policy and its Implementation

Certificate Course in Treatment of Drug & Alcohol in Hong Kong

22nd Sept 2011

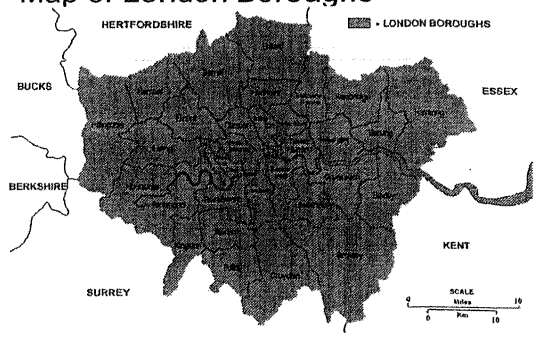
Rosanna Cowan

Content

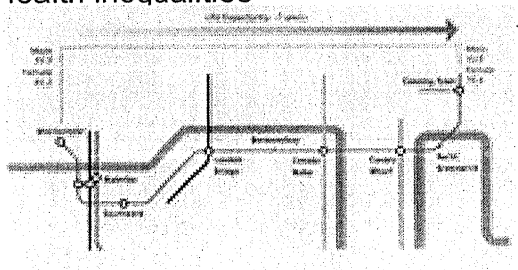
Introduction

- Reforms to the National Health Service, Criminal Justice and Benefits System
- A commitment to £81bn of public spending cuts
- Market Approach – competition & choice, procurement, contracting, accountability, value for money and payments by result
- Public Service Ethos – based on needs rather than finance
- Delay in progress during transition (i.e., 2 years)
- Preservation of standards, governance, expertise and corporate memories

Map of London Boroughs



Health inequalities



Policy Changes: National Health Services

- Abolishing Primary Care Trust in 2013
- Set up Public Health England
- Set up NHS Commissioning Board
- Locally, set up Clinical Commissioning Group, led by General Practitioners and Politicians
- Need to pass Social and Health Care Bill
- £20 billion savings on NHS
- Focusing on Quality, Innovation, Prevention, Productivity

Policy Changes: Public Health Strategy

- Preventative Care in England
- Addressing issues of health inequality
- Health Promotion
- Health Improvement
- Commissioning Support – population study and evidence
- Ring-fenced public health budget
- Relocating to Local Authorities

Policy Changes: New Drug Strategy 2010

- Focus on preventing drug and alcohol misuse in communities
- Put responsibility on individuals
- A holistic approach: taking account factors of offending, debts, benefits, employment and housing
- Building recovery in communities
- Director of Public Health to oversee the commissioning of drug and alcohol treatment
- Stakeholder Engagement and Partnership Working

Policy Changes: Rehabilitation Revolution

- Rehabilitate offenders by getting them off drugs and benefits and into work
- Integrated Offender Management
- Awarding prison treatment contract to independent providers by the method of Payment by Results
- Reduce reconvictions and provide broader collaboration at the community level.

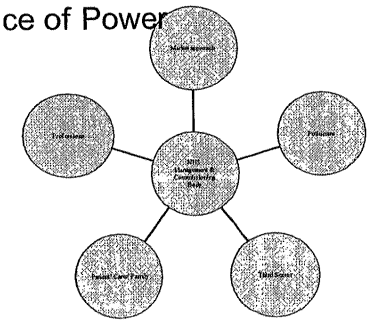
Policy Changes: Benefit Reform

- Develop a single system and motivate people to return to work
- Scrapped educational maintenance, pregnancy and lone parents allowances
- Universal Credit System to assess people's capability for work
- Work Programme to provide advice, training and support for re-employment

Pros and Cons of the Reform

- Big Society
- Localism
- Community Building
- Innovation, Quality, Productivity and Prevention
- Making a broken model bigger does not make it less broken
- Dictated by Performance Indicators
- Lack of resources
- Cost more for innovative projects

