



DRUG DEPENDANTS' TREATMENTS AND REHABILITATION: FROM 'COLD TURKEY' TO 'HOT TURKEY'

Dr Abdul Rani Bin Kamarudin¹

ABSTRACT

This article concerns the treatment and rehabilitation of drug dependants in Malaysia and it assesses the country's drug policy in dealing with problem drug takers since the introduction of compulsory treatment and rehabilitation of certified drug dependants since 1975. It looks at the strength and weaknesses of the 'Cold Turkey' method of treatment which until very lately has been the thrust in the government's policy, and recently, the maintenance on drug prescription to drug dependants. Given the limitations in achievement of residential treatment and rehabilitation cum the 'cold turkey' method, there is now renewed readiness on the government's part to adopt the maintenance on drug prescription for treating and rehabilitating drug dependants, hence gradually moving away from the 'cold turkey' approach. Central to the maintenance on drug prescription for treating and rehabilitating drug dependants is the concept of harm reduction, and this concept will be duly discussed. The experience of United Kingdom in dealing with the treatment and rehabilitation of drug dependants through maintenance on drug prescription cum harm reduction is also highlighted to drive the point why the "cold turkey" method of treating and rehabilitating drug dependants is by now a spent force, and why it is also high time that more leeway should be given to the medical approach rather than penal.

¹ Associate Professor, Ahmad Ibrahim Kulliyah of Laws, International Islamic University, Malaysia; LL.B Hons (IIUM - 1988); MCL (IIUM -1990); PhD in Law (Exeter - 2002); Non-practicing Advocates & Solicitors (High Court of Malaya - 1991 & 1992) & Peguam Syarie (KL & NS - 1996)

**ABSTRAK**

Artikel ini memberi tumpuan kepada aspek rawatan dan pemulihan penagih dadah di Malaysia dengan meneliti Dasar Dadah Negara yang menguruskan masalah penyalahgunaan dadah sejak tatacara rawatan dan pemulihan dadah yang wajib diperkenalkan pada tahun 1975. Ia melihat kepada kekuatan dan kelemahan kaedah rawatan "Cold Turkey" yang menjadi teras kepada dasar kerajaan masa itu dan kini. Pada masa ini, terdapat kesediaan daripada pihak kerajaan untuk menerima kaedah pengekalan melalui preskripsi dadah kepada mereka yang bergantung kepada dadah yang mana sedikit sebanyak ia menunjukkan bahawa dasar dadah telah mula bergerak meninggalkan kaedah "Cold Turkey". Pendekatan pengurangan kemudaratatan merupakan asas kepada kaedah pengekalan pengantungan dadah juga dihuraikan. Pengalaman United Kingdom dalam menjalankan pendekatan pengurangan kemudaratatan dibincangkan dalam konteks. Oleh yang demikian, dasar kini lebih memandu program kepulihan ke arah pendekatan perubatan dan bukannya undang-undang.

INTRODUCTION

Under Article 38 of the Single Convention on Narcotics Drugs, 1961, parties are required to take all practical measures for the prevention of narcotics drug abuse or psychotropic substances and "for the early identification, treatment, education, aftercare, rehabilitation and social re-integration of the persons involved".²

On 8th - 10th June 1998, a United Nations drug summit attended by presidents, prime ministers and senior ministers from 150 countries met at New York and adopted a global strategy to tackle the worldwide drug problem. The three-day special session of the General Assembly adopted a political declaration, which among others commits government to substantially reduce illicit drug demand and supply by 2008. The Assembly also adopted a declaration on the principles of demand reduction to guide governments in setting up effective drug prevention, treatment and rehabilitation programs.

² Malaysia is a party to all three United Nations Conventions, namely, the Single Convention on Narcotics Drugs 1961, the 1971 Convention on Psychotropic Substances, as amended by the 1972 Protocol, article 20 of the 1971 Convention on Psychotropic Substances, and the United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances 1988 - see Malaysia's National Narcotics Agency 1998 Annual Report, at pg 76, Ministry of Home Affairs, Kuala Lumpur.



THE EARLY STAGES OF COMPULSORY TREATMENT AND REHABILITATION

In the early 1970s, treatment facilities that were available for drug dependants in Malaysia were associated with psychiatric and general hospitals. There were no centres for the psychosocial rehabilitation of drug dependants. On 1st October 1975, the Minister of Welfare Services appointed 24 hospitals as detection and detoxification centres (7 detoxification and 17 Detection Centres). The detection centres were there to ensure that a person would be identified as a drug dependant through appropriate tests and observations. These detoxification centres had supportive therapy for the physical building up of the patient and the treatment of other accompanying physical complications.³ Compulsory treatment and rehabilitation of drug dependants at approved institutions was introduced in 1975 as section 37B of the Dangerous Drugs Act 1952, giving social welfare officers and police officers the power to require a drug dependant to undergo treatment. There was also a provision to enable a drug dependant to undergo treatment voluntarily.⁴ Nevertheless, there were very few rehabilitation homes in 1975 to cope with the huge number of drug addicts and the rate of relapse and recidivism among drug addicts was fairly high.⁵ Section 37B was repealed in 1977 and substituted with Part VA comprising of 25 sections, namely section 25A to 25O providing better treatment and rehabilitation structures to drug dependants. With that, a drug dependant may be ordered to undergo treatment and rehabilitation at a rehabilitation centre for a period between six months and one year or a two-year supervision.⁶

Since 1976, every registered medical practitioner, including the government medical officer is obliged to notify the Director-General of any person he treats for drug dependency. Unauthorized treatment and rehabilitation of any drug dependant is not permitted, save those who are lawfully providing medical treatment to any person in relation to any physical or mental condition arising from or involving or relating to the drug dependency of such person.⁷ This is to strengthen the control against drug misuse, and indirectly ensure that no drug dependant

³ Central Narcotics Bureau, Malaysia (1977), *The Drug Abuse Problem in Malaysia*, at pg 17 - 18.

⁴ Dangerous Drugs (Amendment) Act A293/75.

⁵ Syed M. Haq (1990), *Three Decades of Drugs Abuse on the Malaysian Scene*, at pg 16, 22, 24 -25, Universiti Kebangsaan Malaysia, Bangi, Malaysia

⁶ Dangerous Drugs (Amendment) Act A389/77.

⁷ Section 18 & 16(5), Drug Dependants (Treatment and Rehabilitation) Act 1983.



can evade or escape from undergoing treatment and rehabilitation lawfully.⁸

ONE STOP TREATMENT AND REHABILITATION CENTRES

The development of rehabilitation centres in 1976 was in response to the urgency and seriousness of the drug problems then prevailing. With these centres, a suspected or certified drug dependant could undergo examination, detection, detoxification, counseling, vocational, physical restoration, moral and civic education, agricultural and training under one roof. Accordingly, this psychosocial rehabilitation programme has officials from a variety of disciplines who work as a team to rebuild the personality of an addict. Officers and staff placed in these one-stop centres comprise of social workers (social welfare officers and assistants), psychologists, medical officers, religious teachers, youth, agricultural, education and military personnel, industrial trade instructors and security officers.⁹ The number of centres had steadily risen to 21 by early 1995 with a total capacity of 10,000.¹⁰ By the end of November 1997, there were 28 of these centres with a total capacity of 12,550.¹¹

Both military and ex-military personnel seconded to these centres deliver military-like training to the residents. The objectives are to instil discipline and achieve the physical restoration of the residents. Vocational training and or socio-economic projects, such as agriculture and livestock farming serve to provide residents with coping skills. The residents undergo 4 phases of treatment and rehabilitation. In phase one (3-5 months period), a resident undergoes orientation (civic classes), physical restoration (drills), counseling, moral and spiritual rehabilitation. Physical training, religious, moral and civic education, and counseling hours are reduced as a resident proceeds to the next phase. At the same time, vocational training and or socio-economic projects are greatly increased as a resident

⁸ House of Representatives, Parliamentary Debate, the Dangerous Drugs (Amendment) Ordinance 1952, 14th January 1976, at pg 7225 -7226, Malaysia.

⁹ Read the House of Representatives (Parliamentary Debate), 2nd and 3rd reading of the Drugs Dependants (Treatment and Rehabilitation) Act 1983's Bill, 25th March 1983, pg 7585 - 7586; House of Representatives (Parliamentary Debate), 2nd and 3rd reading of Dangerous Drugs (Forfeiture of Property) Act 1988's Bill, 24th March 1988, pg 36 - 71, at pg 69; National Narcotics Agency (1997), *Kenali dan Perangi Dadah*, Ministry of Home Affairs, Malaysia, at pg 62 - 63.

¹⁰ Abdul Malik bin Hj. Ishak (1995), *Re; Some Legal Aspects of the Drugs Problem in Malaysia - A Perspective*, Malaysian Current Law Journal, Vol. 1, cxxv-cxxxix at pg cxxvi

¹¹ National Narcotics Agency (1997), *Maklumat Dadah Semasa - Special Edition*, at pg. 1& 27, Ministry of Home Affairs, Kuala Lumpur, Malaysia; National Narcotics Agency, *Narcotics Report 1996*, at pg. 47, Ministry of Home Affairs, Kuala Lumpur, Malaysia



proceeds from one phase to another. In phase two (4-7 months), in addition to his daily routine as above, a resident participates in vocational training. In phase three (4 - 7 months), a resident is given job attachments. In phase four (4-5 months), a resident is allowed to visit his family, is involved in socio-economic projects as well as re-entry programmes.¹² The Medical Officer is responsible for overseeing medical welfare, including the medical treatment of the residents.¹³ The Director-General, who has superintendence over all matters relating to the apprehension, treatment and rehabilitation of drugs dependants under the Drug Dependents (Treatment and Rehabilitation) Act 1983, may shorten a resident's period of residence in the centre, if he had already completed a period of twelve months for reasons that appear to him to be sufficient for such person. The Director-General could with the Minister's consent, discharge a resident if the period of residence already served is less than twelve months for special reasons pertaining to the welfare of such person.¹⁴ The period of residency in the centre is meant to be flexible, allowing the period of each resident to be assessed on a case-by-case basis. Accordingly, a resident in the centre can be discharged earlier to undergo supervision.

