Support group model for Vietnamese people affected by substance abuse and HIV/AIDS

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ABSTRACT

As commonly seen in East and Southeast Asia, one of the major responses of the Vietnamese government to substance abuse is compulsory drug rehabilitation, which was found not very effective with a high relapse rate. Since 2000s, many people affected by substance abuse (PASA) in Vietnam started actively seeking help from group models in Buddhist temples for their substance abuse and HIV/AIDS problems. This case study aimed to examine the philosophical foundation, theoretical mechanism, implementation, and tentative outcomes of the group work model with the PASA at a Buddhist temple in the North of Vietnam. This qualitative approach study collected data from participation observation, reports collected from the temple, and 14 in-depth interviews with two monks, two rehabilitation therapists, and 10 PASA, mostly narcotic addicts, who participated in the group model in the temple. Results of the study show that PASA were self-motivated to voluntarily participate and maintain their membership in the group model. The head monk/master and his fellow monks played the role of the para-interventionists to provide comprehensive care for PASA members using Buddhist core values and philosophy in its approach. Both the para-interventionists and group members perceived their relationship with each other as equal, respectful, supportive, and therapeutic. The results provide implications for the development of new intervention models that are culturally appropriate in the unique sociocultural context of Vietnam and other countries that shared similar religious influences.

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1. INTRODUCTION

In Vietnam, substance abuse and people affected by substance abuse (PASA) and HIV/AIDS have been one of the greatest concerns of the Vietnamese government. By 2023, there had an estimated 196,110 PASA, with half of them living in community, 50,962 people were drug addicts, and 14,455 were in rehabilitation programs [1]. The Vietnamese government has adopted different interventions to address this problem and support the PASA in its rehabilitation processes and social reintegration.

As commonly seen in East and Southeast Asia, one of the major responses of the Vietnamese government to substance abuse is compulsory drug rehabilitation [2]–[5]. Drug detoxification, including pharmacological management and other therapies, has been mandated for PASA in rehabilitation programs. PASA was allowed to choose to participate in a rehabilitation program in a local or state center. The traditional rehabilitation models with the use of alternatives, such as Methadone, and occupational therapy were found not very effective with a relapse rate of over 90%. Among those who were sent to the

concentrated state-run rehabilitation centers by their families or local authorities, many of them were then forced to enroll in restricted camps for compulsory treatments in Hai Phong, Vung Tau, Dong Nai, and other provinces [6].

In addition to the high rate of relapse, existing studies have established the evidence that clients of the long-term compulsory drug rehabilitation model have reported their poor health, low social, and economic outcomes following their rehabilitation time [7]–[9]. Particularly, they face with significant stigma and discrimination toward them, making it more challenging to find a job, make a living, and reintegrate into the community [7], [8]. Post-rehabilitation PASA in Vietnam emphasizes their demand for an alternative model with better support, particularly health and social support, which is often lacking in the traditional compulsory drug rehabilitation model [10].

This situation in Vietnamese requires new models for PASA. Along with the transition from the criminal justice approach (substance abuse as a crime) to the health treatment approach (substance abuse as a disorder in need of treatment and support), community-based services have been considered a better approach, which the transition from compulsory drug rehabilitation to community-based services has been noted in the country [5], [11]. With this transition, commune-based primary health systems and other community organizations play a significant role in supporting PASA [11]. In addition, international donors are also an important stakeholder, as they provide funding for community-based voluntary methadone maintenance treatment (MMT). However, their donation is unstable, asking for the involvement of the government and other stakeholders in maintaining the program.

Overall, community-based services have been expanding their roles and effects in supporting PASA. These services include both medical and non-medical treatment. Medical services provide clients with methadone and HIV antiretroviral treatments, while non-medical treatments often support clients with legal assistance, financial aid, counseling, vocational training, and job searching [5], [12]. Previous studies also show that PASA highly favor and appreciate comprehensive services with a holistic approach that combines cognitive-behavioral, medical, social, and spiritual aspects, as well as group support [13]. Moreover, community-based services have been reported to be less costly and more effective in remaining drug-free among their clients, compared to those who use the compulsory drug rehabilitation service only [9]. These services, however, are still very limited in Vietnam. In fact, due to inadequate policy, funding, and human resources, most of the available community-based services provide methadone treatment only. Other non-medical treatments are often omitted [5].

