Final Evaluation RAS/I13

:

Improving Access for Young People with ATS Abuse to Effective Treatment

Thematic area

Drug Demand Reduction

Countries

Cambodia, China, Indonesia, Lao PDR, Myanmar, Thailand, Viet Nam

Axel Klein, PhD, External Evaluator from the Centre for Health Service Science, University of Kent

Abbreviations and Acronyms

ATS	Amphetamine Type Stimulants
CCDAC	Central Committee for Drug Abuse Control (Myanmar)
DR	Demand Reduction
DSEP	Department for Social Evil Prevention (Vietnam)
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Use/r
MDMA	Methylenedioxymethamphetamine
MOLISA	Ministry of Labour, Invalids and Social Affairs (Vietnam)
NADC	National Authority for Combating Drugs (Cambodia) NNCC National Narcotics Control Commission (China) NNB/BNN National Narcotics Board (Indonesia)
ONCB	Office of Narcotics Control Board (Thailand)
PC	Project Coordinator
RPF	Regional Programme Framework
WHO	World Health Organisation

Preface

The project was designed to be implemented over a four year period. UNODC was working with one national partner in each participating country, these were specifically the National Authority for Combating Drugs in Cambodia (NACD), the National Narcotics Control Commission in China (NACD), the Lao Commission for Drug Control in Lao PDR (LCDC), the Committee for Drug Abuse Control in Myanmar (LCDC), the Office of the Narcotics Control Board in Thailand (ONCB) and the National Committee on AIDS, Drugs and Prostitution Control in Vietnam (SODC). The project budget comprised a donor contribution of US$ 991,600 and financial and in kind contributions from partner countries amounting to US$36,000

The evaluation was conducted over a four week period by an international drug control expert with no connection to any of the implementing organisations. There was insufficient time to contact all stakeholders in all countries. The evaluation was conducted in conjunction with evaluations of three other projects, which added to the workload, but helped to consolidate the evaluator's grasp of drug demand reduction issues in the region and the commitments and activity of UNODC in particular.

Summary matrix of findings, supporting evidences and recommendations

Findings, problems and issues	Supporting evidence	Recommendations
Output 1, 'Enabling environment' – little impact on framework and policy making	Drug control legislation, interview with informants	Ongoing work needed to adjust legal frame and promote good practice in ATS DR
Output 2 'Staff training' – master trainers in all countries, but in country training truncated by early cessation	Interviews with Master Trainers	Fundraise for national training programme
Output 3 'Good practice for treatment of young people' – treatment rudimentary in most countries; good practice on ATS introduced in Thailand and China; some general improvement in Vietnam	Site visits to treatment centres, interviews with treatment providers, project document	Support master trainers in delivery of national training
Manual drafted – good quality, jointly drafted by participants resulting in ownership	Manual, informants	Ensure output circulated to stakeholders before project completion
Output 4 'monitoring and evaluation' – no activity towards achieving this project objective	Stakeholders, workshop reports	Organise regional workshop on this topic

Findings, problems and issues	Supporting evidence	Recommendations
Regional programme relevant provides opportunity to align national approaches	informants	Maintain regional approach in follow-up projects
Need for evidence base to inform policy	Informants – argument from silence	Promote research and recognition of need of Evidence-based Practice
Premature cessation of programme due to lack of funds	Project Coordinator	Revise budgeting procedure to avoid repetition in future projects
Project meets an identified regional concern as ATS use is spreading	Interviews with drug control bodies in project countries	Maintain momentum on ATS issues – outreach, prevention and legal reform
Little understanding of the popularity of ATS, consumer culture, leisure among young people	Informants, reports	Social research needed to gain understanding – dialogue between generations
ATS in some countries linked to alarm and moral panic	Informants	Research and public discussion to move onto evidence based understanding of phenomenon
Poor understanding of ATS, addiction and treatment among (some) practitioners	Informants	Ongoing training, instruments, and research promotion
Regional project posed logistical challenges that were well met	Project documents	Good coordination and logistical arrangements
Regional project provided opportunity for peer learning and good practice showcasing	Informants	Use as model for other regional projects
Regional project created network of professionals and cadre of Master Trainers	Informants	Support with website, publications (scientific)
Country teams with strong commitment and consistency in team composition made greatest achievements	Project documents, interviews, project coordinator	Tight guidelines for beneficiaries on training attendants
Project objectives overambitious for small, short term and under-funded programme	Project Document	Revise conventions of project formulation – work in partnership with donor agencies
Objectives not always	Project Document	Organise stand alone

Findings, problems and issues	Supporting evidence	Recommendations
complementary – e.g. M&E		Monitoring and Evaluation training
Lack of provision for in-country training holds back realisation of objectives	Informants	Budget in-country training into future regional projects

Executive Summary

- Activities have to finish prematurely (2009 instead of 2011) as total funds anticipated for project could not be secured

- Rise in the use of ATS across the region is a major concern to policy makes who have little experience and technical expertise on how to best deal with the issue – the project therefore met what is widely perceived as a serious regional problem

- Advantage of regional programme is to allow project partners to understand the wider context of issue and learn from best practice of neighbouring countries. It provides the first inspiration of a regional professional network

- The formulation of project objectives suggesting the reversal of social trends that had been a decade in the making, and outputs ranging from policy change to improving treatment delivery was far too ambitious – particularly for such a small, short term intervention

- Partial achievement of project outputs – partly a consequence of project being under-funded, but also because the range of outputs was ambitious for a small project. No activity towards the Monitoring and Evaluation component

- Main achievements of project lay in the training of core groups of Master Trainers. The rollout of training in the different countries varied widely. Some training in Indonesia, Vietnam, Thailand, but no national roll out, and little chance of domestically funded follow up

- Training manual for professionals working on ATS substance misuse produced as joint effort by project participants and external expert. Good degree of ownership and high quality product. Shortcomings are (i) that the absence of any training on working with young people, and (ii) that it was distributed towards end of project, prior to translation and application by beneficiaries

- Sense that project has come to an end just when activities are getting started. Trainers are confident and in place, have a manual as resource and ministries and other agencies are on board. Growing consensus that current approaches to dealing with drug addiction are ill advised and reform is needed

- Sense of disappointment among some beneficiaries that project is not providing support for in country training workshop, where assistance is required most. Project should have included sub-components for such training to ensure that lessons are applied and training is rolled out

- Sense of great potential for project roll out in different countries to impact on drug treatment and to establish a more effective, results oriented drug treatment system

- Information and knowledge gap among policy makers and service providers in all countries (to different degrees) needs to be addressed. Urgent need for social science research to understand drug use trends and risk assessment by young people.

1 Introduction

Background and Context

Historically this region has been renowned for high levels of opiate use. China was in fact the first country to impose systematic controls on the importation and distribution of opium, measures that at the time were deemed illegitimate by Great Britain and led to the invasion of China and partial occupation lasting until 1997. After gaining the support of the United States the Chinese government succeeded in re-invigorating its efforts at controlling opium use and laid the foundations to the modern drug control system by hosting the first drug control conference in Shanghai in 1909. In an accelerating process controls were imposed on opiates and other drugs in China, and now globally. During the extended Chinese civil war, and in the reconstruction period from 1949 onwards strict controls were imposed and opium use almost eliminated. With the opening up of the country and the turns towards the market economy opiate use, mainly in the form of heroin, has returned. Most of it produced in neighbouring Myanmar and to a lesser extent in Laos. In both these countries opium is still used particularly by older people and in rural areas. But all over in the region a major shift has occurred over the past decade. The use of opiates is holding steady or even declining as people, and particularly the young switch to Amphetamine Type Stimulants.

