

# Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion



## An overview and discussion paper

ST/ESCAP/2527

---

UNITED NATIONS PUBLICATION

---

Sales No. E.09.II.F.9

---

Copyright © United Nations 2009  
All rights reserved

---

ISBN: 978-92-1-120574-9

---

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area, or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The views expressed in this publication are those of the authors and do not necessarily reflect the views of the United Nations.

Mention of firm names and commercial products does not imply endorsement of the United Nations.

The publication may be reproduced in whole or in part for education or non-profit purposes without special permission from the copyright holder, provided that the source is acknowledged. The ESCAP Publications Office would appreciate receiving a copy of any publication that uses this publication as a source.

## Acknowledgements

---

A special 'thank you' is due to all the young people who participated in various project activities in the four countries covered by the project, and particularly to those met during field visits. Their great humour, welcomes and enthusiasm are memorable. Most demonstrated remarkable resilience in the face of great adversities, and were usually able to find something to joke about. Likewise, the adults, both staff and volunteers from various government and non-government organizations and the parents and other relatives of young drug users were inspirational.

This discussion paper provides an overview of the project "Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion", which was implemented by the Health and Development Section (HDS), Social Development Division, ESCAP.

The project partners in the participating countries were: the Yunnan Institute for Drug Abuse, Yunnan Province, China; the Participatory Development and Training Centre and the Vientiane Youth Center for Health and Development, Lao People's Democratic Republic; the Institute for Juvenile and Family Justice Development, Thailand; and the Department for Social Evils Prevention, of the Ministry of Labour, Invalids and Social Affairs, Viet Nam.

Generous funding for the project was received from the Bureau for International Narcotics and Law Enforcement Affairs, U.S. Department of State.

The discussion paper was prepared by the HDS consultant for the project, John Howard, Senior Lecturer, National Cannabis Prevention and Information Centre, National Drug and Alcohol Research Centre, University of New South Wales.

From HDS, Marco Roncarati edited the manuscript and Ployparn Khunmuang worked on formatting it.



## Contents

---

<b>Acknowledgements</b> .....	<b>iii</b>
<b>Executive Summary</b> .....	<b>vi</b>
<b>Recommendations</b> .....	<b>ix</b>
<b>Chapter 1</b> Overview of Greater Mekong Subregion and project justification.....	<b>1</b>
<b>Chapter 2</b> Building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: Overview of project .....	<b>7</b>
<b>Chapter 3</b> Building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: Overview of activities, achievements and challenges .....	<b>15</b>
<b>Chapter 4</b> Lessons learned from Phases I to III .....	<b>69</b>
<b>Appendix A</b> Documentation of drug use situation in participating countries .....	<b>80</b>
- China	
- Lao PDR	
- Thailand	
- Viet Nam	
<b>Appendix B</b> UNODC and WHO discussion paper - principles of drug dependence treatment .....	<b>126</b>
<b>References</b> .....	<b>129</b>

## Acronyms

---

↘ ATS	Amphetamine-Type Stimulants
↘ BBI	blood-borne infection
↘ CTC	compulsory (residential) treatment centre
↘ DSEP	Department of Social Evils Prevention
↘ GMS	Greater Mekong Subregion
↘ IJJD	Institute for Juvenile and Family Justice Development
↘ IDU	injecting drug user
↘ MOLISA	Ministry of Labour, Invalids and Social Affairs
↘ PADETC	Participatory Development Training Centre
↘ STI	sexually-transmitted infection
↘ VYC	Vientiane Youth Center for Health and Development
↘ YIDA	Yunnan Institute for Drug Abuse



## **Executive Summary**

---

The Greater Mekong Subregion is home to a very youthful population, and plays a significant role in the production and manufacture of heroin and Amphetamine-Type Stimulants (ATS).

For this project only four of the six countries making up the subregion were included: Yunnan Province, China, Lao PDR, Thailand and Viet Nam (Cambodia and Myanmar were not included).

The subregion has been undergoing massive change over the last few decades: socially, economically and often politically. There has been increased inequitable access to new wealth and substantial strains on urban services, creating fertile ground for involvement in illicit drugs. For some, trafficking and dealing in drugs are ways of accessing the informal economy when entry to the formal economy is limited or barred, and using drugs can ease the experience of impoverishment. With rapid economic development, two youth populations are identified as most at risk of illicit drug use – those with money, and those with nothing.

Injecting of drugs other than heroin is not common in the subregion, but the injecting of ATS is beginning to grow as these drugs replace heroin as the most popular illicit drugs used.

Illicit drug use is most common among young people between the ages of 20 and 35 years, but there are indications that drug users are increasingly becoming younger. Studies of illicit drug use among school students report rising levels of drug use and falling ages of initiation in some countries.

Many young illicit drug users are still living in a family environment – illicit drug use, despite its stigmatization, has not yet led to complete disruption of social connectedness.

Sharing of injecting equipment is widespread, accompanied by unhygienic preparation and disposal practices.

Drug users' high rates of multiple sexual partners are widespread as are low rates of condom use. HIV infection and AIDS are epidemic in almost all countries in the subregion and there is a trend for HIV to move from the initial core group to the wider community, transmitted sexually from injecting drug users (IDUs) – especially where female sex workers are also IDUs. Young people are at the forefront of vulnerability to HIV infection. The prevalence of hepatitis C virus infection among IDUs is commonly 60 per cent or more across the region – up to 90-100 per cent in many places.

Treatment approaches in the main comprise compulsory residential facilities for detoxification and treatment, traditional medicines and military 'boot camp' approaches. Psychological and behavioural counselling is limited, as is effective assistance for drug users to reintegrate into the community following treatment. It is generally agreed that recidivism rates are high.

There are few if any youth specific drug services. Young people who have developed substance dependency and substance-related problems are often treated in adult drug use programmes, even though developmental, psychological, social, cognitive and family differences underscore the need for specialized treatment. It is important that young people who experience problematic drug use are provided with treatment and rehabilitation that is suited to their psychological, social and cognitive developmental needs, rather than being treated in the same settings and with the same approaches that are directed to adults. What community treatment exists is usually for those with access to resources.

Where the health sector develops strong, effective and professional links with other sectors, particularly education, public security, social welfare and civil society, a better range of interventions is more likely.



It is possible to provide young people with interventions that meet their needs and that are less incapacitating, and to do so in a more enabling environment, which keeps them connected with family, school and community. This can reduce stigma and discrimination and strengthen 'protective factors'.

The core of the ESCAP project Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion was the developing and strengthening of community-based treatment interventions for young drug users. In this regard, it aimed to assist the participating organizations in developing the knowledge and skills of young people, their families, communities and schools, community health service providers, residential rehabilitation staff and civil society groups. It was hoped that the strengthening of strategic alliances would, in turn, create an enabling and supportive environment for treatment and rehabilitation.

To enable the outcomes to be achieved, a large focus of the project was workforce development via training workers, young drug users and their families and communities in how to more effectively respond to and intervene with young drug users, their families and communities. This entailed the development of training packages and resources – with the participating organizations, young drug users, family and community members and various levels of staff working in both residential and community drug treatment – that were culturally appropriate, and the delivery of train-the-trainer workshops by the project consultant and then in-country training by those trained subregionally.

Overall, there has been a modest, albeit slowly expanding, capacity for the treatment of young people with drug use-related difficulties within their communities. Much of this capacity is in the support of young people returning from compulsory or quasi-'voluntary' residential treatment in an attempt to minimise relapse and compulsory return to longer periods of time in the compulsory (residential) treatment centres (CTCs).

It is apparent that continuing care/after care is receiving more attention in all four countries and more attempts are being made to provide for it. Many of those in the CTCs in all countries remain a very long way from their homes, families and potential supports, and visiting is difficult due to the constraints of distance, time, cost of travel and need to maintain an income.

There remains a lack of capacity for widespread community treatment for young people with problematic drug use, and the current legislation and policies that almost automatically transfer young people identified as drug users to compulsory residential detoxification and/or rehabilitation centres make it extremely difficult to have a significant impact.

Overly punitive laws, the demonization of drugs, the criminalization of drug users, and an apparent disregard for the human rights of drug users of whatever age in many countries in the subregion continue to work against change.

There is a need to explore the role of pilot drug courts for such cases, and to ensure that there is some mechanism for formal review of involuntary admissions to residential detoxification and or treatment, so that young less dependent or experimental drug users are afforded an opportunity to receive community-based treatment as the preferred option. Of concern is that young people can be 'sent' to CTCs by their parents or police without any apparent capacity for 'appeal' or 'review'.

In spite of the aforementioned challenges, there are positive developments, and a sense of opportunity.

In Lao PDR, an effective Network has been developed linking seven target villages in the Vientiane Capital area, and the CTC (Somsanga) and a quasi-correctional centre (Don Tao). Members of the Network are local village leaders, police, older community members, the Women's Union and trained counsellors from the Vientiane Youth Center for Health and



Development (VYC) who come from varied backgrounds (such as high school and university students, retired and current teachers, nurses, and others from business and trades). Some local VYC-trained peer educators are ex-drug users.

In Thailand, which has already developed a wider range of treatment and processes for dealing with young drug users, the Institute for Juvenile and Family Justice Development is focussing on expanding its involvement in slum and other communities with significant drug use among young people. Tulakarn Hospital has re-oriented some of its services to the community and provides continuing care within selected communities to those returning from their residential treatment services, and community-based treatment to young people in the hope of avoiding a residential placement.

The Thai Juvenile and Family Court in diversion and community treatment, and the Probation Service via provision of a coherent drug treatment process for young people in custody, could become role models to the subregion where there is less 'ownership' of treating drug use by Ministries of Health and more by Public Security.

In Yunnan Province, China, the Yunnan Institute for Drug Abuse (YIDA) has provided a greater focus on young people with illicit drug use and links peer education activities at drop-in-centres, in the community and within CTCs. YIDA has developed effective processes for engaging with young people in CTCs, conducting baseline assessments, supporting young people while in the CTCs via visits from peer educators and YIDA professional staff, and adopting well planned continuing care. Finding pathways to trial 'diversion' for younger low-level or experimental drug users is proving difficult, but YIDA continues to deal with the multitude of barriers in a positive, intelligent, scientific manner.

Viet Nam is developing a focus on providing youth-specific counselling skills for both centre and community workers. They may also attempt to expand the range of services provided by after/continuing care clubs.



## Recommendations

1. There is a need to sustain an adequate core-trained, supported and motivated staff. This requires increased funding to provide ongoing training, development activities and supervision for those trained to date.
2. There is a need to increase emphasis on building up the community 'core' in some locations (such as Viet Nam, China and even Thailand) to ensure a more supportive community environment to reduce substance use problems emerging in youth and to decrease the likelihood of relapse. Lao PDR is providing a good model via the working of the Network which links the seven target villages and the CTC.
3. There is a need to continue to 'institutionalize' the peer education/counselling activities within the regime of the compulsory residential detoxification, treatment and rehabilitation centres.
4. There is a need to further develop family involvement in all four settings, both while a young family member is in a CTC and while in the community.
5. There is a need to devote more attention to developing effective models for providing continuing care/after care.
6. There is a need to identify 'core' effective ingredients of interventions in the various locations. That is, what mix of activity appears to work best in which settings. This implies better research capacity.
7. More consideration needs to be given to establishing 'youth centres' where they do not exist, and strengthening those currently in place to welcome young drug users as members. There is some evidence that having a youth centre from which activities are coordinated, and which provides a location for centre-based activities and service provision is beneficial (for instance in Lao PDR).
8. There is a need to explore the possibilities for formal diversion processes to be developed in three counties (China, Lao PDR and Viet Nam), and consider pilot drug courts as well as ensure that there is some mechanism for formal review of involuntary admissions to residential detoxification and or treatment, so that young less-dependent or experimental drug users are afforded an opportunity to receive community-based treatment as the preferred option.
9. With regard to budget/funding, there is a need to fund at a level where activities can occur, at no additional expense to the agency involved. If current funding processes continue, there is little chance for the establishment of sustainable practices and infrastructure, and effective capacity building.
10. To enable better scaling-up, more frequent monitoring and training 'in country' is needed by skilled personnel.
11. To move forward, there is need for a collaborative approach from the UN system to engage with senior policy makers to ensure a supportive legislative, policy and practice environment, and compliance with international treaties and conventions (such as the Convention on the Rights of the Child and the Beijing Rules).



# Chapter 1

## Overview of Greater Mekong Subregion and project justification

### 1. The Greater Mekong Subregion

The Mekong River, in the subregion often referred to as the 'Mother of Rivers', flows for nearly 5,000 kilometres from the Tibetan plateau through China's Yunnan Province, Myanmar, Lao PDR, Thailand, Cambodia, and Viet Nam. These countries make up a developmental area referred to as the 'Greater Mekong Subregion' (GMS). The subregion is vast, diverse and dynamic, covering 2.5 million square kilometres and home to more than 300 million people with a myriad of ethnicities and cultures. Relative peace since the early nineties, following decades of armed conflicts, has fostered economic liberalization, making the GMS countries more open to the outside world and among themselves (UNESCAP, 2007a).

The GMS is home to a very youthful population, and plays a significant role in the production and manufacture of heroin and ATS. For this project only four of the six countries making up the subregion were included: Yunnan Province, China, Lao PDR, Thailand and Viet Nam (Cambodia and Myanmar were not included).

The GMS is a subregion with a higher than world average population growth rate and proportion of children under 15 in Lao PDR and Viet Nam (UNESCAP, 2007a). In 2006, China had a population of over 1,320,864,000, with children aged 0-14 making up 21.1 per cent; Lao PDR, 5,759,000 with 38.9 per cent under 15; Thailand, 63,444,000, with 21.4 per cent under 15; and Viet Nam, 86,206,000 with 28.9 per cent under 15. All four countries contain large rural populations, despite rapid urbanization occurring across Asia. Urbanization rates, as reported by ESCAP in 2007a, were for China – 41.3 per cent, Lao PDR – 21 per cent, Thailand – 32.6 per cent and Viet Nam – 26.9 per cent.

Thailand and Viet Nam have higher than ESCAP country average rates for HIV prevalence and people living with HIV, and China and Viet Nam have lower access to antiretroviral drugs. Viet Nam, Lao PDR and Thailand have higher than average incidence of tuberculosis. Lao PDR, Thailand and China have higher than average alcohol consumption, and Viet Nam and Lao PDR lower than average secondary school enrolments.

In relation to poverty, and notwithstanding significant growth and prosperity, recently reported percentages of the population living below \$US 1 per day were China – 9.4 per cent (2004), Lao PDR 27 per cent (2002), Thailand 2 per cent (2002), and no available figure for Viet Nam. The proportion of the population living below the national poverty line was: China – 4.6 (1998), Lao PDR – 38.6 (1998), Thailand – 13.6 (1998) and Viet Nam - 28.9 (2002).

There were an estimated 4.9 million people living with HIV in 2007 in Asia. The Commission on AIDS in Asia (2008) noted that, "Preventing an HIV epidemic among drug injectors could be a very effective way of avoiding a wider HIV epidemic" (p.7). Injectors buying and selling sex were of particular concern. The Commission also noted that, there was a need for meaningful and genuine community involvement and that "... programmes for low-risk youth absorb over 90 % of youth prevention resources, but avert less than 5 % of HIV infections among young people" (p.146).

Recently reported prevalence of injecting drug use was as follows: China – 0.25 mid estimate in 2005, no available figure for Lao PDR, Thailand – 0.38 mid estimate in 2007 and Viet Nam – 0.25 mid estimate in 2006 (Mathers, Degenhardt et al., 2008). From the same report, the estimated number of IDUs in China was 2,350,000, no available figure for Lao PDR, Thailand - 160,582 and Viet Nam – 135,305.

The mid prevalence rates of HIV among IDUs was 12.3 for China in 2005, no available figure for Lao PDR, 42.5 for Thailand in 2004 and 33.5 for Viet Nam in 2006.



Methamphetamine use was identified by 14 per cent of first-time treatment entrants in China, with 11 per cent reporting that it had been injected. For Thailand, 75 per cent of first-time treatment entrants reported methamphetamine use, 9 to 49 per cent of populations of injecting drug users reported injecting methamphetamines, and in one study four per cent of those who had injected methamphetamine were HIV positive (Degenhardt, Mathers et al., 2007).

UNODC (2008b) in a discussion paper on *'Reducing the adverse health and social consequences of drug abuse: a comprehensive approach'* stressed the need for facilitating entry into drug treatment, highlighting that "For those who are using drugs, providing accessible, evidence-based, good practice treatment...[is important]" (p.4) and that "'Harm reduction' measures combined with good-practice treatment facilities may prevent immediate adverse health and social consequences and be effective in the long-term reduction of drug-related harm for individuals and society" (p.6).

## Drug Situation in GMS

In 2006 the Australian National Council on Drugs published a commissioned report on drug use in the Asian and Pacific Region (Devaney, Reid and Baldwin, 2006). This report identified a number of factors common to situations where there have been rises in illicit drug production or use. These included:

- Rapid economic growth, with a burgeoning middle class youth population, and with internal migration, and resultant cashed-up migrant labour populations away from their homes;
- Inequitable distribution of the benefits of such growth, with increased gaps between rich and poor, and differential ability to participate in the formal economy;
- Political upheaval, with resultant external migration, creating both human flows for drug trafficking and disenfranchised populations without access to the formal economy;
- Inadvertent results of law enforcement and interdiction operations, moving drug trafficking routes, especially overland cross-border and coastal, to involve new populations;
- Corruption, and its role in the maintenance of power among ruling political elites;
- Poverty and political disenfranchisement, operating through the above processes or on their own;

The report noted that the region has been undergoing massive change over the last few decades: socially, economically and often politically. It also noted that the extent of rapid urbanization and resultant internal migration varied, but where they occur such changes often lead to increased inequitable access to new wealth, and substantial strains on urban services. In addition, this was seen as fertile ground for involvement in illicit drugs. For some, trafficking and dealing in drugs are ways of accessing the informal economy when access to the formal economy is limited or barred, and using drugs can ease the experience of impoverishment. With rapid economic development, two youth populations were identified as most at risk of illicit drug use – those with money, and those with nothing.

The following provides a précis of sections of the comprehensive report, which cautions that reliable estimates of the use of illicit drugs are rare in Asia and the Pacific, with few being derived by any reasonable systematic and data-driven process.

## Prevalence of drug use

- Injecting of drugs other than heroin is not common, and where it occurs is usually a secondary phenomenon to injecting of heroin.
- The injecting of ATS is beginning to grow as these drugs replace heroin as the most popular illicit drugs used.
- There have been examples of extremely rapid spread of injecting as the preferred mode of administration across the region, and this rapid spread continues to evolve in many parts of the region (such as in Lao PDR).

- Heroin remains the drug of choice among entrants to drug treatment centres in China and Viet Nam; this is biased to some extent by the nature of the services offered. Opium is still used in most of Asia, but its popularity and consumption has diminished largely as a result of decreased availability and accessibility; for a variety of reasons, heroin is a more 'marketable' drug than is opium.
- Beginning in 1996-7, and spreading from the Golden Triangle epicentre, a flood of ATS has meant that their use is now well entrenched throughout Asia.
- Methamphetamine use is found throughout Asia, but its use is particularly prominent in Myanmar and Thailand, and increasingly in China.
- Ecstasy (MDMA) use continues to increase throughout Asia, but its retail cost generally appears to make it more confined to urban centres among youth at dance parties and other gatherings.
- The use of ketamine has been identified in some Asian countries, including China.
- Cannabis use is generally widespread, often as the most or second most frequently consumed illicit drug.
- Cocaine use overall is minor, largely due to its distance from the source countries and therefore the cost, but it is found in many major urban centres.
- The use of solvents and glue is common among street children and homeless youth in many parts of Asia and the Pacific.

## Drug supply, production, cost, availability and trade

- Myanmar is the main producer of opium, heroin and ATS in the Asian and Pacific region: while its production of opium has diminished in recent years, it remains the second largest producer globally, surpassed only by Afghanistan.
- Lao PDR is the second largest producer of opium in the region, though, like Myanmar, its opium production has decreased considerably in recent years.
- Most heroin produced in Myanmar is now trafficked through China, rather than through Thailand to the Malay peninsula as previously; China is now the most important transshipment route for the international market. Routes from Myanmar through China have been joined by new routes from Afghanistan into Western China, particularly into and through the Xinjiang Uyghur Autonomous Region.
- Myanmar is one of the world's largest producers of ATS, up to 700 million tablets per year, with China being the major source of precursor chemicals.
- In recent years China has also become a major source of methamphetamine for many countries in Asia and the Pacific, with the discovery of methamphetamine laboratories in provinces along the eastern and south-eastern coastal areas.
- Costs of illicit drugs on the market depend on location, proximity to the drug production zone and occasionally domestic events such as drug seizures.

## Profile of drug users

- Historically, opium smoking was a male phenomenon; it is still the case that the majority of drug users are male.
- There has been a rise in the number of female drug users in Asia in recent years, an increase which has particularly been recognized in association with female sex work especially in parts of China and in Viet Nam. While drug use is stigmatized, use among women is even more highly stigmatized, and thus gender specific data from drug treatment services do not mirror accurately the gender distribution of drug use in overall society.
- Illicit drug use is most common among young people between the ages of 20 and 35 years, but there are indications in some parts of Asia that drug users are increasingly becoming younger.
- Studies of illicit drug use among school students report rising levels of drug use and falling ages of initiation in some countries.



- Many young illicit drug users are still living in a family environment – illicit drug use, in many Asian communities, despite its stigmatization, has not yet led to complete disruption of social connectedness.
- Lao PDR and Viet Nam have substantial populations of street children, increasingly consuming drugs, living precariously with little or without family support or guardians.

## **Drug taking practices**

- Historically, opium has been consumed by smoking.
- Use of heroin often encourages a transition from smoking or ‘chasing’ of heroin towards its injection – driven more by economic factors than anything else.
- The rate of heroin injecting varies from place to place and in different cultural and social settings: once the initial phase of smoking and inhalation of heroin has generally passed, the data suggest around 50-60 per cent of heroin users inject.
- ATS are generally ingested or smoked, but injecting of ATS, albeit in smaller numbers, has begun to be identified in China, Lao PDR and Thailand.

## **Risks and trends**

- Sharing of injecting equipment is widespread, accompanied by unhygienic preparation and disposal practices.
- Pooling of money to purchase drugs and sharing of needles is common: economic necessity drives the social organization of drug use, a major reason for the formation or joining of groups of injectors.
- Common reasons for the high rates of sharing needles include ‘situational’ reasons (such as incarceration), poor accessibility of clean injecting equipment, the urgency to inject, peer pressures and insufficient knowledge of the associated health risks.
- The use of cleaning techniques for injecting equipment is often crude, often incomplete and consequently inadequate to prevent the transmission of blood borne viruses. While an increasing number of IDUs are aware of being at risk of HIV infection through the sharing of contaminated needles, studies generally show this knowledge does not extend to all other drug injecting paraphernalia: sharing of communal water to dilute the drug and/or using a common receptacle to draw up the drug solution is often observed.
- There has been a marked increase in poly-drug use, for several reasons: when particular commonly used drugs are more difficult to access, often because drug seizures result in price increases, it is common for drug users to seek and use a range of alternatives to achieve the desired effect.
- Drug users in Asia have high rates of multiple sexual partners and widespread and low rates of condom use. A recent survey among IDUs in Yunnan Province, China, found 88 per cent had unprotected sex with a regular partner, while 64 per cent never used a condom with a sex worker. Increasing numbers of female IDUs exchange sex for drugs or money to purchase drugs, often the only way open to them to raise the funds to purchase drugs.
- HIV infection and AIDS are epidemic in almost all Asian countries; countries with the highest prevalence of HIV infection among IDUs include China, Myanmar, Thailand and Viet Nam.
- There is a trend for HIV to move from the initial core group to the wider community, transmitted sexually from IDUs – especially where female sex workers are also IDUs.
- The prevalence of hepatitis C virus infection among IDUs is commonly 60 per cent or more across the region and over 90 per cent in many places.



## Health and drug treatment responses

Treatment approaches in the main comprise CTCs for detoxification and treatment, traditional medicines and military 'boot camp' approaches. Psychological and behavioural counselling is limited, as is effective assistance for drug users to reintegrate into the community following treatment. It is generally agreed that recidivism rates are high. Increasingly, the outcomes of current treatment approaches have frustrated some Government policy makers, leading to increases in the length of detention in treatment or rehabilitation centres, and increases in the penalties linked to relapse.

Treatment services in some places are free or subsidized, but generally fees are payable by those detained, paid by the detainee or by families and friends, and for those unable to pay, via labour. Private voluntary treatment and rehabilitation centres appear to be flourishing in some Asian countries, but the fees required are beyond the reach of the ordinary drug user and their family. There are few if any youth specific drug services; as a result, young drug users are integrated with the adults.

Many treatment facilities make an attempt to provide skills and/or vocational training, but the sheer number of drug users make it difficult for many to get access to such programmes; the lack of opportunities after release decreases their desired impact.

## 2. Young people, drugs and current responses

In the GMS - with the influence of various socio-economic factors, including effects of globalization, unemployment and demographic change - drug use among young people is posing significant problems, both on the individual and communal level. If young people are to be a resource for the future, they need to develop to allow their potential to come into effect.

Most countries in the GMS reporting on ATS use have seen increased ATS consumption over recent years, especially among their youthful populations. The GMS is experiencing rapid globalization, modernization and urbanization. These forces facilitate, inter alia, trafficking, increased availability of drug supplies and the spread of drug use-related behaviour, such as that concerning production, experimentation and use of drugs, including ATS.

Young people are at the forefront of vulnerability to HIV infection. A substantial proportion is becoming infected via injecting drug use or unsafe sexual behaviour, often while under the influence of drugs or intoxicants. HIV and AIDS prevalence among IDUs has reached over 50 per cent and in some cases over 70 per cent of the injecting drug use population, and can do so in a very short time (Mathers, Degenhardt et al., 2008).

Young people in the GMS face numerous challenges resulting from rapid social and economic changes. Many cope well and live healthy lives with a positive contribution to society. However, a large number succumb to taking drugs with negative consequences. This problematic drug usage is associated with the transmission of HIV, whether through injection drug use or risky sexual behaviour brought about by intoxication from drugs. It is also associated with mental health disorders, alienation and violent behaviour, including abuse and exploitation.

Widespread drug use among young people is further associated with an increase in criminal behaviour to support drug dependency. The age of initiation into drug use and transition to injecting drug use appears to be getting younger. The widespread manufacture and use of ATS, including methamphetamines, raises the risk of transition to injecting drug use, with attendant risks of blood-borne infection (BBI), as well as communicable diseases, especially HIV and AIDS. Compounded by its association with mental illness, drug use has serious social and economic costs.



Knowledge of the harmful effects and risks related to drugs remains limited among not only young people but those around them, such as their families and community members. This contributes to the stigma and discrimination young drug users face, something particularly experienced after they return from CTCs to their families and communities.

Young people who have developed substance dependency and substance-related problems are often treated in adult drug use programmes, even though developmental, psychological, social, cognitive and family differences underscore the need for specialized treatment. It is important that young people who experience problematic drug use are provided with treatment and rehabilitation that is suited to their psychological, social and cognitive developmental needs, rather than being treated in the same settings and with the same approaches that are directed to adults.

A predominant form of treatment in the GMS appears to be the use of incarceration, often called 'compulsory treatment', in large prison-like facilities. Such treatment can be more punitive than rehabilitative. Enforced work and indoctrination sessions comprise the major part of the programmes offered. The relapse rate is unacceptably high (up to 90 per cent). There is little attention to the development of life skills to complement treatment and rehabilitation. This approach could also worsen social exclusion and discrimination, making it even harder for rehabilitation. Systems of treatment and care need to be developed in a way that caters for the needs of young people and for this to be possible a solid evidence base, policy reform and workforce development are necessary.

Furthermore, the exposure of young people to more hardened, chronic and older drug users greatly increases their vulnerability. Violence is common in such facilities – staff may subject 'inmates' to violence and 'inmates' inflict violence on each other. Some of this violence is sexual. Exposure to more experienced older drug users in the high-risk environments of institutional settings for adults makes it all the harder for young inmates to free themselves from a vicious cycle of drug use and related problems. Thus, they face even higher risk of further exposure to BBIs and sexually-transmitted infections (STIs), in addition to psychological and physical damage.

Young people with developmental disability and those with acute or chronic mental illness are poorly served, if at all. Little attention is paid to educational and vocational training. Most of these institutions are for males, but when young females are also incarcerated, their situation can lead to a much higher risk of negative health and other outcomes.

What community treatment exists is usually for those with access to resources. Little attention is given to increasing the capacity of schools, families, communities and the health and public security sectors to work in collaborative ways for a more comprehensive response involving various members and levels of the community. Likewise, little attention is paid to thorough assessment and effective referral to an appropriate service, if such services exist. In most situations, any drug use is regarded as requiring 'compulsory treatment', irrespective of what substances are used and the level of use. It is ineffective to place young experimental ATS users, for example, in a facility with long-term heroin injectors.

Where the health sector develops strong, effective and professional links with other sectors, particularly education, public security, social welfare and civil society, a better range of interventions is more likely.

It is possible to provide young people with interventions that meet their needs, that are less incapacitating and to do so in a more enabling environment, which keeps them connected with family, school and community. This can reduce stigma and discrimination and strengthen 'protective factors'.

## Chapter 2

---

# Building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: Overview of the project

---

Below is information on various aspects of the ESCAP project and how it relates to improving community treatment and rehabilitation options for young people with drug problems and engendering greater understanding and participation from all relevant stakeholders.

### **Project Goal**

More effective and comprehensive community-based treatment interventions and comprehensive and integrated health systems will be in place to reduce problematic drug use among young people in the Greater Mekong Subregion.

### **Project Outcome**

National counterpart organizations develop an enabling environment through policy change and integrated health systems infrastructure and workforce skill development that provides for diversion of young drug users from compulsory institutional treatment to community-based treatment.

### **The Target Group**

The direct target group is young people experiencing problematic drug use, and their families and schools, community health service providers and residential rehabilitation staff.

Project activities addressed the gender and age dimensions of drug use, to provide knowledge and skills for designing and developing age- and gender-appropriate training programmes on treatment.

### **The Strategy**

The core of the project was the developing and strengthening of community-based treatment interventions for young drug users. In this regard, it aimed to assist the participating organizations in developing the knowledge and skills of young people, their families, communities and schools, community health service providers, residential rehabilitation staff and civil society groups. It was hoped that the strengthening of strategic alliances would, in turn, create an enabling and supportive environment for treatment and rehabilitation.

The project also aimed to facilitate a shift from stigmatizing young drug users to accepting that drug use and dependence could be treated in the community with levels of success comparable to those for other chronic conditions.

To enable the outcomes to be achieved, a large focus of the project was on workforce development via training workers, young drug users and their families and communities in how to more effectively respond to and intervene with young drug users, their families and communities. This entailed the development of training packages and resources – with the participating organizations, young drug users, family and community members and various levels of staff working in both residential and community drug treatment – that were culturally appropriate, and the delivery of train-the-trainer workshops by the project consultant and then in-country training by those trained subregionally.



## **The Participating National Counterpart Organisations**

- China:** The Yunnan Institute for Drug Use (YIDA) in Kunming.
- Lao PDR:** Initially, the Participatory Development and Training Centre (PADTEC) and later the Vientiane Youth Centre for Health and Development (VYC) of the Lao Women's Union.
- Thailand:** The Institute for Juvenile and Family Justice Development (IJFJD) in association with the Nonthaburi Province Juvenile and Family Court and Associate Judges and Community Network.
- Viet Nam:** The Department of Social Evils Prevention (DSEP) of the Ministry of Labour, Invalids and Social Affairs (MOLISA).

## **The Phases**

**Phase I (2002-2004)** focused on providing an overview of alternative drug use prevention, treatment and rehabilitation services for at-risk youth and juvenile drug offenders through capacity building and pilot training projects in the four participating GMS countries with an emphasis on prevention and strengthening of 'protective factors'. Training materials on youth drug use prevention, treatment and rehabilitation were developed: Young people and substance use: prevention, treatment and rehabilitation (UNESCAP, 2006).

From field visits for Phase I of the project and the development of the training materials, it became obvious that one of the greatest impediments to expanding the capacity for community-based treatment was the lack of a skilled and confident workforce. In some locations there was almost an absence of counselling skill development, or only brief workshops held occasionally. Many in the field requested information on counselling in an easy to understand and practical format. In addition, there were few relevant, culturally-appropriate textbooks readily available in local languages or useful in local settings.

**Phase II (2005-2006)** focussed on assisting the participating organizations in strengthening the effectiveness and comprehensiveness of treatment of young drug users. By developing methodologies and reference materials that were relevant and sensitive to diverse cultural and belief systems in the GMS, appropriate knowledge and skills development were provided for health, community, public security and education sector and NGO personnel. There was an attempt to generate information for a baseline against which to measure progress.

The information gathered was used in the preparation of a tool kit for engaging and working with young people, as well as their families and communities on treatment and rehabilitation. Young drug users, their families, as well as school staff, community health service providers and residential rehabilitation staff were trained in the use of the tool kit. The tool kit provided appropriate knowledge and skills development for health, community, public security and education and NGO sector personnel, including orienting school teachers, families of young drug users, community leaders, community health service providers, and residential rehabilitation staff on common drug use issues that young people face and the support required for their treatment and rehabilitation. From feedback it was clear that there needed to be a main focus in the tool kit on basic counselling and treatment planning, especially relapse prevention planning.

Attention was paid to the (re) training of residential rehabilitation staff and to the development of programmes that were more youth- and gender-appropriate. In part, Phase II training also focused on the development of self-help and peer leadership programmes within closed residential environments for both residents and staff members.

This included attempts to change the physical environment (for instance, allocating separate living areas to younger residents), to 'rewarding' real participation in a therapeutic intervention programme, behavioural compliance, being a positive role model and providing assistance to others. Such programming developed strong community linkages, with the use of appropriate

external persons, agencies and organizations to provide specific interventions and programme components within residential facilities.

Prior to discharge, more intensive interventions were provided to assist in the development of realistic relapse prevention plans. These involved staff from various supportive NGOs and community-based and mass organizations.

There was also an emphasis on increasing attempts to engage with families of those in treatment settings and to strengthen their involvement. This aimed at helping keep the young drug users' connections with the 'real world' alive. It was hoped that it would maximize the potential of stronger continuing-care by family and known persons, agencies and organizations, and possibly bring about an earlier release back to the community.

**Phase III (2007-2008)** focused on field-testing the tool kit and documenting related training on community-based treatment and rehabilitation for young drug users: A tool Kit for: building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion (UNESCAP, 2007c). In-country training utilizing various components of the draft 'tool kit' alongside local resources occurred. In Viet Nam, the majority of the draft was translated and the tool kit was utilized as the main training guide. In Thailand and Lao PDR, emphasis was placed on developing 'counselling skills', with Thailand using 'specialists', mostly from the Ministry of Public Health's Mental Health Department to present, and with Lao PDR utilizing the skills of the staff of VYC. In each setting the core elements of the draft tool kit were utilized: assessment, stages of change, individual, group and family counselling, and relapse prevention planning.

Phase III also sought to enhance research capacities and facilitate the development of policies such as those that diverted young drug users from compulsory treatment to community-based treatment, and enhanced the re-integration support available to young people who were still required to be placed for some time in compulsory centres.

Phase III also encouraged the development of an enabling policy environment and addressing issues of sustainability.

The project built on ESCAP's on-going work in identifying, disseminating and promoting good practices in development, including in combating drug use among young people. As the only comprehensive regional organization of the United Nations in Asia and the Pacific, with a special focus on good practices in diverse development sectors, ESCAP has a comparative advantage in implementing certain interventions and advocating for policy change.

## The Products

The publication '**Adolescent Substance Use: risk and protection**' reviews the literature on substance use among young people and its treatment, takes a risk and protection perspective, provides a framework for programme development and implementation, and provides case studies from the region.

The training package '**Young People and Substance Use: Prevention, treatment and rehabilitation**' provides an orientation to conceptualizing substance use by young people that is holistic, non-punitive and based around case studies generated during field visits. It has training modules on 'Understanding substance use', 'Prevention: Principles and strategies for intervention', and 'Treatment and continuing care: Principles and strategies for intervention', together with an introduction, glossary of terms and resource listing. The training methods stress a participatory approach and use of local and culturally-appropriate content.

The '**Tool Kit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion**' contains practical skills for assessment, individual, group and family counselling, and relapse prevention planning.





It introduces a number of case studies and demonstrates the assessment and treatment planning process as they apply to five cases.

The tool kit also contains four videos for use in a variety of training settings that were made by the participating organizations in China, Lao PDR and Thailand:

a) The video **'Noy Story'** presents the first case (Noy – see below) in a dramatic format, and hopes to illustrate how substance use by a young person develops and how various members of Noy's community can assist him with his substance use-related difficulties: teacher, police, family, youth centre, doctor, monk, peer educators and peers. This video was developed and produced in Lao PDR by young staff and peer educators from VYC.

b) The video **'Never too late to change: Payu's Story'** from Thailand illustrates how a specialized service, Tulakarn Chalermprakit Hospital (Tulakarn), which has a residential, therapeutic community programme for young substance users, can assist while the young person is in residential treatment and then support them to implement the skills they have learned when back in their community and attempting to avoid relapse. It also illustrates how a specialized service (such as Tulakarn) has re-oriented its services to provide a greatly expanded 'outreach' and 'community development' role to assist in 'relapse prevention' of those treated at the hospital. In addition, it demonstrates the benefits of providing greater support to the families of the young people, developing community and peer leaders, planning community development activities and strengthening the whole community to address the drug use of young community members. Thus, like Noy Story, it shows that you can 'treat' some young drug users in the community without using residential placement or prison. The video was developed and produced by staff of Tulakarn and members of the Baan Somdej community in Bangkok. The content of this video is described below.

c) The third video, again from Thailand, illustrates how the courts can support community-based treatment. The Chief Judge and the Associate Judges of the Juvenile and Family Court of Nonthaburi Province developed and produced **'New Working Process of Nonthaburi Provincial Court: Juvenile and Family Division'** to demonstrate the role and functions of the Juvenile and Family Court, the roles of the Associate Judges and the Community Network to divert young drug offenders from custody, and how they are assessed, supported and treated in the community.

d) The fourth video is from China, made by YIDA. It is titled **'Seeking the way back'** and illustrates the work coordinated by YIDA and peer educators from the Population Services International (PSI) Drop-in-centre in Kunming with young people while they are residing at a Compulsory Detoxification and Rehabilitation Centre and their journey back to their families and the community. It highlights the difficult work of recovering from drug dependence for the young person, their family and those working with them.

Three additional videos were produced during the life of the project:

**'My Love Story'**, documenting the development of a 'relationship' (drug dependence) between Eddy and ya baa (a form of methamphetamine), was produced by young people from VYC to illustrate the development of drug dependence and the prevention of relapse.

**'Temptation'**, providing information on ATS and exploring the stories of drug users in a CTC, a student and a businessman, was produced by YIDA. Issues covered include the effects of ATS; the expectations of ATS by those about to use; the positive effects sought; the role of boredom, stress and sensation seeking; and mental health complications. It uses some actual interviews with young ex-drug users undergoing treatment at a Compulsory Detoxification and Rehabilitation Centre, and some actors who talk about what ATS are, and their effects (positive and negative) including mental health impact, reasons for use (including weight loss, fun, to escape boredom and in reaction to stress). It also shows some aspects of what 'treatment' in a Compulsory Detoxification and Rehabilitation Centres is like. Featured



are people from a variety of backgrounds – a young person with family problems, a white-collar worker who is stressed and bored, and a student. Professor Li Jianhua from YIDA provides some 'expert' information, and warns against young people seeing ATS as merely 'fun' substances.

**'Flying High'**, which aimed to: a) demonstrate the process of engaging with a young person during and after residential treatment; b) illustrate the roles of various community members in providing treatment and support in the community; and c) illustrate some ways of managing (re)lapse, was developed by Tulakarn Chalermprakit Hospital.

