



MALAYSIAN DRUG TREATMENT POLICY: AN EVOLUTION FROM TOTAL ABSTINENCE TO HARM REDUCTION

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ABSTRAK

Kertas ini bertujuan untuk melihat pelbagai program rawatan dan pemulihan yang terdapat di Malaysia dan bagaimana pendekatan baru telah dieksperimen dengan tujuan mengurangkan jumlah penagih dadah dan yang lebih penting lagi mengurangkan kadar jangkitan HIV di kalangan kumpulan ini. Kertas ini juga bertujuan untuk memahami sebab pelaksanaan beberapa program dan sebab peralihan polisi yang sedang berlaku di Malaysia. Rangka kesihatan awam terhadap penggunaan dadah digunakan dengan strategi 'causalist' untuk polisi kesihatan dan strategi 'consequentialist' digunakan untuk menerangkan polisi kesihatan awam di Malaysia. Secara khusus bagaimana kerajaan pada mulanya bermula dengan program rawatan dan pemulihan di institusi dan beralih kepada menggunakan ubat untuk merawat penagih dadah. Bermula dengan ubat antagonis (naltrekson) dan beralih kepada penggunaan ubat agonis (buprenorphine dan metadon). Program rawatan dan pemulihan di Malaysia juga beralih daripada kawalan dan pelaksanaan sepenuhnya oleh kerajaan kepada penggunaan servis NGO dan pengamal perubatan persendirian. Pada tahun 2005 program pertukaran jarum suntikan dimulakan. Cubaan untuk memahami kenapa Malaysia mengambil masa yang begitu lama untuk beralih kepada pengurangan risiko juga dibuat.

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ABSTRACT

This paper aims to look at the various treatment and rehabilitation programs in the country and how new approaches have been experimented with the aim of reducing the number of substance abusers and more importantly reducing HIV infection among this group. This paper also attempts to understand the reasons why initially certain programs were implemented and the reasons why the current shift in policy has taken place in the country. A public health framework towards drug use using a causalist strategy for drug health policy and a consequentialist one was used to explain this public health policy in the country. Specifically how the government initially started with an institutional treatment and rehabilitation program and moved towards using medication to treat drug users. It first started with antagonist medication (naltrexone) and moved towards agonists medication (buprenorphine and methadone). The treatment and rehabilitation programme in the country also shifted from being totally run by the government to start utilizing the services of NGOs and private medical practitioners. In 2005 a pilot needle syringe exchange program was started. An attempt is also made to understand why the country took a long time to move towards harm reduction.

Introduction

Traditional conservatism associated with drug policies nearly everywhere during the last century is being replaced or modified as we are now faced with new challenges. With the emergence of HIV/AIDS, harm reduction approach that prioritizes public health concerns over those of criminal justice is being implemented in many countries. The national treatment and rehabilitation program in Malaysia has evolved through many phases in the past 30 years. This paper aims to look at the various treatment and rehabilitation programs in the country and how new approaches have been experimented with the aim of reducing the number of substance abusers and more importantly reducing HIV infection among this group. This paper also attempts to understand the reasons why initially certain programs were implemented and the reasons why the current shift in policy has taken place in the country.



Bergeron and Kopp (2002) used Gusfield (1981) understanding on public health policy towards drug use where a causalist strategy for drug health policy and a consequentialist one was used to explain public health policy. Basically, the causalist strategy tries to understand what the causes of drug addiction are and programs need to be implemented to care for their addiction. Two major possible aims for the treatment of addiction is put forward; i) abstinence will be the main aim and a set of therapeutic techniques can be used including methadone but with the aim of progressive withdrawal ii) abstinence is not the main aim as addiction is regarded as a neurobiological deficiency. The consequentialist strategy aims to understand the social and medical consequences of drug use. In this strategy, needle and syringe exchange programs can be implemented as the social behavior of sharing needles and injecting equipment of drug users has serious consequences. Methadone is viewed as more palliative and preventive rather than it being a curative practice. Bergeron and Kopp (2002) further stress that while both the aims are complementary, they show in their paper how the hierarchy established between them has important consequences in French public health policy towards drug abuse.