These centres help take away the element of supply by severing the demand for drugs when drug dependants are rounded up and confined for treatment. Compulsory residential treatment and rehabilitation presents an important means to stabilize the chaotic lifestyles of many drug addicts or drug-misusing offenders. Under this regime of treatment and rehabilitation, the effect of achieving improvements in drug dependants' personal health and inculcating a positive attitude should not be underestimated.¹⁵ It reduces the acceptability of drugs to young people and increases the safety of every community from drug related crimes. In fact coercive treatment ensures that drug misusers get into treatment early, and keeps them in treatment.¹⁶ In Malaysia, drug dependants in prison undergo physical

¹² National Narcotics Agency, Narcotics Report 1996, Ministry of Home Affairs, Malaysia, pg 41 - 43; Scorzelli, *Drug Abuse: Prevention and Rehabilitation in Malaysia*, at pg 93 - 95, Universiti Kebangsaan Malaysia, 1987,

¹³ Rule 28, Drug Rehabilitation Centre Rules, 1983.

¹⁴ Section 12; Prior to the Drug Dependents (Treatment and Rehabilitation) (Amendment) Act A1018/98, the discretion was with the Board of Visitors. See also Rule 78, 79 & 80, Drug Rehabilitation Centre Rules, 1983.

¹⁵ Advisory Council on the Misuse of Drugs (1996), *Drug Misusers and the Criminal Justice System*, in Part 3: Drug Misusers and The Prison System - An Integrated Approach", pg 18, London.

¹⁶ Hough, M. (1996) *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, Home Office Drugs Prevention Initiative, Paper 15, at pg 8 of 11, chapter 4: Communities Penalties. London: Home Office.



treatment, and psychological rehabilitation through counseling, sports and recreation. The programme imitates the therapeutic community approach in instilling positive values in life. Treatment and rehabilitation in prison includes detoxification, orientation, physical restoration, moral and civil education, medication and counseling. A model drug inmate would be given unpaid vocational/trade training and recreational benefits. Incentives are given to residents with good attitude and wages are given for doing work.¹⁷

THE SERIOUSNESS OF THE DRUG PROBLEM

On the 19th of February 1983, drug misuse was declared as the main threat to national security. The declaration was made because drug addiction could reach epidemic proportions if a tough stand was not taken to address the menace. 65% of the addicts were young men between the age of 20 and 29. They represented the backbone and hope of the nation's future. The adverse effect on the uncontrolled drug addiction and trafficking could threaten the socio-economic well-being, spiritual and natural culture of the nation's population, hence undermining national resilience and national security.¹⁸ The then Home Affairs Minister, Dato' Musa Hitam when tabling the Dangerous Drugs (Amendment) Act A553/83 before the House of Representatives on 24th March 1983, spoke of the growing seriousness of the drug problem that threatened and had threatened national security and integrity - it was not merely a social problem. The then Prime Minister, Dato' Seri Dr Mahathir Mohammed, on the 10th of September 1983, following a Cabinet decision signed the National Security Council Directive number 13. The Directive provided for the setting up of an Anti-Narcotics Committee under the National Security Council. Consequently, the earlier Cabinet Committee on Narcotics and all bodies set up on its instruction at federal and state levels were dissolved. The Directive also provided for the establishment of an Anti-Narcotics Task Force to serve as Secretariat to the Anti-Narcotics Committee and to be responsible in carrying out a planned, integrated and coordinated anti-drug efforts. Thus, the Narcotics Secretariat was replaced with the Anti-

¹⁷ National Narcotics Agency (1997), *Kenali dan Perangi Dadah*, at pg 67 - 68.

¹⁸ National Narcotics Agency, *Laporan Dadah, 1997*, Ministry of Home Affairs, Malaysia at pg 12; National Narcotics Agency, *Kenali dan Perangi Dadah*, at pg 48; National Narcotics Agency, *Narcotics Report 1996*, Ministry of Home Affairs, Malaysia, at pg 7; Anti Narcotics Task Force, *Narcotics Report 1995*, Ministry of Home Affairs, Malaysia, at pg 9; Anti Narcotics Task Force, *Narcotics Report 1994*, Ministry of Home Affairs, Malaysia, at pg 5.



Narcotics Task Force.¹⁹ The Anti-Narcotics Task Force was subsequently put under the jurisdiction of the Ministry of Home Affairs with effect from 8th May 1995. The Anti-Narcotics Committee and the Anti-Narcotics Task Force were dissolved on the 7th February 1996, and in their place, the National Narcotics Council and a department under the Ministry of Home Affairs known as the National Narcotics Agency were established in an effort to restructure the government machinery to prevent and control the drug situation. The Agency serves as Secretariat to the Council and is responsible for all aspects of national anti-drug efforts.²⁰ The National Narcotic Agency has now been renamed as the National Anti-Drugs Agency.

DRUG DEPENDANTS (TREATMENT AND REHABILITATION) ACT 1983

The Malaysian government eventually felt that the time had come for a comprehensive Act that could specifically and seriously deal with the treatment and rehabilitation of drug dependants. The government pointed out that the Dangerous Drugs Act 1952 had become overly complicated in its attempt to achieve a number of objectives simultaneously. It would be more effective to produce another Act, which concentrates on the treatment and rehabilitation of drug dependants. In 1983, Drug Dependants (Treatment and Rehabilitation) Act 1983 was enacted to replace and repeal part VA of the Dangerous Drugs Act 1952, the provisions that deal with treatment and rehabilitation.²¹ Section 38A and 38B were correspondingly introduced in the Dangerous Drugs Act 1952.²² Section 38A of that Act enables the court to send a drug offender under the age of 18 years for treatment and rehabilitation under the Drug Dependants (Treatment and Rehabilitation) Act 1983, if it is expedient to do so. It however excludes serious drug offences of trafficking, cultivation or possession under section 39B, 6B and 39A of the Dangerous Drugs Act, 1952 respectively. Understandably, these offences were considered

¹⁹ Anti-Narcotics Task Force, *Narcotics Report 1995*, pg 4 - 5, Ministry of Home Affairs, Malaysia; Anti Narcotics Task Force, *Narcotics Report 1994*, pg 2 - 4, National Security Council, Prime Minister's Department, Malaysia.; Yahya Ismail, *Cawangan Antidadah: Peranan Dalam Memerangi Pengedaran/ Penagihan Dadah, Pengaman, Majalah, Polis DiRaja Malaysia* (1995), vol.47, page 6-15, at pg 10.

²⁰ National Narcotics Agency, *Narcotics Report 1996*, at pg 3 - 4; National Narcotics Agency, *Laporan Dadah 1997*, Ministry of Home Affairs, Malaysia, at pg 5.

²¹ Act 283/83 -passed on the 16th April 1983.

²² Dangerous Drugs (Amendment) Act 283/83, passed on 16th April 1983. See section 29 and 30, of Drug Dependants (Treatment and Rehabilitation) Act 1983 (Act 283): w.e.f. 16th April 1983.



grave and serious. A punitive approach to curb the growing drug menace that was seen as threatening the social fabric of society was preferred here. Under section 38B of the Dangerous Drugs Act 1952, the court is required to order a person convicted of the offence of self-administration of dangerous drugs to undergo supervision between two to three years under the Drug Dependents (Treatment and Rehabilitation) Act 1983, after having completed his prison term.²³ A drug addict could still be charged with the offence of self-administration under Section 15 of the Dangerous Drugs Act 1952, and if convicted could be sent to prison, which also has parallel treatment and rehabilitation facilities.²⁴

Section 3 of the Drug Dependents (Treatment and Rehabilitation) Act 1983, enables an officer (rehabilitation officer or any police officer not below the rank of sergeant or any police officer in charge of a police station) to take into custody any person he reasonably suspects to be a drug dependant.²⁵ He could be detained for twenty-four hours at any appropriate place for the purpose of undergoing tests. The officer may release him on bail (with or without surety), if the tests cannot be held or completed within twenty-four hours. Beyond that period, the officer would have to produce him before a magistrate for an order to detain him for up to 14 days. The magistrate may release him on bail-bond (with or without surety) to attend at such time and place as may be mentioned in the bond for the purpose of undergoing tests. Where tests have been done but the result is yet to be obtained, the magistrate may release him on bail (with or without surety) to appear at such place and time, as may be mentioned in the bond to receive the result of the tests.²⁶

A person who is detained for suspicion of being a drug dependant must be a certified drug dependant before a magistrate can make an order for his treatment and rehabilitation.²⁷ An assessment of his drug dependency will be made, which means that he is obliged to do all acts or procedures that the rehabilitation officer, or government medical officer or practitioner deems necessary.²⁸ Section 2 of the Drug

²³ Public Prosecutor v Ng Hock Lai [1994] 4 CLJ 1056.

²⁴ The Public Prosecutor determines the charge he prefers (section 376 of Criminal Procedure Code).

²⁵ Social welfare officer was deleted from the definition of "officer" by the Drug Dependents (Treatment and Rehabilitation) (Amendment) Act A1018/ 98.

²⁶ Section 3 & 4, Drug Dependents (Treatment and Rehabilitation) Act 1983.

²⁷ Section 6(1), Drug Dependents (Treatment and Rehabilitation) Act 1983.

²⁸ Section 5, Drug Dependents (Treatment and Rehabilitation) Act 1983; Public Prosecutor v Soh Teh Foh [1990] 2 MLJ 383 - High Court



Dependants (Treatment and Rehabilitation) Act 1983, defines a drug dependant as someone who through the use of any dangerous drug, undergoes a psychological and sometimes physical state, which is characterized by behavioral and other responses including the compulsion to take drugs on a continuous or periodic basis, in order to experience the psychological effect, and to avoid the discomfort of its absence. Urine tests serve to corroborate clinical assessments.

