# HARM REDUCTION IN THE CONTEXT OF DRUG USE IN MALAYSIA: A CRITICAL ANALYSIS OF ITS JUSTIFICATION AND ITS COMPATIBILITY WITH THE CRIMINAL JUSTICE APPROACH

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## DECLARATION

This thesis contains no material which has been accepted for the award of any other degree in any university. To the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference has been made.

**PUBLICATIONS BY CANDIDATE RELATED TO DRUGS AND LEGAL CONTROL IN MALAYSIA**

Md. Isa, Y. "Akta Dadah Berbahaya (Langkah-Langkah Pencegahan Khas) 1985: Antara Teori Dan Penguatkuasaan Tangkapan Oleh Polis Diraja Malaysia [Dangerous Drugs (Special Preventive Measures) Act 1985: Between the Theory and the Enforcement of Arrest by the Malaysian Royal Police]." In *2007 Law Conference Proceeding*, edited by K. Mohamed, N. Yaacob, N. Ahmad Shariff, Z.A. Ayub, T.A. Kamal Baharin and N.A. Mohd Noor. 594-605. Sintok, Malaysia: Universiti Utara Malaysia, 2007.

Md. Isa, Y. "Pengedaran Dadah di Malaysia: Undang dan Penguatkuasaannya oleh Polis Diraja Malaysia [Drug Trafficking in Malaysia: Laws and Their Enforcement by the Royal Malaysian Police]." Master Dissertation, Universiti Kebangsaan Malaysia, 2007.

Md. Isa, Y. *Laporan Penyelidikan: Menangani Jenayah Pengedaran Dadah Berbahaya di Malaysia Menurut Perspektif Undang-Undang [Research Report: Addressing Dangerous Drug Trafficking Crime in Malaysia from Legal Perspective]*. Sintok, Malaysia: Universiti Utara Malaysia, 2008.

Md. Isa, Y., R. Ahmad, A. Abd. Rahman, A.N. Azrae, S. Khalil, S.A.J. Abdullah, and R.N.M. Sharif. *Laporan Kajian: Undang-Undang Rawatan dan Pemulihan di antara Malaysia, Negara ASEAN, United Kingdom, Kesatuan Eropah (EU), Jepun, Korea, India, China dan Australia serta Pelaksanaannya [Research Report: The Laws of Treatment and Rehabilitation in Malaysia, ASEAN Countries, United Kingdom, European Union (EU), Japan, Korea, India, China and Australia and Their Implementation]*. Sintok, Malaysia: Agensi Antidadah Kebangsaan & Universiti Utara Malaysia, 2010.

Md. Isa, Y., R. Ahmad, A. Abd. Rahman, A.N. Azrae, S. Khalil, S.A.J. Abdullah, and R.N.M. Sharif. *Laporan Kajian: Definisi Penagih dan Ketagihan Di Bawah Akta Penagih Dadah (Rawatan dan Pemulihan) 1983 (Pindaan 1998) dan Akta-Akta Lain Yang Berkaitan [Research Report: Definition of Drug Dependant and Dependency under Drug Dependants (Treatment and Rehabilitation) 1983 (Amendment 1998) Act and Other Relevant Acts]*. Sintok, Malaysia: Agensi Antidadah Kebangsaan & Universiti Utara Malaysia, 2010.

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# DEDICATION

I dedicate this thesis to my late father Md Isa, for his unconditional love and support. I will remember forever the time when my late father spent his savings to come from Malaysia to Lancaster, in the UK, to feed me with a straw when I was totally weak and unable to move or eat for weeks after my thyroid surgery. Additionally, this thesis is dedicated to the Royal Lancaster Infirmary, especially to Dr Mark Tomlinson and staff, for their invaluable treatment and health support during my major thyroid surgery, and for inpatient treatment of my second son. I also dedicate this thesis to all the poor people and children in the world.

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**Harm Reduction in the Context of Drug Use in Malaysia: A Critical Analysis of Its Justification and Its Compatibility with the Criminal Justice Approach**
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## ABSTRACT

The emergence of a harm reduction approach for drug users has prompted extensive debate in many countries. However, in Malaysia the pertinent issues regarding the bases of such an approach and its consonance with the criminal justice approach have received little attention. This thesis examines the justifications for the harm reduction approach in Malaysia, its compatibility with the existing criminal justice approach and ways of reconciling both approaches in the event of conflicts between them within a socio-legal sphere of analysis. Building on philosophical and scientific judgements, this thesis argues that Malaysia should implement the harm reduction approach and argues that it is congruent with public health ethics, utilitarianism, human rights protection and the Islamic principles of '*hajiyyat*' (needs), '*darurah*' (necessity) and '*al-∂arar al-ashadd yuzalu bi'l-∂arar al-akhaff*' (tolerating a lesser harm to eliminate a greater one). The approach also fits in with the abstinence orientation adopted within drug prohibition policy and the confines of the international drug control conventions. The Methadone Maintenance Therapy (MMT) and Needle and Syringe Exchange Programme (NSEP) harm reduction measures are further justified by their efficacy and cost-effectiveness in decreasing drug use and HIV pathogen transmission. This thesis also argues that any alleged unintended adverse consequences of harm reduction are limited or absent altogether. Moreover, with regard to the issue of compatibility between the harm reduction and criminal justice approaches, this thesis emphasises that there are significant theoretical and practical conflicts between the two approaches as they are currently understood and practised in Malaysia. The tensions arises principally from law enforcement practices, predominantly the street-level policing activities, reflecting the lack of commitment of criminal justice actors to the harm reduction strategy, despite the existence of government initiatives to support harm reduction. The thesis suggests

important options for reconciling both approaches, particularly at a conceptual level. Finally, this thesis argues for incorporating the harm reduction approach as an important component of overall drug policy under a sustained prohibitionist framework.

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*Quayle and Others* v *R* [2005] EWCA Crim 1415, 89 BMLR 169

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*Spokane County Health District* v *Brockett* [1992] 120 Wash.2d 140, 839 P.2d 324

*The 'Reward'* [1818] 165 ER 1482

*Vacco and Others* v *Quill and Others* [1997] 50 BMLR 119

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Dangerous Drugs Ordinance 1952

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Drugs Dependants (Treatment and Rehabilitation) Act 1983

Drugs Dependants (Treatment and Rehabilitation) (Amendment) Act 1998

Drugs Dependants (Treatment and Rehabilitation) (Amendment) Act 2002

Federal Constitution

Guideline on the Endorsement of Methadone Dispensing by Assistant Pharmacists at Methadone Clinics of the Malaysian Ministry of Health

Medical Act 1971

Medical Device Act 2012

Methadone Maintenance Therapy Dispensing Guideline

Methadone Maintenance Therapy Guidelines for Police

National Anti-Drugs Agency Act 2004

National Methadone Maintenance Therapy Guideline

National Needle and Syringe Exchange Programme Guidelines for Police

National Policy and Standard Operating Procedures for Methadone Maintenance Therapy

Penal Code

Poison Act 1952

Poisons (Psychotropic Substances) Regulations 1989

*Program Terapi Gantian Dengan Methadone: Garis Panduan Untuk Polis* [Methadone Maintenance Therapy: Guidelines for Police]

Registration of Pharmacists Act 1951

Tax Ordinance 1870

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1925 Geneva Convention–International Opium Convention

1948 Universal Declaration of Human Rights

1961 Single Convention on Narcotic Drugs

1966 International Covenant on Civil and Political Rights

1966 International Covenant on Economic, Social and Cultural Rights

1971 Convention on Psychotropic Substances

1972 Protocol Amending the 1961 Single Convention on Narcotic Drugs

1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

1998 Declaration on the Guiding Principles of Drug Demand Reduction (Resolution Adopted by the United Nations General Assembly, Twentieth Special Session)

1998 Measures to Enhance International Cooperation to Counter the World Drug Problem (Resolution Adopted by the United Nations General Assembly, Twentieth Special Session)

2001 Declaration of Commitment on HIV/AIDS (Resolution Adopted by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS))

Charter of the United Nations

Commentary on the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988

International Guidelines on HIV/AIDS and Human Rights

Ottawa Charter for Health Promotion

## LIST OF ABBREVIATIONS

| | |
|---|---|
| 1961 Convention | 1961 Single Convention on Narcotic Drugs |
| 1971 Convention | 1971 Convention on Psychotropic Substances |
| 1972 Protocol | 1972 Protocol Amending the Single Convention on Narcotic Drugs |
| 1988 Convention | 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances |
| AIDS | Acquired Immune Deficiency Syndrome |
| ASEAN | Association of Southeast Asian Nations |
| ATS | Amphetamine-Type Stimulants |
| DDA 1952 | Dangerous Drugs Act 1952 |
| DDTRA 1983 | Drugs Dependants (Treatment and Rehabilitation) Act 1983 |
| g | gram |
| HCV | Hepatitis C Virus |
| HIV | Human Immunodeficiency Virus |
| IDU | Injecting Drug User |
| MMT Policy and SOP | National Policy and Standard Operating Procedures for MMT |
| MMT | Methadone Maintenance Therapy |
| MOH | Ministry of Health |
| MOHA | Ministry of Home Affairs |

| | |
|---|---|
| MYR | Malaysian Ringgit |
| NADA | National Anti-Drugs Agency |
| NGO | Non-Governmental Organisation |
| NSEP | Needle and Syringe Exchange Programme |
| QALY | Quality-Adjusted Life Year |
| RMP | Royal Malaysian Police |
| UK | United Kingdom |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV and AIDS |
| UNODC | United Nations Office on Drugs and Crime |
| USA | United States of America |
| USD | US Dollar |
| WHO | World Health Organization |

# INTRODUCTORY CHAPTER

## General Background

Harm reduction in the context of drug use is by no means a new concept. It has a long history, as evidenced by practices including the medical prescribing of opiates in the United Kingdom (hereinafter referred to as the UK) since the 1920s. However, the concept was revitalised in response to the emergence of Human Immunodeficiency Virus (hereinafter referred to as HIV)/Acquired Immune Deficiency Syndrome[1] (hereinafter referred to as AIDS) during the mid-1980s, with harm reduction policies and strategies being adopted by countries in Western Europe, particularly the Netherlands and the UK, to control HIV/AIDS and other blood-borne transmissions among drug users.

The outbreak of drug-related HIV/AIDS epidemics has spurred the global development of harm reduction policies and practices since the late 1980s and early 1990s. The approach has been endorsed as important for national policy and strategic planning, and delivered on all continents. Moreover, it has engaged various interventions including Methadone Maintenance Therapy (hereinafter referred to as MMT), the Needle and Syringe Exchange Program (hereinafter referred to as NSEP), supervised injection facilities, condom programming, and education and counselling designed primarily to reduce the risk of HIV/AIDS infection among drug users. The services also aim to

[1] AIDS was first clinically uncovered as a disease syndrome that attacks the human body's immune system in 1981 (G.V. Stimson, "AIDS and HIV: The Challenge for British Drug Services," *British Journal of Addiction* 85(1990).330).

decrease drug taking and its harmful consequences including other blood-borne diseases such as Hepatitis C Virus (hereinafter referred to as HCV) and fatal and non-fatal overdoses, as well as promoting referrals to drug treatment, health and support services. Harm reduction embraces a number of key principles including pragmatism; humanism in which drug users' rights and dignity are acknowledged; emphasis on the mitigation of the harmful effects of drug taking rather than on the behaviour; costs and benefits assessment; and giving priority to realisable goals of addressing individuals' and communities' most critical immediate needs.[2]

In 2005, Malaysia began to emulate the international initiatives of exercising a harm reduction approach, with the goal of curbing the spread of drug-injection-driven HIV/AIDS. In the fight against drugs, however, the country still maintains a punitive criminal justice approach rooted in a paradigm of abstinence and deterrence. The criminal law retains a dominant role within Malaysia's strict prohibitionist and zero-tolerance drug controlling framework.

Considerable controversy exists over whether the Malaysian government should practise a harm reduction approach. Some scholarly writings in Malaysia highlight the practice of stringent law enforcement against drug users, including MMT and NSEP clients.[3] This practice raises the question of the compatibilities between harm reduction and criminal justice approaches. The question is also sparked by the international literature showing that the criminal justice approach has been a significant obstacle to the

[2] D. Riley et al., "Harm Reduction: Concepts and Practice. A Policy Discussion Paper," *Substance Use & Misuse* 34, no. 1 (1999).11–12.

[3] For example, S. Narayanan, B. Vicknasingam, and N.M.H. Robson, "The Transition to Harm Reduction: Understanding the Role of Non-Governmental Organisations in Malaysia," *International Journal of Drug Policy* 22, no. 4 (2011).315.

initiation and efficient implementation of harm reduction efforts in many other jurisdictions.[4] There is increasing concern within the literature about how to address the contradiction between the two approaches.[5] Unsurprisingly, the debate within Malaysia replicates the wider global debate to some extent. Taking a stance that is supportive of a harm reduction approach, the research presented here will examine these issues and their application in Malaysia.

## The Context of the Emergence of the Harm Reduction Approach: Drug Prohibition Policy and Differing Perspectives on the Drug Use Problem

### Drug Prohibition Policy

Drug prohibition constitutes the predominant drug policy at international and national levels. Within this policy, which derives from the international drug conventions,[6] drug-related activities including production, use, possession and distribution are restricted except for limited medical and scientific purposes. The prohibition framework covers two key policies: supply reduction and demand reduction. The goal of supply reduction is to decrease the availability of illegal drugs, through eradication of illicit crops and

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[4] For example, C.S. Davis et al., "Effects of an Intensive Street-Level Police Intervention on Sringe Exchange Program Use in Philadelphia, P.A.," *American Journal of Public Health* 95, no. 2 (2005).233-34.

[5] For example, Lawyers Collective HIV/AIDS Unit, *Legal and Policy Concerns related to IDU Harm Reduction in SAARC Countries: A Review Commissioned by UNODC* (New Delhi: United Nations Office on Drugs and Crime Regional Office for South Asia, 2007).9-10,132.

[6] The Conventions are the 1961 Single Convention on Narcotic Drugs (hereinafter referred to as the 1961 Convention) and the 1972 Protocol Amending the Single Convention on Narcotic Drugs (hereinafter referred to as the 1972 Protocol), the 1971 Convention on Psychotropic Substances (hereinafter referred to as the 1971 Convention) and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (hereinafter referred to as the1988 Convention).

interception of drug processing, dealing and trafficking.[7] At the other end, demand reduction aims to halt the demand for illicit drugs through prevention and treatment. Both supply reduction and demand reduction share the ultimate abstinence-based goal of mitigating or eliminating illegal drugs and behaviour. Prohibition policy is effectuated through criminal law and its enforcement.[8] States are warranted to determine the magnitude of domestic controlling law, including arrest, prosecution and punishments, to deter people from prohibited activities involving drugs. This has contributed to divergence in approaches among nations, with some adopting heavily punitive measures such as the death penalty while others take a less stringent attitude, for example, by decriminalising personal drug possession. Prohibition-oriented policies are mainly implemented by the criminal justice system, along with medical and public health authorities.

**Different Perspectives on the Drug Use Problem**

The moral-legal, medical (disease), criminal justice and public health stances referred to in this thesis principally represent varied perspectives on drug use. The moral-legal perspective renders drug using as a moral failure or a violation of the law. Involvement in drug consumption is classified as an individual option influenced by lacking moral values. The essential tenets of this notion also include the belief that drug approaches including treatment must engage elements of punishment.[9] The significant problem with this standpoint is that it overlooks physiological, psychological and sociological reasons

[7] S. Pryce, *Fixing Drugs: The Politics of Drug Prohibition* (New York: Palgrave Macmillan, 2012).51.
[8] Ibid.79.
[9] J.A. Schaler, "Drugs and Free Will," *Society* 28(1991).43.

for compulsive drug ingesting. Drug users are regarded as wrongdoers, whatever the factors leading to their behaviour.

The medical perspective connects drug use with drug dependency, which is regarded as a disease. According to many medico-scientific communities, biochemically created dependency results in the condition where control over drug taking is impaired. Thus, any person with such a condition obtains drugs under compulsion and is therefore absolved of responsibility for their actions.[10] The underpinning predisposition is that a drug dependant is a sick person who needs treatment. Given its incurability, drug dependency can be addressed only by a lifelong commitment to absolute abstention. Although this outlook benefits drug users by rendering guilt unnecessary and pointing the way towards treatment rather than punishment, it does have its defects. Allegiance to this standpoint positions drug takers as passive individuals who have a sense of victimised and learned helplessness and low commitment to end their consumption of drugs.[11] Moreover, consistent with the moral perspective, the medical lens does not consider psychosocial determinants of drug using such as cognitive and environmental factors. Despite the ostensible contrast between the moral-legal and medical perspectives concerning the nature and course of drug use and users, both seek to achieve drug-free status, which considerably shapes the prohibitionist paradigm of ‘zero-tolerance’ towards drugs and fighting against drug-related activities.

A particularly dominant perspective on drug use holds that it is essentially a criminal justice issue. The criminal justice approach focuses primarily on promoting

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[10] H. Abadinsky, *Drug Use and Abuse: A Comprehensive Introduction*, Seventh ed. (Belmont: Wadsworth, Cengage Learning, 2011).76.

[11] W. Wilbanks, "The Danger in Viewing Addicts as Victims: A Critique of the Disease Model of Addiction," *Criminal Justice Policy Review* 3, no. 4 (1989).413.

public safety and enforcing criminal laws,[12] a methodology that significantly shapes the global drug prohibition system. The approach focuses on drug users and illicit drugs, rather than on environmental risk influences over private behaviours, and emphasises using criminal law and criminal sanctions against drug use and possession for personal use. Instead of being oriented squarely on morality, these strategies are widely premised upon instrumental factors including economic rationale such as unhealthy money transfer in communities and lost productivity as a result of drug consumption,[13] the social hazards of drug using such as children abandonment and devastation of family life,[14] rates of crimes particularly acquisitive crimes related to drug taking,[15] and the physical and psychological harms of using drugs.[16] Further, the crime control model within criminal justice methodology is strongly linked with political hue as policy-makers continue to retain their commitment to drug policy because they perceive that any fundamental reform would trigger objections from interest groups and the electorate.[17]

The criminal justice approach aims to contain drug taking and possession through deterrence, incapacitation and rehabilitation.[18] The threat of enforcement actions such as arrest, prosecution and imprisonment upon drug taking or possession is intended to deter people from initiating or continuing these behaviours. Incarceration for contravening drug using and/or possession laws is also intended to prevent perpetration of further acts. In addition, the criminal justice approach seeks to address the conducts by rehabilitating the

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[12] W.R. LaFave, *Criminal Law*, Fifth ed. (St. Paul: Thomson Reuters, 2010).27.
[13] Pryce, *Fixing Drugs: The Politics of Drug Prohibition*.31–32.
[14] Ibid.33.
[15] D. Husak, "For Drug Legalization," in *The Legalization of Drugs*, ed. R.G. Frey (New York: Cambridge University Press, 2005).67–69.
[16] Ibid.42.
[17] Pryce, *Fixing Drugs: The Politics of Drug Prohibition*.48.
[18] T. Babor et al., *Drug Policy and the Public Good* (Oxford: Oxford University Press, 2010).164–65.

actors, through treatment that is usually predicated within the punishment matrix; mainly via treatment in prison, referral to treatment through criminal justice procedures (for instance, confinement in compulsory drug treatment centres, drug diversion programmes and drug courts) and strict penalties or actions upon relapse. However, the types and severity of criminal justice methods against drug use and possession for personal consumption vary considerably among states. Although both voluntary participation and coercion play roles within the realm of criminal justice practice, the application of compulsion or force or its threat is given greater significance in criminal justice than in other approaches.

Further, drug use is also frequently viewed as an issue of social and public health, because it expands beyond the individual to groups of people.[19] As a social conduct it adversely impacts upon wider communities and societies. The perspective that drug consumption causes negative effects upon both personal health, including physical and mental impairment, and public health, via injection-driven spread of communicable diseases like HIV/AIDS, is prevalent in the public health system. Drug using is treated as being similar to other serious health conditions within public health management, which seeks principally to prevent diseases and to protect the health of populations. Based on such understanding of drug use, the public health approach focuses on extensive strategies including prevention, educational, pharmacological, psychosocial and harm reduction programmes ensuring drug users' access to drug treatment, decrease of harms and risks associated with drug using, and improvement of life and health. The contemporary public health standpoint prioritises voluntary cooperation and promotion of

[19] B.P. Bowser, C.O. Word, and T. Seddon, *Understanding Drug Use and Abuse: A Global Perspective* (Hampshire: Palgrave Macmillan, 2014).7.

community participation, with intervention in individual behaviour being generally conditioned by the threat to population health.[20] It is significant that public health concerns with respect to drug taking are also closely connected to the criminal justice approach, which in turn is also deeply rooted in public health principles, as one of its main aims in controlling drug-related activities is to enhance individual and public health. (Further discussion is found in Chapter 2, Section 2.2.)

**Explanation of Terms**

In light of the abovementioned context, it is important now to clarify the term 'harm reduction', along with other important terms used frequently within this thesis. The purpose here is to explain their use within the thesis, rather than to give exhaustive analysis of any terms or theories.

**Harm Reduction**

To date, there is no universally recognised meaning of harm reduction in the context of drug use. The existing literature shows a variety of interpretations, with some presenting a broad definition of harm reduction as a goal, describing it as any policy, programme or intervention seeking to decrease the negative effects of drug using. Despite its coherence

[20] Z. Lazzarini, "Forensic Epidemiology: Strange Bedfellows or the Perfect Match? Can Public Health and Criminal Law Work Together without Losing Their Souls?," in *Criminal Law, Philosophy and Public Health Practice* ed. A.M. Viens, J. Coggon, and A.S. Kessel (Cambridge & New York: Cambridge University Press, 2013).199.

and potentiality to integrate a range of drug responses, however, this conception is less plausible since it is very wide, and practically covers entire policies and methods including abstinence-oriented approaches that aim in some manner to minimise drug-related harms, thereby increasing terminological dubiety.

Others propose an empirical definition of harm reduction for policies or interventions that demonstrate actual decrease of net harm.[21] This definition seems to be objectively creditable for inclusion of any harm reduction programme or service based on not belief or deontology but instead on evidence-based analysis. However, this type of conception creates terminological imprecision, and elucidating harm reduction policy and programmes' coverage becomes timely and costly. Moreover, as with the unclear limits of the broad definition, this empirical-related definition could comprise any policy or programme that indicates a net gain, a disadvantage that is also applicable to Lenton and Single's socio-empirical definition of harm reduction.[22] However, this latter definition is more concerned with the probability of a policy or programme's efficacy in mitigating net harms rather than what it stands for, which renders it unlikely to be more convincing than the purely empirical definition.

This thesis adopts a narrower definition of harm reduction as a strategy, construing it exclusively as the policies, programmes and interventions aimed at decreasing the adverse consequences associated with drug use without requiring individuals to stop using drugs. This interpretation is also favourable to many scholars[23]

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[21] S. Lenton and R. Midford, "Clarifying 'Harm Reduction'?," *Drug and Alcohol Review* 15, no. 4 (1996).412.
[22] S. Lenton and E. Single, "The Definition of Harm Reduction," *Drug and Alcohol Review* 17, no. 2 (1998).216.
[23] For example, E. Single, "Defining Harm Reduction," *Drug and Alcohol Review* 14, no. 3 (1995).289.

and international agencies including the World Health Organization (hereinafter referred to as the WHO),[24] as it specifies strategies that focus on mitigating drug-related harms while drug consumption continues. This narrower conception could provide conceptual clarity, distinctively describing harm reduction and distinguishing it from policies and measures grounded within the abstinence paradigm. It may also help to determine the focus and boundaries of harm reduction strategies.

Another contentious issue relates to what denotes harm and to whom it accrues. The argument has been made that harm expansively refers to the economic costs of trying to control drug taking and the unintended effects of such approaches.[25] The stance presented here, however, is consistent with the broad agreement within the literature that harm, including riskiness, should be particularly attributed to illegal drug use and its resultant behaviours. This meaning gives the concept of harm a distinctive set of clear limits, categorising it into health, social and economic domains that affect individuals, communities and society.[26] Harm within the drug use context is frequently understood specifically to include HIV and other blood-borne viruses including HCV infections and transmission, resources expenditure, criminal behaviour, and discarded injection equipment affecting public amenity.

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[24] World Health Organization, *Lexicon of Alcohol and Drug Terms* (Geneva: World Health Organization, 1994).40.

[25] For example, B. Fischer et al., "Charting WHO—Goals for Licit and Illicit Drugs for the Year 2000: Are We 'on Track'?," *Public Health Reports* 111, no. 5 (1997).272.

[26] R. Newcombe, "The Reduction of Drug-related Harm: A Conceptual Framework for Theory, Practice and Research," in *The Reduction of Drug-Related Harm*, ed. P.A. O'Hare, et al. (London: Routledge, 1992).3–4.

**Defining Drug Use/Misuse**

The term 'drugs' within this thesis denotes psychoactive substances that are proscribed or controlled by legislation and that, by their chemical nature, affect mental functions including perception, mood and cognition. They comprise the commonly forbidden narcotic and synthetic drugs as well as diverted medical pharmaceuticals. In line with the narrow focus of this research, the definition does not cover licit psychoactive substances such as tobacco, alcohol and caffeine, even where they fit the meaning of drugs pharmacologically. As this thesis concentrates on MMT and NSEP, the 'drugs' (and drug users) principally referred to are injectable opiates and other injectable substances (and users of injectable opiates, etcetera). However, it is useful to clarify that although this work has injectable substances as its primary scope, use of other forbidden substances has relevance for the wider harm reduction debate.

The term 'drug misuse' has been widely applied and diversely interpreted. Generally, it implies illegal drug using outside therapeutic purpose in a manner that results in problems to self, others and wider communities.[27] In other words, it signifies deleterious use. However, 'drug misuse' is regarded by many as value-laden and vague since, as in Ghodse's words, 'sometimes it seems to mean that the drug is being used without medical approval, sometimes that it is being used excessively'.[28] Notably, the alternative term, 'drug abuse', frequently employed including in international drug treaties, also has the connotation of social disapproval and conceptual ambiguities including with respect to when and how drug use turns into drug abuse. Nelson et al.

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[27] Abadinsky, *Drug Use and Abuse: A Comprehensive Introduction*.4.
[28] H. Ghodse, *Ghodse's Drugs and Addictive Behaviour A Guide to Treatment*, Fourth ed. (New York: Cambridge University Press, 2010).5.

rightly characterise it as ‘an unstandardised, value-laden, and highly relative term used with a great deal of imprecision and confusion, generally implying drug use that is excessive, dangerous, or undesirable to the individual or community and that ought to be modified’.[29]

A third and more recent term, ‘problem drug use’, despite its apparent neutrality and objectivity, carries similar theoretical difficulties and an overtone of judgement. Not only is it imprecise but it also bears unexamined inference regarding its causal link to the costs attributed to it.[30] More importantly, categorising people as ‘problem drug users’ could lead them to display social characteristics that are more likely to bring them to the attention of the authorities. This is particularly prevalent in the criminal justice regime, in which the notion of drug-related crime ignites important focus. Seddon compellingly argues:

> […I]t is through the awareness of this type of effect that interactions happen between the classification and the people who are classified. It influences how people categorised as problem drug users interact with their drug workers, probation officers, social workers, solicitors and so on. This, in turn, reshapes how these ‘authorities’ understand what problem drug use is and what kinds of people problem drug users are.[31]

Considering all of the above, the term ‘drug use’ has fewer pronounced negative implications and so is employed broadly throughout this thesis, described variously as

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[29] J.E. Nelson et al., eds., *Guide to Drug Abuse Research Terminology*, vol. 26 (Rockville: US Department of Health and Human Services & National Institute on Drug Abuse, 1982).33.
[30] F.E. Zimring and G. Hawkins, *The Search for Rational Drug Control* (Cambridge, New York & Melbourne: Cambridge University Press, 1992).34.
[31] T. Seddon, "What is a Problem Drug User?," *Addiction Research & Theory* 19, no. 4 (2011).339.

‘drug consumption’, ‘drug taking’ and ‘drug using’, as a generic term for any using of illegal or controlled drugs. Expressions such as ‘misuse’, ‘abuse’, ‘problematic use’ and ‘recreational use’ of drugs are not employed unless considered important to clarify a point or they constitute part of a quote. The term ‘recreational drug use’ simply refers to drug taking for pleasure.

In this thesis, the term ‘drug dependence’ is also applied to alternate drug addiction, given that it is a comparatively more comprehensive and formalised medical conception. While drug addiction restrictively relates to physical dependency on drugs, which is commonly characterised by the withdrawal syndrome developing upon deprivation, drug dependence encompasses both physical and psychological dependency. Drug dependence is defined by the WHO’s Expert Committee as:

> A cluster of physiological, behavioural and cognitive phenomena of variable intensity, in which the use of a psychoactive drug (or drugs) takes on high priority. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug-seeking behaviour. Determinants and the problematic consequences of drug dependence may be biological, psychological or social and usually interact.[32]

Thus, drug dependence has psychobiological characteristics including loss of control over drug using and preoccupation with getting more drugs that influence continued drug consumption regardless of the adverse effects.

[32] World Health Organization, *WHO Expert Committee on Drug Dependence. Twenty Eighth Report. Technical report series 836* (Geneva: WHO, 1993).7.

## Aims and Significance of the Research

In broad terms, the objective of this research is to develop our understanding of the harm reduction approach for drug users in Malaysia including its roots, the drug use and policy contexts, its goals and the current practice. The central objectives of the research are to critically examine the justifications for the harm reduction approach, to evaluate its compatibility with the existing criminal justice approach and to explore ways of reconciling the two approaches in the event of conflict.

The questions of whether the harm reduction approach should be implemented and whether it is compatible with the existing criminal justice approach are significant not only for academics, practitioners and service providers, but also, and more importantly, for drug users and society. Given the potentially severe impact of drug use upon individuals, families and communities, any issue regarding drug use and ways of addressing it has relevance and implications for them. Further, these questions are critical when it comes to determining the potential role of the harm reduction approach. Such questions are vital in informing policy-makers, public health managers, law enforcement officials and advocates as they try to support and/or implement the harm reduction approach.

Despite the significance of these issues, they have not received sufficient consideration in Malaysia, so this research aims to remedy such lack of attention. It attempts to contribute to our knowledge by providing a thorough discussion of important aspects related to justifying the harm reduction approach and its compatibility with the

criminal justice stance. The research also aims to address the following particular limitations of the available literature in Malaysia.

Consideration of the ethical and ideological challenges to the harm reduction approach is missing from the literature while insufficient attention is paid to consequentialist concerns. Existing local studies regarding the efficacy and cost-effectiveness of the harm reduction approach are very limited, inconclusive and scattered. This is a situation that must be rectified, as currently there is much scepticism and opposition to the harm reduction approach among people in Malaysia, which may impede its delivery and reduce its impact. On the other hand, valid concerns about the harm reduction approach should be taken into account to avoid unethical, illegitimate and counterproductive practices.

There is also very little discussion of the actual or potential conflicts between the harm reduction and criminal justice approaches in Malaysia. At present, the official position and widespread assumption is that the approaches are compatible, and this assumption, which I argue is mistaken, acts as a disincentive to serious exploration of this important issue. To date there is no research on this aspect of the problem, and while there are a few somewhat related scholarly articles and non-academic reports, they contain only short descriptions of some inconsistent legal provisions and law enforcement practices. None has engaged in legal analysis or addressed the many important facets of the issue including the nature and impact of any conflicts, or the reasons behind them. Considering this issue is vital as it affects the harm reduction approach's sustainability and accessibility. The ultimate goal is to add to the available literature by exploring the

criminal law and its enforcement practices that either support or undermine the harm reduction approach.

Finally, what is currently absent from the Malaysian literature and what this research aims to identify are the options for mitigating conflicts between the harm reduction and criminal justice approaches. Examination of this question will help to ascertain the compatibility and rightful domains of the two responses to drug use. This research intends to argue that it is feasible to include both approaches within a general prohibition policy if appropriate ways can be found to reconcile them.

Overall, this research is a significant contribution to knowledge, particularly in relation to drug use, public health and criminal justice. The research breaks new ground in the existing literature by analysing the harm reduction approach in the Malaysian context. It also adds to the Malaysian literature through its interdisciplinary approach and by examining in depth crucial issues that are frequently overlooked. This research is further expected to disclose an important gulf between international and local literatures and hopes to serve as a compelling catalyst for local studies including those employing fieldwork on each issue. In addition, the research findings could serve as advocacy and reference tools for the harm reduction approach, and might also foster positive ideas and suggestions towards bettering harm reduction practices. Some of these findings are relevant to, and may be adaptable for, other countries, especially those seeking to practise the harm reduction approach within a generally punitive environment.

**Research Questions and Methodology**

There are three central questions that guide this research. The first question is whether Malaysia should implement the harm reduction approach for drug users? The second question is if so, whether the harm reduction approach in Malaysia is compatible with the existing criminal justice approach against drug users? The final question is if there are conflicts between these approaches, is there a way of reconciling them, or must one or other of these approaches be abandoned?

This research deploys a legal research methodology involving several approaches: doctrinal analysis ('black letter'), socio-legal analysis and comparative analysis. Fisher et al. argue that 'a commitment to the value of methodology is not a commitment to a particular methodology,[33] but is a commitment to developing methods that are 'best suited' to the types of questions asked',[34] which indicates the need for methods to be responsive and supportive of research questions.

Doctrinal analysis is concerned with legal doctrine, namely, 'the rules, principles, and concepts set out in law books and authoritatively stated in legislation or deduced from judicial decisions'.[35] This method of analysis comprises processes including procuring and interpreting (analysing) the law and communicating the results to other persons.[36] The relevant sources for doctrinal analysis can be classified into two types: primary

[33] D. Feldman, "The Nature of Legal Scholarship," *Modern Law Review* 52, no. 4 (1989). –cited by E. Fisher et al., "Maturity and Methodology: Starting a Debate about Environmental Law Scholarship " *Journal of Environmental Law* 21, no. 2 (2009).227.
[34] "Maturity and Methodology: Starting a Debate about Environmental Law Scholarship ".227.
[35] R. Cotterrell, *Law's Community: Legal Theory in Sociological Perspective* (New York: Oxford University Press, 1995).50.
[36] M.D. Murray and C.H. DeSanctis, *Legal Research And Writing* (New York: Foundation Press, 2006).1.

sources and secondary sources. The former principally consists of legislation (such as statutes, law codes and treaties), administrative regulations and rules, and case law, while the latter covers interpretations of and commentaries on the law in legal textbooks, journal articles, legal encyclopaedias and other materials.

Doctrinal research employs the conventional legal research method to identify and critically examine the body of law that regulates drug using and its related conducts, and that affects the harm reduction approach in the Malaysian case. The thesis refers to and evaluates the relevant doctrinal sources, such as relevant federal laws, which are identified through electronic databases and crosschecked with the indices of federal statutes, and court decisions, which are traced through case databases and written reports. The ultimate purpose is to determine the main applicable legal grounds for the criminal justice approach against drug use and other related activities, the extent of its theoretical consistency and its potential impact upon the harm reduction approach. The research considers questions such as: Are the laws framed correctly? Do they address the key issues? Are courts' decisions consistent? Is legislative reform necessary? Additionally, this approach is a valuable device for looking critically at the international law instruments and relevant secondary sources in terms of tackling the issues relating to the harm reduction approach's incongruity with the international drug controlling regime and its connection to human rights protection.

In contrast, the socio-legal method moves beyond legal doctrine to study the law as a social phenomenon, which involves examining how law operates in a social context. In socio-legal research/analysis, law is also considered based on its theoretical positions including as a social change instrument. According to Salter and Mason, socio-legal

research/analysis engages ‘an interdisciplinary approach focusing on a variety of contextual factors shaping law in action, as well as different theoretical perspectives on the operation of law in society which seek to explain the different functions of law as a social phenomenon’.[37]

In the course of this approach, the law and its applications are studied from various perspectives within and across disciplines such as ethics, sociology, criminology, politics and economics. As Lobhan argues, ‘It is only with the aid of the ‘external’ perspective that we can make sense of the ‘internal’ developments’.[38]

This research adopts a socio-legal approach for several reasons. First, it seeks to explain how and why the harm reduction and criminal justice approaches have taken their present forms in Malaysia, so socio-legal analysis provides a contextual understanding of the historical, legal, social and political circumstances that have come to bear on Malaysia’s drug controlling and harm reduction policies. In addition, the socio-legal method enables description and exploration of the attitudes and arguments of both proponents and opponents of the harm reduction approach, thereby facilitating better understanding of the dimensions of the debate surrounding it. Further, socio-legal analysis is necessary for achieving the research objective of assessing the philosophical and scientific justifications of harm reduction approach. This method of analysis involves exploring the ideological impetus behind the approach, as well as its efficacy, cost-effectiveness and the extent to which it achieves the goals it sets out to attain, along with any unintended consequences that flow from the approach.

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[37] M. Salter and J. Mason, *Writing Law Dissertations: An Introduction and Guide to the Conduct of Legal Research* (Essex: Pearson Education Limited, 2007).138.
[38] A. Lewis and M. Lobban, eds., *Law and History. Current Legal Issues 6* (Oxford: Oxford University Press, 2003).26.

Furthermore, in examining the compatibility between the harm reduction and criminal justice approaches in the case of Malaysia, the research requires that attention be paid to the criminal provisions pertaining to drug use and its related activities and, equally, their enforcement, which intersects to shape the criminal justice regime. Socio-legal analysis is used significantly to effectuate a critical examination of how the legal rules operate in action and other related concerns including whether the mechanisms intended to avoid clashing legal practices work or not and how any discrepancy actually impacts on the operation of harm reduction. Such questions are beyond the capabilities of exclusively doctrinal analysis.

This particular socio-legal analysis relies on data sourced from materials including parliamentary debates, official statistics, published and unpublished public and private sector reports, policy documents, scholarly articles and study findings. Some of these materials are not publicly available, so they were obtained through a series of meetings with certain government agencies such as the Ministry of Health (hereinafter referred to as the MOH) and NGOs including the Malaysian AIDS Council.

Part of the research involved conducting informal, unstructured interviews and discussions with higher and senior officers from key government bodies and academicians involving in drug controlling and harm reduction works and research.[39]

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[39] The informal face-to-face interviews, discussions and/or online communications took place with the Senior Principal Assistance Director and the Head of the Malaysia Harm Reduction Programme of the MOH, the Deputy Director General of the National Anti-Drug Agency, the Director of Malaysian Drug Research, an Associate Professor of Law from the International Islamic University Malaysia, an Associate Professor of Addiction Studies and Behavioural Studies from the Malaysian University of Science, and a Policy Manager from the Malaysian AIDS Council. Key informants were chosen from government publications, studies and suggestions by government personnel. My professional relationship with these government agencies, based on past research experience, facilitated access to the key informants. I conducted all discussions with participants' consent, in accordance with ethical standards, and guaranteed

These discussions provided the opportunity to verify the reliability of unpublished resources and to address the data's limitations in elucidating several aspects including the nature, scope and prospect of drug controlling and harm reduction policies and practices in Malaysia. They were also valuable for exploring the opposition and concerns regarding the harm reduction approach and the measures that should be taken to prevent inconsistent criminal law practices.

Formal interviews with key informants and other actors in this research were not conducted primarily because gaining access to government personnel in Malaysia, including the police and prosecution services, for the purpose of conducting research is difficult, time-consuming and not particularly effective. The administrative 'red tape' is considerable, including circulating an application through many departments and subjecting the interview questions to rigorous scrutiny. Worse is that, after all that, the data collected from the interviews are unlikely to be sufficient or reliable owing to the officers' unwillingness to extensively discuss anything, or to highlight the problems or critically comment on government policies and practices. This is strongly evidenced by my experiences of conducting informal discussions as part of this study and by my previous experience as a member of an academic research team involved in national studies using interviews with multi-ranked officers including police, prosecutors, chemists and medical practitioners.[40] This has been the experience of many other researchers, too, including the recent study done by the United Nations Country Team in

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that the information obtained through the discussions would be used solely for this PhD study and treated as strictly confidential.

[40] For example, when I asked nine prosecution officers about problems that actually or potentially impact the non-conviction of drug prosecution cases, they responded unanimously, and very briefly, that there are no such problems at all. Responses commonly given by key informants from government bodies in previous research have circled around the smoothness and effectiveness of government efforts.

Malaysia in which interviews with key bodies including prosecution services could not be conducted.[41] Such constraints may well explain the lack of socio-legal research in Malaysia, particularly that involving government bodies.

Malaysia's cultural and political spheres are characterised by the workers' submission to and fear of higher-ranked officers. Influenced by deep concerns about possible negative implications and the reactions of the authorities, it is not surprising that they generally avoid expressing views on or criticising institutions or senior officers. I am also doubtful of the importance of ascertaining the officers' responses as they seemingly have limited knowledge and experience regarding the operation of harm reduction in Malaysia, which is still new and in the development stage.