Similarly in Malaysia before the middle of 2005 the portfolio of drug addiction treatment was under the Ministry of Internal Security or previously known under the Ministry of Home Affairs where a abstinence model using long-term institutional incarceration was the primary approach. Currently the Ministry of Health is given the authority to provide medical treatment for heroin dependence in the country. This shift signals a remarkable change in Malaysian policies and approaches to addiction and an important opportunity to develop, implement and disseminate effective treatments (Mahmud Mazlan, 2006). We would attempt to identify the reasons why initially a abstinence model was used and the reasons for the current shift to include harm reduction approaches. Before we discuss these issues we would like to describe briefly the Malaysian drug problem.

Malaysian Drug Problem

Between 1988 and 2006, there were 300,241 registered substance abusers (cumulative) in Malaysia, constituting 1.1% of the general



population. In 2006, 22,811 substance abusers were detected in the country. Majority (97.97%) of them was males and 69.48% were from the Malay ethnic group. Heroin and morphine continues to be the main drug abused in the country (60.73%). This is followed by cannabis (23.12%) and Amphetamine Type Stimulants (ATS) (14.34%). In terms of seizures a total of 155.73kg of heroin, 2, 378.81kg of cannabis, 0.52kg of opium, 145.56kg of methamphetamine, 10, 803.25 liters of codeine, 263, 030 ecstasy pills, 198, 689 psychotropic pills, 191.21kg of ketamine, 2.22kg of cocaine, 125,019 Eramin 5 pills, 5, 093.59kg of Mitragyna and 242, 732 Ya ba pills were seized (National Drug Information System, January, 2007).

Drug Treatment in Malaysia

In order to better understand the issues related to drug treatment in Malaysia it would be useful to first look specifically what has been the treatment and rehabilitation program conducted by the government in the country. The national treatment and rehabilitation program is based on an institutional concept and is managed by the government. There are 29 treatment centers in Malaysia. Currently there are three main treatment modalities; cold turkey detoxification in the institution, institutional rehabilitation for a period of two years and aftercare supervision for a period of between one to two years. If an individual is determined a drug addict he/she is mandated to undergo compulsory government treatment and rehabilitation program. The treatment program is either institutional and community supervision or community supervision. In both this settings, psychosocial approaches are used in the treatment of substance abusers.

In the institution a multi-disciplinary approach is used. This includes spiritual, vocational, military style physical training and psychosocial interventions are used in the phase system. There are four phases (each phase between 3 to 5 months) for patients to undergo before completing the program. In phase one the main concentration is to re-orientate, restore the physical health, counseling and spiritual rehabilitation. In phase two, activities in phase one will be continued with the addition of vocational training. While in phase three the additional activity would be job attachment. In the last phase aspects that will be strengthen are community integration and re-entry programs.



Two types of substance abusers can be put in the supervision program. One are substance abusers who are deemed not chronic users will be place under supervision and this group would not be required to undergo institutional treatment and rehabilitation. The other group is chronic substance abusers that have already undergone institutional treatment and rehabilitation program. In the supervision program, National anti narcotics agency officers in the district patients reside for a period of two years will supervise patients. Patients under supervision are free to carry out their daily activities but will have to report to their supervising officers and undergo counseling as stipulated in their treatment schedule.

In addition to the supervision program mandated by the courts the National Anti Drugs Agency (NADA) has also come out with its own community programs, which aims to reach out to drug users and motivate them to come for treatment voluntarily. In this program the addicts who volunteer for treatment do not have to go through the court system and can undergo residential and community treatment in the local NDA centers specially established for voluntary cases.

This institutional treatment and rehabilitation program, which emphasizes a total abstinence approach, has proven to be not successful. Relapse rates within the first year following discharge are reported to be high ranging from 70 to 90% (Mahmud Mazlan et al, 2006).

Now let us look at the basis why total abstinence approach was the main aim and also why psychosocial approaches were emphasized. In 1972, the government formed the National narcotics bureau under the justice ministry and in 1979 this bureau was deactivated. This was replaced by the national drug task force under the Ministry of Home Affairs and in 1996 the National narcotics agency³ (NDA) was formed. Both the national task force and the National narcotics agency are under the Ministry of Home Affairs. The staff and human resource under the Ministry of Home Affairs have an enforcement background and a social background.

