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Formation of Programme Evaluation Guidelines towards Evidence-Based Practice of Drug Treatment and Rehabilitation for Psychotropic Drug Abusers in Hong Kong: A Mixed Mode Study

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Formation of Programme Evaluation Guidelines for Evidence-Based Practice of Drug Treatment and Rehabilitation for Psychotropic Drug Abusers in Hong Kong: A Delphi Study

Background

The evaluation of treatment programmes is critical to gather credible evidence on programme effectiveness, improve the quality of drug abuse treatment and rehabilitation services, and inform policy-making (WHO, 2020). This report defines program evaluation, aligning with the definition provided by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention, as "the systematic collection of information about the activities, characteristics, and outcomes of programmes to make judgements about the programme, improve programme effectiveness, and/or inform decisions about future programme development" (DHHS, 2011, p. 3). Evaluation of treatment and intervention projects includes the output and outcome evaluations. Although certain basic knowledge about potentially effective treatments of drug abuse and their evaluation has been built in Hong Kong, some areas can be improved to support further service development, particularly in advancing the treatment and rehabilitation outcomes for psychotropic drug abusers.

Evaluation of treatment and rehabilitation services is pivotal to enhancing the efficacy of drug treatment and rehabilitation services in Hong Kong over the long term. Likewise, the WHO (2000) has reiterated the importance of providing practical and comprehensive guidance on the evaluation for treatment and rehabilitation programmes. The increasing trend of psychotropic substance use poses new challenges to intervention and rehabilitation services (Tiu et al., 2020), as a worrying shift to hidden drug abuse was observed given the continual rise in the age and drug history of newly reported cases in recent years (Tam et al., 2018).

According to the key statistics on drug abusers reported to the Central Registry of Drug Abuse in 2019, the total number of reported psychotropic substance abusers (PSAs; N = 3,471) continued to be higher than that of narcotics analgesics abusers (N = 2,874; HKGov, 2020) in which methamphetamine (MA; commonly known as "ice") continued to be the most popular psychotropic substance abused, followed by triazolam/midazolam/zopiclone and cocaine (HKGov, 2020).

It is noted that MA or other psychotropic drug users, to a certain extent, can maintain some basic daily and social functioning. This may potentially perpetuate the delay in accessing rehabilitation or other healthcare treatments. By considering the long-term impact of psychotropic drugs on one's physical and psychological health, especially drug-use induced psychosis, the development of treatment and rehabilitation interventions that can be tailored-made effectively for psychotropic drug dependence has become a major priority of programme evaluation. Indeed, pilot interventions for psychotropic users in Hong Kong seem to be increasing and can be further strengthened with a commonly shared evaluation framework. Currently, the outcome effects of these initiatives are yet to be ascertained and replicated. More importantly, there may be a lack of consensus among the local stakeholders about what to look for from an effective treatment and rehabilitation intervention for psychotropic drug abuse. Thus, to keep improving the quality of the treatment and rehabilitation for drug abusers, particularly those of the psychotropic drugs, establishing programme evaluation guidelines will help justify resources for treatment services and enhance and strengthen evidence-based practices of drug treatment and rehabilitation in Hong Kong.

About this Report

This report will capture the status quo of the current interventions used in the field and highlight the gaps between practice and research. We also document the expectations of local stakeholders and draw a consensus among them regarding treatment settings, interventions,

and modalities. We also aim to conceptualise quality of life (QoL) and present the preliminary findings of a modified measurement tool that could be used as an added intervention outcome to shape future service development in this field.

This report will first present the study goals, objectives, and methodology adopted in the research study. Next, the research findings will be laid out under various major themes identified by the research team, followed by the delineation of analyses and discussions of the findings. Finally, key recommendations derived by the research findings will be put forward in the form of a manual for service providers' perusal.

It is important to note that neither the study nor the guideline intends to provide all the answers to the existing research or service lacuna. Rather, we aim to congregate key stakeholders' views, including those of service users, and aggregate them systematically and thereon streamline and present the unresolved challenges in the field. It is hoped that future resources can be focused on, and awareness can be improved towards these issues with aims to strengthen the treatment outcomes and impacts.

Study Goals

1. Explore local stakeholders' views on drug treatment and rehabilitation programmes for psychotropic drug abusers to provide future direction in service advancements.
2. Compile and develop a set of guidelines for drug treatment and rehabilitation programme evaluations for the Hong Kong context specifically.
3. Explore the concept of QoL from the perspective of drug abusers and develop a measurement tool for local drug abuse as an alternative outcome indicator for treatment and rehabilitation programmes.

Study Objectives

1. To explore stakeholders and service users' views on treatment and rehabilitation efficacy in Hong Kong.
2. To generate consensus among stakeholders on the formation of the evaluation framework for evidence-based practice of drug treatment and rehabilitation.
3. To develop practical evaluation guidelines, including validation of a few measurement tools, to help conceptualise, plan, and commission the evaluation of treatment services

Methodology

We have adopted the Delphi study method to achieve Objectives 1 and 2. Prior to the Delphi study, the research team conducted a systematic review of international projects and a review of local projects. The results of these two reviews were consolidated to inform the formulation of questions for qualitative semi-structured interviews with a panel of local experts (Wave 1) and the survey questionnaire to collect views from an expanded panel of experts (Wave 2) of the Delphi study. To achieve Objective 3, we conducted a validation exercise of a few measurement tools about their well-being through a two-wave questionnaire survey of people with psychotropic drug abuse.

Delphi Study

The Delphi method is a group method that is administered by a research team that reaches out and gathers a panel of experts, puts forward questions, synthesises feedback, and guides the group towards common ground (Donohoe et al., 2012). It was developed by the Rand Corporation in the 1950s and has been subsequently used for programme planning, policy-making, and establishing guidelines for an intervention (Trevelyan & Robinson, 2015). Delphi methodology has strengths in collecting opinion and drawing consensus anonymously among participants, iteration with controlled feedback of group opinion, and statistical

aggregation of group responses. This is especially beneficial when exploring and organising panellists' conflicting values and experiences (Donohoe et al., 2012). To fully understand the challenges of existing evaluation methods used by local service providers and to reach a consensus on an evidence-based evaluation system in future, Delphi methodology is used to identify what could/should be done to improve the efficacy and effectiveness of treatment evaluation in the local context. Before formulating interview questions, the research team completed a systematic review and a review of selected local projects of treatment and rehabilitation for drug abusers to inform the panel of experts with the updated evidence.

Systematic Review

To understand the existing treatment options for drug users, in particular, for substance users of MA, a systematic review was conducted (Chan et al., in preparation). It was based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2015). Eight databases were used in the search: CINAHL Plus, EMBASE, MEDLINE, PsycINFO, Social Services Abstracts, Social Work Abstracts, Sociological Abstracts, and Web of Science. All studies must report the effect of at least one psychosocial intervention for MA or amphetamine users with outcome measures on drug use or abstinence. All studies must include a control group and/or a comparison between two psychosocial interventions. Studies were excluded if the number of MA or amphetamine users was below 50% of all participants. Unpublished studies, dissertations, conference abstracts, and book chapters were also excluded.

Local Projects Review

To enrich our understanding of the programme designs and the theories of change that link the intervention components and the outcomes, a brief review of 24 local non-subvented treatment and rehabilitation projects funded by the Beat Drugs Fund (BDF)[1] between 2014 and

[1] The Hong Kong Government established the BDF in 1996. BDF is managed by the Narcotics Bureau, which operates the regular funding scheme on an annual basis to provide financial support to different organizations, including but not limited to hospitals, non-governmental organisations, (NGO) and tertiary educational institutes, to address the problem of drug abuse in Hong Kong. Over the past 10 years,

2016 was conducted. The review provides us with an overview of the programme nature and the common outcome indicators used. Part of the review results are extracted to form the survey questionnaire of Wave 2. We have noted that the 24 projects were selected from the BDF records within a specific time frame to highlight the merits and unique contributions of these programmes instead of examining their representativeness of the local treatment and rehabilitation services in Hong Kong.

Sampling

In Delphi Wave 1, based on the guidelines laid out by Okoli and Pawlowski (2004), the research team adopted a purposive sampling to recruit 52 experts via email invitation, of which 25 accepted to become the panellists of this study. The response rate was about 73%. The composition of the panel is shown in Table 1.

Table 1

Occupation of Expert Panellists in Delphi Waves 1 and 2

Occupation	Wave 1 expert panellists (n = 25)	Wave 2 new expert panellists (n = 19)
Academia	3	3
NGO service provider	18	12
Medical practitioners	2	4
Government officials (Narcotics Division)	2	0

In Wave 2, the expert retention rate from Wave 1 was 100%; all 25 panellists had fully completed and returned their online survey responses. A total of 43 invitation emails were sent, and 17 new panellists had returned a full valid response. Nonetheless, owing to the

BDF has allocated over 880 million to more than 400 projects that served service users, including drug abusers and hidden drug abusers and their families and caregivers (Narcotics Division, 2021).

underrepresentation of medical practitioners, snowball sampling was adopted to recruit two more new panellists from the medical field. In the end, 44 panellists participated in Wave 2 of the Delphi study.

Semi-Structured Questions of Wave 1

Based on the systematic review and local project review, the research team modified the five domains of evaluation questions (Rossi et al., 2018, pp. 16–17) to guide our interview questions (Table 2).

Table 2

Sample Questions From Wave 1 Interview Guides

Informant group	Sample questions	Programme evaluation domains addressed
Academics	What is the theory of change of substance abuse?	assessment of programme theory
	How can we measure other treatment outcomes, such as quality of life and social functioning of an individual?	impact assessment
	Should drug abusers be categorised to cater to their various needs effectively?	assessment of program theory
Medical practitioners	How essential is medical support in a drug T&R treatment?	setting priorities of treatment components
	Can harm-reduction approaches be one of the primary treatment outcomes?	exploring the extent of use of the harm-reduction approach in the local service field
Government officials (Narcotics Division)	Do treatment programmes have to show compliance to the government's policy of zero-tolerance to be eligible for the funding?	assessment of programme theory
	What is the acceptable range of relapse and drop-out rate of a programme?	outcome assessment
	How do you decide which programmes to fund?	efficiency assessment
Service providers	Are we currently lacking outcome measures on positive outcomes to reflect the merits of programmes?	impact assessment
	Are the current outcome measurements tool succinct to capture the programmes' outcome? If not, what are your suggestions?	impact assessment
	What is the common drop-out and relapse rate in a programme?	impact assessment

	What are the contemporary challenges encountered in the treatment programmes?	assessment of programme process
Service users/ex-users	What elements helped you the most in the treatment programmes that you participated in?	assessment of programme theory
	What drugs did/do you use? What life challenges/impacts you are/have been encountering?	needs assessment
	According to your personal experiences, what can be improved in the treatment programmes?	impact assessment

Questions were also modified and added on for gaining more insights and understandings from previous interviews throughout the data collection process. All interviews were conducted in Cantonese over 3 months from May 2019 to July 2019. Each interview was audio-recorded and transcribed verbatim. The data were examined and analysed using Braun and Clarke's (2012, 2014) 6-phases thematic analysis framework. Data from Wave 1 were analysed to show the diverse views among the expert panellists concerning the interventional approaches and their corresponding evaluation tools used, discussion on their effectiveness, perks and pitfalls, challenges encountered, conceptual frameworks that led the design and outcome measurements, and the theory of change that drives these programmes.

Survey Questionnaire of Wave 2

Based on the results from Wave 1, the research team set out a list of questions to facilitate consensus-building among the panel. To heighten the heterogeneity, the research team had sent out three rounds of invitation emails, wherein personal referral was encouraged, to recruit new panellists to participate in the online survey of Wave 2. The online survey was made available in both English and Chinese by using the online Internet survey tool Quatrics (www.quatrics.com). Panellists were directed to a consent form, a brief introduction of the survey, and a declaration from the outset. Thereon, the survey was divided into three main parts in order:

1. Micro-level pragmatic treatment and rehabilitation programme design and evaluations (five questions).
2. Macro-level policy-making indications and philosophical perspective (five questions).
3. Demographic data collection (four questions).

All panellists were required to answer all questions, while some follow-up sub-questions were only asked according to panellists' ratings. Each question consisted of a summary of the literature review prepared by the research team on that specific question and topic, followed by an encapsulation of the 25 panellists' views and their direct quotes adduced from Wave 1 interviews. A statement was then presented that participants were asked to rate. Panellists were asked to indicate the level to which they agreed or disagreed with each statement using a 7-point scale from 1 = *completely disagree* to 7 = *completely agree*. They were also invited to provide comments for each statement, and justification or elaborations must be provided by the panellists when a neutral point was chosen. The 7-point Likert scale with mandatory justification required for a neutral point of view was employed (Toma & Picioreanu, 2016). Concerning the method adopted in Williams et al. (2004), frequency scores were calculated by the sum of all the items chosen by the participants as their top choices for questions wherein choices were provided. For open-ended questions, relevant items/responses were grouped and frequencies were calculated on the number of responses the aggregated items represented. The full questionnaire can be found in Appendix III.

The seven ratings were collapsed into these three categories to increase the likelihood of obtaining consensus. Scores of 1–3 were considered as disagreement, 4–5 as neutral, and 6–7 as agreement. Consensus criteria for each statement were defined as follows: consensus for inclusion was achieved if ≥75% of participants ranked the item in the top three categories (score 5–7); consensus for exclusion was achieved if ≥75% of participants ranked the item in the

bottom three categories (score 1–3); consensus for unresolved issues was achieved if ≥75% of participants ranked the item neutral (score 4), and no consensus was achieved if all of the above conditions were not met (Diamond et al., 2014).

Validation Study of Measurements of Quality of Life

Brief Description

The current evaluation methods in Hong Kong mainly assess the output of the number of service users, attendance records, and completion rates of treatment. The most common approach used to evaluate outcome is a pre- and post- test on non-random samples without comparable control service recipients of standard care, which often makes it difficult to analyse evidence on the effectiveness of the treatment. The BDF has shown great efforts in developing resources and tools to help local NGOs carry out program evaluations. Questions on treatment effectiveness are commonly measured by drug-use frequency (Q5/Q6), continuous abstinence rate, clients' attitude towards drug abuse (Q1), and self-efficacy to avoid drug use (Q4), which are from the Commonly Used Evaluation Question Sets provided by BDF. Yet, some of the measurement tools have not been locally validated, particularly for those related to relapse and coping during the recovery stage.

Drug use impairs the brain and cognitive and social functioning; therefore, treatment evaluation for drug abusers must probe both short- and long-term consequences on users' social, behavioural, and mental outcomes (Cretzmeyer et al., 2003). Although psychosocial intervention is one of the core interventions available to drug abusers in Hong Kong, systematic research of users' wide range of psychosocial functioning has rarely been conducted. Assessments on functioning from the funded projects typically involve measuring two domains of psychosocial functioning: employment readiness (e.g., attitude to job-seeking) and interpersonal relationship skills (e.g., family relationship). However, studies overseas had also

assessed QoL. Laudet (2011) found that drug abusers' QoL is worse when compared to the general population, but Lundahl and Burke (2009) indicated post-treatment QoL predicts a sustained long-term reduction in drug use and abstinence. Therefore, apart from the presence and severity of addiction and assessment on general psychosocial functioning, QoL should also be considered as one of the outcomes of treatment effectiveness.

Apart from QoL, the severity of dependence can also be an important indicator of treatment and rehabilitation programme evaluation. Abundant previous studies found that there were negative correlations between the severity of dependence on the drugs and QoL (Campelo et al., 2017; Feelemyer et al., 2014; Wang et al., 2020). Besides, as drug abuse has many negative effects on the health of the abusers, health status is also a key evaluation indicator. Health-related quality of life (HRQoL) focuses on the health-related components of life, which has been found to have negative relations with drug abuse (Griffin et al., 2015; Liao et al., 2019; McKetin et al., 2019).

The validation study aimed to achieve Objective 3 by developing a modified measurement scale, namely the Need-based Quality of Life Scale (NBQoL) for psychotropic drug abusers and validated two instruments measuring the severity of dependence and HRQoL to help conceptualise, plan, and commission the evaluation of treatment services. We used a two-wave survey to collect data from psychotropic drug abusers. Prior to the survey, we conducted panel interviews to confirm the content validity of the NBQoL.

Sampling

We recruited 271 [2] participants from 13 organisations providing treatment and rehabilitation services to drug abusers. All the participants were recruited using a snowball

[2] At the time of data analysis in August 2021, a total of 271 questionnaires were collected. All the Fit criteria of the CFA model are met (page 64). Therefore, the findings based on the 271 samples are presented in this report. Thereafter, 58 more participants had responded to the online recruitment exercise which resulted in an accumulated number of 329 participants as of 21 November 2021.

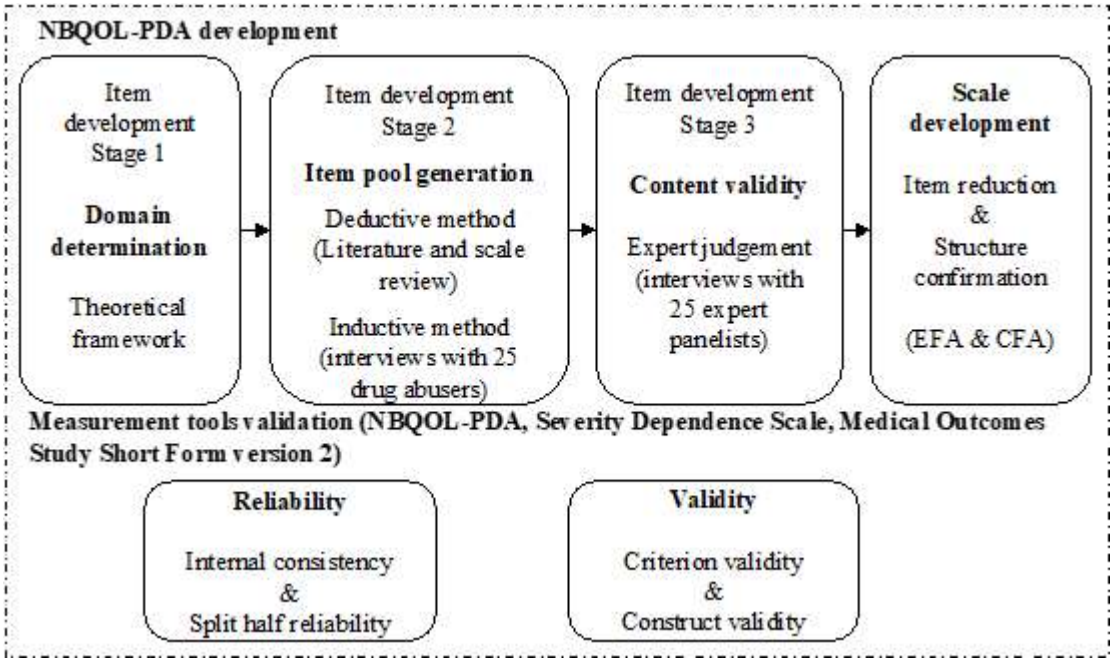
sampling method and met the following inclusion criteria: (a) had abused psychotropic drugs in the past year; (b) over 16 years old; and (c) could read and understand traditional Chinese.

Measurements and Data Analysis Methods

The main procedures of NBQoL development and measurement tools validation are shown in Figure 1. The particular consideration for drug users is the impact of drug use on all aspects of their lives. NBQoL is one of the most widely implemented methods in QoL assessment. Thus, the NBQoL measuring method is used in this study. To better conceptualise the target construct, this study adopted the integrative model of QoL, which defines the QoL as "the interaction of human needs and the subjective perception of their fulfilment" (Costanza et al., 2007). Self-determination theory (Ryan & Deci, 2000), which focuses on more specific basic psychological and basic physical needs (Ryan & Deci, 2017), was adopted to define the domains. Finally, five domains were determined as: autonomy needs, competence needs, relatedness needs, physiological needs and safety needs.

Figure 1

Procedure of NBQoL Development and Measurement Tools Validation



For the scale development study, the data were analysed using the statistical software R to reduce items and confirm the structure. Multiple imputation by chained equation was used to handle missing data (White et al., 2011). Exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) were conducted to understand the structure of the new scale. For the validation study, reliability was evaluated by internal consistency and split-half validity. Validity was assessed by criterion validity. Pearson product-moment correlation was used to estimate the concurrent validity (Boateng et al., 2018).

Ethics Approval

Delphi Study

This study was approved by the Human Research Ethics Committee (Approval Reference No.: EA1903046). All participants volunteered to participate and provided informed consent. All data were stored securely. All participants were asked to sign the informed consent before taking part in the studies.

Validation of Measurements

The validation was approved by the Human Research Ethics Committee (HREC) (Approval Reference No.: EA210124). All participants volunteered to participate and provided informed consent. Each participant in the validation study was given a cash coupon of HKD50 as an incentive for each completed interview or survey. All data were stored securely.

Results and Discussion

In this section, we report on the main findings from Waves 1 and 2 and the validation study on the QoL of drug abusers. The results of the systematic review and local project review are presented in separate sections (See Appendices I and II, respectively).

Delphi Wave 1

There are a few unique characteristics of drug abuse issues. Firstly, the most dominant drug type has shifted from narcotics analgesics, especially heroin, to psychotropic substances, such as hallucinogens (e.g., cannabis), stimulants (e.g., cocaine, ecstasy, and ice), and other substances (e.g., ketamine and cough syrup) in the late 1990s, which has persisted to date. Regarding "Drug Abuse Situation in Hong Kong in 1998", heroin continued to be the predominant drug of abuse in 1998; yet, the proportion of psychotropic substance abusers has increased, albeit to a small extent, from 21.1% in 1997 to 21.6% in 1998. Thereafter, a declining trend was observed for heroin abusers with the number dropping from 16,107 in 1996 to 9,734 in 2005 (Census and Statistics Department [C&SD], 2006) while the number of psychotropic substance abusers rose gradually from 3,389 in 1996 to 6,310 in 2005, the highest in the past decade then (C&SD, 2006). The total number of reported psychotropic substance abusers (at 3,894 in 2018) continued to be higher than that of narcotics analgesics abusers (at 3,598 in 2018; C&SD, 2019). The difference was more evident among the newly reported abusers wherein the number of psychotropic substance abusers is around 6.7 times of narcotics analgesics abusers (C&SD, 2019).

Secondly, there has been a staggering increase of young people using psychotropic substances since the late 1990s owing to the rampant culture of rave parties and discos (C&SD, 2006; Lam et al., 2004).

Thirdly, contemporary drug users have become more hidden than in earlier times wherein users opted to take drugs at home or a friend's home instead of party settings. Regarding the locality of taking drugs, in 2015–2019, over half of the drug abusers took drugs at home or at a friend's home only (C&SD, 2016, 2019). Consequently, drug users are deemed to be more hidden, which is reflected in the constant decline in the total number of reported drug abusers since 2002. A local article also reported how accessibility contributes to the surge

of MA use (Tam, 2016). People can readily have a home delivery service of MA or get in touch with dealers easily (Tam, 2016). The newly reported drug abusers are found to have a drug history, which conveys that it takes several years for agencies to identify them from their initial drug use (5.2 years in 2014; 5.8 years in 2015; 4.6 years in 2017; 4.7 years in 2018; C&SD, 2016, 2019). Furthermore, 59% of lifetime drug-taking students took drugs at home or a friend's home while 88% reported that they had never sought help from others (C&SD, 2019). It is also noted that polydrug users have emerged. Most of the drug abusers (88.6%) were polydrug users and had abused more than three kinds of drugs on average (Lam et al., 2004). The proportion of multiple drug abusers has been increasing from 7.7% in 1996 to 29.1% in 2005 (C&SD, 2006). It is also found that recreational drug use had been normalised by the mid-2000s, although not as widespread as that in the Western countries, like the United Kingdom (Cheung & Cheung, 2006).

As a result, Hong Kong has adopted a multimodality approach to drug therapy and rehabilitation to cater to the divergent needs of drug-dependent persons from varying backgrounds. These services are mainly public-funded and operated by NGOs or semi-government organisations. For example, the counselling centres for psychotropic substance abusers are subvented by the Social Welfare Department, which provides counselling and assistance to habitual/occasional/potential psychotropic substance abusers and young people at risk. There are also 37 residential drug treatment and rehabilitation centres (DTRC), halfway houses run by 16 NGOs (Narcotics Division, 2021, p. 52), and nine substance abuse clinics under the Hospital Authority in Hong Kong. In general, residential and community-based counselling and rehabilitation services serve different purposes (see HKGov, 2021) and target groups with standard output and outcome indicators. These outcome indicators commonly include a change in knowledge (e.g., access to service, knowledge about drugs), attitude (e.g., attitude towards abusing drugs, motivation for withdrawing drugs), behaviours (e.g., duration

of staying abstinent from drugs, frequency of using drugs, relapse), psychological distress (e.g., anxiety, depression, stress), life satisfaction, social and occupational functioning, and satisfaction of service. With this backdrop, we identified seven major themes/specific issues identified from Wave 1. These are described in the following sections.

Changes in Drug-Use Behaviours

All of the panellists agreed on the drug scenes exhibited above with no discrepancy or dissent. The transition from heroin to ketamine, which seems to be the initial wave of major change in drug-use type, may attribute to its convenient administration without any tools or injection risks compared to that of heroin. However, the shift from narcotics analgesics to psychotropic substances is worrying and alarming. By taking a physical health perspective, opioid abuse may post significant social impacts, but the physical harm to the abusers is noticeably less than that of psychoactive drug abuse, specifically the damage to users' internal organs and brain, including the proclivity of developing psychosis.

Do Psychotropic Drug Abusers Need a Different Treatment Approach?

The conventional type of therapy and rehabilitation services, particularly detention or live-in services, were mainly designed for opioid abusers, as they ensure users stay away from a drug source and their old ties with drugs. That said, albeit some panellists support such an idea, others bolster community-based treatment over residential treatment. The former group believes that residential treatment programmes are useful when drug abusers could not take control of their drug usage, are on the verge of getting addicted, and/or their milieu and personal network are filled with drug users and illicit drugs provision. The rationale of the residential programme is that it enables the service recipients to stay away from their usual networks that connect with drug temptation and life stressors, which are two prime triggering factors. Additionally, residential treatment is favourable for monitoring the rehabilitation progress and increases the effectiveness of day-care treatment. Some faith-based residential treatment

programme service providers explained that intensive residential treatment allows rebuilding of life values to take place, as social workers or staff reside with service receivers who serve as life and spiritual companions. They believed drug users' experiences on this sort of selfless companionship seemingly contradicted their previous experience or concepts of interpersonal relationships and humanity, ergo fuels drug users' motivation of drug withdrawal. Moreover, the residential area provides a safe arena, physically and mentally, for service users to be open about their past and trauma. Some have made suggestions including that the duration of the residential programme should be shortened to facilitate people at various life stages to have a gradual drug withdrawal experience. Residential programmes usually include the provision of halfway housing, which assists drug users during the transitional period between post-drugs withdrawal and reintegrating into society.

On the contrary, some shared different points of view, particularly about the drawbacks of residential treatment programmes. Firstly, it is not useful for recreational drug users because the residential programme focuses on life rebuilding. While rebuilding one's life, the social isolation may also rip off the established self-identity of psychoactive/recreational drug users and replace it with the negative label of *drug addicts*. The long duration and the nature of complete isolation may hinder young people from voluntarily receiving residential drug treatment and post adverse impacts on young adults' life planning. Furthermore, residential treatment may not have evolved with the socio-cultural changes. For instance, teenagers want a quick remedy or solution nowadays; hence, residential services of longer periods may not be appealing to them. It is specifically not suitable for female drug users; to illustrate, females have a lower motivation to admit to residential service compared to males because they have greater emotional attachment to familiar environments and are usually the core carers in the families. Some panellists described residential treatment as "impractical," as some people who are in poverty could not simply leave their jobs and admit to the programme without the

concern of supporting their family. Notably, residential rehabilitation programmes embrace a zero-tolerance approach and require complete drug abstinence once service users get admitted to the programme regardless of the severity or duration of drug use prior to admission. Some drug users may find such an abrupt change unbearable, which may result in drug treatment drop-out. Some have further claimed that a sudden halt in certain drugs is dangerous to chronic abusers, such as zopiclone. Community-based treatment panellists suggest that the community-based programmes enable social workers to engage hidden youths, as these programmes are often highly accessible in the community, even if they are not yet ready to go for complete drug abstinence.

Regardless of the specific perks and pitfalls mentioned in both approaches above, most of the panellists agreed that the two approaches do not necessarily have to be mutually exclusive. Indeed, community-based treatment can provide follow-up support, such as vocational and family reconciliation after residential treatments, given that the relapse rate of drug users always remains high. In their opinions, both residential and community-based programmes serve different purposes/target groups and can be complementary to each other.

Prioritising Several Pressing Needs are Necessary When Providing Services to Psychotropic Drug Users

The importance of family elements has started to be recognised as one of the significant protective factors in the drug withdrawal journey. Nonetheless, it has not been commonly employed in the prevailing intervention strategies. Hence, in Wave 1 interviews, it is recommended that service providers should work on the family element, intervene in relationship dynamics, and educate drug users' family members on when to intervene to prevent missing opportunities/or timing to get involved in service or drugs withdrawal treatments. To illustrate, service providers should address family problems that are attributed to drug-use behaviour and collaborate with family members to motivate drug users to withdraw

from drugs and retain in the programme. Service providers should also assist drug abusers to perform better role-taking, such as a responsible husband or a parent, to heighten their sense of competence in parenting. It is also noted by panellists that the drug abuser's family has been actively seeking help while the drug abuser is yet to be ready or motivated to get involved in service or cease drug use. Service to the family is, therefore, vital to alleviate the tension in the family as a whole. Treatment approaches and evaluations that merely focus on drug users are far from sufficient. Nonetheless, the lack of standardisation in interventional approaches with proven outcomes (e.g., frequency of drug-abusing behaviours, attitude towards drugs, knowledge about drugs, psychological distress, QoL, and family functioning) in drug treatment rehabilitation, which has led to the theory of change remain an issue that requires attention.

Harm-Reduction Approach: Is it a Primary Treatment Outcome or a Means to an End?

A few service providers mentioned that Hong Kong's ideology of strict zero-tolerance regarding drugs is because illicit drug use is handled by the Security Bureau in Hong Kong instead of the Department of Health, whereby the focus tends to be on fighting crime and identifying drug sources, which leaves little room for the concept of harm reduction to be measured and tested. Nonetheless, many panellists have seen the perks of the harm-reduction approach. It changes the way one views treatments and relapses. A panellist suggested that they should not adopt a fear approach or general deterrence by portraying drug users as terrifying or haunting figures for educational or primary prevention purposes. We ought to adopt a more inclusive approach to allow the public to acknowledge that drug users opted for drugs to fulfil some of their unfulfilled needs in life. It is a collective problem that we should face together in society instead of excluding them by demonising them. Furthermore, as mentioned above, there are ample factors that treatment services should address instead of drug cessation solely. By incorporating the concept of harm reduction, rehabilitation can also focus on improving users'

QoL and reducing the extent of harm, etc. The application of harm reduction might prolong one's pre-relapse abstinence, which can be recognised as one's progress towards drug abstinence. The harm-reduction approach reduces, if not eliminates, the harms that accompany drug use with immediate effects. While demanding more attention and government support on the harm-reduction approach, panellists, in general, disagree with the radical idea of not intervening in drug users' autonomy and freedom to take drugs. Such an approach may not be seen as applicable to Hong Kong and Asian countries at the moment.