Centres for the production of ATS are said to be in China and Myanmar, and often funded and founded by organised crime groups that are already established in the drug business. There is of course a longer history of ATS use and distribution by the Japanese army during the 1930. The dramatic increase in the availability of the drug is closely associated with the growth of the chemical industry in the region. Producing methamphetamine, Methylenedioxymethamphetamine or Ketamine has become relatively simple. More intriguing is the surge in demand, with consumers trading their preference for a narcotic for a stimulant. It may well be related to the wider social economic changes and could be seen as part of the development dynamic of this fast growing region.

The origin of the project goes back to discussions among countries in the MOU meetings in the early 2000s. The project together with AD/RAS/ I09, are the last two regional programmes undertaken by UNODC in the drug demand reduction field, and there is a sense among beneficiaries of donor withdrawal. Part of the challenge for the region and for the UNODC is to find ways of bringing the donor community back and to point out realistic project opportunities where important risk reductions can be achieved.

B Purpose and scope of the evaluation

The evaluation reviews the problem addressed by the project and the effectiveness of the proposed strategy**.** More specifically:
• whether the needs of executing agencies at the time of project formulation were properly addressed
• whether project activities and resources were allocated adequately
• whether the project's approach has been appropriate

It assesses the outputs, outcomes and any impact achieved by the project as well as the likely sustainability of project results, when applicable. In keeping with the objectives of the Regional Programme Framework 4.4, the focus is on results, namely outputs and outcomes and the direct contribution made by the programme.

Recommendations for any future action in respect of issues related to the implementation or management of the project, as well as concerning replication of the project approach and strategy in other regions or in specific countries covered by the project follow. Lessons learnt and opportunities for follow up are listed.

C Executing Modalities of the programme

Cambodia	National Authority for Combating Drugs (NACD)
China	National Narcotics Control Commission (NNCC)
Indonesia	National Narcotics Board (NNB/BNN)
Lao PDR	Lao Commission for Drug Control and Supervision (LCDC)
Myanmar	Central Committee for Drug Abuse Control (CCDAC)
Thailand	Office of Narcotics Control Board (ONCB)
Viet Nam	Department of Social Evil Prevention (DSEP) Ministry of Labour, Invalid and Social Affairs (MOLISA)

D Methodology

The report follows the multi method evaluation model laid out in the UNODC guidance literature,[1] including the study of secondary sources (project document and its revisions, progress and monitoring reports, where available previous evaluations, self evaluations and client feedback, policy documents, documents from other projects by UNODC or other donors, scientific literature). This was followed by collecting data from a range of primary sources, key of which are interviews with key stake holders (both face to face and by telephone), field visits to project sites including the Drug Rehabilitation Centres Ludlum Kaew in Thailand, in Battambang in Cambodia, and in Bac Ninh in Vietnam, as well as the Addiction Treatment Wing of the Psychiatric Ward of the West China General Hospital in Chengdu China, and the direct observation of practice.

[1] UNODC, 2008. *Evaluation Handbook: A practical Guide for use by UNODC Staff to plan, manage and follow up an evaluation*. Vienna: UNODC, Independent Evaluation Unit.

E Limitations of the Evaluation

The evaluation suffered from constraints in terms of time, availability of stakeholders, and not being able to travel to some of the partner countries such as Lao PDR and Myanmar. Repeated attempts to arrange telephone interviews with focal points and Master Trainers were unsuccessful. In Indonesia and Viet Nam time was extremely limited. As the evaluation was combined with that of three other projects this could lead to confusion at times among informants and evaluator. Some of the stakeholders had limited English language competence which limited communications and skewed the interviewing process towards informants who were possibly less knowledgeable but more fluent. The evaluator has only a limited knowledge of the cultural complexity and political reality of the countries in the region. On the upside, combining three evaluations into a single programme widened the understanding of drug control realities on the ground and the challenges ahead. In Cambodia, the evaluation was supported by a senior officer from the Ministry of Health conducting an independent evaluation into a related project (H83), as well as the staff from the UNODC office. In Vietnam, Nguyen Tuang Dung provided valuable insight, while many members of the regional team in Bangkok were generous in sharing their expertise to provide background and context.

The Project Coordinator accompanied the evaluator to most meetings, introducing him and explaining the purpose of the mission. In many cases this was an important ice breaker, and helped defuse a potentially tense situation. Once the actual interview commenced the Project Coordinator would leave the room until the end of the session. In China a junior staff member from the National Narcotics Control Commission joined the evaluator and came to play an ambiguous role. In some sessions she was asking questions of informants on project delivery, and in others she would respond to the evaluator's questions instead of the project participants. In one session she acted both as evaluator and informant, asking questions and providing answers. It felt at the time that her presence was not conducive to establishing an open dialogue, and that the way she had interpreted her role was to ensure that the 'right' information was given to the evaluator.

II Major Findings and Analysis

A. Relevance of the programme

In all project countries a fundamental shift in drug use patterns is underway. The historically engrained use of opiates, and particularly heroin, is giving way to the consumption of ATS. Not all countries are moving at the same speed. The use of ATS in Thailand is entrenched and prompted the previous government to radical steps in 2004, with the extra judicial executions of suspected drug traffickers by law enforcement. In China information from police and treatment centre testify to the ageing of heroin users. One informant suggested that information about the danger of heroin had been widely disseminated, but many users, especially young people were unaware of the risks involved in the use of ATS. Authorities in Indonesia were quite unaware of any ATS use at all until 2004, and were therefore eager to join the project. While the official prevalence levels in Vietnam were still low, one informant said that these did not reflect the reality on the ground and that Vietnam was no exception in

the region. In Cambodia the government trace the arrival of drugs to the early 1990s, when the country opened its borders and switched to a market economy.

There is little precise information about levels of use, attitudes of users, distribution patterns, initiation into drug use, and the ready contradiction between strong moral condemnation of drug use and the stigmatisation of drug users, and growing 'normalisation' of drug use among young people. It seems that the drug control agencies in Thailand, the ONCB, are pioneers in funding research into drug use and patterns of use, and have established links with the University of Chang Mai. We have to rely, therefore, on rapid assessment and other sources reporting ATS use among different occupational groups such as fishermen and long distance lorry drivers, where the drugs are taken as a performance enhancer or 'medicine.' Yet policy makers and senior drug control officials have, during the interview, shown little interest in these particular aspects even though the potential consequence, like traffic accidents are serious.

The absence of research evidence hampers both the service provision and policy formulation. Most concerning is that there is little recognition among policy makers in several countries that this knowledge gap is problematic. Anecdotal information is deemed quite sufficient to policy making which at times seems fuelled by a moral alarm over generational changes. Hence, at policy level but even among senior practitioners there is a vague understanding of the addictive potential of ATS and the actual harms these drugs entails. It is only poorly understood that ATS are not physically addictive, or at least in extreme cases only, and that physical harms are related to dosage, ingredients, and most importantly the set and setting. A realistic assessment of drug harms, informed by the experience of drug users, is yet to be made. In the meantime, there is a sense of anxiety over rapid social change in countries with large populations of young people, like Cambodia and Vietnam, and the changes incumbent upon rapid economic development. To some extend, the anxiety over ATS use is an extension of a general unease over the fast pace of social change.

The rise of ATS consumption has to be seen as a consequence of the rapid industrialisation of the region, the loosening of social controls, as well as of changing attitudes to consumption and leisure. The substances are perceived as relatively harmless by many actual and potential consumers, with little information about the negative side effects, actual and potential, available to the key target groups.

