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## INTRODUCTORY NOTE

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It is with pride that the United Nations Asia and Far East Institute for the Prevention of Crime and the Treatment of Offenders (UNAFEI) offers to the international community Resource Material Series No. 64.

This volume contains the work produced in the 124<sup>th</sup> International Training Course that was conducted from 21 April to 12 June 2003. The main theme of this Course was, “The Effective Prevention and Enhancement of Treatment for Drug Abusers in the Criminal Justice Process”.

Drug abuse is a major challenge for the international community. It affects every country both developed and developing and the harm it causes is both far-reaching and substantial. The international community has sought to combat this growing menace by promoting international cooperation with the following United Nations Conventions: Single Convention on Narcotic Drugs (1961), Convention on Psychotropic Substances (1971), and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

There is a growing recognition that a comprehensive strategy needs to be implemented that emphasizes the need for drug demand reduction policies. This was addressed by the General Assembly of the United Nations at the 20<sup>th</sup> Special Session in 1998 in its Declaration on the Guiding Principles of Drug Demand Reduction. This Declaration highlighted the need for early detection and prevention of drug abuse and appropriate rehabilitative services.

This course gave the participants an opportunity to share information on the current situation of drug abuse including punishment, prevention and treatment and the challenges faced by each country. Equipped with this information the participants explored more effective measures and strategies for preventing drug abuse and treating drug abusers in both the pre-sentencing stage and post-sentencing stage in order to facilitate the reintegration of drug abusers into the community.

In this issue, papers contributed by visiting experts, selected individual presentation papers from among the Course participants, and the reports of the Course are published. I regret that not all the papers submitted by the Course participants could be published. Also, I must request the understanding of the selected authors for not having sufficient time to refer the manuscripts back to them before publication.

I would like to pay tribute to the contributions of the Government of Japan, particularly the Minister of Justice and the Japan International Cooperation Agency, and the Asia Crime Prevention Foundation for providing indispensable and unwavering support to UNAFEI's international training programmes.

Finally I would like to express my heartfelt gratitude to all who so unselfishly assisted in the publication of this series; in particular, the editor of Resource Material Series No. 64, Mr Simon Cornell (Linguistic Adviser) who so tirelessly dedicated himself to this series.

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Kunihiko Sakai  
Director of UNAFEI

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**Work Product of the 124<sup>th</sup> International Training Course**  
**“THE EFFECTIVE PREVENTION AND ENHANCEMENT OF**  
**TREATMENT FOR DRUG ABUSERS IN THE CRIMINAL**  
**JUSTICE PROCESS”**

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### AN OVERVIEW OF THE UK DRUG STRATEGY WITH A FOCUS ON TREATMENT AND THE DEVELOPMENT OF DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM (ENGLAND AND WALES)

*Shereen Sadiq\**



#### I. INTRODUCTION

The overarching aim of the UK Government's drug policy is to reduce the harm that drugs cause to society - communities, individuals and their families. The key to delivering this aim is to reduce the number of people caught up in the chaotic lives of addiction and crime (problematic drug users) and to stop young people from entering their ranks. Tackling the enormous challenge of drug misuse is not a matter for Government or its agencies alone.

This paper reflects information provided in the Updated Drug Strategy's, Executive Summary and includes some of the current evidence, the progress so far and some of the next steps being undertaken to tackle drug misuse particularly in relation to treatment and the development of drug intervention in the Criminal Justice System in England and Wales.

#### II. TERMINOLOGY

To help set this work in context, this section of the paper will focus on some of the terms which will be used. The ongoing debate about terminology means that a number of different terms are used to describe drug taking behaviour. For the purposes of this paper the terms described below, have been adapted from previous definitions adopted by the Health Advisory Service (HAS), the Advisory Council on the Misuse of Drugs (ACMD) and the National Treatment Agency (NTA).

- *Drug Use* – illegal and illicit drug taking that does not cause any perceived immediate harm- even though it may carry some risk of harm e.g. health problems.
- *Drug Misuse* – illegal and illicit drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence.
- *Treatment* -describes a range of interventions which are intended to address an identified drug related problem or condition relating to a person's physical, psychological or social (including legal) well being. Structured treatment (evidence based) follows assessment and is delivered according to a care plan with clear goals regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions. Drug treatment can encompass a wide range of interventions / treatment modalities (types).
- *Problematic Drug User*: describes those drug users who experience social psychological or legal problems related to their drug use rather than those who use drugs casually or recreationally.

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*The views expressed in this paper are those of the author, not necessarily those of the Home Office (nor do they reflect Government policy).*

### III. BRIEF OVERVIEW OF THE ENGLISH LEGAL FRAMEWORK AND ROLES OF CRIMINAL JUSTICE AGENCIES

To set the work being undertaken with drug users in the criminal justice system in context, in England and Wales, a very brief overview of the legal framework and the role of criminal justice agencies has been provided.

#### A. The Misuse of Drugs Act 1971

The main legislation controlling the misuse of drugs in Britain is the Misuse of Drugs Act 1971. It incorporates the relatively new system of licensing doctors to prescribe heroin and crack cocaine to drug users, the safe custody of drugs and national stop and search powers for the police. It also established the first statutory advisory body the Advisory Council on the Misuse of Drugs (ACMD).

The Act divides controlled drugs into three classes linked to maximum penalties in a descending order of severity from A to C. This three tier classification was designed to make it possible to control particular drugs according to their comparative harmfulness either to individuals or to society as a whole. (See Appendix A which outlines more details, including the proposals relating to cannabis)

#### B. The English Judiciary Process

The English legal system has been built around two distinct court processes:

- Civil Law and
- Criminal Law.

The procedures within the court systems vary greatly; it is the judicial process around the criminal court system which will need to be taken account of in delivery and planning of drug related criminal justice programmes to be described later.

The British Court System is known as adversarial which means that both the Defence and Prosecution try to persuade the bench or jury of either guilt or innocence.

The courts which deal with crime and related issues are the Magistrates Court and the Crown Court. Offences within the criminal judicial system fall into one of three categories. The category determines the court's power to deal with the offence. The categories are outlined in Appendix A.

#### C. The Magistrates Court

Magistrates Courts deal with Summary Offences and less serious Either-way offences. The Magistrates only have the power to sentence individuals to up to one years' imprisonment. There are two types of Magistrates in England and Wales, Lay Magistrates and Stipendiary Magistrates.

*Lay Magistrates* sit on a bench with usually two others. They are members of the local community who have been invited to sit on the 'bench'. They are not qualified in law and their role is voluntary.

*Stipendiary Magistrates* on the other hand are qualified solicitors. They are paid to undertake their duties and have the power to pass sentence by themselves.

Specialist Youth Courts form part of the Magistrates Court Structure. These courts deal with young offenders less than 18 years. Lay Magistrates who have had training in youth matters sit at these courts.

#### D. The Crown Court

The Crown Court is the higher of the two courts. This means that the most serious of offences with sentences up to life imprisonment are conducted within it.

Proceedings in the Crown Court are overseen by a Judge and take place before a jury. The jury consists of 12 members of the public who make a decision on the guilt of the defendant based upon the case presented.

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The judge is qualified in law and will have experience through being a barrister in the higher courts. The judge has the power to pass sentence on their own at the end of a trial.

### **E. Court Roles**

#### **1. The Clerk of the Court**

The Clerk (Legal Advisor) is a qualified solicitor who is neutral in court proceedings. Their role is the day-to-day running of the court. The Clerk advises the Magistrate on points of law and they sit below the bench.

#### **2. The Crown Prosecution Service (CPS)**

The CPS has two roles: they prepare cases against defendants with information given by the police and also prosecute the case against the defendants if there is enough evidence. The CPS solicitor is commonly known or referred to as the Crown or Prosecution.

#### **3. The Client's Solicitor**

The clients' solicitor is also qualified in law like their CPS counterpart. Their role is to defend the client against the charges put forward by the CPS. The clients' solicitor is commonly known as their brief and is often referred to as 'The Defence' in court. In the Crown Court the clients' brief is known as the 'barrister'.

### **F. The Probation Service**

The National Probation Service for England & Wales is part of the Home Office. There are 42 probation services across England & Wales matching police force geographical boundaries.

Their role is to supervise offenders in the community; in a court context they have two roles:

- To assist the court in making decisions about bail.
- When asked by the court, to prepare written reports on those who are found guilty of offences, the report known as a Pre-Sentence Report (PSR) is used.

### **G. The Prison Service**

There are around 135 custodial institutions across England and Wales which comprise of a range of types from high secure, through to establishments for women and young offenders: The role of the prison service is to supervise offenders in custodial institutions.

The main aim of the Prison and Probation Services is to work together to deliver court sentences in order to reduce re-offending and protect the public.

### **H. The Police Service**

There are 43 Police Forces across England & Wales, covering specific geographical areas which are coterminous with the Probation Service. The aim is to protect the public/community and prevent crime. For policing purposes each police force area will be divided into smaller geographic areas, which could be termed Divisions or Basic Command Units, comprised of one or more 'police stations or custody suites. Each division will: operate to meet both the national objectives and targets for all police forces and the needs of its own local community.

## **IV. THE CURRENT POSITION - THE EXTENT OF DRUG USE IN ENGLAND AND WALES**

In order to focus on what will really make a difference, it is important to understand the scale and nature of drug misuse in England and Wales and its consequences. The associated evidence base shows that drug misuse is a changing picture in England and Wales, which is difficult to assess and varies from area to area. As drug taking is an illicit activity reliable data on prevalence is hard to obtain.

The British Crime Survey (BCS 2000) provides the best available guide to changing patterns of drug use among the adult population in England and Wales. It is a large national survey and is designed to be representative of the population of adults. In addition to asking about their experiences of crime the BCS

also asks about a number of other crime related topics, since 1994 it has included a comparative module of questions on drug misuse.

The BCS indicates that in 2000, around one third of those aged 16 -59 yrs had taken illegal drugs at some time in their lives, Using this information it can be estimated that around 4 million people use at least one illicit drug each year, evidence suggests most of this drug use is cannabis.

Further information highlights around 1 million people use at least one of the most dangerous drugs (such as ecstasy, heroin and cocaine) classified as Class A. Many of these individuals will take drugs once, evidence suggests that for many of these individuals, drug use is experimental and use is limited.

#### **A. Estimating the ‘In-Need Population’**

Estimating the number of people who experience serious problems or dependence because of their drug misuse is in itself difficult and problematic.

Estimating the number of people who need drug treatment because of their problematic drug use is also not easy. Research suggests that there are around 250,000 problematic Class A drug users in England and Wales and the large majority of these individuals are engaged in criminal activity (whether or not it is related to their drug use). It is estimated on the basis of the NEW ADAM (New English and Welsh Drug Abuse Monitoring programme 2001) that there are around 180,000 problematic drug users who enter the criminal justice system through police custody suites each year. Of these only a minority (around 15 percent) are already in treatment, although a larger proportion has previously had a treatment episode.

Using the data from the National Drug Treatment Monitoring System (NDTMS) which reflects those seeking help, we can estimate that there are around 100,000 drug misusers in treatment.

These rough estimates highlight that the criminal justice system provides an important opportunity to identify and engage in treatment, problematic drug users who have not previously engaged with treatment services or for whom treatment has failed.

#### **B. Evidence Base - Links between Drug Use and Crime**

The evidence base has helped to inform and drive national policy and targeting work with problematic drug users. Recent research indicates that many drug misusers are also offenders though the relationship between drugs and crime is complex.

Research on offender populations in the UK suggests that acquisitive crimes such as shoplifting, burglary and fraud are the main methods to fund drug consumption (Bennett 2000).

A Home Office research study (New English and Welsh Drug Abuse Monitoring Programme Bennett 2001) involving the drug testing of arrestees irrespective of offence in 8 Police Custody suites found that:

- 65% of arrestees test positive for at least one illegal drug
- 30 % tested positive for two or more such substances
- 29% tested positive for heroin/cocaine
- users of both heroin/cocaine/crack commit between 5-10 as many offences as arrestees who do not use drugs
- 78% saw a connection between drug use and acquisitive crime

The National Treatment Outcome Research Study (Gossop 2001) – Prospective cohort study amongst 1075 drug misusers admitted to specialist drug treatment, found that amongst the treated population over half of those attending specialist treatment centres had some involvement in acquisitive crime (shoplifting was the most common offence).

Strategies aimed at reducing the demand for illicit drugs by breaking the link between drugs and crime have been an integral part of the UK Government’s anti-drug strategies since the mid-1990’s. The importance of this connection can be demonstrated through the recent estimations of the economic and social costs of Class A Drug use. These estimations were derived from a recent study undertaken by York

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University (Godfrey et al 2002) the main focus of which was to estimate the economic and social costs of Class A drug misuse. The study found that the total social and economic costs (including victim) of Class A drug use in England and Wales, was estimated to be between £10 billion and £18 billion per annum. Problem drug users account for almost all economic and social costs (99%) and drug related crime accounts for around 88% of total economic and social costs.

### **C. Evidence that Treatment Works**

The National Treatment Outcome Research Study (NTORS) (Gossop et al, 2001) a 5 year prospective study following a cohort of drug misusers through different treatment modalities, has shown clear reductions in levels of drug use and acquisitive crime one year after treatment, which were maintained at five years. In cost-effectiveness terms, NTORS estimates that for every £1 spent on drug treatment, a concomitant saving of £3 is made on criminal justice and victim costs.

In addition a number of pilot programmes in the criminal justice system targeted at drug misusers (to be explained in a later paper) found that they could be effective in getting them into treatment. These programmes can deliver crime reduction outcomes as evidenced by the early arrest referral pilots which showed that of those interviewed:

- around 60% reported reductions in acquisitive crime
- 75% reduced their spending on drugs
- 31% said they had reduced their drug use
- 28% said they had stopped using heroin or other illicit opiates.

Although there is strong evidence on the efficacy of drug treatment services, evidence (Audit Commission, 2002; Hough, 1996) listed below points to a number of specific issues that need to be addressed if treatment is to work effectively amongst problem drug-using offenders entering the Criminal Justice System:

- Drug using offenders should have quick access and entry into treatment;
- They should be retained in continuous treatment for at least three months;
- They should have the option of methadone maintenance (and not rely on detoxification alone) and should be seen by high quality, committed staff;
- Comprehensive care management techniques are needed to deal with an individual's multiple needs; and
- There needs to be close co-ordination between specialist and generic services across a range of interventions.

## **V. OVERVIEW OF THE UK DRUG STRATEGY**

The policy agenda in the UK for addressing drug misuse problems has been developing rapidly in recent years and has led to a stronger emphasis on drug treatment services.

In 1995 the Government white paper Tackling Drugs Together set out plans to tackle drug misuse over three years. Multi-agency Drug Action Teams were established at a local level with the remit of taking an overview of drug related issues, co-ordinating service planning and delivery and developing local action plans.

The publication of the Government's strategy for tackling drugs, Tackling Drugs to Build a Better Britain in 1998, was and still is a landmark: the UK's first cross cutting strategy across government departments to tackle drugs in an integrated way has four main strands:

*Young People* - to help young people resist drug misuse in order to achieve their full potential in society;

*Communities* - to protect our communities from drug-related anti-social and criminal behaviour;

*Treatment* - to enable people with drug problems to overcome them and live healthy and crime free lives; and

*Availability* - to stifle the availability of illegal drugs on our streets.

#### **A. Overview of the Updated Drug Strategy**

Over the last year, the 10 year Drug Strategy, was reviewed to sharpen its focus and improve effectiveness. The findings and recommendations of the Home Affairs Committee and the work of the Audit Commission, the Advisory Council for the Misuse of Drugs, the Health Advisory Service, the Police Foundation and others have also contributed to the review.

In December 2002 the updated Drug Strategy was published which built on the foundations laid before and took account of lessons learnt so far. The strategy also included the additional availability of resources to be made available and invested. Planned direct annual expenditure for tackling drugs will rise from £1026 million in this financial year 2003/04 to £1244 million in the next financial year; £1344 million in the year starting April 2004 to a total annual expenditure of nearly £1.5 billion in the year starting April 2005.

The overall aim of the updated strategy is: **Reducing the harm that drugs cause to society - communities, individuals and their families**

The updated strategy sets out a range of policies and interventions, which concentrate on the most dangerous drugs, the most damaged communities and the individuals whose addiction and chaotic lifestyles are most harmful, both to themselves and others.

The most effective way of reducing the harm drugs cause is to persuade all potential users, but particularly the young, not to use drugs. Success will only be achieved if there are strategies which stop young people from developing drug problems, reduce the prevalence of drugs on the streets and reduce the numbers of those with existing drug problems by getting them into effective treatment.

#### **Preventing today's young people from becoming tomorrow's problematic drug users**

The section relating to young people in the updated strategy highlights that all controlled drugs are dangerous and no one should take them. Universal programmes of education and information will provide all young people and their families the information and skills they need to protect themselves from the risks and harm of all drugs. The most vulnerable young people will get support before drug problems escalate.

Since 1998, universal programmes of education and information have been expanded. Substance misuse education is now part of the National Curriculum and 80% of primary and 96% of secondary schools have adopted drug education policies.

Much has also been done to improve how to identify and support the most vulnerable young people:

- 80% of England is covered by the new Connexions Service who identify young people with drug problems and arrange for specialist help as a part of their wider role to support all young people.
- All Youth Offending Teams (YOTs) have named drug workers who assess and arrange for support for young offenders with drug problems.
- Treatment services for young people, including detoxification and community prescribing are now provided in 80% of Drug Action Team (DAT) areas.
- Positive Futures - using sport and arts to engage the most vulnerable young people by developing skills to help them resist drugs and re-enter education and training - are available in 57 of our most disadvantaged communities.

16,000 young people currently receive support from local authority and health services, including 4,000 supported by drug treatment agencies and 3,000 by Positive Futures programmes.

By March 2006 young people will be discouraged from using drugs in the first place and support parents and family members who are worried about drugs by:

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- Expanding the provision and improving the quality of drug education so that by March 2004 all primary and secondary schools have drug education policies and further improve the quality so that by March 2006, no drug education lessons will be described as 'poor' by OFSTED.
- Launching in Spring 2003, a major new Communications Campaign driving home the risks of Class A drugs and encouraging young people and their parents to seek further advice and help. It is vital that the message to young people is open, honest and credible. The reclassification of cannabis will support this.
- Clamping down on dealers who prey on the young by increasing the penalties for dealing Class C drugs by July 2003 to match the already severe penalties for dealing Class A and B drugs.
- Expanding prevention programmes so that by March 2004 all young offenders and pupils attending Pupil Referral Units participate.
- Improving services for parents and carers by setting clear standards for the support offered to parents who are concerned about substance misuse or whose family members have a drug problem.

**The provision of substance misuse treatment within the youth justice system** will be expanded to:

- Introduce drug testing and referral of young people for treatment following arrest
- Give courts the power to include drugs treatment as part of community sentences
- Pilot and roll out new programmes of treatment and wider support for young offenders
- Provide drugs workers in all juvenile custodial establishments to organise programmes of prevention, treatment and support on release by December 2003.

There will also be investment to help local authorities support young people with drug problems. This will provide specialist support, outreach workers, training for professionals working with young people and an expansion of the Positive Futures programme. By March 2006 the number of young people with drug problems receiving support will include:

- 12,000 supported by YOTs and in juvenile custody
- 28,000 supported by local authorities, health services and Connexions
- 5,000 supported by Positive Futures programmes
- 5,200 supported by drug treatment agencies

This means that by March 2006, there will be the capacity to support 40-50,000 young people with drug problems every year. By 2008 this will have driven down the number of young people who go onto become future problematic drug users.

#### **B. Reducing the Supply of Illegal Drugs**

Reducing the supply of illegal drugs and tackling the trafficking of all drugs is key. Progress since 1998 includes:

- establishing the Concerted Inter-Agency Drugs Action Group (CIDA) to co-ordinate operational activity across all intelligence and enforcement agencies;
- increasing the number of drug seizures – the results for 2000 show a 53% rise in the number of cocaine seizures and a 30% increase in heroin seizures compared with 1997; the amount of drug-related assets recovered has also increased - £18.9 million from April 2001 to March 2002, almost 20% up on the previous year;
- establishing the National Crime Squad and the National Criminal Intelligence Service in April 1998, with key priorities of tackling hard drugs;

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- more than 60 drug liaison officers are now in post in key drug producing and transit countries, working to identify illicit drug movements, related financial activities, the structure of criminal organisations involved and providing hard intelligence for use in investigations;
- assisting EU candidate countries in their development of drug strategies and enforcement capabilities. The UK is a lead partner in a law enforcement project across 10 candidate countries and also involved in anti-drugs twinning projects in Bulgaria and the Czech Republic;
- the Proceeds of Crime Bill received Royal Assent in July 2002, strengthening investigation and confiscation powers, and the Recovered Assets Fund has been established;
- following the fall of the Taliban, the UK has led in the co-ordination of international efforts to help the Afghan Government counter narcotics production in Afghanistan.

There will be continuing focus on international trafficking, with a renewed focus on middle markets, local policing and tackling crack. New initiatives include:

- *Increasing co-operation with countries on key supply routes so as to increase the quantities of heroin and cocaine taken out en route, at the border and within the UK this includes:* setting up a joint investigation team with Spain to investigate organised crime networks associated with cocaine trafficking; working closely with the Jamaican Government to disrupt the supply of cocaine via Caribbean countries; in close touch with the Turkish authorities, both bilaterally and through the EU, on problems associated with heroin trafficking; and hosting a conference to address organised crime in the Balkans – including drug-related organised crime.
- *Working closely with the Afghan Government to reduce opium production with a view to eliminating production by 70% by 2008 and in full by 2013.* The initial focus will be the 2003 crop.
- *Enhancing intelligence capability and working in co-operation with EU partners* to tackle the secondary distribution of heroin and cocaine from the EU and to prevent the diversion of precursor chemicals used to make illicit drugs, such as Ecstasy.
- *Reviewing the impact of interventions on the drug supply chain from international production to distribution within the UK.* The Government's Strategy Unit working with the Home Office and other key departments will undertake a study.
- *Increasing the recovery of drug-related criminal assets.* The new Asset Recovery Agency will be established by February 2003.
- *Targeting the middle markets.* The police and other agencies are working together to tackle one of the most profitable parts of the supply chain – cross-regional markets. With close support from CIDA, this capacity is being built at a regional level. In addition to the existing team in the West Midlands, middle market capacity will be developed on Merseyside and in South and Mid Wales, before being spread across the rest of England and Wales.
- *Strengthening policing to better disrupt local supply markets.* Police performance is being strengthened through the work of the Home Office Drug Strategy Directorate and the Police Standards Unit. This involves guidance, sharing best practice, developing new targets and understanding drug markets. The Police Priority Area programme supports local policing strategies to better tackle multiple problems like drugs, addressing all aspects of policing.
- *Taking high profile action against suppliers in communities with particular problems.* Recent initiatives in Peterborough and Lambeth have shown how working closely with local partners and the community we can successfully deliver specialist action to tackle local drug markets and associated crime. For example, the Lambeth initiative saw over 100 crack house raids, 564 searches and over 90 people arrested.



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- *Tackling crack.* Policing to disrupt crack markets will be intensified in the areas most affected. Specialist treatment for crack addiction will also be increased and action taken to deter usage. Following a conference in June 2002, a National Crack Action Plan will be published before the end of December 2002.
- *Heavily penalising those caught dealing or drug trafficking* with maximum sentences ranging from 14 years (for Class B and C drugs) to life imprisonment (for Class A).

**C. Reducing Drug Use and Drug Related Offending through Treatment and Support. Reducing Drug Related Death through Harm Minimisation.**

Evidence shows us that treatment works. It is the key to reducing the harm drugs cause to users, family and communities and core to the delivery of the whole Drug Strategy. Problem drug misusers need a variety of interventions, it is not a case of one size fits all.

It is not possible within the scope of this paper to describe the full range of treatment available to 'treat' drug misusers. It is however important to recognise that a holistic approach is needed and which seeks to address the range of assessed needs, related to the individual's drug misuse and may include support with housing, family and finance issues. For this paper the delivery of 'specialist drug treatment' will be described across four main types/modalities these are:

- Community prescribing
- Care planned counselling including structured day programmes
- Inpatient programmes
- Residential rehabilitation

Specialist Drug Treatment is provided and delivered by a range of agencies which may include non-government organisations (known as the voluntary/independent sector), and statutory service providers, such as health and social services.

The availability and effectiveness of drug treatment (delivered by a range of providers) is variable across England and Wales. The Department of Health and Home Office jointly funded the National Treatment Agency (NTA), created in 2001 as a special Health Authority. The NTA's remit, covers England and it's current priorities are to ensure equality in drug treatment; increase the capacity and competence of the drug treatment workforce; increase quality and accountability at all levels of the drug treatment system; improve the availability and accessibility of drug treatment in all areas of the country; and increase the effectiveness of drug treatment.

The Department of Health commissioned the NTA to enhance planning, commissioning and provision of drug treatment services. This resulted in the development of Models of Care, a national framework (See Appendix B). Services for drug misusers can be grouped into four broad bands or tiers. Local areas covered by Drug Action Teams (see delivery section for explanation of DATs) will be expected to ensure that they provide the right balance of local drug treatment services to fit the needs of their local population and can provide access to the types of services outlined in the four tiers.

Models of Care is based on current evidence, quality standards and good practice in England and advocates a systems approach to meeting the multiple needs of drug misusers. It recognises the need for effective assessment which should be needs-led and seen as an on going process.

The three levels of assessment which should be available locally to provide access between the four tiers are:

- Level 1 Screening and referral assessment
- Level 2 Drug and alcohol misuse triage assessment
- Level 3 Comprehensive drug and alcohol misuse assessment

## 1. What is the Aim of Treatment?

For some years a range or hierarchy of goals of treatment have been identified in the UK (ACMD 1988 89, Task Force to Review Services for Drug Misusers 1996). These are

- Reduction of health, social and other problems directly related to drug misuse
- Reduction of harmful or risky behaviours associated with the misuse of drugs (e.g. sharing injecting equipment)
- Reduction of health, social or other problems not directly attributable to drug misuse
- Attainment of controlled non-dependent or non-problematic use
- Abstinence from main problem drugs
- Abstinence from all drugs

This hierarchy of drug treatment goals endorses the principle of harm minimisation, which refers to the reduction of the various forms of drug related harm until the drug misuser is both ready and able to come off drugs (Department of Health 1999). Harm minimisation strategies in the UK have achieved considerable success in preventing a more severe HIV epidemic (ACMD 1998).

## 2. Treatment – Overview from the Updated Strategy

The aim continues to be to increase the participation of problem drug users in the full range of treatment services and increase the proportion of users successfully sustaining or completing treatment by 2008. There has been good progress but much more needs to be done to ensure that treatment is readily available to those who need it. Through national and local action, this will be achieved by:

- *Investing in additional and better quality treatment services.* An expansion in treatment provision will take time to build – there is no quick fix solution. However, by 2008, capacity will have doubled so that 200,000 problematic drug users can be treated per year in the community or in a residential setting, as appropriate.
- *Filling the gaps in services.* Drug users have different treatment needs, it's not a case of one size fitting all. DATs and the NTA are committed to ensuring that all areas have access to an adequate range of services – including advice and harm reduction; GP and specialist prescribing; detoxification and rehabilitation, including residential services; and that new provision is evidence-based and effective.

Services for *crack* and *cocaine* users will be expanded from Spring 2003 with the development of new fast-track agencies - first in areas of greatest need and later across the country - along with new guidance, improved training and support for front line drugs workers.

All those who have a clinical need for *heroin* prescribing will have access to it under medical supervision, safeguarding against the risk of seepage into the wider community.

- *Reducing waiting times further.* The growth in treatment capacity and improved efficiency of services means that by the end of March 2004, maximum waiting times from referral to receipt of treatment should be no more than 2 weeks for in-patient detoxification and GP prescribing and 3 weeks for all other forms of treatment.
- *Improving the health of drug takers through the greater involvement of GPs.* We will increase the number of GPs / primary care professionals working with drug users and improve access to healthcare services for all problematic drug users, irrespective of prescribing needs.
- *More referrals from the Criminal Justice System.* There will be a focus to develop better links to treatment for drug offenders in the areas with the highest levels of crime.
- *Improving prison-based treatment provision.* An additional 2,000 intensive treatment programmes places will be created in prisons. New low intensity programmes will be introduced providing 17,000 places for those serving short sentences. The throughcare element of the system will be enhanced to ensure better continuity of treatment once prisoners leave custody.

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**D. Reducing Drug-Related Crime and its Impact on Communities**

Nothing affects the well-being of local communities as much as drug misuse, drug-related crime and the fear of such crime. Where communities are strong, drugs do not take a hold. The highest incidences of drug-related crime, supply and drug-related nuisance occur in the communities that suffer most from social deprivation.

Since 1998 a number of criminal justice based drug initiatives have been introduced or piloted in England and Wales, designed to either facilitate the referral of drug misusing offenders into drug treatment or deliver treatment within the context of a community or custodial sentence. These initiatives provide access and engagement at key access points in the criminal justice system and have been listed in brief below:

1. Police Custody Suites

Arrest referral schemes now cover all 43 police forces in England and Wales. Drug testing pilots operate in one custody suite in nine police force areas and in additional custody suites covered by four police forces within the street crime areas.

2. Courts

All courts in the drug testing pilot/street crime areas have access to the results (positive/negative) of drug tests in police custody to inform bail/sentencing decisions: and power to order pre-sentence drug tests in the pilot areas. Arrest referral workers have a presence in some Magistrates Courts.

3. Community Sentence

Drug Treatment and Testing Orders were introduced to courts in all probation areas in England and Wales from October 2000. Drug Abstinence Orders/Requirements are being piloted in 9 probation areas since November 2001 (part of the Drug Test pilot programme).

4. Prison

Healthcare teams providing clinical services and detoxification for prisoners received into custody. Counselling, assessment, referral, advice and throughcare (CARAT) teams have operated in all prisons from September 1999. There are a range of structured drug treatment programmes and therapeutic communities available in selected prisons. Mandatory drug testing has been available since 1997, a significant number of prisons have chosen to give prisoners access to voluntary testing units.

5. Post-release

Currently there is no comprehensive aftercare provision for drug misusers returning to the community from custody. Initiatives have developed in an ad hoc manner and prisoners serving less than 12 months are not currently subject to statutory supervision and therefore particularly vulnerable following release. Drug testing as a licence condition is being piloted in the 9 drug testing pilot areas.

**E. The Updated Drug Strategy Highlights in this Area**

- New programmes have been established to get drug misusers off drugs and out of crime through effective treatment – the key to reducing offending. Each year, arrest referral schemes have picked up around 50,000 drug misusers at the point of arrest and referred them into treatment or other programmes of help. Drug treatment and testing orders have enabled around 6,000 offenders per year to address their problems through intensive community based programmes, and drug testing pilots have been introduced to test arrestees and better inform bail and sentencing decisions. Their drug misuse and related crime rates have dropped significantly as a result;
- The Jobcentre Plus initiative progress2work was launched in 2001 and the first participants started in 2002. It helps recovering drug users find and sustain jobs – a key way of returning to a more stable and constructive life;
- £100 million has already been made available through the new Communities Against Drugs fund to support targeted, locally determined measures designed to strengthen communities, disrupt the local drugs markets and tackle drugs and drug-related crime;

- Guidance, training, information and support have been provided on housing management, neighbourhood renewal, homelessness and dance club management to enable agencies and organisations to tackle drug misuse in the context of wider community problems.

To break the link between drugs and crime there will be investment in a major new programme of interventions for adults and young people, which will move offenders out of the criminal justice system and into treatment. Using every opportunity from arrest, to court, sentence and on release, this programme will include:

- making arrest referral schemes more proactive and effective;
- extending drug testing after charge to those local police force areas with the highest crime;
- piloting the introduction of presumption against bail where offenders test positive for drugs but refuse treatment;
- doubling the number of Drug Treatment and Testing Orders by March 2005;
- expanding treatment provision in prisons;
- providing comprehensive programmes of throughcare and aftercare for treated drug misusers returning to the community from prison, including post-release hostels, and for those leaving treatment programmes who have not been in prison; and
- a package of corresponding, but appropriate interventions for juveniles.

#### **F. Delivery of the Updated Drug Strategy**

The problems of drug misuse are complex and require integrated solutions and co-ordinated delivery of services involving education, intelligence and enforcement, social and economic policy, and health. Tackling drugs requires effective joint working between Government Departments at national level and similar partnership working between agencies at local level.

Delivering the Drug Strategy is a cross-government initiative. Following the 2001 General Election, the Home Secretary took over lead responsibility for driving forward delivery of the Drug Strategy, as Chair of the Cabinet Ministerial Sub-Committee on Drugs Policy. The committee includes ministers from the Department of Health, the Department for Education and Skills, the Office of the Deputy Prime Minister, the Cabinet Office, the Treasury and the Foreign and Commonwealth Office.

The Drug Strategy targets are expressed in departments' public service agreements listed below and supporting service delivery agreements. These are embedded in delivery plans which are drawn up in conjunction with the Prime Minister's delivery unit and kept under regular review by ministers and officials. The Public Service Agreements are to:

- Reduce the use of class A drugs and the frequent use of any illicit drug among all young people under the age of 25 especially by the most vulnerable young people;
- Reduce the availability of illegal drugs by increasing: the proportion of heroin and cocaine targeted on the UK which is taken out; the disruption / dismantling of those criminal groups responsible for supplying substantial quantities of Class A drugs to the UK market; and the recovery of drug-related criminal assets;
- Contribute to the reduction of opium production in Afghanistan, with poppy cultivation reduced by 70% within 5 years and elimination within 10 years;
- Reduce drug related crime, including as measured by the proportion of offenders testing positive at arrest; and

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- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year by year the proportion of users successfully sustaining or completing treatment programmes.

The Government set up the National Treatment Agency (NTA) as a Special Health Authority on 1 April 2001, although staff were not in place until the autumn of that year. The NTA's current priorities are to ensure equality in drug treatment; increase the capacity and competence of the drug treatment workforce; increase quality and accountability at all levels of the drug treatment system; improve the availability and accessibility of drug treatment in all areas of the country; and increase the effectiveness of drug treatment.

### **G. Regional and Local Delivery Mechanisms**

The following mainly reflects delivery in England.

*At a local level*, agencies working in partnership through 149 Drug Action Teams (DATs) deliver the Drug Strategy. DATs were initially set up in 1995 and have been aligned with local authority boundaries since April 2001. They bring together representatives of key local agencies, such as health (Primary Care Trusts), social services, the police, probation, education, the Prison Service, and housing. Each DAT is supported by a co-ordinator and is accountable to the Home Secretary. Some include alcohol and solvent misuse within their remit. DATs are supported by one or more drug reference groups, whose membership includes key local professionals involved in the delivery of drug services.

DATs are supported at a regional level by Home Office drug teams (Regional Government Office Teams). There are nine in England. In recognition of the need to operate more effectively at regional level, Home Office teams, including the nine regional teams are being integrated into the regional Government Office structure. This will support closer links between those supporting regional activity on crime, drugs, community cohesion, racial equality, active communities and other Home Office priorities such as neighbourhood renewal, and the wider Government Office agenda.

### **H. Performance Management and Monitoring**

Delivery of the Drug Strategy depends on agencies working effectively in partnership to make a real difference to local communities. Home Office teams support partnership working in a variety of ways, including setting and monitoring standards of performance, and assessment of partnerships' plans through a process which includes the NTA and other regional representatives (for example, the Youth Justice board, the Connexions Service and the Social Service Inspectorate).

Recommendations for action are then agreed between the DAT and the Home Office team; and progress is monitored and reported on a quarterly basis.

### **I. Annual Report**

Each year DATs report on their work by providing statistical and qualitative data on young people, treatment, communities and supply. From April 2001 DATs have provided this information electronically. This in itself is a success story for the Government's e-business strategy and has generated a database, which includes the most comprehensive local information available to date on the delivery of the Drug Strategy and tracking of expenditure. The database allows comparison of DAT performance across "families" and regions, providing DATs with an opportunity to share good practice.

## **VI. WHAT NEXT FOR DEVELOPING DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM?**

The updated Drug Strategy 2002 set out plans to break the link between drugs and crime by extending, enhancing and integrating a range of criminal justice interventions from arrest to court to sentence which are aimed at getting drug misusing offenders in to drug treatment and provide appropriate aftercare.

A new criminal justice interventions programme – drugs, has been introduced to integrate new and existing programmes. The aim of the new criminal justice intervention programme is to reduce drug related offending by moving drug misusing offenders through criminal justice interventions into and through the

drug treatment system. An integrated approach to delivering criminal justice based drug interventions is now being developed.

A range of different initiatives highlighted previously currently deals with drug misusing offenders as they are processed through the criminal justice system. such as Arrest Referral Schemes located in police custody suites, Drug Treatment and Testing Orders managed by the probation service and prison based CARAT schemes. In many instances, lack of co-ordination between these services has lead to inconsistency of care, inefficient working practices and failure to effectively engage and retain offenders in treatment. This is particularly true of offenders who are released from prison without adequate aftercare arrangements.

The updated drug strategy highlights the aim to join up initiatives in the criminal justice system more effectively and develop an 'end to end approach from arrest through to sentence and beyond. Under this new programme supported by the Home Office and NTA, 25 DATs covering areas with the highest levels of acquisitive crime have been asked to adopt a model of working delivered by a 'virtual or dedicated' community based criminal justice drug team for their area. This approach should where possible build on work and arrangements already in place using a combination of existing and new resources from the additional capacity building and aftercare funds.

In line with the Models of Care framework described in this paper, this approach adopts the principle of identifying an integrated care pathway which clearly maps the course of treatment for a drug misuser who is assessed and referred within the criminal justice system

This 'community based team' will accept referrals from police, courts, probation and prisons and their role will extend beyond assessment and referral. There is clear evidence from the arrest referral evaluation (July 2002) that delays between referral and accessing treatment are de-motivating and lead to a high proportion of offenders not engaging in treatment. This learning highlights the need for the community based team to be able to provide and/or access the full range of Tier 2 interventions, including case management and low threshold treatment interventions, to ensure that offenders are engaged and supported and to maximise the prospects of retaining them in treatment.

The new teams will undertake the following tasks:

- Drug and Alcohol triage assessment and referral into appropriate specialist treatment.
- Care planning and co-ordination function.
- Harm reduction advice and interventions.
- Immediate access to low threshold treatment – for instance, structured counselling/motivational interviewing and methadone prescribing.
- Appropriate interventions for crack and cocaine users.
- Work in partnership with probation and police in contributing to the delivery of DTTO, pre-arrest and prolific offender programmes.
- Provide a dedicated aftercare service for prisoners being released into the relevant DAT area to address their drug treatment needs and facilitate access to other services like housing, mental health, employment etc. This will include liaising with CARAT teams and probation staff to prepare jointly agreed release plans. Manage a team of volunteer mentors to provide practical support and encouragement for offenders.

There will also be similar initiatives aimed at young people in the youth justice system, starting with piloting Arrest Referral for under 18s in 10 of the 25 DATs from September 2003.

## **VII. CHANGES TO EXISTING LEGISLATION AND THE LEGAL FRAMEWORK**

The Governments' White paper 'Justice for All', published in the summer of 2002 outlined a range of proposals to be taken forward subject to legislative changes. Some of these have been outlined in this paper.

The legislative process is under way and at the time of writing this paper these proposals amongst others are being considered under the current Criminal Justice Bill. The proposals include:

- extending drug testing provisions after charge with a 'trigger offence' under the Criminal Justice and Court Services Act 2000 to those under 18;
- piloting the introduction of presumption against bail where offenders 18 and over who test positive after being charged must agree to be assessed and/or access treatment or be refused court bail;
- introduction of a single generic community sentence made up of specific elements which will replace all existing community sentences including the DTTO;
- introduce a condition of treatment for young offenders as part of an Action Plan Order or Supervision Order; and
- under the Criminal Justice and Court Services Act 2000 provisions to extend drug testing as a condition after release on licence to include non-trigger offences.

## **VIII. CONCLUSION**

This paper has provided a brief overview of the UK Updated Drug Strategy's, particularly in relation to treatment and the development of drug interventions in the Criminal Justice System in England and Wales. The overarching aim of the UK Government's drug policy is to reduce the harm that drugs cause to society - communities, individuals and their families. The key to delivering this aim is to reduce the number of people caught up in the chaotic lives of addiction and crime (problematic drug users) and to stop young people from entering their ranks. Tackling the enormous challenge of drug misuse is not a matter for Government or its agencies alone, partnership and collaborative approaches are needed from a national, regional and local level to tackle the complex issues raised through use and misuse of drugs across all aspects of the four areas outlined in the strategy. The development of drug interventions in the criminal justice system in conjunction with effective treatment has demonstrated the potential for reducing drug related offending, drug misuse and improving health can be achieved through moving drug misusing offenders through criminal justice interventions into and through the drug treatment system.

## APPENDIX A THE LEGAL FRAMEWORK

### I. THE MISUSE OF DRUGS ACT 1971

Drug misuse is a huge global problem which poses a threat to people in many countries worldwide. In the early 1960s, the international community recognised that restricting the availability of drugs that are liable to misuse would require co-ordinated and universal action and, with this aim in view, has subsequently drawn up three United Nations Conventions on drugs.

The UN Conventions provide controls on several hundred narcotic drugs and psychotropic substances that are liable to misuse. They prohibit or restrict their use by means of a comprehensive range of control measures. The Conventions also recognise that some narcotic and psychotropic drugs have valuable medical and scientific uses. They make specific provision for the production and use of such drugs for legitimate pharmaceutical, medical and scientific purposes, but otherwise prohibit their use.

The UK is a party to these Conventions and has implemented their provisions into UK law by means of the Misuse of Drugs Act 1971 and its associated regulations. As a member state of the European Union (EU), the UK also works in close partnership with other member states to deliver the EU Drug Strategy (2000–2004). The strategy is wide-ranging, covering actions against supply and demand both within the EU and internationally, as well as the development of comprehensive evaluation mechanisms. It is practically implemented by means of the EU action plan on drugs (2000–2004). Subject to the scrutiny of Parliament, a number of elements of the EU strategy will be incorporated into UK law.

The Misuse of Drugs Act and regulations made under the Act establish the controlled status of drugs liable to be misused in the UK. They prohibit and make unlawful the importation, exportation, production, supply and possession of such drugs without authority. The regulations also provide for the legal production and distribution of controlled drugs for pharmaceutical and medicinal purposes.

The Misuse of Drugs Act 1971 also established the Advisory Council on the Misuse of Drugs (ACMD), an independent body of experts in the drugs field, to advise the Government on drug misuse issues. It is part of the ACMD's remit to consider and make recommendations on the classification of new drugs and for keeping the classification of existing drugs under review.

The drugs which are controlled under the Act are listed in Schedule 2 and are separated into Class A, Class B or Class C depending on their harmfulness. Class A drugs are the most harmful and Class C drugs are the least harmful. The Act provides penalties for drug offences. The highest penalties relate to trafficking offences, e.g. unlawfully supplying controlled drugs. Class A drugs attract the highest penalties and Class C drugs the least strict penalties, as shown in the table below.

**Table 1. Misuse of Drugs Act 1971**

Class A	Class B	Class C
Heroin	Amphetamines	Amphetamine related drugs
Morphine	Barbiturates	Buprenorphine
Methadone	Codeine	Most Benzodiazepines
Cocaine	Cannabis	Anabolic Steroids
LSD		(under certain circumstances)
Ecstasy		



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**Table 2. Misuse of Drug Offences – Maximum Penalties**

Offence	Class A	Class B	Class C
Production of a controlled drug	Life or a fine or both	14 years or a fine or both	<u>current</u> - 5 years or a fine or both <u>proposed</u> - 14 years or a fine or both
Supply of a controlled drug	Life or a fine or both	14 years or a fine or both	<u>current</u> - 5 years or a fine or both <u>proposed</u> - 14 years or a fine or both
Possession of a controlled drug	7 years or a fine or both	5 years or a fine or both	2 years or a fine or both

**A. Reclassification of Cannabis**

It is important that the UK Government's message to young people is open, honest and credible. Drug laws must accurately reflect the relative harms of different drugs if they are to be effective and credible in trying to persuade young people in particular of the dangers of misusing drugs. The police and other enforcement agencies need to focus their resources effectively on tackling the drugs which do the most harm.

To ensure that these aims are met, the Government has decided to bring forward proposals to Parliament to reclassify cannabis from Class B to Class C under the Misuse of Drugs Act 1971. Cannabis is illegal and will remain illegal.

Hard drugs like heroin and powder and crack cocaine destroy lives. They cause harm and misery to those who use them, their families and the communities they live in. The Drug Strategy will therefore concentrate on tackling these drugs. Efforts to reduce the supply of such drugs, and the approach to treatment and education, needs to reflect this priority.

The decision to reclassify cannabis is based on the advice of the Advisory Council on the Misuse of Drugs (ACMD). The Council advised that the classification of cannabis as a Class B drug was disproportionate in relation both to its inherent toxicity, and to that of other substances (such as amphetamines) that are currently within Class B. In making its recommendation, however, the Council made it clear that cannabis is unquestionably harmful.

The reclassification of cannabis will mean that the law is brought better into line with what actually happens in practice. The maximum penalty for the possession of cannabis will go down to two years' imprisonment. Most first offences of cannabis possession will be dealt with by the police by way of a warning and confiscation of the drug. The police will retain the power of arrest to be used where there are aggravating factors, such as flagrantly disregarding the law.

A new cannabis enforcement model being developed by the Association of Chief Police Officers (ACPO) will provide police with a clear and firm steer on dealing with cannabis possession, including any aggravating circumstances. Police time saved as a result can then be redeployed, supporting the wider strategy objective of refocusing efforts – including enforcement action – on the drugs that cause the most harm.

**1. Supply Offences**

The Government takes the supply and dealing of cannabis very seriously. It therefore intends, subject to Parliamentary approval, to increase the maximum penalty for supplying and dealing in Class C drugs from 5 to 14 years' imprisonment. This will maintain the maximum penalty for dealing in cannabis at its level as a Class B drug and will enable the courts to continue to impose substantial sentences for serious dealing offences involving cannabis.

## II. THE ENGLISH JUDICIARY PROCESS

### A. Brief Summary and Roles of Agencies

To help set the work being undertaken with drug users in the criminal justice system in context, in England and Wales a very brief overview of the legal system and the role of criminal justice agencies has been provided.

The English legal system has been built around two distinct court processes

- Civil Law and
- Criminal Law.

The procedures within the court systems vary greatly; it is the judicial process around the criminal court system which will need to be taken account of in delivery and planning of drug related criminal justice programmes to be described later.

The British Court System is known as adversarial which means that both the Defence and Prosecution try to persuade the bench or jury of either guilt or innocence.

The courts which deal with crime and related issues are the Magistrates Court and the Crown Court. Offences within the criminal judicial system fall into one of three categories. The category determines the court's power to deal with the offence. The categories are:

- Summary Offences (Magistrates Court)
- Either-way offences (Magistrates or Crown Court)
- Indictable offences (Crown Court)

#### 1. Summary Offences

Summary offences carry a maximum prison sentence of six months; these are dealt with by the magistrates' court.

#### 2. Either-Way Offences

Either-way offences can be tried in either the Magistrates Court or Crown Court. The transfer between courts is known as a committal. The reason for the transfer between the courts can be: the magistrates elect not to deal with the matter and transfer it to the higher court due to the serious nature of the offence; or the defendant elects for trial in the higher court.

#### 3. Indictable offences

Indictable offences are the more serious and can only be tried in Crown Court. The procedure will commence in the Magistrates court being committed to the Crown Court.

### B. Brief Overview of the Courts

#### 1. The Magistrates Court

Magistrates Court deals with Summary Offences and less serious Either-way offences. The Magistrates only have the power to sentence individuals to up to one year's imprisonment. There are two types of Magistrates in England & Wales, Lay and Stipendiary Magistrates.

*Lay Magistrates* sit on a bench with usually two others. They are members of the local community who have been invited to sit on the 'bench'. They are not qualified in law and their role is voluntary.

*Stipendiary Magistrates* on the other hand are qualified solicitors. They are paid to undertake their duties and have the power to pass sentence by themselves.

Specialist Youth Courts form part of the Magistrates Court Structure. These courts deal with young offenders less than 18 years. Lay Magistrates who have had training in youth matters sit at these courts.

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### 2. The Crown Court

The Crown Court is the higher of the two courts. This means that the most serious of offences with sentences up to life imprisonment are conducted within it.

Proceedings in the Crown Court are overseen by a Judge and take place before a jury. The jury consists of 12 members of the public who make a decision on the guilt of the defendant based upon the case presented.

The judge is qualified in law and will have experience through being a barrister in the higher court. The judge has the power to pass sentence on their own at the end of a trial.

### C. Court Roles

#### 1. The Clerk of the Court

The Clerk (Legal Advisor) is a qualified solicitor who is neutral in court proceedings. Their role is the day to day running of the court. The Clerk advises the Magistrate on points of law and they sit below the bench.

#### 2. The Crown Prosecution Service (CPS)

The CPS has two roles. They prepare cases against defendants with information given by the police and also prosecute the case against the defendants if there is enough evidence. The CPS solicitor is commonly known or referred to as the Crown or Prosecution.

#### 3. The Client's Solicitor

The clients' solicitor is also qualified in law like their CPPS counterpart. Their role is to defend the client against the charges put forward by CPS. The clients' solicitor is commonly known as their brief and is often referred to as 'The Defence' in court. In the Crown Court the clients' brief is known as the 'barrister'.

### D. The Role of Criminal Justice Agencies

*The Probation Service* – Established in April 2001 the National Probation Service for England & Wales is part of the Home Office. There are 42 probation services across England & Wales matching police force geographical boundaries.

*The Prison Service* – There are 135 custodial institutions across England & Wales comprised of a mix of high secure, to establishments for young offenders. The role of the prison service is to supervise offenders in custodial institutions.

Prisons and probation services work together to execute court sentences to reduce re-offending and protect the public.

#### 1. Role of the Probation Service

Primary role is to supervise offenders in the community who have received a community sentence or are released 'on licence' from prison (i.e. those adults who having received a sentence of more than a year, or a young person 18-21).

In a court context the probation service provides support in a number of ways.

The first of these is to:

- Assist the court in making decisions about bail. The Probation Officer (PO) or Probation Service Officer (PSO) may be asked to clarify bail addresses or employment circumstances of defendants. In some cases they provide a bail hostel placement for defendants who have no bail address or need a more secure community address.
- When asked by the court, prepare written reports on those who are found guilty of offences. The report known as a Pre-Sentence Report (PSR) is used by the Magistrate or Judge to assist in sentencing. It gives information on the offender's background and their view on their offence. The

PSR also recommends a sentence to the court and if necessary outlines a plan of action that will be used to rehabilitate the offender (as in the case of a Drug Treatment and Testing Order).

### **E. The Police Service**

There are 43 Police Forces across England & Wales, covering specific geographical areas. The aim is to protect the public and prevent crime. For policing purposes each area may be broken down into smaller areas which could be termed / Divisions or Basic Command Units. Each division will operate to meet the needs of its own local community this will also include involvement with partnership work. To assist in understanding the arrest referral programme to be explained later, a brief explanation follows about the role of police custody:

To assist in understanding how arrest referral works within the custody suite, a brief overview of the management within the custody suite/office is given below:

The Custody Office is a secure restricted access area within a police station/custody suite which comprises of a prisoner reception area custody desk interview room medical examination room and cell area. Separate cell areas are provided for males and females. It is normally staffed by a sergeant and one or two constables. The custody sergeant has responsibility for the custody office and all persons in police detention. The constables provide support.

The position of the Custody Officer is unusual in that their role requirement is defined by statute and is a legislative requirement (Police and Criminal Evidence Act 1984).

Upon arrival at a police station a detainee is brought back to the custody desk, where the arresting officer will explain the circumstances leading to the arrest.

The custody sergeant will then consider whether they need to authorise detention. Once detention is authorised the custody officer will open a custody record and the detainee will be given their rights and entitlements in accordance with PACE. (Human Rights etc) It is at this stage that the opportunity to see an arrest referral worker may first be offered.

The detainee will be searched and their property retained by the custody officer in accordance with PACE. Custody offices in some force areas now have video camera systems installed which records all activity within the custody cells.

### **III. POLICE AND CRIMINAL EVIDENCE ACT 1984 (PACE) AND CODES OF PRACTICE (NOTE: PACE WITH NEW CODES OF PRACTICE TO BE INTRODUCED)**

The Police must ensure that they act at all times in accordance with PACE and the codes of practice in relation to arrest referral.

Particular relevance for arrest referral includes the following key codes which relate to interviewing and questioning:

- 11.1 A of PACE Code C (Code of Practice relevant to the detention, treatment and questioning of persons by the police)
- 11.13 of PACE Code C (relating to keeping written record of any comments by a suspected person)
- 3.4 of PACE Code C prohibits Custody Officer from engaging in conversation with the suspect regarding anything to do with the offence
- Section 40 (1) and (2) of PACE – periodic review of need to be in police detention.