On the other hand, the panellists believe the root cause of low motivation in occasional psychotropic drug users may be due to their negligence on the repercussions of the drugs they take on their physical and mental health. They may not see a solid reason to quit drugs. Thus, providing them with a realistic service plan and intended outcome that the clients deem fit and apropos to their expectations may increase their motivation to seek help and build their confidence in the drugs withdrawal journey. Including a variety of treatment outcomes in programme evaluation having taken into account the harm reduction approach are suggested. This is because apart from ceasing drug use, it is important to track the reduction of harm on life functioning and treatment progress or the progress of a drug user's support system; for instance, the ability to handle one's life and family, attitude towards drugs, mental and physical health, physical and social functioning, and QoL.

Zero-Tolerance has a Lucid Definition

Harm reduction in its current form is deemed loose, which hinders its measurement and understanding in the field to a large extent, whereas zero-tolerance allows one to have a clear-cut goal to work towards. Hence, a conceptual and operational definition of harm reduction, as well as its feasibility of measurement, are expected to be embedded in the programme design and evaluation. Therefore, the application of harm reduction has to be addressed with meticulous care, not least the definition and scope of harm reduction that are apropos to the

specific drug field in the Hong Kong local context. Furthermore, since stakeholders from various disciplines have distinct priorities and concerns, the research team is aware that medical practitioners' concerns are valid and worthwhile to hereby delineate. It is mentioned that some people have an inherent genetic predisposition towards addiction and developing psychosis; to illustrate, they might be severely addicted or ill after one-time use as opposed to others taking the same drug for a substantial period to reach the same addictive severity or physical reactions. As a result, medical practitioners do not measure addiction severity by one's drug dosage but one's overall physical and social functioning. They are conservative towards harm-reduction strategies, such as methadone since the functioning of methadone users is compromised in general. Consequently, for psychotropic drugs, such as cocaine and ice, medical practitioners think that complete abstinence is the only treatment outcome in place of recognising drug dosage reduction as the ultimate treatment goal. That said, some panellists have raised a concern that there is no evidence-supported correlation between harm reduction and full abstinence—it may be a speculative practice.

Lack of Standardisation and Comprehensiveness in Capturing Programme Outcomes

The local drug treatment and rehabilitation projects were evaluated by the overall effectiveness and efficacy in achieving expected outcomes and delivering service for recipients. From the review of 24 local drug treatment and rehabilitation programs, there are some common expected outcomes that the majority of programs aim to achieve; however, the assessment tools for outcome indicators are not standardised and aligned with the indicated treatment goals. The significance of a combination of subjective and objective assessments (e.g., urinalysis) is also emphasized in the review, which will further strengthen the validity and reliability of data analysis in the process of the program evaluation. For details, please refer to Appendix II.

Most Programmes are Evaluated Based on Observed Outcomes and not Intended Outcomes

In 24 local drug treatment and rehabilitation projects, program evaluation was mainly based on the level of attendance, participation, and satisfaction of service users, instead of the amount of changes in knowledge, behaviour, psychological distress, and functioning that service users displayed during post-treatment period. Furthermore, the costs and quantity of service users were also emphasised in program evaluation in order to assess whether it is economically feasible. There is hence a gap identified between intended outcomes and interventions employed. For details, please refer to Appendix II.

Delphi Wave 2

Through scrutinising the data from Wave 1 and the 24 BDF projects closely, the research team identified major issues in Wave 1 that were yet to reach consensus in the field (see Table 3), which were then brought forward to Wave 2.

Table 3

Logic Flow of Questions Formulation for Wave 2 Questionnaire

Five domains of evaluation questions	Major specific issues identified in this report (Delphi study Wave 1)	Issues to be addressed in Delphi study Wave 2
1. Service needs of users (needs assessment)	1. Changes in drug-use behaviours 2. Different types or categories of drug users are proven to have distinct needs 3. Prioritising several pressing needs are necessary when providing services to psychotropic drug users	1. Explore whether drug users should be categorised based on their commonality to cater to their unique biopsychosocial needs 2. Identify the essential elements of a rehabilitation programme for psychotropic drug users 3. Identify the most commonly agreed ways to categorise service users 4. Identify critical factors that differentiate the treatment outcomes between recreational/experimental and

		chronic psychotropic drug users
2. The programme's conceptualisation or design (assessment of programme theory)	1. Role of harm-reduction approach is debatable; whether it could be one of the primary treatment outcomes or a mere means to an end.	1. Explore the other treatment goals that can be recognised and regarded as primary treatment outcomes when evaluating a programme in addition to drug abstinence 2. Explore the positioning of illicit drug use in the society 3. Explore the existing and potential roles of harm-reduction approach in the field
3. Programme operations and service delivery (assessment of programme process)	1. Interventions are not standardised in the field; the theory of change is thus unclear. 2. The role of harm-reduction approach in the service is still open to question	1. Explore the needs in establishing an evidence-informed intervention protocol that can be standardised
4. Programme outcomes (impact assessment)	1. Zero-tolerance has a lucid definition and hence a clear dichotomy outcome measurement of whether one is drug abstinence. 2. There is a lack of standardisation (e.g., relapse or drop-out rate) and comprehensiveness (e.g., other treatment outcomes) in capturing programme's outcomes	1. Identify the most accepted relapse rate and drop-out rates of a programme 2. Exploring the most agreed ways to capture harm-reduction approach outcomes
5. Programme cost and efficiency (efficiency assessment)	1. Most of the programmes are evaluated based on cost and quantity of service users instead of their effectiveness.	1. Exploring the most agreed ways to capture other treatment outcomes

Note. Five domains of evaluation questions adapted from Rossi et al. (2018, pp. 16-17).

Wave 2 Questionnaire Formulation

To formulate the Wave 2 online questionnaire, the research team conducted a thorough literature review on topics derived from Wave 1 in accordance with the existing research gap/issues to be addressed, as identified and presented in Table 3 above. The findings from the literature review were summarised and presented prior to each question to allow Wave 2 panellists to have an overview of the latest academic findings or discussions on those particular

topics, where the overview of Wave 1 panellists' comments and quotes were adduced thereafter. The aim of this is to allow Wave 2 panellists to make well-informed decisions regarding each of the questions raised. The full version of the Wave 2 questionnaire can be found in Appendix III.

Delphi Wave 2 Online Survey Results

Data collected from Waves 1 and 2 were analysed using Microsoft Excel. For the quantitative data from Wave 2, the seven ratings were collapsed into three categories to increase the likelihood of obtaining consensus. Ratings between 1 and 3, 4 and 5, and 6 and 7 were considered as disagreement, neutrality, and agreement, respectively. Consensus criteria for each statement were defined as follows: consensus for inclusion was achieved if ≥75% of participants ranked the item in the top three categories (score 5–7); consensus for exclusion was achieved if ≥75% of participants ranked the item in the bottom three categories (score 1–3); consensus for unresolved issues was achieved if ≥75% of participants ranked the item neutral (score 4) and no consensus was achieved if all of the above conditions were not met (Diamond et al., 2014). The overall result of the 13 main questions is depicted in Figure 2 and Table 4 below.

Figure 2

Overall Results of Wave 2 Questionnaire

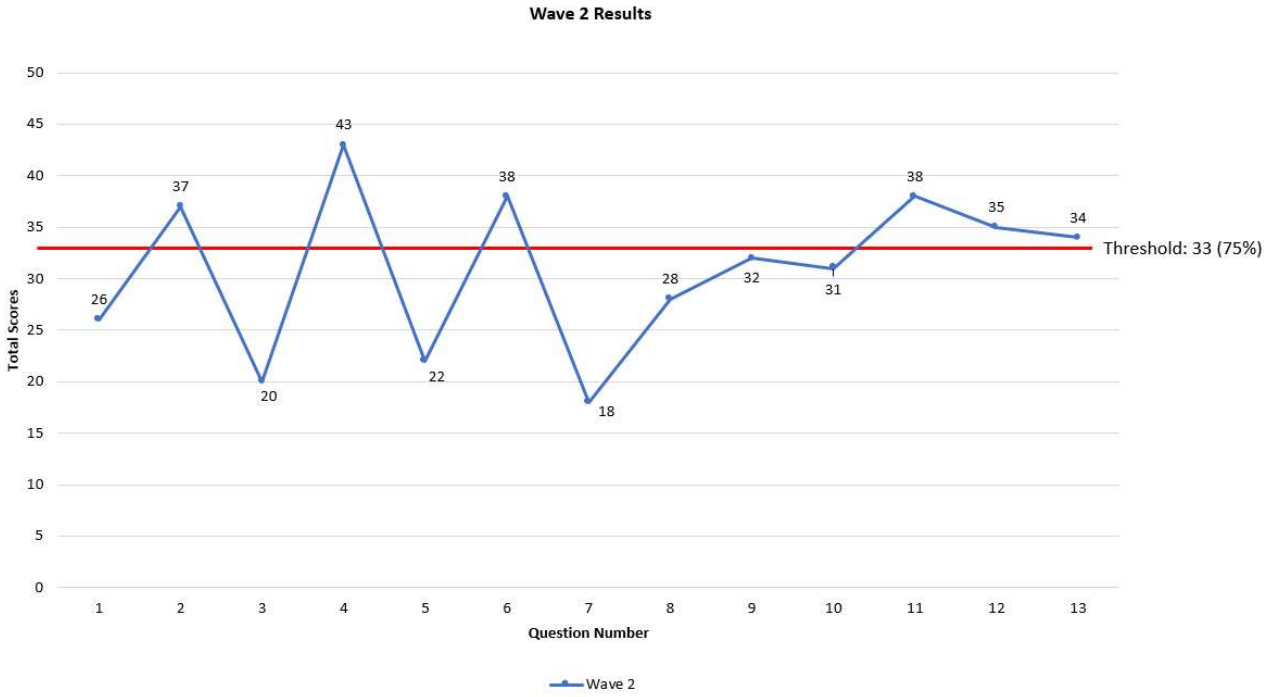


Table 4

Detailed Distribution of Wave 2 Questionnaire Result

Item no.	Main questions in Wave 2	Distribution of responses (n = 44)
1	Given that the mainstream intervention strategy in Hong Kong is a mixture of approaches, namely CBT, MI and narrative, how important do you think it is to establish a standardised intervention protocol in respect of each intervention strategy?	Strongly important: 5 Very important: 8 Important: 13 Neutral: 6 Unimportant: 9 Very unimportant: 2 Strongly unimportant: 1
2	To what extent do you agree drug users should be categorised based on their commonality to cater to their unique biopsychosocial needs in the programme design and evaluations?	Strongly agree: 7 Agree: 10 Slightly agree: 20 Neutral: 3 Slightly disagree: 3 Disagree: 1 Strongly disagree: 0
3	Do you agree that occasional psychotropic drug users will show better treatment outcomes from community-based drug treatment programmes than residential rehabilitation programmes?	Strongly agree: 3 Agree: 7 Slightly agree: 10 Neutral: 15 Slightly disagree: 8

		Disagree: 0 Strongly disagree: 1
4	Do you agree that community-based service should be continuing care for all of the residential treatment post-discharge rehabilitates?	Strongly agree: 13 Agree: 18 Slightly agree: 12 Neutral: 1 Slightly disagree: 0 Disagree: 0 Strongly disagree: 0
5	Do you agree that short-term live-in programmes serve occasional psychotropic drug users better than community-based service alone?	Strongly agree: 0 Agree: 6 Slightly agree: 16 Neutral: 10 Slightly disagree: 11 Disagree: 1 Strongly disagree: 0
6	In addition to drug abstinence, to what extent do you agree that other treatment outcomes can also be recognised and regarded as primary treatment outcomes when evaluating a programme?	Agree: 38 Disagree: 4 Missing data: 2
7	The acceptable relapse rate in 90-day of time after joining an intervention programme can be set as:	30%: 10 40%: 5 50%: 18 60%: 11
8	The acceptable drop-out rate of an intervention programme should be no more than:	40%: 9 50%: 28 60%: 4 70%: 3
9	To what extent do you agree that illicit drug use should be considered as a public health issue instead of a social control or security issue.	Strongly agree: 10 Agree: 12 Slightly agree: 10 Neutral: 0 Slightly disagree: 8 Disagree: 3 Strongly disagree: 1
10	Do you agree that adopting a strict zero-tolerance approach minimises the effectiveness of the drugs treatment and rehabilitation field, in terms of engagement, programme designs and evaluation.	Strongly agree: 6 Agree: 12 Slightly agree: 13 Neutral: 2 Slightly disagree: 6 Disagree: 3 Strongly disagree: 2
11	Do you agree that adopting a harm-reduction approach will lead to actual improvements in drug-use outcomes?	Strongly agree: 6 Agree: 16 Slightly agree: 16 Neutral: 1 Slightly disagree: 1 Disagree: 3 Strongly disagree: 1

12	Full abstinence should be set as the ultimate target while adopting a harm-reduction approach in any drug rehabilitation programmes.	Strongly agree: 10 Agree: 16 Slightly agree: 9 Neutral: 1 Slightly disagree: 5 Disagree: 2 Strongly disagree: 1
13	Harm reduction should be recognised as one of the drug users' service choices other than full abstinence.	Strongly agree: 7 Agree: 13 Slightly agree: 14 Neutral: 1 Slightly disagree: 3 Disagree: 4 Strongly disagree: 2

The detailed findings from Wave 2 will be presented according to the order and structure of the online survey. Responses broken down by panellists' occupations will also be presented.

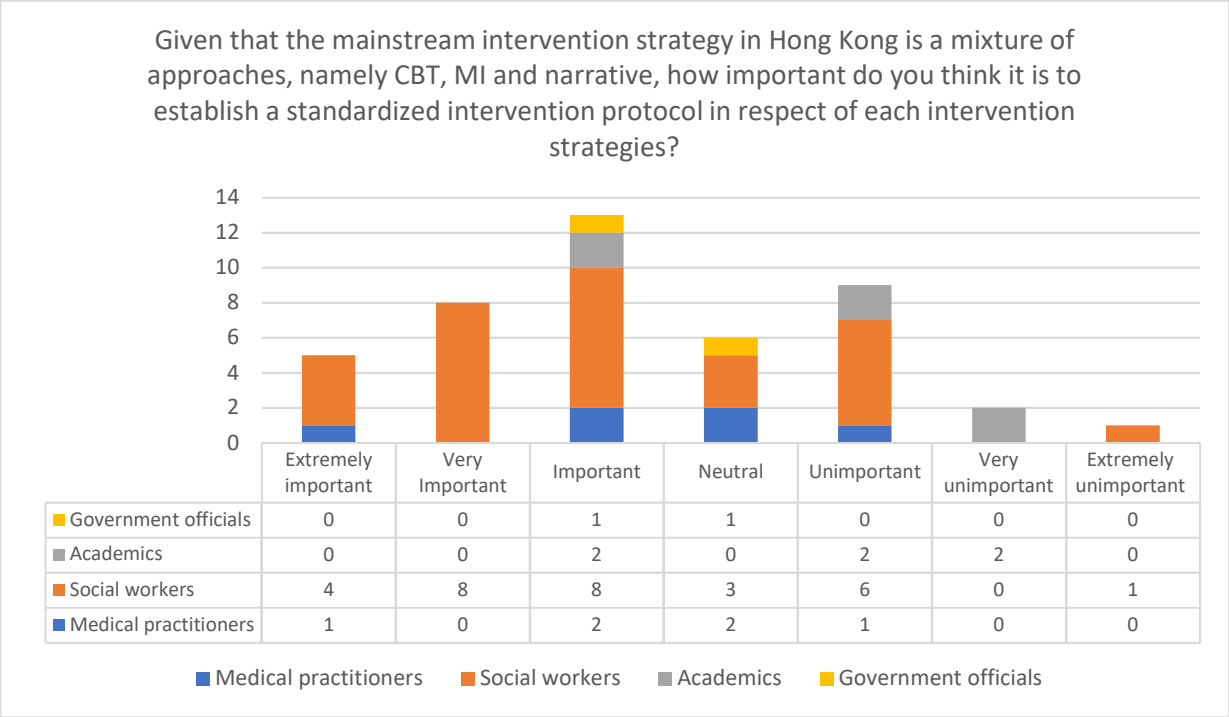
Micro-Level: Treatment and Rehabilitation Programme Design and Evaluation

Unlike overseas, the mainstream intervention strategy in Hong Kong is a mixture of approaches, namely cognitive-behavioural therapy (CBT), motivational interviewing (MI), and narrative; hence, a question was asked in Wave 2 regarding how important it is to establish a standardised intervention protocol in respect of each intervention strategy (Figure 3). Consent was not obtained here. Around 59.1% (26/44) of panellists think it is important while some suggested that it would be more helpful and effective to have an agreed treatment goal or outcome and establish a standardised evaluation/assessment tool targeting different outcomes. Panellists claimed that it is undeniable that social workers adopt an array of approaches that they deem fit for different clients, and having a standardised protocol may impede intervention creativity and flexibility. There are too many individual variabilities in each substance user; consequently, it will be difficult to strictly adhere to the approaches in the manual. Furthermore, brand new intervention strategies are proliferating (e.g., Buddhist counselling), which means the protocol might be irrelevant or outdated soon. By using the same assessment tools, the field

can evaluate the effectiveness of the strategies adopted in accomplishing the intended outcomes. Putting all these ideas together, the research team decided to focus on programme outcome evaluation tools and directions rather than aligning the intervention strategies and approaches that the field is currently adopting.

Figure 3

Distribution of Results of Q1 with Panellists' Occupations



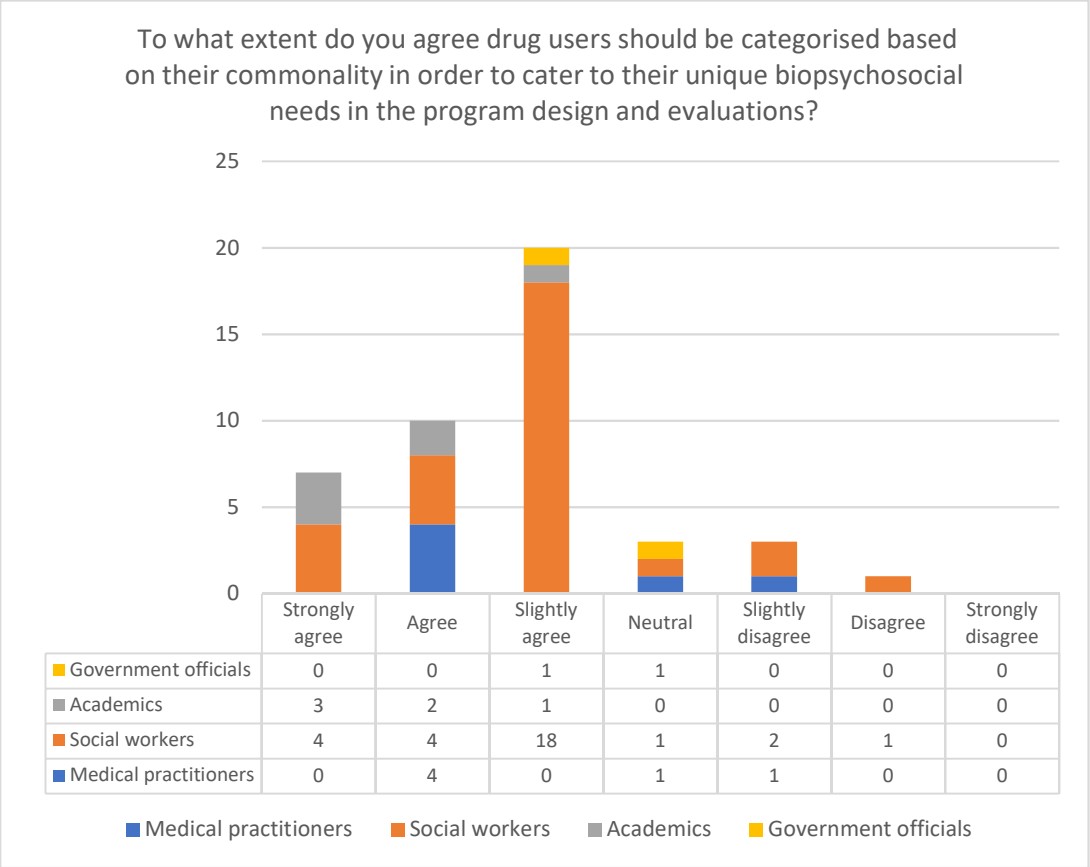
	Extremely important	Very Important	Important	Neutral	Unimportant	Very unimportant	Extremely unimportant
Government officials	0	0	1	1	0	0	0
Academics	0	0	2	0	2	2	0
Social workers	4	8	8	3	6	0	1
Medical practitioners	1	0	2	2	1	0	0

The categorisation of drug users is not standardised across practices in Hong Kong thus far, and hence this item has been taken forward to Wave 2 in an attempt to reach consensus in the field. The question "To what extent do you agree drug users should be categorised based on their commonality to cater to their unique biopsychosocial needs in the programme design and evaluations?" was asked. A majority (84%; n = 37) of panellists agreed on the notion. Polling was also conducted on how to categorise service users, wherein five options (specific drug type, general drug type, the frequency/severity of drug use, specific population, and individualised/tailor-made programme design) were provided to the panellists who agreed that drug users should be differentiated. Panellists were requested to rank the top three most

appropriate ways to categorise service users. The result shows that a majority of panellists chose individualised/tailor-made programme design as the most appropriate way, followed by the frequency/severity of drug use as quite appropriate and specific population, such as pregnant mums, men who have sex with men, as appropriate. Justifications of panellists' choices were provided in the qualitative response. Some of them expressed that a differential approach is preferable in Hong Kong by conducting a comprehensive biopsychosocial assessment and having a multidisciplinary discussion on individual management plans based on their biopsychosocial needs. It is also stressed that each service user is unique even when they are crudely assigned to the same category. Moreover, the participants were concerned that further categorisation may contribute to the power imbalance between client and therapist, which violates the essence of client-centred ideology in counselling since the formulation of the therapeutic relationship is more important than the therapy itself.

Figure 4

Distribution of Results of Q2 with Panellists' Occupations



	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	0	1	1	0	0	0
Academics	3	2	1	0	0	0	0
Social workers	4	4	18	1	2	1	0
Medical practitioners	0	4	0	1	1	0	0

Our research team then asked, "Do you agree that community-based service should be continuing care for all of the residential treatment post-discharge rehabilitates?" in Wave 2, for which 97.7% (n = 43) of panellists agreed with the statement (Figure 5). Nonetheless, one emerging group has been neglected by these two modes of treatment—the hidden occasional psychotropic drug users. It is claimed that hidden drug use is becoming more pervasive because the majority of the occasional psychotropic drug users can still maintain daily, family and social functioning, hence, they are left unidentified and have low motivation to withdraw from drugs since they do not identify their drug use as problematic or harmful. They will only surface when their health has shown severe problems or physical malfunctions, which usually happens after 4–5 years of drug-taking, according to one of the academic panellists. This observation has brought to light in Wave 2 the question, "Do you agree that occasional psychotropic drug

users will show better treatment outcomes from community-based drug treatment programmes than residential rehabilitation programmes?" This question was asked in an attempt to find out whether panellists think the existing modes of programmes could benefit or help this rising population. Consent was not obtained in this question with a significant portion of panellists (n = 15) choosing neutral and agreeing with the notions (n = 20; Figure 6). The reasons are mainly on the hidden nature of occasional users and those with no or low motivation of seeking help since many of them do not perceive themselves as problem users. Therefore, neither of the existing programmes could reach out to this group or attract the group to take initiative to seek help.

Figure 5

Distribution of Results of Q4 with Panellists' Occupations

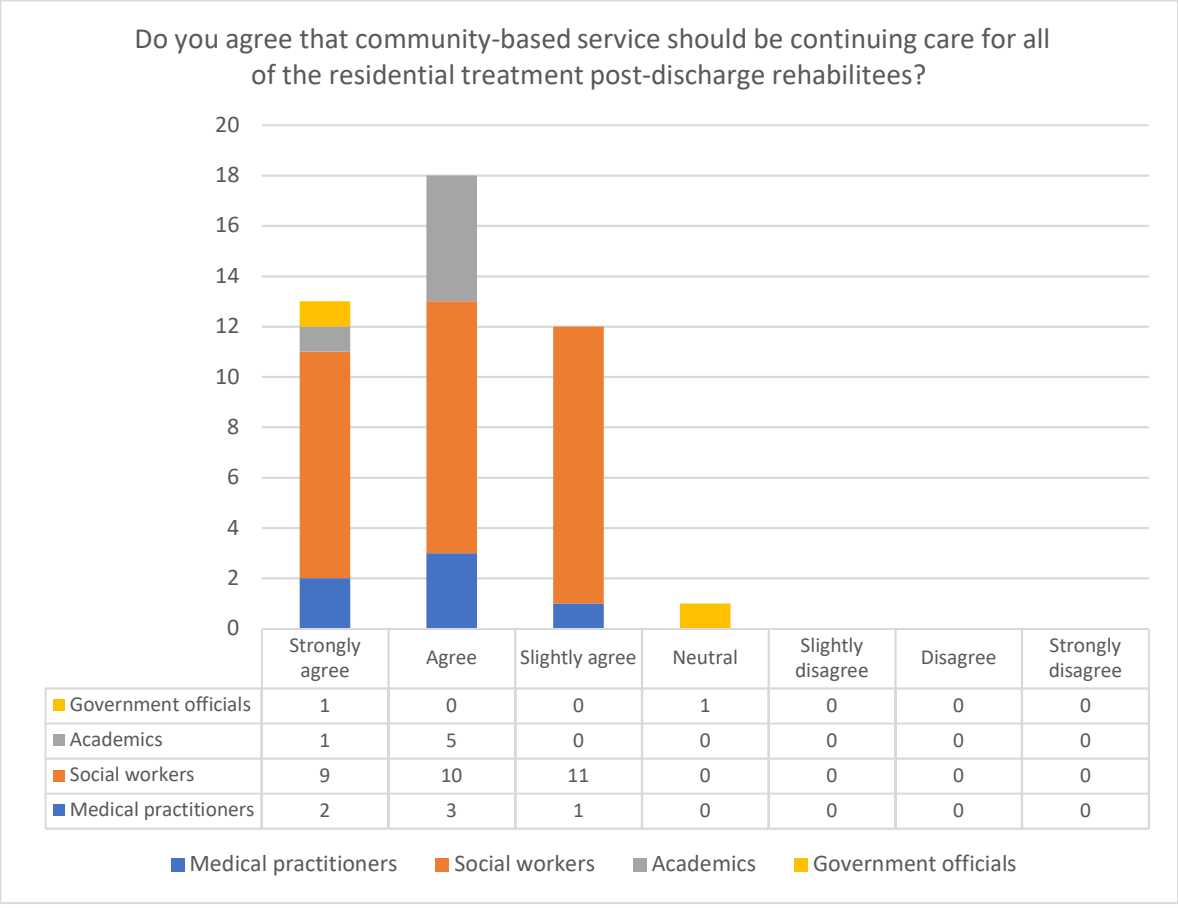
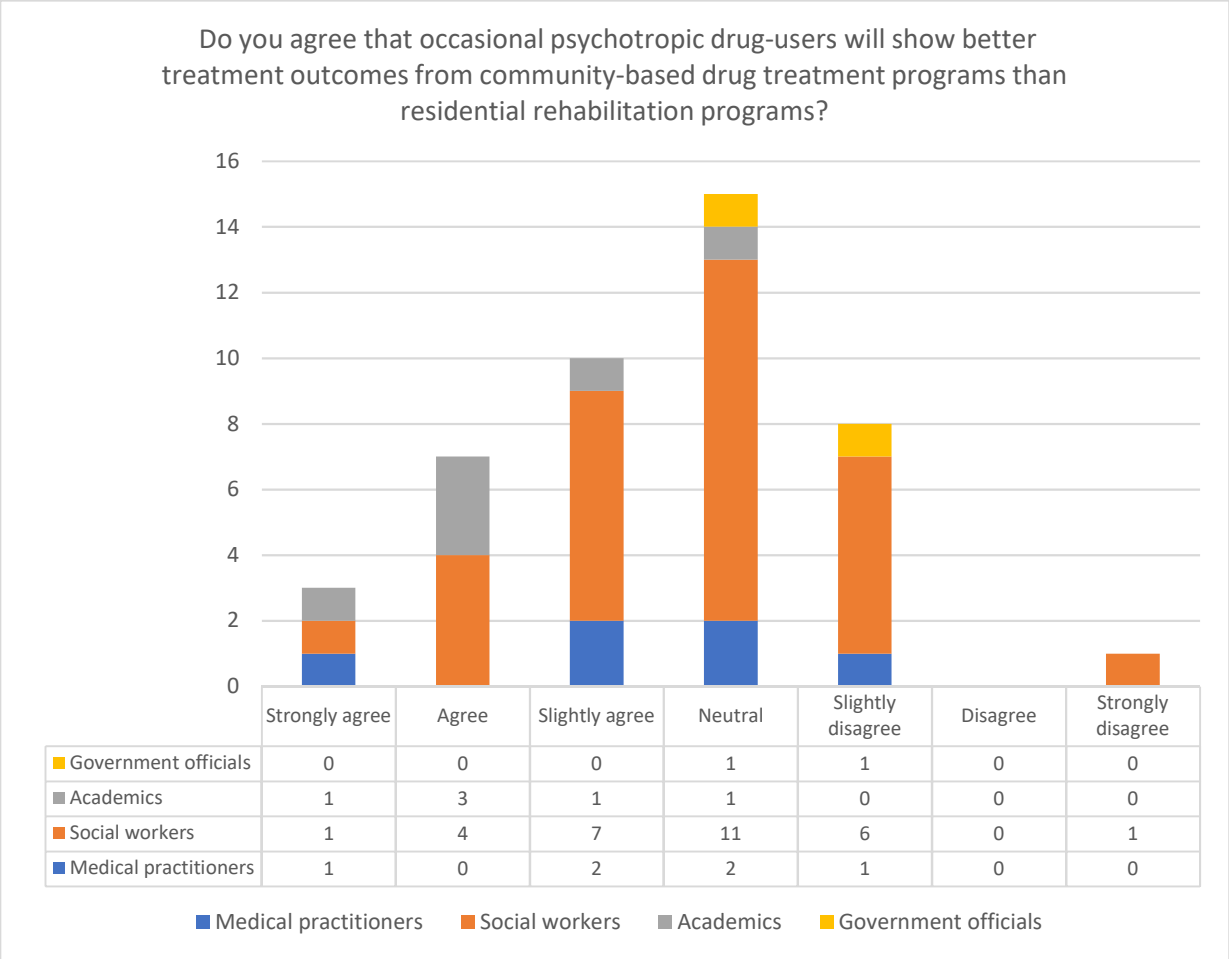


Figure 6

Distribution of Results of Q3 with Panellists' Occupations

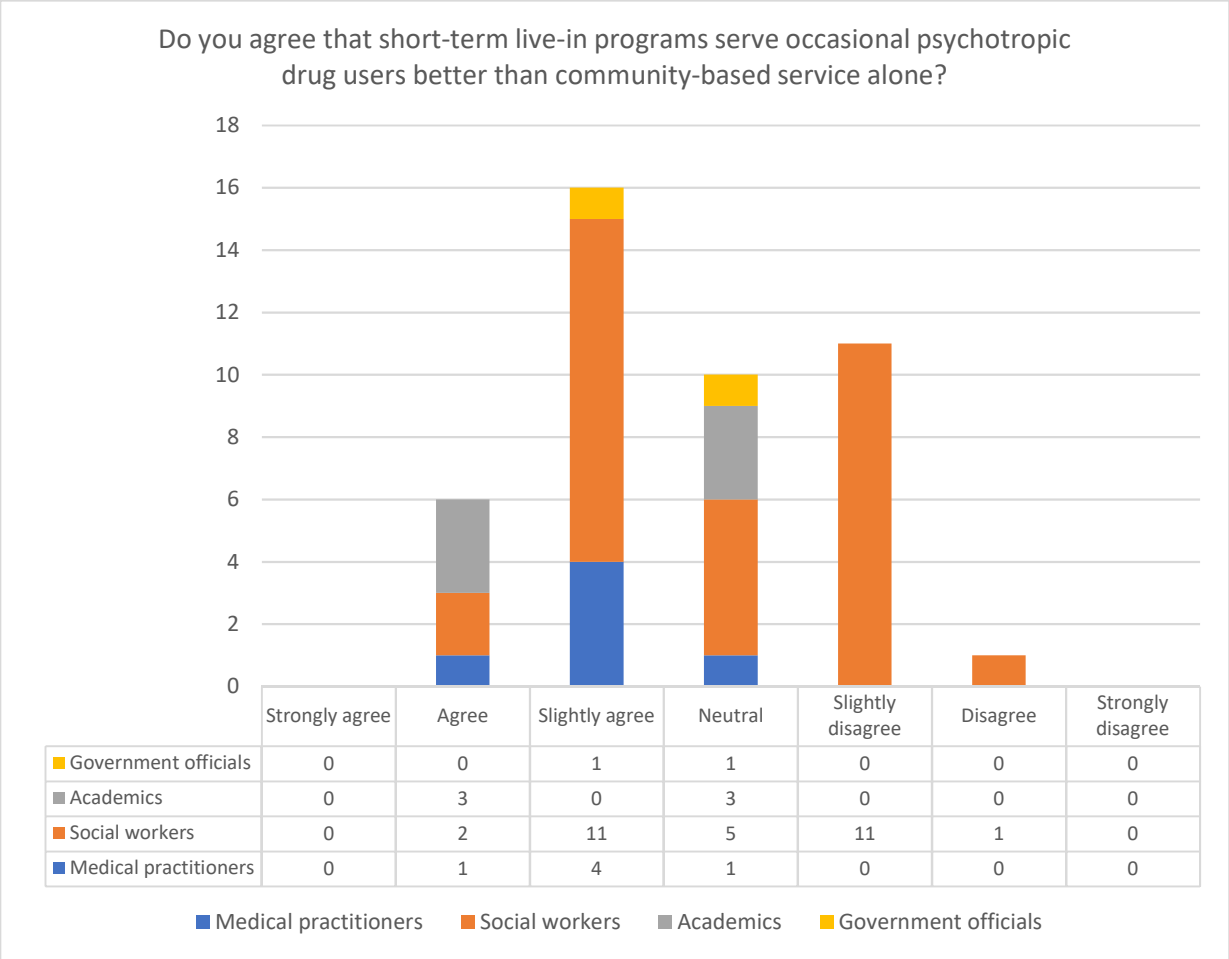


	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	0	0	1	1	0	0
Academics	1	3	1	1	0	0	0
Social workers	1	4	7	11	6	0	1
Medical practitioners	1	0	2	2	1	0	0

In light of this information, the research team attempted to seek panellists' consensus on existing alternatives combine aspects of both community-based and residential treatment modes for this target group through the question "Do you agree that short-term live-in programmes serve occasional psychotropic drug users better than community-based service alone?" in Wave 2 (Figure 7). As a result, only 50% (n = 22) of panellists agree with the statement while the rest answered neutral and disagree.

