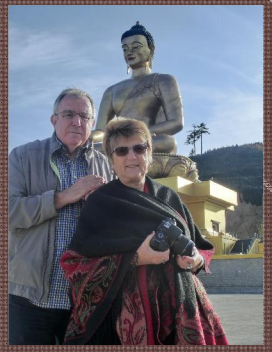
MANY MOUNTAINS, MANY PATHS: ATCA SUPPORTED CAPACITY BUILDING IN BHUTAN

Tshewang Tenzin
Executive Director
Karma Tshering
Peer Counsellor
Chithuen Phendhey Association Bhutan
John Howard
Conjoint NDARC
Lynne Magor-Blatch
ATCA and University of Wollongong



Bhutan – surrounded by China, India and Nepal

- 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

[Dextromethorphn, 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 – 3 centres (one CPA[male] and two one female])

Chithuen Phendhey Association - CPA

- **HO - Thimphu**
  - Executive Director
  - Program Manager
  - Program Officer
  - Human Resources Officer
  - Admin staff accounts, public relations: 3
  - Case Manager, and Outreach/After/Continuing Care Peer Counsellors 3
  - Drop-in-Centre

- **Samzang residential program – Paro:**
  - Manager and 4 Peer Counsellors [aged 23 to 29, except one counsellor 33], and a Cook
  - Attachments 2-4 – assist in running facility – voluntary and gaining experience
  - Up to 16 residents [but at times have 22] – youngest admitted 14, oldest 53, but most 24 to 40
  - Some court referred

- **Drop-in-Centre – Paro**
  - Peer Counsellor

CPA Samzang 'Retreat' [Rehabilitation] Centre

Capacity building to date

Australian:

- Andrew Biven
- John Howard:
  - AOD, Mental Health, Police, Women's Refuge workers on AOD issues and Counselling skills
  - Peer educators: Counselling skills and Clinical Supervision
  - Mental Health and AOD: John Howard and Brent Waters – Psychiatrist
- Lynne Magor-Blatch:
  - Organisational and Administrative matters
- John Howard and Lynne Magor-Blatch:
  - Symposia open to public as well as AOD, Health, Education, Police sectors – principles of effective treatment, working with families
- Ronan O'Connor:
  - Continuum of care

- **Plus:**
  - Colombo Plan – ACCE – Asian Centre for Certification and Education of Addiction Professionals – ICCE - US (NAADAC) – US, Thai and India dominated
  - UNODC
  - Various courses: CBT, etc.
  - University of Adelaide online course

2013 Capacity building

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

2015 – Clinical Supervision – CPA Peer Consellors

I| - Name of a client ÷ DODO.

II| Age ÷ 15.

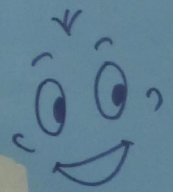
III| SEX ÷ MALE.

IV| EDUCATION ÷ IX (STD).

V| MATRIAL STATUS ÷ UNMARR

VI| EMPLOYMENT ÷ 'No'

VII| DURATION OF USED ÷ ONCE A WEEK (2 YRS).



VIII| CHOICE OF DRUG ÷ GLUE (SNIFIN

IX| LIVING WITH ÷ PARENTS AND SIBLINGS

X| AGE OF FIRST USED ÷ AGE OF 13.

REASONS.

÷ CURIOSITY & TO GAIN CONFIDENT.

÷

XII HIGH RISKS

÷ IMMUTURE DEATH. INVOLVEMENT IN UNLAWFUL ACTIVITIES, OVERDOSE & EXPELLED FROM SCHOOL, ARREST BY POLICE, LOSS OF TRUST FROM FAMILY AND COMMUNITIES, GETING INVOLVE WITH BAD COMPANYS

XIII WHAT DOES HE NEEDS?

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

IT WORKS IF 'U' WORK IT! ....

RELAPSE PREVENTION

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, ~~solat~~ rely

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, ~~[illegible]~~ library & painting.

