

BHUTAN AND BEYOND: CAN ATCA ACCOMMODATE AN EXPANDING REGIONAL PRESENCE?

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- Bhutan is a poor developing country
- educational, health and social services supported by external funding.
- small population (about 750,000), but
- significant AOD use in youthful Bhutan.



Alcohol

- Alcohol is of particular concern, with a significant number of those dependent younger than 25
- Among those under 30, alcohol associated suicide and violence are becoming common, and alcohol related liver disease, the top cause of death, is increasing.



Cannabis – grows wild in and out of towns



- In addition to alcohol,

- Glue



- Cough syrup(Corex)
are used,



And, oral use of a **combination** of pharmaceuticals

- Spasmo Proxyvon

[dextropropoxyphene hydrochloride, paracetamol]



- Relepin

[Dextromethorphan, dicyclomine hydrochloride, paracetamol]

- Nitrazepam (N10)

- Combinations like these – the **South Asian Cocktail** – are injected in neighbouring countries with extremely negative outcomes – from abscesses to HIV and HCV



Additional concerns

- A possible increase in injecting drug use, prevalent in neighbouring Nepal and north-eastern Indian states which have high levels of IDU-related HCV and HIV
- As is the regional spread of ATS use
- Tobacco
- Betel Nut - *Doma*





Current responses in Bhutan

Main Agencies:

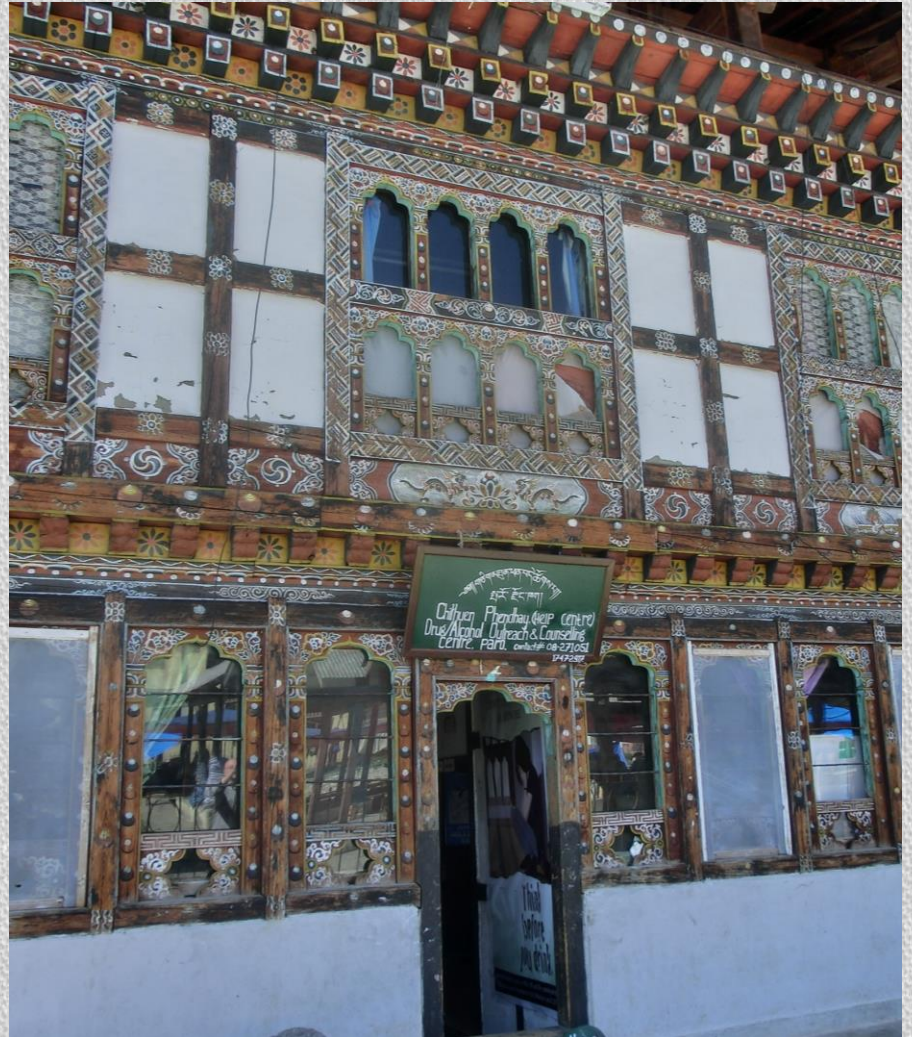
- Bhutan Narcotic Control Agency - BNCA
- Bhutan Youth Development Foundation - YDF
- Chithuen Phendhey Association - CPA

