

CHAPTER 6

Security Bureau

Department of Health

Social Welfare Department

Food and Health Bureau

**Voluntary treatment and
rehabilitation programmes for drug abusers**

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VOLUNTARY TREATMENT AND REHABILITATION PROGRAMMES FOR DRUG ABUSERS

Contents

	Paragraph
PART 1: INTRODUCTION	1.1
Background	1.2 – 1.3
Different modalities of treatment and rehabilitation	1.4
Latest situation on drug abuse	1.5 – 1.7
Harmful effects of psychotropic substances	1.8
Concerns of some Legislative Council Members	1.9
High-level Task Force on Youth Drug Abuse	1.10 – 1.11
Audit review	1.12 – 1.14
General response from the Administration	1.15
Acknowledgement	1.16
PART 2: MONITORING OF DRUG ABUSE SITUATION	2.1
Government system for collecting drug abuse information	2.2
School surveys	2.3 – 2.4
Audit observations and recommendations	2.5 – 2.10
Response from the Administration	2.11
Central Registry of Drug Abuse	2.12 – 2.16
Decrease in number of drug abusers reported to the CRDA	2.17 – 2.19
Audit observations and recommendations	2.20 – 2.32
Response from the Administration	2.33
Supplementary system to collect qualitative drug abuse data	2.34 – 2.41
Audit observations and recommendations	2.42 – 2.44
Response from the Administration	2.45

	Paragraph
PART 3: EFFECTIVENESS OF THE TREATMENT AND REHABILITATION PROGRAMMES	3.1
Provision of different modalities of services	3.2 – 3.5
Early intervention initiatives	3.6 – 3.7
Audit observations and recommendations	3.8 – 3.29
Response from the Administration	3.30 – 3.31
PART 4: MONITORING THE PERFORMANCE OF VARIOUS TREATMENT AND REHABILITATION PROGRAMMES	4.1
Various treatment and rehabilitation programmes	4.2
Treatment and rehabilitation services provided by subvented NGOs	4.3 – 4.8
Audit observations and recommendations	4.9 – 4.12
Response from the Administration	4.13 – 4.15
Methadone Treatment Programme	4.16 – 4.21
Audit observations and recommendations	4.22 – 4.32
Response from the Administration	4.33 – 4.34
PART 5: PROVISION OF SUBSTANCE ABUSE CLINICAL SERVICES	5.1
Substance Abuse Clinics	5.2 – 5.4
Recommendations by PSA Task Force	5.5 – 5.9
Audit observations and recommendations	5.10 – 5.24
Response from the Administration	5.25 – 5.26
Response from the Hospital Authority	5.27
Performance of Substance Abuse Clinics	5.28
Audit observations and recommendations	5.29 – 5.33
Response from the Hospital Authority	5.34
Response from the Administration	5.35

	Page
Appendices	
A : Trend of reported drug abusers in Hong Kong (1997-2007)	70
B : Trend of reported heroin and psychotropic substance abusers in Hong Kong (1997-2007)	71
C : Overseas drug abuse surveillance systems	72 – 74
D : Performance measures of an NGO Counselling Centre for Psychotropic Substance Abusers	75
E : Utilisation of methadone clinics	76
F : Manpower resources deployed by hospitals to provide substance abuse clinical services	77
G : Audit visits to Substance Abuse Clinics	78 – 80
H : Acronyms and abbreviations	81 – 82

PART 1: INTRODUCTION

1.1 This PART describes the background to the audit and outlines the audit objectives and scope.

Background

1.2 The Government's anti-drug policy consists of five elements: legislation and law enforcement, **treatment and rehabilitation (T&R)**, preventive education and publicity, research, and external cooperation. The Action Committee Against Narcotics (ACAN — Note 1) advises the Government on anti-drug strategies and programmes. The Narcotics Division (ND) of the Security Bureau acts on the advice of ACAN and is responsible for the formulation of the Government's anti-drug policy and overall coordination of anti-drug efforts.

1.3 In the financial year 2006-07, the Government spent some \$600 million on anti-drug activities, \$286 million (48%) of which were spent on T&R. Of these \$286 million, \$163 million (57%) were spent on various types of voluntary T&R programmes (Note 2).

Different modalities of treatment and rehabilitation

1.4 In order to cater for the different needs of drug abusers from varying backgrounds, the Government adopts a multi-modality approach in the provision of T&R services. The Government's voluntary T&R services can broadly be grouped into the following four categories:

Note 1: *ACAN is comprised of members coming from various sectors including youth, social work, medicine, academia and Legislative Council. Its tasks are to keep under constant review the programmes and projects undertaken by the Government in the anti-drug cause, to ensure coordination and cooperation among government departments and non-governmental organisations in implementing anti-drug policies, and to enlist public support in the fight against drugs.*

Note 2: *Other than the \$163 million, \$102 million were spent on the compulsory drug treatment programme operated by the Correctional Services Department (CSD) which currently runs one male and one female drug addiction treatment centres. These CSD centres provide compulsory drug treatment programme for the cure and rehabilitation of drug abusers who are found guilty of criminal offences punishable by imprisonment. Another \$21 million were spent by government bureaux and departments in the planning and administration of the various T&R programmes.*

- (a) ***Residential T&R Programme.*** At present, 17 non-governmental organisations (NGOs) are running 39 residential T&R centres and halfway houses. Seven of these NGOs (operating 20 centres) are receiving recurrent subvention from the Government. One NGO, namely the Society for the Aid and Rehabilitation of Drug Abusers (SARDA), is subvented by both the Department of Health (DH) and the Social Welfare Department (SWD). Two other NGOs (Note 3) are subvented by the DH and four (Note 4) by the SWD. The remaining ten NGOs do not receive government subvention for anti-drug cause, but the Government assists in providing land at very low costs where appropriate;
- (b) ***Methadone Treatment Programme (MTP).*** It is operated by the DH through a network of 20 methadone clinics on a voluntary and out-patient mode. The programme offers both maintenance and detoxification options for opiate drug (Note 5) abusers;
- (c) ***Counselling Centres for Psychotropic Substance Abusers (CCPSAs).*** Five CCPSAs are operated by NGOs subvented by the SWD. A wide range of services is offered, including needs assessment, counselling and group work service, and family programmes; and
- (d) ***Substance Abuse Clinics (SACs).*** The Hospital Authority (HA) currently operates five SACs for drug abusers (primarily those with psychiatric complications and/or co-morbidity — Note 6). Their services include drug treatment, counselling and, in some cases, psychotherapy. Patients are treated largely on an out-patient basis.

Latest situation on drug abuse

1.5 The Administration reported the following information on the current drug abuse situation in Hong Kong to the Legislative Council (LegCo) in 2007:

Note 3: *They are Caritas Hong Kong and Hong Kong Christian Service.*

Note 4: *They are Barnabas Charitable Service Association Limited, the Christian New Being Fellowship Limited, the Finnish Evangelical Lutheran Mission and Operation Dawn Limited.*

Note 5: *Opiate drugs include heroin, opium and morphine. Heroin has always been the most common opiate drug abused in Hong Kong.*

Note 6: *Psychiatric co-morbidity refers to the existence of two or more types of psychiatric disorders (e.g. depression, conduct and personality disorder).*

- (a) according to a school survey in 2004, about 3.4% (i.e. 17,300) of the secondary school students had abused drugs. About 0.8% (i.e. 4,300) of the secondary school students had abused drugs in the 30 days prior to the survey;
- (b) based on the Central Registry of Drug Abuse (CRDA — Note 7):
 - (i) the total number of reported drug abusers decreased steadily from 17,635 in 1997 to 13,204 in 2006. However, the first half of 2007 registered a total of 8,208 drug abusers, representing an increase of 1.7% from the 8,071 drug abusers in the first half of 2006;
 - (ii) from 1997 to 2006, the number of reported young drug abusers (aged below 21) fluctuated quite significantly, decreasing from 3,150 to 2,549. The number in the first half of 2007 stood at 1,646, representing an increase of 10.7% when compared to 1,487 in the same period of 2006;
 - (iii) reported heroin abusers decreased from 14,291 in 1997 to 8,101 in 2006, but reported psychotropic substance abusers increased from 3,488 to 7,364 during the same period; and
 - (iv) the average age of young drug abusers was 17 and the average age when a young person first abused drugs was 15;
- (c) the number of Hong Kong residents arrested for drug abuse in the Mainland increased from 191 in 2004 to 350 in 2005, and further to 550 in 2006; and
- (d) young drug abusers were mainly psychotropic substance abusers. The most commonly abused drugs among them were ketamine and ecstasy.

1.6 The following drug seizure statistics reported by the Administration to LegCo also provide indications on the magnitude of drug abuse in Hong Kong:

Note 7: *The CRDA is a registry maintained by the Security Bureau to collect information for monitoring the drug abuse situation in Hong Kong and to provide basic data to facilitate anti-drug policy formulation (see para. 2.12).*

Drug seizure	2005	2006	2007
<i>Opiate drug:</i>			
Heroin (kg)	32	52	42
<i>Psychotropic substance:</i>			
Cannabis (kg)	432	199	558
Methamphetamine (Ice) (kg)	228	7	57
Ketamine (kg)	296	1,006	99
Cocaine (kg)	12	15	200
Ecstasy-type (tablet)	47,694	104,296	59,714

It can be seen that the quantities of heroin seizures from 2005 to 2007 were relatively small, but there were significant increases in the quantities of seizures for psychotropic substances in 2006 and 2007 (particularly for ketamine and ecstasy in 2006 and for cannabis and cocaine in 2007).

1.7 The shift from heroin abuse to psychotropic substance abuse (PSA) and the increasing prevalence of youth drug abuse in recent years have aroused considerable public concern. The Administration also took the issue seriously. In January and February 2008, the Commissioner of Police and the Secretary for Security told the media that:

- (a) the Government was particularly concerned about youth drug abuse in Hong Kong. In 2007, there were 2,769 cases of serious drug offences. Among a total of 3,531 people arrested for serious drug offences, 922 were young people. This doubled the figure of 454 young people in 2006. More than 90% of the young persons arrested were involved with psychotropic substances, the majority of them being involved with ketamine; and
- (b) youth drug abuse was not restricted to Hong Kong. The same situation happened in other metropolitan cities. There were a number of reasons. Firstly, people were getting more and more affluent. Secondly, there was an increase in the supply of psychotropic substances worldwide. Thirdly, drug abuse had unfortunately developed internationally as a subculture among the young people.

Harmful effects of psychotropic substances

1.8 In 2000, the Government set up a Task Force on PSA (PSA Task Force — Note 8) to draw up a comprehensive strategy to tackle specifically the issue of PSA (especially among young people). According to the Task Force, psychotropic substances would have the following harmful effects:

“Similar to heroin abuse, psychotropic substance abuse implicitly or explicitly causes adverse effects to and consequences on one’s mental and physical health, family and peer relationships, schooling pursuits, social life and work performance, etc. Overseas studies revealed that psychotropic substance abuse affects mental health in various ways, from attention deficit, deteriorating memory to depression and hallucination.”

Concerns of some Legislative Council Members

1.9 On various occasions, LegCo Members expressed concern over the deteriorating problem of youth drug abuse. In particular, they were concerned about the increasing trend of cross-boundary drug abuse involving young people and that the situation might worsen as more boundary control points would be opened in the coming years. On 3 July 2007, Members of the Panel on Welfare Services passed a motion urging the Government to:

“immediately conduct a comprehensive review of the outdated and inadequate anti-drug policy, reaffirm the policy and direction of identifying drug abusers at an early stage and helping them to rehabilitate, and allocate more resources to improve the existing reporting mechanism and the extremely insufficient services.”

High-level Task Force on Youth Drug Abuse

1.10 In October 2007, the Chief Executive in his Policy Address announced the appointment of the Secretary for Justice (the incumbent Deputy Chairman of the Fight Crime Committee) to lead a high-level inter-departmental task force to tackle youth drug abuse. The high-level task force would make use of the existing anti-crime and anti-drug networks to consolidate strategies to combat youth drug abuse from a holistic perspective. It would focus on spearheading cross-bureau and inter-departmental efforts at the strategic

Note 8: *The PSA Task Force was formed in April 2000 to tackle the rising problem of PSA. Chaired by a member of ACAN, the Task Force consisted of experts from various fields, including NGOs, professional bodies and government departments. The Task Force produced its report in June 2002.*

level. The high-level task force held its first meeting on 23 October 2007 and aimed to conclude its work in one year's time.

1.11 On 27 February 2008, the Financial Secretary indicated in his 2008-09 Budget Speech that:

- (a) he was deeply concerned about the problem of PSA by young people;
- (b) the high-level task force (see para. 1.10) had conducted in-depth studies of the problem over the past few months and devised a series of initial measures that could be implemented in the short to medium term; and
- (c) he would allocate additional resources of \$53 million in 2008-09 to tackle this problem.

Audit review

1.12 Many of the existing voluntary T&R programmes (such as those programmes in para. 1.4(a) and (b)) have been in operation for many years. Hence, the changes in drug abuse situation pose great challenges to those service providers who are mainly geared to the treatment of heroin abusers. Against this background, the Audit Commission (Audit) has conducted an examination of the Government's **voluntary T&R programmes** (see para. 1.4).

1.13 Audit has found that there is scope for improvement in the following areas:

- (a) monitoring of drug abuse situation (PART 2);
- (b) effectiveness of the T&R programmes (PART 3);
- (c) monitoring the performance of various T&R programmes (PART 4); and
- (d) provision of substance abuse clinical services (PART 5).

1.14 As a related issue, Audit has conducted a review of SARDA. The audit findings are contained in a separate report (see Chapter 5 of the Director of Audit's Report No. 50).

General response from the Administration

1.15 The **Commissioner for Narcotics** welcomes the audit review which has provided useful observations and recommendations on the future development of T&R services for drug abusers in Hong Kong. She has said that:

- (a) in taking forward the current anti-drug policy as embodied in the “five-pronged” approach (see para. 1.2), the Administration is advised by ACAN (and its sub-committees) and the Research Advisory Group (RAG — Note 9). The ND has also kept in touch with anti-drug workers from subvented and non-subvented T&R centres, youth groups, social welfare agencies and drug education experts through the Drug Liaison Committee (DLC — Note 10). All these parties (partners) have played a very important role in shaping the Government’s policy and measures, and have made a substantial contribution to the anti-drug cause; and
- (b) in taking forward the audit recommendations, the ND will continue to work closely with the anti-drug partners in (a) above, and to benefit from their advice.

Acknowledgement

1.16 Audit would like to acknowledge with gratitude the full cooperation of the staff of the ND, the DH, the SWD, the HA and NGOs during the course of the audit review.

Note 9: *The RAG is responsible for overseeing research projects which provide solid and scientific evidence that is crucial in better-informed anti-drug policy making. The Group is indirectly related to ACAN through cross-membership.*

Note 10: *The DLC was formed in 1993 to facilitate cooperation and communication between the ND and NGOs. The committee has 31 members made up of representatives of NGOs, drug education experts, youth groups and organisations as well as government representatives. It facilitates the exchange of views between the Government and NGOs on a wide range of drug-related matters in general, and T&R issues in particular.*

PART 2: MONITORING OF DRUG ABUSE SITUATION

2.1 This PART examines the Government system for collecting information to monitor the drug abuse situation.

Government system for collecting drug abuse information

2.2 The Government collects and publishes two sets of data about the number of reported drug abusers and other related information. They are data/information collected by **school surveys**, and those from the **CRDA** (see para. 1.5(a) and (b)). These are the two primary data sources. In formulating policy and allocating resources, the ND also makes reference to information collected from ad hoc research studies, admission statistics from T&R agencies, and drug-related arrest and seizure figures.

School surveys

2.3 The ND conducts regular surveys of drug use among students. The last two surveys were conducted in 2000 and 2004. In these surveys, students of ordinary secondary day schools, international schools and the Hong Kong Institute of Vocational Education (IVE) were covered.

2.4 Before 2008, school surveys were conducted once every four years. At the requests of LegCo Members and the public, the ND reviewed and revised the survey frequency in view of the increasing trend of drug abuse among youths in recent years. From 2008, the survey frequency is revised to once every three years. According to the ND, the conduct of more frequent surveys has taken into consideration the fact that more frequent data collection would inevitably increase the burden of responding schools/institutes and students, which may affect the response rate and data quality.

Audit observations and recommendations

Limitations of school surveys

2.5 The school surveys conducted by the ND have provided useful information on the drug abuse situation of students, including their drug abuse pattern, and their knowledge of and attitudes towards drug abuse. There are however limitations which may affect the survey results.

2.6 Given the sensitive nature of drug abuse, students may not respond honestly when asked whether they have abused drugs (Note 11). Also, the validity of the data supplied by students in the school surveys could not be verified.

2.7 **Given these limitations, school surveys alone cannot adequately measure the magnitude of the drug abuse problem among students, and have to be supplemented by other methods.** The need for the development of a supplementary drug abuse monitoring system is discussed in paragraphs 2.34 to 2.44.

Voluntary nature of school surveys

2.8 Audit reviewed the 2000 and 2004 school surveys conducted by the ND and noted the following:

- (a) ***School participation was not compulsory.*** Schools were not obliged to participate in the surveys. In the two surveys, some schools, particularly international schools, had declined to participate. Details are shown in Table 1.

