

Malaysian Illicit Drug Policy: Top- Down Multi-Agency Governance or Bottom- Up Multi- Level Governance

Balasingam Vicknasingam*
Centre for Drug Research
Universiti Sains Malaysia
11800 USM, Penang, Malaysia

Suresh Narayanan
School of Social Sciences
Universiti Sains Malaysia
11800 USM, Penang, Malaysia

*Corresponding author: Balasingam Vicknasingam
Centre for Drug Research
Universiti Sains Malaysia
11800 USM, Penang, Malaysia
Tel: 6 012 4300079
Fax: 6 04 6568669
e-mail: vickna@usm.my, vicknab@hotmail.com

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Introduction

Illicit drug policy has been about striking the right balance between supply reduction and demand reduction efforts. While tough supply reduction efforts continue in facing drug traffickers, a softer approach with respect to drug users is becoming evident not only in Malaysia but elsewhere as well. In Malaysia, the emergence of HIV/AIDS among drug users has opened the way for the harm reduction approach that prioritizes public health concerns over the original objective of making the country drug free that resulted in criminalizing addiction. Ultimately, the expectations from the drug policy have to be lowered to realistically achievable aims such as minimizing the dangers it poses to the drug users themselves and society at large (Goldstein and Kalant, 1990).

One of the favourable offshoots of the move towards harm reduction strategies is the constructive engagement of grass root organizations in the initiative. The involvement of a growing network of non-governmental organizations (NGOs) is slowly transforming the form as well as the implementation of drug policy from a top-down multi-agency effort of the government to a bottom-up multi-level initiative of grass root organizations, supervised and financially assisted by the government.

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This paper begins by providing a brief snapshot of the drug problem in Malaysia so as to provide the basis for understanding the issues to be discussed subsequently. This is followed by a discussion on the motivation, structure and organization of the initial top-down approach. We then analyze the factors that led to the development of a parallel,

bottom up initiative spearheaded by NGOs. Finally, we highlight the complementary role education can play at various levels in strengthening the bottom-up approach. The final section concludes the paper.

A Snapshot of the Malaysian Drug Problem

Between 1988 and 2006, there were 300,241 registered drug addicts in Malaysia, constituting 1.1% of the general population. In 2007, 14, 489 addicts were 'detected' (that is, apprehended in organized raids by the police and other enforcement agencies), compared to 22,811 in 2006. In the last two years there appears to be a decline in drug users detected compared to the period between 2000 and 2005 when approximately 30,000 to about 35,000 addicts were detected yearly. This could be a reflection of the widening impact of harm reduction programs that may have dampened the zeal to simply detain addicts.

In contrast, the seizures of drugs continue to rise. Heroin seizures increased to 243.25kg in 2007 compared to 151.53 in 2006. The seizure of ecstasy (powder) increased to 167.55kg in 2007 compared to 9.90kg in 2006. Seizure of psychotropic pills also increased from 65,840 tablets in 2006 to 455, 407 tablets last year. Ketamine seizures also increased from 189.02kg in 2006 to 267.90kg last year. In addition to increased seizures, an increase in the arrests of people dealing with drugs has also been recorded. Last year a total of 54,437 people were arrested compared to 46,062 in 2006 (National anti narcotics agency, 2007:2-5).

In terms of the type of drug being abused in the country, heroin continues to be the main drug; about a third (32.8%) of the addicts detected was heroin users. The use of amphetamine type stimulants (ATS) is also rising in the country.

Another worrying trend is the growing prevalence of HIV/AIDS among drug addicts. In 2006, the number of HIV/AIDS cases reported was 5,830 with 78.5% of them being injecting drug users. The total number of HIV cases between 1986 and 2006 was about 72,500; nearly three quarters of these cases were injecting drug users (National anti narcotics agency, 2007:3-4). Drug abusers were virtually all male and by ethnicity, the majority was Malays.

Top- Down Multi- Agency Governance

The original government response to the drug problem was premised on the notion that it was an illegal activity that threatened the fabric of society and therefore needed to be eradicated by tough actions. The government believed it was the only competent authority powerful enough to handle this task. As Hakkarainen et al., (2007: 543) have noted, 'non-adaptive or repressive responses are needed to justify the image of the State as an efficient and competent actor'. Thus apart from taking charge of the task of reducing the supply of drugs through tough laws and strict enforcement measures, it also assumed a monopoly role in the area of demand reduction. It controlled all treatment programmes and conducted most of the prevention programs in the country.