Activities:

- **Prevention** – community action, education and information, schools...
- **Outreach**
- **Drop-in-centres**
- **Detoxification** – hospital (part of psychiatric ward), women's refuge
- **Treatment**
 - Outclient / Drop-in centres (2 or 3 almost day programs)/Day programs
 - Residential rehabilitation – 2 centres (one CPA and one YDF)

Recent UNICEF report challenged status quo

CPA Drop-in-Centre, Paro



CPA Samzang 'Retreat' [Rehabilitation] Centre



Australia as of potentially great assistance

- Those struggling in Bhutan to develop appropriate and effective evidence-informed services for people and families with substance use-related difficulties, and to build a capable and effective workforce responsive to the complex and changing patterns of availability and use of these substances, have identified Australia
- Have had experience with some Australians – eg Andrew Biven
- Senior psychiatrist – Chencho Dorji – trained Australia – developed AOD services in Bhutan – hospital based and NGO

Capacity building to date - Australia

- Andrew Biven
- General upskilling:
 - AOD, Mental Health, Police, Women's Refuge
 - Peer educators
 - Recent workshops: John Howard
- Mental Health and AOD: Brent Waters – Psychiatrist
- Plus:
 - Colombo Plan – ACCE – Asian Centre for Certification and Education of Addiction Professionals – ICCE - US (NAADAC) – US, Thai and India dominated
 - US marketing – especially Daytop – spreading in region - ?of concern
 - UNODC
 - Various courses: CBT, etc.

BUT – very piecemeal



CPA HANSEN

Training workshop; building capacity for working
with people who use drugs and alcohol.

GAWALING WOMAN CENTRE, Wangsisina, Thimphu
September 2013.

Jointly organized by NEW and
Phendhe (CPA)



2013 Capacity Building – Peer Educators, School Counsellors, Police/Prison, Outreach and Drop-in-Centre workers, Women's Refuge Counsellors



- i) - Name of a client - DODO.
- ii) Age - 15.
- iii) SEX - MALE.
- iv) EDUCATION - IX (STD).
- v) MATRIAL STATUS - UNMARR
- vi) EMPLOYMENT - 'NO'
- viii) DURATION OF USED - ONCE A

WEEK (2 YRS).

- viii) CHOICE OF DRUG - GLUE (SNIFIN

- ix) LIVING WITH - PARENTS AND SIBLINGS



AGE OF FIRST USED - AGE OF 13.

REASONS.

- CURIOSITY & TO GAIN CONFIDENT.

(XII) HIGH RISKS

- IMMATURE DEATH. INVONEMENT IN UNLAWFUL ACTIVITIES, OVERDOSE & EXPELLED FROM SCHOOL, ARREST BY POLICE, LOSS OF TRUST FROM FAMILY AND COMMUNITIES, GETTING INVOLVE WITH BAD COMPANYS

WHAT DOES HE NEEDS?

→ A GOOD FAMILY GUIDENCE, SUPPORT FROM SHG, PROPER COUNSELLING FROM A PERSON He is VERY COMFORTABLE WITH, A GOOD COUNSELLING AND SUPPORT FROM SCHOOL AUTHORITY TOO.

IMIT WORKS RELAPSE PREVENTION UNIF 'U' WORK E IT! PLAN FOR DODO

i. A good support from school Authority & Counsellor.

ii) Counselling from D.I.C / A person (positive).
A person he is comfortable with.

Eg - Trust, safe, open-up,

iii) A co-operative family support

iv) Possible he should opt for detoxification.

v) He should A.B.C because he is likely to be involved in unlawful activities.

vi) He should be engaged in meaningful activities like games, sports, music, dancing, ~~lib~~ library & painting.

1 DAY AT A TIME...

vii) ~~Some~~ ~~sp~~ Visit some holy or spiritual ~~sights~~ sites



2014 Capacity Building – Peer Educators





Case study: Mr Tenzin

- Age: 47
- His family said that he has been mainly using alcohol for 6 to 7 years.
- The client was regarded as ‘mentally unstable’ [was found burning a fire inside a house to keep himself warm, and left the home was begging in the streets], and soon after began to use alcohol and other drugs.
- According to his family he was a ‘very brilliant’.
- He had been in rehabilitation at Sikkim for 8 months and relapsed.
- Family members are very highly qualified.
- Poor support from family, but felt had to try as he was oldest male.
- Family wants to get rid of him.