The magistrate must decide whether a drug dependant should reside in a rehabilitation centre for a two-year period and thereafter undergo supervision, or otherwise supervision for 2 to 3 years under an officer (rehabilitation officer or police officer), where treatment and rehabilitation may be carried out.²⁹ A drug dependant placed on supervision whether in the first instance or subsequent to being discharged from the centre or prison,³⁰ has conditions imposed upon him. These conditions relate to his residence, reporting of his whereabouts, abstaining from drugs, undergoing tests (as and when required by the officer) and attending rehabilitation programs. Breaching these conditions is an offence and punishable with imprisonment of up to three years or whipping of up to three strokes or both.³¹

It is considered that an experimental drug dependant or a new addict does not require an intensive or long period of rehabilitation in the centre. What is needed is counseling and therapy, not forgetting that other factors such as co-operation from the society, family, stable employment and user friendly environment is equally instrumental in keeping him free of drugs. This is done through intensive supervision involving a rehabilitation officer, parents and local leaders. Supervision is a community-based programme that is designed for a drug dependant who does not need residential rehabilitation. It includes orientation, discussion, evaluation and review of rehabilitation objective or plan, urine tests, counseling, work placement, family and society involvement. Supervision inevitably works best for drug dependants with families, relatives, employer or peer's co-operation and support. However, the paramount consideration in deciding whether a drug dependant is placed

²⁹ Section 6(1), Drug Dependants (Treatment and Rehabilitation) Act 1983. Prior to this 1983 Act, treatment and rehabilitation in rehabilitation centre was for six months only or a two-year supervision by a social welfare officer (see Dangerous Drugs (Amendment) Act A389/77 & A413/77).

³⁰ See section 38B, Dangerous Drugs Act 1952.

³¹ Section 6(2), as amended by the Drug Dependants (Treatment and Rehabilitation) (Amendment) Act A1018/1998.



in the centre or on supervision is his own motivation towards his treatment and rehabilitation. A problem drug user however, is a threat to himself and the society. His activities and craving for drugs inevitably results in the emergence of new addicts, particularly among his peers and colleagues. He would peddle drugs to support his habit and is likely to commit drug-related crimes. Preventive enforcement in the centre would positively keep this "menace" in check. These centres enable the intake of many drug dependants for treatment and rehabilitation, hence severing the demand and supply of controlled drugs. Ultimately, it is the determination of drug dependants to stay free from drugs that is crucial and central to the success of the rehabilitation programme.³²

The Supreme Court in *Ang Gin Lee v Public Prosecutor* held that there is no appeal to or revision by the High Court from the order of the magistrate under section 6 of the Act. The order by the magistrate was not an order pronounced by a Magistrate's court in a criminal case or matter for the purpose of section 307(I) of the Criminal Procedure Code. The reason given by the court was that, the criminal jurisdiction of the Magistrate court is provided in section 85 of the Subordinate Courts Act of 1948. Thus, the power of the magistrate to make an order under section 6 was conferred on the magistrate as distinct from the Magistrates' court.³³ Moreover, a drug dependant under the Act is not charged with any offence nor he is convicted of any charges.

THE COLD TURKEY TREATMENT METHOD

Since 1977, the treatment and rehabilitation concept practiced in Malaysia has been the 'cold-turkey' approach i.e. without the use of substitute drugs. Its strategy is to rehabilitate drug dependants to be effective members of society, by severing their dependency on illicit drugs and preventing recidivism. Hence, it works towards sustaining the attitudinal and behavioral change of the recovering addicts to remain free from illicit drugs. Treatment and rehabilitation in Malaysia through opiate maintenance was stopped in 1977, because it does not eradicate dependence and could be abused. A drug dependant may have built up remarkable tolerance, hence may need a higher dosage, which leads to increased health risks from overdose and respiratory problems. Furthermore, it could also cause the patient to find other drugs, the moment the effects of the substitute drugs lose their effect (it may well be due to a smaller dosage of the methadone itself). There is also no

³² National Narcotics Agency (1997), *Kenali Dan Perangi Dadah*, at pg 52-53, & 63.

³³ [1991] 1 MLJ 498 - Supreme Court.



guarantee especially of drug addicts undergoing outpatient maintenance treatment that they would abstain from taking drugs illicitly. Similarly, providing needles and syringes to addicts is not a guarantee that the same will not be shared or used more than once. Such a policy would also convey the wrong signal as to drug taking. Moreover, such a move is incompatible with Malaysia's policy of a lifestyle free from drugs.³⁴ Furthermore, maintenance on methadone would also not work with non-opiate misusers (e.g. cocaine) or multi-drug misusers, thus making inpatient detoxification seemingly the only solution.

Treatment and rehabilitation centres, however, amount to centralization and imprisonment, making it less accessible for drug dependants to get support from families and friends. It may also however, operate as a place for some addicts to establish their drug networking and thus detrimental to their rehabilitation upon their release. The Malaysian government is quite lost, bearing in mind that the treatment and rehabilitation centres have been in Malaysia for quite a long time, yet the relapse rate at times is 75 %, ³⁵ and may even be higher i.e. 85%.³⁶ It is now conceded that 75% to 80% of drug dependants relapse after their discharge from rehabilitation centres. There are now an estimated of 293,000 identified drug addicts between the age of 21 to 29 years old despite an overwhelming budget of RM200 million spent in 2005 on treatment and rehabilitation and RM 92 million in just the first 4 months of 2006.³⁷ Datuk Wira Abu Seman, the Deputy Minister of Federal Territories said that the campaign against drug misuse for the past 20 years amounting to RM 1.3 billion failed to achieve its goal due chiefly to society's attitude of "dumping" the problem solely unto the government.³⁸

³⁴ National Narcotics Agency (1997), *Kenali Dan Perangi Dadah*, at pg 27, 63 - 67; See also Hough, M. (1996) *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, Home Office Drugs Prevention Initiative, Paper 15 at pg 2 of 3 of Executive Summary, and pg 3 of 11 of chapter 4: Communities Penalties.

³⁵ Berita Harian Online (1998b) *Mahkamah Berhak Tentukan Hukuman*, Wednesday, 6th January 1998; Singapore Straits Times (1999a) *Spruce up offices to curb drug abuse*, August 29, 1999: http://straitstimes.asia1.com.sg/reg/mal4_0829.html; Singapore Strait Times, *400,000 workers lost to drug abuse: KL*, August 30, 1999: http://straitstimes.asia1.com.sg/reg/mal9_0830.html

³⁶ Parliamentary Debate, House of Representatives, 25th April 2000, pg 39 - 89 at pg 78 82 - a survey by PEMADAM on 24,000 residents revealed that 85% are relapse cases. This percentage was, however, disputed by the Deputy Home Affairs Minister.

³⁷ Rohana Mohd Nawi reporting for Berita Harian Tuesday, 27th Jun 2006, at pg 17, *Hanya 25 Peratus Pelatih Pusat Serenti Dipulihkan*, in an interview session with Deputy Minister of Internal Security, Datuk Mohd Johari Baharun, after the launching of the International Anti-Narcotics and State of Kelantan Anti-Narcotics Carnival in Kota Baru, Kelantan.

³⁸ Utusan Malaysia (oleh Norizan Abdul Muhid), *Kempen Antidadah Gagal, Kerajaan Rugi RM 1.3 Billion*, at pg 30, Tuesday 27th June 2006.



MAINTENANCE ON DRUG PRESCRIPTION & HARM REDUCTION

Malaysia has however, taken a pilot scheme since March 1997 to supplement the "cold turkey" treatment with maintenance on the *Naltrexone* drug prescription. Maintenance on *Naltrexone* is believed to be able to cut down relapse up to 30% by the year 2003 and its effectiveness has been proven in Singapore, United States, Canada and Germany. More enlightened is the willingness of the Malaysian Government to fully fund those addicts who undertake the program. The intake of addicts to the program would be increased in accordance with the available funding. The pilot scheme runs along the line of compulsory treatment and rehabilitation. Selected candidates with good motivation, family support and good job prospects upon the completion of their duration of treatment and rehabilitation are given *Naltrexone* to see whether it is effective in stopping recidivism. They are required to take *Naltrexone* 3 months prior to being released from a rehabilitation centre, and to continue taking it for another 12 months. The scheme is for two and a half years, and is expected to be completed by the year 2000. *Naltrexone* is an opiate antagonist, and it counters the opiates' desired effect or its desired properties, so that an opiate taker who succumbs to temptation experiences none of its effects, and probably will not bother to try it again. It is taken orally and because its effects last for up to 72 hours, it requires only a thrice-weekly administration. Although theoretically simple, *Naltrexone* administration does not provide an easy answer to opiate dependence. It requires a high degree of motivation on the part of the patient to continue taking the drug, which should be administered under supervision, either by a relative or at the clinic, so as to make sure that it is taken. *Naltrexone* works best on those with a history of stable relationships and employment, and who have a lot to lose, if they resume opiate abuse.³⁹

This scheme is identical to the maintenance on prescriptions of drug addicts in the United Kingdom (UK), where addicts are encouraged to maintain a steady and stable life on prescription until such time when they are deemed ready for withdrawal. The advantages are that addicts can be weaned off the drug after a period of time, while maintaining a steady and stable life and career. Furthermore, under maintenance, there is no stigma of detention. It is also very humane, cost-effective and

³⁹ Berita Harian Online, *Naltrexone Berupaya Bantu Penagih*, www.jaring.my/bharian, 10th January 1998; See also National Narcotics Agency, *Laporan Dadah 1997*, at pg 72 - 73, Ministry of Home Affairs, Kuala Lumpur, Malaysia.