### **Case study examples from the Tool Kit: Noy and Nung**

#### **Noy's Story**

*Noy is a 16 year-old high school student in a small town. His father has a small car and motorcycle repair business. He has an older sister aged 18, a younger brother aged 13 and a younger sister aged 11. Noy has been a good student, but over the past year has begun to get bored with school and family life. He watches TV and sees the fun young people have in discos and bars in the big cities.*

*About six months ago, while riding his bicycle around town one evening, he saw some of the older boys from his school hanging around beer halls near the river. They called him over, talked with him for a while and then asked him for some money. They said they would get him beer if he gave them money. He gave them the money as he wanted to drink beer. They returned, gave him beer and they went to a quiet area near the river and talked. They told him about the fun they had with girls when they went to the beer halls and clubs. Noy was getting drunk and excited. He had been thinking about girls for many months and wondered what sex would be like.*

*Over the next few months he met up with the same group of older boys and drank with them. They introduced him to some girls. Noy had sex with some of them. Some of the girls asked him for money, as did the older boys. He used all his school money and began to steal small items, such as gems from his family. A few months ago, his older friends introduced him to ya baa. He liked the effect, felt excited and sexy. He began to use ya baa more often. Sometimes he came to school feeling very tired after using ya baa the night before. At other times he was excited and not able to sit still as he had used ya baa that day. He also began to sell ya baa to school friends.*

*His parents are worried about him. They ask him what is wrong. His father has even threatened to beat him and send him to his grandparents in a village 80 km away. His teachers have also become worried about him. His grades are falling. He day-dreams most of the time and looks tired. He has started to feel that people are watching him all the time. Occasionally, he hears voices talking to him but cannot see anyone. He also gets irritable when his teachers ask him what is wrong. He says that he feels like hitting someone or smashing doors and cars. The teachers call his parents to the school and tell them about his falling grades and changed behaviour. His sister spends a lot of time at a local youth centre where she is training as a volunteer peer leader. The centre has a youth health centre and gives information on reproductive health. She suggests Noy goes to the centre with her and talks to the health workers or some peer leaders.*

#### **Nung's story**

*Nung is 14 years old. Her peers at school think she is very quiet. She is an excellent student who gets high marks in all subjects. But, when she is praised for her work, she thinks she does not deserve the praise and says her work is not good enough. Her best friend, Som, has noticed that she has become more withdrawn in the past*



*couple of weeks. Nung had also asked Som the other day if she has ever tried methamphetamine or heard of Valium (diazepam).*

*Recently she was offered some methamphetamine on the way home from school. She did not buy it, but has been wondering whether this might help her feel better. She has never used drugs before. Some of the girls give her a hard time by calling her “witch” and “weirdo” because she likes to read fantasy books about life on other planets and in strange far away galaxies. One day she even found a dead rat in her locker. She told the teacher who said it was difficult to find the culprits and subsequently nothing was done about this. She was in the drama team but recently stopped attending because she feels lethargic and does not see much point in being part of the team.*

*Nung lives at home with her mother. She loves her mother, but finds that her mother is often sad these days. Her mother has started taking Valium prescribed by her doctor. Some afternoons when Nung comes home, she finds her mother intoxicated from drinking alcohol and taking Valium. When she is in this state her mother says things to her like, “I wonder why I keep living” and “It’s not really worth it”. Her mother’s depression is affecting Nung. Recently, she took one of the Valium tablets that her mother takes, just to see what it was like. She did not really enjoy it. She got sleepy and later had a headache. But, she also felt that it was something different to do and she liked the dreamy feeling she had before she got the headache. Since then she has used her mother’s medication a few more times, but not regularly.*

*Nung has also started feeling depressed. On weekends when she is at home, she stays in bed most of the day. She is not reading as much as she used to and has stopped going to the library. She has started wondering if anyone would miss her if she were dead. She sees her father every fourth weekend. Her mother and father have been divorced for four years. They used to argue constantly and now do not speak to each other. Nung’s mother often tells her that her father is a bad man. Her father works as a manager in a big export company. She enjoys her visits with her father. It is their special time together and they talk a lot about different kinds of things. Nung has been giving more thought to moving in with her father. She has not asked him because she thinks that his new wife may not be happy with the idea. They have two young children and there is not enough space. She wants to ask him but she knows that she will be extremely disappointed if her father said “no”. She does not get along well with her father’s new wife. Nung thinks that she is always criticizing her. She overheard them arguing over Nung’s influence on the two younger children.*

*Her only real friend is Som. Nung thinks that Som is nice. Som and her family are warm and accepting of Nung. She stays with them some weekends and enjoys the close relationship they have with one another. Her other ‘friends’ are the ‘pills’ she has begun to use more frequently. She steals them from her mother when her mother is too drunk or intoxicated from taking too many pills.*

### **Choi’s Story**

*Choi is very similar to many other young people in his hometown who have come to the city to find work and make money. He used drugs (cannabis) for the first time when he was 15 years old. Soon after he began to smoke opium and sometimes to inhale it – ‘Chasing the Dragon’. Then he was introduced to heroin and started to inject it. He became dependent on heroin when he was 16 years old. He has been hanging around with some of the local drug users and dealers and those involved in crime for the past year. He has helped them sell stolen goods and they have given him heroin in payment and some small amounts of money. He likes the feeling of heroin as it helps him forget his troubles. He has dropped out of school and has no*

job. He has managed to give up heroin several times but was unable to maintain a heroin-free lifestyle.

He did not return to daily heroin use for a short time while he had some work helping in the kitchen of a restaurant owned by friends of his family who did not know about his drug use. However, he has become dependent on heroin twice this year and was using it every day for some weeks. First he detoxified with his friends who were looking after him – ‘cold turkey’ but drinking a lot of alcohol and taking some ‘pills’ (probably anti-anxiety tranquillizers or sleeping pills). The second time he went to a community health centre and they assisted him by referring him to a clinic where he was given methadone daily for some weeks to detoxify him from heroin.

Choi is struggling. Sometimes he cries to himself and wants his life to be happy and ‘normal’. But, at other times, he craves the feeling of heroin in his body – it makes him so relaxed and he forgets all his worries. He is not sure that he can fit in with non-drug using young people and make friends. He feels he has done so much more than them and their lives sometimes look so boring. He has a girlfriend, but he is not sure of her. She is also a heroin user, but uses less regularly than he does.

Recently he has come in contact with some outreach workers from a drop-in-centre where he goes to relax, get clean syringes and equipment and condoms. He has shared injection equipment a number of times with other IDUs, and been now given information on safe sex, HIV and hepatitis. He became very concerned when one of the workers at the drop-in-centre who is an ex-drug user and who underwent treatment at the therapeutic community in the city told him that 70 per cent of those in the treatment centre are HIV-positive and 40 per cent have hepatitis C. Choi has shared injection equipment and knows he has not always practised safe sex. He does not know what to do. He does not want to be sent to the compulsory detoxification programme run by the police and security forces but is not sure he can give up heroin by any other means.

**Video story example: ‘Never too late to change’ – Payu’s Story**  
**By Amorn Virapongse, International Consultant, Tulakarn Chalermprakit Hospital**

Payu is the youngest son of Mama Jun. He is 16 years old and has two older brothers (one in his thirties) and one older sister. Payu lives at home with his mother, as his siblings have left home and started their own families. One older brother is still a drug user, and Payu was never really very close to any of them due to the large age differences. His father died when Payu was a toddler and he has very few memories of him. Payu loves his mother very much, but as she is very shy and gentle, he spends most of his spare time with his friends and so listens to them more than to his mother.

There is a lot of drug dealing and using in his slum community. Even though there is much police and other law enforcement authority drug suppression and seizure activity, there are still many drug users and dealers, which make many families in the community uneasy. Payu felt lonely and bored at home with not much to do. His friends frequently suggested he used ya baa with them and finally he did. First, he just wanted to know how it felt, as his friends talked about it so much. Eventually he became ‘hooked’ and started to ask for money, and even steal it, from his mother to buy the drugs he wanted and needed to ‘feel happy’. When he was caught he was lucky as he was a minor and apprehended during a lenient time in law enforcement which encouraged young users to enter treatment to avoid being sent to a correctional facility. Payu and his mother chose the Tulakarn Chalermprakit Hospital because their neighbours had participated in a support network programme with the hospital and talked favourably about it. Payu entered the four month treatment programme (a



*therapeutic community) with the intention of ceasing his drug use due to his mother's pleading. He felt sorry for his mother and did not want to see her in tears again. He was also tired of hiding and running from the police.*

*During his time at Tulakarn he participated in all activities with curiosity. The attention, caring and encouragement of the staff helped him a lot. At Tulakarn he participated in their drug-free environment, group work, individual and family counselling, vocational skill training and recreational activities. He enjoyed the time in family therapy and other activities with his mother, and this helped him to understand her more.*

*He left Tulakarn with a strong intention not to return to drug use. When he returned to his community, not much had changed. His friends were using drugs and there was still not much to do at home. His strong will was threatened and reduced, but he remained drug-free and sought work. In his community there are many small factories (such as those involved in flute making, mask making, and making and sewing jeans). Payu chose to try to obtain work in a leather bag factory. Mr Sama-ae is the owner and has an intimate and deep understanding of drugs and drug users and the difficulties they face while trying to remain drug-free after treatment. He was trained in sewing leather while in prison and after his release he and his wife worked in a factory that received leather from a much larger factory and made leather bags on contract. After saving enough money they started their own small factory and now have many local and export contracts. Mr Sama-ae employs many young people from the community who have been drug users or who are disabled in some way, and he and his wife are very supportive and kind to them. When Mama Jun brought Payu to apply for a job he was more than willing to accept him. Payu then lived a happy enough and drug-free life for a while.*

*Over time, he started to spend more time with his old friends. He thought he was strong enough to refuse drugs, but he was not and used again (a lapse). Mr Sama-ae noticed the change in his behaviour and talked to Payu about it. Payu admitted that he had used drugs again and Mr Sama-ae discussed what to do with Payu's mother and the Tulakarn staff who were providing follow-up support in the community. They decided to work more closely with the community leaders to tackle the drug and other issues in their community. Tulakarn staff planned, with the community leaders and other members, the setting up of a community network and developing more activities for the young people and their families.*

*The Tulakarn staff also suggested to Mama Jun to stay calm as lapses are very common for drug users. They advised her to talk with Payu more often and suggested to Payu that he enrolled in the 'Diploma Programme' sponsored by the hospital, and continued his education via the evening and weekend classes. They also persuaded Payu to join in many community activities, and asked him to ask his friends to also join the creative and sporting activities that had begun. Payu enrolled in the Diploma Programme and there he met Fon who used to sniff glue and had been apprehended by the police but was allowed to be 'treated' in the community by the Tulakarn Outreach and Follow-Up staff. Fon's mother is a drug dealer and physically abusive towards Fon. Fon's boyfriend is a drug user and dealer. When Tulakarn staff made a visit to Payu, they found Fon in a very low mood. They consoled Fon and encouraged her not to relapse. They asked Fon to join in any of the activities she liked. She did this and Payu and Fon helped each other to stay drug-free and to study together. In addition to the Tulakarn staff, community and religious leaders also provided support and encouragement in many ways.*

*Finally, Payu completed his Diploma with congratulations from everyone. His journey has not ended, but he is now better supported to continue to achieve his goals, feels supported in his community, and the community feels supported and encouraged by Tulakarn and its staff.*



## Chapter 3

# Building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: Overview of activities, achievements and challenges by country

*Regional meeting for project,  
Vientiane, Lao PDR, 2006*



In the following four sections of this chapter a summary of activities, achievements and challenges is presented for each of the four participating countries. These summaries are based on various reports submitted by the national counterpart organizations to ESCAP and field visit reports by the project consultant.

In each section, examples are given of particular activities and brief case studies to illustrate the range and complexity of issues for the young people involved in the project at each site.

## 3.1 China – Yunnan Province

### Main activities and achievements 2002 to 2008

- Providing extensive training, mostly peer educators from key NGOs (including PSI, Red Cross and Rainbow Community) and also university students
- Providing refresher training
- Carrying out supervision (formalized)
- Developing networks and links
- Developing and implementing strategies for advocacy
- Consolidating relationships with public security, health, community and NGOs
- Refining processes for engagement of young people, in-CTC and post-CTC activity
- Reliable attendance at the CTC
- Planning – relapse prevention plans developed with young people before leaving the CTC
- Assistance with getting jobs for those leaving the CTC
- Attention to ‘clinical issues’, such as mental health
- Attention to ‘basic needs’, such as nutrition and transport
- Attention to making contact with staff and support easier via ‘contact cards’
- Attempts to engage with families; making contact before young people leave the CTC (with the young person’s approval), taking them home and follow-up home visits
- Continued data collection and analysis
- Continued critical reflections on practice



- Documentation
- Producing two videos
- Translation of relevant sections of the tool kit and other resources, with appropriate adaptations to better fit local circumstances

### **Main challenges**

- A lack of supportive legislation/policy
- No legal capacity for diversion
- Difficulty in accessing and engaging families, including stigma, financial pressures on parents in one-child culture
- Difficulties in linking parents for mutual support, stigma again
- Linking with target communities, again stigma
- Police 'round ups' and 'quotas', and payments to community members for identifying drug users to the police
- No 'half-way' houses and youth centres

### **Major contributions**

- Sound clinical and research basis
- Mechanisms for data collection and reflection on process and outcomes
- Relapse prevention planning
- Training of peer educators
- Translation of relevant sections of the tool kit, with adaptations to meet local needs
- Gaining broad support from major stakeholders
- Good working relationships developed with CTCs and other organizations that may hold differing views to project staff
- Two useful videos produced
- Recognition of and taking care of basic needs
- Processes for engaging with young people, including the 'taking home' to families of those released from CTCs

### **Implementation of the ESCAP Project (from YIDA and consultant field visit reports to ESCAP)**

#### **Target group**

- ♦ Young drug users under 24 years old in the Chang Po Compulsory Detoxification Centre (the biggest compulsory detoxification centre in Kunming)
- ♦ Families of those young drug users
- ♦ Peer educators and volunteers recruited from related agencies and organizations
- ♦ Policymakers of managing problematic young drug users in Kunming

#### **3.1.1. Management of project activities**

In order to ensure the smooth implementation of the project, staff from YIDA monitored peer educators' and volunteers' project activities. This included the following:

- At the beginning of the project, the project team signed contracts with recruited peer educators and volunteers. In the contracts, mutual rights and responsibilities were specified.
- The project team made a series of recording tables for project activities so that all the activities of peer educators and volunteers had written records.
- The project team made sure that peer educators and volunteers met every two weeks to summarize their activities in the past two weeks and make plans for the coming two weeks.
- The project team facilitated a routine meeting every month for peer educators, volunteers and project workers. In the meeting, the activity records handed in by peer educators and volunteers were checked; the problems of and solutions to every case were analyzed. The activities, difficulties and experiences of the month were also discussed and summarized in the meeting.



- The project team went to the Centre once a month and provided in-the-field monitoring for peer educators and volunteers.
- The project team met with relevant personnel from Kunming Committee of Drug Control and the Centre every month to provide feedback on the progress of the project and to coordinate or deal with problems arising in the implementation of the project.

### 3.1.1.A. Translating and printing key parts of the tool kit

Based on actual needs of project activities, the project team had the three parts (Individual Counselling, Family Counselling and Making Plans to Prevent Relapse) of “A Tool Kit for Building Capacity for Community-based Treatment and Continuing Care for Young Drug Users in the Greater Mekong Subregion” translated into Chinese and printed as independent brochures to give to peer educators and volunteers. The content of the brochures was closely related to the project and very convenient to carry and read. Therefore, the brochure was highly appreciated by peer educators and volunteers.

### 3.1.1.B. Making project contact cards

In order for young drug users and their family members to make contact with the project team, peer educators and volunteers, the project team specially made some “Project contact cards of GMS Adolescent Project”. The cards briefly introduced the activities implemented in the Centre and communities. The cards also provided detailed information on the address of YIDA, contact telephone numbers and the numbers of peer educators’ and volunteers’ mobile telephones.

**Translated sections  
of ESCAP Tool Kit  
and Contact Cards**



### 3.1.1.C. Capacity building for peer educators and volunteers

#### Recruiting and training new peer educators and volunteers

The project team recruited 22 peer educators and volunteers from PSI Mutual Help Bar, Red Cross Sunshine Homeland, DAYTOP Care Centre, Rainbow Community, Kunming Medical College and other places. The training workshop invited experts to train peer educators and volunteers on the topics of “basic knowledge on drug use”, “introduction to counselling and counselling skills”, “individual counselling practice” and “the risk situations of relapse and how to deal with them” by way of lectures, games, group discussions, case studies, actual practices and other means. After the training, the project team selected six new peer educators and four new volunteers to form a new group of peer educators and volunteers which also included four former peer educators that participated in Phase II of the project. The criteria of selecting new peer educators and volunteers were as follows:

- Having basic knowledge on drug use
- Having basic skills to communicate with young drug users and provide them with counselling
- Having objective and non-discriminative attitudes towards drug users
- Being kind, tolerant and responsible
- Being willing to invest half a day’s time and energy into the project during the project duration



## Some examples from relapse prevention training provided to peer educators

### (a) 'My risky situations'

Participants list risky situations/moments they experienced (if ex-users) and imagined (for the non-users), then identify most significant and difficult to manage trigger situations/moments.

Lists included:

- ♦ Memories triggered by places, items of furniture, smell/taste, weather/gloomy days
- ♦ Feeling depressed, anxious, fearful
- ♦ Feeling bored
- ♦ Seeking friends when lonely
- ♦ Feeling excited
- ♦ Talking with people (such as family friends) which trigger negative moods, family/friends using in front of you
- ♦ Roaming around
- ♦ Drug availability
- ♦ Conflict with parents
- ♦ Rebelliousness
- ♦ Over-reacting to comments

The task set for participants was to list actions that could be taken at 'critical moments' in the life stories developed.

Strategies:

- ♦ Music
- ♦ Phone a friend/peer educator
- ♦ Talk to family if they are available and receptive
- ♦ Try not to go out
- ♦ Go to a drop-in-centre or NGO
- ♦ 'Intervention' by friends to 'block' movement to drug use
- ♦ Remember 'the police' who arrested you
- ♦ Role models to build up hope
- ♦ Have family members, for example, purchase buprenorphine or something similar to provide relief when pressure to use is extreme
- ♦ Avoid actual contact with drugs
- ♦ 'Self care' and 'self soothing' rituals – thoughts and activities (especially special music, cooking, writing, sport/exercise, relaxation techniques (such as meditation and yoga). Becoming your 'best friend' and 'supporter'



### **Peer education training session at YIDA**



#### **(b) 'How to manage my emotions'**

Dividing into five small groups after distribution of small slips of paper with an animal listed, and then seeking the same 'animal'. Groups choose a 'favourite' song/piece of music, and decide why and in what circumstances/mood they would sing/use it. Participants identify songs of friendship and songs for when lonely or missing someone.

Developing a list of emotions that could trigger (re)lapse and strategies to deal with the same. For example, when lonely or tense the following were identified: chat/play games on the internet, dance, sleep, exercise, go to the gym, telephone someone, ride a bicycle, play cards, make up, fly a kite, eat, listen to music, go fishing, do deep breathing/meditation, watch a DVD, go shopping, look for a boy/girlfriend (implying sex), clean the house, shout, do extreme sports and go to church. In addition, some negative activities such as drinking/gambling, looking for a fight and driving quickly were identified. Emphasis was on NOT making big decisions when in a negative mood state, bearing in mind 'who makes the knot can undo the knot'.

#### **(c) 'My support system'**

Listing resources available and support systems. Sociogram activity: on paper represent oneself, and identify people who can be of support via linkage lines (two lines equals very good support, one line means less supportive, a broken line implies not supportive), and non-supportive/negative people and groups with no lines of connection.

Friends and parents figured highly, supportive organizations (including NGOs, such as PSI and Sunshine Homeland, hotlines, churches, government organizations, such as YIDA and community offices, methadone maintenance treatment programmes, and needles and syringe programmes) and activities [e.g. Narcotics Anonymous (NA) – where there were younger members in some NA groups already], training institutes, volunteers (such as peer educators), and professionals (for instance, within the NGOs and government organizations, such as psychologists). Also there was a warning against interacting with too many 'do gooders' and those who keep treating you like a 'victim' and 'incompetent'.

#### **(d) Role Plays**

- i) Current drug user, recently ex-compulsory treatment centre: no parents, older sister feeling hopeless and trying to find some assistance for two brothers who are using drugs. Community officials come, but not let in, later come back with peer educators and are admitted. Trust issue as sister recognizes the peer educators as drug users. Peer educators say they have stopped using and community officials reinforce this. Peer educators talk a bit about their stories and tell of the NGOs, such as Sunshine Homeland. Officials mention support, such as available social welfare loans.



Main themes: credibility of peer educators being reinforced by good relationship with local officials, and patience of officials. Thus, sister starts to trust them, and sees she could get some help too; the carers also need support. The discussion that followed stressed the importance of the community officials getting to know the family while the young person is in the centre and the techniques for the crucial first visit that can build trust.

- ii) Current drug user: parents talking of son and daughter-in-law who use drugs. Community members come and ask about their children, and give information about services available – drug treatment centres (for instance, Daytop and CTC) and peer educators. Peer educators come and meet parents with community members. Peer educators talk of detoxification first, then possibility of drop-in-centre involvement. Options include the Chang Po centre, Daytop and methadone maintenance treatment for detoxification. A peer educator talks of personal choice with regard to such things. Young ones arrive, drug affected. Young ones leave and use drugs. Parents are disappointed. The peer educator talks of how common relapse is and the need to make many efforts over time. Young ones try to collude with peer educators to cheat parents. Community staff offer some assistance with finding employment, financial aid, psychological consultation, training, but say that first there is a need for detoxification. Peer educators offer to take the users to the methadone maintenance treatment programme.

Main themes: resisting collusion with current users – remaining ‘enabling and neutral’, perseverance, offering options with information, keeping parents involved and supportive, need for and offering of family-to-family support, role of good relationships with the police to support users trying to access and remain in treatment, cost of methadone maintenance treatment (approximately 10 Yuan, or US\$ 1.20, per day) and that methadone maintenance treatment is not ‘detox’, it is an alternative programme, seating arrangements when visiting homes, being close to family and the young drug user.

- iii) Young person in centre: police warn residents not to say anything negative about the centre to the peer educators. Then the two young residents meet community members, peer educators and social workers. Community members and peer educators introduce what they can provide to them when released.

Emphasis was placed on the importance of:

- ♦ Perseverance – keep trying to build a relationship no matter how many rejections
- ♦ Building trust – with both parents AND the young person – it will take time
- ♦ Having information – and having it in attractive brochure format to leave with young people and families
- ♦ Offering a range of services and options
- ♦ Not colluding with the young drug user
- ♦ Waiting for opportunities to offer suggestions
- ♦ Avoiding too much obvious persuading/pressuring
- ♦ Offering practical assistance – such as bringing the young person home on release, accompanying the young person to the drop in centre/methadone maintenance treatment, financial aid, training, psychological services - BUT not promising what you cannot to
- ♦ Admitting what you CANNOT/ WILL NOT do
- ♦ Supporting parents/siblings/carers
- ♦ Keeping parents/carers involved – not taking their role as parents
- ♦ Maintaining good relationships between community and peer educators
- ♦ Developing family-to-family networks
- ♦ Getting to know the family/carers before the young person returns home
- ♦ Being friendly but not their ‘friend’



- ♦ Supporting peer educators so they do not relapse
- ♦ For peer educators, NOT assuming that the young person's situation is the same as theirs

### 3.1.2. Providing peer educators and volunteers with follow-up training

To meet the training needs of peer educators and volunteers and to solve problems arising in the project, the project team organized a second training workshop for the recruited peer educators and volunteers of the project and some peer educators from drug users' centres in Kunming. In the group the project team introduced the progress, difficulties and plans of the project first. Then 'group counselling skills', 'family counselling skills', 'problems faced by drug users', 'present community service network for drug users', 'how to utilize community resources reasonably' and other issues were taught and practised.

The training workshop lasted for one and half a days and 25 people participated in the training. Besides the recruited 10 peer educators and 4 volunteers, the participants also included peer educators from PSI, Red Cross Sunshine Homeland, DAYTOP Care Centre, Rainbow Community, Jinning Needle Exchange Centre, Yanshan Needle Exchange Centre of China-Australia Programme and some volunteers.

### Routine follow-up training

The project team also worked with peer educators and volunteers to analyse the problems of and solutions to every case in monthly routine meetings. In the meetings, they summarized the progress and difficulties of the project over each past month and made plans and measures for the following month. The project team also utilized the opportunity to provide peer educators and volunteers with continuing technical support and training, especially relapse prevention planning and better group work techniques.

### 3.1.2.A. Activities in the compulsory detoxification centre

#### Identifying the target group in the compulsory detoxification centre

All the residents in the Centre under 24 years old and from Kunming were identified.

#### Baseline surveys

In May 2007, the project team organized peer educators and volunteers to complete baseline surveys on target young people in the Centre. A one-to-one approach was adopted in the baseline survey. The survey covered topics such as demographic data, drug use, family relationships, vocational situations and mental and physical health. After group discussions, intervention plans for each young person were discussed and developed. By mid-December 2007, 40 young people were covered in the completed baseline survey.

Data collection – Chang Po CTC







## **Individual counselling**

During the period from May to August 2007, peer educators went to the Centre twice a month. They provided target young residents with individual counselling according to the specific situation and needs of each person and the plans made at the previous meeting.

For the young drug users who were leaving the Centre, one month before their departure, peer educators began to work with them to analyze the risk factors of relapse, make plans to prevent relapse and hand out contact cards of the project, so that the young drug users could contact the project team, peer educators or volunteers. In line with the requirement of the contracts signed with peer educators and volunteers, all of their activities in the Centre were recorded in detail.

Because the results of the mid-term evaluation were not as positive as anticipated, the frequency of peer educators going to the Centre for peer education was increased to three times a month from September 2007. The main topics of individual counselling were as follows:

- Reasons for using drugs for the first time
- Reasons for continued drug use
- Relapse and how to deal with it
- Relationships with family members
- Relationships with boyfriend/girlfriend
- Plans of what to do after leaving the Centre
- Identifying strengths
- Using available positive resources



***Individual and Group counselling – Chang Po CTC***

## **Group counselling**

According to the schedule of the Centre, the project team and peer educators organized some group activities for young target residents such as 'how to communicate with family members' and 'how to deal with emotions correctly' on Chinese traditional festivals (such as the Mid-autumn Festival and the Spring Festival).

## **Handing out articles for daily use**

Every time when peer educators went to the Centre for activities, they provided young residents some articles for daily use according to their needs. In the process of counselling, one peer educator got to know that one young female resident wanted to record all her thoughts and her changes in the Centre so that she could share them with her family members after leaving the Centre. But she could not do so due to the lack of a notebook. After knowing the story, the project team specially provided her with a diary notebook. This greatly moved all her group

members. The project team prepared notebooks for all those who wanted to write diaries. Now all the female group members of the project are writing diaries. They hope that they can communicate with their family members better by using this approach. In addition, when the winter comes, the project team called for the staff in YIDA to donate winter clothes for young people in the Centre. They also bought some shoes for those who did not have family members to visit them in the Centre and do this.

### **Training on reducing harms**

The project team also cooperated with the “Peer Education Project of Reducing Harms” of PSI in the Centre. When PSI organized training on reducing harms in the Centre, the target young people of this project could participate, which enabled them to acquire knowledge and skills to prevent HIV and AIDS and reduce harms. By mid-January 2008, 25 young residents completed the mid-term questionnaire evaluation and subsequently 20 completed the final questionnaire evaluation.

The knowledge and skills included:

- The steps to reduce harms
- Basic knowledge on HIV and AIDS and how to prevent HIV and AIDS
- How to identify risky behaviour
- Risks of injecting drugs
- Ways of safe injection
- Ways of using condoms correctly

### **3.1.2.B. Activities in communities**

#### **Providing follow-up care and support for those who left the Centre**

In order to provide young drug users with continuing care and support, the project team designed a series of activities in communities, including contact with community leaders, organizing peer educators and volunteers to visit young drug users' homes (once a month), providing individual intervention and counselling, organizing entertainment activities (once every two months) and referring them to other projects and services according to their needs.

#### **Providing counselling and support for young drug users' family members**

- a) From May 2007, the project team made regular telephone contact with young drug users' family members and invited them to come to YIDA for counselling. However, by the end of January 2008 only one family member had come to YIDA for counselling.
- b) By using the opportunity of family members' visiting young drug users in the Centre, peer educators provided the family members with counselling activities.

#### **Providing financial and technical support for the prevention of drug use in four communities in Kunming City**

In June 2007, through the liaison of the Kunming Committee of Drug Control, the project established a cooperative relationship with Shangyi Community, Lianhua Community, Yuchilu Community and Dagan Community and included them into the activities of this project. After discussions with the leaders of these communities, both parties reached consensus that the specific work to be undertaken included the following matters.

First, the project would coordinate community workers' going to the Centre to pick up young people who received detoxification treatment there and the project would provide financial help for this. From August 2007, when young people from these communities were to leave the Centre after treatment, community workers and policemen working in the communities went to the Centre to pick up them and take them home. By the end of January 2008, staff from the four communities had picked up 30 young people from the Centre.

Second, the project was to provide technical and financial support for the prevention of new types of drugs in these communities. The project team got to know that community cadres



usually lack the knowledge on new types of drugs. In order to solve this problem, the project team not only provided relevant information and materials but also organized a one-day training workshop for them.

### **3.1.2.C. Policy promotion meeting**

The project team organized the “Policy Promotion Meeting of GMS Community-based Care and Treatment Project for Young Drug Users”. Relevant leaders or representatives from the Policy Research Office of the Municipal Government of Kunming, Kunming Municipal Government’s Working Committee for Caring Next Generation, the Office of Kunming Committee of Drug Control, Kunming Compulsory Detoxification Centre, Shangyi Community, Lianhua Community, Yuchilu Community and Daguan Community were invited to attend the meeting. The leaders and project managers of PSI, Sunshine Homeland Community of Red Cross, 70 Commune and The Project of Adolescents’ Legal Diversion in Panlong District of Save the Children UK also attended the meeting.

The leaders from Kunming Compulsory Detoxification Centre said that the number of under-18-year-olds was not large in the Centre and that they were trying to separate them from other age groups. However, the number aged from 18 to 24 years old was larger in the Centre and it was harder to separate them from drug users over 24 years old. Participants of the meeting thought that the conditions in the Centre could not fully meet the needs of ‘separate management’, and that clarification and promotion of policies and regulations on under-18-year-olds was important.

Participants of the meeting regarded community members’ going to the Centre to pick up those leaving as a good practice because it could mend the management gap between the Centre and communities; assisted communities participated in later care and treatment. The Kunming Committee of Drug Control planned to include the practice into routine work of communities the following year and made it one part of communities’ help and education work.

### **3.1.2.D. A video on ATS was completed: ‘Temptation’**

The video provided information on ATS and explored the stories of drug users in a CTC, a student and a businessman. Issues covered were the effects of ATS, the expectations of ATS by those about to use, the positive effects sought, the role of boredom, stress and sensation seeking, and mental health complications.



***Liaising with management at Chang Po CTC***



***Filming dvd at Chang Po***

### 3.1.2.E. Outcomes

#### Basic demographic features

Among the 40 target youth who participated in the baseline survey, 22 of them only used heroin. Five of them only used new types of drugs [such as ephedrine, ketamine and ecstasy (MDMA)]. The remaining 13 used both heroin and new types of drugs. Their average age was  $20.15 \pm 2.58$  years old. A total of 15 (37.5 per cent) of them were males and 25 (62.5 per cent) of them were females. A large majority (37) of them had the educational background of junior middle school. In addition, 17 of the interviewed came from single-parent families or families with step-fathers or step-mothers. By mid-January 2008, 25 and 20 target youth had completed mid-term and final questionnaires, respectively.

#### Evaluation of mental health

#### The comparison of the results of the baseline survey and the mid-term evaluation

In Table 1, it can be seen that the results of the mid-term evaluation are similar to those of the baseline survey, except the change for “having bad memory and finding it hard to concentrate and make decisions” and for “Finding it easy to lose temper and become angry, and finding it hard to control temper”. More felt that they lost their temper, became angry or found it harder to control their feelings.

**Table 1. Mental health after intervention - Baseline survey v. Mid-term evaluation**

		Yes	No	P
Being lonely, sad, depressed and desperate when considering the future	Baseline survey	14	26	0.416
	Mid-term evaluation	6	19	
Having lost interest in formerly interesting things	Baseline survey	16	24	0.077
	Mid-term evaluation	16	9	
Having bad memory, and finding it hard to concentrate and make decisions	Baseline survey	17	23	0.013*
	Mid-term evaluation	3	22	
Feeling ashamed and sensitive	Baseline survey	22	18	0.435
	Mid-term evaluation	17	8	
Thinking that others do not understand and appreciate me	Baseline survey	17	23	0.798
	Mid-term evaluation	12	13	
Finding it easy to lose temper and become angry, and finding it hard to control temper	Baseline survey	10	30	0.001*
	Mid-term evaluation	17	8	
Once considered ending my life	Baseline survey	9	31	0.344
	Mid-term evaluation	3	22	
Tried to end my life in the past 3 months	Baseline survey	0	40	–
	Mid-term evaluation	0	25	

\*P<0.05 means statistical significance

Tables 2 and 3 show that after another three months' intervention, the group had better mental health than they had in the baseline survey and the mid-term evaluation. Compared with the baseline survey, more did not feel so “lonely, sad, depressed and desperate when considering the future” and fewer felt ashamed, sensitive and uneasy to others' opinions or comments towards them. Moreover, nobody thought of committing suicide. However, compared with the mid-term evaluation, many still felt that they easily lost their temper, became angry or found





it hard to control their feelings. When compared with the results of the mid-term evaluation, the results of the final evaluation show a decreasing number who felt that they were not interested in surrounding events and did not have energy and felt ashamed, sensitive and uneasy to others' opinions or comments towards them. However, more felt that they had bad memory, and found it hard to concentrate and make decisions.

**Table 2. Change in mental health after intervention: Baseline survey v. Final evaluation**

		Yes	No	P
Being lonely, sad, depressed and desperate when considering the future	Baseline survey	14	26	0.416
	Mid-term evaluation	1	19	
Having lost interest in formerly interesting things	Baseline survey	16	24	0.077
	Mid-term evaluation	4	16	
Having bad memory, and finding it hard to concentrate and make decisions	Baseline survey	17	23	0.013*
	Mid-term evaluation	9	11	
Feeling ashamed and sensitive	Baseline survey	22	18	0.435
	Mid-term evaluation	3	17	
Thinking that others do not understand and appreciate me	Baseline survey	17	23	0.798
	Mid-term evaluation	4	16	
Finding it easy to lose temper and become angry, and finding it hard to control temper	Baseline survey	10	30	0.001*
	Mid-term evaluation	12	8	
Once considered ending my life	Baseline survey	9	31	0.344
	Mid-term evaluation	0	20	
Tried to end my life in the past 3 months	Baseline survey	0	40	–
	Mid-term evaluation	0	25	

\*P<0.05 means statistical significance

## Limitations of the data

First, although peer educators and volunteers introduced themselves and stressed the principle of privacy, it was very difficult to establish a proper relationship and win trust immediately; this affected willingness to be open. By the mid-term evaluation, after three months' communication, the young people trusted the peer educators and were more willing to talk about their true feelings. Furthermore, it was only three months from the baseline to the mid-term evaluation. The period of intervention was probably not long enough for the intervention effects to appear. However, after participating in the project, they began to think about their past, feelings and the future. In addition, life in the compulsory detoxification treatment centre was quite dull. With the passage of the time, losing freedom, some of their parents' unwillingness to visit them and the impact of some negative events in the centre, the young people showed some ambivalence.

The results of the final evaluation showed improved mental health from the baseline. It appeared that the passage of time and increased peer educator and volunteer contact may have influenced the positive results. Furthermore, in the last three months of the intervention, the project team stressed the importance of family counselling and urged peer educators and volunteers to contact the parents of the young participants more actively. Some parents who had been unwilling to accept their children were moved and tried to accept their children again, which increased optimism once more.



**Table 3. Mental health after intervention - Mid-term evaluation v. Final evaluation**

		Yes	No	P
Being lonely, sad, depressed and desperate when considering the future	Baseline survey	6	19	0.112
	Mid-term evaluation	1	19	
Having lost interest in formerly interesting things	Baseline survey	16	9	0.006*
	Mid-term evaluation	4	16	
Having bad memory, and finding it hard to concentrate and make decisions	Baseline survey	3	22	0.019*
	Mid-term evaluation	9	11	
Feeling ashamed and sensitive	Baseline survey	17	8	0.001*
	Mid-term evaluation	3	17	
Thinking that others do not understand and appreciate me	Baseline survey	12	13	0.066
	Mid-term evaluation	4	16	
Finding it easy to lose temper and become angry, and finding it hard to control temper	Baseline survey	17	8	0.755
	Mid-term evaluation	12	8	
Once considered ending my life	Baseline survey	3	22	0.242
	Mid-term evaluation	0	20	
Tried to end my life in the past 3 months	Baseline survey	0	25	–
	Mid-term evaluation	0	20	

\*P<0.05 means statistical significance

## The results of the qualitative study

In order to examine the effects of the project in more thorough ways, the project team conducted interviews on some qualitative aspects during the final evaluation of the project.

Among the 20 interviewed target youth, 5 said that the project “is helpful” and 15 said that the project “is very helpful” to them. As for the most helpful activities of the project, 11 of them chose “monthly heart-to-heart talk”; 6 chose “help to communicate with family members”; the remaining 3 chose “support after leaving the compulsory detoxification treatment centre”. All of the interviewees hoped that the project could last longer and they hoped that they could continue to get help from the project after leaving the compulsory detoxification treatment centre. All (20) of them said that the most urgent help they wanted was to “solve present surviving problems”, which was followed by “communicate with project workers via telephone, talk, etc.” (14 interviewees), “help to communicate with family members” (12 interviewees), “establish special centres by the project so that we can go to the centre to get further help” (10 interviewees), “provide professional and skill trainings” (10 interviewees), “provide job information and opportunities” (7 interviewees) and “provide help to contact organizations committed to helping drug users” (6 interviewees).

### 3.1.3. Project experiences, sustainability and challenges

#### Experiences and sustainability of the project

- Young people use drugs because of multiple reasons. Communities, families and peers play important roles in the process. In the process of implementing the project, it could be seen that young drug users-oriented intervention should not be limited to young peoples themselves. The communities that young people are living in, their families and their peers should be included so as to achieve good effects. Meanwhile, young drug



users' recovery is a long-term process. The intervention in compulsory detoxification treatment centres is far from being enough. Only with follow-up care and support after their leaving compulsory detoxification treatment centres can they be helped effectively. Therefore, the intervention for young drug users is a thorough and systematic process.

- b) Establishing a 'seamless connection' between detoxification treatment centres, communities, families, relevant agencies and the project is the prerequisite of implementing systematic intervention. Because drug use is an illegal practice in China and drug users and their families are discriminated against, young drug users and their families are hard to find and approach. Whether in compulsory detoxification treatment centres or communities, effective interventions for young drug users need family and family members' participation. Mobilizing communities to help young drug users to solve some living problems is not only helpful for recovery but also in establishing trusting relationships between communities and young peoples, which can lay foundations for interventions in the future. In short, using the platform of compulsory detoxification treatment centres to establish trustworthy relationships with young drug users and their families is helpful to conduct proper intervention among them and their family members while in the centres. It is also helpful for project workers to contact or conduct interventions with target youth and their families after their leaving compulsory detoxification treatment centres. Only with such connecting mechanisms can an effective intervention system be established.
- c) Follow-up care plans for young drug users who are leaving compulsory detoxification treatment centres should be based on adequate communication with young people themselves and their families. Family conditions and plans should be taken into consideration in the process of making plans for young people.
- d) Integrating existing resources to meet the needs of target youth is one part of the experiences of the project. It also relates to one objective of the sustainable development of the project. Moreover, after the end of the project, referring young drug users to other agencies and projects worked to consolidate the results of the project to some extent.
- e) Without special policies and systems for the intervention of young drug users, it is hard for project work to achieve real intervention effects. Therefore, effective policy promotion is the important guarantee of the sustainable implementation of intervention. Meanwhile, along with policy promotion, the adoption of the working procedure of the project in relevant functional organizations and the institutionalization of the working procedures can really make the work of intervention effective.

### **Challenges**

- a) Because parents are afraid that other people may know that their children are using drugs and discriminate against them, which in turn may have negative impact on their children's future, young drug users are comparatively more covert than adult drug users and thus harder to find in their communities.
- b) The young drug users in the compulsory detoxification treatment centre live in a wide area. This brings certain difficulties for peer educators to organize activities with young drug users in the centre; it is also hard to organize group activities and group counselling.
- c) Due to the lack of freedom in the compulsory detoxification treatment centre, when they receive intervention, young drug users are usually more concerned about how to deal with the period of time in the centre. Because of their young age, they may not appreciate all the harms of drug use. They tend to simplify the problems of how to deal with drug use in real living environments. So in the special surroundings of the compulsory detoxification treatment centre, how to help young drug users begin to consider whether they should

change and how to change themselves through counselling and sharing experiences with peers, remains a problem to be explored.

- d) The project could not provide practical financial help for young people and their families. Therefore, it was very hard for the project to attract young people who had left the compulsory detoxification treatment centre to continue to participate in project activities or accept peer educators' and volunteers' help. In addition, because those young people lived in dispersed areas of different communities of Kunming City and some young drug users' household registration was not in Kunming, it was quite difficult to make follow-up visits to those who had left the compulsory detoxification treatment centre.
- e) The project had little control over young drug users after their leaving the compulsory detoxification treatment centre. How to make the project more effective for them was one of the challenges faced by the project team at the time of writing.
- f) Though the project team was always trying to include young drug users' parents, they were not willing to pay much attention to children who were using drugs because they were busy with family and financial problems.
- g) The lack of centres for young drug users was a problem. During the period after leaving the compulsory detoxification treatment centre, young people were eager to adapt to the real world. They needed to communicate with people of their own age, they needed entertainment and they needed to understand society. They needed centres to provide specialized services for them. At the time of writing, there were only centres for adults in Yunnan Province. The peer educators were also adults.
- h) Broad family and economic issues had an impact on visiting, participation and early release, and accommodation and support post-release.

## Some locations of project activities

### a) Chang Po Compulsory Detoxification and Treatment Centre

The Chang Po centre is probably the largest CTC in China, with about 3,500 - 5,000 residents at any one time. About 40 per cent of residents are from Kunming. Drug availability and low prices bring drug users to Kunming. The main age range is 25-35 (about 65 per cent), and only 20 of 7,000 admissions in 2006 were under 16. Those aged 17 are regarded as 'almost adults', and, hence, 'almost responsible for their actions'. Relapse is still high, but apparently it has been falling. Under 16 year-olds are housed in a separate dormitory section. About 20 per cent of residents are HIV positive, down from 30 per cent in 2000.