³ The National Drugs Agency (NDA) name was changed to National Anti-drugs Agency (NADA) in 2004.



As described above one of the components of rehabilitation which is used in the government centres to date is the military style training which goes to show the influence of enforcement personnel in the treatment and rehabilitation program in the country. In addition, the Royal Malaysian Police (RMP) previously only had a narcotics division and in 1996 the division was upgraded to a full department (utusan.com.my/utusan/content.asp?y=2007&dt=0324&pub=Utusan_Malaysia&sec=Polis_%26_Tentera... - 35k). While the police was entrusted largely in the supply reduction area they also played an active role in demand reduction. This further strengthens our argument where actors who were involved in drug rehabilitation had a enforcement and social background they would definitely based their treatment and rehabilitation on a abstinence based approach. No medical or therapeutic solution was provided during this era. Looking at it from an international perspective, could the national approach during this period it be conforming to a dominant paradigm which was abstinence as postulated by Bergeron and Kopp (2002) in France. They argue that the anti-psychiatry movement in France and the influence of Foucault's thesis during this era contributed to the abstinence paradigm. The dominant paradigm was to rehabilitate a drug user to 'normal life' grounded from a non-psychopathological basis.

In addition to the national treatment and rehabilitation program described above, NDA also implemented therapeutic community programs (TC). In fact one of the rehabilitation centers in the country is a full TC centre. This further shows how the government promoted the abstinence paradigm.

Medications used for Treatment in Malaysia

The government realizing that the institutional and community treatment and rehabilitation programme was not effective decided to experiment with the use of medication to treat drug users. Navaratnam et al. (1994) carried out a controlled clinical evaluation of the safety, tolerance and efficacy of naltrexone among opiate addicts. Phase III of the nationwide naltrexone study carried out in 1998 among 2029 subjects using a double-blind study design showed that subjects who had high compliance towards medication



and counseling had the best results (Navaratnam and Vicknasingam, 2002). However in summary, subjects on naltrexone only showed slightly better results than the control group.

Prior to this the private medical practitioners were not actively involved in treating drug users in the country. In 2001 agonist maintenance treatment using buprenorphine mono-tablet were first introduced in Malaysia. Since then more than 500 medical practitioners have treated about 30,000 heroin dependent individuals (The Star, 3 May 2005). However after three to four years of introduction of buprenorphine Malaysia seems to be confronted with the problem of misuse of buprenorphine. Physicians often prescribe large quantities of buprenorphine for unsupervised use from the beginning of treatment and leading to problems of poor medication compliance and diversion. Patients are also not provided drug counseling or other psychosocial services (Mahmud Mazlan, 2006). Recent studies (Vicknasingam et al, 2007; Mahmud Mazlan, 2007) note that high number of drug users were found to be injecting buprenorphine. Realizing the problem of misuse with the mono-tablet, the government has limited the availability of the mono-tablet at the end of 2006. Currently, buprenorphine naloxone tablet has been introduced in the country.

The use of methadone was limited in Malaysia as it was against the total abstinence philosophy and also was thought to compromise the nation's goal of becoming drug-free society (UNAIDS and UNDCP, 2000). Advocacy by NGOs and medical professionals resulted in increasing interest in the piloting of drug substitution programmes (Reid et al., 2007). The HIV epidemic among drug users also certainly pushed the re-registration of methadone in the country in 2003. In an initial pilot among 46 subjects, 30 subjects managed to gain employment and work performance improved. All subjects were not involved in crime or high risk behaviors (Gill et al., 2004). Large scale use of methadone was limited due to high cost until late 2005. The government decided to implement a national pilot methadone maintenance programme among 1200 drug users. This programme is part of the national harm reduction strategy and it is hoped that this programme will be able to reduce injecting drug use and HIV infection in the country. The



initial success of this programme has prompted the government to scale-up the programme this year with the aim of to increase the number of the subjects in the programme to 5000.