The services engaging with drug users, treatment facilities, law enforcement, and correctional centres, have very little understanding of the issues involved in ATS abuse. The project was therefore perceived as highly relevant by the countries in the region, filling a gap in capacity and addressing an urgent social issue. What is not so clear if the direction of the project with its emphasis on training a cadre of Master Trainers in drug treatment modalities was the most appropriate response.

B Attainment of the programme of project objectives

Decreasing the use of ATS in MOU countries. Establish an enabling policy environment for comprehensive ATS treatment to young people with illicit ATS abuse

and related problems. Develop accessible, 'youth friendly' ATS treatment facilities in government, non-government, community and involuntary settings.

The formulation of this project is so ambitious in scope that it sets the Project Coordinator and the entire project team up to fail. In over thirty years of drug policy there have been no recorded reversals of drug consumption that can be attributed to a particular project or intervention. Where trend change has been registered,[2] say marijuana consumption, they are best described as 'fluctuations.' More difficult still is the question of causality. Even the most sophisticated and well resourced interventions can fail to have the desired impact if they are running against social trends. In the end, what causes drug use patterns in open, market societies to go up or down is due to a complex mix of factors that are impossible to account for in a project. What can be achieved, however, is to influence consumer behaviour through (i) changes of the drug use environment, (ii) providing credible information to actual or potential drug consumers (iii) providing constructive alternatives to recreational drug use for the most vulnerable target groups (iv) establishing treatment facilities to help habitual and problematic drug users with their cessation.

The second problem arising for an evaluation lies in the lack of quality data. There are no baseline figures for ATS prevalence against which project outcomes could be compared. The information on which assumptions about drug trends are made mostly on the basis of Rapid Assessments, such as conducted by the SMART project. Internal to AD/RAS/I13 was an assessment of service gaps and training needs of staff, but the information on drug use collected slips into the evidence pool, and is referred to as trend data by informants. These data sets are drawn from treatment centres and police stations, reflecting activity of medical services and law enforcement, but they have no realistic bearing on underlying consumption trends. Without establishing the extent of ATS use one cannot assess the impact of interventions. Once again, the importance of data collection has to be established among the MOU countries and independently from this project. If there is genuine concern over ATS and other drug use then governments have to develop ways of collecting information and begin to understand the extent, causes and wider ramifications of this phenomenon. This need for setting up internal data collection, research and analysis systems emerges clearly from AD/RAS/ I13 (as well as AD/RAS/ I09) and should be communicated to all stakeholders.

The other objectives while less ambitious are also problematic. 'Establishing an enabling policy environment' does sound far more realistic and positive. Difficult in terms of evaluation is to clearly understand what is meant and how to give value to different activities listed against these. Would a mention of ATS in a government Master Plan be a positive result in terms of 'environment' if it is not accompanied by activities? Or do legal amendments that divert first time users from compulsory treatment centres to community treatment qualify, if a large number of clients relapse after discharge and are then sent to prison? The vagueness of the formulation that allows Project Coordinator and partners much needed flexibility during

[2] During the 1980s Marijuana consumption in the US dropped from peaks registered in the 1970s, but rose again in the 2000s, for instance. In the UK cannabis use fell slightly in the mid 2000s. In the US powder cocaine has fallen since peaks in the 1980s, and Australia recorded a drop in heroin use in early 2000s.

implementation comes back to haunt the evaluation process, as it cannot be clearly established how judgements are to be formed and what criteria is to apply.

Creating services that are 'accessible', on the other hand' is redolent with analytical simplicity. Increasing services, increasing the numbers of people accessing these are good solid measures that can be counted, and the project has achieved this in China, Indonesia and Thailand. The difficulty here is a technical one, which takes the project (and the evaluator) to the heart of the drug control dilemma. Addiction remains a complex, ill defined condition, the definition, aetiology and disease course of which has never been firmly established. In the absence of a clear understanding of the cause, there are no clear ways of treating the effect. What addiction science has achieved over the years are a range of modalities that provide assistance to problematic users. Everybody in the field knows how fragile such gains are, and the integration of 'relapse management' into the treatment plan that has by now become routine, is evidence of this complexity. But nowhere is this delicate situation more apparent than in the field of ATS treatment.

There simply is no well established methodology specifically designed for problematic users. In contrast to opiate treatments, there are no established medical solutions to tackle cravings or assist with detoxification. What a project can achieve at best is to begin looking at different treatment modalities and to develop standards of good practice. These are defined in part by outcome efficacy (for which a longer time span is needed), and by internal standards, of client care, the quality of activities, the physical facilities, training of staff, attitude of staff, management system, clients well being and so on. Important for the consideration of these 'softer outcomes' is the question of cultural appropriateness. MOU countries (and Indonesia) have different relationships with substances use/abuse, different histories of drug control, and different methods for imposing that control and managing clients that have to be written into any programme. Any treatment delivery therefore has to be harmonized with the culture of treatment and care, and has to accommodate the practical realities of the existing infrastructure of services. It has to take a realistic view of prevailing attitudes and outlook of stakeholders, including service staff. Interventions to succeed need to strike a balance between best practice and what is achievable within these constraints. With all these qualifications then, we are satisfied that the project has moved the project partners into the right direction to improving service standards, improving access, and to be more 'friendly'. The latter is achieved by re-defining drug consumption as a public health issue, rather than as a criminal offence.

If the overall goal is in the very least immeasurable for the moment, we can record that some good progress has been made towards the secondary objectives. It should also be put on the record that the formulation of project objectives leaves staff and evaluator in a difficult position at the end of term. A more cautious approach in target setting is therefore advised for the future.

C Achievement of the programme outputs

One of the complexities of AD/RAS/ I13 is that it is a regional project in a region without a common drug strategy. The only coordinating agency, located in ASEAN and services by UNODC, can only provide the broadest of steers. The consequences of any intervention therefore vary widely among the participating countries. Their

discrepancies are such as to prevent the evaluator from coming to a global conclusion. Instead, each outcome will be discussed on a country basis, and the wider implications for future project planning discussed in subsequent sections.

Outcome 1 *An enabling policy environment for the delivery of comprehensive treatment for young people with illicit ATS abuse and related problems*

The project achievements towards this output are twofold. First, there has been a change in attitude over the quality and kind of drug treatment, secondly, ATS is increasingly on the agenda of drug control agencies and the various treatment providers. In all the countries visited people interviewed welcomed the contribution the project had made to their ways of thinking on the issue, and reported changes in attitude. The concrete results flowing from this shift varied considerably, however.

Cambodia: Treatment centres in Cambodia are predominantly run by the police as strict, disciplinary facilities. There is a UNODC managed pilot providing counselling in the community, and ongoing discussion about setting up a different kind of treatment centre. According to the Deputy Director of the Legislation, Prevention and Rehabilitation Department at the NACD it was now recognised that the 'punishment approach' used to scare people away from drugs was ineffective. The relapse rate was high, and there were complaints from the family. The AD/RAS/ I 13 project had been instrumental into changing the views of members of the Technical Working Group on Treatment and Rehabilitation. They were now looking for financial support for drafting treatment standards and setting up high quality treatment services with the support from the community.

One can therefore register a change in attitude among some of the administrative personnel and drug control professionals which may lead to a different policy environment in the future. But for the moment there are no concrete achievements to report against this output.