Balance of Power



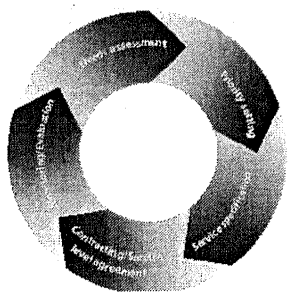
Drug Policy: fundamental concepts

- War on Drugs Vs Health-oriented approach
- Harm Reduction Vs Recovery/ Abstinence
- Control Vs Care
- Needs Vs Market Approach

Commissioning Drug Treatment Services

- In 1997, Tony Blair declared that drug Use would be a policy priority for his government.
- Government's First 10 Year Drug Strategy 1998
- In 2001, the National Treatment Agency (NTA) has been set up to oversee the investment in drug treatment
- Over the past three years, the annual cost of drug treatment investment is around £400m in England.
- 149 Drug Action Teams in England
- Change of Government in 2010 – NHS Reform

Commissioning Cycle



Models of Care 2004

- Provides the framework required to achieve equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in England.
- Advocates a systems approach to meeting the multiple needs of drug and alcohol misusers.
- Reflects professional consensus of 'what works best' for drug misusers, resulting from an extensive consultative process.
- Based upon current evidence, guidance, quality standards and good practice in drug treatment in England.

Definition of Treatment

- *This term describes a range of interventions that are intended to remedy an identified drug-related*
  problem or condition relating to a person's physical, psychological or social (including legal) well-being.
- *Structured drug treatment follows assessment and is delivered according to a care plan, with clear*
  goals, which is regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions.

Four-Tier Treatment Services

- Tier 1: Non-substance misuse specific services interface with drug & alcohol Treatment
- Tier 2: Open access drug and alcohol treatment services
- Tier 3: Structured community-based drug treatment services
- Tier 4a: Residential services for drug and alcohol misusers
- Tier 4b: Highly specialist non-substance misuse specific services

What constitutes Effective Treatment System?

- Integrated care pathways
- Clinical Governance and Monitoring Structure
- Safeguarding Vulnerable Adults, Children and Families
- Information Sharing Protocols and Consents
- Stakeholder Engagement and Effective Communication
- Empowering Service Users, Families and Carers
- Open Transparency and Accountability

Components of Effective Treatment Service

- Provide a package of care from access, intensive interventions to planned discharge
- Be sensitive to the person and his/her cultural, social and economic background
- Focus on the aspiration and user-led support
- Treatment is the beginning and recovery is the end
- Deal with complex issues, such as physical and mental health, criminal offence, poly substance misuse, social and emotional aspect, housing, education and work ability.
- Invest in front-line capacity and staff competency
- Forward looking, social inclusive, efficient and cost effective

Estimates of number of illicit drug users, 16-59 year olds

	Ever taken	Last year	Last month
Class A			
Cocaine (Powder cocaine, Crack cocaine)	2,838,000	813,000	265,000
Ecstasy	3,692,000	517,000	203,000
Hallucinogens (LSD, Magic mushrooms)	2,969,000	161,000	42,000
Opiates (Heroin, Methadone)	283,000	50,000	28,000
Class A/B			
Amphetamines (Amphetamines, Methamphetamine)	3,777,000	319,000	110,000
Class B			
Cannabis	9,912,000	2,152,000	1,250,000
Class B/C			
Tranquilisers	948,000	145,000	73,000
Class C			
Anabolic steroids	226,000	50,000	19,000
Ketamine	656,000	159,000	79,000
Not classified			
Amyl Nitrate	3,091,000	351,000	115,000
Glues	739,000	57,000	17,000

Source: Drug Misuse Declared: British Crime Survey 2009/10

Table 3: Drug Treatment budgets, activity and outcome data 2004/05 to 2008/09

	Adult pooled treatment Budget	Local Funding	Total funding	Number of adults in effective treatment[2]	Total treatment funding per adult in effective treatment
2004-05	£225m	£226m	£481m	134,000	£3,600
2005-06	£300m	£226m	£526m	145,000	£3,600
2006/07	£380m	£224m	£604m	164,000	£3,700
2007-08	£383m	£207m	£590m	183,000	£3,200
2008-09	£373m	£208m	£581m	195,000	£3,000