Chinese law requires residents to stay three to six months and no more than one year. A medicated 'detoxification' period of about six days occurs in the hospital area, and local medication, called "6.26" is still used. The length of stay is usually 6 months for those who can meet the cost of their stay, and about 12 months for those who have to work off the cost via their labour. The cost of the 'package' for voluntary residents is about 1,400 Yuan (approximately US\$ 175), and their stay is much shorter – about one month.

Most activity centres around work in large, factory-style spaces, with some attention to education, propaganda, developing correct attitudes and recreation. However, there is more emphasis now on education and job placement, with about 40 hours plus of education being provided, and certificates from the local Department of Labour awarded for completion of training courses. Under 16 year-olds are supposed to get extra education. Vocational activities include hairdressing, beautician skills, agriculture, noodle making and computing.



**Female residents at work –  
Chang Po CTC**

There were a number of changes evident from when the ESCAP project began to the last visits there (late 2007). The old hospital and compulsory dormitories were well renovated and were for voluntary residents extending their stay (the 'Harmonious Home'). An increasing number were 'choosing' to stay on for some considerable time. A couple had married there and lived in quite pleasant quarters, with a sitting room, a study with a computer and Internet access, a double bed and other facilities. In other areas of the Harmonious Home were a large computer room, a library and other spaces for various activities.

### **Some young people from the Chang Po centre involved in the project**

A meeting was held with a group of five young women, one aged 16 and four aged 17, who had been at the Chang Po centre for about three months. Only one was from Kunming (who asked to be involved in the ESCAP project, as her mother was in prison for killing her father), and others from various towns and cities in Yunnan, but also further afield. All reported being heroin inhalers, never IDUs. Two were introduced to heroin use by boyfriends, two at parties and one from their grandfather's use of heroin and sadness and anger at break-up of her parent's marriage. Three had evidence of self-harm (cutting to forearms and cigarette burns) – reasons for harm were sadness, anger and celebration. Some wanted to return to school, some to work and one did not know. Only one had a more definite plan and possibility of work.

During a later field visit there was a meeting with 12 young people, 10 females and 2 males, aged 16 to 24 (the males aged 21 and 24; of the females, two were aged 16, two were aged 18, three were aged 19, two were aged 22 and one was aged 23). Of the 12, 10 were from the Kunming area, 3 were students, 2 were working and the remainder were unemployed. Drug use consisted of four using ATS, one using ATS and heroin and the remainder using heroin, of which two were IDUs. Five had previously been in the Chang Po centre (one 4 times), six had been in for less than a year. They reported that the cost of ATS was increasing – from 20 to 50 Yuan, as was heroin from 300-400 to 600 Yuan. Of the 12, 6 came from single-parent households, 5 were with their natural parents, 3 had lived in blended families. Four had siblings.

Most did not see differences between ATS and heroin users, but all saw themselves as different from other young people. They felt they suffered a lot of stigma as non-drug users did not want contact with them, and that physically and emotionally they differed – poorer health and immune systems, and being 'emotionally weak'.

In relation to relapse, one young man, who had been in a labour camp (where he lost his right arm in a machine accident) and to the Chang Po centre three times, said he felt hopeless and went back to heroin to assist him to cope. He felt different now because of the YIDA project.

A young woman said she felt lonely and different. She felt her parents loved her, but she could not cope. Another said she was bored and her family was too strict. She said she was rebellious and returned to heroin use.

A number of the young people felt that they would all return to drug use and the Chang Po centre or a labour camp. There was a general feeling of hopelessness and pessimism. Despite some more vocal group members telling the others to “be realistic”, a few said they felt somewhat confident.

Most said there was some aggressive behaviour in the centre, and two had engaged in self-harm, one burning themselves and the other cutting themselves). A few identified the Harmonious Home as the only positive aspect of the Chang Po centre.

However, all valued YIDA involvement and hoped that it would assist them and change what they saw as their ‘fate’. They liked the contact and the time to talk openly, discuss their feelings, and get ‘psychological strength’; the only opportunities for this in the Chang Po centre. They also liked the open and non-judgemental way YIDA and PSI staff acted, and the contact YIDA had with their families.

### Meeting at YIDA with two young men attending for their first visit after leaving the Chang Po centre

The young men, Mr. Yang, aged 20, and Mr. Lee, aged 21, had left the Chang Po centre only two days earlier.

**Mr. Yang** had three admissions to the Chang Po centre. His parents divorced when he was 13 and his father married again and had a new family, while his mother left the area. He was placed in a boarding school (Jingdiang Middle School) and began heroin use at 15, developed a daily habit and was later placed in the Chang Po centre. After his first discharge he relapsed, he lasted about four months and was then returned to the Chang Po centre. After his second discharge there was only a period of a few weeks before returning to the Chang Po centre. At one stage he had swallowed a piece of wire or a nail to avoid placement in a labour camp while at court; he was subsequently placed back at the Chang Po centre. He felt hopeless, but then was connected to the YIDA project by the police officer who was the Chang Po centre contact with YIDA. At first he was sceptical, but he soon began to trust the YIDA and PSI staff, connect and gain huge strength. He was passionate about his changes, and seemed to have quite a strong personality. He said the YIDA staff were very ‘tolerant’ and he liked the way they communicated.

**Mr. Lee** came from Hunan Province, and began heroin use soon after arrival in Kunming after spending time with peers who were users. He only had a two month history of heroin use, and was not a daily user, yet he spent the same time (one year) in the Chang Po centre as a daily, chronic user. He said he did not have family problems, but social ones (drug using peers), that led him to heroin use. His family had then left Kunming and he then only had Mr. Yang.

Both young men were living in a motel (costing about 20 Yuan per night); they said that they had enough to eat and enough clothes, and that money ‘was easy to get’. What the latter comment meant was unclear. They said they were ‘lent’ money from friends, many of whom were drug users with whom they spent some time and had meals. There were obvious risks with this, but they said they were not craving too much and felt very committed to not using drugs again. They denied that any form of peer influence could push them back to use, including while being drunk and due to a potential sexual partner offering ATS to improve sex. They both wanted employment and saw YIDA as helping with this. They also both indicated that they wanted counselling from YIDA so they could cope well with any difficulties that might emerge. Both said that they had no idea of a future; they just took one day at a time. When pushed, they indicated that they would prefer mechanical repair or office work to labouring or





*factory work, but that any work would be acceptable at the current stage.*

*They did not want to attend the PSI drop-in-centre as they felt that it did not provide enough help and were not comfortable with the population of drug users attending. This was despite not having been there, apparently, and that they were spending time with current drug users. They said that they welcomed the opportunity for face-to-face contact with YIDA staff and were interested in the '70 Community' (see below) and the possibility of work. Their YIDA counsellor had set up contact with the 70 Community to explore the possibilities later in the afternoon, and do some 'reality' testing with them about their current living situation and peers. However, after visiting, Mr. Yang and Mr. Lee decided that they did not want to work at the 70 Community.*

*Obviously, both remained very much at risk (with no work, living in a motel, spending time with current drug users and other factors), but both were adamant that they wanted to be drug free. It could have been helpful if Mr. Lee could have been re-united with his family, then in Shanghai. PSI staff that had met him spoke very favourably of him, and felt that he had a genuine desire to live drug-free. If Mr. Yang developed and continued on his positive trajectory, he could be most suitable as a peer educator. At the stage he was at then he was too vulnerable for such responsibility.*

*The enthusiasm demonstrated and the contact made so soon after release from the Chang Po centre was very pleasing and their 'connection' and positive regard for YIDA staff (similar to those seen at the Chang Po centre) was a great credit to persistence of approach of the YIDA staff. They were somewhat negative about the Chang Po centre, except for the police officer connected to the project and YIDA and PSI staff.*

## **b) Population Services International Drop-in-Centre**

The PSI Drop-in-Centre has about 50 participants visiting a day, called 'members', with a total of about 1,000 'members', aged on average 30-45 years. Members engage in activities such as embroidery, talking, weights training, watching TV and videos, table tennis and just resting. The centre has a lively atmosphere with lots of loud story telling and cigarette smoking. Brief 'education activities' are usually offered, for example telling family about their having an HIV test, identifying possible rejection and the need to go for testing with a supportive friend.

There is a 'voluntary counselling and testing' room where rapid HIV tests are available and other associated procedures provided. About 20 per cent of participants are HIV positive, and 70 per cent are on methadone maintenance treatment.

**Meeting with staff:** The ex-drug using staff commented positively on changes at the *Chang Po centre* and said that they felt more trusted by staff there then. They believed that if they had better communication skills (such as knowing how to talk about their problems and having someone interested) when younger they might not have had so many problems in their lives. They said that ATS use was on the rise, and police had discretion to fine minor offender drug users they caught (about 2,000-3,000 Yuan) or place them for 15 days in a detoxification setting.

They noted that of the under 24-year-olds in the Chang Po centre, there were more women than in the older age groups, and that the young women were easier to engage. They had identified about 30 under 24-year-olds in the previous six months in the Chang Po centre. PSI peer educators also serviced other CTCs and communities with their HIV prevention activities.

They discussed the 'dream' of the Harmonious Home being the preferred placement for those first time admissions under age 18 (even under age 24), after their six days 'detoxification' if they appeared cooperative. Also, the Harmonious Home area could house those with disabilities and others with special needs. It was proposed that PSI peer educators could

have developed and supported Chang Po centre Harmonious Home peer educators to mentor and guide these young people during their stay. At the Harmonious Home they could have engaged in more education and vocational skill acquisition, linked strongly with PSI and their families could have been supported by the PSI outreach activities of their peer educators. This idea was considered worth exploring further, although it was recognized that there would be a great deal of preparatory discussion necessary with authorities as well as other efforts.

They felt that parents were becoming less interested in their children who were using drugs. They felt that the parents believed that drug users were hopeless and economic pressure lead to long work hours and extra jobs. Also, the young residents of the Chang Po centre continually asked their parents for money, and to pay the 2,400 Yuan to gain release after six months. Thus, parents often stopped visiting and asked the police to extend the stay of their children.

Of the peer educators trained some time ago at YIDA, many had left being peer educators, one married, one relapsed, some then had other work and one was caring for a sick parent.

The possibility of a 'half-way' house for those under 24 who had no family or needed extra support that could accommodate about four residents with two peer educator houseparents was discussed. There was mixed reaction to this.

**Conversation with Ms ZL** (the 'star' of the YIDA video – '*Seeking the Way Back*'). *She was then 21 and came in looking well, smiling and with a friend's dog. She had significant scarring on her left forearms and some old burn marks. She had been in the Chang Po centre twice for 6 months each time, with only 15 days between admissions. She reported that when she was in her mid-teens she felt very sad and depressed and that no one wanted her. At age 16 her mother took her to a psychiatrist who admitted her to a hospital and she was treated for about a month with anti-depressants. After she left she said she felt good for a while. Then she met a boy, he become her boy friend. He was a heroin user and she felt she could help him. Instead she became dependent on heroin. She was also using heroin with her younger sister.*

*Ms ZL said she hated her time in the Chang Po centre and the lack of freedom. She said she did not get education (other than propaganda videos) or vocational training. She welcomed the intervention by YIDA/PSI – her first contact was Dr. Cumin from YIDA – as she found them nice and caring, and had done well. She said she wished she had known about the YIDA/PSI project before she ended up in the Chang Po centre, but asked how she would have found out about it. She said if a friend told her about it she would have gone, but how would a friend know. This was an issue that needed to be explored, thus letting drug users in the community know what was available. But this, again, raised the issue of the safety for outreach workers (often harassed by some police and not initially trusted by families or users).*

*While she felt her heroin use, sadness and depression were 'in the past', she was now dependent on the Internet and her mother. She did not go out all that much and feared that if she did she would not return home and would fall back into her old ways. She would have liked a job sometime, but was not sure what type of job she would have preferred. She was accepting of the idea put to her by YIDA staff of assisting with the planning and delivery of future peer education training. It was suggested that PSI and YIDA might use email and sms to keep contact with her and to remind her to exercise and to 'get some fresh air' from time to time.*

*At the last report Ms ZL remained drug-free and stable and had married.*



### c) 70 Community

This group is a dynamic collection of over 20 mostly ex-drug users from the Chang Po centre and other CTCs, Labour Camps, Sunshine Homeland and Daytop Therapeutic Community (70 per cent). Referral is usually by peer contact and friendship networks. Due to the employment situation in China, even many graduates cannot get work, so some are working with the 70 Community as, for example, accounts officers.



*Founders of 70 Community*

About 30 per cent of members have come from rural areas, the youngest member is aged 20, 30 per cent are HIV positive and most of the ex-drug users are infected with hepatitis C. Antiretroviral treatments are accessed for free at the No. 3 Hospital. Accommodation is sought from cheaper areas at about 100 Yuan per month. New members are mentored by older ones and taught the work. If a member of their community returns to drug use, the community tries to assist them back to 'clean living' without resorting to police or CTC involvement unless absolutely necessary.

The Community sells, on franchise, telecommunications equipment such as phone handsets and local mobile phones. The best sellers can make about 2,000 Yuan a month. A day starts with a 'morning meeting', and then the community heads out to make sales. When project staff met them, although they appeared a most serious, dedicated, patriotic and hard working group, there was a sense of 'fun' and 'cheekiness', and the group was planning an 'outing' to a pleasant lake area in the near future. A retired policeman assists members in accessing municipal and other government services and departments.

The group see themselves as a bit similar to an Narcotics Anonymous group, with the main difference being that what joins them together is their philosophy (hope in a future and living in reality), and that they all work for the same 'company'.

It was felt that linking some of the target young people in the Chang Po centre to the 70 Community, and providing subsidies or paid 'traineeships' could assist to expand employment opportunities for some of those who have been in compulsory treatment.

### d) Save the Children UK, Kunming Office - Youth Justice Project

The project, in its second phase (11/2006 – 10/2009), aims to divert young people 14 to 18 from custody and courts. The second phase continues with the diversion project, but includes a new focus on early intervention for 'at risk', 'vulnerable' and 'migrant' youth (80 per cent of crimes apparently committed by 'migrant' youth – such as those coming from rural areas

to Kunming). Funding is from the Dutch Embassy. The project will also expand, in various forms from Panlong District to other areas of Kunming (such as Anhu) and to Beijing and Shanghai.

The project partners with government at central and local levels, has involvement by many departments (public security, police, education, etc) and mass organizations (including Care for Next Generation, Youth League, Women's Federation). There is also some private/business involvement – most often 'in kind' – and by colleges and universities where students can volunteer, undertake research that could be helpful for their courses and to the project, and gain practical experience.

Upon the arrest of a young person for a crime, an 'Appropriate Adult' should be called who attends the police station, witnesses the interview, and then begins compiling a background report on the young person and providing support and practical assistance. There are 10 Appropriate Adults mostly retired or mature adults, but two are aged 24 and 25, one is on duty each day at the office, and the others support youth in the community, writing reports and other duties, and are available to attend the office or a police station should the need arise. They receive a subsidy. There is no law as yet requiring an Appropriate Adult to be present during police interviews, but there are recommendations for this to occur, in part, based on the success of the pilot project.

Panlong District in Kunming has a population of about 600,000. There are 19 police stations in Panlong, each with a trained police youth officer (Save the Children is involved in their training). These police have the authority to 'divert' the young person for lower level crimes, and pass more serious crimes to their superiors. Links vary in quality with the police, but have endured and improved over the life of the project. Diversion can simply be bail, or 'discipline and release' (implying a warning/caution). There is no capacity to 'divert' drug users, as drug use is not seen as a crime, but an unacceptable behaviour against administrative order that is responded to by automatic placemen in a CTC.

There have been about 800 'diversions' since the project began, most for low-level crime. Of those followed-up who had been involved in more serious crime, 57 (95 per cent) had not re-offended – a significant success story.

It would be inappropriate to include drug using youth in the project, as it is a pilot and they would not want to change any criteria at this stage, or put the project at risk by including drug users. However, a parallel model could be developed – see diagram in Chapter 3.

The development of a proposal for a project based on the Save the Children project, but for drug users under 18 years of age could be considered. The pilot scheme could allow police in a selected district to exercise discretion, after consultation with an appropriate panel, to divert young drug users to community treatment as opposed to placement in a CTC. The fact that police and Public Security are concerned and requesting advice from YIDA about the management of young ATS users may provide a window of opportunity for a pilot scheme. If this is seen as successful, it could be expanded to divert heroin users who currently must be sent to a CTC. In addition, the establishment of a Youth Drug Court, possibly based on the Nonthaburi Juvenile and Family Court in Thailand, could be considered.

In relation to the above, The Final Evaluation Report on Youth Justice Pilot Project of Panlong District, Kunming, Yunnan Province, China May 2002 — August 2006 by Prof. Xu Jian, Prof. Fan Bin and Dr. Yao Jianlong dated 2 December 2006 is informative as it details the successes and difficulties in establishing a pilot scheme for the diversion of minor offenders from custodial court penalties. The report outlines a significant increase in diversion of minor offenders in the Panlong District of Kunming, and the difficult work in gaining support from the judiciary, police and government officials as well as the establishment of a Children's Activity Centre in the community. The project used Article 40 of the UN Convention on the Rights of the Child and the Beijing Rules as central starting points and China's recent efforts to reform



laws pertaining to the processing and management of young offenders.

All of this raises the need to find a 'physical base' (a 'youth centre') for the activity to be centralized.

In Summary, despite the difficulties with legislation and the processes laid down for what happens to those designated as 'drug addicted' – loosely enough defined to include almost all types of drug users from experimental and intermittent to chronic, dependent users – YIDA has made commendable and persistent efforts to work with and support young drug users in a CTC and in the community. Young people interviewed in the Chang Po centre and after release spoke highly of YIDA staff and what they were providing.

.....

## **3. 2 Lao PDR**

### **Main activities and achievements 2002 to 2008**

- Undertaking extensive training – mainly peer educators, who were university students, and members from target communities (young and older, employed and retired), as basic counsellors
- Providing refresher training
- Providing supervision
- Identifying supportive legislation and policy
- Holding advocacy meetings, inclusive of relevant government ministries and NGOs
- Developing networks and links
- Establishing the 'Network', comprising members of the seven target communities (villages) of Vientiane, the CTC, local narcotics control and prevention, and VYC
- Maintaining relationships with police, the CTC, a mass organization (the Women's Union) and community leaders
- Undertaking planning – relapse prevention planning for those in the CTC and the target communities
- Developing reliability in attendance at the CTC
- Establishing visibility in the target communities
- Visiting and supporting families of drug users
- Establishing young peer educators and young and older 'counsellors' in target communities
- Holding drama and sports events in the target communities and the CTC
- Holding camps for drug users and those at risk, and including residents of the CTC
- Undertaking data collection and analysis, but it remained limited
- Improving written documentation, and made very successful with video and photographic documentation
- Some critical reflections on practice occurred
- Providing assistance with getting training jobs for those leaving the CTC, including financial assistance
- Producing two videos

### **Main challenges**

- The 'youthful' nature of some peer educators, and the associated risk to them from exposure to drug using peers
- Inconsistent attendance at the CTC
- Relapse planning not formalized and routine
- Inconsistent development of relapse prevention plans
- Possibility of greater emphasis on group/mass activities in the CTC, and less on



- relapse prevention planning and counselling
- Research capacity and data collection in early stage of development
- Difficulty in engaging families, often due to distance, the need for parents to work long hours, stigma and lack of time

## Major contributions

- Establishing the Network, and processes for identification of target young people, their engagement, support and follow-up
- In-community activities
- Engagement with and support of families in communities
- Skilling up of basic counsellors from target communities to support young people and families
- Recruitment of peer educators, which was inclusive of former drug using young people, and youth counsellors from varied backgrounds, circumstances and ages
- Having a 'youth friendly' base (VYC) which provided many activities and services – such as a clinic, music, drama, vocational training, personal growth and opportunities for young people to contribute to their community and broader society

## Some highlights of 2007 to 2008 activities

**a) The consolidation of an effective Network**, comprising the VYC-trained counsellors, community leaders, police and others, and a representative from the CTC (Somsanga) was achieved and appeared to be working very well. The Network met monthly, shared intelligence, identified who was in Somsanga, who was about to return from Somsanga, who was 'at risk' and how best to meet their needs and difficulties, and planning activities, including inter-village and Somsanga competitions.

### *A Network Meeting - Sibounheung Village*

*The meeting was attended by at least one member from each target village, and by a staff member from Somsanga, and the Lao Committee for Drug Control and Prevention of Vientiane Capital. Representatives came from many backgrounds – such as young workers, a deputy head of a village, the Women's Union and VYC-trained counsellors.*

*A report was presented on overall activities by VYC. Highlights included the three-day camp held the week before with residents of Somsanga from target villages and residents of Don Tao island, and a visit to Don Tao for all, as well as a moving ceremony with parents and their children where the children acknowledged their wrongdoing and the pain they caused to the parents and sought forgiveness.*

*Participants stated that the main drug of concern remained ya baa, but it had become a little more expensive (day price Kip 30,000 = \$US 3 per pill, Night price Kip 50,000 = \$US 5 per pill).*

*Finding time for follow-up was an issue, as often young people were not on time, or did not show up – requiring many attempts to get one 'visit'. Likewise, they often broke their 'promises', which was not unusual for this population.*

*Engaging with the families was also seen as a difficulty, as many were 'in denial', ashamed and lacked trust. However, most found that talking to the parents before engaging with their drug using son/daughter was the best approach.*

*Then there were verbal reports from each village representative and Somsanga. New and ongoing cases were discussed, frustrations aired, problems solved and plans made for the subsequent time period. The meeting was lively, yet focussed and productive. All were informed of who was 'in treatment', who needed 'follow up' and who was 'at risk of relapse'.*



The Network was seen to be a 'model' for other projects on: cooperation, information exchange, directly linking 'community' to the residential 'treatment' centre, sustaining motivation and enthusiasm, and problem solving.

**Target Villages:** Phiavath, Naxai, Nongthatai, Thatluangklang, Thatluangtai, Thongpong and Sibounheung. Possible new target villages with increasing youth drug use difficulties include: Thatluangneu and Nongthaneu.



*Meeting in Piawat village: Head of village, Women's Union representative, narcotics control staff, youth peer educator, local youth volunteers and VYC project co-ordinator*

- b) Basic counselling skill training was provided and a core youth counselling team were trained. The focus of the training was on individual and family counselling for young people with drug use-related difficulties. Continued theory and skills development workshops and refreshers took place, as well as consultation with team members, as necessary, and ongoing supervision. Community members, village authorities, parents and decisions makers in the seven target villages were trained in basic counselling and support, using the tool kit on community-based treatment for young drug users as a resource, and were able to play an effective role in advocacy, treatment and rehabilitation of young drug users.
- c) Community activities were undertaken. The peer educators and youth counsellors were involved in activities within target communities to assist capacity building, and to attempt to divert young drug users from placement in Somsanga by providing community treatment. These activities involved a mix of life skills development and basic counselling for at risk youth, and basic counselling and relapse prevention planning for current users. Difficult cases were referred to the core counselling team at VYC and/or health services. Family involvement and development was also a focus, and special entertainment events, such as football games, attended by high level officials demonstrated support for the young people and their families.



**Young drug users paying respect to their parents at a ceremony during a camp**



**Visiting a family in a village**

Visits to Somsanga by VYC staff to provide activities for target youth from the seven target communities occurred on a semi-regular basis. This was to become a regular activity (monthly) and to include a counsellor or another suitable person from each of the target communities.



**Data collection at Somsanga**



**Peer educator-led activities at Somsanga**

- d) Post-Somsanga, ex-residents were continually supported through peer education networks and job placement services in the seven pilot villages in order to prevent relapse. The job placement assistance services were provided for reformed drug users (including for training costs, schools and uniforms). Opportunities could be explored to assist individuals or small groups of ex-drug users to access micro-credit so that they could start small businesses, such as candle making, food stall vending, minor mechanical repairs and small market gardening.
- e) In the review processes community members, health professionals, religious leaders, village authorities, parents and young people were brought together to discuss their experiences and best practices to identify strategies that were most effective in preventing relapse and supporting youth and their families. Community evaluation meetings were conducted and annual evaluation/lessons learned workshops took place in order to share experiences and develop best practice strategies for helping reformed drug users.
- f) Research capacity was developed. As peer educators were not skilled in data collection there was a need to educate them to a basic level, especially on how to ask appropriate questions and to document answers. Therefore a research capacity workshop was





held. The workshop trained 14 VYC peer educators (10 female, 4 male, aged 16-22) in data collection and documentation - how to administer the questionnaires and ask and document follow-up questions. Data was collected from individual drug users, family members and community members, including police.

Data collection 'tools' were developed by VYC and the facilitator

For Individuals:

- Basic demographics – gender, age, education, literacy, employment, ethnicity
- Knowledge of drugs – awareness, causes for use, impact of use on individual, family, society and country
- Protective factors
- Relapsing – causes

For Community Leaders:

- Knowledge of drugs
- Knowledge of the project
- How the community was assisting young drug users
- How parents were assisting
- Perceived usefulness of the project
- View as to whether the project should continue, and reasons for view

The use of focus groups was highlighted as another form of data collection, especially its application with families and community members.

Family focus groups with families of young people in Somsanga included the following themes:

- Their understanding of why their children used drugs
- Their hopes and fears
- How they felt about themselves as a family
- What reactions they got from the community
- What they thought was essential in preventing/reducing relapse
- What they needed to keep being hopeful

Community focus groups included the following themes:

- Their understanding of why young people in their village used drugs
- Their hopes and fears for their community
- How they felt about themselves as a community
- How the community treated drug using young people
- What they thought was essential in preventing/reducing relapse
- What they needed to keep being hopeful

For young people who had been involved in drugs, it was suggested that the following themes could form the focus of a qualitative approach to explore the stories of their 'relationships with drugs' and their experience of treatment:

- Their initial view of their future before drug use
- How they 'met' drugs
- Which one(s) were first
- How their relationship with drugs developed
- Good things and less good things about being with drugs
- Getting caught
- What happened
- How their view of the future changed
- What happened during treatment (good things and less good things)
- While in 'treatment' what they thought their life would be like after treatment
- What they thought they would need to have in the future
- What they wanted from VYC

### **Focus group at Somsanga**



It was also suggested that a follow-up questionnaire one month after the return of Somsanga residents to the community could be used to continue their stories – for example what had been good and less good, how they coped if they lapsed and why they saw this as happening, what they learned from it and their ‘new’ plans. This could be repeated some three months later.

- g) A video case study – ‘My Love Story’ - documenting the development of a ‘relationship’ between a young man, Eddy, and *ya baa* (so drug dependence) was produced by young people from VYC to illustrate the development of drug dependence and the prevention of relapse.
- h) An advocacy meeting and workshop aimed at informing key stakeholders about policy changes and plans were held. Participants were drawn from VYC staff and volunteers, communities, Somsanga, police, drug control, education and health.
- i) The situation of young women was given some priority. The Government had renovated a separate section for women on the Somsanga site. There were possibilities for assistance with vocational training and job placements, especially for the young women. Suggestions were to:
  - Link with the Vocational Training School that had some dormitory accommodation
  - Provide support to young people who could return to their homes
  - Establish a group home for maybe 5-8 young people with houseparents, and links to vocational training and/or job placements
  - Use cooperative and helpful villages, such as Ban Nakuonnoi with the monk Sri Ton, to accept some young people and provide training and links to employment

## **Some glimpses of sites and young people from field visits**

### **Somsanga Centre**

Somsanga, a residential facility that accommodates mostly involuntary residents, has a youthful population. It accommodates about 700 people, most of whom have used ATS. There had been many changes to Somsanga from when the project began to the last visit: better documentation; a renovated section opened for women (separate from the male building and well done up); under 17-year-olds sleeping in a separate area; ex-resident staff members; openness of key staff; positive and easy relationship of the Director with residents; activities in the vocational area (handicrafts and computing); and a new toilet/shower block being built in the main section. Yet, conditions in the main section remained difficult, in relation to food availability, how to provide good quality treatment to meet the needs of the mentally ill residents, how to provide effective programmes for large numbers of residents and a relatively small staff (some 600 in one room being read to by a staff member), and limited availability of vocational activities. There were plans to renovate the male section in a similar manner to that for female residents, which would be a much welcomed development.





***Vocational training (IT) and a mass 'education' session at Somsanga***



Lengths of stay remained about 4-6 months for the first admission, around 12 months for the second, and up to two years for the third. After admission, there were 42 days in the hospital for those who could afford to pay for it, then three months in the main section, and then to the vocational section if they were cooperative. There were 805 residents during the visit, with 63 being female, and 18 of them IDUs. While admissions from Vientiane appeared to have reduced considerably, numbers had increased overall due to an influx from other provinces.

Burnett Institute (an international NGO) workers had been attending and providing HIV, STI and drug prevention activities, and final year law students from the National University were providing residents with legal information.

Approximately monthly visits from VYC staff accompanied by a counsellor or other 'network' person from each target village to meet with and support those from their respective villages was occurring, but greater regularity was needed.

Plans for the short term were to: process 'lessons learned' with staff about counselling; give certificates for those in computer courses; start English courses; increase handicraft work; hold a sports camp; involve Somsanga staff with VYC – such as in counselling training – especially advanced training and training of trainers.



***New admission in 'detoxification' section of Somsanga visited by Director and VYC project coordinator***

It appeared that the average age was falling (63 per cent of recent releases were 24 years or younger). Of 67 persons recently released from Somsanga, 22 were aged 20-24, 10 aged 18-19, 8 aged 17-6, 1 was aged 14 and 1 was aged 12. The number of under 18 year-olds in Somsanga was of concern, and reinforced the need for a separate facility for them and suitable alternatives to Somsanga placement within the community for those for whom remaining with their families could be counterproductive.

During one community field visit, there were at least three peer educators from VYC, including one who was involved in counselling in Somsanga – all had relapsed, and all said it was due to mixing with old negative peers. This showed the crucial need for careful and effective support for ex-drug using peer educators.

## **Some target villages**

### **a) Naxay Village**

A meeting was held with, among others, the village elder, the vice head and a police officer who was doing much counselling. There was a general discussion and stress of the importance of work and motivation, and of coming to the village office and signing a formal agreement when released from Somsanga to refrain from bad behaviour and drug use. The police officer was regularly visiting those released and providing a lot of counselling. Families seemed to respect him and were open with him, as his manner was respectful and caring. He also did this for those at risk and for the families of those in Somsanga. The village elder was most enthusiastic and involved; a compassionate yet firm man.

A visit was made to the mother of ex-Somsanga resident (a 20 year-old female), who had an excellent relationship with the community counsellor, stressed the importance of work and something to do, parents not being blamed all the time, and of workers slowly building trust and recognizing the shame and guilt of parents. The young woman was taught to make candles for religious ceremonies by an aunt of hers, and she was making these at home and selling them to a vendor at the market. The mother was cautiously optimistic.

A visit was made to a 19-year-old ex-Somsanga resident and his grandmother. The young man had relapsed and had been home for about four months after his second stay at Somsanga (for 12 months). He was quite a shy youth and blamed his inability to resist negative peers and boredom as triggers for his relapse. He was working, happy-enough and wanting to play sport, but required regular support and encouragement as he remained at high risk of relapse.

### **b) Nongthatai Village**

There were four counsellors in the village – two older females (one a nurse), one older male (a retired primary school teacher) and one young male student. The village leaders felt that they had made a huge change in their community as drug and crime problems had been reduced markedly since they became more active, cooperated with the police and began the counselling of young drug users and their families. They had been able to assist many young people find employment (mainly labouring). They had a counselling office in the village temple, and focused on any issue – including family conflict and drug use. They were working with 23 young people identified as ‘at risk’ by peers and family, and felt they were making gains – especially in relation to employment.

On release from Somsanga, young people from the village were invited in writing with their families to attend a meeting with the village head and other community members (such as counsellors, monks, members of the Women’s Union, older persons and police) where assistance was offered to help with difficulties and indicate that they would ‘follow-up’. The young person and their family were ‘prepared’ for the meeting by a counsellor or another community member, to ensure they did not feel too intimidated and fearful.



There was strong commitment to improving their community and assisting those with needs. The counsellors felt they needed more training in outreach, rather than centre/clinic based counselling techniques, and in assisting parents with 'parenting skills'. More activities were requested [such as sport (football, badminton), drama, and inter-village competitions].

A home visit was made to 'Nop', a 19-year-old whose Vietnamese father left to become a Buddhist monk some two years earlier and intended to remain so, and whose mother was living and working in the United States. He was effectively 'abandoned' by his parents, went to live with an aunt and uncle, began drug use, and was in Somsanga three times – first for detoxification only (6 weeks), then after relapsing for 6 months, and then after another relapse for only 2 of the required 12 months as he absconded. The village told Somsanga that they wished to keep him and treat him in the village, Somsanga and the authorities appeared to have agreed and he had become drug free (to date), and the first recipient of a vocational sponsorship under the ESCAP project. He was training to be a chef. He still experienced cravings, but felt strong and committed. He saw most of the IEC materials and campaigns as not helpful, and relied on his own 'strength'. He reported no drug use in Somsanga, other than some availability of tobacco. He appreciated the care and support provided by the counsellors, VYC and others involved in the project. He was an apparently successful case of diversion from further compulsory residential treatment.

### c) Thongpong Village

A meeting was held with the village head and four counsellors – two young women (one a high school student, one a primary school teacher), an older women and an older man. They reported that the situation in their village was improving as some major drug dealers were now in custody or had left the village. There were 30 'at risk' young people, some in high school. They stressed that there was a need to 'get in early' – as soon as possible after a young person returned from Somsanga. Most returned on Fridays, and this was proving to be difficult to meet them at the earliest possible. Most felt they had good relationships with the young people, and that the age mix of the counsellors was an advantage, but the sex mix required the men to co-counsel at times until trust in the female counsellors was established. Again there was a strong sense of pride in their work and achievements.

Two home visits took place

i) 'Nong' was aged 21 and was four times in Somsanga (4 months, 8 months, 12 months and 15 days), thus about two years in total since he was 16 years old. He said he had been drug-free for 15 months. Nong, despite liking some activities, hated Somsanga overall. His younger brother was regarded as being 'at risk'. Nong said he craved rarely and had inner strength from thinking about the love of his mother – and all the pain he had put her through. He could not do hard work after a motor cycle accident where he broke his leg (which was healed by traditional means), but wished to start a farm growing mushrooms. He had requested a subsidy for training and equipment. He welcomed the support from the counsellors, and was open and appeared committed to change. He remained 'at risk'.

ii) 'Ayang' was a 19-year-old brother of a relapsing youth who was stealing from the family. His mother was present. Ayang had used *ya baa* on a few occasions, but did not appear to be dependent. He had 'promised' his mother that he would not use any more at the recent camp ceremony, and was trying to turn his life around. He wanted to learn motor cycle repair, and could have benefited from a vocational subsidy. He said he was very happy with the counselling and support and 'care' he was receiving, as was his mother. This was another apparently successful diversion from compulsory residential treatment.

#### d) Thatluangklang Village

This village had 10 target youth in Somsangna, 4 follow-up cases and 21 young people regarded as being 'at risk'. It was a central city village and had had serious drug use difficulties – dealers and users. In recent times, drug use and dealing had fallen considerably. The existing dealers were mainly small level users/dealers. The two counsellors were finding it difficult to provide the necessary level of care to the target youth; there was a need for more counsellors and to train some peer educators. There was also a need to provide a 'refresher' counselling course, and include coverage of mental health presentations. The female counsellor was a young woman university student training to be a primary school teacher. She appeared to be a most sensible, energetic and effective counsellor.

Common issues were the time taken to find and engage the young people. As with other villages, it seemed easier to engage with parents first, but this could also be time consuming given levels of denial and shame. Football and drama were the main activities provided, and the recent camp was well regarded by participants. One young man even stated that it was the first time he had ever experienced such a thing (the camp) and when he paid respect to his mother at the final ceremony it changed his view of himself and his life.

Two young people in the village could have benefited from vocational subsidies – one to learn how to repair motor cycles, and one (who had a child and another on the way) to obtain a subsidy to buy some chickens and ducks to rear on a small parcel of land left to him by his mother.

Three home visits took place

i) 'Xiang' was a 21-year-old man living with his family and younger brother. Both his parents were present. Xiang had problems with *ya baa* and alcohol. He was admitted to Somsangna and had then been home for about one year. When drunk he would, at times, become extremely distressed and smash things at home and hurt himself seriously – he had a large cut to the right side of his neck, many scars on his right fist and hand, and deep cuts to his arms. It appeared as if he could have been significantly depressed when younger, but he denied any current or past depressed mood. He said he did not really be experiencing cravings, and kept away from past negative peers. Both parents were very supportive, and he seemed very attached to the family (then). He wanted to learn motor cycle repair skills, and his parents wanted him to then set up a repair shop within the family compound. His father was in the construction business and may be would have been able to pay for the vocational training, but VYC staff and the village counsellor believed a subsidy could be a powerful symbol of encouragement for his excellent progress. He very much valued the support from the counsellors, as did his family. He was poised to become a possible role model and peer educator if his progress continued to be so positive.

ii) 'Kop' was a 19 year old, with a wife and child, who was very much 'at risk'. His mother had died some time earlier, and his father worked hard, was rarely available to him, and was living with his *de facto* wife who was pregnant with their second child (the older female child lived with her aunt). His sister and wife were present. He began drug use and was placed in Somsangna when he was aged 16. He appeared to have some developmental disability and mental health problems, and was possibly still using *ya baa*. However, he had not returned to Somsangna, and the village authorities, counsellors and police were attempting to stabilize him. He wished to live with his wife and child on land left to him by his mother and raise ducks and chickens. He believed that he needed to be away from negative peer influence – a view shared by all. A subsidy was certainly warranted. His prognosis was not optimistic, and he seemed rather adrift despite all the support available.





iii) 'Xay was a 25 year old who had been in prison once when young, and later three times in Somsanga – the first time for 3 months, the second for 18 months and the third for 30 months. He believed that his parents had asked the authorities to keep him in Somsanga. This made him angry. He appeared to be a rather strong-willed young man, who maintained that he had changed for the better and wanted a drug-free existence. His parents had a small roadside restaurant and wished to keep him around home. He had been a soldier, but his continued drug use ended that. He wanted to work in roofing and had plans and believed that his parents might support him. Xay appeared to be concerned with negative peer influence, as did his parents, and being judged by the community after so much time (about four years) in Somsanga. He said he was not craving, but was in some conflict with his parents as he wished to spend time with friends, despite his concerns about negative influence. It was a bit surprising that he still had some friends as he had been out of the community for so long. However, some of the friends seemed to be trying to assist him and help him find work. He was in the position to become a good role model and peer educator, or, if things deteriorated, a very bad example.



***Home visit to ex-Somsanga resident and family by peer educators***

Overall there were some significant positive developments in Lao PDR. There was evidence of an effective and enthusiastic network, productive links between Somsanga and the target communities, resilient and thoughtful counsellors, preparedness to keep working with difficult young people and their families and for diversion from residential treatment to a community-based approach. This was due to the sustained efforts of key staff at VYC who had guided the project's development, despite many difficulties. There remained a need to consolidate, and slowly expand the number of villages involved to have a greater impact on young people at risk of drug use.



***Activity during camp with drug users in treatment***



## 3.3 Thailand

### Main activities and achievements 2002 to 2008

- Training
- Supervision of staff, which was formalized to some extent
- Identifying supportive policy and legislation for diversion
- Developing networks and links throughout Thailand
- Extensive and effective advocacy – especially with judiciary and correctional staff (such as probation)
- Drama and sports events in target communities
- Camps for drug using youth and those at risk
- Establishing a ‘half-way house’
- Increased attempts to engage with families, especially in the target slum community of Ban Somdej
- Developing data collection and analysis
- Some critical reflections on practice
- Improved written documentation
- Developing more effective relapse prevention planning
- Producing three videos
- Visibility in target communities
- Developing firm links with Nonthaburi Juvenile and Family Court and the Associate Judges and Community Network

### Main challenges

- ‘Roll out’ may be greater than could be supported, possibly leading to ‘training’ being more focussed on information and encouragement to think differently than on actual skill development and building capacity and systems to divert and support young drug users
- When raising awareness, the need for a clear ‘model’ and practical steps.
- The need to more clearly link in the well developed and practical Nonthaburi Juvenile and Family Court model with the Thai project
- Increasing consistency of presence and activity in target communities such as Ban Somdej, possibly related to lack of confidence, skills and supervision of staff
- Developing greater external supportive links for Ban Somdej to obtain certain needed things such as health, employment and training
- Despite supportive policy and legislation for diversion, too many young people being sent to CTCs and custody
- The models of treatment in CTCs based on models possibly inappropriate for young people
- In spite of the developed of a number of ‘Networks’, difficulty in gaining clarity on their role and goals

### Major contributions

- Moving from a ‘residential’ focus to recognition of the importance of community development and commencing activity in a slum community with problematic drug use among its young people
- The engagement with and support of the Nonthaburi Juvenile and Family Court and Associate Judge and Community Networks
- Developing mechanisms for identification of, engagement with, and up-skilling of community leaders



## Some highlights of 2007 to 2008 activities

### Tulakarn Chalermprakiat Hospital Rehabilitation Centre

Tulakarn provided extensive training and advocacy workshops throughout Thailand. These aimed at developing supportive networks of workers, families and communities. They also targeted the judiciary, Associate Judges and court, correctional, drug treatment and health-care staff. About 20,000 persons attended in total. Workshops were provided in Bangkok, Nakorn Pathom, Saraburi, Chiang Mai, Ubon Ratchathani, Rayong, Songkhla, Satun, Yala, Pattani and Narathiwat.