After admission to our institution we found his behavior as follows:

- Easily irritated.
- Quite, and isolated.
- Frightened/ Fearful - behaves like somebody is chasing him.
- Repeated visual hallucination - sometimes he say he sees “Guru Rinpoche”.
- Insomnia/roaming around at night and naked.
- Never gets afraid of fire.
- ‘King baby syndrome’ - childish.
- Digging holes like a dog
- Bowing down on the floor
- Laughing in corners when asked questions
- Singing at odd times
- Tried to strangle himself
- Convulsions and seizures

Ways I coped with him - Pelden

- Tried to maintain a good relationship.
- Talking in a humble way.
- Listening to what he says.
- Let him talk more, but it was only possible, as if we talked too long he would get angry.
- Provided holistic care i.e. emotional and moral support.
- Encourage him to participate in all the activities.

BUT

- He stayed double the usual 3 months
- No real changes evident – except some reduction in distress

Pelden – Peer Counsellor Samzang and Brent Waters – Psychiatrist Australia

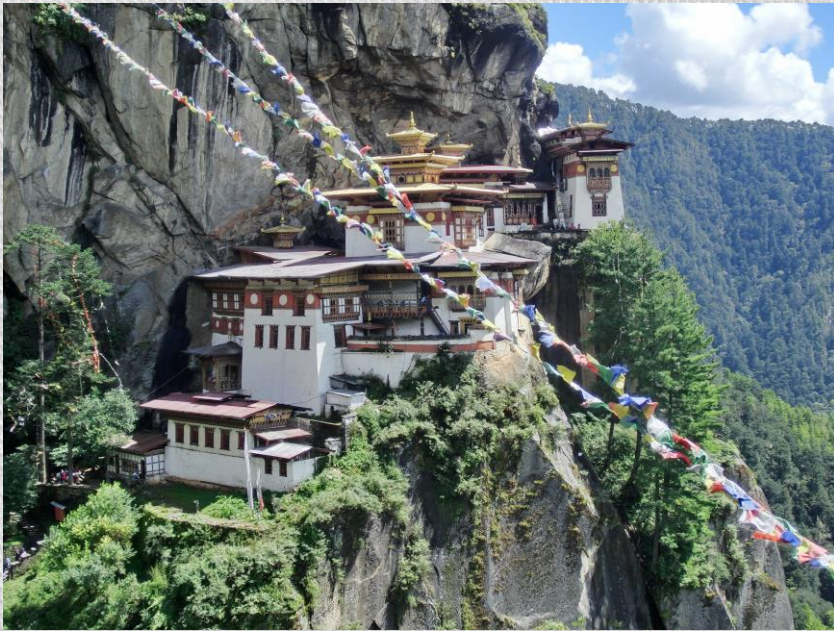


Opportunistic intervention

- During a visit by an Australian Psychiatrist, case was presented
- Dr Waters interviewed Mr Tenzin and diagnoses schizophrenia
- Attempts made to locate any reports on previous treatment – eventually found out had been in a psychiatric clinic, not a drug rehabilitation centre

Issues:

- Poor information available at admission
- Limited psychiatric services [2 psychiatrists in Bhutan]
- Confidence in referring?
- Supervision and case review poorly developed
- Issues of 'safety' for clients and staff
- Should not require a foreign specialist to be available....
- Significant systems and process issues



- **Positives:**

- Keen to learn
- Intelligent thoughtful young workforce
- Have done a remarkable job with what is available
- Drop in centres expanding
- Can involve families

- **Less Positive:**

- Domination of AA/NA approach – but, maybe adapting and developing across the country
- Lured by ‘Daytop’ marketing?
- Geography
- Professional back-up lacking
- No suitable vocational or college courses as yet – though a counselling course does exist
- Technology
- Money...

ATCA can expand its role in the Asia-Pacific region, via sharing and assistance in adapting to culturally diverse settings:

- the development of its approach to TC programming – systems, processes and content,
- quality assurance and accreditation,
- ongoing enhancements/modification to the approach,
- addressing comorbidity and other co-occurring disorders, and
- capacity to engage with providers in other settings around adaptations that suit their own unique, cultural and economic settings.

ATCA could develop:

- Structured visit programs:
 - Group of TCs prepared to host and accommodate those who could benefit from an emersion visit [accommodate = lessen costs, and provide a ‘full experience’]
 - Site visits to other programs, including harm reduction, opioid substitution, outreach,
 - Exposure to processes, documentation, monitoring, evaluation and research activities
- Activities during visits linked to demonstration of outcomes: diary, quiz, case studies, ideas for application back in home country – all matched to appropriate ‘competencies’
- Involvement in development of AOD courses online and available to overseas students, with credits for completion of structured tasks during visits – could lead to enrollment in degree programs at a later stage

Where to?