Conducting interviews with drug users is also complicated as it involves timely, costly and arduous steps. Accessing this group, which is still highly stigmatised and marginalised in Malaysia, is connected to various strict administrative and ethical procedures. Moreover, this population frequently lives 'underground', owing to a heightened fear of law enforcement, and so is hardly approachable. Therefore, even in the event of securing authorities' approval, it is still uncertain whether a sufficient number of drug users who were willing to participate and to provide accurate responses could be traced.

The research also includes considerable reference to the literatures from other countries with experience in harm reduction policies and practices, including the UK, the United States of America (hereinafter referred to as the USA) and Australia. As was

[41] United Nations, *Review and Consultation on the Policy and Legal Environments Related to HIV Services in Malaysia* (Kuala Lumpur: United Nations, 2014).35.

noted above and will be evident in the thesis discussion, there is a dearth in Malaysia of literature and evidence on the issues involved. Considering international literature gives a much fuller picture of the issues, debates and recent developments in the field, and provides deeper insights and support for arguments.

I also use comparative analysis here to explore how other jurisdictions address conflicts. Considering other jurisdictions' experience could assist Malaysia in identifying how applicable different means are to addressing societal issues, including those related to law.[42] For this research, comparative analysis assists in identifying problems and their implications from the concurrent implementation of the two responses in other settings, as well as the merits and demerits of possible strategies for minimising clashes. This is particularly relevant in evaluating the Malaysian criminal justice response that affects harm reduction and in offering suggestions for achieving compatibility between both approaches. In addition to the potential opportunities, however, undertaking comparative analyses on other jurisdictions does present limitations. A number of scholars have highlighted difficulties that arise when comparing international policies or legal contexts. For example, Newburn and Sparks explain the tendency of comparative analysis to focus on similarities in policies, ideas and practices in local jurisdictions based on the understanding of their global transferability, at the expense of considering the influences of national and jurisdictional cultural, political and social influences upon their ultimate pattern.[43] According to Lacey, 'it is crucial to recognise […] that the salience and

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[42] A. Yaqin, *Legal Research and Writing* (Kelana Jaya, Malaysia: Malayan Law Journal Sdn. Bhd., 2007).18.
[43] T. Newburn and R. Sparks, "Criminal Justice and Polictical Cultures," in *Criminal Justice and Political Culture: National and International Dimensions of Crime Control*, ed. T. Newburn and R. Sparks (Devon: Willan Publishing, 2004).9–10.

politicisation of criminal justice vary from country to country'.[44] The writings of many scholars further remind us of the possibilities of divergent substance for the ostensibly convergent symbolisms in policies in every locality.[45] Clearly, there are local divergences even though the policies, terms, rhetoric and dictions between settings are apparently similar. Therefore, while it is helpful to analyse these different jurisdictional policy or legal approaches, the different cultural, political and social contexts in which they operate must be kept in mind. This means that they are not necessarily directly comparable, and that what works in one jurisdiction may not necessarily be appropriate in another jurisdiction.

In short, this research uses a combination of methods suited to the questions raised.

**Scope and Limits of the Research**

This research focuses primarily on the justifications of the harm reduction approach and its compatibility with the criminal justice approach against drug users in Malaysia, but operates within certain self-imposed limits. Although there are varied measures that fall under the harm reduction approach, each of which has ethical and legal issues, the research is limited to MMT and NSEP. This limit arises from space constraints and from the fact that MMT and NSEP are the core and most widely practised harm reduction

[44] N. Lacey, "Principles, Politics and Criminal Justice," in *The Criminological Foundations of Penal Policy: Essays in Honour of Roger Hood*, ed. L. Zedner and A. Ashworth (Oxford: Clarendon Press, 2003).86.
[45] For example, T. Jones and T. Newburn, "The Transformation of Policing? Understanding Current Trends in Policing Systems," *British Journal of Criminology* 42, no. 1 (2002).143.

strategies, not only in Malaysia but also at the international level. Additionally, within the Malaysian context, both measures are the most ethically and legally controversial.

Further, the examination in this research of the effectiveness of the harm reduction approach will focus particularly on a subset of outcomes of MMT and NSEP interventions, namely, reduced HIV and HCV transmissions, decreased drug taking, cost-effective drug using and HIV and HCV preventions, absent symbolic effects of drug consumption promotion, and absent negative consequences in terms of increased crimes and discarded needles and syringes. Of course, this does not indicate that other results are insignificant. The selected effects are considered given their position as targeted outcomes for Malaysian harm reduction measures as highlighted in most government publications. Also, these effects always ignite Malaysian concerns and empirical investigations. While this research will examine the effectiveness of MMT and NSEP, it will not make a detailed assessment of the characteristics, operation and factors of each individual measure.

With regards to the criminal law that affects the harm reduction approach, this research is principally concerned with Malaysian federal drug laws, regulations and practice guidelines relating to the use and possession of illegal drugs and drug paraphernalia and methadone prescribing. State and local laws are excluded from the research, because existent state practice guidelines are merely administrative summaries of the federal legal documents and have no legal effect. Even more significantly, all state drug legislation has been deprived of its importance since the enactment of the Dangerous Drugs Act 1952 (hereinafter referred to as DDA 1952) and other federal drug-related statutes. By virtue of Articles 74 and 75 and the Ninth Schedule of the Malaysian Federal

Constitution, federal laws are given supremacy over local laws with respect to different matters including criminal aspects inclusive of drug controlling.

## Thesis Structure

The thesis is structured as follows:

**Chapter 1** considers the origins of harm reduction in Malaysia. To set out a clear context, this chapter presents a detailed account of historical phases of the drug use problem and controlling drug policy before the adoption of the harm reduction policy. It then tracks the initiation and development of the harm reduction approach.

The thesis then pays attention to the justifications of the harm reduction approach, focusing on MMT and NSEP strategies in two main chapters:

**Chapter 2** examines the normative and philosophical basis of the harm reduction approach, giving a particular account of the conceptual arguments for and against it that arise most commonly in drug discourse.

**Chapter 3** addresses the efficacy and cost-effectiveness of MMT and NSEP strategies. For each measure, it summarises and examines the relevant debates as well as scientific and other interrelated evidence on the important outcomes with respect to drug use and blood-borne pathogen transmissions.

**Chapter 4** centres on the compatibility between the harm reduction and criminal justice approaches in Malaysia. It examines and evaluates the current criminal justice approach that impacts upon the implementation of harm reduction, starting with an analysis of the main legislative and regulatory provisions relating to drug use. This leads to a review of the effect on harm reduction of government initiatives to support the approach and of the impact in practice of the operation and implementation of the legislative and regulatory framework.

Expanding on issues highlighted in the previous chapter, **Chapter 5** explores and examines the possible ways of moving towards a reconciliation of the two approaches. The main focus is on three related aspects, namely, the feasibility of the harm reduction approach within a larger prohibition-based drug policy, its workability alongside an abstinence-oriented goal and its relationship to the criminal justice approach.

**Chapter 6** summarises and draws together the research's conclusions, overall findings and implications. This is followed by an outline of recommendations for change and reform in Malaysia.

# CHAPTER 1

# HISTORICAL OVERVIEW OF DRUG POLICIES IN MALAYSIA: FROM DETERRENCE AND ABSOLUTE ABSTINENCE TO HARM REDUCTION

## 1.1 Introduction

Although Malaysia has longstanding prohibition-based responses for drug-related activities, the year 2005 witnessed a significant evolution in its drug policies during which the government, which had initially adopted control methods based on the philosophies of deterrence and total abstinence, moved towards considering the harm reduction approach. This chapter will depict Malaysian drug policies across several historical periods. What almost all studies undertaken in Malaysia disregard are the processes involved in setting drug policies and regulations. The research often accepts the drug problem as provided objectively by the government. While the discussion presented here will consider how drug use has been constructed and engages with its moral and social responses, it will not substantially examine the accuracy of the varied relevant contentions. It will further explain the integration and present practices of harm reduction running concurrently with other drug policies.

It is crucial to note the significant methodological limitations encountered in attempting to obtain historical data that would have been useful to inform this study. The existing literature in this area is greatly underdeveloped, partly because of the constraints

that researchers face in gaining access to this type of information. This places great limits upon what knowledge is made available. The Malaysian government's approach towards availability and openness of data renders such research difficult. This is despite other countries, especially developed jurisdictions, relatively making this type of information readily available. In Malaysia, materials such as state policy and legislative reports, criminal justice practice records especially in relation to charges and convictions, and debates regarding drug policies and laws are unavailable or have very limited access. Some of the data presented in this chapter was partially obtained during my previous studies. It is important to be careful in relying on the available official statistical data, even though little alternative information or data from other agencies or sources is available. The statistical data available in Malaysia has not been contested so far. Additionally, I made several data applications to key government agencies including the National Anti-Drugs Agency, but were rejected based on the government's policy of credential information. Moreover, there is little debate regarding historical data in Malaysia. All limitations hinder effective assessment of the historical aspects and restrict the scope of this study and future research in this area. As Gummesson claims, gaining access to people (or data) is often one of the biggest challenges that researchers face.[46] This has proved to be true in the context of this research. In the light of these methodological limitations, this first chapter provides a historical backdrop to current policy approaches, giving details of the policy and legislative paradigms that will be critiqued in subsequent chapters. Therefore, this chapter examines pertinent literature on the historical context to drug policies in Malaysia as a basis for elucidating the shift from a focus on deterrence and abstinence, to a greater emphasis on harm reduction.

[46] E. Gummesson, *Qualitative Methods in Management Research* (Thousand Oaks: Sage, 1991).21.

## 1.2 The Legalisation Period (Mid-19th Century to 1924)

Drug use in Malaysia originated from the mid-19th century, while it was under British rule. Opium smoking was routine among immigrants from China who had migrated to work in tin mines in Malaya[47]. Cannabis taking was also traced during that time, but only narrowly practised among Indian migrant workers and native people.[48] Historically, opium had been prevalent as a vital commodity in Asian countries, particularly China, since the early 19th century. It was shipped to the Far East mostly from India by the British-owned East Indian Company.[49]

Opium was generally used by Chinese immigrants in Malaya to relieve aches and pains after their strenuous day's work as well as for relaxation. It was also thought to have therapeutic effects on certain illnesses including diarrhoea and malaria. Opium consumption became customary among Chinese entrepreneurs, too, as they felt it reflected their high status.[50] Some of the contemporary writings supported these recreational and medicinal rationales for Chinese opium taking.[51] Opium using was thus a widespread normalised practice among the Chinese during this time, rather than a typified moral or social problem.

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[47] Before September 1963, Malaysia was called Malaya.

[48] M.N. Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]* (Sintok, Malaysia: Universiti Utara Malaysia, 2008).10.

[49] W. Bailey and L. Truong, "Opium and Empire: Some Evidence from Colonial-Era Asian Stock and Commodity Markets," *Journal of Southeast Asian Studies* 32, no. 2 (2001).174–75.

[50] M.K. Majid, *Dangerous Drugs Laws* (Kuala Lumpur: Malayan Law Journal Sdn. Bhd., 1995).1; R.A. Rogers, *Segi Tiga Emas: Perniagaan Narkotik di Asia Tenggara [Golden Triangle: Narcotic Business in the Southeast Asia]* (Kuala Lumpur: Universiti Malaya, 2008).22.

[51] For example, H.E. McCallum, *Memorandum on the Opium Traffic, Straits Settlements by the Colonial Engineer' in Correspondence on the Subject of the Consumption of Opium in Hong Kong and the Straits Settlements* (London: Great Britain Colonial Office, 1892/1896).53.

Opium also became an important revenue-generating commodity for the British administrators. Through the so-called 'revenue farm system', the British contracted out opium distribution and sale to Chinese merchants and collected excise duty from them. Imported opium trade in the Straits Settlements[52] was then enlarged by the supply from domestic poppy plantations after 1884.[53] The revenue from opium transactions was very extensive. For instance, the average yearly proceeds of opium from 1842 to 1882 accounted for 44.3 per cent of the whole Straits Settlements earnings.[54] Lucas asserts that 'opium and Chinamen go together and opium licenses […] are all-important to the revenue'.[55] Opium continued to hold its value for Chinese personal and business uses right up towards the end of the 19th century, a fact that is confirmed by the majority of publications, both old and more recent.[56] Some contemporary scholarship contradicts this, claiming that the drug problem emerged during this time.[57] However, the opium taking was not commonly looked upon as a moral or social issue, and was even thought to be useful at that time.

The late 19th century, though, saw the emergence of the anti-opium sentiment, particularly among a small number of enlightened Chinese. Having raised concerns about

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[52] The Strait Settlements comprising Penang, Malacca and Singapore were part of Malaya.
[53] Agensi Antidadah Kebangsaan, *Rawatan dan Pemulihan: Dulu dan Kini [Treatment and Rehabilitation: Then and Now]* (Ampang, Malaysia: Creative People Ent. @ Shout ACS (M) Sdn. Bhd., 2009).25.
[54] T. Kenji, "Anti-Opium Movement, Chinese Nationalism and the Straits Chinese in the Early Twentieth Century," *Malaysian Journal of Chinese Studies* 1(2012).85.
[55] Minute, 26 Aug. 1984, on Mitchell to Secretary of State, 8 Mar. 1894, 273/194. –cited by R. Heussler, *British Rule in Malaya: The Malayan Civil Service and Its Predecessors, 1867-1942* (Oxford: Clio Press Ltd., 1981).169.
[56] For example, S.F. Swettenham, *British Malaya: An Account of the Origin and Progress of British Influence in Malaya* (London: George Allen and Unwin Ltd., 1948).253–55; C.A. Trocki, "Opium as a Commodity in the Chinese Nanyang Trade," in *Chinese Circulations: Capital, Commodities, and Networks in Southeast Asia*, ed. E. Tagliacozzo, W.C. Chang, and W. Gungwu (Durham: Duke University Press, 2011).96–101.
[57] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.9.

the dangers of using opium, the anti-opium movement, which arose in the early 20th century, made repeated calls for rendering opium use a social issue in need of the state's prohibitive efforts.[58] Opium's critics frequently highlighted the destructive moral and social consequences of its use, including moral degeneracy. For example, Lim Boon Keng, in *The Straits Chinese Magazine*, says:

> The Government of every civilized country recognizes as its duty the repression of all sources of vice and crime […] We wish to call the attention of the Straits Government to its position in regard to the baneful habit of opium smoking, to the revenue which it derives from this luxury and to the duties which it morally owes to the poor and helpless victims of the opium habit.[59]

Meanwhile, the British, many Europeans and the rich Chinese leaders defended opium taking as a habitual act and a Chinese 'necessity', rather than a problem demanding state control.[60] Some further contended opium's impetus as a merchandise or form of remuneration by Chinese employers.[61] These justifications arose out of the standpoint regarding the relevance of opium taking to the Chinese populace's culture and circumstances. Significant support was also provided by the 1907 Opium Commission's investigation into the magnitude of opium consumption in Malaya. The report concluded that the harmful effects of opium use were usually exaggerated and that prohibition was inessential. It mentioned that 'under existing circumstances, there can be no honest

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[58] C.U. Wen, "Opium in the Straits Settlements, 1867-1910," *Journal of Southeast Asian History* 2, no. 1 (1961).56.
[59] L.B. Keng, "The Attitude of the State towards the Opium Habit," *Straits Chinese Magazine* 2(1898).47.
[60] Ibid.48; Kenji, "Anti-Opium Movement, Chinese Nationalism and the Straits Chinese in the Early Twentieth Century."88.
[61] Heussler, *British Rule in Malaya: The Malayan Civil Service and Its Predecessors, 1867-1942*.156.

alternative to the course of frankly recognising that the habit is one which cannot, in the near future, be eliminated, one which exists as a personal right of its habitués and one which it would be worse than futile to attempt to prohibit'.[62] Unsurprisingly, the British administrators were satisfied with the report findings despite their defects, including bias against anti-opium testimonies and failure to gather fundamental information regarding the overall group size of opium users and the extent of opium used.[63] The results apparently conformed to the British stance regarding legitimate opium consumption.

The British continued the revenue farm system until 1909. In the light of the British's recognition of the vast power bestowed on farmers through the system, it was abrogated in 1909 and replaced by a government monopoly system a year later. Under the new system, the government undertook entire control over the wholesale trade but could license Chinese opium retail shops subject to fees and tax payment. The premises were known as the 'Government's Opium Shops',[64] and were indicators of the British's constant unpreparedness to suppress opium sale and use. Indeed, the system was developed to further increase Britain's authority over opium commerce. Opium thus continued to be positioned not as a problem but as a legitimate source for Chinese consumption and state revenue.

[62] International Opium Commission and C.H. Brent, *Report of the International Opium Commission Shanghai, China, February 1 to February 26, 1909*, vol. I-Reports of the Proceedings (Shanghai: North-China Daily News & Erald Limited, 1909).44.

[63] Wen, "Opium in the Straits Settlements, 1867-1910."73.

[64] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.9; Swettenham, *British Malaya: An Account of the Origin and Progress of British Influence in Malaya*.255.

The opium discourse frequently explains British's clear attitude in tolerating opium smoking across this period in terms of economic interest.[65] While the contention is plausible owing to the evident large financial returns from opium duties, it does not account for opium smoking being perceived as beneficial and a natural way to relax. In this vein, it is possible to argue that the British and other claim-makers' justification relating to the circumstantial and cultural conditions of Chinese opium smoking had merits. Nevertheless, determinants for opium legalisation went beyond that to also cover economic and political factors. The facts as discussed clearly demonstrate that opium taking was a normalised activity among Chinese immigrants and simultaneously a profitable source that supported the British administration in Malaya during this period. These factors also likely explain the failure of anti-opium sentiments to significantly impact opium transactions and consumption.

In sum, opium was prevalently legalised during the period from the mid-19th century to 1924. The presenting social, economic and political contexts dissuaded the construction of opium use as a problem to be at a central stage, thereby disregarding the need for control responses during that time.

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[65] For example, Rogers, *Segi Tiga Emas: Perniagaan Narkotik di Asia Tenggara [Golden Triangle: Narcotic Business in the Southeast Asia]*.23.

### 1.3 From Regulation to Prohibition Period (1925 to 1970s)

British administrators' gradual efforts towards restricting drug use can be traced back to 1925. Britain made a profound change from legalisation to restriction of opium in its opium policy in response to strong international demands. The British has passed Opium and Chandu Ordinances and Enactments for every state since 1925 in compliance with the 1925 Geneva Convention–International Opium Convention aimed at limiting the numbers of opium smokers. Through the legislation, only registered opium smokers, labelled as bona fide users, were permitted to buy and use opium.[66] In 1929, there were 73,000 registered opium smokers in the states of the Strait Settlements, while in the Malay States, there were 52,313 registered opium smokers.[67]

A further restriction against opium was set in 1934, whereby use of opium was limited to only those with medical certification supporting their health need of opium, consistent with the suggestions of the League of Nations Commission of Enquiry into the Control of Opium Smoking in the Far East in 1930. The year 1934 also witnessed Britain abolishing the government monopoly system. In spite of the increasingly restrictive measures against opium, however, claims still came, particularly from anti-opium groups, for British to seriously address opium use as a moral and social issue through absolute

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[66] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.9.

[67] Rogers, *Segi Tiga Emas: Perniagaan Narkotik di Asia Tenggara [Golden Triangle: Narcotic Business in the Southeast Asia]*.34; League of Nations, *Commission of Enquiry into the Control of Opium Smoking in the Far East* (Geneva: League of Nations, 1930). -cited by Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.10.

prohibition. Chen from the Anti-Opium Society even contended that the moral problem of opium using 'presented nothing incapable of solution and that its abolition could only be accomplished by the state, and not by a private individual or a charitable organisation'.[68] That said, it is important to note that the suggestions for prohibitive strategies were negligible. Although likely agreeing to the problem status of opium taking, the British believed that its level was controllable through the existing regulatory measures. Governor Thomas, for instance, reported in 1936 that opium dependants accounted for not more than 35,000 or about 5 per cent of the estimated Chinese populace as of September 1935.[69] But many recent studies have found that the average figure of dependants in the 1930s was greater. Majid, for example, reveals that the number reached approximately 60,000.[70] Thus, it could be argued that the British in Malaya potentially diminished the data in order to hide the inadequacy of its regulatory measures against opium.

British's firm reluctance to proscribe drugs in Malaya continued despite increasing international and domestic pressures to discontinue drug dealings, such as by the International Labour Organization in the USA and by anti-opium movements in Malaya. Though the British Foreign Office was enthusiastic to cooperate, the British in Malaya were uneasy about altering the regulatory system. The arguments forwarded in rejection of prohibiting opium included that the majority of users were old, that there would be increased risk of people resorting to illegal drugs to alleviate their painful

[68] S.L. Chen, *Opium Problem in British Malaya* (Singapore: Anti-Opium Society, 1935).22.
[69] H. Goto-Shibata, "Empire on the Cheap: The Control of Opium Smoking in the Straits Settlements, 1925-1939," *Modern Asian Studies* 40, no. 1 (2006).77.
[70] Majid, *Dangerous Drugs Laws*.2.

cravings and that deterrence was already achievable through pricing opium highly.[71] Arguably, this thesis argues that the British defence was no longer born so much out of the view that opium consumption was tied to Chinese circumstances and culture; but rather out of financial considerations. The available data showed that opium was no longer part of Chinese daily life at this time but still continued to provide revenues even much lower than in past decades. For example, 1938 statistics demonstrate that the revenue derived from opium in the Straits Settlements and the Malay Federated States was not more than 10 per cent of overall revenues.[72] This argument is also based on the earlier declaration of British Committees built by Clifford in 1928 on their expectation to continuously gain revenue income from opium in subsequent years.[73]

The issue of opium prohibition was still unresolved when the Japanese arrived in Malaya in 1942**.** During the Japanese colonial rule from 1942 to 1945, opium sale and use was not restricted at all, and was even encouraged.[74] Arguably, this was related to the Japanese political interest. The residents' indulgence in the habit could have been a benign way of avoiding their resistance to the Japanese occupation in Malaya. The Japanese were completely tolerant of drug use in all their occupied nations.[75] But, no record or data have been found so far regarding the scale of opium use during the Japanese occupation, likely given the war situation. The British administrators who subsequently took over Malaya in 1945 undertook the criminalisation of possession of

[71] Goto-Shibata, "Empire on the Cheap: The Control of Opium Smoking in the Straits Settlements, 1925-1939."78.
[72] A.E. Booth, *Colonial Legacies: Economic and Social Development in East and Southeast Asia* (Honolulu: University of Hawai'i Press, 2007).69.
[73] Goto-Shibata, "Empire on the Cheap: The Control of Opium Smoking in the Straits Settlements, 1925-1939."73.
[74] D. Mackay, *Eastern Customs: The Customs Service in British Malaya and the Opium Trade* (London: The Radcliffe Press, 2005).151.
[75] C.F. Sams, ed. ``*Medic": The Mission of an American Military Doctor in Occupied Japan and Wartorn Korea* (New York: M.E. Sharpe, 1998).153.

opium and equipment for opium smoking through the Opium and Chandu Proclamation in 1946. In an emergency declaration in 1948, the British announced a complete ban on all drug dealings.[76] The British expeditiously assuming the prohibition fortified the designation of opium consumption as a pressing problem. The sudden change was unsurprising, though, considering how rife were the international calls for drug suppression during that time, including from the USA. There are no data showing the presence of any controversy in the aftermath of the announcement, thereby reflecting that the drug prohibition was generally welcomed.

In addition to the external socio-political factor, the developing initiatives of the British towards regulatory and prohibitive measures in this period were somehow supported by several domestic conditions. Consumption of opium was changed from a matter of personal gratification to one of public evil. The standpoint against 'evil' drug taking of the state, its supporters and anti-movements was accentuated in the mass media during this period. The representative claim came from Tan Cheng Lock: 'The pernicious habit of opium smoking should be completely done away with, and more drastic steps should be taken to eradicate the evil which has caused a marked deterioration in the character and physique of the Chinese who indulge in it […]'.[77] The moral discourses were also increasingly rumbled by the connecting of drug consumers to moral irresponsibility to family and society. Likewise, opium-using individuals were increasingly seen as less productive and more health problematic. Prohibiting drugs was reiterated by the state as an important pathway towards curbing the rapid increase of drug

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[76] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.13.
[77] T.C. Lock, *Malayan Problems, from a Chinese Point of View* (Singapore: Tannaco, 1947).36. -cited by Majid, *Dangerous Drugs Laws*.2.

users in colonised Malaya. This was the case even though the rise was evident only in the Federated Malay States, not in the Strait Settlements where opium consumption continued to decrease, as discussed before. For example, by 1940 the available data indicated that the number of users in the Federated Malay States had jumped from 52,313 to 75,000 in 1929.[78] Decades of opium promotion were seemingly responsible for the high rate of opium use in these states.

International pressures, moral and social discourses and increasing opium usage collectively influenced the classification of opium taking as a moral and social problem at this time. This status was not granted much importance during the early British and Japanese periods, and generally people were inattentive towards restrictive or prohibitionist responses against opium during that time. Designating drug using as a social problem gave Britain a resilient basis for moving towards prohibition-oriented drug policies and strategies.

The British government's commitment to strict measures towards addressing the drug use problem in Malaya after the Japanese period triggered the promulgation of the Dangerous Drugs Ordinance 1952 based on the English Dangerous Drugs Acts of 1920 and 1925.[79] The Ordinance continued to be enforced after Independence Day, 31 August 1957. Its intention was to combine past state enactments and ordinances, thereby establishing uniform drug control policies and techniques across the country.[80] It

[78] Rogers, *Segi Tiga Emas: Perniagaan Narkotik di Asia Tenggara [Golden Triangle: Narcotic Business in the Southeast Asia]*.23.
[79] It was revised in 1980; thenceforth named the Dangerous Drugs Act 1952 (DDA 1952).
[80] *Proceedings of the Legislative Council of the Federation of Malaya for the Period (Fifth Session), February, 1952 to February, 1953*, (Kuala Lumpur: Government Printers, 1953).320.

outlawed the manufacture, sale, exportation, importation, sale, possession and use of opium and other drugs and substances listed as dangerous drugs in the First Schedule.

The Malaysian government then gave further serious attention to prohibitionist drug policies. Drug control was sustained primarily under the auspices of the criminal justice system, with progressive governing structures and mechanisms. Before 1972, the various law enforcement machineries acted on an ad hoc basis without any coordination.[81] Then, in 1972 the Central Narcotics Bureau was formed under the Ministry of Judiciary, for the purpose of coordinating all drug control efforts. The Bureau was replaced by the Narcotics Secretariat in the Ministry of Home Affairs (hereinafter referred to as the MOHA) in 1979.[82]

Drug taking was strictly regarded as a crime and there was no focus on the issue of drug treatment before 1975. Drug dependants who were imprisoned and suffered withdrawal were not provided with any medical therapy.[83] One possible reason is that the state saw drug users as criminals who deserved deterrence-based punishment, rather than treatment. The other potential reason is that by the end of the 1950s, the majority of opium dependants were old Chinese males. It could be argued that the ruling government at that time perceived that the drug dependency problem would be relatively short-lived as the old generation taking opium would die. However, certain Chinese groups set up several premises for opium rehabilitation in the early 20th century.[84]

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[81] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.14.
[82] Agensi Antidadah Kebangsaan, *Rawatan dan Pemulihan: Dulu dan Kini [Treatment and Rehabilitation: Then and Now]*.34.
[83] Ibid.
[84] Ibid.31.

The high level of importance attached to punitive approaches against drug-related activities in the 1960s and 1970s was manifested by the arrest rate. For example, in 1969 the total number of persons arrested for offences such as drug trafficking and possession under the Dangerous Drugs Ordinance 1952 was 1,091.[85] This rate had increased significantly to 5,512 in 1979.[86] Notably, gradual development of drug treatment had emerged since 1975 after the government recognised the need to help drug dependants. It aimed to comprehensively rehabilitate drug dependants towards reshaping them as responsible and productive citizens.[87] Arguably, the acknowledgement was late, considering the long history of local drug use. Nevertheless, the state was commended, as accentuated by the mass media and scholars, for its growing enthusiasm and efforts to treat drug dependency, particularly for its imperative to reduce the demand to drugs.[88] The state-mandated treatment, however, did ignite certain criticisms owing to its compulsory nature and strict focus on total abstinence. The government counter-claim was that compulsion and emphasis on abstinence were integral to the smooth implementation of state interventions for protecting the health and safety interests of individuals and society.[89]

Treatment for drug dependants was through detoxification and rehabilitation at selected hospitals under the management of the Ministry of Social Welfare.[90]

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[85] Source: Royal Malaysian Police (hereinafter referred as RMP); S.M. Haq, *Three Decades of Drugs on the Malaysian Scene* (Bangi, Malaysia: Universiti Kebangsaan Malaysia, 1990).31.
[86] Source: RMP; Majid, *Dangerous Drugs Laws*.7.
[87] A. Abdullah, "Developing a National Rehabilitation Programme for Drug Dependents in Malaysia " in *Workshop on Reduction of Demand for Illicit Drugs in South-East Asia, Penang, Malaysia, 14-20 May 1978*, ed. The Colombo Plan Bureau (Colombo: The Colombo Plan Bureau, 1979).209, 214.
[88] For example, Haq, *Three Decades of Drugs on the Malaysian Scene*.28–29.
[89] Ibid.16–17.
[90] Central Narcotics Bureau, Malaysia, *Drug Abuse Problem in Malaysia* (Kuala Lumpur: Central Narcotics Bureau, 1977).17–18.

Detoxification was through ‘cold turkey’ whereby no drugs or substitutions were used.[91] Medication was given only to alleviate withdrawal symptoms. The Dangerous Drugs (Amendment) Act 1975[92] was passed to insert Section 37B, authorising the police or a Ministry of Social Welfare officer to detain suspects for medical examination or observation by a government medical officer and for treatment at approved institutions. In 1975, the Minister of Social Welfare approved 17 hospitals as detection centres and seven hospitals for detoxification.[93] This indicated that, in practice, the focus was on treatment exclusive of rehabilitation. In 1975, 1,757 drug dependants were treated in hospitals. But while this did demonstrate that treatment was being implemented, it covered fewer than half of the total number of drug dependants detected (5,063).[94]

In 1977, treatment options were structurally improved, giving more consideration to rehabilitation and aftercare. The Dangerous Drugs (Amendment) Act 1977[95] was promulgated to insert Part VA comprising 15 sections of DDA 1952, sanctioning institutional treatment and rehabilitation (minimally six months and maximally one year) or supervision (two years). Section 37B was hence repealed. The 1978 statistics show that those who underwent the institutional drug programmes and supervision numbered just 855 and 987 respectively, thereby indicating how low the participation were.[96]

The state’s prohibitionist measures against drugs, including the legislative provisions of the 1960s and 1970s, were mostly uncontroversial and were approved

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[91] Agensi Antidadah Kebangsaan, *Rawatan dan Pemulihan: Dulu dan Kini [Treatment and Rehabilitation: Then and Now]*.34.
[92] Act A293.
[93] Central Narcotics Bureau, *Drug Abuse Problem in Malaysia*.17–18.
[94] Haq, *Three Decades of Drugs on the Malaysian Scene*.34–35.
[95] Act A389.
[96] Abdullah, "Developing a National Rehabilitation Programme for Drug Dependents in Malaysia ".247, 249.

without difficulty in Parliament. The impetus for the extensive government interventions including drug treatment was enhanced during these decades by the claimed upsurge in drug using, mainly involving diverse drugs, greater supply and local youth. The government contended the existence of a rapid upturn in the number of drug use cases in the 1970s. The 1975 official statistics, for example, show a total number of 10,076 drug users, significantly higher than the 1970 rate of 711.[97] Support for the government's contentions regarding the national drug use situation increasingly came from domestic studies. For example, work by the Drug Research Centre at the Malaysian Science University, while validating official data, further concluded that drug use levels had changed significantly.[98] Claims that drug use had increased worryingly dominated drug discourse during this time, despite the presence of certain contradictory research findings. Nowlis and Teng's epidemiological study of drug abuse concluded that the drug problem in Malaysia during this time was mild. The study suggested that there were increasing concerns about drug use even though the number of drug dependants was not substantially high.[99]

To further invite public concern, the state revealed the increased availability of multiple types of drug other than opium on the illegal market since the 1960s. Opiates including cannabis, heroin, morphine and psychotropic substances grew in popularity.[100] At this time, the local drug market was fuelled by the growing production of opium and its derivatives in the neighbouring Golden Triangle; areas shared by Laos, Cambodia and

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[97] K. Foong and V. Navaratnam, *Assessment of Drug Dependence in Malaysia: A Trend Analysis* (Penang, Malaysia: Drug Research Centre, University of Science Malaysia, 1987).45.
[98] Ibid.iv.
[99] Haq, *Three Decades of Drugs on the Malaysian Scene*.15.
[100] V. Navaratnam, "Malaysia: The Beginnings of an Adolescent Drug Problem," in *Drug Problems in the Sociocultural Context: A Basis for Policies and Programme Planning*, ed. G. Edwards and A. Arif (Geneva: World Health Organization, 1980).39.

Thailand. Malaysia consequently became a transit centre and market for drug trafficking syndicates in the late 1970s.[101] Moreover, in the 1960s and 1970s, the government and its supporters began profiling drug users as almost young persons: youths portrayed as submitting to 'hippy-culture' and indulging in unhealthy activities including taking cannabis.[102] As claimed, they were also affected by the heroin and morphine consuming habits of American soldiers[103] who made recreational visits to Penang.[104] The prevalence of drug taking among the youth was further confirmed by local research findings. For example, results of a survey of drug cases in police and hospital records for 1968–70 by the Society of Contemporary Affairs showed a 10 per cent increase among teenage drug users and a 20 per cent increase in the 20–29 and 30–45 age groups.[105] In comparison, there was a 50 per cent decrease in the 45 and above age group.[106]

The government found the drug use problem, especially among the youth, sufficiently pressing to implement stiff measures including criminalising drug-related activities and subjecting drug dependants to compulsory treatment and rehabilitation. This was so, despite some study findings disclosing that local youths particularly resorted to drugs merely for experimental or occasional consumption.[107] Also, the new socio-economic developments that followed in the aftermath of Independence Day furnished

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[101] A. Yaqin, *Law and Society in Malaysia* (Kuala Lumpur: International Law Book Services, 1996).169.
[102] Agensi Antidadah Kebangsaan, *Rawatan dan Pemulihan: Dulu dan Kini [Treatment and Rehabilitation: Then and Now]*.26.
[103] The American soldiers were involved in the Vietnam War and spent their holidays in Penang.
[104] Central Narcotics Bureau, *Drug Abuse Problem in Malaysia*.2–4.
[105] Society of Contemporary Affairs (SCA) Penang, *Trends and Pattern of Drug Addiction in Penang-A Preliminary Report*, Survey of the Drug Scene in the State of Penang (Penang, Malaysia: Society of Contemporary Affairs (SCA) Penang, 1973). -cited by R.L.M. Lee, *The Social Processes of Drug Use and Rehabilitation in Malaysia* (Kuala Lumpur: Institute of Advance Studies, University of Malaya, 1986).2.
[106] Society of Contemporary Affairs (SCA) Penang, *Trends and Pattern of Drug Addiction in Penang-A Preliminary Report*. -cited by Lee, *The Social Processes of Drug Use and Rehabilitation in Malaysia*.2.
[107] Navaratnam, "Malaysia: The Beginnings of an Adolescent Drug Problem."39.

the government with another justification for taking an aggressive stance against the drug problem.[108]

In short, Malaysia's shift from legalisation to prohibition of drugs was related to the elevation of drugs to the status of a social problem. This status was catalysed by the external socio-political forces, the dominant drug discourses and the drug use situation in Malaysia between 1925 and the 1970s. All of the state's restrictive and prohibitionist efforts that had erupted since the mid-1970s, including drug treatment, had prompted a new era of Malaysian drug policy in which dual supply and demand reduction strategies were endorsed.

### 1.4 The Prohibition Period (1980s to 2000s)

In the 1980s, the government further reinforced the moral and social issue status of drug using to justify taking yet stiffer measures against drugs. Drug use was similarly associated with the decay of moral values and familial and social duties as in the previous period. The moral dimension of the prohibitionist measures was further augmented by the government's claim rendering drugs a 'menace' and a 'social scourge'.[109] This period also witnessed drug using being designated as a disease that adversely impacts the

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[108] R. Yatim, "Closing Speech," in *Workshop on Reduction of Demand for Illicit Drugs in South-East Asia, Penang, Malaysia, 14-20 May 1978*, ed. The Colombo Plan Bureau (Colombo: The Colombo Plan Bureau, 1979).369.

[109] Pasukan Petugas Anti Dadah, *Dadah: Apa Anda Perlu Tahu [Drugs: What You Need to Know]* (Kuala Lumpur: Delmu (Malaysia) Sdn. Bhd., 1992).ix.

physical and mental health of consumers. Drug takers were classified as sick persons.[110] Additionally, the 1980s saw discourses claiming the link between drug use and crimes. The state and its advocates continually reiterated that drug users were highly likely to involve themselves in other criminal behaviour including theft, robbery and other violent acts as a result of the financial pressures of supporting their habit and the effects of the drugs. Drug use was also typified as a major peril to national safety as it would weaken citizens, especially youths and security forces, thereby exposing the country to enemies and subversive attacks.[111] There was even an official declaration by the government on 19 February 1983 labelling drugs the number one enemy and threat to national security.

Moreover, despite being outlawed, the state considered drug use to be at a critical level in the 1980s, as evidenced by domestic data indicating its high cases. Uncontested official estimates show that between 1980 and 1989, 199,952 drug users were cumulatively identified of which 100,018 were new users.[112] The number of new users peaked at 14,624 in 1983.[113] As contended by the government, the country's drug using problem had reached an alarming, epidemic level and it spearheaded increased stringent strategies to keep it under control.[114] Youths and Malay race were often portrayed as the majority groups engaged in drug taking, and seen as being vulnerable and in need of

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[110] A.G. Taib, *Dadah Pembunuh [Drug is a Killer]*, vol. 1 (Kuala Lumpur: Delmu (Malaysia) Sdn. Bhd., 1992).5.
[111] Pasukan Petugas Anti Dadah, *Dadah: Apa Anda Perlu Tahu [Drugs: What You Need to Know]*.ix, 51–52.
[112] Ibid.8; Agensi Antidadah Kebangsaan, *Kenali dan Perangi Dadah [Know and Fight Against Drugs]* (Kuala Lumpur: Agensi Antidadah Kebangsaan, 1997).8.
[113] Pasukan Petugas Anti Dadah, *Dadah: Apa Anda Perlu Tahu [Drugs: What You Need to Know]*.9, 11.
[114] Anti Drugs Task Force, "An Overview of the Dadah Problem in Malaysia" (paper presented at the Seminar on Prevention of Drug Abuse-Possibilities and Limits, Kuala Lumpur, 1990).12.

protection.[115] This profiling seemed to erase the Chinese connection to drug consumption of previous decades.

The government's contentions related to the moral and social effects of drug use plus the critical nature of the drug use situation were further catalysed in print and other forms of information delivery by advocating media and scholarship.[116] Very few contradictory discourses regarding drug use existed, and, besides, these were overturned by the dominant claims,[117] which triggered the construction of drug use as a moral and social problem and substantiated the state's stringent interventions in the 1980s.