Source: Tackling problem drug use – National Audit Office 2010

Principles of New Drug Strategy 2010

- Demand reduction – to create an environment where young people are resilient to pressure on drug misuse
- Supply restriction – the estimated £15.4 billion annual cost of drug use on economic, criminal justice system and employment
- Building recovery in community-fundamental to the drug and alcohol treatment model is to get people fully recovered from their dependence.

Future Trend of Substance Misuse

- A high preference of alcohol, cannabis, ecstasy, Ketamine, crack cocaine, powder cocaine by the Young Adults (i.e. 18-25 years).
- Emerging evidence of poly-substance misuse and multiple addictions
- Over-representation of Black young drug users in the criminal justice system
- Migration and culture-specific drug and alcohol use
- Internet purchase of Legal Highs

Recovery in the Community

- Preparing Recovery – Prevention, Education, Access
- Developing Recovery – Engagement and Stabilization, Psychosocial Intervention and Aftercare and intervention
- Family, housing, peer support, a network of recovery champions and community interventions
- Education/ Training/ Employment – linked with Job Centre Plus, College, Volunteering, Apprenticeship Scheme and Employment Training

Measures of Payment by Results

Initial and Final Outcomes applicable to:

- Free of drug(s) dependence
- Employment Ready
- Offending
- Health & Well Being – initial outcome

(Injection, No Fixed Abode, Hep B Vac., Health and Social Functioning)

New Challenges

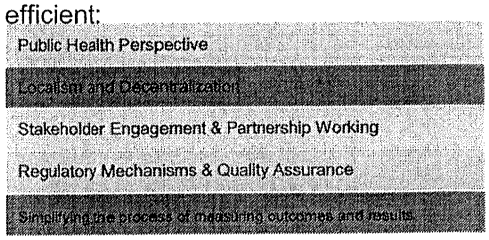
- Public Health England – linking to sexual health, smoke cessation, mental health promotion, immunization, alcohol prevention
- Recovery in the Community
- Quality Innovation Prevention and Productivity
- Budget cuts
- Payment by Results/ Value for Money

Health Inequalities

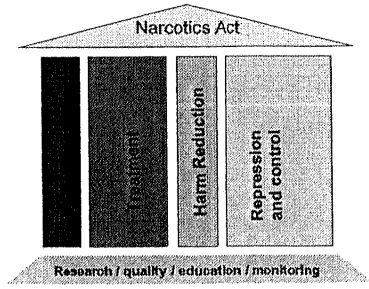
- Alcohol misuse costs UK £18-25 billion a year including loss of productivity in work place, violent crime, drink driving, domestic violence and health and social problems
- Alcohol Concern (2010) estimated 1.6 million dependent drinkers in England
- Ratio of drug to alcohol: 1 to 4
- Issues – no dedicated alcohol treatment funding

Critical Success Factors

To deliver drug and alcohol treatment service that is better, safer and more efficient:

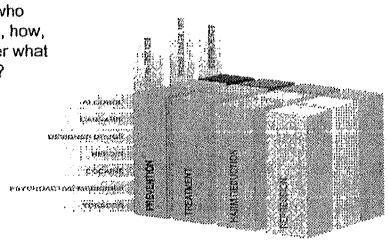


Swiss: the Four-pillar" Drug Policy



Swiss Model: The addiction cube

Key question: who should do what, how, when and under what circumstances?