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**APPENDIX B**  
**MODELS OF CARE - FOUR TIER FRAMEWORK**

**Table 1. Drug Misuse Treatment Tiers and Commissioning Levels**

<b>Tier No.</b>	<b>Tier Title</b>	<b>Service Modality</b>	<b>Commissioning Level</b>
1	<b>Non-substance misuse specific services</b>	For example: Personal/general medical services (primary care) Non-DM specific social services including children and family services; non-DM specific assessment and care management Housing and homelessness services Non-SM specific probation services Vaccination / communicable diseases Sexual health / health promotion Accident and emergency services General psychiatric services Vocational services	Local DAT*/ PCT/ PCG
2	<b>Open access drug misuse services</b>	Drug-related advice and information Open access or drop-in services Motivational interviewing/ brief interventions Needle exchange (pharmacy/service/outreach) Outreach services (detached/domiciliary/peripatetic) Low-threshold prescribing Liaison with drug misuse services for acute medical and psychiatric sector DM specific assessment and care management	Local DAT/ PCT/PCG
3	<b>Structured community-based specialist drug misuse services</b>	Drug specialist care planning and co-ordination Structured care planned counselling and therapy options Structured day programmes (urban and semi-urban) Community-based detoxification services Community-based prescribing stabilisation and maintenance prescribing Community-based drug treatment for offenders on DTTOs Other structured community-based drug treatment services targeting specific groups Structured aftercare programmes Liaison with drug treatment services	Local DAT*/ Multi-DAT
4a	<b>Residential substance misuse specific services</b>	Inpatient drug detoxification and stabilisation services Drug and alcohol residential rehabilitation services Residential drug and alcohol crisis centres Residential co-morbidity services Specialist drug and alcohol residential units targeting specific groups, e.g. mother and child units services	Multi-DAT/ Regional/ National
4b	<b>Highly specialist non-substance misuse specific services</b>	For example: Specialist liver disease units Forensic services Specialist psychiatric units including: personality disorder units; eating disorders units Terminal care services Young people's hospital and residential services providing drug and alcohol treatment services (16 to 21 years) HIV specialist units	Regional/ National

Source : Models of Care for Treatment of Adult Drug Misusers - Part 1 NTA  
(Oct 2002)

# **A BRIEF OVERVIEW OF DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM (ENGLAND AND WALES) WITH A FOCUS ON SPECIFIC INTERVENTIONS PROVIDED AT ARREST - ARREST REFERRAL AND AS A COMMUNITY SENTENCE - DRUG TREATMENT AND TESTING ORDERS**

*Shireen Sadiq\**

## **I. INTRODUCTION**

The overarching aim of the UK Government's drug policy is to reduce the harm that drugs cause to society - communities, individuals and their families. The key to delivering this aim is to reduce the number of people caught up in the chaotic lives of addiction and crime (problematic drug users) and to stop young people from entering their ranks. Tackling the enormous challenge of drug misuse is not a matter for Government or its agencies alone.

The updated Drug Strategy, published in December 2002, sets out plans to break the link between drugs and crime through joining up drug interventions delivered in the criminal justice system more effectively and developing an 'end to end' approach from arrest through to sentence and beyond.

Evidence from early pilots and more extensive evaluation has highlighted that drug interventions in the criminal justice system offer an effective means of putting drug misusing offenders in touch with appropriate services locally where they can receive help to reduce their drug use.

To help provide an overview of the potential benefits and implications for implementation of these types of interventions, particularly at arrest and at the community sentence stage, this paper will outline a brief summary of evidence from early pilots and programmes relating to Arrest Referral and Drug Treatment and Testing Orders. It will include references to the models of delivery as the evidence base as well as practical implementation issues which may need to be considered for effective delivery.

### **A. Terminology**

To facilitate an understanding of assumptions which may be made in the paper, this section will seek to describe some of the terms used which have been adapted from definitions adopted by the Health Advisory Service (HAS) and the Advisory Council on the Misuse of Drugs (ACMD) National Treatment Agency and the Audit Commission.

- *Drug Use*: illegal and illicit drug taking that does not cause any perceived immediate harm- even though it may carry some risk of harm e.g. health problems.
- *Drug Misuse*: illegal and illicit drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence.
- *Treatment*: describes a range of interventions which are intended to address an identified drug related problem or condition relating to a person's physical, psychological or social (including legal) well being. Structured treatment (evidence based) follows assessment and is delivered according to a care plan with clear goals regularly reviewed with the client. It may comprise a number of concurrent or

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sequential treatment interventions. Drug treatment can encompass a wide range of interventions / treatment modalities (types).

- *Problematic Drug User*: describes those drug misusers who experience social, psychological or legal problems related to their drug misuse rather than those who use drugs casually or recreationally.
- *Polydrug user*: describes the pattern of drug misuse where the same person will use opiates particularly heroin as well as crack, cocaine, other stimulants and drugs such as benzodiazepines.

### **B. The Legal Framework and the Roles of Criminal Justice Agencies**

In order to understand how drug interventions are delivered within the context of the criminal justice system in England and Wales there is a need to have some understanding of the legal framework and agencies involved, for the purposes of this paper this is very briefly covered in Appendix A of my first paper.

## **II. EVIDENCE BASE – DRUGS AND CRIME**

The relationship between drugs and crime is complex, though not all drug users commit crime. Research has helped to quantify the potential demand for Arrest Referral and other programmes and provides a 'profile' of those offenders who would most benefit.

The New English and Welsh Drug Abuse Monitoring programme (NEW ADAM), aims to provide basic intelligence on: drug misuse at the point of entry into the criminal justice system and links between drugs and crime. The programme involved adult offenders who had been arrested and subsequently interviewed and drug tested (using urine samples) to check for drug presence, in 8 police custody suites. The study found the following:

- 65% of arrestees test positive for at least one illegal drug
- 30 % tested positive for two or more such substances
- 29% tested positive for heroin/cocaine
- users of both heroin/cocaine/crack commit between 5-10 as many offences as arrestees who do not use drugs
- 78% saw a connection between drug use and acquisitive crime
- users of heroin and crack cocaine were also responsible for more than half, by value, of acquisitive crime

Most of the arrestee group described above were not in treatment. Strategies aimed at reducing the demand for illicit drugs by breaking the link between drugs and crime have been an integral part of the UK Government's anti-drug strategies since the mid-1990's. There is strong evidence that for many problem drugs using offenders treatment can be a cost effective way of reducing their offending. The importance of this connection can be demonstrated through the recent estimations of the economic and social costs of Class A drug use by York University (Godfrey et al 2002). The study found that the total (including victim) social and economic cost of Class A drug use in England and Wales, was estimated to be between £10 billion and £18 billion per annum. Problem drug users account for almost all economic and social costs (99%) and drug related crime accounts for around 88% of total economic and social costs.

### **A. Evidence Base- Treatment and Estimating 'Demand'**

We know that treatment works. Appropriate treatment, can reduce both drug misuse and related offending. Evidence highlights that problem drug using offenders referred through the criminal justice system to treatment, and then retained in treatment, report significant reductions in drug related crime, spending on drugs and use of drugs (NTORS, Gossop 2001).

Findings from early pilots of arrest referral to engage drug misusing offenders in the criminal justice system highlighted that drug using offenders do take up and engage in programmes of help, more findings from these pilots will be outlined later in the paper (Edmunds et al 1998).

Evidence suggests that there are strong links between users of certain drugs and crime particularly acquisitive. It is therefore not surprising to find that problem drug users frequently turn up in the Criminal

Justice System. It is estimated that 180,000 problematic drug users enter the criminal justice system through police custody suites each year, of these only a minority are already in treatment (NEW ADAM). It is also estimated that there are around 250,000 problem Class A drug users in England and Wales (Godfrey et al), of whom 100,000 (NDTMS) may be in specialist treatment.

The brief information provided in this section demonstrates the potential size of the population of problematic drug users in and out of treatment and the criminal justice system as well as the importance and cost effectiveness of treatment.

### **III. DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM**

Drug interventions in the criminal justice system offer an effective means of putting offenders who are using illegal drugs in touch with appropriate services locally where they can receive help to reduce their drug use.

Since 1998 a range of criminal justice based drug interventions have been introduced or piloted in England and Wales, which were designed to either facilitate the referral of offenders into drug treatment, or deliver treatment within the context of a community or custodial sentence.

These interventions have been implemented to provide access and engagement at key points in the criminal justice system; these are listed, in brief, below:

*In police custody suites* – Proactive arrest referral schemes now cover all 43 police forces in England and Wales. Drug Testing Pilot Programme - Drug testing after charge under the provisions of the Criminal Justice and Court Services Act 2000 operate in one custody suite in nine police force areas and in additional custody suites covered by four police forces within the street crime areas.

*Courts* – All courts in the drug testing pilot programme /street crime areas have access to the results (positive/negative) of drug tests in police custody to inform bail/sentencing decisions: and power to order pre-sentence drug tests in the pilot areas. Arrest referral workers have a presence in some Magistrates Courts.

*Probation* – Drug Treatment and Testing Orders were introduced to courts in all probation areas in England and Wales from October 2000. Drug Abstinence Orders/Requirements are being piloted in 9 probation areas (part of the Drug Testing pilot programme).

*Prison* – Healthcare teams provide clinical services and detoxification for prisoners received into custody. Counselling, assessment, referral, advice and throughcare (CARAT) teams have operated in all prisons from September 1999. There are a range of structured drug treatment programmes and therapeutic communities available in selected prisons. Mandatory drug testing has been available since 1997 a significant number of prisons have chosen to give prisoners access to voluntary testing units.

*Post-release* – currently there is no comprehensive aftercare provision for drug misusers returning to the community from custody. Initiatives have developed in an ad hoc manner and prisoners serving less than 12 months are not currently subject to statutory supervision and therefore particularly vulnerable following release. Drug testing as a licence condition is being piloted in the 9 drug testing pilot areas.

#### **A. Drug Treatment Services**

Interventions delivered in the criminal justice system will only be effective when associated with appropriate treatment interventions. Treatment and support needs to be accessible to those who need it regardless of origin, gender, sexual orientation or source of referral. Although waiting times to access specialist drug treatment is reducing there are still problems in some parts of the country (NTORS 2001).

The availability and effectiveness of drug treatment (delivered by a range of NGOs providers) is variable across England and Wales. The Department of Health and Home Office jointly funded the National Treatment Agency (NTA), created in 2001 as a special Health Authority. The NTA's remit covers England and its current priorities are to ensure equality in drug treatment; increase the capacity and competence of the



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drug treatment workforce; increase quality and accountability at all levels of the drug treatment system; improve the availability and accessibility of drug treatment in all areas of the country; and increase the effectiveness of drug treatment. The National Treatment Agency (NTA) is currently taking forward a programme of work to improve accessibility and availability to treatment services, generally and is working with Drug Action Teams (DATs) to ensure that drug misusers in all areas (England) have access to the full range of treatment.

The Department of Health commissioned the NTA to enhance planning commissioning and provision of drug treatment services. This resulted in the development of Models of Care, a national framework (see Appendix A). The range of interventions outlined in the framework are grouped into four broad bands or tiers, which range from the least specialist and intensive in Tier 1 to the most specialist and intensive in Tier 4. Local areas covered by Drug Action Teams (strategic local partnerships) will be expected to ensure that they provide the right balance of local drug treatment services to fit the needs of their local population and can provide access to the types of services outlined in the four tiers.

Models of Care is based on current evidence, quality standards and good practice in England and advocates a systems approach to meeting the multiple needs of drug misusers. It recognises the need for effective assessment which should be needs-led and seen as an on going process. The three levels of assessment which should be available locally to provide access between the four tiers are:

- Level 1 Screening and referral assessment
- Level 2 Drug and alcohol misuse triage assessment
- Level 3 Comprehensive drug and alcohol misuse assessment

The following section on Arrest Referral will briefly describe the term and models, outline the evidence base and links with drugs and crime, from early pilots and programmes and briefly refer to the processes adopted, practical and implementation issues for 'effective delivery'.

### **B. What is Arrest Referral?**

Arrest referral schemes are partnership initiatives between the police, local drug services (delivered by Non Government Organisations NGOs and Statutory Services) and Drug Action Teams (DAT)/Drug and Alcohol Action Teams (DAAT) that *use the point of arrest* within custody suites as an opportunity for independent drug workers to, to make contact with arrestees with drug problems while they are in police detention and *refer them to appropriate treatment* to address their drug use. The pro-active arrest referral initiative is one of a series of criminal justice interventions that seeks to identify problem drug-using offenders in the criminal justice system and refer them to treatment.

Arrest Referral Schemes are not alternatives to prosecution or due process but provide a direct route from the custody suite to drug treatment or other programmes of help.

Evidence has suggested that the proactive approach is (Edmunds et al 1998) most effective. This is where a dedicated drugs worker, independent of the police, based in or on call to a police custody suite, makes contact with problem drug-using arrestees and refers them to appropriate treatment: with the aim of reducing their drug use and drug-related offending. The evidence provided to date supports the recommendation that all those arrested regardless of alleged offence should be introduced and/or informed of the scheme i.e. 'blanket coverage'.

Involvement with arrest referral is voluntary and is not an alternative to prosecution or due process. Focused on the point of entry to the criminal justice system, this initiative aims to identify and help problem drug-using offenders break their cycle of drug use and crime as early as possible.

Arrest referral schemes have been in operation in various forms since the 1980s. Three main models of delivery have been identified in earlier research: (Edmunds et al 1998, 1999).

- Information model. This approach involves the provision of basic information (such as leaflets) about local drug treatment services that can be delivered by police custody staff. Problem drug-using offenders will be expected to contact treatment services through their own volition.

- Proactive model. In this model, a dedicated and independent drug worker based in the custody suite or on-call, assesses problem drug-using offenders and refers them to an appropriate treatment service.
- Incentive or coercive model. This model can provide incentives to seek help. 'Caution Plus' schemes involve cautioning a problem drug-using offender arrested for possession of illicit drugs with the specific requirement to seek advice from a drugs worker. 'Deferred Caution' schemes delay the decision to issue a caution following attendance at a drug service within, for example, 30 days. If a positive report is recorded no further action will be taken.

#### 1. Evidence Base - Arrest Referral

The evidence base for developing arrest referral initiatives consist of three strands of research which demonstrate:

- strong links between drug use and offending behaviour;
- high numbers of potentially problematic drug users entering the criminal justice system; and
- the (cost) effectiveness of treatment in achieving sustained reductions in drug use and related offending.

Evidence already exists which demonstrates the potential of arrest referral schemes to deliver reductions in drug use and offending behaviour. Three demonstration arrest referral schemes in Southwark, Derby and Brighton, were evaluated (Edmunds et al 1998) each adopting the 'proactive' model. Findings showed these pilots addressed an unmet need; whilst offenders had on average 21 previous convictions, previous arrest had not deterred them from drugs/crime; they were poly drug users, injectors with lengthy drug using careers which started when they were young. Only a quarter seen at arrest were in touch with drug services and a third had never been in contact.

At the six month follow up, large reductions were noted in self-reported drug use, rates of injecting were also reduced, average expenditure (median) on drugs fell from £400 per week to £70 per week (six months). The total number of criminal offences committed per month was also reduced from 10,800 in the month before contact with a scheme to 2,200.

The research concluded that the proactive model could be successful by identifying and targeting criminally active drug users who may benefit from treatment, referring this group to specialist drug treatment services and helping to ensure that referrals enter treatment programmes.

#### 2. Expansion of Arrest Referral Schemes through the Joint Funding Initiative

The Home Office Crime Reduction Programme (CRP) was a three-year, evidence-based initiative costing £420 million, aimed at achieving a sustained reduction in crime, improving and mainstreaming knowledge of best practice and implementing cost-effective crime reduction activity. The programme included burglary reduction, targeted policing, violence against women, use of Close Circuit Television (CCTV), sentencing and treatment of offenders, early interventions, youth inclusion and arrest referral.

Encouraged by the evidence from early pilots for arrest referral, the Home Office agreed in summer 1999 to contribute £20 million over three years, from the Crime Reduction Programme (CRP). It is important to note that at the time a Key Performance Target for all Police Forces in England & Wales had been set out in the 10 year U.K Drug Strategy (1998),- to double by 1999 the number of 'proactive schemes in their force, and have full coverage by March 2002.

The Joint Funding Initiative (JFI) was established to help accelerate the development of arrest referral schemes across England and Wales and to learn more about how to maximise the effectiveness of this initiative. Funding was made available from December 1999 until March 2002. Following an invitation to all Police Forces in England and Wales, 41 out of 43 police forces applied for funding under the arrangements set out in the Home Office Circular 41/1999. Forces working in partnership with the DAT and local agencies were asked to identify the number of workers, and associated funding, with a view that police forces would continue funding schemes after 2003. The JFI provided funding for arrest referral workers which had to be 'matched' locally by the relevant police force, DAT or other partnership arrangement (based on prior

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research a unit cost of £40,000 per worker was used including 'on costs') the JFI would contribute a maximum of up to £20,000 per worker.

An additional year's central funding (up to Spring 2003) was subsequently provided by the Home Office. This initial investment from central government funded the establishment of schemes and arrest referral workers as well as contributing to the funding of local drug treatment services.

The majority of arrest referral schemes became operational from April 1st 2000. By the end of April 2002, all Police Forces in England and Wales were operating pro-active schemes (either funded by the Home Office or by police force funding schemes locally), employing approximately 400 workers. Central funding is now available to sustain delivery of drugs work in custody suites and court cells (as appropriate) over the next three years,

### 3. Monitoring and Evaluation of the Joint Funding Initiative

A key objective of the CRP and JFI was to obtain evidence of 'what works' with regard to crime reduction initiatives. To build on the existing evidence base from the previous DPI research (Edmunds et al, 1998), research was commissioned to assess how effective arrest referral schemes were by determining whether:

- arrest referral schemes are successful in targeting the key group of problem drug-using arrestees and ensuring their entry into specialist drug treatment services and;
- whether engagement with specialist drug treatment facilitates reductions in levels of crime (through self-reported offending and in police arrest figures).

A three-year programme of monitoring and evaluation was commissioned comprising two main elements:

- a national monitoring system to collect basic epidemiological information in the number, characteristics and referral outcomes of problem drug-using offenders screened by arrest referral workers (this is ongoing); and
- a programme of area-based research and evaluation studies to provide an assessment of the behavioural outcomes of arrest referral and how these can be maximised (this completes in summer 2003).

We know that arrest referral and treatment are inextricably linked. This programme would build on the work of the earlier pilot programmes and improve both knowledge and understanding of evidence based practice, to do the right things, right.

The Evaluation programme seeks to explore and demonstrate the combination and type of relationships needed to achieve the desired reductions in drug use and crime and improvements in health and social outcomes. This will be undertaken through a range of approaches including:

- Validation of monitoring
- In-depth, qualitative process and non-engagement studies
- Outcome assessments
- Re-arrest and reconviction studies
- Testing veracity of self-reported data
- Economic cost benefit analyses
- Examination of the efficacy of different treatment modalities

### 4. The National Monitoring System

The National Arrest Referral Monitoring System (NARMS) collates information on all arrestees screened, assessed and referred by the worker, this data is then linked to the National Drug Treatment Monitoring System (NDTMS) to identify uptake into specialist drug treatment. A generic monitoring form used across England & Wales (NARMS). See Appendix B.

Data is collected locally by the National Drug Treatment Monitoring System (NDTMS) and allows the anonymous follow-up of arrestees into treatment. One-year follow-up of those in treatment (client review).

### C. How Does Arrest Referral Work?

The arrest referral process can simply be broken down into a number of key stages:

- 'booking in' to police custody and initial offer of referral by the police
- subsequent contact with arrest referral worker to provide more information on the scheme and encourage participation.

In Appendix A of my first paper, the final section on the Police Service, briefly outlines the process undertaken known as 'booking in' of the detainee by the arresting officer and custody sergeant, irrespective of whether the detainee is seeing an arrest referral worker.

- All those at the 'booking in' stage are informed by the police that a scheme operates at the police station as the Custody Officer brings arrest referral to the attention of detainees as part of the booking-in procedure
- However the introduction by the police must comply with PACE
- The introduction must be restricted to a statement of factual information

The following statement is the one which is usually read out to the detainee

*'A drug referral scheme operates at this police station.  
If you are interested, I can arrange for you to see an  
Independent drugs worker in due course.  
Are you interested'?*

- Those who wish to know more are offered an opportunity to see an Arrest Referral Worker who explains how the scheme works, contact is made with the worker according to the arrangements drawn up between the police and the provider agency of arrest referral, it could be the cell or some other venue (see working protocols).
- Workers (according to local agreements may also be permitted by the Custody Officer to 'cold call', that is talk to the detainee directly in the cell. Evidence suggests not all detainees agree to see a worker at the initial stage of booking in, however on reflection in the cells and/or meeting a worker in the cells their perspective may change.
- If the detainee agrees, a screening interview and assessment is undertaken to identify a programme of help.
- The arrest referral worker arranges for client 'entry' or *referral* into treatment or arranges further follow-up.
- The client then attends the first appointment for treatment or is provided with the opportunity of carrying on seeing the arrest referral worker until a treatment place becomes available.

There are a range of practical considerations to be aware of in terms of implementing such a scheme the following lists briefly a few key issues for further consideration:

#### 1. Starting from 'Scratch' in the Community

Need the right people at the 'right level' to be part of a strategic working group of players including Police, Health, NGO's and DAT.

- Identify treatment availability capacity and appropriateness
- Custody suites – how many, throughput of arrestees, other initiatives at arrest
- Agree model and service specification (based on local picture including coverage of custody suites)
- Draw up and monitor Service Level Agreements with providers of arrest referral services
- Agree recruitment, Job Descriptions and CRO (crime) checks
- Agree local monitoring and evaluation
- Manage external and internal promotion - community
- Ensure development of working protocols

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2. Starting from Scratch in the Community - Working Protocols

- Need agreed terminology and definitions
- Operation - how it works, who does what, do's and don't's for 'workers'
- Confidentiality and rules of disclosure
- Agreed hours of cover for workers
- Identification and passes in the custody suites
- Health and safety in the custody environment
- Monitoring responsibilities
- *Where to see arrestees:*
  - The custody area
  - Client's own cell, Solicitors Consultation room, Doctors' consultation room, Police interview room, designated AR office, unoccupied areas of the custody suite.
  - venues outside the police custody area  
Group 4 custody area (private company), locations within magistrate's courts, Probation office, drugs agency.

3. Establishing Arrest Referral - A Typical Service Provider may Include the Following

- Non government organisation (NGO) or state health provider providing community based drop in, practical advice information, advice and counselling and support
- Provide access to prescribing treatment based on philosophy of harm reduction through GP liaison
- Will cover e.g. 6 custody suites at the times when they are 'busy' and review with police to ensure this is appropriate
- Employ trained drug workers, supervised by a manager
- Provide training (focus work in criminal justice system)
- Participate in the local 'steering group'
- Agree risk assessment/referral protocols/information sharing/confidentiality agreements with steering group/police and other stakeholders
- Ensure national and local monitoring arrangements implemented and that forms/data are fully completed where possible and returned appropriately (include analysis).

4. Role of the Arrest Referral Drug Worker

Recommendations are raised later in the emerging findings, but basic responsibilities would include:

- Promoting/explaining scheme to detainees
- Undertaking screening interview and comprehensive assessment to inform referral
- Refer onto other services
- Monitoring client progress
- Development work with police and service deliverers
- Training/inducting police and service deliverers
- Liaison and work with colleagues involved at other points of contact with criminal justice system
- Record-keeping to inform police and agency key performance indicators

**D. National Implementation -Findings from the National Monitoring and Evaluation Programme**

1. The National Monitoring System

Published evidence from the NARMS shows that between October 2000 and September 2001, 48,810 arrestees were screened and interviewed, over half interviewed (58%) were referred to specialist drug treatment, over half (51%) were not currently engaged in treatment. Of those referred 22% made a demand for treatment, but there was variation in treatment take up across England & Wales. The findings from the monitoring system are explored more fully in the analysis of the emerging findings published in July 2002.

2. The National Evaluation Programme- Emerging Findings

In July 2002, a summary of the emerging findings, from the research programmes at 18 months (Sondhi et al, 2002), was published July 2002.

The main findings are listed below; many are being taken forward from 2003/04:

- Proactive arrest referral schemes provide an effective way of reaching problem drug-using prolific offenders and referring them to drug treatment and other appropriate services. (48,810 individuals were screened between October 2000 and September 2001 in England and Wales, of whom over half were voluntarily referred to a specialist drug treatment service).
- Workers had some success in getting problem drug-using offenders into treatment. Of those referred, a quarter made a demand for treatment (or 5,520 individuals), however some were significantly more likely to drop-out of treatment once engaged compared to self or GP referred drug users to the same service. Further evidence provided more information about this group who had difficulties engaging in treatment.
- Black and Asian drug users; older poly-drug users with negative previous experiences of treatment; young crack-using street robbers and female crack-using sex workers were all less likely to engage with treatment than other groups.
- Contact with an arrest referral worker lead to a reduction in re-arrest rates, self-reported drug use and offending. The level of police re-arrest rates significantly declined six months after contact with an arrest referral worker compared to the six months before contact. Two thirds (67 per cent) were arrested less often following referral than before.
- Preliminary analyses suggests that arrest referral schemes can provide significant economic and social benefits analyses suggest that the economic and social benefits of the arrest referral initiative are around £4.4 billion over an eight year period.
- Significant reductions were also reported in secondary indicators such as physical and psychological health.
- Treatment retention has been identified as an important predictor of a successful outcome. It is likely that there is a combined effect of initial contact with an arrest referral worker, impact of community or custodial sentencing and treatment engagement that contributes towards a successful outcome.
- Self-reported drug use was validated by biological assay screening (saliva sampling) and the concordance was high, suggesting that problem drug-using offenders provide accurate information on their drug-using habits.
- The evaluation report also described the process and delivery of arrest referral schemes and presented some recommendations as to how the full potential of such schemes could be maximised. For example, schemes should:
  - remain independent from the police
  - offer harm reduction advice where appropriate
  - provide low threshold treatment interventions through a case managed approach to retention and engagement into treatment
  - develop integrated care pathways consistent with the Models of Care approach (NTA 2002)
  - be extended to juveniles, alcohol users and detainees in Magistrates' courts as appropriate.

### 3. Involvement at a Strategic Level and Partnership Working

Partnerships are key and need ongoing development at both strategic and operational levels. Strategically- the DAT should work with the police and other stakeholders to ensure that there is a clear strategic direction with shared aims and objectives for this work which integrates with other criminal justice interventions. Arrest referral should be considered as part of the overall delivery of local drug service provision. In England it should be considered as an integral part of the Models of Care framework for the commissioning and provision of specialist drug treatment services. (From July 2002, Models of Care had the same status as a national service framework for drug treatment.)

Arrest referral workers need to have knowledge of all available local treatment options including waiting times and be able to contribute to the planning and delivery of drug treatment services. Workers should be

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represented on DAT/DAAT treatment planning forums and have information which can contribute to the development and planning of treatment services.

### 4. Throughcare and Aftercare

Some problem drug-using offenders fail to engage with community-based treatment because they are retained in the criminal justice system. A number of arrest referral workers have used this knowledge to develop appropriate links – for example, with probation services when a Drug Treatment and Testing Order (DTTO is considered) and also with providers of treatment services in prisons. Integrated links are needed to ensure that the substance misuse needs identified at arrest continue to be addressed elsewhere in the criminal justice system, DATs/DAATs should continue to engage with relevant stakeholders to identify how this should be progressed.

### 5. Accredited Training

The development of accredited training was a key recommendation and will contribute towards recruitment and retention of workers. Work is being taken forward to ensure that arrest referral workers are included within the development of a national workforce and training strategy being taken forward in England by the NTA. The implementation of the National Occupational Standards for Drugs and Alcohol (DANOS) will be an ideal opportunity to develop practitioner competency. This will include standards working with a more diverse range of problem drug-using offenders (including crack users and black and other ethnic minorities).

Police custody staff should also be provided with routine training on drug awareness issues (including key harm reduction messages).

### 6. Next Steps Enhanced Arrest Referral and Integration

The recent emerging findings from the national evaluation and monitoring programme (DPAS Paper 18) published in July 2002 identified a number of recommendations, including operational enhancements which would maximise effectiveness of delivery at arrest and minimise non-engagement of drug misusing offenders particularly when referred to specialist treatment interventions.

The evidence base supported by feedback from workers, police, and treatment providers and service users over the last year have contributed to informing the interventions which contribute to the delivery of enhanced arrest referral. It was recognised that many schemes and workers had moved beyond assessment and referral in order to retain and engage drug misusing offenders until structured treatment became available.

Using the sustainable resources and evidence now available those involved in planning and delivering drugs work in custody suites can build on and further extend the role and interventions currently provided by drug workers in a custody suite/magistrates court. Moving beyond assessment and referral, the additional resources and evidence seeks to now enhance delivery to include interventions such as harm reduction advice, caseload management, care planning and delivery of low threshold treatment interventions. These types of services reflect the level of delivery of a Tier 2 type service.

This focus seeks to apply the recommendations and align the work delivered in criminal justice settings more closely with the Models of Care approach but also recognises the expertise of delivery of drug work within a criminal justice setting.

It is recognised that drug workers working within a criminal justice setting such as a police custody suite or magistrates court should be appropriately supported, supervised and skilled to deliver Tier 2 type interventions (at a minimum level). This includes drug advice, information, harm reduction information (including managing overdose), screening and specialist drug assessment, referral, care planning and case management and delivery of low threshold treatment interventions such as motivational engagement.

### **E. Requirements of Enhanced Arrest Referral**

Using the existing knowledge gained through local commissioning and delivery of arrest referral, commissioners, Police and other stakeholders within the DAT should seek to apply the recent evidence base

and recommendations when commissioning criminal justice related drug interventions in police custody suites/magistrates courts in order that workers:

- can deliver drug-and alcohol-related advice, and identify how the offender may access information and referral services (and their families)
- know where and how to access services which reduce risks caused by injecting drug misuse, including needle exchange facilities (in drug treatment services and pharmacy-based schemes)
- deliver and also know where to access services that minimise the spread of blood-borne diseases to drug misusers
- deliver advice and know where to access services that minimise the risk of overdose and other drug-and alcohol-related harm
- as part of local arrangements (i.e. agreed with police, DATs) target high-risk and local priority groups
- undertake specialist drug and alcohol screening and assessment within a criminal context (Triage assessment - level 2)
- initiate care planning and case management in line with Models of Care and which reflects local DAT treatment arrangements
- deliver motivational and cognitive based interventions (drugs)
- access as appropriate community-based, low-threshold prescribing services to sustain engagement of offenders whilst waiting for Tier 3 services

All of these enhancements build on work already being delivered across many of the police forces in England and Wales. Previous Home Office reports have shown, there is much variety between schemes, a basic core set of skills and competences is being developed to inform training and support delivery.

#### **F. Partnership between Agencies**

The DAT/DAATs and Police should ensure with other key stakeholders that there are planning and monitoring arrangements which address both strategic and operational issues. Best practice has highlighted the value of a local steering group, which takes on operational responsibility and ensures the development and delivery of local procedures, protocols and day to day working arrangements. Recognition that information and feedback from workers could inform current delivery of treatment interventions and future commissioning of services. Strategically DATs need to ensure that there are appropriate mechanisms to have feedback from workers such as those working in Criminal Justice settings to inform current and future delivery of interventions.

The following section will now focus on Drug Treatment and Testing Orders briefly describing outcomes from the early pilots, the purpose and methods of delivery.

### **IV. Drug Treatment and Testing Orders**

#### **A. What is the Drug Treatment and Testing Order?**

Drug Treatment and Testing Orders, usually referred to as DTTOs, are a sentence of the court and implicitly a punishment for a crime. They were introduced under the Crime and Disorder Act 1998 in the pilot areas and rolled out to courts in England and Wales from October 2000.

#### **B. Background**

The DTTO was introduced as a response to the growing evidence of links between problem drug use and persistent acquisitive offending; it was a government manifesto, to break this link. , Drug Treatment and Testing Orders (DTTOs) replaced the power to add a requirement for drug treatment to a probation order. There had been low use of earlier legislation and it replaced the provision in the 1991 Criminal Justice Act for offenders to undergo treatment as a condition of a probation order (contained in paragraph 6 of Schedule 1A of the Act.). Lessons learnt and the experiences from USA drugs courts particularly relating to the close involvement of Sentencers in sentence review and management and lastly the ongoing evidence that treatment works and can reduce crime (NTORS), and that coercion could also be as effective (Hearnden et al 2000).

The purpose of the Drug Treatment and Testing Order is to break the link between drug use and crime. It is:



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- a sentence of the court
- a punishment for crime
- in place to prevent future crime
- an integral part of the UK Drug Strategy
- a key component of the crime reduction strategy

It can be imposed on any offender over 16 who has a dependency on or propensity to misuse drugs and for whom treatment may be helpful. The order is available in both the Crown and Magistrates' Courts, so that it has the broadest possible application, within its established targeting criteria.

It obliges the offender to:

- undergo treatment as specified for a set period of between six months and three years
- be tested regularly for drug use
- attend regular court review hearings at which progress under the Order will be reviewed.

Uniquely, in English and Welsh Law, courts have a vital role to play throughout the currency of the order and through the regular court reviews an offender's motivation and progress on the order can be monitored. The conditions of the Order may also be amended if required at the review hearing.

Regular drug testing provides an important reality check. Drug testing is mandatory and courts regularly review the offender's progress. The aim of testing is to help in monitoring the offender's compliance and progress with treatment. If testing requirements are not met and/or attendance at mandatory treatment is not adhered to, the court can 'revoke' a DTTO and re-sentence the offender. DTTOs cannot be imposed without the consent of the offender.

DTTOs aim to bring persistent and dependent drug-misusing offenders into a closely supervised programme of treatment in order to effectively break the links between their drug misuse and their offending.

DTTOs were implemented nationally in October 2000 following pilot schemes in Croydon, Gloucester and Liverpool. The pilot sites were independently evaluated by the Criminal Policy Research Unit at South Bank University. The pilot sites demonstrated the following areas of impact (through self-report interviews with offenders):

- reductions in drug use and offending at the start of the order
- fall in average weekly amount spent on drugs
- reduction in levels of polydrug use
- six-monthly interviews with offenders demonstrated that these reductions were sustained over time

Evidence suggested that drug dependent offenders can be successfully coerced into treatment as they pass through the criminal process (Turnbull et al. 2000).

**C. Key Elements of the DTTO are:**

- Assessment
- Treatment
- Testing
- Enforcement
- Court Review

**D. Assessment**

Home Office National Standards expects suitability for a DTTO to be assessed according to four main criteria:

- type and seriousness of offence
- seriousness of drug problem and susceptibility to treatment
- motivation to change
- volume of drug-related offending.

One key area of learning from the early pilots was the importance of getting the referral and assessment procedures right. With experience now broadening in the supervision of DTTOs what is being found is that an offender's capacity to manage being on a DTTO is a critical factor in assessment.

An initial assessment or screening may also occur in a variety of settings, for example an arrest referral scheme, the probation service or a drug service. The purpose of the initial assessment is to explore the possibility of a DTTO with the offender and to make a decision about whether to proceed to a full assessment. The screener will need to consider the pattern of the offender's drug misuse and nature and volume of their offending, as well as their motivation to undertake drug treatment. The court may receive information about drug related offending from an arrest referral worker, drugs worker in an approved hostel or a probation officer.

However an initial screening assessment will not be sufficient basis for a DTTO recommendation to the court. A full assessment as part of the pre-sentence report (PSR) should always be undertaken. This may either be carried out by the probation area themselves or by a drug treatment service purchased to provide the treatment aspect of the DTTO. The decision to impose a DTTO, whilst ultimately being made by the court, will nevertheless involve all of the stakeholders, the court, the probation service, the drug service, and the offender.

A Specific Sentence Report may provide information that leads to a request for assessment. Once the decision to adjourn for this special assessment is made the court will adjourn to a court date which fits best with the 15 day adjournment.

A question raised early on by some Sentencers was how were they supposed to know who will succeed under this Order - they are not experts?

The answer would be, they are not expected to be. Sentencing is, and will remain, a matter for the court. But the initial assessment of the offender by the probation service and treatment providers will be crucial in identifying and targeting the new Order at those who are causing a disproportionate level of disruption to their community and are most susceptible to treatment. Sentencers should be able to work with and consider the advice of the experts in order to make an appropriate sentencing decision on the basis of all the facts, including the advice of the probation service about what community interventions are available and might be appropriate.

#### 1. Assessment and Pre-Sentence Report

The assessment is usually provided within a pre-sentence report but is undertaken jointly by probation and treatment staff. It should include the following:

- a statement that the offender has been assessed by probation and treatment staff, is dependent upon or having a propensity to misuse drugs and as being susceptible to the kind of treatment being proposed
- a treatment plan, including the name and address of the treatment provider, and whether the treatment will be residential or non-residential
- confirmation that arrangements for this treatment are in place
- the suggested length of the order
- a signed statement from the offender that the requirements of the order and the consequences of a failure to comply have been fully explained by the responsible officer and confirming that the offender is willing to comply with the order
- a proposal for the minimum frequency of drug testing and of court review hearings to be specified in the order
- where there is a need for a residence requirement (other than for residential treatment) a proposal that a probation order be made alongside the DTTO and an explanation of the reasons why this residence requirement is deemed necessary.

#### **E. Treatment and Enforcement through DTTO National Standards**

Home Office guidance (PC43/2000) says that individual treatment programmes should be developed at a local level on the basis of the range of treatment available locally and the individual's need.

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Subsequently Home Office National Standards determined that the contract requirement was:

Commencement of treatment within 2 working days and  
Contact of 20 (now reduced to 15hrs) over 5 days for the first 13 weeks  
then 12 hrs per week for 3 days if progress is being made.

The range of treatment should include:

1. Treatment Related

- In patient detoxification
- Community detoxification
- Structured programmes
- Health Assessment/Education
- Relapse Prevention
- Residential rehabilitation
- Hepatitis test & vaccination
- Counseling

2. Offence Focused Work

- Supervision plan & reviews
- Accredited programmes 1:1 or group
- Victim awareness
- Relapse prevention

3. Lifestyles Packages

- Social skills
  - Training
  - Pre-employment work
  - Basic literacy skills
  - Use of leisure
  - Housing
  - Family support
- 
- The first appointment with the probation service to take place within one working day of the order being made and contact with the treatment provider shall be arranged to take place within two working days of the order.
  - Contact, including treatment, across all the requirements of the order to be on five days per week, for a total of 20 hours a week, for the first 13 weeks of the order. There is discretion for this to be reduced to a minimum of three days a week and 12 hours a week thereafter, if the offender is responding well. The minimum for the first 13 weeks of the order shall be 15 hours a week and nine hours a week thereafter.
  - Contact with the offender to include provision for treatment, offence focused work and lifestyle programmes.
  - It is anticipated that the offender will not usually be employed at the commencement of the order. If the offender obtains employment the probation service and treatment provider shall consider if the treatment and contact requirements shall be reduced to facilitate this and an early review hearing arranged for this to be considered by the court. Nevertheless, the minimum treatment and contact requirements shall be met in all cases.
  - Treatment provided under the order must comply with co-existing national standards, such as those that will be introduced through the DH Models of Care.

**F. Testing**

The purpose of regular testing is to provide supervising officers, treatment providers and the courts with an objective measure of the offender's progress towards becoming drug free. The supervising officer must put these results into the context of the offender's overall progress on the order when reporting to the sentencing court for each review hearing.

Offenders should be tested at least twice a week for the first 13 weeks of the order with discretion for this to be reduced to a minimum of once a week thereafter depending upon progress.

## **G. Court Reviews**

### **1. What is the Purpose of the Court Reviews?**

The purpose of the Court Review is to enable the Court to monitor the offenders progress in treatment and to decide whether any changes to the conditions including treatment need to be made. Preferably held by the same sentencer or specialist bench. Courts can already ask for progress reports on offenders but now the review process is 'designed-in'. The court receives a written report from the probation officer including drug test results. The review hearing provides an opportunity to encourage and support progress, if the court is not happy with the offenders' progress, the offender can be required to explain themselves. If the order is really not working, the court may also amend the Order. Normally the offender attends with a member of the DTTO staff team. Courts have the option of waiving the requirement for an offender to attend the court in person if they are making satisfactory progress as long as this is confirmed by the written reports from the Probation Officer/Treatment Provider. The style of the review hearing may be less formal. The outcomes of the court review hearing could include: amendments to the Order, progress expected before next review and whether breach proceedings are justified.

## **V. SUMMARY**

Evidence from early pilots and more extensive evaluation has highlighted that drug interventions in the criminal justice system offer an effective means of putting drug misusing offenders in touch with appropriate services locally where they can receive help to reduce their drug use.

Interventions particularly at arrest and at the community sentence stage provide opportunities to engage but need to be part of a wider package of interventions across the criminal justice system.

### **Why deliver drug interventions in the Criminal Justice System?**

Because they have the potential:

- to reduce drug related crime
- to reduce drug misuse
- to improve health of drug misusers and
- to assist social reintegration of drug misusers.

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**APPENDIX A**  
**MODELS OF CARE - FOUR TIER FRAMEWORK**

**Table 1. Drug Misuse Treatment Tiers and Commissioning Levels**

<b>Tier No.</b>	<b>Tier Title</b>	<b>Service Modality</b>	<b>Commissioning Level</b>
1	<b>Non-substance misuse specific services</b>	For example: Personal/general medical services (primary care) Non-DM specific social services including children and family services; non-DM specific assessment and care management Housing and homelessness services Non-SM specific probation services Vaccination / communicable diseases Sexual health / health promotion Accident and emergency services General psychiatric services Vocational services	Local DAT*/ PCT/ PCG
2	<b>Open access drug misuse services</b>	Drug-related advice and information Open access or drop-in services Motivational interviewing/ brief interventions Needle exchange (pharmacy/service/outreach) Outreach services (detached/domiciliary/peripatetic) Low-threshold prescribing Liaison with drug misuse services for acute medical and psychiatric sector DM specific assessment and care management	Local DAT/ PCT/PCG
3	<b>Structured community-based specialist drug misuse services</b>	Drug specialist care planning and co-ordination Structured care planned counselling and therapy options Structured day programmes (urban and semi-urban) Community-based detoxification services Community-based prescribing stabilisation and maintenance prescribing Community-based drug treatment for offenders on DTTOs Other structured community-based drug treatment services targeting specific groups Structured aftercare programmes Liaison with drug treatment services	Local DAT*/ Multi-DAT
4a	<b>Residential substance misuse specific services</b>	Inpatient drug detoxification and stabilisation services Drug and alcohol residential rehabilitation services Residential drug and alcohol crisis centres Residential co-morbidity services Specialist drug and alcohol residential units targeting specific groups, e.g. mother and child units services	Multi-DAT/ Regional/ National
4b	<b>Highly specialist non-substance misuse specific services</b>	For example: Specialist liver disease units Forensic services Specialist psychiatric units including: personality disorder units; eating disorders units Terminal care services Young people's hospital and residential services providing drug and alcohol treatment services (16 to 21 years) HIV specialist units	Regional/ National

# RESOURCE MATERIAL SERIES No. 64

## APPENDIX B

TELEPHONE ENQUIRIES:  
020 7273 4045

### ARREST REFERRAL MONITORING FORM

PLEASE SEND THIS COPY TO YOUR  
LOCAL NDTMS

<b>1. CONTACT DETAILS:</b>									
Where was contact made (✓ one)			Date of contact (4 digit year):						
Police <input type="checkbox"/>			Police station:						
Court <input type="checkbox"/>			Drug Action Team area:						
Other <input type="checkbox"/>			Drug worker's code/name:						
<b>2. DETAILS OF CLIENT:</b> <i>Full name, address and postcode are NOT required</i>									
First initial			Date of birth (4 digit year):						
Surname initial			Local authority/ council of residence						
Gender M/F <input type="checkbox"/>			(✓) if NFA <input type="checkbox"/>						
Ethnic group: Which of the following groups do you belong to? (✓ one)									
WHITE: White British <input type="checkbox"/>			White Irish <input type="checkbox"/>			White Other <input type="checkbox"/>			
MIXED: White/Black Caribbean <input type="checkbox"/>			White/Black African <input type="checkbox"/>			White/Asian <input type="checkbox"/>		Mixed Other <input type="checkbox"/>	
BLACK: Caribbean <input type="checkbox"/>			African <input type="checkbox"/>			Black Other <input type="checkbox"/>			
ASIAN: Indian <input type="checkbox"/>			Pakistani <input type="checkbox"/>			Bangladeshi <input type="checkbox"/>		Asian Other <input type="checkbox"/>	
OTHER: Chinese <input type="checkbox"/>			Other <input type="checkbox"/>			Please specify:			
Offence: What alleged offence have you been arrested for? (✓ one) <b>If more than one offence tick the most serious</b>									
Shoplifting <input type="checkbox"/>			Street robbery <input type="checkbox"/>			Burglary <input type="checkbox"/>			
Fraud <input type="checkbox"/>			Other theft <input type="checkbox"/>			Wounding/assault <input type="checkbox"/>			
Auto-crime <input type="checkbox"/>			Soliciting <input type="checkbox"/>			Other <input type="checkbox"/>			
Selling/possession of drugs <input type="checkbox"/>			Handling stolen goods <input type="checkbox"/>			Please specify <input type="text"/>			
<b>3. TREATMENT HISTORY:</b>									
Have you ever received treatment for a drug problem?						Y/N <input type="checkbox"/>			
If yes, are you still receiving treatment for your drug problem?						Y/N <input type="checkbox"/>			
<b>4. DRUG AND ALCOHOL PROFILE:</b> <i>Drugs used in the last month? (Include alcohol as main drug if appropriate)</i>									
Main problem drug			<input type="text"/>				Injected Y/N <input type="checkbox"/>		
Drugs used in the last month			<input type="text"/>				Injected Y/N <input type="checkbox"/>		
			<input type="text"/>				Injected Y/N <input type="checkbox"/>		
Alcohol units			<input type="text"/>				Injected Y/N <input type="checkbox"/>		
Per week			<input type="text"/>				Injected Y/N <input type="checkbox"/>		
On average (to the nearest £), how much do you spend on illicit drugs per week?						£ <input type="text"/>			
<b>5. INCOME AND OFFENDING BEHAVIOUR:</b>									
What are your <b>three</b> main sources of income? (please ✓ three options that apply)									
Legitimate paid work <input type="checkbox"/>			Selling drugs <input type="checkbox"/>			Burglary <input type="checkbox"/>			
Benefits <input type="checkbox"/>			Street robbery <input type="checkbox"/>			Sex work <input type="checkbox"/>			
Shoplifting <input type="checkbox"/>			Auto-crime <input type="checkbox"/>			Begging <input type="checkbox"/>			
Fraud <input type="checkbox"/>			Handling stolen goods <input type="checkbox"/>			Other <input type="checkbox"/> Specify <input type="text"/>			
Do you have any previous convictions?						Y/N <input type="checkbox"/>			
<b>6. SUMMARY:</b> Initial assessment recommendation									
Initial assessment recommendation: <u>Complete after discussing and agreeing the recommendation with the client</u> (please ✓ all that apply)									
No further intervention required <input type="checkbox"/>			Referral refused (by client) <input type="checkbox"/>						
<b>Referral to specialist drug treatment</b>									
Continue in treatment <input type="checkbox"/>			Agency name <input type="text"/>						
Referral to specialist drug agency <input type="checkbox"/>			Agency name <input type="text"/>						
<b>Caseload/case management</b>									
Scheduled for further appointment <input type="checkbox"/>									
<b>Other referrals</b>									
Alcohol service <input type="checkbox"/>			Referral to mental health service <input type="checkbox"/>						
GP/GP liaison or Primary Care <input type="checkbox"/>			Referral to CARATs or Prison Healthcare <input type="checkbox"/>						
DTTO teams <input type="checkbox"/>			Referral to housing agency <input type="checkbox"/>						
Other <input type="checkbox"/>			specify: <input type="text"/>						

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### GUIDANCE NOTES:

The National Arrest Referral Monitoring System collects routine information on the number and characteristics of problem drug-using offenders who report a demand for treatment. The data collected forms a module with the National Drug Treatment Monitoring (NDTMS). All the information collected is anonymous and confidential (initials, date of birth and gender are used to calculate the number of individuals). See Informed Consent sheet for more details. DETACH THE CARBON COPY AND RETURN TO YOUR LOCAL NDTMS.

### PLEASE COMPLETE THIS FORM:

- On all arrestees with whom you have a face-to-face contact. This may lead to a further detailed assessment of clinical or other treatment needs that may lead to a referral to a drugs service.
- For all face-to-face contacts, regardless of whether you have seen the arrestee before.
- Do not complete this form for all contacts such as brief personal interactions, letter or telephone contacts.

#### 1. CONTACT DETAILS

- **Contact** Tick Police if seen in a custody suite; Tick Other for gateway agencies.
- **Drug worker's code/name:** This is used to allow local feedback. Include a code if it has been agreed locally with your NDTMS manager.

#### 2. DETAILS OF CLIENT

- **Initials, date of birth and gender** No names and addresses are required.
- **Local authority of residence** This is the client's Unitary or County of residence
- **NFA** If the client has No Fixed Abode tick this box. This may include living in a hostel, B&B etc.
- **Ethnic group** Please use the client's own definition and select from the list provided
- **Offence** Please tick one option only. If the client has committed several offences then please enter the most serious. If a client has been arrested on a WARRANT then please tick the original offence.

#### 3. TREATMENT HISTORY

- **Ever treated** Include if client has ever accessed treatment for a drug problem, including GPs and generic services.
- **Current treatment** Include if client is currently accessing treatment, including GP services.

#### 4. DRUG AND ALCOHOL PROFILE

- **Main problem drug** Write in the drug that is the main problem for the client. Include alcohol here if appropriate.
- **Drugs used in the last month** Please WRITE in all illicit and licit drugs used in the last month.
- **Alcohol units per week** The number of units of alcohol the client is estimated to use per week.
- **Illicit drugs spend** Include estimates of client's spend per week. If drugs are not directly purchased, enter "0".

#### 5. INCOME AND OFFENDING BEHAVIOUR

- **Sources of income** Please include client's three main sources of income from list.

#### 6. SUMMARY Initial Assessment Recommendation

- Complete any assessment recommendations (tick all that apply).
- If the client refuses a referral following an assessment, please tick REFERRAL REFUSED (BY CLIENT)
- **Caseload/case management** Tick this box if, after assessment, you arrange to meet the client again at another venue.

# INTERNATIONAL DRUG CONTROL FRAMEWORK-FOCUS ON DRUG DEMAND REDUCTION

*Juana Tomás-Rosselló, M.D.\**



## I. INTERNATIONAL DRUG CONTROL INSTRUMENTS AND DRUG DEMAND REDUCTION – HISTORICAL OVERVIEW

Over the last 80 years, a worldwide system for control of drugs of abuse has developed gradually through the adoption of a series of international treaties. The key multilateral conventions currently in force are the Single Convention on Narcotic Drugs of 1961 (1961 Convention), as amended by the 1972 Protocol; the Convention on Psychotropic Substances of 1971 (1971 Convention) and, adopted in 1988, the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention). In the international drug conventions developmental process one can distinguish two stages, the turning point being marked by the adoption of the Single Convention on Narcotic Drugs in 1961. One of the key differences between the two stages is their consideration of drug abuse prevention and treatment.

From the beginning the basic aim of the international drug control treaties has been to limit the production, processing, trade and use of drugs to medical and scientific purposes only. Such efforts began with the International Opium Convention (The Hague, 1912) as a consequence of the International Opium Commission (Shanghai, 1909). Despite the fact that the conference, as well as the convention, came about in response to the international concern for the increase in opium trafficking and abuse, the convention lacked dispositions relating to demand reduction.

During the first stage, the narcotics control system grew rather haphazardly, and by 1960 had become overly complicated. In the period following 1912, a series of 7 consecutive treaties were developed in 47 years: 1912, 1925, 1931, 1936, 1946, 1948 and 1953. This obvious abundance of treaties seems to reflect the frequent political changes of that time (WWI, End of Colonialism, Creation of the League of Nations, WWII, and Creation of the United Nations, etc.) Each treaty was an attempt to adapt the international drug control regime to the evolution of the global situation, as much in political terms as in terms of illicit trafficking, but they did not necessarily invalidate previous treaties.

In this first stage, possession and abuse of drugs are considered, if at all, only from a penal point of view (drug possession was first mentioned in Article 2 of the 1936 Convention and it was considered an extraditable offence in Article 9 of the same Convention). Furthermore, drug abuse prevention and treatment are ignored. In fact, no international legal framework pertaining to prevention and treatment was established during this period.

The fragmented nature of the existing international treaties led to the Single Convention on Narcotic Drugs of 1961, which consolidated most of the earlier international instruments. The Convention, which entered into force on 13 December 1964 and was amended by the 1972 Protocol, is regarded as a major achievement in the history of international efforts to control narcotics. Two other Conventions were adopted during this second stage in 1971 and 1988.