Addressing the practical situation of insufficient community-based services for PASA in Vietnam, lay social workers have devoted to the development and adaptation of new non-medical, social work services for this underserved group [5]. The utilization of social work services in Vietnam has been facing with multiple obstacles, partly due to the public misunderstanding of the term 'social work' and unfamiliarity with professional social work services. 'Social work,' when translated literally into Vietnamese (*cong tac xa hoi*), historically and linguistically signals union, and volunteer work [14]. Therefore, improving the understanding of social work and the familiarization of social work services among stakeholders and the general public has been one of the priorities of the Vietnamese government [14], [15]. It is worth mentioning that Vietnamese people revealed their strong religious and spiritual beliefs and tend to donate to, as well as seek help from religious institutions, e.g., consulting a Buddhist monk, chanting, and practicing meditation in a Buddhist temple, for a wide range of problems, such as family and work-related distress, financial burden, physical and mental illness. It was commonly reported that many of them prefer this source of support to formal social work services [16], [17].

Due to the division between the state and religion, social work activities have been separated from their religious origin [18]. When western-style social work models and service delivery were introduced to developing countries in Asia, religion-related elements were mostly omitted or eliminated. The inappropriateness of many components of western models and service delivery is evidently exposed, leading to the demand for culturally relevant and appropriate approaches in social work practice [19]. Given this situation, the development of accessible, indigenous social work, particularly through faith-based practice and service delivery, plays a more critical role in the sociocultural context of Vietnam. There has been evidence that some religion-related elements, such as Christian [20] and Buddhism core values and philosophy, its practice of charity and good deeds, and techniques of deep breathing, relaxation, and meditation are eventually incorporated into activities provided for Vietnamese people affected by physical illness, mental distress, and substance abuse and HIV/AIDS [16], [17]. For example, PASA from Christian rehabilitation clinics self-report their transformation and independent from drug use with the services and support of pastors, social workers, and peers [20].

Since 2000s, similar to Thailand [17], [21], many PASA in Vietnam started actively seeking help from group models in Buddhist temples for their substance abuse and HIV/AIDS problems [22]. Le *et al.* [23], through a study with 1,329 clients at state-run concentrated centers, identified main causes of relapse

among PASA, particularly drug addicts, including: external influences from other addict peers (84.73%), availability of needles and syringes (68%), places of drug dealing (56.86%); negative emotions, such as discriminations from others in the community (52.7%), and risk situations, such as reuniting with addicted friends (62.34%). On the other hand, the support and environment at the temple could prepare PASA mentally and socially to face the risk of relapse in the community.

In addition to the core religious values, the underlying philosophy and mechanism of the Buddhism-based models for PASA could been seen as a combination of the application of the ecological systems theory [24]–[26], Carl Roger's idea of "client-centered" [27], and peer-support model for PASA [28]–[30]. From the perspective of the ecological systems theory, individual characteristics, microsystems (family and peers), meso-/exo-systems (e.g., household economic, cultural norms), and macro-systems (e.g., rehabilitation policy) critically influence substance abuse intervention and PASA's rehabilitation outcomes [24]–[26]. Additionally, Buddhism-based models tend to emphasize self-awareness and a self-led role in the problem-solving of each individual, which aligns with Carl Roger's idea of "client-centered" [27]. Besides the monks at the Buddhist temples, peer support seems to play a significant role in these models. Peer support refers to nonprofessional, nonclinical support from individuals with similar conditions or circumstances to help others in need achieve long-term recovery from substance abuse problems [28]. Peer support has been widely applied and has shown its effectiveness in assisting PASA's recovery and reintegration into their community [30], [31]. Despite its drawbacks, such as the lack of a clear procedure or commitment mechanism, this Buddhism-based model could be an appropriate and effective alternative option to many PASA, along with the traditional model operated by the state. However, so far, not much evidence has been found about the actual implementation and tentative effectiveness of those models.