practical. In contrast, those treated in boot camps when released, are less prepared or less able to face the vagaries of life in the real world because of the confinement. A lengthy detention period for treatment is 'disruptive' because it puts an abrupt end to the life and career of the drug dependant as a person. Residential treatment and rehabilitation should therefore be limited to special cases only. Supervision of addicts in cooperation with doctors at private drug treatment clinics or the National Narcotics Agency provides a positive treatment and rehabilitation environment, as long as there is proper and consistent monitoring and reporting. An addict can off course be sent to prison, if he breaches his conditions of supervision. It will do Malaysia a lot of good if maintenance on a script is given a bigger role in the treatment and rehabilitation of drug dependants. Residential treatment and rehabilitation can be very costly and the results may not be conclusively better than the maintenance treatment. However, certain drug dependence has no specific treatment, and detoxification with medical and constant careful supervision seems to be the only option. In-patient detoxification or a limited period of detention in the centre therefore would seem most appropriate.⁴⁰

The move to reconsider the "cold turkey" method to maintenance on drug prescription (such as *methadone*, *subutex*) was because the current treatment and rehabilitation of drug dependants was considered a failure, and the Prime Minister Datuk Abdullah Ahmad Badawi was unhappy that the relapse rate was almost as high as 90%.⁴¹ The government has turned around its policy almost 360 degrees to not only treat addicts on maintenance of drug therapy prescription but also to supply needles and condoms to drug dependants to control the spread of HIV. However, the final decision will be made in consultation with the National *Fatwa* (Islamic legal ruling) Council. The Deputy Prime Minister, Datuk Najib Tun Razak, when opening the 30th National PEMADAM annual general assembly in Perak Darul Redzuan on 25th June 2005 said that harm reduction is a drastic step necessitated under dire conditions and is allowed under Islamic law. He said that there were 64, 000 people infected with HIV and if drastic actions were not taken, an estimated 200,000 to 300, 000 people would be infected within the next two or three years.⁴² The Health Minister, Chua Soi Lek on 4th

⁴⁰ Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 80 - 81, Waterlow Publishers. London

⁴¹ Berita Harian, *Malaysia Timbang Kaedah Baru Pulih Penagih*, at pg 1, 21st January 2004

⁴² The Star Newspaper, *Islamic Way For Needle, Condom Programme*, at pg 2, Monday 27th June 2005.



September 2005 said that treatment and rehabilitation based on harm reduction *vis a vis* giving of free needles and condoms which was supposed to commence in October 2005 was rescheduled to January 2006 to lay down more systematic rules, training of staffs and the implementation. However, prescribing problematic drug dependants with drug prescriptions on *methadone* took off as planned in October 2005. This method of treatment and rehabilitation was done in a few major cities and would be monitored after six months, and if proven successful, it would be implemented nationwide.⁴³ The deputy health minister Datuk Dr Abdul Latiff Ahmad also said that drug addicts who have voluntarily undergone replacement therapy treatment with *methadone* can continue doing so for the rest of their lives. The therapy treatment on *methadone* was to help addicts get back to society. There were 1,200 drug addicts who had undergone the treatment nationwide since October 2005 with 18 centres in government hospitals, health clinics and selected private clinics. This maintenance on *methadone* drug prescription scheme is expected to cater for 15,000 drug addicts by 2010. The deputy health minister also said that based on the National Anti-Dadah Agency, there were some 130,000 registered drug addicts in the country.⁴⁴ Obviously, doctors given permission by the Ministry of Health to lawfully prescribe drug dependants on drug maintenance such as *subutex* and *methadone* should not act irresponsibly by selling them to non-drug dependants.⁴⁵

PERMANENT RELAPSING NATURE OF DRUG DEPENDENCY

It is a fact that many and probably most drug dependent individuals take a long time to learn to live without drugs. Though, liberal prescriptions do not seem to lead to a reduced use of illicit drugs any more than abstinence after a prison sentence, drug withdrawal is merely the first stage of treatment and will be ineffective unless followed by the all-important process of rehabilitation. It has been proven for opiates and the same may be true for other drugs that minor symptoms of abstinence may persist for months after the last dose of opiate. In other words, subtle physiological and psychological changes may last long after drug withdrawal, predisposing the individual to relapse.⁴⁶ This

⁴³ Utusan Malaysia (by Sadatul Mahiran Rosli), *Jarum, Kondom Percuma Mulai Januari*, at pg 1 & 4, Monday, 5th September 2005.

⁴⁴ The Star Newspaper, *Lifelong Meth Treatment for Addicts*, Friday, 10th February 2006, at pg 21.

⁴⁵ New Straits Times, *New Programme to Help Addicts Kick the Habit*, at pg 13, Tuesday, 25th May 2004; Berita Harian, *Perangi Gejala Dadah Usaha Berterusan*, at pg 17, Tuesday 27th June 2006

⁴⁶ See Bucknell and Ghodse (1991) *Misuse of Drugs*, pg 71, Waterlow Publishers. London



outcome is common for all treatment approaches.⁴⁷ Detoxifying is the first part of the treatment and not really that difficult to accomplish, but preventing relapse or recidivism is the main problem. This relapsing condition is even acknowledged by local drug expert Dr Mahmud Mazlan that the craving for drugs seem to be permanent, and a former drug addict may easily be tempted into taking drugs again even though he may have been free of drugs for 100 years: Drug taking, he warned, even on a couple of occasions is a one way ticket to hell. He claims that drug dependants undergoing maintenance treatment on drug *Buprenorphine* prescription achieved 65 % success between 6 to 12 months compared to the "cold turkey" method success rate of 20%. More importantly, the drug dependants are able to work and be with their family members.⁴⁸ Maintenance on drug prescription as a pragmatic and effective mode of treatment and rehabilitation of drug dependence cum harm reduction is also shared by lecturer, Dr Rusli Ismail of Molecule Medication Research Institute, Universiti Sains Malaysia, Kelantan.⁴⁹

TREATMENT AND REHABILITATION IN UK

The treatment of addicts in the United Kingdom (UK) is the responsibility of the local health authorities.⁵⁰ Special clinics (drug treatment clinics) funded by the health or social services and mainly staffed by nurses and/or social workers working with doctors exists for the treatment of drug dependants receiving maintenance prescription, while rehabilitation is the statutory responsibility of the social services. The National Health Service (NHS) and the Community Care Act 1990 imposed a duty on local authorities to assess the needs of, and arrange for provisions of residential and other services for drug misusers. Under the community care legislation, there are social services funds and social care for drug misusers including residential rehabilitation. The community drug team would normally consist of senior level executives from local authorities (e.g. City or County representatives), health authorities (a community nurse and administrative staff working with a consultant psychiatrist and/or with links to GP), local criminal justice agencies (a social worker or probation officer) and other representatives,

⁴⁷ Hough (1996), *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, at pg 2 of 3 of the 'Executive Summary'. Home Office Drugs Prevention Initiative, paper 15, London: Home Office

⁴⁸ Laporan Shafinaz Sheik Maznan, *Ketagihan Dadah Ubah Fungsi Otak* dengan pakar penagihan dan psikiatri, Dr Mahmud Mazlan, *Mingguan Malaysia*, at pg 27, Ahad, 1hb Februari 2004.

⁴⁹ Rusli Ismail, *Tukar Paradigma Tangani Dadah*, *Utusan Malaysia*, at pg 6, Thursday, 9th December 2004.

⁵⁰ National Health Services Act 1977 (as directed by the Secretary of State for Social Services).



for example, from the voluntary sector.⁵¹ Social workers are vitally important members of the multi-disciplinary team of drug treatment clinics.⁵²

Rolleston Committee & the Brain Committee⁵³

The treatment in Britain for drug dependence is mainly via the methadone maintenance. This is in accordance with the recommendation of the Rolleston Committee, who in its 1926 report stated that the problem of drug addiction must be regarded as a manifestation of disease, and not as a mere form of vicious indulgence. In other words, a drug is taken in such cases not for the purpose of obtaining pleasure, but in order to relieve a morbid and overpowering craving. The Committee also stated that relapse appeared to be the rule and that permanent cure was an exception. The Committee concluded that it was legitimate to use heroin and morphine for the relief of pain due to organic disease such as inoperable cancer, even if it might lead to addiction. It also concluded that it was legitimate to use such drugs for the treatment of addicts by the gradual reduction method, as part of the treatment plan. Finally, and more controversially, it concluded that it was legitimate to prescribe such drugs for persons who would otherwise develop such serious symptoms that they could not be treated in private practice, and for those who were capable of living a normal and useful life, so long as they took a certain quantity, usually small. The responsibility for dealing with them therefore lay with the medical profession, and not with the authorities dealing with law enforcement. In other words, it was the doctor's right to prescribe drugs, if he judged them necessary for the treatment of his patient and was not challenged.

The problem of drug addiction however, had increased at the beginning of the 1960s, and the majority of the new addicts were recreational rather than therapeutic (in the sense of becoming dependent

⁵¹ Cabinet Office Press Release, *Government's Largest-Ever Push To Tackle Drug Menace*, CAB 182/98, 1st September 1998, Cabinet Office: London; Institute for the Study of Drug Dependence – www.isdd.co.uk/trends/, *UK Trends and Update*, at content 2.2.

⁵² Cabinet Office Press Release, *Working Together To Make A Difference*, CAB 214/98, 21st October 1998, Cabinet Office: London.