This stage is characterized by a more deliberate, yet more integrated, evolution of the international legal system pertaining to drugs. The adoption of the Single Convention on Narcotic Drugs in 1961 was the first attempt to codify the international drug control regime in a single instrument, while International Drug Control continued to be limited to Narcotic Drugs. Drug abuse prevention, treatment and rehabilitation are mentioned for the first time in this Convention, not only in its text, but also in its resolutions, aspirations, explicit commitments to prevent and combat drug abuse. The Convention also introduces the option of

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treatment for drug abusing offenders (the key dispositions are found in: Resolution II adopted by the Conference for the adoption of the Single Convention; Resolution III adopted by the Conference to consider amendments to the Single Convention, the Preamble of the Single Convention; and Articles 36.1(b), 38.1 and 38.3).

Three objectives guided the drafting of the Single Convention: First, to codify all existing multilateral treaty laws in this field as a primary goal. This was successfully accomplished. Secondly, to simplify and streamline the control machinery, which was another important step in strengthening the impact of the international community's efforts. The Permanent Central Board established by the International Opium Convention, of 1925 and the Drug Supervisory Body established by the Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, of 1931 became a single unified body, the International Narcotics Control Board (INCB). In addition, through the Single Convention other administrative duties were consolidated, simplified and amplified.

The third goal of the Convention was the extension of the existing control systems to include the cultivation of plants that were grown as the raw material of natural narcotic drugs. The 1961 treaty continues to keep a tight rein on the production of opium and includes the coca bush and cannabis in the list of plants whose production was placed under international control. The treaty established or maintained certain national monopolies. It also provided for a special national administration to be designed to apply the Convention's provisions. A specific obligation was placed on States parties to limit production of narcotic plants exclusively to the amount needed for medical and scientific purposes.

Some provisions of the Single Convention contained new obligations dealing with the medical treatment and rehabilitation of addicts. Some provisions, such as those on the estimates and statistics system established by the Conventions of 1925 and 1931, were working effectively and were therefore retained virtually without change. Other provisions of earlier treaties also remained intact: those that dealt with the requirement that exports and imports be expressly authorized by government authorities from both sides of the transactions; and those requiring Governments to submit reports on the working of the treaty and to exchange, through the United Nations Secretary-General, national laws and regulations enacted to implement the treaty. Provisions for controlling the manufacture of narcotic drugs and the trade in and distribution of narcotic substances were also continued and new synthetic drugs controlled under the 1948 Protocol were included.

The Single Convention prohibits the practices of opium smoking, opium eating, coca-leaf chewing, hashish (cannabis) smoking and the use of the cannabis plant for any non-medical purposes. A period of transition was established to allow the States concerned to overcome the difficulties that could arise from the abolition of these ancient practices in their countries. The Convention also obliges States parties to the treaty to take any special control measures deemed necessary in the case of particularly dangerous drugs, such as heroin.

Drugs controlled under the 1961 Convention are listed in one of two Schedules (I and II), depending on the relationship between their therapeutic utility and abuse liability. The control provisions applicable to drugs in Schedule I constitute the standard régime under the 1961 Convention; Schedule II consists of drugs which are considered to be less liable to abuse and which are more widely used in medicine. Two additional Schedules III and IV cover, respectively, preparations of drugs in Schedule I and II, and some drugs from Schedule I, which are considered to have particularly dangerous properties and an extremely limited therapeutic utility.

The Single Convention has been recognized as a flexible and effective instrument, and consequently it has been widely accepted.

The Single Convention was further strengthened by the 1972 Protocol which amended it and which entered into force on 8 August 1975. The Protocol underscores the necessity for increasing efforts to prevent illicit production of, traffic in and use of narcotics. It also highlights the need to provide treatment and rehabilitation services to drug abusers, stressing that treatment, education, after-care, rehabilitation and social reintegration should be considered as alternatives to or in addition to imprisonment for abusers who had committed a drug offence. The Protocol places special emphasis on the role of INCB in drug control,

giving it responsibility for ensuring a balance between supply and demand of narcotic drugs for medical and scientific purposes and in endeavouring to prevent illicit drug cultivation, production, manufacture, traffic and use.

With the agreement of the Governments concerned, INCB may recommend that the relevant United Nations organs and specialized agencies provide technical or financial assistance to enable those Governments to carry out their treaty obligations. The amended Convention also stresses the need for cooperative and coordinated international action in dealing with the problems associated with drug abuse.

Growing concern over the harmful effects of a number of psychotropic substances led to the adoption of the Convention on Psychotropic Substances in 1971, which expanded the international drug control system to include several amphetamine-type drugs, sedative-hypnotics and hallucinogens.

The control system provided for by the Convention is based largely on the one in force since 1964 by virtue of the Single Convention on Narcotic Drugs. However, the necessary control measures were categorized in four separate "Schedules". This scheduling of psychotropic substances is based upon an assessment of the relationship between two variables: the therapeutic usefulness and the public health risk caused by abuse. The four schedules use a sliding scale of the two variables: Schedule I implies high public health risk and low therapeutic utility; Schedule IV the opposite: lower public health risk and higher therapeutic utility.

This Convention also regulates inspection of stocks, records and laboratory premises. It bans advertising to the general public. States parties must maintain a system of strict control of the manufacturers, importers, exporters, wholesalers and retail distributors of the substances and the medical and scientific institutes which use them. They must establish or maintain a special administration to oversee these functions, much like those set up under other treaties on narcotic drugs. Efficient methods of record-keeping must be established, differentiating between the types of psychotropic substances and activities concerned.

The Convention contains special provisions relating to the abuse of these substances aimed at ensuring early identification, treatment, education, after-care, rehabilitation and social reintegration of persons who have become addicted to any of the controlled substances. Other articles address illicit traffic control and penalties. The United Nations bodies already involved in implementing and executing the narcotics control system have the added responsibility for the control of the drugs covered by this Convention. These are CND and INCB.

In December 1988, 106 States adopted the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The Convention which entered into force on 11 November 1990 is designed to deprive drug traffickers of their ill-gotten financial gains.

One of the innovative provisions of the 34-article Convention concerns the tracing, freezing and confiscation of proceeds and property derived from drug trafficking. To that effect, courts are empowered to make available or to seize bank, financial or commercial records, bank secrecy cannot be invoked in such cases.

In addition to providing for the criminalization of drug trafficking offences, the 1988 Convention bars all havens to drug traffickers, particularly through its provisions for: extradition of major drug traffickers; mutual legal assistance between States on drug-related investigations; and the transfer of drug related proceedings for criminal prosecution, where such transfer is deemed to be in the interests of a proper administration of justice. Other significant and innovative landmarks are the commitment of parties to take measures and cooperate in the prevention of diversion of certain substances frequently used in the illicit manufacture of narcotic drugs and psychotropic substances (so-called precursors), as well as to eliminate or reduce illicit demand for narcotic drugs and psychotropic substances.

#### **A. In Summary**

Since its beginning, the international drug control regime has recognized the need for State cooperation, above all through global organizations, such as the League of Nations and the United Nations. While treatment and prevention were largely ignored during the first stage, thus limiting treaties to penal

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dispositions concerning possession; during the second stage it included general obligations to combat drug abuse in a coordinated manner, and introduced the requirement for prevention, treatment, rehabilitation and social reinsertion. As such, the present legal framework only foresees general obligations with respect to drug demand reduction, but does not create a specific mechanism or procedure for action, except for the mention of the possibility that measures taken be based on the recommendations of competent international organizations (1988 Convention).

As indicated above, the treaties of 1971 and 1988 do not introduce significant modifications to the general approach to prevention and treatment established by the 1961 Convention (the key dispositions are found in Articles 20 and 22 (1971) and in Articles 3.4(b), (c) and (d) and 14.4 (1988)). The 1988 Convention (Article 3.2) is the first to define the acquisition and possession of drugs, for personal consumption, as a punishable act. The aggravating circumstances clause, introduced in the Convention through the victimization of minors appears in Article 3.5 (1988).

National authorities and interested organizations were exhorted to use the 1987 Comprehensive Multidisciplinary Outline as a basis for national, regional and international strategies aimed at combating all aspects of drug abuse and illicit trafficking, and in particular:

- prevention and reduction of drug abuse with a view to elimination of the illicit demand for narcotic drugs and psychotropic substances;
- treatment, rehabilitation, and social reintegration of drug addicts;
- control of supply of narcotic drugs and psychotropic substances;
- suppression of illicit trafficking in narcotic drugs and psychotropic substances;
- measures to be taken against the effects of money derived from, used in or intended for use in illicit drug trafficking, illegal financial flows and illegal use of the banking system;
- strengthening of judicial and legal systems, including law enforcement;
- resources and structure.

### **B. The Global Programme of Action (GPA)**

The Global Programme of Action (GPA) adopted in 1990 by the General Assembly at its 17th special session, including a political declaration, is devoted to the question of international cooperation against illicit production, supply, demand, trafficking and distribution of narcotic drugs and psychotropic substances, and represents a comprehensive statement of the action that needs to be taken by individual countries and collectively through the system of international organizations. The GPA offers a wide range of guidance to governments facing drug-related problems and recommends concrete measures to address issues such as illicit cultivation and processing, trafficking, money laundering and illicit demand.

In addition, the GPA gives specific and binding directions to the United Nations e.g., to act as an advisory centre for collecting, analyzing and disseminating information on demand reduction; and to provide expertise and assistance to states at their request to enable them to establish the legislative and administrative measures for the ratification and effective implementation of the United Nations Convention.

A new stage, if not of the international legal system pertaining to drugs, then at least in the growing awareness of the need for granting greater importance and cooperation in the area of prevention and treatment started at the Twentieth Special Session of the General Assembly of the United Nations in 1998, at which a Political Declaration and the Declaration on the Guiding Principles of Drug Demand Reduction (A/RES/S-20/3) were adopted. It is worth noting that the Assembly, Council or Commission resolutions lack the obligatory nature of dispositions in the Conventions. In this sense, the declarations merely constitute an expression of concern, intention and aspirations by the international community.

The **Political Declaration** constitutes the most serious and structured effort, to date, at developing a balanced strategy in the global fight against drugs. Not only does it define a plan of action with general objectives, but it also introduces a system of self-evaluation through biennial reports and evaluations at the end of 5 years (2003) and 10 years (2008). The international community has already demonstrated an increased awareness of the scope and complexity of the drug problem, concrete tasks are posed and well-defined commitments are formulated. The Political Declaration calls for a balance between supply and demand reduction, and recognizes demand reduction as a fundamental pillar.

As a consequence of a growing consensus among Governments on the priority policies and strategies that are required to face the challenge of drug abuse, the international community adopted the Declaration on the Guiding Principles of Demand Reduction. The Declaration is the very first international agreement with the sole objective of examining individual and collective problems that arise from individual drug abuse. It constitutes an important step forward in the international arena by strengthening multilateral programmes and reinforcing the commitment of Member States to intensify their efforts in demand reduction.

Among others, the **Declaration** indicates that, as a part of a comprehensive strategy integrating supply and demand reduction, the following elements should be considered:

- Policies should be built on knowledge acquired from research and from lessons learned from past programmes. A systematic and periodic assessment of the problem is imperative for the identification of emerging trends. To further build on experience, demand reduction strategies and specific activities should be thoroughly evaluated to improve their effectiveness, and appropriate emphasis should be placed on training policy-makers, programme planners and practitioners.
- Based on the above knowledge and with a community-wide participatory and partnership approach, demand reduction programmes have to cover all areas of prevention -- from discouraging initial use to reducing the negative health and social consequences of drug abuse.
- Social integration of drug-abusing offenders should be pursued, either as an alternative or in addition to punishment, through education, treatment, and rehabilitation services.
- Demand reduction efforts should be integrated into broader social welfare programmes, health promotion policies and preventive education programmes to ensure an environment in which healthy choices become attractive and accessible.
- Demand reduction programmes should address the needs of the population in general as well as those of specific groups more at risk, taking into account differences in gender, culture and education.
- Every attempt should be made to send the right message. Information should avoid sensationalism and promote trust in order to be effective. States should, in cooperation with the media, seek to raise public consciousness about the hazards of drug use and to promote preventive messages in order to counter the promotion of drugs in popular culture.

The **Joint Ministerial Statement adopted at the 46th Session of the Commission on Narcotic Drugs** demonstrates that the international community continues to be deeply concerned about the incidence and the effects of drug abuse and is becoming more and more aware of the impact that this is having on children and youth. Despite the fact that international politics still do not appear to be ready to introduce a more specific legal system with respect to prevention and treatment of abuse, the community and its organizations must ensure that the national political authorities are conscious of its situation and needs, as the best means of translating them into ever more concrete commitments on an international level. The Joint Ministerial Statement affirms:

“The drug problem is still a global challenge that constitutes a serious threat to public health, safety and well-being of humankind, in particular children and young people”

“A balance is required between supply reduction and demand reduction, as well as a comprehensive strategy that combines alternative development, [...] eradication, interdiction, law enforcement, prevention, treatment and rehabilitation as well as education.”

## II. COMPETENT INTERNATIONAL BODIES

### A. Commission on Narcotic Drugs (CND)

The Commission on Narcotic Drugs (CND), a functional commission of the Economic and Social Council (ECOSOC), is the central policy-making body within the United Nations system for dealing with all

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drug-related matters. It analyzes the world drug abuse situation and develops proposals to strengthen international drug control. The Commission's mandate was enlarged in 1991 to include approval of the budget of the programme of the Fund of UNDCP and the administrative and programme support cost budget of the Fund.

The Secretariat of the Commission on Narcotic Drugs is responsible for ensuring secretariat services to the Commission on Narcotic Drugs and its subsidiary bodies, for finalizing the preparation of documentation on drug-related matters for the Economic and Social Council and the General Assembly; and for ensuring, on behalf of the Executive Director, the discharge of certain specific functions entrusted to the Secretary-General under the international drug control treaties. It services the Commission on Narcotic Drugs and its subsidiary bodies, by providing substantive advice, directing secretariat activities, including preparing in-session documentation, draft resolutions and reports; assisting the Chairman and officers, and preparing strategies and timetables.

### **B. International Narcotics Control Board (INCB)**

The International Narcotics Control Board (INCB or Board) is the independent and quasi-judicial control organ for the implementation of the United Nations drug conventions, established in 1968 by the Single Convention on Narcotic Drugs of 1961. It had predecessors under the former drug conventions since the time of the League of Nations.

The Board is independent of Governments as well as of the United Nations; its 13 members serve in their personal capacity. They are elected by the United Nations Economic and Social Council (ECOSOC) and their work is financed by the United Nations. Three members are elected from a list of candidates nominated by WHO and 10 from a list nominated by Governments.

Its functions are the following:

- To administer international control systems to limit the production, manufacture, trade and use of drugs exclusively to medical and scientific needs;
- To ensure, in cooperation with Governments, that the legitimate demand is satisfied through proper balance between supply and demand; and
- To endeavour, in cooperation with Governments, to prevent illicit activities.

## **III. IMPLEMENTATION OF TREATY PROVISIONS BY GOVERNMENTS**

### **A. Importance of National Legislation**

Once countries become party to the international drug control treaties, they are required to implement their obligations, usually through enacting appropriate legislation to ensure that they are able to comply fully with its terms. For example, the criminalization and punishment of illicit traffic is one of the basic features of the Conventions, and mandatory on all parties. This should be achieved through appropriate changes to national laws, where necessary. While the Convention seeks to establish a common minimum standard for implementation, parties may adopt stricter measures than those mandated by the text if they wish, subject always to the requirement that such initiatives are consistent with applicable norms of public international law, in particular norms protecting human rights.

Under established principles of international law, both bilateral and multilateral treaties may be classified as either self-executing or non self-executing treaties. A self-executing treaty is a treaty that, by its terms and provisions, creates direct rights and obligations for individual citizens or subjects of the contracting parties. Most treaties, however, explicitly state that the signatory nations will have to enact legislation to give effect to the relevant treaty provisions: these treaties are, therefore, not self-executing. For example, the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substance, 1988 requires each party to adopt such measures as may be necessary to establish certain criminal offences under their domestic legislation, so it is non self-executing.

### **B. Inter-Ministerial Coordination**

Formulating a drug control plan and implementing it on a national basis should involve the participation of a number of different ministries. To this end, governments may need to establish an inter-ministerial

committee or commission to coordinate drug control efforts and to be responsible for defining, promoting and coordinating government policy in this regard. It should also ensure that the requirements of the international conventions are effectively fulfilled by the country. Such a body may take a number of forms: it could comprise ministers of state, such as the ministers of health, justice, or interior who could supervise policy and law, it could be an operational body comprising representatives of the law enforcement and security services, or it could oversee the administration and coordination of the departments involved in drug control. The Commission may be supported by a secretariat responsible for implementation of the Commission's policies.

### **C. Law Enforcement Mechanisms**

As was seen above, an effective criminal justice system is vital to the implementation of the international drug control treaties. In addition to national law enforcement mechanisms, the 1988 Convention contains a number of important provisions to foster international judicial cooperation in drug control. These include international cooperation in respect of the confiscation of proceeds from drug-related crime, extradition, mutual legal assistance, transfer of proceedings, controlled delivery, illicit traffic by sea, as well as other forms of cooperation. In particular, the Convention provides a treaty basis for countries to assist each other with requests for the various forms of cooperation, such as gathering and providing evidence and information, identifying, tracing and freezing the proceeds of drug crime, sharing confiscated property, and the rendition of fugitives. Parties are required to cooperate closely with one another, within the requirements of their own legal systems, with a view to enhancing law enforcement action.

### **D. Health and Social Mechanisms**

The 1971 Convention and the 1961 Convention as amended by the 1972 Protocol include provisions to the effect that when drug abusers have committed drug related offences, the parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers undergo measures of treatment, education, aftercare, rehabilitation or social reintegration. The 1988 Convention widens the scope of application to drug offenders in general, whether drug abusers or not. It also introduces distinctions based on the seriousness of the offence committed: for offences of a grave nature, measures of treatment, education etc. may be prescribed only in addition to conviction or punishment: for offences of a minor nature and offences aimed at personal consumption, such measures may be prescribed as an alternative to conviction or punishment.

It should be noted that bridges between the criminal justice system and the treatment system might also be envisaged at different stages of the criminal process, including the prosecution stage (for example, conditional discontinuation of criminal proceedings under condition of attending a treatment programme; or a therapeutic injunction pronounced by a prosecuting magistrate) or at the stage of enforcement of a prison sentence (transfer from prison to a treatment institution or therapeutic community in certain circumstances, or provision of treatment while in prison).

Treatment may include individual counselling, pharmacotherapy such as methadone maintenance, group counselling and a support group, which may be provided in out-patient, day care, in-patient, or therapeutic community environments. The ability to remain drug-free needs to be fostered by rehabilitation and reintegration programmes, such as the provision of further education, job placement and skill training. Therefore measures of treatment, after-care, rehabilitation, social reintegration and education will in practice often be linked and overlapping.

## **IV. UNDCP'S MANDATE AND FUNCTIONS**

### **A. Impact on and Implications of the Treaties for the Programme**

The United Nations has had drug control functions since its inception, having inherited them from the League of Nations. The international community now looks at UNDCP to provide leadership for international drug control efforts and to act as the main vehicle to ensure coherence of United Nations drug control activities in all sectors. The Programme's mandates are an integral component of the international drug control system as a whole, being derived from the drug control conventions, the results of the 1987 ICDAIT Conference and key resolutions of ECOSOC and of the General Assembly. Of particular importance are Assembly resolution 45/179 which established the Programme, and the Global Programme of Action which emanated from the special session on drug control held in 1990.

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International instruments such as the drug control treaties and United Nations resolutions are binding on the Programme. The core functions of the Programme flow directly from these mandates, which have been expanded to include new functions, calling upon UNDCP to act as the main focal point for drug control, and to lead and coordinate international drug control efforts, identifying trends and launching new initiatives. The conventions and the other international drug control instruments now act as the main frame of reference for all of the work of the Programme, whether at Headquarters or in the Field. For example, UNDCP Representatives in the field promote adherence to, and advise governments on the requirements of the drug control conventions and appropriate institutional arrangements, promote drug control cooperation between countries and serve as a key source of information for INCB and the Commission on the drug control situation world-wide in addition to their work developing and backstopping drug control programmes and projects at the national and regional level.

**B. Some Areas of Activity of UNDCP**

The United Nations International Drug Control Programme:

- a) Serves as the central drug control entity with exclusive responsibility for coordinating and providing effective leadership for all United Nations drug control activities and serves as the repository of technical expertise in international drug control for the Secretariat of the United Nations, including the regional commissions, and other United Nations organs, as well as Member States, and in this capacity advises them on questions of international and national drug control;
- b) Acts, on behalf of the Secretary-General, in fulfilling responsibilities under the terms of international treaties and resolutions of United Nations organs relating to international drug control;
- c) Provides advice to Member States on the implementation of international drug control treaties and promotes effective implementation and adherence to the conventions by States;
- d) Provides secretariat and substantive services to the Commission on Narcotic Drugs and its subsidiary bodies and, with due consideration for treaty arrangements, to the International Narcotics Control Board;
- e) Provides substantive services to the General Assembly, the Economic and Social Council and committees and conferences dealing with drug control matters;
- f) Develops and carries out drug control operational activities at the national, regional and global levels, through a network of field offices; assists Governments in the development and implementation of national, sub-regional and regional programmes aimed at reducing illicit cultivation, production, manufacture, traffic and abuse of narcotic drugs and psychotropic substances and in improving the effectiveness of measures for controlling the licit supply of drugs and precursor chemicals;
- g) Cooperates closely with outside research institutions, associations and universities to secure and share information on the latest research findings related to drug control; initiates and participates in joint projects; and promotes coordination and cooperation on drug control activities with regional and international organizations.

**C. UNDCP's Substantive Activities in Demand Reduction**

Given the fact that drug abuse is an ongoing concern in most parts of the world, the international community is increasingly attaching greater importance to addressing the illicit demand for drugs as an essential component of a comprehensive, well-balanced approach to drug control. In this regard, UNDCP's core function in respect of Demand Reduction is the development of strategies and identification of measures by which drug abuse and dependence can be prevented and treated and the illicit demand for drugs can be reduced worldwide. Such measures should include the assessment of drug abuse, as well as prevention, treatment, rehabilitation, and social rehabilitation programmes, including community mobilization. UNDCP also continues to reinforce its unique global position in relation to the collection of data and dissemination of information concerning the extent, pattern and trends of drug abuse worldwide and concerning the promotion of norms and standards in regard to "good practice" demand reduction strategies and measures. It promotes international norms and standards, and also acts as a clearinghouse, in respect of effective "good practice" demand reduction measures as these specifically relate to drug abuse prevention, treatment, rehabilitation and social reintegration.

UNDCP, in the pursuance of its mandates in relation to demand reduction, coordinates international efforts and advocates at global, regional and national level to Member States and other UN and international

organizations and experts to address the issue of demand reduction as an ongoing and integral part of their activities.

As indicated above, this important area of work was given further impetus by the special session in 1998 and thereafter through the adoption of the above-mentioned three key instruments, the Political Declaration, the Declaration on the Guiding Principles of Demand Reduction and its Action Plan, which provide an overall strategic framework for the UNDCP programme of work on demand reduction. Specifically, the Declaration requests UNDCP to:

- Provide guidance and assistance, on request, to Member States in development of demand reduction strategies and programmes;
- Provide advice and assistance for the establishment of national drug abuse monitoring systems;
- Facilitate sharing of “best practice” in various areas of drug demand reduction;
- Encourage the dissemination and application of research findings;
- Promote the development of guidelines;
- Facilitate inter-country exchange of experts and the participation of foreign personnel in national training programmes;
- Establish coordination mechanisms on the evaluation of results and other data assessing the effectiveness of strategies and activities.

UNDCP’s work therefore concentrates on four key thematic areas: data collection, prevention, treatment/rehabilitation, and reducing health and social consequences of drug abuse. It also focuses on five key target groups/special topics: young people and vulnerable groups, special needs / those most at risk, prison populations, HIV, and ATS.

Against that background and as part of the proposed programme of work in the area of demand reduction for the period 2003-2008, UNDCP will provide assistance to Member States towards the goal of achieving significant and measurable results in the field of demand reduction by the year 2008. The programme of work will aim specifically at:

- a) Improving national and global information systems for reporting on activities for the reduction of demand for illicit drugs;
- b) Facilitating the sharing of information on best practices in activities for the reduction of demand for illicit drugs; and
- c) Supporting Member States seeking expertise in developing their own strategies and activities for the reduction of demand for illicit drugs.

#### **D. Laboratory Services**

Drug testing plays a crucial role across all drug control efforts: whether assisting law enforcement authorities and criminal justice in their tasks to arrest and convict traffickers, thereby ensuring the prosecution of the guilty and the security of the innocent; whether supporting health care institutions in their efforts to monitor treatment and rehabilitation programmes for drug users / abusers; whether assisting regulatory authorities in their efforts to guarantee the quality of licit shipments of controlled drugs; or whether enabling customs at frontiers and border points to rapidly detect suspected material.

In view of the key role which drug testing may play in drug control, the need for highly accurate, reliable chemical analytical results which are reproducible worldwide, is clearly understood. UNDCP’s Scientific Section (Laboratory), within its broad range of activities, aims at:

Ensuring the availability of international standards in drug testing, monitoring their overall application and impact on national drug control efforts, assisting national laboratories and law enforcement services in countries with limited resources to meet those standards, and serving as a repository for scientific and technical expertise related to drug control.



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**APPENDIX**

**Some Useful Web Site Links**

United Nations Office on Drugs and Crime (UNODC)  
<http://www.unodc.org/>

Commission on Narcotic Drugs (CND)  
<http://www.unodc.org/unodc/en/cnd.html>

International Narcotics Control Boards (INCB)  
<http://www.unodc.org/unodc/en/incb.html>

The three UN Drug Control Conventions  
[http://www.unodc.org/unodc/en/un\\_treaties\\_and\\_resolutions.html](http://www.unodc.org/unodc/en/un_treaties_and_resolutions.html)

UNGASS 1998 Political Declaration, Guiding Principles on Drug Demand Reduction  
[http://www.unodc.org/pdf/report\\_1999-01-01\\_1.pdf](http://www.unodc.org/pdf/report_1999-01-01_1.pdf)

Documentation for the Commission on Narcotic Drugs – 46<sup>th</sup> Session and Ministerial Segment  
[http://www.unodc.org/unodc/cnd\\_session\\_46.html](http://www.unodc.org/unodc/cnd_session_46.html)

Joint Ministerial Statement, April 2003  
[http://www.unodc.org/pdf/document\\_2003-04-16\\_1.pdf](http://www.unodc.org/pdf/document_2003-04-16_1.pdf)

Encouraging progress towards still distant goals  
[http://www.unodc.org/pdf/document\\_2003-04-08\\_2.pdf](http://www.unodc.org/pdf/document_2003-04-08_2.pdf)

Second biennial report on the implementation of the outcome of the twentieth special session of the General Assembly, devoted to countering the world drug problem together  
[http://www.unodc.org/pdf/document\\_2003-02-17\\_1.pdf](http://www.unodc.org/pdf/document_2003-02-17_1.pdf)

Second biennial report on the implementation of the outcome of the twentieth special session of the General Assembly, devoted to countering the world drug problem together – demand reduction  
[http://www.unodc.org/pdf/document\\_2002-12-18\\_1.pdf](http://www.unodc.org/pdf/document_2002-12-18_1.pdf)

World situation with regard to drug abuse  
[http://www.unodc.org/pdf/document\\_2003-01-27\\_1.pdf](http://www.unodc.org/pdf/document_2003-01-27_1.pdf)

Optimizing systems for collecting information and identifying the best practices to counter the demand for illicit drugs  
[http://www.unodc.org/pdf/document\\_2003-02-07\\_1.pdf](http://www.unodc.org/pdf/document_2003-02-07_1.pdf)

Guidelines on best practices in drug demand reduction  
[http://www.unodc.org/pdf/document\\_2003-02-18\\_1.pdf](http://www.unodc.org/pdf/document_2003-02-18_1.pdf)

World situation with regard to illicit drug trafficking  
[http://www.unodc.org/pdf/document\\_2003-01-20\\_1.pdf](http://www.unodc.org/pdf/document_2003-01-20_1.pdf)

# **DRUG ABUSE TREATMENT AND REHABILITATION IN THE CRIMINAL JUSTICE SYSTEM**

*Juana Tomás-Rosselló, M.D.\**

## **I. INTERNATIONAL REGULATORY FRAMEWORK**

The 1961, 1971 and 1988 Conventions request Member States to provide, as an alternative or in addition to conviction or punishment, treatment, education, aftercare, rehabilitation, social reintegration to drug-abusing offenders, whether in prison or in the community.

The Demand Reduction Declaration, in addition to this, indicates that demand reduction/treatment programmes should:

- cover all areas of demand reduction
- embrace early intervention, counselling, treatment, rehabilitation, relapse prevention, aftercare and social reintegration as part of a continuum of care
- be effective, relevant, and accessible to those groups most at risk, taking into account gender, cultural and educational differences, early help and access to services should be offered to those in need
- integrate into broader policies and programmes and involve the community
- build on experience
- enhance close cooperation between criminal justice, health and social systems in the development of the appropriate capacities for assisting drug-abusing offenders

In addition, the United Nations Guidelines for the Prevention of Juvenile Delinquency adopted by the General Assembly at its 45th session state that comprehensive prevention plans against juvenile delinquency should be instituted, and high priority should be given to drug and alcohol prevention and treatment (resolution 45/112, annex, paragraphs 9 and 45), and the United Nations Rule for the Protection of Juveniles Deprived of their Liberty, adopted at the same session indicates that imprisonment should be the last resort for juveniles, and medical service should seek to detect and treat any substance abuse that may hinder reintegration in society (resolution 45/113, annex, paragraphs 1, 49 and 51).

## **II. EFFECTIVENESS OF TREATMENT AND REHABILITATION**

Drug dependence can be seen as a chronic, recurring disorder that can have serious associated problems, such as family disintegration, lack of job skills, criminality and psychiatric pathology. Drug abuse treatment can and should be expected to improve the health and alleviate the social problems of patients, which can be achieved in a cost-effective manner through proper organization and delivery of care. However, most people entering treatment have tried self-recovery before but were unsuccessful and most people who recover after treatment do so after more than one treatment episode.

The research evidence is clear that, for those with severe forms of drug dependence, the best available treatment services are ongoing, as with treatments for other chronic illnesses; able to address the multiple problems that are factors leading to relapse (i.e. medical and psychiatric symptoms and social instability); and well integrated into society so as to permit ready access and to forestall relapse.

Over the course of three decades, research has repeatedly demonstrated that treatment is effective in reducing drug abuse and dependence and that such reductions are also associated with meaningful reductions in crime, health-related problems and costs.

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**A. Principles of Treatment and Rehabilitation**

“Best practice” treatment includes mechanisms to ensure achievement of the ultimate goals of the treatment process, namely, the successful rehabilitation and social reintegration of the abuser. In most cases, specific treatment goals will be:

- a) To achieve abstinence or reduce the use and effects of substances;
- b) To improve the abuser’s overall health and reduce the health consequences of drug abuse, in particular HIV/AIDS;
- c) To improve the abuser’s psychological functioning;
- d) To improve the abuser’s family life and social functioning;
- e) To develop the abuser’s educational and/or vocational capabilities;
- f) To improve the abuser’s job functioning and financial management;
- g) To reduce drug-related criminal behaviour.

In accordance to scientific evidence the following key principles for the development of drug abuse treatment and rehabilitation systems have been developed:

- a) Adapted to local circumstances and cultural traditions;
- b) Integrated in a community-based, diversified and coordinated system;
- c) Designed to reach and cater to the needs of different drug abuser population groups, in particular women, youth and those involved in the criminal justice system;
- d) Offer readily available services;
- e) Offer a wide range of components, such as counselling, behavioural therapies and medications (taking into account that detoxification is only the preparatory first stage of continued treatment and is unlikely to lead to long-term abstinence);
- f) Offer long-term care, as the treatment of drug abuse often involves multiple episodes;
- g) Attend to the individual’s needs throughout the recovery process, not just his/her drug use/abuse;
- h) Integrate and link with other relevant services (pertaining to health, HIV/AIDS prevention and care, in particular, education, housing, vocational training, social support, etc.);
- i) Involve suitably qualified staff.

Treatment and rehabilitation services also need to respond to the advent of HIV/AIDS as associated with drug abuse, in particular with injecting drug use, as well as to facilitate access to appropriate health and social services, including those in which drug abstinence is not necessarily the primary goal, such as HIV/AIDS prevention services. A continuum of care through mutually reinforcing services therefore needs to be pursued. For example, HIV/AIDS prevention services can function as an “entry door” into drug treatment through motivation and referral. In turn, treatment and rehabilitation services can play a significant role in preventing HIV/AIDS transmission by sharing relevant knowledge and skills concerning HIV/AIDS.

**B. Is Treatment Effective?**

**1. Interventions**

The paragraphs below provide a thematic summary of the effectiveness and main influential factors of contemporary drug abuse treatment (see also the publication *Contemporary Drug Abuse Treatment: A Review of the Evidence Base*, UNDCP, 2002).

**2. Detoxification-Stabilization Phase of Treatment**

This phase of treatment is designed for people who experience withdrawal symptoms following prolonged abuse of drugs. Detoxification may be defined as a process of medical care and pharmacotherapy that seeks to help the patient achieve abstinence and physiologically normal levels of functioning with minimum physical and emotional discomfort.

Evidence suggests that detoxification from heroin and other opioids can be facilitated using dose-tapered opioid agonists and two non-opioid drugs, namely clonidine and lofexidine. The rapid opioid detoxification and ultrarapid opioid detoxification using drugs such as naloxone or naltrexone do not confer substantial advantages over existing methods, nor are they more successful in inducing or retaining abstinent patients

during relapse prevention. Moreover, ultrarapid opioid detoxification has been associated with some medical risks.

Much debate exists regarding the effectiveness of either inpatient (hospital or residential setting) or outpatient (community-based setting) detoxification treatment. In general, inpatient detoxification is viewed as particularly appropriate for patients with acute medical and psychiatric problems and those who are alcohol-dependent. Patients with less acute problems and medical complications and who enjoy a stable, supportive home life may well be able to complete detoxification in the community, however.

### 3. Rehabilitation-relapse Prevention Phase of Treatment

This phase of treatment is suitable for patients who are no longer suffering from acute physiological or emotional effects of recent substance abuse. Main goals include prevention of a return to substance abuse, assistance in developing control over drug craving and (re-)attainment of improved personal health and social functioning.

Strategies employed during this phase have included such diverse elements as medications for psychiatric disorders and for relief of drug craving; substitution pharmacotherapies to attract and rehabilitate patients; group and individual counselling and therapy sessions to guide and support behavioural changes; and peer help groups to provide continued abstinence support.

#### *Patient- and treatment-related factors*

A number of patient- and treatment-related factors have been found to influence treatment outcomes. Patient-related factors include severity of substance abuse, psychiatric symptoms, motivation, employment and family and social support. In turn, treatment-related factors include:

- a) *Setting.* For most treatment systems, it is recommended that patients with sufficient personal and social resources and who present with no serious medical complications be assessed for outpatient/day treatment. Given the typically high demand for residential care, it seems logical to prioritize that setting for those with acute and chronic problems who have social stressors and/or environments that are likely to interfere with treatment engagement and recovery;
- b) *Treatment completion and retention.* Available evidence indicates that patients who complete treatment will have superior post-departure outcomes than those who leave prematurely. This is also true for patients who stay for longer than specific threshold times, for example at least three months in residential programmes, 28 days in inpatient and shorter-stay residential programmes and one year in outpatient methadone treatment. However, time spent in treatment does not directly mediate a good outcome, as the extent or level of therapeutic progress attained has emerged as a stronger predictor of outcome than simply the length of stay;
- c) *Pharmacotherapies.* Several main forms of pharmacotherapy for opioid dependence have been developed and widely evaluated for their role in the rehabilitation-relapse prevention phase. As far as agonist medication (i.e. methadone, Levoalphacetylmethadol (LAAM) and buprenorphine is concerned, methadone has been evaluated in considerable depth in many countries. Numerous studies have reported sustained reductions in heroin abuse, HIV-risk behaviours and drug and property crimes among patients who entered methadone maintenance treatment. A clear finding is that the dose of methadone has a positive relationship with retention in treatment and a negative relationship with heroin abuse. LAAM is a longer acting form of methadone, capable of suppressing withdrawal symptoms for between 48 and 72 hours and permitting administration three times a week. Buprenorphine is a synthetic opioid with mixed agonist and antagonist properties. Research has shown it to be an effective maintenance agent with a better safety profile in cases of overdose than methadone and other agonists. Concerning antagonist medication (i.e. naltrexone), research data support the use of this opioid antagonist as part of relapse-prevention programmes as it is especially beneficial to those patients who are highly motivated to take their daily medication and when used in conjunction with various psychosocial therapies. When comparing this treatment with methadone, patients being prescribed the latter are retained in treatment significantly longer. However, there are no differences in levels of heroin abuse during either treatment. Despite extensive research and

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several attempts to develop antagonists for cocaine-dependence treatment, results have thus far been disappointing. Currently, there is no convincing evidence that any of the various types of cocaine-blocking agents are effective for even a significant minority of affected patients;

- d) *Counselling*. Access to regular substance abuse counselling can make an important contribution to patient participation and treatment outcome. For example, studies have shown that patients in methadone maintenance who also attend counselling sessions obtain greater reductions in drug use. Different types of counselling and behavioural treatments include:
- (i) *General outpatient drug-free counselling*, which refers to abstinence-oriented counselling associated with reductions in drug use and crime involvement together with improvements in health and well-being. Studies comparing the relative effectiveness of psychotherapy and general counselling have however not reached conclusive results;
  - (ii) *Motivational interviewing*, which refers to brief therapeutic interventions designed to facilitate patients' internal commitment to change. Studies indicate that patients who receive motivational interventions report less illicit drug use, remain in treatment longer and relapse less quickly to drug abuse than patients in control groups;
  - (iii) *Cognitive/behavioural approaches*, which involve social and communication skills training, stress and mood management and assertion training. Of all the psychosocial interventions, this approach has received the most frequent evaluation, obtaining encouraging results with, for example, cocaine users in terms of treatment completion and continuous weeks of abstinence;
  - (iv) *Community reinforcement and contingency contracting*, which refers to behavioural treatment integrating community-based incentives and contingency-managed counselling, has shown encouraging results in treating cocaine users as such treatment obtained better outcomes in terms of patient retention, abstinence and personal functioning than standard counselling approaches;
  - (v) *Counsellor and therapist effects*, which highlights that therapeutic involvement along with an increased number and quality of counselling sessions have a direct positive effect on retention. Moreover, studies suggest that counsellors who possess strong interpersonal skills, see their clients more frequently, refer clients to auxiliary services as needed and generally establish a practical and "therapeutic alliance" with their patients achieve better results;
  - (vi) *Participation in self-help groups*, where some studies have shown that participation in post-treatment self-help groups predicted better outcome among groups of cocaine- or alcohol-dependent individuals.

4. Reintegration Phase of Treatment

The ultimate aim of treatment and rehabilitation is the reintegration of the former drug abuser into society. Successful social reintegration requires sustained efforts, which include family and community support, job orientation, assistance at the workplace, reinstatement of health insurance and formal and informal educational services in order to de-stigmatize drug abuse.

**III. DRUG TREATMENT COURTS ("DRUG COURTS")**

When drug abuse prevention fails, the public pays a high price – particularly if abusers commit serious offences under the influence of drugs (e.g., domestic violence) or to help pay for their habit (e.g., burglary, theft).

The UN 1988 Drugs Convention, UNGASS Guiding Principles on Demand Reduction and related Action Plan specifically target drug-abusing offenders and call on governments to take effective multidisciplinary remedial initiatives. Drug Courts can be a very effective initiative in an overall package of responses. Drug Courts began in the United States in 1989 as one way of stopping ongoing crime by addressing underlying drug abuse. Judges, prosecutors and treatment providers initiated the courts.

Successful Drug Courts rest on three pillars requiring a close partnership between the justice and treatment systems:

- appropriate treatment;
- court-based monitoring of programme progress through ongoing case management, regular court appearances, incentives to reward progress and sanctions to correct non-compliance;
- mandatory drug testing to reinforce monitoring and strengthen participant accountability.

**A. UNDCP's Expert Working Group on Drug Treatment Courts – Success Factors and Best Practice**

When UNDCP's Legal Advisory Programme began its Drug Court work in 1996, there were no Drug Courts outside the United States. Since then, UNDCP has built a practitioner network, which enabled initiatives like the December 1999 Expert Working Group. The report of that working group has since been used as a guide to establish Drug Courts outside the United States.

UNDCP's Expert Working Group reviewed collective Drug Court experience and impact, identified core factors underlying effectiveness and success, described what needed to change to achieve success and developed practical guidelines on how best to establish and implement these courts.

The group identified the following 12 success factors:

1. Effective judicial leadership of the multidisciplinary Drug Court programme team.
2. Strong interdisciplinary collaboration of judge and team members while each also maintains their respective professional independence.
3. Good knowledge and understanding of addiction and recovery by members of the court team who are not health care professionals.
4. Operational manual to ensure consistency of approach and ongoing programme efficiency.
5. Clear eligibility criteria and objective eligibility screening of potential participant offenders.
6. Detailed assessment of each potential participant offender.
7. Fully informed and documented consent of each participant offender (after receiving legal advice) prior to programme participation.
8. Speedy referral of participating offenders to treatment and rehabilitation.
9. Swift, certain and consistent sanctions for programme non-compliance but with rewards for programme compliance.
10. Ongoing programme evaluation and willingness to tailor programme structure to meet identified shortcomings.
11. Sufficient, sustained and dedicated programme funding.
12. Changes in underlying substantive and procedural law if necessary or appropriate.

The Expert Working Group then formulated 12 key principles for court-directed treatment and rehabilitation programmes in Drug Courts:

1. Integrated justice/health care system processing of common casework.
2. Non-adversarial approach to case problem-solving by the judge, prosecutor and defence.
3. Prompt and objective identification and programme placement of eligible offenders.
4. Access by participants to a broad continuum of treatment and rehabilitation services.
5. Objective monitoring of participants? Compliance through substance abuse testing.
6. Coordinated strategic response to programme compliance and non-compliance by all disciplines involved (police, prosecution, probation, treatment, social workers and court).
7. Ongoing direct judicial interaction with participants.
8. Programme performance monitoring and evaluation (of both process and impact).
9. Ongoing inter-disciplinary education of the entire Drug Court team.
10. Partnerships for programme effectiveness and local community support.
11. Ongoing case management including social re-integration support.
12. Adjustable programme content for groups with special needs (e.g., mental disorders).

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**B. Growing International Impact of Drug Treatment Courts**

Drug Courts now exist or are planned in a growing number of jurisdictions [(e.g., Australia and Canada (1999); Ireland (2000); Bermuda, Brazil, Cayman Islands, Jamaica, and Scotland (2001); New Zealand, Mauritius, England, Wales, Northern Ireland (2002)].

UNDCP's Legal Advisory Programme has provided technical assistance to help plan, establish and operate courts in Jamaica, Mauritius and in other major demand jurisdictions, like Canada and Scotland.

Although treatment had long been part of the way courts in many countries dealt with drug offenders, the multidisciplinary, therapeutic and intensive way Drug Courts dealt with the offender throughout the programme was new and unique for all legal systems.

Drug Courts have evolved to suit different legal traditions (e.g. common law, civil law), cultures and localities. Underlying objectives, operating principles and core characteristics are usually similar, but priorities and means of achieving them often differ. Differences include target group, eligibility criteria, at what point in the justice process the case is diverted to treatment, etc.

To achieve the full benefits from Drug Courts, both common law tradition and civil law tradition States had to change the way they dealt with drug abusing offenders. For example:

- Common law adversarial system judges had to learn to directly interact with participants, rather than leave the conduct of the case to the prosecution and defence;
- Civil law inquisitorial system judges required legislation to enable them to oversee the programme before sentencing or to continue to supervise the case after sentencing;
- Judges, prosecutors, defence lawyers, police and treatment personnel in all legal systems had to learn the difficult process of effective multidisciplinary teamwork.

Drug Courts reflect a transformation of the way courts traditionally dealt with drug-abusing offender criminal casework. The traditional process was adversarial, emphasized the efficient but backward-looking adjudication of claims, rights and responsibilities and involved few participants and stakeholders. The transformed process practised in Drug Courts is collaborative, needs-based and emphasizes forward-looking, post-adjudication problem-solving and dispute avoidance, with a wide range of participants and stakeholders. It is aimed at efficient case processing and effective case outcomes to stop criminal recidivism and drug abuse.

Evaluations on the various Drug Court programmes show higher non-recidivism and retention in treatment rates than alternatives, whether traditional treatment or prison. They are stopping the revolving door back into prison.

UNDCP's Legal Advisory Programme works closely with professionals, practitioners and organizations in an informal Drug Court network.

**APPENDIX**

**Some Useful Web Site Links**

UNODC's Treatment and Rehabilitation Toolkit  
[www.unodc.org/odccp/treatmenttoolkit.html](http://www.unodc.org/odccp/treatmenttoolkit.html)

National Association of Drug Court Professionals (United States)  
[www.NADCP.org](http://www.NADCP.org)

School of Public Affairs, American University – Justice Programs Office  
<http://www.american.edu/academic.depts/spa/justice/drugcourts.html>

National Crime Prevention Centre (Canada)  
<http://www.crime-prevention.org/english/main.html>

New South Wales Drug Court (Australia)  
<http://www.lawlink.nsw.gov.au/drugcrt/drugcrt.nsf/pages/index>

'Treating Drug Users in Prison - a Critical Area for Health-Promotion and Crime-Reduction Policy'  
<http://www.emcdda.org/infopoint/publications/focus.shtml>



# SUBSTANCE ABUSE IN THE CANADIAN CORRECTIONAL CONTEXT

*Brian A. Grant, Ph.D.\**



## I. INTRODUCTION

Substance abuse and addiction are major challenges for prison and correctional agencies around the world. The association between crime and substance use and abuse is well documented and provides a superficial explanation for why a large percentage of incarcerated offenders are identified with substance abuse problems. The potential magnitude of the challenge is demonstrated by the high frequency of drug use as measured at the time of arrest. A recent study found that 66% of those arrested for any offence had been using drugs in the United States and 59% had been using drugs in England (Taylor & Bennett, 1999). These results are consistent with a study in Canada showing that 50% of those arrested were deemed to be under the influence of drugs or alcohol at the time of their arrest (Pernanen, et. al., 2002). Self-reported drug use during, or just prior to, the commission of crimes is also high, between 50% and 60%.

At a recent international conference, 11 countries offered descriptions of the substance abuse problems within their prisons (Addictions Research Centre, 2002). In most cases they described high rates of drug use prior to admission to prison and continued drug use after admission. All agreed that treatment was an essential element in attempts to address the problems. While some jurisdictions were able to stop the use of drugs in prison, they did this at the cost of restricting contact with the larger community, contact that is often viewed as essential if offenders are to be effectively reintegrated.

The Correctional Service Canada has identified substance abuse as a major challenge. It has put in place treatment programmes, infrastructure, and research and development to address the problem. This paper describes the context in which these interventions have been developed and are delivered. However, before addressing the specifics of substance abuse, it is important to understand the national context in which the Correctional Service Canada operates.

## II. DELIVERY OF CORRECTIONAL SERVICES: SHARED RESPONSIBILITIES

Canada is a parliamentary democracy with a strong federal government that shares government responsibilities with 10 provincial and 3 territorial governments. As with other areas, responsibility for corrections, including supervision of offenders in the community, operation of prisons and halfway houses, and parole decisions, is shared between the two levels of government. However, Canada has a single national criminal code and drug control act so the laws are the same across the country.

### A. Provincial and Territorial Responsibilities

Provinces and territories are responsible for administering the court system and sentences that result in probation, conditional release, fines, community service orders, shorter term prison sentences and conditional sentences. Provincial and territorial governments are responsible for managing remand centers for offenders awaiting trial or sentencing and for custody sentences of less than 2 years duration. This results in a high flow of offenders for the provincial and territorial corrections system that deal with many very short sentences (the average is 30 days). During a year provincial and territorial correctional systems will manage just fewer than 100,000 sentences, but on any one day they will have approximately 12,000 offenders in custody (Statistics Canada, 2002). They must also deal with just over 100,000 remand cases per year. The effect of this large turnover is they have only limited opportunities to provide effective interventions during the period of incarceration (Statistics Canada, 2002).

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Correctional Service Canada

Provincial and territorial governments also provide supervision for offenders sentenced to terms of probation, which typically last from 6 to 24 months, although longer terms are possible. Probation is served in the community with supervision by a probation officer. During the period of probation, an offender may be required to participate in treatment programmes and to abstain from the use of alcohol and illicit drugs; failure to do so can result in a period of incarceration. While provincial and territorial governments provide some substance abuse programming in their institutions, much of the programming occurs in the community and is carried out by community agencies.

## **B. Federal Responsibilities**

Offenders who receive custody sentences of two years or more become the responsibility of the Correctional Service Canada, the federal correctional agency in Canada. In addition to managing the custody portion of sentences, the Correctional Service is responsible for offenders released on parole to the community. Most offenders in Canada are released from prison after serving between ½ and 2/3 of their sentence in custody.

Given the longer sentences of offenders in the federal correctional system, there are more opportunities for programming and other types of intervention. The majority of offenders serve sentences of between 2 and 5 years, but those serving longer sentences account for a substantial proportion of the in-custody population.

## **C. Custody Sentences**

In Canada offenders sentenced to custody receive either a determinate or indeterminate sentence. The most common sentences are determinate, in which the judge sets the maximum length of the sentence. Managing the sentence becomes the responsibility of the Correctional Service and an offender is normally released from custody for a period of supervision in the community before the end of the sentence. Indeterminate sentences are used less frequently, but are used for the most serious crimes and offenders. Indeterminate sentences are generally life sentences for which there is no date for the end of the sentence. The most common indeterminate sentence is a life sentence for murder. Depending on the type of conviction, an offender sentenced to life must serve between 10 and 25 years in prison, before being considered for release to the community. However, even if the decision is made to release the offender they remain under supervision of the correctional system and may be returned to custody if they violate the conditions of their release.

For determinate sentences, there are a number of points at which release to the community with supervision is possible, as summarized in Table 1.

**Table 1. Release Options for Offenders Serving Determinate Sentences**

Type of Release	Time in Sentence	Comments
Day parole	6 months before full parole	Used with lowest risk offenders if granted before full parole; may also be used any time up to statutory release to provide transition to the community
Full parole	At 1/3 of the sentence	May be used up to statutory release
Statutory release	At 2/3 of the sentence	Release required by law, but may be delayed in exceptional situations where there is a threat of violence
Detention period	From 2/3 of sentence to end of sentence	Possibility for release assessed regularly; if risk of violence is reduced release may occur.

## **D. National Parole Board**

Decisions about release from prison are not the responsibility of the Correctional Service; rather, the National Parole Board makes release decisions. The Board reviews all recommendations for release from the Correctional Service and interviews the offender to determine how they are progressing in addressing their correctional plan. If the Board decides there is no risk to the community by releasing an offender, or if they believe whatever risk there is can be managed effectively by parole officers, then they may grant day parole or full parole. The National Parole Board does not make release decisions for offenders who have served 2/3

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of their sentences, but have the authority to impose conditions for the release of these offenders. Where an offender is being released at their statutory release date but there is a belief that they might pose an unacceptable risk in the community, they may be ordered to live at a halfway house.

For offenders who pose a serious risk of imminent violence if they are released at their statutory release date, the National Parole Board may decide to detain the offender in custody until the end of their sentence. If detention is ordered, the case is reviewed annually to determine if the offender is ready for release. Detention is not used frequently, but is an option for the most violent offenders.

### III. CORRECTIONAL SERVICE CANADA

The work of the Correctional Service Canada is guided by the following mission statement:

*The Correctional Service Canada, as part of the criminal justice system and respecting the rule of law, contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure humane control.*

The Mission puts into context two sometimes conflicting goals, the protection of the public, which is the main reason for incarceration, and the belief that offenders can change and become law-abiding citizens. To actively encourage offenders, the Service needs to provide treatment and interventions opportunities. This approach is premised on the fact that almost all offenders will eventually be returned to their communities and it is our goal that they be returned having a greater probability to contribute than before they were sentenced.

A second key component of the mission statement is that the Service must "exercise reasonable, safe, secure humane control." Operationally, this commits the Service to move offenders from the most secure facilities to the successively less restrictive environments. That is, while offenders may start their sentence in a maximum security prison they should be cascaded downward to medium and then to minimum security. If supervision in the community can be used effectively to manage the risk the offender poses, then that should be the option.

#### A. Characteristics

The Service manages 52 prisons across the country with 5 multi-level (security) institutions specially designed for women offenders and the remainder classified as low, medium or high security. Most minimum security institutions hold between 100 and 200 offenders, maximum security institutions generally have a capacity for 200 to 300 inmates, while medium security institutions are the largest, having space for between 500 and 600 inmates.

In addition to the prisons, the Service manages 17 community correctional centres (halfway houses) and contracts with a large number of non-government organizations to provide additional halfway house beds. Parole offices are located across the country.