Useful Website links

- www.alcoholacademy.net
- www.alcoholpolicy.net
- www.dh.gov.uk
- www.homeoffice.gov.uk
- www.nta.nhs.uk
- www.hsj.co.uk
- www.alcoholconcern.co.uk

Out of crime, into treatment

Addiction & Offender Management Policy in England

Certificate Course on Drug Treatment and Rehabilitation

29th September 2011

Rosanna Cowan

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Out of crime, into treatment

Contents

- Introduce the reform of addiction and offender management in England since 2003
- Introduce the Rehabilitation Revolution
- Diamond Initiatives and Integrated Offender Management
- The Drug Intervention Programme (DIP) and a Continuity of Care from Prison to Community
- Share the experience of running DIP/PPO scheme in Harrow

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Criminal Justice Act 2003

Themes

- Based on White Paper: Justice for All July 2002
- Increased use of fines – movement from community orders
- Tougher and more flexible community orders
- Custody for dangerous, serious and prolific persistent offenders
- Short prison sentences capable of rehabilitation

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Policy Changes: Rehabilitation Revolution

- Rehabilitate offenders by getting them off drugs and benefits and into work
- Integrated Offender Management
- Awarding prison treatment contract to independent providers by the method of Payment by Results
- Reduce reconvictions and provide broader collaboration at the community level.

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Sentencing

Purpose

- Punishment, reduction of crime including by deterrence, reform and rehabilitation, protection of the public, making reparation to those affected by their offences

Seriousness

- Determined by two factors: Culpability of offender and Harm caused or risked being caused by the offence

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Sentencing Process for a Community Sentence

- Court indicates initial view of seriousness – Statement of adjournment
- Should indicate whether the offence is in the L, M or H seriousness band
- Should indicate the purpose of sentencing
- (Punishment, Crime reduction, report and rehabilitation, public protection, reparation and other requirements it would like considered)

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Custody – Sentence under twelve months

- Suspended sentence with requirements (same as the community order)
- Intermittent custody (custody blocks at weekends or on weekdays, maintenance of family, home, job, education, etc)
- Custody plus
  - a period of 2-13 weeks followed by a period of 26-49 weeks on licence
  - Licence must contain one out of eight requirements set by the Court

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Custody – Sentence of Over 12 months

Standard Determinate Sentences of Imprisonment 12 Months or more
Automatic release on licence at the half way stage
Licence continues to the end of the sentence
Parole board does not determine release, but reviews recall

Public Protection Sentence for Dangerous Offenders
Life imprisonment for public protection – indeterminate sentence
Extended sentence for public protection – licence period Extended, 5 years for violence, eight years for sexual offences

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Community Order

- A new single community order contains 1 out of 12 requirements (can be mixed subject to compatibility)
- Electronic monitoring back up
- 12 requirements
  Unpaid work, Supervision, Accredited Programme
  Drug Rehabilitation, Alcohol Treatment, Mental Health Treatment
  Residence, Specified Activity, Prohibited Activity
  Exclusion from a place, Curfew, Attendance Centre

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National Standards – Drug Rehabilitation Requirements (DRRs)

Contact – First 16 weeks

- First contact with treatment provider within 2 days
- High Seriousness – 15 hours per week
- Medium Seriousness – 8 hours per week
- Low Seriousness – 1 contact per weeks, hours not specified

Contact after first 16 weeks

As determined by the probation officer in consultation with the treatment co-ordinator

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Testing

- Twice a week for the first 16 weeks
- Once a week thereafter
- If offender admits to drug use in writing the test may be waived
- Court Review – once every four weeks for first 16 weeks, once every 16 weeks thereafter
- Review report must contain (test results, compliance, progress in treatment)

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Enforcement

- Offender must be returned to court for breach of the order following second unacceptable failure in 12 months to attend appointment with probation officer , treatment provider or any other person identified in the supervision plan
- Offenders must be returned to court for breach of the order for refusing to take a drug test
- Positive drug tests are not a breach of the requirement but may influence the decision whether to take action concerning another incidence of non-compliance

Alcohol Treatment Requirement

Report must propose
Length of treatment
Name of provider- person or agency
Treatment provider determines level of contact
National Standards apply

Diamond Initiative

- Cost – 11.1 millions
- Operation since early 2009 (3-year project)
- Led by London Criminal Justice Partnership Board
- Six pilot London Boroughs (Crodyn, Hackney, Lambeth, Lewisham, Newham & Southwark).