⁵³ Advisory Council on the Misuse of Drugs (1982), *Treatment and Rehabilitation – Report of the Advisory Council on the Misuse of Drugs*, at pg 7-9, Department of Health and Social Security. London: Her Majesty Stationery Office; Bucknell & Ghodse (1991), *Misuse of Drugs*, at pg 6-7 & 9; Central Office of Information, *The Prevention and Treatment of Drug Misuse in Britain*, at pg. 3 – 5, London: Central Office of Information, Reference Division, October 1978; Social Morality Council (1975), *Education and Drug Dependence*, at pg 21-22, Methuen Educational Ltd, London



on opiates usually morphine or, after 1945, *pethidine*, in the course of medical treatment). However, an interdepartmental Committee of the Ministry of Health chaired by Sir Russel Brain (Brain Committee) was able to report in November 1960, that no change was required in the British approach to drug addiction because the situation had not changed appreciably in the years since the issue of the Rolleston report. The overall picture later changed for the worse and the Brain Committee reconvened in July 1964 to consider whether their 1961 advice in relation to the prescribing of addictive drugs by doctors needed revision. There had been significant increases in the number of persons known at some time in the year to be addicted to dangerous drugs (from 454 addicts in 1959 to 753 addicts in 1964), and in particular of known heroin addicts (from 68 addicts to 342 addicts over the same period). An added cause for concern was that these new addicts had not originally taken the drugs for therapeutic purposes, but were young addicts introduced into heroin in other ways. In its second report, it stated that the increase in the number of drug addicts was attributed to a few 'unscrupulous' doctors who prescribed large quantities of dangerous drugs, and thus created a surplus in the market conducive towards recruiting of new addicts. In 1962, one doctor alone had prescribed for addicts no fewer than 600,000 normal doses of heroin. There were other examples just as bad, but these doctors were acting legally under the law as it then stood. The Brain Committee made extensive proposals to limit the number of doctors authorized to supply heroin and cocaine to addicts, and to ensure that the supply of such drugs only took place in a setting where there was a comprehensive range of treatment facilities for drug dependency. They also suggested that treatment centres should have the power to detain addicts compulsorily.

Legislative Controls

The Dangerous Drugs Act of 1967 implemented the recommendations of the Second Brain Committee's report, with the exception to compulsory detention. The Home Secretary was given power to make regulations that require medical practitioners to furnish particulars of patients who were addicts, and to prohibit medical practitioners, unless specifically authorized (notably doctors working in treatment centres) from prescribing specified drugs to addicts. Under that Act, the Dangerous Drugs (Supply to Addicts) Regulations 1968, which came into force in early 1968, made it obligatory for a medical practitioner to notify the Chief Medical Officer of the Drugs Branch of the Home Office, when he discovered a patient who was dependent on *heroin* or *cocaine*.



With the exception of *heroin (diamorphine)* and *cocaine*, where specially licensed doctors could prescribe these drugs when they are being used in the treatment of people regarded as addicts, i.e. for so-called 'maintenance' treatment, the long established right of a doctor to prescribe controlled drugs without restriction was maintained. In practice, licenses have only been issued to doctors working in treatment centres, hospitals and other special institutions. However, there is no bar on their prescription for the relief of pain in organic disease (in the case of *heroin*) or as local anesthetic (*cocaine*). That Act too, gave the Home Secretary power over any medical practitioner who contravenes the regulations.

These regulations of notifying addicts had been re-enacted, essentially unchanged as the Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973 (S.I. no. 799).⁵⁴ Rule 3 of Regulation 1973 required a doctor who attended an addict to furnish within seven days a written notification to the Chief Medical Officer at the Home Office of the personal particulars of the addict, unless the controlled drug was required for the purpose of treating organic disease or injury. If possible, the name, address, sex, date of birth and national health number, together with the date of attendance and the name of the drug or drugs concerned should be given. There was no such status as 'registered addict' because these notifications were used only to compile the Addicts Index (strictly confidential) used for epidemiological data, as a check against addicts seeking simultaneous treatment from more than one clinic or doctor, and as an early warning of possible over prescribing.⁵⁵ This notification was limited to persons addicted to one of the drugs listed in the Schedule to the Regulations. Regulation 3(2)(b) made it unnecessary for a doctor to furnish a notification, if one had already been given within the last twelve months.⁵⁶ These statutory requirements on doctors to notify treatment of addicts were revoked on 14th May 1997 by the Misuse of Drugs (Supply to Addicts) Regulations 1997. The restricted range of drugs on which the index focused over the past three decades, meant that its usefulness for epidemiological research had become limited, as more and newer drugs gained popularity amongst drug misusers.

⁵⁴ Central Office of Information (1978), *The Prevention and Treatment of Drug Misuse in Britain*, at pg 4; Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 7; Leech and Jordan (1973), *Drugs for Young People: Their Use and Misuse*, pg 44, The Religious Education Press, Pergamon Press Ltd Hill hall, Oxford.

⁵⁵ ACMD (1982) *Treatment & Rehabilitation-Report of the Advisory Council on the Misuse of Drugs*, at pg 96.

⁵⁶ See section 10 (h) and (i), Misuse of Drugs Act 1971.



Furthermore, there was also the question of the high costs of maintaining the index in the face of alternative database systems.⁵⁷ Information about how many people are asking for help with drugs problem is now collected regionally (Regional Drug Misuse Databases). Thus, the closure of the addicts' index is logical in that it overlapped with the other help-seeking treatment-led indicator, the Regional Drug Misuse Databases, overseen by the Department of Health. This system utilizes a regional reporting structure based on returns from specialist drug and alcohol agencies, GPs, police, surgeons, some hospital departments and prison medical officers. Annual reports are available through the Department of Health's Statistical Bulletin. Regional returns provide data referring to the sex of individuals, area of the return, drugs misused, injecting behavior and agency treatment episodes.⁵⁸

At present, the power of control over medical practitioners and pharmacists are provided by section 12 to 17 of the Misuse of Drugs Act 1971. There are provisions for a tribunal to advise the Home Secretary in respect to practitioners. The Home Office is primarily responsible for the policy and for administering the legislation concerning the misuse of dangerous drugs, including the licensing of doctors to treat addicts and the disciplining of doctors who prescribe irresponsibly. The Home Secretary may issue licenses to certain doctors authorizing them to supply *heroin* and *cocaine* to addicts. Generally, any medical practitioner can treat patients with problems of drug dependence, although only those with a license from the Home Office may prescribe those drugs.⁵⁹

Drug Action Team

Community drug teams offer greater opportunities for drug misusers to maintain positive relationships, find stable employment, develop through educational and training courses, and gain access to good quality medical services and counseling support to help achieve a drug-free lifestyle. The drug team may be based in a hospital or clinic, or may be

⁵⁷ Corkery J.M. (1997), *Statistics of Drug Addicts Notified to the Home Office, United Kingdom, 1996*, at pg 3, Home Office Research and Statistics Directorate, Issue 22/97, London: Home Office.

⁵⁸ Parker, Bury and Egginton (1998), *New Heroin Outbreaks Amongst Young People in England and Wales*, at pg 11, Home Office Police Research Group: Crime Detection and Prevention Series paper 92, London: Home Office; United Kingdom Home Office Annual Report 1998-99: Chapter 9 - *Drugs*.

⁵⁹ Section 30, Misuse of Drugs Act 1971; Regulation 4, Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973.



based in the community or local authority boundaries. Their interventions commonly involve assessment and counseling, sometimes detoxification and prescribing. Activities include advocacy work, child protection work, complementary therapy, writing of court reports, and liaison with the criminal justice system, with prisons and probation officers and referrals on to other services. The majority described their approach as based on concepts of harm-reduction but with abstinence being the ideal eventual goal. They aim is at improving the quality of life of substance misusers by prescribing *methadone* (for opiate users) in place of *heroin*, offering advice and counseling and encouraging safer drug use and where appropriate, abstinence. In the case of some addicts, the prescriptions of *methadone* were available over a longer period of time to discourage a return to street drug misuse and the additional risk of physical harm inherent with drug injecting, such as HIV and Hepatitis. Patients may be referred on to mental health services, specialized services such as Genito-Urinary Medicine or HIV services and to residential rehabilitation as appropriate. The team is also in contact with self-help groups.⁶⁰

Drug-Treatment Clinic

The first stage for an addict seeking treatment is usually to register with an outpatient clinic. This is a clinic that is attached to a hospital and staffed by psychiatrists, social workers, nurses, and probably probation officers. Some clinics have day centres where the addict can spend a good deal of time. Patients may be referred for treatment by their general practitioner or other doctors or by a social worker, probation officer or another agency. Some refer themselves, although some clinics insist on a formal referral letter from another doctor. A probation officer may have clients who are drug dependants, who agree or are obliged to undergo treatment and rehabilitation as requirements of probation under the Criminal Justice Act 1991,⁶¹ or as an additional requirement to his probation order imposed by the Courts under section 3(1) of the Powers of the Criminal Courts Act 1973. Even though the Criminal Justice Act 1991 introduced treatment and rehabilitation of drug offenders, their consent was still required.⁶² The requirement for consent for community sentences for offences has, however, been removed by the Crime

⁶⁰ ACMD (1996), *Drug Misusers and the Criminal Justice System. Part 3: Drug Misusers and the Prison System - An Integrated Approach*, at pg 15; See also Institute for the Study of Drug Dependence (1998), *UK Trends and Update*, in content 3.30 - www.isdd.co.uk/trends/.

⁶¹ As amended by Criminal Justice Act 1993, & supplemented by Criminal Justice and Public Order Act 1994.

⁶² Section 1A of the Powers of the Criminal Courts Act 1973.



(Sentence) Act 1997. Therefore, it is now by no means certain that any probationer receiving treatment as an outpatient under the terms of his license is a volunteer.

All the outpatient centres may refer patients for in-patient treatment for withdrawal and for supportive treatment during acute episodes of their condition. The support of social work, occupational therapy, and other specialized departments of the hospital are equally available where in-patient treatment is given. Patients may be admitted into in-patient facilities for assessment, for stabilization of dosages, for detoxification and for treatment of the complications of drug dependence. They may remain in hospital for a period, which may be on or off drugs. In-patient detoxification is essential for those who are severely dependent on sedative hypnotic drugs because of the risks associated with their withdrawal.⁶³ If an addict wishes to come off all drugs, he will probably be admitted into an in-patient unit (although some addicts come on and off, on an outpatient basis). Once withdrawal is complete, the major task of encouragement to abstain from drugs commences. In this manner, treatment and rehabilitation become almost indistinguishable terms. A long period of after-care is inevitably necessary after the discharge because much of the work of treating the causes of addiction must be done outside hospitals. Co-operation between medical staffs, social workers and lay organizations is therefore crucial.