Tulakarn itself underwent change, with a reorientation of its treatment programme. An Integrated Community Centre was established as was a half-way house, and in-community activities were developed, mainly in Ban Somdej and Wat Pracharnat School communities. Extensive follow-up of young people exiting the Tulakarn therapeutic community programme occurred.

A Planning meeting was held with community members from Ban Somdej and Wat Prachanart, and four Associate Judges from the Central Juvenile and Family Court.

Two working groups, with two Associate Judges in each group, developed draft activity plans for discussion. Three residents of Tulakarn joined the Ban Somdej group as they were from neighbouring communities.

The Ban Somdej group developed a detailed plan with key tasks and persons responsible identified. They also stressed the need to talk with young people first to help shape activities, and planned to start with the core group of 12 young people already involved. Specific community leaders were identified for specific jobs – such as those with links with the Bangkok Metropolitan Administration (BMA), Associate Judges and the local Rajapat University. Education in school was preferred over informal education. Football was identified as the key sport, and music, in particular music from the Muslim culture, was seen as another activity worthy of development. Motorcycle and car repair were identified as key areas for employment training. A meeting was planned with potential key partners for progress on the agenda.



*Community leaders, Associate Judges and young drug users in treatment during small group planning activities*

### Main issues worked on

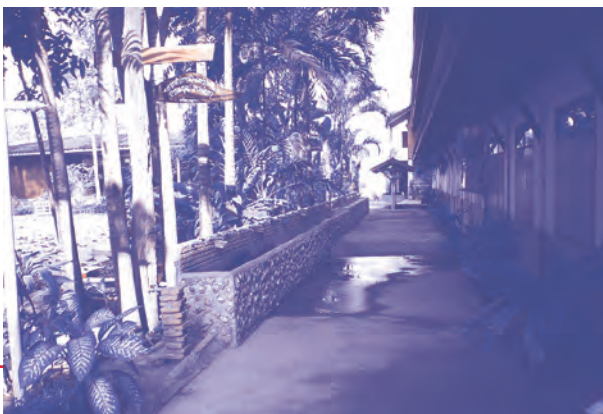
- Increasing activity levels in both communities for 'at risk' and current and ex-drug using youth to decrease boredom and increase skills and fun. Use of youth volunteers to share work. A draft plan was to be developed with core young people and then taken to young people in their community, and any in residential treatment, to seek their views, and then revise the plan after feedback. The Importance of involving young people in all planning was stressed.
- Encouraging more family-to-family support.

- Intensifying network development to gain more support from the project and its activities. Questions to be addressed were: who was needed and how to get their support? Who would do the contacting?
- Regarding education and employment, questions to be addressed were: how to increase opportunities? For example in Ban Somdej, who would contact BMA and seek actual support for activities including sponsorship of employment creation positions, for example, at the leather, mask, flute and jeans making small factories?
- Increasing pool/groups of both youth and adult volunteers. Questions to be addressed were: how to do it? Who would find out the relevant faculties at Rajapat University (for Ban Somdej) and Mahidol University (for Wat Prachanart)? Who would discuss possible course credits for student activities in the community?
  - Three potential groups of youth volunteers were identified: those who lived in the communities (including ex-drug users), students who volunteered for no gain and students who volunteered and got course credits. Youth volunteers could become peer educators/basic counsellors and receive leadership training, and participate in the proposed youth camps.
  - With regard to what adults might be helpful as volunteers or 'champions', questions asked included: who would seek out young adult sportspeople, actors, singers, musicians and so on and who might become role models and become involved in some limited activities in the target communities?

### Wat Prachanart School and community

Wat Prachanart School provides for a community that is reasonably transient. New workers come towards Bangkok and others depart. There community has experienced an increase in drug use and availability. The school principal has taken a great initiative in developing his school as a community resource. He has used readily available resources at no or low cost to beautify the school and its environment, to make it an oasis of peace for all, a skills exchange centre and a focus of community activity.

During a visit to Wat Prachanart School and community with members of Ban Somdej community, opportunities were explored for what to do between community visits, with the possibility for sports (such as football), music, poetry, art and other competitions. For example, grade five students from both communities could start poems on what they thought the other community would be like, then visit, and then finish poems after the visits. Older students could co-write songs. Also, Wat Prachanart could grow plants for Ban Somdej and arrange them in pots or on parts of trees as at Wat Prachanart School, and then when delivering the plants could assist with artistic arrangements similar to those at their school. Likewise, each could help the other with colourful murals on suitable walls (maybe with paint donated by some company or individual sourced by the Associate Judges). The murals could tell the stories of their communities from ancient to modern times. Both of these last two activities could assist with softening and beautifying the communities, Ban Somdej in particular.



**Wat Prachanart  
School environment**







***Wat Prachanart  
School environment***

Both communities and Tulakarn were encouraged to develop activity programmes if money raised (about \$US 50 per activity) could be used to purchase equipment, pay some small stipend to volunteers, and cover transport and snacks. Thus, there needed to be some accumulation of equipment in each community to sustain activities after the project funding ceased. For example, sport, music and art equipment, as well as second hand computers and appropriate software and programmes could be bought. Activity money could also be spent on hiring someone to work with a small group on vocational skill acquisition, for example motor-cycle repair and clothing and handicraft manufacture. Of course, all of this required funding.

### **Camp for young people from Ban Somdej and Wat Prachanart, and some ex-Tulakarn residents**

A three-day camp was held to build 'leadership'. There were about 60 participants, who all received 'medical checks' and engaged in games, competitions, education, a boat trip that included an art exercise, visits to an orphanage for HIV-affected children, an ancient temple and a motor museum, and an art activity that was extremely effectively conducted with young people explaining their drawings. There were discussions on environmental responsibility and community values. The camp was considered a success, and the young people were sad to leave.



***Youth Camp activities***

### Youth camp activities

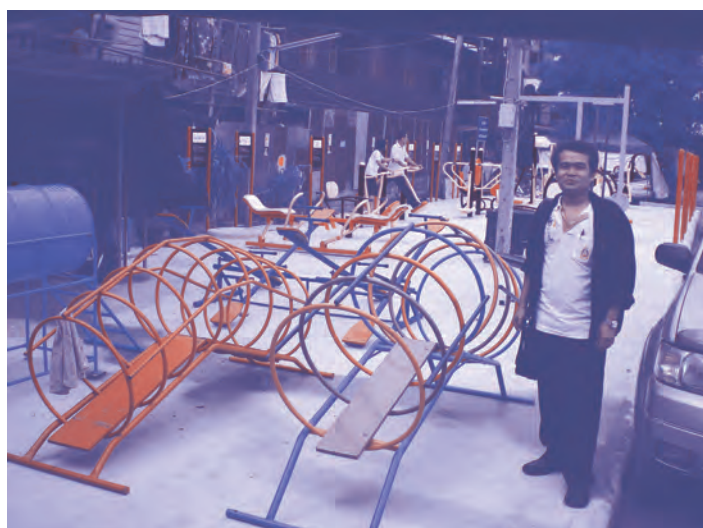


Activities were continuing in Ban Somdej, but needed to be more focused, consolidated and strengthened if it was to realistically become a 'model' for other slum communities in being able to provide effective community-based and led treatment for young drug users.

### **Ban Somdej community**

Ban Somdej is a slum community in Bangkok with high levels of drug use and dealing. It has a predominantly Muslim population. There are three generations of drug users – grandparents who used opium, parents who used heroin and now their children who use *ya baa*. Community leaders felt powerless to stop the drug dealing and use in their community. As the Tulakarn Chalermprakit Hospital had received a number of admissions to its youth drug treatment facility from Ban Somdej, a decision was made to attempt to link the hospital with the Ban Somdej community leaders and to develop a programme of activity that could train and develop peer and community educators and build capacity for community-based treatment of its young drug users.

The community, while very poor and fragmented, had many assets. There were strong and skilled community leaders, a sense of acceptance of responsibility and ex-drug users keenly working with others to rid their community of drugs and related problems, and external linkages were developing to support their activities, such as those with the local Rajapat University. There was a small leather factory owned and operated by an ex-drug user who employed other young ex-drug users and taught them leathercraft.



New playground and gym



Non-formal education





**Advocacy and planning meeting  
with key community members**

As with many such communities, there were gains and losses. There had been increasing confidence among the community that they could tackle the drug problem, and, in fact, a large number of drug dealers had ceased operations (some had been arrested, some had left and some had given up drug dealing). An open air playground and gym had been established, non-formal education and training was regularly provided as was some employment creation and support.

While the community leaders and Tulakarn staff had been active and made large gains, some difficulties remained. Community leader and Tulakarn staff enthusiasm became eroded periodically due to the nature and extent of the work required to turn this community around. Increased role clarity, supervision and support were needed, as was greater attention to increasing the range and frequency of community activities. Documentation, data collection and analysis also needed to be reinforced to better build the evidence base for advocacy and further funding.

### **A young Ban Somdej resident**

*Rena is an 18-year-old girl who began use of ya baa when 13, stealing it from her drug dealing mother. Her aunt tried to assist and took her to a private health provider who talked to her aunt and then gave the aunt medicine (a dark liquid) to assist without actually seeing Rena. She used the medicine once and threw the rest away. The mother and boyfriend had amassed 1 million baht from dealing, but the boyfriend ran off with the money. This induced sadness in the Rena and she attempted treatment. She was treated at Tulakarn and got a job being involved in continuing education provided by them on Sundays. She appeared happy with her life, but did not feel her mother would change much. Her sister was providing great support to her.*



**Family work**



**Family work**

A group of 15 mothers and grandmothers discussed how to get young people to treatment. One had her son in Tulakarn and another had a son who was the best friend of the boy in treatment and was very worried about her own son. They discussed ways of linking the mothers and sons and seeing if 'gentle' peer pressure could entice the boy not in treatment to consider doing something positive about his predicament.

### **A video was produced: 'Flying High'**

This video aimed to: a) demonstrate the process of engaging with a young person during and after residential treatment; b) illustrate the roles of various community members in providing treatment and support in the community; and c) illustrate some ways of managing (re)lapse.

### **Links with the Nonthaburi Juvenile and Family Court**

Links were strengthened with the Nonthaburi Juvenile and Family Court, and the Associate Judge and Community Networks. This remained a significant model for diversion and community involvement in community rehabilitation and support of young offenders, some of whom had been/were drug users.

The emphasis of the Thai Juvenile and Family Court is restorative justice, conflict resolution, mediation and psycho-social interventions, wherever possible, instead of punishment in the form of incarceration.

Associate Judges, who assist the court, are community members of standing and reputation who volunteer for selection as an Associate Judge. The position is very competitive, is recognized by and has the patronage of the King of Thailand, attracts no remuneration, but provides high community status. Associate Judges sit on the bench during cases, usually two Associate Judges at a time, one of which must be female. The Associate Judges have no power to make orders; they can advise and give opinions to the judge.

The activities of the Associate Judge and Community Networks provide various models of working and networking for participating countries of the ESCAP project which maximize community involvement, support diversion from custodial residential settings and build community capacity. The court represents a highly effective link between the power of the judiciary and its legislative base, and the power of the community to bring about better positive outcomes for young people in conflict with the law.

*The Act for the Establishment of and Procedure for Juvenile and Family Court B.E. 2534 (1991) The Third Amended Issue B.E. 2548 (2005)* is a useful document for other countries without special children's or juvenile courts, or where current legislation does not allow for



diversion from custody for suitable young offenders. Relevant sections of note are: 24-29 (the basis for appointment of Associate Judges and their activities); 78 (special consideration of the background and psycho-social status of the young person); 95 (the basis for diversion on consideration of the background of the young person after assessment); and 110 (mediation).

### **The Nonthaburi Children, Juvenile and Family Court ‘Restorative Justice’ project**

Nonthaburi Province is adjacent to Bangkok with a population of about 1 million persons, with similar city pressures, but in some parts also a village/suburb type of environment with a less developed transportation infrastructure. Average annual per capita income is around 113,700 Baht (approximately US\$ 3,200) Nonthaburi is situated on both sides of the Chaopraya River, the East side is more urban and the West side more rural.

In parts of the province there is a long tradition of opium smoking, then use of heroin (some IDU) and then, more recently, ATS. Opium was used for many purposes, including medicinal and recreational pursuits, but is now rarely available. Heroin is also difficult to obtain, and ATS and inhalation of glue are the major concerns. There is some HIV in the community – both IDU and unsafe sexual routes of infection. In some respects, drug use has provided a ‘focus’ for communities in the province to come together. Poverty is seen as a risk factor contributing to drug use, as is the visibility of drug use by older community members. Drug dealing by women and men, mothers and fathers is common.

### **Problems of communities in the province**

- A degraded environment – polluted water in canals, rivers and swamps; accumulating garbage, slum communities on rented land.
- A fragmenting family environment – families breaking apart, poverty, drug use, over-use of computer games by youth, motorcycle gangs, early sexual activity, stealing.
- Evidence of community conflict and lack of management and administrative skills.
- A lack of necessary utilities, such as community radio and sports facilities, while Internet cafes violate ‘game station’ codes and ‘adult’ entertainment violates codes for location and regulation of behaviour.

The aim of the ‘Restorative Justice’ Project is to establish a network in Nonthaburi Province to assist the Nonthaburi Juvenile and Family Court by using a community-based programme as a model. The project targets both community risk and protective factors, and provides a comprehensive approach. There is an attempt to resolve family conflict and other difficulties faced by young people without use of more ‘punitive’ judicial processes, aided by provision of mediation, vocational skill development and family therapy.

### **Objectives**

- Earn the community’s trust in order to work harmoniously with the court by reshaping the behaviour of juvenile offenders and monitoring those on probation in the community.
- Encourage the community to set up a network by providing knowledge related to the law so that it may be able to work collaboratively with the court.
- Develop personnel skilled in judicial procedures from the community-based network to support the objectives of the court’s Master Plan.
- Serve as a model to implement the ‘restorative justice’ approach, such as measures for prevention, correction and rehabilitation, which lead to social development in the community.

### **Target groups**

- Strong communities that have existing structures and activities.
- Communities that have a high prevalence of juvenile crime or young people at risk.



- Communities where activities have begun under the drug enforcement policy.
- Government officials and the private sector which have similar objectives.
- Selected volunteers who have already been trained in workshops on restorative justice.

## The six committees of the project

1. Crime prevention, which targets vulnerable young people – mainly those aged 12 to 16. There is a focus on students and teachers. Seminars give information on the law and visits to the court are arranged. Sport and recreation activities are encouraged, and some young males become novice monks during the summer school vacation. There is an emphasis on problem solving and role plays are used, including conflict resolution and refusal skills.

Volunteers are sought via 'people who knew people' and use of established networks (government organizations and NGOs), then invitation letters are sent out. 1,500 people participated in the seminars organised by the Associate Judges. Values such as 'having heart, compassion and a capacity for caring' and experience in membership of community groups and 'volunteering' (such as drug prevention and health activities) were crucial in selection; formal 'education' is not essential. Screening, written examinations (such as on the law and 'scenarios' which involve problem solving) and face-to-face interviews are then conducted and just over 40 have been selected to date to form the core of the Network Working Group of the Nonthaburi Family Court.

2. Counselling, which aims at resolving family conflict and individual difficulties. Individual and family counselling is provided and the Associate Judges monitor progress. For 'problem cases' case conferences are arranged with membership comprising: Associate Judges, a psychiatrist, a psychologist, a social worker, the offender, the victim, the families of both and a network member.

**Case study:** *'A' is a 12 year old girl. 'A' was sexually active and involved in theft of a motor cycle with six other juveniles aged 15. HIV, pregnancy and STI testing were arranged, psychological assessment was conducted and family work was undertaken. 'A' had to report by phone to the Associate Judges each week, and to the psychiatrist and to the court every three months. Later she was at school and leading a 'normal' life, was receiving 2,000 baht per year from the Social Welfare Office to support her study at a vocational school, and was on a three-year suspended sentence.*

Sometimes financial support is arranged for cases of financial hardship via the Social Welfare Office and/or the Associate Judges Foundation, especially for education and training.

3. **Family Mediation** – Healing Conference and Family Therapy, in which ten Associate Judges are involved in the Family Therapy and ten in the Healing Conferences. Each Associate Judge is allocated five families where the young person has been involved in such offences as drug use, stealing or assault.

Circle Groups are used. They start with an introduction, orientation, group rules discussions, ice breakers, sharing of family problems, identifying problems of the family and brain storming strategies to bring about change. Eight fortnightly sessions are held. Eventually, the child/youth makes a formal apology to the family, gives reasons for their behaviour, makes promises of change, the family hugs and the process is reviewed.

A similar process is used for mediation with the victim(s) of the young person's crime, and a suitable and acceptable outcome is negotiated, often involving community service by the young person, after they make a formal apology.



4. Prevention of recidivism, which provides supervision and support of young offenders.
5. Community Network, which aims at building up local private and community sectors and the 'observation' of young people in the community. A lot of time is spent in 'getting to know' the community, gaining the trust of the community, understanding the 'culture' of the community, and developing a capacity and willingness to 'monitor' the community, and to not be seen as 'police spies'. Workshops are held in each community covering the law, the Convention on the Rights of the Child, child protection, and drug problems. Activities for children on probation are provided, such as handicraft skill development and vocational training. Teacher, student and family networks are being developed.
6. Academic and Evaluation committee, which takes charge of training, data collection, monitoring, evaluation and reporting.

Over 2001 to 2004, the number of drug cases in the Nonthaburi Court dropped, from 218 in 2001 and 397 in 2002 to 74 in 2004.

Women's Networks have been stabilized and there are about 400 members. Workshops have been held and development activities undertaken, mainly focusing on older persons, orphans, the poor and novice monks, and Thai culture and drug prevention. Neighbourhood watches have been implemented. Handicraft and recreational activities have involved local youth, and some younger members have used peer-to-peer approaches to teach skills. After some time the network was getting ready to assist with the rehabilitation of and provision of assistance to probationers. The women have a uniform – a red jacket or polo shirt with a logo – and display immense enthusiasm.

### **Examples of some interventions**

In Pakkred District there was a meeting at the house of a 16 year old, with him and his mother and father. He had been charged with assault and excluded from school. Subsequently he was doing well, working with his grandmother cooking and then selling food, and he and his family got good support from the community network. He wanted to be a businessman and was completing his studies via distance education. The whole family greatly valued the assistance provided by volunteers from the Community Network and support from the Associate Judges.

At another house, a visit was made to another 16 year old who had been involved in the stealing of a motor cycle; he was present with a 14-year-old peer. Since then both were out of school, very bored and 'at risk' of, if not actually involved in, drug use. The father of the 16 year old appeared quite unwell – diabetes, peripheral circulation difficulties and very worried about his son. He had been a heavy drinker in the past. The son and his friend smelled of glue or some other substance, but did not appear to be intoxicated. The Community Network leader said he was going to organize urine tests for the boys in an attempt to force them to address their drug use issues.

Both boys wanted to work for Toshiba (which had a plant nearby), but needed to complete their secondary education. Distance education was being arranged by the Community Network. The younger boy appeared to be quite depressed and probably needed a mental health assessment. There was also a need to engage him in activities independent of the older boy, and to provide some individual counselling for him. The Community Network leader said that when he had visited the younger boy's house recently, he was at home alone, sad and hungry. His father had died and his mother struggled to cope with her three children.

These two youths demonstrated well the multiple issues in working with young drug users and those at risk of drug use. The Community Network appeared to be very active in this community, and doing an excellent job.



*Young peer educator from Ban Somdej with Director of Tulakarn Chalermprakiat Hospital addressing an advocacy meeting*



Some diagrammatic representations follow which attempt to demonstrate an idealized Thai project, mechanisms for diversion and possibilities for more effective linkages.

**Diagram 1** – Community-based treatment - demonstrates the linkages necessary for the implementation of a holistic approach to community-based treatment for young drug users. It indicates that there need to be effective working relationships developed between:

- The ‘community treatment centre’ and the police, public security, courts and the compulsory treatment system
- Families
- Health, education and employment providers
- Mass organisations
- Group homes and drop-in-centres (if they exist)

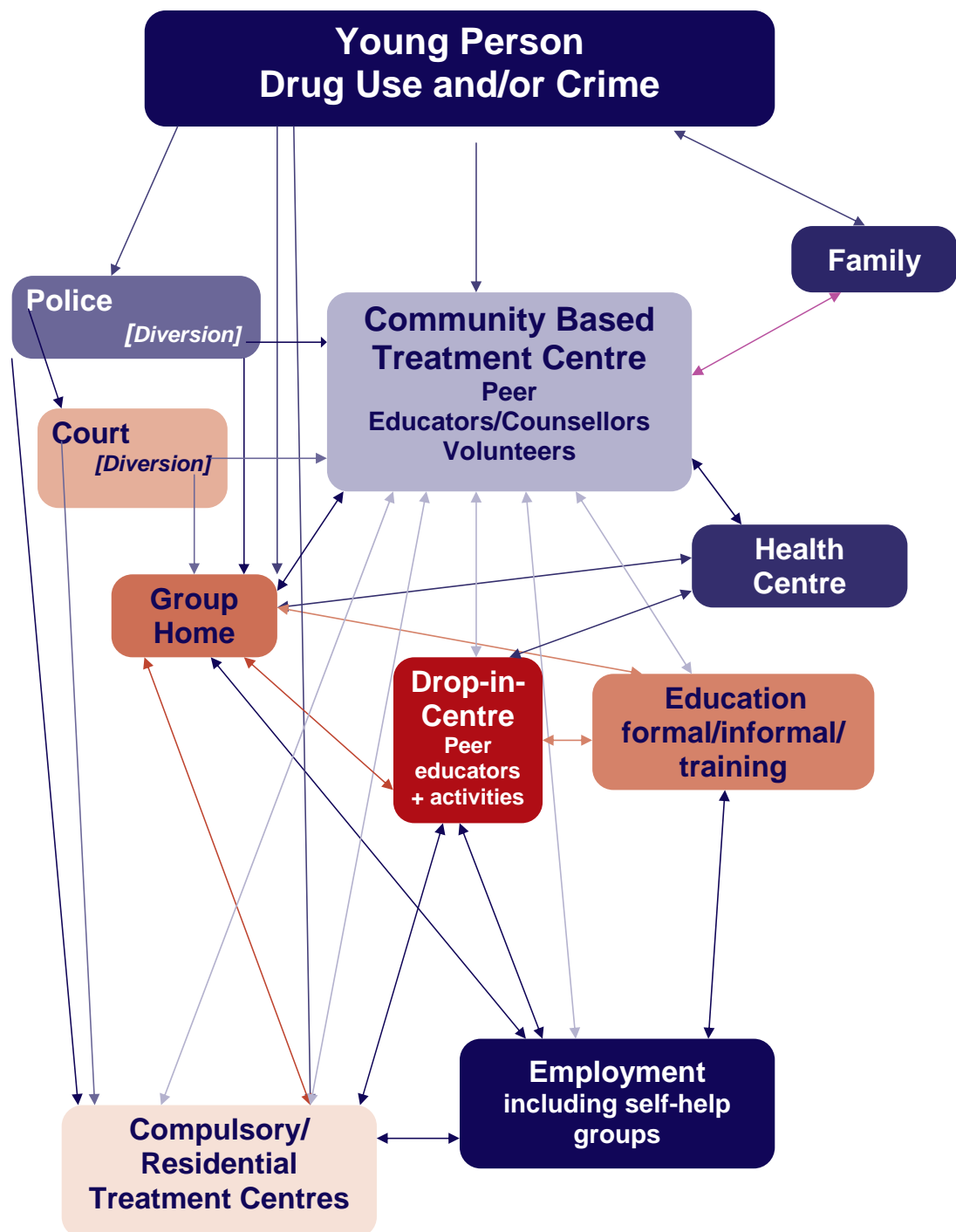
In addition, the importance of external ‘expert’ advice to support programmatic, clinical, research and evaluation components should be recognized.

**Diagram 2** illustrates the capacity for diversion from correctional and compulsory treatment in some jurisdictions in Thailand (for example, Nonthaburi Province). It illustrates the capacity for police and courts to divert young drug users to community programmes.

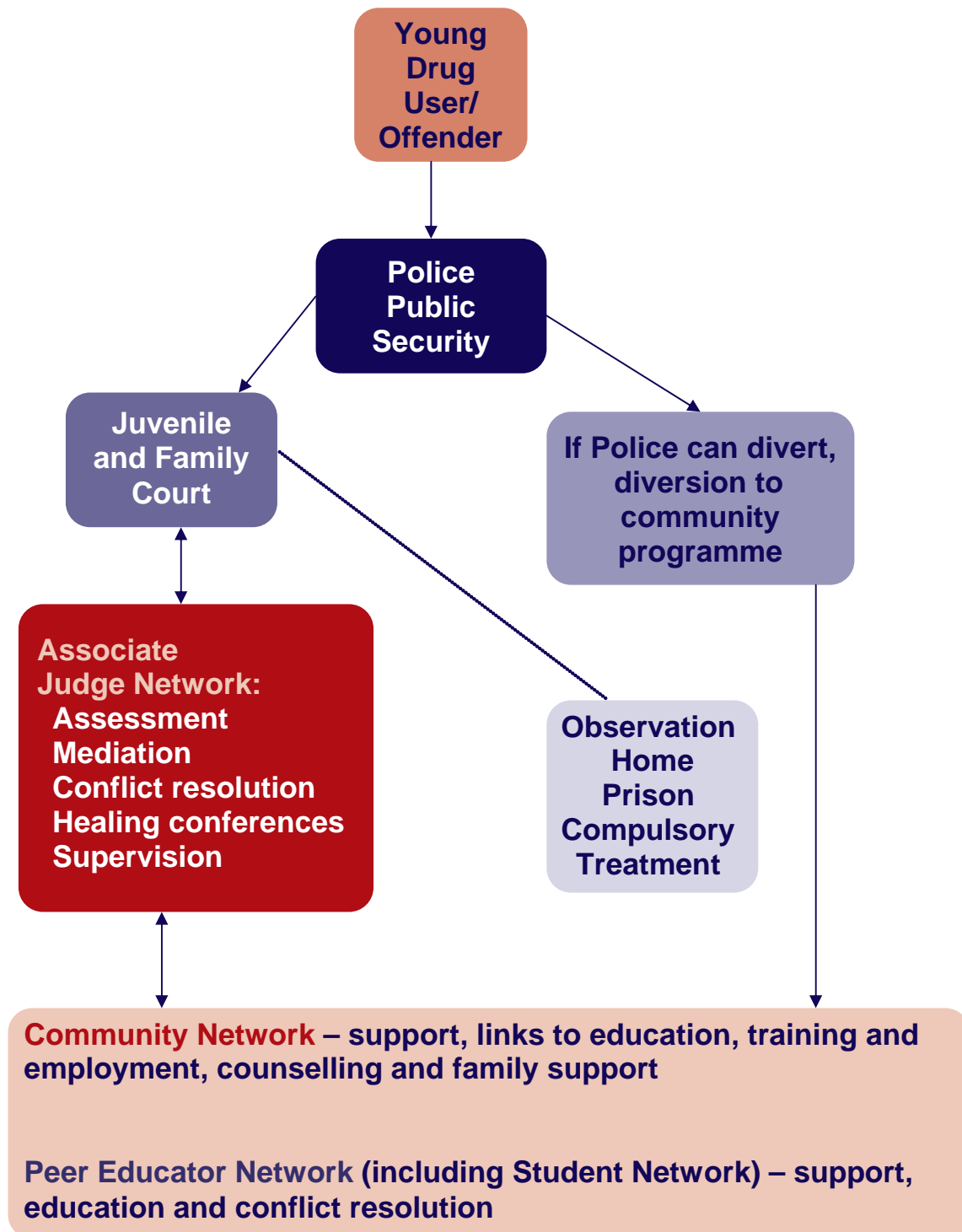
**Diagram 3** illustrates Tulakarn and its links.



**Diagram 1: Community-based treatment model**

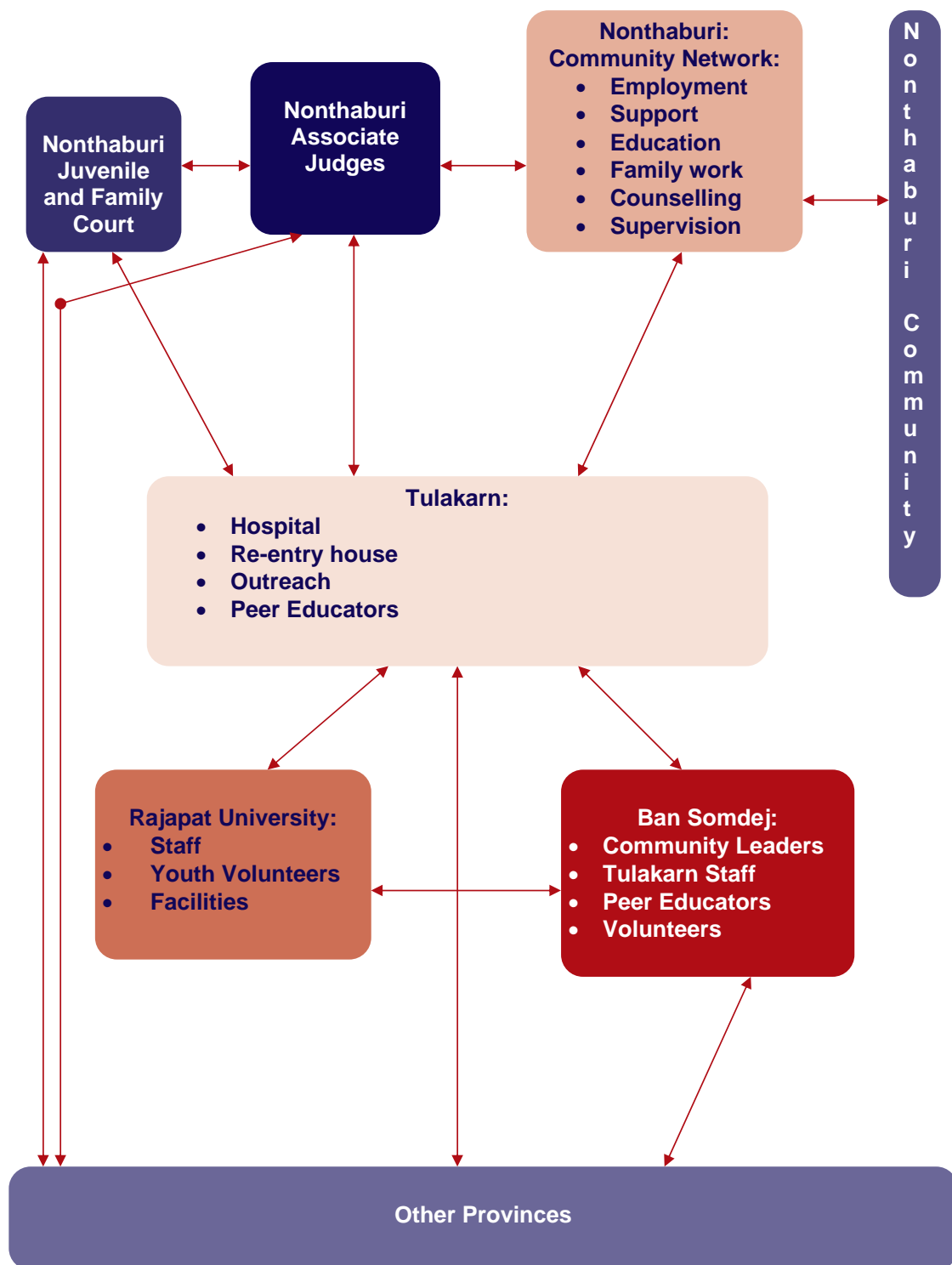


**Diagram 2: Diversion**





**Diagram 3: Tulakarn and its links**





### 3.4. Viet Nam

#### Main activities and achievements 2002 to 2008

- Broad-based information sessions for key individuals and groups to introduce the concept of community-based interventions as alternatives to compulsory residential treatment
- Developing networks and links to some extent in Vinh (the project pilot site, about 300km south of Hanoi and in Nghe An Province)
- Advocacy and commitment evident in Vinh (such as from mass organizations and civil authorities), but issues remained as to what to do with it and how to harness it
- Planning at the local level within Vinh, with good involvement of key community leaders, mass organizations, representatives of 06 Centres (CTCs) and individuals for two target communities
- Attempts to engage with families, especially while their sons/daughters were in 06 Centres
- Data collection and analysis of a high standard in the initial stage of implementation
- Some critical reflections on practice were evident
- Changes within a few 06 Centres to better meet the needs of young residents, engage their families and provide age-appropriate activities and peer support
- Recognizing the importance of developing counselling skills
- Providing training in counselling to 06 Centre and community staff
- Better recognizing the role of 'social work'
- Translation and adaptation of ESCAP resources

#### Main challenges

- Bureaucracy and communication
- Plans developed but little implementation due to slow roll out of funding
- Delegation of decision making (to Vinh) not easy
- Advocacy and commitment evident, but issues remained as to what to do with it and how to harness it and find roles for individuals (such as retired people) and members of mass organizations
- Drop-in-centre discussed and planned for in Vinh, but not established
- While some training provided, skill development insufficient, especially in individual, group and family counselling

#### Major contributions

- Research undertaken on drug use situation among young people in Viet Nam
- Roll out of training with translated tools
- Development of potentially effective processes and plans for two target communities in Vinh
- Assistance with some development of more effective community links between a more 'local' 06 Centre (for instance one closer to the city of Vinh) and the community, especially in relation to family work
- Development of young person-to-young person support processes within a few 06 Centres

The main activities during 2007 were to attempt to re-establish the project after a lapse. Some work continued in Vinh to trial community treatment in two communes (Hung Loc and Le Mao) – targeting a small number of young drug users and their families, to provide community 'detoxification' (at home or in local clinics) and counselling. In addition, activities were undertaken to increase capacity of the local community authorities to more effectively respond to drug use-related difficulties of young people and their families, and work on IEC and other drug related activities and network cooperation. No. 1, 06 Centre in Vinh was developing model interventions, using the ESCAP tool kit, to reduce relapse, increase



cooperation between No. 1, 06 Centre and the community, and had developed a core of peer educators. Residents of the centre and their families appeared to be enthusiastic and involved in the relapse prevention activities.



**Residents of CTC making baskets**

Activities undertaken at No. 1, 06 Centre, Vinh included:

- Capacity building for staff (all sectors – vocational, security and administrative) and volunteers via ongoing training. Core trainers participated in ESCAP training.
- Establishing a Peer Educator Team who were trained by and supported by some of the ‘core training team’.
- Individual and Group Counselling – groups included a trained peer educator with staff monitoring. Contents – drug information and coping skills (especially family difficulties and re-integration obstacles), health, HIV, BBI, STI. Preparing for community return was a focus.
- Family counselling - monthly meetings occurred, and this activity was to be strengthened.
- Relapse prevention and community re-integration – action plans were being developed in cooperation with local authorities and the community.

MOLISA provided training in counselling for staff of the centre, and mass organization and community members. There remained a need to continue to develop and provide counselling skill development training (possibly in a ‘training of trainers’ format) for community level staff from various facilities and staff designations (such as People’s Committee, health workers and Sub-DSEP), and for those in 06 Centres (including nurses and vocational instructors), as well as suitable residents of 06 Centres and youth from the community who could be developed as peer educators/counsellors.

Some issues to assist in the development of the project remained. Regular visiting of community members into the 06 Centre was essential, as was development of an increased research and documentation capacity, and consideration of increased activities within the community possibly via the development of a youth centre.

The processes of coming to a 06 Centre or being allowed to remain in the community under treatment or in family treatment required re-examination. Once detected, a drug user faced a period of about 15 days while his/her situation was assessed by an ‘assessment committee’ and a report with recommendations was prepared for the Chairman of the Local People’s Committee who decided on placement. While waiting for the decision, the drug user could be placed at home or in a ‘house’ next to a 06 Centre – not as restricted, but a fairly controlled environment. The ‘assessment committee’ and the Chairman of the People’s Committee would be able to receive ‘petitions’ on behalf of the drug user from various persons/agencies or ‘the community-based treatment project’.

This was an opportunity for ‘diversion’ that could be explored. To do this, there needed to be a ‘formalizing’ of the project in a location, so that there was some recognized ‘entity’ that could present a proposal to the Committee/Chairman.

### **Meeting with parents and residents at No. 1, 06 Centre in Vinh**

The group comprised the centre director, two parents and a sister of current residents, six residents (four of which were voluntary and three of which were 'relapsers/returnees', with one being both voluntary and a relapser/returnee), the Chairman of the Le Mao community, the Deputy Chairman of the Hung Loc community, and staff of the centre.

The residents, who had experienced previous stays at the centre, spoke positively of the changes, especially the group work, activities, relapse prevention planning focus and connections with their families and communities. They stressed that 'relapse' was influenced by whether they had employment on release, the influence of drug using peers and drug availability.

Three residents said they felt more optimistic about their futures, and indicated that they warmed to their roles as peer educators and that they believed that they needed much support on release.

One of the residents, whose father was present, had 'relapsed' many times and was HIV positive. His father was sceptical about his ability to remain drug free, and believed that his son should remain in the centre for a longer period of time, as did a mother about her son. This began a discussion about the pros and cons of longer stays and the need for intensive support on release.

The HIV positive man, who was carrying his antiretroviral medication made available by the Global Fund said that he would be able to continue on medication post-release via a local clinic, and that having the medication gave him something to live and be rehabilitated for.

The idea of a 'drop-in-centre' was floated, and was supported by both residents and their parents. Centre activities could include mutual support, a base for peer educators, recreational and creative activities, sport and educational groups. The importance of job seeking support and employment opportunity creation, even via micro-credit, was also stressed.

The centre director noted that while the average age of residents had declined, there were few then under 18, and that about 35 per cent were aged 18 to 24. He noted that the average length of stay for 'voluntary' residents was still 6-12 months, and for 'compulsory' residents, the length stipulated by the 'law' was 12-24 months. Relapse rates remained high - around 75-80 per cent.

Difficulties faced in Vinh and Viet Nam generally remained trafficking of drugs, unemployment, treatment models that could be much more effective, stigma and discrimination against those coming back from treatment, and inadequate linking of treatment and community. The latter required some policy revision and support from leaders.

Some tax concessions were becoming available to employers who employed ex-drug users. In the south of Viet Nam there were what could be termed 'industrial estates' where ex-drug users lived for some time (it could be extended voluntarily). Pay was not as high as in general employment, but apparently quite adequate and there was support from other ex-drug users and the community. Some banks were able to give loans to ex-drug users. Residents were able to visit family and others during weekends/time off.



***Vocational and other activities within 06 Centres in Hanoi***

### **Workshop with about 50 participants from 06 Centres and the two target communities in Vinh – Le Mao and Hung Loc**

Senior staff MOLISA Ha Noi gave an overview of the current drug situation in Viet Nam:

- There were 136,959 registered drug users in Viet Nam in 2007 (68,277 in 1995), not including those drug users who were incarcerated in prisons.
- Some 1.1 per cent were under the age of 18, but 56.8 per cent were aged 18-30.
- Over 90 per cent were male.
- There had been a big decrease in minority representation (due mainly to elimination of opium production/use – this also skewed the age figures as minority-group opiate users were older).
- A total of 47 per cent were unemployed, 4.5 per cent were students and 5.6 per cent were drivers.
- Some 72 per cent had been involved in crime.
- IDUs made up 85.7 per cent of those under the age of 18 and 73.9 per cent of those aged 18-30.
- Of those who were HIV positive, 60 per cent were IDUs, and 48.6 per cent of IDUs were HIV positive.
- In 1998 there were 14 per cent and in 2007 there were 44.8 per cent of 06 Centre residents who were HIV positive, with equipment sharing common, despite the low cost of needles/syringes, and group use of opiates may have involved drawing up from the same mix.





The Chairman stressed that: a) his community had been keeping drug users in the community; b) the community had seen a move from fear and exclusion of drug users, to inclusion and confidence; and c) staff capacity to manage young drug users had increased, and they had become more flexible and professional. He also felt that staff needed more training in counselling, and that the broader community also needed some training.

The Chairman stressed that: a) his community had been keeping drug users in the community; b) the community had seen a move from fear and exclusion of drug users, to inclusion and confidence; and c) staff capacity to manage young drug users had increased, and they had become more flexible and professional. He also felt that staff needed more training in counselling, and that the broader community also needed some training.





## Developing draft plans

### Draft plan for Le Mao community

Community safety and a healthy environment were seen as key to positive outcomes for a drug-free community. Activities that were planned included:

- Establishing a steering committee of 10 persons.
- Setting up a counselling group – five counsellors.
- Training seven peer educators from the community.
- Providing training in relapse prevention for community staff and volunteers and family members.
- IEC for in and out of school young people, and the broader community; targeting 80 per cent coverage for the community.
- Developing personal and family counselling – the harms of drug use and a relapse prevention focus.
- Strengthening links between families, the community and drug treatment centres – increased awareness of each other and support provision.
- Developing relapse prevention activities – vocational orientation, training and job creation for five ex-drug users and financial assistance of about US\$150 each (given to the vocational training centre), and small business creation for two ex-drug users via credit support.