The declaration of drugs as a security issue influenced the governance of drug control. The mandate to manage drug control action was shifted to the MOHA.[118] Further, a National Drug Policy was developed in 1983 that sought to address the drug problem by incorporating two major strategies –supply reduction and demand reduction. These strategies were deployed based on the justification that the national drug problem can be eliminated if the supply of and demand for drugs were removed.[119] This somehow indicates the growing recognition of the government to the limitations of law enforcement in mitigating drug taking. Its priorities were increasingly tailored to prevention and rehabilitation as reflected by the drug control plans outlined under the two-pronged strategy; covering prevention and rehabilitation as the main strategies, and human

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[115] Pasukan Petugas Anti Dadah, *Dadah: Apa Anda Perlu Tahu [Drugs: What You Need to Know]*.52.
[116] Haq, *Three Decades of Drugs on the Malaysian Scene*.21–24.
[117] Ibid.25.
[118] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.19.
[119] Pasukan Petugas Anti Dadah, *Dadah: Apa Anda Perlu Tahu [Drugs: What You Need to Know]*.59.

resource development and evaluation, international cooperation and coordination as supporting strategies.[120]

Despite growing attention to prevention and rehabilitation, the 1980s also saw the intensification of the tough punitive approaches against drug-related activities that were largely undertaken by criminal justice system. Since 1983, deterrence and abstinence-oriented policies had been enhanced through stiff laws, wide law enforcement powers and heavy punishments. DDA 1952 was amended to raise penalties the most blatant of which was the death penalty for drug trafficking. Three specific tightly prohibitionist statutes were also promulgated to support DDA 1952, namely: the Drugs Dependants (Treatment and Rehabilitation) Act 1983[121] (hereinafter referred to as DDTRA 1983), which aimed to repeal Part VA in DDA 1952, thereby becoming the main legislative instrument to deal with drug treatment and rehabilitation aspects; the Dangerous Drugs (Special Preventive Measures) Act 1985,[122] which was intended to empower preventive detention of persons suspected of being involved in drug trafficking-related activities for a period of two years without trial subject to extension; and the Dangerous Drugs (Forfeiture of Property) Act 1988,[123] which was mainly passed to authorise the detection, seizure and forfeiture of property derived or obtained from or used in drug trafficking activities. These legislative provisions were made largely in compliance with UN drug conventions.[124] Many practitioners and scholars including Ishak and Adel affirm the government's arguments relating to the comprehensiveness and importance of the drug laws. As they write, the

[120] Ibid.60.
[121] Act 283.
[122] Act 316.
[123] Act 340.
[124] Malaysia ratified all UN drug conventions: the 1961 Convention and the 1972 Protocol, the 1971 Convention and the 1988 Convention.

laws are sufficient to effectively curtail Malaysia's drug problem.[125] They further argue that such prohibitive legislations should be supported by intensive and meticulous enforcement to ensure the desired results of demand and supply reduction.[126]

Enforcement of drug laws indicated a growing trend in the 1980s. For example, the 1986 statistics show that a total of 17,058 drug dependants were detected, a number that increased to 20,118 in 1989.[127] Also, more drug offenders were arrested under DDA 1952 in 1989 than in 1986. In 1986, those arrested for trafficking, possession of drugs and other offences wholly totalled 9,341, a figure that rose to 10,776 in 1989.[128] Additionally, there was an increase in the rate of persons arrested and detained under the Dangerous Drugs (Special Preventive Measures) Act 1985, with 454 arrested and 382 being given a detention order under the Act in 1989 as compared with 218 and 183, respectively, in 1986. The value of the property related to drug trafficking activities that was seized under the Dangerous Drugs (Forfeiture of Property) Act 1988 in 1988 amounted to MYR610,442.21, and it increased to MYR727,646.25 in 1989.[129]

Further, drug treatment was expanded in terms of periods, programmes and mechanisms, driven principally by the growing medicalisation of drug use as a disease at this time. The DDTRA 1983 extended institutional treatment and rehabilitation from six months as implemented before 1983 to two years. From 1983, a certified drug dependant could be ordered by a magistrate to undergo two years' institutional treatment followed by two years' aftercare at rehabilitation centres or supervision in the community for any

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[125] A.M. Ishak, "Drug Legislations in Malaysia," *Current Law Journal* 3(2000).20; D.S. Adel, *Law of Dangerous Drugs* (Selangor, Malaysia: International Law Book Services, 2001).1.
[126] Ishak, "Drug Legislations in Malaysia."20; Adel, *Law of Dangerous Drugs*.2.
[127] Agensi Antidadah Kebangsaan, *Kenali dan Perangi Dadah [Know and Fight Against Drugs]*.127.
[128] Majid, *Dangerous Drugs Laws*.7.
[129] Source: RMP.

period between two and three years. Authority over the voluntary drug dependant was conferred on rehabilitation officers. The treatment and rehabilitation procedures were jointly conducted by multi-governmental agencies including the MOHA, MOH and Ministry of Social Welfare.[130] They were also provided in prisons for drug dependants jailed for drug-related offences.[131] In 1985, there were six governmental rehabilitation centres.[132] By 1989, those detained in the rehabilitation centres numbered 4,242, while 12,854 were under supervision and another 7,649 were undergoing treatment and rehabilitation in prisons.[133] This shows a significant increase of drug dependants in the treatment and rehabilitation in the 1980s as compared with the previous decade.

The drug system provided physical, psychological and psychosocial rehabilitation for drug dependants consisting of eight components: detoxification, health and medical treatment; physical rehabilitation and discipline; psychological and mental rehabilitation; religious and moral education; skills and vocational training; socialisation and recreation; civics and patriotism; and reintegration into society.[134] Detoxification was still done by 'cold turkey', a process that was indeed painful but that was aimed at deterring drug dependants from drug taking. Thus, clearly, in the 1980s, Malaysia enhanced its drug control commitment by implementing drug treatment and rehabilitation within a multi-modality approach. However, it was still strongly attached to absolute abstinence and deterrence principles and discounted any drug substitution or medication approach for

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[130] Agensi Antidadah Kebangsaan, *Rawatan dan Pemulihan: Dulu dan Kini [Treatment and Rehabilitation: Then and Now]*.36, 39–40, 170.
[131] J.F. Scorzelli, *Drug Abuse: Prevention and Rehabilitation in Malaysia* (Bangi, Malaysia: Universiti Kebangsaan Malaysia, 1987).95.
[132] Agensi Antidadah Kebangsaan, *Rawatan dan Pemulihan: Dulu dan Kini [Treatment and Rehabilitation: Then and Now]*.170; Scorzelli, *Drug Abuse: Prevention and Rehabilitation in Malaysia*.92.
[133] Source: NADA.
[134] Agensi Antidadah Kebangsaan, *Rawatan dan Pemulihan: Dulu dan Kini [Treatment and Rehabilitation: Then and Now]*.58–59.

drug dependency. The state's intensified approaches to treatment and rehabilitation mirrors the emerging counter-claims regarding the flaws inherent in such measures being ignored and rejected by the government. The major criticisms include association of the treatment and rehabilitation system with a highly punitive ethos, disciplinary control, bureaucracy and drug dependants participating involuntarily, thereby negatively impact the system's effectiveness.[135]

In sum, Malaysia's drug policy evolved in the 1980s to adopt a bifurcated strategy of supply and demand reduction. Deterrence and abstinence-based drug treatment for drug dependants together with other extensive methods under the strategy widened the net of strict prohibition. Implementing such prohibitionist approaches was in accordance with the government's claims about the need for stringent moral and social regulation against drugs.

In the 1990s and early 2000s, the supply and demand reduction-oriented framework was preserved by the Malaysian government. The National Drugs Council, which undertook the responsibility in formulating the National Drug Policy and coordinating anti-drug programmes in 1996, restructured the drug strategies to encompass new priority areas of prevention, law enforcement, rehabilitation and international cooperation. All anti-drugs actions under these strategies were put under the management of the National Narcotics Agency, which was formed by the MOHA in the same year.[136] During this phase, deterrence-based measures and abstinence-oriented treatment and

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[135] For example, R.L.M. Lee, "Alternative Systems in Malaysian Drug Rehabilitation: Organization and Control in Comparative Perspective " *Social Science & Medicine Journal* 21, no. 11 (1985).1293–95.
[136] National Anti-Drugs Agency, *Malaysia Country Report 2009* (Putrajaya, Malaysia: National Anti-Drugs Agency, Ministry of Home Affairs, 2010).23.

rehabilitation for drug consumption were enhanced. The powers of medical professionals were still limited to detection and detoxification procedures.

Increasing law enforcement efforts were reflected in the number of arrests made. For example, the total number of arrested drug dependants in 1998 was 74,452, and it climbed to 137,159 in 2003. There was also an upsurge in the proportion of those arrested for trafficking, possession of drugs and other offences under DDA 1952 in 2003 as compared with 1998, with cumulatively 16,007 arrested in 1998, rising to 28,706 in 2003. Further, there was growth in the enforcement of other drug legislations. By illustration, in 1995, 994 persons were arrested while 584 were detained without trial under the Dangerous Drugs (Special Preventive Measures) Act 1985. By 2003, the rates had jumped to 2,110 and 830, respectively. Moreover, in 1995, the values of seized and forfeited property under the Dangerous Drugs (Forfeiture of Property) Act 1988 were MYR8,695,130.50 and MYR938,335.23, respectively. These values had escalated to MYR14,697,045.74 and MYR1,633,407.78, respectively, by 2003.[137]

The number of rehabilitation centres rose gently from 24 to 28 with a total capacity of 9,250 residents by 1997.[138] In 1998, the aftercare system was abolished through the Drugs Dependants (Treatment and Rehabilitation) (Amendment) Act 1998.[139] Drug dependants discharged from compulsory rehabilitation programmes had to undergo supervision under rehabilitation staff and police officers instead of aftercare for two years. The figures reveal a greater overall number of drug dependants undergoing government-mandated treatment and rehabilitation in the early 2000s, particularly

[137] Source: RMP.
[138] Majid, *Dangerous Drugs Laws*.265.
[139] Act A1018.

through supervision, as compared with 1990s figures. For instance, in 1994 a total of 11,553 were treated in rehabilitation centres, 10,572 were put under supervision and 8,612 were in prisons. By 2001, there were 8,232 in rehabilitation centres, 35,325 under supervision and 10,615 in prisons.[140]

Malaysia's 2004 National Drug Policy further reinforced all prohibitionist strategies with the aim of making the country drug free by 2015. The objective of the National Drug Policy is to eliminate drug supply and demand to create drug-free families, schools, workplaces and communities. This policy likely extends the original objectives of the 1983 drug policy by specifying targeted outcomes. The coordination and supervision of all strategies towards this major target are the province of the Coordination Machinery on Implementation of Policy to Eradicate Drug Menace, which replaced the National Drugs Council.

In 2004, law enforcement powers were broadened by the promulgation of the National Anti-Drugs Agency Act 2004.[141] Under this Act, a National Anti-Drugs Agency (hereinafter referred to as NADA) – a new name for the National Narcotics Agency – was formally provided with law enforcement functions and powers relating to prevention, treatment, rehabilitation, investigation, special preventive measures, forfeiture of property and administration of the offences provided under all drugs Acts.[142]

The strict prohibition was emphasised during this time despite growing criticisms contending the inefficacy of prohibitionist approaches including drug laws in harnessing

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[140] M.N. Mohamed et al., *Program Pemulihan Luar Institusi untuk Penagih Dadah [The Rehabilitation outside Institution Programme for Drug Addicts]* (Sintok, Malaysia: Penerbit Universiti Utara Malaysia, 2005).20.
[141] Act 638.
[142] Section 6 of the National Anti-Drugs Agency Act 2004.

the drug problem in Malaysia. The claims were based on increasing numbers of arrested drug users and traffickers.[143] Further, the limitations of the government treatment and rehabilitation have been increasingly the subject of drug discourses that find such measure ineffective in ensuring prolonged cessation of individuals from drugs and inefficient owing to factors such as reduced emphasis on psychological approaches and overload of subjects in rehabilitation centres.[144] There were also negligible ideas that provided alternatives to the prohibition policy including Islamic legal approaches.[145] Harring says:

> Malaysia's experience demonstrates the application of a 'drug war' model to the drug problem. In spite of draconian measures – including over a hundred executions, hundreds of death penalties imposed, the conversion of a huge paramilitary police force from fighting communists to fighting drugs, emergency trial processes that circumvent many due process protections, and a police force unfettered by search warrants – hundreds of thousands of Malaysians are still dependent on drugs, and tens of thousands of Malaysians are trafficking in drugs to meet those needs […] However the lesson of Malaysia's failed war on drugs is that other approaches to the drug problem

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[143] S.L. Harring, "Death, Drugs and Development: Malaysia's Mandatory Death Penalty for Traffickers and the International War on Drugs," *Columbia Journal of Transnational Law* 29, no. 2 (1991).405; M.S. Yusoh and C.B.C. Mat, *Penyalahgunaan dan Pengedaran Dadah di Malaysia: Undang-Undang dan Keberkesanannya [Drug Misuse and Trafficking in Malaysia: Law and Its Effectiveness]* (Kuala Lumpur: Dewan Bahasa dan Pustaka, 1996).45–47.

[144] For example, Yaqin, *Law and Society in Malaysia*.184.

[145] For example, Yusoh and Mat, *Penyalahgunaan dan Pengedaran Dadah di Malaysia: Undang-Undang dan Keberkesanannya [Drug Misuse and Trafficking in Malaysia: Law and Its Effectiveness]*.47.

should be tried because sanctioned state violence under the rubric of a mandatory death penalty does not solve the problem.[146]

It was during the 1990s and early 2000s that the dominant moral and social discourses, identical to those of the 1980s, were presented and constantly reproduced by the government and its supporters to maintain the entrenched construction of drug taking as a severe moral and social problem requiring vigorous strict measures.[147] In parallel, there appeared a number of studies suggesting that state drug control measures, particularly punishments for drug offences including the death penalty, imprisonment, preventive detention and forfeiture of property, are useful and suitable for curbing the drug problem.[148] Justification for the state's continued tough intervention was also substantiated by the claimed increase in the drug use level in Malaysia, based on local data. In 1995, 34,104 new drug users were detected, and this number climbed slightly to 35,359 in 1999. As compared with the 1980s figures, there appeared to be a gradual decline in the number of new drug users. The rate of new users in 1990 was approximately half the 1983 rate.[149] For the government, however, it is unlikely that this statistic provided sufficient persuasion that the drug use problem was decreasing, especially considering the high percentage (around 50 to 70 per cent) of relapsing cases[150]

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[146] Harring, "Death, Drugs and Development: Malaysia's Mandatory Death Penalty for Traffickers and the International War on Drugs."405.

[147] Agensi Antidadah Kebangsaan, *Kenali dan Perangi Dadah [Know and Fight Against Drugs]*.45–48; A.M. Takar, "Capital Punishment for Drug-Trafficking: A Comparative Analysis of the Islamic Law and Malaysian Law" (Master Dissertation, International Islamic University Malaysia, 1998).42–43, 45; M.R. Aslie, *Polis Diraja Malaysia [Royal Malaysian Police]* (Kuala Lumpur: Red One Network Enterprise, 2004).533–36.

[148] For example, Waluyaningsih, *Hukuman Mandatori bagi Pesalah Dadah di Malaysia dan Republik Indonesia [Mandatory Punishment for Drug Offender in Malaysia and Republic Indonesia]* (Kuala Lumpur: Dewan Bahasa dan Pustaka, 1997).107; A.M. Noor, *Hukuman Mati ke atas Pengedar Dadah [Death Penalty for Drug Traffickers]* (Kuala Lumpur: Dewan Bahasa dan Pustaka, 2002).85.

[149] Agensi Antidadah Kebangsaan, *Kenali dan Perangi Dadah [Know and Fight Against Drugs]*.127.

[150] They were first formally recorded in 1988.

in the 1990s.[151] While heroin, marijuana and opium were still most prominently used, matters had by now been further compounded with synthetic drugs, particularly Amphetamine–Type Stimulants (hereinafter referred to as ATS), which had been in use since 1996 when the first 23 cases were uncovered.[152] This shows that local drug consumption was no longer limited to traditional drugs.

Further, in the span between 2000 and 2004, the number of drug users seemed to soar. Available statistics show cumulatively 202,518 registered drug users in that period. In 2000, the number of drug users recorded was 30,593, which leapt to 31,893 in 2002 and then again to 38,672 in 2004. The drug use problem was once more labelled critical in the early 2000s in line with increased synthetic drug consumption. Cases demonstrated a sharp rise since their first being traced in 1996, jumping to 1,860 in 2000.[153] Furthermore, the rate of relapse cases was extremely high, with data indicating that 70 to 90 per cent of drug users failed to sustain a drug-free lifestyle in the first year following their discharge from the government's abstinence-based treatment.[154]

Clearly, during the 1990s and early 2000s, the state did not change its firm focus on the rigid prohibitionist drug control approaches of the previous decade. Despite the conventional responses showing no signs of producing promising outcomes, the Malaysian government continued to emphasise its punitive methods against drugs during

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[151] M.N. Mohamed, *Penyalahgunaan Dadah, Aspek Undang-Undang, Pemulihan, Rawatan dan Pencegahan [Drug Abuse: The Aspects of Law, Rehabilitation, Treatment and Prevention]* (Batu Caves, Malaysia: Edusystem Sdn. Bhd., 2009).15.

[152] Y. Md. Isa, "Pengedaran Dadah di Malaysia: Undang dan Penguatkuasaannya oleh Polis Diraja Malaysia [Drug Traffcking in Malaysia: Laws and Their Enforcement by the Royal Malaysian Police]" (Master Dissertation, Universiti Kebangsaan Malaysia, 2007).31.

[153] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.55.

[154] M. Mazlan, R. Schottenfeld, and M.C. Chawarski, "New Challenges and Opportunities in Managing Substance Abuse in Malaysia," *Drug and Alcohol Review* 25, no. 5 (2006).475.

this policy phase. This is unsurprising given the government's ceaseless, strong reliance on deterrence and abstinence philosophies in handling drug issues that were designated as a serious moral and social problem.

## 1.5 The Harm Reduction and Prohibitionist Policies Period (2005 to Date)

The Malaysian government overhauled its longstanding conservatism over drug control in 2005 when it adopted a harm reduction approach with MMT and NSEP as its two major components. Initially, and for a number of years, the proposal to adopt such an approach from NGOs such as the Malaysian AIDS Council was viewed negatively by the government and its advocates. It was thought to be inconsistent with the existing deterrence and abstinence-oriented drug policies and the national vision of a drug-free nation by 2015. Moreover, as signified, the government considered that, without extensive investigation, any new approach would probably result in ineffective intervention that would simply aggravate the drug use problem.[155] Members of the civil society, particularly the 2004 Harm Reduction Working Group hosted by the Malaysian AIDS Council, along with various medical professionals and scholars, held that the approach was necessitated by the grave local HIV/AIDS scene. Many further contended that the harm reduction model was worth a trial.

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[155] House of Representatives, "Parliamentary Debate, House of Representatives, 9 September 2003," http://www.parlimen.gov.my/files/hindex/pdf/DR-09092003.pdf#page=13&search=%22metadon%22.4–5. (Last visited: 10/02/2012)

In October 2005, the government finally approved a national MMT pilot at 17 sites involving 1,241 drug users.[156] The project resulted in decreased drug use and criminality, and increased quality of life among the subjects, which led in the following year to official acknowledgement and implementation of a fully fledged MMT provision for opiate dependence by medical professionals. Drug treatment in Malaysia had finally shifted from mere detoxification to include a pharmacological approach. The National Policy on MMT fixes that involvement in the programme is voluntary subject to eligibilities and medical assessment.[157] Registered clients take methadone in liquid form in front of dispensing medical personnel. Additionally, in 2006, the government launched its NSEP pilot scheme at three sites through local NGOs. This occurred with more than 4,300 clients through 34,300 contacts. Again, the scheme showed positive results, including a significant reduction in the proportion of injecting drug users (hereinafter referred to as IDUs) passing on used injecting equipment to their colleagues, which decreased from approximately 56 per cent before NSEP's introduction to 43 per cent at the end of the pilot programme.[158] The government decided to upscale NSEP at the end of its first year.[159] NSEP operates by providing a free kit containing four needles, four syringes, 16 cotton balls and 16 alcohol swabs in exchange for used injecting instruments, which are safely disposed of.[160] MMT's objective as outlined by the government is to

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[156] L.S. Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia," in *Review and Evaluation on Harm Reduction Programme in Malaysia*, ed. Malaysia and Singapore Office of WHO Representative for Brunei Darussalam (Kuala Lumpur: World Health Organization, 2008).44.
[157] Further discussion can be found Chapter 4, Section 4.2.4.
[158] F. Ibrahim, "Needle Syringe Exchange Program in Malaysia," *Jurnal Antidadah Malaysia* 2, no. 2 (2008).29, 31, 43.
[159] B. Vicknasingam and M. Mazlan, "Malaysian Drug Treatment Policy: An Evolution from Total Abstinence to Harm Reduction," *Jurnal Antidadah Malaysia* 3 & 4(2008).115.
[160] World Health Organization (Western Pacific Region) and Ministry of Health Malaysia, *Good Practices in Asia: Scale-Up of Harm Reduction in Malaysia* (Manila: World Health Organization, 2011).30.

improve the health and quality of life of persons with opiate dependence (with specific aims to decrease blood-borne infections, reduce relapse, improve physical and mental conditions, improve psychosocial functioning and minimise criminality among opiate dependants). NSEP's objective, on the other hand, is to mitigate transmission of HIV and other blood-borne viruses among IDUs, their sexual partners, children and society. Although the state reserved its commitment to harm reduction measures until their effectiveness had been somehow demonstrated in the pilot phases, Malaysia's migration to systematised services is an encouraging progression.

The government's financial resources allocation and scaling-up efforts have enlarged its harm reduction measures. For example, MYR15 million and MYR6 million were apportioned for MMT and NSEP, respectively, in 2009,[161] and there appears to have been a steady rise in harm reduction sites and clients over recent years. MMT facilities under medical practitioners' authority, including government and private healthcare centres, mosques, prisons and NADA sites, expanded from 10 in 2005 to 674 in 2011, with 44,428 drug users enrolled.[162] Notably, since its inception in 2008, MMT in prisons has climbed from just one to 18 prisons in 2013.[163] NADA has also implemented MMT at its open-access services ('Cure and Care 1 Malaysia Clinic'[164]) since 2010.[165] While NSEP is widely undertaken by civil society groups that also recruit NSEP clients as distributors, it started to engage health practitioners in 2008. As of 2013, there were 576

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[161] Ibid.27.

[162] Ministry of Health Malaysia, *Global AIDS Response Country Progress Report 2012: Country Progress Report Malaysia* (Putrajaya, Malaysia: Ministry of Health Malaysia, 2012).34.

[163] *Global AIDS Response Progress Report 2014: Malaysia* (Putrajaya, Malaysia: Ministry of Health Malaysia, 2014).8–9.

[164] The clinic provides five main services for drug dependants to choose from based on their own commitment and need of treatment, namely, inpatient treatment, outpatient treatment, detoxification for 14 days, MMT, and reference and advocacy.

[165] Agensi Antidadah Kebangsaan, *Maklumat Dadah 2010 [Drug Information 2010]* (Kuala Lumpur: Agensi Antidadah Kebangsaan, 2011).50–51.

access points and 152 government clinics providing NSEP, reaching out to 72,686 IDUs.[166] However, NSEP is not offered in prisons or at any of NADA's facilities. This demonstrates how the extension of harm reduction services into varied settings correlates with stakeholders' collaborative efforts.

The real impetus for Malaysia's harm reduction approach was the explosion in the number of HIV/AIDS cases among IDUs. Since the first case was traced in 1986, HIV cases in Malaysia have increased drastically. As of 2005, there were 70,559 cases, 10,663 of whom had AIDS.[167] This demonstrates an upturn of approximately 17 cases per day, largely centralised in IDUs. This rate ranked Malaysia second highest in HIV prevalence among adults (0.62 per cent) and the highest in HIV infection involving IDUs (76.3 per cent) in the Western Pacific Region.[168]

The government has used the fact that HIV/AIDS cases are largely driven by IDUs to treat development of the harm reduction approach as urgent for HIV/AIDS control. A huge number of IDUs share injection equipment, which leads to a high risk of HIV. Estimates of the United Nations Reference Group on Drug Injecting show that there are between 150,000 and 240,000 IDUs in Malaysia in 2004.[169] The supporting study by Fauziah et al. found that 91.6 per cent of IDUs infected with HIV/AIDS were sharing syringes.[170] The government highlighted that efforts to tackle HIV/AIDS risks among opiate dependants could not depend solely on abstinence-based drug treatment, given the

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[166] Ministry of Health Malaysia, *Global AIDS Response Progress Report 2014: Malaysia*.42.
[167] *Harm Reduction Program Malaysia (Needle and Syringe Exchange Program)* (Putrajaya, Malaysia: Ministry of Health Malaysia, 2010).2.
[168] Vicknasingam and Mazlan, "Malaysian Drug Treatment Policy: An Evolution from Total Abstinence to Harm Reduction."116.
[169] C. Aceijas et al., "Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users," *AIDS* 18, no. 17 (2004).2299.
[170] M.N. Fauziah et al., "HIV-Associated Risk Behaviour among Drug Users at Drug Rehabilitation Centres," *Medical Journal of Malaysia* 58, no. 2 (2003).271.

high recidivism rates (80 to 90 per cent).[171] This implicitly shows the government's acknowledgement of the failure of its abstinence-oriented interventions in adequately addressing opiate dependency and its adverse consequences.

Perhaps the strongest force behind Malaysia's move towards harm reduction methods was the United Nations (hereinafter referred to as the UN) and its 2005 Report on the Millennium Development Goal, in which it stated that of the eight Millennium Development Goals, Malaysia had yet to attain the one about reversing HIV/AIDS transmission.[172] Malaysia was a signatory to the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001. This Declaration demanded signatories to undertake varied preventive HIV/AIDS strategies including harm reduction interventions. Clearly, the main triggering factors for the integration of a harm reduction approach in Malaysia are government and public fears over HIV/AIDS transmission through drug users and international pressures.

Against the backdrop of HIV prevalence among IDUs, the government underscored the harm reduction approach's status as a vital HIV prevention strategy in the National Strategic Plan on HIV/AIDS 2006–2010, as well as in its successive National Strategic Plan on HIV/AIDS 2011–2015.[173] It explicitly states:

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[171] Ministry of Health Malaysia, *MMT Guidelines: National Methadone Maintenance Therapy Guidelines*, Second ed. (Putrajaya, Malaysia: Ministry of Health Malaysia, 2006).9.

[172] World Health Organization (Western Pacific Region) and Ministry of Health Malaysia, *Good Practices in Asia: Scale-Up of Harm Reduction in Malaysia*.18.

[173] Ministry of Health Malaysia, *Malaysia: National Strategic Plan on HIV and AIDS 2011-2015* (Putrajaya, Malaysia: Ministry of Health Malaysia, 2011).19.

> As a key intervention for slowing the growth of the epidemic and preventing transition to a generalised epidemic, the National Strategic Plan promotes a harm reduction approach to reducing HIV vulnerability among IDUs. Harm reduction programmes recognize that for many drug users, total abstinence is not a practical option. It aims to help drug users reduce their injection frequency in a safe environment.[174]

This manifests the official recognition of harm reduction as a public health policy, provides clear mandates for the public health community and advocates involvement in implementing harm reduction policy and measures at state and district levels. Harm reduction resides under the MOH in collaboration with other government bodies including the Prison Department, NADA, NGOs coordinated by the Malaysian AIDS Council and private health professionals.[175] A National Task Force on Harm Reduction Committee consisting of the abovementioned stakeholders and law enforcement representatives was formed to oversee these interventions.[176] Thus, the design, delivery and monitoring of harm reduction interventions are now supported by a multi-sectoral partnership of public, private and civil society stakeholders.

Despite the progress of Malaysia's harm reduction interventions, they have still been criticised and opposed by politicians, professionals and the public. For example, one claim is that MMT and NSEP contradict conservative abstinence and Islamic philosophies, and another is that they are expensive and ineffective in reducing drug using

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[174] *Malaysia: National Strategic Plan on HIV and AIDS 2006-2010* (Putrajaya, Malaysia: Ministry of Health Malaysia, 2006).11.

[175] *Global AIDS Response Progress Report 2014: Malaysia*.8.

[176] "The Implementation of Harm Reduction in Malaysia" (paper presented at the APEC Conference on Harm Reduction Approach to HIV/AIDS Control, Taipei, 18-19 August 2011 ).Slide 8.

and its related harms. This has continued even in the face of efforts of government and its supporters, particularly media to persuade people mainly based on scientific standards of rationality relating to HIV/AIDS prevention and other benefits of the interventions.[177] This somehow denotes a significant change in the government towards acknowledging the role of science in the drug discourse. Nevertheless, this has had little real effect in terms of quietening the continual criticisms of the harm reduction approach.

Moreover, the National Anti-Drug Strategy has no mention of either the harm reduction approach generally or MMT and NSEP specifically. This mirrors the notion that the approach is not yet being taken seriously as an important drug response. Further, as some critics have posited, this exclusion has limited the harm reduction paradigm to the HIV/AIDS issue, rather than to wider issues involving overall drug using population.[178] The existing drug policy specifically aims to achieve a drug-free nation by 2015 with the listed strategies of prevention, law enforcement, treatment and rehabilitation, and international cooperation.[179] In the light of this goal and the desire to eradicate demand and supply of drugs, the state maintains its commitment to deterrence and abstinence-oriented measures. Drug use is still treated as a criminal justice issue that demands moralistic and punitive responses. This status, however, does not prevent the government and its supporters from depicting drug consumption as a public health issue that requires the harm reduction approach, too, from the point of view of health imperatives. Simultaneously, the state still uses its compulsory powers in penalising drug

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[177] The issues concerning the justifications will be looked at in depth in Chapters 2and 3.

[178] For example, M. Mahathir, "Changing Mindsets in Changing HIV Epidemics: Why Asia Needs Harm Reduction" (paper presented at the 15th International Conference on the Reduction of Drug Related Harm, Melbourne, 20 – 24 April 2004).50.

[179] Agensi Antidadah Kebangsaan, *Maklumat Dadah 2009 [Drug Information 2009]* (Kuala Lumpur: Agensi Antidadah Kebangsaan, 2010).viii.

taking and treating drug dependency.[180] The government reinforces that it is essential to persevere with these strategies to fix the moral and social interests, by ensuring individual liability upon drug taking and commitment to treatment and rehabilitation.[181]

The government and its advocates have constantly considered the moral and social characteristics of drug using including moral degeneracy, high costs, risks to health, safety, young people, and economic and social progress for many decades to justify its drug control strategies.[182] In the era from 2005 to date, government's claims regarding the close relationship between drug using and crimes have also continued to attract public attention even when not adequately supported.[183] These claims are conjoined by the hardened assertion that the drug use problem in Malaysia is worse than before. Though the number of detected drug users substantially fell from 38,672 in 2004 to 32,808 in 2005,[184] the government has argued that such a picture belies the reality, given the likely greater actual volume covering those undetected. According to the 2005 MOHA estimate, between 9,000,000 and 1.2 million Malaysians were dependent on drugs.[185] The government has further portrayed the seriousness of the drug use problem by indicating

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[180] The detailed discussion appears in Chapter 4, Sections 4.2 and 4.4.
[181] Agensi Antidadah Kebangsaan, "Peranan Aktiviti Penguatkuasaan dalam Menyokong Program Rawatan dan Pemulihan Pesakit Dadah [The Role of Law Enforcement Activities in Supporting Treatment and Rehabilitation Programme for Drug Dependants]," *Majalah AADK* 1(2010).16.
[182] For example, National Anti-Drugs Agency, *Country Report 2010 Malaysia* (Putrajaya, Malaysia: National Anti-Drugs Agency, Ministry of Home Affairs, 2011).1, 28; H.H. Siraj and N. Omar, *Berbicara Mengenai Kesihatan Reproduktif Remaja: Panduan untuk Ibu Bapa dan Guru [Talking about the Reproductive Health of Teenagers: Guidance for Parents and Teachers]* (Kuala Lumpur: PTS Millennia Sdn. Bhd., 2007).97.
[183] Prime Minister's Office, *Government Transformation Programme: The Roadmap 2.0 Catalysing Transformation for a Higher Future* (Putrajaya, Malaysia: Prime Minister's Office, 2011).64. The government often relies on mass media and police reports regarding property crimes, picking up particularly on those committed by drug users.
[184] Mohamed, *Penyalahgunaan Dadah, Aspek Undang-Undang, Pemulihan, Rawatan dan Pencegahan [Drug Abuse: The Aspects of Law, Rehabilitation, Treatment and Prevention]*.15.
[185] Y. Md. Isa, *Laporan Penyelidikan: Menangani Jenayah Pengedaran Dadah Berbahaya di Malaysia Menurut Perspektif Undang-Undang [Research Report: Addressing Dangerous Drug Trafficking Crime in Malaysia from Legal Perspective]* (Sintok, Malaysia: Universiti Utara Malaysia, 2008).5.

the rapid growth of synthetic drug consumption from 1,860 cases in 2000 to 4,609 cases in 2005.[186] The government's estimation and statistical data so far go unchallenged even they showed high figures.

The government and its supporters constantly defend the need of strict prohibitionist measures to address the national drug problem despite its long term appeal and debate regarding their viability. Major arguments against the government approach include that it is ineffective given particularly high drug using and recidivism rates and counter-productive in terms of increased risk behaviours among drug users, stigmatisation and hindered public health approaches.[187] Moreover, there are ongoing calls by contemporary politicians, professionals and scholars for policy and legislative reforms such as decriminalisation of drug use and possession,[188] emphasis on rehabilitative philosophy and practices in the sustained criminal justice approach,[189] and provision of a voluntary health-based approach that operates totally outside the criminal justice system for non-violent drug dependants.[190] However, the government has silenced these calls, and has seemingly not sufficiently and effectively responded to the criticisms regarding

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[186] Mohamed, *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.55.

[187] For example, Commission on AIDS in Asia, *Redefining AIDS In Asia: Crafting an Effective Response* (New Delhi: Oxford University Press, 2008).186–87; F. Rahman, "Effects of Punitive Drug Policy on Drug Supply and HIV Incidence and Prevalence " in *Malaysian Health Law Debates* (2010).; F. Adam, W.I.W. Ahmad, and S.A. Fatah, "Spiritual and Traditional Rehabilitation Modality of Drug Addiction in Malaysia," *International Journal of Humanities and Social Science* 1 no. 14 (2011).175.

[188] M.Z. Khan and F. Rahman, "Policy Recommendations," *The Star Online Malaysia*(2011), http://thestar.com.my/health/story.asp?file=/2011/11/20/health/9908905&sec=health. (Last visited: 11/09/2012)

[189] Y. Md. Isa et al., *Laporan Kajian mengenai Undang-Undang Rawatan dan Pemulihan di antara Malaysia, Negara ASEAN, United Kingdom, Kesatuan Eropah (EU), Jepun, Korea, India, China dan Australia serta Pelaksanaannya [Report of Study: The Laws of Treatment and Rehabilitation in Malaysia, ASEAN Countries, United Kingdom, European Union (EU), Japan, Korea, India, China and Australia and Their Implementation]* [Report: A Study on the Laws of Treatment and Rehabilitation in Malaysia, ASEAN Countries, United Kingdom, European Union Countries, Japan, Korea, India, China and Australia and Their Implementation ] (Sintok, Malaysia: Agensi Antidadah Kebangsaan & Universiti Utara Malaysia, 2010).8.

[190] P. Tanguay, "Policy Responses to Drug Issues," *IDPC Briefing Paper*, no. 2012, 1 January (2011).7–8.

its drug treatment approaches. Despite the adoption of harm reduction approach, there appear to be criticisms such as that the government has put greater emphasis on absolute abstinence orientation and that it has given inadequate attention to medical standpoints.[191] On the contrary, research findings and writings do exist that support the government's drug control approach. For example, the research conducted by Fauziah et al. at eight government-run rehabilitation centres found that a substantial majority (98.5 per cent) of the respondents were satisfied with the effectiveness of the programme in making them aware of the importance of a healthy lifestyle.[192] The researchers conclude that the government-run rehabilitation programme is effective in changing drug dependants into normal, functional, productive individuals. Many also claim that the state-mandated recovery programme has a variety of inputs and medical aids while participants undergo the 'cold turkey' process that can diminish drug users' physical and psychological dependence on drugs.[193]

The government is keeping its commitment weighted on the side of law enforcement, partly evidenced by the substantial growth of arrest indicators of drug offences. For instance, between 2005 and 2007, the number of drug users detained for urinalysis significantly increased from 133,954 to 158,426.[194] A total of 6,534 persons underwent treatment in government rehabilitation centres, with 37,282 under supervision and 18,784 in prisons in 2005. In 2007, the proportion demonstrated an upward trend in

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[191] M.H.R. Noor Zurani et al., "Heroin Addiction: The Past and Future," *Malaysian Journal of Psychiatry* 17, no. 2 (2008).2; Mohamed, *Penyalahgunaan Dadah, Aspek Undang-Undang, Pemulihan, Rawatan dan Pencegahan [Drug Abuse: The Aspects of Law, Rehabilitation, Treatment and Prevention]*.273.

[192] I. Fauziah et al., "The Effectiveness of Narcotics Rehabilitation Program in Malaysia," *World Applied Sciences Journal* 12(2011).76.

[193] A.H. Husin et al., "Dadah Opiat-Candu, Heroin dan Morfin [Opiate Drugs-Opium, Heroin and Morphine]," in *Mengenali Dadah: Rawatan, Pencegahan dan Undang-Undang [Knowing Drug: Treatment, Rehabilitation and Law]*, ed. M.N. Mohamed (Putrajaya, Malaysia: Agensi Antidadah Kebangsaan, 2009).76.

[194] Agensi Antidadah Kebangsaan, *Maklumat Dadah 2009 [Drug Information 2009]*.32.

those treated at rehabilitation centres (7,135), but a slight fall in those under supervision (33,317) and in prisons (16,237).[195] Arrest of other drug offenders went up, too. As an illustration, the figures show that 64,043 were arrested under DDA 1952 in 2007 as compared with 43,106 in 2005.[196] Clearly, law enforcement efforts against drug users and other drug offenders stayed high despite the relentless criticisms and the adoption of harm reduction approach.

Given the remaining extensive focus on the criminal law and practices, discourses also appear concerning the issue of compatibility between the harm reduction and criminal justice approaches that affect the sustenance and efficiency of the former approach.[197] But the state and other supporting scholars contend that both approaches can coexist harmoniously through collaborative efforts and appropriate administrative arrangements between the public health and criminal justice regimes.[198]

Furthermore, as indicated by the WHO review of Malaysian harm reduction programmes in 2006 and 2007, although there was encouraging development in the services including through their scaling up, clear aims, funding, organisational structures, managed staffing and targets, the participation of drug users therein was low (for example, around 5 to 10 per cent for MMT) and the interventions were still surrounded with issues and challenges such as critiques regarding their effectiveness and the enormous focus on law enforcement hindering their operations.[199] Years later, there have

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[195] Ibid.26.
[196] Ibid.32.
[197] For example, G. Reid and N. Crofts, "Historical Perspectives of Drug Use in Southeast Asia," in *Drug Law Reform in East and Southeast Asia*, ed. F. Rahman and N. Crofts (Plymouth: Lexington Books, 2013).8.
[198] This issue will be examined in Chapter 4.
[199] R.M. Power, "Malaysian Needle Syringe Exchange Program (NSEP) Monitoring and Evaluation (M & E) and National Up-Scale Report," in *Review and Evaluation on Harm Reduction Programme in Malaysia*

been no major forward changes in the delivery of harm reduction services. Their coverage lags behind the UN's suggested target of 60 per cent of Malaysia's projected 170,000 IDUs. In 2010, it achieved just 13 per cent,[200] which could reflect the insufficient availability, accessibility and inefficiency of the interventions.

Their actual coverage as defined by the WHO may even be worse. According to the WHO, health service coverage refers to 'a concept expressing the extent of interaction between the service and the people for whom it is intended […] not being limited to a particular aspect of service provision but ranging over the whole process from resource allocation to achievement of the desired objective'.[201] The coverage of harm reduction, like other health service, thus depends on five spheres: availability, accessibility, acceptability, contact and effectiveness.[202] The existing literature still falls short of data regarding Malaysian harm reduction's accomplishment of the spheres. However, considering aspects including disintegration from drug control policy, limited participation of key agencies in NSEP, low coverage of the targeted population, limited attention to drug users in general and remaining issues including those relating to the justifications of the approach and its compatibility with the dominant criminal justice approach, it is doubtful whether Malaysia has attained the overall domains of coverage. Its government therefore needs to address all of the deficiencies and issues that impact the coverage and efficiency of harm reduction interventions.

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ed. Malaysia and Singapore Office of WHO Representative for Brunei Darussalam (Kuala Lumpur: World Health Organization, 2008).29, 39; A. Wodak, "Review of Monitoring and Evaluation of Drug Substitution Treatment in Malaysia," in *Review and Evaluation on Harm Reduction Programme in Malaysia*, ed. Malaysia and Singapore Office of WHO Representative for Brunei Darussalam (Kuala Lumpur: World Health Organization, 2008).4, 12, 17; Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia."47–48.

[200] Ministry of Health Malaysia, *Malaysia: National Strategic Plan on HIV and AIDS 2011-2015*.31.

[201] T. Tanahashi, "Health Service Coverage and Its Evaluation," *Bulletin of the World Health Organization* 56, no. 2 (1978).295.

[202] Ibid.296–97.

## 1.6 Conclusion

This chapter has given an overview of the four phases of Malaysia's drug control policy since the mid-19th century. The first phase (the legalisation period from the mid-19th century to 1924) witnessed the normalisation and legalisation of drugs, particularly opium. While prohibitionist policies and methods were adopted in the second phase (from regulation to prohibition period-from 1925 to the 1970s), the state still put little consideration into drug treatment and rehabilitation. As the construction of drugs as a moral and social problem continued to evolve, Malaysia's drug policy moved into a third phase (the prohibition period from the 1980s to the 2000s) that focused significantly on a dual-pronged strategy of supply reduction and demand reduction. This era also saw keen attention paid to drug control approaches based on deterrence and absolute abstinence philosophies including compulsory treatment for drug dependants. These policies and strategies, against the backdrop of entrenched designation of drug using as a critical moral and social issue, went on to characterise the Malaysian drug policy in its current fourth phase beginning in 2005. It is during this contemporary period that the government has begun to tailor its drugs policy to a harm reduction measures; MMT and NSEP in particular. The government's designing the local drug problem has significantly shaped the landscape of Malaysian drug policies across all historical phases.

The Malaysian government's adoption of harm reduction measures manifests a brave transformation from the previous highly punitive policies and measures. Contributory factors include public fears about accelerated HIV/AIDS transmission

among drug users and international demands. The MMT and NSEP services show notable progress since their inception in 2005, supported by the political leadership's commitment to their initiation, management and expansion; by multi-sectoral involvement; and by increased diverse access points. Against this backdrop, it can be presumed that the harm reduction approach will continue to receive official endorsement and further support in Malaysia.