Addressing the lack of evidence of the scientific foundation, detailed implementation, and tentative outcome of Buddhism-based group models with Vietnamese PASA, this study aims to examine the philosophy foundation, theoretical mechanism, implementation, and tentative outcomes of the group work model with the PASA at a Buddhist temple in the North of Vietnam. Adopting the theoretical foundation of social work practice with groups [31], [32], in this article, we specifically examine the two key aspects of the model, including the human aspect (such as roles and purposes/motivations of stakeholders in the group, and their interpersonal relationships) and the intervention aspect (i.e., its aims and activities, underlying philosophy and approaches, and tentative outcomes). The results of this study are important as they provide some first evidence of a typical indigenous, Buddhism-based model to support PASA as a potential for more culturally appropriate and effective models in the context of Vietnam.

2. METHOD

2.1. Study design

This case study, approved by a university in Hanoi, Vietnam, was exploratory and qualitative in its nature. The study was conducted at P.V. temple in Hanoi, where the Master has run a Buddhism-based intervention model to support PASA and HIV/AIDS since 2003. This model has been open to all PASA who sought refuge and help for their substance abuse problems. Along with the group model, the Head Master also established a community support center for PASA and HIV/AIDS in the form of a counseling coffee shop near the temple.

2.2. Data collection

The master granted the research team approval to participate in activities organized at the temple, as well as to collect data there. In this case study, data were collected from participation observation notes, in-depth interview transcripts, and reports collected from the temple. Over the period of four months, he principal investigator (PI) attended multiple religious and therapeutic activities held at the temple, such as Buddha's teaching sessions, sutra chanting, and meditations for general followers, and group therapy sessions, cleaning and cooking shifts for PASA in the model. The headmaster and other monks at the temple helped introduce the study to potential participants in the PASA peer group and invited them to interview. Before each in-depth interview, participants who agreed to participate in the study signed the informed consent and returned it to the researchers. Each participant received 100,000 VND (US $4) for a completed in-depth interview. In total, we conducted 14 in-depth interviews with two monks, two substance abuse rehabilitation therapists who volunteered at the model, and 10 PASA, mostly narcotic addicts, who were receiving the group therapy at the temple at the time of the study. The key characteristics of PASA participated in the study are presented in Table 1.

The guideline for in-depth interviews with PASA included questions on their current difficulties, the reasons they attended the intervention model at the temple, therapies, and activities they participated in at the temple, and the differences between the temple's model and other models they participated in before. Questions in the in-depth interview guideline for the monks and the rehabilitation therapists focused on what

they perceived as the intervention's underlying philosophy and approaches, and what they have done in the intervention model. Each interview lasted from 30 to 45 minutes on average, and were held at a private room at the temple. All interviews were asked for permission to be audio recorded, and then transcribed verbatim for data analysis. All identifiable information was removed from the transcript. Only the PI and his assistants have the access to the data. We also conducted participation observation, which focused on model activities, group atmosphere and interactions among our participants to triangulate the interview data.

Table 1. Key characteristics of PASA participated in in-depth interviews (N=10)

ID number	Age	Gender	Education level	Current job
1	45	Male	High school	Security man
2	47	Female	High school	Small business owner
3	52	Male	High school	Motorbike driver
4	52	Male	High school	Motorbike driver
5	40	Female	University	Business
6	48	Female	High school	Informal labor
7	50	Male	High school	Worker
8	20	Male	University	Student
9	46	Male	High school	Security man
10	30	Female	University	Unemployment

2.3. Data analysis

All interviews and focus groups were recorded digitally and transcribed verbatim. Interview data transcripts were stored in a password-protected computer and only the research team had access to the data. Data analysis was conducted following the procedure of thematic coding [33]. One of the key researchers started the analysis process by reading and re-reading the transcripts multiple times to familiarize himself with the data. Then, combing with his observation notes, he generated initial codes and searched for the key themes under each key research aim. These codes and themes were presented to the research team for discussion and finalization.