Figure 7

Distribution of Results of Q5 with Panellists' Occupations



	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	0	1	1	0	0	0
Academics	0	3	0	3	0	0	0
Social workers	0	2	11	5	11	1	0
Medical practitioners	0	1	4	1	0	0	0

The divergence was attributed to a few concerns that panellists raised, including the pragmatic challenge to accommodate occasional psychotropic drug users in reality (Table 5). Further, most of the panellists indicated that various individual factors could come into play, such as one's motivation to cease drug-use behaviours, attitude towards residential lifestyle, and environmental protective and risk factors, such as family support and employment. These factors are currently commonly found in the field, which leads to high drop-out rates. Unfortunately, the existing setup does not tailor to this short-term stay. This finding is on par with panellists' penchant for an individualised programme matching or design.

Table 5

Target Service Users and Service Modality in Hong Kong

	Opioid abusers	Habitual psychotropic drug users	Chronic psychotropic drug users	Occasional/recreational psychotropic drug users
Residential T&R programmes	Detox + life rebuilding	/	Detox + life rebuilding	Too hidden to be reached / no to low motivation to receive treatments
Community-based T&R programmes	Provide continuous care	Receive services without leaving a healthy personal network/routine	Receive services without leaving a healthy personal network/routine Provide continuous care	Too hidden to be reached / no to low motivation to receive treatments

Treatment Approaches

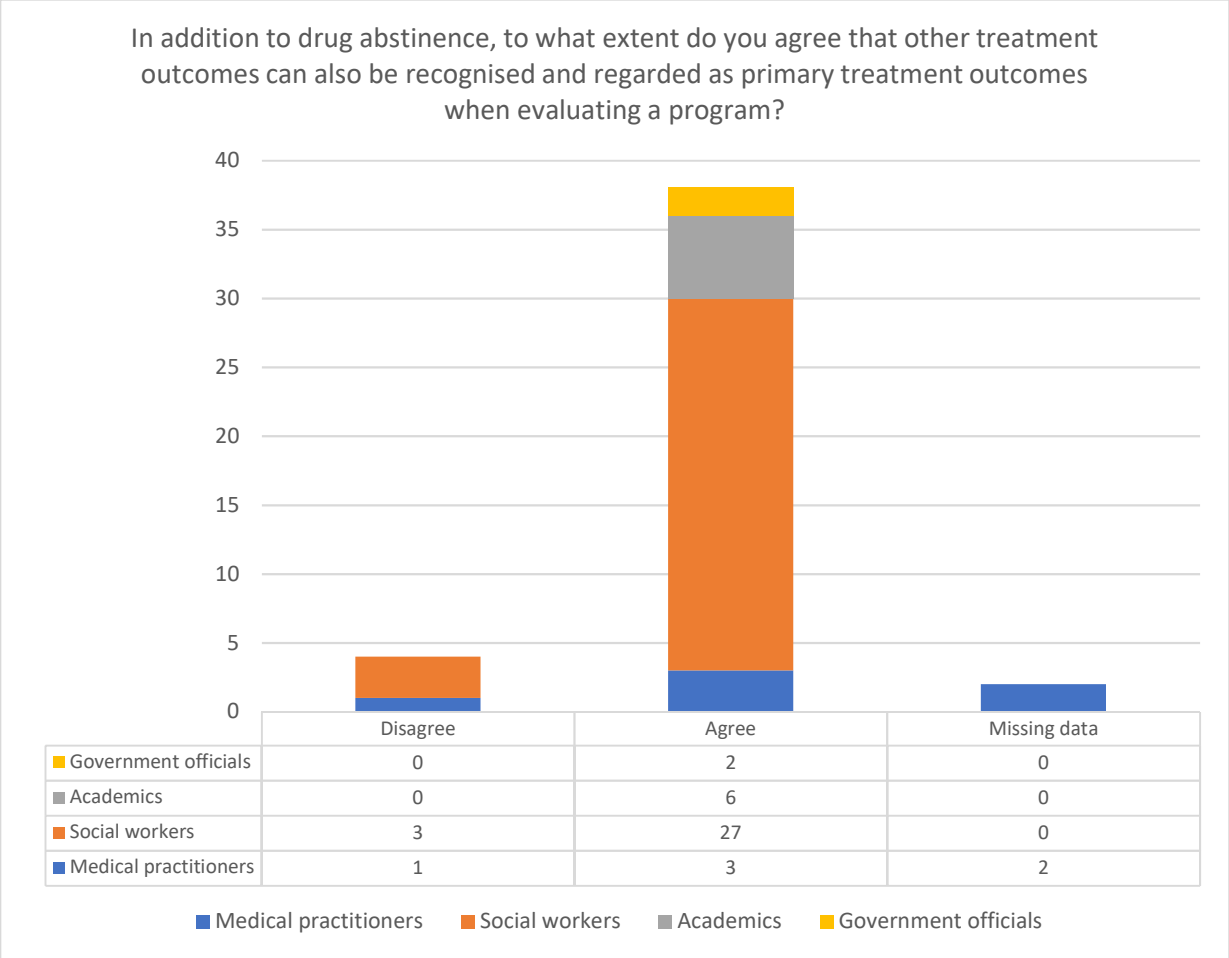
The research team asked the panellists "What are the top 3–5 types of treatment/approaches that you would recommend as the essential elements of a rehabilitation programme for psychotropic drug users?" in Wave 2. After calculating the frequency, social functioning, life planning/reconstruction, develop a support system: family relation, enhancing self-esteem/self-efficacy, and emotional support were the most common answers. To shed more light on the emerging group of occasional psychotropic drug users, another question was asked in Wave 2, "Can you list out the top three critical factors that may significantly contribute to the treatment outcomes for occasional psychotropic drug users?" For this question, developing a social support system, family support/relation, user's self-motivation, and enhance psychological well-being were the most common answers. By comparing these two lists, one can affirm that drug treatment and rehabilitation programmes should not be focusing on quitting drugs merely, but the entire support system, specifically the establishment of safety nets upon discharge or the reduction of risk factors that act as emotional triggers or stressors.

One pronounced factor found in occasional psychotropic drug users is that there is either no or low motivation to receive services.

The research team has also obtained panellists' views on treatment alternatives with the question "In addition to drug abstinence, to what extent do you agree that other treatment outcomes can also be recognised and regarded as primary treatment outcomes when evaluating a programme?" in Wave 2 (Figure 8). As a result, 86.3% (n = 38) of panellists agreed with the statement.

Figure 8

Distribution of Results of Q6 with Panellists' Occupations



Some panellists are well aware that taking drugs is only an outlet of ample underlying problems in which tackling those are more essential than drugs withdrawal itself. For instance, establishing a clear set of life goals, plans to achieve the goals, and relapse prevention strategies

should be a focus of programmes. Therefore, they acknowledged that service providers would be most likely to fail if they solely focus on drug cessation treatments. That said, it is mentioned that even other treatment outcomes are crucial, quitting drugs should always be included as the primary goals in treatment programmes.

Outcome Indicators: Importance and Feasibility

The research team had brought forward a list of possible outcome indicators in Wave 2 for panellists to choose the degree of importance and feasibility of each of the indicators (Table 6). The items on the list include (a) permissive attitude towards drug use, (b) changes in drug-use habit, (c) physical functioning, (d) social functioning, (e) cognitive functioning, (f) compliance with the intervention, (g) condition of drug-induced illnesses, (h) frequency of hospital admissions, (i) urinalysis, (j) drug-free duration, (k) pre-relapse abstinence, (l) frequency of lapses, (m) frequency of relapses, and (n) involvement in high-risk behaviours. The panellists were first asked, "To what extent do you agree these outcome indicators are important on the Likert scale, regardless of their feasibility." After the frequency count, physical functioning, social functioning, drug-free duration, and changes in drug-use habit were the most common, followed by permissive attitude towards drug use, frequency of relapses, and involvement in high-risk behaviours. They can all be deemed as important outcome indicators chosen by the panellists. Subsequently, the question of feasibility was raised in the survey with "How feasible is it to measure each of these outcome indicators in practice?" The same 14 items were presented to the panellists, of which physical functioning, social functioning, and cognitive functioning were the most common, followed by permissive attitude towards drug use and frequency of hospital admissions.

Table 6

Summary of Panellists' Choices in Categorising the Outcome Indicators

	Important	Feasible
Primary outcome indicators		
Physical functioning	√	√
Social functioning	√	√
Changes in drug-use habit	√	×
Drug-free duration	√	×
Cognitive functioning	×	√
Secondary outcome indicators		
Permissiveness towards drug use	√	√
Cognitive functioning	×	√
Frequency of relapses	√	×
Frequency of hospital admissions	×	√
Involvement in high-risk behaviours	√	×

According to the panellists, outcome indicators that are objective and established and validated with research evidence are viewed as feasible, whereas indicators that require self-report data from drug users, such as changes in drug-use habits and drug-free duration, are not feasible. This is a known challenge encountered in the field of drug treatment around the globe, as the reliability, validity, and accuracy of self-report data are commonly challenged in the field.

A programme's performance measurement is one of the most frequently used measurements in Hong Kong. To standardise two of the most used outcome indicators, drug users' relapse rates and programme drop-out rates, the research team had put forward two related questions in Wave 2. Firstly, "The acceptable relapse rate in 90-day of time after joining an intervention programme can be set as:" was asked with the options 30%, 40%, 50%, and 60% provided (Figure 9). Consent was not obtained since the distribution of the answers was quite diverse. Seventeen (38.6%) panellists chose 50% while eleven (25%) chose the option of

30% and 60% independently. Some panellists explained in the survey that relapsing is part of the treatment wherein clients learn from experiences of failing to quit drugs, which might explain the choice of a relatively low threshold of a low acceptable relapse rate. Others claimed that it highly depends on service users' background; for instance, whether they join the treatment based on a probation order, their drug-use type, drug-use history, and their stage of intervention. They all could be factors affecting one's relapse. Secondly, another question was posted, "The acceptable drop-out rate of an intervention programme should be no more than:" with the options 40%, 50%, 60%, and 70% (Figure 10). Consent was obtained with 83.3% (*n* = 37) of panellists agreeing that the range should fall between 40% and 50%.

Figure 9

Distribution of Results of Q7 with Panellists' Occupations

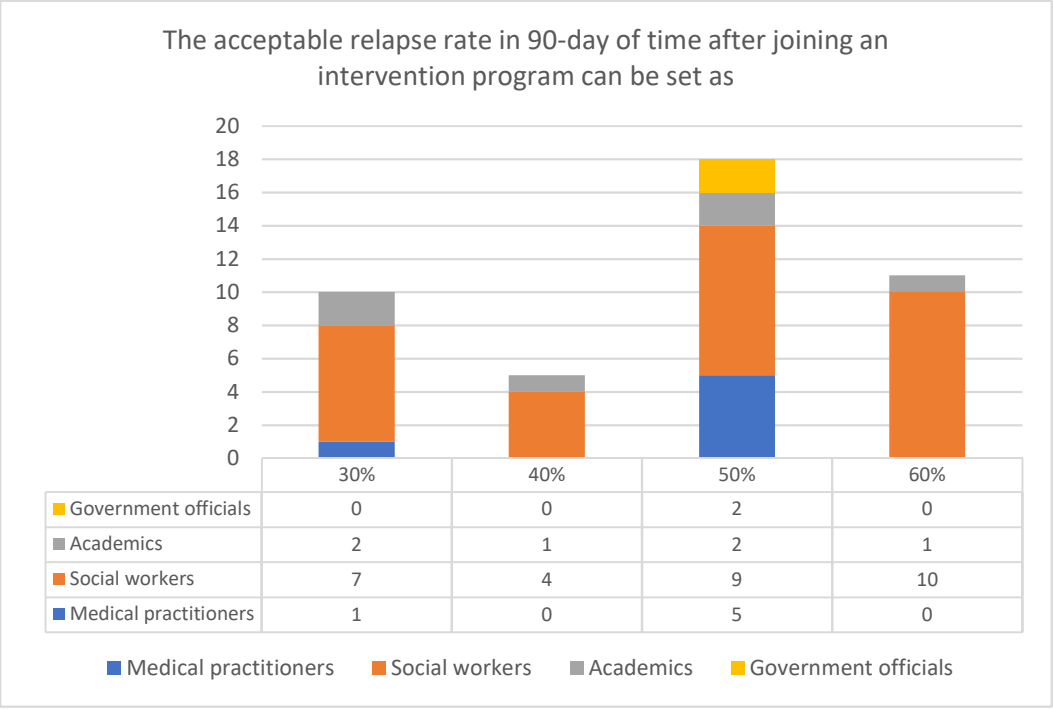
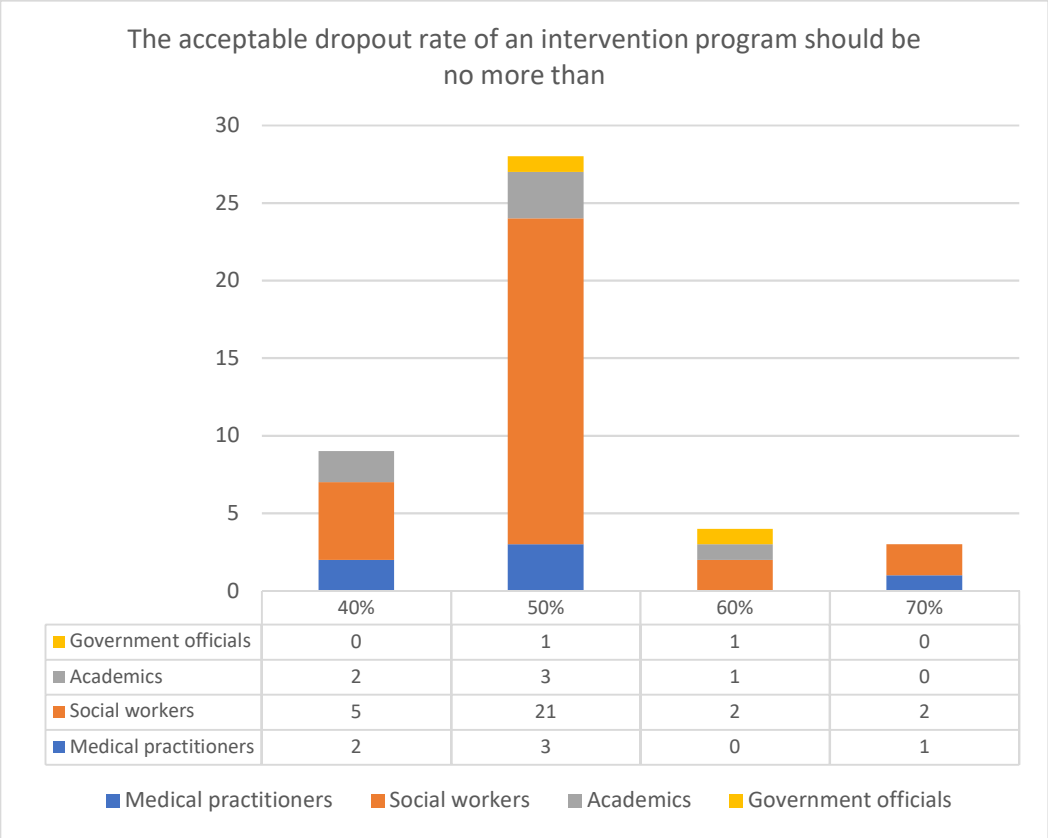


Figure 10

Distribution of Results of Q8 with Panellists' Occupations

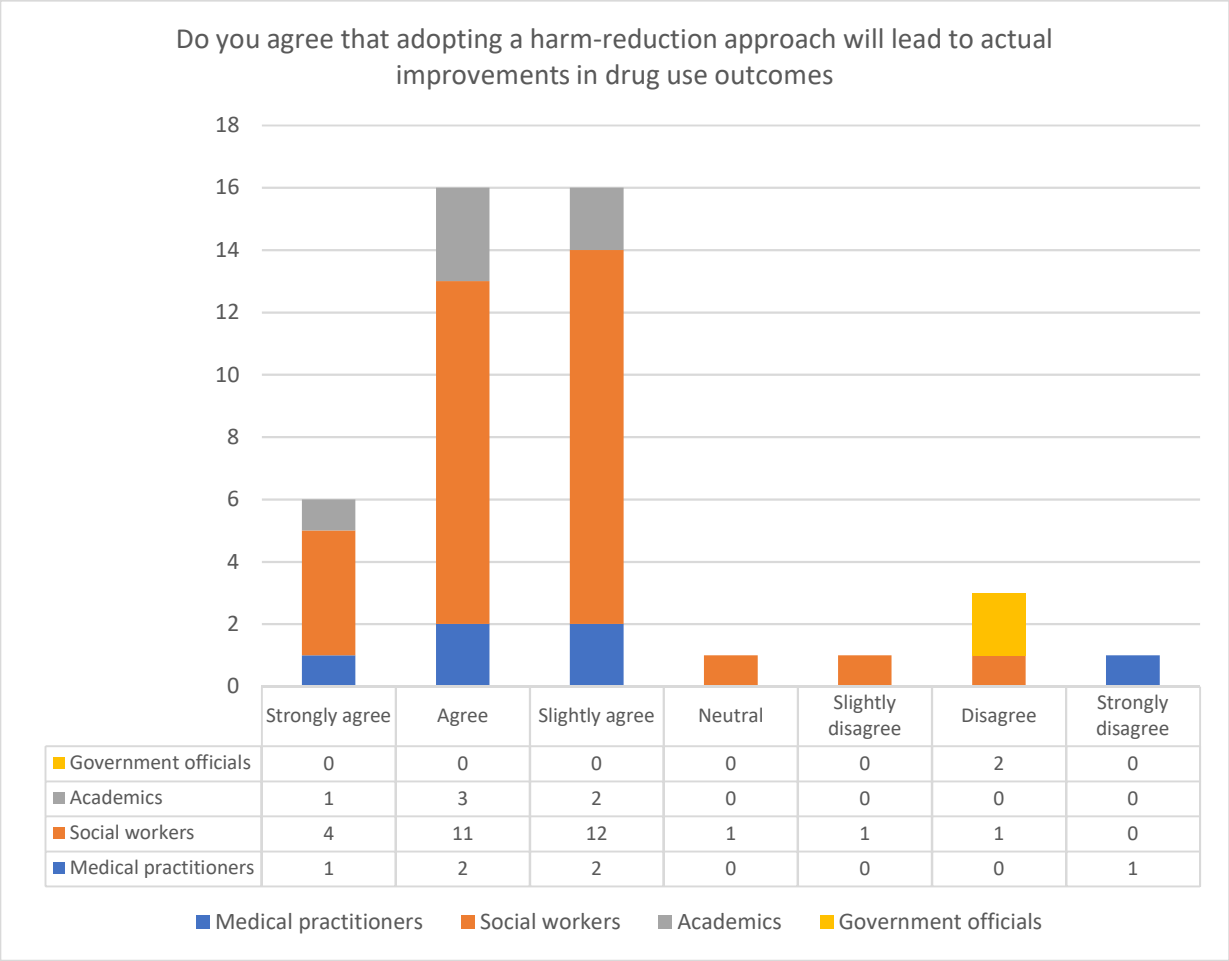


Macro Level: Harm-Reduction Ideology

The majority (86%, *n* = 38) of panellists agreed with the statement "Do you agree that adopting a harm-reduction approach will lead to actual improvements in drug-use outcomes" in Wave 2 (Figure 11). They also stressed in both Waves 1 and 2 that zero-tolerance and harm-reduction approaches are not mutually exclusive and providers should refrain from the dichotomy of harm-reduction versus abstinence-based programmes (Figure 12).

Figure 11

Distribution of Results of Q11 with Panellists' Occupations



	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	0	0	0	0	2	0
Academics	1	3	2	0	0	0	0
Social workers	4	11	12	1	1	1	0
Medical practitioners	1	2	2	0	0	0	1

Figure 12

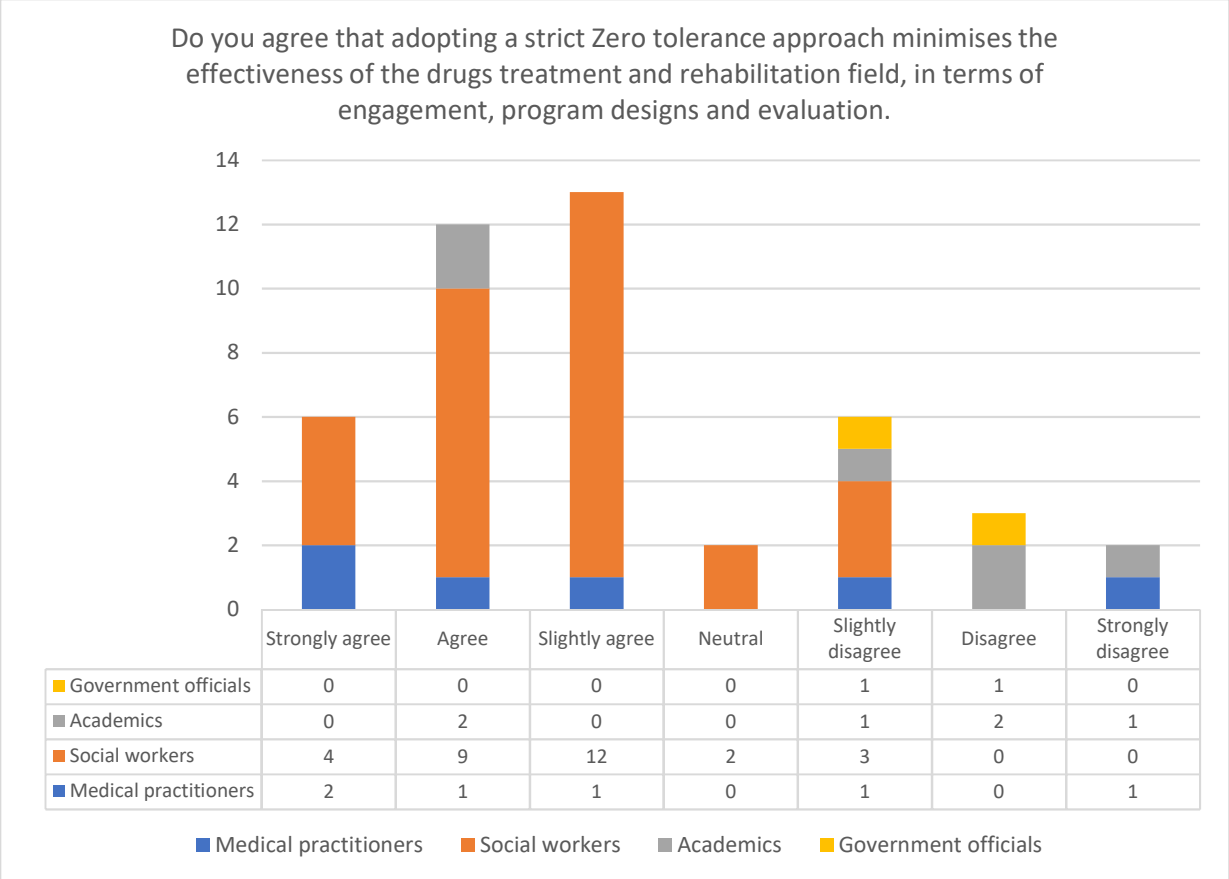
A Visual Presentation of the Spectrum of Ideologies on Zero-Tolerance and Harm Reduction

The question, "Do you agree that adopting a strict zero-tolerance approach minimises the effectiveness of the drugs treatment and rehabilitation field, in terms of engagement, programme designs and evaluation?" was raised in Wave 2, wherein around 70% (n = 31) of

panellists seconded the notion (Figure 13). Yet, they also explicitly stated in the comment section that a harm-reduction approach should be included in the treatment process but reaching zero-tolerance remains as an ultimate goal and as one of the important indicators to show one's rehabilitation progress. Again, the majority (79.5%, n = 35) of panellists agreed that full abstinence should be set as the ultimate target while adopting a harm-reduction approach in any drug rehabilitation programmes (Figure 14). Likewise, 77.2% (n = 34) agreed with the statement, "Harm reduction should be recognised as one of the drug users' service choices other than full abstinence" (Figure 15).