However, so far Malaysia has not managed to develop its harm reduction approach into sufficient coverage and efficiency. Additionally, the approach still faces limitations and challenges including low coverage of drug users, less impact on drug policy, worsening drug problem and endless criticism regarding its worth and compatibility with the preserved criminal justice approach. These are relevant concerns. The issues related to the justifications of harm reduction approach and its congruity with the criminal justice approach are given considerable focus in this thesis and will be discussed in the subsequent chapters. It is pertinent to note that some essential historical points for this chapter could not be covered or extensively elaborated owing to limitations of available data, especially regarding the policy and legislative reports and relevant debates. Caution is also advised because much of the data retrieved from governmental sources including the statistics even has so far mostly gone unchallenged.

# CHAPTER 2

# THE ETHICAL AND THEORETICAL IMPERATIVES OF THE HARM REDUCTION APPROACH

## 2.1 Introduction

Despite significant developments in many countries including Malaysia, harm reduction policy and strategies are still surrounded with unsettled issues pertaining to their ethical and ideological justifications. The purpose of this chapter is to examine the normative and theoretical imperatives of harm reduction approach in the light of relevant debate at international and Malaysian levels. The discussion will cover several main aspects relating to the imperatives including the importance of harm reduction measures within ethical values, their connection with the protection of drug users' human rights, their congruity with Islamic values, their compatibility with the abstinence-oriented paradigm within drug prohibition policy and their consistency with international drug control conventions. Embracing these aspects may assist in establishing the ethical and ideological credentials of the harm reduction approach both internationally and domestically.

## 2.2 The Importance within Ethical Values

While traditional drug policy focuses on the need for individuals to abstain from illicit drugs, the harm reduction approach prioritises the reduction of adverse consequences from drug taking regardless of whether the conduct continues. This leads to intense attacks on the response's ethical legitimacy. This section examines the important issue of whether and how the approach is ethically justified.

The harm reduction approach is subject to ethical questions relating to its apparent non-emphasis on abstinence and sanctioning of persistent intake of illegal drugs. Abstinence-based strategies including law enforcement, prevention and treatment are rendered as the solely acceptable and ethically justifiable drug responses. Mangham exemplifies the disagreement with the harm reduction approach in preference to prohibitionist approaches: 'We cannot have a drug policy ideologically attached to harm reduction and also achieve the vital goals of prevention […] Placing harm reduction ideology aside, reduction of cannabis use (and other illicit drugs) onset is defensible as a drug policy goal'.[203] This shows a type of antagonism towards harm reduction that stems from beyond the concern for the approach's impacts. The objection reflects opponents' strong embedment to the core values related to intolerance to drug use and abstinence ideal, constituting the so-called deontologist response.[204]

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[203] C. Mangham, "Prevention Versus Harm Reduction as Drug Policy Concerstone," *Addiction Research & Theory* 14(2006).579.

[204] Deontology, founded by Immanuel Kant, is the ethical approach that requires adherence to a set of universally agreed ethical principles, rather than presumption about the outcomes. In other words, the moral quality of actions is determined by the intention of the agent, rather than by the consequences.

The responses of many harm reductionists are made in terms that are inconsistent with the opponents' ideological language. They lie on a technocratic argument regarding the pragmatism of the approach and scientific evidence of its efficacy and cost-effectiveness in decreasing drug-related harms. They also offer rhetorical amoral standpoints regarding drug taking, drug takers and acceptable state responses. Erickson et al. articulate that 'harm reduction programs are not dogmatic and coercive structures. Rather, they are designed on the basis of accurate, scientific knowledge about drugs and drug use'.[205] The essence of the proponents' argument is that the harm reduction approach denotes a justifiable pragmatic drug response given that it is not founded on abstract normative claims but instead on objective evidence-based scientific grounds. In the face of this, harm reduction measures are assessed based on their actual outcomes, rather than on their moral worth. This clearly signifies the consequentialist perspective, a value-neutral orientation that is viewed as part of the approach's strength. Keane asserts that the value-neutrality makes harm reduction a 'powerful rhetorical intervention' in deeply value-laden drug policy discourses.[206]

Mere silence on the ethical perspective in favour of scientific justification renders the defending argument fundamentally handicapped. The value-freedom does not, however, denote perfect neutrality. Values are entrenched within harm reduction, as indicated by its outlined principles. However, the ethical principles are seemingly hidden or discounted by its proponents in responding to the condemnations. Their argument ignores the important link between scientific and value positions, and therefore does not

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[205] P.G. Erickson et al., *Harm Reduction: A New Direction for Drug Policies and Programs* (Toronto: University of Toronto Press, 1997).9.

[206] H. Keane, "Critiques of Harm Reduction, Morality and the Promise of Human Rights " *International Journal of Drug Policy* 14, no. 3 (2003).227.

address the deontological vis-à-vis consequentialist drug debate. Indeed, making inroads on both standpoints is important if the intention is to provide a strong basis for any drug response. Steven affirms this, claiming that despite the effectiveness of drug treatment, it is still not justifiable in the case where it contradicts morality and ethics.[207] This manifests that self-reflexive pragmatic argument alone is inadequate for sidestepping inevitable ethical disputes about harm reduction. Neglecting to engage values will hinder proponents' capability to better convince the critics of the approach's validity. This is reflected in the fact that ideological challenges to the harm reduction approach continue to be brought forward despite its extensive scientific support. As MacCoun states: 'It may be hard to persuade others to acknowledge the full complexity of harm-reduction logic unless the values that support it become more salient in drug policy discourse'.[208] It is clear that a value-free approach that prioritises scientific impetus may limit the justifiability and potentiality of the harm reduction approach. It is therefore necessary to highlight explicit and clear ethical underpinnings of harm reduction as well, so that they balance the approach's scientific aspects and enhance its justification.

Notably, the harm reduction approach is strongly rooted in public health. It fits well with the prevention strategies for illness and health risks that exist within the traditional public health framework. Through the provision of strategies including MMT and NSEP, the harm reduction approach moves towards preventing the incidence of diseases and health problems such as HIV/AIDS and other blood-borne infections connected to drug consumption via injection instrument sharing and progression to drug

[207] A. Stevens, "Drug Policy, Harm and Human Rights: A Rationalist Approach," *International Journal of Drug Policy* 22, no. 3 (2011).233.
[208] R.J. MacCoun, "Towards a Psychology of Harm Reduction," *American Psychologist* 53, no. 11 (1998).1206.

dependence. Dependence on drugs is classified as a chronic health problem which is associated with a 'chronic relapsing condition' with a series of recovery and relapse prior to the last cessation.[209] Harm reduction strategies also seek to address drug-related harmful consequences including overdose mortality. Infectious diseases and other health-related impacts from drug taking pose threats to the health and well-being of the wider population. For example, infected HIV drug users could transmit the virus to others prenatally and sexually. Harm reduction interventions become important tools for modifying drug users' risky behaviours in order to lessen drug-related harms, and for bridging the group to drug treatment and mainstream healthcare services. In support of harm reduction, Hickman stresses the approach's aim in inhibiting the adverse effects of drug taking, which is to mitigate the disease-related problems and to ameliorate their health status.[210]

Additionally, this thesis argues that the harm reduction approach can be considered as a part of health promotion work grounding on the principle of new public health. Health promotion as a concept refers to enabling people to involve and control over health determinants and hence effectuate improvements to their own health.[211] It is commonly characterised as empowering health citizenship. Similarly, harm reduction programmes empower drug users to achieve control over their health and behaviour change. In the light of health citizenship values, individuals including drug takers have

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[209] C.P. O'Brien and A.T. McLellan, "Myths about the Treatment of Addiction," *Lancet* 347, no. 8996 (1996).237, 239–40.
[210] M. Hickman, "HCV Prevention-A Challenge for Evidence-Based Harm Reduction," in *Harm Reduction: Evidence, Impacts and Challenges. Monographs 10*, ed. D. Hedrich, T. Kerr, and F. Dubois-Arber (Luxembourg: European Monitoring Centre for Drugs and Drug Addiction, 2010).85.
[211] T.H. Tulchinsky and E.A. Varavikova, *New Public Health*, Second ed. (London: Elsevier Academic Press, 2009).41.

both the right and the duty to maintain their own health. This responsibility could to some extent justify state's extensive intervention in drug users' territories if it is evidently to optimise common health. The argument here is that this notion of health citizenship within the drug use context must also be made subject to limitations and other ethical elements. This will be further discussed in Chapter 5, Section 5.3.

Harm reduction is hence an important strategy for addressing the public health aspect of drug using. It is worth elaborating (pursuant to the explanation in the Introductory Chapter) that the health or public health imperative in relation to drug taking is not only embraced by the public health system but also dealt with by the criminal justice regime. The criminal justice approach's role in mitigating drug use and its adverse health and other effects mainly underlies the international drug controlling conventions. For instance, the preamble of the 1988 Convention considers that the production of, demand for and trafficking in prohibited narcotic substances 'pose a serious threat to the health and welfare of human beings and adversely affect the economic, cultural and political foundations of society'. Notably, the public health and criminal justice approaches converge and vary conceptually in many ways. While the two approaches connect to a larger political system in which their legitimacy and scopes are significantly shaped,[212] both differ in their primary goal. While the public health approach centrally aims to inhibit diseases and safeguard the health of populations, the criminal justice approach holds the principal goal of protecting public safety and order. The former approach regards drug use as a threat to population health, but the latter approach views it

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[212] A.M. Viens, J. Coggon, and A.S. Kessel, "Introduction," in *Criminal Law, Philosophy and Public Health Practice* ed. A.M. Viens, J. Coggon, and A.S. Kessel (Cambridge & New York: Cambridge University Press, 2013).7.

mainly as a threat to societal order and safety. As public health, public safety and public order are important goods for communities and society, they are covered under the ambit of the public good goal and state responsibilities for their promotion and protection. In fact, both approaches share the grounding principle of protecting social interest. But, while the public health approach is more attentive to the health interest, the criminal justice approach has concerns that extend beyond and even encompass the public health interest. In the drug use problem context, the criminal justice approach is created to achieve not solely public health aims but also social, welfare, economic and other aims given the numerous types of drug use harm (refer to the Introductory Chapter). In other words, health is just part of a number of values stimulating criminal justice actions.

The two approaches also differ in the substance of the social interest principle including the preferred measures for advancing the health interest. The public health approach typically engages operations including surveillance, disease investigation and control activities as well as provision of services for disease prevention and health promotion.[213] On the other hand, the criminal justice interventions encompass a wide array of activities including policing, investigation, prosecution, punishment and crime preventive acts.[214] Such legal measures are applied to achieve structural or behavioural changes or to enable the delivery of measures for the public good. The legal strategies are considered vital for controlling and protecting human conduct, rather than other interventions including educational methods as prioritised by the public health community.

[213] Ibid.8–9.
[214] Lazzarini, "Forensic Epidemiology: Strange Bedfellows or the Perfect Match? Can Public Health and Criminal Law Work Together without Losing Their Souls?."197–98.

Further, public health is distinguished from criminal justice as it focuses on preventing harm before it occurs with supplementary consideration tailored to treatment and other therapeutic measures.[215] Criminal justice, in contrast, seems far more reactive as it commonly takes actions after an offence has happened. Another variance between public health and criminal justice responses is that the former primarily concentrates on reducing harms, but the latter turns its attention towards deterring wrongful acts. Additionally, while the goals of public health and public safety are similarly attuned to the state's power to act, yet another significant contrast between the public health and criminal justice approaches is that the former is particularly attentive to voluntary cooperation between public health officials and the community, while the latter relies heavily on the employment of coercion or the threat of coercion over individuals. Ashworth states: 'Criminal liability is the strongest formal censure that society can inflict, and it may also result in a sentence which amounts to a severe deprivation of the ordinary liberties of the offender'.[216] From all of the above, it is clear that drug use has been put at the centre of the concerns of both public health and criminal justice approaches, which have shared and divergent characteristics.

Given the public health approach's basic features and its consideration of the common good, it also aligns with the consequentialist approach of utilitarianism which is famously connected with John Stuart Mill and Jeremy Bentham. This theory justifies action based on whether it produces 'the greatest happiness to the greatest number of people'. The action is ethical if its benefits outweigh the costs. It could also be argued that

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[215] R. Bowser and L.O. Gostin, "Managed Care and the Health of a Nation," *Southern California Law Review* 72, no. 5 (1999).1291.
[216] A. Ashworth and J. Horder, *Principles of Criminal Law*, Seventh ed. (Oxford: Oxford University Press, 2013).1.

this notion is impliedly intended by the harm reduction approach owing to its emphasis on harms or costs mitigation as a consequence. Approaching MMT and NSEP from a utilitarian perspective clearly shows their effectiveness. There is strong evidence demonstrating the positive impacts of both interventions in decreasing drug use, HIV-risk behaviours and infection incidents, and in increasing referrals to drug treatment and health services, and cost-saving. Moreover, the assessments suggest that the strategies do not appear to lead to negative effects such as increased drug taking, crime and discarded syringes. (Detailed discussion regarding the scientific implications of harm reduction strategies can be found in Chapter 3). Drawing on these positive outcomes and the absence of harms and burdens, this thesis claims that both measures are intended to achieve good for both individuals and entire communities. Thus, there is no reason to believe that utilitarianism as a theory does not apply to harm reduction. However, arguably, this philosophy alone insufficiently entails a strong case for the approach. Criticisms arise surrounding the risk of wider state actions that may extend to undermine individuals' rights in the name of the common good.[217] This is likely reasonable given that there is no key rule as to the definition and measurement of good. Additionally, many still reject the harm reduction approach's utility owing to its perceived conflict with their desirable normative belief. It is therefore important that the utilitarian grounds for harm reduction are enhanced and balanced with other values related to the public health realm.

An increasing orientation has appeared towards invoking normative principles to justify the harm reduction approach. Some provide its moral stand through the lens of

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[217] For example, S. Mugford, "Harm Reduction: Does It Lead Where Its Proponents Imagine?," in *Psychoactive Drugs and Harm Reduction: From Faith to Science* ed. N. Heather, et al. (London: Whurr Publishers Ltd., 1993).29.

virtue ethics, which is a theory concerned with the moral qualities of the person doing the action. It suggests that virtues including courage, compassion, fairness, honesty, kindness and loyalty are essential parts of the individual character.[218] Christie et al. use the virtue of compassion to defend the harm reduction approach. For them, harm reduction is an aspiration brought about by the trait of compassion within people engaging in the programmes. The initiatives are implemented to assist the drug using population to mitigate their suffering and pain and to gain health and well-being.[219] Although the techniques under harm reduction manifest a compassionate response to commonly marginalised drug users within which their risk behaviours are dealt with in a way that is respectful of the group, it is doubtful whether this value could offer a compelling ethical argument for the practices. Adopting this value would mean that less weight is given to actions and obligations. Thus, drug users could not be obliged to take actions to protect their health as in the health citizenship conception. Moreover, the degree to which compassion should be practised is uncertain. Reflectively, policy-makers and harm reduction service providers lack guidance on how to strike the balance between excessive and insufficient compassion. Additionally, while there are divergent interests and perceptions among individuals and communities that may impact harm reduction, the missing clear mean to reconcile these makes this value less applicable for the approach.

Further, the harm reduction approach is discussed in terms of its consistency with communitarian ethics, which attribute the highest priority to public interests and the common good. Communitarian ethics as a theory 'emphasises social connectedness, and

[218] T. Christie, L. Groarke, and W. Sweet, "Virtue Ethics as an Alternative to Deontological and Consequential Reasoning in the Harm Reduction Debate," *International Journal of Drug Policy* 19, no. 1 (2008).56.
[219] Ibid.56–57.

sees individuals as members of a community embedded in the community norms and history, and not as the atomised individuals of classical liberalism'.[220] This means that the good of action is evaluated in terms of the community's preferences. Some scholars such as Fry et al. promote the engagement with communitarian ethics within the harm reduction realm.[221] It might be reasonable to elicit this ethical theory in harm reduction considering its ground in public health and social relativism. Thus, the conceptual setting of the harm reduction approach needs to be consistent with valued societal interests. This may go some way towards addressing the clash between relevant theories. However, guidelines pertaining to these are absent from the existing literature. Further, communitarianism is not without other problems. Similar to virtue ethics, it is unclear whether communitarian ethics are capable of providing equitable consideration to differing ethical perspectives of various communities in tackling ethical problems. This makes the notion of a shared stance of common good with regard to harm reduction or other matters less likely. Another facet of fundamental criticism relates to the fluid and ambiguous conception of community itself. The community notion is of dubious importance to social, welfare and criminal justice innovations because it is fraught with inherent inconsistency and a plethora of positions. The term is commonly employed in the literature in two different senses: first when referring to small and face-to-face communities such as villages, and second when discussing wider political or cultural communities. Both types have contesting accounts of certain aspects including how liberal values are deliberately excluded in the latter's case but unnecessarily so in the

[220] C. Sindall, "Does Health Promotion Need a Code of Ethics?," *Health Promotion International* 17, no. 3 (2002).202.
[221] C.L. Fry, C. Treloar, and L. Maher, "Ethical Challenges and Responses in Harm Reduction Research: Promoting Applied Communitarian Ethics," *Drug and Alcohol Review* 24, no. 5 (2005).457.

former's case.[222] Further, the complex label of 'community' attracts various terms including culture, society, state and nation, theories, values and preferences.[223] Critics are also concerned about some of the conceptual issues related to communitarian theory including the terminology's indefinite elements, and the scope and methods of its appropriate application.[224] Additionally, there is the risk of 'the tyranny of the majority' as a consequence of the unclear ambit of common good.[225] The majority viewpoint, while inequitably discounting the interest of minority drug users, could give preference to the policies infringing drug users' human rights to attain a drug-free environment.[226] Based on these limitations, this value is unlikely to be a candidate for the ethical basis underpinning the harm reduction approach.

Another option is principlism, which some champion as the underlying ethical basis for harm reduction.[227] Principlism is a kind of bioethics umbrella term incorporating four principles, namely: respect for autonomy (respecting the personal right to make decisions of actions, privacy and confidentiality); beneficence (maximising benefits); nonmaleficence (mitigating harms and risks); and distributive justice (equitably distributing benefits and burdens). These principles seem to be a worthy framework for harm reduction measures. For instance, MMT and NSEP comply with respect for autonomy as the strategies recognise and aid drug users in making informed judgements

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[222] K. Dalacoura, "A Critique of Communitarianism with Reference to Post-Revolutionary Iran," *Review of International Studies* 28, no. 1 (2002).77–78.
[223] Ibid.80; S. Holland, *Public Health Ethics*, Second ed. (Cambridge & Malden: Polity Press, 2015).75.
[224] E. Frazer, *The Problems of Communitarian Politics: Unity and Conflict* (New York: Oxford University Press, 1999).56.
[225] A. Ashworth, "Crime, Community and Creeping Consequentialism," *Criminal Law Review* (1996).225.
[226] A. Carter, P.G. Miller, and W. Hall, "The Ethics of Harm Reduction," in *Harm Reduction in Substance Use and High-Risk Behaviour* ed. R. Pates and D. Riley (West Sussex: Wiley-Blackwell, 2012).116.
[227] For example, S. Loue, P. Lurie, and L.S. Lloyd, "Ethical Issues Raised by Needle Exchange Programs," *Journal of Law, Medicine & Ethics* 23, no. 4 (1995).382–83,385; C. Aceijas, "The Ethics in Substitution Treatment and Harm Reduction. An Analytical Review " *Public Health Reviews* 34, no. 1 (2012).5–7.

about how to address their high-risk behaviours and drug dependence, all conducted within a maintained confidential and non-compulsive sphere. Further, the measures satisfy beneficence and nonmaleficence principles through their effectiveness and safety in reducing drug-related harms and increasing admissions to and retention in therapeutic and healthcare services. Moreover, in concordance with justice, the government's financial support of the programmes for well-being and health improvement denote fair allocation of resources for the needs of the drug using population including those unable or unready to respond to abstinence-based efforts. Despite its distinctive appeal based on simple conceptualisation and practicality for clinical and public health professionals, there are problems underpinning principlism that deserve to be mentioned. There is no certain method that is specified to address the potential conflicts among the four principles. For critics, there are also concerns that autonomy dominates over the other three principles[228] (in clear contrast to communitarianism theory), that the theory disregards other important life aspects including moral values and the public good[229] and that it decontextualises ethical problems[230]. These suggest the challenges of utilising the philosophy in support of the harm reduction approach.

Moreover, growing attention has been focused on human rights perspectives of the harm reduction approach. Human rights privilege individual dignity and rights, rather than the public interest. Cohen and Csete write: 'Human rights inhere to the person and are not contingent on consensus or majority view'.[231] Drug users, like all other

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[228] D. Callahan, "Principlism and Communitarianism," *Journal of Medical Ethics* 29, no. 5 (2003).288–89.
[229] Ibid.289.
[230] A.V. Campbell, "The Virtues (and Vices) of the Four Principles," *Journal of Medical Ethics* 29, no. 5 (2003).296.
[231] J. Cohen and J. Csete, "As Strong as the Weakest Pillar: Harm Reduction, Law Enforcement and Human Rights," *International Journal of Drug Policy* 17, no. 2 (2006).103.

individuals, have human rights as enshrined in international human rights law. Article 55 of the UN Charter conversely mentions that the UN 'shall promote […] solutions of international economic, social, health, and related problems; and universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language or religion'. The states therefore have duties to respect, protect and fulfil human rights. In the light of this notion, appropriate and effective ways to protect drug users' rights must be implemented without any barriers. This might include harm reduction measures that are clearly initiated towards securing drug users' health and well-being-related needs and benefits. The human rights paradigm has therefore significant potential for justifying harm reduction initiatives and counterbalancing the utilitarian stance of public health, thereby satisfying personal and societal interests as well as professional integrity. More explanation of the human right imperative and relevant debates about how it fits with the harm reduction approach can be found in Chapter 2, Section 2.3.

To summarise, absolute evidence-based arguments are not compelling enough to crack the opposition to the harm reduction approach, especially from those who take a deontological stance towards drug prohibition. The value-laden, as opposed to value-free, nature of the harm reduction approach should be explicitly highlighted through debate and dialogue. This would assist in providing strong ethical justification for the approach. Harm reduction is a firmly public health approach. It matches the components of prevention of diseases and health risks under the traditional public health framework and health promotion under the new public health. Utilitarianism offers more insights into the theoretical paradigm of harm reduction. Additionally, the approach is linked to the human

rights imperative. This value could be a relatively more appropriate resource than other ethical theories as it effectuates the idea of reinforcement and counterbalances the public health and utilitarianism bases for harm reduction.

### 2.3 Connection with the Protection of Drug Users' Human Rights

Human rights have acquired increasing significance in drug use discourse since the mid-1990s. However, the importance of the harm reduction approach from a human rights perspective is still the subject of debate. This section presents a perspective regarding this aspect while considering the existing debate.

Providing harm reduction measures is crucial to secure drug users' internationally accepted right to the highest standard of health. The Universal Declaration of Human Rights (UDHR) states that 'everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including […] medical care and necessary social services'.[232] Similarly, the International Covenant on Economic, Social and Cultural Rights (ICESCR) attests 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[233] The UN Committee on Economic, Social and Cultural Rights (CESCR)[234] specifies the ambit of right of health, pointing out that 'the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the

[232] Universal Declaration of Human Rights 1948, Article 25.
[233] International Covenant on Economic, Social and Cultural Rights 1966, Article 12.
[234] The body monitors countries' compliance with their duties under the International Covenant on Economic, Social and Cultural Rights.

highest attainable standard of health'.[235] In other words, the right to health covers the reach of available diverse medical and healthcare services and support. Drug users are therefore entitled to the same respect and dignity as other persons to get healthcare protections including through harm reduction services.

To effectuate the right of health, the international law commits states to taking steps including 'those necessary for [...] the prevention, treatment and control of epidemic, endemic, occupational and other diseases' and 'the creation of conditions which would assure to all medical services and medical attention in the event of sickness'.[236] Specifically for the control of HIV transmission, the International Guidelines on HIV/AIDS and Human Rights (IGHHR) encourage countries to ensure 'the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support'.[237] This means that national governments are obliged to undertake positive action and to move progressively towards promoting health and making adequate, effective and good-quality healthcare measures accessible to individuals.

Harm reduction programmes would perfectly fit as components of states' positive actions in promoting health and preventing diseases and other drug-related effects detrimental to the health of drug users and the wider population. MMT is scientifically and medically pertinent to ameliorating or decreasing opiate dependence and its adverse

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[235] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, E/C.12/2000/4 (Geneva: United Nations, 2000).para.9.
[236] International Covenant on Economic, Social and Cultural Rights 1966, Article 12.
[237] Office of the High Commissioner for Human Rights (OHCHR) and Joint United Nations Programme on HIV/AIDS (UNAIDS), *HIV/AIDS and Human Rights International Guidelines: Revised Guideline 6. Access to Prevention, Treatment, Care and Support* (Geneva: UNAIDS, 2002).14.

health consequences. NSEP further contributes in constraining the dangers associated with risky behaviours among IDUs including HIV/AIDS and other blood-borne infections. Additionally, both services could bridge the gap to other healthcare services. Certainly, the harm reduction approach, according to Paul Hunt, UN Special Rapporteur on the Right to Health, 'enhances the realisation of the right to health' of the drug-using population.[238] This significance is also affirmed by UN human rights monitors.[239] Thus, it can be argued that states are legally bound to implement harm reduction strategies.

Further, delivering harm reduction services constitutes a stepping stone for states to be compliant with the right of freedom from inhuman and degrading treatment. International human rights law unequivocally recognises the individual entitlement to be protected from torture and ill-treatment. Article 5 of the Universal Declaration of Human Rights (UDHR) provides: '[N]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment'. Countries have a positive legal obligation to realise this right based on the term of right and provisions calling them to forbid all acts of torture and other cruel, inhuman or degrading treatment or punishment.[240] The states' duty engenders their responsibilities in practising effective measures for freeing all persons from acts or conditions amounting to torture and ill-treatment, potentially include preventable painful physical ailments and suffering.

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[238] United Nations Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt, Mission to Sweden*, vol. UN Doc No A/HRC/4/28/Add.2 (Geneva: United Nations, 2007).16.
[239] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant: Concluding Observations of the Committee on Economic, Social and Cultural Rights: Ukraine* E/C.12/UKR/CO/5 (Geneva: United Nations, 2007).7–8.
[240] International Covenant on Civil and Political Rights, Article 7; United Nations General Assembly, *Resolution 39/46: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/39/51 (New York: United Nations, 1984). Articles 1and 2.

MMT and NSEP are evidence-based techniques to reduce drug consumption and its negative effects, thereby securing drug users against harms and suffering. Writing in the context of drug users' human rights in closed settings, Bruce and Schleifer note: '[…S]tates' failure to provide available and necessary medical attention to opioid-dependent prisoners, thus increasing their vulnerability to HIV and other blood-borne diseases, could result in prisoners being subject to inhuman and degrading treatment in violation of basic legal obligations to prevent such occurrence'.[241] By analogy, the same can be claimed of harm reduction programmes in the community, given the life and health threats faced by street drug users. Denied or interrupted access to the programmes may seriously affect drug users' physical and mental health and well-being. The population would be susceptible to avoidable harms and risks including HIV/AIDS and other virus transmissions, withdrawal symptoms and fatal overdose. Thus, the national government's failure to ensure accessibility to harm reduction measures seems to cause inhuman and degrading treatment in breach of fundamental responsibility to inhibit such incidents. Arguably, the failure, however, could not be directly equated with de facto 'inhuman and degrading treatment' without taking into account other national conditions including economic capacity.

Clearly, harm reduction practices precondition the safeguard of drug users' rights to health and protection from inhuman and degrading treatment. The human rights discursive style presented in this thesis obviously disregards the notion of drug-taking entitlement grounded on civil liberties as promoted by a few commentators. In critiquing

[241] R.D. Bruce and R.A. Schleifer, "Ethical and Human Rights Imperatives to Ensure Medication-Assisted Treatment for Opioid Dependence in Prisons and Pre-Trial Detention," *International Journal of Drug Policy* 19, no. 1 (2008).20.

the value-neutral discourse of harm reduction, which, as claimed, neglects its embedded human rights values, Hathaway materially considers drug using a right within the ideals of freedom of will and autonomy of the individual.[242] It is reasonable to argue that this human rights theme could not make a strong case for the harm reduction approach. The liberal humanism account of drug consumption clashes with both health-optimising and prohibition imperatives, and is thus inappropriate to be considered as underpinning the approach's ideals. Additionally, adopting a libertarian foundation would oppose the harm reductionists' mainstream call for state intervention to protect the health and welfare of drug users, thereby possibly sparking fruitless conflict within the harm reduction domain. (Further comments regarding the liberalist view on drug use can be found in Chapter 5, Section 5.3.)

Ezard offers the other dimension of the rights-oriented viewpoint of harm reduction. This scholar invokes a wider human rights basis encompassing social and economic rights to point to the state's duty to provide care and protection to individuals through decreasing drug-related harm, its risks and vulnerability. In particular, she claims that human rights duties are connected to drug using in a number of ways. First, the state has the duty to ensure the availability of interventions and conditions that mitigate drug-related harms and risks. Second, the state's failure to fulfil human rights duties potentially increases individual vulnerability to harms associated with taking drugs.[243] In the light of her distinctively enlarged harm reduction spectrum covering the minimisation of vulnerability to and risks of drug-related harms, Ezard firmly relates the approach's

[242] A.D. Hathaway, "Shortcomings of Harm Reduction: Toward a Morally Invested Drug Reform Strategy," *International Journal of Drug Policy* 12, no. 2 (2001).134–36.
[243] N. Ezard, "Public Health, Human Rights and the Harm Reduction Paradigm: From Risk Reduction to Vulnerability Reduction," *International Journal of Drug Policy* 12, no. 3 (2001).215–16.

adoption to the human rights commitment to protect people from harms, risks and vulnerability.[244] While impressive as far as it goes in applying a human rights lens other than that of civil libertarian entitlement to drug-ingesting as is integral in Hathaway's view, it is unclear whether Ezard's human rights analysis for harm reduction based on vulnerability protection undertaking is useful. At present, this notion is not within the harm reduction common accounts. Vulnerability to risk is also relatively more remote and beyond those risks directly related to drug consumption.

Notably, injecting a rights-based perspective into harm reduction is important, as such values would strengthen the legitimacy of harm reduction strategies. While acknowledging the inadequacy of available scientific evidence to effectively assuage ideological objections to harm reduction, Wodak and McLeod highlight the approach's justifiable use for human rights protection.[245] Additionally, human rights analysis could be a potent weapon for insisting on the state's positive involvement in harm reduction interventions as part of its legal obligations under the international human rights norms and standards.[246] Article 103 of the UN Charter suggests that priority should be given to states' duties under the document including with regard to human rights over duties in any other conventions. This indicates that human rights obligations would prevail even in the case of their conflict with the duties embodied within the international drug treaties,

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[244] Ibid.213, 216–17.

[245] A. Wodak and L. McLeod, "The Role of Harm Reduction in Controlling HIV among Injecting Drug Users," *AIDS* 22, no. Suppl 2 (2008).S86,S89–S90.

[246] Even though Malaysia has not ratified many international human rights treaties or covenants, the human rights obligations including those in respect of health and protection from torture and ill-treatment do apply, given the pledge of UN states to show 'universal respect for, and observance of, human rights' (UN Charter, Article 55). Further, the Universal Declaration of Human Rights has attained the legitimacy as a customary international law with which all countries must comply.

which is explicitly confirmed by the Commentary on the 1988 Convention.[247] Nonetheless, the government's being able to provide interventions is undoubtedly impacted by economic considerations and the availability of resources. Regard for the country's particular economic conditions should be treated as an essential compromise to the obligations it has assumed under the human rights treaty.[248] That said, resource constraints must not be paraded as excuses for the state's desertion from meeting its obligations. The state must be held fundamentally responsible for ensuring 'at the very least minimum essential levels of every right' under Article 2 of the International Covenant on Economic, Social and Cultural Rights in whatever economic circumstances. One of the core obligations proposed by the UN Committee on Economic, Social and Cultural Rights is 'to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population'.[249] Arguably, this should cover immediate actions to provide drug users with evidence-based services including harm reduction at a realistic standard adapted to a country's economic faculty, considering the serious detrimental effects of drug taking including blood-borne viruses transmission. Harm reduction measures are a necessary, efficacious and cost-effective way of saving lives and ameliorating or preventing avoidable harms to individuals and the population as a whole (further discussion regarding the scientific imperative of harm reduction appears in Chapter 3). Further, it is incumbent upon national governments to address the policies, legislations

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[247] Paragraph 3.3 of the Commentary states: '[… T]there is nothing to prevent parties from adopting stricter measures than those mandated by the text should they think fit to do so, subject always to the requirement that such initiatives are consistent with applicable norms of public international law, in particular norms protecting human rights'.

[248] P. Alston and G. Quinn, "The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 9, no. 2 (1987).175.

[249] United Nations Committee on Economic, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*.para.43.

and other approaches that hinder harm reduction programmes' efficiency or that result in negative impacts that counteract their objectives.

However, critics find problem with respect to applying human rights dimensions to social issues including drug use. One of their important arguments is that human rights result in undue constraints on states' public good efforts including decreasing the harmful effects of drug taking. Keane writes: '[I]ndividual rights [...] are a way of defending individual desires against the competing claims of collective goals and general benefits, such as the reduction of harm'.[250] Such an ambivalent attitude towards individualism is prevalent in Asian countries including Malaysia. The premise upon which the criticism is based is that the pursuit of individual rights is incompatible with the commitment to community good. Whilst I here agrees that human rights might clash with state undertakings for advancing public interest in certain cases, especially when states take action to limit individual freedoms such as through mandatory quarantine on the basis of societal benefit, adopting human rights norms is important for checking and balancing public interest strategies. Cohen et al. argue that 'human rights provide the moral and legal 'brakes' to redirect public health (and other social interests) to more constructive tactics'.[251] This would prevent unnecessary rights infringement by states in the name of public good, which in turn would lead to effective and just rights-oriented public strategies that may substantially benefit individuals and wider community. Therefore, attaching human rights principles to drug use and other social issues does not mean the

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[250] Keane, "Critiques of Harm Reduction, Morality and the Promise of Human Rights ".230.
[251] J. Cohen, N. Kass, and C. Beyrer, "Human Rights and Public Health Ethics: Responding to the Global HIV/AIDS Pandemic," in *Public Health and Human Rights: Evidence-Based Approaches*, ed. C. Beyrer and H. Pizer (Baltimore: Johns Hopkins University Press, 2007).387.

loss or subordination of public interest to personal interest; rather, it would be a mistake to disregard them.

Resistance to human rights conceptions based on 'Asian values' is a distinctive feature of debate in Asian settings including Malaysia. The popular argument is that human rights dignifying the individual are exclusive values emanating from Western culture that are not well suited to Asian cultural traditions. This implies that a cultural relativism separates Asia from the West, but this justification is fundamentally flawed owing to the absence of two major fixed sections of Asian and Western values. Traditions continually evolve as a result of intercontinental cultural exchange.[252] Additionally, human rights are not necessarily culturally specific to the West; they can be traced in non-Western morality, religions and traditions. For instance, the Western conceptions of the rights of health and freedom of movement are considerably consonant with Islamic values.

The notion of human rights' universality as frequently highlighted by many in response to the Asian values premise has merit only to the extent that it is not construed as a global homogeneity of cultures but instead as a group of essential minimal general principles that are still open to interpretation and application by local circumstances and cultural traditions. This is consistent with the Universal Declaration of Human Rights reminder that 'the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind' while applying human rights universally. Consideration of domestic particularities would mediate

[252] W.A. Manan, "A Nation in Distress: Human Rights, Authoritarianism, and Asian Values in Malaysia," *Journal of Social Issues in Southeast Asia* (1999).378.

considerable differences in Asian human rights conceptions. This would also give ethical and political weight to using human rights to attain a 'dignity life'.[253]

Moreover, there is widespread suspicion that human rights norms and practices will threaten national social and economic progress. Asian leaders believe in the justifiable prioritising of measures to ensure political and security stability towards attaining undisturbed economic growth, though they need to curtail civil and political liberties. This manifests in individual rights being necessarily compromised to accommodate material necessities. To refute this, the argument is oversimplified as there appears to be no evidence demonstrating a general causal link between protection of rights and handicapped economic development. Instead, fulfilling individuals' and groups' rights might mobilise them to participate in activities that are geared towards social and economic preservation.[254] It is hence invalid to generalise the priority of enhancing political and security stability. Furthering public good including national security while constraining individual rights is permissible only for a short term in specific cases where there is a true necessity for the former and a sound analysis to reconcile the clashing interests.

Precisely, there is a clear relationship between harm reduction interventions and protection of individual rights to health and freedom from inhuman, cruel and degrading treatment. The practice of harm reduction is agreeable to and in many ways demanded by states' duties under the international legal instruments. The human right norms further

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[253] M. Freeman, "Universal Rights and Particular Cultures," in *Human Rights and Asian Values: Contesting National Identities and Cultural Representations in Asia*, ed. M. Jacobsen and O. Bruun (London: Curzon, 2000).47.

[254] D.A. Bell, "The East Asian Challenge to Human Rights: Reflections on an East West Dialogue," *Human Rights Quarterly* 18, no. 3 (1996).645.

give a philosophical basis for harm reduction services delivery in Malaysia and other nations. The principles help to ensure their efficient and equitable implementation, thereby benefiting both personal and public interests.

## 2.4 Congruity with Islamic Values

While the relevant data are scant, vehement protest from Muslim communities about the approach's claimed contradiction to Islamic values can be somehow detected in Malaysia and other countries predominated by Muslims including Jordan, Oman and Syria.[255] In quick response, some harm reductionists seem reluctant to consider the religious perspective on harm reduction because of its perceived hindrance to the approach.[256] Such a negative assumption is problematic, as Islamic values will not necessarily cause predicament, but will instead potentially provide more justification for the approach in Islamic settings. Moreover, Muslims' deep concern regarding any issue cannot simply be abandoned as they represent the majority of citizens in those countries. Harm reduction can only continue with their support. Also, within the Malaysian context, Muslim Malays are the majority of drug users and HIV patients.[257] It is therefore inevitable to consider

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[255] C. Cook and N. Kanaef, eds., *The Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics* (London: International Harm Reduction Association, 2008).102.

[256] For example, Y.T. Ku, "Managing' Drug Use to Prevent Spread of the AIDS Tide," *New Straits Times*, 28 November 2004.2.

[257] Prime Minister Department Economic Planning Unit and United Nations Development Programme Country Team Malaysia, *Malaysia: Achieving the Millennium Development Goals* (Kuala Lumpur: United Nations Development Programme Country Team, Malaysia, 2005).158; Agensi Antidadah Kebangsaan, *Maklumat Dadah 2012 [Drug Information 2012]* (Kajang, Malaysia: Agensi Antidadah Kebangsaan, 2013).14.

this type of opposition and respond accordingly. The following discussion is assigned to an analysis of this issue.

As invariably stressed by opponents, harm reduction strategies connote assistance with and promotion of sinful illicit drug using and neglect of the abstinence-based philosophy towards prohibited conducts. The Fatwa Committee National Council of Islamic Religious Affairs Malaysia[258] issued a '*fatwa*' (Islamic legal reasoning) regarding the impermissibility of NSEP.[259] In a similar vein, Perak's[260] '*mufti*'[261] submits that NSEP would incite more people to get involved in injecting drugs, thereby bringing about negative effects.[262] A serious weakness of this argument is that it is not backed up by coherent support. The reasoning is straightforward, based on the relevance of harm reduction measures to drug consumption. This mirrors the opponents' strict adherence to the Islamic jurisprudence principle of 's*add al-dhara'i*' (blocking the means), which signifies that any method that leads to evil or harm is prohibited, whether the particular result was intended or not.[263] Thus, harm reduction programmes are seen as pathways to sinful and harmful drug taking. This argument has flaws, though. In pointing out the Islamic ruling, the opponents do not comprehensively take into account the pivotal role of

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[258] The '*fatwa*' committee consists of all '*mufti*' in Malaysia.

[259] Jabatan Kemajuan Islam Malaysia (JAKIM), "Hukum Pelaksanaan Program Pemberian Kondom, Jarum dan Metadon Percuma sebagai Langkah Pencegahan Jangkitan HIV/AIDS [The Ruling on the Implementation of Provision of Free Condom, Needle and Methadone Programme as a Preventive Measure for HIV/AIDS Infection]," JAKIM, http://www.e-fatwa.gov.my/keputusan-pks/hukum-pelaksanaan-program-pemberian-kondom-jarum-dan-metahadone-percuma-sebagai-langka. (Last visited: 18/11/2013)

[260] Perak is a state in Malaysia.

[261] '*Mufti*' is an appointed Islamic legal jurist. He is authorised by states' Islamic statutes such as Sections 34, 38 and 39 of the Administration of Islamic Law (Federal Territories) Act 1993 to derive '*fatwa*' on any matter related to Islam with the guidance of Islamic sources for public interest.