China: Professor Li Jing, Professor of Psychiatry at the Mental Health Center, West China Hospital, Sichuan University, was a core member of the Chinese team and one of the Chinese Master Trainers. She was invited by the Ministry of Public Health as part of the consultation of experts before the drafting of the 2008 drug control law to advise on the treatment of drug addicts. The project objectives, of introducing high quality drug treatment, have therefore found expression in the reform of the legislative framework. The law introduced last year marks a significant step away from Compulsory Drug Treatment in closed settings and the move towards community based treatment. It is, in the words of one informant from the NNCC, "more pragmatic and humane." It can therefore be said that the project has contributed towards achieving an enabling policy environment.

Indonesia: Since 2004 the number of ATS using clients referred to drug treatment centres has been increasing, the reasons why Indonesia, though no MOU country decided to join the project. There have been a number of changes to drug treatment in recent years, including a directive that Mental Hospitals around the country should dedicate 10% of their capacity to drug treatment. The BNN comprises treatment, outreach, community units and aftercare though the actual quality of services varies across the 33 provinces. It cannot be said that the project has contributed much if at

all to the development of these facilities. At best, the awareness regarding the needs of clients using ATS has been raised.

Thailand: Thailand has the most developed system of service provision among participating countries and was more of a resource than a beneficiary. Many informants from other countries commented on how they had learnt from the Thai example. In turn, Thai participants seemed to have gotten less in terms of concrete results out of the project. There was no impact on policy and the environment can not be said to have improved much, though the Deputy Director of the ONCB was much impressed by the Australian facility he saw during the study visit, and is keen to develop "open access" and outreach programmes.

Vietnam: The Vietnamese partners for this as for the I09 project were the Ministry of Labour, Invalids and Social Affairs, in the Department for Social Evil Prevention. Officials emphasised that Vietnam had very little experience with ATS abuse, and reported some statistics that suggested only 2% of drug offenders were ATS users. The majority of drug related offences are heroin related. But officials also pointed out that Vietnamese society was changing fast and that the trends from neighbouring countries were likely to be repeated in Vietnam, the project was therefore relevant and was providing an opportunity to train capacity and lay down the infrastructure.

The participants in AD/RAS/ I13 were invited to make recommendations to the Policy Committee coordinating the drafting of the new drug control law and contribute to the treatment section. It was therefore reported that the two regional UNODC coordinated projects contributed to establishing a more positive legislative framework for drug treatment provision in general.

Outcome 2 *Trained staff to deliver comprehensive treatment for young people with illicit ATS abuse and related problems*

Cambodia: During interviews Cambodian informants opted for the word 're-education' when referring to their centres. There was no treatment, as we know it, but quasi incarceration in a camp run by the military police. In the one facility visited some of the staff had attended workshops on drugs when visiting Phnom Penh. The project had made no impact on them and the director of the camp was aware and frank about his therapeutic shortcomings. None of the other project participant reported having conducted any training, with the NACD team leader reporting that it was difficult to organise training without funding.

Many informants regretted that there was no in country follow up after the regional event for master trainers. Informants reported discussions in different fora, such as the TGW, about training sessions and new treatment centres. One of the most original ideas that had been floated was to send trainers and treatment centre staff to neighbouring countries and get an exchange programme working with Vietnam and Lao PDR. But all of this remained in the air, there had been no delivery on the ground and the output had simply not been achieved. The in-country training issue ought to have been addressed at the design stage, or at the latest, during the inception meeting.

China: The Master Trainers have put on workshops for the Chinese Drug Abuse Association at the Mental Health Center, West China Hospital, Sichuan University in which some 100 professionals participated. Workshops have also been held with staff police treatment centres. In addition, there have been a number of academic articles published and conference papers given. At the coming congress of the Chinese Association of Psychiatry a number of papers will be given on ATS issues, addiction and treatment. There is a strong sense that the team from Chengdu are making rapid progress in convincing academic and medical circles of the benefit of their approach to treatment. At the same time practitioners from different professional backgrounds are also coming on board. It seems that the argument is being won, and that it is now a question of building capacity.

Indonesia: Treatment facilities are still dedicated in the main to opiate users. After the project an ATS working group was set up at the BNN. There have been training workshops in Jakarta for counsellors, religious leaders, former users acting as peer counsellors, but no work in the rest of the country.

Thailand: The manual has been received and is yet to be translated into Thai. No training has been conducted in country as a result of AD/RAS/I13, and informants did lament the lack of funds for an in country follow up. The official commitment by national governments, reiterated by the Project Advisory Committee in November 2008 to implement national trainings cut had not, according to the practitioners interviewed, been followed by any action.

Vietnam: The training needs of Vietnam became quite apparent from interviews with treatment staff at the Drug Treatment and Rehabilitation Centre in Bac Ninh province. Staff had no concept of psychotherapeutic intervention. The idea of counselling was to talk to clients about the dangers of drug abuse. They had received no training and were naïve about drug effects, the addiction syndrome and the cycle of change. Against the background of this skill shortage the project made some contribution. Master trainers were trained, and some local training was reported. Information about ATS treatment was integrated into the training provided for over 600 MOLISA staff, and the modules developed after regional training were now integrated in the training curriculum. Equally important were planning techniques, such as the log frame, and teaching methods, particularly participatory approaches, learned from the project.

It is not possible to assess the quality of these activities and whether they can be sustained. It was made clear that without external support no designated training exercises could be run, though learning would be integrated into existing training modules. The most valuable outcome of the project was the enthusiasm of the DSEP team for the project and the positive spirit of cooperation. The project has created much good will and laid the foundation for good ongoing cooperation.

Outcome 3 *Good practices for treatment of young people with ATS related problems*

Cambodia: In the absence of drug treatment facilities there can be no discussion of good or bad practice. The Cambodian team did send participants to the study visit to

Australia and this may have inspired them in their discussions about future drug treatment services. The Training Manual has been provided but has to be translated into Khmer, which one of the informants said she would do. This would at least provide a basis for an establishing good practice in the treatment of young people for ATS disorders.

China: Part of the project has been the expansion of the Drug Treatment Wing at the Psychiatric Ward in the General Hospital at Chengdu. It is the leading facility in the country, with beautifully equipped wards, a 1-5 staff – client ratio, and a dedicated team of psychiatrists applying project learning and research insights to their practice. They have been able to expand their facilities from 30 beds to 60 in the course of I 13. The team have developed a treatment package that includes psychotherapy as well as medical interventions. They have developed packages of medication to accompany withdrawal and get clients drug free in a short period of time. In-patients are kept for two to four weeks, and receive a phone call as follow up. The team is excited with the results themselves, and the establishment of what is essentially a voluntary treatment service – unique in China. The majority of clients are self referred, or referred by family, there is no coerced treatment even though records are shared with the police.

The team are eager to share their experience and showcase their treatment model. They have developed a theory for explaining ATS addiction and related problems, have undertaken some animal studies and published the results in international and Chinese journals. The medication they are using is said to show promising results. Inquiries from across the country are reported, suggesting that there are many inquiries and much emulation by psychiatric wards in the country. To give justice to this professional interest a number of workshops are urgently needed, according to Professor Huang Mingsheng, for psychiatrists, but also for psychologists and social workers.

Because of the centralisation of Chinese policy and decision making a successful pilot can have significant knock on effects. If the treatment can be demonstrated to the right experts and a critical magnitude be reached this can impact on policy decision and lead to rapid change all over the country. The underlying theory was confirmed in Bejing, where it was pointed out that change in China is fast when the decision is taken and that there is much experimentation, as with MMT for instance. The feeling at Chengdu hospital remains, however, that the project is coming to an end just at this critical moment.