At any one time, there are approximately 12,000 offenders in custody in federal prisons. About 3% or just over 300 of these are women. In the community, there are about 10,000 offenders on parole, of which about 6% are women.

#### B. Intake Process (General)

To effectively manage offenders admitted to the Correctional Service Canada it is important to adequately assess their needs and the risk they present to the correctional system and the community. All offenders admitted to the Service undergo an extensive assessment process that requires between 60 and 90 days to complete.

During the assessment period, parole staff collect information that helps them to develop a correctional plan with the offender. The types of information collected include criminal history records, court records and police records related to the offences they were convicted of and community assessments of the offenders needs and background. In addition, a number of objective assessments are conducted to identify risk and needs and these are discussed below.

## 1. Criminogenic Needs

An extensive research literature has identified a number of areas in an offender's life that are associated with criminal behaviour and increased risk of offending (See for example Andrews and Bonta, 1998). These are referred to as criminogenic needs because of their relationship to criminal behaviour. The criminogenic needs are also dynamic and can be affected by programming. For the Correctional Service, criminogenic needs are assessed using 197 indicators that are assessed by parole officers in the institution. The indicators were developed to identify the seven need areas identified in Table 2, along with samples of the indicators.

**Table 2. Need Domains and Sample Indicators**

Need Domain	Sample Indicators
Education and employment	Has less than grade 8 Has problems writing Has poor attendance record Has difficulties with co-workers
Marital and family relations	Mother absent during childhood Parents dysfunctional during childhood Family members involved in crime Unable to handle parenting responsibilities
Associates and social interaction	Associates with substance abusers Has many criminal associates Easily influenced by others
Substance abuse	Began drinking at an early age Drinking interferes with health Drug use resulted in law violations
Community functioning	Has unstable accommodation Has physical problems Has no bank account
Personal and emotional functioning	Has difficulty solving interpersonal problems Aggressive Manipulative
Attitudes	Negative towards law Intolerant of others Lacks direction

Based on an assessment of each of the indicators, parole officers determine which of the need areas represent an asset or a problem for the offender; those identified as a problem require treatment. An assessment is also made of the overall need level (low, moderate or high) and this is an excellent indicator of risk of re-offending. Offenders who are identified as being high need require special attention during their sentence.

## 2. Criminal History Risk

Criminal history risk is assessed in two ways. First, 174 indicators of criminal history risk are assessed. These indicators include information on youth and adult court involvement, current and previous offences, sex offending and victim information. Based on these indicators, parole officers assess the criminal history risk on a three point scale, low, moderate or high risk.

In addition, offenders are assessed on the Statistical Information on Recidivism (SIR) scale (Nafekh & Motiuk, 2002). This is an actuarial tool that was developed specifically for the Canadian correctional population. The scale was constructed by comparing criminal history items with actual recidivism observed after release in a large sample of offenders. Criminal history items are weighted and an overall score is generated. As with the other assessment tools, SIR results can be classified as low, moderate or high to characterize the risk the offender will present after release from prison.

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3. Custody Rating Scale

The Custody Rating Scale (CRS) is used to determine the level of security offenders need and therefore the type of institution they will be assigned by (Grant & Luciani, 1998). The CRS rates the offender on two broad areas, Institutional Adjustment and Security Risk. Institutional adjustment is assessed by looking at institutional incidents, escape risk, street stability, substance abuse and age. Security risk is assessed by factors like prior convictions, outstanding charges, sentence length, street stability, prior release and age.

4. Additional Assessments

During the assessment process requirements for more detailed assessments may be identified. Offenders may undergo additional educational and employment testing, psychological assessment and programme specific assessments for sex offender treatment and substance abuse.

**C. Correctional Plan**

The final product of the assessment process is the development of the correctional plan. The correctional plan presents the programme needs and challenges to be addressed by the offender while incarcerated. Normally, the correctional plan will identify what programmes the offender should take while in custody, what programmes would be appropriate to follow after release to the community and provide information to the offender on release planning. The plan is then used by parole officers to organize and track the progress of the offender during incarceration and community supervision. The National Parole Board will use the correctional plan to determine if the offender has been making progress towards addressing the criminogenic needs during the period in custody.

**D. Offender Management System**

Almost all of an offender's file information is stored electronically in computer systems that can be accessed across the country. Most of this information is used for administrative purposes to ensure proper calculation of sentences, completion of reports, programme participation etc. However, it is also an extremely useful tool for management planning and for research. It is a relatively easy task to provide profiles of the entire offender population or of subgroups that one may be interested in. Profiles make it possible to design interventions to meet specific needs of subgroups of the offender population. While the full implementation of a system like this may be very difficult, starting to build a data system that contains descriptive information of offenders in custody and in the community will help with planning and development of any correctional system.

**IV. ADDICTIONS RESEARCH CENTRE**

In 1999 the Correctional Service Canada identified the need for a more focused effort in addressing the substance abuse problems of offenders both in custody and in the community. While there was an extensive infrastructure in place to address substance abuse treatment, there had not been sufficient research and development activity to support this activity. Therefore, a new research division was created within the existing Research Branch dedicated to addressing the challenges of substance abuse (Grant, 2001).

The division, known as the Addictions Research Centre, was established in Montague, Prince Edward Island and is responsible for all programme development and research related to substance abuse. The Centre has a staff of 20 people and is located in a newly constructed 1000 square metre building with an adjoining residence for up to three visiting experts and interns. The building opened in May of 2001 and the Centre is now fully operational.

The role of the Addictions Research Centre is:

*...to advance the management of addiction issues in criminal justice towards the goal of contributing to public protection. The Centre is committed to enhancing corrections policy, programming and management practices on substance abuse through the creation and dissemination of knowledge and expertise.*

The Centre has established five goals that will assist it in fulfilling its role within the criminal justice system:

- (i) Meet applied research needs of CSC to assist in the development of policy, programming and management practices
- (ii) Build co-operative and complementary relationships with partners
- (iii) Provide a location for internationally recognized researchers to conduct research
- (iv) Promote research in addictions and corrections
- (v) Provide research training and development

Work at the Centre is organized into four areas:

- (i) Programme development;
- (ii) Programme research;
- (iii) Assessment and measurement; and
- (iv) Knowledge sharing.

The following section provides a description of projects in each of these areas. These are brief descriptions and more detailed information on methodology and results, where available, will be presented in the third paper in this series

## **A. Programme Development**

### **1. Women Offenders' Substance Abuse Programme**

A review by an international panel of experts identified a number of deficiencies in the programming available for women offenders. To address these limitations the ARC initiated the development of a new programme. This programme, guided by the expert panel, will provide state of the art treatment to women offenders. The programme is designed to meet the specific needs of women offenders taking account of their unique pathways to addiction and the impact of substance abuse on their lives (Hume & Grant, 2002).

### **2. High Intensity Substance Abuse Programme.**

The High Intensity Substance Abuse Programme (HISAP) was developed by a team of substance abuse programme coordinators. The programme has been tested at a number of sites and preliminary results indicate that it has been received positively and intermediate measures of outcome appear promising (Grant et.al., 2003). The ultimate test is its impact on recidivism and those results will not be available for two or three years. The programme has been reviewed by an accreditation panel, and was approved subject to the follow-up data requirements.

### **3. Aboriginal Offender Substance Abuse Programme**

Aboriginal offenders have unique needs in the area of substance abuse based on their social and cultural experiences. Accounting for more than 15% of offenders in federal penitentiaries it has been long recognized that specialized programming would be more effective for these offenders than current core programmes. The ARC is working towards the development of a new programme, based on Aboriginal needs and issues that will better meet the treatment goals of offenders.

## **B. Programme Research**

### **1. Intensive Support Units**

Intensive support units (ISU) were established at five locations, one in each region, across the country. Offenders wishing to live in the ISU must sign a consent form agreeing to increased testing and searching to reduce the likelihood of alcohol or drugs being available. In addition, staff on the units receive training about issues associated with addictions so they can better assist offenders while they are participating in treatment and during the period after treatment has ended and they must work to remain free of drugs and alcohol. Offenders on the ISU continue to work and take their recreation periods with the general population of the institution, so it is not like a Therapeutic Community. While not directly responsible for managing these units, the ARC is responsible for conducting research to determine if the units are having the expected benefits. In particular, the research is looking at what offenders and staff expect to achieve through living on these units, how living on the units impacts their release and how it impacts their outcome after release into the community (Grant, Varis & Lefebvre, 2004).

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2. Methadone Maintenance Treatment

Methadone Maintenance Treatment (MMT) has been shown to be an effective intervention for offenders addicted to opiates. In this study, offenders were monitored after release from prison to determine how effective the treatment had been at impacting their criminal behaviour. Results indicated that there was a decreased chance of offenders returning to custody after release compared to a similar group of offenders who had not received MMT. There were also changes evident in institutional behaviour, but these were limited. The study points to the need for additional research, particularly research that follows offenders into the community to determine the effect of MMT on continued drug use (Johnson, van de Ven & Grant, 2001).

3. Managing Addictions in the Community (MAC)

Providing interventions for high need offenders released into communities is challenging. They require access to multiple community resources, but very often the people who provide services in communities are reluctant to work with problematic offenders. The Service contracted with a community agency to develop a programme that would meet the needs of the high need offenders by together community resources. The MAC programme employs a "Wrap Around" process that brings together the required community services to prepare an action plan to work with offenders. Evaluation of the programme will need to await the participation of more clients, but an evaluation plan is in place.

**C. Assessment and Measurement**

1. Computerized Assessment of Substance Abuse

For the past ten years institutional staff have relied on the Computerized Lifestyle Assessment Instrument (CLAI) to assess the severity and nature of substance abuse problems. The CLAI used old computer technology and contained many items that were not relevant to substance abuse treatment. Therefore, a new system has been redeveloped to focus on substance abuse issues only and to improve the administration of the test and the reporting of results. The new system provides an audio component that allows offenders with literacy problems to have questions read to them. New methods of transferring data to other systems (intake assessment, programme planning etc.) are being investigated to reduce the need for offenders to repeatedly provide the same information. A fully integrated system will reduce staff time for assessments (Kunic, in press).

2. Random Drug Testing

Random drug testing has been underway in the Correctional Service since 1994 and a large quantity of data has been collected. However, there have been limited opportunities to analyze these data to determine what we can learn from it. Analyses are underway at the ARC to make more complete use of these valuable data (MacPherson, 2004). Studies are looking at linkages between drug use in prison and admission data to develop profiles of offenders who continue to use drugs. Work is also underway to look at those offenders who refuse to provide samples for urinalysis to determine patterns of refusal and appropriate sanctions. Finally, analyses are underway to link drug use in prison with programme outcomes and release outcome.

3. Fetal Alcohol Spectrum Disorder

Fetal alcohol Spectrum Disorder (FASD) is a permanent neurological disorder resulting from the use of alcohol by expectant mothers. It is generally associated with high use of alcohol, but timing of alcohol use relative to the development of the fetus is more critical than the quantity of alcohol consumed. FASD affected individuals have trouble with judgement and learning and are more likely than others to become involved with the criminal justice system (Boland, et.al., 1998). Affected individuals are a challenge for staff in correctional facilities and it may be that sending them to prison is not the most effective method for dealing with their behaviour problems. However, there are no standardize screening tools for FASD, nor is there good information on the number of individuals in correctional systems who may be affected by this disorder. Knowing the number of individuals who may be affected by FAS is important in planning interventions. A study is currently underway to develop a screening instrument appropriate for adults and to develop estimates of incidence of FASD within a correctional population (Boland, Chudley & Grant, 2003).

**D. Knowledge Sharing**

Knowledge sharing is an important function for the Addictions Research Centre. There is little value to be gained by creating new knowledge that remains only in reports. The Centre seeks to share knowledge through organizing conferences, supporting knowledge sharing activities, making conference presentations

and producing reports, working collaboratively with academic and non-government organizations to conduct research and programme development and by providing a location for experts and interns to learn and share their expertise.

In 2002 the Centre organized the *International Experts Forum 2002: Setting the agenda for correctional research in substance abuse*, a major international meeting of correctional experts to discuss priorities for research and development designed to address the problems of substance abuse. The conference was attended by 150 delegates representing 11 countries and over 25 correctional jurisdictions. The conference included participation by experts from community treatment agencies to ensure that correctional agencies were aware of the most recent trends in treatment and intervention (Addictions Research Centre, in press).

Results from the Forum indicate that jurisdictions are interested in working together to address problems and many priorities were identified (Grant, et.al., in press). Discussion of these priorities will be presented in the third paper in this series.

The Centre has hosted many meetings of Canadian correctional officials to discuss the challenges they face in the prison environment. Work is currently underway to develop a series of international internships that will allow correctional officials from around the world to visit and learn about treatment, development and research in substance abuse that is occurring within the Correctional Service Canada. Interns will be encouraged to work on a project of direct relevance to their home countries while developing research skills.

## V. SUBSTANCE ABUSE ASSESSMENT AND TREATMENT

### A. Magnitude of the Challenge

As noted earlier, all offenders admitted to federal prisons are assessed to determine if they have a substance abuse problem. The assessments indicate that 70% of offenders admitted have an identifiable substance abuse problem that is linked to their criminal activities. In addition, most require some form of treatment while they are incarcerated. Between 50% and 60% of those with a problem are assessed as requiring a moderate level intervention, while 20% are assessed as having a serious or severe problem requiring a high intensity treatment programme. The balance has a low severity problem.

In addition to the number of offenders with an identifiable substance problem, approximately 20% of those in institutions have been involved with the drug trade based on convictions for importing, producing, trafficking and possessing drugs (Motiuk & Vuong, 2001). The combination of people who are suppliers of drugs and the large percentage who are users results in a challenging environment in which all elements of the drug trade are in very close contact with each other.

Urinalysis evidence indicates that approximately 12% of offenders use drugs while they are incarcerated (MacPherson, 2004). Nine to ten percent of offenders test positive for cannabis with the balance testing positive for other drugs. Long-term trends have indicated that drug use has remained relatively constant following the full introduction of drug testing. The distribution of drugs used has not changed significantly although fluctuations are noted in the results.

### B. Theoretical Perspective

Substance abuse programmes offered by the Service have been developed on a social learning model. The focus of social learning theory is that behaviours are learned and the most effective method of changing behaviour is through learning new approaches to problems. Treatment programmes are built around a cognitive/behavioural approach that relies more on teaching new skills and new ways of thinking about drug and alcohol use. Based on research to be discussed later, this approach has been shown to be very effective in working with offenders.

### C. Assessment Process

Assessment of substance abuse problems occurs at two levels. As part of the offender intake assessment process parole officers determine the link between substance abuse and criminal behaviour and assess the impact that substance abuse has on the offender's behaviour. There are 28 items in the intake assessment process for identifying substance abuse problems. Sample items from the assessment are presented in Table 2.



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In addition to the basic assessment, and done partly in conjunction with it, is a more detailed assessment that uses standardized assessment instruments to determine the severity of offenders' problems. These assessment instruments have been incorporated into the automated assessment systems such as the Computerized Lifestyle Assessment Instrument and the new system called the Computerized Assessment of Substance Abuse. The key standardized instruments used are the Alcohol Dependency Scale (ADS) (Skinner & Horn, 1984) and the Drug Abuse Severity Test (DAST) (Skinner, 1982), and the Problems Related to Drinking (PRD) scale. In addition the computerized assessments ask questions about drug use in the period prior to incarceration to develop a clearer picture of the link between the offender's drug use and their criminal behaviour.

At the time of release from prison offenders are again assessed on the impact that substance abuse will have on their successful reintegration. Using an internally developed scale, the Community Intervention Scale, parole officers determine if each of the seven needs domains assessed at intake will have a positive or negative impact on recidivism if they are released to the community. Those identified as representing a problem are addressed early in the parole period.

### **D. Assignment to Programmes**

Based on the intake assessment information an offender will be judged as having no substance abuse problem or a low, moderate or high severity problem. They can then be referred to the most effective programming options for the severity of their problem. Assignment to appropriate levels of treatment is a key element in effective correctional programming, a topic that will be discussed in more detail in the next paper. However, making effective use of limited programme resources and ensuring that the level of treatment is appropriate to the problem is the main goal of the assessment process. Programme recommendations are included in the correctional plan and arrangements are made for participation in the selected programme when the offender arrives at their destination institution.

### **E. Types of Programmes**

Currently the Service has five national programmes for the treatment of substance abuse. Each of these is described briefly in the following section.

#### **1. Offender Substance Abuse Pre-release Programme (OSAPP)**

This is a 26-session programme designed for moderately addicted offenders taken over a 2 to 3 month period. It employs a cognitive behavioural approach to treatment and is designed to be delivered prior to release from custody. There is an emphasis in this programme on identifying the factors that lead to criminal behaviour and the relationship to substance use. The study of the crime cycle is a key component of relapse prevention. Offenders work at identifying the factors associated with their drug and alcohol abuse and learn how to recognize the factors or situations that are likely to lead to repeated use.

OSAPP is delivered as part of the daily routine of the offender with each session lasting 2 to 3 hours. It is most like an out-patient form of treatment as the remainder of the day is spent in educational or work activities.

#### **2. Offender Substance Abuse Programme for Long Term Offenders**

This programme was modeled after OSSAP, but has been redesigned to take account of the fact that for many offenders release from custody will not occur until much later in their sentence. Therefore there is a need for a programme that can be presented earlier in the sentence and is not linked to release. This programme is specially designed for offenders who may remain in custody for extended periods of 5 to 15 years, or longer.

#### **3. High Intensity Substance Abuse Programmes**

This programme was developed recently and is still undergoing testing at sites across Canada. The programme uses over 100 treatment sessions, over a period of four to five months and is designed for those offenders who are the most severely addicted and who tend to be the most resistant to change. The preliminary results of the evaluation indicate that there is good retention of training and those involved find themselves affected by the programme content. In addition, intermediate results indicate changes in attitudes and other factors that are thought to be important to changing behaviour (Grant et.al., 2003).

4. Choices

If an offender is deemed to have a substance abuse problem that is moderate to severe they will be referred to the Choices programme. The Choices programme serves two purposes, providing a low-intensity treatment programme in the community for offenders after release and providing aftercare support for the more seriously addicted offenders after they have been released. The Choices programme is only offered in the community and starts with a 10-day intensive treatment phase and this is followed by weekly meetings.

5. Women Offenders Substance Abuse Programme

Women offenders have been receiving treatment for their substance abuse through interim programme activities, but a newly redesigned programme will be implemented in the summer of 2003. This new programme will meet the specific needs of women offenders, and more details about this programme will be presented in the third of these presentations.

**F. Infrastructure**

Managing the offender programming requires an extensive infrastructure. At the institutional level, specially designated staff are trained and certified on the delivery of programmes. The programme delivery officers may be organized at the institutional level, but in some cases are organized at the regional level to ensure efficient use of resources. In addition, each region maintains a substance abuse coordinator to provide management and policy support. Finally, at the national level there are two positions coordinating the work of the substance abuse programme delivery. They work to ensure standards are maintained, develop materials for accrediting programmes and coordinate the resolutions of issues across the system.

**G. Accreditation**

To ensure programmes will meet recognized programme standards an accreditation process has been developed in the Service. An external, international review panel must review all core programmes. Accreditation requires that a programme have a sound theoretical basis, is structured, has training for facilitators, is monitored to ensure consistency of presentation and has a research and evaluation framework. In addition to programme accreditation, there is site accreditation to ensure each prison, or treatment facility meets standards and has properly trained staff and support structures. Finally, work is underway to ensure the programme facilitators are accredited. This ensures that they are properly trained and are knowledgeable about the programmes they deliver.

**VI. CONCLUSION**

The forgoing was a brief overview of the Correctional Service Canada and its efforts to deliver substance abuse programming to offenders. The work presented shows a strong commitment by the organization to the problems of substance abuse in the correctional setting. Much of the material in the next two papers either guided the development of the programming approach presented here, or results from the desire to move forward and continue with the development of new and improved methods of treatment.

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# **SUBSTANCE ABUSE PROGRAMMES: PRINCIPLES OF GOOD DESIGN AND ASSESSMENT**

*Brian A. Grant, Ph.D.\**

## **I. INTRODUCTION**

Effective correctional programmes have been shown to reduce the likelihood that offenders will be readmitted to prison (Andrews et.al., 1990; Gendreau, Little & Goggin, 1996; Lipsey, 1995; Lösel, 1995). Through the use of good programming it is possible to assist offenders to become productive citizens and to reduce crime. Over the past 20 years research has been conducted to determine the types of programmes that will be effective at reducing new offending and to determine the characteristics of successful programmes. During the 70's and 80's some researchers in criminology argued that programmes cannot work with offenders, but this literature has been largely discredited in recent years (Andrews & Bonta, 2002).

However, while research is showing positive effects of treatment on offender behaviour there remains a need for high quality research to support and guide programme developers. Investing resources in programmes that may have no effect is inefficient, and in some cases, can be counterproductive, leading to higher rates of recidivism. Research can help to understand the impacts of interventions on offenders and improve the quality of programming by identifying those components that produce positive results.

For the purposes of this paper, the general correctional treatment research literature will be examined as this literature is applicable to all forms of correctional programmes. Whenever possible, examples will be presented from research on substance abuse.

## **II. THEORETICAL MODEL**

Psychological and sociological theories help in understanding human behaviour. By selecting an appropriate theory one has a road map of how behaviour may be changed and what to look at when evaluating the effectiveness of programmes. Sociological theories are effective for helping us understand the changes that are observed in groups, but treatment is focused on the individual. Therefore, psychology, with its emphasis on individual behaviour, provides a starting point for appropriate theories to assist with programme development.

Among the many psychological theories that could be considered, social learning theory is one that has been applied successfully to treatment programmes and to understanding the behaviour of offenders (Andrews & Bonta, 2002). Social learning theory, in its simplest form, suggests that increases in rewards for a behaviour will increase the probability that a behaviour will occur again (Bandura, 1971, 1986). Rewards may be concrete and tangible like money or food, but they may also be more conceptual and abstract. Positive praise can be as effective, or more effective, than tangible rewards and the expectation of rewards also has a strong effect on behaviour.

Modeling is another way in which people can learn appropriate behaviours. In correctional settings, staff and programme facilitators can model positive, prosocial behaviours as examples to the offenders in custody. Offenders observing these behaviours will model them and learn appropriate responses. One implication of modeling is all staff in a correctional institution must be expected to show appropriate behaviours, not just programming staff. Correctional staff who do not deliver programmes have much greater contact with offenders than programme staff who may only work with an offender group for one or two hours a day, or a week.

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Given a good theoretical background it is possible to design and develop effective correctional programmes.

### III. RISK/NEED RESPONSIVITY

One of the most prolific writers in the area of assessment and treatment delivery for offenders has been Prof. Don Andrews from Carleton University in Canada. In his writing he has argued that there are four basic principles to be taken into account when assessment and treatment services for an offender population (See for example, Andrews & Bonta, 2002). The four principles are:

- (i) Risk
- (ii) Need
- (iii) Responsivity
- (iv) Professional discretion

Each of these principles will be explained in the following sections.

#### A. Risk Principle

The risk principle states that offenders with the highest risk of re-offending are the most in need of intervention and the most likely to benefit from intervention. To apply this principle, an assessment of risk to re-offend is required. The assessment may be done using a variety of assessment instruments, like the ones used by the Correctional Service Canada and described in the previous paper (Grant, 2003), and others, such as the Level of Service Inventory (LSI) (Andrews & Bonta, 1995) that will be described later in this paper. Whatever type of assessment is conducted, the goal is to determine which offenders are at greatest risk to offend (Andrews, 1996). Having identified those at greatest risk to re-offend, treatment resources may be directed at the highest risk group.

Why is this important? Resources for treatment are never unlimited and planners and policy makers must decide how to effectively use the resources. Research has shown that using treatment resources to address the problems of offenders who are at a low risk to re-offend is not very effective. Those who are unlikely to re-offend will serve their sentence, be released to the community and are unlikely to return, regardless of whether any treatment is offered. This does not mean that the lowest risk groups are ignored, but that they require only minimal resources.

Offenders who are at the highest risk to re-offend require the most intensive treatment services if the goal is to reduce the likelihood of returning to prison. As this group is also likely responsible for the highest volume of crime, changing their behaviour through treatment will result in the largest decrease in criminal activities. The risk principle is an important principle in the treatment of offenders, but is also a management principle that directs resources to where they can have the greatest impact.

#### B. Need Principle

The need principle states that in a correctional system only criminogenic needs should be addressed. The reason for this is that if one is trying to change criminal behaviour, it is only those factors that are associated with criminal activity that should be addressed. Other factors may seem likely to be targets for treatment, but they will not result in reduced crime by the offender. Extensive research has identified a number of needs areas that are associated with criminal behaviour. The research has demonstrated that if these need areas are addressed through treatment programmes the likelihood of a new criminal offence will be decreased. The need areas most likely to have an impact on criminal behaviour are presented in Table 1.

**Table 1. Criminogenic Needs Identified in the Level of Service Inventory (LSI)**

Need area	Samples from the LSI
Education/employment	Employment history
	Employment skills
	Minimal education
Financial	Reliance on social assistance

**Table 1. Criminogenic Needs Identified in the Level of Service Inventory (LSI)**

Need area	Samples from the LSI
Family/Marital	Dissatisfaction with marital situation
	Problems with family
	Criminal family
Accommodation	Poor
	Frequent changes
	High crime neighbourhood
Leisure/recreation	Poor use of time
	Lack of participation in organized activity
Companions	Social isolate
	Criminal acquaintances & friends
	Limited non-criminal associates
Substance abuse	Alcohol and drug problem (past & current)
	Substance abuse associated with criminal behaviour
Emotional personal	Interference with normal behaviour
	Psychological/psychiatric treatment
Attitude/orientation	Supportive of crime
	Poor attitude toward sentence and supervision
	Unfavourable toward convention

These needs are similar to those used by the Correctional Service in its assessments of offender needs, although the descriptions of the needs in this case are taken from the Level of Service Inventory (LSI), a different assessment instrument.

### C. Responsivity

The Responsivity principle states the treatment should be offered in a form that is most appropriate to the offender. This means that the style of the treatment should be consistent with the learning needs of the offender and in a style that the offender is accustomed to. The selection of the best treatment approach should be based on empirical research. The basic premise is that people have specific styles of learning and if a treatment is to be effective it must take account of learning styles (Andrews & Bonta, 2002).

An example of the responsivity principle in action is the finding that cognitive behavioural programmes are most effective with correctional populations (Gendreau, Little & Goggin, 1996). The learning style used in these programmes is consistent with the learning experience of the offenders, relying on participative learning exercises, skill development and repetition. On the other hand, treatments that rely on psychodynamic principles of introspection and self-analysis have not been effective with offenders because they are less inclined to verbalize their problems, or to think about the impacts their behaviours have on others. Psychodynamic methods will work with other groups of people who are accustomed to verbalizing their problems and for whom introspection is not problematic. Another example of the responsivity principle in practice is designing programmes that take account of cultural differences rather than copying programmes from other cultures. It may not be appropriate for your country to copy a programme from Canada, rather the programme should be designed from basic principles, but include proper adaptation of cultural norms.

### D. Professional Discretion

The principle of professional discretion recognizes that assessment instruments cannot be designed to address every case. There are, at times, unique characteristics of an individual or situation that must be taken into account when making decisions about treatment. This means that there will be situations when the assessment tools might indicate an offender is low risk to re-offend, but special circumstances, such as

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behaviour since arrest, may indicate that there is a high risk or probability of re-offending. The professional classification officer should use this information when making decisions.

Professional discretion must be used with care. Professional judgments that override the assessment from objective assessment instruments should be monitored to ensure they are being made with appropriate understanding of the issues. Ideally, all override decisions would be recorded and reviewed regularly to ensure they are based on an understanding of the goals of the assessment. There have been instances within the Correctional Service where a new assessment instrument has been overridden in 40% of cases. Analysis of these overrides indicated that the decision makers did not fully understand the results of the assessment and believed their personal judgments were more accurate. Personal judgment, without supporting reasoning, is not an effective method of decision making. Many studies have indicated that properly completed, structured and objective assessment is more accurate and consistent than the judgment of professionals alone (Andrews & Bonta, 2002).

A final point about assessment in the context of professional judgment is that decisions about treatment and interventions are never made in isolation or based on a single assessment instrument. Rather, one must look at multiple sources of information from interviews, assessment instruments and background information. This is sometimes referred to as a multi-method approach. It is when all of the information is considered that we can be more certain that assessments are accurate.

### **E. Static and Dynamic Risk**

Assessments of risk may be made using two types of information, static and dynamic. Static information is information that cannot change. For example, age and gender are clearly static factors. History of previous offences and type of crimes committed are also static factors. It is not possible to change these factors through treatment, so knowing them will not effectively guide the type of treatment needed. In addition, if a subsequent assessment is completed it will produce the same result because it is based on the same information. Therefore, it is not possible to measure change, or reductions (or increases) in risk using static measures. Criminal history risk is measured using static information.

Dynamic risk factors are important because these are factors that are changeable. Risk factors that are changeable are amenable to treatment and with these it is possible to measure changes to determine if the offenders have increased or decreased their risk of reoffending. The criminogenic needs identified earlier are examples of dynamic risk factors that can be changed. For example, treating substance abuse problems can reduce the risk of drug use that is likely to result in a return to prison and educational and employment programmes can increase skills and work opportunities thereby providing for jobs after release.

## **IV. DOES PROGRAMMING WORK**

To determine if correctional programmes have an effect on offender behaviour requires the review of an extensive research literature. Earlier, reviewing this literature would have meant reading and summarizing each study and then attempting to locate the consistencies across each study. When the number of studies to be reviewed is in the hundreds finding trends in their results becomes very difficult and other methodologies are required.

Researchers started to address this problem in the eighties through a method called Meta-analysis. Meta-analysis is basically a structured means by which a large number of studies can be reviewed. The results of each study are coded to identify the presence or absence of key factors of the studies and then the outcome measures are associated with these factors. Following the analyses, it becomes possible to identify the factors that are the most effective at achieving behaviour change. In effect, a meta-analysis is a quantitative method of summarizing the outcome or results from a diverse group of studies. Statistics have been identified for measuring the strength of observed results and these include the Phi coefficient, Pearson's *r*, *z*+ score and the Common Language Effect size. The first three of these are standard statistical measures of association and provide a means of looking at vastly different studies to summarize their results.

A major meta analysis completed in 1996 by Dr. Paul Gendreau at the University of New Brunswick in Canada (Gendreau, Little & Goggin, 1996) looked at which factors are associated with reductions in

recidivism. This study is important because it provides clear empirical evidence of the factors associated with positive correctional outcomes.

The study had four main goals:

- (i) Determine which factors are the best predictors of recidivism
- (ii) Demonstrate the link between the predictors and theory
- (iii) Compare differences in the ability of dynamic and static factors to predict recidivism
- (iv) Compare effectiveness of measures or risk, both individually and in combination

The study looked at the results of 131 studies and from these obtained over 1,000 effect relationships. Research included in the study had a minimum follow-up period of 6 months, the recidivism was measured for adults, there had to be a clear measure indicating whether or not there was recidivism, and statistical tests of results had to be present.

The factors investigated in the study are presented in Table 2.

**Table 2. Predictors of Recidivism used in Gendreau et.al., (1996)**

Static Risk Factors	Dynamic Risk Factors	Risk Measures (use combinations of factors)
Adult criminal history	Anti-social personality	Level of supervision inventory (LSI)
Pre-adult antisocial behaviour	Companions	Salient Factor Score (SFS)
Family criminality	Criminogenic needs	Wisconsin system
Family rearing practices	Interpersonal conflict	Others
Family structure	Personal distress	
Age	Social achievement	<b>Antisocial personality scales</b>
Gender	Substance abuse	Psychopathy checklist (PCL)
Intellectual functioning		Other
Race		
Socio-economic status		

Table 3 presents the results of the meta-analysis. The larger the number in the second column the more correlated the factors are with recidivism, and therefore the more effective they are for assessing offenders' risk of reoffending.

**Table 3. Results of Meta-analysis of Predictors of Recidivism**

Factor Studied	Mr
<b>Individual Factors</b>	
Criminogenic needs factor	.17
Criminal history	.16
Social achievement	.15
Age, gender & race	.14
Family factors	.12
Intellectual functioning	.07
Socio-economic status	.06
Personal distress	.06



**Table 3. Results of Meta-analysis of Predictors of Recidivism**

Factor Studied	Mr
<b>Dynamic vs. static factors</b>	
Dynamic predictors	.15
Static predictors	.13
<b>Risk scales</b>	.30

The study shows that the three factors that were the most correlated with recidivism were criminogenic need factors, criminal history and social achievement. Other important factors were age, gender and race, and family background. These therefore, are the factors that should be assessed when determining who requires the most intervention. You will note that these are the factors that are included in the risk and need assessments described earlier. Also of note, is the finding that factors like socio-economic status, intellectual functioning and personal distress are not highly correlated with recidivism. Therefore, these are not good targets for effective intervention. Sociological theories of the criminal behaviour often raise socio-economic status as an important factor in understanding criminal behaviour, but these results suggest that it is not a factor that needs to be considered.

The results in Table 3 also compare the effectiveness of static and dynamic factors. From the results in the table it can be seen that dynamic factors are slightly more effective at predicting recidivism than static factors, but both types of factors are very similar in their predictive abilities.

Next, the results in Table 3 show that risk scales are actually the best predictors of recidivism. This occurs because risk scales studied in the meta-analysis combine the most important predictors of criminal behaviour into a single assessment instrument. The result demonstrates the importance of considering multiple factors in the assessment of risk and how this can improve the accuracy of prediction. In addition, the risk scales generally include both dynamic and static factors thereby further improving their predictive accuracy.

Finally, the study compared the effectiveness of a number of different risk scales. Overall, the Level of Service Inventory (LSI) (Andrews & Bonta, 1995) provided the most effective prediction of recidivism. This scale includes many of the dynamic and static factors discussed. Other scales studied include the Salient Factor Score (SFS) (Hoffman, 1983), the Wisconsin risk assessment tool (Clear & Gallagher, 1985) and the Psychopathy Checklist (PCL) (Hare, 1990, 1996). Full results are presented in Table 4.

Overall, the results of this study provide a list of the factors that should be addressed in correctional programming and they show that using risk assessment tools that combined different factors and both dynamic and static measures are the most effective tools for predicting the likelihood of new offences after release from prison.

**Table 4. Comparison of Risk Assessment Scales**

Risk scales	Mr
Level of Service Inventory (LSI)	.35
Salient Factor Score (SFS)	.29
Wisconsin	.27
Other	.30
<b>Antisocial personality</b>	
Psychopathy checklist	.28
Other	.16

## V. WHAT WORKS IN PROGRAMMING

Meta-analysis has also been used to identify the programme elements that are most likely to have an impact on recidivism. A number of meta-analyses have shown similar results (Andrews et.al., 1990; Gendreau, Little & Goggin, 1996; Lipsey, 1995; Lösel, 1995), but the study by Andrews et al. (1990) illustrates the conclusions.

Andrews et al. (1990) reviewed 154 correctional treatment evaluation studies and classified the programmes they evaluated into one of four treatment groups:

- (i) Criminal sanctions studies in which there was a variation in the sentence, but no variation in the rehabilitation component. In these studies options comparing more vs. less probation, or probation vs. incarceration were compared to determine which produced lower recidivism.
- (ii) Inappropriate correctional service not consistent with the risk/need principles. These studies provided intervention to low risk offenders, used non-directive relationship based or psychodynamic counselling. Other kinds of interventions included in this group were group counselling programmes that did not use prosocial modelling, non-directive educational and vocational programmes and programmes like scared straight, designed to discourage continued criminal activity by showing what prison is like.
- (iii) Appropriate treatment options include delivery to higher risk offenders, behaviourally oriented interventions, have responsivity comparisons, and a small number of non-behavioural studies that addressed criminogenic needs.
- (iv) Unspecified treatment was the fourth category and was used where the treatment was unspecified, or could not be classified as either appropriate or inappropriate.

The authors compared the recidivism results across the different programme types and the results of the analyses are summarized in Table 5. The effectiveness measure used was the Phi coefficient, a measure of association, in this case demonstrating the impact the programme type had on recidivism. A positive number indicates the programme decreased recidivism, while a negative number indicates the programme increased recidivism. As can be seen in Table 5, programmes that followed the risk/need principles and were structured and behavioural in content, have the highest Phi coefficient. Studies that evaluated the use of criminal sanctions or used programme elements that were described above as being inappropriate either had no effect, or increased recidivism.

**Table 5. Type of Intervention and Impact on Recidivism**

Type of treatment	Number of studies	Mean Phi
Appropriate	54	.30
Unspecified	32	.13
Inappropriate	38	-.06
Criminal sanctions	30	-.07

Summarizing the outcome of a number of meta analysis Gendreau (1996) has proposed a set of 8 principles of effective programme design:

- (i) The risk and need levels of offenders are specified and used in selection of participants and criminogenic needs are targeted.
- (ii) Programmes are highly structured with content and contingencies under the control of the facilitators not the participants and antisocial attitudes are not reinforced.
- (iii) Account for Responsivity of participants. For example, highly structured programmes are most appropriate for offenders who are not effective at conceptualising ideas; higher levels of interpersonal interaction for high anxiety offenders; and additional contingencies are put in place for offenders who have low motivation.

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- (iv) Offender characteristics are matched to staff including personal characteristics (gender, age, life experiences, training) and relationship styles (empathy, fairness, firmness, spontaneity).
- (v) Positive reinforces outnumber punishers by a ratio of 4:1.
- (vi) Intervention periods of 3 to 9 months are used since shorter periods do not provide sufficient time for relationships to develop and there is need for time in the treatment setting to practice interventions learned.
- (vii) Programme staff are adequately trained with an understanding of the theory behind the intervention, they are provided with time to become experienced and familiar with the programme content before delivering it, and smaller programmes (number of locations where the programmes are being delivered) are often observed to be more effective.
- (viii) Assessment and evaluation of the programme is on-going and integral to the programme so changes in behaviour and attitudes can be measured, skill development can be assessed and programme outcomes can be demonstrated.

In addition to these principles, Gendreau argues that the following components are important for successful interventions:

- (i) Prosocial attitudes and behaviours are reinforced during treatment sessions.
- (ii) Prosocial behaviours are modelled, or demonstrated, in treatment.
- (iii) Role playing and practice of learned behaviours is needed.
- (iv) Focus on skill development.
- (v) Relapse prevention is included in the programme training.

In addition, to identifying the characteristics of effective interventions, Gendreau offers the following summary of interventions that are not effective with correctional populations.

- (i) Programmes that rely on psychodynamic therapies requiring high levels of introspection, self evaluation and good verbal skills.
- (ii) Nondirective therapies in which anti-social attitudes are not challenged and groups in which criminal attitudes and behaviours are reinforced.
- (iii) Treatment strategies that rely on punishment such as "boot camp", intensive supervision and shock incarceration
- (iv) Programmes that externalise blame, fail to develop empathy for the victims of crime and are directed at venting anger towards the system, or that only accept self-motivated offenders.
- (v) Programmes that provide intensive services to low risk offenders.

A final point on the effectiveness of programming. A study recently completed for the Correctional Service (French & Gendreau, 2003) looked at the impact of correctional programming on offender behaviour while offenders were still in custody. For this study this meta analysis looked at research using institutional incidents. Their findings demonstrate that with increased programme options institutional incidents decline. That is, with programming, correctional institutions become safer places.

## VI. RESEARCH AND EVALUATION

### A. Introduction

Determining what works and developing an evidence based correctional approach requires an understanding of research and its importance. Ideally, a correctional agency will have, at least, a small number of research staff who can carry out research projects and maintain knowledge of new and developing trends in the research world. Where research staff are not available, efforts are needed to build relationships with universities and colleges to encourage research in corrections that is consistent with local cultural and social norms.

### B. Research Needs

Research requires the systematic collection of information, but this information can serve more than one purpose. Basic information on when offenders are admitted to an institution and when they leave can be useful for research. Assessment information for offenders may not only assist in ensuring services are

delivered appropriately, but can assist correctional management in planning and developing their correctional systems.

To conduct research on an intervention, it is necessary to know what is being evaluated. That is, it must be possible to describe the programme or intervention and the intervention must be applied consistently so all participants receive the same service. It is not possible to effectively evaluate programmes that are constantly changing since one will never know what is producing the observed results.

With knowledge about the offender population being studied it is possible to subset the population to look at how the intervention impacts different groups. Under the responsivity principle we would expect differential effects for subgroups of the population. Therefore, knowing the population allows one to determine who the programme works for. Examples of characteristics one might look at are age and gender, risk and need, type of crime committed and level of motivation.

The third requirement is for measures of outcome. Outcome measures are the things that you hope to change through the intervention. Early in the programme development cycle the behaviours that are being targeted for change should be clearly identified and these behaviours should be monitored. In correctional settings, the easiest behaviour to measure is recidivism. While this is often a relatively crude measure, it is the goal of most programming, to reduce the commission of new offences. Measuring recidivism then is a key element in evaluating correctional programmes.

However, waiting until recidivism occurs can take a long time and often estimates of the effectiveness of programmes are needed earlier. In addition, there is value in determining if there are immediate impacts of a programme on attitudes and behaviour, impacts that may be reduced over time. Intermediate measures of outcome can be very effective in understanding which parts of a programme or intervention are effective, and in new interventions, can identify problems early in the development process. Intermediate measures of outcome might include assessment of attitudes to determine if there was change, assessment of understanding and learning to determine if the information presented has been understood, and level of programme participation and programme performance.

For a correctional organization without a strong history of research support it can be challenging to convince senior managers of the value that research can provide. When resources are limited, and funds used to pay for research must be taken from programme funds it is easy to decide that research is an unnecessary luxury. However, research helps to answer fundamental questions, and can actually lead to increased efficiencies in the operation of the correctional system. Providing programming is expensive and knowing who it works best for, under what conditions and what intensity of programming is needed increases the probability that resources will be used in the most efficient manner.

Research helps to eliminate programmes and interventions that do not have an impact on the offender. Many interventions have little or not impact on offender behaviour, and yet are continued at great cost because management does not know the impact.

### **C. Measuring Recidivism**

The effectiveness of a correctional intervention is frequently measured using recidivism. However, defining what is meant by recidivism is important as there are a number of factors that influence the rate of recidivism that is observed.

In the United States recidivism is often measured by using arrest information. This is available in a national database from their national police, but it must be remembered that arrest does not mean conviction. Therefore, in the U.S., recidivism rates may appear higher than in other countries that use convictions as a measure of recidivism. In Canada, recidivism is usually measured in terms of convictions because the national police force maintains an extensive database containing all convictions for criminal offences. It is necessary when reading research reports, and when writing reports, to be clear about the type of measure being used to calculate recidivism.

Other factors that can affect the recidivism rate include the length of the follow-up period, the status of the offender during the follow-up period, and the types of offences included in the measurement of

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recidivism. The length of the follow-up period is the most critical factor in studies that report recidivism rates. Short follow-up periods will often result in evaluations making a very weak programme look successful, as the offender has not had time to commit additional crimes, or more accurately, to be detected by official sources (the police) for having committed a new crime. For this reason, studies that report recidivism with a follow-up period of less than 6 months or less are not very useful. The minimum period of follow-up should be one year, and two years is much better. To determine the length of the follow-up period needed one must also consider the type of offender being studied. For example, sex offenders who have child victims must be followed for extended periods of time, as their recidivism generally takes longer to show in official records.

The status of the offender during the follow-up period is also important. An offender who is being supervised in the community on parole will be more likely to be detected for having committed new offences than one that is not being supervised. Therefore, studies using supervised and unsupervised offenders must be careful to correct for the different probabilities of detection.

Finally, there must be a determination of what types of offences will be included in the recidivism measure. Frequently, offences that receive fines only, or very short sentences (less than 30 days), are not included in follow-up data collection, particularly if the group being studied has in the past been convicted of serious offences. It is necessary to ask if conviction for a minor assault that results in 5 days in prison should be considered as a failure, or a slip that does not help to understand the problem being investigated.

Follow-up periods may be fixed or variable. Studies with fixed follow-up periods may include periods after the sentence has been completed. Variable follow-up periods are often used when a group of offenders with different release dates are used in a study, but the study must conclude on a particular date. The problem with variable follow-up periods is that those released last will have the shortest follow-up periods and therefore, will have lower recidivism rates. If the type of offender is associated with the time of release in the study and variable follow-up periods are used, then results could be biased.

Alternative measures of recidivism have been used in many studies such as return to custody and failure of conditional release. While these are not truly recidivism measures, as they do not require that a crime be committed, they are useful measures of criminal tendencies for research on programme outcome. It may be that keeping an offender in the community for an additional three or four months is a positive outcome. Return to custody as a measure of outcome is very simple to obtain with a correctional system where all admissions are recorded centrally. An alternative to return to custody is a measure of failure on conditional release such as parole. This outcome measure is intermediate, and may not result from new offending, but it does reflect a deterioration in behaviour in the community.

In research that is conducted by the Correctional Service a combination of measures of outcome are frequently used. The most basic measure is return to custody, and this provides information on how well the offender did after release. However, it is also useful to know if the return to custody occurred as a result of parole violation or as a result of a new criminal conviction, therefore we also collect this information. It is possible to refine the measure of recidivism by looking at the type of new offence, such as whether it was a new violent offence, or non-violent offence. Sometimes it is useful to know if the new offence is similar to previous offences or reflects a change in behaviour that may be indicative of positive outcomes.

Measuring recidivism as a percentage of offenders committing new offences in a fixed period of time is useful, but there are more effective measures that provide additional information. For example, survival analysis provides information on how long offenders remained in the community, the rate of failure over the full range of the follow-up period and it provides statistical tests for comparing different groups. How survival analysis helps in the evaluation of a treatment programme can be seen in the following example. A programme is evaluated and the final recidivism rate is the same for both groups after two years. However, survival analysis might reveal that failures in the untreated group occurred mostly in the early part of the sentence; while for the treated group failure occurred in the latter part of the follow-up period. If one only looks at the overall rate it would appear that the intervention had no effect, but the survival analysis would reveal a very real effect, keeping some offenders out of prison for a longer period of time.

## VII. SUMMARY AND CONCLUSION

Programmes that provide appropriate interventions to offenders can reduce the probability that they will return to prison. Programming that reduces recidivism also reduces the crime problem in our communities. Results of the research reviewed indicate that programmes that address criminogenic factors, those factors that have been shown through research to be associated with criminal behaviour, should be the targets of correctional programming. Substance abuse is one of the most important criminogenic factors. Programmes that are structured and well organized are more effective than those that are not and those programmes that take account of the offenders learning needs, including cultural differences, will be more effective than those that do not. Programming that applies the risk/need responsivity principles will be more effective and more efficient than those that do not.

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# CURRENT SUBSTANCE ABUSE INTERVENTIONS, RESEARCH AND EMERGING DEVELOPMENTS

*Brian A. Grant, Ph.D.\**

## I. INTRODUCTION

Recently, a number of new approaches to the treatment of addiction and substance abuse have been developed. Many of these approaches work well within the correctional context and the following section provides an overview of these approaches. The purpose is not to provide a detailed explanation of any one of these approaches, but to provide a description and sense of how they are applicable to working with offenders who have substance problems.

The paper also presents the results of new research and development activities that are underway within the Correctional Service Canada. These examples are presented in part to highlight the concepts discussed in this, and the other papers in this series, and partly to demonstrate how a research programme can be involved in the development of programming. These examples should bring together many of the concepts that have been discussed and provide concrete examples of their use. It is hoped that through these examples, the importance of research for both developing and maintaining substance abuse interventions within a correctional system will be evident.

## II. GENERAL STRATEGIES IN TREATMENT

Four treatment approaches will be presented in this section, harm reduction, stages of change, relapse prevention, and motivational interviewing.

### A. Harm Reduction

Harm reduction is a concept that grew from awareness of the deadly consequences of injection drug use following the appearance of HIV/AIDS. Through the very common practice of sharing syringes and other drug paraphernalia it became possible for an individual to suddenly have an incurable, fatal disease. People working with drug abusers recognized the need to take some action that would lessen the probability of the spread of disease without passing judgment on the drug using behaviour. Since those origins, harm reduction has become a strategy for dealing with the behaviour and consequences of all types of substance abuse. The approach is often misunderstood and rejected outright by some decision makers and programme delivery experts. Usually, the rejection of the approach results from seeing it as simply a call for needle exchange programmes and safe injection sites.

Harm reduction is more than a number of specific interventions. It is an approach to intervention that seeks to reduce the negative consequences of substance abuse to the individual and to the society. Rather than looking at drug or alcohol misuse as an inherently bad thing, harm reduction takes no position on the acceptability of the behaviour. However, it recognizes that substance abuse has negative effects and therefore actions can be taken to reduce those harms. Simply reducing the harms may help to stabilize the behaviour of individuals, assist in keeping them alive and reduce the negative consequence for the community in which the substance abusing individual lives.

Harm reduction is not a treatment programme, but an intervention. However, one of the values of harm reduction is that it can provide opportunities for further intervention with addicted individuals that may lead to their participation in more traditional programming, thereby leading to a reduction in their use of drugs and alcohol, and in many cases to their total abstinence from drug and alcohol use if that is warranted.

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Marlatt (1998a) provides a more detailed picture of harm reduction approaches in different countries as it relates to different substances, populations and challenges. Marlatt (1998b) provides a set of five principles for harm reduction (pp. 49 - 58):

- (i) *Harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction*

Harm reduction does not presume that substance abuse is morally wrong and must therefore be punished using criminal sanctions, nor does it take the view that substance abuse is a disease that requires treatment. However, given the negative consequences of substance abuse, encouraging people to stop using is a goal as indicated in the next principle.

- (ii) *Harm reduction recognizes abstinence as an ideal outcome, but accepts alternatives that reduce harm*

Harm reduction can be viewed as having a continuum of responses. At one end of the continuum is the cessation of all substance abusing behaviours, thereby eliminating all of the harms associated with substance abuse. At the other end of the continuum is any small reduction in the harms caused by substance abuse. Frequently, harm reduction becomes associated with only the most controversial options such as safe injection sites. While safe injection sites are at the leading edge of harm reduction, they are not the place to start developing a harm reduction policy. A Correctional system can take a harm reduction approach by ensuring that its policies and procedures go as far as they can to reduce the harms associated with substance abuse.

- (iii) *Harm reduction has emerged primarily as a "bottom up" approach based on addict advocacy, rather than a "top-down" policy promoted by drug policy makers*

As a result of how the harm reduction approach was developed, it is well accepted and meets the needs of people who require intervention.

- (iv) *Harm reduction promotes low-threshold access to services as an alternative to traditional, high threshold approaches*

Traditionally, many programmes required a commitment to total abstinence before a person could be accepted into treatment. If there was drug or alcohol use during the programme the person was removed from treatment. These types of strict rules set high-thresholds for participation. Programmes that have low-threshold access have very few rules for initiating and participating in the intervention. Effective needle exchange programmes do not require anything of the substance abuser other than collecting clean syringes. It is easy to image a needle exchange programme that required participation in treatment, completion of forms, etc. to obtain clean needles. Experience has shown that any of these requirements reduces the effectiveness of needle exchange. Another example of a low threshold programme is a methadone treatment programme offered in Halifax, Canada, in which there are a minimum number of requirements for participation, unlike most methadone programmes. Individuals in this programme must obtain their methadone each day, and must undergo urinalysis to check for the presence of other drugs. The presence of other drugs results in counselling, and cessation of methadone only occurs if the level of use of other drugs is seen as a threat to health.

- (v) *Harm reduction is based on the tenets of compassionate pragmatism versus moralistic idealism*

Making condoms available in correctional settings is one example of compassionate pragmatism. We recognize that sexual activities will occur in prison, we want to prevent the spread of diseases, and providing condoms does not provide any security risk, therefore they are made available.

Harm reduction approaches are not only applicable to treatment after an addiction or problem behaviour has occurred. Harm reduction approaches can be applied to prevention programmes as well. Recognizing that there are safe and unsafe behaviours associated with an activity and promoting the safer methods is one way to reduce harm. Programmes to reduce drinking and driving are an example of harm reduction programmes at the prevention level. These programmes recognize that the consumption of alcohol will occur away from home and provide alternative behaviours to driving to reduce the likelihood of accidents. Alternatives include, taking a taxi, arranging for a designated driver, or staying overnight at the location of the event.

## **B. Stages of Change**

Prochaska and DiClemente (1992) propose a model of readiness to change that allows treatment providers to match treatment to an individual's willingness to change. In their model, they propose five stages of change and provide examples of what should be addressed at each stage and what is required for the person to move to the next stage (Connors, Donovan & DiClemente, 2001). These stages are meant to be representative of what happens and individuals will not pass through the stages as if they were discrete events.

### **1. Pre-contemplation**

In the pre-contemplation phase an individual has no intent to change behaviour and current substance abuse may be viewed as being both positive and negative for the individual. During this phase it is not useful to focus on changing behaviour, but rather to use motivational techniques that will move the person to the next phase. The person may need to acknowledge that there is a problem, develop a better understanding of the negative consequences of the substance abuse behaviour and develop an understanding of the factors that trigger drug or alcohol use. An individual at this stage may believe they are in control and can stop anytime and believe that the benefits of using outweigh the benefits of not using.