Figure 13

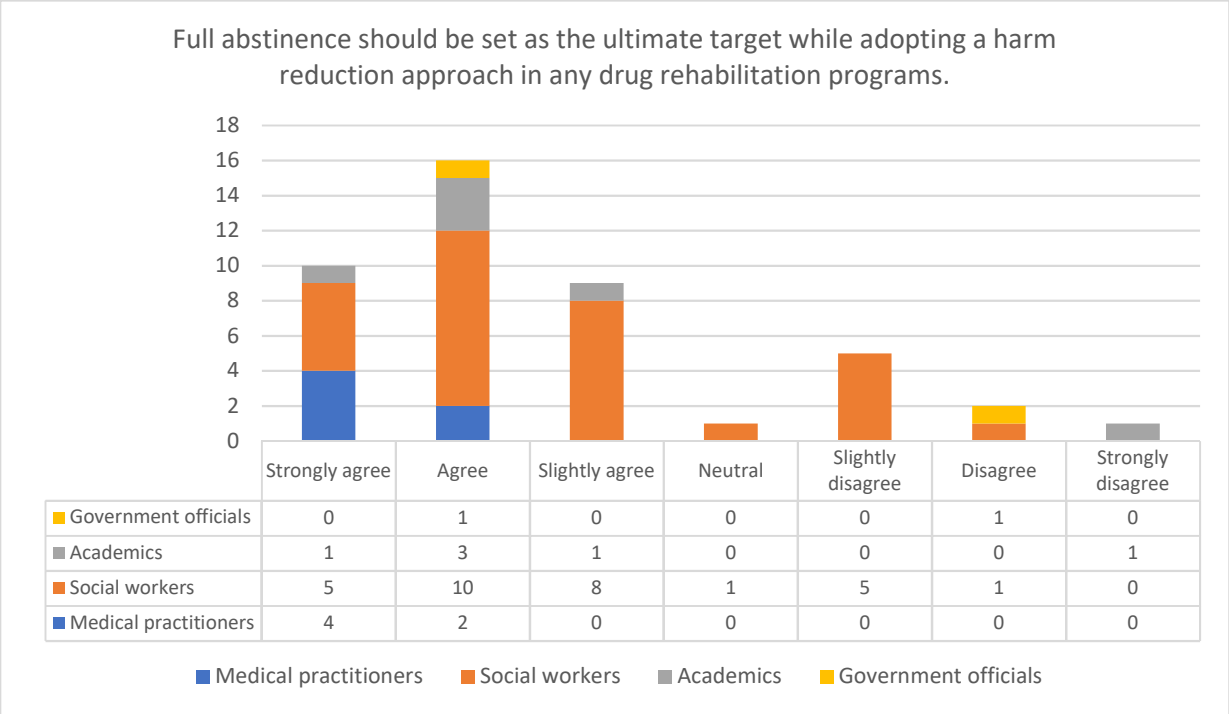
Distribution of Results of Q10 with Panellists' Occupations



	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	0	0	0	1	1	0
Academics	0	2	0	0	1	2	1
Social workers	4	9	12	2	3	0	0
Medical practitioners	2	1	1	0	1	0	1

Figure 14

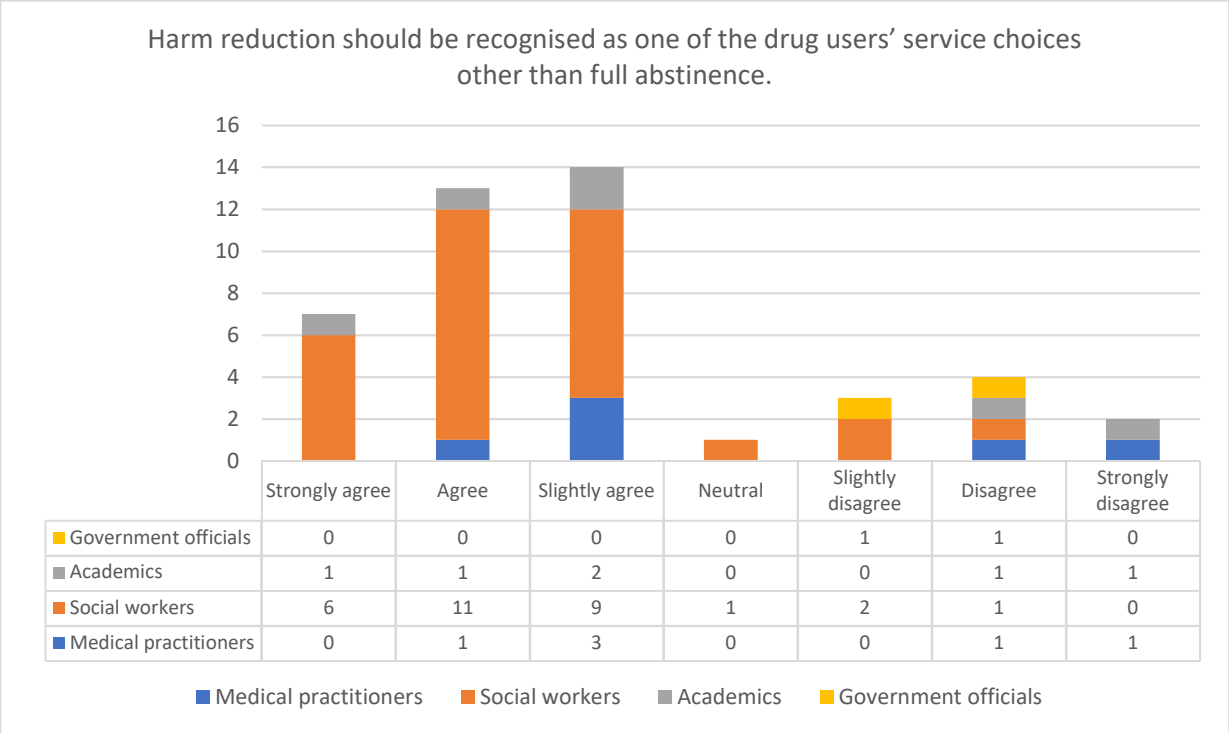
Distribution of Results of Q12 with Panellists' Occupation



	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	1	0	0	0	1	0
Academics	1	3	1	0	0	0	1
Social workers	5	10	8	1	5	1	0
Medical practitioners	4	2	0	0	0	0	0

Figure 15

Distribution of Results of Q13 with Panellists' Occupations

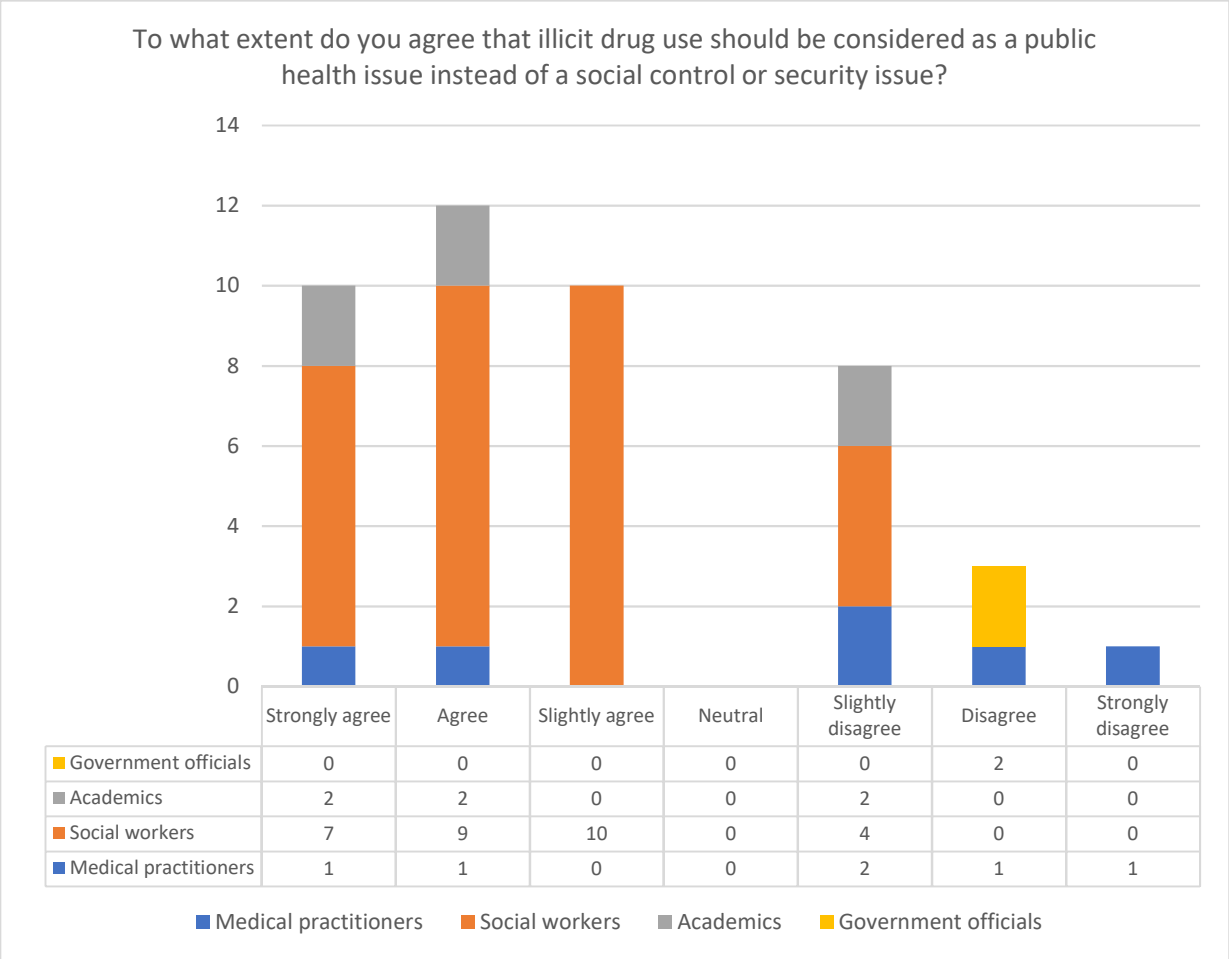


	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	0	0	0	1	1	0
Academics	1	1	2	0	0	1	1
Social workers	6	11	9	1	2	1	0
Medical practitioners	0	1	3	0	0	1	1

The panellists also acknowledged that some users may not be motivated to quit drugs for various reasons and the harm-reduction approach should be an available choice for them to kick start the rehabilitation. It is also mentioned that therapists may keep total abstinence as an ultimate goal, but the field has to recognise the fact that harm reduction could be a patient's choice as an interim measure. Panellists explained they are not looking for a free market or seeking harm reduction as the final destination but more of a strategy to progressively assist drug abusers to reduce drug-use dosage and frequency in which they remain critical to its vision of abstinence. The research team thus included the following question in Wave 2: "To what extent do you agree that illicit drug use should be considered as a public health issue instead of a social control or security issue?" (Figure 16). In response, 72.7% (n = 32) of panellists agreed and consent was obtained. Panellists have also stated their views concerning their support of the decriminalisation of non-violent and summary drug offences and the establishment of a drug court. They also agreed that, in dealing with illicit drug-use issues, it should be a collaborative matter between government policy bureaus, such as security control, health, and rehabilitation.

Figure 16

Distribution of Results of Q9 with Panellists' Occupations



	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
Government officials	0	0	0	0	0	2	0
Academics	2	2	0	0	2	0	0
Social workers	7	9	10	0	4	0	0
Medical practitioners	1	1	0	0	2	1	1

Discussion of the Delphi Study Results

A consensus was obtained in some questions; however, some issues remained divergent, which could be of interest for further investigation and deliberation in the field. Unlike the overseas practice observed in the systematic review, although there is no standardisation in interventional approaches in Hong Kong, the need for standardisation appears to be valid but not a priority. Establishing a standardised evaluation/assessment tool targeting different outcomes requires more attention and development in the Hong Kong context.

Tailor-Made Programme Design for Individuals

Drug users at different stages require divergent treatment services and support. For instance, individuals who are attempting to quit drugs and those who have already withdrawn

from drug use require two different treatment approaches: residential and community-based treatment. Furthermore, different types of drugs require discrete services support, as discussed above. Distinct needs are also identified within psychotropic drug use. To illustrate, ice and cocaine entail vast medical support while social drugs, such as marijuana, require early or primary prevention. Hence, a variety of programme designs to suit users' needs is needed. The majority of panellists consistently showed a strong proclivity for an individualised programme matching or design for drug users in Hong Kong because an array of individual factors could come into play, such as one's motivation to cease drug-use behaviours, attitude towards residential lifestyle, and environmental protective and risk factors, such as family support and employment. These factors are strongly associated with high drop-out rates due to the inflexibility and low pertinence of treatment programmes and users' needs.

Therefore, a risk assessment form is one of the key tools suggested. Service providers are advised to complete an accurate risk assessment and a comprehensive biopsychosocial assessment, followed by programme matching and thereafter an individualistic programme and management plan with corresponding components. A panellist warned that the self-efficacy of some drug users is high, which led them to think they have control over their drug use when it led them down the slippery slope. Drug users can be assisted in assessing their self-efficacy level realistically to prevent them from getting over- or underconfident. The focus should be on assisting drug users to understand and comprehend their own selves. Moreover, programmes that tailor to individual users' needs may be useful to link with the expected outcomes that can be tracked over time.

Fostering Collaboration, Coordination, and Integration

After completing all the aforementioned assessments, having a multidisciplinary discussion on individual management plans based on users' biopsychosocial needs is the next step. It is strongly encouraged by the panellists that we should have more and closer

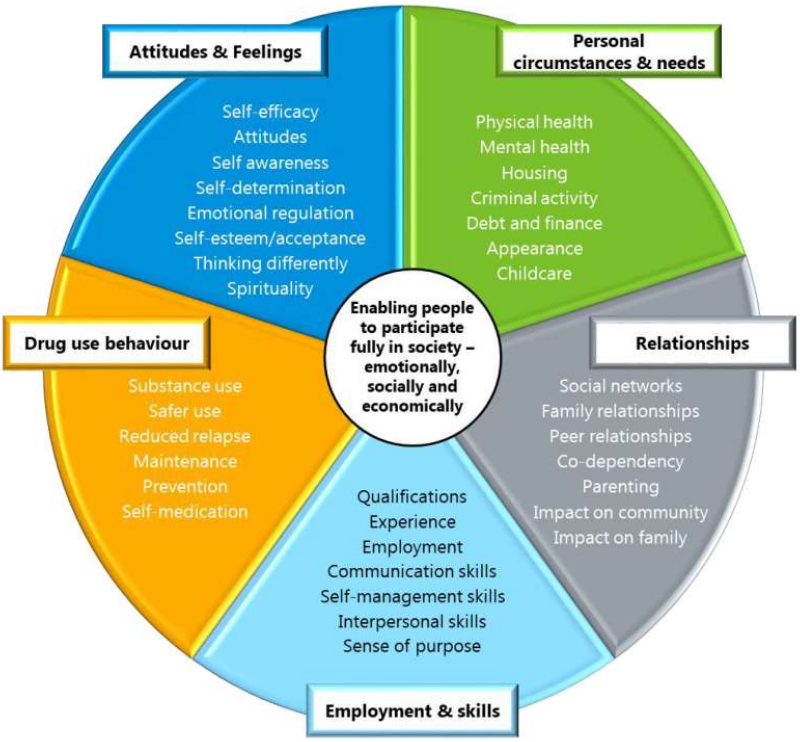
collaboration between social and medical sectors. It is acknowledged that the medical sector has, to some extent, encompassed social service provision into their service, regarding the existing substance abuse clinics run by the seven service clusters of the Hospital Authority. Social service is included in the aftercare service (Narcotics Division, 2021) as opposed to the community centres, referring to the 24 BDF-funded programmes. It is hence advised that the two sectors may incorporate or expand the role of the other sector to make their programmes more holistic and integrated. It appears to be more effective if each substance user has an integrated team encompassing various appropriate professions, such as peer counsellor, psychiatrist, and social workers, to cater to their needs concisely and aptly with professionalism. Multidisciplinary efforts and seamless transitional support services from school to work, from incarceration to aftercare, and from hospitalisation to community rehabilitation have been recommended in the field (Tam et al., 2018). Community-based service can further enhance its role in continuing care for post-discharge rehabilitates. The aftercare service needs to be very specific in its goal that aligns with the needs of ex-drug abusers (e.g., sustaining their skills to stay in a job or coping with stressful family relationships). Programmes that emphasise the continuity of care across different sectors and services for individual users may be useful to link with the expected outcomes that can be tracked over time.

Treatment Outcomes and Measurements

Panellists of the Delphi study suggested more treatment outcomes should be included and measured to reflect service users' progress in their drug withdrawal journey. For psychotropic drug users, it is agreed that working on one's support system, including strengthening interpersonal bonding and improving one's mental health and esteem, are paramount, whereas boosting the motivation to quit drugs is particularly important for occasional psychotropic drug users.

Figure 17

The Drug and Alcohol Recovery Outcomes Framework



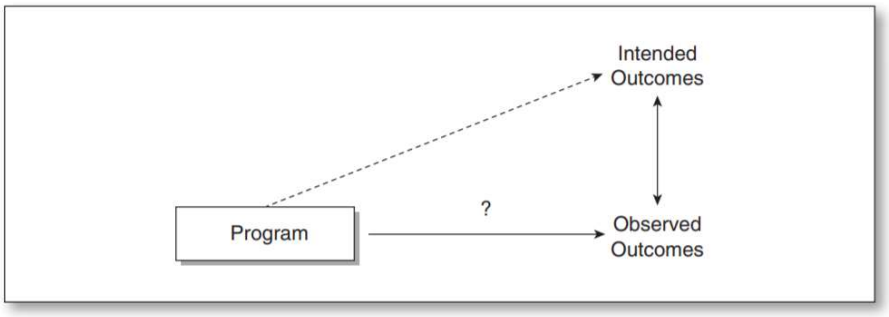
Note. Figure adopted from Ógáin and Hodgson (2017).

McDavid et al. (2013) raised some crucial questions apropos to programme evaluation. They subdivided outcomes into observed and intended outcomes. Essential questions that we should be asking are (a) To what extent, if at all, are the observed outcomes consistent with the intended outcomes? (b) To what extent did the programme contribute to the outcomes we observed in the evaluation? (c) Were the performance measurements measuring the achievement of intended outcomes or merely the implementation performance? (d) Are the results are consistent with intended outcomes. In Figure 18, the question mark above the causal arrow raised the question of whether the programme caused the outcomes one observes. The dashed arrow connects the programme to the intended outcomes, and assessments of that link are often a focus of performance measurement systems (McDavid et al., 2013). Service

providers may consider the risk of misalignment between observed and intended outcomes in practice.

Figure 18

The Two Programme Effectiveness Questions Involved in Most Evaluations



Note. Figure adopted from McDavid et al. (2013).

Table 7

Summary of Panellists' Choices of Treatment Components and Critical Factors in Wave 2

Essential treatment components in T&R programmes for psychotropic drug users	Critical factors impacting treatment outcomes for occasional psychotropic drug users
Social functioning	Social support system
Life planning/reconstruction	Family support/relation
Develop a support system: family relation	User's self-motivation
Enhance self-esteem/self-efficacy	Enhance psychological well-being
Emotional support	

To measure the above core areas in treatment services, some outcome indicators are suggested by the panellists and are summarised in the table below.

Table 8

Summary of Outcome Indicators Chosen and Categorised by Panellists

	Categories	Important	Feasible
Primary outcome indicators			
Physical functioning	Objective	√	√
Social Functioning	Objective	√	√

Changes in drug-use habit	Subjective/Self-report	√	×
Drug-free duration	Subjective/Self-report	√	×
Cognitive functioning	Objective	×	√
Secondary outcome indicators			
Permissiveness towards drug use	Objective	√	√
Cognitive functioning	Objective	×	√
Frequency of relapses	Subjective/Self-report	√	×
Frequency of hospital admissions	Objective	×	√
Involvement in high-risk behaviours	Subjective/Self-report	√	×

Referring to Tables 7 and 8 (obtained from Wave 2 results), one can see that service providers might have some intended outcomes to achieve (e.g., the key treatment components) but failed to identify them in the list of outcome indicators because they do not usually measure them. In light of this, service providers are strongly encouraged to list out the intended outcomes of each programme and have a corresponding measurement or assessment tool tied correspondingly to illustrate the theory of change clearly and concisely.

Occasional Psychotropic Drugs Users

To surface and engage the hidden drugs user or the high-risk group, we have to create an inclusive environment and eliminate stigmatisation. To illustrate, the existing preventive measures, such as public advertisement, should refrain from adopting a fear and deterrent approach. To create a more inclusive and supportive environment or community, one should explore more welcoming therapy and rehabilitation programmes for drug users. Concerning Table 9, one can see that there is limited, if any, appropriate service option that is favourable for occasional psychotropic drug users in Hong Kong.

Table 9

Target Service Users and Service Modality in Hong Kong

	Opioid abusers	Habitual psychotropic drug users	Chronic psychotropic drug users	Occasional/recreational psychotropic drug users
Residential T&R programmes	Detox + life rebuilding	/	Detox + life rebuilding	Too hidden to be reached / no to low motivation to receive treatments
Community-based T&R programmes	Provide continuous care	Receive services without leaving a healthy personal network/routine	Receive services without leaving a healthy personal network/routine Provide continuous care	Too hidden to be reached / no to low motivation to receive treatments

In Wave 2, half of the panellists (n = 22) espouse the idea of a short-term, live-in programme, which conveys that this option is of some value despite all sorts of implementation challenges in its current form. So far, the evidence of the short-term stay on rehabilitation outcomes is yet to be certain. We suggest service providers are given resources to try out different options of residential care to suit the changing needs of users. For instance, panellists suggested that the duration of the short-term live-in programmes should vary with the type of drug use (i.e., ketamine: 6–16 weeks, MA: up to 6 months or longer), the presence of psychiatric illness and physical illness, the presence of one's adverse and beneficial social factors, the design and the modus operandi of services offered, skills of programme staff, and the client's progress on drugs withdrawal progress.

Notably, Polcin et al. (2010) conducted a longitudinal study on sober living houses, which are alcohol and drug-free living environments for individuals attempting to abstain from alcohol and drugs where residents could choose to live as long or short as they wish. The 12-steps self-help groups and developing a social network that supports ongoing sobriety are the

key components in the recovery model used in these settings (Polcin et al., 2010). Polcin et al. found improvements in alcohol and drug use, arrests, psychiatric symptoms, and employment.

Outreaching is one of the key channels to engage and surface this hidden group; hence, further development and advancement in this aspect is highly recommended. There is a lacuna in the existing field in formulating or exploring possible alternative paths to recovery for occasional psychotropic drug users specifically. Likewise, it is seconded by other local researchers that resources need to target raising awareness to reveal these hidden abusers and provide them with dual treatments, handling their mental wellness and substance use simultaneously (Tam et al., 2018).

Most of the panellists agreed that other treatment outcomes could also be recognised as primary treatment outcomes when evaluating a programme. Nonetheless, they also showed concerns that it is difficult to quantify and measure some of the treatment outcomes, which is also the concern of incorporating harm-reduction ideology into the treatment designs. It is understood by many that harm reduction could be an effective strategy in the treatment design, yet it could only be regarded as a means to an end of drug abstinence. However, some panellists have raised a concern that there is no evidence-supported correlation between harm reduction and full abstinence, it is thus a speculative practice. In other words, they believe it is a dogma that progressing in a harm-reduction approach will lead to full abstinence eventually. This association may require more rigorous methods in research to ascertain in the future. To begin with, we suggest the alignment between the harm-reduction driven program design and intended outcomes can be more logically linked and evaluated. Lastly, the conceptualisation and operationalisation of harm-reduction outcomes should be empirically tested.

Validation Study of the Need-Based Quality of Life Scale and Other Measurement

Tools

Study Population Characteristics

A total of 271 psychotropic drug abusers participated in the study. Six sets of questionnaires indicating anomalous response patterns were excluded, leaving 265 datasets for analysis. The sociodemographic information of the participant sample is shown in Table 10, and drug-use information is shown in Table 11.

Table 10

Sociodemographic Information

Variables	Category	n (%) / mean ± SD, range
Gender	Male/ Female	149 (56.4%)/ 115(43.6%)
Age		33.73± 9.69, 16-67
Marital status	Single	153 (59.53%)
	Married	57 (22.18%)
	Divorced	44 (17.12%)
	Widowed	3 (1.17%)
Education Status	Primary Education	12(4.56%)
	Secondary Education	218(82.89%)
	Post-secondary Education	33(12.55%)
Economic Status	Economic active	109 (42.75%)
	Economic inactive	146 (57.25%)

Table 11

Drug-Use Information

Variables	Category	*n* (%) / mean ± *SD*, range
Last time took drug	Within one day	52 (19.70%)
	Within one week	33 (12.50%)
	Within one month	42 (15.91%)
	Within three months	33 (12.50%)
	Within six months	33 (12.50%)
	Within one year	30 (11.36%)
	More than one year	41 (15.53%)
Frequency of drug use	Once or several times a day	107 (40.68%)
	Once or several times a week	77 (29.28%)
	Once or several times a month	50 (19.01%)
	Once or several times a year	19 (7.22%)
	Less than one time a year	10 (3.80%)
Drug use type	Cannabis	77(29.1%)
	Methamphetamine	129 (48.68%)
	Ketamine	73 (27.55%)
	Cocaine	72 (27.17%)
	Zopiclone	29 (10.94%)
	Cough Syrup	28 (10.57%)
	Ecstasy	19 (7.17%)
	Organic solvents (thinner)	2 (0.75%)
	Midazolam	7 (2.64%)
	Nimetazepam	8 (3.02%)
	Happy water	6 (2.26%)
	Heroin	4 (1.51%)
	GHB	5 (1.89%)
	LSD	3 (1.13%)
	Others (poppers/panadol)	3 (1.13%)
Severity of drug dependence		5.9± 3.7, 0–15

Structure Confirmation

The first round of EFA was conducted on the 38 items (including 6 items on importance weighting). The results of Bartlett's test, Kaiser-Meyer-Olkin, and parallel analysis are shown in Table 12. The loadings of EFA for the first round are shown in Figure 19. We had excluded those items considering two aspects: factor loading smaller than 0.4 and the meaning and

context of the items. At last, 13 items were deleted and 25 items remained. The Need-based Quality of Life Scale (NBQoL) developed in this study could be found in Appendix IV.

The second round of EFA was conducted with the 25 items. The results of Bartlett's test, Kaiser-Meyer-Olkin, and parallel are shown in Table 12. The six eigenvalues explained 66.1% of the total variance (ML1: 13.4%, ML2: 11.7%, ML3: 11.6%, ML4: 10.9%, ML5: 9.6%, ML6: 9.0%). To simplify the structure of the factor loading matrix, it was rotated. Since the correlation coefficients between several factors were greater than 0.3, the oblique rotation axis method was used. The loadings of each item are shown in Figure 20.

Table 12

Results of Bartlett's Test, Kaiser-Meyer-Olkin, and Parallel Analysis

	Bartlett's test	KMO	Parallel analysis	Cumulative loadings
Round 1	$p = .00$	0.75	6	54.5
Round 2	$p = .00$	0.75	6	65.8

Figure 19

Factor Structure and Loadings for 6-Factor Structure of 19-Items NBQoL

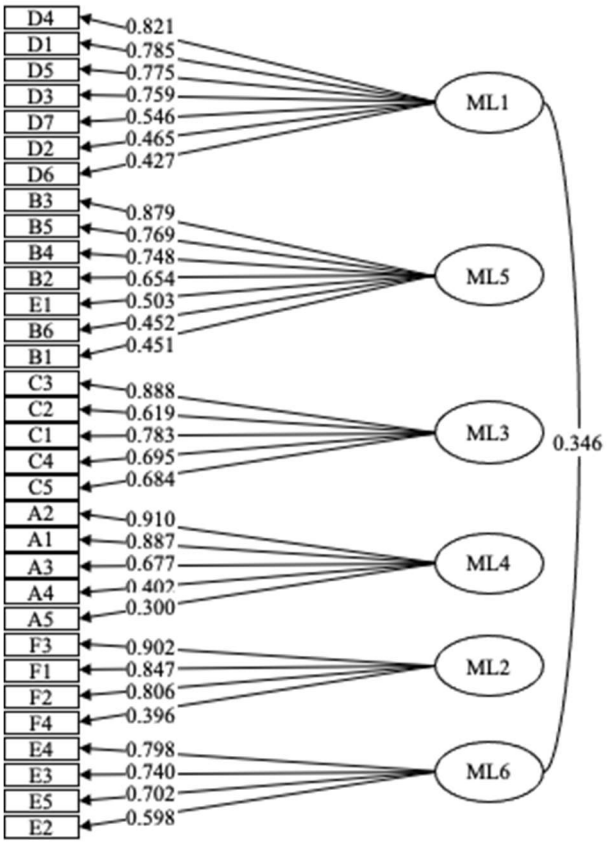
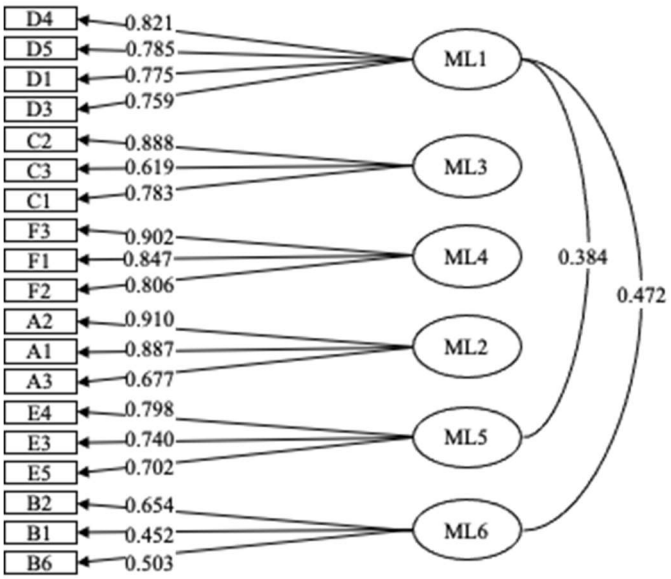


Figure 20

Factor structure and loadings for 6-Factor Structure of 19-Items NBQoL



The final scale with 25 items was tested with CFA. The standardised parameter estimates of the defined CFA model are shown in Figure 21. Fit indicators of CFA and criteria are shown in Table 13.

Figure 21

Confirmatory Factor Analysis of NBQoL

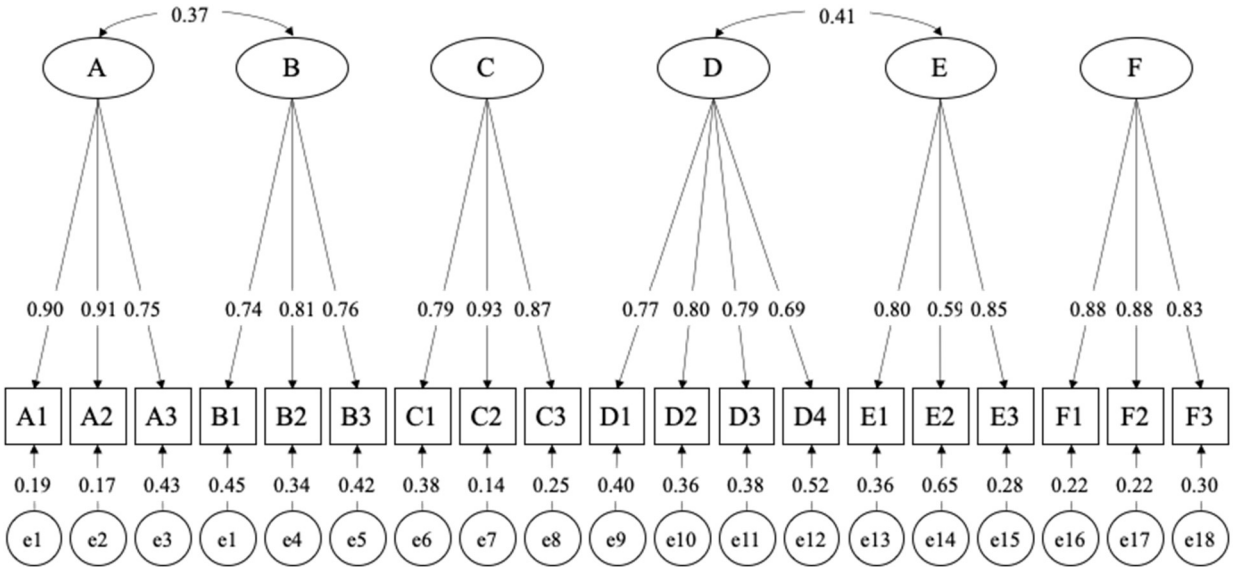


Table 13

Fit Indicators of Confirmatory Factor Analysis

Fit Indicators	Criterion	Level
df	≥3	171
Comparative Fit Index (CFI)	>0.95	0.975
Tucker-Lewis Index (TLI)	>0.95	0.968
SRMR	<0.06	0.054
RMSEA	<0.05	0.042
P-value RMSEA ≤ .05	>0.05	0.718
GFI	>0.8	0.876
AGFI	>0.8	0.829
NFI	>0.8	0.883

Scale Evaluation

Internal consistency and split-half reliability were used to evaluate the reliability of the scale in this study. Cronbach's coefficient alpha tested the internal consistency of the scale.

Cronbach's alpha of each domain was larger than 0.78, which showed good internal consistency of the scale. Besides, the distribution of all possible splits for the 19 items showed that the greatest split-half reliability was .93, the average was .86, and the lowest was .68.

Both criterion (concurrent) and construct validity (convergent and discriminant validity) were evaluated. The correlations confirmed that the scores of each domain and total score of NBQoL were all positively correlated with the subscale and total scores of WHOQOL-BREF, demonstrating appropriate concurrent validity.

Convergent and discriminant validity was assessed using the multitrait-multimethod (MTMM) matrix (Campbell & Fiske, 1959). Items belonging to the same subscale should correlate highly (higher than .60) amongst themselves, while items belonging to different subscales should not correlate highly (lower than .60; Fayers & Machin, 2007). Correlation coefficients (*c*) within the items and the subscales were more than .60 except for Item B1 (*c* = .58) and Item E2 (*c* = .53). Correlation coefficients (*c*) between the items and other subscales were lower than .40 (Table 8), which showed good discriminant validity of the scale.