Assessment of Drug Dependency

At the clinic, an accurate diagnosis of a patient's dependent status is essential, as regular prescription of opiates could convert an occasional user into an addict. A clinical/social assessment on a multi-disciplinary basis needs to be thoroughly done and this usually takes 2-3 weeks. Various means are used to gauge the presence and extent of addiction, including biochemical tests to establish the actual fact of drug use. The diagnosis of opiate dependence also relies heavily on urine tests being positive for opiates. A careful history is taken, including the age at first use, subsequent drug taking, injecting, medical complications, etc. Checks are made at the drug misuse databases to ensure that the patient is not already obtaining drugs from another centre. A patient is not normally accepted at his or her first appearance, but is asked to return on at least one further occasion, so that it can be ascertained whether he

⁶³ Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 74 and 80; Leech and Jordan (1973), *Drugs for Young People: Their Use and Misuse*, at pg 89 - 90.



or she is using the drugs in question persistently.⁶⁴ In practice, there are wide variations in assessment, treatment and prescribing policies, depending on the facilities and the available staffs, the needs of the individual patient and the philosophy of the clinic. Some clinics operate on a non-opiate prescription policy.⁶⁵

Prescribing

The clinic has to decide whether it is justifiable to prescribe drugs, either as a prelude to gradual withdrawal or for maintenance therapy, if the patient is genuinely addicted. The aim is to stabilize the patient and enable him or her to function normally in the community until he or she is motivated to accept the withdrawal treatment. If the patient is diagnosed as being physically dependent on opiates, an opiate will be prescribed. The dose to be prescribed is decided individually, the aim being to prescribe the minimum dose so that the patient has to take it all personally to prevent the onset of the withdrawal syndrome, and has no surplus, either to produce euphoria or to sell. In some areas, the risk of diversion of supplies of the drugs prescribed is avoided by posting prescription forms to retail pharmacists willing to undertake this type of dispensing, usually on a daily basis in the first instance. In other words, the patient goes to the pharmacy each day to collect the day's supply, with two days supply on Saturdays since pharmacies are generally closed on Sundays.⁶⁶

Some clinicians are prepared to continue the maintenance prescription over an indefinite period of time to enable stabilization, but lately this is less commonly accepted. More recently there has been a marked trend away from opiate maintenance for newly notified addicts, and strenuous, often repeated, attempts are made to effect opiate withdrawal and to encourage a drug free lifestyle, though the option of maintenance treatment for opiate dependence remains.⁶⁷ This could be due to the fact that the drugs they had received legitimately for many years, has diminished for good their prospect of becoming drug-free in the foreseeable future. Another reason is, many drug misusers have little or no wish to opt for rehabilitation, and seek medical help for the sole

⁶⁴ Central Office of Information (1978), *The Prevention and Treatment of Drug Misuse in Britain*, at pg 21; Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 79.

⁶⁵ ACMD (1982), *Treatment & Rehabilitation - Report of the Advisory Council on the Misuse of Drugs*, at pg 14-15, & 28.

⁶⁶ Central Office of Information (1978), *The Prevention and Treatment of Drug Misuse in Britain*, at pg 21-22; Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 79.

⁶⁷ ACMD (1982), *Treatment and Rehabilitation - Report of the Advisory Council on the Misuse of Drugs*, at pg 27; Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 73.



purpose of obtaining drugs.⁶⁸ This is so as indefinite maintenance on prescribed opiates is permissible and theoretically possible, even though, it may lead to a state of chronic dependence. Clinic staffs in such situations merely operate in the manner of a vending machine issuing prescriptions. They become frustrated by their therapeutic impotence and frequent confrontations with patients about which drugs should be prescribed and as well as the dosage.⁶⁹ Furthermore, addicts who are expected to attend treatment clinics, whereby after stabilization they are to be weaned off drugs, rarely do so, and often remain on opiate (*methadone*) maintenance.⁷⁰

Harm Reduction

On the other hand, a policy not to prescribe drugs at clinics would without doubt deter opiate misusers from seeking treatment, and hence induce an illicit market in drug dealing. It would also prompt them to turn to doctors in general practices who are prepared to prescribe on a regular basis. The problem then is that they do not have the resources to provide the full range of support services needed for the treatment and rehabilitation of drug misusers. General practitioners in the UK are quite free to prescribe any drugs (e.g. *methadone* is mostly dispensed by retail pharmacists for unsupervised use) they consider to be appropriate in the treatment of addiction, with the exception of *diamorphine*, *cocaine* and *diphanone*, which can only be prescribed under special licence.⁷¹ On the other hand, continued maintenance prescribing has not prevented a substantial growth in drug misuse or the availability of the drug in the illegal market.⁷² Addicts undergoing treatment sometimes also use illicit supplies of drugs other than those prescribed.⁷³ This has prompted an

⁶⁸ ACMD (1982), *Treatment and Rehabilitation - Report of the Advisory Council on the Misuse of Drugs*, at pg 33; Flemming, Philip M. (1995), *Prescribing Policy in the UK- A Swing Away from Harm Reduction?*, International Journal of Drug Policy, Vol. 6, No. 3, 1995.

⁶⁹ Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 79.

⁷⁰ Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 73; Leech and Jordan (1973), *Drugs for Young People: Their Use and Misuse*, at pg 87.

⁷¹ Section 30, Misuse of Drugs Act 1971; Regulation 4, Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973; Hough (1996), *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, at pg 3 of 11 of chapter 4: 'communities penalties'.

⁷² ACMD (1982), *Treatment and Rehabilitation - Report of the Advisory Council on the Misuse of Drugs*, at pg 28 and 33; HM Government (1998), *The Government's Ten-Year Strategy for Tackling Drugs*, pg 1 of 3; Greenwood, J. (1991) *Persuading General Practitioners to Prescribe - Good Husbandry or a Recipe for Chaos*, British Journal of Addiction, Vol. 87, 1992; at 567-575; Flemming, Philip M. (1995), *Prescribing Policy in the UK- A Swing Away from Harm Reduction?*, International Journal of Drug Policy, Vol. 6, No. 3, 1995.

⁷³ Central Office of Information (1978), *The Prevention and Treatment of Drug Misuse in Britain*, at pg 22; Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 73.



approach whereby a contract is agreed between patients and staffs before opiates are prescribed for the first time. Opiate prescription is only part of the contract, which includes weekly attendance, getting a job wherever possible, and giving up illicit drug use. The dose of opiate is gradually reduced over an agreed period (a few months), and other goals towards a drug free lifestyle are worked on simultaneously. This approach reduces confrontations between staffs and patients regarding drug dosage and enables them to work together towards other goals, putting the drug abuse into its true perspective. Repeated assessment of the patient's drug dependency may be necessary, if the prescription is to continue.⁷⁴ The Edinburgh Community Problem Service (EDCPS) for example, in liaison with a general practitioner would ask a drug dependant offered a script to agree to a schedule of medication, regular contact with a key worker and random urine checks. Continued use of street drugs by mouth or injection would risk the cessation of the script. ECDPS would also not tolerate any lost scripts or aggression to the surgery staff members. The agreement would be reviewed periodically to evaluate changes in behavior etc.⁷⁵

Prescribing is generally used to attract drug users to the services offered, help stabilize the patient's lifestyle, reduce harmful injecting and the spread of diseases such as AIDS or HIV, remove the need to deal in drugs - thus reduces the supply, causes an impact upon criminal offending (particularly acquisitive crimes), and enables a therapeutic relationship between the drug taker and clinicians. The basic rationale for drug substitution and maintenance is that of harm reduction: if some people are unable to quit using drugs, both users and society at large benefit if these users, i.e., addicts, are able to switch from the "black market" drugs of indeterminate quality, purity or potency to legal drugs, of known purity and potency, obtained from physicians, pharmacies and other legal channels. The risks of overdose and other medical complications decline; the motivation and need for addicts to commit crimes to support their habits drop; for addicts are more likely to maintain contact with drug treatment and other services, and more able and likely to stabilize their lives and become productive citizens.

⁷⁴ Bucknell and Ghodse (1991), *Misuse of Drugs*, at pg 79.

⁷⁵ Greenwood, J. (1992), *Persuading General Practitioners to Prescribe - Good Husbandry or a Recipe for Chaos*, at pg. 2 & 3 of 10.



The objective of this conciliatory and reciprocal approach is to make contact with as many drug users as possible, in order to offer a broad spectrum of services. These might range from services intended to support continued drug use in a safer manner (for example, needle exchanges or advice on safer sex) to opportunities for detoxification or support for abstinence. The strength of the programme lies in the fact that it enables treatment to be carried out by helping the client to develop a more stable lifestyle, and dose reduction and the achievement of abstinence can then be approached within this context. The ultimate goal without doubt is abstinence, though it may take years to realize, but stability on a prescription without illicit drug use is conceded to be less harmful than chaotic, illicit multiple drug use. In order to establish this, regular monitoring is essential, which includes urine tests, psychiatric and therapeutic help when required.

These arguments have been reinforced by the advent of AIDS. Intravenous drug-abusers are high-risk groups for AIDS and an important route for the transmission of HIV into the general heterosexual population. The ACMD has brought out three reports on AIDS and drug misuse in 1988, 1989 and 1993. Its report on AIDS and drug misuse of 1988 and 1989, acknowledged that AIDS was more of a threat to the individual and the public's health than drugs. Its 1993 report stated that the *methadone* maintenance programme were beneficial for both the individual and the public's health. Maintenance is one way of keeping clients in treatment, whilst other therapeutic processes can take place. In other words, it may provide the client both the time and environment he requires to acquire the confidence and strength to change.⁷⁶ Harm reduction is however, only a short-term strategy.