Note 11: *Audit noted that the ND had taken various measures to help relieve the psychological burden of students in providing sensitive information. Such measures included, for example, requiring all students to answer the same number of questions within a similar completion time, locating in the questionnaire forms almost all “ovals” to be filled in near the centre of each page (so that drug-using students would not be identified easily by their neighbouring schoolmates), asking all teachers and school staff to leave the rooms/halls during data collection and the anonymous return of completed questionnaires.*

Table 1

School participation in 2000 and 2004 surveys

Type of school	Total number of schools	Number of schools surveyed	Remarks
<i>2000 survey</i>			
Ordinary day school	446	118	182 schools had been invited to participate in the survey. However, 64 (35%) schools declined to participate. Although it was originally intended to survey 138 schools, due to difficulties in identifying schools to participate, only 118 schools were surveyed.
International school	25	15	10 (40%) schools had declined to participate in the survey.
IVE	9	9	—
<i>2004 survey</i>			
Ordinary day school	456	97	115 schools had been invited to participate in the survey. 15 (13%) schools declined to participate. 3 schools did not reply to the ND invitation for participation.
International school	24	17	It was originally intended to survey all international schools. 7 (29%) schools declined to participate. 2 of these 7 schools had also declined to participate in the 2000 survey.
IVE	11	11	—

Source: ND records

- (b) **Student participation was not compulsory.** The 2000 and 2004 surveys achieved an overall student response rate of 87.3% and 81.6% respectively. However, the response rate was not high for IVE and a few international schools, as shown in Table 2.

Table 2

Student participation in 2000 and 2004 surveys

Type of school	Student response rate
<i>2000 survey</i>	
International school	15 international schools had participated in the survey, with an average response rate of 91.2%. Of these, one had a very low response rate of less than 15%.
IVE	An average response rate of 67.3% was achieved.
<i>2004 survey</i>	
International school	Although the international schools achieved an overall response rate of 81.6%, 6 of the surveyed schools had response rates of less than 70%, with 3 below 50%.
IVE	An average response rate of 67.5% was achieved.

Source: ND records

Audit noted that there was an obvious drop in the student participation rates for international schools in the 2004 survey. In fact, a few schools allowed only selected grades/classes to participate in the surveys. The less-than-complete response from some schools and students is an issue that calls for close monitoring, as it may affect the survey results.

2.9 Audit noted that the ND had taken various measures to improve participation. Such measures included simplifying the questionnaires, attempting to accommodate the timetable of schools in conducting the surveys, and seeking the assistance of the Education Bureau in promoting the surveys. The ND advised Audit in February 2008 that in terms of sample size/sampling proportion/school participation and student response rates, the school surveys in Hong Kong were comparable with similar overseas surveys and, having regard to the internationally recognised statistical standards, the results of the surveys in Hong Kong were highly reliable (see para. 2.11(c) and (d)). **Despite these, given the resources involved in a school survey (Note 12), Audit considers that the ND needs to closely monitor the participation trends and, where appropriate, take further actions to improve the school and student participation rates.**

Note 12: *This involves the time and efforts spent by schools, students, consultants and staff of the Security Bureau in organising the survey and analysing the results.*

Audit recommendations

- 2.10 **Audit has recommended that the Commissioner for Narcotics should:**
- (a) **consider supplementing the school surveys with other fact-finding methods to ascertain the drug abuse situation among students (see also paras. 2.34 to 2.44); and**
 - (b) **closely monitor the trends of school and student participation in school surveys and, where appropriate, take further actions to improve the participation rates.**

Response from the Administration

2.11 The **Commissioner for Narcotics** agrees with the audit recommendations. She has said that:

- (a) the 2004 school survey included a number of measures to relieve the psychological burden of students in providing sensitive information (see Note 11 to para. 2.6). These measures should be useful in facilitating students to provide honest answers to the questionnaire. As with any statistical survey, there is no guarantee of the full validity of the information provided;
- (b) nevertheless, apart from the school survey, the ND also refers to other supplementary information to facilitate a more comprehensive understanding of the drug abuse situation among young people. For example, the ND will make reference to admission statistics from T&R agencies, drug-related arrest and seizure figures, as well as thematic research studies. The ND will continue to make reference to the supplementary information and explore more effective means for better understanding of the situation among young people;
- (c) in statistics, the accuracy of the survey result highly depends on the sampling proportion (i.e. the sample size relative to the size of the population under survey). The 2004 school survey in Hong Kong had a sample size of about 95,600 students, representing a sampling fraction of 19% of about 509,100 students under study. A similar school survey conducted in the United States had a sample size of 50,000, representing 0.4% of 12 million students under study. In the UK, the sample size was 10,000, representing 0.3% of 3 million students under study;
- (d) the school surveys in Hong Kong, in terms of school participation rate and student response rate (e.g. 83% and 82% respectively for the 2004 school survey), are also comparable with similar overseas surveys. Out of some 12,700 students in international schools in 2004, 5,500 (43%) responded to the 2004

school survey. Out of some 35,000 students in IVE, some 23,600 (67%) responded. These represent very encouraging sampling proportions, much higher than the overall sampling proportion (19% of all students); and

- (e) the ND will continue to explore ways to further improve the response rates in future surveys. For example, in the coming 2008 survey, the ND will consider possible ways to provide incentives to schools to encourage their participation.

Central Registry of Drug Abuse

2.12 The CRDA was developed by the ND in 1972. It is a government registry required under the Dangerous Drugs Ordinance (DDO — Cap. 134). It provides relevant drug abuse statistics for monitoring changes in drug abuse trends and characteristics of drug abusers to facilitate the planning of anti-drug strategies and programmes. The objectives of the CRDA include:

- (a) identifying trends in the nature of drug addiction and the addict population in Hong Kong with reference to the demographic characteristics of the overall population;
- (b) coordinating statistics from various sources for analysing the characteristics of the reported addict population at any given time, and to contrast these characteristics among abusers reported from various sources; and
- (c) providing a database which is responsive to requests for monitoring selected groups of drug abusers with regard to their drug abusing patterns over a period of time for research.

Methodology

2.13 Reports on confirmed or suspected drug abusers are submitted to the CRDA via a standard record sheet by a wide network of reporting agencies comprising law enforcement departments, T&R agencies, welfare agencies, tertiary institutions, hospitals and clinics. A list of 67 CRDA reporting agencies is specified in the Fourth Schedule to the DDO (Note 13).

Note 13: *To enhance the representativeness of the CRDA, in May 2005, the DDO was amended to include 33 additional reporting agencies in the Fourth Schedule, making up a total of 67 reporting agencies.*

2.14 The CRDA record sheet solicits information on the social and demographic characteristics and drug-taking information of drug abusers who have come into contact with the reporting agencies. According to the CRDA Report published by the ND in 2007:

- (a) the Hong Kong Police Force (Police) and the Customs and Excise Department would complete a record sheet for every confirmed or suspected abuser arrested by them;
- (b) the Correctional Services Department (CSD) would report on drug abusers on their admission to prisons or drug treatment centres and also on relapsed prisoners;
- (c) T&R agencies would report on new and re-admitted cases;
- (d) welfare agencies would report when a confirmed or suspected drug abuser approached them for assistance;
- (e) outreaching social workers would report on drug abusers who came to them for services; and
- (f) hospitals and clinics would complete a record sheet in respect of any patient who had shown withdrawal symptoms of drug addiction or who confessed to being a drug abuser.

2.15 For the purpose of reporting, a drug abuser is defined as a person who has taken any kind of substances which harms or threatens to harm his physical or mental health or social well-being, in doses above, or for periods beyond, those normally regarded as therapeutic in the **last four weeks**, irrespective of the number of takings. Taking alcohol and tobacco is, however, not regarded as drug abuse.

2.16 All record sheets received in paper form are checked and coded in the Security Bureau, and the data are input into the computer. Together with those record sheets submitted electronically through the Internet to the CRDA, the input data are validated. To avoid multiple counting of the same person and to enable identification of newly reported cases as against the previously reported ones already in the CRDA database, computer matching of the data input with previously known cases in the database, using the name, identity card number, date of birth, sex, etc., is carried out. With the updated CRDA database, tabulations are produced. Regular statistics on drug abuser characteristics are compiled.

Decrease in number of drug abusers reported to the CRDA

2.17 Based on the CRDA, the total number of reported drug abusers decreased from 18,513 in 2001 to 13,491 in 2007, with the number of reported heroin abusers decreasing from 11,575 to 7,390. For young drug abusers, the reported number decreased from 3,902 in 2001 to 2,186 in 2004, but rising in 2005 and reaching 2,919 in 2007. More details are given at Appendices A and B.

2.18 Some LegCo Members queried, on different occasions, the accuracy of the CRDA data in reflecting the magnitude of the drug abuse problem. For example:

- (a) *Meeting of the LegCo Panel on Welfare Services on 3 July 2007.* A LegCo Member said that according to surveys conducted by organisations in the private sector, the magnitude of the drug abuse problem among young people was far more serious than the statistics gathered by the reporting agencies. He suggested that the Administration should improve the existing reporting mechanism with a view to providing an accurate number of young drug abusers for formulation of anti-drug measures and support services; and
- (b) *Meeting of the LegCo Panel on Security on 30 October 2007.* A LegCo Member expressed the view that the youth drug abuse situation was more serious than that reflected in the statistics provided. He said that a large number of young people abused drugs at private parties, or crossed the border to abuse drugs in the Mainland. Another LegCo Member also said that the social welfare sector generally considered that the statistics provided in a Panel paper were “grossly under-estimated”. He remarked that the increased supply and low retail price of ketamine had led to the increase in drug abuse among the youth.

2.19 In response, the Administration explained that:

- (a) the CRDA collated statistical information regarding drug abuse and tracked the changing trend; and
- (b) as the information was submitted by an extensive network of reporting agencies **voluntarily**, CRDA figures did not represent the total number of abusers but reflect the general trend of drug abuse which was useful in guiding policy-making.

Audit observations and recommendations

2.20 The CRDA reporting network encompasses a large number of reporting agencies. **However, because the CRDA is a voluntary reporting system which only records drug abusers who have come into contact with, and been reported by, the agencies, there is a risk of under-reporting (Note 14).** Given these limitations, the Administration considered that the CRDA statistics could only be taken as indicators to monitor the overall drug abuse trend. **Audit has however found that there might have been significant under-reporting by some reporting agencies, and the CRDA may not be entirely reliable in reflecting the drug abuse situation and trend, as explained in paragraphs 2.21 to 2.32.**

Analysis of drug abuser cases in the CRDA

2.21 The reporting network was broadened in May 2005 with the number of reporting agencies increasing from 34 to 67 (see Note 13 to para. 2.13). An analysis of the summary statistics kept by the ND on the number of drug abuser cases reported by reporting agencies to the CRDA from 2003 to 2006 (Note 15) has shown that:

- (a) over the four years, there was **a general decline** in the total number of drug abuser cases collected by the CRDA;
- (b) of the 67 reporting agencies listed in the Fourth Schedule to the DDO, many had **not** reported any case to the CRDA. For example, in 2006, **39 agencies** (58% of 67) had **not** reported any case;
- (c) in the four years, drug abuser cases were reported by **five agencies** which were **not** included in the Fourth Schedule to the DDO. There was no legal backing for the reports submitted and the abuser cases were not protected by the DDO on data confidentiality;

Note 14: *The PSA Task Force (see para. 1.8) stated in its report of 2002 that as the CRDA could only record those drug abusers who had come into contact with and been reported by the reporting agencies, it was inevitably incomplete. Together with the voluntary reporting of the CRDA, there were limitations inherent in the statistics compiled, which could only serve as one of the indicators to monitor the overall drug abuse trend in Hong Kong.*

Note 15: *Audit did not gain access to the drug abuser cases submitted by the reporting agencies to the CRDA as they were classified as confidential information under section 49A of the DDO.*

- (d) although there were 67 reporting agencies in the Fourth Schedule to the DDO, a **high percentage** of the drug abuser cases submitted to the CRDA were reported by just a **few agencies**. Many of the other reporting agencies either had not reported any case (see (b) above) or had reported a relatively small number of drug abuser cases, although some of them should have direct and frequent contacts with drug abusers; and
- (e) there were also parties who should have direct and frequent contacts with drug abusers, but were **not** included as reporting agencies in the Fourth Schedule to the DDO.

ND review of the CRDA in 2001

2.22 In a review commissioned by the ND (completed in 2001 — Note 16) on the CRDA system, the review team found that reporting agencies had encountered the following problems in CRDA reporting:

- (a) many reporting agencies that provided outreaching social services (outreaching agencies) did not report data to the CRDA mainly due to **privacy concerns**. In particular, there were widespread privacy concerns from outreaching agencies about the possible impact of the Personal Data (Privacy) Ordinance (PDPO — Cap. 486) on their reporting of drug-abusing clients' data to the CRDA. From the agencies' perspective, they needed to maintain a good relationship with their drug-abusing clients. Their clients were very conscious about the privacy of their drug abuse problem. If drug abuser cases were reported to the CRDA, some of the drug abusers would not come forward for treatment or services lest their drug-abusing status could be identified by the law enforcement agencies;
- (b) some outreaching agencies had difficulties in obtaining personal information from their clients and worried about the legal consequences of obtaining and reporting them;
- (c) staff turnover was very common in various reporting agencies and new staff were not familiar with the procedures for CRDA reporting;
- (d) the reporting agencies did not have adequate manpower to compile and submit CRDA data; and
- (e) the agencies and their staff did not recognise the significance of the CRDA data in policy formulation.

Note 16: *The review was conducted by a research team of a local university and overseen by a monitoring group comprising members of ACAN and representatives from relevant fields.*

Subsequent to the review, the CRDA system was redeveloped in 2005 (Note 17). A recent audit survey has however found that some of the problems encountered by reporting agencies (such as data privacy concerns) still existed.

Audit survey

2.23 In December 2007 and January 2008, Audit conducted a questionnaire survey of selected reporting agencies (Note 18). Audit found that most of them (77% of 69 respondents) did not always report drug abuser cases to the CRDA. Their reasons were as follows:

- (a) priority needed to be given to providing counselling/treatment services to the clients, with lower priority being given to CRDA reporting;
- (b) there was no obligation for them to report to the CRDA;
- (c) there were legal and privacy concerns from the reporting agencies;
- (d) there were data privacy concerns from individual abusers;
- (e) in the case of young drug abusers, consent from their parents/guardians was not given;
- (f) individual abusers and reporting agencies were not clear about the use of CRDA data and had reservations on the proper protection of data reported;
- (g) there was a lack of manpower to collect relevant data and report to the CRDA;
- (h) there were staff changes (with new staff not familiar with the procedures for reporting to the CRDA); and

Note 17: *The CRDA system was redeveloped to enhance system functionality to cope with changing drug trends. Such new system functionalities included the provision of on-line electronic data submission and on-line enquiry functions, supporting the use of Chinese characters, the adoption of a more informative record sheet for data input and the availability of on-line management statistics.*

Note 18: *A reporting agency can have one or more CRDA reporting units. The survey covered 90 randomly selected CRDA reporting units, representing 33% of a total of 271 reporting units. By the end of February 2008, Audit received completed questionnaires from 78 reporting units. Of these 78 completed questionnaires returned, 9 reporting units advised that they had not handled any drug abuser cases in 2007. That is, only 69 reporting units which had responded to the survey had handled drug abusers cases in 2007.*

- (i) the reporting agencies needed to maintain a good relationship with their drug-abusing clients.

Need to review and enhance the CRDA

2.24 The ND review of the CRDA in 2001 had already highlighted the risk of under-reporting of drug abuser cases. The audit analysis and survey (see paras. 2.21 and 2.23) also showed that the number of drug abuser cases in the CRDA could have been significantly under-reported. **As mentioned in paragraph 2.2, school surveys and the CRDA are the two primary data sources that help the Government monitor the drug abuse situation in Hong Kong. However, both of them cannot provide a full picture of the magnitude of the drug abuse problem, which is important to help the Government formulate its anti-drug strategies.** Audit considers that the ND needs to ascertain the extent of CRDA under-reporting by reporting agencies, and the reasons that have discouraged the agencies from reporting to the CRDA. The audit survey may help in shedding light on the causes for under-reporting.

2.25 **Given that the success of the CRDA relies heavily on the cooperation of the reporting agencies, Audit considers that the ND needs to step up its efforts to promote CRDA reporting.** The ND needs to strengthen its communication with reporting agencies and help them recognise the importance of reporting and encourage them to report. The ND also needs to initiate measures to amend the Fourth Schedule to the DDO as early as possible by including the five reporting agencies mentioned in paragraph 2.21(c), and other potential parties (see para. 2.21(e)) in the Schedule. A mechanism should also be set up for regular reviews of the reporting network and for collecting agencies' feedback on the CRDA reporting system.

2.26 The PSA Task Force considered in its 2002 review that statistics produced by the CRDA could only serve as **one of the indicators** to monitor the overall drug abuse trend in Hong Kong (see Note 14 to para. 2.20). In order to assess the magnitude of the drug abuse problem, Audit considers that the ND needs to explore developing other systems to supplement the CRDA (see paras. 2.34 to 2.44).

Need to address agencies' concerns

2.27 As noted in the audit survey (see para. 2.23), many reporting agencies did not report to the CRDA due to privacy and legal concerns. In this connection, the ND needs to take measures to address their concerns. For example, it should organise more regular seminars to explain the implications of the PDPO and to remind reporting agencies the steps to take in collecting data from drug abusers.

2.28 As early as April 1997, the ND issued guidelines on the measures to be taken by reporting agencies to comply with the PDPO (PDPO guideline). In the PDPO guideline, it was stated that the reporting of data to the CRDA would not contravene the provisions of the PDPO. The guideline also listed various measures to be taken by reporting agencies in collecting data from the drug abusers, including the display of a “Notice to Data Subject Regarding Collection of Personal Data Disclosed to the Central Registry of Drug Abuse” at the location where information was to be collected and the delivery of a copy of the statement to the abusers. Audit noted that the notice was not commonly posted in the reporting agencies’ offices. **Audit considers it desirable for the ND to regularly re-circulate the PDPO guideline and consider including a reference to it in the CRDA reporting guidelines.**

2.29 In response to the audit survey, the reporting agencies also made the following suggestions to improve the operation of the CRDA:

- (a) need to simplify the information to be provided in a CRDA record sheet and to simplify the procedure for data submission;
- (b) need to dispense with the requirement for inputting some sensitive personal data (such as Hong Kong Identity Card number and date of birth);
- (c) need to explain to CRDA reporting units the importance of reporting;
- (d) need to improve the guidelines on CRDA reporting; and
- (e) need to send reminders (e.g. quarterly electronic mails) to CRDA reporting units to remind them to report abuser cases.