[262] S.M.R. Aidid, "Jangan Ikut Iran, China Beri Jarum Percuma [Don't Follow Iran, China to Provide Free Needles]," Utusan Melayu (M) Berhad, http://www.utusan.com.my/utusan/info.asp?y=2005&dt=0609&pub=utusan_malaysia&sec=Forum&pg=fo_02.htm. (Last visited: 14/09/2013)

[263] M. Abu Zahrah, *Usul al-Fiqh [The Principles of Islamic Fiqh]* (Cairo: Dar al-Fikr al-'Arabi, 1958).288.

harm reduction techniques in reducing drug use and its adverse consequences. Furthermore, there is no consideration of the alarming rate of HIV/AIDS cases or of the lack of success of the abstinence-based response to the drug consumption problem. Given the interventions' importance and relevant issues, it would appear that harm reduction has become a specific case meriting conclusive Islamic legal analysis that looks beyond its connection to drug using and individual interest. The analysis must acknowledge the wider scope of issues as well as both public and personal good.

This thesis posits that MMT is justifiable in Islam owing to the '*hajiyyat*' (need) for treating dependency to drugs and its-related harms. This conforms to the Islamic principle that 'anything which is prohibited due to the concept of '*sad al-zarai'k*' could then be permitted if there is '*hajiyyat*' (need).[264] Though the majority of classical jurists including al-Zarkashi, al-Ruyani, al-Bazazi and al-Nawawi originally ruled on the impermissibility of drug use, an exemption is given when there are '*hajiyyat*' (need) of using drugs for medication on the conditions that there is no better lawful substitute and that it is verified by trusted experts.[265] While drugs are generally prohibited because they are analogised to '*khamr*' (intoxicants) that are impermissible in Islam,[266] there is an exemption to the prohibition when drugs are used for medical purpose. The same exception, however, is inapplicable to '*khamr*' (intoxicants). This is given that drugs are

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[264] M. Ibnu Qayyim, *I'lam al-Muqi'in 'an Rabb al-'Alamin [Divine Notification from the Creator of the Universe]*, vol. 3 (Beirut: Dar al-Kutub al-'Ilmiyyah, 1991).108.

[265] M.B. Al-Zarkashi, *Zahr al-'Arish fi Tahrim al-Hashish [The Blossom of 'Arish in the Prohibition of Hashish]* (Mansurah: Dar al-Wafa', 1990).135–36; F. Rosenthal, *The Herb-Hashish versus Medieval Muslim Society* (Leiden: E.J. Brill, 1971).115–18.

[266] No direct ruling has been found in the *Quran* or the *Sunnah* as drugs were first known during Tartar's administration in 106H and 107H; A.F. Bahansi, *Al-Masuliyyah al-Jina'iyyah fi al-Fiqh al-Islami [Criminal Liability in Principles of Islamic Jurisprudence]* (Beirut: Muassasah Halabi, 1969).227.

not totally similar to intoxicants.[267] The '*khamr*' is prohibited by the *Quran* and the *Sunnah* owing to its '*zat*' (evil nature) and intoxicant effects, while drugs are prohibited only for their intoxicant implications.[268] The permissible use of drugs for medicinal purpose is reaffirmed by contemporary Islamic jurists. Al-Zuhaili, for instance, states that it is allowable to use drugs in treatment when there is either '*hajiyyat*' (need) or '*darurah*' (necessity) to save life. This includes using drugs for surgical operation and pain relief.[269] Therefore, concurring the Fatwa Committee National Council's ruling regarding MMT[270] this thesis argues that the strategy is lawful as a form of drug treatment. Conventional abstinence-oriented treatment should not be the only acceptable practice, given its failure to reduce drug consumption and the high number of relapse cases. MMT also complies with Islamic rules as it is supervised and controlled by medical experts including in terms of the eligibility of clients and the amount of methadone dispensed.

Through a different lens, the Malaysian government and some Muslim scholars defend harm reduction interventions based on the Islamic legal maxim of '*al-darurah tubihul mahzurat*' (necessity legalises what are prohibited). As contended, the originally impermissible provision of methadone and syringes for drug users is authorised temporarily to address a critical level of HIV prevalence.[271] Mohd Safian in her PhD

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[267] The prohibition of use of intoxicants for treatment is derived from the Prophet Muhammad S.A.W.'s saying that they are 'a disease and not a cure'.

[268] Al-Zarkashi, *Zahr al-'Arish fi Tahrim al-Hashish [The Blossom of 'Arish in the Prohibition of Hashish]*.123–25.

[269] W.M. Al-Zuhaili, *Al-Fiqh al-Islami wa-Adillatuh [Islamic Fiqh and Its Evidences]*, vol. 4 (Damascus: Dar al-Fikr, 2004).2626.

[270] Jabatan Kemajuan Islam Malaysia (JAKIM), "Hukum Pelaksanaan Program Pemberian Kondom, Jarum dan Metadon Percuma sebagai Langkah Pencegahan Jangkitan HIV/AIDS [The Ruling on the Implementation of Provision of Free Condom, Needle and Methadone Programme as a Preventive Measure for HIV/AIDS Infection]".

[271] S. Barmania, "Malaysia Makes Progress Against HIV, but Challenges Remain," *Lancet* 381, no. 9883 (2013).2071; N. Mohd. Yasin, "Methadone Treatment as a Harm Reduction Method for Reducing the Incidence of HIV Transmission In Malaysia: A Comparative Paradigm," in *Issues in Medical Law and*

thesis concerning '*darurah*' suggests that Malaysian MMT and NSEP meet the preconditions of '*darurah*' and are hence temporarily legitimate ways of preserving the life and health of drug users and the communities endangered by the HIV epidemic and drug dependence.[272] The '*darurah*' principle makes what is prohibited permissible owing to arising absolute necessities. As al-Suyuti noted, '*darurah*' refers to 'a situation in which one reaches a limit where if one does not take a prohibited thing, one will perish or be about to perish'.[273] In relation to the '*darurah*' principle, supporters also invoke the Islamic legal maxim of '*al-∂arar al-ashadd yuzalu bi'l-∂arar al-akhaff*' (a greater harm is eliminated by tolerating a lesser harm) [274].[275] In the light of this principle, any action, even one with associated harm, is morally justifiable if it is to avoid a relatively greater harm. Both dictums are connected to the main underlying maxim of '*la ∂arara wa la ∂irar*' (let there be no infliction of harm nor its reciprocation) proposing that harms need not be inflicted on oneself or others.

Generally, the perils in terms of HIV infection and drug dependence determine the necessity for harm reduction programmes. However, to be justifiable under '*darurah*', these programmes need to comply with its requisites. The preconditions include that what is legalised owing to necessities will be permissible to the extent that is sufficient to secure the necessities that exist, as says the maxim '*al-darurah tuqaddar biqadriha*'

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*Ethics*, ed. P.N.J. Kassim and A.H.M. Abdullah (Selangor, Malaysia: Medical Law and Ethics Unit, Law Centre, Ahmad Ibrahim Kuliyyah of Laws, International Islamic University Malaysia, 2003).223.

[272] Y.H. Mohd Safian, "Necessity (Darura) in Islamic Law: A study with Special Reference to the Harm Reduction Programme in Malaysia" (Ph.D Thesis, University of Exeter, 2010).229, 237–39.

[273] A.R. Al-Suyuti, *Al-Ashbah wa al-Nazair [Similarities and Comparison]*, vol. 1 (Beirut: Dar al-Kutub al-Ilmiyyah, 1990).83.

[274] Provision of methadone and injection instruments is considered 'evil', though it is approved as a lesser harm associated with drug use to prevent a greater harm in terms of HIV spread.

[275] S.M. Salleh, "Harm Reduction Way to Tackle AIDS," *The Star Online*(2005), http://www.thestar.com.my/Story.aspx?file=%2F2005%2F1%2F12%2Ffocus%2F9746943&sec=focus. (Last visited: 08/11/2013)

(necessity is estimated by its extent thereof). Thus, when necessity disappears, the permissibility will cease, too.[276]

MMT might thus fall squarely within '*darurah*' preconditions. It is implemented along with certain safeguards and limitations to avert HIV transmission and drug dependence, which are inimical to life. However, to fully adhere to '*darurah*' requirements, MMT has to be ended when the life threat or real necessities vanish. As noted by Ibn Hajar, critical drug dependence detrimental to life is a necessity that justifies the use of drugs and that lasts until the abolition of the harms.[277] Arguably, the '*hajiyyat*' principle would provide a sufficient and powerful Islamic ethical basis for MMT, without demanding recourse to '*darurah*'. Consequently, the programme is not required to comply with stricter requisites under '*darurah*'. Within '*hajiyyat*', it would also enjoy prolonged permissibility as long as the individual needed to be dispensed with methadone for treating drug dependence certified by medical professionals.

However, the dictums of '*darurah*' and '*al-∂arar al-ashadd yuzalu bi'l-∂arar al-akhaff*'' might be relatively more applicable to NSEP. Many drug users have difficulty quitting or are reluctant to quit their habit. Despite enabling drug injecting, provision of syringes is essential to avoid broader harms including HIV infection detrimental to the life of individuals and society. But, based on the '*darurah*' concept, NSEP must be restricted. It should be offered only to critical IDUs who are unlikely to respond to more therapeutic methods. Moreover, it should be persistently controlled by the authorities including with regards to quantity and duration for syringe provision.

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[276] Al-Suyuti, *Al-Ashbah wa al-Nazair [Similarities and Comparison]*, 1.84.
[277] I.H. Al-Makki, *Al-Fatawa al-Islamiyya [Islamic Rulings]*, vol. X (Dar al-Ifta' al-Misriyya).3519–20.

Arguably, '*hajiyyat*' and '*darurah*' give stronger philosophical justifications for harm reduction strategies than other Islamic ethical principles. Several commentators invoke '*maqasid al-Shariah*' (the objectives of '*Shariah*') to validate the interventions. The programmes are regarded as part of '*dharuriyat*' (essentialities); all the things necessary to preserve – religion, life, intellect, progeny and property of mankind – which are endangered by drug use and HIV/AIDS epidemics.[278] The significance of this argument is mitigated by the fact that applying '*maqasid al-Shariah*' as a direct basis for the ruling is inaccurate as seen through the lens of Islamic law. In fact, '*maqasid al-Shariah*' signifies the core objectives or goals of Islamic law towards the '*masalih*' (benefits) of the public. An understanding of '*maqasid al-Shariah*' is important for legal reasoning.[279] It is applied for '*tahqiq manath*' (verification of '*nas*' (Islamic textual references; *Quran* and *Sunnah*)) in the process of issuing ruling. If there is no specific '*nas*' concerning an emerging new issue including with respect to the harm reduction approach or drug treatment, the issue needs to be resolved by '*ijtihad*', or legal reasoning. The legal reasoning should derive its ruling from general or indirect '*nas*' by employing the methods embodied in Islamic jurisprudence. '*Maqasid al-Shariah*' assists the Islamic jurists in using the appropriate method for a particular issue. It becomes a tool for guiding the understanding of the meaning and objectives of '*nas*' and applying it to the new issues, rather than a direct source for producing judgment or legal reasoning. It is also vital to ensure that Islamic jurists give prominent consideration to the effects of their

[278] For example, A. Kamarulzaman and S.M. Saifuddeen, "Islam and Harm Reduction," *International Journal of Drug Policy* 21, no. 2 (2010).116.

[279] I.M. Al-Syatibi, *Al-Muwafaqat fi Usul al-Syariah [The Confirmity to the Principles of Islamic Law]*, vol. 2 (Cairo: Dar Ibnu A'ffan, 1997).17.

deduced ruling. Thus, the proponents' justification for a harm reduction policy directly based on '*maqasid Shariah*' is invalid.

In a nutshell, the ideological resistance to harm reduction strategies based on the argument that they are contradictory to Islamic teachings has no ground. Harm reduction programmes are in line with Islamic values. MMT is warranted under the '*hajiyyat*' principle, while NSEP is permissible on the basis of '*darurah*' and '*al-∂arar al-ashadd yuzalu bi'l-∂arar al-akhaff*''. This provides more foundational support for harm reduction operations in Islamic nations. However, to ensure constant legality under the Islamic dimension, appropriate controls over and limits to the interventions should be pursued in accordance with the preconditions of the '*hajiyyat*' and '*darurah*' rules.

## 2.5 Compatibility with the Abstinence-Oriented Paradigm within Drug Prohibition Policy

An old but unresolved challenge to the harm reduction approach exists internationally and domestically on the premise of its contradiction to abstinence-based policies and practices. It is essential to address this issue given that the abstinence paradigm is still dominant in the majority of prohibitionist countries including Malaysia and hence it might affect the acceptability and feasibility of harm reduction interventions therein. Accordingly, this section explores this significant issue.

The standard claim spouted by prohibition enthusiasts is that the harm reduction approach deviates from the prohibition regime, considering its ostensibly different philosophy and practices for drug control.[280] Khalib illustrates the depth of ideological defiance of prohibition within Malaysia's context:

> There is an urgent need to answer the question: 'How does harm reduction, especially in the context of providing free needles, fall into place with Malaysia's more than 30 years of aggressive fight against drug abuse?' […I]t is unacceptable to assume that Malaysians should and can switch their perception to a tolerance of drug use practically overnight.[281]

The opponents' main argument seems to focus on the harm reduction approach's separate paradigm which is regarded inharmonious and detrimental to abstinence. In fact, the abstinence paradigm generally exists in the criminal justice and public health systems. Most substance abuse interventions including drug treatment in numerous jurisdictions including Malaysia incorporate abstinence as a goal. Perhaps, one could argue that emphasising abstinence is much more associated with criminal justice goals as it aims to prevent illegal behaviour alongside benefits to health, and plays a direct role in practising states' duties with regard to drug prohibition as embedded in the international drug control treaties. Bean states that abstinence 'has the obvious virtue of making treatment compatible with the goals of criminal justice'.[282] However, in some states, the criminal justice regime turns out to be tolerant of the aims of abstinence. For example, despite

[280] J. Rehm et al., "Perspectives on Harm Reduction-What Experts Have to Say," in *Harm Reduction: Evidence, Impacts and Challenges*, ed. T. Rhodes and D. Hedrich (Luxembourg: European Monitoring Centre for Drugs and Drug Addiction, 2010).79.
[281] A. Mohd Khalib, "Listen to Experts on New AIDS Initiative," Bernama, http://blis2.bernama.com.eserv.uum.edu.my/mainHomeBypass.do. (Last visited: 06/11/2013)
[282] P. Bean, *Drugs and Crime* (Cullompton: Willan Publishing, 2002).72.

emphasis on total separation from illegal drugs in prison settings, European probation systems including the UK's, which are concerned with individual rehabilitation, have turned their focus away from the total abstinence ideal. Drug taking while on probation is usually countenanced provided that no other criminal behaviour is done.[283] Even though harm reduction initiatives have not been established to do away with abstinence-oriented strategies within either the criminal justice regime or the public health regime, the speculative inconsistency between both appears to be owing to the initiatives' disparity in shifting the focus away from getting people off drugs to decreasing their harms. Criticisms of harm reduction for its deviation from the abstinence ideal somehow mirror the stringent 'zero tolerance' perspective on illegal drug use. This also presumably explains the most vehement allegation that the approach constitutes a platform towards drug legalisation.[284] Contained in this is that harm reduction is a part of liberal idealism that departs from prohibition.

Recent times have seen further criticisms of harm reduction measures by 'new abstentionists', particularly in the UK and Australia. Ashton mentions: 'Around Bonfire Night 2007 a rocket shook the peak of England's drug treatment structure-someone asked how many patients ended up drug-free. Clothless as the fabled emperor, 3% was the answer […] The new abstentionists were on the march and the statistics seemed to be with them'.[285] Some consider harm reduction as a paradigm to be in conflict with abstinence recovery, considering its inefficacy in producing individuals who are clean

[283] A. Stevens, H. Stöver, and C. Brentari, "Criminal Justice Approaches to Harm Reduction in Europe," in *Harm Reduction: Evidence, Impacts and Challenges. Monographs 10*, ed. T. Rhodes and D. Hedrich (Luxembourg: European Monitoring Centre for Drugs and Drug Addiction, 2010).380–81.
[284] For example, R.L. DuPont and E.A. Voth, "Drug Legalization, Harm Reduction and Drug Policy," *Annals of Internal Medicine* 123, no. 6 (1995).463.
[285] M. Ashton, "The New Abstentionists," *Druglink* 18, no. 43 (2007).1.

from drugs. The claim frequently relies on the statistical data demonstrating the low abstinence achievement among MMT clients. The 3 per cent attainment of abstinence in England, as disclosed by the chief executive officer of the National Treatment Agency, has triggered the abstentionists to demand the prominent reorientation of abstinence.[286] They correctly questioned about the 97 per cent failing to quit drug dependency. Several UK studies also found a small percentage of MMT patients in Scotland and Ireland (8 per cent and 19 per cent, respectively) totally separating themselves from drugs after approximately three years of treatment.[287] While the 'new abstentionists' inherit the 'traditional abstinentionists' deep concerns for abstinence as an ultimate result of drug interventions, the former has begun to bring empirical support, rather than merely based their concerns on ideology as the latter do. The failure of harm reduction interventions to ensure absolute abstinence from illegal drugs is rendered as an indication that they only control through medium- and long-term maintenance on substitute drugs rather than truly treating or stopping the drug consumption. This means that the initiatives seemingly do not contribute to demand reduction, which is key to the elimination or reduction of substance use prevalence underlined in the prohibitionist eventual aim.

In response to the objections, numerous harm reductionists are adamant in their traditional views privileging harm reduction solutions at the expense of abstentionist techniques. As argued, the abstinence-based goal is unrealistic because it ignores the reality of drug using as part of the world. Embedded in this claim is the perspective that attaining the abstinence is highly difficult if not impossible owing to the inevitability of drug taking. Thus, appropriate methods for addressing drug-related harms must be

[286] Ibid.2.
[287] N. McKeganey, *Controversies in Drugs Policy and Practice* (New York: Palgrave MacMillan, 2011).56–57.

emphasised. Moreover, the strict emphasis on abstinence restricts the admission and retention of certain drug users, including those who use drugs recreationally,[288] those who resist to immediately abstain from drugs at initial stage of treatment, those who have the history of failure of abstinence in previous treatment programmes, those who pursue taking drugs while in the abstinence-oriented treatment,[289] and those take drugs for self-medicating or relieving pain and suffering.[290] In other words, abstinence-based approaches would not benefit all drug users because they can not cater to this population's varied classifications and problems. Accordingly, in the face of pragmatism, harm reduction is promoted as a rational response because it accepts the incapability and disinclination of many to be free from drugs and risk of relapse and works towards the more achievable goal of decreasing the adverse consequences of continued drug use.[291] This claim likely engages the understanding that mitigating drug-related harms is more necessary than reducing drug using. The argument is weak in terms of rebutting the ideological protests against harm reduction, given its self-consciousness about the significance of the approach while overlooking the worth of abstentionist strategies. Perhaps the most troublesome aspect is that the argument concentrates on a narrow question concerning the harmful effects of drug taking while avoiding other wider issues about abstinence and use prevalence reduction. The unabated drug use in the world hardly makes the case for surrendering from considering these issues.

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[288] R. Coomber et al., *Key Concepts in Drugs and Society* (London: SAGE Publications Ltd, 2013).141.
[289] N.A. Haug et al., "Relapse Prevention for Opioid Dependence," in *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*, ed. G.A. Marlatt and D.M. Donovan (New York: The Guilford Press, 2005).153–54.
[290] N. Hunt, "Recovery and Harm Reduction: Time for a Shared, Development-Oriented, Programmatic Approach?," in *Harm Reduction in Substance Use and High-Risk Behaviour* ed. R. Pates and D. Riley (West Sussex: Wiley-Blackwell, 2012).160.
[291] For example, E.A. Nadelmann, "Common Sense Drug Policy," in *The Drug Legalisation Debate*, ed. J.A. Inciardi (London: Sage Publications, 1999).159–60.

The existing arguments from both sides seem futilely to polarise the abstinence-oriented and harm reduction paradigms. Countering this, the argument presented in this thesis is that harm reduction neither necessarily stands in marked contrast to abstinence-based strategies nor relates to drug legalisation. Both paradigms basically function consistently in the direction of protecting drug users' health and well-being, but through different processes. Abstinence-oriented methods involve procedures including detoxification, withdrawal and rehabilitation for persons searching for cessation from drugs or with the ability to change rapidly, while harm reduction strategies including MMT and NSEP commonly provide immediate and feasible ways to mitigate high-risk behaviours, HIV and other pathogens transmission and other drug-related harms for those who are unready or unable to discontinue consuming drugs. Considering the functions of abstinence-oriented and harm reduction interventions, they can operate together alongside other drug supply and demand reduction techniques to effectively tackle drug use and its associated harms. It is worth thinking about integrating the harm reduction and abstinence-based paradigms since both are clearly underlined by a shared concern to secure drug users' health and well-being.

Undeniably, abstinence is a coherent goal for drug treatment and the ultimate key to the elimination or reduction of drug taking and its associated harms. Sustained abstinence leads to betterments in drug-using individuals' physical, psychological and social functioning. While arguing for the abstinence pursuit, Zelvin considers spiritual recovery from abstinence achievement to include: 'not only breaking the compulsion to use the addictive substances in spite of adverse consequences, but along with quantifiable improvements in the quality of life in such areas as work, health, and interpersonal

relations, the recovery of hope, optimism, and self-confidence'.[292] Research findings provide further evidence regarding an association between achieved abstinence and varied outcomes including greater health, social network, employment and educational participation and reduced engagement in excessive drinking, attempted suicide, self-harm and criminal behaviours including acquisitive crimes and risk of mortality.[293]

Despite the range of health, legal and social benefits in attributable to enduring abstinence from illicit drugs, it does have limitations. An emphasis on abstinence seems to be inefficient for those who are indisposed, unable or otherwise lacking in motivation to embrace it. Numerous drug users, if not most, are equivocal about abstaining at the outset of treatment. Based on research findings relating to addictive behavioural changes, Prochaska et al. suggest large variances in substance users' personal goals concerning substance use, their motivation and readiness to alter their behaviour. They contend that a huge majority of individuals do not seek abstinence at the precontemplation stage of drug treatment.[294] This could be because they believe they are being subservient to the authorities by abstaining, they perceive negative effects from abstaining such as disconnection from their varied social web, they are sceptical about the benefits of a drug-free life or they have had negative experiences in relation to drug treatment.[295] Also,

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[292] E. Zelvin and D.R. Davis, "Harm Reduction and Abstinence Based Recovery: A Dialogue," *Journal of Social Work Practice in the Addictions* 1, no. 1 (2001).126.

[293] For example, N. McKeganey et al., "Abstinence and Drug Abuse Treatment: Results from the Drug Outcome Research in Scotland Study," *Drugs: Education Prevention and Policy* 13, no. 6 (2006).541; M.l. Dennis, M.A. Foss, and C.K. Scott, "An Eight-Year Perspective on the Relationship between the Duration of Abstinence and Other Aspects of Recovery," *Evaluation Review* 31, no. 6 (2007).605; C.K. Scott et al., "Surviving Drug Addiction: The Effect of Treatment and Abstinence on Mortality," *American Journal of Public Health* 101, no. 4 (2011).742.

[294] J.O. Prochaska, C.C. Diclemente, and J.C. Norcross, "In Search of How People Change," *American Psychologist* 47, no. 9 (1992).1103, 1105.

[295] A. Tatarsky, "Harm Reduction Psychotherapy: Extending the Reach of Traditional Substance Use Treatment," *Journal of Substance Abuse Treatment* 25, no. 4 (2003).250; S.H. Kellogg, "On "Gradualism"

many drug users are incapable of committing to stopping from using drug. The existing literature suggests that majority patients in drug treatment are unable to achieve or maintain abstinence.[296] This frequently results in early dropout or discharge of drug-using clients from abstinence-based treatment. Similarly, abstinence-oriented treatment is often criticised for its high rate of relapse. Available studies revealed the low rate of sustained abstinence (around 25 per cent on average) over a year.[297] Wodak and McLeod, on the drawbacks of abstinence, say: 'Abstinence after drug dependence has been established is, however, inevitably precarious as relapse to drug use is an ever-present risk, especially if abstinence has only recently been achieved'.[298]

Therefore, the abstinence only orientation is an inappropriate treatment approach. It should be supported by other perspectives for handling drug use behaviour and reducing its associated effects and other risks including relapse. Harm reduction methods could assist in preserving the life, health and well-being of drug users, particularly those who are present unwilling or unready to quit using drugs, relapsing and out of treatment. This is not tantamount to softening or legalising drug using or disregarding the abstinence impetus. Further, abstinence is inclusive in the harm reduction paradigm given its position as the most effective pathway to preventing overall drug-related harms. Despite the objection and neutral stance of part of harm reductionists to abstinence-based ends, a

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and the Building of the Harm Reduction-Abstinence Continuum," *Journal of Substance Abuse Treatment* 25, no. 4 (2003).243; Haug et al., "Relapse Prevention for Opioid Dependence."153.

[296] L.L. Judd et al., "Effective Medical Treatment of Opiate Addiction," *Journal of the American Medical Association* 280, no. 22 (1998).1937.

[297] R.A. Roffman and R.S. Stephens, "Harm Reduction and Cannabis," in *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*, ed. G.A. Marlatt, M.E. Larimer, and K. Witkiewitz (New York: The Guildford Press, 2012).156.

[298] Wodak and McLeod, "The Role of Harm Reduction in Controlling HIV among Injecting Drug Users."S82.

number of contemporary harm reductionists consider abstinence a desirable element of the hierarchy of harm reduction aims.[299]

Abstinence-oriented and harm reduction measures could hence be included as a series of steps under an extensive consecution of protection for drug users. Harm reduction strategies could form important steps in similar consecution towards drug use reduction, well-being improvement and cessation from drug taking, particularly for those who are unable, unready or resistant to quit using drugs at the beginning phase of treatment. It is not limited to those who consume drugs addictively and may move or support all drug users throughout the spectrum of steps, shifting from a low to high motivational state to abstain and from high-risk behaviours towards managed consumption and abstinence as the optimal outcome. The consecution towards behavioural modification and reduction of use and risk levels is commonly in agreement with a continuum model as espoused by scholars including Marlatt and Tapert,[300] and Pomeroy and Steiker.[301] There are also case studies in drug-free settings including the Alberta Alcohol and Drug Abuse Commission in Alberta[302] and We Help Ourselves in

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[299] Harm Reduction International, "What is Harm Reduction? A Position Statement from Harm Reduction International " Harm Reduction International, http://www.ihra.net/what-is-harm-reduction. (Last visited: 14/04/2015)

[300] G.A. Marlatt and S.F. Tapert, "Harm Reduction: Reducing the Risks of Addictive Behaviors," in *Addictive Behaviors across the Life Span: Prevention, Treatment and Policy Issues*, ed. J.S. Baer, G.A. Marlatt, and R.J. McMahon (California: Sage Publications, Inc., 1993).250.

[301] E.C. Pomeroy and L.H. Steiker, "Prevention and Intervention on the Care Continuum " *Social Work* 57, no. 2 (2012).103, 105.

[302] D. James, "Harm Reduction: Policy Background Paper. Prepared for the AADAC Board ", no. 2012, 6 February (2007), http://www.albertahealthservices.ca/Researchers/if-res-policy-harm-reduction-background.pdf.2–20. (Last visited: 07/02/2012)

Australia[303] showing the practicality of combined harm reduction initiatives and abstinence-based treatments for managing drug dependence.

This integration may provide spaces for both approaches to cooperate, apply their strengths and minimise their weaknesses, thereby creating a viable drug use, dependency and relapse management system. It would also enhance the availability and accessibility of multifaceted services for drug-taking behavioural change, prevention, treatment and harm mitigation. Harm reduction measures' welcoming ambience might increase drug users' participation and length of stay in drug programmes and improve their therapeutic alliance with services staff.[304] Most importantly, the dichotomies between abstinence and harm reduction paradigms could be transcended, with the protection of drug users' health and welfare and their cessation of drug consumption potentially to be realised through this framework.

Arguably, the integrated harm reduction and abstinence paradigms on the consecution basis could be situated within both criminal justice and public health systems, not either one of them alone. This is basically owing to the position of drug use as not only a public health issue but also a criminal justice issue, with the shared concerns of both approaches to health impacts from drug using, as stated previously. However, it is pertinent to note that conflicts might arise, particularly when the criminal justice platforms remain inconsistent with public health strategies including the harm reduction approach. Nonetheless, this thesis suggests that the tensions between criminal justice and

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[303] World Health Organization (Western Pacific Region), *Integration of Harm Reduction into Abstinence-Based Therapeutic Communities : A Case Study of We Help Ourselves, Australia* (Geneva: World Health Organization, 2006).4–23.

[304] R. Futterman, M. Lorente, and S. Silverman, "Integrating Harm Reduction and Abstinence-Based Substance Abuse Treatment in the Public Sector," *Substance Abuse* 25, no. 1 (2004).5–7.

public health responses are addressable where both are given paramount focus, clear spheres, and reconciled accordingly. These will be further discussed in Chapters 4 and 5.

Summarily, the harm reduction paradigm is congruent to abstinence orientation adopted in drug prohibition policy. Despite dissimilar focuses, neither is totally exclusive or competing. They have common concerns about protecting the health and well-being of drug users, and thus could be united within a consecution of protection framework. Such integration would reinforce both capabilities to contribute benefits to individual drug users and wider communities. The notion of consonance and incorporative prospect between the harm reduction and abstinence perspectives would positively impact the acceptance of and support for harm reduction interventions in prohibitionist settings. Prohibition-oriented nations should not then sacrifice the approach in favour of abstinence. Specific discussion regarding whether the abstinence-oriented goal should be a fundamental end target or a recommendable but unnecessary aim within the drug treatment context is discussed in Chapter 5, Section 5.4.

## 2.6 Consistency with the International Drug Control Conventions

Intense debate pertaining to the legal implication of harm reduction approach vis-à-vis the international drug control treaties sparks at the international level. Yet, there has been relatively little discussion on the issue in Malaysian literature. However, it considerably impacts Malaysia and other states that have ratified and implemented drug policies modelled on the international instruments. The answer to the issue is unlikely to be found

directly in the 1961 Convention as amended by the 1972 Protocol, the 1971 Convention and the 1988 Convention. The possible reason for the loophole of specific guidance therein is that the harm reduction concept to primarily confront HIV/AIDS threats was unforeseeable at the time when the convention texts were drafted. Engagement with the issue is crucial in making a legal case for the approach. In light of this, this section would examine the issue with particular reference to MMT and NSEP.

Indeed, the harm reduction approach brings a new paradigm of dealing with the drug problem that is significantly different from punitive methods enshrined in prohibition-based treaties. This seemingly causes many critics and prohibitionist national governments to see the approach as contravening the conventions. An example can be found in a statement in the Declaration of the World Forum Against Drugs in 2008: ''Harm reduction' is too often another word for drug legalisation or other inappropriate relaxation efforts, a policy approach that violates the UN Conventions'.[305] The criticism forwarded frequently relies on the interventions' discrepancy from the law enforcement-oriented framework underlined by the drug conventions. Consequently, the treaties arise as leading hurdles to state responses to mitigate the adverse consequences of drug use. The argument manifests the opponents' application of strict convention interpretation, and constitutes another comfortable ground for the opponents' disagreement upon the paradigm.

In response, it is unquestioned that drug treaties sought to codify criminalisation and penal sanctions upon acts associated with illicit drugs. The conventions impose elemental obligation on parties to proscribe the acts including production, cultivation,

[305] World Forum against Drugs, "Declaration of World Forum Against Drugs Stockholm Sweden, 2008" (paper presented at the World Forum against Drugs, Stockholm, 8-10 September 2008).para.3.

manufacture, export, import, distribution, trading and possession of illegal substances except for medical and scientific reasons.[306] The signatories are also urged by the 1988 Convention particularly to criminalise possession of controlled substances for personal consumption.[307] However, there is no any provision in the treaties expressly blocking any approach to reduce drug-related harms. More importantly, there also exist important flexibility of interpretation and qualifications permitted under the treaties to accommodate harm reduction programmes. Many scholars are of identical attitude regarding these latitudes. Elliot et al., for instance, correctly submit that the initiatives may invoke 'exceptions, caveats or particular interpretations of drug treaties'.[308] In similar vein, Bewley-Taylor and Krajewski suggest that there is interpretative leeway for states in adhering to their obligations under the conventions based on several factors such as domestically interpreting space, particular clauses and vagueness of wording plagued to the drug conventions.[309]

The main spaces for considerable interpretation of drug treaties to permit harm reduction strategies are outlined here. First, the 1961 and 1971 Conventions permit the production, distribution or possession of controlled substances exclusively 'for medical and scientific purposes'.[310] The phrase 'for medical and scientific purposes' is left undefined and hence provides states with discretion in its interpretation and application.

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[306] The 1961 Convention, Article 4, 33, 35 and 36; the 1971 Convention, Articles 21 and 22; the 1988 Convention, Article 3.
[307] The 1988 Convention, Article 3(2).
[308] R. Elliott and T. Kerr, "Harm Reduction, HIV/AIDS and the Human Rights Challenge to Global Drug Control Policy," *Health and Human Rights* 8, no. 2 (2005).114.
[309] D. Bewley-Taylor and M. Jelsma, "The UN Drug Control Conventions: The Limits of Latitude," Transnational Institute (TNI) & International Drug Policy Consortium (IDPC), http://www.undrugcontrol.info/images/stories/documents/dlr18.pdf.47–48 (Last visited: 20/12/2012); K. Krajewski, "How Flexible are the United Nations Drug Conventions?," *International Journal of Drug Policy* 10, no. 4 (1999).330–31.
[310] The 1961 Convention, Article 4(c); the 1971 Convention, Articles 5 and 7.

Thus, the phrase could be inclusively construed to allow the provision of methadone for reducing opiate using and its risks.

Second, it can be understood from the conventions that parties enjoy freedom to determine the practicable measures for prevention of use of illicit drugs, treatment, education, aftercare, rehabilitation and social integration they are warranted to take.[311] This is because the treaties do not particularise what constitutes the measures. Harm reduction strategies are feasibly encompassed under the practicable measures facet. NSEP is to decrease risky behaviours among IDUs and to limit HIV/AIDS and other blood-borne pathogens transmission; hence is permissible under the conventions. Despite the advice of Resolution II of the UN Conference for the Adoption of the 1961 Single Convention for drug-free treatment, it does not forbid states to implement other types of treatment or 'practicable measures' as provided in the conventions. Further, while drug-free treatment is considered as the often quoted and used treatment for drug dependency, the Commentary to the 1988 Convention also expressly recognises pharmacological treatments including MMT.[312] MMT is also included under treatment in other treaty commentaries.[313]

Third, it seems evident that all treaties leave countries with the autonomy to provide the abovementioned practicable measures for drug use to substitute or supplement the criminal sanctions for offences of a minor nature committed by drug

[311] The 1961 Convention, Article 38; the 1971 Convention, Article 20.

[312] United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988, Done at Vienna on 20 December 1988*, E/CN.7/590 (New York: United Nations, 1998).109.

[313] *Commentary on the Convention on Psychotropic Substances, Done at Vienna on 21 February 1971*, E/CN.7/589 (New York: United Nations, 1976).332; *Commentary on the Protocol Amending the Single Convention on Narcotic Drugs, 1961, Done at Geneva on 25 March 1972*, E/CN.7/588 (New York: United Nations, 1976).84.

users.[314] Consequently, even personal consumption and drug possession for use are criminalised, MMT and NSEP that operate to ensure health, care and support for drug users can be legally implemented either as addition or alternative to punishments for the offences.

Fourth, signatories are granted leeway in medically prescribing controlled drugs if they consider that the prescription is necessary or desirable and not contradictory to the general purposes of the convention. However, some regulations including with regard to medical prescriptions, record keeping and other controlling methods should be complied with.[315] States are therefore exempted from prohibition of supply and distribution of any controlled drugs including methadone listed in Schedule 1 when it is deemed necessary or desirable along with specified safeguards in their national law.

Fifth, the parties' duty for criminalising drug possession for personal consumption under the 1988 Convention connects to the prohibition of drug consumption in both prior conventions.[316] Arguably, the successor convention has no backward effect of criminalising drug consumption as some believe.[317] As much literature and this analysis find, states still sustain their discretion to make drug use a criminal offence in accordance with the 1961 and the 1971 Conventions.[318] Arguably, this is significant to avoid the criminal justice approach for minor drug offences to be inappropriately employed under national laws. Therefore, adopting techniques including MMT and NSEP alternative to

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[314] The 1961 Convention, Article 36(1)(b); the 1971 Convention, Article 22(1)(b); the 1988 Convention, Article 3(4)(b).
[315] The 1961 Convention, Article 30.
[316] The 1988 Convention, Article 3(2).
[317] D.R. Bewley-Taylor and C.S. Fazey, "The Mechanics and Dynamics of the UN System for International Drug Control," www.forward-thinking-on-drugs.org/reviewl-print.html.15.
[318] For example, Elliott and Kerr, "Harm Reduction, HIV/AIDS and the Human Rights Challenge to Global Drug Control Policy."114.

criminal measures falls within the treaties' flexibility. This elasticity is further supported by the understanding of the 1988 Convention provision that the criminalisation of personal consumption is not required if it breaches the state constitution and fundamental legal principles.[319]

Clearly, drug conventions contain leeway that concedes sufficient legal room for harm reduction strategies. The international documents could be construed so as to authorise engagement with the measures. MMT and NSEP practices are hence legitimate within the convention framework parameters.

This thesis's point regarding consistency is generally in line with that of the Legal Affairs Section (LAS) of the then UN International Drug Control Programme (UNDCP). In its 2002 legal opinion commissioned by the International Narcotics Control Board (INCB), it makes clear the view that almost all harm reduction interventions including MMT and NSEP are congruous with the terms of the drug treaties.[320] In contrast to the conclusive remark on legality under treaties which this thesis makes, the legal opinion subject it to the specific qualities and implications of each harm reduction measure at the national level.[321] Implicit in this is the conditionality of the strategies' permissibility within the conventions upon domestic operations. Such partial legitimacy is less compelling as it might not absolutely support the approaches and might make individual domestic service require a separate legal case.

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[319] The 1988 Convention, Article 3(2).

[320] Legal Affairs Section, United Nations Drug Control Programme, *Flexibility of Treaty Provisions as regards Harm Reduction Approaches*, E/INCB/2002/W.13/SS.5 (Vienna: United Nations International Narcotics Control Board, 2002).4–6.

[321] Ibid.6.

Furthermore, it is significant to acknowledge that there are international declarations and resolutions seemingly providing milestones for harm reduction practices. The Declaration on the Guiding Principles of Drug Demand Reduction of the UN General Assembly Special Session in 1998 states: 'Demand reduction shall (i) Aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse'.[322] A similar kind of commitment is subsequently documented in the Action Plan supplementing the Declaration,[323] the other UN General Assembly (GA) and the Commission on Narcotic Drugs (CND) resolutions.[324] While the political declarations and resolutions likely denote collective undertaking towards the harm reduction paradigm at the international level, this thesis posits that they could not concretely underlie legal mandate for the measures, as contended by some including the Legal Affairs Section (LAS) regarding the 1998 Declaration.[325]

There are several factors that apply here. In particular, the majority of declarations and resolutions do not employ the term 'harm reduction'. Coverage of the approach under the terms used is hence exposed to varied perspectives. Additionally, they are non-binding soft laws. Thus, they could not become the main basis, constituting only supplementary support for the legally binding treaties that justify harm reduction. Finally, they may not be deemed representative of the whole voice of the international community on harm reduction, given the constantly unfixed and splintered consensus under the UN

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[322] United Nations Special Session of the General Assembly Devoted to Countering the World Drug Problem Together 8-10 June 1988, *Political Declaration: Guiding Principles of Demand Reduction and Measures to Enhance International Cooperation to Counter the World Drug Problem* (Vienna: United Nations, 1999).9.

[323] United Nations General Assembly, *Resolution 55/65: International Cooperation Against the World Drug Problem*, A/RES/55/65 (New York: United Nations, 2000).10.

[324] For example, Commission on Narcotic Drugs, *Resolution 46/2: Strengthening Strategies regarding the Prevention of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome in the Context of Drug Abuse*, Res.46/2 (Vienna: United Nations, 2002).1-2.