1 DAY AT A TIME...

VII| ~~Some spir~~ Visit some holy or spiritual ~~sights~~ sites

2014 Capacity Building – Peer Counsellors

Symposium - 2015

Case Study:
Karma – Peer Counsellor Samzang

Case study: Mr Kinley

- Age: 26
- Bhutanese born
- Only son, one older sister
- Drug of choice – Alcohol – from age 22 – as 'self-esteem booster'
- Other drugs used – N10 (Nitrazepam), Spasmo Proxyvon [c.= Digesic], Relepin [also synthetic opioid] – when aged 19 for 5 years, Cannabis – age 22 to 23, injected 'brown sugar [heroin]' - once age 23
- Met DSM criteria for substance dependence
- Completed equivalent of Year 12, and from 2008- 2012 was studying Law at Royal Institute of Management
- Significant trauma history – serious physical assaults by father, teacher and uncle – hit, kicked, standing for hours, tied up, put in cold water in winter
- Depression
- Two suicide attempts – jumping from bridge, hanging
- Fatty liver
- In relationship from 2011 to 2014
- Father has now died
- Lived with older sister

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

- Often talking to himself
- Some aggression – punching doors and tables
- Difficult to control him
- Sometimes carrying a wooden cross around facility
- Not attending groups sessions
- Feelings of anger
- Concentration poor
- Fairly non-communicative – sometimes just nodding when asked questions
- Would walk away and punch table when further attempts made to talk with him
- Not interacting well with peers
- After four days settled, completed full assessment

Ways I coped with him - Karma

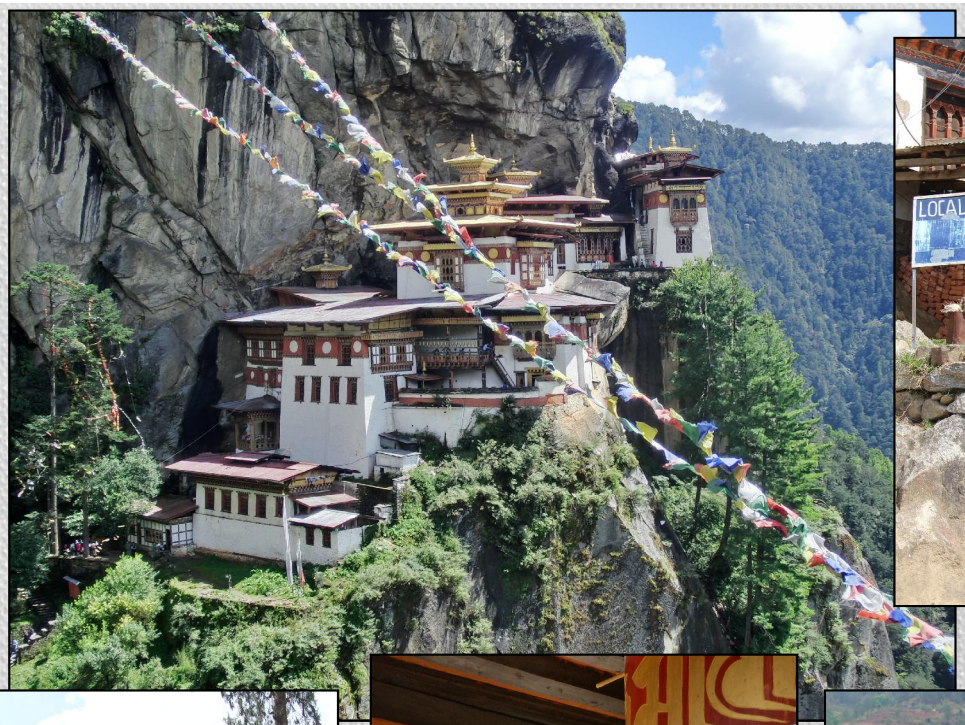
- *Gave him space and time*
- *Tried to maintain a good working relationship with him*
- *Empathic understanding and listening*
- *Talking in a 'humble' way*
- *Providing holistic and extra care*
- *Encouragement to participate in all activities*