Audit considers that the ND needs to take into account these suggestions in considering its measures to promote the CRDA.

Need to review the definition of drug abusers in the CRDA

2.30 According to the existing CRDA Guidelines issued to reporting agencies, a reference period of “4-week” is used for determining whether a drug abuser should be reported to the CRDA (see para. 2.15). **Given that there has been a shift from heroin abuse to PSA in recent years and the drug-abusing pattern keeps on changing, there is a need to keep the reference period for drug abusers under review, and to refine and revise it where appropriate.** In this regard, the ND should consider the following:

- (a) ***Overseas practices.*** In drug-related surveys in the United States (see paras. 3 and 4 at Appendix C), drug abuse information were categorised according to “current/past month” use, “past year” use and “lifetime” use. Similarly, in drug-related surveys among young people in the UK (see para. 13 at Appendix C), students were surveyed for taking specific drugs in the last month and the last year;
- (b) ***Different reference period adopted by the SWD.*** The SWD has defined young psychotropic substance abusers as those young people under the age of 21 who have used or been reported to have used psychotropic substance “at least once over the past six months” upon revelation of drug abuse history (Note 19); and
- (c) ***Flexibility in determining drug abusers.*** In the Government review of the CRDA in 2001 (see para. 2.22), the review team opined that the “4-week” guideline was “not absolutely inflexible” and that, in case a drug abuser was found to have taken drugs irregularly but persistently, a reporting agency should still report the case to the CRDA if it had strong reason to believe that the person was an active drug abuser.

Need to improve the efficiency of the CRDA

2.31 The CRDA, redeveloped in 2005, is a web-based information system. This should have greatly streamlined the workflow and improved data quality and timeliness. Audit has however found that in 2006, paper submissions still represented 35% of the total reported cases. For example, as at November 2007, one major reporting agency was still sending, once every 10 days, hard copies of input forms to the ND for input into the CRDA. Paper submissions by reporting agencies to the ND are delivered by hand or sent by confidential mail. **Audit considers that the ND needs to review the CRDA’s reporting arrangement with the agencies, with a view to streamlining the procedures and encouraging agencies to make electronic submissions as far as possible.**

Audit recommendations

2.32 **Audit has recommended that the Commissioner for Narcotics should:**

Note 19: *The SWD has adopted the 6-month reference period in its definition of young psychotropic substance abusers when it works out targets on workload and performance with the subvented NGOs.*

Need to review and enhance the CRDA

- (a) ascertain the extent of under-reporting, and the reasons that have discouraged the agencies from reporting to the CRDA;
- (b) step up the ND's efforts to promote the CRDA, including strengthening its communication with reporting agencies;
- (c) take measures to include the five reporting agencies referred to in paragraph 2.21(c) and other potential parties in the Fourth Schedule to the DDO;
- (d) establish a mechanism for regular review of the reporting network and for collecting agencies' feedback on the CRDA system and reporting form;

Need to address agencies' concerns

- (e) take measures to address the reporting agencies' concerns about reporting to the CRDA (e.g. organising more regular briefing sessions/seminars, improving the CRDA Guidelines and re-circulating the PDPO guideline on a regular basis);

Need to review the definition of drug abusers in the CRDA

- (f) keep the definition of drug abusers used in the CRDA under review and refine and revise it where appropriate; and

Need to improve the efficiency of the CRDA

- (g) review the CRDA's reporting arrangement with the reporting agencies, with a view to streamlining the procedures, and encourage agencies to make electronic submissions as far as possible.

Response from the Administration

2.33 The Commissioner for Narcotics agrees with the audit recommendations. She has said that:

- (a) the overall abuse trend as indicated by the CRDA has been generally in line with the situation reflected by the drug crime statistics. Between 1997 and 2006, heroin and ketamine seizures as well as heroin and ketamine arrests are all in line with the respective declining and rising trend of heroin and ketamine abusers;
- (b) to better appreciate the extent of under-reporting by the reporting agencies, the ND is considering a new form for them to record information (without any personal identity information) of those drug abusers who are engaged by the agencies but may not be willing to report their information to the CRDA due to various concerns;
- (c) the ND is well aware of the reasons quoted by Audit (see para. 2.23) as to why reporting agencies do not always report drug abuser cases to the CRDA. The ND has taken actions over the years to promote the CRDA, collect agencies' feedbacks and address agencies' concerns including:
 - (i) issuing the CRDA guidelines to the reporting agencies every six months, and organising briefing sessions from time to time;
 - (ii) sending fax or electronic mails (where applicable) to remind the reporting agencies to report cases to the CRDA from time to time; and
 - (iii) introducing a new function since February 2008 on the electronic submission system (Note 20) to facilitate data reporting by the agencies, and the conduct of two briefing sessions about the electronic submission system (with over 60 participants);
- (d) the ND will continue to maintain close contact with the reporting agencies, promote the CRDA to them and step up measures to help address their concerns and suggestions. The ND will continue to collect feedback from the agencies through the DLC, ACAN (and its sub-committees) and daily contacts with them;
- (e) the ND will consult the reporting agencies referred to in paragraph 2.21(c) on their inclusion in the Fourth Schedule to the DDO in due course;

Note 20: *The new function involves an enhancement to the CRDA that allows reporting agencies to revise or supplement any information of a drug abuse record already submitted electronically to the CRDA during the past year.*

- (f) the regular exercise to prepare the Three-year Plan on Drug Treatment and Rehabilitation Services in Hong Kong (Plan — Note 21) provides an ongoing platform for reviewing the reporting network and collecting feedback. The ND will continue to make optimal use of the channel; and
- (g) the ND has always encouraged reporting agencies to report abuser cases to the CRDA, whether via paper form or electronic form, in the way they find it convenient and efficient, as not all NGOs are resourceful or comfortable enough in using computers. The ND will continue to try its best to facilitate their reporting work and encourage agencies to make electronic submissions as far as possible.

Supplementary system to collect qualitative drug abuse data

PSA Task Force's comments on data collection

2.34 The PSA Task Force stated in its report of June 2002 the following:

- (a) given the fast changing nature of PSA, there was a need to capture more timely information on the trend and pattern of psychotropic substance abusers to assist policy formulation;
- (b) no single method, by itself, was sufficient to study all aspects of the drug abuse problem. The adoption of multiple methods was necessary. There was a need to explore other methods which could shed light on the problem in a more qualitative manner in order to supplement the quantitative output of the CRDA; and
- (c) with reference to the Guide to Drug Abuse Epidemiology produced by the World Health Organisation, **qualitative methods** were particularly invaluable in the identification of emerging issues such as changes in drugs used, the circumstances of use, routes of administration, the sub-groups using drugs, and for discovering information that would be ignored in routinely formatted data collection methods. Populations that could be best reached or studied through qualitative methods included hidden populations (groups engaged in illegal or socially unacceptable activities), groups usually not detected through traditional household or student surveys (small cultural groups or individuals engaged in infrequent or rare behaviours), and those that did not commonly participate in health, welfare, or justice institutions (including elite populations or protected classes).

Note 21: *Every three years, the ND prepares the Three-year Plan in consultation with relevant government departments and NGOs (see para. 3.19). By January 2008, the ND had promulgated four such Plans, with the current one covering 2006 to 2008 (2006-08 Plan).*

PSA Task Force's recommendations

2.35 To assist the formulation of effective policies and programmes, the PSA Task Force recommended that the Government should supplement the CRDA by a system to be developed outside its ambit to gauge drug abuse qualitative data. The PSA Task Force considered that, in addition to collecting the socio-economic and demographic characteristics of psychotropic substance abusers, the following core data should be collected in the supplementary system:

- (a) drug abuse characteristics, including drug abuse habits, drug abuse history and their change of patterns over time;
- (b) possible consequences of drug abuse, including psychological and social effects of drug abuse;
- (c) new drug information, including new drugs of abuse, new patterns of drug abuse and new groups at high risk; and
- (d) data pertaining to new efforts to prevent and manage drug abuse.

2.36 Given the complexity of the supplementary system, the PSA Task Force recommended that more researches should be conducted and a detailed work plan on the development of such a system should be drawn up. A dedicated working group should also be formed to pursue this task.

Implementation of PSA Task Force's recommendations

2.37 To implement the PSA Task Force's recommendations, in 2003 ACAN endorsed a university professor's proposal for the development of a supplementary drug abuse monitoring system with funding support from the Beat Drugs Fund (BDF — Note 22). The system eventually produced by the university professor included two modules, one quantitative and one qualitative.

Note 22: *The BDF was a fund set up in 1996 by the Government with a capital base of \$350 million to provide funding support for worthwhile anti-drug projects, including T&R. The BDF is administered by the BDF Association, with the ND providing secretariat support. A bid for developing the supplementary monitoring system at \$0.6 million was approved by the BDF Governing Committee in April 2003.*

2.38 The **quantitative module** (named as “Drug Intelligence System”) was delivered by the university professor in 2005 and, after the completion of a prototype of the system in 2006, was brought into operation by the ND in October 2006. The Drug Intelligence System is a computerised database that draws together a variety of drug-related statistics currently compiled and kept by different government departments and agencies in Hong Kong (Note 23).

2.39 Although the university professor had produced the qualitative module, to put it into operation, the ND needed to recruit a research team with external expertise to collect, on an on-going basis, the qualitative information required. To meet this, the ND launched an open invitation for proposals in October 2006. However, only one proposal (from a researcher) was received. The RAG scrutinised the proposal and recommended offering the contract to the researcher subject to certain conditions. However, after a series of discussion between the ND and the researcher, the latter withdrew his proposal due to personal reasons. Owing to the distinct nature of the qualitative module, the ND found it difficult to identify suitable alternative researchers. As a result, despite the great efforts exerted, the qualitative module had not yet been put into operation.

2.40 The **qualitative module** of the supplementary system was aimed to help in the early detection of new drugs and new drug-abusing patterns (Note 24) and was packaged with the conduct of one drug thematic study a year (Note 25). In order to meet an urgent need to obtain more information on cocaine abuse in Hong Kong, which was one of the original thematic studies identified to be conducted under the qualitative module, in 2007, the ND commissioned, as a separate exercise, a consultancy study on cocaine abuse. The study was expected to be completed by mid-2008.

Note 23: *These include the Police, Customs & Excise Department, CSD, Coroner’s Court, Government Laboratory, DH and HA. The statistics/data encompass drug-related seizure/arrest, drug price, drug purity, drug-related medical attendance, drug-related AIDS statistics, drug-related deaths and relevant statistics of neighbouring countries.*

Note 24: *Qualitative data were to be collected from reviewing professional literature/newspapers/magazines, and conducting Internet research, key informant interviews and focus group interviews.*

Note 25: *The thematic studies to be conducted are aimed at soliciting more in-depth information in respect of the drug-related phenomena, the rationales behind and their impacts to the local drug scene, with a view to assisting formulation of relevant strategies.*

2.41 In February 2008, the ND advised Audit that although the qualitative module was not in place, it had all along commissioned thematic research studies to collect qualitative information for better understanding of the latest drug abuse situation. Research results so obtained were/would be analysed by the RAG and ACAN (and its sub-committees) as appropriate. Apart from the cocaine abuse study, the ND had recently commissioned a number of other research projects, notably the following:

- (a) study on drug abuse situation among ethnic minorities in Hong Kong;
- (b) study on the engagement of parents in anti-drug work;
- (c) study of drug tests using conventional and new technologies; and
- (d) longitudinal study of psychotropic substance abusers in Hong Kong.

Audit observations and recommendations

2.42 Research has indicated that drug abuse trends abroad are monitored by multiple surveillance systems (see Appendix C). As indicated by the PSA Task Force, multiple methods were required to support the study on the drug abuse problem (see para. 2.34(b)) and, given that the pattern of PSA changed rapidly, more timely information needed to be collected. Besides, psychotropic substance abusers usually relate to the younger population, who are often less motivated to seek help. There are some “hidden youth” who may stay out of reach from the conventional help system and cannot readily be caught by the conventional reporting networks (e.g. school surveys do not cover school dropouts who may be in the drug abuse high-risk group).

2.43 Audit notes the ND efforts in commissioning a number of thematic research studies to collect qualitative information. With the quantitative module in operation (see para. 2.38) and with the qualitative information obtained through the various thematic research studies conducted, the ND needs to critically reassess the need for and the urgency of further developing the qualitative module and, if required, develop the qualitative module as early as possible.

2.44 **Audit has recommended that the Commissioner for Narcotics should consider, in consultation with the RAG and ACAN, further means to supplement the school surveys and the CRDA and, if required, develop the qualitative module as early as possible.**

Response from the Administration

2.45 The **Commissioner for Narcotics** agrees with the audit recommendation. She has said that:

- (a) apart from the school survey and the CRDA, the ND also makes reference to other information or figures (such as admission statistics from T&R agencies, and drug-related arrest and seizure figures — see para. 2.11(b)) for a more comprehensive understanding of the drug abuse situation, policy formulation and resource allocation. The ND also commissions thematic research studies to collect qualitative information and closely monitor the drug situation through sharing with ACAN (and its sub-committees), RAG and the DLC, liaison with other external counterparts and participation in regional and international conferences; and

- (b) the ND will explore, in consultation with ACAN and RAG as appropriate, further means to supplement the school surveys and the CRDA (e.g. the possible establishment of the qualitative module). For instance, the ND is considering launching a study to understand more about the drug abuse situation among the “non-engaged” youth.

PART 3: EFFECTIVENESS OF THE TREATMENT AND REHABILITATION PROGRAMMES

3.1 This PART examines the effectiveness of the Government's T&R programmes.

Provision of different modalities of services

3.2 Hong Kong has adopted a multi-modality approach in providing T&R services to meet the divergent needs of drug abusers from varying backgrounds (see para. 1.4). Because of the long history of heroin abuse, many of the existing drug treatment facilities are mainly geared to the treatment of heroin abusers (e.g. the MTP and the SARDA treatment centres). CCPSAs and SACs are facilities specifically set up to tackle the problem of PSA. The first CCPSA was set up in 1988 with successive ones established in 1996, 1998 and 2002. The first SAC was set up in 1994 with five more established in 1995 to meet the increasing demand. The SAC at the Queen Mary Hospital (QMH) was however closed in 2005.

3.3 The PSA Task Force recommended in its report of June 2002, among other things, that:

- (a) T&R agencies should be encouraged to re-engineer their services having regard to the needs of young psychotropic substance abusers; and
- (b) subject to the availability of resources, youth-specific T&R programmes gearing to a continuum of care should be developed.

3.4 Subsequently, in the ND's Three-year Plan (2003-05), the ND recommended T&R agencies to re-engineer their heroin-oriented services. In the 2006-08 Plan, the ND also encouraged T&R agencies in the social service and health care sectors in both public and private domains to periodically review their service modes to respond to the latest drug abuse trend and to see if adjustment or re-alignment would be necessary to achieve the objectives they set.

3.5 It was reported in the 2006-08 Plan that:

- (a) a number of T&R agencies had re-engineered their services to include intake of short-term patients and enhancement of vocational training;

- (b) for centres subvented by the DH, while the majority of patients were heroin abusers, multiple drug abusers including psychotropic substance abusers were also admitted;
- (c) CCPSAs had been expanded in recent years to cope with the increasing demands; and
- (d) since 2005-06, additional resources had been allocated by the SWD to 18 Integrated Children and Youth Services Centres (Youth Centres) to enhance their manpower to assist young night drifters through more timely identification of problems and intervention.

Early intervention initiatives

3.6 In the light of the PSA problem among the youth, the ND has enhanced various early intervention initiatives to help identify abusers to come forward for treatment. Among these, the five CCPSAs have been provided with additional funds of \$3.7 million per year for the period April 2007 to September 2010 to strengthen their outreaching services and early intervention work, and their collaboration with schools, law enforcers, medical practitioners and other NGOs to help the young drug abusers. The SWD has also adopted an early intervention strategy for its services targeting the youth in general. It has injected additional resources to expedite the formation of additional Youth Centres. As at February 2008, there were 135 Youth Centres. To strengthen the outreaching social work services, the SWD has also set up 16 District Youth Outreaching Social Work Teams in NGOs to focus on the needs of high-risk youths (including young drug abusers) and to deal with the problem of juvenile gangs.

3.7 In 2007-08, the ND commissioned a two-year pilot collaboration scheme to draw in the input from private medical practitioners. The scheme involved social workers referring abusers to designated medical practitioners who provided body check service and motivational interviews. Through the cooperation between the medical practitioners and social workers, young drug abusers would be early intervened and be alerted of any signs of health deterioration as a result of drug use and be prompted to seek early treatment. The scheme would be commissioned in the first quarter of 2008 and the ND would review the scheme in one year's time and upon completion before deciding the way forward.

Audit observations and recommendations

Alignment of resources with changing demands

3.8 Audit notes and supports the various early intervention initiatives taken by the Administration, but considers that more efforts need to be exerted, particularly on the allocation of resources among the various types of voluntary T&R programmes (see para. 1.4(a) to (d)). From 2003-04 to 2006-07, the Government (including the HA) spent some \$160 million a year on the various T&R programmes. Audit analysed the government expenditure of \$163 million for 2006-07 (see para. 1.3) and noted the following position:

- (a) **\$110 million (67%)** spent on T&R services were mainly for heroin abusers;
- (b) **\$28 million (17%)** spent on T&R services were mainly for psychotropic substance abusers; and
- (c) **\$25 million (16%)** spent on T&R services were for both heroin and psychotropic substance abusers.