[325] Legal Affairs Section, *Flexibility of Treaty Provisions as regards Harm Reduction Approaches*.3.

system. As evidence, the explicit term 'harm reduction' is still confounded in the Commission on Narcotic Drugs (CND) resolutions, and political strife occurs over the strategies within the new 2009 Declaration and Action Plan.[326] The USA, some other prohibitionist states and UN bodies also move on the track of sluggish support for the approach. Particularly, the International Narcotics Control Board (INCB);[327] the strong bulwark of prohibition-based UN regime, has never publicly endorsed the measures and the legal analysis of the Legal Affairs Section (LAS). Though agreeing on the approach's consistency with the conventions in its 2003 annual report,[328] the International Narcotics Control Board (INCB) also still casts doubt on the interventions through its precarious interpretation of conventions, unsubstantiated alarm about their negative potential and calls for its strict operation.[329]

Considering the ongoing tension, it is reasonable to expect that there are more practicable ways to enable harm reduction interventions than merely basing them on interpretative leeway within drug treaties. Elliot and colleagues encourage signatories to form a coalition to jointly announce their interpretation of the approach's legality and their partially opting out of the UN regime. These, as commentators believe, are more feasible alternatives than making amendments to drug conventions or building a new treaty on harm reduction that is politically arduous, costly and time-consuming.[330] While this thesis accepts the possibility of state withdrawal from treaties, either single or

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[326] Bewley-Taylor and Jelsma, "The UN Drug Control Conventions: The Limits of Latitude".11.

[327] The International Narcotics Control Board (INCB) is the independent, quasi-judicial monitoring body for the implementation of international drug control conventions.

[328] International Narcotics Control Board, *Report of the International Narcotics Control Board for 2003*, E/INCB/2003/1 (Vienna: International Narcotics Control Board, United Nations, 2003).3.

[329] For example, *Report of the International Narcotics Control Board for 2005* E/INCB/2005/1 (New York: United Nations, 2006).para.75. (The International Narcotics Control Board (INCB), for instance, calls states to restrict the accessibility to MMT for preventing methadone diversion).

[330] Elliott and Kerr, "Harm Reduction, HIV/AIDS and the Human Rights Challenge to Global Drug Control Policy."126.

collective, based on the *rebus sic stantibus* principle relative to the drug problem metamorphose, this thesis could not agree more on its viability. States' exercise of doctrine has shortcomings, given its potential impact upon treaties' validity.[331] It may cause the conventions to lose their binding effect upon the signatories. This could eventually undermine the convention regime's solidity. Therefore, revision and amendment of the conventions, despite the potential challenges, seems more legitimate and beneficial for ensuring the clarity and sustainability of harm reduction under the treaties. Moreover, the measures deserve clearer and stronger basis under the treaties, than merely to act, borrowing the words of Bewley-Taylor '…through glitches in the software' in the treaties which hardwire the zero-tolerance[332].[333] The suggestion is parallel to the proposals of many that drug treaties should be revised in order to resolve tensions about their terms of unclear meanings and outdated provisions.[334]

In short, the discussion in this section puts forward a legal argument for harm reduction operations within the confines of drug conventions. It is evident that the international documents do not wholly resist MMT and NSEP programmes but instead allow their implementation at state levels, including within Malaysia. This thesis advocates the amendment of treaties to explicitly sanction the measures given the fractured international and domestic political consensus regarding how the interventions

[331] D.R. Bewley-Taylor, "Challenging the UN Drug Control Conventions: Problems and Possibilities," *International Journal of Drug Policy* 14, no. 2 (2003).177.
[332] The international drug treaties need to be amended to explicitly legalise harm reduction interventions. This will give a stronger legal basis for the services, rather than make them dependable on the interpretations of terms. Notably, the drug treaties have the direct or explicit words sanctioning the zero-tolerance policy but not for the harm reduction approach.
[333] Bewley-Taylor and Jelsma, "The UN Drug Control Conventions: The Limits of Latitude".50.
[334] For example, K. Malinowska-Sempruch, J. Hoover, and A. Alexandrova, *Unintended Consequences: Drug Policies Fuel the HIV Epidemic in Russia and Ukraine. A Policy Report Prepared for the UN Commission on Narcotic Drugs and National Governments* (New York: Open Society Institute, 2003).15.

are compatible with the conventions. By embedding this explicit legalising provision, there can be a stronger foundation for harm reduction strategies under international law.

## 2.7 Conclusion

The oppositions to the harm reduction approach, influenced by a deontological stance or strict prohibitionist ideological belief, are weakened by the approach's ethical and theoretical imperatives as explained in this chapter. The harm reduction response is ethically justifiable mainly on the basis of public health, satisfying the components of the prevention of diseases and health risks under the traditional public health framework and the health promotion under the new public health framework. It also complies with the utilitarian analysis for its efficacy in attaining good for both individuals and entire communities. These theoretical bases are further reinforced and counterbalanced by the approach's importance for the protection of human rights of health and freedom from inhumane and degrading treatment. Moreover, MMT and NSEP are permissible within the Islamic values, respectively falling under '*hajiyyat*' principle and the notions of '*darurah*' and '*al-∂arar al-ashadd yuzalu bi'l-∂arar al-akhaff*'. Additionally, the validation of harm reduction is extended by its congeniality with abstinence-oriented paradigm within drug prohibition policy due to the shared concern for the protection of drug users' health and wellbeing. Further, the harm reduction approach is in harmony with the international drug control conventions.

Together, these positions entail strong philosophical justification of the harm reduction approach and measures in Malaysia and across the globe. The justifiability can be further strengthened in several ways including making the ethical and theoretical foundations for harm reduction clear in drug discourse; integrating the approach with abstinence-oriented paradigm within a consecution of protection under a broader drug prohibition framework; and amending the international drug treaties to explicitly endorse it.

However, the scientific-based lens of harm reduction approach should not be discounted as they have the potential not only to cripple consequentialist-based attacks against it but also to supplement theoretical justifications in providing powerful credentials for the approach. The next chapter is devoted to this subject.

# CHAPTER 3

# THE EFFECTIVENESS AND COST-EFFECTIVENESS OF HARM REDUCTION APPROACH FOR DRUG USE AND BLOOD-BORNE VIRUSES-RELATED OUTCOMES

## 3.1 Introduction

The harm reduction approach is adopted in Malaysia to control drug use and HIV transmission. Controversy has erupted on the main issue of whether harm reduction strategies are effective and cost-effective in achieving the outcomes. This chapter seeks to determine the effectiveness and cost-effectiveness of MMT and NSEP with regards to drug use and HIV-related implications, and their scientific evidence from Malaysia and international sources. Consideration is also given to efficacy and economic efficiency in relation to HCV disease control, given its prevalence among drug users. Focus will be given to the most common effects relevant to harm reduction approach effectiveness; namely, reduction of HIV and HCV virus transmission, decrease of drug use, cost-efficacy for drug consumption, HIV and HCV prevention, absence of symbolism for drug use encouragement, and absence of negative consequences diminishing the public amenity. The discussion in this chapter is important to provide further justification for harm reduction measures in Malaysia.

## 3.2 Effectiveness in Reducing HIV and HCV Transmission

As highlighted in the previous chapters, the primary rationale underpinning the adoption of harm reduction measures in Malaysia is to contain HIV transmission among drug users. The issue that arises is whether MMT and NSEP are actually efficacious in decreasing HIV infection and prevalence. Accordingly, this section attempts to address this issue along with related evidence. Consideration is also given to the issue of whether the interventions could effectively contribute towards halting other blood-borne viruses. The available literature deals more with the measures' effectiveness with regards to the HCV virus and is therefore focused upon in this discussion.

Notably, MMT and NSEP are considered important strategies when seeking to restrain HIV spread through syringe use, by providing substitute drugs and adequate sterile syringes to drug users. The underlying prediction is that, as a consequence, drug users will no longer take part in syringe-related HIV risk behaviours including sharing, lending, borrowing and reusing of syringes and needles, thereby avoiding HIV infection.

An impressive volume of studies from many jurisdictions, including Malaysia, contain evidence regarding the actual efficacy of MMT and NSEP for risk behaviours. There is research available that has discovered the relationship between MMT attendance and reduced HIV vulnerability.[335] Findings are also documented by a meta-analysis of

[335] For example, K. Wong et al., "Adherence to Methadone is Associated with a Lower Level of HIV-Related Risk Behaviors in Dug Users," *Journal of Substance Abuse Treatment* 24, no. 3 (2003).235; J.S. Gill, A.H. Sulaiman, and M.H. Habil, "The First Methadone Programme in Malaysia: Overcoming Obstacles and Achieving the Impossible," *ASEAN Journal of Psychiatry* 8, no. 2 (2007).69; L. Zhao et al., "HIV Infection as a Predictor of Methadone Maintenance Outcomes in Chinese Injection Drug Users," *AIDS Care* 24, no. 2 (2012).198.

multiple studies in Asia, Europe and North America.[336] Although it is remarkable that vast studies from various jurisdictions reveal similar findings on the beneficial impact of MMT on risk behaviours, opponents still invoke negative or neutral research results to propose a contradictory outcome. A study in a Malaysian hospital found that most of the subjects continued with HIV risk behaviours despite their MMT use.[337] A study by Van Ameijden et al. in Amsterdam found negative or no benefit of 'low threshold' MMT in mitigating risk behaviours.[338] Some research has reported no difference between attendees, post-attendees and non-attendees of MMT programmes in needle-borrowing and lending.[339] Arguably, these negative or mixed findings are limited exceptional cases that are insufficient to exclude conclusive evidence on MMT efficacy from larger positive empirical data sources.

Further, the outcome of risk behaviour reduction is achievable via NSEP use. Theoretically, NSEP may affect diminution in patterns and time of syringe circulation. This is accomplished by adding more new syringes per IDU over a particular time period and increasing the volume of syringes evacuated from circulation through exchanging practice. Thus, the time for risk behaviours, including contaminated syringe sharing and reusing and the presence of used injection items in public settings, are possibly lessened, thereby decreasing HIV spread. The theoretical causality is confirmed by practical data in Malaysia and other countries regarding NSEP effectiveness. Numerous studies

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[336] G.J. Macarthur et al., "Opiate Substitution Treatment and HIV Transmission in People who Inject Drugs: Systematic Review and Meta-Analysis," *British Medical Journal* 345(2012).5945.
[337] M. Ramli et al., "High-Risk Behaviours and Concomitant Medical Illnesses among Patients at Methadone Maintenance Therapy Clinic, Hospital Tengku Ampuan Afzan, Malaysia," *Malaysian Family Physician* 4, no. 2-3 (2009).82–83.
[338] E.J.C. Van Ameijden, A.A.R. Van Den Hoek, and R.A. Coutinho, "Injecting Risk Behavior among Drug Users in Amsterdam, 1986 to 1992, and Its Relationship to AIDS Prevention Programs," *American Journal of Public Health* 84, no. 2 (1994).279–80.
[339] A. Baker et al., "HIV Risk-Taking Behaviour among Injecting Drug Users Currently, Previously and Never Enrolled in Methadone Treatment," *Addiction* 90, no. 4 (1995).551.

demonstrate the decrease of self-reported risky behaviours among NSEP clients.[340] The WHO comprehensive assessment discovers 'detectable impact (of Malaysian NSEP) on reducing needle and syringe sharing among PWUD (IDUs)'.[341] The WHO review of NSEP found convincing evidence for the protective effect of NSEP against drug-related risks. The review found that most (23) of the 29 studies located showed results confirming the NSEP efficacy. There was only one piece of research finding negative outcomes and five studies reporting no effect.[342] All evidence strongly shows the NSEP's outcome to lower HIV risk behaviours.

Despite evidence of the benefits of NSEP, there is much criticism of it which arises from the negative or mixed research findings. For example, the studies by Valenciano et al. and Hope et al. reveal the association of NSEP use to high risk behaviours.[343] Some others discover no significant difference between NSEP attendance and non-attendance in the frequency of needle-sharing.[344] Within this thesis it is argued that these data sources are inconclusively used to point towards NSEP inefficacy and give less consideration to the other potential factors affecting HIV risk behaviours such as

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[340] For example, R.N. Bluthenthal et al., "The Effect of Syringe Exchange Use on High-Risk Injection Drug Users: A Cohort Study," *AIDS* 14, no. 5 (2000).609; S. Zamani et al., "Needle and Syringe Sharing Practices Among Injecting Drug Users in Tehran: A Comparison of Two Neighborhoods, One with and One without a Needle and Syringe Program," *AIDS and Behavior* 14, no. 4 (2010).888–89; T. Kerr et al., "Syringe Sharing and HIV Incidence Among Injection Drug Users and Increased Access to Sterile Syringes," *American Journal of Public Health* 100, no. 8 (2010).1451–53.

[341] World Health Organization (Western Pacific Region) and Ministry of Health Malaysia, *Good Practices in Asia: Scale-Up of Harm Reduction in Malaysia*.51.

[342] A. Wodak and A. Cooney, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users* (Geneva: World Health Organization, 2004).11.

[343] M. Valenciano, J. Emmanuelli, and F. Lert, "Unsafe Injecting Practices among Attendees of Syringe Exchange Programmes in France " *Addiction* 96, no. 4 (2001).603–08; V.D. Hope et al., "Sustained Increase in the Sharing of Needles and Syringes among Drug Users in England and Wales," *AIDS* 16, no. 18 (2002).2494–96.

[344] For example, C. Hartgers et al., "Needle Sharing and Participation in the Amsterdam Syringe Exchange Program among HIV-Seronegative Injecting Drug Users," *Public Health Reports* 107, no. 6 (1992).678–79.

homelessness and depression symptoms.[345] Braine et al. noted that the attributes of NSEP clients and environmental factors should be considered in analysing the subsisting risk behaviours.[346] Therefore, the argument for NSEP influence on increased risk behaviours is unpersuasive.

Additionally, some critics raise the methodological issue of self-reporting. They question the accuracy of self-reported data about risk behaviours.[347] As contended, self-reporting potentially results in social desirability, recall or observational bias that affects the accuracy of derived data. Accepting this argument means evidence for risk behaviours reducing efficacy have less strength as they mostly come from studies relying on self-reported data. However, the claim has less merit when considering the sufficient validity and reliability of self-reporting achieved in most research involving using drugs and risk behaviours.[348] Further, the self-reported behaviour change could be considerably verified by options including comparing HIV seropositivity rates among IDUs obtaining supplied injection items and those who do not,[349] conducting computer-assisted self interviews[350] and corroborated urinalysis.[351] Thus, the data derived from self-reporting, with or without

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[345] N. Braine et al., "Long-Term Effects of Syringe Exchange on Risk Behavior and HIV Prevention," *AIDS Education and Prevention* 16, no. 3 (2004).269–71.
[346] Ibid.273.
[347] For example, M. Safaeian et al., "Validity of Self-reported Needle Exchange Attendance among Injection Drug Users: Implications for Program Evaluation," *American Journal of Epidemiology* 155, no. 2 (2002).174.
[348] S. Darke, "Self-Report among Injecting Drug Users: A Review," *Drug and Alcohol Dependence* 51, no. 3 (1998).261–62.
[349] E.H. Kaplan, "Needle Exchange or Needless Exchange? The State of the Debate," *Infectious Agents and Disease* 1, no. 2 (1992).93.
[350] D.S. Metzger et al., "Randomized Controlled Trial of Audio Computer-assisted Self-Interviewing: Utility and Acceptability in Longitudinal Studies," *American Journal of Epidemiology* 152, no. 2 (2000).105.
[351] M.F. Sherman and G.E. Bigelow, "Validity of Patients' Self-Reported Drug Use as a Function of Treatment Status," *Drug and Alcohol Dependence* 30, no. 1 (1992).1.

verification, is valid and reliable enough to show the efficacy of harm reduction interventions for reducing HIV risk behaviours.

Drawing on evidence regarding MMT and NSEP outcomes of decreased drug-related risk behaviours, it seems plausible to claim their potential to decrease the rate of HIV seroconversion and prevalence. However, opponents argue that the modest risk behavioural change, if any, would not necessarily effectuate into actual reduced HIV infection. As a response to this, there is evidence that sufficiently demonstrates the contrary. The studies in Malaysia and other countries evaluate the impact of MMT on HIV prevention and have found a positive association between the programme admission and decreased HIV infection.[352] The results of a study in Tampin Health Clinic, Malaysia, demonstrate that none of the 143 subjects were infected with HIV during the course of the study from November 2006 to March 2009.[353] The findings are further confirmed by international research, including by Metzger et al. recording a high difference in HIV seroconversion levels between those continuing with MMT compared to those not receiving MMT.[354]

Moreover, the intervention can significantly affect HIV prevalence in many settings. Indeed, in the WHO collaborative study using longitudinal cohort design, the

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[352] For example, D.M. Novick et al., "Absence of Antibody to Human Immunodeficiency Virus in Long-term, Socially Rehabilitated Methadone Maintenance Patients," *Archives of Internal Medicine* 150, no. 1 (1990).97–98; D.S. Metzger and H. Navaline, "Human Immunodeficiency Virus Prevention and the Potential of Drug Abuse Treatment," *Clinical Infectious Diseases* 37, no. Suppl 5 (2003).S454; M.N. Mohamed and M.D. Kasa, "Research Report. Drug Substitution Therapy: Success and Limitations of the Methadone and Buphrenorphine Maintenance Programs," (Sintok, Malaysia: Universiti Utara Malaysia, 2006).54.

[353] A. Norsiah et al., "Can Primary Care Clinic Run MMT Service Well?," *Malaysian Family Physician* 5, no. 1 (2010).21.

[354] D.S. Metzger et al., "Human Immunodeficiency Virus Seroconversion among Intravenous Drug Users In- and Out-of-Treatment: An 18-Month Prospective Follow-Up," *Journal of Acquired Immune Deficiency Syndrome* 6, no. 9 (1993).1054.

data from opiate substitution treatment programmes, principally MMT, in selected developing countries (China, Indonesia, Thailand, Lithuania, Poland, Ukraine, Iran and Australia) indicates the protective effect of the substitution treatment in decreasing HIV prevalence. The rate of HIV prevalence reduced significantly in almost all the studied countries that provide the service. The report concludes that such positive implication achieved in high-resource countries could also be gained in countries with fewer resources.[355] Many systematic reviews of studies confirm this effectiveness.[356] All positive findings constitute strong data on the impact of MMT on the decrease of HIV infection and prevalence.

Despite the evidence, the opposition to MMT efficacy is based on a few study results showing less favourable outcomes of MMT on HIV seroconversion. The studies involved cocaine and heroin injectors[357] and ‘low threshold’ MMT.[358] This outcome is unsurprising considering the absence of any pharmacotherapeutic treatment for cocaine. The few negative findings should also not be interpreted as overall inefficacy of MMT in HIV prevention as it is outweighed by the amount of research with positive results. Rather, the findings can be treated as a factor to ameliorate the service’s quality and intensity. This may cover incorporating MMT with psychosocial facilities including healthcare and rehabilitation, ensuring longer retention in treatment and dispensing of a

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[355] P. Lawrinson et al., "Key Findings from the WHO Collaborative Study on Substitution Therapy for Opioid Dependence and HIV/AIDS," *Addiction* 103(2008).1485,1490–91.
[356] For example, D.R. Gibson, N.M. Flynn, and J.J. McCarthy, "Effectiveness of Methadone Treatment in Reducing HIV Risk Behavior and HIV Seroconversion among Injecting Drug Users," *AIDS* 13, no. 14 (1999).1813–14;M. Farrell et al., "Effectiveness of Drug Dependence Treatment in HIV Prevention," *International Journal of Drug Policy* 16(2005).S74.
[357] For example, R.E. Chaisson et al., "Cocaine Use and HIV Infection in Intravenous Drug Users in San Francisco," *Journal of the American Medical Association* 261, no. 4 (1989).563–65.
[358] For example, E.J.C. Van Ameijden et al., "The Harm Reduction Approach and Risk Factors for Human Immunodeficiency Virus (HIV) Seroconversion in Injecting Drug Users, Amsterdam," *American Journal of Epidemiology* 136, no. 2 (1992).241.

sufficient dosage of methadone. Such comprehensive strategies would increase MMT's benefits in halting adverse consequences including HIV infection from consumption of drugs including cocaine.[359]

Further, despite the limited findings in Malaysia, a handful of international studies using diverse research designs indicate that participation in NSEP is substantially associated with decreased HIV infection.[360] By contrast, the lack of NSEPs may have resulted in the growth of HIV incidence, as suggested by high seroconversion levels observed in Pakistan and the USA.[361] This data concerning the reversed situation supports the consistency of efficacy arguments. The accumulated evidence strongly indicates the NSEP's protective effects against HIV seroconversion.

Additionally, there are studies that provide compelling evidence on this intervention's efficacy in reducing HIV prevalence. For instance, Hurley et al. conduct a large ecological analysis of HIV rates and NSEP use, comparing 81 cities across Asia, Europe, North America, South America and the South Pacific. 52 cities without NSEP had a mean annual growth of 5.9 per cent in HIV prevalence, compared to a mean annual fall of 5.8 per cent for 29 cities with NSEPs.[362] More recently, the study of McDonald et al. involving 99 cities discloses the difference in HIV prevalence rates in cities with and without NSEPs; there was a decline of 18.6 per cent and an increase of 8.1 per cent

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[359] Gibson, Flynn, and McCarthy, "Effectiveness of Methadone Treatment in Reducing HIV Risk Behavior and HIV Seroconversion among Injecting Drug Users."1816.

[360] For example, D.C. Des Jarlais et al., "HIV Incidence among Injecting Drug Users in New York City Syringe-Exchange Programmes," *Lancet* 348, no. 9033 (1996).990.

[361] F. Emmanuel et al., "Factors Associated with an Explosive HIV Epidemic among Injecting Drug Users in Sargodha, Pakistan," *Journal of Acquired Immune Deficiency Syndromes* 51, no. 1 (2009).88–89; P. Lurie and E. Drucker, "An Opportunity Lost: HIV Infections Associated with Lack of a National Needle-Exchange Programme in the USA," *Lancet* 349, no. 9052 (1997).606–07.

[362] S.F. Hurley, D.J. Jolley, and J.M. Kaldor, "Effectiveness of Needle-Exchange Programmes for Prevention of HIV Infection," *Lancet* 349, no. 9068 (1997).1798–99.

respectively.[363] The results lend strong support to the argument that NSEP is effective in minimising HIV prevalence. The capability of NSEP as part of a comprehensive set of measures to decrease HIV prevalence also extends to settings where HIV is already developed, including New York City.[364] The outcome of NSEP on HIV infection and prevalence is consistently supported by comprehensive reviews.[365]

On the contrary, several studies did not discover the effect of NSEP attendance against HIV seroconversion. Higher levels of HIV infection substantially connected to NSEP access are observed by prospective cohort research in Montreal and Vancouver.[366] Additionally, Strathdee et al. research reported the outburst of HIV prevalence subsequent to the five-year operation of vast NSEPs in Vancouver.[367] Consistent with the above findings, the results of some studies in Amsterdam indicate no significant link between the presence of NSEPs and decrease in HIV incidence.[368] These findings are deduced by opponents to attribute the greater HIV incidents to NSEP presence.

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[363] M. MacDonald et al., "Effectiveness of Needle and Syringe Programmes for Preventing HIV Transmission," *International Journal of Drug Policy* 14, no. 5 (2003).354.

[364] D.C. Des Jarlais et al., "Reductions in Hepatitis C Virus and HIV Infections among Injecting Drug Users in New York City, 1990-2001," *AIDS* 19, no. Suppl 3 (2005).S24.

[365] For example, D.R. Gibson, N.M. Flynn, and D. Perales, "Effectiveness of Syringe Exchange Programs in Reducing HIV Risk Behavior and HIV Seroconversion among Injecting Drug Users," *AIDS* 15, no. 11 (2001).1338; A. Ritter and J. Cameron, *Drug Policy Modelling Project Monograph 06: A Systematic Review of Harm Reduction* (Fitzroy: Turning Point Alcohol and Drug Centre, 2005).17; A. Wodak and A. Cooney, "Do Needle Syringe Programs Reduce HIV Infection among Injecting Drug Users: A Comprehensive Review of the International Evidence," *Substance Use & Misuse* 41, no. 6-7 (2006).801.

[366] J. Bruneau et al., "High Rates of HIV Infection among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study," *American Journal of Epidemiology* 146, no. 12 (1997).1001; S.A. Strathdee et al., "Needle Exchange is Not Enough: Lessons from the Vancouver Injecting Drug Use Study," *AIDS* 11, no. 8 (1997).F62–F63.

[367] "Needle Exchange is Not Enough: Lessons from the Vancouver Injecting Drug Use Study."F64.

[368] For example, Van Ameijden et al., "The Harm Reduction Approach and Risk Factors for Human Immunodeficiency Virus (HIV) Seroconversion in Injecting Drug Users, Amsterdam."241.

As Strathdee et al. suggest, the negative result is considerably affected by the insufficiency of NSEP on its own as a HIV prevention tool.[369] Despite the coherent argument given the complexity of HIV transmission, this thesis argues that stronger explanation considering selection bias could be provided for mixed or negative results of research that compare NSEP clients and non-clients. The NSEPs attracted IDUs who were significantly associated with higher risk activities, than non-attendees.[370] This position is supported by studies and commentaries.[371] Further, there is the possibility of the dilution factor. The Dutch, Canadian and UK studies with counterintuitive results were carried out in settings where lesser risk IDUs might have obtained syringes from alternative sources such as pharmacies, giving NSEP access to relatively individuals of greater risk of HIV seroconversion. This confounded the findings.[372] All these arguments could give potential explanations for the discouraging data.

By taking into account the high efficacy of MMT and NSEP for the most dangerous virus of HIV, it is likely tenable to claim their potential for HCV, another blood-borne pathogen. Some scholars including Bastosa argue for the efficacy of interventions to decrease HCV seroconversion rates among IDUs.[373] The argument is backed up by research findings in Malaysia and other countries. For instance, the research

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[369] Strathdee et al., "Needle Exchange is Not Enough: Lessons from the Vancouver Injecting Drug Use Study."F63–F64.

[370] Gibson, Flynn, and Perales, "Effectiveness of Syringe Exchange Programs in Reducing HIV Risk Behavior and HIV Seroconversion among Injecting Drug Users."1338; A. Wodak and A. Cooney, "Effectiveness of Sterile Needle and Syringe Programmes " *International Journal of Drug Policy* 16(2005).S34.

[371] For example, P. Lurie, "Invited Commentary: Le Mystère de Montréal," *American Journal of Epidemiology* 146, no. 12 (1997).1004; H. Hagan et al., "Volunteer Bias in Nonrandomized Evaluations of the Efficacy of Needle-Exchange Programs," *Journal of Urban Health* 77, no. 1 (2000).110.

[372] D. Vlahov and B. Junge, "The Role of Needle Exchange Programs in HIV Prevention," *Public Health Reports* 113, no. Suppl 1 (1998).79.

[373] For example, F.I. Bastosa and S.A. Strathdee, "Evaluating Effectiveness of Syringe Exchange Programmes: Current Issues and Future Prospects," *Social Science & Medicine* 51, no. 12 (2000).1778–79.

conducted by Norsiah et al. involving the MMT at Tampin Health Clinic, Malaysia, found only one new case of HCV infection among 143 subjects during the study period.[374] The positive research finding has also been documented in Tacoma and New York, showing a dramatic decline in HCV acquirement connected to the participation in NSEPs.[375]

The detected reduction, however, is unlikely to provide strong evidence for harm reduction measures to halt HCV transmission, considering the persistent very high HCV prevalence and incidence among IDUs across jurisdictions. A review of literatures found that HCV prevalence ranged from 65 to 80 per cent in almost all IDU populations in European nations.[376] This confirms the high prevalence in Europe shown by prior reviews.[377] The prevalence of high levels of HCV is also reported in non-European countries, accounting to more than 50 per cent.[378] Furthermore, IDU populations show high incident rates of HCV despite the presence of MMT and NSEP. A study in Australia discovered large HCV incidence among MMT clients who were HCV-seronegative at baseline and the similarity of incidence levels between participants in the service and those not participating.[379] The same finding of high HCV incidence is documented by

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[374] Norsiah et al., "Can Primary Care Clinic Run MMT Service Well?."19,21.

[375] H. Hagan et al., "Reduced Risk of Hepatitis B and Hepatitis C among Injection Drug Users in the Tacoma Syringe Exchange Program," *American Journal of Public Health* 85, no. 11 (1995).1531,1536; Des Jarlais et al., "Reductions in Hepatitis C Virus and HIV Infections among Injecting Drug Users in New York City, 1990-2001."S20,S24.

[376] H. Pollack and R. Heimer, "The Impact and Cost-Effectiveness of Mathadone Maintenance Treatment in Preventing HIV and Hepatitis C," in *Hepatitis C and Injecting Drug Use: Impact, Costs and Policy Options*, ed. J. Jager, et al. (Luxembourg: European Monitoring Centre for Drugs and Drug Addiction, 2004).347.

[377] For example, K. Roy et al., "Monitoring Hepatitis C Virus Infection among Injecting Drug Users in the European Union: A Review of the Literature," *Epidemiology and Infection* 129, no. 3 (2002).582–83.

[378] For example, M.A. MacDonald et al., "Hepatitis C Virus Antibody Prevalence among Injecting Drug Users at Selected Needle and Syringe Programs in Australia, 1995-1997," *Medical Journal of Australia* 172, no. 2 (2000).57.

[379] N. Crofts et al., "Methadone Maintenance and Hepatitis C Virus Infection among Injecting Drug Users," *Addiction* 92, no. 8 (1997).1003–04.

other research.[380] This practical data confirms the results of studies using epidemiological and analytical models showing how the measures have little efficacy for HCV when compared to HIV.[381] This makes the argument for their protective effect on the HCV virus less compelling.

Clearly, important evidence from epidemiological and practical data, mostly from outside Malaysia, invites the consideration that MMT and NSEP have significantly fewer protective benefits in controlling HCV incidence and prevalence than HIV within drug-using populations. The lower effectiveness is possibly attributable to HCV already being widespread prior to the initiation of such programmes.[382] Additionally, HCV is more easily transmitted than HIV, given greater parenteral infectivity.[383] It can readily spread even through the sharing of drug paraphernalia such as filters and cookers. The infectious disease has no effective antiserum and may not be sufficiently controlled by MMT, NSEP, detoxification drug treatment or educational programmes alone without other measures. This is because, as Pollack claims, the effective prevention for HCV is

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[380] For example, H. Hagan et al., "Syringe Exchange and Risk of Infection with Hepatitis B and C Viruses " *American Journal of Epidemiology* 149, no. 3 (1999).212; D.M. Patrick et al., "Incidence of Hepatitis C Virus Infection among Injection Drug Users during an Outbreak of HIV Infection," *Canadian Medical Association Journal* 165, no. 7 (2001).892–94;H.A. Pollack, "Cost-Effectiveness of Harm Reduction in Preventing Hepatitis C among Injection Drug Users," *Medical Decision Making* 21, no. 5 (2001).364–65.

[381] For example, N. Crofts et al., "Epidemiology of Hepatitis C Virus Infection among Injecting Drug Users in Australia," *Journal of Epidemiology and Community Health* 51, no. 6 (1997).695–96; J. Ward, R.P. Mattick, and W. Hall, "The Effectiveness of Methadone Maintenance Treatment 2: HIV and Infectious Hepatitis," in *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*, ed. W. Hall, J. Ward, and R.P. Mattick (Amsterdam: Harwood Academic Publishers, 1998).68–69; X. Wang et al., "HCV and HIV Infection among Heroin Addicts in Methadone Maintenance Treatment (MMT) and Not in MMT in Changsha and Wuhan, China," *PLoS ONE* 7, no. 9 (2012).3.

[382] D.M. Novick, "The Impact of Hepatitis C Virus Infection on Methadone Maintenance Treatment," *Mount Sinai Journal of Medicine* 67, no. 5-6 (2000).438, 440.

[383] D. Mather and N. Crofts, "A Computer Model of the Spread of Hepatitis C Virus among Injecting Drug Users," *European Journal of Epidemiology* 15, no. 1 (1999).8–9.

conditional on more extensive behavioural changes, including the frequency of drug injecting and needle sharing, than merely using sterile injection equipment.[384]

Therefore, this inefficacy should not be considered as harm reduction failure. Rather, MMT and NSEP must be regarded as key components of more extensive public health programmes to prevent or decrease drug taking and blood-borne epidemics. The consolidation of various strategies including education, drug treatment, HCV treatment, MMT, NSEP and the provision of sterile injection items including filters can confer benefit in reducing the incidence, frequency, duration and infectivity of drug injecting, thereby somewhat curbing HCV transmission.[385]

Overall, there is little doubt that MMT and NSEP do mitigate HIV risk behaviours, incidence and prevalence. Drawing on that point, this thesis contends that the availability of such strategies possibly constitutes the main factor in the gradually declining trend of new HIV infection cases among IDUs in Malaysia in recent years. The cases fell from between 70 to 80 per cent of overall cases in the 1990s to 39 per cent by 2011.[386] This achievement rebuts Shan's presumption in 2008 that the HIV rate in Malaysia would not decrease in the following three years despite harm reduction services.[387] Malaysia's successful attainment in HIV prevention is endorsed by international bodies including the Joint United Nations Programme on HIV and AIDS

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[384] Pollack, "Cost-Effectiveness of Harm Reduction in Preventing Hepatitis C among Injection Drug Users."365.

[385] N.M.J. Wright and C.N.E. Tompkins, "A Review of the Evidence for the Effectiveness of Primary Prevention Interventions for Hepatitis C among Injecting Drug Users," *Harm Reduction Journal* 3, no. 1 (2006).6; P. Vickerman et al., "Can Needle and Syringe Programmes and Opiate Substitution Therapy Achieve Substantial Reductions in Hepatitis C Virus Prevalence? Model Projections for Different Epidemic Settings," *Addiction* 107(2012).1992.

[386] Ministry of Health Malaysia, *Global AIDS Response Country Progress Report 2012: Country Progress Report Malaysia*.20.

[387] Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia."48.

(hereinafter referred as UNAIDS) and WHO.[388] Thus, the hypothesis that both services do not contribute to halting HIV is invalid. The outcome is unaffected by negative empirical data as there is a compelling expounding explanation for them. Supporting evidence regarding this efficacy absolutely exceeds the contradicting evidence. However, the interventions cannot effectively contribute to a reduction in the spread of HCV. The effectiveness of the interventions for reducing drug taking and blood-borne viruses may be further increased by multi-integrated strategies. Additionally, considering scant local empirical results, the effectiveness of harm reduction interventions, particularly with respect to HCV prevention, warrants further research.

### 3.3 Effectiveness in Decreasing Drug Use

In addition to the control of blood-borne disease transmission, harm reduction measures are regarded critical to reducing drug use. The issue exists whether MMT and NSEP are effectual in attaining this outcome. This section will give an account of this issue and present related evidence.

Methadone has been included in the WHO list of essential medicines since 2004. It is important in the management of opiate dependency. It can inhibit withdrawal symptoms and block heroin and other opiate euphoric effects. It is also clinically proven to abolish cravings from opiates which is a factor in continuous opiate consumption. The

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[388] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010* (Geneva: UNAIDS, 2010).61; World Health Organization (Western Pacific Region) and Ministry of Health Malaysia, *Good Practices in Asia: Scale-Up of Harm Reduction in Malaysia*.14.

pharmacological effects of methadone potentially influence the reduction of opiate use, as documented by many health scholars.[389] Notably, methadone also has the potential to mitigate drug injecting as it can be dispensed orally.

NSEP could further contribute to lessened drug use through its possible role as a gateway to other harm reduction, drug treatment and health-care services. Its contact with the commonly hidden drug-using population with limited or no access to the services may enable their referral to the programme. This may lead them to decrease or cease drug taking and thereby improve their health. The NSEP's potentiality as a referral point is confirmed by multiple international research results. It has been found that substantial numbers of drug users seek treatment as a result of their participation in NSEP.[390] The WHO's policy brief also equates the rising enrolment of drug using individuals in drug treatment and health-care initiatives with the NSEPs.[391] Arguably, the NSEP's contribution towards decreased drug taking is conditional upon the referral of its clients to other services. The unusual or limited practice of referral, as occurs in Malaysia, would make the objection to NSEP difficult to be abated.[392] To address this, this thesis argues that establishing a linkage between NSEP and other services is essential.

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[389] For example, A. Fareed et al., "Effect of Methadone Maintenance Treatment on Heroin Craving, a Literature Review," *Journal of Addictive Diseases* 30, no. 1 (2010).36; D. Vlahov, A.M. Robertson, and S.A. Strathdee, "Prevention of HIV Infection among Injection Drug Users in Resource-Limited Settings," *Clinical Infectious Diseases* 50, no. 3 (2010).S116.
[390] For example, P. Lurie et al., eds., *The Public Health Impact of Needle Exchange Programs in the United States and Abroad: Summary, Conclusions and Recommendations*, vol. 1 (San Francisco: Institute for Public Health Studies, University of California, 1993).10; H. Hagan et al., "Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-Exchange Participation in Seattle Drug Injectors," *Journal of Substance Abuse Treatment* 19, no. 3 (2000).250–51.
[391] World Health Organization, *Evidence for Action on HIV/AIDS and Injecting Drug Use. Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission* (Geneva: World Health Organization 2004).2.
[392] Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia."49.

Despite the overwhelming support of such benefits, there appear to be attacks from the opponents of harm reduction in Malaysia and other settings regarding the actual effectiveness of the approach in reducing drug taking. The condemnation specifically points towards MMT by arguing that it merely replaces dependence on one drug with another. PENGASIH Malaysia[393] highlights in its official website that 'Through MMT, addiction problem will subsist and the change merely relates to the type of addiction [...] we cannot extinguish fire with fire [...] Methadone will make drug users continuously be trapped in drug addicting'.[394] The belief behind this argument is that MMT dispenses a substitute drug which the client becomes dependent upon. The service is not classed as useful for the opponent that upholds the moral model on the grounds that it is a sanction for the continuance of drug consuming. For those who subscribe to disease model, it is a strategy that effectuates perpetuating reliance on drugs. Their deontological attitude against MMT stems from the belief that abstinence is the single admissible method of arresting drug dependency.

Responding to the criticism, there is the tendency of many harm reductionists to utilise a pragmatic utilitarian explanation by contending MMT's benefits to outweigh its costs. The example can be seen through the expression of Crofts et al.: 'Substitution programs (including MMT) do not 'cure' the addiction, but they allow IDUs to escape the criminal world of illegal drugs into a more socially acceptable environment, and have

[393] PENGASIH Malaysia is one of the NGOs offering voluntary abstinence-based treatment to drug users.
[394] This is a translation from the original PENGASIH statement written in the Malaysian language. (PENGASIH Malaysia, "Methadone Maintenance Program, Needle & Syringe Programme," PENGASIH Malaysia, http://pengasih.org/methadone-maintenance-program-needle-syringe-programme/.).(Last visited: 06/09/2013)

been demonstrated to decrease HIV transmission among IDUs'.[395] In other words, this type of response holds that even if there are risks accompanied with MMT, the strategy is still justifiable as long as it contributes to decreased drug-related harms. Some others (for example, Noor Zurani et al. and McLellan et al.) analogise MMT for heroin dependence as medications in constant care of chronic disorders such as hypertension and diabetes that cannot be fully treated but where resulting harms may be reduced.[396] This perspective manifests the reliance of commentators to the original philosophy of long-term methadone maintenance to stabilise opiate dependence as a 'metabolic deficiency', as promoted by Dole and Nyswander.

Both types of arguments cannot sufficiently rebut the opponents' argument deeply rooted in ideological fixation on abstinence from drug use. These arguments may result in the perception that instead of a drug treatment, MMT is simply a mean for controlling drug consuming behaviour. The proponents of harm reduction neglect the main issue regarding abstinence attainment. Arguably, it is more prudent to defend MMT on its role as part of a continuing framework of protection for managing drug dependency. (This has previously been discussed in Chapter 2, Section 2.5.) It is worthwhile repeating that MMT can play a key role in mitigating drug-related harms and preparing unable or unready drug users for an abstinence-based process of staying off drugs. Methadone is also mistakenly classified as a substitute for other drugs. At an appropriate dose, methadone stabilises and normalises drug users' functioning and wellbeing and is not intoxicating. This pharmacology distinguishes it from other opiates and may result in a

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[395] N. Crofts, G. Costigan, and G. Reid, eds., *Manual for Reducing Drug Related Harm in Asia* (Melbourne: The Centre for Harm Reduction, 2003).B1.9.

[396] Noor Zurani et al., "Heroin Addiction: The Past and Future."4; A.T. McLellan et al., "Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance and Outcomes Evaluation," *Journal of the American Medical Association* 284, no. 13 (2000).1693–94.

reduction in opiate consumption. Much local and international evidence confirms that the MMT's benefit of ensuring the stability and wellbeing of its clients is not only theoretical but real.[397]

Additionally, numerous opponents frequently cite concerns that harm reduction measures may result in increased drug consumption while not effectively stopping the behaviour. Mohamed, for instance, claims that though Malaysian NSEP is effective in reducing HIV spread, it is incapable of mitigating drug use.[398] This perspective reflects that of NADA in its policy to reject involvement in the NSEP programme even though it is the main public body entrusted to handle drug issues in the country.[399] The constant fear of critics is the potential increase of drug taking among drug users. Also, there are concerns that methadone may be used by drug users to supplement other drugs they have procured such as heroin or given away or sold on to other users to finance their habit of illicit drug taking. Central to these concerns is that harm reduction interventions tolerate and make room for drug using behaviour, due to their sole focus on the mitigation of drug-related harms. The provision of methadone and drug paraphernalia is seen as a facilitation of persistent drug taking and consequently impact the growth of its prevalence.