### Draft plan for Hung Loc community

In relapse prevention activities for ex-drug users it was agreed that focus should remain on young people involved in the project in 2006 as they were already engaged but the community was still not focussing enough on them and their needs. Most of the young people remained unemployed, not 'mobilized' to be involved in prevention activities among other youth, and at risk of relapse. Possible activities, each to be offered at least three times during a year included:

- Skill development in relapse prevention planning for staff and volunteers and families of drug users via more training programmes.
- Counselling with an emphasis on relapse prevention to their homes or to clinics.
- Connecting with vocational training services to increase skills and opportunities for ex-drug users.
- HIV education, in conjunction with another project (World Bank funded), to develop peer education prevention skills among at least two ex-drug users.
- Drug prevention activities in the community for youth using mass media and direct contact.
- Keeping the possibility open for community detoxification of young drug users within the community, and keeping contact with those who were in or went to a O6 Centre to assist with their relapse prevention planning.



**Police Chief, later Chairman, Hung Loc Community, Vinh, presenting plan**

## Draft plan for 06 Centres

The target group was those 16 to 25 years old in the centres. Unemployment, family and community care, peer influence and availability of drugs were identified as key factors in relapse. Thus, they were to be the focus of relapse prevention plans. This required better links between centres and the community, and linked training for staff, volunteers and peer educators. Activities that were planned included:

- Establish an implementation committee, with coordination and training for staff and peer educators.
- Train seven staff and six peer educators at each centre.
- The six trained peer educators could be involved in training the new peer educators to replace them once the core group returned to the community. There would always be six peer educators at each centre.
- Awareness raising and assessment. Counselling for 36 young residents in each centre.
- Expand music and other activities.
- Increase groups with focus on life skills, relapse prevention and HIV prevention.
- Have six 'active members of the community' when the trained peer educators returned to the community.
- Vocational training, skill development and employment assistance and credit provision while waiting for employment.
- Strengthen centre, community and family links and provide activities once per month.
- Link returning residents to after-care clubs.
- Alert the community to impending releases from the centre.

## General suggestions from the workshop

1. Develop greater support for the establishment of a pilot 'drop-in-centre' for unemployed and other young drug users, including those returning from residential treatment in 06 Centres, in Vinh City, Nghe An Province. This support could be in the form of providing a location, staff with some counselling skill training, and assisting them to develop a 'family support network' connected to No. 1, 06 Centre. The drop-in-centre could be the base for the core peer educator/counselling team. An expansion of the existing Youth Union Club in Le Mao could be an initial model, or, if considered more appropriate, a completely different model such as that of PSI in Kunming, Yunnan, China.
2. Encourage some ex-drug users to start their own small businesses, with micro-credit and/or loans. Once stable, these businesses could employ more suitable ex-drug users. The young people should be linked to the drop-in-centre/club to gain support, in addition to their own self-help meetings.
3. Strengthen the support and education for families of young drug users from high drug use communities on minimizing relapse. This could take the form of developing the capacity for a drop-in-centre/club to involve and support families of young drug users while in community and/or 06 Centre treatment. Thus, family support could develop prior to release of young drug users from residential treatment and continue after their release. A 'family support network' could develop independent of services for the young drug users, but also connected via the drop-in-centre/club providing aftercare. This could have an impact in reducing relapse, and reducing (re)admissions to 06 Centres via the enhanced capacity of communities to treat young drug users within their very communities.





## Chapter 4

### Lessons learned from Phases I to III

#### Summary

The project set out to build capacity for community-based treatment and continuing care for young drug users.

The main ingredients identified as required to build capacity for community-based treatment and continuing care for young drug users were:

- ◆ Supportive policy legislation
- ◆ Ability to gain and maintain key stakeholder support
- ◆ Ability to engage with individuals, families and communities
- ◆ Access to young drug users – in community and residential settings
- ◆ A trained and competent work force – in both residential facilities and the community
- ◆ An enthusiastic and youth-friendly work force
- ◆ An appropriate curriculum for training, especially in relation to individual, group and family counselling, relapse prevention planning and continuing care
- ◆ Appropriate resources for training individuals, communities, and community and residential facility staff
- ◆ On-going skill development and refresher training
- ◆ Transfer of skills
- ◆ Reflection on practice – supervision and review
- ◆ Data collection capacity
- ◆ Capacity to analyse data and reflect on outcomes
- ◆ Time to engage key stakeholders, young people, families and communities, and time to trial various ways of intervening
- ◆ Stable enough funding
- ◆ Rewards – acknowledgement for the difficult work done
- ◆ Ability and evidence to counter some of the ‘ideological and political issues’. For example, how to approach those who support: ‘drug wars’; the criminalization of young drug users, stigma and discrimination; having a ‘free’ workforce in ‘treatment’ centres; the reliance on approaches many believe are working, despite the very high relapse rates; and the often contrary advice of external ‘experts’ which can be tied to approaches that promise ‘funding opportunities’ even if they are ineffective and not based on evidence as well as if they do not work in spite of being politically or ideologically acceptable

#### Introduction

The application of the project in each country correlated with the skills of the existing workforce, availability of supportive policy and legislation and existing and new relationships formed among key stakeholders – government, NGO and community.

Overall, there is a modest, albeit slowly expanding, capacity for the treatment of young people with drug use-related difficulties within their communities. Much of this capacity is in the form of supporting young people returning from compulsory or quasi-‘voluntary’ residential treatment in an attempt to minimize relapse and compulsory return to longer periods of time in the CTCs. Even in Thailand, where there is some capacity for voluntary community treatment, capacity is not extensive. Official policies and procedures remain somewhat punitive, and the use of compulsory treatment centres is widespread, and apparently receiving some internal and external critique.



Still readily acknowledged are the high relapse rates for those released from compulsory treatment centres in the region, mostly over 80 per cent.

While the benefit of keeping contact with family, children, partners and positive peers appears to be more widely acknowledged, there is not much in the way of effective responses by the authorities. There is even debate in some countries (for instance Viet Nam) about extending the time in CTCs to about two years, and expanding the capacity of some already large CTCs (such as the Chang Po centre in Yunnan, China). While the lengths of stay still vary, they are increasingly being correlated with income; for instance, shorter stays with better conditions for those with independent or family financial resources (as in China and Viet Nam). Likewise, some stays are reduced if families request the return of their sons/daughters, demonstrate that they can care for them, and have the backing of local authorities (as in Lao PDR).

The focus on 'relapse' rates can create other difficulties. There appears to be an assumption that being 'treated' by whatever regime should lead to a drug-free lifestyle due to some form of 'moral conversion' or insight that drug use is 'bad' and should be stopped. There also appears to be little understanding of why anyone, let alone young people, use drugs and why they maintain their use. Moral education, mass activities such as marching and chanting slogans; watching, *en masse*, boring video exhortations to adopt a 'correct lifestyle'; and long work days seem to miss the point of the variety of aetiologies for youth drug use initiation, escalation and maintenance. In many cases the reduction of drug use, risk, criminal and anti-social behaviour, and improvements in health, social functioning and engagement in education, training or employment do not seem to be regarded as acceptable enough outcomes; abstinence appears to be the only 'acceptable' outcome.

In addition, there remains to some extent the belief that detoxification must occur before 'treatment' can begin and that this should be done in a medically supervised setting. There appears to be growing recognition that there are alternative options to residential, medically supervised detoxification or withdrawal management, and more examples of alternatives exist. For example, the use of community health services with community and family support (such as in Vinh, Viet Nam).

However, it is apparent that continuing care/after care is receiving more attention in all four countries and more attempts are being made to provide for it. Many of those in the CTCs in all countries remain a very long way from their homes, families and potential supports, and visiting is difficult due to the constraints of distance, time, cost of travel and need to maintain an income.

The specific needs of young people are recognized, but remain largely unmet in most settings. In China and Lao PDR, while those under 18 in CTCs apparently sleep in separate sections, most of their day is spent with the adults and there is minimal night supervision, if any, in some centres (such as in Lao PDR). Residents as young as 14 were observed in most CTCs visited during the project, spending most of their days among much older fellow residents. Workers in some CTCs said they did not think separating the younger ones out was really necessary. Thus, there are daily breaches of the intent of international covenants and declarations that pertain to the rights of young people and their placement and treatment in residential settings.

The lack of current capacity for community treatment for young people with problematic drug use, and the current legislation and policies that almost automatically transfer young people identified as drug users to compulsory residential detoxification and/or rehabilitation centres make it extremely difficult to make a significant impact.

Overly punitive laws, the demonization of drugs, the criminalization of drug users, and an apparent disregard for the human rights of drug users of whatever age in many countries in the subregion continue to work against change.

Likewise, many young drug users are sent to prisons, as the crimes they commit while using drugs may necessitate them being sent to prison rather than being diverted to drug treatment. There is little, if any, capacity for diversion from prison in such cases in countries such as China. In some countries there is recognition that a drug user should try to voluntarily admit themselves for treatment before they are arrested for a 'crime'. Stigma is extensive in many settings, and those returning from CTCs find it difficult to be accepted back by their families, obtain employment, and interact with non-drug using peers. They quickly become alienated, feel hopeless and return to drug use.

There is a need to explore the role of pilot drug courts for such cases, and to ensure that there is some mechanism for formal review of involuntary admissions to residential detoxification and or treatment, so that young, less-dependent or experimental drug users are afforded an opportunity to receive community-based treatment as the preferred option. Of concern is that young people can be 'sent' to CTCs by their parents, police or local community authorities without any apparent capacity for 'appeal' or 'review'.

Models for diversion for youth crime exist – such as the Juvenile and Family Courts in Thailand, especially in Nonthaburi Province with their Associate Judge and Community Networks, and the small pilot project in Kunming, China led by Save the Children UK, which utilises Appropriate Adults to support young people diverted from custody after arrest for certain crime categories. These models could be expanded to include young drug users, as is possible in Thailand. Some of these models are presented below.

There are financial constraints in some countries, as the large, mainly work camps that are termed 'rehabilitation centres' provide income for the state and sustain the cost of their own activities (such as to provide food and minimal resources for inmates). In addition, irregular, short-term and mostly external and donor support has an impact on motivation and implementation of the longer-term and complex processes required for necessary changes to policy and/or legislation and the building of workforce skills, programme capacity and broad community support.

There also remains a limited capacity to provide substantive alternative treatment interventions due to a fairly widespread lack of skill among workers in relevant intervention techniques, such as individual, group and family counselling. In some locations where it has been underdeveloped or even non-existent, there is growing formal social work or counselling training (for example in Lao PDR and Viet Nam), and this needs to continue and be expanded.

In addition, there are possible differences of approaches needed due to the local 'drug of concern'. In Yunnan Province of China and Viet Nam, the major concern is injection heroin use, whereas in Lao PDR and Thailand it is the oral use or inhalation of ATS. However, there are some trends emerging with ATS use being identified as of increasing concern in both China and Viet Nam, and with regard to injection of heroin and 'ice' among young people in Lao PDR. Historically, many treatment approaches and beliefs were developed for people with heroin dependence, which may require significant modification for those with ATS dependence.

However, there are positive developments, and a sense of opportunity.

In Lao PDR, where young drug users are often 'treated' in CTCs or linger in prison or police lock-ups, VYC is focussing on developing counselling skills among a variety of youth-serving agencies. This would link to pilot capacity building in some districts and villages and link those in CTCs with youth-serving agencies and peer volunteers. VYC is taking the lead in facilitating the development of a core youth counselling team that is providing treatment and supervising and supporting peer volunteers in various locations.

An effective network has been developed linking seven target villages in Vientiane Capital



area, and the CTC (Somsanga) and a quasi-correctional centre Don Tao. Members of the network are local village leaders, police, older community members, people from the Women's Union, and the VYC-trained counsellors who come from various backgrounds (such as high school and university students, retired and current teachers, nurses and others from business and trades). Some local VYC-trained peer educators are ex-drug users. The hope is that relapse rates can be reduced, and, via building community capacity, fewer young people will develop significant drug dependence or require 'compulsory' residential treatment as there will be an effective and competent community alternative.

In Thailand, which has already developed a wider range of treatment and processes for dealing with young drug users, IJFJD is focussing on expanding its involvement in slum and other communities with significant drug use among young people. Tulkarn Hospital has re-oriented some of its services to the community and provides continuing care within selected communities to those returning from their residential treatment services, and community-based treatment to young people in the hope of avoiding a residential placement. However, sustaining the activity level in Ban Somdej has been difficult, and the bulk of the work has to be undertaken by already busy community leaders who mostly have full/part-time employment and must support their families financially and emotionally. Ban Somdej could be a 'teaching site' for this activity, but there is a need for intensification of involvement by experienced external professionals, support of community leaders, development of a core team of peer educators from the community and the university located within Ban Somdej, and greater involvement of other sectors including local health centres and vocational training providers.

Thailand has voluntary and compulsory treatment centres, based on the Daytop model, for young drug users. For those young drug users who commit crimes and are involved in the juvenile justice system there is some possibility of diversion from custody into community treatment (for example in Nonthaburi Province) or they receive some treatment in the form of group work focussed on relapse prevention within juvenile remand and custody facilities. However, there appears to be often direct placement into the CTCs without a court being involved. It is unclear if there are mechanisms for the review of such placements, so that experimental or low level users could be diverted to community-based alternatives. Strengthening and supporting diversion processes and interventions is also worthy of attention.

The role of the Thai Juvenile and Family Court in diversion and community treatment, especially as developed in Nonthaburi Province, and the Probation Service via provision of a coherent drug treatment process for young people in custody, could become role models to the subregion where there is less 'ownership' of treating drug use by Ministries of Health and more by Public Security. There is also the need for modelling of greater cooperation between 'health' and 'police' and the use of the community as a 'resource'.

In Yunnan Province, China, young people who are apprehended for drug use are sent by public security officers (police) to a CTC such as the one at the edge of Kunming (the Chang Po centre), where they undergo what is called 'treatment' with over 5,000 adults of average age 25-30. YIDA is providing a greater focus on young people with illicit drug use and links peer education activities at drop-in-centres, in the community and within the CTCs. They have developed effective processes for engaging with young people in CTCs, conducting baseline assessments, support young people while in CTCs via visits from peer educators and YIDA professional staff, and well planned continuing care. Finding pathways to trial 'diversion' for younger low-level or experimental drug users is proving difficult, but YIDA continue to deal with the multitude of barriers in a positive, intelligent, scientific manner.

In Viet Nam, where young people should be kept in separate facilities, but in reality may be found in adult CTCs, MOLISA/DSEP could develop a focus on providing youth-specific counselling skills for both centre and community workers. They may also attempt to expand the range of services provided by after/continuing care clubs and consider developing a drop-in centre in Vinh (Nghe An Province), with the aim of providing increased and 'youth-



friendly' support and reduced relapse rates and (re)admissions to CTCs.

## Lessons learned

1. Sustaining an adequate core trained, supported and motivated staff. This requires increased funding to provide ongoing training, development activities and supervision for those trained to date. The core groups remain small, and expansion via training of new participants is required to broaden the scope of the project and replace naturally occurring drop-outs (due to job change, re-location, promotion and other reasons). More funding than anticipated has gone into training at the request of the participating organizations, as the existing skill capacity, especially in basic counselling and family interventions, was much lower than initially recognized. Thus, there has been less financial support than necessary to support actual interventions in some settings, and have these sustained. This has an impact on attempts to scale-up.
2. There is a need to increase emphasis on building up the community 'core' in some locations (such as Viet Nam, China and even Thailand) to ensure a more supportive community environment to reduce substance use problems emerging in youth and to decrease the likelihood of relapse. Stigma and discrimination against drug users has a great impact in China. In Viet Nam the difficulty is more in coordination and focus. In Thailand there is a need to involve more government and other stakeholders (such as police, health and education sectors). Lao PDR is providing a good model via the working of the network in Vientiane which links the seven target villages and the CTC.
3. There is a need to continue to 'institutionalize' the peer education/counselling activities within the regime of the compulsory residential detoxification, treatment and rehabilitation centres. This has required extensive dialogue with public security and other sectors to 'legitimize' the activity and regard it as a part of normal centre routines. Much consideration will need to be given to the implications of this on the income of centres and the residents via 'loss' of more traditional work/income generation activities. The proposed activities in No. 1, 06 compulsory treatment centre in Vinh, Viet Nam may become a model for this, if the Viet Nam project proceeds. In China there now appears to be a much improved situation, and the same is evident in Lao PDR, with staff welcoming project staff and facilitating their access to young people.
4. There is a need to further develop family involvement in all four settings, both while a young family member is in a CTC and while in the community. There are the beginnings of this in both China, and to a lesser extent in Viet Nam, while in Lao PDR the counsellors and other project allies have developed good working relationships with family members, particularly parents. The development of accessible and appropriate family interventions and family-to-family support networks requires development, and will be a more difficult task, especially where stigma and shame are predominant.

In addition, especially in China, there are difficulties in engaging and maintaining families due to both the economic situation and the 'one child' policy. Most contact is by phone as families are driven by economic necessity to work hard and for long hours, and/or feel ashamed and worried others will know of their difficulties. Also, many families have given up on their drug using child either from experience and/or popular stereotypes of drug users as 'hopeless' and unable to change. They need to work more to earn more to provide for their retirement as they cannot rely on their child to support them. Given the high relapse rates from CTCs, this is in part understandable. Likewise, parents with one child are worried about their own futures when they retire and need someone to support them financially or some form of income. They get tired of their children asking for money when they visit them in the CTC, and of them asking for enough money to obtain an early release from the CTC. The 'criminalization' of drug use exacerbates this, as do 'police quotas' for finding drug users and placing them in a CTC or labour camp.



5. There is a need to identify 'core' effective ingredients of interventions in the various locations. That is, what mix of activity appears to work best in which settings. This implies better research capacities.
6. There is some evidence that having a youth centre from which activities are coordinated, and which provides a location for centre-based activities and service provision is beneficial (as seen in Lao PDR).
7. There is a need to explore the possibilities for formal diversion processes to be developed in three countries (China, Lao PDR and Viet Nam), and consider pilot drug courts. In addition, there is a need to ensure that there is some mechanism for formal review of involuntary admissions to residential detoxification and or treatment, so that young less dependent or experimental drug users are afforded an opportunity to receive community-based treatment as the preferred option. Some models below illustrate possibilities of how these might work. Of concern is that young people can be 'sent' to CTCs by their parents or police without any apparent capacity for 'appeal' or 'review'.
8. In dealing with complexity, many 'health' interventions target a disease (such as malaria) or a behaviour (such as unsafe sex) and interventions to deal with them are difficult enough. Drug use is an illegal and complicated activity. Issues initiating and supporting it are complex (including individual, family and social components, as well as availability, trends and fashions) as are needed responses – supply, demand and harm reduction. They involve many 'actors' – police, governments, families and communities as well as individuals.

Response systems also become complex – CTCs often become 'institutions' that serve many purposes – punishment, rehabilitation, and making money for their own existence and/or for the state (for instance from the work done, including manufacturing and agriculture). Less admissions to CTCs can lead to, among other things, loss of jobs for staff, reduction of income, less spending and loss of income to the 'state' from the selling of the 'products'.

Change is threatening both politically and socially, as is how to undertake it. Policy is vital and leadership is essential. But, who wants to 'lead' a process that can be seen as unpopular and/or threatening to 'security' and 'stability'; especially when there is sparse evidence that what works in other settings would work in their own. Involvement of public security/police is essential, yet there can be various levels of obstruction and even corruption. Many NGOs and agencies are not used to so many players – especially including public security. Likewise research can be difficult, especially as to how to get a 'baseline' on 'illegal activity' such as drug use. This can be more difficult than obtaining data on 'safe sex' activities.

Among other challenges, 'treatment' outside CTCs (for instance in communities) can be time intensive, motivation is difficult to maintain, the skill set of workers is not well developed, financial support is not readily available and many ministries 'pass the buck' and claim it is someone else's responsibility. Moreover, issues of complex aetiologies and responses need to be addressed.

9. Budget/funding continues to be an issue. Most funding approaches seem to be based on a model suitable for preparing a report – an existing staff member does some activity – paid half up front, half on completion. Where a fair amount of funding is held back or distributed over time, and a agency has little/no 'cash' it is very difficult to advance monies for activities and some six months later get 'reimbursed', especially for financially strapped NGOs. Thus, there is a need to fund at a level where activities can occur, at no additional expense to the agency. If current funding processes continue, there is little chance for the establishment of sustainable practices and infrastructure, and little capacity building.

A related issue is projects expending too much of their funds on one-off, often-expensive activities such as a camp, a contest, a large meeting where there is little interaction but a large number of fairly didactic presentations. This can reduce ongoing workforce development capacity building, especially induction of new staff and re-training of existing staff, and also hamper sustainability.

10. To enable better scaling-up, more frequent monitoring and training 'in country' is needed by skilled personnel. It is clear that there are great limitations in trying to work via email, and many instances where difficulties become obvious and resolvable when the actual situation is witnessed. However, this can be problematic in that it can increase the 'travel' component of the funding.
11. To move forward, there is need for a collaborative approach from the UN system to engage with senior policy makers to ensure a supportive legislative, policy and practice environment, and compliance with international treaties and conventions (such as the Convention on the Rights of the Child and the Beijing Rules).

The overall key themes were: not stretching reach too far without consolidation; increasing activity level in target communities; developing and strengthening useful linkages – especially to employment opportunities, health, university student and other volunteer opportunities; increasing family involvement; developing research systems; and influencing policy.

## Some models

What follows are some diagrammatic representations of how the project could be conceptualized overall, or based around a youth drop-in-centre or youth club, as well as pathways for diversion that exist (as in Thailand) and are possible (as in China).

**Diagram 1** – The 'hub' approach - demonstrates the linkages necessary for the implementation of a holistic approach to community-based treatment for young drug users. It indicates that there need to be effective working relationships developed between:

- The 'community treatment centre' and the police, public security, courts and the compulsory treatment system
- The families
- The health, education and employment providers
- Mass organizations
- Group homes and drop-in-centres (if they exist)
- The importance of external 'expert' advice to support programmatic, clinical, research and evaluation components

**Diagram 2** – represents an approach with a drop-in-centre or ex-drug users 'club' as central. It also indicates that there needs to be effective working relationships developed between:

- The 'community treatment centre' and the police, public security, courts and the compulsory treatment system
- The families
- The health, education and employment providers
- Mass organizations
- Group homes (if they exist)
- The importance of external 'expert' advice to support programmatic, clinical, research and evaluation components

**Diagram 3** – illustrates the capacity for diversion from correctional and compulsory treatment in some jurisdictions in Thailand (for example, Nonthaburi Province). It illustrates the capacity for police and courts to divert young drug users to community programmes.

**Diagram 4** – illustrates a possibility for China based on a pilot for young offenders operating

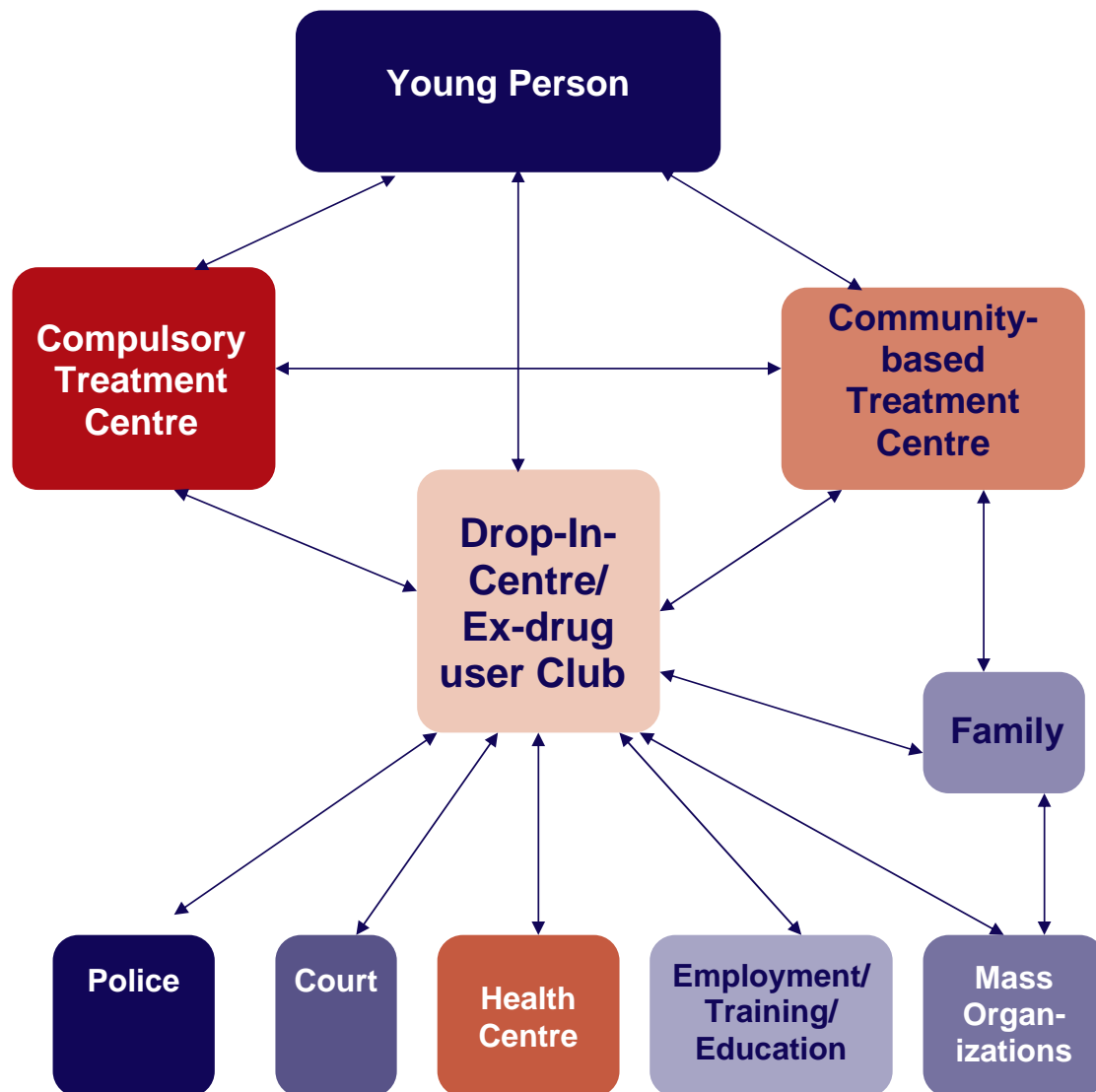


## Community-based treatment for young drug users



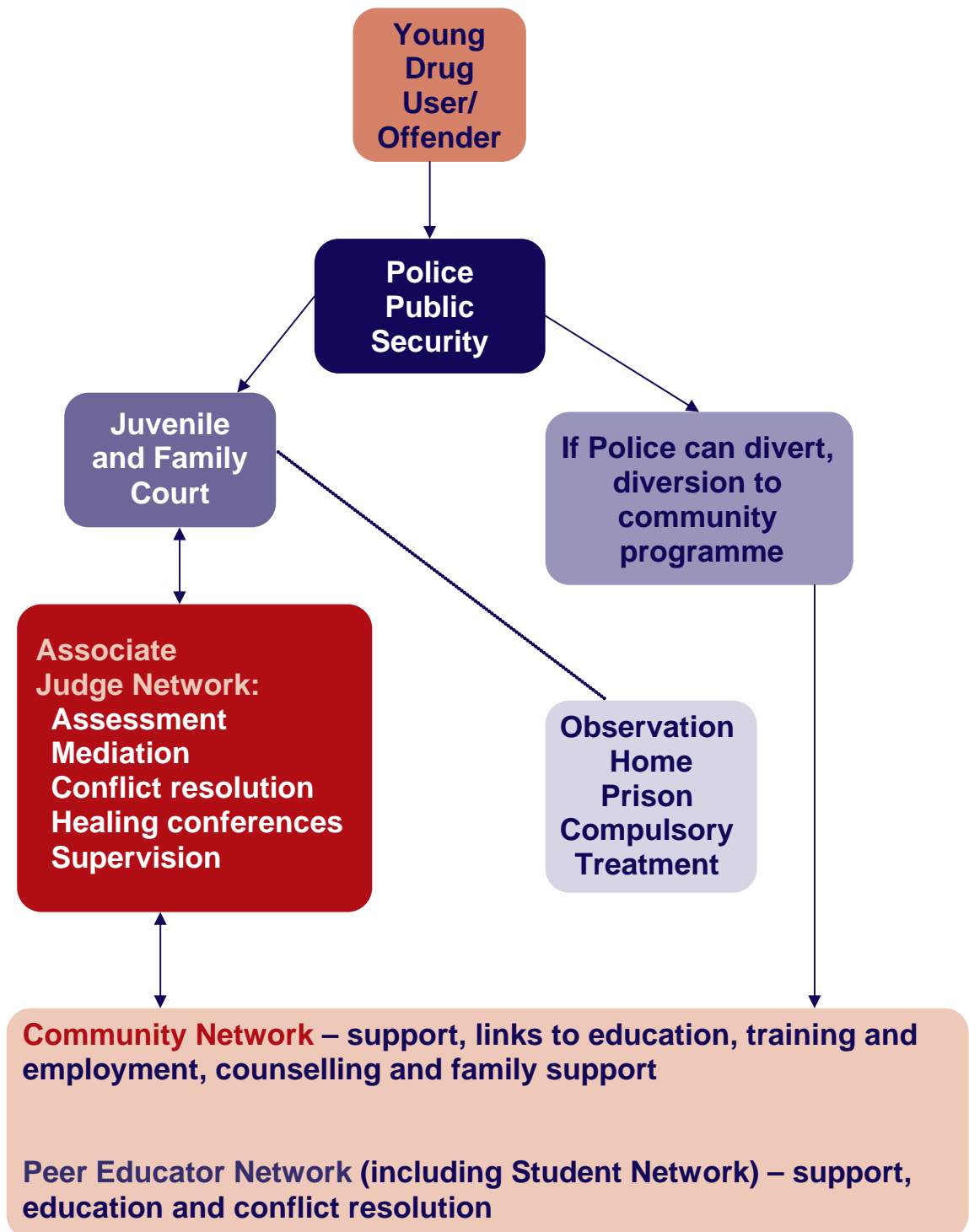


## The HUB approach – for example a Drop-In-Centre

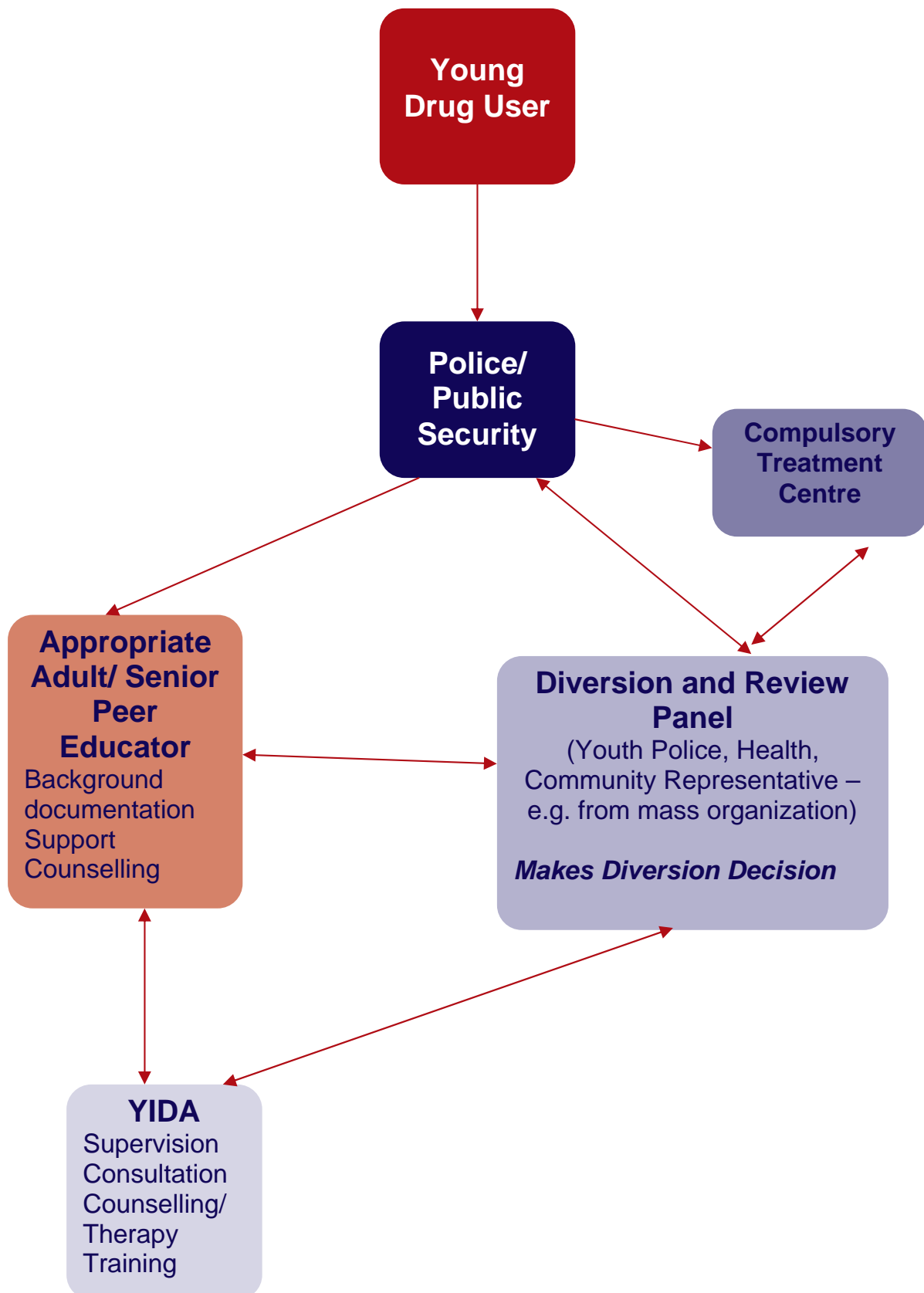




## Diversion - Thailand



## China: Possible Diversion for Young Drug Users





## Appendix A

### Documentation of the drug use situation in the participating countries

#### 1. China

This section includes edited material provided in various reports to ESCAP by the Yunnan Institute for Drug Abuse (YIDA).

#### Drug use among youth in China

##### 1.1. Introduction

Between December 2002 and March 2003 YIDA carried out substantive research in order to analyse the drug use situation among young people in Yunnan Province.

##### 1.1.1. Research methodology

Data were collected via five methods: documentary analysis; 41 key-informant interviews; focus group discussions with a total of 172 participants; quantitative surveys of 4,955 students from 11 middle schools; and case studies. The documentary analysis took into account all relevant books, articles and magazines on youth drug use, its prevention and treatment published in China since 1990.

##### 1.2. Youth drug use patterns

##### 1.2.1. Patterns of use

##### 1.2.1.1. Drug use spreading

In 1999, the National Drug Control Committee identified Yunnan, Guangxi, Guangdong, Guizhou, Sichuan, Gansu, Ningxia, Anhui, Henan and Xinjiang provinces as severely drug-afflicted areas. According to the Ministry of Public Security, the number of recorded drug users increased from 520,000 in 1995 to 901,000 in 2001.

Heroin and opium are the main drugs used in China. It is also common for people to use heroin with benzodiazepines such as triazolam and diazepam. Ecstasy and ketamine are also used, and poly-substance use is common.

##### 1.2.1.2. Users tend to be younger and less educated

Surveys show that new drug users who have used heroin for less than one year make up 28 per cent of the total drug users. In Yunnan Province, by the end of 2002, more than 50 per cent of new drug users were aged 18 to 25 years with the average age of female drug user lower than that of their male counterparts. In Yunnan Province, 62 per cent of all heroin users and 80.4 per cent of female drug users were younger than 25.

The majority had only finished primary school and 70 per cent had not completed junior middle school. A large proportion was jobless. Workers, farmers and self-employed persons also made up a considerable portion of those who used heroin. The use of heroin and other opioids by students was rare.

##### 1.2.1.3. Number of female heroin users is increasing

Since the beginning of the 1990s, the number of young female drug users has been rapidly increasing in China. A survey by the National Drug Control Committee in drug use centres in



14 provinces found that female drug users made up about 28 per cent of admissions. Also, the ratio between male and female drug users is shrinking: from between 4 and 10 males to every female, to about 3 male to every female drug user.

#### **1.2.1.4. Unsafe injection is very common**

Injection is the favoured administration route for heroin, with more than 60 per cent of heroin users being IDUs. Heroin is also 'inhaled' (by being heated on foil) or, to a lesser extent, smoked in cigarettes.

A survey among heroin users in Kunming City revealed that one syringe is used for two to three times on average. More than 68 per cent of surveyed heroin users admitted that they shared syringes with others or lent syringes to others. Most drug users who were younger than 20 years old thought that sharing syringes was very common.

The number of drug users who are infected with HIV is increasing, and the prevalence of other BBIs remains high. Ministry of Health statistics from 1985 to 1997 indicate the sharing of contaminated syringes accounted for 67.4 per cent of all HIV infections, and 50.2 per cent of patients with AIDS-related illnesses were IDUs. Data from Yunnan Province showed that the HIV prevalence among IDUs was 26.1 per cent in 2001, hepatitis B and hepatitis C prevalence among heroin users was 33.4 per cent and 39.6 per cent respectively, with a high proportion infected with both.

#### **1.2.1.5. Sexual risk behaviours are common**

Studies showed that it was common for drug users to have multiple sexual partners and that, at the same time, the rate of condom use was very low. In 2002, 38.2 per cent of drug users in 're-education through labour centres' in Kunming had from two to five sexual partners, with 36.7 per cent having had more than five sexual partners and 30.2 per cent never using condoms, 43.2 per cent using occasionally, 15.6 per cent using often and only 3.5 per cent reporting using condoms every time they had sex.

Another survey among 126 drug users in Kunming City revealed that 39.2 per cent of the female survey participants had been involved in sex work prior to their drug use, with around 88 per cent involved in sex work after having developed drug dependence.

#### **1.2.1.6. Drug availability**

Drugs enter Yunnan Province mainly through the border regions, especially through the areas bordering Myanmar, since these areas are close to the places where drugs are produced and processed. Scattered dealing occurs in towns and in the countryside along the three national roads leading to Kunming, serving as the main transporting routes for drugs. The linking areas between urban and rural areas, recreational places, crowded places, and the areas where administrative district limits meet are places where drugs can easily be bought.

Drug prices vary considerably. Drugs are quite cheap in the border areas and increasingly expensive the closer to Kunming they are sold. Meanwhile, drug prices also correlate with the efforts being undertaken to fight drug use. When the fight against drug production and drug trafficking is powerful, drug prices are likely to increase. Survey results have shown that most drug users spend between 1,000 Yuan (US\$ 120) and 2,000 Yuan on drugs every month.

A survey among 186 heroin users showed that the money for drugs mainly came from salary (39.8 per cent), doing business (25.3 per cent), demanding and asking relatives (21 per cent), selling property (17.7 per cent), stealing (11.8 per cent) and drug trafficking (4.3 per cent). According to a survey carried out in Sichuan, more than one third of the drug users who were younger than 25, and who were receiving treatment tried to obtain money for drugs through illegal activities such as stealing, defrauding, drug trafficking and sex work. Survey results



revealed that two out of three drug users had at one point been arrested or been sent to a re-education through labour centre.

## **1.2.2 Risk and protective factors**

### **Individual risk factors**

Present data and interviews revealed a set of personal variables that made it more likely that a young person would get involved in the use of drugs. These risk factors included:

- Curiosity, sensation seeking, searching for stimulation, impulsiveness
- Low self-esteem, emotional problems, depression
- Immature defence mechanisms (such as projection and denial)
- Antisocial behaviours, such as fighting, truanting and stealing
- Poor educational performance and school-dropout
- Interaction with drug users at a young age
- Lack of awareness of drugs and their effects
- Multiple sexual partners

The documentary analysis revealed that motivations leading to first drug use were curiosity, ignorance, seeking pleasure and overcoming depression. Research data also suggested that low self-esteem and the sense of incompetence were the two most prominent factors increasing the risk of drug use.

### **Family risk factors**

Family risk variables included:

- Lack of communication between parents and children, lack of mutual agreements and lack of mutual help and support
- Too much care and overindulgence
- Parents' indifferent attitude toward children
- Another family member's drug dependence
- Intense relationship between parents
- Parent's divorce
- Scolding/physical-punishment-centred family attempts at limit setting
- Child abuse

### **Social risk factors**

Social variables included:

- Drug accessibility.
- Social transformation: At present, China is in the process of changing from a traditional to a market economy. The related social transformation has exerted influence on people's values and morals. Research has shown that many young people are influenced by the idea that 'pleasure is most important' and regard drug use as a symbol of fashion, enjoyment and wealth.
- Unemployment: In recent years, it has become increasingly difficult for young people to find jobs. Thus, a growing number of unemployed youth may be idle at home and seek stimulation.
- Insufficient/inadequate drug prevention: At present, drug prevention is not carried out efficiently or in enough depth. Some shortcomings include lack of in-depth information, limited coverage, inflexible methods and 'officialism'.

### **Protective factors**

Some protective factors were mentioned during the interviews. These included:

- Being selective in making friends
- Avoiding contact with drug users
- Receiving good family education
- Strong will power

### 1.2.3. (Meth)Amphetamine use

In June of 2001, an investigation on the use and spread of methamphetamine was carried out in Menglian County of Simao Prefecture, Menghai County and Jinghong City of Xishuangbanna Prefecture, all in Yunnan Province. A one-to-one questionnaire survey was used with 74 methamphetamine users. Personal in-depth interviews were carried out with 22 methamphetamine users. Group interviews were conducted with local personnel, such as anti-drug staff, responsible leaders and staff of drug use centres.

At the time of this study the production cost of amphetamines in Myanmar was estimated at 0.2 to 0.3 Yuan per tablet with the lowest retail price on the market being 0.5 to 1.0 Yuan per tablet. When the drug entered Simao and Xishuangbanna Prefectures the price rose to 5 to 10 Yuan per tablet (about US 60 cents to US\$ 1.20).