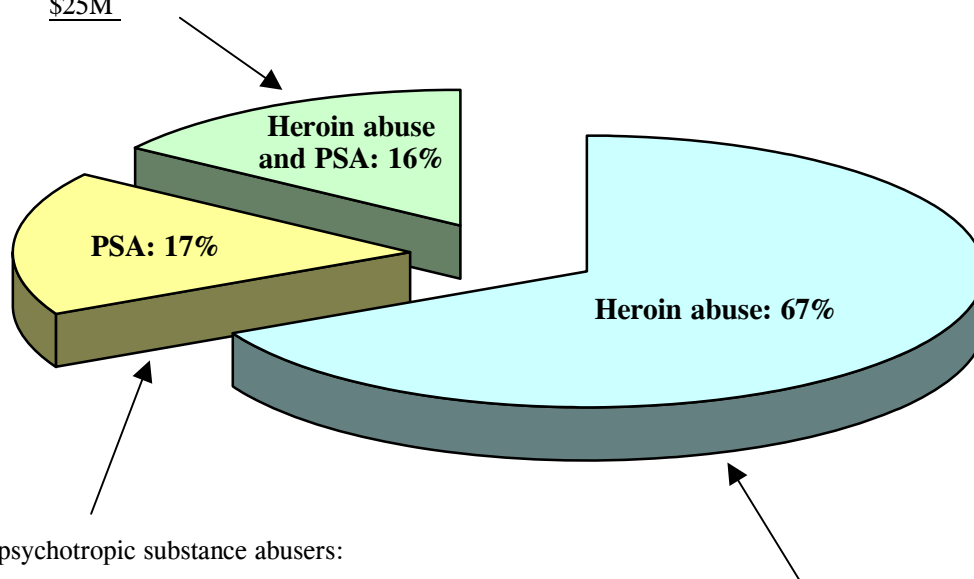
Details are in Figure 1.

Figure 1

**Government expenditure on voluntary T&R programmes
(2006-07)**

Services for both heroin and psychotropic substance abusers:

- (a) \$16M (NGOs subvented by SWD — para. 1.4(a))
- (b) \$9M (NGOs subvented by DH — para.1.4(a))



Services mainly for psychotropic substance abusers:

- (c) \$16M (CCPSAs subvented by SWD — para. 1.4(c))
- (d) \$12M (SACs operated by HA — para. 1.4(d))

Services mainly for heroin abusers:

- (e) \$35M (MTP operated by DH — para. 1.4(b))
- (f) \$72M (SARDA subvented by DH — para. 1.4(a))
- (g) \$3M (SARDA subvented by SWD — para. 1.4(a))

Source: Audit analysis of ND, DH, SWD and HA records

3.9 Figure 1 shows that a significant proportion of resources was still allocated to heroin-oriented T&R services. It is understood that the majority of heroin abusers are treated in methadone clinics and residential T&R centres provided under various T&R programmes (see (a), (b) and (e) to (g) in Figure 1). The costs incurred by residential T&R centres in providing round-the-clock services should be higher than those provided by the CCPSAs and the SACs. As such, the resources spent on treating heroin abusers were much greater than those spent on treating psychotropic substance abusers.

3.10 Given the shift from heroin abuse to PSA in recent years, Audit considers that the ND needs to critically review the existing distribution of resources for T&R services and assess the need for allocating resources to deal with the treatment of psychotropic substance abusers. In this regard, the ND also needs to pay special attention to a number of related issues, as set out in paragraphs 3.11 to 3.29.

Drop in demand for SARDA and MTP services

3.11 As shown in Figure 1, government expenditure of \$75 (72 + 3) million and \$35 million were spent on SARDA and MTP services respectively. Both the SARDA and MTP programmes are basically geared to the provision of T&R services for heroin abusers. With the shift from heroin abuse to PSA in recent years, there was a continuous fall in the demands of SARDA and MTP services.

3.12 SARDA was established in 1961 as a non-profit-making NGO to provide free residential T&R services to heroin abusers who seek treatment on a voluntary basis. It operates four residential T&R centres subvented by the DH and five half-way houses (including four subvented by the SWD). A separate audit review of SARDA indicated that the total number of admissions of its four residential T&R centres decreased by 29%, from 2,152 in 1997 to 1,525 in 2007. In particular, admissions to the Shek Kwu Chau (SKC) Centre decreased by 32% (from 1,988 in 1997 to 1,360 in 2007), with the bed occupancy rate of the Centre dropping from 71% in 2004 to 64% in 2007. In June 2004, SARDA put forward an initiative to establish a Centre for Anti-drug Education and Disciplinary Training (CAEDT) at SKC. As at February 2008, the CAEDT proposal was still under examination by the ND and the DH (Note 26). Meanwhile, SARDA service is still mainly geared to the needs of heroin abusers and has not been re-engineered to cope with the changing community needs.

Note 26: *The CAEDT initiative proposed by SARDA aimed to provide outward-bound style of training to the youth (especially students) in the territory with a theme that emphasises the prevention of drug abuse. As the initiative submitted in June 2004 was a very preliminary proposal (which involved substantial capital cost), the ND and the DH had to examine it in close liaison with SARDA. In April 2006, the ND advised SARDA that the Administration supported the initiative in principle. In January 2008, SARDA submitted the latest version of its proposal. As at February 2008, the proposal was still under examination by the ND and the DH. As advised by the ND in February 2008, the under-utilisation of the SKC Centre and the CAEDT proposal were two separate issues and the Administration would examine the CAEDT proposal on its own merit.*

3.13 The MTP was a drug treatment programme introduced in 1972 when there was an upward trend of heroin abuse. From 1997 to 2007, the CRDA recorded a drop in the number of heroin abusers (see Appendix B). Statistics kept by the DH also indicated that the caseload of methadone clinics was on the decline. New patient demand of MTP services was dropping (with new admission cases reducing from 1,350 in 1997 to 309 in 2007) and the overall utilisation of the methadone clinics had dropped from 76% in 2004 to 69% in 2007 (see paras. 4.25 and 4.26(a)).

3.14 **Audit considers that the ND needs to critically review, in consultation with the DH, the roles played by SARDA and the MTP to assess:**

- (a) **whether or not they should be continued in the present mode of operation (including a review of their operational sizes and staff resources); and**
- (b) **how their existing resources and facilities could be rationalised.**

Re-designing of T&R programmes

3.15 Audit noted that the ND did not have a mechanism to help monitor the pace of re-engineering in the T&R agencies. According to the 2002 review of the PSA Task Force, whilst some of the residential T&R agencies had in recent years extended their services to accept psychotropic substance abusers, they treated such abusers in very much the same way as heroin abusers.

3.16 Based on a research study commissioned by the PSA Task Force, it was considered that it might not be appropriate to treat heroin and psychotropic substance abusers together since these two groups of abusers had different withdrawal symptoms and patterns. Their reasons for abuse and risk factors were not similar and they might seduce their counterparts in trying new types of drugs. Furthermore, the research study found that psychotropic substance abusers had a higher chance of suffering from various forms of co-morbid psychiatric illnesses and required intensive treatments. In this regard, the Task Force considered that a separate treatment programme catering for the special needs of psychotropic substance abusers should be developed.

3.17 Whilst most of the T&R agencies have extended their services to cater for psychotropic substance and occasional drug abusers, it is not known if they have taken adequate measures to re-engineer their services to meet the special needs of psychotropic substance abusers. **Given the uneven distribution of T&R resources between heroin abusers and psychotropic substance abusers (see Figure 1 in para. 3.8), Audit considers that the ND needs to step up its efforts in urging and facilitating the T&R agencies to re-engineer their services.**

Improvement to quarterly returns on caseload

3.18 Under the existing practice, all T&R agencies submit quarterly returns on their caseloads (the numbers of new and follow-up patient admission cases) to the ND. However, they do not provide breakdowns of their caseloads by heroin, psychotropic substance and multiple drug abusers. In the absence of such information, the Government cannot monitor accurately the service demands of each category. **Audit considers that such information would be very useful to help the ND make informed decisions on resource planning and allocation. Audit considers that the ND needs to collect statistics from T&R agencies on the numbers of heroin, psychotropic substance and multiple drug abuser cases they handled.**

Implementation of Three-year Plans

3.19 The ND attaches great importance to the Three-year Plans which were prepared with the objectives of:

- (a) examining the adequacy of the existing T&R services in Hong Kong to see whether the services provided align with the distribution of drug abusers' characteristics and needs;
- (b) identifying room for adjustment or enhancement of the existing T&R services in Hong Kong; and
- (c) mapping out the strategies and future direction which T&R services in Hong Kong should take in the three years.

In formulating the Plans, the ND made extensive consultations with the anti-drug sector. ACAN and its sub-committees (such as the Sub-Committee on T&R — Note 27), and the DLC were actively involved before the Plans were finalised.

3.20 Although the ND indicated in the Plans that it would work closely with relevant stakeholders (including concerned government departments, the HA and NGOs) to draw up action plans and would make regular progress reports to ACAN and the DLC, Audit noted that there was no effective mechanism to ensure the successful implementation of the Plans. This was because:

Note 27: *The Sub-Committee on T&R monitors the trend in the characteristics of drug abuse and drug abusers, reviews the progress and effectiveness of government-funded T&R programmes and advises ACAN on the development of T&R facilities.*

- (a) the ND did not control the funds to be allocated for implementing the initiatives included in the Plans. It only provided policy support to back up the roll-out of the recommendations; and
- (b) the ND expected government departments and T&R agencies to make reference to the Plans and to propose initiatives (either individually or in partnership) to meet the strategic directions in the Plans.

3.21 The adoption of such an approach does not provide adequate assurance that recommendations in the Plans would be properly followed through for implementation by different parties concerned in the three years. Examples included the slow progress in rolling out the multi-disciplinary approach (see paras. 3.22 to 3.28) and in expanding SACs to cope with the community needs (see para. 5.20). The inadequate follow-through of recommendations in the Plans may also have attributed partially to the failure in the timely alignment of T&R service provision to meet the changing demands (see paras. 3.8 to 3.10). **To combat the drug abuse problem and to ensure that resources deployed to meet the demand changes can be appropriately adjusted, Audit considers that the ND needs to take the lead in planning and overseeing the roll-out of recommendations in the Plans.**

Multi-disciplinary approach recommended by PSA Task Force

3.22 The PSA Task Force recommended in its review of 2002 that the Government should consider developing a “shared-care” model (subsequently renamed as a **multi-disciplinary approach** by the ND — Note 28) among different sectors and the setting of common goals (to be agreed and communicated among all sectors) to ensure the continuity of care. The Task Force considered that the multi-disciplinary approach could avoid duplication and fragmentation of services and facilitate most effective use of resources through collaboration instead of competition.

3.23 In April 2003, the ND advised the LegCo Panel on Security that the PSA Task Force’s recommendations provided a comprehensive framework for guiding the Government’s formulation and implementation of specific measures to tackle the PSA problem. The ND also informed LegCo Members that:

Note 28: *According to the ND, a multi-disciplinary approach entailed shared working across, and between, a number of different agencies and professionals within the drug field and beyond. Such agencies and professionals may include general medical practitioners, pharmacies, T&R agencies, health specialists, social work teams and providers of correctional service, housing service, aftercare and other support services.*

- (a) some of the more urgent recommendations had already been put into implementation;
- (b) the Government would follow up with the remaining recommendations; and
- (c) regular progress reports would be submitted to ACAN and its sub-committees.

3.24 In November 2003, the ND submitted the final progress report of the implementation of the PSA Task Force's recommendations to the ACAN Sub-Committee on T&R. In the final progress report, the ND stated that it would coordinate efforts to follow up the Task Force's recommendation of developing a multi-disciplinary approach in the 2003-05 Plan.

3.25 In the 2003-05 Plan, the ND recommended that:

“In the long term, consideration should be given to the development of a multi-disciplinary approach straddling different sectors (such as health, welfare, law enforcement, justice, housing) for improved care to drug dependent persons. In developing the multi-disciplinary approach, it will be useful to study the experience of overseas countries in implementing such concept as well as take into account the unique circumstances and features of the local drug treatment services.”

3.26 However, the ND did not make any further reference to the multi-disciplinary approach in the 2006-08 Plan. Instead, it made the following recommendation:

“Cooperation among Anti-drug Professionals

Medical Practitioners and NGOs. *Initiatives that encourage cooperation between NGOs and community primary health care providers to provide support services in various stages of treatment, rehabilitation and relapse prevention are needed. It is recommended a cooperation model between the service and healthcare sectors should be worked out.*

Better Communication and Cooperation. *Anti-drug workers from various disciplines in the same geographical area could organise formal or informal groups for networking and to understand the work of one and other, share information, complement service deliverables, and eliminate duplication of service.”*

3.27 Although the PSA Task Force recommended that the Government should consider developing a multi-disciplinary approach among different sectors to ensure the continuity of care and to avoid duplication and fragmentation of services, an overall strategic plan (Note 29) to meet this objective had **not** been developed and included in the 2003-05 and 2006-08 Plans.

3.28 Audit notes that the two-year pilot collaboration scheme (see para. 3.7) is an initiative that draws together social workers and medical practitioners to provide early intervention and motivational interviewing services to drug abusers. As explained by the ND in February 2008, having regard to the difficulties envisaged in developing a multi-disciplinary approach among different sectors, it was taking a pragmatic and incremental approach in bringing together different disciplines to help the drug abusers systematically. As a first step, the ND drew together social workers and medical practitioners in the two-year pilot collaboration scheme. **Audit welcomes the ND's initiative, but considers that, to ensure the successful roll-out of the multi-disciplinary approach, the ND needs to take a more active role and should work out a strategic plan (for example, to be subsumed under the forthcoming Three-year Plan) on how to take forward the multi-disciplinary approach recommended by the PSA Task Force.** The strategic plan should include common goals and key milestones agreeable among all parties concerned. Funding to support the implementation of the strategic plan (Note 30) should be sought by the ND in collaboration with responsible policy bureaux/departments.

Audit recommendations

3.29 **Audit has recommended that the Commissioner for Narcotics should:**

Alignment of resources with changing demands

- (a) **critically review the existing distribution of resources for T&R services and assess the need for allocating resources to deal with the treatment of psychotropic substance abusers;**

Note 29: *According to ND research on experience abroad, the implementation of a multi-disciplinary approach would involve the identification of the potential partners, the development of a strategic plan, the definition of a set of common goals and the setting of a platform for information sharing by agencies concerned.*

Note 30: *Although government departments and NGOs can bid for funds under the BDF to implement initiatives under the strategic plan, there are constraints in the use of funds approved under the BDF. For example, the BDF provides only one-off grants to projects which normally cannot exceed the limit of \$3 million and have to be completed within two years.*

Drop in demand for SARDA and MTP services

- (b) **critically review, in consultation with the Director of Health, the roles played by SARDA and the MTP to assess:**
 - (i) **whether they should be continued in the present mode of operation; and**
 - (ii) **how their existing resources and facilities could be rationalised;**

Re-designing of T&R programmes

- (c) **set up a mechanism to monitor the pace of re-engineering in the T&R agencies;**
- (d) **step up the ND efforts in urging and facilitating the T&R agencies to re-engineer their services;**

Improvement to quarterly returns on caseload

- (e) **collect statistics from T&R agencies on the numbers of heroin, psychotropic substance and multiple drug abuser cases they handled;**

Implementation of Three-year Plans

- (f) **take the lead in planning and overseeing the roll-out of recommendations in the Plans;**

Multi-disciplinary approach recommended by PSA Task Force

- (g) **take a more active role in rolling out the multi-disciplinary approach, and work out a strategic plan (which may be subsumed under the forthcoming Three-year Plan) on how to take forward the multi-disciplinary approach recommended by the PSA Task Force;**
- (h) **set common goals and key milestones in the strategic plan, and have the goals and milestones agreed by all parties concerned; and**
- (i) **in collaboration with responsible policy bureaux/departments, seek funding for the implementation of the strategic plan.**

Response from the Administration

3.30 The **Commissioner for Narcotics** agrees with the audit recommendations in paragraph 3.29(a), (e), (f) and (i). She also agrees in principle with the remaining audit recommendations (i.e. para. 3.29(b) to (d), (g) and (h)). She has said that:

Re-designing of T&R programmes

- (a) the ND is keenly aware of the changing drug abuse pattern and has made solid efforts in facilitating the T&R agencies to re-engineer their services and in updating the skills and knowledge of anti-drug workers;
- (b) the ND will continue to monitor the re-engineering pace and reinvigorate its facilitating and training efforts, notably through the cyclical preparation and implementation of the Three-year Plan. The drawing up of the next Plan covering 2009 to 2011 will start shortly. The ND will also work closely with the Director of Social Welfare and the Director of Health, who, as Controlling Officers, would discuss with the subvented agencies in updating their programmes and performance targets as appropriate;

Implementation of Three-year Plans

- (c) the Three-year Plan is a policy paper mapping out the strategies and future direction which drug T&R services should take. The Plan provides anchor points for T&R agencies, subvented or non-subvented, to reflect on their services and develop complementing strategies and programmes to meet their service objectives in view of the latest drug trend;
- (d) the ND plays a coordinating and overseeing role in the preparation and roll-out of the Plan. The formulation of the Plan is in itself a consensus building process among the relevant stakeholders. Both public and community resources have been invested in implementing the Plans over the years;
- (e) the ND will take on board the audit recommendations and continue to take a leading role in preparing the Fifth Three-year Plan (2009 to 2011) and overseeing its implementation; and

Multi-disciplinary approach recommended by PSA Task Force

- (f) the ND will continue to pursue the multi-disciplinary approach in a pragmatic and incremental manner in the context of preparing the Plan (2009 to 2011) and Resource Allocation Exercise bids.