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[397] For example, A.H. Ghodse, F.J. Creighton, and A.V. Bhatt, "Comparison of Oral Preparations of Heroin and Methadone to Stabilise Opiate Misusers as Inpatients," *British Medical Journal* 300, no. 6726 (1990).720; A.H.M. Hussin et al., "Kajian Amalan Terbaik Program Rawatan dan Pemulihan dalam Institusi dan Komuniti [The Study on Best Practices of Treatment and Rehabilitation Programmes in Institution and Community]," (Kajang, Malaysia: Universiti Sains Islam Malaysia & Agensi Antidadah Kebangsaan, 2011).106.

[398] M.N. Mohamed, "Penyalahgunaan Bahan di Malaysia: Trend Kini dan Cabaran Masa Depan [Substance Abuse in Malaysia: The Recent Trend and Future Challenge]," in *Mengenali Dadah: Rawatan, Pencegahan dan Undang-Undang [Knowing Drug: Treatment, Rehabilitation and Law]*, ed. M.N. Mohamed (Putrajaya, Malaysia: Agensi Antidadah Kebangsaan, 2009).12.

[399] *Perubahan dalam Senario Rawatan dan Pemulihan Dadah: Cabaran dalam Pengurusan Pemulihan Dadah di Malaysia dan Arah Masa Depan [The Changing Scenario of Drug Treatment and Rehabilitation: Challenges in Managing Drug Rehabilitation in Malaysia and Future Directions]*.94–95.

The opponents' claim is problematic and has some drawbacks. While most of them do not provide supporting evidence for their claim, some point to inconclusive statistical data pertaining to high drug use prevalence in certain countries despite the approach's practice for many years.[400] The data is not accompanied with coherent statistical analysis that considers other potential factors leading to increasing or unchanging drug prevalence or that shows a causal relationship between the harm reduction approach and prevalence. Moreover, there is no fair comparative analysis with the condition in which the harm reduction approach is absent, whether the prevalence will be lower or otherwise. Thus, the contention is unreliable due to deficient evidence.

Furthermore, there exists a handful of scientific evidence that challenges the opponents' contention. Research findings suggest that harm reduction initiatives result in a significant decrease in drug use. This indicates that the theory of reduced drug use readily translates into actual impact. The research findings in Malaysia demonstrate no rise in the quantity of opiate users but, in contrast, a persistent drop is recorded.[401] The pilot MMT programmes in some cities indicate a fall in persistent opiate use among clients from 45 per cent at baseline to 10.7 per cent at 6 months. This finding is supported by other empirical data on reduced drug use among MMT clients.[402] Similarly, the bulk of international assessments found MMT's effectiveness in mitigating opiate consumption was relatively higher than other types of drug treatment such as

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[400] For example, N. McKeganey, "The Lure and the Loss of Harm Reduction in UK Drug Policy and Practice," *Addiction Research & Theory* 14, no. 6 (2006).563,565–66, 568–69; *Controversies in Drugs Policy and Practice*.38–41.

[401] For example, Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia."50.

[402] For example, R. Musa, A.Z.A. Bakar, and U. Ali Khan, "Two-Year Outcomes of Methadone Maintenance Therapy at a Clinic in Malaysia," *Asia-Pacific Journal of Public Health* XX no. X (2011).3–5.

detoxification and drug-free treatment.[403] A study by Vaillant suggests that MMT significantly mitigates heroin taking. The data indicates a higher percentage of one-year abstinence among MMT clients when compared with other heroin dependents in detoxification programmes either in hospital or short-period imprisonment. It has been documented that 67 per cent of 15 heroin dependents in MMT sustained the abstinence while only 3 per cent of 361 dependents in hospital and 363 in short imprisonments became abstinent from heroin without MMT.[404]

Many international studies have also discovered a reduction in or stability of drug using through injecting among NSEP clients.[405] The findings are supported by comprehensive reviews by scholars including Wodak and Cooney, and international bodies including WHO.[406] Additionally, as found by various studies, there is no evidence that the NSEP programme raises injecting drug taking[407] or shift in the drug consuming method from non-injecting to injecting.[408] Therefore, it is clear that harm reduction interventions do not lead to the growth of drug use but do, on the contrary, impact its reduction.

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[403] For example, National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, "Effective Medical Treatment of Opiate Addiction," *Journal of the American Medical Association* 280, no. 22 (1998).1939; L. Amato et al., "An Overview of Systematic Reviews of the Effectiveness of Opiate Maintenance Therapies: Available Evidence to Inform Clinical Practice and Research," *Journal of Substance Abuse Treatment* 28, no. 4 (2005).326.

[404] G.E. Vaillant, "What Can Long-Term Follow-Up Teach Us about Relapse and Prevention of Relapse in Addiction?," *British Journal of Addiction* 83, no. 10 (1988).1151–52.

[405] For example, D. Vlahov et al., "Reductions in High-Risk Drug Use Behaviors among Participants in the Baltimore Needle Exchange Program," *Journal of Acquired Immune Deficiency Syndromes* 16, no. 5 (1997).400, 402–04.

[406] For example, Wodak and Cooney, "Do Needle Syringe Programs Reduce HIV Infection among Injecting Drug Users: A Comprehensive Review of the International Evidence."802;World Health Organization, *Evidence for Action on HIV/AIDS and Injecting Drug Use. Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*.2.

[407] For example, D.G. Fisher et al., "Needle Exchange and Injection Drug Use Frequency: A Randomized Clinical Trial," *Journal of Acquired Immune Deficiency Syndromes* 33, no. 2 (2003).203–04.

[408] For example, J. Guydish et al., "Evaluating Needle Exchange: Are There Negative Effects?," *AIDS* 7, no. 6 (1993).874.

The concern over the risk of methadone diversion or improper use is as plausible as it is real, especially in relation to take-away dose dispensing. A study by Mohamed and Mohamad Kasa reveals the occurrence of diversion of prescribed substitute drugs in Malaysia. The growing opiate-related overdose fatalities recorded in the UK are also connected with a relatively more liberal methadone takeaway policy.[409] The government needs to protect against diverted methadone use given its substantial dangers such as increasing opiate use, fatal overdose[410] and injection-driven HIV/AIDS infection.[411] Despite that, this thesis strongly dissents that the diversion risk necessitates disallowing either methadone prescribing to those in need or takeaway dispensing in necessary circumstances. The stance of this thesis relies on some reasons.

Firstly, methadone prescribing and takeaway policies have public imperatives. Methadone accounts for positive impacts including the reduction of HIV/AIDS transmission and illicit drug consumption while takeaway dispensing is essential to address the troubles of daily-oriented supervised dispensing experienced by certain clients such as employed individuals. Secondly, the magnitude of diversion practice is equivocal. Arguably, it is not a general phenomenon or an extensive issue considering that there is no apparent evidence supporting this. Despite the potentiality of being diverted, the legally provided methadone is also not a prime drug of diversion. Research in the USA found that much of the diverted and abused methadone is attributable to the analgesic

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[409] J. Bell and D. Zador, "A Risk-Benefit Analysis of Methadone Maintenance Treatment," *Drug Safety* 22, no. 3 (2000).181.

[410] Babor et al., *Drug Policy and the Public Good*.193.

[411] Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries, Board on Global Health, and Institute of Medicine of the National Academies, *Preventing HIV Infection among Injecting Drug Users in High-Risk Countries: An Assessment of the Evidence* (Washington: National Academy Press, 2006).100–01.

market rather than the methadone prescribing programme.[412] Thirdly, methadone diversion is affected by many factors which are not limited to the legal methadone administration or takeaway dispensing practices. The evidence shows that the diversion relates to multiple determinants including take-home policy, drug preference, the availability of drugs, availability of treatment and the scale of treatment coverage.[413] Finally, a pertinent consideration of the benefits of methadone and its risks should be undertaken to ensure its total positive impacts. Therefore, the prevention of diversion or improper use should be done in a way which does not affect the methadone's availability for harm reduction purposes. The appropriate strategies aimed at minimising its potential diversion or improper use may include direct observed methadone consumption; 'cautious clinical judgment' in dispensing takeaway doses[414]; suitable regulatory restrictions directed at physicians, clients and methadone administration including their eligibility and behaviours and the operation's settings, time and record-keeping; and prescribing monitoring (for example, through prescription data submission).[415] It is clear that the MMT operation, with specific safeguards to prevent diversion or improper use, may not trigger increased illegal drug use.

Overall, harm reduction interventions could significantly result in reduced drug consumption. Abundant scientific evidence attests to the benefit and absence of consequences of sustained individual drug dependency or growing drug use. With this

[412] T.J. Cicero and J.A. Inciardi, "Diversion and Abuse of Methadone Prescribed for Pain Management," *Journal of the American Medical Association* 293, no. 3 (2005).297.
[413] A. Ritter and R. Di Natale, "The Relationship between Take-Away Methadone Policies and Methadone Diversion," *Drug And Alcohol Review* 24, no. 4 (2005).351.
[414] S. Darke, "The Effectiveness of Methadone Maintenance Treatment 3: Moderators of Treatment Outcome," in *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*, ed. J. Ward, R.P. Mattick, and W. Hall (Amsterdam: Harwood Academic Publishers, 1998).83.
[415] Babor et al., *Drug Policy and the Public Good*.187.

outcome, the measures can complement abstinence-based strategies, thereby assisting the attainment of prohibition-based policy for drug use. In contradiction to international evidence, there is a lack of local evidence identifying the potential effect of NSEP on drug use patterns and frequency. This should trigger an agenda for additional future studies. NSEP could link drug users to drug treatment and other health interventions. The interconnection may increase the effectiveness of NSEP in contributing to the reduction of drug use.

## 3.4 Cost-Effectiveness for Controlling Drug Use, HIV and HCV Transmission

To justify harm reduction measures, it is vital to consider their economic efficiency given that there are limits on resources. The public funds used to bear the expenditures of public health programmes are commonly justifiable on the basis of their economic returns in terms of improved population-level health and quality of life. Therefore, it is important for this section to consider the aspect of MMT and NSEP cost effectiveness and the surrounding evidence.

For determining the monetary advantages of harm reduction measures, the assessments that usually employ the standard methods of cost-effectiveness analysis[416] and cost-benefit analysis[417] have been undertaken by economic analysts. By applying varied methodologies, modelling techniques and cost assumptions while incorporating

[416] This method is for determining the cost of one unit of outcome.
[417] Benefits and costs accessed are in terms of money.

sensitivity analysis,[418] most existing economic evaluations have focused on the cost-effectiveness of harm reduction programmes as strategies for handling drug dependency and HIV and, increasingly, HCV transmissions. Thus, these domains of cost-effectiveness are concentrated upon in this section.

Many opponents argue that there are no economic gains from the financial investment in harm reduction programmes. The state governments of Selangor and Terengganu, Malaysia, have previously stated that the provision of harm reduction services is a waste of resources due to its vague monetary values.[419] Some critics substantiate their arguments based on the harm reduction programme's ineffectiveness in reducing drug-related harm. Gyngell, for example, contends that the high investment of money for the initiative in the UK does not yield benefits when considering the growing harm from drug use. This includes blood-borne seroprevalence and mortality, an insignificant decrease in the crime rate, prolonged drug dependency, health problems and increasing costs related to welfare dependency and collateral child and family damage.[420] These arguments may be classified as weak when considering the evidence. They are unsupported by compelling relevant evidence in terms of reliable economic efficiency evaluations and statistical data analysis. Presented statistics indicating the increased drug-related harms are inconclusive when considering the harm reduction programme's economic inefficiency. This aspect demands prudent economic analysis. Furthermore,

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[418] Sensitivity analysis is included to indicate the validity of the drawn conclusion.

[419] Z. Raban, "Bazir Wang Rakyat-Jika Bekal Jarum Suntikan, Kondom kepada Penagih Dadah [Waste Public Money-If Supply Injection Needles, Condoms to Drug Addicts]," Utusan Melayu (M) Bhd., http://www.utusan.com.my/utusan/info.asp?y=2005&dt=0605&pub=Utusan_Malaysia&sec=Muka_Hadapan&pg=mh_01.htm#ixzz2eQStm8gf. (Last visited: 09/09/2013)

[420] K. Gyngell, "The UK's Treatment War on Drugs: A Lesson in Unintended Consequences and Perverse Outcomes," *Journal of Global Drug Policy and Practice* 5, no. 1 (2011), http://www.globaldrugpolicy.com/Issues/Vol%205%20Issue%201/UK%27s%20Treatment%20War%20on%20Drugs.pdf.2–6. (Last visited: 12/05/2013)

available empirical data suggests that the measures might provide economic advantages to society, rather than wasting public funds.

The common finding of empirical assessments across multiple settings is that harm reduction policy generally, and MMT and NSEP individually, are significantly cost-effective and even cost-saving methods for controlling drug use and HIV spread. The evidence presented in this section may disavow arising criticism regarding harm reduction cost-effectiveness.

MMT has the potential to economically manage drug dependency. This is supported by the results of cost-effectiveness evaluations of MMT, mostly conducted in the USA and UK. For example, Zaric and colleagues make estimates relating to mortality, life quality, HIV spread and MMT's consequence on medical care costs to reveal the service's cost-effectiveness ratio ranging from USD9,700 to USD17,200 per life year achieved and from USD6,300 to USD10,900 per Quality-Adjusted Life Year (hereinafter referred as QALY) attained.[421] There is additional evidence for the cost-effectiveness of MMT through research findings comparing the variant methods with other drug treatment modalities including detoxification.[422] Moreover, a small number of cost-benefit analyses have discovered the MMT's net benefits. The evidence is weighted towards its cost savings as a result of decreased criminal activity.[423] The cost-effectiveness and cost-

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[421] G.S. Zaric, M.L. Brandeau, and P.G. Barnett, "Methadone Maintenance and HIV Prevention: A Cost-Effectiveness Analysis," *Management Science* 46, no. 8 (2000).1021,1024.

[422] J. Strang et al., "Randomized Trial of Supervised Injectable versus Oral Methadone Maintenance: Report of Feasibility and 6-Month Outcome," *Addiction* 95, no. 11 (2000).1641–42; C.L. Masson et al., "Cost and Cost-Effectiveness of Standard Methadone Maintenance Treatment Compared to Enriched 180-Day Methadone Detoxification," *Addiction* 99(2004).724–25.

[423] For example, M. Gossop, J. Marsden, and D. Stewart, *NTORS After Five Years: The National Treatment Outcome Research Study. Changes in Substance Use, Health and Criminal Behaviour during the Five Years after Intake* (London: National Addiction Centre, 2001).17; R.P. Schwartz et al., "Interim versus

saving aspects of MMT are recognised in certain reviews, including that by Simoens et al.[424] Together, this evidence demonstrates that MMT can control drug dependency in a cost-effective way and produce economic benefits for communities.

Furthermore, harm reduction measures are cost-effective in preventing HIV infections. This point is adduced by considering available Malaysian and international economic findings. Assessments of the cost-effectiveness of harm reduction programmes with respect to HIV prevention are commonly based on the predicted quantity of HIV infections averted by the service. The measured outcome is the ratio of the service's expenses for the averted infections to the prospective saving associated with the avoided HIV/AIDS medical care expenditure. There are fewer extensive studies across the world examining the cost-effectiveness of harm reduction as a policy for HIV prevention. The results of a study by Naning et al. demonstrate that harm reduction programmes in Malaysia resulted in an estimated saved health-care cost of MYR47.1 million and prevented 12,600 HIV cases from 2006 to 2013, suggesting the approach's high cost-effectiveness.[425] Consistent with the findings, Kumaranayake et al. studied the harm reduction approach in Eastern Europe and concluded its cost-effectiveness in the control of HIV even in its soaring prevalence.[426] This conclusion is confirmed by many seminal

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Standard Methadone Treatment: A Benefit-Cost Analysis," *Journal of Substance Abuse Treatment* 46, no. 3 (2014).311–12.

[424] S. Simoens et al., "Pharmaco-Economics of Community Maintenance for Opiate Dependence: A Review of Evidence and Methodology," *Drug and Alcohol Dependence* 84, no. 1 (2006).38.

[425] H. Naning et al., *Return on Investment and Cost-Effectiveness of Harm Reduction Program in Malaysia* (Washington, D.C.: World Bank, 2014).10, 35.

[426] L. Kumaranayake et al., "The Cost-Effectiveness of HIV Preventive Measures among Injecting Drug Users in Svetlogorsk, Belarus," *Addiction* 99, no. 12 (2004).1573.

works including those by Wilson et al.[427] Notably, despite the lack of research, harm reduction policy can be expected to yield economic benefits.

Some local empirical findings specifically show the MMT's cost-effectiveness in Malaysia in relation to HIV prevention. The research by Naning et al. found that the incremental cost-effectiveness of MMT for HIV spread in Malaysia is MYR2,354 per QALY gained from 2006 until 2013.[428] The programme attained the cost-saving of MYR3.85 million in the period and is projected to be MYR41.56 million for the period between 2013 and 2023.[429] The result indicates that MMT for HIV control is highly cost-effective.

This positive outcome is in agreement with international research findings. For instance, the economic analysis by Pollack reveals that the estimated MMT cost per HIV infection prevented ranges from USD100,000 to USD300,000.[430] The supporting empirical findings also derive from resource-poor countries such as Indonesia[431] as well as international bodies. The joint report of WHO, United Nations Office on Drugs and Crime (hereinafter referred as UNODC) and UNAIDS mentions the efficacy and cost-effectiveness of substitution treatments including MMT for managing opiate dependence

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[427] D.P. Wilson et al., "The Cost-Effectiveness of Harm Reduction," *International Journal of Drug Policy* 26(2015).S9.

[428] Naning et al., *Return on Investment and Cost-Effectiveness of Harm Reduction Program in Malaysia*.33–34.

[429] Ibid.32.

[430] H.A. Pollack, "Methadone Treatment as HIV Prevention," in *Quantitative Evaluation of HIV Prevention Programs* ed. E.H. Kaplan and R. Brookmeyer (New Haven: Yale University Press, 2002).119.

[431] J.J. Wammes et al., "Cost-Effectiveness of Methadone Maintenance Therapy as HIV Prevention in Indonesian High-Prevalence Setting: A Mathematical Modeling Study," *International Journal of Drug Policy* 23, no. 5 (2012).364.

and HIV transmission.[432] All findings reinforce the argument that the service has good value for money when compared with HIV-related medical care costs.

Moreover, NSEP for HIV prevention generates monetary benefits. This is supported by the results of the study by Naning et al., indicating that the Malaysian NSEP for HIV prevention yielded cost-savings of RM45.53 million from 2006 until 2013. The cost-saving was projected to increase to RM200.88 million by 2013.[433] This indicates that the NSEP in Malaysia is a modestly effective financial investment.

Local evidence reinforces the international evidence that NSEP is a highly cost-effective method of HIV prevention. The cost-benefit analysis by Reid proved the NSEP's net benefit in preventing HIV infection.[434] In Holtgrave et al.'s cost-effectiveness evaluation of NSEP in the USA, researchers found a cost-saving of USD34,278 per HIV infection prevented. This is substantially below the estimated cost of treatment accrued over the lifetime of a HIV case ofUSD108,469. The calculation considers an estimated 12,350 HIV infections avoided, with subsequent expenditure savings of HIV health-care amounting to nearly USD1.3 billion and an overall annual cost of USD423 million for 100 per cent covered NSEPs (including through pharmacy).[435] The conclusion to be reached from this study is that NSEP can be expected to become cost-effective and hence cost-saving in the control of HIV infection.

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[432] World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), and Joint United Nations Programme on HIV/AIDS (UNAIDS), *WHO/UNODC/UNAIDS Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention* (Geneva: World Health Organization, 2004).21.
[433] Naning et al., *Return on Investment and Cost-Effectiveness of Harm Reduction Program in Malaysia*.32.
[434] R.J. Reid, "A Benefit-Cost Analysis of Syringe Exchange Programs " *Journal of Health & Social Policy* 11, no. 4 (2000).53.
[435] D.R. Holtgrave et al., "Cost and Cost-Effectiveness of Increasing Access to Sterile Syringes and Needles as an HIV Prevention Intervention in the United States," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 18, no. Suppl 1 (1998).135–38.

Similar positive results are found by other research including that by Laufer and Guinness et al. (the first cost-effectiveness evaluation on harm reduction programmes in Asia).[436] The conclusion regarding the NSEP's cost-effectiveness for HIV cases is confirmed by several reviews (such as Wodak and Cooney backed by WHO and Pinkerton et al.).[437] In Wodak and Cooney's review of numerous studies, it is found that the average expenses per HIV infection prevented is lower than the lifetime health care costs of prevented HIV infections, thereby making the strategy cost-effective and cost-saving.[438] Moreover, the international agencies such as UNAIDS endorse the sterile needle provision as one of the cost-effective methods for HIV prevention.[439]

No economic analysis in Malaysia has been carried out regarding the cost-effectiveness of harm reduction services in HCV prevention. Indeed, few international evaluations on this aspect have been traced. The calculation of cost-effectiveness often relies on the volume of prevented HCV infections.

Drawing on the limited existing evidence on this aspect, it seems that MMT is likely less cost-effective for the prevention of HCV spread. It could therefore be expected to be less cost-saving and in fact generate a net economic cost to public money. Studies, including those by Brown and Crofts, and Pollack and Heimer, found that the costs per

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[436] F.N. Laufer, "Cost-Effectiveness of Syringe Exchange as an HIV Prevention Strategy," *Journal of Acquired Immune Deficiency Syndromes* 28, no. 3 (2001).277; L. Guinness et al., "The Cost-effectiveness of Consistent and Early Intervention of Harm Reduction for Injecting Drug Users in Bangladesh," *Addiction* 105, no. 2 (2010).324–26.

[437] Wodak and Cooney, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users*.28; S. Pinkerton, J. Kahn, and D. Holtgrave, "Cost-Effectiveness of Community-Level Approaches to HIV Prevention: A Review," *Journal of Primary Prevention* 23, no. 2 (2002).191.

[438] Wodak and Cooney, "Do Needle Syringe Programs Reduce HIV Infection among Injecting Drug Users: A Comprehensive Review of the International Evidence."796–97.

[439] Joint United Nations Programme on HIV/AIDS (UNAIDS), *UNAIDS Practical Guidelines for Intensifying HIV Prevention Towards Universal Access* (Geneva: UNAIDS, 2007).46.

HCV case avoided significantly exceeded those associated with HIV infection.[440] Similarly, the Commonwealth Department of Health and Ageing highlighted that the NSEP's cost-effectiveness on HCV prevention is relatively less than for HIV prevention. Their comprehensive evaluation of investment return for NSEPs in Australia demonstrates that the programmes saved about USD7,808 million of lifetime treatment costs of the prevented 25,000 cases of HIV and 21,000 cases of HCV by 2000. The averted cases were calculated from 1988 when the NSEPs were initially established. However, the findings revealed that the saved costs of treatment for HCV were lower, merely almost 10 per cent of overall saved costs. However, this still contributed net savings in addition to prevented HIV cases.[441]

Moreover, the results of Pollack's theoretical modelling research assessing the cost-effectiveness of NSEPs found that the expense per HCV infection prevented was far above the projected health-care costs for the disease. Thus, the study concludes that there is less effect from intervention on HCV.[442] The NSEP's lack of monetary benefits is further confirmed by several reviews including de Wit and Bos, and Ritter and Cameron.[443] This indicates that NSEP has no potential to control the transmission of HCV pathogens at small per-capita costs and hence is less cost-effective.

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[440] K. Brown and N. Crofts, "Health Care Costs of a Continuing Epidemic of Hepatitis C Virus Infection among Injecting Drug Users," *Australian and New Zealand Journal of Public Health* 22, no. 3 (1998).387–88;Pollack and Heimer, "The Impact and Cost-Effectiveness of Mathadone Maintenance Treatment in Preventing HIV and Hepatitis C."356.

[441] Health Outcomes International Pty. Ltd., The National Centre for HIV Epidemiology and Clinical Research, and M. Drummond, *Return on Investment in Needle and Syringe Programs in Australia: Summary Report* (Canberra: Commonwealth Department of Health and Ageing, 2002).10, 12–14.

[442] Pollack, "Cost-Effectiveness of Harm Reduction in Preventing Hepatitis C among Injection Drug Users."364–65.

[443] A. De Wit and J. Bos, "Cost-Effectiveness of Needle and Syringe Programmes: A Review of the Literature," in *Hepatitis C and Injecting Drug Use: Impact, Costs and Policy Options. Monographs. 7*, ed.

Obviously, identified empirical data sources are less supportive for the MMT and NSEP's cost-effectiveness in preventing HCV transmission when compared with HIV prevention. The low economic benefits are seemingly influenced by its inefficacy in reducing the virus spread. Notably, the effectiveness of strategy is always accorded with its cost-effectiveness as in the case of harm reduction measures for HIV control. If this trend is to reverse, then the intervention might not arise as economically efficient. However, this thesis argues that the negative evidence in HCV prevention does not affect overall MMT and NSEP cost-effectiveness. The cost-effectiveness of the services for drug dependency and HIV prevention is sufficiently strong to justify their continuation. As manifested in Degenhardt et al.'s writing, the cost-effectiveness of MMT (and NSEP) is sustained, even when taking into account HIV benefits only.[444]

Summarily, MMT and NSEP are economically justified. Bodies of evidence, especially from developed countries, support the cost-effectiveness of both interventions in the control of drug taking and HIV infection, impacting cost-savings to society. The services are seemingly less cost-effective singly in relation to HCV. The opponents who are pragmatic or consequentialist in their objection to these interventions should be swayed by the economic returns produced. Critics who claim that the interventions are not cost-effective do not provide plausible evidence that could desert the measures. However, generalising about the cost-effectiveness of such measures is erroneous due to the scarce economic evaluations, including in Malaysia where there is an obvious lack of evidence. Additionally, the compatibility of cross-studies is limited when considering

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J. Jager, et al. (Luxembourg: European Monitoring Centre for Drugs and Drug Addiction, 2004).341; Ritter and Cameron, *Drug Policy Modelling Project Monograph 06: A Systematic Review of Harm Reduction*.19.
[444] L. Degenhardt et al., "Prevention of HIV Infection for People who Inject Drugs: Why Individual, Structural and Combination Approaches are Needed," *Lancet* 376, no. 9737 (2010).297.

specific aspects including magnitude of savings, costs, time and epidemiological features in localities that affect disease prevalence. Therefore, consideration needs to be given to more local cost-effectiveness analyses of harm reduction measures.

### 3.5 Absence of the Symbolism of Drug Use Encouragement

Harm reduction approach elicits a storm of controversy in Malaysia as it is seen as promoting illicit drug consumption. The objective of this section is to examine whether harm reduction is a symbolic encouragement of drug use and consider the existing relevant evidence.

The interventions are seen by their opponents in Malaysia, particularly among politicians and the public, as transmitting implicit messages that advocate drug taking.[445] Such claims also appear in other jurisdictions, particularly those implementing aggressive responses to drug offences. While there appear variances in views among politicians, states and drug organisations in the USA, the Office of National Drug Control Policy (ONDCP) gives a representative example of the pessimistic view that NSEP (and other harm reduction strategies) officially validate drug consumption and thereby undermine the societal message of the immorality of drug use.[446] The reasoning behind the criticism is that the harm reduction approach conveys the message that drug consumption is tacitly endorsed by the government. Additionally, by helping to lower drug-related risks, the

[445] S.N. Zulkifli et al., *Study on the Impact of HIV on People Living with HIV, Their Families and Community in Malaysia* (Kuala Lumpur: United Nations Development Programme (Country Team, Malaysia), 2007).107–08.
[446] H. Abadinsky, *Drug Abuse: An Introduction* (Chicago: Nelson-Hall Publishers, 1994).371.

approach communicates the message that drug use is safe and hence possibly impacts upon the initiation of drug use.

It is hard to accept the argument when considering the harm reduction practices of promoting health and wellbeing and reducing the adverse effects of drug consumption, rather than legalising and publicising its benefits or risk-free position. The government applies the approach for the interest of public health while still pursuing prohibition-oriented policy and methods against drugs. This draws the conclusion that the implementation of harm reduction as an approval and promotion of drug taking is unreasonable. Additionally, there seems to be no evidence concerning the interpretation of drug-using or non-drug-using individuals of the negative message of harm reduction programmes. The claimed implicit message conveyed could be characterised, as MacCoun proposes, as rhetorical implications which demand empirical evidence. MacCoun clarifies that:

> the rhetorical hypothesis is that irrespective of their effectiveness in reducing harms, harm reduction programs literally communicate messages that encourage drug use…Without intending to do so, harm reduction sends tacit message that are construed as approval - or at least the absence of strong disapproval - of drug consumption[…] Ultimately, whether any such rhetorical effects occur is an empirical question.[447]

Therefore, the contention that harm reduction programmes send message of promoting drug use is based on conjecture and is unsupported empirically.

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[447] MacCoun, "Towards a Psychology of Harm Reduction."1202.

Moreover, there appears to be evidence showing that the harm reduction approach has the potential to convey the opposite message. For instance, a Malaysian study by Sarnon et al. investigated the perception of 13 IDUs who attended NSEP for over 10 months. They found that most of the IDUs believed that the government's service encouraged the use of sterilised needles to prevent HIV/AIDS infection and alteration of methods to obtain needles and caused them to have the feeling of being acknowledged and given attention.[448] This indicates that drug users and the public may construe a positive message from the harm reduction approach. The type of message is dependent on the individual interpretation which is verifiable by empirical work, rather than mere presumption.

The second possible rationale for the claim of communicating the wrong message through drug-related harm mitigation is in line with the evidence of compensatory behavioural reactions to safety measures. Specifically, individuals may initiate or increase drug taking behaviour given the decrease of drug-related harms and risks through harm reduction initiatives. This is similar to the supposed reaction by drivers to drive faster as a result of improved automobile safety including seat belts that reduce driving risks. MacCoun states:

> […S]ome of the safety gains brought about by a reduction in the probability of harm given unsafe conduct have been offset by increases in the probability of that conduct[…] The compensatory behavioural mechanism suggests that if reductions in average drug-related harm were to motivate sufficiently large

[448] N. Sarnon et al., "Psychosocial Reactions of Injecting Drug Users` (IDU) towards Needle Syringe Exchange Program in Malaysia," *World Applied Sciences Journal* 12(2011).81–83.

increases in drug use, micro harm reduction would actually increase macro harm.[449]

Yet there is no empirical evidence to confirm the notion's application in a harm reduction context. Thus, the opponents' argument is merely speculative and somewhat reflective of their deontological stance against harm reduction policy.

By contrast, there exists scientific evidence to weaken the hypothesis. Research findings demonstrate that harm reduction measures are not associated with growing initiates to drug use. A few Malaysian studies, such as by Shan, found that MMT and NSEP have not recruited new drug takers, but on the contrary, have decreased their number. The number of new drug users declined in the years after the services were introduced.[450] The University of California's extensive review of investigations involving IDUs in the USA and other countries including Canada, the Netherlands and England also concludes that there was neither a rise in drug taking prevalence nor the levels of drug injecting by reason of NSEP's accessibility.[451] The comparable result is revealed by Norman et al. assessing the evidence from numerous studies.[452] Thus, these data sources indicate that the harm reduction approach is unlikely to promote and increase drug use. This conclusion is consistent with the arguments of scholars including Yoast et al. and Vlahov et al.[453]

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[449] MacCoun, "Towards a Psychology of Harm Reduction."1203.
[450] Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia."50.
[451] Lurie et al., *The Public Health Impact of Needle Exchange Programs in the United States and Abroad: Summary, Conclusions and Recommendations*.357.
[452] J. Normand, D. Vlahov, and L.E. Moses, eds., *Preventing HIV Transmission: The Role of Sterile Needles and Bleach* (Washington, D.C.: National Academy Press, 1995).252.
[453] For example, R. Yoast et al., "Report of the Council on Scientific Affairs: Methadone Maintenance and Needle-Exchange Programs to Reduce the Medical and Public Health Consequences of Drug Abuse,"

Even if initiation of drug taking grows after the implementation of the harm reduction approach, the approach should not be simply blamed for the personal autonomous act to use drugs. It is unfair to link the two variables while presuming that the other possible determinants of an individual's decision to act remain stable, non-important or non-existent. Carter et al. insist that the action is the result of the application of personal autonomy rather than the consequence of the harm reduction approach's availability.[454]

It is therefore important to conclude that harm reduction initiatives, both locally and globally, have no symbolic encouragement of drug use. The opponents' concerns regarding the implication are unsubstantiated reasonably or empirically either for a rhetorical or a compensatory behaviour mechanism notion. Further, their claims are repudiated by volumes of scientific findings. More research should be conducted in every jurisdiction regarding these subjects.

## 3.6 Absence of Negative Consequences Diminishing the Amenity of the Community

Another area of issues regarding the harm reduction approach in Malaysia and other nations that may impact its justification has been in relation to public amenity, including concerns pertaining to the rise of crime, and discarded needles and syringes in public

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*Journal of Addictive Diseases* 20, no. 2 (2001).30; D. Vlahov et al., "Updating the Infection Risk Reduction Hierarchy: Preventing Transition into Injection," *Journal of Urban Health* 81, no. 1 (2004).17.

[454] Carter, Miller, and Hall, "The Ethics of Harm Reduction."115.

settings. Thus, this section focuses on the issue of whether the interventions lead to such negative effects and presents related evidence.

The questions about the negative implications of harm reduction strategy to communities are not necessarily driven by conflicting ideology pertaining to the appropriate drug controlling methods. Malatesta et al. categorise this debate pertaining to the negative effects of the approach as a manifestation of the conflicts between two 'logics of action'; the necessity for delivering health and social protection to the drug-taking population and the necessity for keeping public order.[455] While this thesis concurs with the potential influence of the public's commitment to preserving the security of communities to their fears upon the negative impact of harm reduction approach, considering the Malaysian context, this thesis argues that the concerns stem from mixed scepticisms about the approach's effect on compromising public order and inefficacy to tackle drug use and its associated consequences.

The local community's worry regarding worsening crimes from the harm reduction approach somewhat drives them to challenge the services. In Paul's report, Musa Jantan, a medical practitioner involved in MMT delivery, is mentioned disclosing that the interruption occurs owing to the belief of the public on the programme's facilitation of drug consumption that drives criminal acts in the neighbourhood.[456] This shows that the Malaysian public concern pertaining to the outcome of a rise in crime is

[455] D. Malatesta et al., "Between Public Health and Public Disorder: Harm Reduction Facilities and Neighborhood Problems," in *AIDS in Europe: New Challenges for the Social Sciences*, ed. J.P. Moatti, et al. (New York: Routledge, 2000).183.

[456] R.D.J. Paul, "Doktor Rawat Penagih Dipandang Sinis oleh Masyarakat [Doctors Treating Addicts Viewed Cynically by Community]," http://mstar.com.my/variasi/rencana/cerita.asp?file=/2009/10/30/mstar_rencana/20091030081341&sec=mstar_rencana. (Last visited: 10/09/2013)

grave. The possible reason is that the national media has always reported on the growing prevalence of crime in public settings including thefts and bag snatching and associating them with drug use. This leads to public stigma towards drug users and pessimism about non-prohibition-based drug approaches. Similar grave concerns emerge in other jurisdictions.[457]

Arguing from an evidence-based point of view, it seems that the prediction of rising crime rates as a consequence of harm reduction programmes is implausible due to less conclusive supporting evidence. Some critics quote national crime statistics. EURAD (Europe against Drugs) for example, draws attention to the crime rate in the UK in 2005/2006, whereby 178,502 drug-related offences were recorded, marking a 23 per cent increase since 2004/2005.[458] Additionally, Gyngell contends that since 2007, the rate of drug-related crimes has increased by 2.9 per cent and there has been an annual average of 2.6 crimes committed by every drug user in the UK.[459] This statistical data cannot effectively give weight to the critics' claim as no attempt is undertaken to put the data into statistical perspective including considering differing factors which may contribute to the existing data and converting data into rates.

Additionally, a few international studies show results that give less support for the MMT's impact on reducing crimes. By way of illustration, the research in London comparing self-reported crime by MMT clients with non-client drug users found no

[457] For example, Normand, Vlahov, and Moses, *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*.134.
[458] Europe Against Drugs (EURAD), "From Methadone to Recovery," http://www.eurad.net/en/news/drug_treatment_+_recovery/From+Methadone+to+Recovery.9UFRjU1E.ips. (Last visited: 12/05/2013)
[459] Gyngell, "The UK's Treatment War on Drugs: A Lesson in Unintended Consequences and Perverse Outcomes".4.

significant variances in the overall volume of violent or acquisitive offences.[460] The researchers state that 'our data provide another challenge to the idea that there is a simple, mechanistic relationship between […] substitute prescribing and criminal desistance'.[461] Despite that, the study results are less notable because they are based on self-reporting and small sample sizes (100) and hence make generalising the MMT's impact on crime reduction problematic.

The presumption of increased crime can be further challenged by contradictory evidence. There is overwhelming empirical data that does not demonstrate support for the presumption. Norsiah et al. found a nominal proportion of Malaysian MMT clients involved in drug-related crimes, with no individuals committing other crimes such as theft and robbery after their participation in the programme. The researchers conclude that the service's presence mitigates drug-connected offences.[462] Consistently, there are some other evaluation reports in Malaysia such as those by Gill et al. and Kaur et al. confirming the hypothesis that MMT does not lead to a growing crime rate but instead causes its decline.[463] Some research also found no significant evidence suggesting the rise of criminal acts as a result of NSEP practice.[464]

Local research findings correspond with the results of international investigations. The study of MMT in New South Wales, Australia discovered a relationship between the

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[460] D. Best et al., "Crime and Expenditure amongst Polydrug Misusers Seeking Treatment - The Connection between Prescribed Methadone and Crack Use, and Criminal Involvement," *British Journal of Criminology* 41, no. 1 (2001).123.
[461] Ibid.125.
[462] Norsiah et al., "Can Primary Care Clinic Run MMT Service Well?."21–23.
[463] Gill, Sulaiman, and Habil, "The First Methadone Programme in Malaysia: Overcoming Obstacles and Achieving the Impossible."69–70; S. Kaur, H. Mohd., and M.N. Mohamed, "Projek Perintis Program Rawatan Terapi Gantian (RTG) Menggunakan Methadone di Pusat Khidmat AADK [Project of the Methadone Maintenance Therapy at AADK After Care Centres in Malaysia]," *Jurnal Antidadah Malaysia* 5, no. 1 (2009), http://www.adk.gov.my/html/pdf/jurnal/2009/5_3.pdf.23,29. (Last visited: 06/09/2013)
[464] Ibrahim, "Needle Syringe Exchange Program in Malaysia."54.

strategy and reduced criminal activity. The study used a vast and fairly representative sample (8,154) of people obtaining a methadone prescription during a two-year-period. It found that 12 months of each 100 individuals in MMT were associated with 12 fewer robberies, 57 fewer breaks in and 56 fewer motor vehicle thefts.[465] Additionally, the Cochrane meta-analysis results indicate that MMT has a positive, even non-significant connection to crime decrease.[466] Other large-magnitude studies and reviews such as by Farrel et al. and Havnes et al. are in agreement with the findings that MMT contributes to lowering crime rates.[467]

Moreover, international studies have found that NSEP has not resulted in the rise of crime or violence but instead has minimised the rates.[468] The results of a survey in Harlem, New York, USA show that the proximity to NSEP services is not linked to violent incidents.[469] In reviewing the evidence across a number of studies, Dolan et al. point out that 'there is no evidence to suggest that NSEP increase crime or violence'.[470] Obviously, harm reduction measures have no impact on growing crime, but in contrast, have an impact on reducing it.

Therefore, it is clear that harm reduction approaches do not cause increased crime incidences. There is no evidence of a causal relationship between the rise of crimes

[465] B. Lind et al., "The Effectiveness of Methadone Maintenance Treatment in Controlling Crime: An Aggregate-Level Analysis," *British Journal of Criminology* 45, no. 2 (2005).209–10.
[466] R.P. Mattick et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," *Cochrane Database of Systematic Reviews*, no. 3 (2009).10.
[467] M. Farrell et al., "Methadone Maintenance Treatment in Opiate Dependence: A Review," *British Medical Journal* 309, no. 6960 (1994).997–98; I. Havnes et al., "Reductions in Convictions for Violent Crime during Opioid Maintenance Treatment: A Longitudinal National Cohort Study," *Drug and Alcohol Dependence* 124, no. 3 (2012).308.
[468] For example, M.A. Marx et al., "Trends in Crime and the Introduction of a Needle Exchange Program," *American Journal of Public Health* 90, no. 12 (2000).1935.
[469] S. Galea et al., "Needle Exchange Programs and Experience of Violence in an Inner City Neighborhood," *Journal of Acquired Immune Deficiency Syndromes* 28, no. 3 (2001).287.
[470] K. Dolan et al., *Needle and Syringe Programs: A Review of the Evidence* (Canberra: Australian Government Department of Health and Ageing, 2005).18.

correlating with the existence of MMT or NSEP. By contrast, the interventions substantially lower offending behaviours. The weight of empirical results show significantly lower rates of criminal behaviour, particularly property and drug-related crime, for most drug users participating in harm reduction programmes compared to those who do not. Presumably, this finding is driven by the programmes' efficacy in decreasing illegal drug consumption. (This was discussed in Chapter 3, Section 3.3.) The reduction in using drugs to some extent leads to a reduction in drug users' involvement in drug dealing and acquisitive crimes to finance their drug consumption.