Emerged from the data, two key themes were identified, including: i) The human aspect of the group model; and ii) The intervention aspect of the group model. Under each key theme, associated categories were also identified. Specifically, under theme 1 (the human aspect of the group model), three categories detected, including: i) Roles and purposes/motivation in the group; ii) The para-interventionists; and iii) The interpersonal relationships in the group. Similarly, under theme 2 (the intervention aspect of the group model), three categories were introduced, including i) The key aims and activities of the group model; iii) The underlying philosophy and approaches; and iii) The tentative outcomes.

3. RESULTS AND DISCUSSION

3.1. The human aspect of the group model

3.1.1. Roles and purposes/motivation in the group

In the group model at the temple, the monks and rehabilitation therapists, as the facilitators, made it clear to the group members that they only played a supporting role in the group. PASA, as group members, were considered the key actors of their detoxification process and other activities of the group. The PASA participated in the group model at the P.V. temple was all self-motivated to enroll in and remain their status as a group member. Before coming to the temple, most of them tried with the rehabilitation program at a state concentrated center yet could not achieve their goals of coming clean of drugs. They knew of the group model at the temple after being introduced and referred to by volunteers of the temple or through the newspapers. All group members shared that they decided to visit the temple on their own, and voluntarily participated in the group model, which was different from being sent to a concentrated center and forced to participate in a rehabilitation program by their families or local authorities. By being in charge of their own decision to try and remain their membership in the group model in the temple, they revealed their sense of autonomy and self-esteem that they reported to feel 'long lost.' The participation of the loyal members provided the new members real-life role models of those who successfully came clean of drugs and meaningfully reintegrated into social life and contributed to the community.

Importantly, half of the group members were returning or, in other words, loyal members, who reported to successfully detox themselves and come clean of drug after attending the group model in the past, and then made their liberating decision to come back to the group model to support other peers. To these loyal members, their continuous participation in the group was not only helpful for them to keep grounded and staying clean of drugs, but also gave them a sense of purpose and helpfulness. It was considered a form of their 'paying back' to the community to practice the key values of compassion and gratitude they learned from the monks in the temple.

The para-interventionists. To run the model with PASA, the monks, particularly the master (the head monk), played the role of a para-interventionist. To prepare for this role, they were trained to professionally support PASA.

> *"I myself studied and trained on HIV/AIDS prevention in Thailand and Taiwan. PV temple is a member of the Vietnam HIV/AIDS Prevention Association, I am a member of the Association's Executive Committee. I myself have been working in this field for more than 10 years."* [The head monk]

With the training, the head monk has actively undertaken the roles of a para-social worker/para-interventionist, such as connection and resource mobilization:

> *"First of all, Hanoi City provides methadone medicine. In addition, the temple mobilizes support resources from the community, philanthropic people and business organizations, NGOs. We directly contacted and connected them to get support."* [The head monk]

> *"There are many activities the Master has done. It is impossible to describe them all thoroughly. Perhaps, given some activities, He call on charity organizations, Buddhists, businesses... to have funds to maintain the club's activities."* [A PASA in the group model]

3.1.2. The interpersonal relationships in the group

The relationship between the therapists and clients plays an important role in the success of a therapeutic process in a group model. In the studied group model, the monks and volunteered rehabilitation therapists played the role of therapists/social workers, and participated PASA, as group members, played the role of clients. Study results show that the relationship between the facilitators (the monks and therapists) and group members was perceived equal, respectful, supportive, and therapeutic from both sides. The monks explicitly stated to all group members that they were always willing to help, and they would respect and listen to them whenever they needed, even after they left the temple. A loyal group member noted:

> *"The master is the facilitator of our groups and an excellent teacher. If we have any issue, just share with him, or consult him. For example, last month a member faced some difficulties, the Master agreed to help immediately after being informed. I mainly go to the community and support others."* [A PASA in the group model]

In addition, group members' religion- and spirit-based trust toward the monks strongly foster their therapeutic relationship. As they share their beliefs in Buddhism to different extents, group member highly looked up to and valued their relationship with the monks. Receiving support from the monks helped them feel their bond with the temple and Buddhism spiritually. Some of the group members were living with HIV/AIDS and they have experienced social stigma and discrimination against them. Receiving support from the group model in the temple, they reported to find a strong source of support and strength, and relief that their last days in life would still be supported by the monks and others in the group model.

3.3. The intervention aspect of the group model

3.3.1. The key aims and activities of the group model

The group model for PASA and HIV/AIDS in the P.V. temple was cohesive and comprehensive with multiple components and activities to address different aims, see Table 2. As summed up in Table 2, the group model focused on four key aims, including: i) Becoming educated about substance abuse and HIV/AIDS and detoxing, coping with drug cravings & withdrawal; ii) Improving health condition; iii) Improving self-awareness and motivation for drug detoxification; and iv) Providing social support and motivating each other for social reintegration. To meet these aims, the group model was designed with different activities.

> *"At the club, the Master teaches us physical exercises, relaxation exercises, and repentance sutras compiled by him. Furthermore, the temple provides free food, accommodation, and medicine. Everyone's activities at the temple follow a schedule from morning until bedtime."* [A PASA in the group model]

PASA in the group joined other temple followers to listen to lectures on Buddha's teaching, reciting sutras and praying on the regular basis. In addition, they participated in exclusive activities for the PASA group, such as: practicing meditation and yoga; participating in occupation therapy; counseling about

substance abuse and HIV/AIDS; participating in clubs and peer groups; and enrolling in job market network. Particularly, the temple has collaborated with the District Health Center to provide weekly health checkup and Methadone delivery for prescribed PASA at the temple. Many of the group members stayed in the residential home in the temple, and all members actively helped with cleaning and cooking in the temple.

> *"At the temple, we have applied many therapies and have appropriate therapies depending on each case, combining taking Methadone (issued by the Hanoi City) with occupational therapy, studying and practicing Buddhist teachings, especially studying the law of cause-and-effect... to change the participants' perception and psychology. At the temple, everyone is treated equally and respected. At the club, long-term members who have been in the group for many years are responsible for guiding and supporting new members joining the club. The monks and volunteers communicate with each other based on love. It helps them feel not abandoned, eliminates barriers from stigma and discrimination towards drug users and people with HIV/AIDS."* [The head monk]

The core activities were incorporated into the group sessions held on average two to three times every week. Each group session lasted for approximately one to two hours, with different activities assigned by the monks and therapists.

> *"The master teaches us to practice Zen. He even teaches us to sweep and clean the temple, and take care of ornamental plants in the temple grounds. Regularly according to the scheduled timetable, the members receive Dharma teachings and repentance sutras from the teacher. He uses his network with business men to help those who qualified to apply for a job. He also connected with hospitals to introduce and refer those who were seriously ill to those hospitals."* [A PASA in the group model]

The monks used some typical social work techniques, such as pedigree charts and ecological diagrams, to consult each drug addict. Different from a typical group model in social work practice, the group model for PASA and HIV/AIDS in the temple was continuous without a fixed closing session. Group members decided to participate in the group model as long as they wanted, as well as leave and return at their will. New members came to the group and joined with other old members. The model also provided follow-up procedure with their members after they left the model. This approach helps foster the continuity and a timeliness of support for group members when they came back to their communities. The continuity of support of this model was a significant strength, compared to the traditional detoxification model at government-run rehabilitation centers.