3.31 The **Secretary for Financial Services and the Treasury** agrees in general with the audit recommendations. Regarding the proposal for the ND to bid for resources through the Resource Allocation Exercise to support the implementation of the strategic plan (see paras. 3.28 and 3.29(i)), he has said that additional resources have been provided in the 2008-09 Estimates for the high-level task force (led by the Secretary for Justice — see para. 1.10) to tackle the youth drug abuse problem with a multi-pronged approach.

PART 4: MONITORING THE PERFORMANCE OF VARIOUS TREATMENT AND REHABILITATION PROGRAMMES

4.1 This PART examines the Government's monitoring of the performance of various T&R programmes (excluding the provision of SAC services which will be discussed in PART 5).

Various treatment and rehabilitation programmes

4.2 The Government spent \$151 million on various types of voluntary T&R programmes in 2006-07 (see (a) to (c) and (e) to (g) in Figure 1 of para. 3.8). Audit has reviewed the Government's monitoring of the performance of these programmes and notes that there is room for improvement in the monitoring of the following services:

- (a) T&R services provided by subvented NGOs (see paras. 4.3 to 4.15); and
- (b) the MTP run by the Department of Health (see paras. 4.16 to 4.34).

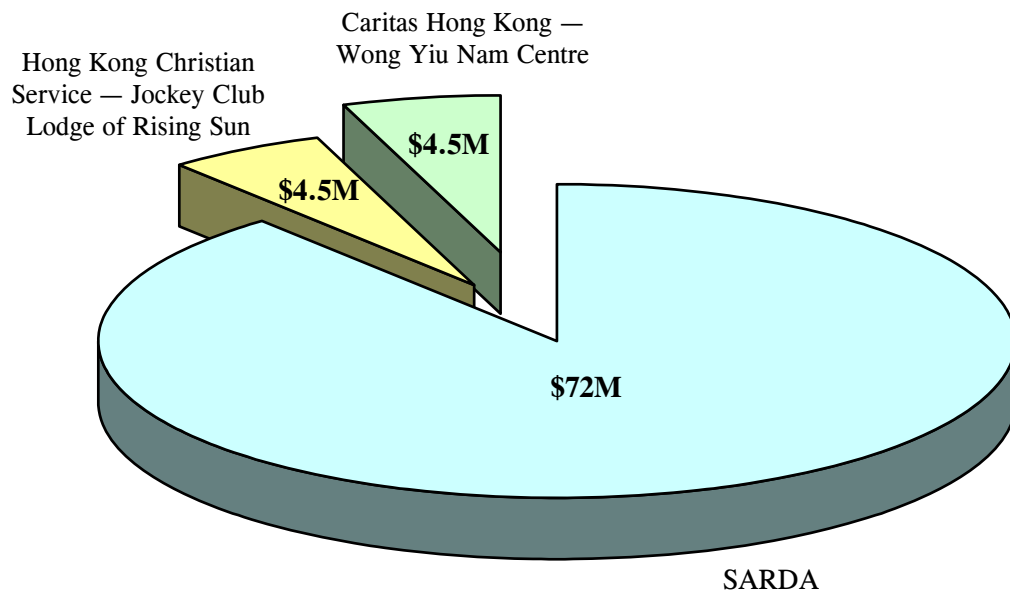
Treatment and rehabilitation services provided by subvented NGOs

DH's monitoring of NGOs

4.3 The DH provides subvention to three NGOs (see para. 1.4(a)). They operate voluntary residential T&R programmes that adopt a medical approach in detoxification. The 2006-07 government subvention was \$81 million (see (b) and (f) in Figure 1 of para. 3.8). Details are in Figure 2.

Figure 2

DH subvention to NGOs
(2006-07)



Source: DH records

4.4 The DH monitors the NGOs’ performance mainly based on their pledged service output and performance targets. The DH has required the NGOs to submit quarterly returns on various performance measures, such as “detoxification/rehabilitation rate for in-patient service”, “number of patients admitted for residential treatment” and “bed-days occupied at treatment centres”. Should there be any over-/under-achievements of the targets, the NGOs have to give explanations and take follow-up actions, particularly on under-achievement.

4.5 Based on DH records, all the three subvented NGOs had, by and large, achieved the targets in the past three years (2005 to 2007). Table 3 shows the performance achieved by SARDA, the major NGO, as reported in the DH Controlling Officer’s Reports (CORs).

Table 3
Performance of SARDA

Performance target	Target	2005 (Actual)	2006 (Actual)	2007 (Actual)
Completion rate of SARDA's in-patient treatment courses				
• detoxification (%)	>70	79	80	82
• rehabilitation (%)	>60	72	72	73

Source: DH records

SWD's monitoring of NGOs

4.6 The SWD provides subvention to nine NGOs for operating non-medical voluntary residential T&R centres (including halfway houses) and CCPSAs. The total subvention for 2006-07 amounted to \$35 million (see (a), (c) and (g) in Figure 1 of para. 3.8).

4.7 To monitor the performance of the subvented NGOs in operating the various T&R programmes (including the CCPSAs), the SWD has maintained a Service Performance Monitoring System. The system includes:

- (a) ***Funding and Service Agreements (FSAs).*** The SWD enters into FSAs with individual NGOs. In the FSAs, the nature of services to be provided and the performance standards expected to be achieved by the NGOs are defined. The FSAs also define the SWD obligations and role in overseeing the NGOs' performance;
- (b) ***Service Quality Standards.*** The SWD has defined the policies, procedures and practices which an NGO should have in place in order to deliver quality services. The requirement for the NGOs to observe the Service Quality Standards is also stipulated in the FSAs; and

- (c) ***Service Performance Monitoring Tool.*** This is a management tool which helps the SWD monitor the compliance of the NGOs with the FSA and Service Quality Standards. The tool involves the conduct of a self-assessment by the NGOs and the preparation of a specific action plan to improve on non-compliant areas. The tool also involves the monitoring of the NGOs' performance against the standards pledged in the FSAs, and the conduct by the SWD of review visits (Note 31) and on-site assessments (Note 32) to identify improvement opportunities.

4.8 Based on SWD records, all the subvented NGOs had, by and large, achieved the agreed levels of performance standards in the four years from 2003-04 to 2006-07. A typical example of the output and outcome measures used to reflect the performance of a CCPSA run by an NGO is shown at Appendix D.

Audit observations and recommendations

Need to enhance management of subvented NGOs

4.9 The SWD and the DH have adopted different approaches in monitoring their NGOs' performance. The SWD has set up a very comprehensive framework for the management of subvented NGOs through the Service Performance Monitoring System (see para. 4.7). On the other hand, the DH monitors the performance of the NGOs mainly through a review of their submitted returns on achievement of service outputs and performance measures (see para. 4.4). As at the end of 2007, the DH had not entered into any FSAs with the NGOs, in similar manner as the SWD. Besides, the DH had not laid down any requirement for the conduct of regular review visits and on-site assessments to monitor the performance of the subvented NGOs. **To enhance accountability, Audit considers that the DH should enter into FSAs with the subvented NGOs.** Such FSAs should set out in detail the services to be provided (e.g. target groups and eligibility criteria), the agreed performance outputs, the service standards required and the DH's role in overseeing the NGOs' performance.

Note 31: *Review visit by the SWD entails a scheduled and regular visit to assess the performance of an NGO against the terms of the FSA, including the implementation of the Service Quality Standards. It is also an opportunity to identify good practices on service performance so as to promote continuous service quality improvement. Review visits will be made to all subvented NGOs at least once in three years.*

Note 32: *On-site assessment by the SWD is a purposeful visit, at short notice or unannounced, to examine a quality-related issue unique to an NGO. It is usually conducted when a new service unit has been set up or when there are identified or suspected problems in service performance.*

Need to keep performance targets under review

4.10 The NGOs subvented by the SWD had largely achieved the agreed levels of service standards from 2003-04 to 2006-07 (see para. 4.8). As shown at Appendix D, for a number of output/outcome measures, the NGO's actual performance had been persistently well above the agreed levels. **Given that performance targets have to be meaningful for encouraging continuous improvement, Audit considers that the SWD needs to keep the targets under review and fine-tune them regularly.**

Audit recommendations

4.11 **Audit has recommended that the Director of Health should enter into FSAs with the DH-subvented NGOs and take measures to ensure that the NGOs would comply with the agreements.**

4.12 **Audit has also recommended that the Director of Social Welfare should keep performance targets under review and fine-tune them regularly.**

Response from the Administration

4.13 The **Director of Health** welcomes the audit recommendation, which is in line with the DH's position. He has said that:

- (a) besides reviewing NGOs' returns on performance measures (see para. 4.9), the DH also keeps abreast of developments in NGOs through attendance at meetings and official functions, ad hoc visits to various institutions and assessment visits while processing funding applications. Such contacts do facilitate its monitoring work; and
- (b) to further improve the control framework, the DH has been desirous of entering into FSAs with its NGOs and has concluded one with the Hong Kong Red Cross in early 2008. In the drug T&R field, the DH has wished to start the FSA exercise with SARDA which receives about 90% of total funding for the three NGOs subvented by the DH.

4.14 The **Director of Social Welfare** agrees with the audit recommendation. He has said that the last review on T&R programmes was conducted in 2005-06 and the SWD will strive for continuous service improvement in joint effort with the ND and the operating NGOs.

4.15 The **Commissioner for Narcotics** also agrees with the audit recommendations.

Methadone Treatment Programme

4.16 The MTP is operated by the DH through a network of 20 methadone clinics, 4 on Hong Kong Island, 9 in Kowloon and 7 in the New Territories. It has adopted an open-door policy, and services are provided to patients in a voluntary and out-patient mode. No referral is required. Any person who is addicted to heroin (or other opiate drugs) and has no life-threatening medical illness may apply for admission.

Objectives of the MTP

4.17 The objectives of MTP are as follows:

- (a) to provide a readily accessible, legal, medically safe and effective alternative to continued illicit opiate drug use;
- (b) to help patients to lead a normal and economically productive life;
- (c) to help in the reduction of crime and anti-social behaviour related to illicit opiate drug use;
- (d) to assist in the prevention of blood-borne diseases like hepatitis and HIV infection by reducing intravenous drug use and needle-sharing through surveillance, health education and counselling;
- (e) to encourage drug abusers to come forward for treatment by providing an extensive network of clinics; and
- (f) to assist drug abusers to achieve a drug-free state by providing a detoxification scheme.

Operation of the MTP

4.18 The MTP offers two options to its patients, namely the maintenance scheme and the detoxification scheme. Under the maintenance scheme, patients are prescribed adequate dosage of methadone (Note 33) each day to block their craving for heroin. Under the

Note 33: *Methadone is a synthetic narcotic analgesic that can be used as a substitute for heroin or other opiates in addiction treatment programmes. Although methadone is also an addictive drug, it blocks the euphoric and sedating effects of opiates and does not produce any significant side effects.*

detoxification scheme, patients are prescribed reducing dosage of methadone until they are completely drug-free. Patients who have been detoxified successfully will receive aftercare service by SARDA for a period of 18 months.

4.19 On admission, a Medical Officer (MO) will conduct a detailed and structured assessment of the patients including their medical, social history and physical conditions. An initial recommended dosage of methadone will be prescribed and increased gradually according to individual needs assessment. Apart from a daily dose of methadone, patients are provided with a range of support services which include individual and group counselling, health education and referral to residential T&R programmes.

4.20 The Government spent \$35 million in 2006-07 on running the MTP (see (e) in Figure 1 of para. 3.8). As at December 2007, some 8,000 patients were registered with the MTP, 97% of whom were under the maintenance scheme and 3% were under the detoxification scheme.

Review of the MTP

4.21 In May 1999, a Working Group under ACAN (MTP Working Group) was formed to conduct a comprehensive review of the MTP with a view to evaluating the programme's usefulness and effectiveness and identifying areas for improvement. In its Report of December 2000, the MTP Working Group concluded that the MTP fulfilled its declared objectives and was effective in helping drug abusers to sustain their employment and social life, as well as helping society to reduce instances of drug overdose, drug-related deaths and the spread of blood-borne diseases.

Audit observations and recommendations

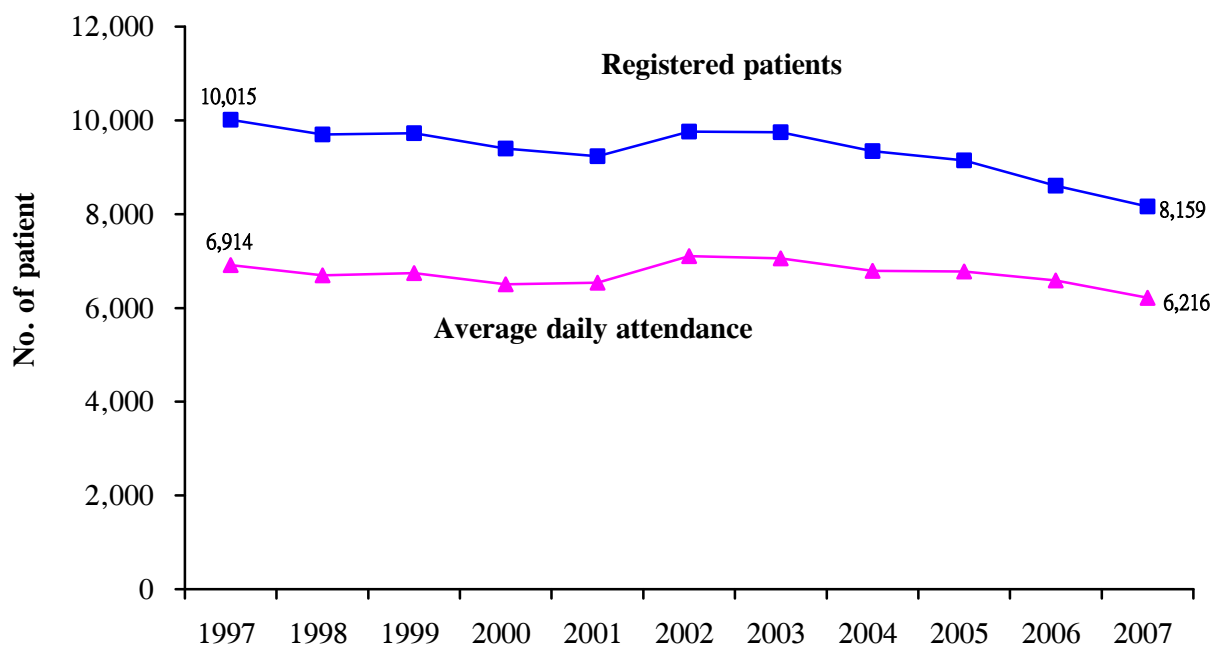
Caseload of methadone clinics

4.22 Of the 20 methadone clinics in Hong Kong, 7 are day clinics and 13 are evening clinics. Day clinics generally operate from 7:00 a.m. to 10:00 p.m. with evening clinics operating from 6:00 p.m. to 10:00 p.m. The MTP is overseen by a Directorate staff (at DH Headquarters). As at December 2007, the MTP was manned by 3 full-time Senior Medical Officers (SMOs), 36 part-time MOs, 120 Auxiliary Medical Services members and other supporting staff (e.g. clerical staff and workmen). In addition, 26 full-time medical social workers from SARDA were deployed to provide counselling services to methadone patients.

4.23 With the shift from heroin abuse to PSA, there was a general decrease in the demand for MTP services. Audit noted that over the years 1997 to 2007, there was a reduction in the caseloads (numbers of registered patients, daily attendance and new admissions) handled under the MTP, as shown in Figures 3 and 4.

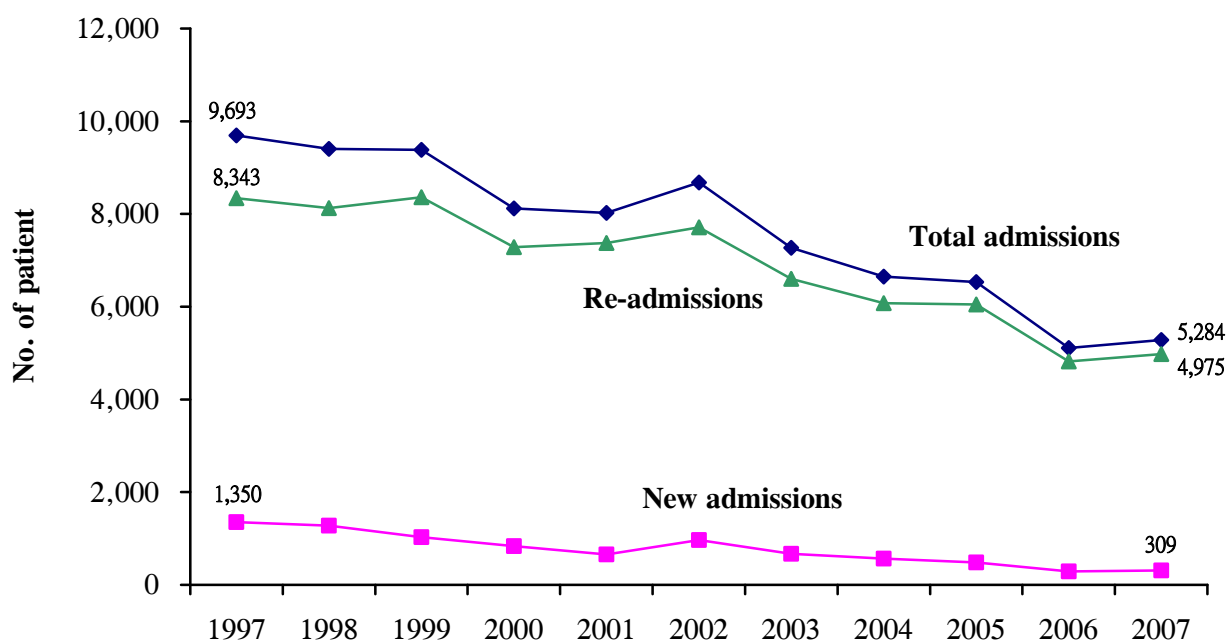
Figure 3

**Patient registration and attendance under the MTP
(1997-2007)**



Source: DH records

Figure 4
Admissions to the MTP
(1997-2007)



Source: DH records

4.24 Figure 3 shows that over the years 1997 to 2007, although the number of patients registered with the MTP decreased by 19% (from 10,015 to 8,159), the number of average daily attendance at methadone clinics dropped by only 10% (from 6,914 to 6,216). This was due to the fact that the patients' attendance rate had improved from 69% to 76% over the same period.