Validation of Other Measurement Scales

The reliability of the SDS was tested by the internal consistency and split-half reliability test. The reliability estimation calculated by Cronbach's alpha coefficient was 0.81. Table 14 shows the results of each item. The distribution of all possible splits for the five items showed that the greatest split-half reliability was .83, the average was .80, and the lowest was .77.

Table 14

Internal Consistency of the Severity of Dependence Scale

	Mean (*SD*)	Item-total correlation	Reliability if an item is dropped
Item 1	1.9 (0.9)	.78	.76
Item 2	1.9 (1.01)	.82	.75
Item 3	2.2 (1.03)	.81	.75
Item 4	2.9 (1.08)	.67	.82
Item 5	2.0 (0.84)	.70	.79

The analysis of drug-use patterns (last abuse time and drug abuse frequency) and SDS found that both variables showed statistically significant relationships with SDS, which could be evidence for the convergent validity of SDS.

The reliability of the Medical Outcomes SF-12v2 was tested by the internal consistency and split-half reliability test. The reliability of both SDS and the Medical Outcomes Study SF-12v2 as measured by the Cronbach's alpha coefficient was .76. Table 15 shows the results of each subscale. The distribution of all possible splits showed that the greatest split-half reliability was .88, the average was .83, and the lowest was .74.

Table 15

Internal Consistency of the Medical Outcomes Study SF-12v2

	Subscales	Mean (*SD*)	Item-total correlation	Reliability if an item is dropped
PCS	GH	43(26)	.75	.70
	PF	82(27)	.75	.71
	RP	63(27)	.73	.72
	BP	62 (31)	.81	.68
MCS	RE	57 (26)	.78	.68
	MH	52 (19)	.75	.69
	VT	47 (27)	.74	.73
	SF	62 (29)	.80	.69

The analysis of drug-use patterns (last abuse time and drug abuse frequency) and the sub and total scores of SF-12 showed that both variables had statistically significant relationships with the sub and total scores of SF-12, which supported the convergent validity of SF-12.

Discussion of the Validation Study Results

This study developed and validated an NBQoL scale for psychotropic drug abusers. The use of an NBQoL measurement has certain advantages in evaluating drug treatment and rehabilitation services. Firstly, compared to measurements for the general population, NBQoL measurements are more sensitive to changes in QoL that are affected by treatment. McKenna and Wilburn (2018) pointed out that although the traditional HRQoL instruments helped measure results, they could not determine the value of the patient because they could only identify the presence or absence of symptoms, not how these symptoms affected the patients. In addition, these general HRQoL scales are usually short, making it difficult to measure the factors that patients believe are the most important in a particular disease. Some studies have found that need-based measurements could show patient value obtained from non-clinical interventions, but no changes have been found in HRQoL (Goksel Karatepe et al., 2011). Doward et al. (2004) tested the effectiveness of NBQoL measurements and found that compared with many HRQoL instruments (e.g., SF-36 and NHP), the tested NBQoL measurements had better psychometric quality. Secondly, the contents of these instruments are derived from interviews with relevant people, and the items reflect the concerns of the target group rather than the researcher. NBQoL instruments use the life experience of the target population as the centre of scale development rather than generating items from previous research. At last, these instruments are easy to manage and improve and are accepted by investigators and respondents (Oyebode et al., 2019). Thus, NBQoL is considered to be especially useful for treatment evaluation.

In addition to considering the NBQoL, the scale also considers the relative importance of different needs for drug abusers. One of the most critical assumptions of value theory is that all people have the same values no matter where they are, but the relative importance of each value to them is different (Rohan, 2007). It is important to understand the value priorities of

psychotropic drug abusers to help them have a better life. In this study, the importance of each need was scored from 1 (*very unimportant*) to 7 (*very important*). The physical need was considered as the most important need by mean score and autonomy needs as the most unimportant one. This result was similar to the findings of the interview. Psychotropic drug abusers considered material well-being as the priority of QoL, but which was often overlooked by expert panellists. In drug treatment and rehabilitation services, services aimed at improving material well-being and personal development may be somewhat inadequately compared with interpersonal relationships. Employment is related to material well-being and personal development. It has been identified as an important part of drug abuse treatment in existing studies and is considered the ideal result of drug abuse treatment. It can significantly reduce the possibility and severity of relapse and reduce harm (Harrison et al., 2020; Webster et al., 2014). Earning wages is also important for recovery by providing stability and expanding drug abusers' options to pursue recovery (Jason et al., 2021). But as the interviewees mentioned, drug abusers often faced obstacles in finding and keeping jobs. To help drug abusers overcome barriers to employment, employment training programmes and interventions have been incorporated into existing drug abuse treatment services. Through a systematic review, Magura and Marshall (2020) found that the intervention with the most empirical support is individual placement and support, which is also supported by the findings of Harrison et al. (2020). In addition, community-based treatment of drug users during the transition period can reduce drug-use levels, thereby increasing their likelihood of obtaining better financial benefits (O'Connell et al., 2007).

NBQoL also measures the satisfaction degree of different needs of participants. The score of need satisfaction showed that the needs of participants related to quitting drugs were met the most. This indicated that the existing treatment and rehabilitation services better met the needs of drug abusers for quitting drugs. Still, at the same time, it needs to be considered

that the participants in the study are all service users. This sample bias may have an impact on the results.

Among the three psychological needs (autonomy, competency, and relatedness), relatedness needs were met the least on average. Some drug abusers had experienced family problems when they were young and some traumas cannot be recovered from in adulthood. Some setbacks or injuries they experienced in their past lives may have caused them to lack confidence in themselves. Due to drug abuse, drug abusers may face many relationship problems, and whether they can solve these problems can affect their life experience. They and their families care about each other, but they may not be close enough. Friends, partners, children, parents, bosses, etc., are important people to drug abusers. Relationships with important people will also greatly affect their feelings about life. Many experts also emphasise that interpersonal relationships and the support of others can bring great help to drug abusers. A good, equal, and stable family and partner relationship can significantly improve their QoL. Some relationships can give drug abusers a sense of accomplishment, such as playing the roles of mother, wife, and child in the family. The feeling of accomplishment brought by taking on family responsibilities allows them to affirm themselves, believe in themselves, and increase their confidence in staying away from drugs. At the same time, cherishing this sense of accomplishment has also become their motivation to stay away from drugs. Interpersonal relationships are vital for drug abusers, but they also face many obstacles and challenges.

Physical needs were met the least of participated drug abusers among all six needs. Due to the environment of Hong Kong and the characteristics of drug abusers, their physiological needs are more challenging to meet. Physiological needs may be easily overlooked because they are not so easily met through treatment and rehabilitation services. However, as discussed before, the results enlighten that rehabilitation and treatment services should also pay attention to the satisfaction of physiological needs, such as vocational skills training, provision of

potential work, and housing information. It also indicates that policymakers must formulate policies to help drug abusers meet their basic physiological needs.

In addition to the developed QoL scale, this study also validated the Chinese version of the SDS and 12-Item Short-Form Survey (SF-12), which measures HRQoL. The validation results of the SDS were consistent with the studies for different types of drugs in Western countries, indicating the SDS had good cross-cultural validity. Further, significant correlations were found between the total score of the SDS and drug-use patterns (last time of drug use and frequency of drug use), which indicated good concurrent validity. The results confirmed that the Chinese version of the SDS was a valid and reliable scale to measure the severity of dependence among psychotropic drug abusers in Hong Kong. The score of the SDS is significantly related to the characteristics of drug use and the QoL, so the severity of drug dependence should also be an important indicator of intervention evaluation. McKetin et al. (2019) found that in all MA use patterns, dependence on MA was the primary factor leading to poor QoL. However, effective interventions for MA dependence rarely use HRQoL as a result. The BDF evaluation also does not include any question measuring the severity of dependence. Compared with the provided Chinese Drug Involvement Scale (C-DIS; Lam et al., 2002) with 22 items measuring the related concept of drug involvement, the SDS has only five items. The SDS is more concise and efficient to be used to measure drug dependence before and after an intervention.

Drug abuse is a health problem, and the HRQoL of drug abusers cannot be ignored. A systematic review of Bray et al. (2017) found that the use of validated HRQoL measures in the literature on opioid use disorder treatment programmes was rare, whereas the Medical Outcomes Study SF-12v2 was the most commonly used. The validation results of the Medical Outcomes Study SF-12v2 also showed that it had high reliability and validity. Compared with other lengthy scales, using the Medical Outcomes Study SF-12v2 to collect HRQoL

information is more feasible for interventions. Given the increasing importance of patient-reported results and cost-benefit analysis, the benefits of using such short instruments may exceed the cost of treatment programmes.

Theory of change incorporated in the interventions with specific aims to improve quality of life in the above-mentioned domains are recommended.

Recommendations for Programme Evaluation

The WHO (2020) published a set of evaluation guidelines for different countries to follow, namely the International Standards for the Treatment of Drug-Use Disorders. They have pointed out the need "to update guidelines for the treatment of drug-use disorders, procedures and norms regularly to keep up with new evidence of the effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research." The evaluation of treatment and rehabilitation services is significant to enhance the efficacy of drug treatment and rehabilitation services, whereas establishing programme evaluation guidelines will help to justify resources for treatment services and increase and maintain an evidence-based practice of drug treatment and rehabilitation in Hong Kong in the long term. This section recommends a few guidelines with reference to Chapter 4 of the WHO (2020), consisting of details on treatment setting, modalities, and interventions.

Description and Goal

Individualised programme design is preferred and advocated because there are too many personal factors making every single drug user unique (e.g., distinct genetic predisposition, personality traits, motivation to cease drug-use behaviours, attitude towards residential lifestyle, and the presence/absence of environmental protective and risk factors). Hence, to succinctly and aptly cater to their divergent needs, programmes that tailor to individual users' needs may be useful to link with the expected outcomes tracked over time. After completing all the assessments, it is more effective if each substance user has an

integrated team encompassing various appropriate professions, such as peer counsellor, psychiatrist, and social workers, to cater to their needs concisely and aptly with professionalism. Programmes that emphasise the continuity of care across different sectors and services for individual users may be useful to link with the expected outcomes tracked over time.

Models and Components

The 4P factor model (i.e., predisposing, precipitating, perpetuating, and protective elements) could be useful in guiding the assessment and programme-matching process for substance users. The research team has advanced the 4P model by combining it with the bio-psycho-social-environmental model and believe it could help guide future research (Table 16).

Table 16

Overview of the 4P Factor Model and the Bio-Psycho-Social-Environmental Approach

4P factor model	Bio-psycho-social-environmental approach			
	Biological	Psychological	Social	Environmental
Predisposing	Genetic predisposition in psychosis development/ addiction	Personality traits, trauma	Family instability, Low SES, childhood trauma, Drug-using parents/ significant others	4A model: Availability: Easy access to drug source Acceptability and Awareness: Normalisation of drug use Affordability: Low drug price in the drug market
Precipitating		Recent loss, life stressors, emotional triggers	Peer influence, Societal norms, poor interpersonal relationship, social alienation	Life stressors, Changes in drug policies
Perpetuating	Euphoric effect from drugs	Personality traits, coping mechanisms, previous relapses	Role of stigma to access to treatment, poor social functioning	Prolonged life stressors and adversities, Poor social mobility
Protective	Adequate sleep, medical assistance, normal physical functioning	Coping skills, mindfulness, cognitive behaviour strategies	Availability of effective and accessible treatments, inclusive societal climate	Inclusive community, a support network including family and friends

Outcome Measurements

Other treatment outcomes, other than drug abstinence, could also be recognised as primary treatment outcomes when evaluating a programme. Service providers are strongly encouraged to list out all the intended outcomes of each programme and have a corresponding measurement or assessment tool tied correspondingly to illustrate the theory of change clearly

and concisely. To increase the reliability and validity of the measurement, it is advised to utilise both objective and subjective measurement tools, which are listed below in Table 17.

Table 17

Primary and Secondary Outcome Indicator Categorisation

	Categories
Primary outcome indicators	
Physical functioning	Objective
Social Functioning	Objective
Changes in drug-use habit	Subjective/self-report
Drug-free duration	Subjective/self-report
Cognitive functioning	Objective
Secondary outcome indicators	
Permissiveness towards drug use	Objective
Cognitive functioning	Objective
Frequency of relapses	Subjective/self-report
Frequency of hospital admissions	Objective
Involvement in high-risk behaviours	Subjective/self-report

Key Requirements

- A treatment plan has to be as flexible as possible because it is a common trait among drug users to move forwards and backwards in stages.
- Interventions ought to be gender-sensitive.
- Service providers are suggested to complete an accurate risk assessment and a comprehensive biopsychosocial assessment, followed by programme matching. Having a multidisciplinary discussion on individual management plans based on their biopsychosocial needs is essential.
- Having an integrated team consisting of various professions is crucial.
- To illustrate, registered social workers will be suitable for service users who have a family breakdown where intervention can be conducted on the family as a unit, whereas a psychiatrist will be needed for individuals who are mentally distressed or have psychosis, ergo requires regular hospital visits or check-ups.

Peer counsellors are suitable for individuals who are malleable and prone to follow norms and peer influences.

- Outreaching is one of the key channels to engage and surface the hidden group (occasional psychotropic drug users); hence, further development and advancement in this aspect is highly recommended.

Quality of Life Scale Development and Scales Validation Study

- The use of an NBQoL measurement has certain advantages in evaluating drug treatment and rehabilitation services because it is more sensitive to changes in QoL that are affected by treatment and could reflect the concerns of the target group. The developed and validated NBQoL scale for psychotropic drug abusers could help evaluate the intervention.
- Service providers need to value service users' views on QoL and develop treatment plans linked with their own goals.
- Psychotropic drug abusers considered material well-being as the priority of QoL, but this was often overlooked by expert panellists. Service providers could design more services that could improve material well-being and personal development, such as employment promotion services.
- Expert panellists could be beneficial by communicating and exchanging opinions with different groups (social workers, doctors, academics, etc.).
- The Chinese version of the SDS and the Medical Outcomes Study SF-12v2 were valid and reliable scales to measure the severity of dependence and HRQoL among psychotropic drug abusers in Hong Kong.
- Theory of change incorporated in the interventions with specific aims to improve quality of life in the above-mentioned domains are recommended.

Limitations

It is noted that despite the additional measures adopted, such as recruiting psychiatrists/medical practitioners by undergoing an extra round of snowballing in May 2021, in attempt to expand the pool of representatives from medical sector, the number of medical practitioners is still suboptimal. This might be attributed to the bias sample drawn from personnel involved in the BDF consultation board, which is mainly made up of social sectors staffers. Furthermore, Hospital Authority (HA) rarely participates in BDF project funding schemes. To illustrate, only 4 HA projects are found amidst the 24 reviewed projects. To accommodate the pitfall, the qualitative data of medical practitioners was scrutinised and adduced where applicable.

Conclusion

Being informed by overseas studies and local wisdom, this report highlights a few critical observations and offers recommendations for future program evaluation. The 24 reviewed local treatment programs were crudely categorised into 3 domains: psychosocial counselling, life-skill development, and medical treatment driven programs. It is observed that local treatment and rehabilitation programs tend to adopt a mixture of intervention strategies. This has highlighted the importance of developing a standardised protocol for program evaluation. The assessments on treatment and rehabilitation outcomes, such as the awareness and knowledge of drugs, drug-abusing behaviours, physical and mental well-being, individual capacities and skills, and family and social functioning, are critical in understanding the extent of accomplishment in the intended outcomes and also in improving the programs' effectiveness in general. Although certain basic knowledge about potentially effective treatments of drug abuse and their evaluation has been built in Hong Kong, some

areas can be improved to support further service development, particularly in advancing the treatment and rehabilitation outcomes for psychotropic drug abusers.

The increasing trend of psychotropic substance use and hidden drug users poses new challenges to intervention and rehabilitation services which may require a more proactive mind-set in searching for program's efficacy in meeting the service users' different set of needs, both in rehabilitation and quality well-being. While we acknowledge the merits of adopting a multimodality approach to drug therapy and rehabilitation to cater to the divergent needs of drug-dependent persons from varying backgrounds, we have come to learn from the local experts and service users that a more holistic and inclusive approach is needed to support the psychotropic drug users to receive treatment and rehabilitation without separating them from their healthy ties such as their work, families, and social support system.

In this report, we have tried to address the above concerns with the following three strands:

1. drawing the consensus among the local experts and service users' views on the clues of reaching the treatment and rehabilitation efficacy in Hong Kong.
2. formulating a set of recommendations, if not an evaluation framework, as good practices for future evaluation. The evaluation can allow identifying evidence and supporting models of a standard care of drug treatment and rehabilitation to evolve.
3. conceptualising and developing measurement tools to depict the domains and extent of change in quality of life for service users with psychotropic drug abuse.

We have noted that it is a pragmatic approach to adopt different means and strategies (including but not limited to harm reduction approach) in drug treatment and rehabilitation to engage and support drug abusers for achieving complete abstinence, even though the role of harm reduction and its significance in reaching to full abstinence is yet to be ascertained.

When we discuss harm reduction in drug treatment and rehabilitation, there are two levels of meaning:

1. the exact scientific evidence on the extent of use of other substances in reducing the addiction to the drug abuse, e.g., use of Methadone as opioid maintenance therapy
2. the extent of harm induced by drug addiction on the level of individual functioning (i.e., biopsychosocial) being reduced as well as the quality of life of the service users being improved.

In this report, panellists seemed to focus more on the second level of meaning that harm reduction can be made more specific in prolonging one's pre-relapse abstinence, which can be recognized as one's progress towards drug abstinence. One's work, family, and health are considered as important functioning areas where harm reduction approaches can be applied in enriching the overall quality of life. Upon setting several intended outcomes specifically for an individual, it is recommended to utilise a combination of objective (validated scales) and subjective (self-report) measurement tools for each intended outcome for a more overarching assessment and progress tracking. The following outcome measurement tools could be incorporated in programs extensively; For objective measurement tools include the Need-based Quality of Life Scale (NBQoL) for psychotropic drug abusers, physical Functioning (e.g., Patient Health Questionnaire-9 (PHQ-9)), Social Functioning (e.g., Family Assessment Device (FAD) for family functioning; and for subjective measurement tools include self-report on frequency of relapse or Severity Dependence Scale (SDS).

To allow any innovative type of services to start up, mature and then scale up, it is important to ascertain their efficacy in meeting the treatment and rehabilitation needs of the

targeted service users in terms of the theory of change and its logical links with the intended outcomes. We suggest that resources or incentives can be provided to support evaluation that tests alignments between program design and intended outcomes. In particular, programmes that tailor-made to individuals' needs and emphasise the continuity of care across different sectors and services for individual users are suggested as priority of evaluation. Their efficacy in leading to the intended outcomes of individual users can be tracked over time.

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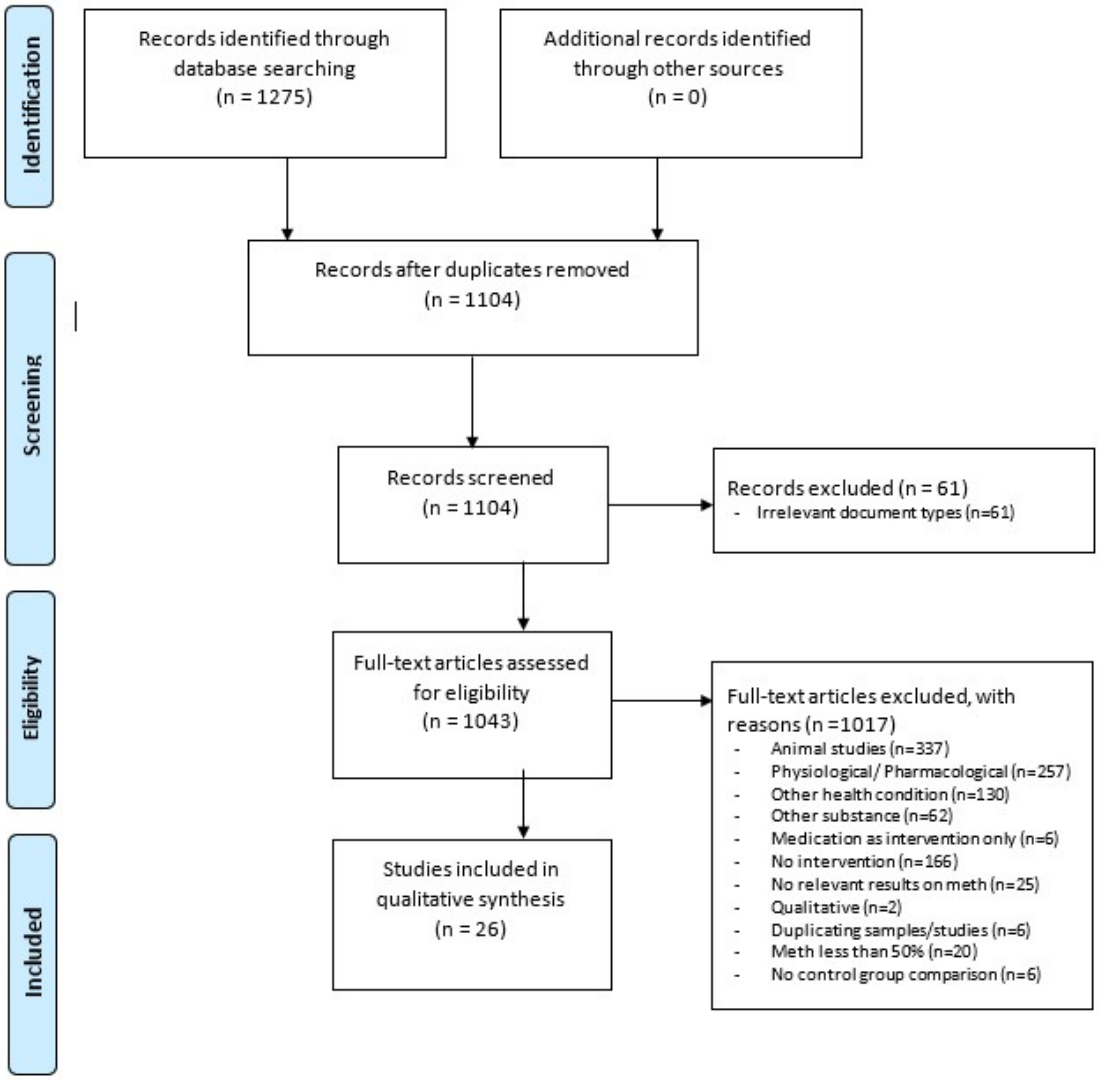
Appendix I: Systematic Review

The number of citations identified from the search engines were 1,275, and the final number of included studies in this review was 26. The PRISMA flow diagram of the search is presented below.

Figure 22

PRISMA Flow Diagram of the Systematic Review Search



A total of 2,464 participants underwent at least one psychosocial intervention, and 1,892 participants were assigned to the control or the treatment-as-usual group. Twenty studies included 100% MA users, two studies stated that the participants were predominantly MA users (Chinkijkarn & Kanato, 2020; Smout, 2010), and the remaining four ranged from 56% to 94%. Participants in 13 studies were recruited from hospitals and clinics, with the remainder recruited from various places in the local community (n = 5), drug rehabilitation centres/camps (n = 4), university research setting (n = 1), and social services (n = 3). Seven studies included gay or bisexual men as an inclusion criterion in participant recruitment. Thirteen studies were conducted in the United States, four were conducted in Australia, and another four in Iran. Three were carried out in Thailand and the remaining two were conducted in Germany and South Africa. Interventions used in these studies are summarised in Table 18 below

Table 18

Number of Studies Found on Various Interventions

Interventions used	Number of studies
Cognitive-behavioural therapy (CBT),	5
Contingency management (CM)	5
Brief motivational interviewing (MI)	4
Family intervention	3
Combined treatment (CBT and CM)	2
Combined treatment (CBT and MI)	2
Acceptance and commitment therapy	1
Twelve-step programme	1
Behavioural activation	1
The matrix model	1
General telephone counselling	1

The key findings from the systematic review are summarised below.

1. Marlatt's cognitive-behavioural model (Marlatt CBT) has the best result, which focuses on relapse analysis and coping, and a brief introduction of MI to increase participants' motivation to relapse prevention or harm reduction. Marlatt CBT suggests that both immediate determinants (e.g., high-risk situations, coping skills,

outcome expectancies, and the abstinence violation effect) and covert antecedents (e.g., lifestyle factors and urges and cravings) can contribute to relapse.The results showed that Marlatt CBT led to decreased relapse and cravings (Marlatt & Gordon, 1985).

2. Contingency management (CM) is the practice of providing incentives for meeting a specified behavioural goal (e.g., abstinence from substance use) and withholding incentives when the goal is not met. CM is considered as a strong intervention when the fishbowl technique is used appropriately to reinforce MA users in engaging in the CM programme for better prizes/reward for the submission of negative urine samples. The prizes involved were kitchen or other household items attractive to the users. When CM is mixed with another intervention (smartphone app or medication), the potential effect of CM might be clouded in terms of both treatment effect and fair research comparison.
3. Brief intervention of MI focuses on initiating the participants' motivation to change and reduce the use of MA for whatever reason that works for their situation: physical health, family, or simply a life with better function. It demonstrates better results than intensive MI. There were three studies categorised as using family intervention, with one used directly to caregivers of MA users and the other to MA users who are mothers themselves. All were psycho/parent education programmes and targeted at caring for MA users and children in meth-involved families.
4. All programmes showed significant reduction in drug use in both studies by the end of 6 months.

Appendix II: Review of Local Treatment and Rehabilitation Projects

Introduction of 24 Drug Therapy and Rehabilitation Projects

The Hong Kong Government established the BDF in 1996. The BDF operates the regular funding scheme on an annual basis to provide financial support to different organisations, including but not limited to hospitals, NGOs, and tertiary educational institutes, to address the problem of drug abuse in Hong Kong. According to project statistics, 978 projects targeting drug therapy and rehabilitation had been funded by BDF from 1996 to 2020, and approximately 227 projects focus on treatment and rehabilitation services for drug abusers and their families (Narcotics Division, 2021). The rest are non-interventional projects, for example, renovation projects, infrastructure purchases, professional training, and various public engagement activities, delivered to a variety of beneficiary groups, such as school students, general youth, high-risk youth, teachers, social workers, volunteers, professional, sexual minorities, and the general public. Grantees funded by BDF mainly include counselling centres for psychotropic substance abusers, DTRCs, halfway houses, medical institutions, academic institutions/schools, and other providers of drug treatment and rehabilitation service. Besides professional counselling (20.7%), there has been a surge of treatment projects with various interventional strategies, such as medical service with support medical assessment or treatment (11.8%), vocational training or aftercare service (12.7%), supportive service by peer counsellors or volunteers (20.7%), and multi-media service (12.3%).

To date, it appears that Hong Kong has a similar distribution of residential and community-based treatment projects. Furthermore, there has been a rise in projects designed for specific target groups, such as pregnant drug users, high-risk teens, rehabilitees, arrested young drug abusers, and drug users' family members. Funded organisations have to report the project activities they deliver as well as the corresponding outputs and outcomes to BDF.

In this section, the research team reviews and summarises the project design, inputs, outputs, and outcomes of the drug therapy and rehabilitation projects from 2014 to 2016 in Hong Kong. The objective is to capture the treatment components and approaches adopted by the local service providers and the outcomes they intended to achieve. The results were used to inform the formulation of the Delphi study for Waves 1 and 2. The data were made available through the BDF and with the informed consent from the respective service providers. The total number of projects included in the review was 24.

PICO Framework for Projects Review

The PICO framework has been widely used in research of evaluating evidence-based approaches for identifying components and evaluating project effectiveness (Higgins et al., 2019). In the PICO framework, the interventions, target populations, control/comparison, and outcomes of projects are introduced and reviewed for research purposes. However, in the community-based treatment projects conducted by the counselling centres for psychotropic subtance abusers, DTRC, and other service providers, few have control/comparison groups due to the limited number of service recipients. Compared with research study, the community-based treatment projects funded by the BDF focus not only on achieving expected outcomes for target population, but also on efficacy and effectiveness of projects.

In this review, the PICO was defined as an evaluation tool and the components of evidence-based approaches were adjusted to the following: (a) population represents how the project describes the group of service users; (b) intervention shows which main intervention approaches are delivered to service users, (c) comparison does not apply to data analysis, but suggestions for future projects were provided; (d) outcomes represents how expected outcomes are measured and achieved in projects. In this section, data from 24 local drug therapy and rehabilitation projects are reviewed and analysed following the components of the PICO framework. According to standards of the WHO (2020), goals of treatment for drug-use

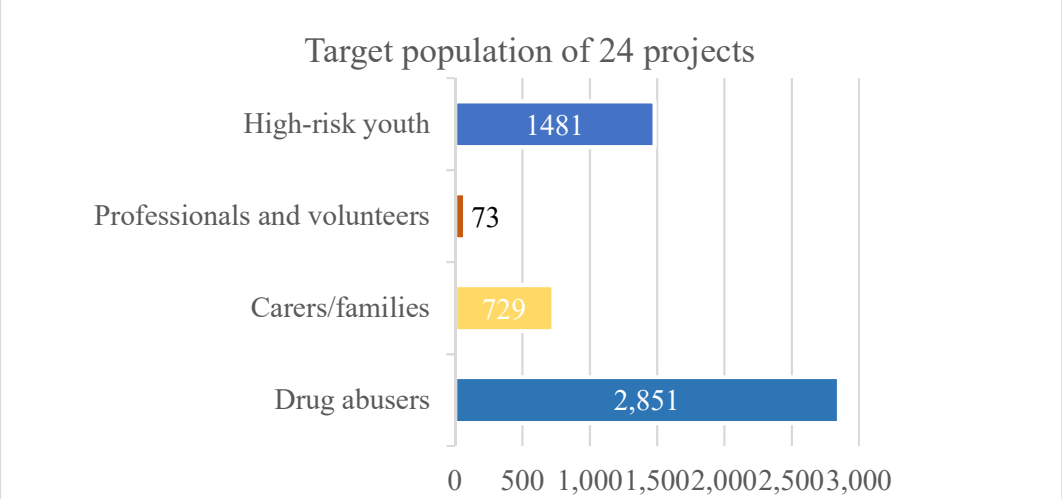
disorders include (a) stop or reduce drug use, (b) improve health, well-being, and social functioning of the affected individual, and (c) prevent future harms by decreasing the risk of complications and relapse. It is worth noting that reducing drug use is suggested to be the primary goal of treatment for drug-use disorders as a priority by the WHO.

Population

These 24 drug therapy and rehabilitation projects provided service to a total of 5,616 people, including drug abusers, caregivers/families of drug abusers, professionals, employees and volunteers, and high-risk youth. Different types of the target population are shown in Figure 23. Among these 24 projects, a total of 22 projects mainly provided treatment to 2,851 drug users, and the other two projects served a total of 1,481 youths with high risk of drug use. In addition to potential/current drug users, 12 out of these 24 projects delivered services to 729 carers and families of drug users in total, and one project provided drug-related educational training for 73 supporting employers and professionals, such as social workers, front-line workers, and volunteers.