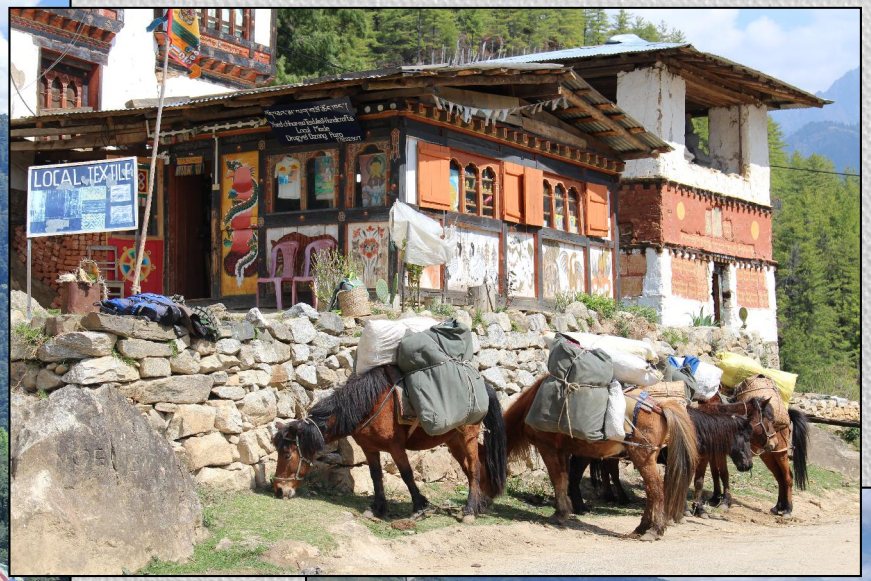
BUT

- He stayed longer the usual 3 months
- Real changes evident – 'odd' behaviour ended, no evidence of psychosis, cooperative, participating, and somewhat reserved with unfamiliar people

Outcomes

- Increased willingness to participate in centre activities
- Became interested in the program
- Made appointments for medication review with psychiatrist – was on Olanzapine and Risperidone [? For odd behaviour] – diagnosed with depression, but no medication prescribed, previous medication terminated
- Maintained personal hygiene and self-care
- Developed a comprehensive relapse prevention plan
- Developed a manageable continuing care plan, including a schedule for daily activities
- Has returned to his Law course, and appears to be doing wel