4.25 Figure 4 also shows that there was a decline in the number of new admissions to the MTP, reducing from 1,350 in 1997 to 309 (23% of 1,350) in 2007. **This indicates that new patient demand for MTP service was dropping and the MTP was mainly serving a group of re-admitted patients.** As noted by the MTP Working Group in its review of 2000, 38% of the patients in 1998 were re-admitted within one to two years and about 9% of the patients had 15 or more previous admissions.

4.26 The review by the MTP Working Group was conducted in 2000, more than seven years ago. Given the changing drug abuse pattern in recent years and the continuous downward trend of the MTP caseload, there is a need for another review of the MTP. As mentioned in paragraph 3.14, the ND needs to critically review the role played by the MTP to assess whether it should be continued in its present mode of operation (including a review of its operational size and staff resources) and how the existing resources and facilities should be better utilised. In this connection, Audit examined the utilisation of the individual methadone clinics (see Appendix E) from 2004 to 2007 and found that:

- (a) the overall utilisation of all methadone clinics had decreased from 76% in 2004 to 69% in 2007; and
- (b) four methadone clinics had persistently been operating at less than 50% of their capacities, with the lowest utilisation rate at 30%.

4.27 **Audit considers that the DH needs to keep under review the justifications for maintaining those methadone clinics with extremely low utilisation in their present mode of operation, taking into account the availability of similar clinics in the neighbourhood and the methadone patients' needs.**

Performance reporting

4.28 The DH reported the following performance measures in its CORs:

Performance target	Target	2005 (Actual)	2006 (Actual)	2007 (Actual)
— Average attendance rate of patients registered with methadone clinics (%)	> 70	74	76	76
Performance indicator		2005 (Actual)	2006 (Actual)	2007 (Actual)
— Patients registered with methadone clinics		9,150	8,600	8,200
— Average daily patient attendances at methadone clinics		6,800	6,600	6,200

Source: DH records

4.29 It appears that the performance information reported in the CORs does not adequately reflect the effectiveness of the MTP. This is because the performance measures focus mainly on workloads. **Audit considers that the DH needs to report more key outcome measures in the CORs.** Such outcome measures should help reflect the extent to which the MTP has achieved its operational objectives. Examples of such outcome measures may include:

Maintenance scheme	Detoxification scheme
<ul style="list-style-type: none"> — retention rate: number of patients remaining in the scheme without dropping out over a certain period of time 	<ul style="list-style-type: none"> — percentage of patients opting for detoxification — success rate of detoxification for patients joining the scheme — number of patients detoxified and completing the 18-month aftercare service without relapse

Extent of achieving detoxification

4.30 One of the objectives of the MTP is to assist drug abusers to achieve a drug-free state by providing a detoxification scheme (see para. 4.17(f)). Audit, however, noted that this objective was not met. From 2002 to 2007:

- (a) only 2% to 3% of the methadone patients opted for the detoxification scheme (see column (c) in Table 4);
- (b) less than 50% of the methadone patients opting for the detoxification scheme had succeeded in detoxification (Note 34 — see column (f) in Table 4); and
- (c) a high proportion of the detoxification cases (rising from 16% in 2002 to 32% in 2007) were re-admitted cases, indicating that many methadone patients relapsed after discharge from the scheme (see Table 5).

Note 34: *Under the detoxification programme, a patient is declared as having been successfully detoxified when the methadone dosage he received had been reduced to zero and this lasted for four weeks.*

Table 4
Analysis of detoxification cases

Year	Patient registered for the MTP	Patient admitted to the detoxification scheme		Patient discharged from the detoxification scheme (Note)	Patient successfully detoxified	
	(a) (Number)	(b) (Number)	(c) = (b) ÷ (a) (%)	(d) (Number)	(e) (Number)	(f) = (e) ÷ (d) (%)
2002	9,758	261	3%	227	97	43%
2003	9,748	266	3%	236	94	40%
2004	9,343	257	3%	250	122	49%
2005	9,145	257	3%	235	98	42%
2006	8,603	269	3%	274	126	46%
2007	8,159	185	2%	201	79	39%

Source: DH records

Note: Patients discharged from the detoxification scheme included patients who had successfully detoxified, patients who had failed in detoxification, and patients who had dropped out without completing the detoxification programme.

Table 5
Analysis of admissions to the detoxification scheme

Year	Admission (Number)	New admission		Re-admission	
		(Number)	(%)	(Number)	(%)
2002	261	218	84%	43	16%
2003	266	209	79%	57	21%
2004	257	202	79%	55	21%
2005	257	189	74%	68	26%
2006	269	190	71%	79	29%
2007	185	126	68%	59	32%

Source: DH records

4.31 The ND states in its 2006-08 Plan that the long-term success of any T&R programme hinges on non-relapse of the rehabilitated drug abusers. Hence, the DH needs to assess whether the results of detoxification so far achieved (see Tables 4 and 5) are satisfactory and whether there is a need to step up efforts:

- (a) to encourage more methadone patients to undergo detoxification; and
- (b) to provide more intensive care and counselling to help them become drug-free.

Audit recommendations

4.32 **Audit has recommended that the Director of Health should:**

Caseload of methadone clinics

- (a) **keep under review the justifications for maintaining those methadone clinics with extremely low utilisation in their present mode of operation;**

Performance reporting

- (b) **report more outcome measures in the DH's CORs and in its quarterly returns to the ND; and**

Extent of achieving detoxification

- (c) **assess whether the results of detoxification so far achieved are satisfactory and whether there is a need to step up efforts with a view to:**
 - (i) **encouraging more methadone patients to undergo detoxification; and**
 - (ii) **providing more intensive care and counselling to help them become drug-free.**

Response from the Administration

4.33 The **Director of Health** accepts the audit recommendations. He has said that:

Caseload of methadone clinics

- (a) the conduct of utilisation reviews on methadone clinics has been in practice for many years;
- (b) in a 1992 review, the Administration came up with some principles underlying the setting up and operation of methadone clinics. These principles, as endorsed by ACAN, included the need to provide methadone clinics in densely populated areas, the need to ensure easy access and convenience to patients, and the role of methadone clinics as a "safety-net", with capacity to cope with sudden demands for treatment due to reductions in the supply of drugs on the streets;
- (c) as a result of the review, the number of methadone clinics dropped from 25 to 20 over the years 1992 to 2002. This was made possible by closing or merging clinics that had alternative clinics nearby. Further closure of clinics is not desirable as easy accessibility will be hampered. On the other hand, setting up of new clinics in new towns where service needs exist is practically impossible due to neighbourhood's general resentment and District Councils' opposition;
- (d) in any case, the DH keeps under constant review MTP statistics in order to monitor utilisation and assess changes in service needs. Over the years, adjustments in the number of clinic sessions, doctor sessions and social workers' counselling sessions, clinics' opening hours, as well as manpower resources have been made accordingly. Furthermore, to maximise the use, the methadone clinics have been expanded and/or renovated to provide venue for group counselling and health education whenever possible;

Performance reporting

- (e) the DH will discuss with the ND on the appropriate outcome measures to be included in the CORs and in its quarterly returns to the ND;

Extent of achieving detoxification

- (f) the conduct of reviews on the results of detoxification has been put into practice for many years;
- (g) the main objective of the MTP in Hong Kong is to provide a readily accessible, legal, medically safe and effective treatment to combat against illicit self-administration of opiate drugs. It also aims to enable opiate abusers to lead a normal productive life and reduce intravenous drug use (including needle-sharing). Hopefully this can result in the prevention of spread of blood-borne diseases like AIDS and hepatitis B. All along, there has been a good coverage of opioid users by the MTP. The compliance of the methadone users to treatment is satisfactory. The attendance rate has been steady at around 75% in the past few years;
- (h) drug users who regularly receive service from the MTP have been found to have less criminal convictions, higher employment status and better family relationships than those who have not joined the programme. Furthermore, the prevalence of HIV infection among drug users in Hong Kong has remained low and stable over the years;
- (i) the MTP Working Group (see para. 4.21) concluded in its Report of 2000 that the MTP fulfilled its declared objectives and was effective in helping drug abusers to sustain their employment and social life as well as helping the society to reduce instances of drug overdose, drug-related deaths and the spread of blood-borne diseases. The MTP Working Group's review confirmed that MTP should continue to comprise maintenance and detoxification elements in order to offer choices, while the **mainstay** of the programme should remain a substitution (**maintenance**) therapy with a harm reduction objective;
- (j) regarding the results of detoxification, a literature review on comparing drug abstinence rates of 14 opioid detoxification programmes in the United States, the UK and Sweden revealed that the pooled abstinence rate was around 33%. The average detoxification success rate for the MTP in Hong Kong is approximately 40% which compares favourably with that abroad;
- (k) it is well recognised worldwide that opiate drug addiction is a chronic relapsing condition. While some abusers can be successfully detoxified, the majority have to revert to drug use or an alternate replacement/maintenance; and

- (1) though the admission of methadone users to the detoxification scheme is entirely voluntary, MTP staff will continue to encourage and facilitate opiate abusers (particularly new methadone users, youths, women and those with a short history of opiate abuse) to join the detoxification programme. Intensive counselling and continuous support service are provided to facilitate them to abstain from drug use.

4.34 The **Commissioner for Narcotics** welcomes and agrees with the audit recommendations.

PART 5: PROVISION OF SUBSTANCE ABUSE CLINICAL SERVICES

5.1 This PART examines the Government's provision of substance abuse clinical services.

Substance Abuse Clinics

5.2 SACs and CCPSAs are the two main streams of dedicated services provided for psychotropic substance abusers. SACs provide medical treatment services whereas the CCPSAs provide non-medical counselling services. SACs are operated by the HA whereas the CCPSAs are operated by NGOs receiving SWD subventions.

Services provided by SACs

5.3 SACs are provided as part of the HA's mental health services. There are five SACs (see paras. 1.4(d) and 3.2). Their operating expenditure was some \$12 million a year (see (d) in Figure 1 of para. 3.8). SACs provide the following services for drug abusers (primarily those with psychiatric complications and/or co-morbidity):

- (a) treatment of psychiatric co-morbidity of abusers (e.g. depression, and conduct or personality disorder);
- (b) treatment of psychiatric complications of abusers (e.g. drug-induced psychosis, cognitive impairment); and
- (c) provision of detoxification services on a very limited basis to those very motivated patients with psychiatric complications and/or co-morbidity.

5.4 SACs accept referrals of patients primarily with psychiatric complications and/or co-morbidity from CCPSAs, welfare agencies, medical practitioners and other health care providers. SACs mainly provide out-patient services for psychotropic substance abusers. The need for a period of in-patient treatment is determined by the specific clinical needs of the patients. Specific treatment is provided for in-patient detoxification and treatment of those with identified drug induced psychiatric complications or co-morbid psychiatric illnesses.

Recommendations by PSA Task Force

- 5.5 In its review of 2002, the PSA Task Force noted that:
- (a) there were six SACs. They handled a total of 727 abuser cases in 2000 and some SACs had patient waiting lists; and
 - (b) the services of these SACs were provided mainly through doctors (psychiatrists), nurses, and clinical psychologists on part-time basis.

5.6 Having noted the accelerating trend of psychotropic substance abusers, the PSA Task Force recommended that the substance abuse services provided by the HA should be strengthened.

5.7 On the understanding that PSA might cause serious physical and psychiatric complications, the Task Force also recommended that comprehensive assessment and laboratory screening should be conducted for all psychotropic substance abusers before they were admitted to a drug treatment programme.

Follow-up of the PSA Task Force's recommendations

5.8 In the follow-up of the PSA Task Force's recommendation on the need to strengthen SAC services, the Kwai Chung SAC (the SAC at the Kwai Chung Hospital) applied funding of \$3 million from the BDF for a "MEET Day Hospital" Project (Note 35). The Project, which started in September 2002, involved the setting up of a day-time detoxification ward and the running of a Day Hospital Programme for the treatment of psychotropic substance abusers. However, the Project ended in April 2004 and lasted for 20 months only.

5.9 In addition, the ND included the need to strengthen SAC services in both its 2003-05 Plan and 2006-08 Plan. In the two Plans, the ND made the following recommendations (Audit emphasis):

Note 35: *The "MEET Day Hospital" Project was a special cognitive motivation modality developed by the Kwai Chung SAC to treat multiple drug abusers. "MEET" stands for motivational interviewing, esteem building, empowering and therapy.*

“In the long term, efforts could be made to strengthen the substance abuse treatment service under the HA through setting up of tertiary centres for psychotropic substance abusers. Those centres would provide full-time service, enhanced social workers’ input and be equipped with specialist in-patient facilities which are separate from the general psychiatric ward settings. Its services will also include the development of new facilities such as day hospital and alcohol treatment services, etc.” (2003-05 Plan)

“Faced with a rising percentage of persons abusing psychotropic substances and multi-drug taking, there is an increasing demand to provide treatment to this group of clients. Judging from utilisation figures, there is a steady increase in demand year on year with the exception of 2004. The services offered by SACs are indispensable and need strengthening, otherwise, treatment applicants can be lost if we fail to address their needs in a timely manner.” (2006-08 Plan)

Audit observations and recommendations

No significant expansion of SACs

5.10 Although the 2003-05 Plan and the 2006-08 Plan both recommended the need to strengthen SACs, Audit noted that as at January 2008, there had **not** been any significant expansion to SACs. The Kwai Chung SAC expanded its operation in 2002 through the running of a day-time detoxification ward and a Day Hospital Programme with funds obtained from the BDF, but the project ended in April 2004 (see para. 5.8). As at June 2002 (time of the review by the PSA Task Force), there were six SACs. **In 2006-07, there were only five SACs. They were manned in total by four doctors and eight nurses. All SAC doctors worked on part-time basis and were mainly provided within the hospitals through staff redeployment.** From 2004-05 to 2006-07, there was no significant increase in the manpower resources deployed to the provision of SAC services (see Appendix F).

5.11 As mentioned in paragraph 3.2, the HA set up the first SAC in 1994 on a pilot basis at the Kowloon Hospital. In 1995, with government support, the HA set up five more SACs to meet the increasing demand. In 2005, due to a re-organisation of services, the HA closed the SAC at the QMH. Nonetheless, the psychiatric Specialist Out-patient Department (SOPD) of the QMH has continued to provide consultation on PSA cases (although no designated sessions are assigned for PSA cases as in the case of a SAC). In February 2008, the HA advised Audit that it would reopen the SAC at the QMH later in 2008.

5.12 As at February 2008, the five SACs operating at different hospitals served the following hospital clusters.

Table 6
SACs serving different hospital clusters

Hospital cluster (Note)	Hospital providing the SAC
Hong Kong East Cluster	Pamela Youde Nethersole Eastern Hospital
Kowloon Central Cluster	Kowloon Hospital
Kowloon West Cluster	Kwai Chung Hospital
New Territories East Cluster	Prince of Wales Hospital
New Territories West Cluster	Castle Peak Hospital

Source: HA records

Note: Under a cluster management structure adopted by the HA, its hospitals and related services are organised into seven clusters. In each cluster, the health services provided are tailored to meet the needs of the population in that cluster. SACs are operated by the psychiatric departments of the hospitals and each SAC provides services to patients living in the catchment area covered by its hospital cluster.

5.13 There was no SAC for the Hong Kong West Cluster and the Kowloon East Cluster (which covered the Central, Western and Southern Districts, Kwun Tong and Tseung Kwan O Districts). Without any SAC, abusers living in these areas either had to seek treatment with other psychiatric patients at the psychiatric SOPDs of hospital clusters in their districts (e.g. the QMH and the United Christian Hospital), or had to approach private medical practitioners to seek referral to SACs of other hospital clusters. **Given that the motivation to seek treatment can be affected if medical consultation is not readily available or accessible, and that the population living in the catchment areas of the Hong Kong West Cluster and the Kowloon East Cluster is quite large, this is an issue of concern.** Even if the abusers would subsequently be accepted for treatment in SACs of other hospital clusters, the long distance might have discouraged the abusers from seeking treatment.

5.14 CCPSAs provide rehabilitative services for psychotropic substance abusers (Note 36), preventive education programmes for potential or occasional abusers, counselling services for family members of the abusers and other assistance to abusers and youth at risk in the territory. As at February 2008, there were five CCPSAs which were set up in 1988, 1996, 1998 and two in 2002 (see para. 3.2). In April 2007, the SWD provided additional funds of \$3.7 million a year to enhance the staffing provisions of these five CCPSAs (see para. 3.6). **Despite several rounds of enhancing the capacities of the CCPSAs (notably in 2002 and 2007), there was however no corresponding expansion of SACs.** Instead of expansion, one SAC was closed in 2005. Owing to the reduction in the number of SACs, coupled with the completion of the “MEET Day Hospital” Project (see para. 5.10), staff turnover and an increase in the number of follow-up cases, there was a downward trend in the total number of new admission cases handled by SACs in 2006 and 2007, as shown in Table 7.