Indonesia: Treatment for ATS is rudimentary; yet the involvement of NGOs in the process has created the potential for good practice both at service delivery and in the creation of strategic partnerships.

Thailand: Thailand has a range of drug treatment and rehabilitation facilities. The one visited at Ludlum Kaew did provide a range of therapeutic interventions, with counselling sessions, life skills, relapse prevention integrated into the programme. One of the clients interviewed compared it very positively to a military run centre he had been to before. While these centres are a very positive step in the direction of a health focused approach towards drug treatment, there is little that I 13 has contributed to the way in which they are run. No training, no new information, no techniques.

Vietnam: The good practice drug treatment and rehabilitation service shown to the evaluator was located in Bac Ninh province some 2 hours outside Hanoi. It was still unfinished, with a fine office and administrative structure in place and residential units under construction. Clients, some of whom were farmers, were being put to work in the vegetable garden of the facility, continuing the work they had been raised to do but now in the service of a state institution. There was no psychotherapy to speak of, no treatment plans, no therapeutic alliances, no self help groups. When asked about case management, the evaluator was informed that records were being kept – but the principle entry were disciplinary items. Judging by this showcase alone, the project is yet to make an impact at the service delivery level.

Outcome 4 *A scientific approach to monitoring and evaluation that identifies 'good treatment' practice and components, and outcomes for young people receiving treatment*

This final output is well conceived as it goes to address the knowledge gap remarked on earlier, which hampers so much with regard to drug policy and the quality of the interventions. It also introduces an element of rigour in the collection of data. By keeping records, sharing them, and reviewing the actual process of activities, services open themselves up to reflection and constructive criticism, which are in turn prerequisites for an adaptable, flexible organisation that can change according to client need. It is therefore regrettable that because of the foreclosure of the project no activities have been carried out towards achieving this output and no results can be recorded.

The evaluator would like to add a note of caution on this enthusiastic expansion of a very medical model of treatment. Treatment history is replete with examples of medical interventions seeking to cure problematic substance use, from aversion therapies, to blood transfusion. Indeed, cocaine was marketed as a medicine for weaning people off morphine. Moreover, while the interventions are successful in the detoxification stage, the team admitted to a high relapse rate. If there is an over reliance on medical interventions the basic approach of treating people rather than confining them in DTCs is excellent. The hospital is a bright, light and positive place, and there are additional interventions. It is an excellent alternative, and a good starting point for a wrap around service that provides a continuity of care.

D Institutional and management arrangements

The Project Coordinator quickly established good working relationships with in-country project partners which has been critical in ensuring the delivery of activity once the series of workshop commenced. Both regional representatives strongly supported and took a close interest in the project. This backing put the PC in a much stronger bargaining position, particularly over issues such as DSA distribution to participants. The downside of this detailed interest was that in the process procedural concerns were flagged up that contributed to the delay in the publication of the manual.

The project was originally scheduled to continue until 2011, but failed to attract additional funding budgeted for in the project document. Falling US$ 200,000 short of anticipated costs, it had to close prematurely, and what was scheduled as a mid-term evaluation has now turned into an end of project evaluation. This convention of budget presentation in which funds not yet secured are listed is confusing and precarious. It has contributed to the early cessation of a series of activities that are just building up momentum and has left a sense of upset among many project partners.

Notwithstanding this, most participants were satisfied with management arrangements. They enjoyed the rapport built up with the PC and found the support from the UNDOC office generally satisfactory. A number of issues that were brought to attention and worth listing were:

- Too little attention had been paid to local concerns, particularly when it came to scheduling activities. It was felt that the programme schedule overrode local needs and constraints
- Holding workshops in expensive, international hotels was neither cost effective nor appropriate for treatment professionals. It was suggested that they be held in treatment centres instead, where there were conference room facilities and were accommodation could be provided in guest houses. According to the PC, however, the compulsory treatment centres could not provide training/conferencing services at a regional basis and for outsiders since this was not their mandate. It was also argued that competitive rates had been negotiated allowing the project to provide good quality conditions at low cost to the project
- Management costs were too high – a point raised in China, where the Deputy Secretary General of the NNCC brought his inside experience on UNODC procedures to play. He identified UNODC as an expensive donor as 13% of a project budget were collected by Headquarters, and that this was followed by a further contribution under Indirect Cost Recovery

III Outcomes, Impact and Sustainability

Outcomes

With a small budget and a big mission the project coordinator opted for the delivery of three distinct activities, workshops, study visit and manual. These are standard training modalities used in developing cooperation and in raising drug control capacity. The advantage of international workshops in different locales is that participants can experience different approaches and of course showcase their own. It is team building and invigorating, but also expensive. The holding of these international workshops came at the expense of local roll out and delivery. Yet, the budgetary limitations did not allow for both. It has been suggested that savings could have been achieved by holding workshops inside treatment centres, an option that could be explored in future trainings.

Workshops

At the core of the project were six international workshops for professionals from the participating countries. The benefit and potential impact at national level depended greatly on the consistency of attendance and coherence of teams. Where the same

trainees attended, expertise could develop over the period of the programme. It was stipulated in the project document signed by beneficiaries that countries would send participants in accordance with the criteria laid out by the Project Coordinator, and that there should be continuity and cohesion. In effect, only China and Thailand seem to have fully complied with these stipulations. Some of the participants had poor English language skills, which raises the questions as to the value of their participation in such events, and for the others.

Workshop 1: Inception meeting
Workshop 2: Training manual design
Workshop 3: Test the draft training manual on Master Trainers from RAS I09
Workshop 4: Training of Master Trainers
Workshop 5: Review pre-test training feedback and peer reviews
Workshop 6: Guidelines for ATS treatment (funded from outside project budget)

Comments on the workshops were mixed. Chinese informants were enthusiastic about the quality of the training, the intervals, and the management itself. In Thailand and Indonesia informants were more critical about the level of expertise of some trainers, and the general standard being too low given the existing standard of service provision and professional experience in both countries. There were also complaints about the travel and the long gaps in between workshops and the fact that there was no clear structure about dates at the outset of the project. While a fair complaint, this problem arose because different countries faced difficulties in sticking to the original schedule drawn up at the inception meeting and was probably an inevitable side effect of regional programming.

It is difficult to form a view as to how the workshop delivery could have been improved to meet with the requirements of all participants. Suggestions for less travel and longer sessions may suit some participants, but would rule out the participation of others. Intervals do appear long, but it also takes time for information to be absorbed, and the bureaucratic processes involved in obtaining travel permits are awkward and time consuming in some countries (Cambodia, China) where participants do need the lead time. With regard to training level, the Project Coordinator took the position that no-one should be left behind and excluded. This meant starting form the lowest common denominator, which, given the difference in expertise between the countries in the region disadvantaged the more advanced countries, particularly Thailand. This was the price paid for a regional project and in the event an unavoidable dilemma.

Judging from reports, power point presentations and the manual that was in part developed in the process, the quality of the training workshops was high. Activities were well managed and engaging, allowing participants to get the full benefit of a week long training session. We have noted above qualifications as to the content; there are three observations to repeats – (i) the emphasis on treatment as opposed to prevention or outreach work; (ii) absence of material specifically designed for young people; (iii) no workshop on monitoring and evaluation

Study visit
Trainees were invited to visit drug treatment centres in Australia with experience in working with ATS users. The experience of study visits of people from developing countries to facilities can be contentious. It exposes trainees to a level of service

sophistication, at least in technical and process terms, they can rarely hope to reach because resources will simply not stretch. This realisation can make trainees feel their own provisions are inadequate and instil inferiority complexes. But one informant said that it was important to have a vision to work towards even if it could not be realised. More important still was exposure to such a different method of approaching addiction therapy, especially the shift of looking at the client as a medical patient with a right to health, rather than as an offender who had to make up his debt to society. Finally, one informant expressed a certain, mischievous reassurance that in spite of their high level of development the Australians were struggling just as much with the intractable problem of relapse. This suggests that one of the most positive results is to get people from different countries realise that they are involved in a similar programme, battling with similar problems, and that in the absence of perfect solutions all delivery has to be adapted to local reality.