Table 2. The matrix of the group model aims and activities

Core activities	Aim 1 Becoming educated about substance abuse and HIV/AIDS & detoxing, coping with drug cravings and withdrawal	Aim 2 Improving health condition	Aim 3 Improving self-awareness and motivation for drug detoxification	Aim 4 Providing social support & motivating each other for social reintegration
Listening to lecture on Buddha's teaching, reciting sutras, and praying			x	x
Receiving healthcare checkup and methadone from the District Health Center	x	x		
Practicing meditation and yoga		x	x	
Participating in occupational therapy			x	x
Counseling about substance abuse and HIV/AIDS	x		x	
Participating in clubs and peer groups	x		x	x
Enrolling in job market network			x	x

3.3.2. The underlying philosophy and approaches

Overall, the underlying philosophy of the Buddhism-based intervention model for drug addicts at the Phap Van temple was centered around: i) The key values of free-will, self-management, and respect for all members; ii) The comprehensive approach of mind–body–spirit with the use of mindfulness; and iii) The importance of a judgment-free and supportive environment.

First, the group model at the temple was built upon the concepts of free-will and autonomy of the members. PASA in the model shared that these concepts attracted them to the model. During Dharma lecture

sessions, the monks taught the group members about the roots of their suffering, which was from their own desire, greed, hatred, and delusion. Buddhist teachings emphasize three types of suffering (dukkha), including: i) physical or mental pain, ii) dissatisfaction with changes, and iii) karma. According to Buddhism, in order to eradicate suffering, one must eliminate their desires to remove greed, hatred, and delusion. Adopting these teachings, the monks at the temple taught PASA to look deeply into their desire for narcotic drug as the cause of their suffering that covered not only mental and physical suffering, but also karma.

> *"From my observation, at state-run social protection centers, staff still lack knowledge about PASA, mainly lacking knowledge about the psychology and physiology of PASA and people with HIV/AIDS. Staff there use power to coerce PASA and people with HIV/AIDS, and treat them as criminals."* [The head monk]

The therapeutic process was built on the core concept of the Eightfold Paths, which emphasize the "self" of PASA. To be more specific, the monks in the model focused on helping group members build their mental strength to abandon the drug-induced desire, which could shift their minds, increase their physical health and consistency in action. They were also encouraged to perform good deeds in and outside of the temple to eliminate their bad karma.

In general, the Vietnamese society held a lot of stigmas toward PASA and HIV/AIDS. Meanwhile, the key values of free-will, self-management, and trust from the monks and therapists made the group members feel being respected, which encouraged them to visit and remain in the model. Observing the monks and many Buddhists practicing mediation, chanting, and sermons also contributed to enhance drug addicts' motivation to get involved in the temple. A group member affected by narcotic addiction commented:

> *"We all come here voluntarily. We watch what other people are doing and we follow them. We can decide for ourselves our way of rehabilitation. The teachers [the monks] will come when we need them or when we are having a drug withdrawal. The teachers will show us how to meditate and talk with us about our responsibility with our parents and children. They also assigned other people to help us if needed."* [A PASA in the group model]

Furthermore, the master, as a para-interventionist/pare-social worker, who coordinates the intervention group of PASA, empowered them by training the next leader of the group, who was expected to lead the group on their own in the future:

> *"Every Saturday, the master directly trains a team of volunteers (doctors, nurses...) on consultation, counseling, support, and how to take care of the members of the club. I was also invited to attend. Because the master also wants me to become the core of the club and know how to effectively support other members, because he thinks that no one is always with you 24/24h. It would be us together. Volunteers only come for a few hours during the day."* [A PASA in the group model]

Second, the fundamental approach of body–mind–spirit was adopted in the model with extensive use of mindfulness techniques, such as meditation, to help group members cope with their drug craving and withdrawal. These concepts and techniques were not only helpful for group members during their own rehabilitation process at the temple, but also in the next phase, when they played the role of supporter for new group members. One of the monks in the model shared:

> *"Meditation helps clean the mind and detox the body. It is a form of toxin disposal for human consciousness. The toxin that our consciousness produces is horrible. In science, it is reported that positive thinkers or optimists have less illness than pessimists. In Buddhism, there is a method of changing one's mind, which is changing the concept of the mind. The more you meditate, the subtler your thoughts will be. The more they practice, the clearer they will observe*." [A monk in the group model]

Third, the monks in the model particularly cared about the environmental factors that supported group members. In addition to activities that enhancing physical and mental health for the members, the monks endeavored to create an environment that foster bonds and trust for group members. Being respectful, non-judgmental, compassionate, and flexible was the typical approach of the monks and therapists in the model. A monk shared about his approach when working with each group member:

"First of all, when the drug addicts come, we would spend time with them to learn about their characteristics, and the duration depending on how long they stay. We give them a place to live to support the learning process. From there, we assess their case and plan on how to help them. We mostly provide psychological support, motivate their determination through cognitive change and meditation. Here, they learn from working. The drug addicts are divided into teams and the duty is shifted among them. We also let them practice different exercises. The exercises are adjusted to fit the strength of each person with many different training methods and techniques." [A monk in the group model]

A group member also commented on the positive and constructive environment of the group:

"We live and eat at the temple for free. The master and the monks are close to us. They always check on us, encouraging us. The members of the club are considered a peer group with some role models. The Master connects and unites members into a peer group that knows how to share with each other, comfort and encourage each other, and help each other grow up." [A PASA in the group model]

3.2.3. The tentative outcomes

The Master had not conducted a formal evaluation by the time of the study. He could only recall that from 2003 to 2012, approximately 300 PASA had been supported in the group model, and many of them successfully reintegrated into their social lives without any relapse. He did not keep track of the record of cases in recent years, as the model was run informally. Currently, the monks and volunteers at the temple have continued to run their model to support PASA and their families, especially who were affected by HIV/AIDS.

Through interviews, all group members who participated in the interview of the present study shared their positive feedback and outcomes of drug detoxification, rehabilitation, and social reintegration. They all commented on their improvement in health condition, emotions, and motivations to maintain their participation in the model to help their own detoxification and rehabilitation, as well as to help other peers. All new members reported the reduction in their drug craving and withdrawal and increase in their self-control of drug use. It is worth noting that half of the group members at the time of the study were loyal members who successfully stayed clean of drug and reintegrated into their communities. However, much more long-term evidence-based outcomes were needed to evaluate the actual effectiveness of the model.

"In fact, when I voluntarily joined the club, I felt comfortable. The Master and my friends in the club care about me, so my mind was somewhat at ease and less stressed... Busy schedule. No more confusion to worry or think about miscellaneous things. Health has improved significantly, mood is no longer melancholic, much happier. Because everyone was in the same situation and lived together under the organization and teachings of the Master with compassion, everyone felt that the Master respected us, not shunned or looked down upon as if we were outside. We consider the Master as our father. The Master even pays for social insurance for everyone. Even when the family of a member of the club has difficulties, the temple always provides financial support. When unfortunately, a member was seriously ill and died, the Master held a live prayer ceremony for them. Seeing that scene made us feel good." [A PASA in the group model]

4. DISCUSSION

As a pilot, exploratory study, the present study has its own limitations, such as small sample size, and that group members as informants were introduced by the monks at the temple, leading to potential bias in the findings. Moreover, there was a lack of information about the formal evaluation and measurable outcomes of the model at the time of the study. This study, however, has its unique contribution to the scant literature on effective community-based, group-based support model for PASA in the unique sociocultural context in Vietnam.

The study findings provide an overview of the group model for PASA peers delivered at a Buddhist temple. The comprehensive group model established and run by the head monk and his fellow monks. Regarding the human aspect of the group model, PASA were self-motivated to voluntarily participate and maintain their membership in the group model. The head monk/Master and his fellow monks played the role of the para-interventionists in the model. Both the para-interventionists and group members perceived their relationship with each other as equal, respectful, supportive, and therapeutic.