### **2. Contemplation**

In the contemplation stage the individual is thinking about their problem and is looking for information that will help them to understand it. They are looking at the positive and negative characteristics of their substance abuse problem, but they are not yet prepared to stop using drugs or alcohol. Intervention at this stage involves providing increased understanding of the effects of substance abuse, evaluation of life goals and consideration of the context in which the person may be living. In the case of offenders, if they are incarcerated it is a good opportunity to point out the negative impacts that being in prison have on their life and what the alternatives might be.

At this stage, the person must make a decision to act if they are to move to the next stage. They might begin to take some preliminary action such as meeting with a counselor, changing behaviour to reduce consumption, or to reduce the risk associated with drugs and alcohol use.

### **3. Preparation**

The third stage is preparation to change. Persons in this stage are prepared to change both their attitudes and their behaviour. They may have taken some early steps to monitor their use of alcohol or drugs with the goal of reducing consumption. They are ready to be encouraged to participate in treatment so intervention should work to increase their commitment to stopping their use of drugs or alcohol. This can be done by further development of information on the consequences of substance abuse and the positive benefits they may experience by reducing their use of substances or stopping completely.

At this stage individuals will need to establish goals and priorities that can be set to help them stop abusing substances. They will need to develop a change plan that can guide them to stopping their use.

### **4. Action**

In the action stage individuals have begun to change their behaviour. They are learning new skills that help them to remain free from drug and alcohol use. Their desire to change at this stage makes them ideal candidates for programmes that apply behaviour change practices in treatment. Treatment needs to provide skills development that will assist in the cessation of the drug and alcohol use and while providing alternatives to their former life-style. Participants also need to learn about what may trigger their desire to use drugs and alcohol so they can avoid these situations.

Prochaska and DiClemente (1992) suggest that interventions in this stage should last for an average of six months, and work is needed with the individual to increase their belief that they can maintain the desired changes in behaviour.

### **5. Maintenance**

The final stage in this model is maintenance, the process by which the individual maintains their desired behaviour. This is a critical phase as it is the one that must last for the remainder of a person's life if they are to avoid returning to an addictive state. They must have in place practices that will allow them to avoid

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substance abuse and continue to practice the skills learned in treatment. Very often, treatment programmes do not provide for maintenance support. Rather, the programme is delivered, the person successfully completes it and then is expected to maintain the change without any additional support. Effective programmes have maintenance components that provide support and skills reinforcement during the maintenance stage.

An individual does not move through these stages in a straight line. They may move from precontemplation to preparation, only to slip back to the contemplation stage. Or, they move all the way to maintenance, but as a result of life circumstances, may find themselves starting the process again (Connors, Donovan & DiClemente, 2001). This is both expected and normal and is one of the reasons that effective programmes stress the need for understanding of lapses in drug and alcohol use during and after treatment.

### **C. Relapse Prevention**

Relapse prevention should be an important component of treatment programmes. As noted earlier, relapse is a common occurrence and the individual who abuses substances needs to be prepared for it when it occurs. The goals of relapse prevention are to provide information useful in recognizing high risk situations that may lead to relapse and providing the skills needed to deal with the relapse when it does occur. At the time of a relapse, it is important that the client does not give up.

Seven models of relapse are identified by Connors, Donovan and DiClemente (2001), but there is a consistency across the approaches they present. The model presented by Marlatt and Gordon (1985) is based on cognitive behavioural principles and is a good example to use here. In this model, relapse is seen as the interaction between the high risk situations associated with drug or alcohol use and the individual's perceptions of his/her ability to control the situation and therefore, avoid using drugs and alcohol. The individuals' expectations about the usefulness of drugs and alcohol in the particular situation will also play a role in whether or not they choose to relapse (Connors, Donovan & DiClemente, 2001).

When the high risk situation arises, the individual who has learned coping skills to deal with the event or environment will be more likely to resist the relapse. The coping skills that have been learned will provide alternative courses of action, that hopefully will avoid the relapse. Individuals who have not learned appropriate coping skills will be less able to choose alternative behaviours and therefore will be more likely to return to substance use.

For the Marlatt model, there are two key components that must be addressed during treatment, identifying the high risk situations and developing coping skills to deal with the situations in a positive way. Treatment programmes that use relapse prevention spend time helping the offender to identify their unique high risk situations through review of past events and their outcomes. Events that consistently lead to drug and alcohol use become the targets for developing coping strategies.

Developing coping strategies follow the identification of the high risk situations. For each high risk situation the offender must identify a number of alternative ways of dealing with the risk created. For example, if meeting with friends in a large group is a high risk situation, then coping strategies might include avoiding being with friends in large groups, leaving the group when it gets large, or finding alternative activities that are normally done only in small groups of two or three people. Other coping strategies that have been identified in the research literature include, reminders of the consequence of drug or alcohol use, thinking about the positive effects of not using drugs or alcohol, recalling periods of non-use that were positive, and remembering that avoiding use is an important personal goal.

The coping strategies are identified on an individual basis following discussion in groups. After identification of coping strategies, they must be practiced in role play activities. Through the identification of the high risk situations, development of coping strategies and practicing the strategies the offender is better prepared to deal with the situations when they occur.

Relapses are to be expected and may be viewed as learning experiences. Analysis of the relapse events, the antecedent behaviours and the results will assist in the development of more effective coping strategies that can be used during the next high risk situation. Following the relapse, or lapse, the client needs to be reassured that they can continue without using drugs and alcohol. The treatment programme should include

discussion of what to do after a relapse and how to restart the process of remaining drug and alcohol free. This is one of the main reasons that treatment maintenance programmes are important. It is during the maintenance sessions that lapses and relapses can be addressed in a supportive environment.

#### **D. Motivation Interviewing**

Miller and Rollnick (1991) state:

*Motivational interviewing is a particular way to help people recognize and do something about their present or potential problem. It is particularly useful with people who are reluctant to change and ambivalent about changing. (p. 52).*

Many offenders are not willing to commit to changing their drug or alcohol using behaviours. There are too many positive features associated with their lifestyle. They are in the precontemplative stage of change. However, treatment providers must work to encourage these individuals to move forward along the continuum towards change. Motivational interviewing is one of the methods that have been shown to be effective for starting the change process.

Miller and Rollnick (1991) present five general principles of motivational interviewing.

##### **1. Express Empathy**

For motivational interviewing to be effective the counselor must express empathy with the client. The client is accepted for what he or she is at the time of counseling, there is no judgment about how they arrived at that point, or the consequences of their behaviour. Accepting the individuals as they are reduces their resistance to the counseling setting. Ambivalence about change is acceptable for the client.

##### **2. Develop Discrepancy**

Developing discrepancy has to do with gently demonstrating the conflicting values in a person's life and guiding them towards the more appropriate goals. This is different from confrontation that may result in resistance to change. While discussing the current situation with the client the counselor looks for positive personal goals that the individual has and contrasts these with the current behaviours that prevent the achievement of these goals. The object is to encourage the client to see the importance of alternative goals they have and to give these greater priority than the desire to use drugs and alcohol.

##### **3. Avoid Argumentation**

The counselor needs to avoid argumentation to maintain a positive therapeutic relationship with the client. However, this does not mean that the therapeutic interview follows the client's thoughts. Rather, inconsistencies are detected and used to correct judgments and beliefs. Miller and Rollnick (1991) refer to this as "soft confrontation". They also note that in many treatment settings argumentation can occur around the need to admit to having a problem. This is unnecessary at this early stage of change, and may only be recognized as a goal much later. Recall that the purpose of motivational interviewing is to prepare the client for change, to move them along the continuum so they are ready to start the change process or in some cases after a relapse, to re-start the process.

##### **4. Roll with Resistance**

It is to be expected that the offender will be resistant to change, and it is the job of the counselor in motivational interviewing to work with this resistance to find ways to reframe and redirect the resistance. Redirecting the resistance can motivate offenders to find their own solution which is the ultimate goal.

##### **5. Support Self-Efficacy**

The offender will often feel that they are unable to succeed in treatment so why bother trying. Motivational interviewing helps the offender to believe that they can change; it works with their desire to change and develops confidence that change is possible. The counselor may encourage small steps towards change to assist the offender to build on success.

Motivational interviewing is often used as an adjunct to other therapies. An offender who is in the precontemplative, or even the contemplative stage of change is not ready for a directive behavioural programme. Motivational interviewing can move them along so they better understand the need for change,

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see the value it may provide for them, and provide the belief that they have the ability to stop using drugs and alcohol if they want to. Miller and Rollnick (1991) also point out that results from an assessment process can be an effective tool during motivational interviewing. A parole office reviewing the results of objective testing can provide the offender with concrete evidence of how his or her addiction compares to that of other offenders.

The report produced by the Correctional Service Canada's Computerized Assessment of Substance Abuse (CASA) is designed to be shared with the offender for this reason. It is our intention, in the near future, to include normative data in the report, so offenders can see how their problem compares to that of other people. This approach should help to address problems of denial that are common among drug and alcohol abusers.

### **III. CORRECTIONAL SERVICE CANADA RESEARCH AND DEVELOPMENT**

#### **A. Women Offenders Substance Abuse Programme**

The Women Offenders Substance Abuse Programme (WOSAP) has been developed over two and half years and will be implemented in the women's correctional facilities in Canada in June of 2003. The programme has a number of unique characteristics that represent attempts to design a programme consistent with evidence based programme development (Hume & Grant, 2001).

First, the programme was designed through consultation with women offenders, experts in women offender treatment and operational staff at correctional facilities. Early consultations with international experts indicated the programming we had available did not adequately meet the needs of women offenders. Following a decision to develop a new programme, additional consultations were held to determine the programming model that was to be used and the structure of the programme (Hume & Grant, 2001). In its design and development, the programme was to be women-centred, not a derivation of a programme for men, and was to address the unique characteristics of women with substance abuse problems.

The second feature of the programme is that it takes account of the entire sentence. Rather than a programme that lasts for a set period of time, the programme is designed to deliver elements throughout the entire sentence, and do this in a consistent manner. While we refer to it as a single programme it is actually four programmes.

The third feature of the programme is it tries to combine two approaches to treatment that have in the past been seen as incompatible. To meet current standards of effective correctional programming the programme needed to have a cognitive behavioural component that would encourage skill development for addressing substance abuse problems. However, experts in women's programming advised that the problems of substance abuse for women are often entangled with relationship issues and if these are not addressed then it is likely the programme would not be successful. The challenge has been to combine these two approaches within one programme.

As noted above, the programme has four major components:

1. Education

The education component of the programme has 8 sessions designed to teach women about the negative effects of substance abuse on their lives, both long and short term effects, provide basic information on how to deal with triggers that cause cravings, and to motivate them to continue the process of change. It is anticipated that all women offenders will be assigned to participate in this component of the programme as almost all women offenders have a connection to the problems of substance abuse either through their own experience, or through a spouse or family member.

2. Intensive Treatment

The intensive treatment component consists of two parallel programmes one designed from a cognitive behavioural perspective and one based on relational theory. These programmes proceed in parallel so issues discussed in one part are also discussed in the other ensuring consistency of message and learning. Each programme is 20 sessions in length would

### 3. Maintenance

The maintenance component is a 20 week follow-up programme with sessions offered once per week. To ensure continuity with the community the same maintenance programme is available after offenders are released. This approach ensures there is a consistent experience in both the institution and the community. One of the major challenges we face with the programme is how to deliver the maintenance session in the community when the women participants are widely dispersed across the country.

### 4. Community Building

The community building component of the programme is designed to create an environment within the institution that promotes a drug and alcohol free lifestyle and provides support to those offenders who are trying to change their behaviour. This component has two characteristics, peer led discussion groups and institution wide activities. The peer led discussions groups have programming material available, but the participants choose the topic to be discussed each week. The community building exercises include health activities that involve correctional staff, social activities, and community activities in which individuals from outside the prison come to present information of relevance to the women.

Unfortunately, this programme has not yet been evaluated as it is too new. However, an evaluation plan has been established and we should have preliminary results within one to two years. The evaluation will address perceptions of the programme, intermediate and long term outcomes, and measures of recidivism.

## **B. Intensive Support Units**

In an effort to provide environments for offenders that will support their efforts to reduce drug and alcohol dependency, Intensive Support Units (ISU) have been established in all prisons (Grant, Varis & Lefebvre, 2004). These units are part of the regular prison environment, but they provided increased assurance that drugs are not available on the unit. Offenders wishing to live on the units must sign an agreement in which they accept increased testing for the presence of drugs and increased searching for drugs and alcohol. The staff on these units receive additional training on the problems of substance abuse and the challenges faced by offenders with an addiction. With the training, staff can provide additional support to the offenders when they experience problems.

To evaluate the effectiveness of the units, participants completed a number of surveys when they first joined the units and again when they moved to other prisons or were released. Data are not yet available on the recidivism outcomes from participants, but intermediate measures of impact of the units indicate that both staff and inmates believe the units will make a difference in their ability to stay away from drugs and alcohol, that the units will have a positive effect on their lives after release from custody and that the units have fewer drugs available. Analyses of misconduct and search data for the units indicates that there are increased searches, but few drugs found and misconduct by offenders on the units are lower than for offenders on other units (Varis, 2001).

## **C. Methadone Maintenance Treatment**

Methadone maintenance treatment has been available to offenders in the Correctional Service for a number of years. However, until recently only those offenders who had been prescribed methadone in the community could receive it in the institution. Recently, a study was conducted to compare the release outcomes of offenders who had participated in the methadone maintenance programme and a comparison group consisting of those offenders who had not participated in the methadone programme.

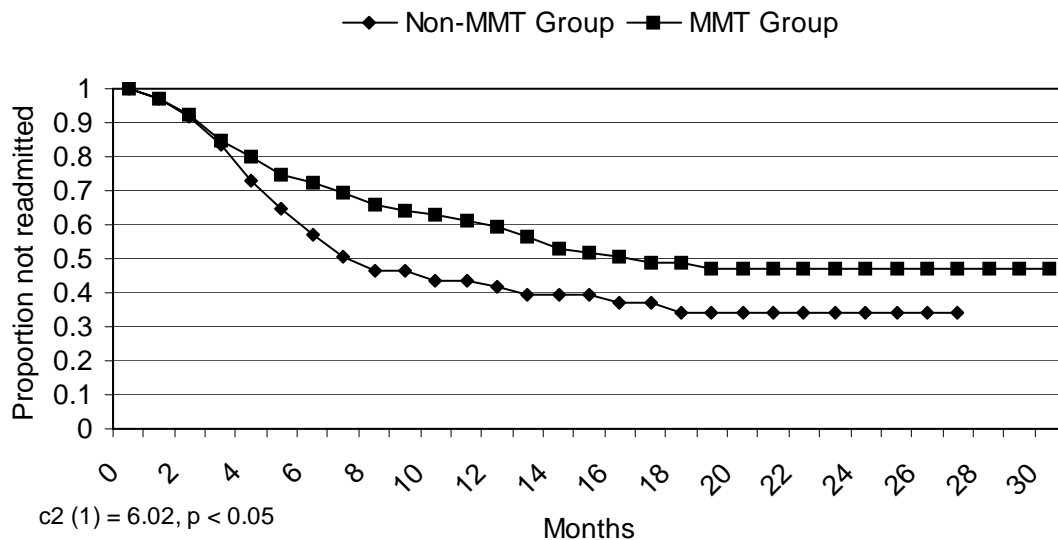
Previous research has indicated that methadone maintenance treatment can produce reductions in illicit opiate use (Marsch, 1998); reductions in other drug use (Fischer, et.al., 1999); HIV risk behaviours (Darke, Kaye & Finlay-Jones, 1998); criminal behaviour (Coid, et.al., 2000; Maddux & Desmond, 1997); and access to health care (Marsch, 1998). The purpose of this study was to determine if we could identify a reduction in criminal behaviour after release from prison for those offenders who participated in the MMT programme.

One of the challenges in research of this type is to determine who should be in the comparison group. The offenders who receive MMT are the most seriously addicted offenders and generally the most problematic. They have a high rate of recidivism so comparing them to the general population of offenders would certainly indicate the MMT had no effect. We were able, within our data systems, to identify a group

of offenders who had tested positive for opiates in random drug testing and who were identified at admission as having a substance abuse problem. This group served as a comparison for the MMT group.

The results of the study are summarized in Figure 1 in the form of a survival analysis. The survival analysis indicates that both groups had a high probability of failure in the community

**Figure 1. Survival Analysis for MMT Study: Readmission Rate**



While more than 50% of the MMT group were readmitted to prison within 24 months of their release, almost 65% of the comparison group were readmitted. The observed differences are statistically reliable. Similar results were identified when a new offence was used as the outcome measure, but the results were not statistically reliable.

#### **D. Offender Substance Abuse Pre-release Programme (OSAPP)**

The Offender Substance Abuse Pre-release Programme has been in use within the Correctional Service for more than ten years. Five years ago a study was conducted to determine how effective the programme was at reducing recidivism (T<sup>3</sup> Associates, 1999).

The programme follows a behavioural model employing cognitive behavioural techniques. Modules in the programme include alcohol and drug education, self-management, problem-solving skills, social skills, leisure and lifestyle planning and pre-release planning. In addition to the 26 structured group treatment sessions of approximately 3 hours each, the programme includes three individual sessions with facilitators. A summary of session topics are presented in Table 2.

The evaluation of the programme was based on approximately 1,600 offenders, from across the country, who completed the programme. The completion rate for the programme was 89%. Evaluation of intermediate measures indicated that participants increased their knowledge of the consequences of substance abuse, improved their understanding of how their use of substances were affected by other people, increased their ability to communicate effectively with peers about their substance abuse problem and increased their problem solving skills.

A 12 month follow-up was conducted to determine the programmes effect on recidivism. Almost 800 cases were included in the follow-up and these cases were matched to other offenders to provide a comparison group. Of those offenders who completed the programme, 42% were readmitted after one year,

compared to 49% of the comparison group. New offences were committed by 15% of the programme group and 22% of the comparison group (T<sup>3</sup> Associates, 1999).

**Figure 2. Offender Substance Abuse Pre-release Programme: Units and Sessions**

**Unit I: Introduction**

Session 1: Programme Introduction  
Session 2: Orientation and Pretesting

**Unit II: Alcohol and Drug Education**

Session 3: Alcohol & Drug Education I  
Session 4: Alcohol & Drug Education II  
Session 5: Alcohol & Drug Education III  
Session 6: Alcohol & Drug Education IV  
Session 7: Alcohol & Drug Education V

**Unit III: Self-Management Training**

Session 8: Self-Management Training  
Individual Counselling Session I  
Session 9: Understanding Your Behaviour  
Session 10: Substance Use Self-Management Skills Training  
Session 11: Problem Solving  
Session 12: Coping by Acting  
Session 13: Coping by Thinking  
Session 14: A Review of Problem Solving  
Individual Counselling Session II

**Unit IV: Social Skills Training**

Session 15: Basic Communication Skills  
Session 16: Assertion Training  
Session 17: Using Social Skills in Personal Relationships

**Unit V: Job Skills Refresher**

Session 18: Employment Readiness  
Session 19: Job Finding Skills

**Unit VI: Leisure and Lifestyle**

Session 20: Leisure and Lifestyle

**Unit VII: Pre-Release Planning**

Session 21: Pre-Release Planning Exercise  
Session 22: Pre-Release Planning (Cont'd)

**Unit VIII: Relapse Prevention and Management**

Session 23: Relapse Prevention  
Session 24: Relapse Management

**Unit IX: Post Testing and Graduation**

Session 25: Programme Review and Post-Testing  
Session 26: Graduation  
Individual Counselling Session III  
Maintenance

Additional results indicate that the combination of the programme with other interventions such as the Correctional Service's Choices programme offered in the community and participation in self-help programmes decreased the recidivism rate further.



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**E. Computerized Assessment of Substance Abuse (CASA)**

The Computerized Assessment of Substance Abuse is a computerized assessment system provides an assessment of substance abuse severity for both drugs and alcohol, along with measures of the link between substance abusing behaviour and criminal activities. The system provides a written report to the parole officer and this can be shared with the offender. Results of the assessment are used to determine the level of programming required by the offender.

The system incorporates a number of unique features that improve its functionality within the correctional environment. Literacy is often a challenge with assessment systems but in addition to presenting the questions in text form, offenders have the option of having the questions read to them along with the possible responses.

The system also incorporates the Paulhus Deception Scale (Paulhus, 1999) that provides information on the likelihood that an offender is answering in a manner designed to enhance his image, that is, is responding untruthfully. The Paulhus Deception scale provides measures of Impression Management and Self-deception Enhancement.

The system is also designed to be time efficient, so questions that do not apply to an offender are not asked. If at the beginning of the assessment an offender indicates he or she has never consumed alcohol the alcohol questions will not be asked. However, later in the assessment another question will be asked about alcohol use, but in a slightly different way. If they respond positively the second time they are asked all of the alcohol questions.

One additional feature that was added to the system during the testing phase is a brief tracking game that provides the offender with the opportunity to practice mouse skills. Some offenders may be unfamiliar with using a computer mouse so the game was designed to give them practice tracking a bouncing ball on the computer screen. After the practice session they are ready to proceed to the test.

Results from the testing are available immediately to the parole officers, but they are also stored in a data file that is sent electronically to the Addictions Research Centre each month. These data are available for analysis to develop profiles of offenders and other research activities. Data from the early version of the system have been shared with external researchers who have used the information to determine the costs of crime associated with drug use (Pernanen, Cousineau, Brochu & Sun, 2002).

**F. International Experts Forum**

The International Experts Forum was held in May 2002 and brought together 150 researchers, academics and clinicians from across Canada and 10 other countries. The goal of the Forum was to develop priorities for research and development in substance abuse for corrections. While the initial hope had been to develop specific projects that could be worked on together in a collaborative manner, this proved to be an impossible task. There was too much information to share about current research activities and research needs were too varied to identify specific projects. The participants identified two broad issues, the need for collaboration and the need for additional research and development. For each of these, three themes emerged as presented in Table 1. For each of the themes specific project ideas were also identified.

**Table 1. Priorities for Research and Development in Substance Abuse and Corrections**

<b>Need for Collaboration</b>
(i) Provide opportunities for dialogue, networking and collaboration
(ii) Communicate relevant and timely research results to a range of audiences
(iii) Create a climate to foster dialogue that acknowledges and challenges existing ideologies and practices
<b>Research and Development</b>
(iv) Research on the effectiveness of existing and emerging correctional models and interventions
(v) Respond to the differing needs of offender populations including gender, culture/ethnicity, and age, as well as issues related to mental & physical health
(vi) Research on the impact of correctional cultures and environments on treatment models and regimes

The proceedings of the Forum and the summary of the priority setting exercises that were undertaken at the Forum are due for publication within the next two months (Grant, Hume & Kunic, 2004).

#### IV. SUMMARY AND CONCLUSIONS

A number of approaches to treating offenders with substance abuse problems have been reviewed and discussed. Overall, the most important approach is that of harm reduction that seeks to reduce the harms that substance abuse causes to individuals and to communities. Using a harm reduction approach, criminal justice agencies can work to reduce the impact of substance abuse on our communities. Samples of research studies were presented to highlight various methodological issues and to demonstrate the integration of research and programme development within a correctional system.

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# THAI COMMUNITY-BASED CORRECTIONAL PROGRAMMES FOR NARCOTICS ADDICTS IN RESPONSE TO THE 2002 REHABILITATION ACT: A SYSTEM APPROACH

*Decha Sungkawan, Ph.D.\**



## I. OVERVIEW OF THE CURRENT SITUATION OF ILLICIT DRUGS AND NARCOTICS ADDICTION IN THAILAND

Drug abusing has been listed as one of the most serious social problems in Thai society for decades. Since the country listed opium as one of the illicit drugs in the middle of the last century, Thailand has faced problems of drug abuse among its population with many other illicit drugs. The recent official reports on illicit drugs in Thailand always include the following major illicit drugs:

1. Methamphetamine is currently reported as the most serious illicit drug in terms of amount of supply and number of abusers in the population. During 1998-2002 there was a large amount of methamphetamine that had been illegally trafficked into the country from the neighbouring countries together with some domestically produced that was to be distributed in Thailand. The number of official arrests for methamphetamine and the quantity of this type of illicit drug have increased drastically in recent years as shown in Table 1.

**Table 1. Number of Arrests and the Quantity of Methamphetamine Seized for the Whole Country**

Year	Number of arrests	Weight of drug seized (Kilograms)	Tablets (millions)
1998	130,689	3,012	33.5
1999	147,789	4,518	50.2
2000	149,827	7,422	82.4
2001	152,773	8,441	93.7
2002*	75,071	5,969	66.3

\* Compiled on 4<sup>th</sup> October and the figures shown for the period of January-September only

2. The demand for heroine in Thailand has decreased recently as it has been replaced by other types of illicit drugs, particularly methamphetamine. Since 1999 there is evidence for the proposition that there is no heroine produced domestically in Thailand. Most of the supply of heroine that is available is from outside the country. The epidemic of heroine has been drastically reduced due to a change in demand among the users as methamphetamine gains the advantage over heroine in both accessibility and cost. The number of official arrests for heroine thus also decreased as shown in Table 2.

**Table 2. Number of Arrests and the Quantity of Heroine Seized for the Whole Country**

Year	Number of arrests	Weight of drugs seized (Kilograms)
1998	13,858	541
1999	7,538	405
2000	4,184	386
2001	3,062	475
2002*	1,136	514

\* Compiled on 4<sup>th</sup> October and the figures shown for the period of January-September only

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3. Opium is found to be used mostly among the members of hill tribe minorities who live along the borders of the country. Although the area for opium cultivation was vastly reduced from 54,860 Rai in 1984 to 6,897 Rai in 2001, the opium plantations are still found in remote areas in eleven northern provinces and one northeastern province of Thailand. Similar to the situation of heroine, the number of official arrests for opium has been decreasing, as shown in Table 3.

**Table 3. Number of Arrests and the Quantity of Opium Seized for the Whole Country**

Year	Number of arrests	Weight of drugs seized (Kilograms)
1998	3,834	1,783
1999	3,014	2,046
2000	2,440	1,595
2001	2,188	2,319
2002*	1,077	3,573

\* Compiled on 4<sup>th</sup> October and the figures shown for the period of January-September only

4. Cannabis Sativa or marihuana that flows in Thailand could be either domestic product or a trafficked drug item from the neighbouring countries. Cannabis could be cultivated in any part of Thailand but the major cultivation area is concentrated in the northeastern region. Cultivation of cannabis in Thailand is mainly for domestic usage with some for export. The epidemic and demand for cannabis in Thailand has decreased as the usage of methamphetamine is on the rise among drug addicts. The number of official arrests and the quantity of cannabis seized are shown in Table 4.

**Table 4. Number of Arrests and the Quantity of Dry Cannabis Seized for the Whole Country**

Year	Number of arrests	Weight of drugs seized (Tons)
1998	25,714	5.88
1999	22,156	14.68
2000	19,312	10.32
2001	15,294	11.30
2002*	7,727	6.8

\* Compiled on 4<sup>th</sup> October and the figures shown for the period of January-September only

5. Glues and Solvents are restricted and controlled by law for limited industrial uses but somehow they are widely abused by numbers of young addicts in Thailand. Glues and solvents are particularly used among youngsters, mostly from the lower and working class families that lack parental supervision. The epidemic of glues and solvents among young addicts is evident in every part of the country, particularly in the urban areas. The number of official arrests and the quantity of glues and solvents seized are shown in Table 5.

**Table 5. Number of Official Arrests and the Quantity of Glues and Solvents Seized for the Whole Country**

Year	Number of arrests	Weight of seized glues and solvents (Kilograms)
1998	17,983	599
1999	16,929	4,141
2000	12,450	453
2001	10,240	357
2002*	6,149	217

\* Compiled on 4<sup>th</sup> October and the figures shown for the period of January-September only

6. Ecstasy is an illicit drug that has been trafficked from overseas and used among specific groups, particularly the urban young and teenagers. Ecstasy is usually used among the young middle class customers as they seek pleasure while attending the entertainment establishments in urban areas. The number of official arrests and the quantity of ecstasy seized are shown in Table 6.

**Table 6. Number of Official Arrests and the Quantity of Ecstasy Seized for the Whole Country**

Year	Number of arrests	Weight of ecstasy seized (Tablets)
1998	115	5,919
1999	182	21,794
2000	365	72,177
2001	316	67,120
2002*	206	58,373

\* Compiled on 4<sup>th</sup> October and the figures shown for the period of January-September only

7. Cocaine was recently introduced into the country by tourists and the affluent class members who have experienced the drug overseas. Due to the high market price, as it is an imported drug item, cocaine is used mainly among limited numbers who can afford to pay for the drug. Similar to ecstasy, cocaine is used as a pleasure stimulant among entertainment establishment customers. Although the amount of cocaine seized from arrests is low the number of users is on the rise. The number of official arrests and the quantity of cocaine seized are shown in Table 7.

**Table 7. Number of Official Arrests and the Quantity of Cocaine Seized for the Whole Country**

Year	Number of arrests	Weight of cocaine seized (Kilograms)
1998	22	3.56
1999	16	0.61
2000	16	4.00
2001	14	4.62
2002*	16	7.99

\* Compiled on 4<sup>th</sup> October and the figures shown for the period of January-September only

8. There are some other types of illicit drugs that are found to be used among specific groups in Thailand for instance; Ketamine - a medical substance that is reprocessed into a drug and used among specific groups, Codeine - a cough mix syrup is found to be used among young Muslims in the southern provinces who are prohibited by religion from alcohol consumption.

## II. MAGNITUDE AND DISTRIBUTION OF NARCOTICS' ADDICTS

It is complicated to figure out the total number of addicted people in a society, however, there are different ways to estimate the number of addicts in a population. Based on a study conducted concurrently with the National Household Survey of 2000-2001 by the Office of the Narcotics Control Board with the collaboration of researchers from various educational institutions, the approximate number of drug addicts in Thailand could be estimated from the potential drug using population aged between 12 to 65 years old or 44 millions. The study covers the sampling of 39,000 from 40 provinces in every region around the country. Types of drugs included in the study were; methamphetamine, heroine, opium, cannabis sativa, hemp, glues and solvents, ecstasy, cocaine, and ketamine. The magnitude of drug addicted persons for the whole country was estimated as follows:

1. Approximately 7 million or 16 per cent of the potential drug using population (44millions) had experienced drug using;
2. Approximately 1.9 million or 4.3 per cent of the potential drug using population (44 million) had been using drugs within the last year;

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3. Approximately 1 million (998,700) or 2.2 per cent of the potential drug using population (44 million) had been using drugs within the last 30 days;
4. The population that had been using drugs within the last 30 days (approximately 1 million) differs by region in the addiction rate (number of drug addicted persons per 1000 population) accordingly;
  - a) Bangkok Metropolitan: estimated number of potential drug using population is 40,400 or 10 persons per 1000.
  - b) Greater Bangkok areas: estimated number of potential drug using population is 43,100 or 24 persons per 1000.
  - c) Northern Region: estimated number of potential drug using population is 64,600 or 7 persons per 1000.
  - d) Central Region: estimated number of potential drug using population is 82,600 or 10 persons per 1000.
  - e) Northeastern Region: estimated number of potential drug using population is 486,900 or 30 persons per 1000.
  - f) Southern Region: estimated number of potential drug using population is 281,1000 or 49 persons per 1000.

Types of drugs used among 1.9 million (4.3 per cent of the potential drug using population or 44 millions) who have declared using drugs within the last year were estimated as follows:

- a) Number of methamphetamine users is 1,092,500 or 2.4 per cent of the potential drug using population
- b) Number of cannabis sativa users is 667,200 or 1.5 per cent of the potential drug using population
- c) Number of hemp users is 643,800 or 1.4 per cent of the potential drug using population
- d) Number of glues and solvents users is 199,700 or 0.5 per cent of the potential drug using population
- e) Number of ecstasy users is 46,500 or 0.1 per cent of the potential drug using population
- f) Number of opium users is 38,600 or 0.1 per cent of the potential drug using population
- g) Number of heroine users is 22,700 or 0.1 per cent of the potential drug using population
- h) Number of ketamine users is 7,200 or 0.02 per cent of the potential drug using population
- i) Number of cocaine users is 4,900 or 0.01 per cent of the potential drug using population

### III. PROBLEMS OF NARCOTICS WITH REFERENCE TO THE CRIMINAL JUSTICE SYSTEM

According to Thai law, all activities dealing with illicit drugs, from consumption, possession, trafficking, as well as contributing are considered crimes. Drug offences are a major criminal activity in every criminal justice agency. The recent general drug offence statistics show a large amount of drug offence cases together with a large number of offenders.

**Table 8. Number of General Drug Offence Arrested and Number of Offenders for the Whole Country**

Year	Number of drug offences	Number of offenders
1999	206,170	223,294
2000	222,498	238,153
2001	205,375	218,166
2002	176,480	186,545
2003*	5,024	5,490

\* Compiled on 5<sup>th</sup> March and the figures shown for the period of January-February only

The arrested drug offences deal with all major types of narcotics available in the country. In recent years, different types of narcotics show their trends differently in terms of arrest incidents and quantity seized. While heroine and opium cases are shrinking, methamphetamine cases show an all time high since it was criminalized in 1996. The number of drug offences by type of drug is shown in Table 9. The quantity of major drugs seized for the same period is shown in Table 10.

**Table 9. Number of Drug Offences by Major Types of Drugs for the Whole Country from 1999-2000**

Year	Methamphetamine	Cannabis	Glues	Heroin	Opium	Ecstasy
1999	154,028	22,720	17,004	7,872	3,022	183
2000	180,287	19,890	13,107	4,926	2,466	374
2001	167,173	20,461	10,640	3,461	2,284	378
2002	142,761	14,563	12,938	2,170	1,891	484
2003*	4,033	388	420	35	88	20

\* Compiled on 5<sup>th</sup> March and the figures shown for the period of January-February only

**Table 10. Quantity of the Major Types of Drug Seized in Kilograms for the Whole Country**

Year	Amphetamine	Cannabis	Glues	Heroin	Opium	Ecstasy
1999	4,518	14,684	4,141	404	2,046	5
2000	7,549	10,323	455	384	1,595	18
2001	8,459	10,921	360	474	2,289	17
2002	8,627	12,095	453	634	4,034	37
2003*	1,474	669	16	40	9,684	14

\* Compiled on 5<sup>th</sup> March and the figures shown for the period of January-February only

Most of the investigated drug offences are processed at the prosecution office for prosecuting in the criminal court. Drug offences were prosecuted in the criminal court, juvenile court, and military court, shown in Table 11, 12, and 13 accordingly;

**Table 11. Number of Drug Offences Processed by Prosecution Offices and Criminal Courts\***

Year	No. of investigated cases		No. of cases prosecuted in court	
	Case	Offender	Case	Offender
2000	238,343	256,647	237,882	254,847
2001	247,254	264,126	246,261	262,855
Differ.	+ 8,911	+ 7,439	+ 8,379	+ 8,008

\* Source: Bureau of Prosecution

**Table 12. Number of Drug Offences Processed by the Juvenile Courts\***

Year	No. of cases on trial	No. of cases sentenced
2000	17,937	19,160
2001	14,270	n.a.
Differ.	- 3,667	

\* Source: Judicial Information Centre, Ministry of Justice

**Table 13. Number of Drug Offences Processed by the Military Courts\***

Year	No. of cases on trial	No. of cases sentenced
2000	1,372	1,154
2001	1,483	1,371
Differ.	+ 111	+ 217

\* Source: Bureau of Military Judiciary, Ministry of Defense



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The majority of drug offenders who are sentenced receive imprisonment and a few receive the death penalty. Drug offenders are the highest in number when compared to other types of offences in prison as well as in juvenile institutions. The number of drug offenders in correctional institutions and juvenile institutions are shown in Table 14 and 15 accordingly:

**Table 14. Number of Drug Offenders in the Correctional Institutions for the Whole Country\***

Year	Number of male offenders	Number of female offenders	Total
2000	66,210	22,256	88,466
2001	74,316	26,390	100,706
Differ.	+8,106	+4,134	+12,240

\* Source: Planning Division, Department of Corrections

**Table 15. Number of Drug Offenders in the Juvenile Institutions for the Whole Country\***

Year	Number of male offenders	Number of female offenders	Total
2000	17,901	1,842	19,743
2001	12,014	1,429	13,443
Differ.	- 5,887	- 413	- 6,300

\* Source: Central Juvenile Institution, Ministry of Justice

#### IV. THE CURRENT DRUG CONTROL POLICY

##### A. Policy Initiatives

The present Thai government has declared war on drugs and set drug control policy as one of its priorities. The government's drug control policy has put prevention measures over suppression measures and the need for narcotics addicts to receive effective medical rehabilitation while drug traffickers will face severe punishment. With this policy guideline, the government has called for a specific strategy in order to succeed with these mandated goals. This specific strategy was announced by the government as "*Ruam Palang Pandin*" which literally means the strategy of strengthening national integrity to fight drug problems. The strategy is well integrated into the 9<sup>th</sup> National Economic and Social Development Plan (2002-2006) where human resources are considered central among the other important elements for development. Due to this strategy, attacking drug problems either by prevention, suppression, or rehabilitation measures will take place and centre around the community. Thus, the community is considered as an operational unit for the war against drugs and the community members have to be involved as an essential part of the strategy. The government clearly specifies that the policy and strategy involve all public and private entities to participate in the mission but the central coordinate body for the scheme is the Ministry of Interior, the public office that holds community networks throughout the country. The strategic planning for tackling drug problems has been implemented by the following steps:

1. The villages and the community are the operational units to fight drug problems in all the measures designed; drug prevention for particular potential groups such as teenagers, the suppression of the drug supply through strong pressure on the local drug traffickers and street level drug dealers, and drug rehabilitation for those narcotics addicts in the locality. The above measures are operated together with strengthening the village and community infrastructure that supports the stability of the village, community, and society as a whole.
2. Focus on coordinating and uniting the operating organizations involved in every stage in implementing the plan. An implementation budget has been allocated to every province that is required to operate the plan to be effected directly to every target group at the village and community levels.
3. Set integrative policy implementation on drug prevention and problem solving at the local level by the following process:

- a) Awareness raising among the youngsters in the village and community on problems concerned with drug using.
- b) Re-conceptualization of drug addicts among community members that drug addicts, who were usually considered as a burden to their family members as well as to the community, actually are potential members of the community who need effective drug rehabilitation programmes.
- c) Surveillance of former drug addicts who have been rehabilitated is expected to be conducted by the local volunteers who take their responsibilities on behavioural control of the former drug addicts with a social and cultural approach.
- d) Career and income development is an essential part of the rehabilitation process as most drug addicts lack life and career skills before entering into addiction.
- e) Enforcing law and social order as well as social and community organization to create a social environment that discourages drug using; particularly the young and other potential drug addicts groups.

### **B. Local Operating Units for Drug Suppression and Prevention Measures**

The Prime Ministerial Order 119/2544 dated 31 May 2001 has directed concrete guidelines for the strategy in the war on drugs policy. The Order has assigned the provincial, district, and sub-district offices that are staffed with the different levels of the government officers to set up an “Operating Centre to Win the War on Drugs” as the operating units to fight with drug problems in their responsive areas.

According to the order, the government officials at the local “Operating Centres” have to be responsible for the following duties on drug suppression and prevention measures:

- a) Continuously survey and compile drug information that includes drug using as well as drug trafficking in their areas and make ready to use the report for suppression and prevention measures to their higher level offices.
- b) Launch suitable operating plans of drug suppression and prevention for their local areas by focusing on participatory and integrating principles that involve all entities in the areas.
- c) Direct and unite all public officers in the areas to work with other parts of the community in order to achieve the effective government drug control policy.
- d) Appoint the committees, the working committees, or the individuals to facilitate the policy with specific drug control measures.

### **C. Guidelines for the Operating Centres**

The operating centres also have a coordinating role for the various units that are working on their parts in fighting with drug problems in their responsive areas. The coordinating functions of the centres could be roughly divided into three different major measures.

#### **1. Protection and Drug Prevention Measures**

The drug control policy requires the protection of the potential demand groups and general population from drug consumption as its priority. This measure differentiates the potential groups into two different age-groups:

- a) The general population is protected from drug problems through these following measures: to strengthen the communities and their networks to fight with drug problems in the areas, to develop the civil society process among individuals and groups in the community, to raise awareness of drug problems among the community members, to unite the potential forces from all sectors to fight against drug problems, to empower the civil societies, groups, as well as community members, to expand the roles of community and civil society to both preventive and suppressive measures in fighting drug problems, and to follow up closely on the results of the drug control policy.
- b) Youth and adolescent groups are protected from drug problems by the collaboration among the involved agencies; the Ministry of Education, the Ministry of Social Development and Human Securities, the Ministry of Labor, the Ministry of Tourism and Sports, and the various local agencies under the Ministry of Interior. These responsive government agencies are expected to support the drug control policy through various measures including; to create social forces among youth and adolescent groups to fight existing drug problems, to develop immune systems to protect and prevent

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adolescent and youth groups from drug problems, to strengthen family and community networks to protect and prevent young people and adolescents from drug using, to reduce the causal factors and conditions that encourage drug problems in the local areas, to develop and promote discouraging conditions and factors such as sports and leisure activities for preventing drug using among the young, to encourage non-government and private sectors as well as the community to participate in drug prevention and protection measures.

2. Suppression or Supply Reduction Measures

Drug suppression measures have been viewed primarily as the responsibilities of the police and the Narcotics Control Board Office. However, according to the new drug control policy, the government believes suppression measures are the responsibility of all parties, both public as well as private sectors. Every local drug control operating centre is required by the government to actively participate and support illicit drug control, law and order, cracking down on drug trafficking, as well as forfeiture of assets activities. The drug control operating centres are assigned to be the information agencies for drug control activities in the communities with these following activities:

- a) To facilitate the community members so that they can secretly inform on drug trafficking and drugs use in their communities through various means such as a P.O. Box, hotline service, or in the form of written mail.
- b) To compile a name list of the individuals and groups of drug traffickers, the drug links and the public officers who are involved with illicit drug business in the whole area at different local levels.
- c) To set the area operating plans that continuously pressure, investigate, arrest, and search suspected individuals, and groups that are involved with drugs.

3. Rehabilitation or Demand Reduction Measures

Drug consumption by drug users and drug addicts makes up the majority of drug demand. Thus, the effective drug rehabilitation programmes would automatically reduce the demand for drugs in the market. Drug rehabilitation programmes for drug users and drug addicts currently are classified into three different systems:

- a) Volunteer-based treatment system that is open for drug users and drug addicts to access the rehabilitation programmes without having committed a drug using offence at the drug rehabilitation centres provided by the Ministry of Public Health and other private agencies. There are 723 rehabilitation centres throughout the country providing drug treatment services by the following steps:
  1. Searching for drug users and drug addicts in the local areas using a basic survey form.
  2. Classifying the target groups into different types of drug consumption such as a potential or risk group, a drug using group, and a drug addict group by the local health care volunteers and officers.
  3. Setting up drug treatment and rehabilitation centres in the local area out of the existing establishments such as barracks, National Guard units, Boy Scout camps, temples, and schools.
  4. Treatment process that includes physical exercise and therapy, disciplinary training, detoxification, and psycho-social therapy that involve all concerned parties, professionals, volunteers, as well as family members of drug users. Career training programmes are also provided for those who need to work after the rehabilitation process.
  5. Aftercare, follow up, and surveillance of those who have gone through the treatment programme by the volunteers and the community members. The voluntary-based treatment system may readmit the former patients who fail to maintain a drug-free life after treatment.
- b) Coercive treatment system under the Narcotics Addict Rehabilitation Act B.E. 2545 that allows those who are arrested for drug taking and drug possession for use offences to get into the drug treatment programme with no penalty at the treatment centres set up by the Act. The coercive treatment includes the following steps:
  1. Searching for drug users and drug addicts by community members and urging them to use the voluntary drug treatment system. However, those drug users and drug addicts who refuse to join the voluntary-based treatment programme may be coerced to join the coercive treatment system by the Act.

2. Diagnosis of drug consumption for those who are arrested by the sub-committee on drug rehabilitation as either drug users or drug addicts.
  3. The sub-committee on drug rehabilitation orders drug users and drug addicts to take the treatment and rehabilitation programmes either with or without physical confinement.
  4. Aftercare, follow up, and surveillance of those who have gone through the treatment programme by the volunteers and the community members. Those who fail to maintain a drug free life after rehabilitation will be sent into the criminal procedure and receive a penalty. After serving their penalty, the ex-drug users or drug addicts may apply for the voluntary treatment system under supervision of volunteers or community members.
- c) Institutional Treatment Programmes. Those who are in the correctional or juvenile institutions may attend the drug treatment programmes provided for them in such institutions and after they are released from the institutions they have to report to the operating units in their local areas.

## **V. THE NARCOTICS ADDICT REHABILITATION ACT B.E. 2545 (2002)**

Since the promulgation of the law to prohibit opium usage in the last Century, there are a number of drug control laws in Thailand. The Narcotics Addict Rehabilitation Act B.E. 2545 is the first major piece of law on drug control that has been passed in the 21<sup>st</sup> Century. The previous Drug Addict Rehabilitation Act B.E. 2534 (1991) has been abolished as there are some enforcing elements that go against the principle of rights protection in the current constitution law. The new Rehabilitation Act is considered to be the first piece of law that addresses the direction to conditional decriminalization of drug users in Thai society.

### **A. The Act has been Passed with the Following Major Principles**

1. The Act complies to the principles of right and liberty protection of the individual that is in the Constitutional Law B.E. 2540 (1997).
2. The Act sets a new paradigm on drug users who were always considered as criminals in Thai society but now are considered to be sick persons with health problems that need to be cured and rehabilitated with proper medical, social and psychological treatment.
3. The Act introduces the diversion process into the criminal justice procedure with the suspension of prosecution measure for the offences of drug using and drug possession for using.
4. The Act provides the person with a right to appeal the command of the officials on the identification of drug consumption and drug rehabilitation such as the right to appeal the other administrative orders.
5. The Act extend the rehabilitative procedure to cover these following drug offences:
  - a) Drug users with a small amount of drugs in their possession
  - b) Drug users with a small amount of drugs in their possession and for sale
  - c) Drug users with a small amount of drugs for sale.
6. The Act extends the authorized establishments for drug consumption identification and drug rehabilitation under the Ministry of Justice to some other agencies.

### **B. The Act Covers a Number of Responsive Bodies Including the Following Individuals, Commission and Committee**

1. The Minister of Justice.
2. The Narcotics Addict Rehabilitation Commission that is chaired by the permanent secretary of the Ministry of Justice.
3. The provincial sub-committees of the narcotics addict rehabilitation in each province that are appointed by the Commission and these sub-committees are chaired by the public prosecutors as the representatives of the Ministry of Justice in the province.
4. The investigation officers.
5. The public prosecutors.
6. The judicial officers.
7. The directors of the Narcotics Addict Rehabilitation Centres.
8. The probation officers.
9. The other officers who are assigned to enforce the Act.

### **C. The Act Contains the Following Rehabilitation Processes**

#### **1. The Investigation Process**

The investigation of those who have been arrested for the drug offences that have been mentioned above, the investigation officers are responsible for taking the offenders to court within 48 hours and 24 hours in the case of juvenile offenders for the court order to identify the drug consumption and drug addiction of the offenders.

The courts order the offenders to be sent to the Narcotics Addict Rehabilitation Centres for drug using and drug addiction identification and inform the sub-committee of the narcotics addict rehabilitation in the areas. While the offenders are under confinement at the Narcotics Addict Rehabilitation Centres for drug consumption and drug addiction identification, the investigation officers are responsible for continuing the investigation process of the offence by submitting the investigation reports to the public prosecutors office with the information on the confinement of the offenders in the Narcotics Addict Rehabilitation Centres.

#### **2. Drug Consumption and Drug Addiction Identification Process**

By order of the court, the provincial sub-committee of the narcotics addict rehabilitation is responsible for identifying whether the offender is either a drug user or drug addict. The sub-committee has to investigate the biological, socio-economic background as well as the offensive behaviour of the offenders within 15 days after the offenders are referred by the court. For those offenders who are identified by the sub-committee as drug users or drug addicts, the treatment plans for them have to be drawn up by the sub-committee and the report forwarded to the public prosecutors for the consideration of suspension of prosecution. For those offenders who are identified as neither drug users nor drug addicts, the sub-committee has to refer them back to the police officers or public prosecutors with the report for further consideration of the cases.

#### **3. Drug Treatment and Rehabilitation Process**

For those who are identified as drug users or drug addicts; they are assigned to take the treatment programmes according to the treatment plans at the narcotics addict rehabilitation centre for a period of 6 months. The treatment period of 6 months could be extended for those who the sub-committee believe need more treatment. However, the extension of the treatment period should not exceed a total treatment period of 3 years.

Those who escape from the treatment centre during their treatment plan period will be considered escaping from officials' custody as indicated in the penal code.

If the sub-committee is satisfied with the treatment results of those who have gone through the drug treatment programmes, they will be released without being charged for the drug offence. The results of the cases are reported to the investigation and public prosecution officers. Those with unsatisfactory treatment results by the sub-committee will be referred back for further consideration to be prosecuted by the public prosecutors.

#### **4. Right to Appeal**

Those offenders who are not satisfied with the identification of drug consumption and drug addiction by the sub-committee retain their right to appeal such identification to the Narcotics Addict Rehabilitation Commission within 14 days after the notice of the identification. The identification of the appeal cases are finalized by the Commission.

#### **5. The Suspension of Prosecution and Adjudication Processes**

As the public prosecutors receive the identification results of drug consumption and drug addiction by the offender, the case will further depend on the identification results accordingly:

- a) For those offenders who are identified by the sub-committee as drug users or drug addicts, the public prosecutors have to call for an order of suspension of prosecution of the cases until they receive the results of the drug treatment of the cases from the sub-committee on the narcotics addict rehabilitation.

- b) For those offenders who are identified as neither drug users nor drug addicts, the public prosecutors have to forward the cases to be prosecuted to the court.
- c) For those offenders who are specified as non-eligible to be treated under the Narcotics Addict Rehabilitation Act they will be prosecuted by the public prosecution officers and the sub-committee will be informed of the decision on the cases.
- d) For those who have gone through the treatment plan and the sub-committee deems their results unsatisfactory they will be prosecuted by the public prosecution officers.

#### **D. Penalties**

The facts and document records and other personal information that are obtained and used as evidence for the offences under this Act will be protected and are not to be disclosed by any persons involved with the case. A person who discloses such information will be liable for penalties. The disclosure of such information is permitted only for the following reasons:

- a) disclosure of information by the duties of the authorized officers
- b) disclosure of information in investigation and adjudication processes
- c) disclosure of information that is permitted by the Narcotics Addict Rehabilitation Commission or by the sub-committee on narcotics addict rehabilitation.

Those who do not comply with the authorized officers or the Commission's orders will be prosecuted and penalized with imprisonment or a fine.

### **VI. THE COMMUNITY-BASED CORRECTIONAL PROGRAMMES FOR NARCOTICS ADDICTS**

The Narcotics Addict Rehabilitation Act B.E.2545 (2002) contains the principle of decriminalization of drug offences that compose the majority of the offences in the current Thai criminal justice system. The enforcement of the Act is expected to bring down the number of criminal offences from the whole system from the investigative agencies to the correctional institutions. The Act contains the principles to avoid imprisonment measures that were previously applied for such offences. The Act introduces the new diversion programmes for the criminal justice system by encouraging the de-institutionalization process for those offenders who are covered by the Act. It is expected that the Act will be an effective measure for the re-direction of the majority of drug offences in Thai society with the principle of the community-based correctional programmes for drug users and drug addicts who would otherwise be prosecuted and imprisoned without the Act. The community-based correctional programmes that are effective according to the Act may be considered in different degrees and levels.

The community-based correctional programmes for narcotics addicts under this Act can be viewed from these following perspectives:

First, the Act has toned down the criminality of the drug users and drug addicts by changing the public's perception of drug addicts from criminal offenders to persons with sickness that need health care services.

Second, at the beginning of drug treatment and rehabilitation according to the Act, the process focuses on the role of the communities in searching for and noticing suspected persons with drug problems in their communities.

Third, the Act has transferred the major decisions of the drug offences from the criminal justice agencies to the Narcotics Addict Rehabilitation Commission that comprises of a number of parties concerned with the process of community-based correctional drug rehabilitation programmes. The Commission is chaired by the Permanent Secretary of the Ministry of Justice. The high authorities from the Ministries of Education, Public Health, Labor, Interior, Social Development and Human Security, and the Supreme Commanders of all the Defense Forces, Commander of National Police Force, Supreme Public Prosecutor, Secretary- General of the Office of Justice Court, Secretary- General of the Narcotics Control Board, Secretary- General of Food and Drug Board, four other qualified experts are members of the Commission and the Director- General of the Department of Probation is a member and Secretary of the Commission.