The Manual

The main physical output produced by the project was the 'Training of Trainers Manual on Amphetamine Type Stimulant Abuse for Service Providers.´ A range of experts contributed to this manual, including several of the course participants, technical experts in their own right. As a method this is indeed commendable, it gives value to the professionalism of the participants, further melds them into a team, and renders the document relevant to local needs. Unfortunately, various revisions at the Regional Office delayed the publication of the manual to the point where it was made available to stakeholders during the end of project evaluation. Regrettably, the project could not be tested out in the field, translated into target languages and distributed at national level, and the feedback looped back into a second, adjusted version.

One criticism the evaluator picked up in Indonesia pertained to the topics covered in the manual. As Indonesia was not part of the development and design of the manual, this is a flaw that should be laid at the door of the entire working group involved, but the comment is valid. It is, in essence, a training manual for drug workers with a client load of ATS users. But there is nothing about the particular needs of the actual client group of young people. In the light of the project title and design this does seem to be a major omission. It may perhaps be explained by a fundamental divergence in drug control approaches by the participant countries on the one hand, and that developed in inter alia in Europe, North American and Australia and advocated by UNODC. In the latter the view the drug user is a patient, addiction a medical condition, a disease, which deserves to be treated. But the disease course of an addiction spans years, and as a result treatment is mainly provided to more mature drug users. The programmes targeted at young people prioritise the strengthening of resistance, or factual information on harms, or services to minimize risks. Few cater for young addicts as these are rare. Most young drug users, and the vast majority of young ATS users do not present with addictive behaviour patterns. They are therefore not strictly in need of treatment.

In the project countries the approach to working with young drug users is quite different. Even where legal changes have defined the drug users as a 'patient' who is sick and in need of 'treatment' such as in China and Vietnam this is based on a very different diagnosis. It is not the application of ICD 10 criteria that confirms the addiction but the drug use, and in particular repeated drug use itself. What the patient needs is to be re-educated into a different set of behaviours through drills and the

instilling of fear. We have discussed above that this view is changing among participants particularly, the dilemma remains on how to work with young people who may not be addicted, but whose recreational or habitual use has got them into trouble.

The project could have taken a different approach by emphasising the needs of young people, and taking a more prevention oriented direction from the outset. It could have focused on working with vulnerable groups in the community, looking at alternatives, drug free activities, on how to integrate drug users suffering social exclusion and stigma, and it may have explored outreach services. According to the project document prevention would have been covered in the final workshop that now has been abandoned because of lack of funds. No project can achieve everything, but the priority given to treatment has to be noted as coming at some cost.

On the other hand, investing in treatment systems does have one long term benefit. While the current emphasis has fallen on young people, many of these youngsters will grow into mature drug users, some of whom will experience problems at a later stage in life. The trained up drug workers and the by then perhaps dusty pages of the manual will come in useful with the turning of the generational wheel.

Impact

The workshops provided all participants with a valuable learning experience introducing entirely novel ideas to working with drug users. Most, though not all, participants were highly receptive and eager for the new knowledge. The project therefore raised the technical capacity enormously, creating cadres of Master Trainers and thereby the first critical element in a national training required for change throughout the system.

What was much lamented in Cambodia, Vietnam, and even China was that there was no follow up in country. According to one Chinese informant the programme stopped half way. According to another informant in China “from now it is time to begin.” That feeling was shared by participants in other countries. They had all taken part in the training, were now in possession of their manual, had in some cases at least, instigated pilot activities when things were coming to a premature end.

Sustainability

One of the refrains throughout the interviewing process was why was there no in-country follow up to the regional training workshops. The underlying assumption, that the Master Trainers would share their newly gained expertise at country level was not borne out by reality. There were some workshops, some trainings, but nothing on a scale large enough to create its own momentum. It is felt that this is a flaw in the project design which did not build in a component for in-country training, and this should be revised in future project documents. Project documents are drafted on the understanding that the participating countries will conduct training themselves under the commitment made in the MOU. While the idea of ownership is important, many

of the countries involved will require financial assistance if such training sessions are to be realised.

Not all is lost, however. Changes have been made to the training curriculum for MOLISA in Vietnam, and technical working groups have been established on ATS treatment in Cambodia and Indonesia. In China the treatment innovations at Chengdu Hospital are promising and could yet lead to wider results. The region has been left with a high quality training manual that, once translated and adapted, will provide a valuable resource for practitioners and trainers.

Most importantly, by promoting the idea of dedicated ATS treatment in response to a regional request, and by training a cadre of Master Trainers the idea has become embedded in the region and national drug control agencies have taken ownership. There will therefore be ongoing activities, though they may be different from what was foreseen in the project document.

With the Manual published and available for future use, this could help sustain training/learning activities run by partner organisations.

Lessons Learned and Best Practice

Lessons Learned

The UNODC is in a strong position in the region because it has the mandate to work on drug control, an issue that is taken very seriously across the region. In China particularly the memory of the opium wars, associated with political weakness and national humiliation remains strong. Drug control is therefore a topic of political and social urgency. The other countries also have strong concerns over the spread of drug use, as it is perceived, and the implicit challenge to authority, the potential for disruption and crime. But they all recognise their inexperience and the need to raise technical capacity. They are happy to turn to the UNODC for leadership and putting projects and programme together. Regional programmes, for all their problems with regard to language and diverse levels, are highly attractive in that participants get a rare opportunity to gain insight into alternative ways of doing things. In a centralised and highly structured country like China this is critical for picking up new ideas. Much was learnt from visits to other countries and the exchanges in workshops. Indonesia also reported the value of learning from countries like Thailand that already had experience in the field. There is something to be said for looking at regional leadership and the possibility of a centre of excellence on some issues at least, to conduct regular training and workshops for practitioners.

As the region is in no position to organise itself, and indeed some countries are wary about the potential of political dominance in this field, the role of the UNODC is important in maintaining regional activity and coordinating all stakeholders. But UNODC has no resources of its own and therefore has to look to the donor community to fund activities. In the process of looking for funding the agency tends to oversell the results and outputs. This is understandable from a fundraising perspective but leaves programme staff in an awkward position later on as they find it difficult to live up to promises made. The discrepancy between the results outlined in

project documents, and the resources committed is striking. It is therefore advisable to revisit the way in which projects are written up so as to make delivery more realistic.

While this comes with a clear disadvantage of not being as attention catching and dramatic, it should also be coupled with a more long term perspective to programming. It is highly unrealistic to design a four year project that sets out to reverse a social trend that has been a decade in the making. To have realistic impact projects need to be nested in long term programmes, that move down from regional to national level, with a clear exit strategy for UNODC that does not lead to cessation of activities. There has to be local follow up to each component, with workshops, training programmes, legislative reform and so on at local level.