In 1971, a narcotics section was formed within the Criminal Investigation Department (CID) of the Royal Malaysia Police (National Narcotics Agency, 1997:1-2). In 1972, a separate Central Narcotics Bureau was created to deal with the drug problem. The first cabinet committee on drugs was set up in 1975. In 1979 the Central Narcotics Bureau was dismantled and its functions were taken over by the Drugs Secretariat. In 1983 an anti-drug national task force was established under the Ministry of Home Affairs to coordinate all drug related activities in the country. In the same year, a national

committee on drugs was formed under the National Security Council. In 1996, the National Narcotics Agency (NNA) was created¹. This agency was given form by merging the National task force and the Treatment and Rehabilitation section of the Ministry of Home Affairs. The NNA reports to the National Drug Council chaired by the Minister of Home Affairs (National Narcotics Agency, 1997:1-2). It is clear from these developments that all the actors involved in fighting the drug problem were drawn from the Ministry of Home Affairs and came largely with an 'enforcement' background.

In the area of treatment and rehabilitation, 24 government hospitals were assigned as detection and detoxification centers in 1975. In 1976, rehabilitation centers were formed under the Ministry of Home Affairs². Drug addicts who are detained are mandated to undergo rehabilitation at these centers for a period of two years. Also in 1976 every registered medical practitioner was obliged to inform the Director General about any person treated for drug addiction. Any unauthorized treatment for drug dependence, even by a registered medical practitioner, was disallowed. Thus, the medical fraternity was restricted to the task of detecting and detoxifying addicts. There was hardly any treatment given from a medical standpoint and the rehabilitation of drug addicts emphasized only the physical aspect of an addict³.

¹ The National Drug Agency was renamed National Anti Drug Agency in 2004.

² By 2007 there were 29 government drug rehabilitation centers in the country.

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

The national drug policy that had evolved by 1996 used four strategies to deal with the drug problem. There were prevention, enforcement, rehabilitation and international cooperation. Treatment was not an option and the objective was still to attain a drug free society.

NGOs were virtually shut out from this initiative and even the first NGO created in 1976 to play an active role in drug rehabilitation work quickly lost its NGO credentials. Known as PEMADAM (Association for Drug Prevention Malaysia), it effectively came under strict government control by virtue of the fact that under its constitution the patron is the Prime Minister and the chairperson is the Minister of Home Affairs (www.pemadam.org.my). Not surprisingly, despite its NGO costume, the top-down organizational structure prevailed and has impeded its ability to reach out to effectively to those it was intended to serve.

With the government controlling all aspects related to the drug problem in the country, including the various committees and agencies, through the Ministry of Home Affairs, it is difficult to shake off the conclusion that the problem was viewed primarily as a national security concern rather than a health issue. Even the emergence of HIV/AIDS among drug users did little to alter the philosophy of total abstinence underlying the national drug policy. In any event, this forced rehabilitation of drug addicts yielded limited success and was marred by high relapse rates among participants. Relapse rates ranged from 70 to 90 per cent within the first year following discharge (Reid, et al., 2007: 137-8). The top-down multi-agency approach was not only making very little headway in rehabilitating addicts but was proving to be of limited effectiveness in stemming the rising incidence of HIV/AIDS among drug addicts as well.

Interestingly, despite these failings the government was slow to consider other, and at that time, non-conventional approaches. Two main factors account for this initial hesitancy (Vicknasingam and Narayanan, 2008). An important consideration was that alternatives such as harm reduction, although gaining ground in Europe⁴, were based on a philosophy completely contradictory to that upon which the prevailing drug policy had been built. To argue for an 'about-face' required special, pressing circumstances that were not yet evident at that time. The other major obstacle was the opposition from religious leaders to harm reduction as it was perceived as being a concession to permissiveness. Muslim religious leaders and organizations were uneasy with this approach and since most of the addicts were Malay Muslims their opinions could not be simply ignored⁵.