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Fourth, although the Narcotics Addict Rehabilitation Commission is responsible for the enforcement of the Act, its responsibility lies at the national level. The enforcement of the Act actually lies with the decision making of the sub-committees on the narcotics addict rehabilitation who are appointed at the local level in each province.

Fifth, although the sub-committee members are appointed from the official authorities in the local areas and chaired by the provincial public prosecutor, the inter-professional team; the psychiatrist or physicist, psychologist, social worker, and two qualified experts are the members of the sub-committee. The legal status of the sub-committee is a quasi-judicial unit and responsible only for cases assigned by the Act. However, the decisions of the sub-committee will be treated as an administrative order where the offenders obtain the right to appeal to the authority at the higher level.

The community-based correctional programmes for the narcotics addict rehabilitative function of the sub-committees under the Narcotics Addict Rehabilitation Act at the local areas can be demonstrated accordingly:

The sub-committee could make the decision on the compulsory treatment plan for those offenders who are identified as drug users or drug addicts to be treated and rehabilitated into two different plans:

### **A. The Coercive Treatment Plan**

Within the confinement facilities the coercive treatment plans are classified into two different degrees of physical control; intensive physical control and less intensive physical control.

#### **1. The Intensive Physical Control Plan**

There are two different methods usually used in the intensive physical control plan; the therapeutic community which has been imported and practiced with numbers of drug addicts particularly in confinement institutions, such as in the correctional institutions. The other method is the *Jirasa* method that has recently been developed and used in the local areas.

The treatment programmes in the intensive physical control plan normally take at least 4 months in duration. The treatment locations for the intensive physical control plan will take place in the Narcotics Addict Rehabilitation Centres that are established under the supervision of the Department of Probation and the Air Force physical confinement drug treatment camps that are located in 13 areas throughout the country.

#### **2. The less Intensive Physical Control Plan**

This plan normally uses the FAST treatment model with 4 months of treatment. The treatment location for the less intensive physical control will take place at 8 Army drug treatment camps, 3 Navy drug treatment camps, and 10 drug treatment camps of the national volunteer defense force that have been located in different areas throughout the country.

### **B. The Voluntary Basis Treatment Plan**

The Voluntary Basis Treatment Plan without physical confinement for those who are identified as either drug users or drug addicts. The treatment methods for the drug addicts may be therapeutic community or FAST model for the in-patient addicts. The psychosocial therapeutic method or Matrix programme and Methadone maintenance may be used for the out-patient addicts.

The duration of the treatment for drug addicts varies from 4 to 6 months. The location for the treatment of drug addicts may be any public or private hospital around the country, public and private drug rehabilitation facilities, the community centres as well as the Buddhist temples that offer such services.

For those who are identified as drug addicts or drug users who are assigned to the treatment plans under both the intensive and less intensive physical control and those who are identified as drug addicts and are assigned to take the treatment plan without physical confinement are required to attend the activities arranged for behaviour adjusting at the facilities provided by the Department of Probation in the community for two months. Such activities may include group counselling, social support group activities, for instance the urine test group, life skills development programmes such as vocational training, head start career programme, educational and occupational loan, and the social service programmes. The Department of

Probation and the community will provide the facilities for behaviour adjusting in the communities. The process of all the above treatment plans are followed up by the local volunteers such as volunteer probation officers, National Guard volunteers, community health care volunteers, and other volunteers in the local areas.

Those who are identified as drug users may receive one of these following treatment methods: A training programme for drug abstaining, attend a rehabilitative camp, attend a community day treatment programme, attend life skills and career development programmes, or attend community service programmes. The duration of treatment programmes for drug users may vary from 1 to 6 months. The location for such programmes and activities may be the community centres and the Buddhist temples around the country.

Those who are identified as drug users and have gone to the treatment programme without physical confinement are also required to be followed up by the community volunteers such as the volunteer probation officers, the National Guard volunteers, the community health care volunteers, and the other volunteers in the local community.

## **VII. ISSUES, PROBLEMS AND CONCLUSIONS**

The Narcotics Addict Rehabilitation Act B.E. 2545 (2002) has been effective since it was passed in October 2002. The Act came into force for certain parts of the country in March 2003 and in April 2003 the Act came into force for the whole country. There are a number of critical issues and problems among the Act's stakeholders in putting the Act into practice.

First, at the initiating period of the enforcement of the Act, the law enforcement officers faced the problem of identifying and treating drug users and drug addiction activities as a sickness instead of as criminal activities as they used to be. As the police officers are confused, particularly drug charges covered by the Act, they are reluctant to enforce the law. Thus, there are few drug cases (approximately 2500 cases for the whole country at the moment) that have been arrested and processed under this law by the police officers since the Act came into force. The small number of arrests does not reflect the existing magnitude of drug using and drug addiction problems in Thailand. According to the law enforcement officers, the Act fails to identify the specific drug charges at the practice level thus the law enforcement officers are facing difficulties in specifying the drug charges among drug users possessing small amounts of drugs, drug users possessing small amounts of drugs for their own use and for sale, and drug users with small amounts of drugs for sale. The problem leads to a lack of enforcement of the law as well as to turn the cases into other criminal charges that are not covered by the Act.

Second, according to the current official statistics there are a number of drug users and drug addicts in Thai society that need to be treated with different venues and different techniques and methods. The treatment provisions provided by the Act are too broad and insensitive to the problems. For instance; there are a number of loopholes in the diagnostic process for the sub-committee to identify the case as a drug user or drug addict. The treatment periods provided by the Act are not suitable for the hard-core drug users and drug addicts that need a specific treatment duration and method, and the Act also provides coercive treatment only for those who get into the treatment programmes through arrest that may lead to a criminal charge but numbers of drug users and drug addicts need coercive treatment provisions, especially young drug users and drug addicts whose parents have expressed the desire for the coercive treatment provision, without police arrest and criminal charges.

Third, the Act requires numbers of individuals, organizations, and networks both from the public as well as the voluntary sectors in order to enforce and implement the treatment process according to the Act effectively through the identifying, diagnosing, treating, and rehabilitating processes. The Act requires not only the quantity but also the quality out of the Act's stakeholders to conduct their professional as well as the voluntary based responsibilities at the national and the local level at each of the drug rehabilitation centres throughout the country. The ultimate rehabilitative goals of the Act are overarched and over-expected as the existing quantity and quality of the human resources are taken into account for the drug treatment and rehabilitation processes specified by the Act.



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Fourth, the drug treatment and rehabilitation model designed by the Act heavily relies on community-based correctional programmes that place demands on the community resources, particularly the follow up and aftercare services from the community voluntary organizations. However, as the criminal justice system and the voluntary activities of the community members are linked, the Act requires specific features and authorities in its treatment and rehabilitative processes. The Act fails to indicate the specific position and responsibilities of the volunteers who are expected to take their part in the follow up and the aftercare processes. While the drug users and drug addicts may not trust the volunteers in abusing their functions, the volunteers themselves may be worried that their services would violate the principle of the presumption of innocence as well as the basic rights of the drug users and drug addicts.

Fifth, the drug treatment and rehabilitative processes may be effective at the micro level as the Act is enforced and implemented concomitantly with the potential demand protection and the supply reduction measures of the current drug control policy, drug addiction problems may not be solved because the Act does not address the problems at the macro level where the actual implementation of the national development plan and the current economic policy focus on economic growth and disregard of the human aspect and social development. As the legal perception of drug using and drug addiction has been adjusted from a criminal activity to an unhealthy and sick behaviour by the new drug rehabilitation Act, the drug using and drug addict population is expected to be treated and rehabilitated within the same social and economic environment that had pushed numbers of them into the addiction problems. While methamphetamine has been wiped out from the illicit drug market due to the implementation of the current drug control policy, the rise of glue and solvents use as well as alcohol consumption among drug users and drug addicts reflects the remains of the substance abuse problem in Thai society.

Although the Narcotics Addict Rehabilitation Act B.E. 2545 (2002) poses a number of problems and issues as mentioned above, it is too soon to conduct a valid assessment and evaluation of the Act as it has only been in force a short time. As the Act has indicated the right direction for joint action of the criminal justice system and the treatment programmes for substance abuse problems at the community level in Thai society, the implementation problems of the Act need to be solved with both short term and long term provisions.

# DRUG ABUSE AND ITS PREVENTION IN MALAYSIA

*Vong Poh Fah\**

## I. INTRODUCTION

Drug abuse is indubitably widespread and endemic to the South East Asian region. The principal reason for this undesirable phenomenon can be attributed to the easy availability of narcotics in this region. For as long as most of us can remember, South East Asia has been, and still is, well known for its bountiful production of traditional narcotics such as opium and cannabis. Despite being outlawed internationally, the cultivation of poppies and cannabis is viewed in some South East Asian countries, notably by the indigenous, as a legitimate cash crop. The cultivation of these egregious produce become augmented when law enforcement in the area affected is constrained and hampered, or sometimes stifled, by political turmoil, armed conflicts, insurgencies, difficult geographical terrain, the want of resources of the country concerned or the lack of a political will on the part of the governing authority to stamp out the drug menace. Not surprisingly, this has led to South East Asia becoming a major producer and supplier of the world's demand for opiate based drugs and cannabis. Additionally, the lack of a stringent legislative proscription and poor enforcement in some of these jurisdictions has also contributed substantially to the flourishing drug trade in the region.

## II. THE DRUG ABUSE SITUATION IN MALAYSIA

Malaysia is not a narcotic producing country and there is no known or reported cultivation of poppies or cannabis in Malaysia. This is not a fortuitous circumstance. We attribute it to the stringent legislative proscription and strict enforcement regime adopted by the Malaysian Government in her war against illicit drugs. However, in spite of her harsh stand against drug related offences, the pervasiveness of drug abuse in the country is, in our view, still rampant and alarming. The principal cause of this is due to our geographical proximity to the major narcotic producing region. From the seizures of drugs made by the police and customs authorities, it is found that most, if not all, of the opiate based drugs and cannabis recovered were smuggled into the country from the Golden Triangle, Thailand and Cambodia. One thing for sure, however much we may wish to put a stop to the smuggling activities, it is not possible to eradicate totally the smuggling menace. In our case having a long and porous border hinders our cause substantially. The availability of narcotics through such smuggling activities inevitably gives rise to two most reprehensible activities in the subject of illicit drugs: drug trafficking and drug abuse. Historically, Malaysia has, by reason of her reasonably good communication and infrastructure systems, been a favourite transit point for drugs destined for other more affluent parts of the world, notably Europe and Australia. Though we believe that the drug syndicates' preference of Malaysia as a transit country may have changed over the years from that of a preferred status to one that is less preferred due to her harsh trafficking laws, cross border trafficking of drugs is still rampant. This is because apart from the use of Malaysia as a transit point, there is also a ready market here for these illicit drugs. We in fact face a larger problem from those who abuse drugs than those who traffic in them. Undeniably where there is trafficking of drugs there will also be abuse of drugs. The twain constantly co-exists and can never be put asunder, otherwise without a demand there would be no reason for drugs to be trafficked. In Malaysia, a great amount of human resources is wasted annually through drug addiction with an equally great amount of money spent annually by the government in rehabilitating these addicts. Additionally, the drug menace has also contributed significantly to an unhealthy rise in crime rates. There is invariably a link between violent and acquisitive crimes, and the proliferation of narcotics. Certainly, if the drug menace is left unchecked, the stability of the economy and internal security of the country would be open to risk of being compromised.

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### III. THE DRUG ABUSE PROFILE

Broadly speaking, the types of illicit drugs commonly abused in Malaysia can be classified into two categories; that is to say, plant-based drugs and synthetic drugs. Examples of plant-based drugs are opium (both raw and prepared), heroin, morphine, monoacetylmorphines, codeine and cannabis. The types of synthetic drugs commonly abused here are syabu (methamphetamine), ecstasy (Methylenedioxy-amphetamine, 3, 4-Methylenedioxymethamphetamine and N-ethyl), ketamine and psychotropic pills.

Historically, drug abuse in Malaya<sup>1</sup> started with opium smoking in the late nineteenth century. A habit that was brought here by migrant workers from China, which for some unknown reasons, our colonial master did not deem fit to outlaw in the beginning. Over time, and as the country became developed and more affluent, other derivatives of opium, such as morphine and heroin, began to emerge. For many years in the twentieth century the profile of drugs abused in Malaysia was very much confined to opium, morphine, heroin and cannabis. Today, opiate-based drugs remain the preferred drug among abusers in Malaysia. Most of these opiate-based drugs seized in Malaysia are found to have originated from the "Golden Triangle" while cannabis is usually smuggled from countries such as Thailand, Cambodia and lately, Indonesia.

Most countries in the world today do not insulate themselves from world trade. Malaysia, for one, does not practice a closed-door policy. Globalization, a hackneyed phrase these days, has its undesired side effects. As a result of globalization, the drug trend in Malaysia is inexorably influenced by the changes in the global drug abuse scenario. As the world advanced rapidly in the realm of science and technology over the last quarter of the twentieth century, she too has witnessed the flip side of that advancement. It has brought about the emergence of a new breed of narcotics, i.e. the synthetic drugs - the kind that needs no cultivation. This in turn brings more bad news. It means a faster production rate and a cheaper production cost in that vast tracts of land that were previously necessary for cultivation of traditional narcotic is now not required. Apart from generating variety in the drug market it also brought down the price of drugs, making it more affordable for the man in the street. Experience shows that those who abuse drugs do not necessarily confine themselves to one particular type of drug.

Over the last few years, we, in Malaysia, have detected a steady rise in the abuse of synthetic drugs. This may be a harbinger of a changing trend in the drug abuse profile in the days to come. There are compelling reasons as to why these designer drugs are fast gaining popularity. First, in contrast with opiate-based drugs, they are easier and more convenient to be consumed. It does not require drug-consuming paraphernalia such as syringes or smoking utensils. Use of such paraphernalia has its downside. Addicts can either be easily detected or the unhygienic conditions in its use constantly expose them to great risk of deadly infectious diseases such as HIV or HCV. If they do not succumb to their own drug addiction, these diseases are, most certainly, there to see them off. Second, synthetic drugs are usually odourless and can easily be concealed and transported thus rendering detection extremely difficult. Third, consumption of these drugs generally does not lead to the manifestation of any addiction syndrome. Synthetic drug abusers are, hence, less easy to detect. Fourth, pervasive misconception that synthetic drugs are less deleterious than heroin or cocaine and there is no tendency to become addicted to them. Fifth, synthetic drugs are currently fashionable among the younger generation. Drugs like ecstasy and methamphetamine are frequently abused in entertainment places such as discos, a popular night spot among the young and affluent.

Information obtained from Malaysian drug enforcement agencies reveals that most of the methamphetamine sold in Malaysia is smuggled from countries such as China, Thailand and the Philippines. Ecstasy comes mainly from Holland. A major portion of the psychotropic pills found here is known to have originated from Japan.

The following is a summary of the types and quantities of drugs seized by the Malaysian police over the last few years.

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<sup>1</sup> As Malaysia was then known prior to her independence.

RESOURCE MATERIAL SERIES No. 64

Type of Drug	1998	1999	2000	2001	2002
Raw Opium	31.54	17.9	-	60.67	-
Prepared Opium	0.21	0.016	0.17	8.77	0.54
Heroin Base	3.62	52.19	-	66.56	34.08
Heroin No.3	279.076	148.52	106.09	210.49	417.58
Cannabis	1,513.12	1,617.15	1,612.58	1,570.53	1,910.51
Cocaine				0.017	4.23
Methamphetamine (Syabu)	6.43	5.35	208.11	51.29	28.03
Ecstasy*	7,191	46,970	48,996	224,684	169,296
Psychotropic Pills*	1,633,877	147,652	102,147	155,764	122,217
Cough Medicine (Codeine)**	24,337.95	18,133.33	17,982.48	5,864.04	8,548.26
Ketamine				7.34	12.92
Erimine*				16,265	170,702

\* represents number of tablets seized

\*\* represents number of litres seized

Except where otherwise indicated, the above figures shown are in kilograms.

The number of persons arrested for drug related offences over the last two years is as follows:

Type of Drug	2001	2002
Opium	35	28
Heroin	4,721	11,070
Cannabis	2,929	3,563
Cocaine	2	3
Methamphetamine (Syabu)	585	1,522
Ecstasy	267	769

From 1988 to 2002, 235,495 drug addicts were identified by the relevant drug prevention agencies. This, however, may not represent the actual number of addicts that exists in the country. The number of new addicts recorded in 2002 was 17,080 compared with a figure of 15,831 in 2001. Of the 17,080, 53.55% were new addicts while the remaining 46.45% were recidivists. The following are statistics for the type of drugs abused and the corresponding number of addicts in 2002:

Type of Drug	Number of Addicts
Heroin	12,266
Morphine	9,076
Cannabis	6,867
Opium	20
Methamphetamine	2,083
Psychotropic pills	334
Ecstasy	388
Amphetamine	535
Codeine	307
Inhalants	17

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**IV. NATIONAL POLICIES AND STRATEGIES**

Like most other countries, Malaysia has for a long time been plagued with the drug abuse and trafficking problem. The Malaysian Government recognizes the importance and urgency in dealing with the drug problem in the most effective way possible. Pursuant to a Cabinet decision dated 10th September 1983, the National Narcotic Committee was established by the National Security Council to combat the drug abuse and trafficking problems. Several other governmental committees and agencies were also formed shortly thereafter to tackle the drug problem both at the federal and state level. Among these agencies, the Narcotic Task Force acted as the principal drug prevention agency. This agency was charged with the responsibility of:

- overseeing the implementation of national policies on drug prevention;
- coordinating, monitoring and evaluation of drug prevention programmes and activities;
- coordinating the allocation of drug prevention programmes to the various sub-agencies;
- monitoring the drug situation from time to time by creating an information database and feedback system;
- overseeing the development and enhancement of international cooperation in relation to drug abuse prevention; and
- acting as a secretariat to the National Narcotic Committee.

In 1996, the National Drug Agency (NDA) was established under the Ministry of Home Affairs to take over the functions of the Narcotic Task Force and the Department in charge of treatment and rehabilitation of drug offenders. The amalgamation of these two agencies was aimed at enabling the principal national drug enforcement agency to be more effective and comprehensive in its approach in the combat against drug abuse. The primary objective of the NDA is to ensure that all efforts undertaken in combating the drug menace are implemented in a well-planned, coordinated and systematic manner to create a drug free society. The functions of the NDA are:

- To formulate and determine national policies relating to drug prevention, enforcement, treatment and rehabilitation, and international relations;
- To monitor all activities and programmes relating to the prevention and control of drug abuse;
- To coordinate all activities of governmental agencies and non-governmental organizations that are involved in the prevention and control of drug abuse;
- To implement drug abuse prevention programmes;
- To implement drug treatment and rehabilitation programmes;
- To upgrade the system for data collection and to evaluate the effectiveness of all national drug abuse prevention programmes;
- To enhance regional and international cooperation to combat the drug problem; and
- To serve as the secretariat to the National Drug Council.

**A. Primary Prevention (Education)**

The importance of primary prevention can never be over-emphasized. It is one of the primary considerations to be taken into account in any drug abuse prevention strategy. Primary prevention concerns educating the society on the ill effects of drug abuse and the importance of staying away from it. It flows from the time proven adage that prevention is better than cure. For any educational programme to be effective, it must begin at school. It can hardly be open to dispute that good habits are most effectively inculcated in the younger generations. That, however, does not mean that the older ones are to be forsaken. The NDA educational programmes fall into 3 broad categories. They are:

- the school-based programme;
- the community involvement programme; and
- the information and publicity programme.

**1. The School-Based Programme**

The Students' Resilience and Interpersonal Skills Development Educational (STRIDE) is a drug education programme that is implemented at primary school level (for children between the ages of 7 and 12). Thus at a very young age students are informed of the existence of the different types of narcotics and

the pitfalls of drug addiction. The STRIDE programme is essentially a joint effort of the NDA, the Ministry of Education and the Narcotics Department of the Malaysian police. The objectives of this programme are to:

- enhance the knowledge and living skills of primary school students in order to resist peer pressure to take drugs;
- enhance the self-esteem and interpersonal skills of primary school students to say “no” to drugs;
- encourage primary school students to participate in drug abuse prevention and healthy activities; and
- create a sense of abhorrence for drugs and to ensure that schools in Malaysia are free from drugs.

In 2002 the STRIDE programme was implemented in 416 schools. To ensure a successful implementation of this programme, teachers and drug prevention personnel were also required to undergo training in interpersonal skills on drug abuse prevention. In 2002, a total of 16 training sessions for teachers throughout the country were carried out.

The NDA also conducts surprise random urine screening for students as part of its effort in making early detection. Students found to have abused drugs will be counselled by the school counsellor. In addition, they will also be required to attend motivational camps/courses to redeem their self-esteem and to enhance their interpersonal skills. In 2002, 773 urine screening exercises were carried out involving a total of 35,000 secondary school students.

## 2. Community Involvement Programme

The NDA conducts seminars at government departments and at offices of the private sectors as part of its exercise in implementing the drug abuse prevention programme at workplaces. A total of 65 such seminars were conducted in 2002.

## 3. Information and Publicity Programme

In 1990 the mobile drug abuse prevention unit was created. These units traverse the length and breadth of the country to meet the general public with the objective of creating awareness among the community about the drug abuse problem that currently betide the nation and the strategies that are being employed by the government in dealing with the problem. In 2002, 300 exhibitions were held in schools, institutions of higher learning, government departments and public places throughout the country. Additionally, the National Narcotic Week was celebrated from the 19th till 25th February 2002. During that week various activities focusing on the prevention of drug abuse were held with ample coverage given by the media.

## **B. Treatment and Rehabilitation**

Malaysia practises a compulsory treatment and rehabilitation regime for drug dependants. This compulsory treatment and rehabilitation programme is aimed at aiding drug dependants to overcome their physical and psychological addiction to drugs and to, thereafter, live a drug free life. We are of the view that without compulsion and governmental support and assistance, the probability of these hopeless souls in being able to overcome their drug-taking habits, should they be left to their own devices, would be extremely remote.

In 1983 the Drug Dependants (Treatment and Rehabilitation) Act was passed by the legislature. This Act empowers the designated rehabilitation officer and the police to arrest any person suspected of being a drug dependant for the purpose of subjecting him to a medical examination to ascertain whether he is a drug dependant or otherwise. If the test result is positive the rehabilitation officer is required to apply to the Magistrate’s Court for an order to detain him at a drug rehabilitation centre for compulsory treatment and rehabilitation. The period of treatment and rehabilitation is 2 years followed by aftercare for another 2 years. The rehabilitation centres that treat and rehabilitate these drug dependants are established and sponsored by the government. There are currently 28 such centres situated throughout the country. In addition, the country also has 56 privately managed drug treatment and rehabilitation centres. In 2002, 13,760 drug dependants were reported as having undergone treatment and rehabilitation at the government sponsored centres.

## **C. Legislation**

The seriousness with which a country views the drug problem and the extent to which it desires to eradicate them is, I believe, often characterized by the legislation it employs in dealing with the problem.

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Malaysia has always been single minded in her approach in the fight against drug abuse. This is because we see it as a threat to national security. The serious measures employed in our drug prevention legislation are a testament to that commitment. We are well known for our mandatory death penalty imposed on convicted drug traffickers. While we may have earned many accolades for our tough stand against the drug menace, simultaneously, we have also earned much flak, notably from Amnesty International, for imposing the mandatory death sentence and the use of presumptions of fact in the prosecution of drug offenders. Coming to a topic that is closer to my heart, I take great pleasure in being able to provide you with a birds-eye-view of the various legislative measures employed by the Malaysian Government in dealing with this social calamity.

1. The Dangerous Drugs Act 1952

The leading Malaysian statute enacted to curb the drug menace is the Dangerous Drugs Act, 1952 (DDA). The DDA criminalizes the self-administration (consumption), possession, importing and exporting, manufacturing, and the trafficking of illicit drugs. The severity of punishment provided under the DDA varies with the nature and gravity of the offence committed. As it is not possible to discuss every offence prescribed in this Act, I will confine myself to the more common ones.

The most severe punishment, i.e. the death sentence, is imposed on those who traffic in drugs. There are three ways by which the prosecution may prove the offence of trafficking in drugs. The first is by way of direct evidence where the accused person was actively engaged in the sale of narcotics. This process usually involves the use of an *agent provocateur* (undercover agent) where trap evidence will be obtained. It is, however, not possible to do this all the time as such opportunity does not come by everyday. Furthermore, the safety of the agent is invariably put to extreme risk in such undercover operations.

The second is by way of the definition of the word 'trafficking' in the DDA. 'Trafficking' is defined here as including the "manufacturing, importing, exporting, keeping, concealing, buying, selling, giving, receiving, storing, administering, transporting, carrying, sending, delivering, procuring, supplying, or distributing" of any dangerous drugs. Admittedly, the meaning of trafficking under the DDA is much wider than that as used in the ordinary context.<sup>2</sup> The natural meaning in the context of trafficking involves dealing between two parties at least. Therefore, acts such as the keeping, concealing, transporting, storing and carrying of drugs in the above definition would appear to be more consistent with the notion of possession<sup>3</sup> rather than that of trafficking. At first blush this might appear unjust in that those who are merely guilty of drug possession run the risk of being convicted of drug trafficking and in the process suffer the peril of a harsher punishment. To distinguish between those who traffic drugs from those who merely keep them for their own consumption, the Privy Council, in a seminal judgment in the case of Ong Ah Chuan v PP<sup>4</sup>, laid down a rule of interpretation that the "keeping, concealing, transporting, storing or carrying of drugs" will amount to an act of trafficking only if it was done for the purpose of being distributed. This interpretation thus brings the statutory definition of 'trafficking' in line with its natural meaning.

The third way of proving trafficking is through the use of presumption of facts, as provided in the DDA. For example, if a person is found in possession of 15 grams or more in weight of heroin,<sup>5</sup> the operation of the statutory presumption is immediately attracted in that he is presumed to be trafficking in the said drug. This presumption is premised on the logical assumption based on human experience that when a person is found in possession of a large quantity of drugs, it is usually not intended for his own personal consumption but for trafficking. The larger the amount, the stronger the presumption applies. Even if the drug was in actual fact kept for the purpose of the accused person's personal consumption, there is no injustice caused to him because the presumption is a rebuttable presumption. The accused person is at liberty to produce evidence in court to show that the drug was not meant to be trafficked. He may, for example, introduce evidence to show that he is an addict and that the contraband was kept merely for his own personal consumption. That would be sufficient to discharge the application of the presumption. However, if the amount of drug found on him is unduly large, he faces an uphill task in persuading the court that the drug was not meant to be trafficked. In

<sup>2</sup> The Concise Oxford Dictionary defines 'traffic' as "to trade or deal in something illegal".

<sup>3</sup> The DDA imposes a less severe penalty for the offence of drug possession than drug trafficking.

<sup>4</sup> [1981] 1 MLJ 69.

<sup>5</sup> Section 37(da) of the DDA contains a list of drugs and the minimum statutory amount thereof which will trigger the application of the presumption of trafficking.

evaluating the accused person's evidence, the court must weigh it on a balance of probability. Contrary to common belief, the purpose of the presumption is not to presume guilt. It merely shifts the evidential burden on to the accused person requiring him to show by way of evidence that the drug found in his possession was not intended to be sold or distributed to a third party.

A lot of criticism had been levelled against us for employing such presumption of fact in the prosecution of drug trafficking offenders. We are nevertheless undeterred. We see the need to resort to such measures because, from experience, the dividing line between addicts and traffickers is often tenuous. It is to ensure that trafficking of drugs at every level of the trafficking chain is effectively curbed. As of today, 127 convicted drug traffickers have been hanged for the period between 1990 and 2002.

Apart from trafficking another important concept that is usually associated with drug proscription laws is 'possession'. The concept of possession is important for two reasons. The first being possession of drugs is by itself a distinct and separate offence. Frequently when a person is found to be in custody of some quantity of drugs, there is a high probability that he is guilty of possession even though he is not guilty of trafficking. Under the DDA the offence of possession of drugs is often punishable by imprisonment and sometimes whipping too. The severity of the punishment is dependent on the amount of drug possessed. For example, a person who is found guilty of having in his possession a small quantity of heroin will, at the very least, be liable to be punished with a fine not exceeding RM100,000 or to imprisonment of a term not exceeding 5 years or both. However, if the amount of heroin possessed is 2 grams or more but less than 5 grams the offender will be liable to be punished with a sentence of imprisonment for a term not less than 2 years but not exceeding 5 years and, in addition, mandatory whipping of not less than 3 strokes but not exceeding 9 strokes. If the amount of heroin possessed is 5 grams or more, the offender is liable to be punished with imprisonment for a term of not less than 5 years but not exceeding 20 years and, in addition, mandatory whipping of not less than 10 strokes but not exceeding 24 strokes.

The second reason is; to prove trafficking one must first prove possession, for without possession there can be no trafficking. The concept of possession has often been a difficult area of law for us. This concept has two elements, the physical and the mental. The former is rather straightforward and easy to prove. It is the latter that is problematic. Accused persons who are caught carrying drugs frequently deny knowledge of the drugs they were carrying. It is indubitably the prosecution's duty to prove beyond reasonable doubt that the accused person knew of the nature of the drugs carried. This is the rub of the problem. Where proof of knowledge is concerned, it is always a difficult task to handle because one cannot prove knowledge conclusively unless direct evidence is available. However, in reality direct evidence is seldom available. Most of the time one has to rely on inferences. The critical question at the end of the day is whether from the total inferences adduced in court it is possible to say that the accused person knew of the nature of the drug carried. How much is enough? The answer is elusive and this is where the problem lies. The court is often reluctant to accept the sum total of the available inferences as constituting sufficient proof of the accused person's knowledge of the drug. My view of the matter is that sometimes the death penalty seems to hurt us more than it helps us. Because the process involves the taking of a person's life, one obviously cannot blame the courts for being too careful in their approach. This is an area where we are currently facing a big challenge.

The DDA also renders illegal those who administer drugs to themselves or to a third party. The former offence is punishable with fines not exceeding RM5,000 or imprisonment for a term not exceeding 2 years while the latter offence is punishable with fines not exceeding RM10,000 or imprisonment for a term not exceeding 3 years or both.

## 2. Dangerous Drugs (Forfeiture of Property) Act 1988 (FOPA)

Despite the imposition of the death penalty under the DDA, the rampancy of drug trafficking in Malaysia did not seem to abate. Recognising that these drug traffickers may have more regard for materialistic gains than their own life, the government introduced this Act in 1988 in a further attempt to curb the trafficking of drugs. The FOPA empowers the Public Prosecutor and senior police officers to trace, freeze and forfeit assets that are suspected to be the proceeds of drug trafficking activities or assets that were used in the commission of drug trafficking offences. Forfeiture proceedings can be commenced even if no one has been prosecuted for a drug offence provided that there are valid grounds to believe that the assets seized were concerned in a trafficking offence. However, the FOPA is not as draconian as it may sound. The Act allows ingenuous



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owners to challenge the forfeiture in court if the seizure was wrongful. In 2000, RM 3,945,300.89 worth of assets was forfeited under the FOPA.

3. The Dangerous Drugs (Special Preventive Measures) Act 1985

Like the FOPA, this Act was also specifically enacted to combat the drug trafficking menace. It provides for the arrest and preventive detention of persons whom the authorities have reason to believe are involved in or associated with the trafficking of drugs. The arrestee will not be tried in court but could be detained upon the issue of a detention order by the Minister of Home Affairs. Detention without trial has always been a sensitive subject among human rights activists. To ensure that innocent people are not wrongly detained, several safeguards are built into this Act. Before the Minister decides to issue the detention order he must give due consideration to two reports submitted to him under the Act. Once a person is arrested for the purpose of being detained under this Act, the police must investigate the circumstances that led to his arrest. The purpose of this investigation is to obtain further information concerning the person's background and activities prior to his arrest; such as whether he was truly involved in drug trafficking activities and the extent of his involvement. Upon completion of the investigation, the police officer concerned must prepare a report for the consideration of the Minister. At the same time a legally qualified officer, designated as an Inquiry Officer under the Act, will conduct a separate and independent inquiry into the allegations against the arrestee. The Inquiry Officer in conducting his inquiry is mandated to interview the arrestee and any other person who is able to give relevant information about the arrestee, and to review any relevant documentary evidence. The purpose of this inquiry is aimed at procuring further information about the arrestee independent of the police investigation and at the same time gives the arrestee a right to be heard, a fundamental rule of natural justice. Upon completion of the inquiry, the Inquiry Officer must submit his report to the Minister. If a detention order is issued, the detention period cannot exceed a period of 2 years. If the Minister is of the opinion that detention is not an appropriate remedy, he may issue an order to restrict the arrestee's residence to a designated area subject to police supervision for a period not exceeding 2 years. The procedure laid down under the Act must be strictly complied with. Such detention orders can be challenged in court and if the challenge is successful the order will be invalidated.

4. The Poison Act 1952

The purpose of this Act is twofold. To regulate a category of drugs that does not come under the purview of the DDA and to regulate the use of these drugs. In this respect, this Act is complementary to the DDA. These drugs are described as poison because they are generally harmful to the human body and cannot be consumed freely. The Act does not outlaw the use of these drugs but merely restrict and control their import, possession, sale and use. These drugs are usually needed for medicinal, agricultural or industrial purposes. Only persons who are designated under the Act are permitted to store and sell these drugs and every sale must be documented. The frequently abused drugs regulated under this Act are psychotropic pills and codeine.

5. Drug Dependancy (Treatment and Rehabilitation) Act 1983

This Act was enacted for the purpose of introducing compulsory treatment and rehabilitation of drug dependants. The working of this law has already been discussed in the preceding paragraphs.

**V. INTERNATIONAL COOPERATION**

Malaysia plays an active role in fostering regional and international cooperation in the reduction of demand and supply of illicit drugs. As of this moment we are signatory to 3 United Nations Conventions, namely:

- Single Convention on Narcotic Drugs, 1961;
- Convention on Psychotropic Substance, 1971; and
- Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1988.

We are also signatory to bilateral agreements with countries such as the United Kingdom, Hong Kong, United States of America, Venezuela and the Russian Federation to facilitate bilateral cooperation on prevention of drug trafficking. Additionally, the Malaysian police maintain a close working relationship with drug enforcement agencies of other countries such as:

- Australian Federal Police;
- US Drugs Enforcement Administration;
- Narcotics Bureau, Hong Kong Police;
- Royal Canadian Mounted Police;
- New Zealand Customs and Police; and
- Drugs Sub-Directorate, Interpol.

## **VI. CONCLUSION**

Our current objective is to achieve the status of a drug free society by the year 2015. We hope to achieve this with a multi-disciplinary approach some of which have been highlighted above.

# AN OVERVIEW OF THE MANAGEMENT OF THE DRUG SITUATION IN SOUTH AFRICA

*Elma Nel\**

## I. INTRODUCTION

South Africa is by far the largest market for illicit drugs entering Southern Africa. Its relative affluence within the region makes it a tempting 'emerging market' in its own right. The country's geography, porous borders and international trade links with Asia, Western Europe and North America have made it an attractive drug transit country. Drug trafficking and abuse have escalated in recent years, with the point of escalation traceable to the liberalization of most aspects of society in the years immediately surrounding the country's first democratic elections in 1994. The relaxation of strict controls of land, air and sea borders, along with the enhancement of international trade and commerce, plus the influx of new cultural trends among the more affluent segments of the population, are all associated with the increase in drug trafficking and abuse as well as violent and organized crime. To a greater degree than in many other countries, the drug trafficking activities of organized crime groups are linked to a multitude of other criminal acts, ranging from car hijackings and robberies to the smuggling of firearms, stolen cars, endangered species and precious metals.

South Africa is a society in transition. Drug use correlates strongly with the pressures placed upon social capital by rapid modernization and the decline in traditional social relationships and forms of family structures. Another factor contributing to the increased prominence of illicit drug use in South Africa is high unemployment. Using the expanded definition of unemployment (including people who are unemployed and looking for work, as well as those who are too discouraged to try to find a job or too poor to travel to look for one), the general unemployment rate in 2000 was 40,9% and that for young males (15-24 years) 53,3% and for young women 57,9%.

In its ninth year of democratic government, South Africa is a major power in Africa, carrying with it an enormous burden of regional leadership on most political and economic issues. Difficulties of social transformation in South African society are exemplified by the somewhat slower than expected pace of the redistribution of economic power throughout the society. Huge gaps remain in the distribution of wealth. South Africa's gross national product was 129 billion US Dollars in 2001. The richest fifth of the population earns 22 times more than the poorest fifth. Compared to the United States this figure is 9 times and even if compared with developing countries in sub-Saharan Africa, the existing income gaps in South Africa are large. The figure for Zimbabwe is 12 and 13 for Nigeria. This has a number of implications:

- Relatively higher levels of income in S.A. – even for the underprivileged – make the country attractive as a location for immigration which, as experience has shown, tends to create a favourable climate for drug trafficking activities;
- At the same time, strong income inequalities raise the readiness of underprivileged groups to participate in illegal activities, including drug trafficking;
- The high levels of income among the wealthy make the country attractive for drug imports from abroad.

Social transformation is also hampered by the harsh realities of an HIV/AIDS pandemic whose impact is falling principally upon the black community. According to available statistics 5 million people lived with HIV/AIDS in 2001 and 360 000 people died from AIDS in 2001. The medium to long-term effects on social

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capital of a generation of “AIDS orphans” (it is estimated that this number could be as high as 300 000 at present) are only now being calculated. South Africa combines, in many respects, the characteristics of a highly industrialized country with those of a developing country in sub-Saharan Africa. The geography, population, economic wealth and income distribution, economic growth and unemployment explains the special vulnerability of the country to drug abuse, drug trafficking and crime in general. According to Statistics South Africa, South Africa’s population was estimated at 44.3 million in 2001 (the fifth most populous country in Africa). Of these 77.8% were Black/African, 10.2% White, 8.7% Coloured and 2.5 % Indian/Asian. Approximately 58% of the population lives in urban conglomerations compared with 34% in sub-Saharan Africa and 40% in developing countries on average.

## II. CURRENT SITUATION

### A. Illicit Drug Trends in South Africa

#### 1. Cannabis

Cannabis is the most prevalent illicit drug used in South Africa. Most of the cannabis cultivation takes place in small, remote plots in the following provinces (by order of importance): Eastern Cape, Kwazulu-Natal, Limpopo (formerly Northern Province) and Mpumalanga by poor rural people. Some cannabis is also imported from Swaziland, Malawi and Lesotho. Much of the cannabis trafficking to Europe is reportedly in the hands of British and Dutch expatriates living in South Africa, working in conjunction with South Africans. Western Europe in general, and the United Kingdom and the Netherlands in particular, are the main final destinations. In 2000, an estimate based largely on an aerial survey undertaken either by the South African Police’s Service’s Aerial Application Unit or subcontractors (both are related to crop eradication efforts) estimated 1,247 areas under cultivation. The average size of a cannabis field in South Africa is 300 square meters which will earn about R1 200.

#### 2. Mandrax

Mandrax (methaqualone) is the second most commonly-used illicit drug. After the Second World War, mandrax emerged as another important psychoactive substance. Following the identification of its abuse potential, mandrax was removed from the legal market and classified as a prohibited dependence-producing drug in part 1 of the schedule of the South African narcotics law (Act 41 of 1971). However, following its official withdrawal from the local market, mandrax tablets were diverted from international distribution channels-mostly originating in India and China. In recent times, they have also been manufactured in neighbouring African countries as well as in South Africa itself. In 2002, eight laboratories where mandrax was manufactured were detected and dismantled in South Africa. Abuse was originally primarily concentrated in South Africa’s ethnic Indian/Asian population. It has since spread to other ethnic groups, notably the Coloured community. Mandrax is frequently smoked with cannabis, a combination which is referred to as “white pipe” (this is apparently a phenomenon rather unique to South Africa).

Although the use of *heroin*, *cocaine* and *ecstasy* is less prevalent, this has increased notably since the mid-1990’s. Treatment data suggests that cocaine use is substantially more prevalent than heroin or ecstasy use. The number of people seeking treatment for cocaine use since mid-2000 has been broadly similar to that for mandrax. Worryingly, heroin use has also increased significantly in major urban areas, particularly in Gauteng (which includes Johannesburg and Pretoria) and Cape Town. In 2001, among treatment patients reporting heroin as their primary drug of abuse, evidence points to 51% of such patients in Cape Town reporting some injecting (or “intravenous”) use and 36% doing so in Gauteng. One risk associated with injecting heroin is the spread of HIV/AIDS. The second half of 2001 also witnessed the appearance of heroin users among the Black/African communities in South Africa’s urban and peri-urban areas.

#### 3. Cocaine

South Africa’s *cocaine* market originally catered to upper-income consumer groups, with trafficking originally controlled by White networks. Following the influx of Nigerian criminal organizations in the early to mid-1990’s, the cocaine import and distribution markets have come under the control of these groups. These criminal organizations tend to operate out of residential hotels in the large urban centres (Johannesburg, Cape Town, Durban and Port Elizabeth), but have been concentrated – until very recently – in the Hillbrow area of Johannesburg. *Crack* use has also become prominent among vulnerable groups in society, for example commercial sex workers.

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4. Heroin

*Heroin* is sourced by criminal organizations from markets in Southeast and Southwest Asia. As a low-volume/high-value item, it is couriered into South Africa principally via Johannesburg International Airport. Other sources of supply do exist, but these primarily involve seaport entry principally via Mombasa, Kenya and Dar Es Salaam, Tanzania. The drugs are then transported down East Africa's main arterial road networks toward South Africa.

The use of '*club drugs*' (principally *ecstasy* and *LSD*, but including a wide range of substances) has grown dramatically in the white community since the early 1990's, in part due to active interaction with the youth cultures of industrialized nations. While amphetamine-type stimulants, notably *ecstasy*, are mainly imported from Europe to satisfy domestic demand in the club scene, there is also evidence of local manufacturing of these substances.

Although increasing social ethnic integration is evident, the drug consumption markets of South Africa remain ethnically differentiated. The extreme income inequalities between the different broad ethnic segments affect drug affordability and thus consumer choice.

Ongoing research in South Africa is demonstrating a link (other than that related to injecting drug use) between substance abuse and the spread of HIV/AIDS. It indicates that adolescents who use alcohol and other drugs are more likely to engage in sex and in unsafe sex than are adolescents who abstain from using them.

**B. Drug Trafficking**

Following a decade of opening up to the outside world, South Africa has now unfortunately become part of the major international drug trafficking networks. These are often organized by West African –principally Nigerian-criminal groups which since the late 1990's have established permanent operational bases in Southern Africa in general and South Africa in particular. Over the past few years, these groups have integrated South Africa into their pre-existing networks linking the drug producing countries of Latin America (cocaine) and Asia (heroin) with the "traditional" cocaine and heroin consuming markets of Western Europe and North America. Cannabis trafficking networks from South Africa to Western Europe tend to involve white South Africans and Dutch and British expatriates living in South Africa. There have been recent inroads into this market chain, however, by other organized criminal groups in the context of reported bartering arrangements (or at least two-way sales) of cannabis for other drugs which are then consumed within South Africa. Trafficking of illicit drugs has increased dramatically in South Africa over the last decade. Aside from the fact that drugs are highly associated with dependency or addiction and thus the frequently desperate search for instant cash – often through prostitution or acquisitive crime – there are other obvious links to criminal activity. Drug trafficking is an extremely profitable enterprise for organized crime syndicates which are often heavily engaged in numerous other criminal acts, ranging from car hijackings and robberies, to the trafficking of illegal firearms, stolen cars, endangered species and precious metals. For example, organized crime syndicates have also become involved in stealing vehicles and trading them across South Africa's land borders in exchange for drugs. South Africa now features prominently in international drug trafficking networks. Drug trafficking and organized crime have unquestionably grown in a symbiotic relationship in South Africa since the mid-1990's. In 1997, the South African Police Service (SAPS) conducted a survey which demonstrated the existence of 192 organized crime groups operating in South Africa of which 92 were primarily focused on the international smuggling of drugs. This survey formed the basis of the SAPS Organized Crime Threat Analysis (OCTA) system. The SAPS OCTA (2002) showed 238 threats.

**C. Drug Use and Crime**

Within the past three years, ground-breaking research work by the South African Medical Research Council and the Pretoria-based Institute for Security Studies has confirmed a high positive correlation between drug use and crime. Results of the 3-Metros Arrestee Study (in Gauteng, Cape Town, Durban) conducted between August 1999 and September 2000 among a representative sample of arrestees (n=2 859) has revealed much about the drugs/crime link in South Africa. The study found that the percentage of arrestees testing positive from urinalysis for at least one drug was 46%. Positive tests for cannabis, mandrax and cocaine occurred in 40%, 21% and 4% of cases respectively (Parry, Louw and Pluddeman 2001). Arrestees under the age of 20 were most likely to test positive for some substance (66%). Those testing

positive for a substance (51%) were more likely than those who tested negative (29%) to have been arrested before (ISS 2002). The research suggests a very strong link between drug use and various crimes. For example, the percentage of arrestees testing positive for any drug (excluding alcohol) in connection with housebreaking, motor vehicle theft and rape was, respectively, 66%, 59% and 49%. Up to one-third of arrestees who indicated that they were under the influence of substances at the time that the crime took place stated that they had used substances to assist them committing the offence.

The current situation in respect of drug abuse in South Africa must be viewed against four milestones in the history of our country, namely:

- The emergence of South Africa out of apartheid isolation in 1994
- Accession by South Africa in 1995 to the United Nations (UN) signing of The Single Convention on Narcotic Drugs, 1961 and the 1971 Convention on Psychotropic Substances
- Accession to the UN Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1998
- The development of a National Drug Master Plan (NDMP) 1998

The re-entry of South Africa into the international arena brought with it prosperity and commitment on the one hand and a range of new problems and challenges on the other hand. The rapid expansion of international air links, combined with our geographic position on major traffic routes between East Asia and the Middle East, America and Europe, a well-developed transportation infrastructure, modern international telecommunications and banking systems, long porous borders and weak border control, make South Africa a natural target for drug traffickers. The winds of change, however refreshing, thus brought with it a sober chill.

#### **D. Basic Policies and Strategies in South Africa**

##### **1. South African National Drug Master Plan**

The basis for the national drug control framework is the (5 year) National Drug Master Plan adopted by Parliament in February 1999. The elaboration of such a plan was necessary as the Government's response to the drug problem – as stated in the Master Plan – had become “disjointed, fragmented and uncoordinated”. A number of national plans and strategies to address different aspects of substance abuse were drafted during the 1980s and early 1990s. They did not, however, provide a comprehensive response to the deteriorating drug problem of South Africa, and they were not properly implemented. Thus in 1997, the Minister of Welfare and Population Development requested the Drug Advisory Board to develop a Drug Master Plan for South Africa to rectify these problems “in accordance with international practice”.

Taking a balanced approach to reducing the supply and demand for drugs, the overall objectives of the Master Plan are “to build a drug free society together and to make a contribution to solving the global problem of substance abuse” The Master Plan's six priority areas are: (a) to reduce drug-related crime, (b) protect youth, (c) support community health and welfare, (d) strengthen research and information dissemination, (e) encourage international involvement, and (f) improve communication on substance abuse with all groups in South Africa's highly diverse population.

One aspect of the Government's demand reduction policies includes “harm reduction” which aims to reduce the negative social and health consequences associated with drug use rather than to reduce or eliminate drug use per se.

The Master Plan sets forth a broad strategy for integrating the efforts of various government departments and civil society to prevent and reduce drug-related problems, substance abuse and illicit trafficking in South Africa. Recognizing the social costs of addiction, the document calls for greater resources to be diverted to disadvantaged communities. It calls for a workable strategy at the community level through *Local Drug Action Committees* (in all 382 magisterial districts) and *Provincial Drug Forums* comprising the various government agencies, the private sector, experts and community organizations. It stresses the importance of

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shifting the focus from supply to demand reduction and from the individual to the community. Further, the Master Plan aims to ensure that “all educational material and other information (that) is disseminated is contextually correct, that is in a form and language appropriate to the culture, language, level of education and socio-economic background of its intended recipients”. (South Africa has 11 official languages.)

**2. Central Drug Authority**

A Central Drug Authority (CDA) comprising both governmental appointees and experts from the non-governmental sector was established in 2000. Representatives from the Departments of Justice, Health, Education, Welfare, Correctional Services and the South African Police Services among others serve in the Central Drug Authority. The selected members of civil society come from research councils, universities, trade unions and business establishments concerned about drugs. The CDA is charged with giving a lead to the nation's drug control efforts and monitoring implementation. The CDA is required to report back to Parliament on regular occasions regarding progress achieved.

Local drug action committees and provincial drug forums are in various stages of formation and readiness. The entire Master Plan architecture can be considered to be only slowly making progress.

**E. Legislation**

The control of licit drugs in South Africa is organized and managed through a number of pieces of legislation, two of which are of special note:

- (i) The Medicines and Related Substance Control Act (101/1965): This supports the processes set out in the major UN Conventions on drug control and provides the definitional and conceptual basis for drug control policy in South Africa.
- (ii) The South African Drugs and Drug Trafficking Act (140/1992): This makes it an offence to supply substances to anyone while knowing or suspecting they will be used for the manufacture of illegal drugs. The Act further prohibits any person from converting property that he or she knows or suspects to be gained from the proceeds of drug trafficking, and it makes dealing in dangerous and undesirable drugs an offence punishable by up to 25 years imprisonment. The maximum sentence for the possession of drugs is 15 years. There are no prescribed minimum sentences.

Other relevant laws governing this field are:

- The Prevention and Treatment of Drug Dependency Act, 1992 (Act 20 of 1992).
- The Criminal Procedure Act, 1977 (Act 51 of 1977).
- The Extradition Act, 1962 (Act 67 of 1962).
- The Criminal Procedure Act, 1977 (Act 51 of 1977) with special reference to the Witness Protection Programme established in terms of section 185A of 1992.
- The Extradition Amendment Act, 1996 (Act 77 of 1996).
- The International Co-operation in Criminal Matters Act, 1996 (Act 75 of 1996).
- The Proceeds of Crime Act, 1996 (Act 76 of 1996).
- Institute for Drug-Free Sport Act, 1997 (Act 14 of 1997).
- Road Transportation Act, 1977 (Act 74 of 1977).
- Prevention of Organised Crime (Act 121 of 1998).

## **F. Drug Control Institutions-Supply and Law Enforcement**

At present the South African Police Service's Narcotic Bureau (SANAB) is giving the lead on the enforcement side primarily in detecting and investigating drug crimes. However there is also an important profiling, interdiction and controlled delivery role for SAPS Border Police and SARS (South African Revenue Service) Customs. Border control coordination takes place under a Border Control Coordinating Committee.

Over the past two years a series of restructuring initiatives were undertaken in the SAPS. Thus the Organized Crime "component" has been given the responsibility for drug law enforcement. This component serves as the reporting entity for several units including the Specialized Investigating Units, one of which is SANAB. The Organized Crime component also has 24 "task teams" reporting to it from throughout the country, each of which in principle contains at least one officer with specialized narcotics expertise. The specialized investigation units are being phased out of the police force and staff are being integrated into the police organized crime component. With some 40% of SANAB offices already closed in this manner, the future of the remaining units is still uncertain. The impact of this on the country's medium- to long-term capacity to deal effectively with the threat posed by organized criminal groups dealing in drugs is unclear. In late 1999, a new unit entitled Directorate for Special Operations (more commonly known as the "Scorpions") was launched under the authority of the National Director of Public Prosecutions, who reports to the Minister of Justice but is required to report on issues related to the Scorpions directly to the President. The Directorate, combining elements of criminal justice and prosecution, was formed to tackle high profile crimes and corruption, including drug crimes.

The four Drug Sections of the SAPS Forensic Science Laboratory (based in Pretoria, Cape Town, Port Elizabeth and Durban) deals with analysis, crime scene attendance, illicit laboratory investigations, drug intelligence, and recording and keeping of seizures. The SAPS established a Chemical Monitoring Programme in 1999 primarily to prevent the diversion of precursor chemicals from the licit market to illicit drug manufacturing.

International involvement is achieved through the posting of an international Drug and Organized Crime Liaison Officer (DOCLO) in the United Kingdom and Brazil and the appointments of DOCLOs to Pakistan, India, Argentina, Thailand, Kenya, Nigeria, Zambia and Zimbabwe have been approved. The expansion of the DOCLO network is intended to enhance cooperation on intelligence sharing and joint investigations with participating countries.

In terms of regional cooperation, S.A. is also a signatory to the *Protocol on Combating Illicit Drug Trafficking* in the *Southern African Development Community (SADC)* region. South Africa also participates actively in the *UN Commission on Narcotics Drugs (CND)* and cooperates with *Interpol*.