It has been made clear within the region that there are no funds for regional activities. But there are in many countries ongoing training for staff in public health, law enforcement and correctional facilities. Regional programmes should foresee the long term implementation of project outputs in-country and provide some support. Much of this will be in a technical supporting role, as to inspire activity. In some case small financial contributions will be needed (Cambodia, Laos, Myanmar, Vietnam), but these will be minor. Workshops for 50 – 100 professionals can be organised for under US $15,000. There should then be a review stage, and factored into the long term programme, a second regional phase where results and experience is shared and the project design is revisited.

There is no reason why the project planning system can not be adapted so that projects are set within wider programme cycles, with national sub components, developed as template but then re-negotiated by national stake holders and their partners in each country. It would involve closer collaboration with in-country donors and divide responsibility for programmes between the Regional Office and UNODC field offices.

The major difficulty noted by the Deputy Secretary-General of the Chinese NNCC was the high cost of UNODC. As a large slice of project funding is taken to fund organisational overheads it makes the agency expensive and potentially uncompetitive when compared to bilateral agencies. This can be countered by arguing that UNODC provides added value by the technical capacity invested in the organisation and its affiliated UN agency that can be brought into a project. But not all projects enjoy the same level of support from the agency – this evaluator, for instance, was stood up by UN experts who had a role in the project but could not find time for the evaluation in Indonesia and Vietnam. Informants in Indonesia complained about the relevance of UNODC information on drugs received under the project, including for instance literature on crack cocaine which is not found in the country. Where the agency is committed, there is no doubt that added value can be brought to a project, but this can not be guaranteed in each instance.

All too often, then, projects components are conducted not by UNODC staff but external consultants, which returns us to the question of added value. These points are mentioned as they came up in the evaluation and are important lessons for future programming, but any discussion of possible solutions falls outside the scope and expertise of the evaluator, scarce to say that in general UNODC may want to start at

programme planning level to involve implementing partners from bilateral agencies and the international NGO community.

Best practice

Participants in Cambodia, China, Indonesia and Vietnam all commented positively on the training centres they had visited in Thailand. It seems that Thailand, with its relatively extensive history of both ATS use and ATS treatment, and its more diverse range of treatment provisions and general attitudes to drug treatment has impressed many of the other beneficiaries. This may well be something to build on, but it has to be stressed that these achievements have little to do with project input. They have been recognised by the other participants as a result of the project, which is perhaps an indirect result.

More direct perhaps, is the treatment of the psychiatric ward at the Sichuan General hospital in Chengdu China. Here new treatment facilities were developed and expanded during the period under the influence of the programme. It provides and example of good practice in the sense of demonstrating a change of direction towards a client centred, public health approach, as well as in terms of resource mobilisation, high standards of care, and innovative practice. It should be kept in mind that other countries may not be able to emulate the last three.

What the Chinese example also demonstrates is how a pilot in a single centre can trigger national change – at least potentially. Yet again, not all countries have the same degree of effective centralisation as China.

V Recommendations

Actions recommended

- At the end of the project the general understanding of ATS use and the associated problems among the young people in particular and the population in general has not dramatically improved. There is an urgent need for improving the knowledge base on drugs, drug use, and the impact of policy on the patterns of use. The region could gain much from accepting the concept of evidence base drug control policy to better guide its legislative deliberations and direct interventions. UNODC could advocate this need more pro-actively – including by pointing out the shortcomings of the Rapid Assessment Survey method.

- There is an urgent need for engaging with young people in this fast growing region – there should be a comprehensive package of drug information and education, which is accessible, factual, and adjusted to changing circumstances on the ground. A good practice guide for engaging with young people on drugs should be provided for regional partners, with support via website construction and information packages.

- Develop a package on monitoring and evaluation – this could be stand alone project for drug services, for treatment centres, but also for law enforcement agencies. The project should be based inside the coordinating agencies (DSEP, NACD, NNCC, ONCB) to promote the principles of M&E, run short courses, and provide some basic instruments on information collection and planning tools. It should also provide advice on routine data gathering and feedback mechanisms with a view towards integrating findings into future strategy with an end view of percolating upwards and lead to evidence-based policy

- Regional programmes should incorporate components for in country delivery of the very outputs identified in the project document. A budgetary allowance should be made for in country delivery, particularly of training exercises, in which trained Master Trainers take the lead, and UNODC has a technical support and mentoring role.

- Small bursaries should be included in future programmes to help assist staff exchanges within regions to allow for learning from good practice – Cambodia, Laos, Myanmar, Vietnam could send treatment professionals for a short work placement at a treatment centre in Thailand

- Holding workshops in treatment centres and accommodating participants in guest houses may deliver both cost savings and provide an enhanced learning opportunity for treatment professionals – while there are possible restrictions on this option it seems worth exploring in each MOU country

- Relapse prevention and relapse management as topic for future training workshops – as countries are up-skilling their treatment practice they are running into the problem of relapse, which is demotivating to staff and have serious legal consequences for client

- Only country to actively involved NGOs in the project was Indonesia – other countries should be encouraged to broaden the involvement of NGOs in all aspects of drug treatment, prevention work and reintegration

Conclusion

To a Project Coordinator the task of running a regional project presents significant conceptual and logistical challenges. In this case they have been fairly well met, in spite of a number of difficulties. Participants from all countries enjoyed the experience, did learn from each other's practice, and gained confidence from learning that they are part of a wider, international field of professional practice. But there are also differences in the technical competence, the commitment and political support for the participants from each country. The low levels of commitment of some can hold back the others, which does lead to resentment and a sense of not getting the full benefit from the training.

A further point pertains to the follow up from regional training workshops. The objective of getting countries to fund national activities from their own resources is in the cases of some of the participants at least, entirely unrealistic. Without funding

provisions and technical backstopping by UNODC for in-country training sessions these are unlikely to take place, or to be as effective as envisaged in the process. Given that risible amounts of money involved in terms of wider project costs, there should be no obstacle for incorporating such national training in the drafting of future project proposals.

The quality of the workshops was very high and the manual produced with the cooperation of participants is of high quality. It leaves a legacy beyond project duration and will hopefully form the foundation for ongoing activities. It is also hoped that future projects pick up on the needs of young people and the monitoring and evaluation component, where project delivery has fallen short.

Finally we return to opening remarks regarding evidence and information. Policy makers and even drug control professionals in the region have a limited understanding of the drug consumption trends, the processes by which young people in particular come to be initiated into drug use, the role that drugs play in the repertoire of leisure activities, the meaning of risk taking, and so on. Nor is there a grasp of the importance that drug peddling has in the informal economy in these emerging market economies with widening social differences. There clearly is a need for drug policy to be evidence based and to take account of wider social contexts.

Annex 1 Documents consulted

1. UNODC, 2007, Report on the Inception Meeting RAS/I 13, May 9-11, 2007 Yangon, Myanmar

2. UNODC, 2007, REPORT Workshop on Developing Training Manual, July 2-6, 2007, Bangkok, Thailand

3. UNODC, 2007, Rapid Situational Analysis on ATS treatment and training gaps and needs. Bangkok, Thailand

4. UNODC, 2008, Report, "Training of Trainers in improving access for young people with Amphetamine Type Stimulant (ATS) abuse to effective treatment", Hanoi, June 16 to 20 2008

5. UNODC, 2008, Report on the Workshop to Pretest the ATS Training Manual 10-14 March 2008, Chiang Mai, Thailand Manual

6. UlNODC, 2008," REPORT workshop to review ATS Training Manual, 25-28 March 2008, Krabi, Thailand

7. UNODC, 2008. *Evaluation Handbook: A practical Guide for use by UNODC Staff to plan, manage and follow up an evaluation*. Vienna: UNODC, Independent Evaluation Unit.