Aims of DI

- Identify offenders based on where they live (or may return to live) focusing on areas with high concentrations of offenders leaving custody;
- Work with offenders and local communities in order to reduce absolute levels of reoffending;
- Deliver services through a combination of criminal justice agency (police, probation and prison) resource and that from a wider range of stakeholders (particularly local authorities, health, and third sector organizations); and
- Share good practice with existing initiatives such as Safer Neighbourhoods and resettlement programmes.

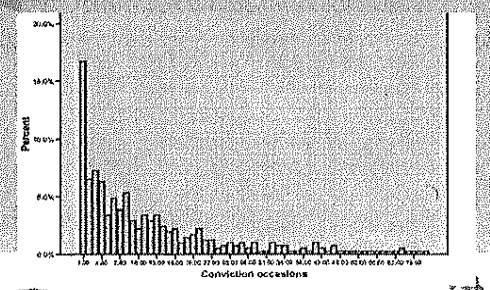
Research: Methods and Study

- Examine 3 characteristics of the DI offenders, process and impact and a control group
- Survey, Interview and Data Analysis
- Staff survey-wave 1 51/76 wave 2 67/73
- Recruit 418 offenders analyzed by each borough
- Interviewed 29 offenders

Table 3: The Diamond Initiative cohort by borough

Geographic spread	Southwark	Croydon	Hackney	Lambeth	Lewisham	Newham	Total
Total sample (N)	115	97	57	14	78	57	418
Mean age	33	30	29	39	34	32	32
Mean age of first conviction	22	22	22	21	24	23	22
Mean no. of conviction occasions	14	12	8	21	13	10	12
Mean no. of offences	25	20	16	36	25	19	23
% White	49	36	29	57	29	61	42
% Black Caribbean	33	49	45	42	48	24	40

Distribution of Conviction Occasions



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Types of Offender

	Type 1 *Property crime*	Type 2 *Impulsive/expressive violence*	Type 3 *Instrumental violence*	Type 4 *Vehicle related offending*	Type 5 *Sexual offending*
% of violence	28.1%	6.0%	7.5%	6.6%	6.2%
Offences	Handling offences (0.69)	Harassment / Threats (0.67)	Weapons offences (0.53)	Vehicle (theft of / from) (0.75)	Sexual offences (0.32)
	Shoplifting (0.58)	Criminal Damage (0.66)	Robbery (0.44)	Driving offences (0.50)	
	Burglary (0.57)	Violence (0.43)			
	Other theft offences (0.55)	Public Order (0.39)			
	Breach offences (0.46)				
	Drug Offences(-0.21)				

(Fraud and Forgery and 'other' offences did not fit strongly with any of the five factors)

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Key Learning

It is too early to robustly assess impact, but we know that the 6 month re-offending rate for Diamond Initiative cohort (28%) was lower than a comparison group generated by the academic reference group (43%).

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DI- Critical Success Factors

- Staff recruitment/ Ethos of DI
- Team working
- Refresh training
- Basic Resources (building, IT systems)
- Co-location as a critical method
- Deselection – non-standarized criteria
- Present a range of complex needs
- Mixed views of wearing police uniforms, visibility and ensuring the right stakeholders

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Integrated Offender Management

1. Prevent & Deter
   - to stop the most active young offenders escalating into tomorrow's prolific offenders through youth justice interventions & continued post-sentence support
   - Early identification of those most at risk and provide intensive targeting programmes

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Integrated Offender Management

2. Catch & Convict
   - Local scheme to select the IOM cohorts who are causing the most harm to their communities
   - Prevent IOM cohorts from offending through apprehension and conviction and through licence enforcement.
   - Work closely with all relevant agencies, and develop an integrated approach to support the rehabilitation of the IOM cohorts.