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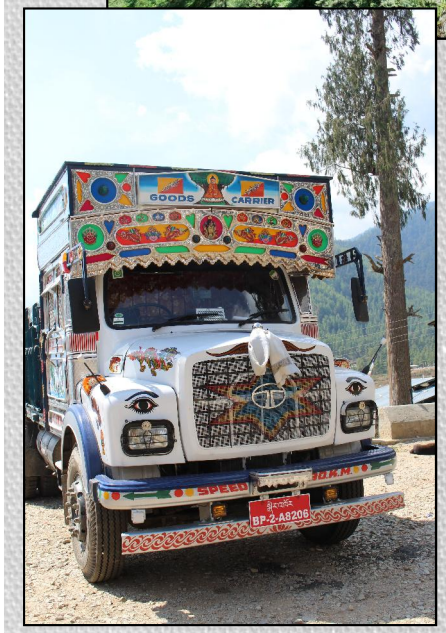
GOODS CARRIER
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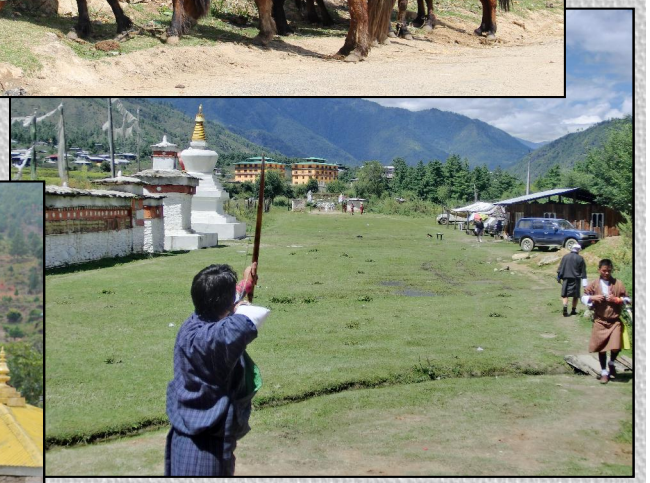
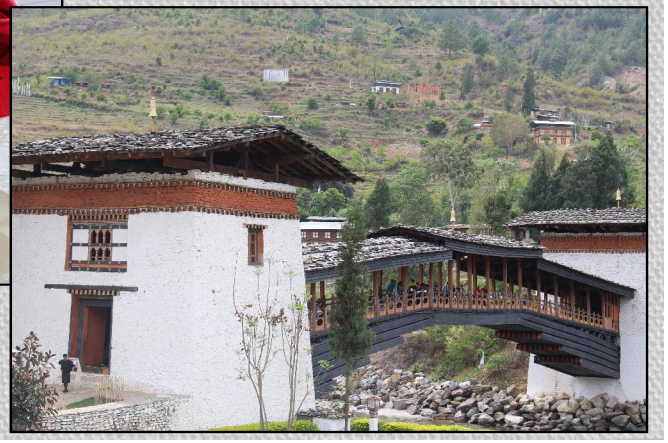
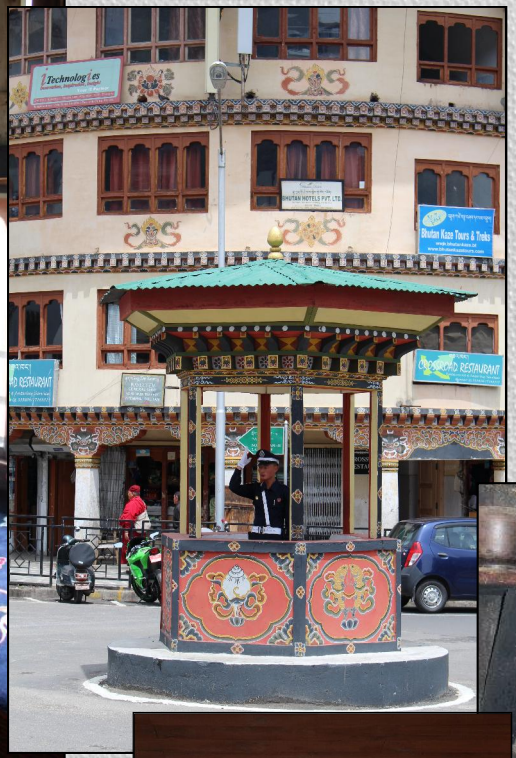
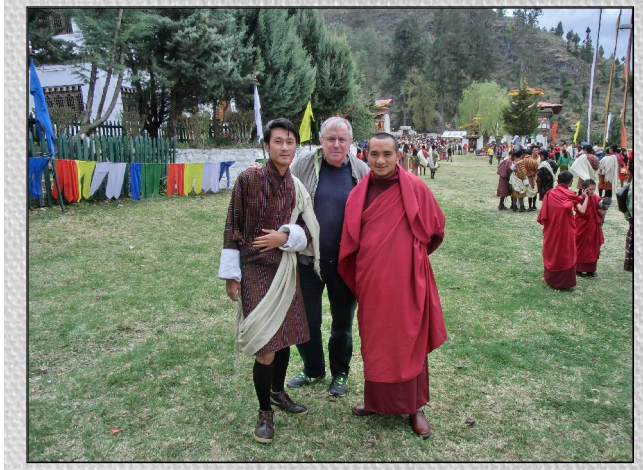





Technologies
BHUTAN HOTELS PVT. LTD.
Bhutan Maze Tours & Treks
ORCHARD RESTAURANT



ATCA has expanded its role in the Asia-Pacific region, via sharing and assistance in site visits for Bhutan:

- Sharing:
  - the development of its approach to TC programming – systems, processes and content,
  - quality assurance and accreditation,
  - ongoing enhancements/modification to the approach,
  - adressing comorbidity and other co-occurring disorders, and
  - engaging with Bhutanese around adaptations that suit their own unique, cultural and economic setting.

ATCA role:

- 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'

- Future? 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

Learning to date

- **Positives:**
  - Keen to learn
  - Intelligent thoughtful young workforce
  - Have done a remarkable job with what is available
  - Drop in centres and outreach expanding
  - Can involve families
  - Expanding continuing care, and vocational training

- **Less Positive:**
  - Domination of 'western' approaches– some less useful than others - but, maybe adapting and developing across the country
  - Geography – getting around Bhutan is difficult – terrain and transport
  - Professional back-up lacking
  - No suitable vocational of college courses as yet to 'qualify' peer counsellors
  - Technology and administrative systems over-stretched
  - Taking on too much – expanding fast
  - Money…

Thanks

- ATCA
- ATCA Conference Committee
- WHOS, Odyssey House – Sydney, Melbourne, Auckland
- Kirketon Road
- Karralika
- Solaris
- Arcadia House
- Yass Rotary
- Higher Ground
- Spring Hill Prison

- And extra special thanks to Anne-Maree Kaser and Windana community for funding one Bhutanse participant for travel to Australia and New Zealand+

Where to?