8. UNODC, 2008, Annual Progress Report (2008) To the United Nations Trust Fund for Human Security, Phnom Penh, UNODC Field Office.

9. UNODC, 2009, Report on Regional Seminar, 'DRUGS AND THE COMMUNITY – A LAW ENFORCEMENT RESPONSE', 27-29 May 2009, Ayuthaya, Thailand.

10. UNODC, 2009, Report, Exploring ATS Treatment availability and structured guidelines in East Asia and the Pacific.30 March-03 April 2009, Jakarta, Indonesia

11. UNODC, 2009," Training of Trainers on Amphetamine Type Stimulant Abuse for Service Providers, Bangkok, Thailand

Annex 2 Schedule of interviews

Date and country	Name	Organisation
Thailand 31/08	Ms. Manjul Khanna	UNODC, Project Coordinator,
01/09	Mr Gary Lewis	UNODC, Regional Representative, RCEAP
	Mr William Wu	Regional Specialized Offices Interpol
	Mr Michel Bonnieu	UNODC , Senior Regional Legal Adviser
	Tele-interview Mr Akira Fujino	UNODC, former Regional Representative
	Mr Mark Stanley	UNODC
02/09	Mr. Pithaya Jinawat	ONCB, Deputy Secretary General
	Ms. Tanita Nakin	ONCB, Senior Drug Demand Reduction Advisor
	Ms Rachanikorn Sarasiri	ONCB, Director of Foreign Affairs Bureau
	Ms Anchalee Sirisabphya	ONCB, Director, Demand Reduction Bureau
	Ms Chuanpit Choomwattana	ONCB, Director of Demand Reduction Strategy
	Ms Supodjanee Chutidamrong	ONCB, Development and Administration Division
	Mrs Phornprapha Klaewkla	ONCB, Chief of System Development of Drug Rehabilitation Section
	Ms Phunnee Atibodhi	ONCB, Registered Nurse
	Ms Nipa Ngamtrairai	ONCB, Public Health Officer
	Mrs Phunnee Atibodhi	Acting Director, Drug Addicts Rehabilitation Center
	Mr Mipa Ngumbarai	Public Health Officer, Department of Correction
	Mr Montol Kaewkao	Director, Drug Addicts Rehabilitation Center
	Ms Supawadee Nayaw	Professional Nurse, Drug Addicts Rehabilitation Center
Indonesia 03/09	Dr. Indrarini Listyowati	National Narcotics Board
	Ms. Betty Sri Retnaningdyah	National Narcotics Board
	Ms. Vera Octarina	Pelita Ilmu Foundation
04/09	Dr Bennie Ardjil	Head of Kepala Therapy and Rehabilitation Center
	Dr Kusman Suriakusmah	Head of Kabid Therapy and Rehabilitation Center
	Dr Amrita Singgih	National Narcotics Board

Cambodia 07/09	Dr. Anand Chaudhuri	Project Coordinator, UNODC Cambodia
	Mr Lour Ramin	Permanent Vice Chair, NACD
	Tony Lisle	UNAIDS
	Dr. S Vonthanak	NIPH Expert
08/09	Graham Shaw	WHO
	Amy Canon	US Embassy
	Prof Eng Hout	Secretary of State, MOH
	Mr Martin Lutterjohann	German Integrated Expert (GTZ/CIM)
14/09	Ms Iv Sry	Director Planning and Training Department
	Mr Neak Yuthea	Project Coordinator
	Ms Chak Thida	Deputy Program Officer
	Mr. Ling Tonghuot	NACD
Vietnam 16/09	Mr. Le Duc Hien	Deputy Director, Department for Social Evil, Molisa
	Ms Vui Thi Hai Hoa	International Cooperation Officer, Department for Social Evil
	Mr. Tran Xuan Nhat	Department for Social Evil
	Ms. Nguyen Thanh Huong,	Department for Social Evil
	Ms. Nguyen Thi Dang	Department for Social Evil
	Mr. Nguyen Tuong Dzung	UNODC, Programme Officer
China 22/09	Professor Huang Mingsheng	Professor of Psychiatry, Sichuan General Hospital, Department of Psychiatry
	Professor Li Jing	Sichuan General Hospital, Department of Psychiatry
	Dr. Kang Lin	Sichuan General Hospital, Department of Psychiatry
	Ms Chen Defnag	Head Nurse, Sichuan General Hospital, Department of Psychiatry
24/9/09	Mr. Wang Qianrong	Deputy Secretary-General, National Narcotics Commission
	Mr Wang Hongru	National Narcotics Commission

Annex 3 Question Matrix

Design	Verification	Comment
1. Was the project developed in consultation with MOU?		
2. Why the emphasis on ATS/young people – evidence, what social problems identified?		
3. How was the format of regional training programmes arrived at?		
4. Who trained – what expertise		
5. What has the impact of the main output, the manual been?		
6. What activities have taken place in-country?		
7. How have policies been adjusted to create an enabling environment?		
8. What monitoring and evaluation mechanisms have been set up – do they effect practice		
9. What is the follow-up to project?		
10. Are project activities sustainable?		
11. Has the management been effective		

Annex 4
Evaluation assessment questionnaire

Project/programme title: Improving Access for Young People with ATS Abuse to Effective Treatment

Project/programme number: RAS/I13

The evaluators are required to rate each of the items shown below on a scale of 1 to 5 (1 being the lowest and 5 being the highest), as follows:

5 = Excellent (90-100 per cent)
4 = Very good (75-89 per cent)
3 = Good (61-74 per cent)
2 = Fair (50-60 per cent)
1 = Unsatisfactory (0-49 per cent)

These ratings are based on the findings of the evaluation and thus are a translation of the evaluation results.

A	**Planning**	**Rating**				
		1	**2**	**3**	**4**	**5**
1	**Project design (clarity, logic, coherence)**			**x**		
2	**Appropriateness of overall strategy**				**x**	
3	**Achievement of objectives**			**x**		
4	**Fulfilment of prerequisites by Government**		**x**		**x**	
5	**Adherence to project duration)**		**x**			
6	**Adherence to budget**			**x**		

B	**Implementation**	**Rating**				
		1	**2**	**3**	**4**	**5**
7	**Quality and timeliness of UNODC inputs**				**x**	
8	**Quality and timeliness of government inputs**		**x**		**x**	
9	**Quality and timeliness of third-party inputs**					
10	**UNODC headquarters support (administration, management, backstopping)**			**x**		
11	**UNODC field office support (administration, management, backstopping)**				**x**	
12	**Executing agency support - Coordinator**				**x**	

C	**Results**	**Rating**				
		1	**2**	**3**	**4**	**5**
13	**Attainment, timeliness and quality of outputs**				**x**	
14	**Achievement, timeliness and quality of**			**x**		

	outcomes					
15	**Programme/project impact**				**x**	
16	**Sustainability of results/benefits**			**x**		

D	**Recommendations** ***The evaluator should choose ONE of the four options below***	**Rating**				
		1	**2**	**3**	**4**	**5**
	Continue/extend without modifications					
	Continue with modifications				**x**	
	Revise project completely					
	End project					

E	**Comments** Country performance varied widely. Where a consistent team of participants attended all/most sessions, follow-up was sustained. They could develop good interventions back home. The lack of funds for training in-country should be addressed in future as partner governments can not be relied upon to deliver on training commitment. Delays, shortfall in the budget, and technical hold ups meant that the manual, the key physical output of the project, arrived on the desks of participant just as the project ended. This is poor timing, dragging down the quality score of the manual itself.