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Integrated Offender Management

3. Rehabilitate and Resettle
   - Encourage IOM cohorts to join the scheme on a voluntary basis Offender management whether in the community or custody, and provision of support and priority access to service
   - Develop a multi-agency pre-release support for those serving custodial sentences
   - Work with all agencies to support treatment, rehabilitation, recovery, housing, education, volunteer work, vocational training and employment

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Drug Intervention Programme

1. London- 33 Boroughs with 22 intensive DIP and 11 non-intensive DIP
2. Roles of Partners – Key partners to the Home Office are the police, prison, probation service and courts, along with the Dept of Health, NTA and treatment providers as well as those who offer wraparound service such as housing and job-seeker support
3. Delivery at a local level through Drug Action Team, using integrated teams, with a case management approach to offer access to treatment and support. The journey of the offender in contact with the criminal justice system can include custody, court, sentence, treatment and beyond into resettlement.

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Treatment

- Works where it is based on a proper assessment of individual needs and circumstances and can end or reduce criminal activity in many clients
- Such assessment informs decision-making across the criminal justice system and treatment and healthcare sectors, such as in court where bail and sentencing is being considered, and in prison for the development of a discharge plan and onward referral to other community treatment and support service .

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Drug Intervention Programme Team

1. A single point of contact
2. Provide Arrest Referral Services (from 7 a.m. to 10 p.m at Custody Mon thru Fri)
3. Throughcare – arranging the continuity of care provided to a drug misuser from the point of arrest through to sentence and beyond
4. Aftercare – services after release from prison
5. Throughcare and aftercare involve the DIP, NTA and NOMS (National Offender Management Service)

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Single Point of Contact - as a minimum phone line should offer following services:

- Referrals and/or appointments to DIP Team within their residing DAT
- Initial screening
- Harm reduction advice
- Emergency advice on overdose
- Phone numbers & information about local services including emergency services.

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Policy Area

1. Increasing Client Engagement
2. Race Equality and Diversity
3. Workforce Issues

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Increasing Client Engagement

- Implement Tough Choices enacting sections of the Drugs Act 2005- including testing on arrest and required assessment in intensive areas in England and follow-up assessment across non-intensive areas from 1 April 2007
- Expand Restriction on Bail – increase the number of drug misusing offender being assessed and referred
- Workers and managers to direct resources and efforts into appropriate client groups
- All partners and stakeholders share understanding of the end DIP process
- Ensure that accessible and appropriate services are available
- DIP services and treatment, including aims and outcomes are communicated effectively to all stake-holders
- Ensure that data collection and management processes are clear, appropriate and communicated to all parties

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Race Equality and Diversity

- Set up a panel to map race equality and diversity activity through DIP, including any barriers to inclusion
- DIP to meet its statutory duty in regards to race equality and diversity
- Ensure that DIP is engaging well with all those who need its service and meet the diverse needs
- DIP to develop Race Equality and Diversity Action Plan
- Set priorities on a yearly basis enabling the race equality and diversity agenda across DIP to move forward

Workforce Issues

- Autumn 2006 saw the launch of new recruitment campaign by the DIP to recruit CJDrug Workers
- Identified people with high calibre CJDWs to be based in London
- Implement an advanced apprenticeship scheme in January 2006 and 35 apprentices were recruited and started the two-year scheme.
- Skill of Justice has developed a national toolkit and guidance for employers
- Differentiation between Criminal Records Bureau (CRB) and Police Checks (granting vetting clearance)

Interventions

- Drug testing- "trigger" was introduced in April 2003
- Restrictions on Bail – acts as an incentive for defendants who have tested positive for Class A drug to address their problem of drug misuse and engage in any proposed treatment and support or face an increased risk of being refused bail
- Required Assessment – impose requirement of attending initial assessment offered by treatment providers
- Breach and Enforcement – DIP workers undertake follow-up assessment with the goals of reducing attrition and improving breach and enforcement within DIP team
- Conditional Cautioning – a condition that is conducive to restoration or rehabilitation can be attached to a police caution as an alternative to prosecution
- Drug Intervention Record – two versions, 2005 and 2007 (the latest include alcohol, accommodation and employment status)