In spite of the problems faced by introducing medication for drug users in the country, the medical profession has now become actively involved in treatment of drug users in the country. As mentioned in the introduction section of the paper now the Ministry of Health is given the authority to provide medical treatment for heroin dependence in the country. In the international drug field, there is growing evidence that opioid agonist maintenance treatment is effective and is being widely used (Institute of medicine, 2006). This could also be one of the reasons why the Malaysian government has started using drug substitution therapy in addition to psychosocial approaches in its national treatment programs.

Policy Paradigm Shift Towards Harm Reduction

We have shown above how the government initially started with an institutional treatment and rehabilitation program and moved towards using medication to treat drug users. It first started with antagonist medication (naltrexone) and moved towards agonists medication (buprenorphine and methadone). The treatment and rehabilitation programme in the country also shifted from being totally run by the government to start utilizing the services of NGOs and private medical practitioners.

Since the first diagnosed HIV infection in the country in 1986, drug users continue to be main group affected by the epidemic. About 75% of HIV cases in the country are from drug users. In the Western Pacific Region, Malaysia is reported to have the second highest HIV prevalence (after Vietnam) among the adult population (0.62%) and also the highest proportion (76.3%) of HIV infection related (or attributable) to injection drug use (World Health Organisation, 2003). There are few reasons why injecting drug use has remained high in the country. Street purity levels of heroin have been low in the last few years and this has resulted in drug users injecting more frequently and also converting to injecting drug use from chasing/smoking more rapidly. In addition, as a result of low street purity levels of heroin drug users are also using heroin in



combination with benzodiazepines to inject⁴ (Vicknasingam and Navaratnam, 1999; Vicknasingam and Navaratnam, 2008). The diversion of buprenorphine has also resulted in illicit injecting of buprenorphine⁵ recently in the country (Mahmud Mazlan et al., 2006; Mahmud Mazlan et al., 2007). As there were no needle and syringe exchange programme in the country, drug users were practicing risky injecting behavior. In addition, they were also practicing risky sexual behavior. While drug users did not have a problem purchasing syringes at the pharmacy they were afraid to carry needles for fear of being arrested with injecting paraphernalia. Section 37 of the Dangerous Drug Act 1952 states that possession of needles can result in up to 2 years imprisonment (UNAIDS and UNDCP, 2000).

This being the injecting situation in the country, a needle syringe exchange programme was needed to reduce the number of HIV infection in the country. The Harm Reduction Working Group (HRWG) of Malaysia was established in 2004 to advocate the implementation of harm reduction initiatives in the country (Reid et al., 2007). The government in early 2005 agreed to implement the methadone maintenance programme but they had reservations about implementing a needle syringe exchange programme (NSEP).

However in mid 2005, Malaysia realized that they did not achieve one of the United Nations Millennium Development Goal (MDG). This goal was to halt the spread of HIV/AIDS. This finding prompted the government to implement a pilot NSEP programme in early 2006. The programme initially started in three sites in the country and by the end of the first year of implementation the government has decided to scale-up the programme similar to the methadone maintenance programme. In 2007 the government hopes to expand the NSEP to six sites in the country.

⁴ Benzodiazepines tablets are crushed and injected together with heroin. This risky injecting behavior also has other health consequences to the drug user for example infection at injection sites, such as abscesses and thrombosis.

⁵ Buprenorphine is sold under the trade name of Subutex in Malaysia and drug users prefer to crush the tablet and inject them. Subutex is not allowed to be sold in the country due to high levels of misuse and it is now replaced with Suboxone which contains buprenorphine and naloxone.



In an attempt to understand the reasons for changes in Malaysian drug policy we again looked at how Bergeron and Kopp (2002) used Boudon's (1986, 1990 and 1995) work in classifying decisions made by policy makers. The 'positional effect'⁶ and dispositional effect'⁷ were used as terms to understand the changes. Using the 'positional effect' in the Malaysian context the actors involved in decision making in the 90s until 2005 did not see that harm reduction approaches could benefit drug users. The National drug information system (NADI) database continues to indicate that injecting drug use is still low in the country (Vicknasingam and Navaratnam, 2008).