Figure 23

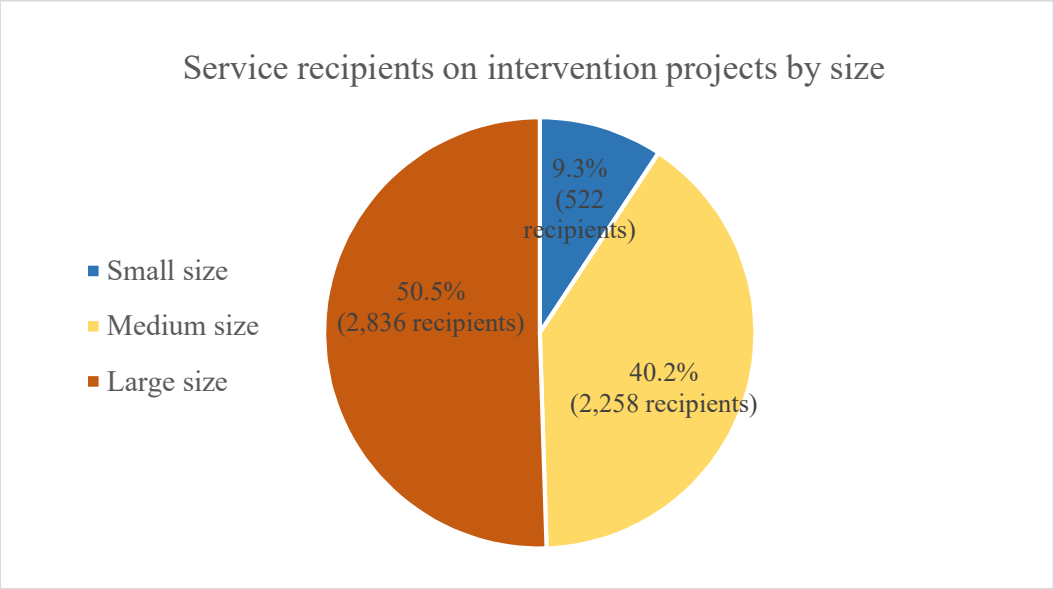
Target Population by Service Recipients (*N* = 5,616)



Based on the taxonomy of project size, all projects are grouped into small-size (number of recipients < 100), medium-size (number of recipients = 101–400), or large-size (number of recipients > 400) projects, according to the number of service recipients in every project. Among 24 projects, there are 7 small-size projects, 13 medium-size projects, and 4 large-size projects. Adding up the number of recipients in each type of projects, the results indicated that 522 recipients were treated in small-size projects, accounting for around 9% of the total number of recipients in all 24 projects. Thirteen medium-size projects provided treatment and rehabilitation service to 2,258 service users in total, while a total of 2,836 recipients received service of large-size projects, accounting for around 50.5% of total number of recipients in all 24 projects (See Figure 24).

Figure 24

Target Population by Project Size



Interventions

In general, there are different types of community-based drug therapy and rehabilitation projects either directly subvented by the government, or funded by private donations or the BDF. According to the BDF regular funding scheme information (Narcotics Division, 2021), the intervention activities adopted by these projects in creating effect leading to drug abstinence

can be classified as incentive-driven projects (e.g., projects on social support, peer support, and family support and vocational training), cognitive-approach projects (e.g., motivational interview and CBT), medical treatment, and integrated treatment. It is observed that drug therapy and rehabilitation projects are currently grouped into different categories based on intervention activities and the engagement strategies, which will cause overlap between different types of projects and cannot present the nature of the intervention. With data collected from 24 drug therapy and rehabilitation projects, different characteristics of projects, such as intervention approaches, sample sizes, and activities were analysed and summarised, which contributed to understanding the core components and effective elements of Hong Kong drug therapy and rehabilitation projects. Based on the nature of intervention approaches, drug therapy and rehabilitation projects were categorised into psychosocial counselling, life-skill development, and medical treatment-driven projects. The definition of different intervention types is introduced below (Table 19).

Table 19

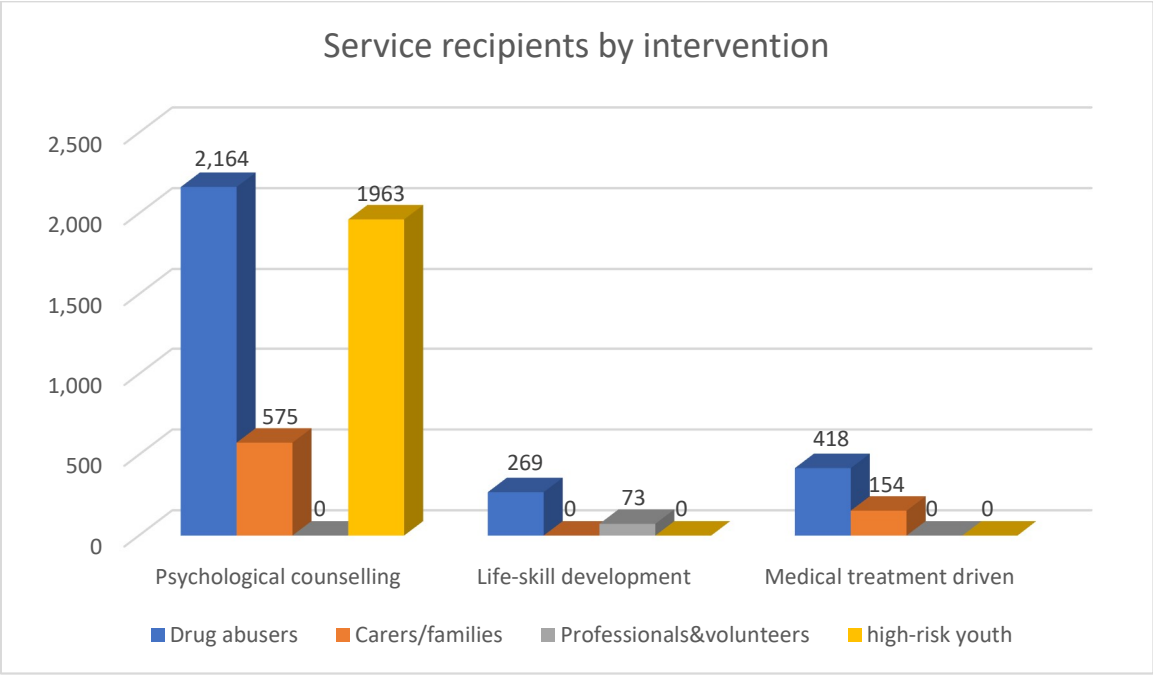
Description of Intervention Types by Nature

Intervention types	Objectives	Possible components
Psychosocial counselling	Aiming to change drug users' attitude, reduce their problematic behaviours, improve their quality of life and functioning through counselling services in various aspects such as physical health problems, mental illness, living difficulties, financial management, etc.	Cognitive-behavioural therapy (CBT) Motivational intervention (MI) Individual recovery goals setting
Life-skill development	Targeting to teach drug users skills which enable them to accept responsibilities of social roles and to face demands and expectations of others.	Vocational training Job placement Practical skills training
Medical treatment-driven	Focusing on treating co-occurring medical issues and relieve severe physical symptoms caused by drugs such as anxiety, sweating, headaches, insomnia, and pain and discomfort.	Professional assessment Individualised tailor-made care project Home visits and on-site depot injection service

Eighteen of the projects were psychosocial counselling and the other six projects delivered life-skill development or medical treatment-driven service (four for life-skill development, two for medical treatment-driven). Among a total of 5,616 service recipients, 342 (6.1%), 572 (10.2%), and 4,702 (83.7%) service recipients received life-skill development, medical treatment driven, and psychological counselling projects, respectively. Different target population for each type of intervention are shown in Figure 25.

Figure 25

Different Types of Service Recipients by Intervention



Theory of Change

Most public health treatments worldwide are inherently complex with multiple modalities and components delivered under multiple settings. This complexity makes them difficult to be evaluated by traditional experimental designs (Hai et al., 2019). Not all projects can meet the basic standards of conducting evaluation of randomised control trials (RCT).

Therefore, some researchers suggested that understanding the theory of change is also essential to improve the evaluation of complex and comprehensive treatment projects. Theory of change illustrates the underlying mechanism of how and why an expected change happens in a particular context and develops the links between treatment activities and desired goals (Breuer et al., 2015).

Theory of change, which precisely shows the links between activities or interventions and achievement of long-term goals, can lead to better project planning and evaluation. Among 18 psychological counselling projects, seven projects (Project No. 3, 5, 12, 13, 19, 20, and 21) that posited family and social supports can enhance drug abusers' motivation for reducing or stopping drug use had the highest expenditure (81%–93%) on recruiting social workers to enhance family functioning of drug abusers and their families. Three projects (No. 2, 14, 24) posited that improvement of psychological health would result in changes of motivation for resisting drugs. In comparison, two projects (No. 7, 8) adopted the theory of change that improvement of social/occupational functions helped drug abusers to reintegrate into society and motivate them to quit drugs. In the other five projects, four (No. 4, 16, 17, 18) insisted that increasing knowledge of drug harms or skills of coping with drug abuse contributed to the reduction of drug use, and the other one (No. 23) only used outreaching activities to attract drug abusers and increase treatment participation, which is not consistent with the previous commonly used theory of change. All four life-skill development projects (No. 1, 6, 10, 11) supposed that improvement of social/occupational functions would motivate drug abusers to stay drug-free. In two medical treatment-driven projects, one (No. 2) adapted the theory of change of family support and the other designed individualised tailor-made activities to help drug abusers to quit drugs. The intervention types, objectives, target population, duration, outcomes, and measurements of projects are shown in Table 20.

Table 20

Descriptive Information of 24 Projects

Project No.	Intervention types	Target population	Duration	Objectives	Theory of change	Outcomes	Outcome measurements
1	Life-skill development	81 drug abusers, 23 supporting employers, 50 volunteers	24 months	Aims at providing employment assistance and support to drug abusers to help them reintegrate into society.	The project supposes that providing employment and occupational training helps drug abusers to reintegrate into the society. With more social recognition and support, they will be motivated to quit drugs.	Changes in knowledge, attitude, behaviours	BDF No. 2, BDF No. 3, BDF No. 7, GSE, LASER
2	Medical treatment-driven	216 drug abusers, 116 carers of drug abusers	36 months	Aims at promoting new approaches to tackle the problem of hidden drug abusers with co-morbid psychiatric disorders by providing early assessment, screening, problem identification and treatment.	The project supposes that individualised tailor-made care programme and treatment plan can help drug abusers to quit drugs.	Changes in attitude, behaviours, psychological distress	BDF No. 6, BDF No. 13, CISS, BPRS, BDI, HADS
3	Psychosocial counselling	114 drug-abusing mothers	24 months	Aims at reducing and eliminating the participants' drug use, enhancing their parenting skills, improving their family functions and fostering a healthy and drug-free lifestyle in their families.	The project supposes that developing the competence of living a healthy and drug-free life and improving parenting skills can help drug abusers quit drugs and improve their relationships with family.	Changes in knowledge, behaviours	BDF No.5, BDF No.20, Community Education Questionnaire, Marital Relationship Scale
4	Psychosocial counselling	226 hidden drug users, 120 occasional drug abusers, 55 habitual drug abusers	24 months	Aims at providing early identification services and stage-specific counselling for potential drug abusers and drug abusers.	The project supposes that identifying the situations and demands of drug-abusing youth in different stages (at-risk youth, drug abusers, hidden drug abusers) and delivering stage-specific counselling services can help them to quit drugs and satisfy their needs.	Changes in attitude, behaviours, psychological distress	BDF No.1, BDF No.5, BDF No.6, BDF No.13, PHQ-9, GAD-7, Subjective Units of Distress Scale (SUDS)

5	Psychosocial counselling	48 female drug abusers, 48 families	24 months	Aims at reducing the risk of relapse among female ex-drug abusers through a structural relapse prevention model.	The project supposes that enhancing the competence of coping with relapse and increasing social support from family can help drug-abusing females to prevent relapse and stay abstinent.	Changes in knowledge, attitude, behaviours	BDF No.7, BDF No.12, Self-image scale, Acceptance for drug rehabilitees scale
6	Life-skill development	53 drug abusers	24 months	Target on providing vocational training courses including dessert making, baking, graphic design and pre-employment training to female residents of the drug treatment and rehabilitation centre to enhance their employability and to prevent relapse.	The project supposes that vocational development and basic life-skill training can help drug abusers to develop a positive attitude towards life and society and therefore, stimulate their motivation for quitting drugs.	Changes in behaviours, social/occupational functioning	BDF No.6
7	Psychosocial counselling	117 drug abusers	24 months	Aims at providing community-based cognitive remediation (e.g., cognitive assessment and training, psychoeducation), occupational enhancement and lifestyle redesign services for drug abusers.	The project supposes that improving cognitive and occupational functioning is beneficial to reducing or stopping drug abuse.	Changes in knowledge, behaviours, social/occupational functioning	BDF No.5, A-CER, COPM
8	Psychosocial counselling	90 pregnant drug abusers, 77 parents	36 months	Aims to develop a holistic parent counselling support and education project for pregnant abusers and drug-abusing parents.	The project supposes that enhancing parenting skills and childcare and development training for drug-abusing parents or pregnant drug abusers can help them to take care of their children and quit drugs.	Changes in attitude, behaviours, social/occupational functioning, service satisfaction	BDF No.6, PSOC, PSS, Parent self-appraisal questionnaire, Client satisfaction scale
9	Psychosocial counselling	73 female drug abusers	24 months	Aims to integrate animal assisted therapy/activities into drug counselling for female drug abusers or those who have quitted drugs for at least 3 months in Hong Kong.	The project supposes that animal assisted therapy can help drug abusers to raise their empathy and love and strengthen awareness of cherishing life and health, and further increase the motivation for staying drug abstinence.	Changes in behaviours, psychological distress	BDF No. 6, BDF No. 7, HADS
10	Life-skill development	60 drug abusers	24 months	Aims to offer vocational training including paint and white wash, plumbing and sanitary ware and electrical appliances installation courses for drug rehabilitees.	The project supposes that providing occupational training can help drug abusers to seek for jobs and reintegrate into the society. With more social recognition and support, they will be motivated to quit drugs.	Changes in social/occupational functioning	Professional tests

11	Life-skill development	75 drug abusers	24 months	Aims at encouraging drug abusers to live a healthier lifestyle through sport intervention therapy.	The project supposes that teaching drug abusers to develop a healthy lifestyle and do sports can help them to obtain more social recognition and support and increase motivation for quitting drugs.	Changes in attitude, behaviours, service satisfaction	BDF No.4, BDF No.5, BDF No.14a, BDF No.16
12	Psychosocial counselling	80 hidden drug abusers, 55 families of hidden drug abusers	24 months	Target at providing treatment and support services to hidden drug abusers and their families.	The project supposes that family support can motivate drug abusers to engage in treatments and quit drugs.	Changes in attitude, behaviours, psychological distress, social functioning	BDF No.5, BDF No.13, BDF No.20, Symptoms Checklist-28, FAD
13	Psychosocial counselling	410 drug abusers, 40 families of drug abusers	24 months	Aim at providing aftercare services to drug rehabilitees, supporting the family members of drug abusers as well as strengthening collaboration among various sectors including probation offices, medical professional and anti-drug social workers.	The project supposes that helping family members to manage negative emotions and deal with drug-related problems can help drug abusers to get more family support and improve family relationships. With more family support and a good family atmosphere, drug abusers can obtain more motivation and self-efficacy for quitting drugs.	Changes in attitude, behaviours	BDF No.3, BDF No.6, BDF No.14a, BDF No.16, BDF No.20
14	Psychosocial counselling	95 drug-abusing LGBT youths	22 months	Aims at developing specific drug prevention and treatment programme for the LGBT community as well as enhancing the capability of practitioners in working with drug-dependent LGBT persons.	The project supposes that education on harms of drugs and stress management in community can help LGBT drug abusers to build up a supportive network and increase motivation for quitting drugs.	Changes in attitude, behaviours, psychological distress	BDF No.5, BDF No.13, BDF No.16, QIDS, Professional training questionnaire
15	Psychosocial counselling	157 drug-abusing youths, 100 families of drug abusers	30 months	Target on providing tailor-made counselling and treatment programmes for hidden drug abusers and high-risk youth with drug-related criminal offences.	The project supposes that training workshops for professionals and social workers can develop their skills of identifying and approaching hidden drug abusers and delivering appropriate and attractive services to them.	Changes in attitude, psychological distress	BDF No.9, BDF No.13, GAD-7, SUDS
16	Psychosocial counselling	1369 high-risk youths	24 months	Aims at cultivating anti-drug attitudes among ethnic minority high-risk youths and young adults, promoting early help seeking and facilitating early identification of drug abusers.	The project supposes that changing attitude towards drugs among ethnic minority drug abusers can motivate them to seek for rehabilitation programmes and quit drugs.	Changes in attitude	BDF No.3, BDF No.4, BDF No.13, BDF No.16, BDF No.18

17	Psychosocial counselling	176 hidden drug abusers, 28 families of drug abusers	24 months	Aims at identifying hidden drug abusers and their families as well as promoting anti-drug messages to high-risk youth and general public.	This project supposes that providing online and on-site services is beneficial to identifying hidden drug abusers and providing appropriate service to them and their family.	Changes in attitude, behaviours	BDF No.6, BDF No.13, BDF No.18, BDF No.20
18	Psychosocial counselling	80 drug abusers	26 months	Aims at (a) providing drug abuse counselling service to HIV/AIDS-infected drug abusers; (b) providing sharing sessions to professionals working in HIV clinics and HIV/AIDS service organisations; and (c) providing preventive education to HIV/AIDS-infected patients who are at risk of drug abuse.	The project supposes that education training on harms of drugs and individual counselling can help HIV/AIDS-infected patients to prevent drug use and motivate HIV/AIDS-infected drug abusers to quit drugs.	Changes in attitude, behaviours	BDF No.5, BDF No.13, BDF No.21, WHO QoL
19	Psychosocial counselling	63 hidden drug abusers, 63 carers/families	24 months	Aims at enhancing hidden drug abusers' motivation to quit drugs and family member's competence in supporting drug abusers.	The project supposes that enhancing family support and developing a healthy lifestyle can motivate drug abusers to engage in treatments and quit drugs.	Changes in knowledge, attitude	BDF No.16, BDF No.20
20	Psychosocial counselling	70 drug-abusing youths, 30 families of drug abusers	24 months	Aims at enhancing the motivation of arrested young drug abusers and their hidden peers to quit drugs and helping them start up treatment plan through pre-trial intervention supportive services.	The project supposes that family support can motivate drug abusers to engage in treatments and quit drugs.	Changes in knowledge, attitude	BDF No.9, BDF No.10b, BDF No.13
21	Psychosocial counselling	144 drug abusers	25 months	Target at providing support to community dwelling rehabilitees through strength-oriented approach and mindfulness-based relapse prevention activities.	The project supposes that mental wellness and social support from family can motivate drug abusers to quit drugs.	Changes in knowledge, attitude, behaviours	BDF No.7, BDF No.10b, BDF No.20
22	Medical treatment-driven	202 drug abusers, 38 carers/families	24 months	Aims at enhancing the motivation and readiness of ketamine abusers for abstinence through a hospital-based treatment programme.	The project supposes that family support and awareness of harms of drugs can motivate drug abusers to engage in treatments and quit drugs.	Changes in attitude, behaviours	BDF No.6, BDF No.7, BDF No.13

23	Psychosocial counselling	112 high-risk youths	13 months	Aims at identifying drug abusers at the early stage by peer led outreaching service.	The project supposes that various attractive outreaching and engaging activities for drug abusers will increase their motivation for quitting drugs.	Changes in knowledge, attitude	Outreach record, Participation/attendance record
24	Psychosocial counselling	46 drug abusers, 20 families of drug abusers	24 months	Aims at providing various rehabilitation and treatment programme and counselling to female rehabilitated drug abusers, their parents and graduates from sister hostel.	The project supposes that music and art therapy can help drug abusers manage emotions and develop focus and determination. The improvement of mental wellness can motivate drug abusers to reduce or stop drug use.	Changes in knowledge, attitude, behaviours	BDF No.1, BDF No.5, BDF No.14a, BDF No.16, BDF No.20

Outcomes

Concerning the process of project evaluation, projects were evaluated by the effectiveness and efficiency in the delivery of the projects, especially the expected outcomes for service receipts. The lack of robust project evaluation hinders the effectiveness of local drug therapy and rehabilitation projects overall. The multiple and diverse needs of drug users shown in Figure 26 are considered as expected outcomes to be satisfied by drug therapy and rehabilitation projects. Indicators are measurable tools used to determine if the project is implementing its project with high fidelity and achieving its expected outcome, which is highly related to the project objectives, descriptions, as well as logic model. As outcome indicators measure the changes that occur over time in the short, intermediate, or long run, indicators should be assessed at least at baseline and the end of the projects (pre- and post-treatment test).

Figure 26

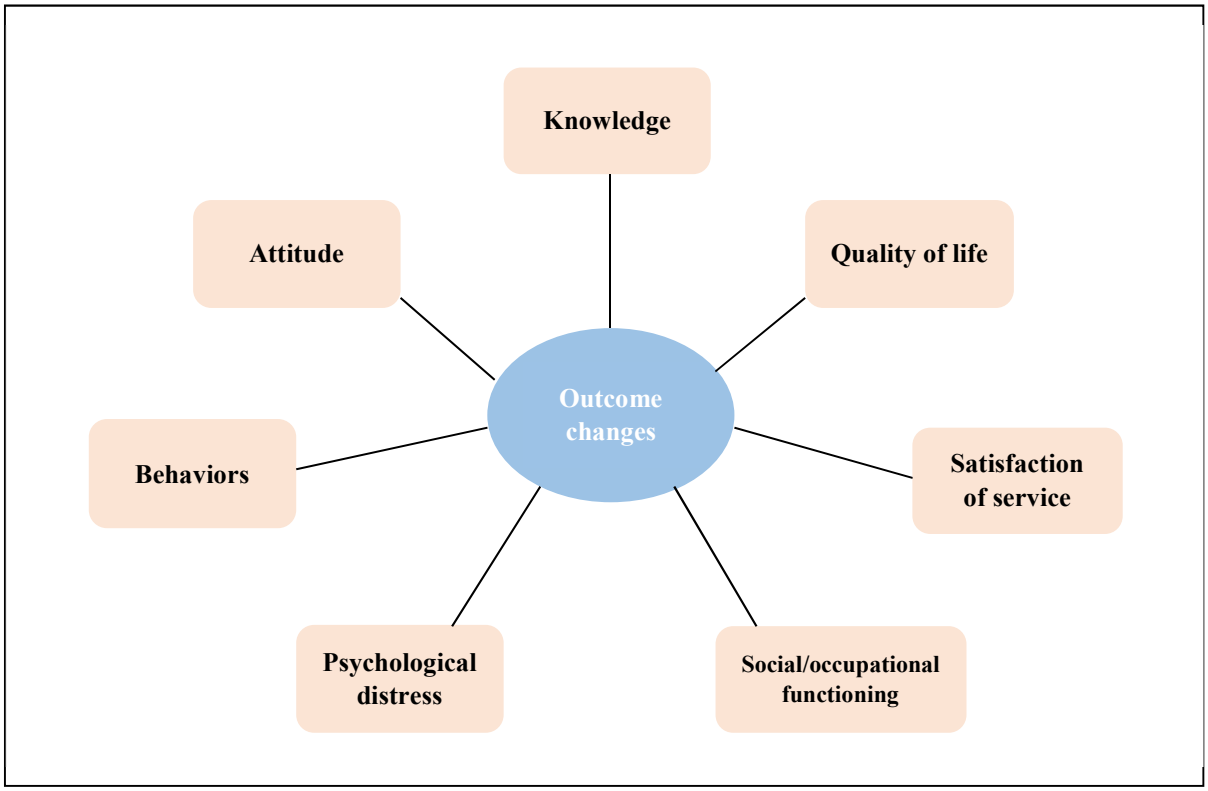
Needs of a Drug Abuser

Outcome Indicators in Hong Kong

Responding to the various needs of drug users, drug therapy and rehabilitation projects took efforts in delivering enriched services to satisfy their needs and improve their functions. Outcome indicators in this study are sorted by nature—change in knowledge (e.g., access to service, knowledge about drugs), attitude (e.g., attitude towards abusing drugs, motivation for withdrawing drugs), behaviours (e.g., duration of staying abstinent from drugs, frequency of using drugs, relapse), psychological distress (e.g., anxiety, depression, stress), life satisfaction, social and occupational functioning, and satisfaction of service (Figure 27).

Figure 27

Changes of Outcome Indicators in 26 Projects



Measurement Tools

The common outcome indicators in Hong Kong drug therapy and rehabilitation projects include changes in awareness and attitude, physical and mental well-being, intended

behaviours, and individual capacities and skills. Subjective outcomes are evaluated from two sources: affects and thoughts. The first source of information captures individuals' feelings, emotions, and moods, whereas the second source concerns individuals' thoughts and views under the cultural and social contexts. Objective outcome indicators are traditionally captured through a survey. The main types of outcome indicators are shown in Table 21. The BDF has shown great efforts to develop resources and tools to help local NGOs carry out project evaluation. The questionnaires about drug use and attitude developed by BDF, especially BDF No. 5–7 (frequency of drug use in the past 1/3/6 months) were the most commonly used outcome measurements in 24 projects. Regarding the outcomes on psychological distress, PHQ-9, GAD-7, and SUDS were the most widely used measurement scales.

Table 21

Assessment Scales for Outcomes Among Drug Abusers

Outcome assessments	
Subjective outcomes	
Changes in knowledge of drugs	BDF No. 2 (knowledge about the harm of drug abuse) Community Education Questionnaire
Changes in attitude towards drug use/relapse	BDF No. 1 (Attitude towards drug abuse) BDF No. 3 (self-efficacy on drug avoidance) BDF No. 4 (Self-efficacy to refuse drug use) BDF No. 9 (Treatment needs and motivation) BDF No.12 (The Adolescent Relapse Coping Questionnaire) BDF No. 13 (Contemplation ladder) BDF No.16 (erceived risks associated with drug abuse) Acceptance for drug rehabilitees scale Addenbrooke's Cognitive Examination Revised (A-CER)
Changes in behaviours of using drugs	BDF No. 5–7 (Frequency of drug use in 1, 3, 6 months) BDF No.14a (Stimulant Relapse Risk Scale)
Changes in psychological distress	General Self-Efficacy (GSE) Scale Coping Inventory for Stressful Situations (CISS) Brief Psychiatric Rating Scale (BPRS)

	Beck's Depression Inventory (BDI)
	Hospital Anxiety and Depression Scale (HADS)
	Patient Health Questionnaire-9 (PHQ-9)
	General Anxiety Disorder-7 (GAD-7)
	Subjective Units of Distress Scale (SUDS)
	Chinese version of Parental Stress Scale (PSS)
	Symptoms Checklist-28
	Quick Inventory of Depressive Symptomatology (QIDS)
Changes in quality of life	WHOQoL questionnaire
Changes in social/occupational functions	Chinese Lam Assessment of Stage of Employment Readiness
	Marital Relationship scale
	Canadian Occupational Performance Measure (COPM)
	Chinese version of Parenting Sense of Competence (PSOC) Scale
	Family Assessment Device (FAD)
	Professional tests (whether they passed the examination and obtained a professional licence)
Changes in satisfaction of Service	Client Satisfaction Scale
Objective outcomes	
	Urine sample
	Service referral record
	Participants enrolment/registration record
	Intake record and risk assessment form

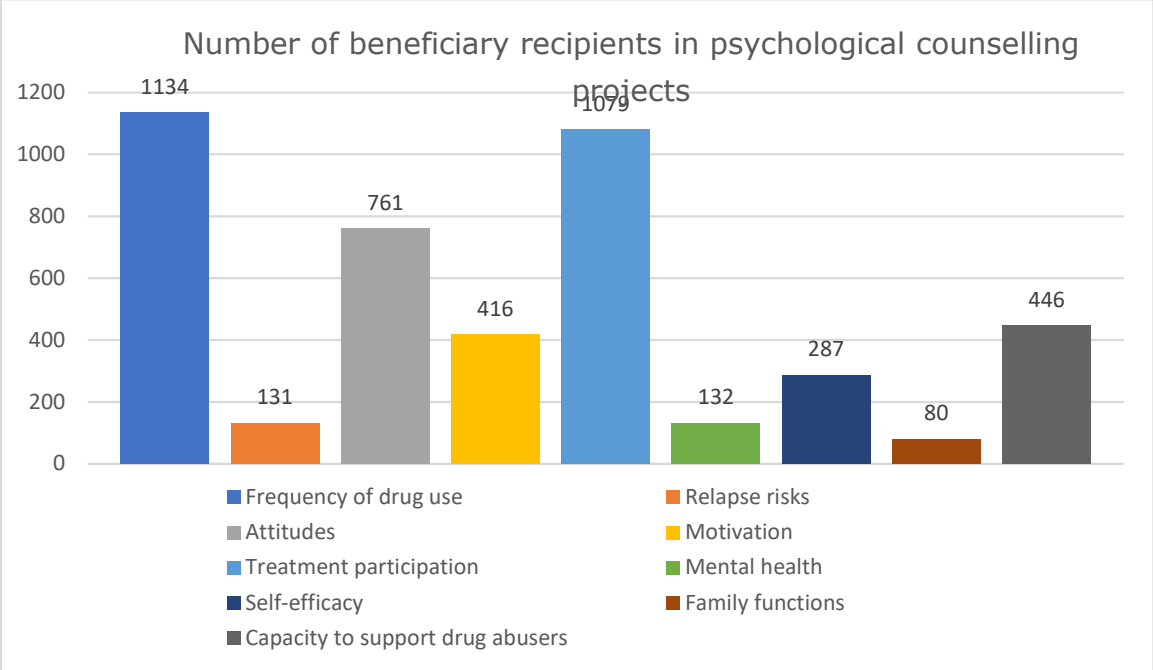
Outcomes of 24 Drug Therapy and Rehabilitation Projects

Regarding the changes in outcomes, psychosocial counselling projects showed best results, which were effective in achieving expected outcomes (Figure 28). A total of 1,134 drug abusers benefited from 18 psychological counselling services and achieved outcomes of reducing the frequency of drug use or staying drug-free. A total of 131 drug abusers in three psychological counselling showed reduction in risk of relapse, while 287 drug abusers showed improvement in self-efficacy of coping with drug-related problems. The outcome of psychological counselling included increased motivation for withdrawing drugs or staying

drug-free for 416 drug abusers. Conerning high-risk youth, 1,079 increased their attitude towards seeking help and participating in treatment in the future. As some counselling projects also delivered service to caregivers and families of drug abusers, results indicated improved mental health for 132 drug abusers and families. Eight counselling projects provided education and training to family members, teaching them how to support drug abusers and deal with drug-use problems, which benefited 446 recipients in total.