Key Implications

- The DIP was introduced in April 2003
- The data shows, comparing offending level pre and post DIP contact, is that offending level in the six months following DIP were lower than in the six months before DIP
- The overall volume of offending by a cohort of 77,27 individuals was 26 % lower following DIP contacts
- Around 50% showed a decline in offending of around 79%.
- There was a subgroup of around ¼ for whom offending increased following DIP contact.
- Rates of entry into treatment for DIP entrants equalled those of non-criminal justice route entrants to treatment
- The semi-coercive measure is effective to reduce the attrition from the DIP programme

Challenges to the DIP implementation

- Change of Leadership – Police, Probation, Local Authority and Primary Care Trust
- Culture of treatment – acute care and chronic care
- Inter-agency working – resistance and competition
- Infrastructure – competency of workforce and the quality assurance framework
- Future funding – Credit Crunch and significant cut of future funding

Good Practice

Treatment Outcomes Profile (TOP)

NHS

National Treatment Agency for Substance Misuse

About the TOP

The Treatment Outcomes Profile (TOP) is a new drug treatment outcome monitoring tool that has been developed by the NTA in partnership with drug treatment providers in over 70 sites across England. It is applicable for use in all of the structured treatment modalities as defined by Models of Care for Treatment of Adult Drug Misusers: Update 2006. For the first time, service users, clinicians, service managers and commissioners will be able to obtain objective and comparable data about real improvements in service users' lives that will be able to inform and improve practice on both an individual and strategic level.

The TOP is a simple set of questions that will improve clinical practice by enhancing assessment and care plan reviews for clients. The data it provides will improve performance monitoring. Data will be reported into the National Drug Treatment Monitoring System (NDTMS) from October 2007 and results fed back to providers and commissioners from March 2008. There will also be monthly exception reports from NDTMS on non-returns and multiple submissions.

The TOP should be completed at the start of each client's treatment journey to record a baseline of behaviour in the month leading up to starting a new treatment journey. Follow up scores should be recorded every three months during treatment (usually at the same time as a care plan review) to capture changes in behaviour. It should also be completed at discharge and may be used by some services to measure post-discharge outcomes. Note: when services are introducing TOP, existing clients (as well as new presentations) should also have TOP forms completed with them as part of the care plan review process.

How to complete the TOP

Start by entering:

- Name and identifiers of your client (date of birth and gender)
- Your name
- Date of assessment
- The stage at which the TOP is being completed – modality start, care plan review, discharge or post-discharge.

Types of responses:

- Timeline – invite the client to recall the number of days in each of the past four weeks on which they did something – for example, the number of days they used heroin. You then add these to create a total for the past four weeks in the blue NDTMS box
- Yes and no – a simple tick for yes or no, then a "Y" or "N" in the blue NDTMS box
- Rating scale – a 20-point scale from poor to good. Together with the client, mark the scale in an appropriate place and then write the equivalent score in the blue NDTMS box.

You should aim to ask and complete every question. Do not leave any of the blue boxes blank. Enter "NA" if the client refuses to answer a question or, after prompting, cannot recall.

(See TOP keyworker guidance for more detailed information: www.nta.nhs.uk/TOP)

Alcohol units converter

Drink	%ABV	Units
Pint ordinary strength lager, beer or cider	3.5	2
Pint strong lager, beer or cider	5	3
440ml can ordinary strength lager	3.5	1.5
440ml can strong lager, beer or cider	5	2
440ml can super strength lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9

Drink	%ABV	Units
Glass of wine (175ml)	12	2
Large glass of wine (250ml)	12	3
Bottle of wine (750ml)	12	9
Single measure of spirits (25ml)	40	1
Bottle of spirits (750ml)	40	30
275ml bottle alcopops	5	1.5

Thank you for your contribution to the TOP