On the other hand, HIV infection rates continue to rise among drug users in the country (Ministry of Health, 2006). If the actors involved in decision making used NADI as their evidence to make decision than they rightly did not see the importance of implementing harm reduction initiatives. Using the 'dispositional effect' in the local context, these would be addicts who have repeatedly attended treatment and rehabilitation programs in the government institution and are still unable to abstain from drugs and they will be considered today as the main targets to be recruited for harm reduction programs. Previously these group of addicts would be considered not motivated enough to stop their addiction.

However we would also like to state that there are also other reasons why harm reduction programs were slow to be implemented in the country. Cultural, social structures and legal restraints are some of the possible reasons for this delay. This is why the NSEP while being supervised and supported by the government is being implemented by NGOs whilst the MMT is fully implemented by the government using its district hospitals and clinics to reach out to drug users.

⁶ Is a cognitive perspective. Supposes that you see reality according to the position you hold (Bergeron and Kopp, 2002).

⁷ Entails the process by which theories or systems of ideas to which one adheres slowly become a cognitive frame through which reality is interpreted in a specific direction (Bergeron and Kopp, 2002).



However there are still many challenges that need to be addressed. While the government has scaled-up harm reduction programs in the country it also has to ensure that high enough intervention is achieved to reverse the trends in HIV prevalence among drug users. In doing this we have to ensure that there is sufficient human resource. In Malaysia currently there is an urgent need to train more professionals and develop the needed human resource capacity to sustain these programmes. For example in the country, there are not enough addiction counselors and local educational institutions do not offer specific courses in addiction. Most of the counselors in the government institution are only trained as para-counselors. More outreach and field workers need to be trained to further reach out to drug users in the more remote parts of the country. Technical experts are needed to ensure these programmes are monitored and evaluated for its effectiveness. NGOs and faith based organisations capacity need to be strengthened. They need to be engaged more closely as they are well placed within the community to address issues related to stigma. The government need to ensure that the supply of needles/syringes and methadone is not disrupted. A disruption in supply can rapidly alter the injecting behaviour of drug users in a particular area. Whilst the majority of HIV infections in the country are among IDUs, they represent a minority of those receiving ARV treatment. Steps need to be taken to motivate drug users who are infected to come forward and receive treatment. Treatment for HIV can be part of the harm reduction package.

Another important issue is that the use of medication to treat drug users in the country need to be monitored more carefully. This is to ensure there is as minimal diversion of this medication and also to reduce these medications from being misused, i.e injected. The government has taken the right direction in this aspect and has developed a web based database to monitor the sale of medication by private physicians. Institute of medicine (2006:77) suggest that countries policies and regulations regarding opioid agonist maintenance treatment should balance the potentially competing goals of increasing the accessibility and utilization of opioid agonist maintenance treatment and reducing the likelihood of diversion of agonist maintenance medications. National guidelines has also been in placed on the proper use of these opioid agonist



medications with emphasis on reduce probability of diversion and misuse. Another setback in the misused of prescription medication is the high misuses of injecting midazolam, which may or may not combine with the opioid agonist medications (Mahmud et al, 2007). These injections of legal medications defeat the whole idea of harm reduction model, and further strengthened the arguments for proponents of anti-medications such as therapeutic community and drug enforcement agencies.

Conclusion

The politicized nature of illicit drug policy gives rise to vexation and mockery. Often politicians are blamed for ignoring the evidence-base or adopting populist policies (Hughes, 2007). The first diagnosed case of HIV infection in the country was in 1986 and it took the country almost 20 years to implement harm reduction initiatives. Europe, Australia and North America started harm reduction programs two decades ago (Stimson, 2007). Bergeron and Kopp (2002) used a sociological approach to ideas approaches in political science and conclude that they are two advantages. First how socialization and institutionalization takes place. We have attempted to understand this in the Malaysian scenario by showing how the background and cognitive belief of actors resulted in formation of the drug policy. The second approach is that the beliefs and actions of individuals have to be viewed from multiple dimensions. We again show in the local context how multiple dimensions also had an influence. For example, how the growing body of evidence internationally, increasing participation of NGOs and non-compliance to the UN criteria for achieving developed countries had an influence on the drug policy locally. While it is difficult to understand why the country took so long to move towards harm reduction, we have attempted to show in this paper what were the process and trying to understand the basis of the government for shifting from a total abstinence model to start incorporating harm reduction programs.

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