Table 7

Caseloads handled by SACs

Year	New admission case	Follow-up attendance	Total attendance
	(number)		
2000	727	4,314	5,041
2001	701	5,415	6,116
2002	869	7,285	8,154
2003	745	8,424	9,169
2004	806	8,062	8,868
2005	888	11,485	12,373
2006	729 } (Note)	13,097 } (Note)	13,826
2007	568 }	12,038 }	12,606

Source: ND and HA records

Note: The figures include in total 90 new admission cases and 3,435 follow-up attendances handled by the psychiatric SOPD of the QMH.

Note 36: Such rehabilitative services include assessment services, matching of mode of detoxification, relapse prevention, individual and group counselling.

5.15 In January 2007, a CCPSA asked one of the SACs (Clinic A) if it could refer more cases to Clinic A, as its partnership SAC (Clinic B) was fully utilised and had an average waiting time of two months. Clinic A advised the CCPSA that referrals of cases from agencies outside its hospital cluster would have to be considered case by case. Understandably Clinic A could not accede to the request because its clinical resources were fully utilised and it had to comply with the HA policy of cluster management.

Resource constraints faced by SACs

5.16 The DH had from time to time referred abuser cases under its MTP to other T&R agencies (such as SARDA and SACs) for specialist services (e.g. in-patient detoxification). Based on statistics kept by the DH, 191 and 89 abuser cases were referred by the methadone clinics to SACs for treatment in 2006 and 2007 respectively. Referrals for 66 (35% of 191) and 10 (11% of 89) of the cases were not successful. An analysis by the DH of these 76 referral cases revealed that in 26 (34% of 76) cases, because the abusers did not have psychiatric complications or co-morbidity, they were not given priority for treatment and had given up SAC treatment due to the long waiting time. As long waiting time for treatment might reduce the abusers' motivation for seeking treatment, the situation is less than desirable.

5.17 Under the existing arrangements, SACs would only provide detoxification services to those drug abusers with psychiatric complications and/or co-morbidity and with a high level of motivation. In other words, SACs only provided limited detoxification services (see para. 5.3(c)). They sometimes encountered problems in handling these cases because of resource constraints. For example, the Tuen Mun SAC stated in its Annual Report for 2006-07 the following:

“Some of the problems mentioned in the previous reports are still present, e.g. inability to provide structured programme (e.g. social skill training and family counselling) that is important in the rehabilitation of the clients after they are detoxified.

Quite a lot of substance abusers, especially those without psychiatric co-morbidity, dislike to mix with general psychiatric patients because they do not accept they are mentally ill and they find difficulty in social interaction with those patients.

Not all the frontline doctors are skilful in managing this group of patients Similar problems may occur in the nursing aspect especially during the night shift They may be inexperienced in monitoring withdrawal symptoms with standard scale or performing quick urine toxicology test. Training of doctors and nurses are important to improve quality of care of substance abusers.”

5.18 According to the SWD “Code of Practice for Drug Dependent Persons Treatment and Rehabilitation Centres” (December 2001), a T&R centre should obtain the detailed drug abuse history of an abuser and should take care that the applicant, in applying for admission for treatment:

- (a) has passed the initial detoxification period and does not have acute and severe withdrawal symptoms and/or abnormal behaviour; or
- (b) has been assessed by a registered medical practitioner to be medically fit to undergo the residential treatment programme.

To satisfy that the applicant is mentally fit, T&R agencies used to refer the applicant to SACs for the conduct of a pre-admission body check (although it was understood that SACs were not obliged to provide such body check services — see para. 5.3). However, since early 2007, apparently due to limited resources, most SACs (except the SAC at the Prince of Wales Hospital — Note 37) have gradually stopped providing such pre-admission body check services referred by T&R agencies. As a result, the T&R agencies have to ask the abusers to approach private medical practitioners for body check. It appears that the PSA Task Force’s recommendation, that comprehensive clinical assessment and laboratory screening should be conducted for all abusers before accepting them for any drug treatment programme (see para. 5.7), has still not been fully implemented.

Audit visits to SACs

5.19 Audit visited all the five SACs and noted the following:

- (a) all five SACs were mainly manned by doctors on a part-time basis. For example, the SAC at the Pamela Youde Nethersole Eastern Hospital was manned by 0.1 SMO and 0.1 MO, and the SAC at the Prince of Wales Hospital by 0.5 MO;
- (b) the operating hours of SACs ranged from five half-days a week (in the case of the Kwai Chung SAC) to two half-days a week (in the case of the SAC at the Prince of Wales Hospital and the Kowloon Hospital SAC);

Note 37: *In an audit visit to the SAC at the Prince of Wales Hospital in January 2008, Audit noted that the SAC still continued to provide such pre-admission body check services for T&R agencies and such abuser cases represented some 68% of new admission cases handled by the SAC in 2007.*

- (c) the waiting time for a new case appointment ranged from 2.6 weeks in the case of the Kwai Chung SAC to 10 weeks and 15 weeks in the case of the SAC at the Pamela Youde Nethersole Eastern Hospital and the SAC at the Prince of Wales Hospital respectively; and
- (d) the Kwai Chung SAC was the only SAC that provided day-time detoxification for drug abusers (see para. 5.23).

Details are at Appendix G.

5.20 Audit notes that SACs have played a very important role in providing medical treatment for psychotropic substance abusers with psychiatric problems. There are indications that the service demand for SACs is increasing, but SAC services have not been strengthened as recommended by the PSA Task Force in 2002 and by the ND in its Plans for 2003-05 and 2006-08. **Audit considers that there is an urgent need for the Commissioner for Narcotics and the Secretary for the Food and Health (as the Controlling Officer of government subvention to the HA) to assess critically, in consultation with the Chief Executive, HA, the service demand for SACs and expedite the implementation of the PSA Task Force's recommendation by strengthening SAC services to meet the community needs.**

Extension of day-time detoxification programme to other SACs

5.21 As mentioned in paragraph 5.8, in 2002, the Kwai Chung SAC launched a "MEET Day Hospital" Project. The Project included a Day Detoxification Programme that involved the development of a day-time detoxification treatment protocol to drug abusers as an alternative to in-patient detoxification.

5.22 In a post-implementation report of the "MEET Day Hospital" Project, the Kwai Chung SAC considered that the Project was a success and, among many benefits achieved, a total of 131 abusers had successfully been detoxified in 18 months under the Day Detoxification Programme. As a result, the target set in the funding application was over-achieved. It was considered that the Day Detoxification Programme had opened up new opportunities for those who were motivated to quit heroin but unable to be admitted to residential treatment settings (such as those who were working and could not afford to take long leave, mothers with young children, and early relapse cases) and those who were reluctant to use the MTP for detoxification.

5.23 Although the “MEET Day Hospital” Project was completed in April 2004, the Kwai Chung SAC has continued providing day-time detoxification for some patients. In 2005-06 and 2006-07, it handled 92 and 147 day hospital cases respectively. Audit noted that day-time detoxification provided the flexibility required by some patients (see para. 5.22). Audit, however, noted that other SACs did not operate similar day-time detoxification programmes. **Given that day-time detoxification provides an opportunity for more effective use of resources, the HA may wish to explore the feasibility of extending the provision of such a service to other SACs.**

5.24 **Audit has recommended that the Commissioner for Narcotics and the Secretary for Food and Health should, in consultation with the Chief Executive, HA:**

- (a) **assess critically the service demand for SACs and expedite the implementation of the PSA Task Force’s recommendation by strengthening the SAC services to meet the community needs;**
- (b) **in assessing the service demand, take into account the various constraints facing SACs as highlighted in paragraphs 5.10 to 5.20, including:**
 - (i) **provision of treatment to psychotropic substance abusers residing in districts not covered by the catchment areas of existing SACs;**
 - (ii) **need for enhancing the detoxification services to be provided for psychotropic substance abusers; and**
 - (iii) **conduct of pre-admission body checks for abuser cases referred by T&R agencies to SACs; and**
- (c) **explore the feasibility of extending the provision of the day-time detoxification service at the Kwai Chung SAC to other SACs.**

Response from the Administration

5.25 The **Commissioner for Narcotics** welcomes and agrees with the audit recommendations. She appreciates the audit observation on the medical service needs of drug abusers. She has said that the ND will work with the Food and Health Bureau and other relevant parties on appropriate enhancement of SAC services and other appropriate means to meet the needs.

5.26 The **Secretary for Food and Health** welcomes the audit recommendations. He has said that he has initiated follow-up action with the Commissioner for Narcotics and the Chief Executive, HA on strengthening the support and services of SACs as appropriate, taking into account the role of SACs, the demand for the services, the service delivery model and the resources requirement.

Response from the Hospital Authority

5.27 The **Chief Executive, HA** welcomes the audit recommendations. He has said that:

- (a) while the HA provides its psychiatric services on a cluster basis and patients are arranged to attend at a SAC within their residential district as far as possible, the HA will not deny treatment to a patient just because he/she is not living within the service catchment area of a SAC. However, if the patient in a referral case does not require the kind of specialist services available in SAC or the patient does not have the motivation for treatment, the case would not be taken up for follow-up;
- (b) decisions on any SAC expansion cannot be made in isolation. For example, impacts on other services, availability of resources (such as floor space) and competing priorities all need to be considered. As to the provision of SAC service to psychotropic substance abusers residing in Hong Kong West and Kowloon East (see para. 5.13), the HA is planning to reopen the SAC in QMH later in 2008 and is exploring with the Food and Health Bureau the possibility of opening a SAC in Kowloon East. Currently, while the Hong Kong West Cluster and the Kowloon East Cluster do not have SACs, drug abusers with psychiatric problems could receive treatment through the services available in their respective SOPDs. As such, medical consultations are available and accessible in these clusters although they are provided through other means in the absence of SACs;
- (c) historically, some SACs had performed pre-admission body check for residential drug T&R centres on a limited basis (see para. 5.18). But this service does not fall within the scope of SAC services. SAC has the designated function of providing specialist intervention for drug abusers who have developed psychiatric complications and/or co-morbidity. As a tertiary care provider, the HA is of the view that its services should be better targeted to those who need specialist services. At present, the T&R agencies approach medical practitioners for body check services; and
- (d) with regard to the recommendations for enhancing the detoxification service for psychotropic substance abusers and extending the day-time detoxification service (see para. 5.24(b)(ii) and (c)), the HA will review the need for and the effectiveness of the day-time detoxification service and explore the feasibility of extending this service to other SACs, covering also psychotropic substance abusers.

Performance of Substance Abuse Clinics

5.28 For statistical purposes, the HA submits quarterly returns to the ND on the numbers of patient attendance cases (new admissions and follow-up attendances) the SACs handled (see para. 3.18). Based on the quarterly returns, there was a downward trend in the number of new admissions handled by SACs in 2006 and 2007 (see Table 7 in para. 5.14).

Audit observations and recommendations

5.29 For many years, the Tuen Mun SAC at the Castle Peak Hospital has compiled treatment statistics and issued Annual Reports on its manpower resources deployment, service performance (in terms of success rate in detoxification), problems encountered, future development, and major service statistics. Examples of useful statistics compiled and reported in its Annual Report for 2006-07 include:

- Of the 106 new abuser cases accepted by the SAC in the year, the mean age was 31.8. 11.3% of the abusers were aged below 21. 88.7% of the abusers studied above primary level but only 24.5% were above Form 3 level. 51.9% of the 106 new cases were single. 61.3% were unemployed.
- **The top four common primary substances of abuse were “Cough Medicine” (28.3%), “Heroin/Methadone” (24.5%), “Zopiclone” (15.1%) and “Ketamine” (13.2%).**
- **68% of the abusers had abused more than one substance in the past year before consultation, with 32% of the abusers being multiple drug abusers (abusing more than two substances in the past year). This reflected that multiple drug abuse was rather common among the abusers.**
- Among the 106 new abuser cases, 58 (54.7%) abusers had a history of past detoxification and 29 of the 58 abusers had received more than one form of treatment in the past.
- **50% of the new abuser cases suffered from co-existing psychiatric disorder, with the top three disorders being drug-induced psychosis (24.5%), depression (10.4%) and schizophrenia (4.7%).**
- Based on the treatment outcome of 513 abuser cases managed in the year, the success rate in detoxification was 45.4% (compared with 35.6% for 2005-06 and 37.3% for 2004-05).

Source: Tuen Mun SAC Annual Report for 2006-07

5.30 Audit welcomes the Tuen Mun SAC's initiative, and considers that the treatment statistics produced by the Tuen Mun SAC are very useful to support future anti-drug policy formulation and strategic planning. These include, for example, "the most common primary substances of abuse", "the extent of abusers taking multiple drugs" and "the success rate in detoxification".

5.31 Other than the Tuen Mun SAC, the remaining four SACs have not produced similar treatment statistics. Audit considers that the other four SACs should also be encouraged to compile similar treatment statistics as far as possible.

5.32 Audit has recommended that the Chief Executive, HA should encourage the other four SACs to compile treatment statistics in a similar manner as the Tuen Mun SAC.

5.33 Audit has also recommended that the Commissioner for Narcotics should collect such useful statistics from the HA to facilitate her future policy formulation and strategic planning.

Response from the Hospital Authority

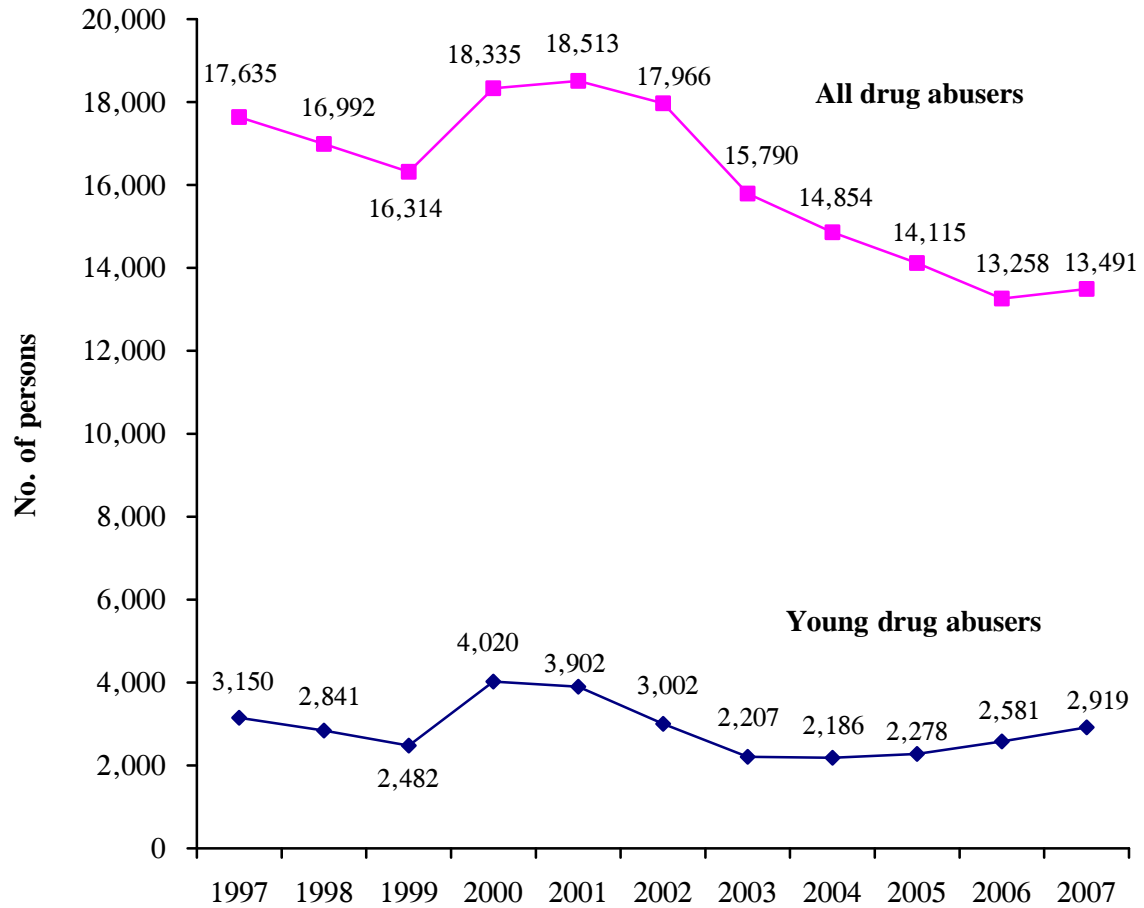
5.34 The **Chief Executive, HA** welcomes the audit recommendation. He has said that:

- (a) the HA has set performance measures for its psychiatric services which include length of stay and re-admission rates of psychiatric patients; and
- (b) at the request of the ND, the HA provides quarterly service statistics of its SACs to the ND. The HA will discuss with the ND and explore the feasibility of collecting further treatment statistics (e.g. the percentage of multiple drug abusers) in other SACs to facilitate the ND's policy formulation and strategic planning and where the HA is the most appropriate source for collecting the information.