## **G. Drug Control Institutions-Demand Reduction, Prevention and Treatment**

Prevention programmes are the responsibility of the Department of Social Development (formerly Welfare), while treatment falls under the auspices of the Department of Health. However, the respective roles are blurred in practice and constraints also exist with regard to funding. Treatment facilities are unevenly distributed throughout the country and the health and education sectors are minimally involved in prevention programmes. The latter gap is filled in part by a highly dedicated group of NGOs and concerned citizens, but their capabilities and mandates are limited. Government thus largely provides resources for the treatment of persons having substance abuse problems through NGOs such as the South African National Council on Alcoholism and Drug Abuse (SANCA). SANCA has a network of drug treatment and outreach centres around the country (38 centres and 76 satellite offices in all 9 provinces) and also trains drug abuse counsellors and others in related roles (e.g. teachers and social workers). As SANCA'S main objectives are prevention and treatment, it also has public education programmes in high schools e.g. TARDA (Teenagers against Drug Abuse). The treatment objective is achieved through the provision of treatment services for chemically dependent people and their families as well as support groups in high schools.

### **1. Department of Social Development**

Treatment falls into the following categories: (a) voluntary treatment in the community; (b) voluntary institutional treatment and (c) statutory treatment under the terms of the Prevention and Treatment of Drug Dependence Act (1992) This department is providing interim secretariat services for the functioning of the



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Central Drug Authority. The Department has developed a prevention strategy aimed at youth, which is currently in the form of a discussion document.

2. Department of Education

This Department is implementing its Revised Curriculum 2005 initiative. This includes a Life Orientation Area of Learning which has a component that seeks to address adolescent risk behaviours, such as drug use and teenage sexuality as part of a holistic initiative aimed at the healthy development of young people. The substance abuse component is currently being reviewed and made stronger in order to address the escalation of the drug abuse problem within South Africa. The Department has developed a "Policy Framework for the Management of Drug Abuse by Learners in Schools and Further Education and Training Institutions" which is intended to give guidance to schools in developing substance abuse policy. The policy also calls for all teachers, both pre-and in-service, to receive appropriate education on substance abuse, as it does for all parents.

3. Department of Health

Although the main role of this department pertains to treatment, it also provides different levels of tertiary prevention. The Department's aim is to ensure greater access to treatment via (a) primary care, (b) general hospitals, and (c) existing treatment centres. This Department is also involved in an initiative to develop a five-year community-based project, aimed at the primary prevention of substance abuse among young people.

4. Soul City

Soul City is a multi-media health education/counter-advertising initiative seeking to address a range of risk behaviours, including alcohol/smoking and violence against women, through a very popular prime-time sitcom aired on TV, as well as on radio and via the printed media. Soul City is considering broadening its message base to include substance abuse with a focus on drugs.

5. SACENDU (South African Community Epidemiology Network on Drug Use)

SACENDU was established in 1996 by the Medical Research Council of South Africa and the University Of Durban-Westville's School of Psychology with the technical assistance of the WHO/PSA and the U.S. National Institute on Drug Abuse (NIDA). It is a network of researchers, practitioners and policy makers (e.g. law enforcement, health and welfare treatment services, and public health research) from 5 sentinel areas in South Africa (Cape Town, Durban, Port Elizabeth, Gauteng and Mpumalanga). Members of SACENDU meet every 6 months to report on alcohol and other drug (AOD) use trends and associated consequences through the presentation and discussion of quantitative and qualitative research and other data.

6. MRC – Medical Research Council

MRC is primarily engaged with epidemiological research into the nature and extent of AOD use and with measuring the health impact of the misuse of AOD. Another key focus is in the area of formulating local and national policy.

7. CSIR-Council for Scientific and Industrial Research

Its research mainly focuses on alcohol, and drug-related traffic infringements.

8. HSRC – Human Sciences Research Council

HSRC researches all aspects of substance abuse through its Centre for Alcohol Drug Related Research. Its research includes major surveys that target specific population groups, national surveys and expert analysis of statistical data.

9. SAAPSA – South African Alliance for the Prevention of Substance Abuse

SAAPSA was established in 1995 with the assistance of WHO/PSA. It includes members from 70 organizations. Its goal is to "facilitate networking among all organizations, government and civil society, concerned with drug and alcohol abuse in S.A. with a view to optimizing cooperation in the prevention and treatment of alcohol and drug abuse".

10. Other NGOs prominent in the drug field

- Cape Town Drug Counselling Centre (treatment, training, prevention and research)

- Narcotics Anonymous
- Bridges (prevention programmes in schools)
- RaveSafe (harm reduction at major rave parties)
- Drug Wise (Counsellors)
- Elim Clinic (Treatment)
- Stepping Stones (Treatment)
- Institute for Security Studies (includes drug-related research)

There is a relatively wide network of public and private substance abuse treatment facilities in South Africa. These include some 300 organizations where support and after-care are provided: 67 community treatment facilities, 147 provincial and private hospitals and psychiatric hospitals, 12 detoxification facilities and 25 specialist in-patients units/half-way houses. All these facilities are largely in urban areas. The overcrowded former townships, informal settlements and rural areas are grossly under-served.

#### **H. Programmes and Service Providers Utilized by the Department of Correctional Services**

- Most of the programmes used in Department of Correctional Services includes Awareness of the dangers of drug abuse as well as Life Skills training. Counselling is also part of these programmes. The Social Workers are usually the professionals dealing with drug abuse in prevention programmes. Due to their large case loads, the programmes are usually presented to groups of inmates. In prisons there are Drug Awareness Programmes for all inmates and Intervention and Treatment Programmes for individual problem cases. The Drug Awareness programmes consist of the sharing of knowledge, acquisition of skills, individual growth and role play. Some of these aspects are also included in individual therapy.
- *Ekuseni Youth Development Centre's Alcohol and Drug Programme* consists of three modules:  
 Module 1: Orientation on Alcohol and Drugs (8 sessions)  
 Module 2: Personal values on drug use and its effects ( 6 sessions)  
 Module 3: Me and my drug – self-appraisal and assertiveness (7 sessions)
- SANCA will launch the *Aganang (Let's work Together) Programme* in conjunction with Dept. of Correctional Services in June 2003 in seven prisons with juvenile offenders countrywide. The 13-session Programme's focus is on substance abuse and Life Skills. The programme is based on the Alcohol and Substance Programme of Ekuseni Youth Development Centre.
- *DRUG WISE* strives to provide an accessible community based, multidisciplinary service for drug related problems. Drug education, early identification, intervention and sympathetic counselling is a more effective tool against drug abuse than a judgmental anti-drug approach. This is achieved by positioning the community pharmacist as the first port of call for all medicine and drug related problems. Drug Wise also provides school education programmes as well as Teacher Training Programmes and Parent Education. The latter aims at assisting parents in understanding the adolescent drug scene, what their children are exposed to and how as parents they can intervene.

In some prisons Drug Wise has also started Drug Peer Counselling Training through *Khulisa*, an organization whose main objective is the prevention of crime. The Drug Peer Counsellors who completed the training are very enthusiastic and play an important role in addressing the drug abuse problems in prisons where overcrowding is a big problem and professional staff members, such as social workers, are battling with large case loads.

- Other Substance Abuse Programmes used by Dept. of Correctional Services are regionally based to take into consideration the differences in culture for example. The main objectives of these programmes are to make offenders aware of the dangers of substance abuse and the consequences hereof; addiction, types of drugs, defence mechanisms, withdrawal symptoms and the availability of treatment programmes.
- For the ongoing development of such programmes, it is of vital importance that proper and relevant statistics should be kept – especially of successes, reoccurrences of problems, time periods, number

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of inmates reached by programmes, referrals to other agencies etc. For research purposes it is also very important that statistics are obtained and kept in a uniform way so that it is easily accessible.

### **I. Community Mobilization and Collaboration with Relevant Sectors**

In South Africa networking exists among different health care and welfare agencies as well as state departments such as Department of Correctional Services, Department of Justice and the South African Police Service.

- When *Correctional Supervision* instead of imprisonment is recommended for an offender, he/she will have to attend a certain number of sessions of a specific programme designed for the type of offence he/she has committed, as part of his/her sentence. If the offence was drug abuse, the programme will be regarding the dangers of drug abuse, long term effects on health, family, social aspects etc. Experts from e.g. health care services will be invited to certain sessions to share their knowledge on the specific subject.
- The same goes for the *Diversion Programmes*, which were designed to keep children under the age of 18 out of prison, to prevent them from having a criminal record and to give them a second chance. The relevant agencies (such as Dept. of Social Development) will play a role in the specific diversion programme as well as some non-governmental organizations such as *Khulisa*. Khulisa's main objective is crime prevention. Khulisa is concentrating its efforts mainly on the youth, both in prisons and in the community. In prisons they conduct a Life Skills Programme called "My Path" consisting of three phases of twelve modules each. The programme runs for one year and participants attend a two hour session each week. The rest of the work is self-study. The programme in the community is called "Make it Better" and equips youth leaders with the necessary skills to make a difference in their own communities and to make life better out there. The main focus still remains crime prevention. Sixty percent of Khulisa's employees are ex-offenders.

These are just a few examples of the collaboration that does exist. Local funding for such projects still remains problematic as there are so many social issues in our country that need attention and funding. Therefore the collaboration with foreign countries, especially for funding of specific projects, is still much needed at this stage.

### **III. POSSIBLE SOLUTIONS TO ENHANCE EFFECTIVE PREVENTION OF DRUG ABUSE AND TREATMENT OF DRUG ABUSERS**

1. Training of counsellors who can operate in their own mother-tongue (11 languages).
2. Existing programmes in use should be tailor-made for use in the different departments.
3. In the Department of Correctional Services every employee is now seen as a rehabilitator. For that reason the disciplinary staff should also receive training in drug abuse programmes as they spend more time with the inmates than the education and therapeutic staff.
4. The Diversion Programmes for children under 18 should be expanded rapidly with properly trained facilitators.
5. All stakeholders who supply either preventative or treatment services should keep statistics. These statistics must be kept at a central place-easily accessible in order to be available for evaluating and planning processes. Success/failure stories regarding specific programmes and the reasons why it works/does not work (evidence-based) should also be available at a central place.
6. Different professionals working for example in one department, should put professional jealousy aside in order to obtain better results in their fight against drug abuse. Experts in this field should also be willing to travel and to share information at regional workshops.
7. Modern technology e.g. the Internet, could also play a vital role in getting information to the people to deliver a better service to the community at large.

8. Large campaigns should be launched nationally with participation from every Government Department, Local Authorities and the media to make people at the grassroots level aware of the dangers of drug abuse and where help can be obtained. This must be an ongoing project with a change in focus from time to time to keep people's attention.

#### **IV. FUTURE PROSPECTS AND CONCLUSIONS**

During my research for information to compile this paper, it came to my attention that quite a number of senior state employees who are experts in the field of drug abuse, resigned and took jobs in the private sector or with other organisations working in the field of drug prevention and treatment. We need their expert knowledge in the Criminal Justice System and must plead with the Government to try and keep them in the service of the government. We cannot afford this brain drain from the Criminal Justice system. They are especially now needed in the Department of Correctional Services where rehabilitation has become a core function next to safe custody.

- We must continue on the guidelines set out in the National Drug Master Plan, but at the same time not refrain from making valuable recommendations for the next NDMP (2005-2009) from practical experiences regarding prevention and treatment of drug abuse in the Criminal Justice System.
- The Criminal Justice System must collaborate closely with expert role players and organisations in the community regarding drug abuse because our clients (offenders) come from the community and have to return at some stage to the community. The reintegration process of ex-offenders could benefit greatly from this, especially if the ex-offender can be referred to a suitable support group or self-help group in the community.
- More money should be made available for Prevention and Treatment Programmes, especially in prisons. This could lead to programmes being rolled out for trial awaiting prisoners as well, which make up a large proportion of the prison population, but are normally not included in specific programmes.
- Programmes must be made available in all the eleven languages of our country if we really want to make an impact on society at large, but also on our Criminal Justice Community.
- Prevention and Awareness Programmes should also be part and parcel of school programmes. More emphasis must be placed on the importance of these types of programmes, almost to the same level as the attention the HIV/AIDS campaign is receiving in our country.
- In the final instance we are aware of the fact that the focus on substance abuse can easily be lost given the overwhelming social problems facing South Africa today. We dare not lose our focus – too much is at stake.

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# PUBLIC HEALTH STRATEGIES IN PREVENTION AND TREATMENT FOR DRUG ABUSERS IN THAILAND

*Duangta Graipasong\**

## I. INTRODUCTION

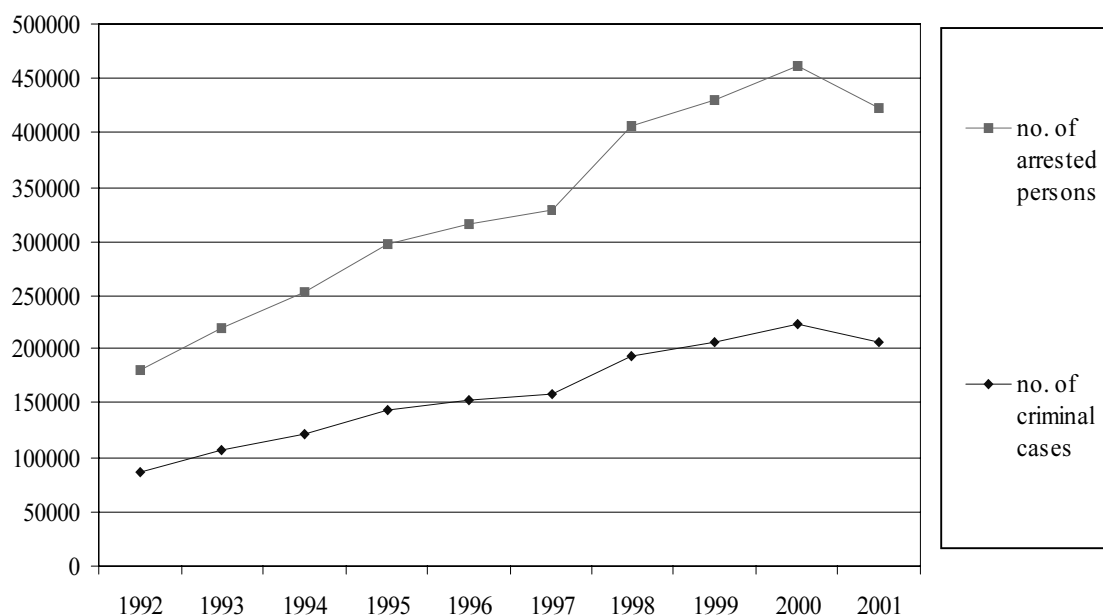
In the decades of civilization, economic growth has been one of the most important issues that the governments have declared in their policies. Materialism has been the social value that determined the people's lifestyle. Illegal drugs trading has become a tremendously profitable business. The weakest groups of victims have been entrapped by the intriguing marketing strategies. The reluctance of law enforcement, the loose ties of the families, the challenging value to abuse illegal drugs, as well as the biological and psychological effects of the drugs to the brains have aggravated the detrimental situations. The increase of illegal drugs crimes and their associates is inevitable. To achieve such crime prevention purposes, not only the effective and systematic jurisdiction process should be administered, but also acute public health strategies should be implemented.

## II. THE CURRENT SITUATION

### A. Drug Trends and Characteristics of Drugs Abusers

#### 1. Statistics of Narcotic Drugs Seized

During this last decade, narcotic drugs, especially the psycho-stimulant amphetamine, seized in Thailand has been increasing at breakneck speed in terms of the numbers of arrested persons, the criminal cases and the quantities of drugs seized. The statistics reported by the Office of the Narcotics Control Board are shown in figure 1 and figure 2.

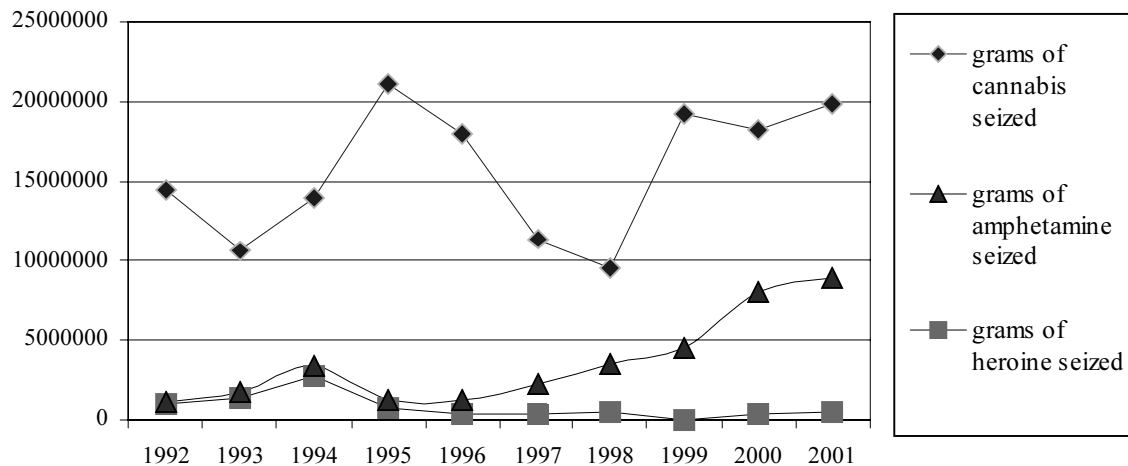


**Figure 1. Number of Arrested Persons and Numbers of Criminal Cases**

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Assistant Director of Galya Rajanagarindra Institute,  
Department of Mental Health,  
Thailand

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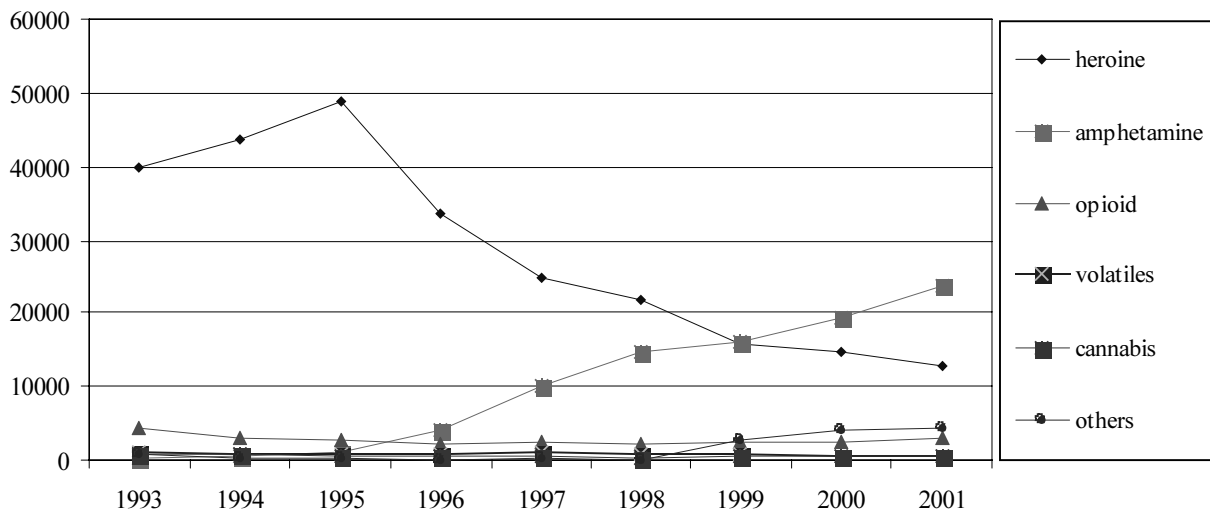
From figure 1, the number of arrested persons and the criminal cases in 2001 were less than in 2000, but when considering the amount of amphetamine seized, as shown in figure 2, it still indirectly shows the increase in the spread of amphetamines. Because there are many factors influencing the number of criminal cases reported and sometimes it is difficult to identify who are the criminals or the scapegoats, the statistics in figure 1 and figure 2 may not show the whole story.



**Figure 2. Amount (in Grams) of Heroin, Amphetamine and Cannabis Seized**

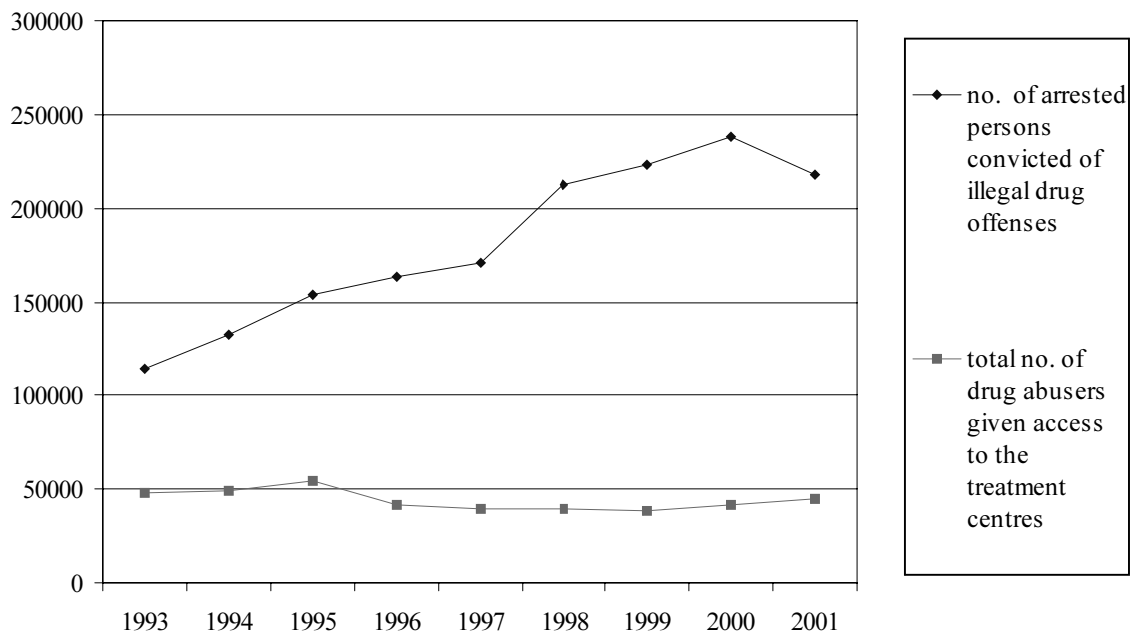
### 2. The Increase of Amphetamine Abusers

An epidemiological study of drug abuse has found that the trend of abusers that have accessed therapy has changed. The number of amphetamine abusers in therapeutic settings, which were reported by the Office of Narcotics Control Board, overtook the number of heroin abusers in the years 1999-2001 as shown in figure 3.



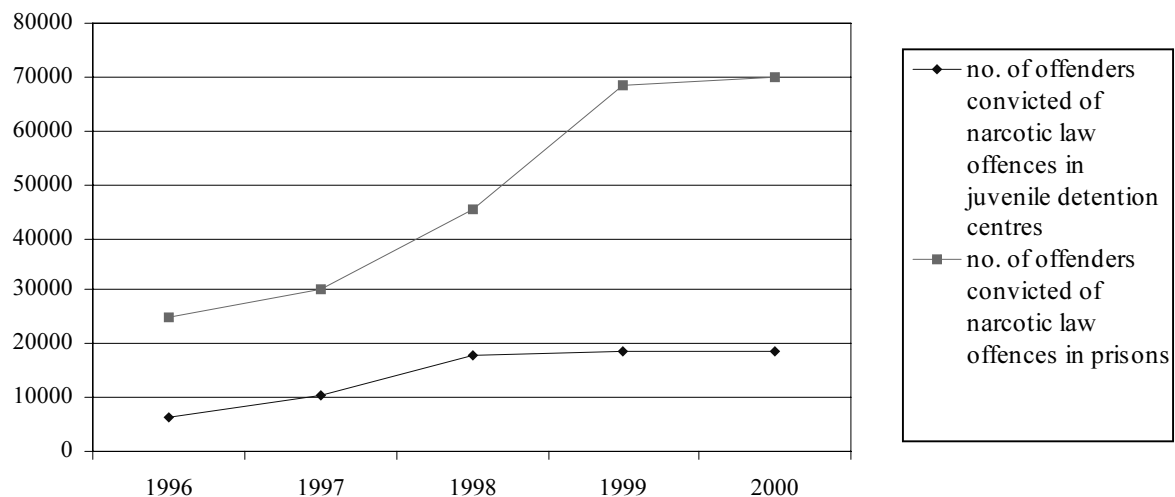
**Figure 3. Number of Drug Abusers who have Accessed Therapy**

Consideration to the number of arrested persons, most of whom are abusers or abusers and minor dealers (the data as shown in figure 1), and the accessibility of therapy (the data of total cases in figure 3), the figure shows that only twenty percent of the cases who need therapy can access treatment as shown in figure 4. Three-quarters of cases that received treatment used outpatient clinics, and the rest were residential patients.



**Figure 4. The Number of Convicted Drug Offenders and the Number who Received Drug Treatment**

The majority of the cases were in the criminal justice process thus the imprisonment and detention rate in the prisons and juvenile detention centres were high due to narcotic law offences as shown in figure 5. The source of the data was derived from the Annual Report of Department of Correction and Juvenile Detention Centre.



**Figure 5. The Increase in Imprisonment and Detention Rates due to Convictions for Narcotic Law Offences**

The Office of the Narcotics Control Board reported the findings of the national survey study, which was accomplished by the Drugs Academy and Information Consultant Committee. The committee was comprised of academics from Chiangmai University, Khonkaen University, Songklanagarind University, Assumption University, the Social Research Institute and Institute of Health Research of Chulalongkorn University. The study was carried out among the population of 12-64 year olds, during June 2000- December 2001. It was revealed that 16.4% of the total population have used narcotic drugs, while 4.3% have used one year and 2.2% have used one month prior to the study period respectively. About one-half of the target population was amphetamine abusers. The studies of drug abuse patterns among the youths summarized by the Bureau of Drugs Prevention and Correction Development, Office of Narcotics Control Board reported



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that the average age of those first exposed to drugs was 15-19 years old. Amphetamines have been the most popular drugs since 1997. About two-third of the abusing youngsters accepted that they had gone to discotheques and indulged with their peers.

## **B. National Policies in Combating Illegal Drugs**

### **1. The Government Strategies**

The spread of drugs is a crucial national problem that the present government is strongly concerned with. Collaboration among every part of society is essential; hence the government has determined the strategy of 'people power to conquer illegal drugs' and the 'separation of addicts from traders and producers'. The associated organizations under the Ministry of Parliament Secretaries, Ministry of Interior, Ministry of Public Health, Ministry of Justice, Ministry of Military, Ministry of Labour and National Police Bureau have to establish action plans that cover three domains: (1) demand control, (2) potential demand prevention and (3) eradicate supply. The nine guidelines for every collective organization in society to follow were declared on May 31st, 2001. The nine guidelines declared by the cabinet are as follows: (1) drug suppression (2) administration and coordination (3) encouraging people power and prevention (4) therapy, treatment and rehabilitation (5) drugs and chemical precursors control (6) overhauling laws and the justice process (7) investigative reports (8) international cooperation (9) research development monitoring and evaluation. In addition, on February 1st, 2003 the government launched a three-month nationwide drug suppression campaign, the 'anti-drug crusade'. There was a tremendous increase in drugs seized and many of the drug dealers were slain or arrested. The police claimed that the death toll comprised mostly murders perpetrated by trafficking rings to eradicate the risk of minor dealers providing information to the authorities. The human rights groups asked the government to consider the violation of human rights and the law because of the extra-judicial killing. However, after the massive drugs crackdown occurred, the numbers of drug offenders was obviously decreased. The spread of glue sniffing and the abuse of alternative substances inhalation were reported.

### **2. Role of the Royal Family**

His Majesty King Bhumibol has great concern for his people, especially the negative effects of drug addiction that badly affect national development. In order to succeed in fighting against drug addiction, the national motto "Love our king, care for our offspring, against drugs altogether" which represents the Thai people's loyalty to the King, has become one of the significant campaigns.

Princess Ubolratana, the first daughter of their Majesties King Bhumibol and Queen Sirikit, following in the footsteps of her Royal Father and graciously accepted the invitation to be the chairperson of the campaign. She wants the campaign directed mainly at youngsters by creating a trend of keeping away from drugs through the provision of an arena for them to display their individual talents and contribute positively to their own lives and those of others. The Princess has therefore initiated the "To Be Number One Club" in educational institutions to create the value of being number one without drugs. The Princess has also set up a drug rehabilitation facility under the theme of "Raise your hand if you're a drug addict". In addition, Princess Ubolratana has been working as the chairperson of collaborative clinical research on the impact of amphetamine use among Thai people.

## **III. PUBLIC HEALTH STRATEGIES**

### **A. Strategies and Programmes**

The Ministry of Public Health has the responsibilities that follow through the strategy of mass people power to conquer illegal drugs in three guidelines as: 1) therapy, treatment and rehabilitation in order to prevent and correct the addicts; 2) encouraging people power and prevention in order to prevent the potential demanders from becoming addicts; and 3) drugs and chemical precursors control in order to control supply.

The integrated action plans have been established and effective and efficient standards of therapy, treatment and rehabilitation have been developed for countrywide implementation.

## **B. Strategy of Encouraging People Power and Prevention**

### **1. Local Level**

The local collaboration among the community institutions which comprise of families, communities, authorities, temples or other religious organizations, schools and various government sectors from the Ministry of Public Health, Military, Education, Interior, Justice and Labour have been set up as the Against to Conquer Drugs Operational Centres at the district and provincial level. The A-I-C (Appraisal-Influence-Control) technique is one of the chosen methods used to encourage and empower people, especially the leaders in the communities to fight drugs in their communities. By brainstorming, they will determine the prioritized actual activities to protect their offspring from preventable devastation. Surveillance and screening techniques to differentiate the groups of drug abusers in the communities were employed. Potential demanders who are occasional abusers, have some degree of behavioural change and still have a normal daily life but continue using though they know the risks of drugs, are classified as drug abusers. These identified risk groups will be sent to the behavioural modification camps in the communities or to access psychosocial therapy for drug abusers in the schools or in the community clinics in order to prevent them from becoming drug addicts. Both of the psychosocial therapy programmes are modified from the Matrix Model of Intensive Outpatient Treatment developed by the Matrix Centre, UCLA of U.S.A., which was introduced into Thailand by the Department of Medical Services and Department of Mental Health, Ministry of Public Health at the end of 2000. Most of the attendance of the programmes is voluntarily. However, after the promulgation of the amendment of the Drug Addicts Rehabilitation Act which enters into force one year following the day after its publication in the Royal Gazette on 30 September, 2002, the compulsory cases under court order and court probation will engage in the programmes.

Types of prevention for potential demanders

#### **(i) *Behavioural modification camps***

The behavioural modification camps are in charge of the military camps, the troops of cavalry, the border patrol police, the vocational schools, the ordinary schools, the provincial public health offices and the community or the provincial hospitals. The five clusters of learning experiences were designed for the camps curriculum as: 1) knowledge of drug hazards and group therapy, 2) emotional intelligence development, 3) family functions, 4) individual skill encouragement, and 5) Thai civil obligations. There are two activities in the cluster of knowledge of drug hazards and group therapy. After finishing the session on the knowledge of drugs hazards, the participants are expected to be able to explain the hazards of drugs, to identify the causes of their drug abuse behaviours, to explain the nature of drug abusers, to differentiate the level of drugs abusers and to explain the complications of drug abuse. There are four sessions of group therapy, which apply the group process and emotional intelligence principles to change the participant's attitudes and problem solving towards relapse prevention. The activities in the emotional intelligence development cluster consist of self-awareness activities; emotional managing activities; motivate oneself for goal achievement activities; empathy with others activities; and social skills training activities. The activities in the cluster of family functions are composed of oneself's role in family, problem solving in the family, behaviour control skills, family ties and care, emotional response in the family and communication skills in the family. The activities in the cluster of individual skills encouragement are the activities called 'my favourite club' and 'club networking'. The activities in the Thai civil obligations cluster are comprised of environmental conservation activities, cultural conservation, country and local important person admiration activities and religious encouragement activities. Games, group activities, role-playing, case studies, skills training and exercises are utilized for the nine days and nights course. The monitoring period after the camp is one year.

#### **(ii) *Psychosocial therapy for drug abusers in the community clinics***

The out-reach activities can be held in the health centres or even in the communities such as in temples and factories, etc. The programme is comprised of 11 sessions of 1-2 hours. The group size is limited to twelve. The participants go twice a week for 6 weeks. Their families have to participate in the first individual session and the tenth and eleventh group sessions. After the end of the continuous activities, the staff follow up once or twice a week for 2-3 months, and then once a month for one year. The topics of the sessions, in order, are as follows:

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1. Service Agreement and Consent (the conjoint session between the abuser and his/her family). The purpose of this topic is to motivate and to prepare the abuser and his/her family's mind. The information of the therapeutic process and the service agreement will be interactively clarified.
2. Stop the Cycle. To learn about the relapse cycle, especially to explore the triggers and to find ways to avoid the triggers are the objectives of the session.
3. Identifying External Triggers. To explore the external triggers, to review their daily life timetable and to avoid the external triggers appropriately are the objectives of the session.
4. Identifying Internal Triggers. By the group activity, the participants will understand the trigger effects of both positive and negative feelings that lead to relapse. The group will learn from each other to manage their internal triggers.
5. Body Chemistry in Recovery. To provide knowledge about the physical change during drug use and the changes which occur in the recovery process are the purposes of the session.
6. Early Recovery Problems. The problems that occur in the early recovery phase are valuable to learn and to prepare for problem solving.
7. Thinking, Feeling and Doing. The participants have to learn how to separate their thoughts, feelings and behaviours. To learn how to change and control their behaviours in the process of abstinence is essential.
8. Self-help Groups. Self-help groups that are established by the participants and their families will be beneficial for sharing experiences and psychological support.
9. Simple tips from 12-Step Activities. To review the twelve steps principle of the Narcotics Anonymous Group is valuable for the participants.
10. Avoiding/Coping with Relapse (family group session). The families should understand both the external and internal triggers which are the conditions promoting relapse. The families should learn how to prevent those conditions.
11. Living with Addiction (family group session). By discussion in the group, the participants and the families can learn to live together from other families' experiences.

(iii) *Psychosocial therapy for drug abusers in the schools*

This programme is modified for the students in schools. The trained teachers and students who have drug abuse screening ability will report to the classroom teachers. The classroom teachers will verify the data by confidentially interviewing the suspected students. Urine tests for drugs are requested from the strongly suspected but the students refuse. After verification and persuasion, the students and their parents will be introduced to the programme. The school director and administrators have to set the guaranteed system for indiscrimination prevention. In this programme, the teacher will be trained to be the group leader and the 8-12 potential demand students are the group participants. Seventeen sessions are run over nine consecutive weeks with two sessions per week. It takes 1-2 hours for each session. The component of the programme is the integration between the application of the Matrix Model of Intensive Outpatient Treatment and the Life Skill Group. The 6 sessions of the Early Recovery Skills Group, 2 sessions of the Relapse Prevention Group and 3 sessions of the Family Education Group are modified from the Matrix Model of Intensive Outpatient Treatment. However, the sessions contained in this programme are somewhat different from the above programme in the community clinics. The included five Life Skill Group sessions are also identified from the psychosocial implicit need of the youngsters. The sequencing topics of activities are as follow:

1. Mind Contract (the parents join in the group). The objective is to encourage the parent, the students and the teachers to join hand-in-hand in order to change the drug abuse behavioural pattern of the students in the school.

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2. Life Tree. To promote the students to compare their own condition before and after drug abusing is the objective of this activity.
3. Speedy-Pill Hazard. The group activity encourages the students to identify the triggers that lead them to drug abuse, and to list the impacts of the abuse behaviours.
4. External Triggers. The designed group activity is to facilitate the students to realize the influences of external triggers over their thoughts, feelings and behaviours. The students should identify their own risks in order to avoid such situations.
5. Internal Triggers. The students will learn their emotional states, the internal triggers, which are the causes pushing them back to abuse drugs. Emotional management skills are one of the preventable factors that will be taught in the group activity.
6. Thought Stopping Technique. The students are facilitated to identify the applicable thought stopping techniques, which are the critical steps to short cut the drug abuse behaviour cycle.
7. Recovery Roadmap. The students can find their own methods to avoid or correct the trigger situations in each step of the drug abuse cycle.
8. Trust. The students will be encouraged to accept that even though they are in the steps of abstinence, their families and friends still might not trust them. Trust depends on the students' intention to change.
9. Family Roles. The parents will join in the group session. The students and their families will solve the problems caused by drug abuse together. They will identify their definite roles in such events.
10. Quit the Risk Behaviours. The activity will provide for the students to analyze and to be aware of the risk behaviours which make them prone to relapse.
11. Leisure Activities. The students can identify appropriate leisure activities because wasting time is one of the triggers.
12. Study Development. From the group activity, the students will realize the importance of study. They will respect themselves after they have progression in studying.
13. Decision-Making Skills. The students will be trained to have the decision-making skills that are important, especially in risky circumstances.
14. Assertiveness. The students will learn how to say no and still keep a good relationship.
15. Old Friends and New Friends. The students will explore their strengths and weaknesses in order to choose good friends and to establish positive relationships with friends.
16. Life Goals. The parents have to join in the group session. The students and the parents will be encouraged to determine the students' life goals together. The students will have enthusiasm and motivation to achieve their goals.
17. Monitoring. The monitoring sessions are set up in order to maintain the students' continuous relation and self-help group activities. They will meet each other regularly on the 1st, the 4th and the 8th month after group closing.

However, the above-mentioned programme has been in the pilot process. If there isn't a school-based programme, but there are students who need it, the students will be advised to access the outpatient treatment programme at a nearby hospital.

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2. Country Level

The nationwide campaign has been launched by the coordination of the government sectors and non-government sectors. As mentioned above, Princess Ubolratana, as the leader, has performed concerts in the universities and colleges to cheer up the students under the slogan of "To Be Number One". A famous Thai professional tennis player is the presenter and role model for youth on various channels of the mass media. The picture of his endurance, perseverance and intention to achieve his life goal is the symbol of a new challenge that would replace the value of drug use.

**C. Diversified Treatment and Rehabilitation Programmes**

The holistic approach of standard treatment and rehabilitation for drug addicts are (1) to develop the clients and their families' potential, (2) to encourage the clients to set up the structure of their life to accord with normal living in society, and (3) to enhance vocational skills.

1. Outpatient Programme

The 16-week Matrix Intensive Outpatient Programme of the Matrix Centre, the prototype for the treatment of stimulant abuse and dependence disorders, has operated in Thailand since 2000. The programme consists of 10 sessions of Individual/conjoint sessions, 8 sessions of Early Recovery Skills sessions, 32 Relapse Prevention sessions, 12 sessions of Family Education and 4 sessions of Social Support Group. The participants have to meet the therapist three days a week. Urine testing for drugs is conducted weekly. After finishing a 16 weeks intensive course, the clients are encouraged to participate in the Social Support Group once a week from the 17th through 52nd week. The Individual Sessions are designed to orient the patients and his/her family members to the expectation of the Matrix Programme, complete the administrative documentation, and establish rapport with the client to encourage treatment entry. The progress review at 30-45 days of the treatment course helps the client create a continuing care treatment plan. The Early Recovery Skills Group will help the client to receive many of the basic skills they need to achieve initial sobriety. An introduction to 12-Step involvement is also included. The Family Education Group is the one element of the programme that regularly involves family members. The group is designed to be interactive. The Relapse Prevention Group is the central element of the treatment model that is designed to deliver information, support, and camaraderie to patients as they proceed through recovery. The Social Support Group is designed to assist patients in learning re-socialization skills in a familiar and safe environment. The treatment courses have been started in the pioneer hospitals such as Thanyarak Hospital, the Psychiatric Department of Rachaburi Centre Hospital, the Northern Drug Dependence Treatment Centre and the North-eastern Drug Dependence Treatment Centre. The Drug Dependence Treatment Centres were established under the Department of Medical Services, and were gradually set up in the northern, north-eastern and southern part of Thailand since 1975. The second wave of pioneers consists of the multidisciplinary teams of the psychiatric hospitals and institutes under the Department of Mental Health and the rest of the Drug Treatment Centres in Songkla, Pattanee and Maehongsorn Province. Incomplete attendance of clients is common among the pioneers though the therapeutic teams use persuasion, motivational interviews and telephone follow up, and so on. The modified programmes are variable, in terms of the duration, and the frequency of sessions over a week. Almost all of the modified models are adjusted in order to overcome the common complaints of the clients and his/her families that they don't have enough time, they have to earn money. At present, the course duration of the FRESH (F=Family, R=Relapse Prevention, E=Early Recovery, SH-Self-Help) model, the so-called modified MATRIX Model in Thailand, has been shortened from 16 weeks to 12 weeks by condensing some repeated contents in the Relapse Prevention Group, and adjusting the courses of the Individual/conjoint sessions and the Family Education sessions. The follow up duration after the course is one year.

2. Inpatient Programme

The 4 months course of the FAST Model and the shortened course from 12-24 months of the Therapeutic Community Model, has been innovated by Thanyarak Hospital (now called the Thanyarak Institute) since 2001 because of the increasing need. The innovation of the FAST Model is expected to be the model for inpatient stimulant drug dependants in the Regional Drug Dependence Treatment Centres under the Department of Medical Services, Ministry of Public Health and Drug Dependence Rehabilitation Centre under the Department of Probation, Ministry of Justice.

The FAST Model is comprised of the following components: (1) 'F' is Family Participation, (2) 'A' means Alternative Treatment Activity, (3) 'S' means Self Help and (4) 'T' stands for Therapeutic

Community. The objectives of Family Participation are to provide the essential knowledge for understanding and supporting the clients who struggle with drug abstinence. Moreover, to encourage the family to function appropriately is one of the important objectives. The essential skills training includes problem solving skills, communication skills, family role skills, affective involvement skills, affective responsiveness skills and behaviour control skills. The Alternative Treatment Activity is set up to promote the clients to achieve their full potential, to encourage the client spending time in useful leisure, to facilitate them to express their interest and to encourage them to have acceptable careers. Self –Help activities are derived from the emotional intelligence promoting principle. The clients will be encouraged to analyze their basic emotional intelligence, to synthesize the new skills in the component of emotional intelligence intuitively. The Therapeutic Community is set up for the inpatient client to learn how to live as a part of the community. The ‘help’ in ‘self help’ is the main principle. The variety of activities designed in group therapy, occupational therapy and re-shape behavior therapy are based on the clients’ background and needs. Confrontations in the meetings, regulation in the dormitory and positive reinforcement are the key tools in the Therapeutic Community.

The Drug Treatment Centres and other hospitals are the referral resources for treatment and rehabilitation and are the professional supporters for the prevention programmes in the catchment areas. The roles and functions framework are determined by the associated Against Drugs Operational Centres.

#### **D. Public Health Organization and Drug Addicts Rehabilitation Act**

The new Drug Addicts Rehabilitation Act, the legal mechanism follow through, the national guideline of overhauling laws and justice process was implemented on 30th September 2002. The intention of the law is to view drug users as ‘patients’ instead of ‘criminals’. The law introduces a system of compulsory rehabilitation. Anyone arrested for using, possessing or selling drugs that the characteristics and the amount of drugs correspond to the declaration of the Regulation of the Ministry of Justice, will appear in court within 24-48 hours. Checks on suspects’ physical and mental condition and social background will decide whether they should go for rehabilitation or be prosecuted by the consideration of the Drug Addicts Rehabilitation Subcommittee. The ordinary drug users or addicts will be sent for a suitable rehabilitation programme not longer than 6 months. The rehabilitation period can be extended no longer than six months each time if the outcome is unsatisfactory. The total duration cannot exceed 3 years. The public health organization will join in the stage of drug abuse or addict approval, the rehabilitation scheme and aftercare follow up in the community.

The compulsory outpatient cases will attend the treatment and rehabilitation programme mentioned above in the hospitals near their homes, while the compulsory inpatient cases will be admitted to Thanyarak Institute, Regional Drug Dependence Treatment Centres or Drug Dependence Rehabilitation Centre, depending on the convenience of the cases and their family’s accessibility.

#### **E. Department of Mental Health and Criminal Justice Process in Drug Abuse Crime Prevention**

In cases in which the addicts have a psychiatric illness that is a complication of drug abuse or there are dual illnesses existing, the psychiatric hospitals or institutes under the Department of Mental Health will take responsibility. Psychiatric treatment is essential for preventing recidivism because the patients’ judgment is disturbed by their illness. In addition, the Department of Mental Health also has the role of developing mental health promotion; prevention, technologies associated with drug abuse problems, while Thanyarak Institute, Department of Medical Services, has the major role in treatment and rehabilitation models development, standard of services monitoring and carrying out the associated research.

The Galyarajanagarindra Institute and the Department of Mental Health has cooperated with the Department of Correction to transfer mental health technology through the staff and the mental health inmate volunteers in the prisons. They will not only help other inmates to cope with their mental and behavioural problems, but by the process of helping others, they also improve their sense of self-esteem, especially the inmate volunteer groups. Basic mental health skills will be beneficial in enhancing their competency in the drugs rehabilitation activities in the jails in the future.

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**IV. CHALLENGES AHEAD**

The government has been active in the suppression of illegal drugs smuggling, drugs prevention, treatment, rehabilitation and correction for many years. Substantial resources have been employed to develop anti-drugs strategies, but the situation does not seem to have been satisfactorily rectified. Data collection of illegal drugs crimes, drug abuse treatment accessibility and ad hoc research have been established through the reporting system to the Office of the Narcotic Control Board. However, there is no systematically designed data collection at the grass-roots level, which is linked to upper levels respectively. The data analyzing and the channels of their dissemination also have limitations. Operational Centres are expected to be the source of drug abusers data base in their regions. The well-organized data collecting systems need diligent work. The consistency and continuity of any operational centres for any ad hoc strategies waxed and waned in Thailand, thus political and administrative support are one of the success determinants. Many projects could not be identify which organizations are the real hosts, thus many projects have a short life-span; the discontinuation of the outcomes inevitably occurred. The government under the leadership of Prime Minister Thaksin Shinawatra has great faith in the government service reform, hence the certainty strengthening will be the expected substitution. In regard to the treatment and rehabilitation model development, though the teams have been enthusiastic in modifying and applying the Matrix Model for Thai culture, nevertheless there is no systematic research support because of the lack of a project monitoring system. The role of the Institutions and organizations resulting from the government structure reform such as the Thanyarak Institute and the Galya Rajanagarindra Institute etc. will be beneficial to eradicate the mentioned weakness in the future.

**V. DISCUSSION AND RECOMMENDATIONS**

The declaration of the crusade against drugs under the leadership of the government, the massive drugs crackdown, compulsory rehabilitation instead of imprisonment and countermeasures according to the national guidelines are accepted nationwide. However, the conflicts of violations of human rights and law because of extra-judicial killings require careful attention and administration from the government. The burnout of the staff taking responsibility for implementing the Drug Addicts Rehabilitation Act should be detected and prevented. The research and development projects of the effective prevention and enhancement of treatment that is suitable for the Thai people's lifestyle needs a strong support policy. The mental health immunization booster for self-development is the essential element for crime prevention and correction in the long-term.

**VI. CONCLUSION**

Whatever the perspicacious strategies and planning, the effective prevention and enhancement of treatment for drug abusers will not become true if they are not implemented intentionally. The collaboration among the criminal justice process, the public health sector and the community organizations has to be emphasized. The strengthening of the family institution and the other social institutions are the important determinants in drug prevention and treatment. Let's give a chance for the good people to return back to our society.

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## REPORTS OF THE COURSE

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### GROUP 1

#### EFFECTIVE PREVENTION OF DRUG ABUSE AND ENHANCEMENT OF TREATMENT FOR DRUG ABUSERS IN THE PRE-SENTENCING STAGE

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### I. INTRODUCTION

Worldwide, drug abuse is realized to be on the increase. Several reasons may be adduced for this. In the majority of our countries, drug abusers are convicted without much consideration to their treatment. Current research knowledge from some countries namely UK, Canada, Thailand, USA and Australia strongly indicate that pre-sentencing treatment is very successful in reducing recidivism and assuring rehabilitation of the abuser. Pre-sentencing treatment is given before sentencing to all drug abusers who come in contact with the criminal justice system of these countries. It is designed to detoxify, rehabilitate and afford reintegration of drug abusers into society.

The legal position of some participating countries however is that drug abusers are criminals and should only be punished. This position is accepted by the group and will be discussed in our workshop.



## II. CURRENT SITUATION OF DRUG ABUSE AND MAJOR PROBLEMS

### A. Current Situation of Drug Abuse: Sanctions by the CJS, Major Illicit Drug Trends and High-risk Population

Each country has respective laws against drugs. According to those laws, in almost all countries both self-use and possession of drugs are punished, but in El Salvador self-use of all drugs is unpunished.

The drugs that are abused vary from country to country. In Malaysia, Maldives, Bangladesh and Indonesia, heroin is the most abused. Ghana and El Salvador have cannabis, Japan has methamphetamine and Bhutan has dendrite (adhesive glue), as the most abused drugs.

The younger generation is thought to be the highest risk population in all our countries.

However, the unemployed are also thought to constitute quite a high-risk group.

### B. Available Programmes for Prevention

Each country has some programmes for prevention, enlightenment programmes and educational programmes in the community or school by the government or NGOs.

In most countries, the relevant authorities conduct public relations activities to enhance awareness of the dangers and harmfulness of drug abuse among the general public in cooperation with NGOs. In addition, to prevent juvenile drug abuse, special education programmes are implemented in elementary schools, junior and senior high schools and in some countries the police also cooperate in such programmes.

### C. Available Programmes for the Treatment of Drug Abusers in the Pre-sentencing Stage

Almost all countries do not have such programmes, but some participant nations have the following treatment programmes in the pre-sentencing stage.

Japan has a rather unique system, whereas it has no treatment for adult offenders, it has a treatment schedule for juveniles. This programme is made available by the family court probation officer and the medical officer in the pre-hearing stage.

In criminal cases involving adults, a Non Profit Organization (Asia-Pacific Addiction Research Institute) manages a recovery-training programme for the prevention of drug abuse for defendants released on bail.

Malaysia has a pre-sentencing treatment programme under the Drug Dependents (Treatment and Rehabilitation) Act, enacted in 1983.

Drug dependants treated under the act are not regarded as offenders. Upon being medically certified as drug dependants, they are required to undergo compulsory treatment and rehabilitation at a drug rehabilitation centre independent of the offence they may have committed.

### D. Major Problems in Prevention and Treatment of Drug Abusers in this Stage

#### 1. Prevention

Each country has similar problems with prevention programmes such as the lack of a monitoring evaluation system to estimate the result of those programmes. Besides, some participant countries face the problem of low literacy rates among their population, and as a result, a large majority are unable to appreciate the full impact of drug prevention programmes. This has also, in a way, failed to enhance voluntary participation in community-based drug prevention programmes.

#### 2. Treatment

Most of the countries do not have any treatment programme at the pre-sentencing stage.

But, if this kind of programme was implemented, the greatest obstacles are deeply related to the following matters:

- (i) The general perception that drug abusers are criminals  
It is necessary to change this particular point of view, in order to successfully implement reintegration and rehabilitation treatments with the cooperation of the community.
- (ii) Updated database  
Without accurate information and statistics, it is impossible to adopt effective measures and appropriate treatment.
- (iii) The issue of presumption of innocence vis-à-vis the imposition of a pre-sentencing treatment regime  
There is a fear that subjecting the arrestee to this kind of programme may prejudice his/her defence in the criminal proceedings, which he/she is later subjected to.
- (iv) It is also important to discuss whether these pre-sentencing programmes should be compulsory or voluntary.
- (v) Coordination of related authorities  
Such as government institutions, NGO's and non-profit organizations.
- (vi) Lack of funds and human resources in implementing a pre-sentencing treatment and rehabilitation framework  
Some countries face financial constraints and lack of expertise required in carrying out such pre-sentencing treatments.
- (vii) Law amendment  
Legal basis is indispensable for the implementation of any programme.

As the problems listed in the above 6 and 7 are beyond the group's capacity, they will not be discussed as separate problems.

### **III. POSSIBLE MEASURES FOR ENHANCING EFFECTIVE TREATMENT AND PREVENTION FOR DRUG ABUSERS**

#### **A. Treatment**

##### **1. Necessity of a Pre-sentencing Treatment Programme**

Issues:

- (i) Whether drug abusers should be regarded as patients or ordinary offenders
- (ii) Whether drug abusers ought to be offered medical treatment or punished
- (iii) Whether drug abuse / use ought to be criminalized or otherwise

It was generally felt that these issues are closely connected to each other and was, therefore, necessary to discuss them together. In the ensuing discussion, some participants reflected on their countries' position and put up a strong case that it is necessary to criminalize drug consumption. The argument being that drug consumption is harmful not only to the abuser himself but also to family members as well; and this phenomenon ultimately disrupts the peace and harmony of society. There is a fear that decriminalization of drug use would be perceived as giving an official stamp of approval to the misuse of drugs which in turn would engender an uncontrollable surge in the number of drug users. This argument is obviously premised upon the precept that criminalizing drug use deters people from taking drugs. It was also noted that in some countries drug consumption is prohibited by the religion embraced by the common majority of the population. The national law of these countries would often be premised upon doctrines drawn from religious edicts, which consider drug consumption a sin. It was, therefore, inconceivable for these countries to legislate a rule that runs contrary to their religious belief. For these reasons, these countries viewed the decriminalization of drug use as an issue that could not be compromised.