Figure 28

Number of Projects with Changes in Different Outcomes by Intervention Types



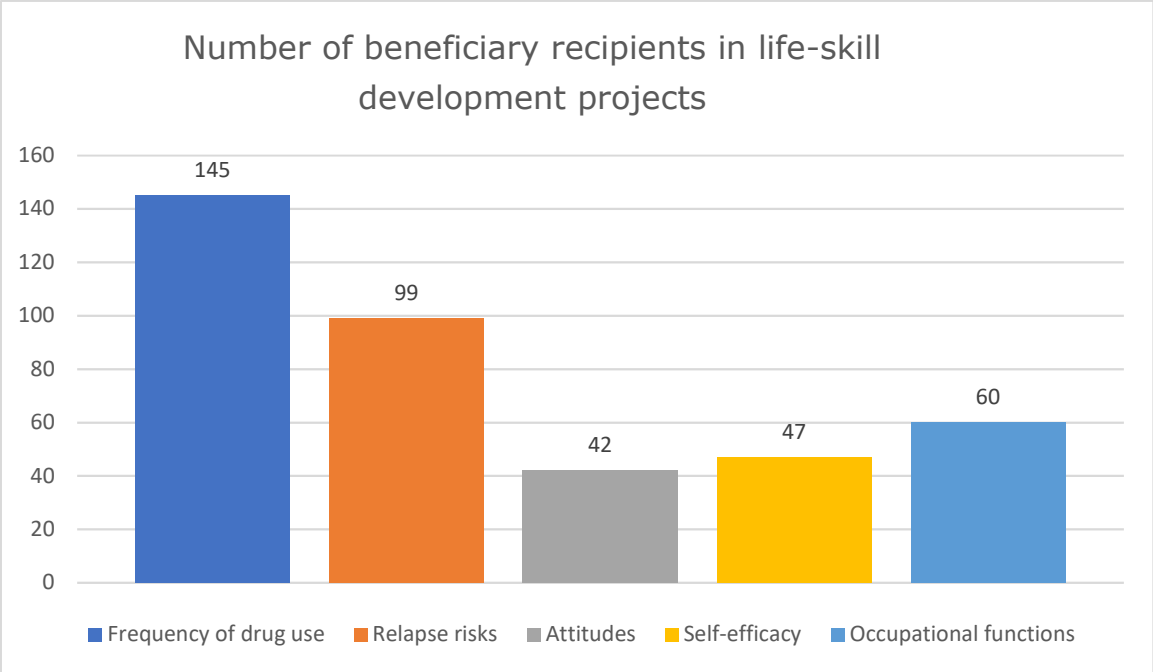
Note. Recipients may show changes in different types of outcomes simultaneously (e.g., changes in frequency of drug use, attitudes toward drugs, and mental health).

Among four life-skill development projects, two were effective in decreasing the frequency of drug use with a sample of 145 drug abusers (Figure 29). A total of 99 drug abusers showed reduction in risks of relapse after participating life-skill development projects. One project achieved outcomes of improving attitude towards drug use among 42 drug abusers and increasing the self-efficacy of coping with drug-abusing problems for 47 drug abusers. Two

projects provided training and workshops on employment skills and improved the occupational functions of 60 drug abusers in total.

Figure 29

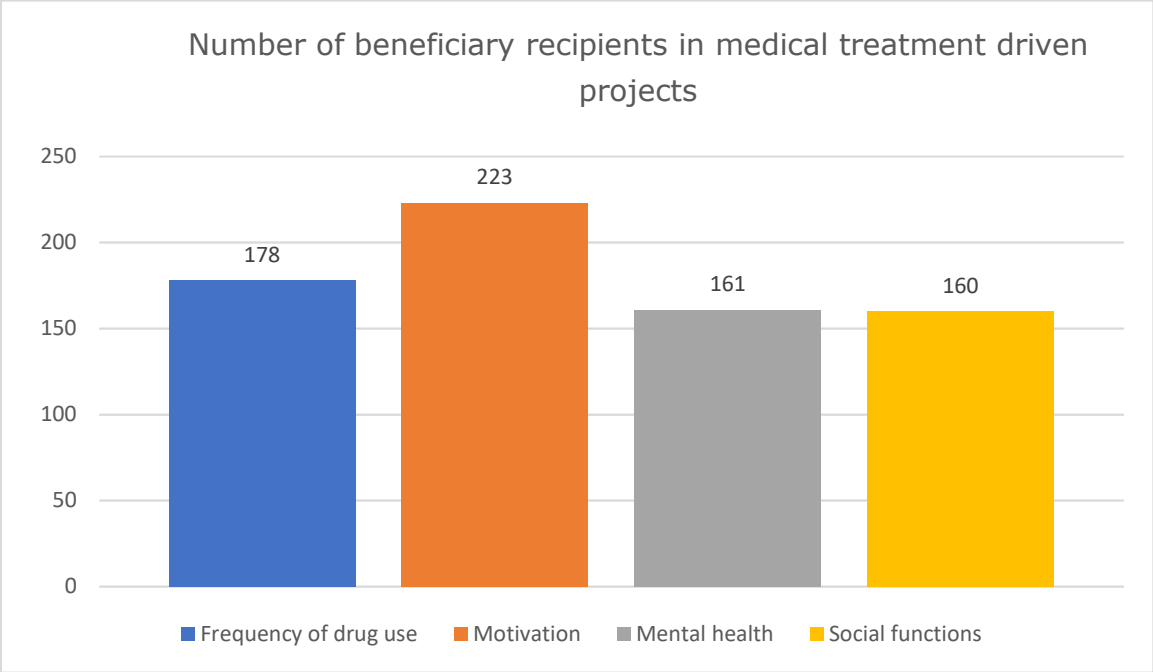
Number of Recipients that Benefited from Life-Skill Development Projects



In two medical treatment-driven projects, a total of 145 drug abusers showed changes in the frequency of drug use, while 223 drug abusers improved their motivation and readiness to resist drugs after treatment (Figure 30). One project was also effective in improving the mental health and social functions of 160 drug abusers.

Figure 30

Number of Recipients that Benefited from Medical Treatment-Driven Projects



Observations in the Hong Kong Context

Although drug therapy and rehabilitation projects have obtained exciting progress worldwide in the past few decades, there is a lack of effective and comprehensive intervention models to treat drug abusers using evidence-based techniques and strategies in service providers of Hong Kong. Those 24 drug therapy and rehabilitation projects funded by the BDF were reviewed and analysed in each component of the revised PICO framework.

Population

Regarding target population, psychological counselling projects delivered service to more than 2,000 drug abusers, about 600 caregivers and families, and almost 1,500 high-risk youth. The target population of life-skill development projects only covered drug abusers and professionals and supportive volunteers, while medical treatment-driven projects mainly focused on drug abusers and caregivers and families. Notably, three psychological counselling projects aimed to deliver service to drug-abusing mothers or pregnant women with drug abuse,

who present a unique population in special need of treatment. It is essential to provide treatment to both drug-abusing women and their children who may also be adversely affected by drugs. Moreover, drug-abusing mothers and pregnant women also benefit from parenting skills training for childcare and development. The standards of the WHO (2020) also stressed the importance of tailor-made project design, which should be supported by specialised services with required skills and competence to respond to the specific needs of all special populations.

Intervention

For the component of intervention, it is observed that social service providers usually provide a range of services and counselling to the drug users that cover various aspects of their routine lives and works and range from cooking and financial management skills to emotional management capacity and psychosocial function development. Such projects are effective in helping drug users change their problematic behaviours and improve their social or occupational functioning to a certain extent. Nevertheless, these projects can be further improved in terms of service pertinence and precision, as the theory of change is not clear or valid to build the link between intervention design and expected outcomes. For example, some projects (project No. 1, 6, and 10) posited that occupational training can help drug abusers to reintegrate into the society and obtain more social support, which will further motivate them to quit drugs and live a normal life. According to information from the project budget, the projects did not recruit occupational professionals and used about 73% of their budget to hire assistant social workers instead. Following the suggestions by the WHO (2020), the treatment project should have multidisciplinary teams with competencies in medicine, psychiatry, clinical psychology, nursing, social work, and counselling. Therefore, projects that secure funding not only for project coordination but also professional staffing recruitment may have especially good effects on drug abusers. This also highlights the significance of this study to review drug

therapy and rehabilitation projects in Hong Kong and examine the effective intervention components to achieve the expected outcomes.

Further, social service providers seldom conduct evaluations based on the therapeutic interventions or approaches adopted in the treatment projects; hence, no data is available to ascertain the theory of change of service recipients upon completion. In other words, it is challenging for researchers or service providers to affirm which component(s) has catalysed the change in an individual from the projects. It is challenging to keep track of the effectiveness of intervention components on expected outputs and outcomes.

Comparison

The RCT is considered to provide the most reliable evidence on the effectiveness of interventions because the processes used during the RCT minimise the risk of confounding factors influencing the results. A RCT is a trial in which subjects are randomly assigned to one of two groups: one (the experimental group) receiving the intervention that is being tested and the other (the comparison or control group) receiving an alternative treatment. The two groups are then followed up to determine if any differences in outcomes can be found. Randomisation ensures that every patient has an equal chance of receiving any of the treatments under study, generating comparable intervention groups, which are alike in all the important aspects except for the intervention each group receives. Although the 24 drug therapy and rehabilitation projects showed effectiveness in achieving changes of desired outcomes, it is widely suggested that new treatment projects should be developed as clinical trials with key elements of randomisation, control/comparison group, and at least two points (pre and post) of assessment.

Outcomes

Psychological counselling projects achieved most expected outcomes, such as reducing frequency of drug use and relapse risks, improving attitude towards drug resistance, increasing motivation for staying drug-free, improving mental health and family functions for drug

abusers, raising awareness of drug harms for high-risk youth, and improving capacity of supporting drug abusers among family members. Life-skill development projects were effective in reducing drug use and relapse risks, improving attitude towards and self-efficacy of coping with drug abuse, and increasing occupational functions. Medical treatment-driven projects showed more improvements in mental health and motivation for drug resistance.

Yet, some of the measurement tools have not been locally validated, particularly for those related to relapse and coping during the recovery stage. Only a few projects used urinalysis to assess reduced drug use frequency in addition to self-report questionnaires, whereas the majority of the remaining projects relied on self-reported questionnaires, which raises issues related to validity and reliability of the data. Despite the evidence of effectiveness found within the existing drug therapy and rehabilitation projects, the validity of this evidence can be further improved with evaluation design consisting of objective measures other than self-report questionnaires (e.g., urine sample, pulse rate, risk assessment form). Furthermore, there is a lack of standardised evaluation protocol for some specific intervention approaches. A lack of theoretical framework in project design can also result in poor outcomes and implementation fidelity (i.e., how well a project is being adhered to).

Appendix III: Delphi Study W2 Questionnaire (Restricted)

Default Question Block

Topic of the study: Formation of program evaluation guidelines towards an evidence-based practice of drug treatment and rehabilitation for psychotropic drug abusers in Hong Kong: A Delphi Study

Have you participated in the previous round (Round 1 - in-depth interviews) of this Delphi Study?

- ◯ Yes
- ◯ No

Introduction and Disclaimer

Topic of the study: Formation of program evaluation guidelines towards an evidence-based practice of drug treatment and rehabilitation for psychotropic drug abusers in Hong Kong: A Delphi Study

Thank you for your kind participation in the 1st round of individual interview. After consolidating the valuable opinions of all 25 panellists, we have identified and shortlisted 10 key issues that require your further inputs. The questions listed below are formulated by using a thematic analysis approach. The research team has coded all the interview transcripts from the 1st round and generated a set of themes by aggregating codes that address the same area of enquiries. We have also conducted a literature review on the relevant issues to provide more insights into the existing approaches adopted by overseas for your reference.

To recap, the purpose of this research project is to understand challenges of the existing drug treatment and rehabilitation program for psychotropic drug abusers evaluation methods used by local service providers and to reach consensus on an evidence-based evaluation system in the future. Please note that the research team upholds neutrality, and this survey does not contain any subjective or personal stances of the research team but purely derived from the data obtained from the first round (Qualitative Interviews) and the findings from the literature review. We would like to stress that there is no right or wrong answer, please feel free to state your opinion; wherein your answers will only be accessible to the research team members only.

You may be invited to make comments on the result generated from Round 1 and 2 in the next round (Round 3), if necessary, which will be the last round of this Delphi study. Similarly, you will receive an online questionnaire via email to review and rank the questions and items by using a Likert scale. The questionnaire

will also ask for your opinions concerning several areas, for example, the priority of standardising the evaluation criteria of T&R programs, a proposed evaluation framework, the content validity of quality of life of substance users and contemplation of behavioural change.

Lastly, we will complete and present the results to all the panellists. Your involvement during the whole study will be anonymous. No personal and professional identities will be released. But with individual consent, they will be fully acknowledged after the completion of the entire study, that is when the data are aggregated, and results are deliberated after consolidations.

Your participation and support in this study are vital, and we have to thank you once again for your great support.

Yours sincerely,
Dr. Frances Law Yik Wa
Department of Social Work and Social Administration
The University of Hong Kong
Associate Professor

Informed Consent Form

Dear Madam/Sir,

The Department of Social Work and Social Administration of The University of Hong Kong (HKU) cordially invite you to participate as one of our expert panelists in the panel interview part of our study, ***Formation of program evaluation guidelines towards an evidence-based practice of drug treatment and rehabilitation for psychotropic drug abusers in Hong Kong – a mixed-method study.***

Purpose of the study

The present study will utilize the Delphi method to guide researchers' collection of advice and feedback from local and overseas expert panelists on the challenges of existing evaluation methods for the local drug treatment and intervention projects. Based on the gathered data from you and other panelists through individual interviews, the Delphi method will help identify "what could/should be" done to improve the

efficacy and effectiveness of project evaluation and reach a consensus on an evidence-based evaluation system for future drug treatment and rehabilitation programs. Through the exercise, we aim to: -

1) explore stakeholders' view on treatment and rehabilitation efficacy in Hong Kong;

2) generate consensus among stakeholders on the formation of the evaluation framework for evidence-based practice of drug treatment and rehabilitation; and,

3) develop practical evaluation guidelines, including validation of a few measurement tools to help to conceptualize, planning and commissioning the evaluation of treatment services.

Procedures

Delphi study often involves several rounds of interviews with the panelists. The first round of the interview was individual face-to-face interviews where the researchers will panelists' own experience and expectation about the process and evaluation of the existing services of drug treatment and rehabilitation in Hong Kong. After the first round of interviews, our research team will synergize all the feedback and generate a draft evaluation protocol regarding the study subject. A second interview will be delivered, through emails, by sending this draft evaluation protocol along with further questions regarding the evaluation protocol to the panelists for further comments. Subsequent rounds of email interview will be delivered in the same fashion until a consensus among the panelists is reached.

All face-to-face interviews or video-conferences will be audio-taped with your consent. All email exchanges in the second and subsequent rounds of interview/survey will also be recorded as a part of our data collection.

Voluntary participation

Your participation in this study is entirely voluntary. You have the right to reject joining the study if you have questions or concerns. You may withdraw from this research any time you wish or skip any question you do not feel like answering.

Confidentiality

All the data collected will be used solely for this research and will be processed according to the confidentiality codes of conduct of HKU. You can choose whether or not to disclose your identity to other panelists, as well as to the public. We will process the data according to your choices. All the data collected from this study will be destroyed in five years after the research project is completed.

Questions and Concerns

Should you have any questions about your rights of participation in the research, please feel free to contact Human Research Ethics Committee, HKU at 2241-5267.

Should you have any questions about this research, please feel free to contact Dr. Frances Law Yik-wa, Associate Professor of the Department of Social Work and Social Administration via telephone at (852) 3917 5940, or email at flawhk@hku.hk.

If you have read and understood the above, and the purpose of this research has been well explained to you by our researchers, please fill out and sign the consent form below, indicating your participation in this "Formation of program evaluation guidelines towards an evidence-based practice of drug treatment and rehabilitation for psychotropic drug abusers in Hong Kong – a mixed-method study", organized by the Department of Social Work and Social Administration, The University of Hong Kong.

Title of Project: Formation of program evaluation guidelines towards an evidence-based practice of drug treatment and rehabilitation for psychotropic drug abusers in Hong Kong – a mixed-method study (panel interview part)

Name of Principal Investigator: Dr. Frances Law Yik-wa, Department of Social Work and Social Administration, The University of Hong Kong

☐ I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

☐ I agree to take part in the above study.

☐ I request the research team to identify/de-identify my name and affiliation to other panellists. (Please type your preference below)

☐ I request the research team to identify/de-identify my name and affiliation in any publications resulted from this study.(Please type your preference below)

☐ Your signature (you may type your name below)

Block 3

Introduction and Disclaimer

Topic of the study: Formation of program evaluation guidelines towards an evidence-based practice of drug treatment and rehabilitation for psychotropic drug abusers in Hong Kong: A Delphi Study

Thank you for your kind participation in the study. After consolidating the valuable opinions of all 25 panellists, we have identified and shortlisted 10 key issues that require your further inputs. The questions listed below are formulated by using a thematic analysis approach. The research team has coded all the interview transcripts from the 1st round and generated a set of themes by aggregating codes that address the same area of enquiries. We have also conducted a literature review on the relevant issues to provide more insights into the existing approaches adopted by overseas for your reference.

To recap, the purpose of this research project is to understand challenges of the existing drug treatment and rehabilitation program for psychotropic drug abusers evaluation methods used by local service providers and to reach consensus on an evidence-based evaluation system in the future. Please note that the research team upholds neutrality, and this survey does not contain any subjective or personal stances of the research team but purely derived from the data obtained from the first round (Qualitative Interviews) and the findings from the literature review. We would like to stress that there is no right or wrong answer, please feel free to state your opinion; wherein your answers will only be accessible to the research team members only.

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Lastly, we will complete and present the results to all the panellists. Your involvement during the whole study will be anonymous. No personal and professional identities will be released. But with individual consent, they will be fully acknowledged after the completion of the entire study, that is when the data are aggregated, and results are deliberated after consolidations.
Your participation and support in this study are vital, and we have to thank you once again for your great support.

Yours sincerely,
Dr. Frances Law Yik Wa
The University of Hong Kong
Associate Professor
Department of Social Work and Social Administration

Section 1: Micro-level: Treatment and Rehabilitation program design and evaluati

Please read the consolidated summary that the research team has prepared for each item before selecting the answers that can best describe your views. If you wish to let us know your views in detail, please feel free to elaborate them in the open box.

Overseas systematic review studies of psychosocial interventions for Methamphetamine dependence (Chan, Lok & Law, 2020) found that:
There are numerous studies conducted on adopting specific interventional approaches in treating Methamphetamine dependence. So far, using Cognitive behavioural therapy (CBT) alone has the best result. Contingency management (CM) alone also shows a better effect when comparing with a mixture of CM and other interventions, such as medication or smartphone applications. Besides, a brief version of Motivational Interviewing (MI) proves to have better results than intensive MI. There are preliminary results on Acceptance and Commitment Therapy (ACT), telephone counselling, Gay-specific Cognitive Behavioral Therapy (GCBT) and Matrix interventional strategies, but they require to be rigorously tested by randomised controlled trials.

Local experts' views:
- My colleagues in my centre are using various approaches, but SATIR is the most common approach. Some colleagues use narrative and some use CBT. The approaches we use really depend on the nature of different cases. **(Panellist#12)**

-我們中心內不同同事有不同方法，但我們最主要都用SATIR。有同事用敘事治療，有同事用CBT，當然很個別個案會按其性質而選用不同方法**(受訪者#12)**

- I wouldn't say we're standardised. Everyone follows the case plan. Some of us prefer CBT and some prefer narrative. It all depends on their own case. We started emotion-focused therapy (EFT) 3 years ago but in the end, the decision's up to the colleague since not everyone's work are family-based; therefore, we've adopted different approaches. **(Panellist#21)**

-我們的方法未至於很標準化。各人都按個案計劃去處理，其中部份同事偏好用CBT，部份偏好敘事治療，因應他們各自的個案而定。三年前我們開始做情緒為本治療（EFT），但最終仍取決於同事本身，因為部份同事未必會使用家庭為本的角度去處理，因此有各種各樣不同的方法 **(受訪者#21)**

- We work under the major framework of Marlatt's relapse prevention, which is under our main structure of CBT. **(Panellist#14)**

-我們有大框架，就是Marlatt的復發預防（relapse prevention），歸類於我們CBT整個大架構裏面**(受訪者#14)**

- Many of my colleagues use narrative and expressive art. I'm most familiar with MI. Some of my colleagues use SATIR and I wouldn't object when they work out a new way. But as part of a team, I would support working more on what I'm most familiar with.

Challenges in standardising evaluation measurements:

- Different interventions linked to different outcomes which require specific measurement tools
- Standardising measurement tools may overlook the core components of some specific intervention approaches that can lead to changes in expected outcomes. **(Panellist#20)**

-我們很多同事都使用敘事治療、表達藝術治療，我最熟悉MI，有些同事則用SATIR，他自己開了新路，我不會反對。不過我作為團隊中的一個單位，我一定會支持多做我最熟悉的方法

將評估準則標準化的難度：

- 不同介入方法有不同結果，但不同結果又需要特定的評估準則
- 將評估準則標準化時或會忽略了某些特定介入方法的核心元素，或會對預期結果構成影響。 **(受訪者#20)**

- Different approaches of intervention has a different measurements criteria, so it's difficult for us to come up with a consolidated and standardised questionnaire to assess the drug users or reflect their changes at different stages. We have yet to have a clear indicator for improving the effectiveness and speeding up the process. The existing approaches are very diversified, but each of them requires their own set of evaluation criteria. Narrative needs its own set of evaluation criteria. If I crossover these evaluations and try to standardise them, it could be hard to integrate some specific features of different approaches, while the

general common factors may not easily show the specific features of an intervention approach or those features may be downgraded. That's the difficult part. **(Panellist#9)**
-因為使用不同介入手法會產生不同的評估準則，使我們未必容易設計一份綜合問卷評估吸毒者，或者顯示他在不同階段的轉變。我們仍未有一個清晰的指標提升成效或加快進度。其實目前的手法百花齊放，但手法百花齊放的同時其實可能亦需要有各自一套評估指標，敘事治療要有自己一套評估指標，如果我混合了這些評估指標，從中取一個比較統一標準化的指標，就難以統一某些針對性的部分，而籠統的部分又似乎未必容易呈現到個別介入手法的精粹，或者會縮小了某部分精髓，就是當中比較困難之處。**(受訪者#9)**

Q1a: Given that the mainstream intervention strategy in Hong Kong is a mixture of approaches, namely CBT, MI and narrative, how important do you think it is to establish a standardized intervention protocol in respect of each intervention strategies?

Extremely unimportant	Very unimportant	Unimportant	Neutral	Important	Very important	Extremely important
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Q1b. To establish a standardized intervention protocol in respect of each intervention strategies, what are your experiences, recommendations or opinions in this regard?

Item 2: Elements of overseas' rehabilitation programs

Literature Review findings:
- Matching patients to treatments can take place on many levels: 1) drug-free versus pharmacotherapy, 2) inpatient versus outpatient, 3) treating or not treating psychiatric or medical disorders in the context of the drug-abuse program, 4) using different types of counselling or psychotherapy, 5) choosing various

behavioral contingencies, 6) matching the personality or background of the therapist with the patient, 7) combining legal pressure with treatment in a therapeutic community versus a less intensive and briefer rehabilitation program, etc.
- To conduct patient matching, [according to Treatment Services Review], three elements are needed: 1) comprehensive assessment tools to identify patient problems and needs) placement criteria to ensure placement in the appropriate level (setting), phase (detoxification, rehabilitation, etc.), and intensity of care; and 3) a means of facilitating movement through a continuum of treatment service. Ideally, all three elements are incorporated into patient placement criteria. There is, however, no national consensus about the most appropriate patient placement criteria.

Local experts' views:
Psychotropic drug users may require different programs/interventions:
- I would say it all depends on the kind of target group that the program is addressing. For most of the youth at risk, changing their self-identity is effective. **(Panellist#3)**
-我認為取決於計劃處理的對象。處理一般邊青時，改變他們的自我身份是有用的方法。**(受訪者#3)**
- I would like to differentiate those who we call chronic drug users from those with very strong craving for drugs. One of the treatment goal is to cut off their past social networks and help them to re-establish new networks. Their networks are drug subcultures and that's why I must re-establish new networks. But the networks of our current recreational or occasional psychoactive drug users are not subcultures that revolve only around drugs. They still have other conventional networks, such as colleagues at work, which I believe can help them detach from psychoactive drugs. **(Panellist#2)**
-以往我們所講很長期和毒癮很深的人，我們要切斷他們過往的網絡和連繫，然後在治療過程中協助他重新建立。而那些網絡連繫是毒品次文化，所以我要重新建構他的網絡。但是我們消遣性質或間歇性的吸毒者本身的網絡並非完全圍繞毒品的次文化，其實他本身也有其他傳統的人際網絡，譬如工作上的同事，我相信這些都能助他脫離藥物。**(受訪者#2)**

- We have two types of groups, one for those still undergoing the process of detoxification, and the other group for those under rehabilitation and have been maintaining their result of abstinence for a period of time. Those undergoing the process of detoxification may be receiving medical treatment, and apart from western medical treatment, they reflected that Chinese medicine could help them cope with some symptoms of detoxification, such as insomnia and loss of appetite. **(Panellist#12)**
- 我們有兩類小組，一類個案處於戒毒過程中，仍在浮浮沉沉；而另一類是已經進入了復康狀態、已經戒毒一段時間的個案，仍在維持他們的戒毒成果。所以戒毒途中的個案有機會仍在接受醫療跟進，除了西醫之外，他們也反映中醫能幫助他們面對一些失眠和胃口差等的脫癮症狀 **(受訪者#12)**
- Some of these teenagers are only 15 or 16. We have work a lot to outreach them, such as E-engagement. **(Panellist#12)**
-這些年青人確實部分是15、6歲，我們要做很多外展方法去接觸這群年青人，我們要做網上外展**(受訪者#12)**
- Different drugs lead to different physical harm. We may advice them to see psychiatrists, urologists or even Chinese doctors. **(Panellist#11)**
- 不同的毒品會產生不同的身體傷害，我們可能會建議去找精神科醫生，去找泌尿科醫生，或者去找中醫**(受訪者#11)**

Individualised program plan
- I think there are so many combinations for drug use nowadays, with completely different causation, needs and risks. An effective way would be forming a more accurate risk assessment and carry out program matching, which means everyone has an assessment, a tailor made plan. **(Panellist#3)**

-我覺得現時吸食毒品有很多不同組合，有很多不同的成因，需要和風險完全不同。需要做一個比較準確的風險評估，然後做程序匹配，即每一個人都有一個評論，一個度身訂造的計劃才會比較有效
(受訪者#3)

Q2a: To what extent do you agree drug users should be categorised based on their commonality in order to cater to their unique biopsychosocial needs in the program design and evaluations?

Strongly Disagree	Disagree	Slightly disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Q2b. What are the top 3-5 types of treatment/approaches that you would recommend as the **essential elements** of a rehabilitation program for psychotropic drug users? (e.g. Chinese medicine, family relations, social functioning etc.)

Treatment/approaches:	
Treatment/approaches:	
Treatment/approaches:	
Treatment/approaches:	

Treatment/approaches:

Q2c. Local panellists have identified a number of ways to categorise service users, please indicate the top 3 most appropriate ways in categorising service users in the table below:

	Rank the top 3 (by using '1' as the most appropriate, '2' and '3' as the least appropriate among the three choices)
Specific Drug Type: Methamphetamine, Ketamine, Cannabis, Cocaine and so on	
General Drug Type: Narcotics analgesics and Psychotropic drug users	
The frequency/pattern of drug use: recreational, experimental, habitual and chronic drug user	
Specific population: e.g., Men who have sex with men (MSM) ,pregnant mothers, etc. and so forth	
Individualised/tailor-made program design (e.g. conducting risk assessments followed by program matching for each service user)	
Other suggestion (optional)	
Other suggestion (optional)	
Other suggestion (optional)	

(Optional) If you have any comments or justifications you may wish to add below

Item 3a: Community-based program versus residential treatment

Literature Review findings:
- A recent systematic review on the most recent studies in the field of [substance use disorders] (2013–2018) provides moderate-quality evidence that residential treatment may be effective in reducing substance use and improving mental health. There is also some evidence that treatment may have a positive effect on social and offending outcomes.
- Inpatient/residential treatment has tended to be reserved for individuals who have tried but have been unsuccessful in the community, or whose problems are too complex or too severe to be safely managed in the community.
- The complicated interaction between treatment, cognitive factors as well as the environmental circumstances play a role in changing the addictive behaviour. One particular aspect of addiction treatment planning that would benefit from reliable outcome predictors is placement matching, i.e. the allocation of each individual to a particular treatment setting.
- Stress, the ready availability of drugs, peer pressure and exposure to drug-related cues are all known factors that may contribute to relapse into drug use after a period of abstinence. Thus, since treatment in a residential setting may at least in part shelter from these (for example, patients are less likely to be offered drugs while in treatment in a residential, than in a community setting), the relationship between decision-making deficits and treatment outcome may differ across different settings.

Notes:

1.Recreational drug user < - > drug use for medical purposes: differentiate based on the purpose of drug taking

2.Occasional drug user < - > habitual and chronic drug users: differentiate based on the frequency of drug taking

Thus, to enhance the clarity and consistency of the survey, 'occasional user' will be used which includes the population of 'recreational drug users'

3. Community-based treatment and rehabilitation programs: include all non-residential treatment programs (e.g. CCPSA and ad hoc projects funded by Beat Drugs Fund)

Local experts' views:
Overview
-Residential and community-based drug treatment and rehabilitation programs are not mutually exclusive wherein they complement each other to cater to different target groups or an individual at different stages.
-Residential drug treatment and rehabilitation programs focus on life rebuilding and detoxification for habitual and chronic drug users; whereas community-based drug treatment is more suitable for occasional drug users who require more attention to counselling.

Residential drug treatment works for some but not for all

- Some patients are willing to take a break in the “village”, and in fact we recommend them to stay there too. After half a year or one year, depending on the duration of the “village”, we will set adjustments for them, which are some measures to rebuild their life. **(Panellist#12)**
-部份個案願意去「村」裏安靜、停一停，其實我們也建議他入去住，視乎該「村」為期半年抑或一年，我們會再和他做重整和生命重建的工作。**(受訪者#12)**
- I don’t think it is appropriate for teenagers to start residential treatment since they are not the same as the kind of heroin users of the previous generation. In fact, keeping these young drug users, who are fairly elusive, in residential treatment may not be effective for their life planning. It is good to have social workers counselling these teenagers. **(Panellist#2)**
-其實我認為青年不太適合入療養中心藥物治療，因為他不是上一代海洛英用者，但對於一些我們不經常接觸到或者不太可見的青年濫藥者，要他純粹困在一個療養中心，對他整個生命規劃未必太有效。純粹有社工輔導會更適合這些青少年**(受訪者#2)**
- I think residential treatment doesn’t benefit marginal youths and occasional drug users. Instead, they should be treated with a combination of experience and theory as well as community-based approaches; besides, they shall not be labelled as drug users. A mix of residential and community-based approach is possible too, but it is still labelled.**(Panellist#3)**
- 對於邊青和間歇性用藥者，我認為住院式治療不太合適。相反，這群人應該用經驗理論法，社區為本，不要標籤他們為吸毒者。可用住院式治療加上這個以社區為本的管治方法，但始終都被人標籤了。**(受訪者#3)**

Q3a: Do you agree that occasional psychotropic drug-users will show better treatment outcomes from community-based drug treatment programs than residential rehabilitation programs?