Response from the Administration

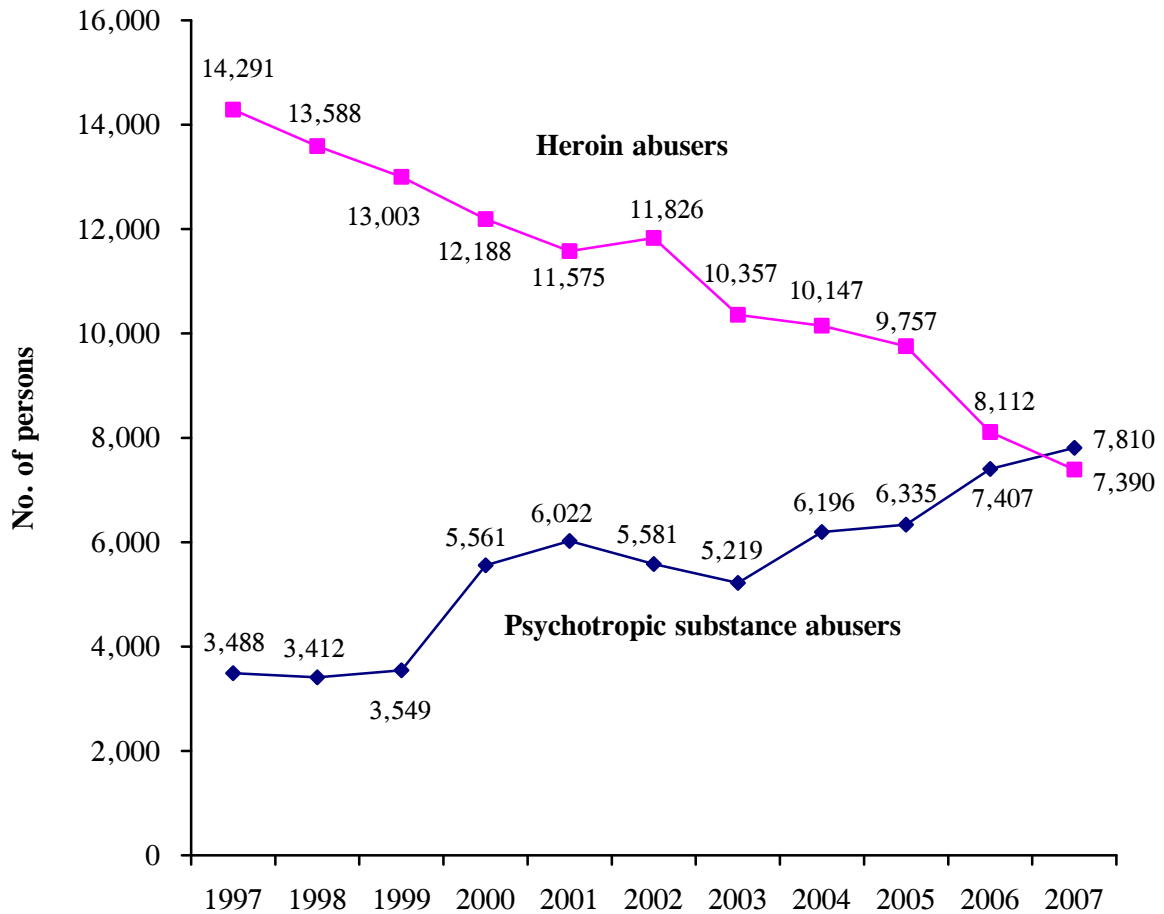
5.35 The **Commissioner for Narcotics** welcomes and agrees with the audit recommendations.

**Trend of reported drug abusers in Hong Kong
(1997-2007)**



Source: ND records

Trend of reported heroin and psychotropic substance abusers in Hong Kong
(1997-2007)



Source: ND records

Overseas drug abuse surveillance systems

The United States

Drug Abuse Warning Network

1. The Drug Abuse Warning Network is a national surveillance system that collects data on all types of drug-related deaths and drug-related visits to hospital emergency department. To collect the data for the Network, emergency department medical records and death investigation case files are reviewed. The data collected do not contain personal information. Patients, their families, and their physicians are not interviewed.

2. The objectives of the Network are to identify substances associated with drug-related episodes and deaths that are reported by emergency departments and medical examiners, to monitor trends in drug use consequences, and to detect new drugs of abuse and to assess health hazards associated with drug use. It helps communities and member facilities identify emerging problems, improve patient care, and manage resources.

“Monitoring the Future” survey

3. The “Monitoring the Future” survey, began since 1975, is an ongoing study of the behaviours, attitudes, and values of American secondary school students, college students and young adults. Some 50,000 students (8th, 10th, and 12th graders) participated in each survey. Survey participants report their drug use behaviours across three time periods: lifetime, past year, and past month. The results of the survey are, among others, used to monitor trends in substance use and abuse among adolescents and young adults, and are used routinely in developing the White House Strategy on Drug Abuse.

National Survey on Drug Use and Health

4. The National Survey on Drug Use and Health is an annual national wide survey involving interviews of randomly selected 70,000 individuals of age 12 and above. The individuals are asked to voluntarily participate. They will be asked questions on health, illegal behaviours, and other topics associated with substance use. The primary objectives of the survey are to collect timely data on the magnitude and patterns of alcohol, tobacco, and illegal substance use and abuse, assess the consequences of substance use and abuse, and identify those groups at high risk for substance use and abuse. Survey participants report their drug use behaviours across three time periods: lifetime, past year, and past month.

Drug abuse surveillance system run by the Community Epidemiology Work Group

5. The Community Epidemiology Work Group is a well-established epidemiology network of researchers functioning as a drug abuse surveillance system to identify and assess current and emerging drug abuse patterns and trends, and issues, using multiple sources of information. Each source provides information about the abuse of particular drugs, drug-using populations, and/or different facets of the behaviours and outcomes related to drug abuse.

6. The information obtained from each source is considered a drug abuse indicator. Data on items submitted for forensic chemical analysis serve as indicators on availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility and potency of specific drugs. Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas.

7. The Community Epidemiology Work Group representatives meet semi-annually. The Work Group representatives and guest researchers present information on drug abuse patterns and trends using various kinds of quantitative and qualitative data. Information is most often obtained from local substance abuse treatment providers and administrators, personnel of other health-related agencies, medical examiners, poison control centres, law enforcement officials and drug abusers. The Work Group representatives can and do get anecdotal information from street contacts, key informants, and other qualitative research methods.

The United Kingdom

National Drug Treatment Monitoring System

8. The National Drug Treatment Monitoring System (NDTMS) was introduced in the UK in April 2001 to replace the previous Regional Drug Misuse Databases. The NDTMS is a live database, updated each month with data extracted from service providers' clinical information systems. Data are collected on drug misusers presenting for treatment as well as those in treatment (excluding those in prisons).

9. Reporting to the NDTMS is voluntary. Data are collected on individuals who are in contact with T&R agencies and general medical practitioners for structured drug treatment. The NDTMS collects, collates and analyses data from and for those involved in the drug treatment sector, to produce official statistics on drug treatment activity. It is a key source of information for monitoring the numbers in treatment for the UK government's 10-year drug strategy.

British Crime Survey

10. The British Crime Survey is a large nationally representative survey of adults living in private households in the UK. It covers crime-related topics such as the self-completion module of questions on illicit drug use with a particular focus on young people aged 16 to 24.

11. At the close of face-to-face part of the interview under the Crime Survey, the interviewer will hand to the respondents, who is eligible for the drugs module of the survey (i.e. aged 16 to 59), a laptop for them finish the self-report component. Their answers will be hidden and they can pass the laptop back to the interviewer. This provides the respondents with increased confidence in the privacy and confidentiality when answering questions on illicit behaviour. In 2006-07, the final sample size was 29,144 out of the nationally representative sample of 47,203 adults living in private households.

12. As a household survey, the British Crime Survey provides an effective measure of the more commonly-used drugs for which the majority of users are contained within the household population. It provides estimates of the prevalence of use of an illicit drug at least once in a lifetime, use in the last year and use in the last month. It also estimates the number of drug users for each type of drug. It helps explore key messages arising from the trends in drug use since 1998.

National survey on smoking, drinking and drug use among young people

13. The survey on “Smoking, drinking and drug use among young people” is a major national survey of secondary school pupils aged 11 to 15 in the UK. It is carried out every year, with emphasis alternating between smoking and drinking (2000, 2002, 2004 and 2006) and drugs (2001, 2003 and 2005). The survey includes measures of truancy and exclusion from school, and fieldwork is designed as far as possible to include pupils not present on the initial fieldwork visit (e.g. those on truancy or excluded on that day). For the 2006 survey, 8,200 pupils in 290 schools in the UK completed questionnaires. Relating to the drugs, key measures of this survey include the proportion of pupils taking the specific types of drugs and estimates of the prevalence of drug use in the last month and the last year.

Source: ND Report on Review of CRDA (December 2001) and audit research

**Performance measures of an NGO Counselling Centre
for Psychotropic Substance Abusers**

Output/outcome measure	Agreed level	Actual performance			
		2003-04	2004-05	2005-06	2006-07
Total number of cases served with case plan	180	198	184	186	212
Total number of counselling group sessions	225	240	260	264	225
Total number of professional training sessions	60	64	63	66	61
Percentage of schools served in the catchment areas in a year	70%	92%	115%	121%	71%
Success rate of cases closed with achieved case plans in a year	50%	73%	71%	72%	66%
Drug-free cases upon termination	50%	70%	77%	74%	64%
School served having increased awareness and knowledge on harmful effect of drug abuse	70%	96%	98%	100%	100%

Source: SWD records

Appendix E
(para. 4.26 refers)

Utilisation of methadone clinics

Clinic	Capacity (Note)	2004		2005		2006		2007	
		Average daily attendance	% of capacity	Average daily attendance	% of capacity	Average daily attendance	% of capacity	Average daily attendance	% of capacity
MC1	200	111	56%	109	54%	104	52%	89	44%
MC2	300	122	41%	118	39%	111	37%	99	33%
MC3	300	196	65%	179	60%	161	54%	148	49%
MC4	1,000	734	73%	702	70%	670	67%	646	65%
MC5	500	251	50%	235	47%	226	45%	204	41%
MC6	200	125	62%	105	53%	103	51%	98	49%
MC7	500	331	66%	341	68%	340	68%	333	67%
MC8	200	101	50%	86	43%	89	44%	86	43%
MC9	200	186	93%	179	89%	149	74%	129	65%
MC10	1,200	865	72%	850	71%	851	71%	812	68%
MC11	1,300	1,312	101%	1,352	104%	1,381	106%	1,351	104%
MC12	200	114	57%	112	56%	107	54%	99	49%
MC13	500	461	92%	474	95%	424	85%	377	75%
MC14	100	33	33%	35	35%	33	33%	30	30%
MC15	1,000	677	68%	700	70%	688	69%	680	68%
MC16	200	171	85%	170	85%	176	88%	160	80%
MC17	300	239	80%	227	76%	209	70%	191	64%
MC18	200	174	87%	158	79%	149	75%	133	67%
MC19	300	379	126%	399	133%	386	129%	352	117%
MC20	300	227	76%	247	82%	224	75%	199	66%
Overall	9,000	6,809	76%	6,778	75%	6,581	73%	6,216	69%

Source: DH records

Note: The capacity of a methadone clinic is determined on the basis of various factors, including the size of the clinic and the staffing resources provided.

Appendix F
(para. 5.10 refers)

Manpower resources deployed by hospitals to provide substance abuse clinical services

SAC at Hospital	2004-05			2005-06			2006-07		
	Doctor (Note 1) (No.)	Nurse (Note 2) (No.)	Others (Note 3) (No.)	Doctor (Note 1) (No.)	Nurse (Note 2) (No.)	Others (Note 3) (No.)	Doctor (Note 1) (No.)	Nurse (Note 2) (No.)	Others (Note 3) (No.)
<i>Services provided by SAC</i>									
Castle Peak Hospital	0.87	1.94	1.23	0.87	2.44	1.42	0.87	2.44	1.25
Kowloon Hospital	0.31	1.05	—	0.77	1.05	—	0.77 (Note 4)	1.05	—
Kwai Chung Hospital	1.50	3.00	1.00	1.50	3.00	1.00	1.50	3.00	1.00
Pamela Youde Nethersole Eastern Hospital	0.20	0.40	—	0.20	0.40	—	0.20	0.40	—
Prince of Wales Hospital	0.50	1.00	—	0.50	1.00	—	0.50	1.00	—
Sub-total	3.38	7.39	2.23	3.84	7.89	2.42	3.84	7.89	2.25
<i>SAC services provided by the psychiatric Specialist Out-patient Department (SOPD) of the Queen Mary Hospital (QMH — Note 5)</i>									
QMH	0.54	0.18	0.43	0.54	0.10	0.38	0.54	0.10	0.38
Grand total	3.92	7.57	2.66	4.38	7.99	2.80	4.38	7.99	2.63

Source: HA records

Note 1: Doctors include Consultant Psychiatrists, SMOs and MOs.

Note 2: Nurses include Nursing Officers (Psychiatric), Registered Nurses (Psychiatric), Enrolled Nurses (Psychiatric) and equivalent.

Note 3: Others include Clinical Psychologists, Occupational Therapists, Clerks, and General Service Assistants.

Note 4: In July 2006, 0.1 Consultant Psychiatrist and 0.17 MO were redeployed from the SAC to man the Kowloon Psychiatric Observation Unit newly set up at the Kowloon Hospital. As a result, since July 2006, the SAC at the Kowloon Hospital was manned by 0.5 doctor only (see Appendix G).

Note 5: With the closure of the SAC at the QMH in the first quarter of 2005, the psychiatric SOPD of the QMH has continued to provide consultation on PSA cases for the Hong Kong West Cluster.

Audit visits to Substance Abuse Clinics

Tuen Mun SAC at Castle Peak Hospital

Audit visited the SAC on 1 November 2007. The SAC was manned by 0.32 SMO and 0.55 MO, who were deployed on part-time basis from the Castle Peak Hospital. To cope with the increased workload, the operating hours of the SAC had twice been extended since September 2001. The following number of doctor-sessions (one session lasted for half a day) were provided in a week:

Before 2001-02	4
2001-02 to 2003-04	6
Since 2004-05	8

In 2007, the SAC was open for three half-days a week to provide out-patient services.

The Tuen Mun SAC also provided in-patient treatment services for detoxification or management of co-existing psychiatric problems. The number of in-patient cases managed by the Tuen Mun SAC increased from 100 in 2002-03 to 148 in 2006-07. Cases to be accepted for in-patient detoxification had to be reviewed by a nurse assessment board, comprising the Ward Manager and case nurse of the SAC, to assess the suitability of the case for in-patient treatment.

The SAC informed Audit in November 2007 that its service demand was still very keen and the average waiting time for a new case appointment was around 4 weeks.

SAC at Pamela Youde Nethersole Eastern Hospital

Audit visited the SAC on 28 December 2007. It was understood that the SAC was dedicated for treatment of PSA cases for only one half-day a week (one doctor-session). For three other half-days, the SAC provided out-patient services for both general psychiatric and PSA cases.

According to the SAC records, only 0.1 SMO and 0.1 MO were deployed to handle PSA cases. Since the setting up of the SAC in 1995, there had not been any increase in manpower resources deployed to work at the SAC.

Based on the SAC records, the average waiting time for a new case appointment in 2007 was around 10 weeks. In arranging the booking of appointments, the SAC gave priority to those young abuser cases. This was due to a request in 2005 from the Eastern District Council.

SAC at Kwai Chung Hospital

The Kwai Chung SAC mainly concentrated on providing medical detoxification and follow-up treatment for patients with psychiatric problem. About half of its patients were heroin abusers.

Audit visited the SAC on 19 December 2007. The Kwai Chung SAC was manned by 0.5 SMO and one (2 × 0.5) MO deployed from the Kwai Chung Hospital. The SAC was open for five half-days a week (7 doctor-sessions) to provide out-patient services.

The SAC also provided day hospital treatment for its patients by allowing them to receive day-time detoxification (see para. 5.21 of the Report). Ten beds were assigned for in-patient treatment. The service demand for in-patient treatment had however decreased.

On average, the waiting time for a new case appointment was around 2.6 weeks.

SAC at Prince of Wales Hospital

Audit visited the SAC on 21 January 2008. The SAC was manned by 0.5 MO and was open for two half-days a week (2 doctor-sessions) to provide out-patient services for treatment of drug abusers with psychiatric problem. Since March 2003, the SAC had stopped from providing in-patient treatment services for detoxification.

The SAC had continued to provide pre-admission body-check services for several voluntary residential T&R centres with which it worked in partnership (see Note 37 to para. 5.18 of the Report).

Owing to the fact that only one part-time MO was deployed to the SAC, the SAC service would temporarily be suspended when he was on vacation leave.

In December 2007, the average waiting time for a new case appointment was around 15 weeks.

SAC at Kowloon Hospital

Audit visited the SAC at the Kowloon Hospital on 23 January 2008. The SAC was manned by 0.2 Consultant Psychiatrist and 0.3 MO, and was open for two half-days a week (2.5 doctor-sessions) to provide out-patient services for treatment of drug abusers with psychiatric problem. Ten beds were assigned for in-patient treatment.

The SAC had been downsized since 2006 because in mid-July 2006, 0.1 Consultant Psychiatrist and 0.17 MO were redeployed from the SAC to man the Kowloon Psychiatric Observation Unit newly set up at the Kowloon Hospital.

On average, the waiting time for a new case appointment for the SAC was around 4 weeks.

Source: HA records and Audit visits

Acronyms and abbreviations

ACAN	Action Committee Against Narcotics
Audit	Audit Commission
BDF	Beat Drugs Fund
CAEDT	Centre for Anti-drug Education and Disciplinary Training
CCPSAs	Counselling Centres for Psychotropic Substance Abusers
CORs	Controlling Officer's Reports
CRDA	Central Registry of Drug Abuse
CSD	Correctional Services Department
DDO	Dangerous Drugs Ordinance
DH	Department of Health
DLC	Drug Liaison Committee
FSAs	Funding and Service Agreements
HA	Hospital Authority
IVE	Hong Kong Institute of Vocational Education
LegCo	Legislative Council
MO	Medical Officer

Appendix H
(Cont'd)

MTP	Methadone Treatment Programme
ND	Narcotics Division
NDTMS	National Drug Treatment Monitoring System
NGOs	non-governmental organisations
PDPO	Personal Data (Privacy) Ordinance
PSA	Psychotropic substance abuse
QMH	Queen Mary Hospital
RAG	Research Advisory Group
SACs	Substance Abuse Clinics
SARDA	Society for the Aid and Rehabilitation of Drug Abusers
SKC	Shek Kwu Chau
SMOs	Senior Medical Officers
SOPD	Specialist Out-patient Department
SWD	Social Welfare Department
T&R	Treatment and rehabilitation