The group model was developed with focus on four key aims, including: i) Becoming educated about substance abuse and HIV/AIDS and detoxing, coping with drug cravings & withdrawal; ii) Improving health condition; iii) Improving self-awareness and motivation for drug detoxification; and iv) Providing social support and motivating each other for social reintegration. To meet these aims, PASA, as group members, participated in a wide range of core activities, such as: listening to lecture on Buddha's teaching, reciting sutras and praying; receiving healthcare checkup and Methadone from the District Health Center; practicing meditation and yoga; participating in occupation therapy; counseling about substance abuse and HIV/AIDS; participating in clubs and peer groups; and enrolling in job market network. These aims and activities were found to be centered around there underlying principles, including: i) the key values of free-will, self-management, and respect for all members; ii) the comprehensive approach of mind – body – spirit with the use of mindfulness; and iii) the importance of a judgment-free and supportive environment. All PASA, who were group members and participated in the study, expressed their beliefs that participating in the model had positive impact on their outcomes of drug detoxification, rehabilitation, and social reintegration.

The study results provide some evidence on the necessity and appropriateness of the transition from the compulsory drug rehabilitation to community-based services in Vietnam [5], [11], as well as the importance of a comprehensive approach that combines medical and non-medical treatment in supporting PASA [5], [12], particularly in the group/peer support format [13]. In line with results from previous studies, key findings of the present study emphasize that the combination of methadone, HIV antiretroviral treatments, if needed, and other services, such as legal assistance, financial aid, counseling, vocational training and job searching. importantly addresses the needs of PASA [5], [9], [12], [13].

The study results also expand knowledge on indigenous, faith-based social work in Vietnam. Very few existing studies discuss the link between Buddhism and social work [16], [17]. This study particularly focuses on a long-term, sustainable rehabilitation model that has incorporated both traditional Buddhist teachings and practice and professional social work helping model to support a challenging group of PASA and HIV/AIDS. This model, in some ways, reflects the indigenization of social work in a developing, Asian country, as it refers to phase three in the three-phase development of social work in a developing country, including: i) an introduction of social work from the West, ii) localization of the profession, and iii) an intensive and comprehensive development with both western and local factors [34]. Indeed, the group model presented in this study incorporated both the Eastern, Buddhist philosophy, and the western, professional social work approach. Regarding the Eastern, Buddhist philosophy, the model was built upon the core concepts of Buddha's teachings, such as suffering and the way to reduce and eliminate sufferings (Eightfold Paths), and the awareness of the self.

Regarding the western, professional social work approach, the underlying philosophy of the model at the P.V. temple is consistent with Carl Roger's idea of "client-centered," which emphasizes self-awareness and self-led role in problem-solving of each individual [27]. In this approach, the monks, in role of para-social workers, or para-interventionists, built the trusting and supportive relationship with their clients - the group members, and created a friendly and change-supported environment. This approach is particularly appropriate in supporting PASA, as it is in line with the humanistic approach in the 1960s, which marked a milestone in changing the view of "social diseases/diagnosis" to a more strength-based view [27]. In addition to the application of the client-centered perspective [27], the group model at the temple successfully adopts the ecological systems theory [24]–[26], and peer-support model for PASA [28]–[30] in its design and approach.

5. CONCLUSION

Results of the study show that the studied temple provided a comprehensive care for its unique clients, PASA and HIV/AIDS, using Buddhist core values and philosophy in its approach. In the context that the state-run traditional, concentrated rehabilitation model has shown its limitations in appropriateness and effectiveness, a Buddhism-based rehabilitation group model for PASA could be a potential alternative. The group model delivered at the P.V. temple in the present study is a critical example of a comprehensive community-based, faith-based support model for PASA in the limited resource and unique sociocultural context of Vietnam. While this Buddhism-based model has shown its strengths, it has still been quite new and lack scientific evidence of its long-term effects. Further studies on this model are much needed before an expansion of the model could be made nation-wide. This model could be an example for other Buddhist countries, particularly in Southeast Asia, to adapt to support underserved people in need in their own contexts.

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