The extensive availability of 'ice' provided the basis for a sharp increase in its use: More than two thirds of the interviewed amphetamine users (52 out of 74) started using 'ice' in the year of the study (2001) or the year before. The respondents either got the pills from their friends or bought them on the black market. Nine out of ten 'ice' users in this study were men. A large majority of respondents (57 out of 74) asserted knowing another 2 to 20 drug users who also used 'ice'. Some amphetamine users reported that there was a high proportion of regular and irregular 'ice' users among people working in casinos, hair salons and entertainment places.

Needing to stay alert or increase physical strength, resisting exhaustion, curiosity, detoxification from alcohol, and peer pressure were cited as reasons for consuming amphetamines. As for other effects of 'ice', respondents mentioned aggressiveness and increased sexual desire and activity.

## 1.3. Treatment

### 1.3.1. Treatment policies

#### Laws

An important legal basis for China's current drug control policy is the Decision on Drug Prohibition (promulgated by the Standing Committee of the National People's Congress on 18 December 1990). It defines different kinds of drug offences, and stipulates the respective penalties as well as the compulsory treatment modalities: "Those who take and inject drugs shall be detained for less than 15 days by public security organs. They shall be subject to a fine of less than 2,000 Yuan (about US\$ 240) as a single or mixed punishment. The drug and instrument for taking and injecting drugs shall be confiscated." In addition, "Those who are addicted to drug taking or injection shall, apart from being subject to the punishment specified in the previous section, be subject to mandatory abstention through therapy and education. Those who take or inject the drug again after the mandatory abstention shall be subject to second mandatory abstention by indoctrination through labour."

#### Regulations

In 1995, the State Council specified the appliance of different drug treatment methods in the Regulations on Compulsory Detoxification Centres. It stipulates that the time for drug abstention (detoxification period) should normally last two to three months and not exceed one year. The time for indoctrination through labour should not exceed three years. The regulation puts the public security organ in charge of the compulsory detoxification centres. As a law enforcement agency, it has the right to force drug users into pharmacotherapy, psychotherapy, legal education, moral education and physical training for a certain period.



## Rules

The Action Plan of China for Checking, Preventing, and Treating AIDS (2002 to 2005) envisages interventions in order to reduce risk behaviour which could lead to HIV infection. The plan suggests that community medical institutions offer experimental pharmacotherapy to drug users and thus provide a policy foundation for drug use harm reduction initiatives.

### The review of relevant policies as they relate to young drug users

In China, juvenile offenders are put on trial in juvenile courts. The overwhelming majority of juvenile courts only take charge of criminal cases committed by young peoples who are between 15 and 18 years. There is no court specifically responsible for drug-related young offenders.

All parties involved are to follow the basic rule that “education plays the major role and punishment the minor role” if the suspect shows any of the following:

- He/she has committed crimes only occasionally and the offences are of minor gravity.
- Though the crime is serious, he/she has surrendered to the police and contributed to the legal proceeding.
- He/she is an accessory offender, has been coerced into committing the crime and has shown remorse.

The use and injection of drugs is illegal in China. Drug users who are younger than 18 years are destined for compulsory treatment for three to six months, with a maximum period of one year. The compulsory treatment is provided by public security agencies.

Interviews among drug use centre staff and in other relevant institutions revealed that young people who are both drug users and drug offenders are at first sent to compulsory drug use centres for treatment, and then transferred to detention centres for judicial procedures.

During compulsory treatment in the drug use centre, juvenile drug users who have a criminal background undergo the same treatment as other clients, meaning that they are not separated from other juvenile or adult drug users, who apart from their drug use are not involved in any other criminal activity. Due to limited resources, young and adult drug users, offenders and non-offenders live in the same surroundings.

Relevant legislation is briefly summarized below.

Addiction to drugs is defined in “The Ministry of Public Security’s Official Reply on the Definition of Drug Users’ Addiction” as follows: If evidence shows that a user’s urine tests positive, then he is defined as being addicted. As for the people who used drugs in the past but evidence shows that they do not use drugs again and their urine test shows that they are not using drugs, they will be defined as not being addicted. For those whose urine tests are positive but drug use evidences are not adequate, urine tests should be made again for confirmation. If conditions are available, naltrexone may be used for further medical examination and confirmation.

**“The Law of Drug Control of the People’s Republic of China (Draft)” stipulates that:**

1. Public security agencies can demand drug users to accept community detoxification treatment and notify their sub-district offices or township/town governments where their household registers are. The duration of community detoxification treatment is three years.
2. If addicted drug users have one of the following phenomena, the public security agency at the county level or higher level can make decisions for them to undergo compulsory detoxification treatment:
  - a) Refusing to accept community detoxification treatment;
  - b) Continuing to use or inject drugs during community detoxification treatment;
  - c) Violating community detoxification contract seriously;



- d) Continuing to use or inject drugs after community detoxification treatment or compulsory isolated detoxification treatment;
  - e) If the users are seriously addicted and it is hard to get rid of addiction by way of community detoxification, public security agencies can make direct decisions for users to undergo compulsory isolated detoxification treatment.
3. Compulsory isolated detoxification treatment is not applicable to women who are pregnant or feeding babies younger than one year old. Compulsory isolated detoxification treatment may not be applicable to people younger than 16 years old.

**“The Law of the Protection of Juveniles of the People’s Republic of China” stipulates that:**

1. Juveniles are citizens younger than 18 years old.
2. Juveniles in detention or imprisonment should not be kept with adults. Relevant agencies should provide compulsory education for juveniles in detention or imprisonment who have not finished compulsory education.

**In “The Law of the Prevention of Juveniles’ Crimes of the People’s Republic of China” it is stated that:**

1. This law defines juveniles’ use or injection of drugs as “serious unhealthy behaviours”.
2. As for juveniles who have serious unhealthy behaviours defined in this law, their parents/guardians must cooperate with their schools to discipline them strictly or send them to reformatory schools for correction and education.
3. During the period when juveniles are in detention, authorities should ensure that the juveniles can continue to receive schooling, legal knowledge and vocational/technical education. For the juveniles who have not finished compulsory education, they should ensure that they can continue to receive compulsory education.

**It is stipulated in “Measures for the Management of Compulsory Detoxification Treatment” that:**

1. “Women who are pregnant or feeding babies younger than one year old” should not be sent to compulsory detoxification centres. Decisions must be made for them to conduct detoxification treatment outside compulsory detoxification centres.
2. Compulsory detoxification centres must manage drug users separately according to the difference of sex, or whether juveniles or adults.

**It is mentioned in “The Regulation of Drug Control of Yunnan Province” that:**

Parents or guardians should educate juveniles to prevent drug use. If juveniles have the behaviours of using or injecting drugs, parents or guardians must discipline them strictly and demand they give up drug use.

### 1.3.2. Treatment modes

At present, there are two kinds of therapies for drug users in China, namely compulsory and voluntary detoxification. While the latter is mainly carried out with medical consideration paramount, the former is a mandatory approach in accordance with the law. Currently, compulsory detoxification and drug abstention by re-education through labour are the main treatment modes in China.

Drug treatment may take place in four settings:

- Compulsory detoxification centres operated by public security;
- Mandatory re-education through labour centres operated by the Justice Department;
- Voluntary medical drug treatment institutions which are part of the health system; and
- Households of a few drug users who have managed to complete their drug treatment in the community.

There about 750 compulsory detoxification centres and 170 mandatory re-education through



labour centres in the country. There are over 90 compulsory detoxification centres in Yunnan Province as well as about 25 voluntary detoxification centres.

### **1.3.3. Compulsory detoxification**

The majority of the clients of compulsory detoxification centres are heroin users. None of the centres where interviews were carried out had received or treated amphetamine users. This was not the case in 2008 where a significant minority of new admissions were young ATS users. Drug users under the age of 20 accounted for 10 to 30 per cent of the total number of clients treated.

The re-education through labour centres receive drug users who have finished compulsory detoxification. Juveniles under 16 are not subjected to this treatment. The compulsory detoxification centres adopt a uniform management throughout the country. Most centres do not offer special treatment for juvenile or teenage clients.

Young drug users who are at the same time guilty of serious violations of a law are subject to judicial procedure after compulsory drug treatment.

### **Medical management**

The drug abstention institutions have doctors and nurses. Drug users are subject to ordinary physical examination and diagnosis in order to select correct medication for the detoxification. High-risk patients with serious illness and/or serious psychological problems that demand treatment exceeding medical and technical capacities are transferred for specialized treatment.

### **Detoxification**

Detoxification methods include substitution of opium-like or non-opium-like medicines, traditional Chinese medicines, or 'cold-turkey', appropriate to diagnosis on admission.

### **Recovery**

Recovery therapy does not allow much room for individual therapy schemes. Clients are required to adapt to a military-like management routine which includes: a strict daily schedule, drill and physical exercise, housekeeping, courses on culture, the legal system, current events, morality, physical health, self-examination activities (such as acknowledging drug harm and writing personal experiences), various recreational and sports activities, adequate productive labour, as well as 'heart-to-heart' talks.

A group interview with teenage drug users in a treatment centre showed that about 50 per cent received education on drug use. It also revealed that present drug education is far from being in depth or effective.

Treatment centres report to have carried out harm reduction activities and to have developed prevention education communities, but according to teenage focus group members they scarcely do so. In addition, relapse rates are quite high.

### **Expenses**

Clients and their families have to pay the cost of living and the therapy expenses. Those who are truly unable to bear the expenses may benefit from a cost reduction or exemption. The country appropriates a certain amount of drug abstention funds to support the institutions.

## Exit management

When a client completes compulsory detoxification and leaves the institution, a “Contract of Guaranteed Education” is required and signed by the immediate relatives. The contract demands that the relatives conduct after-care recovery supervision. Clients who have completed re-education through labour are given a certificate. There are rarely effective.

### 1.3.4. Voluntary detoxification

Voluntary detoxification is offered in both mandatory as well as medical drug abstention institutions. However, the two types of institutions are quite different in management and therapy.

Compulsory detoxification centres usually establish a separate section for voluntary detoxification in order to receive drug users who are either seeking drug abstention of their own accord or have been sent by their families. The voluntary detoxification section is usually situated in a separate ward and the therapy term is two to three months.

Medical drug abstention institutions use mainly medicated detoxification approaches. The centres are usually staffed with medical and nursing personnel specialized in psychological health. The majority of clients of these centres use heroin or hypnotics as well as sedatives. Occasionally, stimulant users are present for diagnosis or consultation.

Voluntary detoxification centre therapy can be carried out in the form of an *ambulatory therapy* or through *hospitalization*. Ambulatory therapy focuses on medicated detoxification combined with counselling and psychological guidance. The therapy lasts about seven days and the reported relapse rate is as about 30 per cent to 40 per cent.

Hospital-based detoxification is provided in a closed ward and mainly offered to drug users between 20 and 35 years old. Less than 10 per cent of the clients are younger than 20. The process takes 10 to 20 days and the relapse rate is reported as about 20 per cent. However, there are few systematic individual therapies provided, little assessment and a lack of post-detoxification care and rehabilitation. Also, there are few interventions for young drug users and their families. The drug user and his/her family assume the expenses, amounting to around 2,000 to 3,000 Yuan.

### 1.3.5. Harm reduction

Among the ongoing harm reduction programmes currently provided in China are:

- IEC activities
- Peer education – outreach and within compulsory treatment centres
- Needle exchange projects
- Promotion of condom use
- HIV counselling and testing
- Drug substitution treatment - methadone

Evaluations of these interventions are showing promising results.

### 1.3.6. Case studies

#### 1. Yang

Yang was born in Guandu District, Kunming City. He is the only child of his parents. Currently, he is living in a village which has 50 to 60 households, with 14 or 15 drug users, most of them aged 24 or 25. Among local villages, Yang's village has the highest number of drug dependant persons and has even had drug-related deaths. One drug dealer, a drug user himself, encourages others to use drugs. So far no drug user in the village has



been successful in abandoning drugs. The village does not have a villagers' committee or an equivalent organization, and has never conducted activities to educate drug addicts or publicize knowledge on drug dependence. In Yang's family history, aside from the Yang, there is no history of drug dependence.

Until the age of six, Yang developed much like his peers. Academically, he performed poorly at grade one and two and had difficulties in understanding what the teachers were explaining. Although his parents helped him review his homework after school, he failed to catch up with his classmates. It was only when he moved to grade three and a new teacher took over his class that he began to perform better. Soon he became a member of the class committee, responsible for disciplining his classmates and aiding the teacher in class affairs. When he moved to grade five and six, he began to dislike doing his homework and sometimes asked others to do it for him. As a result, his academic performance began to gradually decline. His primary school teacher thought him a rather quiet student being able to get along well with his classmates, but in fact, he often fought others after he moved to grade three. He was admitted to middle school by cheating during the entrance examination.

Because of an overall bad academic performance at primary school, he had difficulties to understand what his middle school teachers taught. His parents had not received middle school education, so they could not help him with his study. Starting from grade two, he began to play truant frequently, spending his class hours wandering about or playing video games on the streets.

At grade one and two, he began to smoke from time to time out of curiosity or the desire to imitate the students at senior grades. But when he moved to grade five, he smoked so much that he soon became dependent. He often smoked outside school in order to not be caught by his teacher. Afterwards, his parents caught him smoking but seemed not to be opposed to it. At grade four, he had his first love affair with a girl from a higher grade of the same school, and at grade six, he had another love affair with a girl at junior middle school grade two, both girls being introduced to him by friends.

Since his entrance to the primary school, he performed well in physical training. He was a member of the track and field team of his primary school and middle school and once a member of the class committee in charge of class affairs in physical training at middle school. He was good at short-distances and playing basketball.

He was reluctant to change schools and cut class for one week, killing time by playing video games on the street all day long. After being caught by his teacher, he discontinued his studies in 2000.

Back home, he had nothing to do, spending time with his peers in the village, who had also left school. He had a close friend in the village who was four years older than him and with whom he had got along well since they were little boys. Their homes were very close to each other, and their parents got on well. It was not until he saw his friend using heroin together with some of his other friends that he began to realize that his friend was addicted to drugs. He had known that there were people in the village taking drugs when he was at grade six of primary school. However, he did not receive any drug prevention education at school. His parents and some of the drug addict's families told him never to touch drugs when he was studying at the middle school.

After staying with the drug users in the village for a period of time, he became curious about his friends' experience and decided to have a try. One day in early 2001, he used heroin for the first time. At the beginning, he felt really sick, with slight dizziness and itching of the skin. He used again one week later, and then again five days later. Four or five months later, he found himself dependent on heroin. He used heroin once a day in the beginning, mostly between 11 and 12 at night when he and other drug users in the village went out to have midnight snacks. He took a small dose at first, about 10 Yuan's worth. But after he became



dependent, he used twice a day with a doubled dose. He got money from his parents. He and his friends took the drugs by smoking instead of injecting them. While heroin was the main drug he took, sometimes he would use a combination of heroin and triazolam (halcion). When he tried the first and second time the heroin was provided by his friends for free. Since then, upon his friends' advice, he bought it at a village about 7 kilometres away from his home.

In late 2001, his parents sent him to his uncle-in-law to learn to sell auto parts at the Kunming Eastern Bus Station. Before that, he once tried to abandon drugs at home, after realizing their harmfulness. While staying with his uncle-in-law he did not take drugs for more than one month. But when he went back home for the weekend, he met his old friends and soon relapsed into his old habit. Later, he found himself more drug dependent than before, having to take drugs four or five times a day with his drug related spending increasing to 50 to 60 Yuan a day. Soon his parents, finding him looking not well and becoming thinner day-by-day, realized he was dependent. Then, he gave up the job with his uncle-in-law and stayed idle at home.

While taking drugs regularly, he found himself in weak health, lacking strength and motivation. He also found it not as enjoyable as before, feeling more prone to irritation, although he still did not want to abandon drugs. But when his drug dependence began to show side effects he started to blame and hate himself for it. He had sex with three girls and never used a condom.

In late 2002, his friends reported his situation to the police when they were imprisoned for drug offences. After being informed by the police, his mother decided to send him to a drug-relief reformatory for compulsory treatment. They used Gong'an No. 1, a drug-relief pill, to treat him at the reformatory. He had a well-regulated time at the reformatory with jogging in the morning, staying in his dorm all day and night except for short dining periods and outdoor activities. At present, he has been physically drug-free for three months, and has basically recovered his health condition. Now he is in a relationship with a girl who knows his drug history.

His parents have spoiled and coddled him since he was born, and done their best to supply all his wants (satisfy all his requirements). They have verbally blamed him for mistakes he has made, and have done little else if he does not listen. When he was a little boy, his parents did not seem to have placed particular hopes on him, only wishing him to study as hard as he could at school. When he discontinued his study at school, they seemed to have no expectation of him any more, only wishing him to be away from drugs. His parents felt really disappointed after learning that he was dependent on drugs, since they and other relatives had always seen in him an obedient person. However, they have shown great care for him since that.

## 2. Li

Li was born in Guiyang City in China's Guizhou Province. She is the first child of her parents and has a younger brother. She is 17 years old, currently staying idle at home. Her maternal grandparents brought her up till the age of four. Since then she has lived with her parents.

Many of her neighbours took drugs, but they did not associate with her. She went to school at the age of seven. At the beginning, she was not bad academically, but when she moved to grade four (about 11 years old), she became too fond of playing. She often went to video game rooms on the street, staying there about one hour each day, her spending being the pocket money from her parents. On the street, she made friends with some children who were two or three years older than her, and she often played truant in order to play with them. Accordingly, her academic performance began to decline. At the age of 12 when she moved to grade five, she imitated some of her classmates and began to smoke. At the beginning, she bought some loose packed cigarettes at the grocery near the school, and had half a cigarette each day. Now she smokes six or seven cigarettes each day. Her parents did not know about this at first, but did not stop her when they found out. She began to drink at the



age of 13, but did not drink much. After she finished her primary school education at the age of 13, her parents asked her if she wanted to continue schooling. She answered “No”. Ever since, she has stayed idle at home. She has an extroverted and cheerful disposition and is fond of music and singing.

One day at the age of 12 she went out to play with some of her classmates, and stayed over at a classmate’s place. One of her male classmates forcibly had sex with her that night. Feeling very upset she intended to expose him, but did not do so considering it to be too shameful. Later on, she talked it over with one of her close friends and asked him to find someone to punish the culprit, but she had no idea what to do. Since, she has had four boy friends, two of them two years older, one three years older and one five years older than her. She has voluntarily had sex with each of them, but has broken up with them. She has not been pregnant so far, but her parents worry that her early sexual behaviour will have a negative effect on future childbirth.

She has been on very good terms with her maternal grandparents, who brought her up at a young age. Her maternal grandfather, aged 73, is a former construction worker. Her maternal grandmother died of gastric disease in 2001, at the age of 60. Regarding men as superior to women, her paternal grandparents often blamed the subject’s parents of having given birth to a girl. As they apparently did not like the subject and her family, they rarely associated with them. Li’s grandfather died of cirrhosis in 1995, while her grandmother died in late 2002. Her grandparents did not have very harmonious relations, often quarrelling with each other. Her two uncles are both alcohol dependent.

Li’s parents have only elementary education and run a small grocery. They do not have harmonious relations, often getting into arguments. Her father is also dependent on alcohol. In the subject’s earliest memories from about the age of two, her father was often drunk and used to come home late at night quarrelling with her mother and beating her. After staying at home doing little, her father often got her up scolding and even beating her at times asking why she did not go to school.

She rarely cared about her homework before she dropped out of school. Generally speaking, her parents educated her mainly with words and rarely used violence, and the subject seems able to accept most of their advice. Meanwhile, her father is having a relationship with another woman, and both the subject and her younger brother hope that their parents will divorce.

After Li had dropped out of school, she made friends with some drug-using young men in 2002. After she had seen them taking drugs several times, some of them asked her one day if she wanted a try. She thought it to be an interesting thing and tried heroin although she knew that it was harmful. Immediately after, she felt dizzy and uncomfortable. Later, finding it interesting, she took drugs once a month or once a week. About two months later, she found herself dependent. Physically she found it uncomfortable, and mentally she was seriously dependent. At the beginning, she took 0.2g of heroin each day by smoking it. Half a year later, after her friends had told her that injection saved dosage and gave a longer lasting effect, she began to take heroin by injection.

Prior to her first stay in a drug-relief reformatory, she injected herself 0.9g of heroin each day in three separate doses. Starting from December 2002, she began to take triazolam orally (three times a day, 0.5mg each time) after heroin injections. She once shared a syringe with her friends. In the beginning, she got free drugs from her friends, but once she developed addiction she had to pay them. When she was about 15 years old, she began to work for a nightclub, entertaining the customers by encouraging them to sing, dance and drink. They touched her sometimes, but never had sex with her. She received 3,000 to 4,000 Yuan from the nightclub each month, spending most of the money on drugs. Her family never knew that she worked for the nightclub. By and by she became thin, lacked strength and often caught colds, but without coetaneous infections. In the meantime, she became more and more unsociable and unwilling to associate with others and to talk to others about her situation. She

spent all her time on making money and finding drugs. She regretted having become drug dependent and once burned her arms with a cigarette butt. She once tried to cease drug use on her own, but found it extremely torturous to suffer from sleeplessness, fever and 'itching inside the bones' after stopping use. After having been told by her friends that Tramadol (a strong analgesic) would help, she bought some at a private drug store and took it twice a day, two tablets each time. It helped a little and she could stand the withdrawal syndromes for the next two hours at most. Three days later, unable to stand it anymore, she relapsed.

After learning that it was easy to find drugs in Kunming City, she went to there in 2002 bringing her little brother with her, telling her parents that she would travel to Kunming together with her brother. The police caught her in January 2003 when she was found injecting herself at a hotel, and she was then sent to the Kunming Drug-relief Reformatory. Except for her brother, her family has not discovered that she takes drugs and that she has been imprisoned in a drug-relief reformatory in Kunming. Her parents were suspicious of her before she left for Kunming, but she denied using drugs and her parents did not look into it and were just telling her never to touch drugs. The police promised to send her brother home, but the result remains unknown. They used a kind of drug-relief medicine on her; three times each day five capsules each time. The medicine had a mediocre effect on her. Now she is engaged in physical training, labour and other compulsory activities regulated by the reformatory. She is sleepless sometimes, feeling in-depth regret and depression, but has no intention of committing suicide. She wishes to never touch drugs again, but has no idea how to succeed. She is unwilling to tell her parents about her situation. She desperately wants to go home to celebrate the Spring Festival but has no plans for the future.

Li has not received any education concerning drug use and/or HIV/AIDS so far. She once had a close female friend to whom she could talk honestly and who had tried to convince her many times to abandon drugs.

She had promised this friend never to touch drugs again. After talking deeply with her about her problems one day in mid-2002, her friend became disappointed with her. Now her brother is the person to whom she is most willing to talk to about her thoughts and worries. She has broken up with her drug-using friends now, and four of them have been sent to re-education and rehabilitation schools.



## 2. Lao PDR

### Drug use among young people in Lao PDR

This section provides edited material supplied in various reports to ESCAP by the Participatory Development Training Centre (PADETC) and VYC and the project consultant's field visit reports.

#### 2.1. Introduction

PADETC carried out substantial countrywide research on youth drug use during the first quarter of 2003. PADETC investigated current patterns of drug use among youth, tried to identify risk and protective factors influencing young peoples' attitudes towards drug use, and assessed existing drug prevention and treatment services for youth.

The research was mainly based upon quantitative surveys and focus group discussions among seven sample groups: construction workers, *tuk tuk* drivers, secondary school students in rural and urban areas, dormitory students (university and college level), garment workers and drug rehabilitation centre clients. In addition, existing documents on drug use in Lao PDR were analysed and a few in-depth interviews undertaken.

Data collection was carried out in the provinces of Luang Namtha, Luang Prabang, Vientiane Municipality and Savannakhet.

The focus groups were conducted by a team of young interviewers in each site, who were trained thoroughly on focus group and survey techniques and who were familiar with hidden populations such as street children, unemployed people, sex workers and truck drivers. Each focus group discussion lasted approximately ninety minutes.

#### 2.2. Drug use among secondary school students

A survey on drug use among secondary school students was undertaken in four provinces of Lao PDR: Vientiane Municipality with its school population; the transit hub Savannakhet; the tourist centre of Luang Prabang; and Luang Namtha, one of the main places of opium-poppy cultivation.

Of roughly 14,500 students in these four provinces, a total number of 1,006 students (or almost 8 per cent of the total school population of these provinces) filled out a structured questionnaire. Survey participants were aged between 12 and 20, both male (55 per cent) and female (45 per cent) and living in urban as well as rural areas.

#### *Findings*

The large majority of respondents (94 per cent) lived with their family or relatives, 60 per cent lived in cities, 27.6 per cent in towns and 10 per cent in rural areas, and the majority were supported financially by their parents.

While every fourth student reported spending his/her money primarily on living expenses, 6 per cent said that spending their money on drugs was their first priority. For 17.5 per cent of the respondents buying drugs was their second priority.

#### *Knowledge about drugs*

Six out of ten secondary school students (59.7 per cent) reported that they knew of at least one drug. The most familiar substances were cannabis, opium and ATS. However, knowledge about different categories of drugs varied considerably in the four provinces, with ATS being the most well known drug in Vientiane and Luang Prabang. Knowledge about drugs in general appeared to be much lower in these two survey sites than in the other provinces, as

in Savannakhet where 235 out of 270 students (87 per cent) claimed to know ATS. Cannabis and opium were known by 36 per cent and 20 per cent of respondents respectively.

In the poppy growing province of Luang Namtha students had by far the most knowledge about drugs. Also, students from Luang Namtha province appeared more open on the issue than other groups and were very enthusiastic to respond to the questions. Cannabis and opium were very well known (by 89 per cent and 79 per cent of students respectively), followed by ATS, which was mentioned by 64 per cent.

In general, secondary school students got information on drugs through the media or from their teachers. Friends and acquaintances also played a role as drug information providers. The majority of students underestimated the grave consequences drug use could have. For all drug types, except ATS, more than half of the students did not know whether the respective substance was addictive or not. A significant proportion of respondents believed that certain types of drugs were not addictive at all (17 per cent for opium, 16 per cent for heroin, 15 per cent for morphine, 18 per cent for cannabis, 1 per cent for cocaine). Almost every fourth student (23 per cent) thought that ATS did not cause dependence.

Knowledge about harmful consequences of drug injection was limited. While some respondents (18 per cent of the sample) knew that injecting drug use could lead to HIV infection only 34 out of 1,006 students (3.4 per cent) were aware of the risk of hepatitis B or hepatitis C transmission through drug injection.

Every fourth respondent (26 per cent) acknowledged having at least one drug user among their friends. Respondents who reported having one or more drug using friends tended to be drug users themselves ( $p < 0.05$ ).

### **Drug use patterns**

Study results indicated that 14.3 per cent of the Lao secondary students surveyed had tried some form of drug at some point during their lifetime. However, lifetime drug use differed enormously between the four provinces. Lifetime prevalence was as high as 24.1 per cent in Luang Namtha. In Savannakhet every fifth respondent (20 per cent) had ever used a drug. In Luang Prabang, lifetime drug use was 9 per cent.

In Vientiane Municipality only 5 out of 267 students (1.9 per cent) reported to have ever used a substance. This is a considerable decline compared to November 1999 when a study by UNODC among 2,631 students in Vientiane Municipality identified a prevalence of lifetime drug use at 17.5 per cent.

Comparison of the current study with the UNODC survey from 1999 reveals the contrary trend for Luang Prabang and Savannakhet provinces where lifetime prevalence of drug use among students in 1999 accounted for 5.5 per cent and 7.6 per cent respectively.<sup>1</sup>

The present data show that quite a few students used ATS (lifetime prevalence 9 per cent) and cannabis (lifetime prevalence 6.2 per cent) at some point in their lives. Opium was predominant in Luang Namtha. The group most at risk for drug use were those between 15 to 19 years old. Men reported a higher percentage of drug use at some point during their lifetime (19.4 per cent) compared to women (6.5 per cent).

Current prevalence of any drug use for the total sample was 8.2 per cent with a peak current drug use of 19.3 per cent in Luang Namtha province. In Luang Namtha province 32 out of 52 current drug users used cannabis and 7 students used opium, a drug that none of the respondents in the three other regions reported to have used. Savannakhet province had some current ATS use (7.8 per cent). Current drug use in Vientiane Municipality was limited to 2 students (0.75 per cent) both using ATS.

<sup>1</sup> UNODC (2002). Drug Abuse Among Youth in Vientiane. School Survey, Internal document of the UNODC Regional Centre for East Asia and the Pacific, Bangkok, p.6 and pp.47-49.





Those who used several substances at the same time tended to combine ATS and cannabis (22 students), ATS and opium (18 students) or opium and cannabis (10 students). Inhaling and smoking were the predominant routes of drug administration. Some students took drugs orally, while only one respondent reported to inject substances. The main reasons for drug use were curiosity, peer pressure (“imitating friends”) and the search for expected benefits such as “relaxed feeling” or “happy feeling”. As indicated earlier, the drug used by most students seems to be ATS. Prescribed drugs (sedatives, barbiturates, etc.) which were, according to UNODC, the most popular substances in 1999/2001, were apparently out of fashion.

### ***Risk factor: disharmonious family background***

Physical abuse occurred intermittently during some respondent’s childhoods. There is an important relationship between the use of ATS and physical abuse ( $p < 0.05$ ). Emotional maltreatment was quite critical and significantly linked to ATS use ( $p < 0.05$ ). Some students had suffered from occasional sexual abuse during childhood. The use of some drugs (ATS, opium) appears to be closely linked to sexual abuse during childhood ( $p < 0.05$ ).

### ***Delinquency, family interaction patterns and family drug use***

A small number of secondary school students (2 to 8 per cent) had been involved in illegal activities at least once in the last twelve months. A significant correlation was observed between stealing and the use of ATS, opium or cannabis ( $p < 0.05$ ). Those who had been arrested by the police were at the same time likely to be among those who used ATS or cannabis ( $p < 0.05$ ). ATS or cannabis use was also correlated to financial penalties during the previous 12 months. Imprisonment was significantly associated with the use of ATS or opium ( $p < 0.05$ ).

A significant relationship could be observed between divorced parents and the child’s cannabis use ( $p < 0.05$ ). Also, students whose parents were not living together were more prone to use ATS. The present survey confirms family drug use as a major risk factor leading children to drug use. Opium/ATS use among secondary school students was strongly correlated with parents’ drug use ( $p < 0.05$ ). Students also tended to use ATS or opium if their grandparents or their uncle/aunt had been using drugs ( $p < 0.05$ ).

## **2.3. Drug use among students of National University, Vientiane**

The National University of Laos, with its headquarters in Dongdok, Saythani District, Vientiane Municipality, has about 8,000 students. While it was believed that ATS (*ya baa*) was the preferred drug among students and that its use was widespread, an assessment of the drug use situation among these students had never been conducted.

A survey that comprised both a qualitative as well as a quantitative part was conducted. Three focus group discussions with 8 to 10 participants each were held among male students aged 17 to 26 years and living in the dormitory of the National University. The students were selected randomly and took part in the discussion on a voluntary basis.

### ***Findings***

Comprising 60 students in total, the sample group was 70 per cent male and 30 per cent female. Most of the students (58 per cent) were between 20 and 24 years of age, 30 per cent were between 17 and 19 and 12 per cent were aged 25 or 26. All students had accomplished upper secondary school education prior to the admission to the National University.

The majority of students received subsistence money from their parents, some had part-time jobs. Only one student out of 60 said that he used money primarily to buy drugs. Two students considered drugs to be the second most important thing to spend their money on, four students rated drugs as their third priority. The majority of students used the money received from their parents primarily for subsistence expenses. Spending money on alcohol and gambling seemed to play a minor role.

### **Student knowledge about drugs**

Thirty six students (60 per cent) knew at least one drug, with ATS being known by almost half (29) of the respondents. Opium was known by 20 students and cannabis by 17. Sedatives were mentioned by 8 and heroin by 7 respondents.

Male students were more knowledgeable about drugs than their female peers. Whereas 32 out of 42 male respondents (76 per cent) knew at least one drug, only 4 out of 18 female students (22 per cent) knew any substance.

Eight students could give an estimation of the price of one *ya baa* tablet, while four were able to estimate the price of opium.

The large majority (88 per cent) reported getting information about drugs from the media. A fourth of the students mentioned friends as a source of information, 20 per cent of students reported receiving drug information from teachers.

### **Student drug use patterns**

Thirteen out of the total sample of 60 students had tried some form of drugs at some point in their lifetime. While lifetime prevalence of drug use in all students was 22 per cent, male students at 31 per cent were more prone than female students at 11 per cent.

The most important drugs of initiation were opium (3 respondents), ATS (3 respondents) and nicotine (3 respondents) as well as alcohol (2 respondents), glue and sedatives (1 respondent respectively).

Poly-drug use was common among those who used drugs. Most lifetime drug users had experience in using combinations of three to five substances. However, there was no considerable poly-drug use among the six current drug users.

Current drug use prevalence was 10 per cent with the majority of current drug users (4 out of 6) being between 17 to 19 years of age. Current drug use prevalence for the 17 to 19 year age group was 6.7 per cent.

ATS was the most commonly used drug. Six students (10 per cent) had used it at least once in their life and four were currently using ATS. Opium and cannabis had been used at least once by five respondents, but no one had used either of these drugs within the previous 12 days. Eight students said that they had used substances which fall under the category of sedatives (excepting barbiturates) and one student was currently using sedatives other than barbiturates. Preferred routes of drug administration for the entire sample were smoking and inhaling.

The main reasons given for drug use by the 13 lifetime drug users were curiosity followed by expected benefits through an energetic boost (staying up late, being strong), increased sexual desire, happiness and peer imitation. Relaxation and avoiding misery and sadness were also mentioned.

Six lifetime drug users reported the frequency of their drug use. One subject used drugs more than four times a day while the other five students reported to use substances once a week. All eight subjects who commented on drug availability said that it was easy or very easy to get drugs. Most of them bought drugs from acquaintances.

More than every third student (21 subjects) had at least one friend who used drugs. Five students reported to have more than five drug using friends. As among the drug users in the sample, smoking and inhaling was reported as the preferred route of administration among the respondents' drug using friends. Three students reported to have friends who took drugs parenterally (by injection). Almost two thirds of the students (65 per cent) reported not having any friend who used drugs.



### **Qualitative results**

According to participants of the three focus group discussions, university students used ATS (*ya baa*), alcohol and nicotine as well as cannabis (*ganja*) and opium. The accessibility to drugs was reported to be easy because drug users usually had friends who could provide drugs. However, some of the students mentioned that access to drugs could be limited by current law enforcement efforts.

Focus group participants indicated that between 30 and 40 per cent of students used drugs. Drug users were considered to be aggressive, antisocial, pale and thin. Hence, drug use was generally seen as unhealthy although respondents linked it to a bad physical health appearance instead of the transmission of blood-borne diseases. Many students thought that using drugs was an individual's choice based on curiosity and peer pressure.

Family conflicts, social environment (drug using friends, family members or peer pressure), school problems and relationship problems with girlfriends or boyfriends were regarded by participants as risk factors which might lead to drug use. High self-esteem, the ability to adapt to challenging life situations, as well as the awareness of the harmful effects of drug use were considered to be protective factors. Focus group participants thought that drug users should primarily appeal to their family and relatives in order to get help.

### **2.4. Tuk tuk drivers**

At the time of the study there were 1,050 *tuk tuk* drivers in Vientiane Municipality. They were defined as a high-risk group. There had been no study on drug use among this group, especially young *tuk tuk* drivers. This group was seen as knowledgeable about drug use and availability.

There were 10 *tuk tuk* drivers aged 18-25 in each of the two focus groups.

### **Main findings**

#### **Drug problems – knowledge about drugs**

The majority of respondents mentioned that *ya baa* was the most popular or 'fashionable' drug of use among *tuk tuk* drivers when compared to other groups. They agreed that people started using this drug by the age of 17. They did not mention the expected benefits from each kind of drug used. They said that if people used too much of any kind of drug, they would hallucinate - similar to symptoms of a psychotic disorder - their memory would decrease, and they would feel dreamy. They added that if people used glue or heroin, they would be dreaming, if they used cannabis, their ability to do things would be increased. Most of them remarked that the accessibility of drugs had become more difficult than before, because the police seemed to be strictly enforcing the law and so the supply was reduced. They estimated that 30-40 per cent of young people were using drugs. They thought that students were the most vulnerable groups to drug use due to their curiosity.

Many people were curious to consume a drug and to discover the effects. The everyday life of those who continued to use drugs then changed, for instance they became a source of danger for their own family and they stole and committed delinquent acts. Participants remarked that the community needed to provide care for drug users.

#### **Discouraging factors for drug use – negative consequences of drug use**

All respondents said that people who did not use drugs knew about the negative consequences of drug use. The main sources of information were from the media, such as from television or the radio.

#### **Knowledge on HIV/AIDS, hepatitis B and C and STI related to injecting drug use**

Participants were aware that injecting drug use was very risky and associated with HIV/AIDS, hepatitis B and C and STIs.

### **Help-seeking**

Participants believed that if people had used drugs, they needed to get support from mass organizations and their families, in collaboration with the concerned organization. If they chose self-help, they decreased use gradually until they felt that they could stay abstinent from the drug.

## **2.5. Drug use among garment workers in Vientiane**

Among the roughly 2,000 enterprises in Vientiane Municipality at the time of the study there were over 50 garment factories employing about 23,000 garment workers, most of them female. This group had been the target of several studies on HIV/AIDS and other STIs conducted by Population Services International (PSI). However, an assessment of the drug use situation among garment workers had never been carried out.

Based on anecdotal evidence it was believed that the use of *ya baa* was widespread among garment workers in order to work longer and harder at night shifts. The aim of the study was to assess the nature and extent of the drug use situation amongst garment workers in Vientiane Municipality.

Three focus group discussions were conducted in February 2003 with eight to ten voluntary participants in each. Participants were chosen randomly among female garment workers aged 16 to 28 years in Vientiane Municipality.

In addition, 60 garment workers responded to a structured questionnaire. Questionnaire respondents included the participants of the focus group discussions as well as male garment workers.

### **Findings**

The majority of survey participants (six out of ten) were aged 20 to 24. Some 30 per cent of the respondents were older than 25 while 10 per cent were between 15 and 19 years old. The majority of respondents (70 per cent) had finished lower secondary school. Some 22 per cent had completed secondary school level, while less than 9 per cent had only finished primary school.

Almost all garment workers (97 per cent) were single. The majority lived with friends (83 per cent). Two thirds of the respondents reported to have a permanent post, the others being either part-time employees, unemployed or refusing to reveal their employment situation.

Among those who specified their income (29 out of 60 respondents), five reported to earn less than 50,000 Kip (US\$ 6.8) per week. Ten workers said they made between 50,000 and 100,000 Kip (US\$ 13.6) a week and ten respondents had a weekly income of between 100,000 Kip and 150,000 Kip (US\$ 20.5).

When asked what their income was mainly spent on, 4 workers indicated that buying drugs was their first priority, while 14 respondents considered buying drugs as the second most important thing to spend their income on.

### **Knowledge about drugs**

A total of 26 out of 60 garment workers (43 per cent) knew at least one drug, with older respondents more knowledgeable in this respect. ATS or *ya baa* were the most well known drugs followed by cannabis, opium and heroin. Only 9 out of 60 persons reported the price of at least one drug.

Over half of the respondents reported that they ignored the addictive effects of opium and heroin (68 and 53 per cent respectively) and some even thought that opium (5 respondents) and heroin (6 respondents) were not addictive at all.



As for morphine, ATS, cocaine and cannabis, roughly half of the respondents did not know if the drugs were addictive or how addictive the respective drugs were. The majority of respondents ignored the relationship between HIV/AIDS and injecting drug use. Almost 80 per cent were unaware of the relationship between injecting drug use and the transmission of hepatitis C and B.

### **Drug use patterns**

Eight respondents admitted that they had tried at least one type of drugs in their life. In all eight cases the drug tried was ATS with one respondent having also tried cannabis. Five respondents had used ATS during the previous twelve months, four were currently using it with a frequency of either once, or maximum twice, per week. Smoking seemed to be the most fashionable route of drug administration.

Most of the five current drug users reported that they used drugs in order to feel relaxed. Curiosity and to forget misery and sadness were also mentioned as reasons for drug use. All drug users usually took drugs in places where there were few people. Most of them regarded present drug accessibility as difficult.

Drug use among the respondents' relatives seemed to be statistically irrelevant. Ten persons (17 per cent) revealed that they had one or two friends who used drugs, two (3.3 per cent) reported frequently visiting two to five friends who used drugs and two (3.3 per cent) had five to ten drug using friends. None of these friends injected drugs.

### **Qualitative results**

The three focus group discussions with female garment workers revealed that the preferred drug among garment workers were stimulants like ATS, including *ya baa* and nicotine.

Participants stressed that current law enforcement limited drug availability considerably. While some focus group members thought that most people started to use drugs at the age of 15 others reported that some people were as young as 5 to 6 when they first used drugs.

### **Risk and protective factors**

Curiosity and the quest for self-esteem were, according to many focus group participants, important risk factors increasing a worker's susceptibility to take drugs. Furthermore, unemployed workers, people with authoritarian and non-affective parents as well as people who were in contact with offenders were considered to be at risk of becoming drug users. Other risk factors, such as contact with drug using friends, family conflict, and lack of knowledge about negative consequences of drug use were also mentioned. Accordingly, participants considered information about the harmful effects of drug use as a protective factor discouraging workers from using substances.