Bottom-up Multi- Level Governance

The harm reduction movement was initiated by NGOs in the late 1990s. An NGO called IKHLAS started actively engaging with drug users. They offered shelter and other forms of assistance to help drug users. They also tried to provide bleach to clean injecting equipment to minimize the spread of infections (Ng, L, personal communication, 2006). In addition, the Malaysian AIDS Council (MAC), another NGO, showed great concern

⁴ By the end of the 1980s, Germany, Switzerland, Spain and, in some respects, Italy too, had followed suit. France was the only country remained stubbornly to the traditional curative approach to drug abuse (Bergeron and Kopp, 2002: 38).

⁵ The *Mufti* (the appointed Muslim consultant jurist) of the state of Perak, for example, condemned the harm reduction programme that, among other measures, provides free needles and condoms because "it brought no benefit to the addict or society". The *Mufti* of the state of Penang feared that the free availability of needles and condoms would increase drug addiction and encourage sexual promiscuity among drug users. A member of parliament from the state of Sabah rejected the programme because it would permit addicts to continue with their 'undesirable' practices (Utusan Malaysia Website). ABIM, an influential Malay Muslim youth movement handed a memorandum to the Ministry of Health strongly opposing the pilot project on harm reduction (ABIM, nd.). In contrast, IKIM, an Islamic think tank aligned to the government took a pro-harm reduction approach citing the existence of such efforts in other Muslim countries like Iran, Pakistan and Bangladesh (Shaik Mohd. Saifuddeen, 2007)

about the increasing number of drug users infected with HIV/AIDS. The increased level of advocacy by NGOs such as these and the medical fraternity sympathetic to their perspective opened the way for the establishment of the National Harm Reduction Working Group (HRWG) in early 2004. The group presented the rationale behind the harm reduction initiative and evidence about its effectiveness elsewhere to the government. Their initiative was successful enough to elicit a mild response of interest from the authorities. While a pilot substitution therapy (methadone maintenance therapy) program was approved involving 1200 injecting drug users in three states, approval for the implementation of a needle syringe exchange program (NSEP) was not yet forthcoming (Reid et al., 2007:138).

In what was seen as a greater role accorded to the Ministry of Health, in 2005 it was entrusted with the authority to provide medical treatment for drug users in the country (Mazlan et al., 2006).. Government hospitals, which fall under its jurisdiction, were pressed into service as treatment centers for drug users on the methadone maintenance program. The initial success of the program prompted the government to widen the coverage in 2007 to 5000 drug users.

The door was opened for the NSEP in 2005 when it became known that Malaysia had failed to achieve one of the targets in the Millennium Development Goal (MDG) set by the United Nations. More specifically, the country had failed to contain the spread of HIV/AIDS. In June 2005, the Deputy Prime Minister disclosed that 64,000 people had been infected with HIV/AIDS; he further warned that this number could rise to 200,000 – 300,000 in the course of two to three years if drastic alternative strategies were not implemented. He made the case that under such urgent circumstances Islam permitted harm reduction measures (Star, 27 June 2005: 2). This was soon followed, in 2006, by

an announcement that the government had allowed a pilot NSEP to be introduced (Reid et al., 2007:138). With the implementation of NSEP, the role of the NGOs has become not only critical but also prominent.

The adoption of harm reduction brought the role of NGOs to the forefront on several counts. First, as noted previously, the initial moves towards harm reduction were pioneered by the NGOs. Second, even as the scope of the initiative widened, the active participation of NGOs became a vital ingredient. They were close to the ground, they had intimate links with drug users and they instilled confidence in addicts to expose themselves to treatment, counselling and supervision with respect to compliance to therapy protocols. Third and perhaps no less important, the active involvement of NGOs in the frontline work of the harm reduction initiative allowed the role of the government in supervising and financing it to remain in the background. This proved to be a comfortable arrangement for the government since it avoided a direct confrontation with powerful groups that were opposed to NSEP (Vicknasingam and Narayanan, 2008). In short, the implementation of harm reduction programs in the country necessitated a shift from the top-down multi-agency approach coordinated solely by the government to a more grass-root organization fuelled bottom-up multi-level governance structure since the problem was being viewed from human development and medical perspectives.