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

Observation:

-Community-based services, especially CCPSA, are dominated by habitual/chronic adult drug users instead of habitual/experimental drug users **(Panellist#14)**

-社區為本服務，特別是遍佈全港的戒毒輔導中心(CCPSA)，服務對象多是成年人，習慣/長期及間歇濫用者，反而很少服務消遣/試驗濫用者。**(受訪者#14)**

Q3b: If occasional psychotropic drug-users are likely to show better treatment outcomes from community-based drug treatment programs than residential rehabilitation programs, what are the reasons hindering this target population from getting the community-based treatment services?

(Optional) If you have any comments or justifications you may wish to add below

Q3c. Can you list out the top 3 critical factors that may significantly contributed to the treatment outcomes for occasional psychotropic drug-users?

Critical factor 1

Critical factor 2

Critical factor 3

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Item 3d: Community-based program versus residential treatment

Literature Review findings:
- Continuing care post-discharge has been found to be [one of the] significant predictors of recovery.
- There is a clear need for integrated mental health treatment among individuals with substance use disorders. For example, in Australia, an estimated 64%–71% of people in residential treatment for a substance disorder are diagnosed with a mental illness.

Local experts' views:
- The lengths for live-in programs varies. For instance, ketamine users may stay there for 6 weeks and when he has passed the toughest period and the score drops to a certain level, he'll be allowed to be discharged. It's like ICU, where severe cases may be sent to ICU for a week or two for intensive treatment. Then it will be followed by supporting rehab measures, for example, to continue in the community. **(Panellist#11)**
- 住禁閉式、住院式，都有長短之分。例如K仔的個案就住六個星期，讓他最辛苦的一段時間過了，分數下跌至某個水平，便可讓他出去。就像深切治療的概念，病重就入深切治療部，進行了一兩週高強度治療，然後便由配套跟進，例如在社區中繼續。**(受訪者#11)**
- After drug rehab in the village, he will eventually return to the community. In order to ensure a smooth transition back to the community, there is a lot of after-care service provided in the village. We also play a role in supporting him when he returns to the community, like work, job-seeking programmes and relationship with the family. **(Panellist#15)**
- 在村裏戒毒後其實他都會回歸社區，為了幫助他重投社區，村都會做好多後續的關懷工作，或者我們都會有個角色，就在他回歸社區時給予支援，例如工作方面或者求職和家庭關係。**(受訪者#15)**

Q3d: Do you agree that community-based service should be continuing care for all of the residential treatment post-discharge rehabilitees?

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

Q3e: Do you agree that short-term live-in programs serve occasional psychotropic drug users better than community-based service alone?

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

Q3f: How long should the short-term live-in programs be in order to benefit occasional psychotropic drug users substantially?

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Item 4: Treatment outcomes

Literature Review findings:
- A number of drug treatment goals have been overtly or implicitly advanced in authoritative statements, [such as the American Bar Association/American Medical Association, Office of Drug Abuse Policy of the U.S., and Office of National Drug Control Policy of the U.S.], over the years:
1) Legitimate employment;
2) Personal values to be adjusted to a more closely mainstream commitment regarding work, family, and the law;
3) Normalise or improve the treated individual's overall health, longevity, and psychological well-being
- When asked what they [the drug abusers] wanted from their drug treatment, they frequently began by talking about desires that were indirectly, rather than directly, related to their drug consumption.
- The most common goals are related to personal relationships (e.g., meaningful relationship with a partner or spouse, developing good friendships and repairing damaged relationships with family members)

- Recovery goes well beyond abstinence; it is experienced as a bountiful "new life," an ongoing process of growth, self-change, and reclaiming the self.

Local experts' views:
Other primary treatment goals and their measurements:

- First, physical symptoms. For example, having pain and going to the toilet frequently after taking ketamine predicts poor quality of life. Second, psychiatric symptoms. For example, we need to see if they feel distressed because of their drug-abusing behaviours, or if they are clinically depressed as well as reporting experience of hallucination. In addition, we need to consider the level of their cognitive ability which may require some further testing. Third, social functioning. For example, we need to see if they are able to work, if they have family or friends. Some would also consider the spiritual aspect. **(Panellist#11)**

- 第一，身體上有否癥狀，譬如服食K仔後經常都痛，要去廁所。這樣已經是生命負面徵兆。第二就是精神上，他有否繼續受到吸毒而困擾，有沒有抑鬱症。另外也有精神科上的困擾，例如幻覺。另外他的智能程度，需要做認知評估。第三就是社交上，能否工作，家庭、朋友方面，也有人會提及靈性。 **(受訪者#11)**

- There are many different indicators. From a medical perspective, you may observe whether their symptoms have been alleviated. Apart from face-to-face interview, there are also different scales available for assessing their conditions. You may also keep track of their hospital admission rate as well as the length of stay. These are some of the indicators of improvement. Psychologically speaking, you may see whether there's any improvement in memory, concentration and cognition. Socially speaking, you may observe how he works and studies. **(Panellist#23)**

-其實有很多不同的指標，醫學方面，可以觀察他的病徵有否減少，除了你和他面對面傾談之外，另外還有很多不同的評分可以評估到他的病症有否改善。另外你可以觀察他入院次數有否減少，以及他留院的時間有否減少，這些都是他有否改善的指標。心理方面就觀察他的記憶力、專注力、認知方面有沒有改善。社交方面就觀察工作、讀書。 **(受訪者#23)**

- Positive youth development is also one of the constructs in addition to self-efficacy and self-esteem. **(Panellist#2)**
-正向青少年發展都是其中一個方法，還有自信心、自專心。 **(受訪者#2)**
- In fact, urinalysis and drug tests are just some of the very small indicators. I think the relationship between the social worker and the client is more important. After abstinence, he has network including stable work,

strong family bonding and his own supportive network. **(Panellist#12)**
-其實驗尿或者驗毒都是其中一個很微小的指標，我覺得更重要是我們社工和受助人的關係，即他戒了毒之後其他的網絡，包括有穩定的工作，他的家人網絡強健，而且他自己有支援網絡。 **(受訪者#12)**
- We would observe the frequency, place of drugs taking and administration route. We think he needs to have an improvement in his attitude towards drugs and himself. **(Panellist#19)**
-我們有時會觀察他吸毒的次數、地方、吸食方法，我們都覺得他在面對毒品的態度方面或者個人都要有改善。**(受訪者#19)**

- I would observe his compliance, like his attendance to CCPSA. It is a good sign if he has visited the centre 4 times a month for 3 months already. **(Panellist#11)**

-觀察他有否遵從指引。他去濫用精神藥物者輔導中心是否足夠，例如約了一個月會去四次，並已經去了三個月，就是理想情況。**(受訪者#11)**

- I mainly help them build up a healthy environment and life. I think it is very important to have a job. **(Panellist#25)**

-我會主要幫助他們建立健康的環境和生活。我覺得有工作十分重要。 **(受訪者#25)**

- Job satisfaction like rapport with colleagues may be able to help his treatment. He may also reduce the use of medication, but right now the evaluation is unable to measure this area. **(Panellist#19)**
-工作上的滿足感，或他與同事之間關係融洽都對他的治療有不同幫助。他也可以在用藥方面減少，但目前的評估中就未能量度這一方面。**(受訪者#19)**

- First, we wouldn't emphasise this person is successful for his abstinence. Instead, he is successful for having solutions to his problems in life, like he cares about his life and he can maintain his family. These are important. **(Panellist#20)**

- 首先我們不會標榜某人戒了毒就很成功。而這人很成功是因為他很多生活上的影響得到解決，他着緊自己的生活，可以維持自己家庭，這些才重要 **(受訪者#20)**

Question 4a: In addition to drug abstinence, to what extent do you agree that other treatment outcomes can also be recognised and regarded as primary treatment outcomes when evaluating a program?

Agree ○ ○ ○ ○ ○ Disagree

(Optional) If you have any comments or justifications you may wish to add below

In an attempt to measure and capture other treatment outcomes, panellists have suggested a list of items that should be added as outcome indicators, please indicate **to what extent do you agree** these outcome indicators **are important** on the Likert scale, regardless of their feasibility, and **provide an explanation if your score ranges from 1-4.**

Permissive attitude towards drug use: the extent the individual thought that drug use is acceptable. Two types of drug use were distinguished: regular or occasional use. A permissive attitude was differentiated into 2 variables: permissiveness to regular drug use ("Regular drug use is acceptable"), and permissiveness to occasional drug use ("Using drugs occasionally is acceptable" and "Using drugs with friends in recreational settings such as disco/rave parties is acceptable")
Pre-relapse abstinence in the first and second intervals were each examined to see if it could affect the total drug-free time in the next interval. Pre-relapse abstinence and total drug-free time were measured by the percentage of drug-free weeks in an interval in which the subject was not in treatment.

	1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Agree	6 Agree	7 Strongly Agree
Permissive attitude towards drug use	○	○	○	○	○	○	○
Changes in drug use habit (e.g. venue, dosage and administration route)	○	○	○	○	○	○	○
Physical functioning (e.g. on-job period, mobility, ability of self-care and sleeping quality)	○	○	○	○	○	○	○
Social functioning (e.g. social support, family and interpersonal relationship)	○	○	○	○	○	○	○
Cognitive functioning (e.g. acquisition of knowledge, manipulation of information, and reasoning)	○	○	○	○	○	○	○
Compliance with the intervention	○	○	○	○	○	○	○

	1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Agree	6 Agree	7 Strongly Agree
Condition of drug-induced illnesses (e.g. pain, organs functioning, psychosis)	○	○	○	○	○	○	○
Frequency of hospital admissions	○	○	○	○	○	○	○
Urinalysis	○	○	○	○	○	○	○
Drug-free duration	○	○	○	○	○	○	○
Pre-relapse abstinence	○	○	○	○	○	○	○
Frequency of lapses	○	○	○	○	○	○	○
Frequency of relapses	○	○	○	○	○	○	○
Involvement in high-risk behaviours (e.g. share of needles, impulsive behaviours or sex without protection)	○	○	○	○	○	○	○

How feasible is it to measure each of these outcome indicators in practice? Please indicate your answer on the Likert scale accordingly and **provide an explanation if your score ranges from 1-4.**

Permissive attitude towards drug use: the extent the individual thought that drug use is acceptable. Two types of drug use were distinguished: regular or occasional use. A permissive attitude was differentiated into 2 variables: permissiveness to regular drug use ("Regular drug use is acceptable"), and permissiveness to occasional drug use ("Using drugs occasionally is acceptable" and "Using drugs with friends in recreational settings such as disco/rave parties is acceptable")

Pre-relapse abstinence in the first and second intervals were each examined to see if it could affect the total drug-free time in the next interval. Pre-relapse abstinence and total drug-free time were measured by the percentage of drug-free weeks in an interval in which the subject was not in treatment.

	1 Very Infeasible	2 Infeasible	3 Somewhat infeasible	4 Neutral	5 Somewhat Feasible	6 Feasible	7 Very Feasible
Permissive attitude towards drug use	○	○	○	○	○	○	○
Changes in drug use habit (e.g. venue, dosage and administration route)	○	○	○	○	○	○	○
Physical functioning (e.g. on-job period, mobility, ability of self-care and sleeping quality)	○	○	○	○	○	○	○
Social functioning (e.g. social support, family and interpersonal relationship)	○	○	○	○	○	○	○
Cognitive functioning (e.g. acquisition of knowledge, manipulation of information, and reasoning)	○	○	○	○	○	○	○
Compliance with the intervention	○	○	○	○	○	○	○
Condition of drug-induced illnesses (e.g. pain, organs functioning, psychosis)	○	○	○	○	○	○	○
Frequency of hospital admissions	○	○	○	○	○	○	○

	1 Very Infeasible	2 Infeasible	3 Somewhat infeasible	4 Neutral	5 Somewhat Feasible	6 Feasible	7 Very Feasible
Urinalysis							
Drug-free duration							
Pre-relapse abstinence							
Frequency of lapses							
Frequency of relapses							
Involvement in high-risk behaviours (e.g. share of needles, impulsive behaviours or sex without protection)							

Item 5 Relapse rate

Literature Review findings:
- Several studies have suggested that the relapse rate [for subjects who have been treated in an addiction center] is around 30.4%.
- The findings showed that 73.1% of drug-users [found in substance abuse centers] have used substance during the past 12 months, and 72% have experienced a full relapse.
- It is necessary to monitor and supervise the drug-users treatment to reduce the relapse rate, which should be implemented more effectively and accompanied by the contribution of addicts' families

Local experts' views:
- The relapse rate within 90 days is high, at 60% to 70%. But if we think optimistically, the relapse rate is even higher during a 12-month period. **(Panellist#14)**
- 90日內的復吸比率為6成至7成，即比率屬高水平。但如果再理想一點，12個月的復吸比率就更加高。**(受訪者#14)**
- We would feel great if 8 out of 10 graduates can stay drug-free. But if 5 or more out of 10 relapse, we would be disappointed. If 30% to 40% do not relapse within a month, the programme is counted as successful. **(Panellist#8)**

-十個畢業的人若果有八個都可以持守，我們就會覺得很滿足很感恩了。但轉過來，十個裏面有五個或以上是重吸的，我們會失望。若果計劃中3至4成人在一個月不復吸，就算是成功的。 **(受訪者#8)**

Q5: Relapse is considered as one of the most common processes that drug abusers undergo; hence, in order to avoid the service providers' reluctance to recruit more complex cases, the acceptable relapse rate in 90-day of time after joining an intervention program can be set as

- ◯ 30%
- ◯ 40%
- ◯ 50%
- ◯ 60%

(Optional) If you have any comments or justifications you may wish to add below

Item 6: Compilance to treatment

Literature Review findings:
- The main reasons for premature termination of treatment:
Clinicals: 1) individual motivation; 2) staff connection issues
Service users: 1) social support; 2) staff connection issues.

Q6: Low motivation is considered as one of the most common characteristics of drug abusers; hence, the acceptable dropout rate of an intervention program should be no more than

- ◯ 40%
- ◯ 50%
- ◯ 60%
- ◯ 70%

(Optional) If you have any comments or justifications you may wish to add below

Section 2: Macro level: Policy-making level/philosophical perspective

Please indicate the level of your agreement to the below sentences:
Item 1 Public health versus crime rehabilitation

Literature Review findings:
- The Outcome Document of the 2016 United Nations General Assembly Special Session on Drugs (UNGASS 2016), unanimously approved by the 193 Member States, has recognised drug addiction as a is preventable and treatable and not the result of moral failure or criminal behaviour.
- A comprehensive public health approach should offer accessible evidence-based prevention, treatment, and recovery options to drug users, and engage those who commit criminal offences in evidence-based treatment during and following, or in lieu of, incarceration, to prevent relapse and recidivism.
- In response to a balanced policy suggested by United Nations in 2015, some researchers suggested to "decriminalize minor, non-violent drug offences—use, possession, and petty sale—and strengthen health and social-sector alternatives to criminal sanctions."

Local experts' views:
- They have all the socially undesirable features. When you are continuously creating an image of drug abuse, they will just isolate themselves from others rather than come out. **(Panellist#25)**
- 所有社會上最不能夠接受的事都集中在他們身上。你不斷製造一種吸毒的形象，而其實這樣不會令到他們願意踏出，相反只會令到他們更加隱藏自己。**(受訪者#25)**
- I believe substance abuse is the basic needs of human.**(Panellist#11)**
- 因為我相信濫用物質，是人的基本需要 **(受訪者#11)**
- Actually, they can promote in a more positive way. For example, you can convey a message to them that they are alone, you are not alone; we are all the same; as a human, I have my own needs too, I just fulfil them in a different way. I think the approach should be positive, instead of a fear approach.**(Panellist#25)**
-他們可以用正面一點的宣傳，例如：訊息可以表達你並非自己一個，你並不孤獨；其實大家都一樣；我一個人生命中都有些需要，不過用不同嘅方法去填補失落的地方。我覺得應該用正面的方法，而非恐怖的恐懼手法。**(受訪者#25)**

Q1: To what extent do you agree that illicit drug use should be considered as a public health issue instead of a social control or security issue.

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Item 2: Zero tolerance versus harm reduction

Literature Review findings:
- Given that more than half of high school seniors report having used illegal drugs during their lifetime, messages that espouse "zero tolerance" for drug use … are likely not believable to, or effective with, many young people.
- The emphasis [on abstinence] held individuals as responsible for change, positioned all drug use as harmful and immoral, and served to undermine the importance of harm reduction approaches aimed at improving health and the social environments of drug use.

Local experts' views:
The penetration and execution of 'harm reduction approach' in Hong Kong

- It is the reality that drug users are really hard to reach. But if you only position your service as detoxification, you can only find the drug users like a cat chasing rats. But imagine, if more concepts of harm reduction are introduced into the service, there are actually many organisations, social workers and professionals willing to help these drug abuser, but we don't solely aim at an absolute abstinence in one go, instead, we want to improve his quality of life and reducing the harm of drugs. This may make the entire scenario different. **(Panellist#18)**

- 其實現實就是現時很難接觸吸毒人士，但你的服務定位只有戒毒，其實你永遠都會像貓捉老鼠，很難將他們找出來。但相反你想像一下，其實整個服務發展裏引入多些降低危害的概念，其實很多機構團體、社工或者專業人士都很希望幫這批濫藥人士，但我們的目標並非純粹一下子就要他戒清，而是想改善他的生活質素，想減低藥物帶來的危害，整件事有可能令情況有所不同**(受訪者#18)**

- I agree that indeed some patients may not quickly reach complete abstinence at one go. Therefore we would split counselling and medication reduction into stages, so that we set some targets for medication

reduction before he achieves complete abstinence. In some cases they may be able to stop drugs from the beginning, yet for some cases we have to gradually reduce their reliance, including the frequency and the dosage. At the end we aim at improving his quality of life, so that he can gradually perform his ability of self-care or reach his interpersonal expectations. **(Panellist#15)**

-我同意有一類戒毒者其實未必可以很快一下子完全戒毒，所以在我們工作中，其實某程度上我們都會分階段做一個輔導減藥，在他未戒清之前，我們都會與他訂立一些目標去減，有些個案他可能一開始已經完全停了，但有些個案其實要將他的依賴漸漸減低，包括頻率、劑量，而目標其實都是希望他改善生活質素，即他可以逐漸有他自己的生活能力，或者達到他期望與人的關係**(受訪者#15)**

Criticisms of 'harm reduction' ideology

- We can't guarantee gradual progress can lead to success, so I don't completely agree with this assumption. I have no evidence proving it works or not. Firstly, I don't think harm reduction must be a method for substances abuse. Secondly, those currently popular drugs are different from those in the past. For example, I only smoke cannabis at parties, so the element of addiction is low and harm reduction doesn't mean much for him. Harm reduction is very clear for heroin. Harm reduction is a method. Does it work for all kinds of drugs? I'm not sure. For me, we all want zero tolerance. We all want him to be drug-free. But I know that things all go through progress. He wants to get rid of it completely, but he can't, but he's improving. I wouldn't call this harm reduction. Our concept of harm reduction uses methadone. So I don't think there is a framework for harm reduction. And when a service emerge and you call it harm reduction, it may not actually be harm reduction. So I think other than methadone where there's substantial evidence, there is no proof for other drugs. In that case, the so-called harm reduction is just a concept rather than a scientifically proven method. And I think it is risky because it is just a concept. **(Panellist#4)**

-我們不敢肯定慢慢戒就會成功，所以我並非完全認同這假設，我沒有證據證明是否可行。第一，我不認為降低危害一定是濫藥情況下的一個方法。第二，現時新興的毒品與以前的毒品不同。例如大麻，我去派對才用，根本上癮的元素很低，這樣降低危害對他來說又不太有意思。降低危害針對白粉就很清晰。降低危害是一個方法，是否對每種毒品都有用呢？我不肯定。在我來說，我們都想零容忍，都想他戒清。但我知道凡事總有個進程。他想戒清，但他不可以，但他的確在進步。我就不

會將這稱為降低危害，我們降低危害的概念是用美沙酮。所以我又覺得沒有降低危害的框架，或者某種服務浮現出來時你將它稱為降低危害，但其實又未必算是降低危害。所以我覺得除了美沙碉有實證之外，根本其他藥物都沒有實證，這樣降低危害只是個說法，而非一個科學實效的措施，亦有很大風險，因為是一個說法。**(受訪者#4)**

- I think harm reduction itself has been controversial. Harm reduction was suggested mainly for addressing heroin, so at least there was methadone as a substitute. I see many people drinking methadone but they can't function at all, not eating or studying. Therefore I'm quite suspicious about harm reduction. No matter how much you reduce harm, you can't prevent mental problems. So in my opinion, methamphetamine and cocaine must be cut completely and harm reduction probably doesn't work. **(Panellist#23)**

-我覺得降低危害本身已經很具爭議性，當年提出降低危害主要針對海洛英，起碼有美沙酮替代。因為我見很多人雖然在飲美沙酮，但個人完全沒有運作，吃不下飯又讀不到書，所以我對降低危害抱懷疑的態度。就算你怎樣降低危害，你都不能預防精神問題。所以我個人的角度就是冰毒、可卡因等其實要徹底戒除。我覺得降低危害這條路應該不可行**(受訪者#23)**

Q2a: Do you agree that adopting a strict Zero tolerance approach minimises the effectiveness of the drugs treatment and rehabilitation field, in terms of engagement, program designs and evaluation.

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Q2b: Do you agree that adopting a harm-reduction approach will lead to actual improvements in drug use outcomes

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Item 3: Harm reduction is a means to an end of full abstinence

Literature Review findings:
- For some drug users, abstinence could be an aspiration but was not realistic. For instance, they were surrounded by families or friends who were still taking drugs.
- The prioritisation of abstinence over harm reduction in drug users treatment aspirations was consistent across treatment setting (prison, residential and community) gender, treatment type (with the exception of those receiving methadone) and severity of dependence.
-In the forced-choice item, 86.5% [of individuals who identify themselves as "in recovery"] endorsed total abstinence from all drugs and alcohol as their definition of recovery, and 83% endorsed total abstinence as their recovery goals.
- In a study conducted in the UK, more than half of the participants (56.6%) endorsed support for abstinence as the only goal they wanted to achieve from attending the drug treatment agency. Of the 24% who wanted more than one goal, most aspired to abstinence and harm reduction goals simultaneously.

Local experts' views:
Possible effectiveness of harm reduction approaches as a mean to an end

- I think it's worth doing if harm reduction is more of a stopgap measure. But your ultimate goal is drug free.

There is no contradiction. **(Panellist#1)**

-我認為若降低危害是權宜之計就值得去做，但呢最終目標是希望他能戒毒，兩者沒有衝突 (受訪者#1)

- We would record the type and dosage of drugs taken, and then set targets gradually. If we suddenly keep him away from something without fulfilling his needs, he would collapse. The concept of harm reduction is reducing dosage gradually, and hoping to achieve drug free one day, no matter how long it takes or how little the amount of dosage reduced each time. **(Panellist#21)**

- 我們會記錄他服用的藥物、劑量，然後慢慢與他訂立目標。如果一下子抽離他一些東西，而又沒有填補，其實他會撐不住。而降低危害的概念就是慢慢為他減劑量，不論減的劑量或者次數，希望有一日他能夠完全戒毒 **(受訪者#21)**

- Personally, I think methamphetamine and cocaine must be cut completely, but if he can't do it at one go, you should help him reduce the dose first. In the end, our goal is complete drug abstinence. But I think harm reduction doesn't work, because for drugs like methamphetamine and cocaine, despite a small dose, they will eventually lead to mental problem. **(Panellist#23)**

- 我個人的角度是，冰毒和可卡因等其實需要徹底戒除的，在過程中你如果不能一步到位，你就來幫他，叫他先減量。始終我們的目標就是要完全戒除，但我覺得降低危害並不可行，因為冰毒和可卡因等即使食低分量，早晚都會引致精神方面問題 **(受訪者#23)**

Q3: Full abstinence should be set as the ultimate target while adopting a harm reduction approach in any drug rehabilitation programs.

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

Item 4: Harm reduction

Literature Review findings:
- Harm reduction approaches have been shown to be effective in reducing morbidity and mortality in adults with substance abuse problems for whom abstinence was not feasible [or abstinence was not a realistic goal for those with addictions].
- The definition of full abstinence is ill-defined; [for instance, when probed by the researcher, some [participants in an interview] said that they never wanted to use heroin or crack again, but would probably always smoke cannabis, drink alcohol, take ecstasy, or use cocaine. In addition, some initially reported that they did not want to use drugs again, but later clarified that they wanted to be 'in control of' their drug use rather than totally abstinent.
- Even when individuals stated that they wanted abstinence, studies have suggested that harm reduction services play a crucial role in offering support to, as well as minimising, the many personal, psychological, material and social harms associated with drug misuse.
- It was suggested that treatment goals and aspirations are more important than drug consumption in the views of some drug users. Indeed, when they are receiving treatment, they wanted to achieve the goals that are related to relationships; everyday life; physical, mental and emotional well-being; and material possessions.

Local experts' views:
- During harm reduction, we would respect the client's right. He would not lose some opportunities due to their drug-taking behaviors, and zero-tolerance is not the only indicator. **(Panellist#20)**
- 降低危害的過程中我們會尊重個當事人的想法，他不會因為吸毒而失去某些機會，亦非只得零容忍作為唯一指標 **(受訪者#20)**
- You need to understand that drug abusers have the needs to take drugs. If the ultimate objective of harm reduction is to respect personal choice so they can live with dignity, I would support this idea. **(Panellist#20)**
- 你理解濫用藥物者其實有需要去用藥，而如果降低危害最終的目標就是尊重個人的選擇，而令一個用藥的人都能有尊嚴地生活，我就更加想持有這個想法 **(受訪者#20)**

Q4: Harm reduction should be recognised as one of the drug users' service choices other than full abstinence.

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
○	○	○	○	○	○	○

(Optional) If you have any comments or justifications you may wish to add below

(Mandatory) You have chosen a neutral response (midpoint), please explain your neutral point below

DEMOGRAPHICS:

Please complete the following to help us know a little about you.

Q1. I have been working in the following areas and the relevant years:

- ☐ ☐ CCPSA / Centre for Drug Counselling (CDC) (___ years)
- ☐ ☐ Youth Outreaching Team (__years)
- ☐ Residential Drug Treatment & Rehabilitation Centre (DTRC) (___ years) ☐
- ☐ ☐ Substance Abuse Clinic (under Hospital Authority) (___ years)
- ☐ ☐ Academic research (___ years)
- ☐ ☐ Government official (___ years)
- ☐ ☐ Other (please specify) (___ years)

Q2. What is your occupation?

☐

Q3. Please fill in your Email address so that the research team could reach you, if necessary.

☐

Q4. Please fill in your assigned **reference number**, which can be found in **your invitation Emai**l.

Rest assured that the identification will only be used for research analysis within the research team.

Block 14

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Appendix IV: Need-based Quality of Life Scale (NBQoL) for psychotropic drug abusers

基於需求生活質素量表（精神藥物濫用者）

請先閱讀以下文字：

自主需求指的是人需要感到自己是命運的主人，感覺到自己能控制自己的行為，對自己的生活有一定的控制權。

A. 自主需求對你來說有多重要呢?

非常不重要	不重要	有些不重要	介於重要和不重要之間	有些重要	重要	非常重要
☐	☐	☐	☐	☐	☐	☐

請考慮過去 4 週內您一直在做的和遇到的事情，然後選出您對以下每個陳述的態度。

	非常不同意	不同意	難以判斷	同意	非常同意
A1 我可以自由選擇自己做的事	1	2	3	4	5
A2 我按照自己的想法做決定	1	2	3	4	5
A3 我一直在做自己真正感興趣的事	1	2	3	4	5

請先閱讀以下文字：

能力需求指的是人需要機會和支援來進行鍛煉、擴展和表達個人的本領和才能。如果個人發展、理解或掌握技能的過程被阻礙，能力需求便無法被滿足。

B. 能力需求對你來說有多重要呢?

非常不重要	不重要	有些不重要	介於重要和不重要之間	有些重要	重要	非常重要
☐	☐	☐	☐	☐	☐	☐

請考慮過去 4 週內您一直在做的和遇到的事情，然後用✓選出您對以下每個陳述的態度。

	非常不同意	不同意	難以判斷	同意	非常同意
B1 我有能力達成自己的目標	1	2	3	4	5
B2 我滿意自己的工作能力(包括學習、義務工作、照顧家人及料理家務等)	1	2	3	4	5
B3 我滿意自己從事日常生活的能力	1	2	3	4	5

請先閱讀以下文字：

聯結需求指的是感到與他人關係親密並具有歸屬感，既關心他人，又被關心的需求。當個人被他人關心，以及有機會關心他人時，聯結需求就可以得到滿足。

C. 聯結需求對你來說有多重要呢?

非常不重要	不重要	有些不重要	介於重要和不重要之間	有些重要	重要	非常重要
☐	☐	☐	☐	☐	☐	☐

請考慮過去 4 週內您一直在做的和遇到的事情，然後用✓選出您對以下每個陳述的態度。

	非常不同意	不同意	難以判斷	同意	非常同意
C1 我在乎的人也在乎我	1	2	3	4	5
C2 對我來說重要的人讓我感到親切	1	2	3	4	5
C3 同經常相處的人在一起時，我會感到溫暖	1	2	3	4	5

請先閱讀以下文字：
生理需求指的是最基本的需求，譬如：水、睡眠、相對恆定的體溫、身體健康、衣食住行等。

D. 生理需求對你來說有多重要呢?

非常不重要	不重要	有些不重要	介於重要和不重要之間	有些重要	重要	非常重要
☐	☐	☐	☐	☐	☐	☐

請考慮過去 4 週內您一直在做的和遇到的事情，然後用✓選出您對以下每個陳述的態度。

	非常不同意	不同意	難以判斷	同意	非常同意
D1 我滿意自己的睡眠狀況	1	2	3	4	5
D2 總體來說，我的健康狀況良好	1	2	3	4	5
D3 我食得很好	1	2	3	4	5
D4 我有充足的休閒活動	1	2	3	4	5

請先閱讀以下文字：
安全需求指的是人避免威脅的需要，包括具體威脅和抽象威脅。譬如，犯罪襲擊、疾病、戰爭、社會混亂、自然災害等。還包括諸如工作安全、財務安全、醫療保險和退休保障等。

E. 安全需求對你來說有多重要呢?

非常不重要	不重要	有些不重要	介於重要和不重要之間	有些重要	重要	非常重要
☐	☐	☐	☐	☐	☐	☐

請考慮過去 4 週內您一直在做的和遇到的事情，然後用✓選出您對以下每個陳述的態度。

	非常不同意	不同意	難以判斷	同意	非常同意
E1 我的生活是井然有序的	1	2	3	4	5
E2 在有需要時，我能得到其他人的幫助	1	2	3	4	5

戒毒和康復需求

F. 戒毒和康復需求對你來說有多重要呢?

非常不重要	不重要	有些不重要	介於重要和不重要之間	有些重要	重要	非常重要
☐	☐	☐	☐	☐	☐	☐

請考慮過去 4 週內您一直在做的和遇到的事情，然後用✓選出您對以下每個陳述的態度。

	非常不同意	不同意	難以判斷	同意	非常同意
F1 沒有毒品，我可以過得很好	1	2	3	4	5
F2 我對治療和康復服務感到滿意	1	2	3	4	5
F3 我有足夠的動力遠離毒品	1	2	3	4	5