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In contradistinction, some participants felt that drug abusers are distinct from common criminals because they suffer from a medical condition. They were of the view that these people ought to be treated differently because they require urgent medical treatment more than they needed to be punished. Denying drug dependants the requisite treatment is therefore not an exercise taken in the best interest and welfare of these individuals. More importantly, it was felt that incarcerating drug abusers would not achieve the desired effect of deterring them from further abusing drugs, or curb recidivism. Notice was taken of the fact that some countries, particularly the developed ones, do not criminalize drug consumption.

At this juncture, the views of the visiting expert on this issue as well as the rationale for the decriminalization of drug use were sought. The visiting expert explained that while it has been a general trend for most countries to impose severe criminal sanctions to deter people from using drugs, experience shows that the rate of drug use is still high even when harsh punishments are imposed. He is of the opinion that the belief that harsh criminal sanctions do effectively deter drug abuse is not adequately proven. Studies have shown that punishment does not seem to have a positive effect on offenders. Drug use, he says, is linked to the person's criminal behaviour. It is that behaviour that needs to be dealt with. Drug abusers, apart from abusing drugs, generally would have also committed other offences. One therefore needs to deal with the criminal behaviour in order to reduce the number of crimes committed. And, giving timely treatment to these offenders would be one of the ways of dealing with that criminal behaviour.

Further views were offered which postulated that a stringent legislative regime may still fail to achieve its desired effect if enforcement of these laws is lacking or hampered by the want of human resources. It was felt that these are policy considerations of which further ventures in the discussion would undoubtedly prove unfruitful. In short, strict laws may not be the sole determinant in bringing about the necessary deterrent effect.

In resolving this extremely difficult and complex issue, the meeting recognized the diversity of circumstances that prevails in each country. Some jurisdictions have found it feasible and efficient to decriminalize drug abuse while others have found it imperative to consider it as a criminal offence. As the problems faced by each country vary according to its own individual needs, there is clearly no panacea to be offered here. Therefore, the question as to whether the misuse of drugs ought to be criminalized or otherwise would be best left to the sovereign decision of the respective countries. It was also resolved that the question as to whether drug abusers ought to be given the necessary medical treatment instead of merely being incarcerated should be decided by the government of the respective countries. In conclusion the group recognizes the need to give medical treatment to drug abusers in addition to or in place of punishment.

### (iv) The Necessity of an Updated Database

As this issue is highly technical in nature, the views of the visiting expert were sought. According to the visiting expert, research carried out in Canada<sup>1</sup> on offenders showed that there is a strong relationship between crimes and, alcohol and drug abuse. The results showed that more than 50% of those who commit crimes have been using drugs or alcohol. These results were consistent with similar research carried out in the US and UK where approximately 50% to 60% of the offenders were found to be using drugs. He clarified that, generally, drug abuse gives rise to three different types of crimes. First, crimes of violence that are associated with the drug trade. Second, drug trafficking and possession, which are, by themselves, prohibited. Third, acquisitive crimes, which are committed to finance the offenders' drug taking, habit. The first and second categories are punishable by law. The third, according to him, is problematic because it is not the money that drives them to commit crimes. In comparison with the first and second categories, this type of offender needs to be dealt with in a different way. Following this, one needs to know who has been committing crimes and what kind of crimes were being committed under the influence of or associated with drug use. This is where a database would not only be useful but necessary. It was further explained that for this purpose it was not necessary to have a national database. To develop a system, a regional database would suffice. For example, Japan could use a particular prefecture to conduct the research. The results could then be used to argue whether a pre-sentencing treatment regime ought to be implemented or otherwise. The working group concurred with and adopted the views of the visiting expert.

<sup>1</sup> Grant, Brian A. Substance Abuse in the Canadian Correctional Context. VE Lecture presented at the 124 International Training Course at UNAFEI. 26 May 2003. Fuchu, Tokyo.

## 2. Legal Problems – Presumption of Innocence

Some concerns were felt regarding the imposition of a pre-sentencing treatment regime in that it may impinge on the time honoured and universally recognized rule that a man is presumed innocent until proven guilty. This is relevant, particularly in countries which criminalize drug use. There was a real concern that submission by the arrestee to pre-sentencing treatment for drug addiction before trial could be perceived as an admission to a charge of drug abuse and may therefore prejudice his defence. In response to this, several solutions were canvassed to overcome the problem. Some of the suggested measures, which may be seen as a palliative to this predicament, are:

- a) The introduction of a voluntary pre-sentencing treatment scheme as opposed to one that is compulsory; or
- b) Excluding from the criminal proceedings any evidence pertaining to the pre-sentencing treatment.

Recognizing that the interests at stake here are diametrically opposed, an opinion was given to the effect that if the benefits that can be derived from a pre-sentencing treatment regime outweigh the prejudice that an arrestee may suffer from the receipt of such treatment, such a scheme ought to be given favourable consideration. In any event, it was agreed that it was inappropriate for this issue to be discussed at length here. Rather, it was felt that it would be more convenient for it to be addressed at the time when the structure of the proposed treatment scheme was being discussed. It was also agreed that the treatment scheme proposed must take into account the rule on presumption of innocence.

## 3. Forms of Pre-sentencing Treatment Programmes that may be Introduced

- (i) *The target of the programme – should it be confined strictly to drug offenders or to include other offenders, who are drug abusers, as well?*

This was by far the most difficult and controversial issue. Some participants were of the opinion that the treatment programme should be confined to those who have committed drug offences only. Others felt that limiting the programme to drug offences only would render the programme as being too restrictive in scope. There was a concern that the effectiveness of the programme would be undermined if, regardless of the offence committed, offenders having a drug problem were not treated at an early stage. Some views were expressed that it would be difficult to regard those who have committed serious offences such as rape, robbery and murder as patients merely because they happen to be drug users as well. Additionally, questions were raised as to how these offences were to be dealt with in accordance with the criminal procedure if pre-sentencing treatment was given to the offenders. There was no consensus on this issue and neither was there any solution in sight.

- (ii) *Voluntary or compulsory treatment scheme: whether consent to treatment by the offender is required*

The question here was which of these alternatives was the better and more appropriate choice. The working group was again equally divided in its deliberation on this issue. Some participants were in favour of a voluntary scheme because it would not impinge on the rule of presumption of innocence. It was also felt that making it compulsory may violate the arrestee's personal rights. Some participants, on the other hand, favoured a compulsory regime because a voluntary scheme may not be as effective as one that is compulsory. Drug offenders could refuse treatment and the authorities would be powerless to do anything to remedy the situation. In the end, the objective of the programme would not be achieved. To overcome the issue of presumption of innocence, it was also suggested that the treatment programme be placed outside the criminal justice system. By separating the treatment programme from the criminal justice system, a much more effective result would be achieved without encroachment into the rule of presumption of innocence.

The working group heard the views of the visiting expert on the programme that is currently implemented in Thailand<sup>2</sup>. According to him, the programme is compulsory rather than voluntary. Prosecution of the drug offence is suspended temporarily while the arrestee undergoes treatment. Prosecution will resume if the arrestee refuses treatment or if he fails to be successfully treated due to a lack of cooperation on his part. The progress and condition of the arrestee during treatment are monitored by a sub-committee who makes its recommendation to the public prosecutor on whether the arrestee ought to be

<sup>2</sup> Sungkawan, Decha. Thai Community Based Correctional Programmes for Narcotics Addicts in Response to the 2002 Rehabilitation Act: A System Approach. VE Lecture presented at the 124 International Training Course at UNAFEI 28 May 2003. Fuchu, Tokyo.

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prosecuted for the drug offence. It was further explained that this programme is limited in that it only applies to drug offences. Some participants felt that this system is not appropriate for their jurisdiction because the public prosecutor has no power to suspend prosecution.

In conclusion, this issue could not be resolved one-way or the other. It was therefore suggested and agreed that a voluntary scheme could be implemented in countries that criminalize drug use, and the choice between a compulsory and a voluntary scheme would be available in countries that do not criminalize drug use. However, should a compulsory scheme be implemented, due process must be taken into account.

#### *(iii) The agency responsible for the management of the programme*

Various views were heard on the different types of agencies or institutions that are capable of handling such a task. Examples of which are the: Narcotic Board, health department, correctional institutions, national agency responsible for the prevention and treatment of drug abusers or a non-profit organization. The meetings heard the views of some participants where post sentencing treatment is currently being successfully carried out in their countries by the national drug prevention agency and it was felt that this agency could also be capable of managing the pre-sentencing treatment. Criminal justice agencies such as the police and prosecutors may be involved effectively in some way in pre-sentencing treatment, such as referring offenders to treatment or in reviewing their progress, etc. However, as regards the possibility of the police or prosecutors being responsible for the management of a particular treatment programme, the meeting was unanimous in its opinion that such an approach would be inappropriate. Not only would they lack the necessary manpower, skill, knowledge or capability, there would also be a conflict of interests. Relying on law enforcement officers to carry out treatment programmes would undoubtedly hinder the success of the treatment programme.

An ancillary issue cropped up in the above discussion. There was a concern as to whether information obtained by the institution responsible for such a treatment programme could be made available to the public and law enforcement agencies. Many views were heard and most favoured the disclosure of information. It was, however, suggested that there was a need to distinguish between information that could be made public and information that could not be made public. General information such as the planning, execution, success and costs of such a programme, as well as the scientific information derived from the implementation of the programme ought to be made available to the public for the purpose of public accountability and to further the progress of society. Private information that relates to the arrestees, on the other hand, must be safeguarded in order to protect the integrity of the programme and to ensure its success. Additionally, it will also eradicate any fear of invasion of privacy.

#### *(iv) Whether such treatment should be accepted as a mitigating factor*

The meeting was again divided in its deliberation as to whether pre-sentencing treatment should be accepted by the court as a mitigating factor when the offender is found guilty and sentenced. Some were of the view that it could only be a mitigating factor if the offence committed was a drug related offence while others felt that it can be a mitigating factor regardless of the crime committed as it shows that, since his arrest, the offender has been repentant and cooperative by reacting positively to the pre-sentencing treatment.

A further issue was discussed as to whether the court could dismiss the charge if the offender had submitted himself to pre-sentencing treatment. However, some participants felt that this suggestion was overtly radical as certain offences like drug trafficking and possession are too serious an offence to merit dismissal merely because the offender had received treatment. Often in such cases the prosecution of the offence would take precedence as opposed to dismissal. A dismissal would be possible only in cases where the charge is for drug abuse.

4. Drug Treatment and Testing Orders (DTTO)<sup>3</sup> and the Drug Court<sup>4</sup>

As these two programmes were somewhat similar, in that they are court-supervised programmes, the working group discussed them simultaneously. Some participants see these programmes as an attractive option as it offers a way out of the presumption of innocence dilemma. Additionally, if the arrest of the offender culminates with a successful completion of treatment rather than mere punishment, there is a strong motivation factor for the arrestee to follow the treatment programme. It was also felt that having the drug court system safeguards the arrestee's interest in that the decision to subject him to treatment is given by the court as opposed to that of a law enforcement officer. This ensures impartiality and transparency. Concerns, however, about the suitability of the use of the drug court system were also raised. It was recognized that these programmes generally require the court to decide on the appropriate treatment to be given to the drug user and to, thereafter, monitor his progress and response to the treatment. In short, the drug court is obliged to administer and supervise the treatment of the offenders. Some participants felt that judges, generally, lack the necessary skill, knowledge and training to juggle between inquiring into the arrestee's offence and, treatment dispensation and supervision. Others, however, do not view this as an obstacle as the court could always be guided by expert evidence on technical matters or judges could receive short term specialized training. There was another concern that the disposal of cases by the drug court must be speedy otherwise the objective of giving early intervention would be defeated.

Further, an opinion was expressed to the effect that the role of the drug court is limited in that it was not created to deal with all kinds of offences. It is basically designed to deal only with cases where crimes were committed as a result of the offenders' drug dependency; for example, acquisitive crimes which are committed to obtain money to buy drugs. The drug court can only deal with less serious offences; because if the offender undergoes successful treatment, there is no prosecution for the offence committed. The system is designed to deal with the drug addiction problem faced by the man in the street as opposed to serious or organized crimes. Drug users who commit serious offences would have to be dealt with under the usual penal laws outside the drug court system. Notice was also taken of the fact that under the DTTO programme the arrestee must consent to the treatment. This is another limitation in the scope of that programme.

Further concerns were raised as to whether the drug court could continue to inquire into the offence committed by the drug user if he fails in the treatment programme. Would he be prejudiced by the fact that the same court had ordered him to undergo treatment earlier? Has he abandoned his right to a fair trial by submitting to pre-sentencing treatment?

Several suggestions were offered to overcome these jurisprudential problems. First, it was suggested that the court should proceed to inquire into the offence and subject him to treatment if he is found guilty and convicted for the offence. He will not be sentenced if he undergoes successful treatment. Second, the arrestee would be tried by the normal criminal court should the treatment programme fail to produce any positive results.

In addition to these schemes, the Arrest Referral<sup>5</sup> of the United Kingdom and Australian Police Diversion Programme<sup>6</sup> were looked at by the group, and the group realized that treatment may be introduced in various stages of the Criminal Justice system.

<sup>3</sup> Sadiq, Shereen. A Brief Overview of Drug Interventions in the Criminal Justice System (England and Wales): With a Focus on Specific Interventions Provided at Arrest-Arrest Referral and as a Community Sentence- Drug Treatment and Testing Orders. VE Lecture presented at the 124 International Training Course at UNAFEI. 15 May, 2003. Fuchu, Tokyo.

<sup>4</sup> Gebelein, Richard S. The Rebirth of Rehabilitation: Promise and Perils of Drug Courts Sentencing & Corrections. U.S. Department of Justice. May 2000.

<sup>5</sup> Sadiq, see note 3.

<sup>6</sup> Vaughn, Stephan. Australian Diversionary Programmes – An Alternative to Imprisonment for Drug and Alcohol Offenders. Paper presented at the 121st International Training Course at UNAFEI. June 2002. Fuchu, Tokyo.

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**B. Prevention**

1. Problems Relating to the Implementation of Drug Education Programmes, Particularly those in Relation to the Coordination and Cooperation between Respective Governmental Agencies

There was a general consensus that drug education programmes are absolutely necessary to combat drug abuse and since time was short the issue was not discussed further.

2. The Failure of Drug Education Programmes to Create an Impact on High Risk Groups

This issue was raised as some participants felt that the existing drug prevention programmes are not achieving the desired results with the high risk groups such as juveniles and the unemployed. There was thus a need to reappraise the strategy that is currently employed.

In dealing with the former, the following suggestions were offered:

- Implementing compulsory drug education programmes in schools;
- Getting people from the community and non-governmental agencies to speak about drugs in schools, especially rehabilitated drug offenders who can talk about their past experiences with drugs;
- Screening of documentary films in schools to show the debilitating effects of drugs;
- Holding drug prevention activities in places of entertainment; and
- Conducting advertising campaigns on prevention of drug abuse.

As for the unemployed, it was recognized that this group of people usually lacks the necessary skills and have very little education. It was therefore suggested that vocational training be given to enable them to find gainful employment easily. By so doing the risk of exposure to drugs would be reduced. The group also heard how community based education programmes were successfully carried out in some countries while it has also failed in others because drugs in these countries were cheap and easily available.

3. Harm Reduction

This was raised as an additional issue for discussion. In line with what the visiting experts have touched on in their lectures, questions were posed as to whether it was necessary to distribute syringes or condoms to drug dependants in order to reduce the risk of the spread of HIV or HCV among them. There was no unanimity in the deliberation. Although the intentions are noteworthy, some participants felt that this would not be possible in countries that criminalize drug use. First, there would be a strong likelihood of a public outcry and, second, it would be a serious contradiction for the authorities to give out free syringes to drug users on one hand and to prosecute them on the other. Some participants, however, felt that no such contradiction exists and that the reduction of harm is done for the good of society.

**IV. CONCLUSION**

Most of our countries do not have treatment programmes for drug abusers at the pre-sentencing stage. Also, there are considerable differences regarding the ways in handling drug abuse problems, i.e. whether drug abuse should be criminalized or decriminalized, therefore, we have found many difficulties and problems concerning the introduction of such programmes without contradicting the current legal framework of the respective countries. Nonetheless, we have made our best efforts to explore any possible future programmes at the pre-sentencing stage for the purpose of rehabilitation and reintegration of drug abusers, creating a safer community and reducing the caseloads of criminal justice agencies.

We then reach the general consensus as follows:

1. It is necessary to introduce pre-sentencing treatment in dealing with drug abusers in the interests of criminal justice and our society.
2. It is desirable that the implementation of the pre-sentencing treatment programme should be in accordance with each country's legal framework, social background and so on.

3. In the introduction of any pre-sentencing treatment, the following factors should be considered:

- (i) Presumption of innocence.
- (ii) The target of the treatment: persons who commit drug abuse. However, countries may wish to consider the possibility of enlarging the scope of the programme by encompassing drug abusers who commit other offences under the influence of drugs or for the purpose of obtaining drugs.
- (iii) Necessity of consent: A voluntary scheme could be implemented in countries that criminalize drug use and a compulsory scheme would be a better option in countries that do not criminalize drug use, the choice between a compulsory and a voluntary scheme would be available in countries, which do not criminalize drug use. However, should a compulsory scheme be implemented, due process must be taken into account.
- (iv) Agencies responsible for the management of the programme: Criminal justice agencies may be involved in some way in pre-sentencing treatment. However since most criminal justice agencies lack the necessary manpower, skill and knowledge in administering effective treatment, it is necessary to rely on other agencies, e.g. Narcotic Boards, Health Ministries, Interior Ministries and NGOs for the execution of the programme.
- (v) Coordination: it is indispensable to establish and maintain coordination among treatment agencies and criminal justice agencies.
- (vi) Effect of treatment: Successful completion of treatment may result in non-prosecution or dismissal of charge, or be taken as a mitigating factor if a charge is for drug abuse only.
- (vii) Updated database.

4. Drug education programmes

It was unanimously agreed that drug education programmes are absolutely necessary. In order to enhance existing drug prevention programmes, the following points are suggested:

- (i) Implementing compulsory drug education programmes in schools;
- (ii) Getting people from the community and non-governmental agencies to speak about the harmful effects of drugs in schools, especially rehabilitated drug offenders who can talk about their past experiences with drugs;
- (iii) Screening of documentary films in schools to show the debilitating effects of drugs;
- (iv) Holding drug prevention activities in places of entertainment; and
- (v) Conducting advertisement campaigns on prevention of drug abuse.



## GROUP 2

### EFFECTIVE PREVENTION OF DRUG ABUSE AND ENHANCEMENT OF TREATMENT FOR DRUG ABUSERS IN THE POST-SENTENCING STAGE

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<i>Co-Chairperson</i>	Ms Felicidad Cuizon Auxtero	(Philippines)
<i>Rapporteur</i>	Ms Oiytip Ratanagosoom	(Thailand)
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## I. INTRODUCTION

In the century of globalization, the social problems in one country implicitly have an effect on other countries. Drug abuse and related crimes are not solely related to the criminal justice procedures. A comprehensive understanding of the nature of the drug abuse problem is necessary for the legislators, the correction and probation officers in the other criminal justice services, the health care providers as well as the whole society. Research findings (e.g. meta-analysis study by Andrews. et al 1990) confirm that neither pure criminal sanction nor inappropriate correctional treatment had any effects in decreasing recidivism.

While the criminal justice procedures in many countries confront the hindrance constraint of law amendment to decriminalize and enforce the treatment and rehabilitation process for the drug abuse offender, the effectiveness of existing treatment and correction needs to be proved as well. Should the fragmented legitimate procedures and interventions among the treatment and rehabilitation stakeholders be renovated? Is it time to introduce the new paradigm for the chronic, dynamic and complex nature of the drug abuse problem? Or will through care be the needed answer for the clients?

One of the purposes of this course is to explore more effective measures for preventing and treating drug abusers to promote their reintegration into society in the post-sentencing stages. We discussed the programmes, measures and systems, the major prevention and treatment of drug abusers in participating

countries and unanimously agreed that Through Care is imperative to enhance the effective prevention and rehabilitation of the drug abuse problem.

## II. SITUATION OF MAJOR ABUSING DRUGS AND AVAILABLE PREVENTION AND TREATMENT OPTIONS IN THE POST-SENTENCE STAGES

### A. Major Abusing Drug Trends and High-risk Population

**Table 1. Major Abusing Drug Trends and High-risk Population in Participating Countries**

Country	Major abusing drug	High-risk population	
		At risk	Age of abusers in the correctional institutions
Japan	Methamphetamine	Juvenile	30's
Malaysia	Heroin	Juvenile	25-34 years old
Philippines	Methamphetamine	Juvenile	25-35 years old
South Africa	Cannabis	Juvenile	25-35 years old*
Sri Lanka	Heroin	Juvenile	25-35 years old
Thailand	Methamphetamine	Juvenile	19 up*
Korea	Methamphetamine	Juvenile	30-39 years old

\* In South Africa and Thailand, it is average age in general population

Juvenile: under 18 or 20 years old

### B. Programmes, Measures and Systems for Persons at Risk and Abusers

**Table 2. Major Programmes, Measures and Systems for At Risk and Abusers in Participating Countries**

Country	Programmes, measures, systems	
	For the person at risk	For abusers (under CJS)*
Malaysia	1. Education programme 2. Information and publicity programme	1. Correctional services
Philippines	1. Nationwide campaign 2. Education programme	1. Diversion for juveniles 2. Correctional services 3. Probation services
South Africa	1. National drug master plan (prevention and treatment)	1. Diversion for juveniles 2. Correctional services 3. Community supervision
Sri Lanka	1. School awareness programme	1. Correctional services 2. Community-based correction treatment
Thailand	1. Potential demand and supply prevention strategy 2. Nationwide and local campaign for school and community	1. Correctional services 2. Probation services
Korea	1. Nationwide campaign 2. Education programme 3. Poster contest for high school students	1. Correctional services 2. Probation services

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**Table 2. Major Programmes, Measures and Systems for At Risk and Abusers in Participating Countries**

Country	Programmes, measures, systems	
	For the person at risk	For abusers (under CJS)*
Japan	1. Nationwide- campaign 2. Local-meeting 3. Education programme	1. Diversion for juveniles 2. Correctional services 3. Probation and parole services

\* Abuser: Person who abuses drugs and is handled in the criminal justice system

**C. Major Treatment Programmes of Drug Abusers in the Criminal Justice System of Participating Countries**

Major treatment programmes of drug abusers in participating countries, see table 4 (Appendix).

**III. MAJOR PROBLEMS RELATED TO THE PREVENTION AND TREATMENT OF DRUG ABUSERS: MAINLY FOCUSED UPON THROUGH CARE**

**A. Why do we need Through Care?**

Initially we started to identify the problems related to the prevention and treatment of drug abusers by brainstorming. Based on this activity, we identified thirty problems. After that, we classified these problems into four groups by using KJ analysis. The names of groups are as follows: Through Care, quality management, psychosocial factors and government policy.

We analyzed each problem group by using 5W1H (what, when, who, where, why and how).

Since the major task of our group is to explore effective measures for the treatment of drug abusers in the post-sentencing stage, we mainly focused upon Through Care. Evidence shows that treatment of drug abusers normally takes a long time. We identified the following elements as vital for examining Through Care:

*Aftercare, family intervention, job placement, re-integration, staff training, networking, community involvement and collaboration (cooperation).*

Through Care provides an ongoing client-centred treatment and rehabilitation process for drug abusers, to be free from drug use, having a good quality of life and self-reliance competency, by using an evidence-based, quality management and transparency approach. The criminal justice system forms part of Through Care.

**B. Definition**

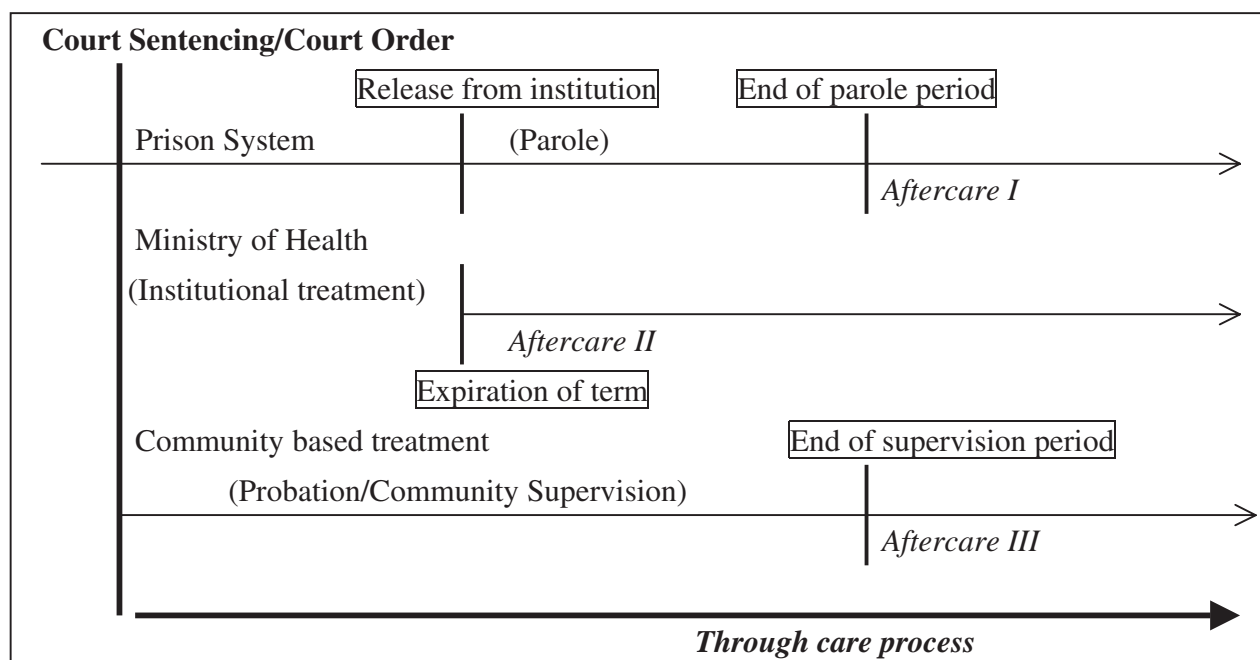
1. Through Care

Through Care is the process of continuous supervision and support provided to the drug abuser in the criminal justice system by means of institutional and community based treatment and rehabilitation, and provides support through aftercare from the public and private sector in order to facilitate reintegration into society.

2. Aftercare

Aftercare is the continuous service delivered to the ex-drug abuser on a voluntary basis, appropriate for the individual, in the transitional period from institutional treatment and/or community-based treatment (e.g. parole and probation), to reintegration into society, to assist them to stand by themselves.

**Chart 1. Concept of Through Care**



### C. Major Obstacles for Achieving Effective Through Care

#### 1. What is the Problem of Each Country?

- Since there is a negative perception of the community to ex-drug offenders, it is very hard for them to find a suitable job (All participating countries).
- There is a lack of institutional collaboration and networking among criminal justice agencies, other competent agencies and organizations such as public health centres, welfare offices, child guidance centres, mental hospitals and so on (Japan).
- There is insufficient crisis intervention at community-based treatment and the aftercare stage (Japan).
- There is no parole, probation and aftercare system (Malaysia, Sri Lanka).
- Since there is not sufficient networking and community involvement, there is difficulty re-integrating drug offenders back into society (South Africa).
- There is not enough basic training for both institutional and field services staff (Thailand, Sri Lanka).
- There are a lack of specific programmes for drug abusers in institutional facilities (Korea).

#### 2. Why is it the Problem in Each Country?

- People in the community have low awareness and a negative perception of drug offenders (All participating countries).
- Negative influence of general unemployment on re-integration into the community (All participating countries).
- Integrated policy on institutional coordination among competent agencies and organizations for treatment of drug abusers is insufficient (Japan).
- Because of the limited staff and budget, staff training is limited (Thailand, Sri Lanka).
- There is no legal system for aftercare (Malaysia, Sri Lanka).
- The Institutional treatment system and community-based treatment system are fragmented, so the work is not fully functioned (South Africa).

#### IV. COUNTERMEASURES TO ADDRESS PROBLEMS EXPERIENCED IN THROUGH CARE

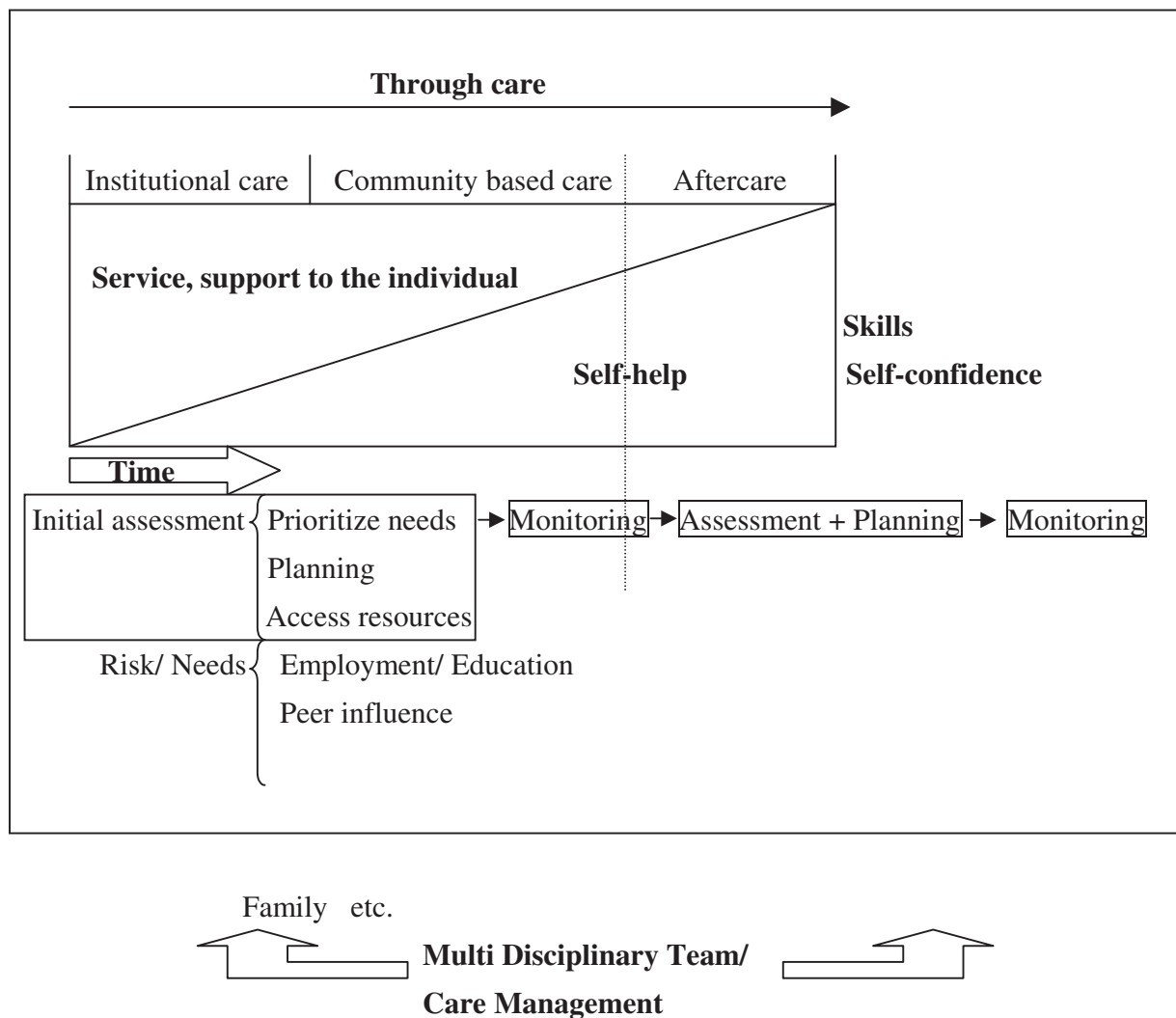
Through Care consists of institutional treatment, community based treatment and aftercare. The purpose of Through Care is as follows:

- a) To prevent relapse
- b) To improve quality of life
- c) To prevent drug related crime/problems

It should be kept in mind that at some stage during treatment, agencies must hand over responsibility to the individual. The end goal of rehabilitation must be independent functioning with the necessary life skills to cope, as well as the necessary knowledge of where and how to get help if needed. An integrated approach and a transitional period (during which the formal support is gradually decreased and the individual's responsibility is increased) are needed for treatment. (See Chart 2 for an explanation). In the Through Care process, the following elements are important for each transitional stage:

- a) Assessment system
- b) Planning guidance
- c) Care management (consultation & case work)
- d) Networking (integrated delivery of services)

**Chart 2. Diagram of the Rehabilitation Process**



### A. Countermeasures for Enhancing Effective Service Delivery

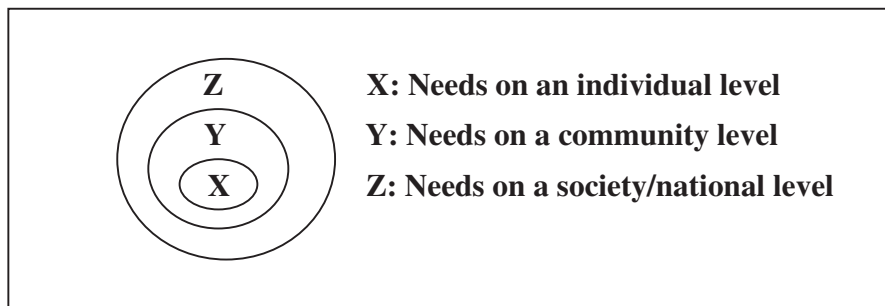
Introduce/ improve Through Care system

1. Identify needs
2. Identify resources for providing services
3. Connect needs and resources
4. Raise public awareness about relationship between needs and resources

### B. Needs of Drug Abusers

1. Employment (X)
  - a) Employment Skills
  - b) Education
  - c) Sustainability
2. Information (accessibility of services) (X & Y)
3. Social acceptance (Z)
4. Family & community support (which includes employer) (Y)
5. Accommodation/shelter (X)
6. Medical & welfare services (X)
7. Self-realization (X)
  - a) Self-confidence
  - b) Self-esteem
8. Life skills (X)

**Chart 3. Needs of Drug Abusers**



It is important to keep in mind that the family of the drug abuser also has needs, especially support. The family is the one constant factor throughout the rehabilitation process. If the help and support of the family can be obtained early on in the treatment of the drug abuser, it is of great help to the practitioner/service deliverer. It would enhance aftercare and the process of re-integration into the community.

### C. Rehabilitation Services for Drug Abusers

The Through Care system consists of three major pillars namely institutional treatment, community based treatment and aftercare. Table 3 shows examples of available services/programmes for each stage of Through Care corresponding to the needs of drug abusers.

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**Table 3. Rehabilitative Services for Drug Abusers**

*Criminal Justice System*

*Voluntary base*

Needs	Institutional	Community based	Aftercare
Specific treatment and rehabilitation	a) Therapeutic Community programme b) Relapse prevention programme c) Drug awareness programme	a) Therapeutic Community programme b) Drug awareness programme c) Matrix programme (including relapse prevention programme) d) Diversion	a) Self help group e.g. (i) Narcotics Anonymous (ii) Alcoholics Anonymous b) Family support group c) Relapse prevention programme d) Drug awareness programme
Employment	a) Vocational training	a) Cooperative employer b) Social skills training	a) Public employment office
Accommodation/shelter		a) Half-way houses	a) NGO b) Religious places
Medical	a) Detoxification b) Physical and psychiatric care	a) Cooperative medical facilities and agencies	a) Hospital b) Mental hospital
Welfare	a) Social work	a) Cooperation with social welfare office	a) Public welfare office
Self-realization 1. Self-confidence 2. Self-esteem	a) Counselling b) Spiritual	a) Counselling b) Social skills training	a) Self-help group b) Public health centre
Life skills	a) Social skills training	a) Social skills training	a) Self-help group b) Public health centre
Information	a) Drug awareness programme	a) Psycho-social group work b) Information leaflet	a) Self-help group b) Public health centre
Family and community support	a) Family meeting	a) Family meeting b) Family counselling	a) Self-help group b) Public health centre c) Family
Social acceptance	a) Community service	a) Campaign (local, nationwide) b) Community services	a) Mass media and public relations

**1. Institutional Treatment**

The closed-environment of institutional treatment has its strengths in providing intensive care for those who have serious drug-dependence problems and mental/psychiatric or physical complications. In addition, we can utilize close-interpersonal relationships, positive peer pressure and interaction, and group cohesiveness for therapeutic purposes. For example, Therapeutic Community programmes conducted in an institutional setting are shown to be effective in rehabilitating drug abusers.

**2. Community-based Treatment**

Community-based treatment is an intermediate stage between institutional treatment and aftercare. Serious cases will start from institutional treatment and less serious cases may start from community treatment. The most important characteristic of this stage is that drug abusers have access to drugs while they spend a normal life in the community. Under these circumstances, probation/parole and other services

provide close supervision for drug abusers. For example, the Matrix programme provides intensive treatment for a four-month period followed by a one-year follow-up period. During those periods, drug abusers have a chance to find employment, reunite with their family and reintegrate fully into community life.

Both institutional treatment and community-based treatment are the preparation stage for aftercare of drug abusers.

### 3. Aftercare

This stage is indispensable to the recovery process of drug abusers for whom relapse is a constant threat. The unique feature of this stage is the use of self-help groups where drug abusers are supported by ex-drug abusers to maintain their drug free status. This stage is very important to improve quality of life and to establish new healthy lifestyles.

## **D. How to Enhance the Through Care System**

### 1. Enhancement of Institutional Collaboration and Networking

To manage the through-care system effectively, networking is necessary. Networking includes information sharing, communication and coordination/collaboration to achieve the same goal (see chart 2). Networking can be divided into internal and external networking:

#### *Internal networking*

- (i) Consists of bottom-to-top/top-to-bottom communication as well as horizontal communication.
- (ii) Training can enhance this process.
- (iii) Importance of information sharing and collaboration must be stressed in training.
- (iv) It is very important to identify who has to take responsibility.
- (v) Information must be properly managed.
- (vi) Contents of responsibility: described in job description/internal circular.
- (vii) Reporting to superiors and sharing information with colleagues is important.
- (viii) The type of information that should be reported can be covered by an internal circular.
- (ix) Establish a working group/treatment team to set and share goals for treatment.
- (x) Shared goal: responsibility to achieve the goal should be divided into segments and each member of team/service provider should take responsibility for his/her segment.

#### *External networking/ Institutional collaboration*

- (i) Establishment of a common framework.
- (ii) To build up effective implementation (system)
  - a) Raise public awareness- with a national campaign
  - b) Information delivery to each respective agency, body and organization.
- (iii) Different agencies must realize their responsibility towards other agencies too and understand other agencies' functions.
- (iv) Second staff to other agencies-can lead to better understanding and co-operation.
- (v) At the policy level it must be realized that this problem relates to all departments.
- (vi) Decisions at a policy level must be implemented and monitored.
- (vii) At the practitioner's level: practitioners must be sent to conferences; difficult cases must be handled with case conferences e.g. involve health sector through-out process.
- (viii) All government departments must share the same concept.

### 2. Training of Staff

- Send experts to train staff at the institutions e.g. prisons.

More cost-effective

- More staff can be involved without too much disturbance of normal daily routine at prisons (especially in cases of limited manpower.). Security measures should be taken to ensure safety of visiting lecturer/s.



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- The training programme can be tailor-made for specific agency/institution's staff needs regarding content and length of time. More flexible curriculum. Encourage training report.

Involvement of disciplinary staff in correctional institutions in Drug Treatment Programmes are important as they spend more time with prisoners than rehabilitation staff. Indicate to them the importance of their supportive role regarding (a) prisoners in the programme and (b) staff delivering the programme.

All staff members need to receive basic training regarding:

- Drug awareness, especially recognizing behavioural characteristics of drug abusers (must be able to distinguish between normal behaviour and drug-induced behaviour).
- Referral system.
- How to support inmates in programmes and programme-deliverers (help to increase motivation).

Service- deliverers of Drug Treatment Programmes need more intensive and specialized training.

### 3. Quality Management

Effective integrated treatment delivery towards successful re-integration of drug abusers heavily relies on quality management of multi-dimensional levels or a multi-disciplinary approach, from the criminal justice system level to the individual treatment programme level. We identified the following elements as vital for examining quality management.

*Quality management, infrastructure, modern technology (sophisticated urine drug detecting devices, security machines for prevention of drug smuggling into correctional institutions), research and development, monitoring and evaluation system, statistics, information.*

*What and why is there a problem in each country?*

- (i) The comprehensive monitoring, research and evaluation system for drug offenders is insufficient (Japan).
- (ii) There is insufficient knowledge and readiness of management among institutional staff in running rehabilitation programmes for drug abusers, and a lack of a benchmark indicator to measure a programme's effectiveness (Malaysia).
- (iii) There has been no development and evaluation of the programme (Sri Lanka).
- (iv) There is no standard statistics format for drug offenders (Thailand).
- (v) The number of offenders is too big to address diversified needs of drug abusers (Thailand, South Africa).
- (vi) The number of facilities for juvenile drug abusers is insufficient (Philippines).
- (vii) Most correctional facilities are not equipped with modern technology for treatment of drug abusers (Philippines).
- (viii) Programme research and development is limited and accessibility to official statistics and other information resources is insufficient (South Africa).

### 4. Evaluation

To realize effective quality management, we need a standard to measure it. Unfortunately, several participating countries lack those standards. Therefore, we have to establish such standards first in the respective countries, in regional areas such as Asia and then worldwide.

*Need for standard statistical format and data collection*

In order to facilitate efficient and effective rehabilitation services, we need to gather relevant statistical data to know the trends and characteristics of drug abusers, to monitor progress in the rehabilitation process, and to evaluate outcomes of the relevant services. These data give us reliable evidence-based information, which is subsequently used for decision and policy making for improving current practices. Especially, for the purpose of achieving good results in the Through Care process, different agencies need to share relevant information in order to be able to conduct both process evaluation and outcome evaluation. Differences in gathering and analyzing data often can be obstacles in analyzing/comparing relevant practices (e.g. measures

of recidivism are quite different among various jurisdictions, which make it very difficult to assess effectiveness of a given programme or system).

*What is the standard for inspection?*

The standard must be documented and circulated to ensure standardized practices and integrity of programmes and services. We need to follow standards by checking:

- (i) documents (documents must be approved by policy makers/stake holders/top management); and
- (ii) practice.

In a through-care system minimum standards are needed for each process. Standards can be divided into quality and quantity. To establish the standard for inspection we need to include the following elements:

- (i) Leadership/responsibility of top management
- (ii) Information management
- (iii) Treatment and rehabilitation
- (iv) Manpower (number), training and supervision
- (v) Environment: facilities, equipment
- (vi) Continuous quality improvement
- (vii) Client focus

#### 5. Psycho-social Factors

We cannot achieve quality management without taking effective measures for psycho-social factors. These are mainly problems related to negative community perception, low morality and drug smuggling.

*Negative community perception*

When we examine the negative perception of the general public towards ex-prisoners/ex-drug abusers, we identified the following problems and countermeasures for them:

- (i) Transparency is important.
- (ii) The general public needs to be aware of their role in aftercare for drug-abusers.
- (iii) Public relations e.g. community service.
- (iv) Collaboration with neutral agencies to support the positive work being done in prisons.
- (v) Evidence-based research is very necessary. What effect can a specific treatment programme have in the long term for a community?
- (vi) Make use of mass media.
- (vii) A positive perception of political/community leaders (people in power) can have a big influence on the general public's perception.
- (viii) At the grassroots level support of self-help groups can help toward changing the public's perception.
- (ix) Restorative Justice.
- (x) More acceptable names for Correctional Institutions (might help to remove the stigma and "labeling"). Be more appreciative of the work correctional officers are doing. Attitude of both correctional officers and the public can be changed positively.
- (xi) If the public's experience of community sentences (probation/supervision/parole) is positive and they receive more information/knowledge regarding them, it can help towards a more positive perception.

*Low morality, drug smuggling*

- (i) Low morality of drug abusers leads to a vicious circle  
Community has a prejudice against drug abusers. Drug abusers use defence mechanisms such as denial. Both the community and the abusers overlook reality.

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#### (ii) Drug smuggling in prison

Keeping a drug free environment in prison is a basic requirement for treatment of drug abusers. There are two ways of smuggling drugs into prison; (a) by prison staff, (b) contact with people from outside prison (visitors etc.).

The following are the reasons for this problem:

- Not all prisoners have quick access to programmes (overcrowding)
- Demand for drugs in prison (many abusers)
- Gang activities (prison culture)
- Inefficiency of treatment programmes
- Low salaries of prison staff (corruption)

The effective countermeasures for this problem are (1) to improve working conditions and salaries of prison staff, (2) quick classification of inmates after entering prison into high risk groups re. drug-abuse/treatment.

#### 6. Government Policies

The Present CJS practices in handling drug abusers among participating countries tend to put a heavy reliance on imprisonment, which causes prison overcrowding. In addition, current legislation treating drug abusers have various flaws in achieving effective Through Care for them: e.g. lack of provisions to extend appropriate treatment measures in probation/parole and discontinuity of treatment in relevant settings, etc. In order to expand effective treatment options conducted in some countries (e.g. diversion programmes, a mandatory parole period combined with an incarceration period to continue necessary services; introduction of special conditions to order medical treatment in the probation period, etc), we need to persuade politicians and the general public by demonstrating the effectiveness and possibilities of alternative options' outcomes. Governments can utilize evidence-based practice or a "what works" approach to address various issues concerning appropriate allocation of budget, manpower and resources, which form a basis for policy reform.

## V. RECOMMENDATIONS

### A. Importance of Through Care

Through Care is a continuous and long process of supervision and support from institutional and community-based treatment to aftercare. Therefore, not only criminal justice, health, welfare, employment and other agencies, but also various kinds of organizations/bodies, community and individual citizens should cooperate to realize effective management of the Through Care process. Major agencies and organizations should formulate multi disciplinary teams to plan and manage the entire Through Care process.

To maintain and improve the quality of the Through Care process, evidence-based practice should be the basic method. The continuous circle of research, monitoring, assessment and planning during the Through Care process is of vital importance.

### B. Early Family Participation in Treatment

Most of the drug abusers and/ or other criminals have a background of family disruption. Family rejection occurs often. Thus, family therapy and counselling from the beginning of the Through Care process is important. The sooner family participation starts, the better outcome will be achieved. Understanding of the drug recovery process will help the family to tolerate the relapse and recognize their important role in supporting the abuser in refraining from drugs. The family re-union is the ultimate goal for the long-term prevention of relapse and the improvement in the quality of life of the drug abusers.

### C. Relapse Prevention Programme

Drug relapse is a common phenomenon along the process of recovery. There is evidence and theories that support and explain this unwanted event. General treatment and rehabilitation cannot guarantee the expected outcome; hence the relapse prevention programme should be implemented in Through Care. Starting the relapse prevention programme merely during aftercare will be too late for the drug abusers to learn and develop skills for overcoming the triggers which drag them back to the re-using road. Relapse prevention should receive attention throughout rehabilitation.

**D. Emphasize Collaboration and Coordination**

The ideal Through Care can be achieved by emphasizing collaboration and coordination of agencies and departments. Participation and sharing the common goal and information is the key to success.

**E. Information Management**

To set up a common database management system, which can be utilized by all of the stakeholders for programme implementation, monitoring and evaluation cannot be ignored in this technologically advanced century. Dissemination of the analyzed information should be the input for the policy makers in effective and efficient strategies and policy determination. At the operational level such information can be used for monitoring and evaluation of treatment programmes.

**F. Vicious Cycle Interception**

Effective strategies should be put in place to intercept negative practices such as drug smuggling in prison.

**VI. CONCLUSION**

Since the recovery process of individual drug abusers is a dynamic and chronic situation, Through Care is of vital importance. For effective prevention of drug abuse and treatment in the post-sentencing stage, there are many factors to be considered as stated above. In order to achieve the same goal, we need to develop and enhance the Through Care, as it is a process that supervises and supports the drug abuser in institutional and community based treatment and provides aftercare. Services that share this common goal should collaborate to share information and intervention plans as well as the outcome by giving feedback. Therefore effective prevention of drug abuse and enhancement of treatment for drug abusers in the post-sentencing stage is of the utmost importance to reduce the crime rate which will lead to peace and harmony in society.

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APPENDIX

**Table 4. Major Treatment Programmes of Drug Abusers in the Criminal Justice System of the Participating Countries**

Country	Prison	Juvenile School/ Centre	Probation	Drug Rehabilitation Centre	Others
<b>Malaysia</b>	O	O	X	O	X
	1. Counselling 2. TC programme 3. Religious programme 4. Physical/discipline programme	Nearly the same as prison but different in the degree		1. Re-integration programme 2. Counselling 3. Religious programme 4. Physical/ discipline programme 5. Med. & health care 6. Vocational training 7. Sports/ recreation 8. Job placement 9. Relapse prevention skills 10. Strengthening of family ties 11. Involvement of community activities 12. Peer group support activities	
<b>Philippines</b>	O	O	O	O	X
	1. Counselling	1. TC programme 2. Counselling		1. Compulsory treatment 2. Voluntary treatment (i) Counselling (ii) Vocational programme (iii) Medical care (iv) Physical programme (v) Recreation/ sports	

**Table 4. Major Treatment Programmes of Drug Abusers in the Criminal Justice System of the Participating Countries (continued)**

Country	Prison	Juvenile School/ Centre	Probation	Drug Rehabilitation Centre	Others
South Africa	O	O	X	X	O
	1. Drug awareness programme by social workers 2. Group sessions 3. Counselling 4. Medical treatment like detoxification in certain prisons with hospital facilities	1. Drug awareness programme by social workers 2. Specific drug programmes 3. Counselling			1. Diversion (for juveniles) 2. Community supervision (for adults) (i) Specific awareness programme-usually group sessions 3. Drug peer counselling
	O	O	X	X	O
Sri Lanka	1. Counselling 2. Family meeting	1. Counselling 2. Family meeting			1. Community based supervision
Thailand	O	O	O	O	O
	1. The TC 2. Religious/ meditation 3. CARE model 4. Early release programme (Boot camp, agricultural programme)	1. Matrix model 2. FAST model	1. Treatment for adult drug abusers 2. Community based programme (in coordination with probation officers and volunteer probation officers)	1. Medical treatment 2. Compulsory treatment 3. Voluntary treatment	1. Hospital/ Clinic 2. Diversion

Table 4. Major Treatment Programmes of Drug Abusers in the Criminal Justice System of the Participating Countries (continued)

Country	Prison	Juvenile School/ Centre	Probation	Drug Rehabilitation Centre	Others
<b>Korea</b>	O	O	O	X	X
	1. Special educational programme (i) Counselling (ii) Lecture (iii) Physical training				
<b>Japan</b>	O	O	O	X	O
	1. Special educational programme for drug offenders	1. Special programme guidance for juvenile drug offenders 2. Individual counselling 3. Meeting session for supporting the family of abusers	1. Categorized treatment (stimulant & thinner offenders) 2. Group treatment for abusers 3. Meeting session for supporting the family of abusers 4. Crime prevention activities 5. Intensive treatment for adult stimulant offenders (including urine testing)		1. Tentative probationary supervision (in charge of Family court; diversion for juveniles)

(Notes) CARE: Correctional Addicts Rehabilitation  
FAST: Family participation, Alternative treatment activities, Self help and Therapeutic community  
The TC: Therapeutic Community





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## **APPENDIX**

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***COMMEMORATIVE PHOTOGRAPH***

***• 124th International Training Course***

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**UNAFEI**

## The 124<sup>th</sup> International Training Course



**Left to Right:**

**Above:**

Dr Tomás-Rosselló (UNODC), Ms Sadiq (U.K.)

**4th Row:**

Mr Koyama (Staff), Mr Saito (Chef), Mr Miyake (Staff), Ms Yamashita (Staff), Mr Tada (Staff), Mr Dai (Staff), Mr Miyakawa (Staff), Ms Masaki (Staff), Ms Yanagisawa (Staff), Ms Tsubouchi (Staff), Ms Fujimura (Staff), Ms Nagaoka (Staff), Ms Kuramochi (JICA)

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Ms Miyagawa (Staff), Mr Nakayama (Staff), Mr Adu-Amankwah (Ghana), Mr Goto (Japan), Mr Nomura (Japan), Mr Sakai (Japan), Mr Effendy (Indonesia), Mr Vong (Malaysia), Ms Graipaspong (Thailand), Ms Kojima (Japan), Mr Nagphey (Bhutan), Mr Kamiya (Japan), Mr Tomihari (Japan)

**2nd Row:**

Mr Nakamura (Japan), Mr Yamashita (Japan), Mr Choi (Korea), Mr Dhanasinghe (Sri Lanka), Mr Sitinjak (Indonesia), Mr Wan Mahmood (Malaysia), Ms Auxtero (Philippines), Ms Shujau (Maldives), Ms Nel (Space South Africa), Ms Ratanagosoom (Thailand), Mr Yamada (Japan), Mr Ashraf (Bangladesh), Mr Kikuchi (Japan), Mr Fukumoto (Japan), Mr Martell (El Salvador)

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