Despite the involvement of a wider range of NGOs and government agencies and the encouraging response to the harm reduction initiative, several challenges remain. With the participation of the medical fraternity in providing treatment to drug users, there have been reports of the misuse of prescription drugs. Vicknasingam et al., (2007) and Mahmud Mazlan et al., (2007) found that buprenorphine injecting was taking place in the country. Some physicians were also prescribing large quantities of buprenorphine for unsupervised use from the beginning of treatment, resulting in

problems of poor medication adherence and the diversion of the drug from approved use. Counselling and other psychosocial services are also not being delivered as planned (Mahmud Mazlan et al., 2006: 475). Furthermore, although the two pilot harm reduction programs have been scaled up, it is doubtful that they have reached levels that can reverse the rising HIV prevalence among the drug using population. Capacity constraints are holding back effective delivery. For example, there are an insufficient number of trained counsellors to deliver the psychosocial interventions that are required. The capacities of the NGOs involved in the initiative also need to be strengthened since harm reduction is a relatively new idea in the country. Finally, the government must deal decisively to decriminalize the drug addict and actively address issues relating to the stigma of addiction.

Education

Education has a key role in strengthening the harm reduction initiative and can be utilized at three levels concurrently. First, it can be pressed into service to not only effectively sensitize society on the benefits of harm reduction but also to change the way in which it views drug addiction. Drug addiction, to a large segment of society, is still a security problem which needs intervention from enforcement authorities. There is a need to emphasize the health perspective in dealing with drugs and drug addiction and this is best done through a clearly defined and sustained programme of education.

At the second level, the medical fraternity needs to be educated on responsible and safe dispensing of prescription medication including methadone and buprenorphine. There is high concurrent use of benzodiazepines and heroin in the country (Vicknasingam and Navaratnam, 2007). The medical fraternity must ensure that prescription medication is not being misused and is being dispensed responsibly in the country. There is also an

urgent need to train and educate more social workers in the field. The psychosocial intervention in the harm reduction program needs to be strengthened and social workers are the best resources available to make this happen.

Finally, the education of current drug users on the dangers of drugs and safer injecting practices need to be intensified. Vicknasingam and Navaratnam (2007) found that while some drug users have access to clean needles they still share the “cooker” used to cook and mix the drug. Drug users need to be made aware of the need to modify their drug using behavior. Currently in Malaysia ATS drugs are gaining popularity among the younger population and the mode of administration of this drug is either by smoking or snorting. The harm reduction definition needs to be broadened to include these groups in a comprehensive education programme that highlights the dangers of ATS drugs, the non-availability of maintenance therapy for addictions of this kind, and more importantly, the high risk associated with the injecting of this type of drugs.

Concluding Observations

The approach to drug policy was slowly redefined from a top-down multi-agency effort sponsored solely by the government and its subsidiaries to a bottom-up initiative led by grass-root organizations at various levels. This coincided and, indeed was spearheaded by a changing perspective on drug addiction and how to deal with it. The top-down approach was consistent with a hard line view on drug addiction, its consequences and the means to eradicate it. When this view was softened, largely by the failure of the previous approach to produce tangible results in drug addiction and the incidence of HIV/AIDS among addicts, the way was opened for harm reduction strategies that of necessity called for a great involvement of NGOs and other grass root organizations that enjoyed the confidence of drug addicts.

Despite the positive developments however, the depth and scope of the new initiatives remain limited and is unlikely to reverse the unhealthy trends of addiction and HIV/AIDS incidence significantly in the near future. This is further compounded by resource and personnel constraints. Efforts must be stepped up to increase the reach of these new initiatives by addressing these concerns. In order to do this, the government must be willing to take a bolder stand in support of the harm reduction programmes.

Education has a significant role in changing the mind set of the public with respect to the philosophy guiding harm reduction and in sensitizing public attitudes towards drug addiction and the drug addict.. Health and NGO personnel involved in harm reduction projects need to be trained and educated as well on the nuances of the therapy and its implementation. Finally, drug addicts themselves have to be educated in their role and responsibilities for harm reduction to succeed. It is not evident that that the key role of education has been fully recognized or utilized.

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