Statements of focus group members about the number of garment workers supposedly using drugs differed considerably from the quantitative data. While only 13 per cent of survey participants had ever taken drugs, focus group members estimated that between 30 per cent (focus group C) and 70 per cent (focus group B) of garment workers had used substances.

All focus group discussions revealed a very low level of knowledge about the relationship between drug use and health problems, especially the relationship between injecting drug use and STIs, including HIV/AIDS. Also, knowledge about services for drug users and treatment options was very poor.

## **2.6. Construction workers**

There were few studies on drug use among construction workers in Lao PDR. So it was important to carry out research on this issue. Construction workers were considered as a high-risk group for drug use.



The selection of participants for the focus group was made randomly and based on the list of construction workers provided by the chief of the selected villages. Six focus group discussions were conducted – three each in Vientiane Municipality and in Savannakhet. Each focus group comprised eight to ten construction workers.

## **Focus group discussions with construction workers in Vientiane**

### ***Drug problems – knowledge about drugs***

Construction workers mostly consumed alcohol and cigarettes. They remarked that the age of first drug use was between 15 and 18, but they were very reticent toward the type of drug they first used. Most of respondents did not know the expected benefits of drug use. They thought that accessibility to drugs depended on the money available to people. They estimated that 30-50 per cent of young people were using drugs. Young people who liked to have fun at night were considered the most at risk.

### ***Factors encouraging drug use***

Peer pressure played an important role in pushing friends to use drugs, as did curiosity. As they continued to use drugs, their health deteriorated, they became pale and asthenic. A number of workers disliked this behaviour; they judged drug users as unintelligent. Most drug users were heavy money spenders and considered to have ruined their own future. Users were perceived as bad, worthless and stigmatized by society.

### ***Discouraging factors for drug use – negative consequences of drug use***

Participants stressed that the main factors discouraging drug use were: strong awareness of drug use and associated problems, a dislike of 'addictive' substances, preferring to spend leisure activities with their family at home, not wanting to waste money and having been told by their friends about drug use and its consequences.

### ***Knowledge of HIV/AIDS, hepatitis B and C and STI related to injecting drug use***

Participants tried to compare two groups of people: drug users and non-drug users. Non-drug users were stronger than drug users who believed that drug use could increase their energy but they were wrong. Drug users very much preferred wandering around at night time. They agreed that injecting drug users could be highly affected by HIV/AIDS and other diseases.

### ***Help-seeking***

The majority of respondents said that families could provide support and the rehabilitation centre could provide health care to drug users. If drug users underwent self-help, they would decrease the dose gradually and do some physical exercise. They had no idea of organizations which were involved in providing assistance to drug users. They stressed that police played a role as law enforcers. They also suggested that young drug users should listen to parent's recommendations.

## **Focus group discussions with construction workers in Savannakhet Province**

### ***Drug problems – knowledge about drugs***

Among this group, cigarettes, beer and Lao alcohol were mostly consumed. In addition, they felt that students preferred *ya baa*. Participants believed that people started taking drugs at the age of 13. Regarding the statement "What do people experience when they use *ya baa*, glue and other drugs?" participants did not specify effects for each substance. They raised general positive (such as pleasant feelings of drunkenness, leading to speaking more convincingly and greater self-confidence) and negative effects (such as paleness, thinness and looking older than one's real age). Getting drugs was harder when compared to previously. However, it seemed that drugs were available even in markets due to an increasing number of drug sellers. They estimated that 10-20 per cent of construction workers were using drugs. They mentioned that the upper secondary school population was the most vulnerable group



because it was an age of curiosity, they expected to discover social events by wandering with a gang of friends.

### **Factors encouraging drug use**

Participants said that reasons of drug use were multiple, including: peer imitation, fear of non-acceptance by peers, family conflict and girlfriend/boyfriend conflict. Moreover, curiosity was considered as a main factor pushing young people to take drugs. A second one was the belief that drugs were fashionable and perceived as a 'tonic'. Drug use was considered to lead to poverty and families becoming poorer and poorer. When a drug user was craving, and there was no drug in hand, he/she would try to find a job, even an illegal one, to get money. Participants found that drug users were not good, were unhealthy and had no future. Some also felt that drug users were people who were too passionate, too dreamy and were not able to plan their own life.

### **Discouraging factors for drug use – negative consequences of drug use**

Participants argued that people who did not use drugs belonged to a warm, happy family and parents devoted their time to rear and guide their children in a suitable way. Non-drug users were strong enough to say "no to drugs". They knew about the negative consequences of drug use and were capable of distinguishing good and bad things. Most of the participants revealed that mass media (radio, television and pamphlets) were the main sources of drug awareness.

### **Knowledge of HIV/AIDS, hepatitis B and C and STI related to injecting drug use**

Participants assumed that drug users were bad and non-drug users were good people. Any kind of drug administration route damaged life and lead to death in the near future.

### **Help-seeking**

Mostly drug users got help from medical professionals, information professionals and teachers. They believed that self-help was not successful if the individual was not strong enough to deal with the withdrawal symptoms alone. Participants said that drug users could get help from local authorities who referred them to the drug detoxification centre. They ignored the technique of self-help. They said that there were some agencies dealing with drug demand reduction but they were not capable of identifying these agencies. Police were involved in law enforcement (of drug dealing and drug use) by arresting them and putting them into prison.

It was observed that Savannakhet construction workers had a more realistic picture of the drug situation than the Vientiane group.

## **2.7. Rehabilitation Centre**

Treatment statistics from the Mental Health Unit of Mahosot Hospital, show that substance use rose considerably after 1998. In 1998 there were only 11 cases of cannabis and solvent use. In 2002 there were 150 cases. From 1999 to 2002, among those seeking treatment for substance use, the most popular drug was methamphetamine (or *ya baa*). 'Chasing the dragon' was the most common route of administration among those patients seeking treatment at this unit. Curiosity, peer influence and family problems were the main causes of drug use. The age group 15 to 25 years was the most vulnerable group.

**Table 1: Treatment statistics of drug use, at the Mental Health Unit, Mahosot Hospital, 1998 – 2002**

Year	1998	1999	2000	2001	2002
Cases	11	192	210	124	150

There were approximately 800 drug users at the Rehabilitation Centre of Mahosot Hospital where there had been no special study of these people and their drug use.

## **Sampling method**

The selection of those to participate in the focus group was made randomly and based on the list of drug users provided by the manager of the Rehabilitation Centre of which comprised a rehabilitation unit where recreational activities and vocational training were provided, and a treatment unit. Ten young people seeking assistance participated.

## **Main findings**

### **Drug problems – knowledge about drugs**

Ya baa was the most popular drug of use among participants. The majority of them believed that other groups also used *ya baa*. They assumed that people usually initiated their drug use at the age of 13. They described expected benefits as follows: euphoria, feeling high, being energetic and strong and staying awake late at night (dancing, having fun the whole night). As people used this drug for longer periods (more than 3 years), they would have visual hallucinations, for example, they perceived trees as human beings and experienced phobia and loss of self-control. When they misused drugs, they felt anxious, asthenic, they could not stay still, they could not sleep, they were not willing to work and could not control themselves. Respondents admitted that accessibility to the drug had become harder. However, drugs were widely circulated in the northern provinces of the country: Bokeo, Luang Namtha, Phongsaly and Oudomxay. At the first use, a peer always offered drugs for free. As the new user became dependent, they had to pay for drugs so they requested money from their parents, but if the parents did not give them money, they stole things (worthless or valuable) in their house or from their neighbours in order to pay for their drugs. They believed that nearly 80 per cent of young people were taking drugs. They argued that people aged between 13 and 25 years old were at high risk due to their curiosity, their ignorance of the negative consequences of drugs.

### **Factors encouraging drug use**

Participants remarked that curiosity was the first cause of drug use followed by peer influence. Drug use made the everyday life of drug users unfruitful and unproductive because of laziness, lack of enthusiasm in studying or doing profitable work, which itself would dishonour their family and relatives. As participants were themselves drug users, they perceived other drug users as non-docile and disobedient. Respondents wanted to transmit this message to non-drug users:

- Don't think to use drugs;
- Don't be too obsessed by the curiosity;
- Don't make relationships with drug dealers;
- Listen to your parents and teachers' advice.

### **Discouraging factors for drug use – negative consequences of drug use**

Participants identified that non-drug users:

- (1) Had parents who sacrificed their time to listen to their children's voice and to their opinions, were aware of how to rear them and motivate them to play sports, are were aware of where their children went at night and encouraged them not to frequent drug user gangs;
- (2) Listened to their parents' advice.

### **Knowledge of HIV/AIDS, hepatitis B and C and STI related to injecting drug use**

Participants felt strongly that drug users were more exposed to HIV/AIDS and STI than other groups because they always had unsafe sex with any kind of partner. They admitted that IDUs were at high risk of those blood-borne virus transmissions because of needle sharing. During their drug use, IDUs expected only to get high.

### **Help-seeking**

Parents and local authorities convinced drug users to undergo drug detoxification at the Rehabilitation Centre, and raised awareness of drug use and its consequences. Police at the district level mostly transferred them to the centre. If drug users underwent self-help,



participants assumed (1) parents and friends were of big help by supporting them morally in order to enhance their self-confidence and their self-esteem; (2) drug users needed to make a strong decision to abstain from drugs; and (3) drug users needed to avoid frequenting their drug user gangs. Participants revealed that UNDCP (now UNODC) provided financial support in constructing the building of the treatment facility. Police were aware of the tranquillity and calm in the centre. Police organized recreational activities like sports, gardening, traditional dance and music.

.....

### **3. Thailand**

Material for the overview of the drug use situation in Thailand comes from an ANCD commissioned report prepared by Devaney, Reid, Baldwin (2006) on drug use in the Asia-Pacific region. Other material comes from reports prepared by IJFJD, Nonthaburi Juvenile and Family Court, Associate Judges and the Community Network, and the project consultant's field visit reports.

A number of factors contribute to increasing Thailand's vulnerabilities to drugs and their negative effects. Thailand has witnessed a shift away from opium and heroin use to a dramatic increase and expanding use of ATS. It is now estimated that up to 5 per cent of the population uses ATS. An additional risk of increasing drug use within the population is the number of people facing criminal charges associated with drugs. Despite a policy shift toward treating drug use as a medical issue, many people are still imprisoned for drug related offences.

Other factors that could predispose Thailand to increased problematic drug use are the effect of the rapidly urbanizing community. Increased use of cocaine, ecstasy and ketamine have been reported among the urban wealthy. Another, perhaps more worrying, effect of urbanization is the inequality of access to drug specific treatment and services. As Thailand shifts to a more private sector model of medical care access for the most marginal (and most needy) to drug treatment and mental health services could become more difficult.

Over the last three decades Thailand has also played an important role as a transit country in the global narcotics trade. Given its proximity to the Golden Triangle and porous borders, drugs flow easily into Thailand whence they are shipped to other cities via Bangkok's busy sea and air ports. This constant flow of drugs also supplies the domestic market.

In the early 1990s, heroin use (almost exclusively by injection) was documented in villages in Northern Thailand. Injecting drug use quickly spread beyond the hill tribe villages of the north and was reported among urban youth, migrant fishermen and other marginalized groups.

In 1996 the heroin market was disrupted by the surrender to the Burmese Government of Khun Saa, considered at that time as the leader of one of the biggest heroin trading networks in the world. Many analysts suggest that the reduction in heroin supply and tightening law enforcement lead to increased production of illicit methamphetamine (ATS).

Thailand had already witnessed a period of high prevalence of ATS use during the 1970s before the synthetic medulla drug, available over the counter, was taken off the market and classed as a narcotic. However, various new forms of stimulant drugs, made from legal substances such as caffeine, ephedrine and pseudo-ephedrine continued to be consumed by people working long hours, especially transport workers, unskilled labourers, as well as farmers and fishermen. Another contributing factor to the increase demand for ATS was that users shifted from orally ingesting the drug to smoking it which resulted in a more rapid onset of its effects and feelings of increased euphoria. Similarly a growing market was being created among urban Thais, harnessing its effects for social events and nightclubbing.

### 3.1. Population estimates of use for all drugs

Estimates of drug users in Thailand in 2003 ranged from two to three million or approximately 5 per cent of the population. According to the 2003 National Household Survey on Narcotic Use, the most commonly used drugs in 2003 were ATS ( $n = 1,925,000$ ), followed by cannabis ( $n = 667,000$ ), kratom ( $n = 643,000$ ) and inhalants ( $n = 199,000$ ). It was estimated that 22,700 people used heroin in 2003. The survey suggests that about 3,500,000 people have ever used ATS in Thailand. It was estimated that about one million people used ATS in the last year, representing a three-fold reduction in use as compared to the 2001 survey. Use of ATS in the last 30 days was estimated at about 490,000 people, with 73 percent of the population reporting use in the past 30 days aged between 12 and 24 years old. It was estimated at in the previous 30 days 94,000 and 123,000 people had used Heroin and opium respectively.

It was estimated that the prevalence of the use of other drugs such as ketamine and cocaine was about 30,000 people or 0.1 percent of the population. According to the household survey about 100,000 people had ever used ecstasy in Thailand. Ecstasy users were typically male, aged between 12-24 years and lived in major cities. Use of ecstasy was thought to largely be confined to wealthy youth and students as well as night time workers in entertainment compounds in the cities.

A number of recent studies revealed widespread use of cough medicine by students and young workers and increasing use of diverted anti-anxiety medication, *ice* and performance enhancing drugs by athletes.

### 3.2. Drug taking practices, risk factors and trends

Drug taking practices in Thailand have remained stable over the last few years. High levels of ATS use prevail, with smoking being the most prominent route of administration. Several studies have suggested links with increased HIV risk associated with ATS use, especially among youth who report increased sexual contact and reduced condom use while intoxicated. Links between ATS use and mental health problems have also been reported.

Once arrested, drug users are sent to Narcotic Rehabilitation Centres to be assessed by subcommittees. Subcommittees act as quasi-judicial units and are made up of locally appointed officials and two qualified experts (such as psychologists or psychiatrists) and are chaired by a provincial public prosecutor. The subcommittees have the responsibility of sentencing people they identify as drug users to one of two treatment models. Drug users are initially required to undertake a 4-6 month treatment programme which can be extended for up to three years if deemed necessary by the subcommittee. Drug users are sentenced to either confined or unconfined treatment settings. Confined treatment settings are further broken down into either intensive physical control settings or less intensive physical control settings. All drug users are required to participate in activities arranged for behaviour adjustment, including group counselling, social support group activities and educational and vocational training. If drug users escape from the confined settings or do not satisfy the requirements of their treatment programme they are referred back for consideration by the judicial system. If they satisfy the treatment requirements they are released without charge.

Due to the legal status of injecting drug use in Thailand, it is strongly correlated with incarceration, with almost 70 per cent of the total prison population incarcerated for narcotic related offences.

### 3.3. Health and treatment responses

The majority of drug treatment for ATS offered in Thailand is based around a combination detoxification and the Matrix model of treatment which is an outpatient treatment experience that combines behavioural, educational and 12 step counselling techniques.





### 3.4. Case studies

#### 1. Deng

Deng was assessed as methamphetamine dependent, but has since worked to change things. He is 22 years old and lives in a slum on the outskirts of a big city. His family are poor and his parents separated and had no time to take care of their children.

He was born in Sa Kaeo Province. He had two brothers and one sister and he was the youngest in the family. His family moved to Saphansung, Bangkok. There were about 115 *soi* (lanes) and each *soi* had about 18 households with a total of 2,070 households. This village had been known to have an average level of drug trafficking. There had been deaths due to heroin usage. Some dealers and users had been arrested and sent to jail. Deng was selling and using drugs. In his village there was a village committee and a government unit called “Civil Volunteer Protection”. There were activities to educate the population about drugs and aimed at preventing drug use.

Deng’s father is a police officer and aged 45 years old. The father finished high school and was the only son in the family. Deng’s father had separated from his mother after Deng was born. Deng’s mother died soon after he was born. Deng’s stepmother is unemployed and aged 42 years old. Everyone in Deng’s family has been a smoker, but he has not smoked and drunk.

Deng was raised as many normal children in his early years, though lacked attention. His grades were good, and he was in the top ten of his classes until he moved to high school in Bangkok. His grades declined and he had problems with his family over money issues and had other quarrels. He felt so much pressure within his family and was depressed.

He ran away to be with his friends, who drank and used drugs. The first time he tried drugs (ATS) was in the restroom of his school at the age of 16. He did not have to pay for it and he felt excited and fun. Later on he had to pay his share and had no money so he started to sell drugs to make some money to buy more.

At the beginning his stepmother and sister did not know that he was selling drugs but later on when his stepmother found out she encouraged him to sell more since she needed money too. Later on she had become a drug seller herself, was eventually arrested and was sent to jail.

Deng was arrested twice when he was aged 17. He was released on probation the first time and later was arrested for using drugs and was released on bail. In the first case he was sentenced to imprisonment for 6 months and was sent to a training school for youth offenders. He volunteered to get treatment and was sent to for rehabilitation to the Tularkarn Chalermprakiat Hospital and stayed for one year. This has had a positive impact on him and he now has a job as a salesman in a department store and is able to earn an honest income. His boss and his friends encourage him and support him. His girlfriend is a good person and encourages him to be good.

#### 2. Sor

Sor was born in Bangkae district, Bangkok. He was the third child of his family. His mother had been married before, and had one child from her first marriage. Sor was expelled from school because of misbehaviour and not doing any homework. He skipped school and often wandered around in department stores with his stepbrother. When his father heard that Sor was expelled from school he went to request the headmaster to change it to be a voluntary leaving, but the headmaster would not do it.

Later on his father took a new wife, partly due to his first wife's gambling, drinking and socializing too often. Sor had known about this problem for sometime and after his parents separation he and his mother were sent to live with his grandparents (his mother's parents) and his uncle in Nonthaburi Province.

Sor's stepbrother and stepsister from his mother's previous marriage still lived with his father in Bangkok. His father provided child support but Sor felt deserted and always thought that his father did not love him.

When he was in grade 4 there was an older student in the junior high school grade 3 who persuaded him to smoke cigarettes. Sor tried it due to his curiosity. At the same time his uncle and his stepsister were using *ya baa* and selling drugs and made him sell and deliver drugs too. Later on his uncle was arrested and was imprisoned but his stepsister was able to run away and hide. His grandparents moved away with shame. Sor moved in with his stepsister and her husband, but not long after he began to quarrel with his brother-in-law and moved back to live alone in the old house.

Sor met a cousin who was drug dependent and fishing near his house and he asked Sor to try methamphetamine. In the beginning, Sor used drugs without paying but then both of them gained money to buy drugs from fishing and catching frogs to sell. Sor never thought of the harmful effects of drugs, only noticing that when he used drugs it made him feel good and happy. They were using drugs for about two years, then his cousin disappeared for a long time. One day he came back and told him that he had stolen some drugs from a dealer and had to run away and now he had come to stay with Sor. Sor met a friend and persuaded him to use drugs and buy them from his cousin who had a new supplier near Klong Yong.

Sor and his friend each consumed at least 5 pills of drugs each day, and the most was 20 pills a day. Sor became a seller himself until his mother and his stepbrother and stepsister came to live with him. His stepbrother was also drug dependent. Sor tried to quit drugs because of the loss of money but not because of the harmful effects of drugs. He once quit for three months but used again because of his environment and his friends. He was also still selling drugs and when he made enough money he began using again. His mother never knew that he was a drug user and dealer until the school found out and informed her. After she found out she tried to persuade him to quit and get therapy at the Tularkarn Chalermprakiat Hospital but he refused. He told her that he did not want to quit and stop selling drugs because he made money for things he needed and wanted. When he had problems with his mother he would usually turn to drugs.

When he was studying in junior high school grade 2, he was arrested and his mother was very hurt and asked him to quit drugs and took him to be treated as an outpatient at the Tularkarn Chalermprakiat Hospital. However, he ran away. Later on he was caught again, and this time he had been using another kind of drug which he was inhaling. This time he became a patient at the Tularkarn Chalermprakiat Hospital, but he still did not want to be treated and rehabilitated.

Sor became thinner, developed blurred vision and smelled of glue. He would not return to his house but spent the night with friends and had no fixed home and was hard to find.

His mother and staff from the treatment centre when they can find him continue to support Sor, and hope that one day he will re-admit himself for treatment and become rehabilitated.

### 3. Gap

Gap was born in Bangkok Noi District, Bangkok. He had one sister and was the only son in the family. His family later moved to Nakorn Pathom Province.



In his village there were about 30 households and there were about 10-14 people who used drugs. Most were male and around 18-24 years old. This community had a moderate level of drug use. No one had died from drug use, but two had been arrested and sentenced to jail. There were three of them who found it particularly difficult to quit drugs. There was only one committee in the village, called the “local community development”, which organized activities against drugs, such as sports and put up billboards to educate the community about drugs.

Gap’s father was 68 years old and had finished primary school at level 4. He was the fifth child of his parents. He had three older brothers, one older sister, two younger sisters and one younger brother. He was for hire to do any general work.

Gap’s mother was 47 years old, and had no education. She was the third child of six. She had one older brother, one older sister, two younger sisters and one younger brother.

There was no one in the family who used illegal drugs, but some relatives smoked cigarettes and drank alcohol.

Gap grew up in a normal enough environment. He was mischievous and hung out with friends since he was aged 7-8. He was in the top ten of his class until he was 13 years old when he moved to junior high school. He was a ‘big brother’ of the Cub Scouts in school. At the age of 15 he transferred to a vocational school with a three-year programme. At the same time, he also studied at the extension school for high school level 6 and was elected to be one of the committee of the vocational school.

During the ages of 15 and 16, Gap had friends in school, some of which used drugs. He was curious to try, and wanted to help his family to earn some money, and so finally he tried them too. One of his closest friends, who also used drugs, urged him to stop. He took his friend’s advice and stopped.

Occasionally, this friend asked Gap to accompany him on the ride to purchase drugs. Later, his family had money problems and he decided to sell drugs himself. He was able to help his family because he made a lot of profit. He had asked his friend to help because some time when he was alone the drug supplier would not sell drugs to him. So he had to use his friend as the front and share a percentage of the profit with his friend. He was making as much as 200-300 Baht (around US\$ 6-8) a day. Later on some of his friends who were drug dependant had no money to buy drugs, so they asked Gap if they could sell drugs for them. Gap made so much money and he used it to purchase more drugs from every source available, and wasted much on things he desired. One day he had found out that some of his drugs were fake so he started to study them himself and was able to tell which ones were good which ones were fake. He used this to his advantage.

He had been using drugs, and had been smoking and drinking occasionally until his school did some urine tests but also gave students a chance to voluntarily admit that they were using drugs without taking the test. Gap admitted to his teacher and took a test which he regretted later because his result was negative. However, since he had admitted his wrong-doing he was ‘guilty’.

His school sent Gap and some of his friends to treatment and therapy at the Tularkarn Chalermprakiat Hospital. He was treated with the Matrix Programme for four months, and then he received a scholarship to study in the vocational school and later transferred to do a bachelor degree at the Sukhothaimathiraj University with his major being mass communication. He was also selling bakery products he made and working part time in a company in Bangkok to assist in his studies.

His drug use had affected him physically, as he ate more and slept longer, and emotionally, as he had a bad temper and got irritated easily. He liked to socialize and spend money. The reason that he quit using and selling drugs was because he was afraid he would be arrested

and would not have any future. He did not want to disappoint his parents, and he was afraid of his health and afraid of becoming socially unacceptable. He was able to quit because of the therapy that helped him to have stronger will power, together with his family's support and encouragement.

## 4. Viet Nam

This section provides edited material provided in various reports to ESCAP by MOLISA, and the project consultant's field visit reports.

### 4.1. Introduction

Between January 2003 and April 2003, DSEP, under MOLISA, carried out substantive research in order to analyze the drug use situation among youth in Viet Nam. The research aimed at getting an overview of current young people's drug use patterns and trends, identifying risk and protective factors influencing youth drug use and reviewing present drug prevention programmes as well as treatment options.

#### *Past research on youth drug use*

According to MOLISA, nationwide 116,178 drug users were treated in both communities and treatment centres in 2002. An additional 25,000 drug offenders were held in treatment facilities and jails. Other estimates suggest that the prevalence of drug use rose from 0.9 per cent in 1995 to 1.3 per cent in 2001, equating to more than 950,000 Vietnamese drug users.

In 1999, supported by UNODC, MOLISA carried out a large-scale survey among 7,905 clients and inmates of medical services, drug treatment facilities, prisons and detention centres in seven provinces and cities. A total of 71 per cent of respondents were aged 30 years or younger, 5.8 per cent were under 18 and almost half of the respondents (46.2 per cent) were aged 18 to 25.

In 2001, MOLISA surveyed a total of 65,859 persons in 35 out of 61 provinces and cities in order to study the drug use situation. Findings indicated that 5 per cent of those respondents who were drug users were under 18 years old and 63 per cent were between 18 and 30.

The 2003 study by DSEP was the first comprehensive research on drug use among youth in Viet Nam, laying the foundation for proposing effective intervention, prevention, treatment and rehabilitation programmes in the whole country.

#### *Research methodology*

Data collection was carried out in February 2003. In order to represent the Vietnamese population appropriately in terms of geographical and socio-economic features, three survey sites were selected for the study: Lao Cai Province representing the northern mountainous area; Ha Noi City as one of the two major cities; and Bac Ninh Province in the south as typical of the Mekong Delta area.

#### *Quantitative survey*

In these three sites a total number of 180 young drug users (60 from Lao Cai, 45 from Ha Noi, and 75 from Bac Ninh) aged 16 to 25 years took part in the quantitative survey. The sample comprised both drug users who were living in the community and clients of local treatment and rehabilitation centres. The selection of drug users from the community was based on lists provided by local authorities. In addition, some respondents were approached by the snowball technique.

For drug users in treatment facilities, random sampling was carried out via treatment centre inmate lists. Questionnaires for drug users in treatment centres were designed in a way



that made it possible to exclude information on the current treatment status. In other words, the survey instrument gathered data about the period prior to the respondent's entry to the facility. Thereby, data from drug users living in the community and treatment centre inmates was comparable.

### Focus group discussions

After the research team had studied initial results from the quantitative survey, focus group discussions were carried out in the three sites in order to obtain in-depth information about young drug use.

A total of seven focus group discussions (two in Hanoi, three in Bac Ninh province and two in Lao Cai province) with ten participants each were held either with employed or unemployed young drug users or with young drug users who were undergoing treatment in a centre.

### In-depth interviews

In addition, a total of 28 in-depth interviews were held with representatives from various sectors and organizations that were directly involved in drug use prevention, treatment and rehabilitation. The key-informants comprised representatives from the health sector, the public security sector, the cultural sector, trainers and teachers, and representatives from mass organizations.

### Case study

During focus group discussions one young drug user was identified as a typical of the group for a case study.

## 4.2. Findings

### Youth drug use patterns – quantitative study

#### Profile

The age distribution of the 180 interviewees was as follows: 2 drug users (1 per cent) were between 16 and 17 years old, 24 (13 per cent) fell into the age group 18 to 20 and the large majority (154 persons or 87 per cent) were between 21 and 25 years old. The sample contained three female drug users (1.7 per cent) who were clients of the drug treatment centre in Bac Ninh.

During the previous 12 months, 28 per cent of the respondents had held a part time job, with 37 per cent in stable employment. More than a third of the interviewees (35 per cent) had been unemployed over the previous 12 months. (The general unemployment rate of the urban workforce was about 6 per cent in 2002.) Focus group discussions revealed that drug users saw the primary reason for their unemployment in their 'addiction'.

*"I used to be a porter in Bac Ninh station. I could manage to pay for my family. Since I followed my friends to use drugs, I lost my job. I tried many other jobs such as a mason, hired labourer... yet I couldn't do anything for long, because employers found out about my drug use." (Nguyen Van T, 22 years old, Bac Ninh.)*

The survey suggested that 50 per cent of the total drug user population lived on their own legal income. More than 38 per cent lived off their parents and 8.3 per cent relied on the financial support of their partners (wife or husband). Some 1.7 per cent reported having illegal income sources.

The large majority (72 per cent) said that spending their income on drugs was their top priority. Subsistence expenses ranked second, while spending money for gatherings with friends, drinking and gambling was third.



Not only were drugs a top priority in terms of income spending, the interviewees also spent a large part of their leisure time on drug use. Respondents estimated that they usually spent three or more hours per day on activities such as purchasing and using drugs. Watching television (about two hours a day) was the respondents' second most important activity during leisure time followed by gathering with friends (between one and a half and two hours per day).

Almost every fourth respondent (43 out of 180) had lost at least one parent, with five respondents having lost both their father and mother. For those whose parents were alive, 8 per cent (11 out of 137) said their parents were divorced and/or lived separated. During the focus group discussions numerous participants pointed out the close relationship between their broken family and their drug use history.

40 respondents (22 per cent) came from families with drug use histories - meaning that either the parents (4 respondents) or relatives such as grandparents or uncles/aunts (36 respondents) were drug users.

As a whole, the respondents did not have a 'so-called' poverty-stricken life. Only 4 per cent of interviewed drug users had occasionally suffered food shortages during childhood. About 6 per cent had been physically abused since their early years (corporal punishment and overwork), 10 per cent were emotionally abused (being maltreated, threatened and reviled) and 2 per cent suffered from sexual abuse.

Research findings suggested that young drug use and youth delinquency were closely interrelated. About 16 per cent of interviewees reported that they had stolen things worth at least 50,000 Dong (about US\$ 3) during the previous 12 months. In the same period, about 15 per cent had been administratively punished for drug use and 7 per cent were put into jails.

## **Drug knowledge**

The most well known substances were heroin (known by 89 per cent) and opium (known by 73 per cent). Few were knowledgeable about cocaine (6 per cent), or hallucinogens and stimulants such as ATS (7 per cent).

Almost nine out of ten respondents (88 per cent) had one or more drug users among their friends, the majority being acquainted with one or two drug users (45 per cent) or three to five drug dependent persons (40 per cent).

## **Routes of drug administration**

Drug injection was the main route of administration among the respondents' drug using friends. Almost every second interviewee (48 per cent) reported that his or her friends injected drugs. According to 29 per cent of the respondents, drug using friends would use several routes of administration, with 14 per cent reporting that their friends smoked substances while 9 per cent said that friends would sniff.

## **Personal drug use history**

A total of 87.8 per cent of respondents had used heroin at some point in their life. Heroin use seemed to be extremely common in Ha Noi where all 45 interviewees had used the substance at some point.

Some 60 per cent of the total had used opium at least once. In the northern mountainous region of Lao Cai, where cultivation of opium poppies was common, 59 out of 60 young drug users had used opium at least once.



Sedatives and morphine were of minor importance and had ever been used by 13.9 and 12.8 per cent of respondents, respectively, but much more likely by those from Lao Cai. Some 3.9 per cent of surveyed drug users had used ATS at least once.

Every second young drug user had used more than one type of substance, with about a quarter reporting the use of two drug types. Another quarter had used between three and eight different substances at some point in their drug history.

The average age of first drug use was 19 years. The biggest group (42 per cent) had the first experience with drugs between 18 and 20. A total of 29 per cent were between 21 and 23 years old when they took drugs for the first time and 10 out of 180 respondents started using drugs between 10 and 14.

In Ha Noi drug use appeared to start earlier than in the other provinces. More than every second respondent was under 18 when he/she took drugs for the first time, whereas in Bac Ninh only 4 per cent of the respondents started drug use being under 18. The average duration of drug use was three years and four months.

### Reasons for drug use

Most young drug users (69 per cent) disclosed that they began drug use out of curiosity and because they were introduced to drugs by friends. About 19 per cent took drugs in order to be relaxed and get a high feeling. Some 6 per cent were hoping to increase their sexual ability and 3.3 per cent were expecting to be able to work harder and to stay up late without falling asleep.

*“One evening when I was going out with my friends, they gave me a small pack of heroin and asked me to “try”. I was scared at first but they provoked me not to be so cowardly and said that being a man meant mastering everything. I tried and three months later I became dependent on heroin.”* (Focus group discussion with treatment centre clients, Bac Ninh province.)

*“Being a driver, I had to use opium to keep me awake. Opium is available in Sa Pa. Besides, opium helped me to satisfy my girlfriend’s sexual needs.”*

*“I made friends without realizing that they were drug users. When I found out their secret, I decided to quit them but once thinking of my family situation – my parents being divorced – I wanted to have friends to share and find solace in them. Generally speaking, they were very good to me and helped me a lot. Whenever I was sad, they would call me at home to go out. It was at that time that they introduced me to use drugs in order to forget all sadness. I accepted and became a drug addict then.”* (Focus group discussion in Bac Ninh province.)

Some youth were introduced not by their friends but by drug dealers who initially offered some doses of drugs for free in order to tie down the user to the substance.

*“Long is my close friend. One day he called me to go to Thang’s place with him which is about ten houses away from mine. When we arrived, we saw two people inhaling and injecting heroin. As Long breathed in the smell of heroin he longed for it. At that moment I knew that he was an addict. Thang offered me free drugs while Long was taking heroin. He told me not to be afraid and that I wouldn’t have to pay for it. Taking drugs was one way to discover the wonders of this world, he added. I had no idea why I accepted his offer, maybe my curiosity urged me to see how it was. But my first time of sniffing heroin just made me tired, dizzy and partly afraid. I said that to Thang, about half an hour later he gave me another dose and told me this was enough for me. After that, Long and I came to Thang’s place several times without paying for the heroin we used. I also asked Long to buy it for me. Four months later, I realized that I had become a drug abuser. One*

*day, Long promised to bring the substance for me but he didn't come. I really wished for it."* (Focus group discussion among unemployed drug users, Bac Ninh.)

## Initial and primary drugs of use

All 180 respondents started drug use with either heroin (62 per cent) or opium (38 per cent). However, the survey revealed considerable differences in the different survey sites. While in Ha Noi 96 per cent of interviewees used heroin as their initial drug (compared to 4 per cent using opium), the majority of respondents (78 per cent) in the opium cultivation area of Lao Cai province had started drug use with opium.

The study also indicated that the importance of opium as an initial drug decreased over time while heroin became the primary drug of first use. All respondents who started drug use between 1990 and 1994 initially used opium. Among those who initiated drug use between 1995 and 1999 a total of 45 per cent started with opium, while 55 per cent started with heroin. During the period 2000 to 2003 more than two out of three (68 per cent) initiated drug use with heroin. The study findings also suggested that young people who initiated drug use with opium tended to turn to heroin as the primary drug at some point of their drug use history. Also, the shorter a respondent's drug history was the more likely his/her primary drug was heroin.

## Unsafe injection is common

Eight out of ten interviewees (81 per cent) said that they used drugs at least once a day, the majority thereof using substances two or more times daily. Some 10 per cent reported to use drugs twice a week and 9 per cent once a week.

Injecting was by far the most common way of drug administration. More than half of those surveyed reported injecting drugs (53 per cent). In addition, 21 per cent reported other routes of administration; 15 per cent reported smoking drugs and 11 per cent sniffing.

Usually, young people initiated drug use by smoking opium or heroin and then turned to sniffing and finally injecting heroin. When asked for an explanation for this shift most young drug users said that it was easier, faster and less expensive to obtain feelings of pleasure through drug injection.

*"I used to smoke opium but it was easy to be found out due to its smell, in addition it required such tools as an opium-tray, wasting much time, so I changed to sniff and then inject heroin."* (Focus group discussion, Lao Cai.)

*"Most addict friends became more and more dependent on drugs so they had to increase the drug dose, yet they didn't have enough money so they had to inject. Thus, in my opinion, injecting was an indispensable way of those who once sniffed and smoked heroin."* (Focus group discussion, Bac Ninh.)

A total of 57 per cent of interviewed IDUs reported that they never shared needles and syringes with others whereas 43 per cent said that they sometimes shared injection equipment. The majority of respondents knew that needle sharing included the risk of HIV infection. Despite this knowledge, many young drug users were involved in high-risk behaviour as focus group discussions revealed:

*"We usually used our own needles and syringes, but when we couldn't purchase we had to share by using boiled water to decontaminate them. Sometimes we couldn't wait any longer and used them immediately. We were afraid but when the 'high' of the drug dominated our mind, there was no fear. Now and then I had no money, not even 1,000 Dong to buy a needle so I had to share with other peers. One of my friends saw a used syringe in the street. He picked it up and used it again."* (Focus group discussion in a treatment centre, Ha Noi.)



*“I shared needles and syringes at times. Generally speaking, it depended on my addict friends. I would share with those who just changed from smoking, sniffing to injecting, so they hadn’t jointly used with others. For those who had experienced injecting drugs for a long time I would never share with them. I injected once a day with two other addict friends. Each had separate needles but we shared a syringe.”* (Focus group discussion, Ha Noi.)

Peers seemed to have a considerable influence on young people’s drug use habits since two out of three respondents (66 per cent) stated that they took drugs with friends while a third used alone. There was a significant statistical correlation between the route of drug administration of the respondent and the administration route of his/her drug using peers.

### Drug expenditure

Most of the sample (75 per cent) spent up to 50,000 Dong (about US\$ 3) per day on drugs. Some 19 per cent spent between 50,000 and 100,000 Dong and 6 per cent spent more than 100,000 Dong per day.

Drug expenditure turned out to be quite different in the three survey sites. The survey revealed that young drug users in Ha Hoi spent almost twice as much money on drugs (71,000 Dong / US\$ 4.5 per week) as drug users in Bac Ninh (35,000 Dong / US\$ 2.3) and Lao Cai (32,500 Dong / US\$ 2) provinces.

The average weekly drug expenditure among all 180 interviewees was about 300,000 Dong (US\$ 20) per person, whereas the respondents’ legal weekly income averaged out at 185,000 Dong (US\$ 12). Results of focus group discussions suggested that many young drug users filled the gap between legal income and drug expenditure needs through illegal activities such as stealing or drug dealing.

*“Due to poverty and my addiction, I didn’t have enough money for drug so I had to deliver drugs for drug traders and then I would get revenue.”* (Drug user from Bac Ninh Province.)

*“My family was quite well off; my parents owned a shop selling things made of aluminium. I used to steal their money to buy drugs. Gradually, they found out so I had to try other ways. I stole my wife’s money. I felt ashamed of myself.”* (Focus group discussion in a treatment centre, Bac Ninh.)

### Drug availability

Respondents usually took drugs in public places where there were few people (46 per cent) or at home (44 per cent). A few drug users (6 per cent) preferred secret venues such as lodgings or karaoke rooms and some (5 per cent) used drugs at the place where they purchased them.

The majority of respondents (57 per cent) found it easy or very easy to purchase drugs in their residential area while 43 per cent of interviewees said it was difficult to do so. Young drug users from Ha Noi considered purchase of drugs easier than their peers from Bac Ninh and Lao Cai provinces.

*“You can purchase anywhere you want providing you have enough money. If you have money, drug providers will bring drugs to your house.”* (Focus group discussion, Ha Noi.)

*“Drugs are available everywhere, we can obtain drugs through friends, at small tea shops in sidewalks. It’s easier than buying vegetables. Yet, the police have recently worked to hunt for drug buyers and sellers so it’s more difficult and rather high in terms of cost.”* (Focus group discussion, Bac Ninh.)

*“At first, it’s quite difficult to buy drugs, you have to ask a drug peer to take you to the drug trading plot and introduce you to drug providers. After that everything will be fine. However, this is such a closed cycle that outsiders do not find it easy to find out.”* (Focus group discussion, Lao Cai.)

## Knowledge about drug related harm

Generally speaking, the young drug users’ knowledge about harmful consequences of drug use was inadequate. Although all respondents had used or were currently using drugs, some of them were still underestimating the addictiveness of certain substances. For instance, 4.7 per cent of interviewees thought that drugs in general were not addictive at all, 3.8 per cent said that about heroin. Between 2 and 4 per cent asserted that substances such as morphine, cocaine or ATS were not addictive. About 6 per cent of those questioned ignored the interrelationship between injecting drug use and HIV infection. Almost a third (32 per cent) knew nothing about the risk of hepatitis B and C infection through injecting drugs.

Most (88 per cent) received information about harmful effects of drug use through the mass media. Family members (mentioned by 54 per cent of respondents), friends (46 per cent) and teachers (29 per cent) were other important sources of information on drug-related harm.

## Knowledge about treatment options

Although the majority of the young drug users (61 per cent) had at some point been looking for drug treatment services, many (39 per cent) considered themselves unable to give up drug use, mainly due to high availability of substances in the community and peer pressure of people who use drugs.

*“My health has got worse since I tried drugs; I really want to be in drug treatment. Yet, I haven’t done so because my friends now continue using drugs.”* (Focus group discussion, Lao Cai.)

*“I know about the effects of drugs but I can’t abandon them as there are many drug users living around me.”* (Focus group discussion, Ha Noi.)

*“Drugs are available in my living place now. I also wish to be free from drug abuse, but whenever I sense its smell I cannot control myself. The policemen have merely caught a few drug dealers; they failed to unmask the so-called major network. We wish authorities succeeded in eliminating such elements. Then we could make ourselves free from drugs.”* (Focus group discussion, Bac Ninh.)

With relapse rates of 70 to 80 per cent, drug use treatment had not proven to be effective. Being well aware of this, many young drug users’ preparedness to undergo treatment was very low. Others did not see any necessity to enter treatment because they ignored or underestimated the seriousness of their substance use.

*“I’ve never wanted to give up drugs because people say drug addicts have to writhe with pains but still relapse.”* (Focus group discussion, Bac Ninh.)