Drug substitution and maintenance experiments have shown that prescribing reduces both illegal heroin use and related crimes. It also revealed that those on higher dosages, aimed for maintenance rather than abstinence fared even better.⁷⁷ It must, however, be emphasized that though maintenance on prescription reduces crime and has health benefits to society, it still does not remove the dependency of the addicts, and thus it is acknowledged that the reductions and benefits are at most

⁷⁶ Hough (1996), *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, at pg 7 of 11, chapter 4: Communities Penalties.

⁷⁷ Hough (1996), *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, at pg 2 of 3 of 'Executive Summary, and pg 3 of 11 of Chapter 4: Community Penalties; The Lindesmith Centre, *Focal Point: Drug Substitution and Maintenance Approaches*, www.lindesmith.org/library/focal11.htm, at pg 1 and 2 of 4 - 11th September 98.



superficial or superimposed.⁷⁸ Furthermore, such a policy has its inherent risks and dangers, as it may lead to the widespread use of drugs in society, rather than abstention.

The maintenance treatment favored in the UK can lead to chronic dependence on drugs as well as the danger that once tolerance is developed, addicts would strive to acquire more potent drugs illicitly. Moreover, the prescribed *methadone* can be sold to subsidize the illicit purchase of *heroin*, which is dearer. Prescribing as a panacea to drug related harm is an oversimplified response to the drug problem. Addicts on a *methadone* prescription could still continue to use street *heroin* as well, and may therefore continue to raise money for heroin through crime. The leakage of prescribed drugs in significant quantities onto the illicit market is inevitable because the *methadone* prescribed may fail to meet addicts' needs.⁷⁹ For many addicts, remaining on a prescription for a long time seems to be the rule. Furthermore, despite the considerable benefits of *methadone* (like crime reduction, client stabilization, reduction of illicit drug use) there is little evidence of success in weaning heroin users off *methadone*.⁸⁰

The Home Office Police Research Group study - *New Heroin Outbreak Amongst Youth in England and Wales* - made recommendations for better and more widely available drug services for young people, which do not involve the routine prescribing of *methadone* as a first instance. Further, it accepted that maintenance on prescriptions should not and cannot be a first response to the treatment of drug addicts except in a desperate situation, namely for detoxification.⁸¹ Prescribing drugs is not an effective answer to drug dependency. It leads to spillage or leakage in the illicit drug market, and encourages complacency in the addicts' and in the society as well. The Brixton Drug Project in London asserted that over the past ten years, the British drug strategy has been nothing

⁷⁸ Parker, Bury & Egginton (1998), *New Heroin Outbreaks Amongst Young People in England & Wales*, at pg 55.

⁷⁹ HM Government (1998) *Tackling Drugs to Build a Better Britain: The Government Ten-Year Strategy for Tackling Drug Misuse*; Hough (1996), *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, at pg 3 of 11, chapter 4: Communities Penalties; See also Central Office of Information (1987), *The Prevention and Treatment of Drug Misuse in Britain*, at pg 22.

⁸⁰ ACMD (1982), *Treatment & Rehabilitation - Report of the Advisory Council on the Misuse of Drugs*, at pg 1; Central Office of Information (1978), *The Prevention & Treatment of Drug Misuse in Britain*, at pg 22, and 27.

⁸¹ Parker, Bury and Egginton (1998), *New Heroin Outbreaks Amongst Young People in England and Wales*, at pg vii and 56; Home Office News Release 314/98, *Tackling Drugs in Northumberland: George Howarth Launches New Project*, 3rd November 1998, London: Home Office.



more than harm-reduction. Harm reduction honestly is not about eradicating drug addiction or dependence, but rather, of reducing drug-related problems. The provision of drugs arguably will help addicts avoid the illicit market, HIV/AIDS and acquisitive crime. However, prescription by general practitioners as a first step has the potential to pave the way to drug use, not abstinence, unless there is clear advice and guidelines. It also sends a wrong signal to the addicts themselves and their peers that drug taking is not a taboo. The harm reduction policy, which should be a short-term strategy, inevitably continues in practice to be a permanent and integral part of the treatment and education policy, though such a move is technically an affront to the criminal justice system. It is like an indirect endorsement to drug use in the face of its widespread use in the society. What it amounts to is a pragmatic response to the fact that drug use cannot be curtailed. The view is that, the least that can be done is to ensure that it is used responsibly to reduce the drug related problems. It might be thought that this is an acceptable response, as far as the health issue is concerned, but quite incompatible with the criminal justice system.

The UK Central Drugs Co-ordination Unit, in its document published in May 1995 titled '*Tackling Drugs Together*' recognized the need to take effective action by vigorous law enforcement, accessible treatment and new emphasis on education and prevention to: increase the safety of communities from drug-related crime; reduce the acceptability of drugs to young people; and to reduce the health risks and other damages related to drug misuse, through multi-agency co-ordination at national and local levels. The Home Office Minister, George Howarth told senior police officers that though much of the Government's emphasis in the ten-year strategy, '*Tackling Drugs to Build a Better Britain*', is on treatment, education and harm reduction, enforcement is still a priority.⁸² The recent Public Entertainments Licenses (Drug Misuse) Act 1997 introduced in May 1998 enables the local authorities to shut down clubs immediately where the operators cannot, or will not, deal with a serious problem of drug misuse on the premises. The UK Government's White paper '*Tackling Drugs Together, 1995*' is silent on harm-reduction. The strategy or the ultimate goal must be to ensure that people

⁸² HM Government (1998), *Tackling Drugs to Build a Better Britain: The Government Ten-Year Strategy for Tackling Drug Misuse*, Cm 3945, London: Home Office. (1998), in 'Aim (ii): Communities - To Protect our Communities from Drug-Related Anti-Social and Criminal Behaviour', pg 1 of 3; Home Office News Release 219/98, *Minister Praises Police Commitment to Tackling Drugs*, 15th June, 1998, London: Home Office.



do not take drugs in the first place, but if they do, they should be helped to become and remain drug free. The UK government does not condone drug taking or support any initiatives that could be interpreted as such. It however acknowledged that there would always be those, who through ignorance or other reasons will misuse drugs, whatever the consequences. For these people, information and facilities aimed at reducing the risks should be provided because that may save lives. However, such information must be coupled with the unambiguous message that abstinence from drugs is the only risk-free option. Sections 61 – 64 (Drug Treatment and Testing Orders) of the Act which received Royal Assent on the 31st July, 1998, introduced a new community penalty, the Drug Treatment and Testing Order (DTTO), which is aimed at those who are convicted of crime(s) to fund their drug habit and who show a willingness to co-operate with treatment. DTTO was created in order to break the links between drug misuse and other types of offences, thereby preventing further offences. Section 61 allows the court with the offenders' consent, to order the offender to undergo treatment for their drug problem, either in tandem with another community order, or on its own. Unlike the Criminal Justice Act 1991, proof of drug misuse is not necessary so long as the court is satisfied that the offender is a dependent drug-misuser. It is open to the court, with the offender's consent, to order a drug test before sentencing, which may assist in the court's assessment of whether the offender is a dependent drug-misuser. The order is available for any offender aged 16 or over whom the court considers is dependent on drugs and is assessed as being a suitable candidate for treatment. It is a community order within the meaning of section 6 of the Criminal Justice Act 1991 and will last between six months to three years. Section 62 requires that the order specify the nature of the treatment required, whether the treatment is residential or non-residential, its location, the frequency of drug testing, and the petty session area where the offender will reside. Section 62 (1) requires the offender to submit for treatment with a view to the reduction or elimination of his dependency on or the propensity to misuse drugs. The offender is thus obliged to provide samples for testing at such times or in such circumstances as may be determined by the treatment provider. The offender may have ulterior motives for consenting to the order without seriously wanting to change. Section 63 therefore enables the court to periodically review the offender's DTTO progress from the probation officer's written report. The report would necessarily include the results of drug tests or the regularity of the offender's attendance at appointments. It will also include judgments by the treatment provider on the offender's attitude



and the responses to the treatment programme. Hence, the treatment provider's confidentiality policy must be compatible with the necessary provision of information to the Probation Service and the court. DTTO provides that the offender should liaise (not to frustrate the supervision) with the officer responsible, if the letter and spirit of the order is to be achieved. During the review, the court may amend the order. If the offender does not consent, it may revoke the order and re-sentence the offender for the original offence with the possibility of a custodial sentence. Since addiction is a relapsing condition, the court needs to recognise that a degree of failure must be viewed as part of the treatment process, and not by itself a breach of the DTTO orders. The manner and extent of the failure to comply with the requirements of the order, rather than simply not responding well to the treatment needs to be distinguished by the court. Section 64 therefore ensures that the offender knows the effect and meaning of the order, and the consequences of failing to comply with it.

The prison practices a policy aimed at reducing the demand and supply of drugs in prison. Accordingly, it will not tolerate the presence and use of illicit drugs in its establishments, and mandatory drug testing remains the centrepiece of this punitive supply-focused strategy. Consequently, the harm reduction approach is less important in the treatment and rehabilitation of inmates with a drug problem. The ACMD (1996)⁸³ was of the view that the harm reduction measures should be accorded a more important role than was allowed in view of the legal, medical and practical issues prevalent in prison. The ACMD (1996) believed that the consequences of drug misuse in terms of violence, intimidation and extortion are as important as the impact on the individual's health. The prison programme (varies from prison to prison) includes detoxification services, therapeutic communities, education, and counseling. Detoxification through education prescribing of *methadone* or other drugs is normally the case, though the practice is less common than under the NHS treatment. Usually, a limited number of prison staff such as probation officers, psychologists and hospital officers can provide basic help and advice, and the Medical Officer is responsible for providing detoxification, which is done more quickly, and on a much more limited basis than in the community. These facilities are in-house, but may also use expertise from other agencies, particularly from the

⁸³ ACMD (1996), *Drug Misusers and the Criminal Justice System. Part 3: Drug Misusers and the Prison System - An Integrated Approach*, at pg 33-34, 38 and 76 -77.



drug action teams. There is no provision for needle exchange or other services to minimize the harm from drug use. The best help usually comes from the small number of drug agencies around the country who specialize in working in prisons, and whom most prisoners prefer because they are seen as independent from the prisons, and as having specialist knowledge. These agencies provide counseling, group work programs, information, support and advice, and try to link prisoners into drug services in the community when they go to court or are due to leave prison. This partnership with other drug-related agencies may continue after their release from prison.⁸⁴ Since 1995 (Prison Rule 86), prisoners will be required to provide urine sample for testing purposes, and it is a disciplinary offence for inmates to use controlled drugs without medical authorization. Drug testing on prisoners is done at reception and randomly throughout their sentences. Those prisoners suspected of taking drugs, or those prisoners who have persistently tested positive over a period of time, will be tested most frequently. Though prison inmates cannot be forced to provide a sample for testing, refusal to provide a sample (not necessarily urine) for testing is a disciplinary offence. The same goes for adulterating or substitution of the sample given. Prisoners who test positive are subject to a range of punishments, including additional days of imprisonment, or the loss of privileges and earnings.⁸⁵

CONCLUSION

The non-prescribing policy of Malaysia on therapeutic drugs in the past for purposes of weaning and stabilization would mean that a drug dependant seeking treatment and rehabilitation would have to think 'very hard'. This policy could in actual fact deter problem drug takers from seeking treatment, though giving prescriptions liberally may lead to dependence or spillage of the same into the illicit market. Further, there is also no guarantee that an addict undergoing treatment (whether

⁸⁴ ACMD (1996), *Drug Misusers and the Criminal Justice System. Part 3: Drug Misusers and The Prison System - An Integrated Approach*, at pg 36, 70-71; Hellowell, K. (1998) *Making the Community A Safer Place*; Cabinet Office Press Release 276/98, 18th December 1998, London: Cabinet Office; Hough (1996), *Drugs Misuse and the Criminal Justice System: A Review of the Literature*, at pg 2 -3 of 6, Chapter 5: Intervention in Prisons; Durham/Darlington Drug Action Team Home Homepage, *Prison Matters: What Help Is There for Drug Users in Prison?* in <http://web.ukonline.co.uk/drug.action/Prison.htm>.

⁸⁵ Flynn N. (1995) *Drugs in Prison: Another quick fix?*, pg 2 of 4, Drugs Edition, Issue Four, in www.drugtext.nl/release/four1.html. - Release Publications Ltd, London; ACMD (1996), *Drug Misusers and the Criminal Justice System. Part 3: Drug Misusers and the Prison System - An Integrated Approach*, at pg 49-51.



for gradual withdrawal or on maintenance) would not take drugs illicitly (even by way of acquisitive crime). Harm reduction is less about eradicating drug addiction or dependence than reducing drug-related problems. Thus, Malaysia's initial "cold turkey" approach is quite justified i.e. abstinence from drugs is the only risk-free option. As such, it is important not to overlook the acknowledged benefit inherent with maintenance on prescription in terms of health, drug use, offences and social integration. Stabilization of clients for a longer period of time till such a period when he is prepared for withdrawal might seem the most practical avenue, particularly for hard-core addicts who are 'hooked for good'. The "cold turkey" approach is idealistic and impractical. It must be recognized that the problem of drug addiction or misuse is also undeniably a medical one. The best approach for dealing with and combating the drug problem is one that combines effective enforcement with humanity. In this respect, the Malaysian Dangerous Drugs Act 1952 makes referral to treatment and rehabilitation, in accordance with the Drug Dependents (Treatment and Rehabilitation) Act 1983. Treating drug addiction through medical and educational supervision within the criminal justice system is the best way forward, preserving proportionality and therefore fairness.

Malaysia must exercise a certain degree of patience and restraint, so that stabilization and weaning are acceptable methods of treating addicts, especially for those who have taken drugs for many years. A certain degree of failure to come off the drugs must be viewed as part of the treatment process and not by itself a breach of the order. Addiction is a relapsing condition, and so a degree of failure must be viewed as part of the treatment. The manner and extent of the failure to comply with the requirements of the order, rather than simply not responding well to the treatment would have to be distinguished by the treatment provider. However, the period should not be very long and should not lead to chronic dependence of the drugs being prescribed. Malaysia has now acknowledged that opiate maintenance has its benefits. With proper and careful use of it on drug dependants, there is no reason why drug dependants could not eventually be weaned. The responsibility has to be entrusted to the services and advisory centre or private doctors or private clinics (in liaison with the centre) to review the progress report of the drug dependants. It would also help to take the pressure off the limited numbers of boot camps with the heavy financial burden they face. Promising drug dependants from rehabilitation centres could be released early to undergo supervision at private centres or the



government's drug treatment clinics, as a transition into society. Progress reports of every drug dependant at private centres have to be submitted to the nearest government advisory and services centre or the National Anti-Drugs Agency for evaluation.

The probation-like form of supervision is a good move that signals to the discharged drug dependants that any untoward relapse to drugs cannot be tolerated. Putting penal sanctions for relapse is inevitable and is no more different than undergoing treatment as part of a probation order. Drug dependants must also be forewarned that they must show progress and be committed to the terms and conditions of the supervision. Punishing them for breaching the terms and conditions is therefore justified, provided that the breaches are because of the manner and extent of the failure to comply with the requirements of the order, rather than not responding well to the treatment provider. Mandatory drug testing in prison for drug inmates is also inevitable to curb drug misuse in prison, so that it doesn't become a nesting ground for the misuse of drugs. Penalization or disciplinary actions are inevitable to ensure compliance. Efforts must however, be taken to ensure that they get treatment and rehabilitation in the prison as well as after their discharge.

Rehabilitation centres should not be the main thrust in the treatment and rehabilitation of drug dependants. Given the fact that most drug dependants need a longer time to learn to live without drugs, their treatment and rehabilitation for the period should not be done in confinement, except for special cases, namely on medical grounds (problem drug takers). The patient must immediately thereafter be put on supervision and their family must be made responsible in monitoring him. The period of residency should be limited, as opposed to what is now being currently practiced. Residential treatment should not be prolonged but designed merely to stabilize the problem drug takers, or reserved for critical cases. Its role should end there. The answer therefore is to make available conveniently accessible multi-disciplinary drug treatment clinics in many localities, to effectively monitor patients who are put on a drug prescription for weaning and gradual withdrawal. Even though these measures may or may not be able to affect permanent recoveries, at least they do not constitute severe intrusions into human rights and may help some addicts. More leeway has to be given to the more open and decentralized drug treatment clinics with facilities for detoxification, stabilization, the supervision and monitoring of drug dependants on an outpatient basis, and possibly inpatient basis too.



Prolonged residential treatment and rehabilitation is not necessary, especially when outpatient treatment and rehabilitation is no less effective. Keeping a drug dependant incarcerated for a lengthy period can be counter-productive because treatment and rehabilitation cannot work in confinement. It also highlights the need for Malaysia to give more emphasis to supervision, and reconsider the entrenched idea against maintenance on prescriptions when treating addicts. Supervision, which requires the drug dependants to regularly register with the service and advisory centre, or the police station, achieve the same effect as confining addicts at boot camps. It also allows a drug dependant the time he needs to kick the drug habit, and at the same time avoid causing major disruptions in terms of his finance, family and social circumstances. There is also no stigma. These are important factors of treatment and rehabilitation the Malaysian government perhaps seems to have overlooked and is now seriously re-evaluating.

Malaysia should not be overzealous to obtain quick results. Zero-tolerance policy need not mean opposing maintenance on prescription for the stabilization and weaning of addicts. In fact, it is compatible with the aims of the zero-tolerance policy. It is the doctor-client relationship that matters most. Flexibility is important, especially when the period of treatment and rehabilitation of drug dependants is inevitably very long and resources tend to be limited. Supervision at localized multi disciplinary drug treatment clinics allow a drug dependant the time he needs to kick the drug habit while continuing his socio-economic activities, which is also vital to the rehabilitation process. Here the concept of harm reduction and maintenance on a script are intertwined, as are both sides of the same coin. Prolonged residential treatment and rehabilitation, and the "cold turkey" approach, have fared no better than the UK's approach. Given the lack of evidence that any of these treatments are effective, the individuals' rights and freedoms should be protected. Here, UK's practice is less invasive than Malaysia.

Malaysia has decided to be patient by extending the deadline to make the country narcotics-free by end of 2015 since declaring it as enemy of the State in 1983. Drug taking is only a symptom. There is no easy and fast way to eradicate the drug menace and Malaysia needs to be more sensitive in treating and rehabilitating drug dependants the way drinkers and smokers are tolerated. What is required is, to deal severely against those who intentionally and illicitly cultivate, supply and finance drug taking.



With the move from the “cold turkey” to maintenance on drug prescription and the harm reduction approach, it is also high time that the families of drug dependants play a proactive role physically and monetarily in their treatment and rehabilitation by not making treatment and rehabilitation centres as their easy dumping ground. Drug dependants and their families should also realize that they too have to find ways to change and improve themselves, and they should also look into the possibility of training their own drug dependants to be self-employed or worthy of employment. Without these, the treatment and rehabilitation by the government, no matter how superb would eventually go down the drain. The question is whose fault is it then (the government or the individuals)? The government can only do to a certain extent, but families are equally responsible for the end products of their own members. It is never too late to ponder what the Prime Minister Datuk Seri Dr Mahathir (as he then was) said in May 2003 that inculcation of good values and proper education is the key to success in eradicating drug misuse in the younger generation, and severe punishment alone could not possibly wipe out the drug menace in the society. He emphasized that parents too must inculcate in their children the heinous nature of narcotic drugs if misused or unlawfully used.⁸⁶

⁸⁶ New Straits Times, *Dr Mahathir on the Only Way to Rid the Country of Drug Scourge*, at pg 2, 20th May 2003.