*“Because of curiosity, I commenced to smoke heroin three months ago when my friends enticed me. At first, I sometimes used it but during the last month I have been a daily heroin smoker because I felt really pleasant later. I don’t think I am now a drug abuser, just for my liking, so I have no intention to give it up.”* (Drug user, Ha Noi.)

Various drug treatment services were available in Viet Nam: drug treatment at state treatment and rehabilitation centres, community-based drug treatment and private drug treatment centres. However, few young drug users knew about the different treatment options.





Residential treatment was the most well known treatment and mentioned by two thirds of the respondents, many of whom had undergone detoxification at home. Some 30 per cent of the respondents said they knew there were state drug treatment centres, 24 per cent were aware of detoxification services at medical clinics and 18 per cent knew about private detoxification centres. In general, young drug users from Ha Noi were more knowledgeable about treatment services than their peers in Bac Ninh and Lao Cai provinces.

### Drug treatment experience

Almost seven out of ten interviewees (68 per cent) had undergone treatment at some point of their drug use history, some of them up to six times, although the majority had been through treatment once. Residential detoxification was the most common treatment mode and had been undertaken by 91 out of 180 respondents. Detoxification in government centres, community-based treatment and treatment in private clinics was used by about 30 drug users, respectively.

Treatment at government detoxification centres required 246 days on average, whereas the average treatment period was much shorter in community-based centres (75 days), medical centres (93 days) and private detoxification centres (25 days). A great number of respondents shared the opinion that private and government-run treatment centres operated more effectively and had lower relapse rates than residential, community-based or clinical treatment services. A total of 10 out of 180 young drug users attended a 'peer-to-peer' education group for between two to six months. Nine out of the ten respondents highly appreciated this activity and stated that peer education helped them prevent relapse to drug use.

Almost 60 per cent of the survey interviewees said they could give up drug use if they received more attention and care from the family and the community. Commonly cited reasons for relapse were peer pressure, family problems and unemployment.

*"Returning from the treatment centre I felt that the community didn't accept me. It seemed to me that they didn't let their children make friends with me, they continued keeping away from me. Hence, I felt tired of life and used drugs again when my friends induced me."*

*"It's easy for us to relapse since we have no jobs, we always gather with friends. After the time at the centre I wished to have a stable job to be able to keep myself away from drugs." (Focus group discussion, Bac Ninh.)*

*"I wish everybody in my family and society wouldn't despise and discriminate us after we leave this place. We know what we have done is wrong and really want to correct all mistakes. Family and society please welcome us with open arms so that we can recommence our life."*

*"Our wish is nothing special. We just want the state and related authorities to have stronger methods to eliminate drug areas because my living place is now a chief drug area, drugs are traded openly like vegetables. As a result, we are easily attracted." (Focus group discussion in a treatment centre, Bac Ninh).*

## 4.3. Treatment

### Referral of drug users

In Viet Nam, community members as well as students are required to contribute to the elimination of drug use by reporting the identity of drug traffickers and drug users to the authorities. In many regions special letterboxes have been installed that can be used to denounce suspected drug users who then will have to undergo a urine test and be sent to a treatment centre if the test turns out to be positive.

Although drug users are asked for general information such as the initial time of drug use, types of drugs used, earlier treatments, criminal records and HIV-status by local social workers or policemen, there is neither a standardized questionnaire nor an in-depth assessment of drug use history prior to entering the treatment facilities.

## Services for young offenders

Although Vietnamese law supports treatment for drug dependent prison inmates, most correctional centres do not provide proper drug treatment as required by the official guidelines. Detoxification is usually limited to compulsory withdrawal without any medical assistance, known as 'cold turkey'. In 2002 the police in Ha Noi commenced detoxification for drug users at correctional centres, in line with the treatment approach of the Ministry of Health.

## Treatment models

The Government, through the responsible ministries and mass organizations, offers two kinds of drug use treatment: centre-based (residential) treatment and community-based or family-based (non-residential) treatment. Although treatment centres are required to have special sites for underage clients, there is no special treatment model for young drug users. Depending on their level of drug dependence and the family's request, young drug users will be referred to residential or non-residential treatment or they will be treated in health services or private treatment centres.

**1. Residential treatment.** In 2003 there were 80 state-run drug treatment centres in Viet Nam with a total capacity of more than 36,000 clients. These institutions accounted for almost two thirds of all 234,000 drug users that had been treated nationwide during the previous nine years (1994 to 2002). Young drug users were either offered compulsory or voluntary treatment.

According to the law *compulsory treatment* is provided to drug users who are aged 12 or older and who have repeatedly undergone treatment at home or in the community. In addition, homeless drug users are referred to compulsory treatment. The decision on admission of drug users to compulsory treatment is incumbent upon the District People's Committee. The compulsory treatment lasts one to two years. While the state gives financial assistance to treatment centre clients, the drug users are required to work during the treatment period. Labour is both an element of the therapy and a way of increasing income and improving the client's living conditions in the centres.

Drug users who are 12 years or older can register for *voluntary treatment* at state treatment centres if they wish to. The treatment lasts six months and requires a treatment fee. Voluntary and compulsory treatment are similar in terms of treatment regulation and daily activities. Government regulations determine five treatment and rehabilitation phases: drug use assessment and classification at entry; detoxification; behaviour and personality rehabilitation education; integration into community and relapse prevention through labour; relapse prevention; and community-based after-care.

After a 15 to 30 day long detoxification period, centre residents are offered basic education as well as outdoor, sports and cultural activities. In addition, centre staff organize self-help groups and regular meetings to manage and to get feedback on day-to-day centre life. Vocational training (such as on industrial sewing, civil electricity, bike and motorbike repair, mushroom growing and mat weaving) is provided according to the client's educational level and health status. The training options also comply with the demand of the local labour market in order to facilitate the client's reintegration into the community.

Labour is considered useful in several ways. It helps drug users to recover from drug dependence, enhances their working skills and gives them the opportunity to improve their own and their family's income and living conditions.



**2. Non-Residential treatment.** Drug users of any age can undergo *community-based treatment*. Drug users usually undergo a 10 to 15 day detoxification period in local health facilities. They are then sent back home where they are supposed to be supervised by family members or community workers for about two years.

**3. Other models of treatment.** Voluntary drug use treatment is also offered by *private treatment services*, detoxification departments, certain hospitals or doctors who treat drug users at home. Any individual or organization can provide drug treatment to drug users as long as adequate skills, treatment processes and the respect of legal procedures are guaranteed.

Between 1995 and 2001 the number of private treatment services increased rapidly, their treatment and detoxification techniques being mainly based on traditional methods. However, most of the private facilities were not in line with the treatment process that the Vietnamese legislation required since 1 June 2001 and hence had to suspend their services. These businesses were waiting for government agencies to publish guidelines that may clarify on what conditions treatment licences will be granted.

**4. The Tuyen Quang Model.** In some mountainous provinces of Northern Viet Nam where drug use is considerably widespread, the capacity of provincial drug treatment centres does not respond to the needs. Also, geographical features make it difficult to gather drug users in treatment centres. Therefore a special treatment model has been developed for this area that commonly known as “Tuyen Quang Model” referring to the province where the model had been initiated. It consists of three phases:

**Phase 1:** Compulsory detoxification, which takes place in the drug user’s community and usually lasts two months. In some areas such as Lao Cai, Son La and Thai Nguyen detoxification takes place in provincial treatment centres and lasts three months.

**Phase 2:** Labour on so-called “06 construction sites” (“06 referring to the number of the legal document the Tuyen Quang model is based on). Former drug users are taken to working sites that are specifically set up for this purpose. Drug users are divided into groups or self-managed teams and assigned for activities such as mining and road repair work. Recreational activities are offered after work. This phase lasts between one and two years depending on each region’s regulation.

**Phase 3:** Supervision and aftercare in the community. Returning from “06 construction sites”, former drug users participate in community-based treatment and are supervised by family members, local authorities or community organizations. Drug users are offered counselling in terms of job training and income generation. Besides a monthly self-assessment programme, participants undergo drug tests every month. Those who relapse have to return to 06 construction sites after detoxification. After two years of successful supervision, drug users are issued a certificate of non-drug use.

This three-phase treatment model is considered to be relatively effective for mountainous provinces where referral to treatment centres proves to be difficult. However, the model is generally limited to drug users who are 18 years or older.

With regard to *drug substitution therapy*, pilot programmes for methadone substitution therapy have begun in Viet Nam.

### Harm reduction projects

Although drug-related harm reduction activities such as needle and syringe exchange programmes, have not yet been widely introduced in Viet Nam, some programmes are being implemented by the public health sector and funded by international and non-governmental

organizations. Needle exchange programmes are considered to be temporarily acceptable in order to prevent injecting drug users from being infected with HIV. However, drug use is a criminal offence in Viet Nam, especially if committed repetitively. Thus, needle and syringe distribution is met with strong political and societal opposition. As a result, the implementation of harm reduction activities is extremely difficult.

### Environmental factors aiding treatment and continuing care

- a) *The role of family in service provision.* Family is of great importance before and during a young drug user's treatment process. Family members are particularly valuable in encouraging young drug users to enter treatment and to respect the regulations of the treatment facility once they have entered. The family also provides material and moral support for the drug user during and after treatment, and helps the former drug user to reintegrate into his/her community. Family is of utmost importance in terms of aftercare and can effectively help prevent relapse by closely supervising the former drug user.
- b) *The role of the community.* The community plays an important part in treatment and rehabilitation for drug users in general and for young drug users in particular. Representatives of governmental agencies and mass organizations are assigned to support aftercare of former drug users by offering counselling and by encouraging the former drug user to stay away from substances. Many provinces generate jobs and give loans to people during aftercare, helping them stabilize their lives and reintegrate into society. However, as community members are not skilled in private, group or family counselling or the monitoring of aftercare, their contribution to the rehabilitation process has limitations.
- c) *Self-help groups.* In many regions, self-help groups or peer groups with names such as "Ex-addicts Club" (Ha Noi), "Friend helps Friend" group (Ho Chi Minh City and Lang Son) or "Compassion Club" (Bac Ninh) have been set up recently. The members of these clubs are usually former drug users in aftercare or non-drug user volunteers. The clubs facilitate reintegration into the community and management of relapse since the members can mutually support each other because most of them share similar experiences.
- d) *Local authorities.* These typically set up and financially support self-help clubs. The clubs also receive assistance from social workers. Anecdotal evidence suggests that club membership decreases the former drug user's relapse risk. According to an assessment of Ha Noi Sub-DSEP covering 56 self-help clubs, relapse rates among the almost 500 members was more than 40 per cent lower than the city's average rate of 80-90 per cent. In addition, findings suggest that self-help club members stay drug-free longer than their non-member peers.

### 4.4. Evaluation of current treatment

In 1999, a UNDCP-funded evaluation of drug use treatment by MOLISA revealed that the average actual drug treatment period was much shorter than prescribed by the law. At the same time, the study findings showed that longer drug treatment was statistically related to lower relapse rates.

Whereas legal regulations required drug users to undergo treatment for one to two years, the above-mentioned survey reported that almost 90 per cent of drug users were treated in less than six months. About 9 per cent were treated from 6 to 12 months and only 1.3 per cent received more than one year of treatment.

While there has been some disagreement regarding actual relapse rates, MOLISA reported that the average relapse rates of drug users who had been treated less than six months was 63 per cent. After a treatment period from 6 to 12 months 41 per cent of drug users relapsed.



For those who underwent drug treatment for more than a year the average relapse rate was 31 per cent. There was obviously some conflict with the 80-90 per cent relapse rates reported above. As a consequence, debate has continued with regard to increasing the length of stay in 06 centres. This has already occurred in some areas of the south.

## **4.5. Conclusion**

### **Drug use**

- The most frequently used drug by young people is heroin, but there are important regional differences. A considerable number of young drug users in mountainous areas use opium, a traditional drug.
- Drug injection is increasingly popular and seems to be indispensable among heroin users.
- Although some drug users are aware of the risk of HIV infection, young peoples' knowledge on drug related health-risks is insufficient.
- Curiosity and peer pressure is the most important reason for initial substance use.

### **Treatment**

- Specific drug use treatment for young people is not available in Viet Nam. However, some treatment centres provide separate lodging sites for drug users under age 18.
- Depending on the level of dependence and the family's preferences, young drug users can undergo centre-based compulsory or voluntary treatment; compulsory or voluntary community-based treatment; treatment in hospitals, health-care services or private treatment agencies; or family-based treatment.
- Young offenders who are drug users are provided with centre-based treatment under the control of the respective public security agency (such as rehabilitation schools, educational establishments or prisons).
- Continuing care services are mainly provided by the community, and the involvement of treatment centres is very limited.
- Former drug users have started to offer aftercare services in the form of self-help groups with financial and logistical support from the Government
- Some harm reduction interventions, such as needle exchange programmes, are being implemented with international donor funding. However, harm reduction is not widely accepted.

## **4.6. Case studies**

### **4.6.A. Lao Cai Province: Do**

Over the past 10 years, like the plains and urban areas elsewhere in Viet Nam, the situation of drug use in Northern mountainous provinces has been fluctuating. This area was the main opium poppy area of Viet Nam, and people smoked opium as part of their traditions. Opium was a part of traditional festivals such as in betrothal ceremonies, marriage and funerals. On implementing a national policy to eliminate opium poppy production, cultivation has been generally reduced and in some provinces the rate of opium users has decreased by 70-80 per cent.

Although there are differences in the nature of drug use in the mountainous areas to those of urban areas and plains, people in Lao Cai mainly use heroin and the route of administration is injection.

#### **4.6.A.I. Summary**

Do Ba H. is 18 years old, and lives in Sa Pa town, Lao Cai Province. Do first used a drug when he was 15 years old. Do became drug dependent at 16. At first, he smoked opium and then turned to injecting it, then to inhaling heroin and then to injecting that. He injects 3 doses



a day at a cost of 100,000 Dong. He dropped out of school and has no job. He has managed to give up for several times but he failed in the long run. His case is typical of other youngsters in towns in Lao Cai Province.

#### 4.6.A.II. Reasons for drug use

##### 1. Do's living situation

- a) Lao Cai is a northern mountainous province, sharing a 203 km border with China. The population is 594,300 (1999). There are 27 minorities living together (such as Kinh, H'mong, Dao, Thai, Nung and Pa Di), which account for 66.3 per cent of the population. The annual average GDP per capita is US\$ 150 (in 2000). Before 1993, opium poppies covered more than 1,000 hectares, and at the peak there were 9,447 addicts (1995) - now the figure is 2,140.
- b) Do's parents are lowlanders (Kinh), they moved to Lao Cai decades ago. They moved from Bao Yen district to Sa Pa town. Sa Pa is situated 35 km southwest of Lao Cai and 376 km north-east of Ha Noi by land.

Do's family settled in one of the four biggest streets in Sa Pa town near Sa Pa market, rest houses and hotels, and live among drug users here because there are over 100 'addicts' in Sa Pa of which 80 per cent live in these four streets. Apart from residents, tourists also use drugs; they prefer smoking opium to using heroin and drugs are easy to buy.

##### 2. Direct reasons

###### a) Family problems

There are four children in Do's family. His two elder sisters are married, and his 20-year-old brother is now studying. Do's father worked for a fruit company but retired because of poor health, and has become despondent, drinking all day and paying no attention to the children. Do's mother also worked at the fruit factory and retired because of poor health. She now does small business activities at home and is too busy to take care of the children. In 2000, Do's father suddenly died, this loss made him closer to drugs.

###### b) Friends

When Do was in seventh grade, there weren't any drug users among his classmates. Yet, Do made friends with those who were around 10 years older than him, working as professional carriers with motorbikes. They were drug users, and sometimes Do bought or held drugs for them, and they encouraged him to try.

*"At first I refused because I heard about taking drugs before, I knew how harmful it was to users' health. From whom did I know? My father warned me at times when he was alive but I didn't care. Besides, there were some meetings against drugs during my time at school. I didn't like TV much, except for football programmes at night (Premier Cup, the Champions League), occasionally, I saw news about drug trafficking cases on TV or people undergoing treatment in provinces, and they said that drugs would ruin one's youth and transmit HIV."*

*"To be honest, I didn't imagine the effects of drugs at that time. If only they had described in detail when the hunger for drugs came one writhed so much, I wouldn't have tried. Meanwhile, they spoke a lot of the feelings we would have when using drugs, especially sexual ability would be incredibly greater, maybe tens of times."*

*"They said 'it is easy for the newly addicted to quit and many have succeeded.' It sounded palatable and with money at hand, I tried."*



**c) Labour**

Do's brother-in-law owns a camera shop (300 m from Do's house), which is the biggest photo shop in Sa Pa. Besides, his learning, Do was in charge of the main photo processing activities (minilab), and he received 1,500,000 Dong (US\$ 100) per month, the highest income among that of youngsters there, especially considering he was at school. Do had chances to meet different people. With a high income, he thought of how to spend his money and amuse himself.

**d) Learning/studying**

Do was sent to Ha Noi to learn more about photography, but every day he sneakily bought opium in Thanh Nhan ward, Hai Ba Trung district, which was considered a drug dealing spot.

Returning home, Do had to leave school due to his six-month absence. His parents didn't agree, then they sent him to a continuation school where he attended ninth grade and spent four months more at tenth grade. One day, he was informed that there would be a urine test to see whether drugs would be detected. He was so scared that he dropped out of school. *"In addition, it was no use; I thought of drugs all the time, therefore, I didn't have enough time and energy to study."*

**e) Ceasing work at the photo shop**

Having left school, Do continued working at the camera shop. Though his family realized that he was addicted, they let him work and pushed him to get treatment. Do tried many times but he could not do it. In the middle of 2002, after him failing to get treatment, they didn't allow him to continue to work there. Do became unemployed, staying with his mother, helping her and playing.

#### **4.6.A.III. The process to dependence**

##### **1. The first time using drugs**

*"I had two or three days of vomiting uncontrollably after my first time of opium use. But it got better, just like wine - drunk, having no headache, turning lucid, everything was fine. Later on, when I began injecting heroin, I was over-intoxicated at times, especially using heroin with 'seduxen', 'fentanyl' ('sen' or 'fen' by addicts). It has pleasant smell, like apple or whisky exhaling from the mouth."*

##### **2. Where to buy drugs**

*"I often buy at some acquaintances' in the town. The providers sell beverages or groceries. Although there are many dealers in stations and it's easier to buy, I rarely go there because I don't trust them except for some occasions that I so 'hunger for drugs'. They have already packed drugs, a liquid plastic bag of opium costs 10,000 Dong; a dosage of heroin is 30,000 Dong. There's no bargaining because of relations between dealers and users. The providers know exactly who needs heroin and who needs opium. Syringes are available at pharmacies."*

Because Lao Cai has eliminated opium poppies and its people cannot process drugs now, opium and heroin in particular are trafficked from Lao PDR to Son La and Lai Chau provinces, or they come from the plains. 'Addictive medicine' drugs mainly come from China.

##### **3. Opium and heroin, smoking and injecting**

Do has been an addict for 4 years - the first 17 months he used opium and then turned to heroin. He smoked and inhaled it first, then changed to injecting.

#### 4. The reason for changing from smoking to injecting opium

*"It's easy to be discovered using the oral route of administration because of its smell. Besides, it takes time to do that. Due to the increasing demand (2-3 dosages at first then 7-10 dosages a day), more time is needed. Meanwhile, it's faster if we inject, about 3 minutes including making up. We can also save money by injecting opium because if we take it orally, an amount of the drug is burnt. But it leaves no waste when we inject, all the drugs will be directly injected into the blood veins, and result in more satisfaction."*

#### 5. The reason for changing from opium to heroin

*"We have to boil opium, this requires much time and action and we don't have all the needed things all the time. For heroin, in the first stage of inhaling (not injecting) it's very fast, what we have to do is to place the lighter under a cigarette tin foil and scroll a piece of newspaper or money note, everything will be completed in 15 seconds' time. My friends say that using heroin is stylish. It's easier to buy and inject, and gives a smoother feeling. It's easier to prepare and the dosage is up to users."*

*"That pleasant feeling will be double if we mix a bit of heroin with liquid opium for injecting - opium creates satisfactory feelings in the head and heroin makes smooth feelings."*

#### 6. Dosage and cost

Do has to inject three times per day (in the morning, afternoon and evening) with the cost of 30,000 Dong per dosage for the heroin and about 100,000 Dong (US\$ 7) for the distilled water and syringes. *"Whenever I have money, however, I spend 400,000-500,000 Dong for 6-8 times with my friends"* [each time he uses a dosage of heroin (30,000 Dong), 1.5 ml of distilled water, a half of "seduxen" ampoule, a half of "fen" ampoule].

#### 7. Location of usage

When he was going to school, Do used to take drugs in hidden places behind his house (once in the morning when he went to school and once again on the way home), he was afraid of being unmasked so he rarely used at school. In the afternoon at home he could use whenever he wanted, but often at 4-5 p.m. During the time that he worked for the camera shop, Do used to take drugs in the toilet. Occasionally, he went to refreshment bars with two or three friends.

*"Initially, I injected into my arm veins then those of my legs. Finally, I injected in my groin veins - the easiest way because the veins here are big, we can feel the heartbeat by touching them and we can inject despite the darkness."*

#### 8. Resources of money

Do had to spend at least 3,000,000 Dong for drugs monthly, while he only received 1,500,000 Dong so he had to manage any way he could. *"Don't trust any addicts when they long for drugs and they want to earn as much as possible."*

He stole from the photo shop - over-charging and giving false receipts. He asked his mother, sister, and brother for money, telling lies that he had to attend birthday parties or he wanted to get something. He borrowed money from relatives giving different reasons and he pawned home applicants such as videocassettes, a TV and a radio. If he could not redeem the pawned things he left them there.

*"Doing all possible ways, but sometimes the additional money was 60,000 Dong and I injected only twice, I was tired for the rest of that day. I even had to turn to opium (smoking or injecting) because I had no money; I got fever, like malaria. Nevertheless, I had never stolen*



*or picked foreigners' pockets or sold drugs to earn money to meet my need. The main reason is that I was afraid of being caught, beaten. Moreover, I could manage money from my family and the photo shop."*

## **9. Why ATS were not used**

ATS were not used because they were expensive (60,000 Dong per pill) and the effects were seen to be less satisfying than heroin. Moreover, the ATS market was not popular in Sa Pa, so there was low availability.

## **10. Sharing syringes and needles**

*"I have shared syringes with my friends several times though I knew the possibility of being infected with HIV. They were times when I couldn't buy syringes (for example, it was too late or all the pharmacies were closed). I washed the syringes with distilled water, my friends did the same."*

## **11. Enticing others to use drugs**

Do used to entice his girlfriend to use drugs by offering her a cigarette with heroin inside. She vomited in the first instance, then she got used to it and soon liked it so much. Fortunately, her family discovered in time and helped her to give up.

*"The reason why I persuaded her was I wanted to share experiences with my friend, we could help each other if needed. I knew in doing so meant I would harm her but that thought was vague. Additionally, she didn't strongly refuse; she seemed to be interested in trying."*

## **12. Treatment**

Do had five experiences of treatment at home and in community facilities. The longest time until he relapsed was two months. He also asked to be locked up in his house for a month.

*"I had no medicine for my treatment except for some tonic pills. I thought I would die for the initial days. Being encouraged and forced by my family I was determined to be through with drugs, but, to be honest, I didn't believe myself then. My mum and sisters spent their time and energy on me; I could have whatever I wanted. During my first days, there were always two thoughts in my mind: I was so thirsty for the substance that I wished to be out to inject without fearing death and I had to definitely succeed in giving up drugs so that I'd never have to be like this again."*

## **13. Do's expectations**

Do wishes to be free from drugs because he has realized how harmful they are, he suffered a lot and felt ashamed when he used drugs. Do wishes to continue working for the photo shop after his treatment. This is also what Do's sister and brother-in-law want.

### **4.6.B. Ha Noi: Tuan**

Tuan is 22 years old and is from a working family. All family members work for a state garment and textile company (father, mother and older brother). In addition, they employ workers to run an industrial garment factory of their own. Because they are relatively wealthy, Tuan's parents often give him money. He spends it mainly on betting, gambling and playing with friends.

His first time of using drugs was when he was about to finish his twelfth grade in preparation for the final exam. Having graduated from high school in 1999, Tuan was sent to an intermediate sewing course. After he finished the course, he became an official employee and was paid

1,200,000 Dong per month. Meanwhile, his family also wanted him to work in their factory, he was assigned to deliver and collect money at shops in the city. In 2002, after a long time of taking heroin by inhaling, Tuan decided to inject instead, because smoking heroin did not give him the same effects as before yet cost more money.

After gambling, he mortgaged his motorbike and asked the family to pay off his debts. Having done such things many times, his family finally disagreed. He then admitted that he was addicted and his family sent him to a hospital for a blood test. As the result indicated drug use, his family sent him to the countryside for a month in order to treat him. Then his parents took him home and managed him closely; he was offered a job in their garment and textile factory. After a long time of being tested to see whether he was using drugs or not, he received his parents' trust and worked at home. However, he bought drugs again when he had the chance to go shopping for the first time without being watched. One week later, his family discovered his relapse then they decided to send him to the treatment centre. Now they hope that he will end up drug free.

#### 4.6.C. Bac Ninh province: C

##### 1. Personal information

C is 24 years old. His father worked in a provincial ministry, and his mother for a paper company. They retired six and seven years ago, respectively. There are four children in his family and he is the youngest, his eldest sister is a teacher, his brother-in-law is the vice head of a provincial education and training unit. C's older brother is serving in the army. C left school when he was at eighth grade due to economic difficulties; the pension of his parents was spent on his sister for her studies in Ha Noi.

C hasn't married but has a girlfriend working for a paper company. They have been in love for six years and they share many things, especially viewpoints and lifestyles.

After leaving school for one year, C was employed to drive a motor vehicle to carry construction materials. Two years later, his parents lent him money and he brought a lorry for both him and his brother to do business on their own. Then his brother went to serve in the army and C had to hire another person. His earnings were good; he brought home from 1,000,000 to 1,500,000 Dong monthly. This was C's main income.

##### 2. Understanding of drugs

When asked about types of drug, C only knows of heroin, but he is aware of cocaine and morphine though has never seen them. About heroin he said: *"It's a white, smooth flour, when we touch it we feel it fresh, it has a specific taste, we find it sweetish"*. On the one hand, *"it destroys users' health and mind, it makes them addicted"* but also *"it helps release pains, making people in high spirit and relaxed as well"*. The price of one dose ranges from 20,000 to 50,000 Dong. Dealers provide drugs near the place where C lives. C said: *"They sell drugs on their own; there are hundreds of users who come here to buy"*. Besides, there are many retailers at small shops on the sidewalks or addicts who are hired to sell drugs. He adds: *"Buying drugs in Bac Ninh is as easy as buying vegetables."*

##### 3. Reasons for drugs use

In general, C's family situation was rather good but in some senses their circumstances were tricky. Due to economic difficulty, his sister had to do extra work when she studied in Ha Noi. Their parents were so happy to see how well she managed to study and work and had to rely less on their pension for support; after a while she presented them with money every month saying that she did some teaching as an extra work. Unfortunately, via C's sister's friend, his family came to know that she was serving in a karaoke house and she was using drugs. Since then, the parents forced her to leave the university for home. But when she was





at home, she was using much more, and lacking money to buy drugs and then she returned to working for a bar, even selling sex in order to have enough money for her drugs. She was sent to the provincial rehabilitation centre.

When spoken to, C was moved and confused, he felt sorry for their circumstance, for himself, for his sister. The whole family tried so hard to dissuade her but they failed. After drugs came into the picture there was always a tense atmosphere in the family, even quarrels; C said it was like an “ulcer” that made people sad and furious. C felt disappointed and tired of his family. He was always obsessed by an idea: *“There’s no future for this family, it will be broken because my sister is an addict.”* The more he thought the more he got into great difficulty.

C said: *“I saw my father and my sister quarrelling with each other one evening, my father was so angry that he broke some furniture, I was sad and went out with my friends. That night I was in deep sadness. When my friends gambled, I didn’t want to do anything. Some persons tried to tease me but they failed, so they told me to inhale heroin to forget all the things and not become ‘a decrepit old man’. They told me that heroin would help me sleep well, so I took the drug for the first time of my life. It really worked, I felt relaxed, excited and then I was addicted without realizing when.”*

At first, C only used drugs when he was tired, sad or with friends. Then about four or five months later, C knew that he had got used to using drugs. If he did not have a dose per day he could not stand it. He has used two or even three doses per day in recent months. In the early days he had his friends buy heroin, later on, he had to manage himself and he spent the money earned by carrying building materials for construction works.

He spends at least 20,000 Dong a day on drugs, but it will be more if he wants to satisfy his needs because *“the appetite for drugs constantly comes, especially only few hours after injecting”*. He is aware of deeper addiction if he uses more, so he tries to contain himself. C says: *“I think about my family, girlfriend and the good times we shared together whenever I long for drugs”*.

#### 4. Drug treatment and reasons for relapse

This is the second time C has been under treatment. His first time was at home for three months and he subsequently stopped using drugs for about eight months. At that time, he was highly determined and all the family members helped him a lot. He thought and tried to carry out his determination: *“I can use so I can quit.”* He strongly believed in his standpoint.

After that time, everyone was happy, they loved him, but his girlfriend did not think that he could really give up drugs. She told him she heard that *“if one had used drugs too much, he couldn’t get rid of them”*. She also talked about some cases of people that had undergone the treatment but relapsed. C wanted his girlfriend to believe him many times but the more he tried, the more he felt disappointed - it seemed to be an invisible barrier between them, he couldn’t sit close to her as they used to. She said *“drug users can easily transmit HIV”*, and they no longer kissed as before. C said: *“she loves me but she can’t go on, things would be different if I gave up drugs”*. She did not mention marriage though the two families had prepared for it.

The way his girlfriend behaved pushed C into the impasse; he was always distressed and bored with himself. Sometimes he thought about those who had given up and ‘shuddered’ because what his girlfriend said was basically right in such cases. He was completely at a low ebb and so were his family; they tried to persuade his girlfriend to change her attitude, but did not succeed.

Consequently, C often met and went out with friends. Because of the smell of the drugs they inhaled, C felt like using and then relapsed. C confided: *“I thought when I relapsed that there was nothing to loose, my girlfriend didn’t believe me any more. This put an end to my life.”*

The family's attitude toward C changed after he relapsed for the second time. His father scolded him, his girlfriend wanted to be rid of him. His father even drove him from their house since *"your sister and you have stained your grandfathers' reputation before neighbours and friends."*

He does not know what he will do after his second treatment in the centre, whether family members, friends will trust him or not. C's parents, friends and girlfriend visit him every month, especially his brother-in-law who comes to see him more; he shows great compassion for him.

Experiencing two drug treatments, he thinks each way of treatment has its own strong points. Being treating at home is suitable for those at the age of C but it may not work well because they are not separated from society. While they live apart from their communities when at the treatment centre, where they have access to education and help, this means that they cannot be near their families and girlfriends.

Although every one in C's family is sad and often scolded him when he was using drugs, he is aware that his parents, friends, and especially his girlfriend all love and support him. For C, the sympathy and support from his family, friends, local authorities and mass organizations are essential, helping him to have strong will and determination to deal with difficulties. He is determined to do his best to regain the trust of his parents, friends and society.



---

## Appendix B

---

### Excerpts from Discussion Paper: PRINCIPLES OF DRUG DEPENDENCE TREATMENT - UNODC and WHO March 2008

#### Introduction

Drug dependence and illicit drug use are associated with health problems, poverty, violence, criminal behaviour, and social exclusion. Its total costs to society are difficult to estimate. In addition to the health-care costs and other costs associated with the consequences of drug use, drug dependence also involves social costs in the form of loss of productivity and family income, violence, security problems, traffic and workplace accidents, and links with corruption. These result in overwhelming economic costs and an unacceptable waste of human resources.

Unfortunately in many societies drug dependence is still not recognized as a health problem and many people suffering from it are stigmatized and have no access to treatment and rehabilitation. Over recent years, the *biopsychosocial* model has recognized drug dependence as a multifaceted problem requiring the expertise of many disciplines. A health sciences multidisciplinary approach can be applied to research, prevention and treatment.

The notion that drug dependence could be considered a 'self-acquired disease', based on individual free choice leading to the first experimentation with illicit drugs, has contributed to stigma and discrimination associated with drug dependence. However, scientific evidence indicates that the development of the disease is a result of a complex multi-factorial interaction between repeated exposure to drugs, and biological and environmental factors. Attempts to treat and prevent drug use through tough penal sanctions for drug users fail because they do not take into account the neurological changes drug dependence has on motivation pathways in the brain.

'Nothing less' must be provided for the treatment of drug dependence than a qualified, systematic, science-based approach such as that developed to treat other chronic diseases considered untreatable some decades ago.

The best results are achieved when a comprehensive multidisciplinary approach which includes diversified pharmacological and psychosocial interventions is available to respond to different needs. Even taking into account the requirements for the delivery of evidence-based treatment, its costs are much lower than the indirect costs caused by untreated drug dependence (prisons, unemployment, law enforcement, health consequences). Research studies indicate that spending on treatment produces savings in terms of reduction in the number of crime victims, as well as reduced expenditures for the criminal justice system. At a minimum there was a 3:1 saving, and when a broader calculation of costs associated with crime, health and social productivity was taken into account, the rate of savings to investment rose to 13:1. These savings can improve disadvantaged situations where opportunities for education, employment and social welfare are undermined, and increase possibilities for families to recover battered economies, thus facilitating social and economic development. Individuals involved in the criminal justice system may be at higher risk of health and social consequences of drug dependence. Drug taking behaviour inside the prison involves more harmful patterns leading to increased risk of contamination with infectious diseases like HIV and hepatitis. The potential for imprisonment to cause harm should not be underestimated. Depending on human and financial resources available and the quality level of the existing health system in each country, the actions suggested by the present document may be progressively and gradually implemented, taking into account the outlined components for each principle as a general framework.

## PRINCIPLE 1: AVAILABILITY AND ACCESSIBILITY OF DRUG DEPENDENCE TREATMENT

### Description and Justification

Drug dependence and its associated social and health problems can be treated effectively in the majority of cases if people have access to continuum of available and affordable treatment and rehabilitation services in a timely manner. To this end, all barriers limiting accessibility to treatment services need to be minimized for people to have access to the treatment that best fits their needs.

## PRINCIPLE 2: SCREENING, ASSESSMENT, DIAGNOSIS AND TREATMENT PLANNING

### Description and Justification

Patients affected by drug use disorders often have multiple treatment needs across a range of personal, social and economic areas that cannot be addressed when taking into consideration only their addictive symptoms in a standardized way. As for any other health-care problems, diagnostic and comprehensive assessment processes are the basis for a personalized and effective approach to treatment planning and engaging the client into treatment.

## PRINCIPLE 3: EVIDENCE-INFORMED DRUG DEPENDENCE TREATMENT

### Description and Justification

Evidence-based good practice and accumulated scientific knowledge on the nature of drug dependence should guide interventions and investments in drug dependence treatment. The high quality of standards required for approval of pharmacological or psychosocial interventions in all the other medical disciplines should be applied to the field of drug dependence.

## PRINCIPLE 4: DRUG DEPENDENCE TREATMENT, HUMAN RIGHTS, AND PATIENT DIGNITY

### Description and Justification

Drug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes responding to the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination.

## PRINCIPLE 5: TARGETING SPECIAL SUBGROUPS AND CONDITIONS

### Description and Justification

Several subgroups within the larger population of individuals affected by drug use disorders require special consideration and often specialized care. These groups with specific needs include young people, women, pregnant women, people with medical and psychiatric co-morbidities, sex workers, ethnic minorities, and socially marginalized individuals. A person may belong to more than one of these groups and have multiple needs.

The implementation of adequate strategies and provision of appropriate treatment for these patients often require targeted and differentiated approaches regarding contacting services and entering treatment, clinical interventions, treatment settings and service organization that respond best to the needs of these groups.

**Young people:** Ideally specialized training should be available for counsellors, outreach workers and other professionals involved in treatment of young people with drug use disorders, and child/adolescent psychiatrists and psychologists should be part of these multidisciplinary teams. It may be counterproductive for young patients in early stages of drug use disorders to get in contact with people in more advanced stages of the disease through the treatment setting, and therefore, whenever possible, separate settings for young people and their parents can be considered. Planning and implementing interventions with young people will benefit from close cooperation with families and, when appropriate, schools.



## **Principle 6: ADDICTION TREATMENT AND THE CRIMINAL JUSTICE SYSTEM**

### **Description and Justification**

Drug related crimes are highly prevalent, and many people are incarcerated for drug related offences. These include offences to which a drug's pharmacologic effects contribute, offences motivated by the user's need for money to support continued use and offences connected to drug distribution itself. A significant proportion of people going through criminal systems worldwide are drug dependent.

In general, drug use should be seen as a health-care condition and drug users should be treated in the health-care system rather than in the criminal justice system where possible.

Interventions for drug dependent people in the criminal justice system should address treatment as an alternative to incarceration, and also provide drug dependence treatment while in prison and after release. Effective coordination between the health/drug dependence treatment system and the criminal justice system is necessary to address the twin problems of drug use related crime and the treatment and care needs of drug dependent people.

Research results indicate that drug dependence treatment is highly effective in reducing crime. Treatment and care as an alternative to imprisonment or commenced in prison followed by support and social reintegration after release decrease the risk of relapse in drug use, of HIV transmission and of re-incidence in crime, with significant benefits for the individual health, as well as public security and social savings. Offering treatment as an alternative to incarceration is a highly cost-effective measure for society.

## **PRINCIPLE 7: COMMUNITY INVOLVEMENT, PARTICIPATION AND PATIENT ORIENTATION**

### **Description and Justification**

A community based response to drug use and dependence can support and encourage behavioural changes directly in the community. This might imply a paradigm shift from a directive to a more cooperative form of service delivery, for which the active involvement of local stakeholders (governmental and non-governmental organizations, private sector, community leaders, religious organizations and traditional healers), community members (families) and the target populations is needed to establish ownership and an integrated network of community-based health-care services.

## **PRINCIPLE 8: CLINICAL GOVERNANCE OF DRUG DEPENDENCE TREATMENT SERVICES**

### **Description and Justification**

A drug dependence treatment service requires an accountable, efficient and effective method of clinical governance that facilitates the achievement of its goals.

Service organization needs to reflect current research evidence and be responsive to service user needs. Its policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and target population.

## **PRINCIPLE 9: TREATMENT SYSTEMS: POLICY DEVELOPMENT, STRATEGIC PLANNING AND COORDINATION OF SERVICES**

### **Description and Justification**

A systematic approach to drug use disorders and patients in need of treatment, as well as to planning and implementation of services, require a logical, step-by-step sequence that links policy to needs assessment, and treatment planning and implementation to monitoring and evaluation.



## References

Commission on AIDS in Asia (2008). *Redefining AIDS in Asia: Crafting an effective response*. Oxford University Press, New Delhi.

Degenhardt, L., Mathers, B., Guarinieri, M., Panda, S., Phillips, B., Strathdee, S., Tyndall, M., Weissing, L. and Wodak, A. (2007). *The global epidemiology of methamphetamine injection: a review of the evidence on use and associations with HIV and other harm*. NDARC, UNSW, Sydney, Australia.

Devaney, M., Reid, G. and Baldwin, S. (2006). *Situational analysis of illicit drug issues and responses in the Asia-Pacific region*. ANCD, Canberra.

Mathers, B., Degenhardt, L., Phillips, B., Weissing, L., Hickman, M., Strathdee, S., Wodak, A., Panda, S., Tyndall, M., Toufik, A. and Mattick, R. (2008). *Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review*. The Lancet, November 15; 372 (9651); 1733-1745.

UNESCAP (2003). *Young people – partners in HIV/AIDS prevention*. UN, New York. Available: <http://www.unescap.org/esid/hds/resources/publications.asp>

UNESCAP (2003). *Adolescent substance use: risk and protection*. UN, New York. Available: <http://www.unescap.org/esid/hds/resources/publications.asp>

UNESCAP (2005). *HIV prevention among young people: Life skills training kit*. UNESCAP, Bangkok. Available: <http://www.unescap.org/esid/hds/resources/publications.asp>

UNESCAP (2006). *Young people and substance use: prevention, treatment and rehabilitation*. UNESCAP, Bangkok. Available: <http://www.unescap.org/esid/hds/resources/publications.asp>

UNESCAP (2007a). *Health without borders: improving health and reducing HIV/AIDS vulnerability among long-distance road transport workers through a multisectoral approach*. UNESCAP, Bangkok. Available: <http://www.unescap.org/esid/hds/resources/publications.asp>

UNESCAP (2007b). *Statistical Yearbook for Asia and the Pacific*. UNESCAP, Bangkok. Available: <http://www.unescap.org/publications/detail.asp?id=1275>

UNESCAP (2007c). *A tool Kit for: building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion*. UNESCAP, Bangkok. Available: <http://www.unescap.org/esid/hds/resources/publications.asp>

UNODC (2008a). *Principles of Drug Dependence Treatment: a discussion paper*. Available: [http://www.who.int/substance\\_abuse/publications/principles\\_drug\\_dependence\\_treatment.pdf](http://www.who.int/substance_abuse/publications/principles_drug_dependence_treatment.pdf)

UNODC (2008b). *Reducing the adverse health and social consequences of drug abuse: A comprehensive approach: a discussion paper*. Available: [http://www.unodc.org/docs/treatment/Reducing-adverse-consequences-drug-abuse\[1\].pdf](http://www.unodc.org/docs/treatment/Reducing-adverse-consequences-drug-abuse[1].pdf)