Nonetheless, the thesis's argument should not be understood to imply that a harm reduction approach is an optimal crime-control device or that it eliminates offending behaviour among those engaging in its programmes. Hall's review of research suggests that a significant number of those remaining in MMT persist in their criminality although at much lesser rates than prior to their entry to the programme.[471] Moreover, there are variations in the efficacy of harm reduction strategies in minimising crimes. As found by numerous studies, the differences of crime reduction outcome are considerably influenced by aspects such as client characteristics and programmes.[472] Thus, there is a need for caution in making a generalisation regarding the impact of such strategies in controlling crimes. Despite that, this analysis rejects the widespread perception pertaining to the possible crime growth resulting from the presence of harm reduction facilities and shows that it instead does contribute to criminality engagement reduction. This wholesome effect benefits both the drug using population and wider society.

[471] W. Hall, *Methadone Maintenance Treatment as a Crime Control Measure*, vol. 29, Crime and Justice Bulletin (Sdney: NSW Bureau of Crime Statistics and Research, 1996).7.
[472] For example, Lind et al., "The Effectiveness of Methadone Maintenance Treatment in Controlling Crime: An Aggregate-Level Analysis."210.

Furthermore, there is bound to be some degree of anxiety among the Malaysian public and law enforcement agencies for the NSEP's iatrogenic implication of an increase in the quantity of discarded needles and syringes in areas close to where the programmes are delivered.[473] Relative to increased crime, the issue of discarded needles creates less intense controversy in Malaysia. The possible reason is that the incidents are rarely reported by electronic or printed publications. Fewer used needles and syringes are found in public places except in hidden settings such as abandoned buildings. Despite that, the arising concern should not be underestimated as it might emerge to be a significant issue impacting public health interventions as has happened in some other nations.[474] In some cases, the controversy relating to this issue has resulted in the closing of NSEPs. Broadhead et al. recall the story of an NSEP programme in Windham, Connecticut, which was shutdown in 1997. The four year NSEP service came to an end as a consequence of a campaign led by the district attorney and public controversy after a child was punctured with a discarded needle.[475]

Beneath the concern of an increase in discarded needles is a fear of accidental needle-stick injuries and blood-borne infections from the discarded items. However, mere concern, even heightened, has no sound basis unless supported with credible evidence. While many critics fail to provide any supporting evidence, some attempt to certify the hypothesis based on limited and unconvincing empirical data. Christian argues that harm reduction strategies, including needle distribution, do not result in fewer discarded

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[473] Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia."50.

[474] For example, Normand, Vlahov, and Moses, *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*.216; G.E. Macalino et al., "Community-Based Programs for Safe Disposal of Used Needles and Syringes," *Journal of Acquired Immune Deficiency Syndromes* 18, no. Suppl 1 (1998).S111–S112.

[475] R.S. Broadhead, Y. Van Hulst, and D.D. Heckathorn, "Termination of an Established Needle-Exchange: A Study of Claims and Their Impact," *Social Problems* 46, no. 1 (1999).51.

needles in Sydney as no decrease has been observed.[476] Subsequent to the NSEP's initiation in Amsterdam, the figures for accidental needle-stick injuries reported to the Municipal Health Service increased. However, this finding does not give plausible support for the NSEP's negative impact given a possible bias in reporting which related to the public's growing awareness about blood-borne pathogens.[477]

The other rebuttal to the concern is that, theoretically, the one-for-one rules applied by NSEP may remove injection equipment from circulation and hence lessen the quantity of discarded items. The proponents including Doherty et al. point out that the discard of needles can be averted by the operation of a one-for-one-based NSEP programme since the quantity of returned needles will be concomitant to the quantity of prescribed needles.[478] The impact of discarded injection items may also somewhat be prevented by the NSEP's supplementary operations. In furtherance to distributing injection equipment, it provides education on safe disposal, collects used injection items, makes containers and disposal bins available and sanitises areas with discarded syringes. These aspects support the argument that NSEP may contribute to fewer discarded injection instruments in public settings. This is further confirmed by local reports showing that the service in practice has effectively collected a number of used needles. For example, the MOH of Malaysia discloses that the overall return rate for NEPs at the

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[476] G. Christian, "The Sydney Injecting Centre -Assessing the Evidence-Base," *Journal of Global Drug Policy and Practice* 5, no. 1 (2011), http://www.globaldrugpolicy.com/Issues/Vol%205%20Issue%201/JournalofGlobalDrugPolicyVol5Issue1.pdf.15–16. (Last visited: 09/04/2013)

[477] A. Verster, *Seven Years Needle and Syringe Exchange in Amsterdam* (Amsterdam: Municipal Health Service, Department of Public Health, 1992).2-5.

[478] M.C. Doherty et al., "Discarded Needles Do Not Increase Soon after the Opening of a Needle Exchange Program," *American Journal of Epidemiology* 145, no. 8 (1997).731.

end of December 2006 was 61.6 per cent of total distribution of 42,000 needles.[479] In 2011, the return rate climbed to 64 per cent.[480] In some cases, it is reported to have achieved more than 90 per cent.[481]

The theoretical explanation is strengthened by direct empirical evidence suggesting no rise in the number of discarded needles in public settings following the NSEP's introduction in Malaysia and other countries. The research findings relating to Malaysia's pilot NSEP disclose the gradual increase of the total return rate, achieving nearly 60 per cent, and no increased needle and syringe litter in public settings near the service sites after the first year of its operation.[482] This finding is compatible with the results of international studies demonstrating that the NSEP's establishment does not increase the quantity of needles and syringes discarded in the vicinity but instead causes its decline.[483] The research by Broadhead et al. assessing the condemnations of the local residents in association to iatrogenic consequences of NSEPs leading to their closure in Windham, reveals that the negative perceptions had no foundation. Discarded needles and syringes did not reduce after the closing of NSEPs.[484] Also, the results of research in Vancouver show an independent relationship between NSEP and the safer disposal of

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[479] Kementerian Kesihatan Malaysia, *Laporan Tahunan Kementerian Kesihatan Malaysia 2006 [Annual Report of Ministry of Health Malaysia 2006]* (Putrajaya, Malaysia: Kementerian Kesihatan Malaysia, 2006).95.

[480] Malaysian AIDS Council and Malaysian AIDS Foundation, *Annual Report 2011: Malaysian AIDS Council, Malaysian AIDS Foundation. Getting to Zero* (Kuala Lumpur: Malaysian AIDS Council & Malaysian AIDS Foundation, 2012).21.

[481] Shan, "Report on An Interim Review and A Gap Analysis of the Harm Reduction Programme in Malaysia."50.

[482] Ibrahim, "Needle Syringe Exchange Program in Malaysia."35, 51, 54.

[483] For example, K.J. Oliver et al., "Impact of a Needle Exchange Program on Potentially Infectious Syringes in Public Places," *Journal of Acquired Immune Deficiency Syndromes* 5, no. 5 (1992).534; Doherty et al., "Discarded Needles Do Not Increase Soon after the Opening of a Needle Exchange Program."736.

[484] Broadhead, Van Hulst, and Heckathorn, "Termination of an Established Needle-Exchange: A Study of Claims and Their Impact."58–62.

syringes.[485] Considering the evidence against the hypothesised increased discard, the prediction of such consequence is hence fragile.

In summary, harm reduction measures have not resulted in unintended negative consequences, either worsening crime rates or increasing needle and syringe litter. Failure to engage with conclusive and persuasive evidence makes the relevant fears unfounded. The theoretical analysis and empirical evidence further demonstrate that harm reduction interventions can be expected to produce the opposite outcome. However, it is worth noting that caution is needed for applying the findings from specific jurisdictions to other countries, as the indicators of public amenity are subject to considerable variances across the countries such as socio-culture and drug consuming means. This analysis discovers a dearth of research in Malaysia and many other countries specifically evaluating the unintended negative impacts of harm reduction measures to the communities. It is timely for further specific assessments on the implications and, if discovered, appropriate methods to tackle them should be developed.

## 3.7 Conclusion

This chapter has shown that harm reduction measures are effective and cost-effective in controlling drug use and HIV transmission. There exists compelling scientific evidence locally and globally to suggest that MMT and NSEP can reduce drug taking, HIV-risk

[485] E. Wood et al., "An External Evaluation of a Peer-Run "Unsanctioned" Syringe Exchange Program," *Journal of Urban Health* 80, no. 3 (2003).462.

behaviours and infection incidents among drug users. The strategies may also produce economic benefits, considering their proven cost-effectiveness and cost-saving for drug use and HIV prevention. The efficacy and financial efficiency of the measures are strong enough to justify their implementation despite their less protective and economic effects for HCV pathogen prevention. Further, no evidence is found to suggest that the strategies result in harms including increased drug consumption, drug taking encouragement and negative effects against public amenities in terms of a rise in crime and discarded syringes. The encouraging outcomes are unaffected by some negative empirical data, considering persuasive expounding explanations for negative research findings and generally the overwhelming volume of supporting study results. The opponents' claims to the interventions' inefficacy, economically inefficiency and adverse consequences are implausible due to missing, inconclusive or deficient evidence.

Drawing on the outcomes of MMT and NSEP, both can be expected to yield wider health-related and other benefits to drug-using populations and communities. The interventions' effectiveness and cost-effectiveness could be improved through the integration of multiple methods. Given the proven effectiveness and cost-effectiveness, their practices are highly justifiable and worthwhile. More research on these aspects should be undertaken, particularly in Malaysia where scarce evidence is detected.

Despite the justifiability of harm reduction measures in Malaysia from ethical (as highlighted in chapter 2) and scientific imperatives, the remaining major issue is whether their implementation is compatible with existing criminal justice approach. This will be the focus of the next chapter.

# CHAPTER 4

# IS THE HARM REDUCTION APPROACH IN MALAYSIA COMPATIBLE WITH THE CONTINUED USE OF THE CRIMINAL JUSTICE APPROACH?

## 4.1 Introduction

Despite the formal recognition and implementation of the harm reduction approach in Malaysia, criminal laws which prohibit drugs have been historically and constantly practised in Malaysia. Therefore, there appear an important question relating to the compatibility between the harm reduction and criminal justice approaches being pursued at the same time. The present widespread assumption and official position is that the two approaches are compatible, particularly due to the adoption of government initiatives including collaborative efforts towards preventing the conflict. This thesis intends to challenge this perspective, arguing that significant conflict between the two approaches may occur despite the presence of such mechanisms to eliminate the conflict.

The main objective of this chapter is to consider whether there is compatibility between the harm reduction and criminal justice approaches as they are practised in Malaysia, and if not, where the conflict originates and what it reflects. To date, there has not been any significant discussion of these issues in Malaysia. The discussion in this chapter will focus on several relevant important aspects including: the legislative and regulatory framework in Malaysia related to drug use that may clash with and/or affect

the harm reduction strategy; the government initiatives to avoid the conflict between the two approaches; the impact in practice of the legislative and regulatory framework and government initiatives upon the harm reduction operation; the issue of uniqueness of the conflict between both approaches to Malaysia; the seriousness and significance of the conflict and factors related to the police exercise of their discretion in relation to harm reduction. The issue of compulsory drug treatment will also be considered in this chapter. The examination of this issue is important because the compulsory drug treatment has constituted the principal and dominant approach for drug users in Malaysia for many decades. The question of compulsory treatment further relates to the wider issue of compatibility between the harm reduction and criminal justice approaches because within the Malaysian context, it shapes significantly the criminal justice method for addressing the drug use problem, which contrasts strongly with harm reduction principles and practice.

The discussion in this chapter will engage 'gap' analysis in which, in the words of Feeley, 'legal aspiration is contrasted with actual practice as a first step toward accounting for the 'gap''.[486] While gap analysis can be a significant analytical tool for socio-legal research, there have been criticisms that the attention of gap analysis tends to be drawn to organisational level analysis at the expense of broader environmental influences.[487] This chapter will attempt to apply gap analysis sensitively to the social and cultural contexts in which the law operates rather than merely the organisational factors. Furthermore, the discussion is supported with local evidence together with consideration of the international literature.

[486] M.M. Feeley, "Three Voices of Socio-Legal Studies," *Israel Law Review* 35, no. 2-3 (2001).185.
[487] For example, ibid.187.

## 4.2 A Review of the Legislative and Regulatory Framework in Malaysia relating to Drug Use

The development of harm reduction services in Malaysia has not been accompanied with any explicit legal provision authorising their operation and Malaysia's responses to drug use are still fundamentally based on the criminal justice approach. This section will assess the legislative and regulatory framework in Malaysia relating to drug use and its consistency with and/or potential effects to the harm reduction principles and practices. For that purpose, an analysis of present various relevant legal provisions is made. However, consideration of how the legislative and regulatory framework actually impacts in practice on the implementation of harm reduction will be given in a later section of this chapter.

### 4.2.1 Criminal Offences in relation to Self-Administration and Possession of Drugs

#### *4.2.1.1 Self-Administration of Drugs*[488]

The criminalisation of illicit drug consumption and possession, even for personal use, with attendant sanctions ranging from a fine to long-term imprisonment remains the primary legal approach for controlling drug use. Self-administration and consumption of drugs are made unlawful by section 15 of DDA 1952. The penalties on conviction consist

[488] The discussion in this section relates generally to the act of self-administering illicit drugs. The act of administrating methadone, with or without authority, is discussed specifically later in this chapter, in Sections 4.2.4.

of imprisonment for a term of up to two years or a fine of up to RM5000.00.[489] Section 15(2) defines the word 'consumes' as to include eating, chewing, smoking, swallowing, drinking, inhaling or introducing into the body in any manner or by any means whatsoever. The statute, however, does not provide the meaning of 'administer'. Considering the exemption of the medical administration of drugs to others under section 14(2) of the DDA 1952, it is argued that the term 'administers' as mentioned in section 15 similarly refers to the common ways of administering medicines i.e. orally by swallowing or intravenously.

To prove offences, the law authorises the coerced testing of suspects. The High Court in *PP* v *Chan Kam Leong*[490] held that the accused could be convicted of the offence upon the proof pertaining to (1) his self-administering of dangerous drugs or allowing another person, contrary to section 14, to administer the drugs to him; and (2) that dangerous drugs had been found in his urine which had been clinically tested. Despite the issues concerning urinalysis such as a possible presence of *opiates metabolites* in legal drugs and a broken chain of evidence[491], a biochemist's report confirming a urine sample's positivity for *opiates metabolites* may sufficiently convict a person who pleads guilty for this offence. In the Drugs Dependants (Treatment and Rehabilitation) (Amendment) Act 2002[492], the offence may now be proved based on statutory presumption as provided in section 37(k) DDA 1952, thereby easing the convicting of the

[489] Pursuant to section 376 of Criminal Procedure Code, the public prosecutor is authorised to determine whether to charge drug dependants under section 6 of DDTRA 1983 or section 15 of DDA 1952. See the High Court's ruling in *PP* v *Chan Kam Leong* [1989] 2 CLJ (Rep) 311, 313. The alternative basis of criminal liability for drug users might be consuming prepared opium punishable with imprisonment of not more than two years or a fine of not more than MYR5,000 or both upon conviction as provided in section 10(2)(b) of DDA 1952. Section 10(2)(3) of DDA 1952 provides a similar meaning of consuming as given by section 15(2) of the same Act.
[490] [1989] 2 CLJ (Rep) 311, 313.
[491] Majid, *Dangerous Drugs Laws*.128, 130.
[492] Act A1167.

offence. The finding that tested urine contains dangerous drugs may be used to presume that the accused has consumed the drug, has self-administered the drug or has allowed another person to administer the drug.

This clearly shows that despite the formal recognition of a public health approach, including harm reduction programmes for drug users, the group is highly exposed to penal approaches including coercive testing and imprisonment for consuming drugs. This is also how the law likely treats those who self-administer drugs as they have a connection to a drug use problem and are therefore in need of monitoring and rehabilitation. This is manifested by the provision subjecting a person convicted of the offence of self-administration of drugs to supervision under a rehabilitation officer of between two and three years immediately after discharge from prison.[493] The law can leave drug users facing the daily risks of investigation and arrest. In the absence of any statutory exemption, MMT and NSEP clients found that by consuming illicit drugs they can technically be detained and convicted for the offence. Even finding urine to contain drugs may lead to incarceration which is generally disconnected from harm reduction policy. Drug users bear the burden of challenging the prosecution, given the statutory presumption based on the urine test. As we shall see later in this section, the criminalisation of drug taking may also influence drug users' relocation to secluded areas and may deter their involvement in community-based drug programmes, including harm reduction, for fear of being detected and arrested. This indicates that the legislative provisions criminalising drug taking may pose a potential threat of criminal liability for

[493] DDA 1952, s 38B. The High Court in *Public Prosecutor* v *Ng Hock Lai* [1994] 4 CLJ 1056, 1058 ruled that pursuant to section 38B of DDA 1952, the court should make the supervision order after deciding the drug offender's conviction and sentence under section 15.

drug users including those participating in MMT and NSEP and possible obstacle to the strategies' accessibility.

#### *4.2.1.2 Possession of Drugs*[494]

Drug users risk criminal charges for possessing illicit drugs if they are caught with drugs, even if they are solely for personal consumption. The law does not distinguish possession between personal and commercial use. Possession, even a small quantity of illegal drugs, is prohibited as the criminalisation accounts for the possession of drugs, rather than drug quantity. The offences relating to possession and their punishments are prescribed under several sections of DDA 1952 (shown in Table A). The penalty upon conviction of a possession offence ranges from a fine to life imprisonment. The penalty depends on the nature and quantity of illicit drugs.

Table A: Types of Offence for Drug Possession under DDA 1952

Note: (<): Not greater than; (>): Not less than; MYR: Malaysian Ringgit

| **Section** | **Offence** | **Punishments** |
|---|---|---|
| 6 | Possession of raw opium, coca leaves, poppy straw and cannabis, or the seeds of the plants | Imprisonment: <5 years or fine: <MYR20,000, or both |

[494] This section provides general discussion on illicit drug possession. Specific discussion on the possession of methadone, with or without authority, can be found later in this chapter, in Sections 4.2.4.

| 9(1)(b) | Possession of prepared opium | Imprisonment: <5 years or fine: <MYR20,000, or both |
|---|---|---|
| 12(2) | Possession of other dangerous drugs listed in Part III, IV & V of the First Schedule | Imprisonment: <5 years or fine:<MYR100,000, or both |
| 39A(1) | Possession of:<br>• 2g<5g heroin or morphine or monoacetylmorphines or a mixture of any of them;<br>• 5g<15g cocaine;<br>• 20g<50g cannabis or cannabis resin or a mixture of them;<br>• 100g<250g raw or prepared opium or a mixture of them;<br>• 250g<750g coca leaves;<br>• 5g<30g 2-Amino-1-(2, 5-dimethoxy-4-methyl) phenylpropane or Amphetamine ort 2, 5-Dimethoxyamphine (DMA) or Dimethoxybromoamphetamine (DOB) or 2, 5-Dimethoxy-4-ethylamphetamine (DOET) or Methamphetamine or 5-Methoxy-3, 4-Methylenedioxyamphetamine (MMDA) or Methylenedioxyamphetamine (MDA) or N-ethyl MDA or N-hydroxy MDA or N-methyl-1 (3, 4-methylenedioxyphenyl)-2-butamine or | Imprisonment: >2 <5 years and whipping:>3 <9 strokes |

| | | |
|---|---|---|
| | Methylenedioxymethamphetamine (MDMA) or<br>Paramethoxyamphetamine (PMA) or<br>3, 4, 5-Trimethoxyamphetamine (3, 4, 5-TMA) or a mixture of any of them. | |
| 39A(2) | Possession of a prescribed amount of certain drugs:<br>Possession of:<br>• 5g> heroin or morphine or monoacetylmorphines or a mixture of any of them;<br>• 15g> cocaine;<br>• 50g> cannabis or cannabis resin or a mixture of them;<br>• 250g> raw or prepared opium or a mixture of them;<br>• 750g>coca leaves;<br>• 30g>2-Amino-1-(2, 5-dimethoxy-4-methyl) phenylpropane or<br>Amphetamine or<br>2, 5-Dimethoxyamphine (DMA) or<br>Dimethoxybromoamphetamine (DOB) or<br>2, 5-Dimethoxy-4-ethylamphetamine (DOET) or<br>Methamphetamine or<br>5-Methoxy-3, 4-Methylenedioxyamphetamine (MMDA) or<br>Methylenedioxyamphetamine (MDA) or<br>N-ethyl MDA or<br>N-hydroxy MDA or | Imprisonment: >2 or imprisonment for life and whipping:>10 strokes |

| | | |
|---|---|---|
| | N-methyl-1 (3, 4-methylenedioxyphenyl)-2-butamine or<br>Methylenedioxymethamphetamine (MDMA) or<br>Paramethoxyamphetamine (PMA) or<br>3, 4, 5-Trimethoxyamphetamine (3, 4, 5-TMA) or<br>a mixture of any of them. | |

Possession is not defined in drug law or Penal Code but a great number of cases show that the accused is regarded to be in possession of a prohibited drug when it is proved that he had custody and/or control of dangerous drugs and had knowledge of the nature of the drugs found.[495] In *Director of PP* v *Brooks*[496], Lord Diplock, in delivering the Privy Council's judgment, stated 'In the ordinary use of the word 'possession', one has in one's possession whatever is, to one's own knowledge, physically in one's custody or under one's physical control'. According to Taylor J in *Leow Nghee Lim* v *R*[497], custody can be interpreted as: '[…] having care or guardianship; goods in custody are in the care of the custodian and, by necessary implication, he is taking care of them on behalf of someone else'. The Lordship also gave elucidation of the word 'control': 'Control must be proved as a fact and it must arise from the relation of the person to the goods, irrespective of whether they are contraband'.[498] The custody or control must also

[495] For example, *PP* v *Muhamad Nasir bin Shaharuddin & Anor* [1994] 2 MLJ 576, 592; *PP* v *Reza Mohd Shah bin Ahmad Shah* [2009] 2 MLJ 490, 499, 502.
[496] [1974] AC 862, 866.
[497] [1956] 22 MLJ 28, 29.
[498] Ibid., 32.

be shown to be exclusive.[499] In the light of judicial decisions, particularly the superior courts, the prosecution no longer holds the burden of proving that the accused has the power of disposal over the drugs[500].[501]

The requirements of the offence may be proved by direct evidence or based on statutory presumption. Section 37(d) presumes the possession of dangerous drugs and knowledge of the nature of drugs when custody or control is established. This may give advantage to the prosecution and against the accused. This presumption may only be rebutted by the accused discharging the evidential burden on balance of probabilities that he was neither in possession of the drugs nor he knew the nature of the drugs.[502]

Even though possession and the self-administration of drugs are independent offences, drug users may risk a dual charge due to their connection to both acts. They often possess a drug before consuming it. A conviction for possession is highly possible if they are caught with a drug, facilitated by statutory presumption. Both practitioners and law-makers have failed to pay sufficient regard to the effects of the strict liability nature of section 37(d) on drug users and the harm reduction approach.

The continued criminalisation and use of punishments with lengthy incarceration and whipping for possession, even for personal use, are problematic from the perspective

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[499] *Abdullah Zawawi bin Yusoff* v *PP* [1993] 3 MLJ 1, 7; *PP* v *Mohd Zambri bin Mohd Zelah* [2005] 2 AMR 23, 28.

[500] Gordon-Smith Ag. CJ's dictum in *Toh Ah Loh &Mak Thim* v *R* [1949] MLJ 54, 55 highlighted the power of disposal element of possession. This was followed by several cases including *PP* v *Ang Boon Foo* [1981] 1 MLJ 40, 43 whereby Gun Chit Tuan J elucidated power of disposal to denote the capability of dealing with a moveable thing as owner excluding others by saying: 'There is therefore a power of disposal, and therefore possession in law where a person is so situated with respect to a moveable thing, such as a dangerous drug in this case, if he has the power to deal with it as owner to the exclusion of all other persons and when the circumstances are such that he may be presumed to do so in case of need'.

[501] The Supreme Court in *PP* v *Kau Joo Huat* [1988] 2 MLJ 91, 94.

[502] *Illian & Anor* v *PP* [1988] MLJ 421, 424.

of the harm reduction approach. They reflect the fact that the control of drug use is still dominated by the principle of deterrence and retribution rather than by considerations of public health. Drug users will hence remain at high risk of receiving criminal sentences. The fear of enforcement actions, including investigations, may affect their readiness to attend harm reduction services. Legal detention, criminal charges and sanctions may further interrupt their accessibility to harm reduction interventions. There is a clear possibility that they will lose the opportunity to obtain harm reduction services, given the non-existence of any regulatory or policy document securing their rights to obtain the services in criminal justice settings, including police lock-ups and prisons. We shall consider later in this section the extent to which the law penalising drug possession, even for individual consumption, undercuts the missions and efforts of harm reduction interventions.

### 4.2.2 Compulsory Treatment for Drug Use

The law governing compulsory treatment constitutes another feature of the sustained legal response to drug use which is inconsistent with the harm reduction approach. It refers to the legislated involuntary detention or civil commitment of persons for drug treatment. It is important to devote some attention to the justifiability issue of this intervention because it is a dominant response to drug use in Malaysia. Support for compulsory drug treatment mostly hinges on the argument relating to the role of state-mandated treatment in managing and rehabilitating drug users. Some argue that this approach embodies

therapeutic and harm reduction elements albeit with the threat of criminal sanctions if drug users fail to comply. As Wu has written, compulsory treatment centres function to protect individuals and the community by decreasing drug use and its attendant harms including mortality, criminality associated with drugs and risky behaviours. From this, Wu claims that compulsory treatment suits the harm reduction and safety imperatives.[503]

State-mandated treatment is seen by its advocates as effective in achieving the aims of drug treatment. However, there is no evidence to support the approach's effectiveness. By contrast, studies in multiple jurisdictions have found high relapse rates ranging from 60 to 100 per cent upon discharge.[504] The approach also does not decrease but may rather heighten the health and safety problems among people detained. The evidence shows that the compulsory drug treatment centres are unaccustomed to evidence-based drug interventions, particularly harm reduction measures.[505] Additionally, the centres lack health programmes and skilled medical personnel.[506] Unsurprisingly, the cases of blood-borne infections, especially HIV/AIDS, are highly recorded in the

[503] Z. Wu, "Arguments in Favour of Compulsory Treatment of Opioid Dependence," *Bulletin of the World Health Organization* 91, no. 2 (2013).142–43.
[504] World Health Organization (Western Pacific Region), *Assessment of Compulsory Treatment of People who Use Drugs in Cambodia, China, Malaysia and Vietnam: An Application of Selected Human Rights Principles* (Geneva: World Health Organization, 2009).29.
[505] Ibid.19; G. Reid, A. Kamarulzaman, and S.K. Sranc, "Malaysia and Harm Reduction: The Challenges and Responses," *International Journal of Drug Policy* 18, no. 2 (2007).137–38; J. Godwin, *Regional Issues Brief: Laws and Practices Relating to Criminalization of People Living with HIV and Populations Vulnerable to HIV* (New York: Global Commission on HIV and the Law, 2011).17.
[506] For example, World Health Organization (Western Pacific Region), *Assessment of Compulsory Treatment of People who Use Drugs in Cambodia, China, Malaysia and Vietnam: An Application of Selected Human Rights Principles*.26, 29; United Nations Office on Drugs and Crime Regional Office for Central Asia and Canadian HIV/AIDS Legal Network, *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform* (Ashgabat: United Nations Office on Drugs and Crime, Regional Office for Central Asia & Canadian HIV/AIDS Legal Network, 2010).56.

centres.[507] The poor therapeutic and harm reduction outcomes of the approach call into question the supporters' claim that it is effective.

More importantly, mandatory treatment for drug users is also ethically flawed. This is because it is still penal in nature[508] which is contradictory to ethical medical standards including informed consent and international human rights including the rights to freedom of movement,[509] freedom from arbitrary detention[510] and protection from inhuman and degrading treatment or punishment,[511] subject to the limited guarantee of due process of law and strict emphasis on abstinence from drugs. Drug users are forced to enter residential drug treatment or be put under the supervision of rehabilitation staff for an extended period of time. They are liable to punishment upon returning to drug consumption. Obviously, the operation of compulsory treatment is widely carried out through what Foucault calls 'coercive technologies'. According to Seddon, the words mean: 'techniques, devices and mechanisms that use force, violence or threats to govern or direct the behaviour of individuals'.[512] An additional complication is that the detainees are exposed to inhuman or degrading practices such as physical violence and mistreatment by in-charge officers as revealed by past studies.[513] The argument put forth by the proponents in the defence of state intervention relies on its importance for restoring

[507] W. Hall et al., "Compulsory Detention, Forced Detoxification and Enforced Labour are not Ethically Acceptable or Effective Ways to Treat Addiction," *Addiction* 107, no. 11 (2012).1891.
[508] *Sanuar Kamarudin bin Ahmad* v *Menteri Hal Ehwal Dalam Negeri Malaysia & Anor* [1996] 5 MLJ 1.
[509] International Covenant on Civil and Political Rights (ICCPR), Article 12.
[510] International Covenant on Civil and Political Rights (ICCPR), Article 9.
[511] Universal Declaration of Human Rights (UDHR), Article 5; International Covenant on Civil and Political Rights (ICCPR), Article 7; United Nations General Assembly, *Resolution 39/46: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Articles 1and 2.

[512] T. Seddon, "Court-Ordered Treatment, Neo-Liberalism and Homo Economicus," in *The Drug Effect*, ed. S. Fraser and D. Moore (Cambridge: Cambridge University Press, 2011).161.
[513] For example, K. Dolan and A. Rodas, "Drug Users and Imprisonment," in *Drug Law Reform in East and Southeast Asia*, ed. F. Rahman and N. Crofts (Plymouth: Lexington Books, 2013).45.

the autonomy of drug users. As argued, individuals who are drug dependent lack the ability for autonomy and self-determination.[514] This premise is less credible given a number of countering scientific findings.[515] Additionally, advocates justify this in terms of the need to balance drug users' rights with communities which are negatively affected by drug use.[516] In response, violations of individual rights are not directly justifiable on the basis of the public good unless circumstances make such violations a necessity. The deprivation of individual liberty in exceptional situations is, however, subject to certain criteria including a short period practice and a prior reliable assessment of conflicting interests.[517] This is somehow not satisfied by Malaysia as reflected by the current legislative provisions and practice. Thus, the ethical arguments for mandatory drug treatment based on its good for drug users and the general public seem to be unsound.

However, it can be noted that compulsory drug treatment can be ethical in certain exceptional circumstances. The first situation is connected to critical drug dependency or demonstrable high risk behaviour.[518] Drug users who have either of these cause harm or imminent risk to the health and safety of themselves and others. Mandatory detention would serve the public health and security imperative by treating drug dependency and altering dangerous behaviour. But, the justifiability of compulsory treatment must be made dependent on certain criteria, particularly the due legal process and non-

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[514] For example, A.L. Caplan, "Ethical Issues Surrounding Forced, Mandated, or Coerced treatment," *Journal of Substance Abuse Treatment* 31, no. 2 (2006).118–19.
[515] For example, B. Foddy and J. Savulescu, "Addiction and Autonomy: Can Addicted People Consent to the Prescription of Their Drug of Addiction?," *Bioethics* 20, no. 1 (2006).15.
[516] Wu, "Arguments in Favour of Compulsory Treatment of Opioid Dependence."142.
[517] Discussion of public good vis-à-vis human rights can be found in Chapter 2, Section 2.3.
[518] More discussion on this appears in Chapter 5, Section 5.3.

involvement in voluntary or less restrictive strategies.[519] This is not the case in Malaysia. The structural and procedural framework and practice related to Malaysian compulsory treatment has many issues including a lack of consistency to the due process of law; no exemption for those undergoing voluntary public health measures in the community; and liability to more stringent criminal sanctions in a recidivism case or breach of relevant conditions.[520] The second situation relates to a referral mechanism. The compulsory treatment may be offered as an alternative to criminal justice sanctions for individuals who commit property crimes to finance their drug taking.[521] The justification relies on the preference of treatment over punishment in managing drug-dependent offenders in terms of individual right to treatment, and the medical, public health and safety imperatives as supported by extensive evidence.[522] Further, the diversion to treatment is consistent with the principle of proportionality as it is not more severe or restrictive than the alternative disposed criminal sanction.[523] This, however, must be subject to some prerequisites. Gostin suggests that the diversion to treatment should be focused on those with serious dependency to drugs and susceptibility to treatment, in compliance with the due process of law and being less restrictive of liberty than the usual punishment.[524] Indeed, this referral mechanism is not generally adopted in Malaysia.

The above discussion demonstrates that compulsory drug treatment is highly problematic in terms of its effectiveness and ethical basis. However, it is acknowledged

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[519] L. Gostin, "Traditional Public Health Strategies," in *AIDS Law Today: A New Guide for the Public*, ed. S. Burris, et al. (New Haven & London: Yale University Press, 1993).74–75.
[520] More evidence can be found later in this section.
[521] More discussion appears in Chapter 5, Section 5.3.
[522] G. Gerra and N. Clark, *From Coercion to Cohesion: Treating Drug Dependence through Health Care, Not Punishment* (Vienna: United Nations, 2010).2–4.
[523] A. Stevens, "The Ethics and Effectiveness of Coerced Treatment of People who Use Drugs," *Human Rights and Drugs* 2, no. 1 (2012).13.
[524] L.O. Gostin, "Compulsory Treatment for Drug-Dependent Persons: Justifications for a Public Health Approach to Drug Dependency," *Milbank Quarterly* 69, no. 4 (1991).584, 586.

within the Malaysian legal framework. DDTRA 1983 mandates arrest, forced examination and treatment in rehabilitation centres or supervision of drug dependents. The Act empowers any police officer or rehabilitation officer to take any person into custody who is suspected to be drug dependent.[525] Drug dependent is defined by section 2 as someone who, through the use of any dangerous drug, undergoes a psychic and sometimes physical state which is characterised by behavioural and other responses including the compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effect and to avoid the discomfort of its absence.

The person may be detained for 24 hours for dependency assessment.[526] In the case of an incomplete assessment, he may be released on bail (with or without surety) or taken to a magistrate for application of further detention for a maximum period of 14 days.[527] This period is worded differently from that envisaged by the Criminal Procedure Code governing the criminal procedure of detention in lawful custody.[528] Moreover, the wording of 'shall, if the officer reports to the Magistrates that it is necessary to detain him for the purpose of undergoing tests, order him to be so detained' in section 4(1) of DDTRA 1983denotes that the court is obliged to issue the order of further detention in accordance to the officer's claim of its necessity. Decided cases show that the order is justified based on just one officer's submission of the need to conduct a drug test. Research shows that such an extensive period of remand is unnecessary as the results of

[525] DDTRA 1983, ss 2 and 3(1).
[526] DDTRA 1983, s 3(2).
[527] DDTRA 1983, s 4(1).
[528] Section 117(2) of the Criminal Procedure Code, in relation to the offences punishable with imprisonment of less than 14 years, authorises a remand order for up to four days for first application and up to three days for second application, while for the other offences punishable with minimum 14 years of imprisonment or the death penalty, the remand is warranted for up to seven days for first and second applications, respectively.

urinalysis in Malaysia are achieved within one day.[529] This provision obviously curtails judicial discretion. A magistrate has to approve a remand application without judicially scrutinising its substantiation. Many assessment reports disclose the cases of Malaysian magistrates acting as 'rubber stamps' in remand proceedings.[530] Moreover, for the purpose of the assessment, suspects are subject to a range of forcible acts and procedures[531] with the common practices being urine tests and observation by medical practitioners.[532]

The detainee must subsequently be brought before the court upon the medical practitioner's certification confirming drug dependency. By considering the certification, rehabilitation officer's recommendations and drug dependant's representation (if it is made), a magistrate may order him to undergo compulsory treatment in a government-run rehabilitation centre for two years and then placed on supervision for two years, or otherwise a two to three year supervision.[533] There is no detailed procedure or other requirement for the recommendation and representation stipulated by legislative provision, thereby exposing the risks of incredible or insufficient statements. As compared to the position before the amendment by Drugs Dependants (Treatment and Rehabilitation) (Amendment) Act 1998[534], more mandatory procedural requirements have been provided including the magistrate's consideration of the circumstances of the drug dependant's case, age, education, character, health, employment, antecedents and other

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[529] S. Mohamed, "Mandatory Assessment of Drug Users in Malaysia: Implications on Human Rights," *Drugs: Education Prevention and Policy* 19, no. 3 (2012).3.
[530] For example, Human Rights Commission of Malaysia (SUHAKAM), *Law Reform Report: Rights of Remand Prisoners* (Kuala Lumpur: SUHAKAM, 2001).8.
[531] DDTRA 1983, s 5.
[532] *Re Roshidi bin Mohamed* [1988] 2 MLJ 193,197.
[533] DDTRA 1983, s 6(1).
[534] Act A1018.

circumstances, the rehabilitation officer's report, supplying a copy of the report, reading it out and explaining its contents to a drug dependant.[535] A further complication is that the magistrate's order, upon treatment or supervision, has a final effect and therefore cannot be appealed or revised by the High Court, or held by the Supreme Court in *Ang Gin Lee* v *PP*[536]. The court's reasoning is that the order falls under the jurisdiction of a magistrate rather than the magistrate's court in a criminal case or matter which can be appealed as described in section 307(i) of the Criminal Procedure Code. Thus, the related procedures and treatment order are likely arbitrary and less congruent to the principle of the due process of law.

Moreover, based on section 38A of DDA 1952, the judicial order of treatment or supervision under DDTRA 1983, in lieu of other criminal sanctions, may be made for a convicted drug offender below 18 if he is a certified drug dependant and it is expedient to do so. This provision is, however, not applicable to those committing drug offences of trafficking,[537] planting or cultivation,[538] or possession,[539] which attract severe punishments. This provision purports to acknowledge the nexus between drug offences and drug problems amongst juvenile offenders. However, no similar lenient treatment is provided for adult or other crimes caused by drug dependency, including acquisitive crimes.

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[535] These procedures are stated in sections 6(3) and (4) prior to the amendment.
[536] [1991] 1 MLJ 498, 500–01.
[537] DDA 1952, s 39B. The offence is punishable with death on conviction.
[538] DDA 1952, s 6B. The offence is punishable with life imprisonment and whipping of minimum six strokes on conviction.
[539] The offence refers to the possession punishable with maximum life imprisonment and whipping of minimum 10 strokes on conviction under section 39A of DDA 1952.

For drug dependants who volunteer for treatment, the law permits rehabilitation officers to decide whether there will be treatment in a rehabilitation centre or supervision after drug dependency tests and certification by a medical practitioner.[540] This can take place without the need for getting the consent of volunteer drug dependants, as was the case before the amendment by Drugs Dependants (Treatment and Rehabilitation) (Amendment) Act 1998.[541] Even though they will not be subject to court proceedings, they cannot choose their own type of treatment whether in a rehabilitation centre or supervision, and are not guaranteed by law to obtain harm reduction services.

The drug dependant placed in a rehabilitation centre needs to undergo an abstinence-based treatment and other organised activities.[542] A drug dependant undergoing supervision in the community must comply with stringent conditions on liberty regarding residence, cessation of drug consumption and compulsory procedures including drug testing, reporting and participating in rehabilitation programmes.[543] The person is usually compelled to undergo detoxification to comply with the condition of abstaining from drugs. In the case of the contravention of supervision restrictions, the individual may be subject to a maximum three-year imprisonment or maximum three-stroke whipping, or both.[544] This may constitute another basis for incarcerating drug users even though they still have a dependency problem. This mirrors another penal characteristic of drug use control.

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[540] DDTRA 1983, ss 8 and 9. Pursuant to these provisions, drug treatment can be voluntarily applied for by drug dependants, parents, or guardians for those below 18 years.
[541] Act A1018.
[542] DDTRA 1983, s 26.
[543] DDTRA 1983, s 6(2).
[544] DDTRA 1983, s 6(3).

Drug users are at a high risk of compulsory treatment if they show signs of drug dependency. Even though they may already be involved in MMT or NSEP, those who are found to be dependent on illicit drugs could still be subjected to compulsory drug treatment programmes because there is no any legal exception for MMT or NSEP clients. The risk is enhanced by the relevant procedures which have been put at minima. The compulsory treatment is not in line with the harm reduction approach as it emphasises the only aim of absolute abstinence from drugs, applies detoxification as the principal approach and disregards harm reduction principles. This is confirmed by many international and national analyses.[545] Obviously, the law and policy applicable to treatment and supervision does not take into account the aspects of harm reduction programmes. It is not followed by any specific legislative or policy document specifying the treatment systems or standards and it does not make the link between institutional treatment and harm reduction programmes. Successful completion of treatment means sustaining a drug-free state and hence a harsh penalty may be imposed for relapse. The law provides for punishment of imprisonment of between five and seven years plus a maximum whipping of three strokes. Another punitive approach should a person relapse after two periods of discharge or a conviction for self-administration of drugs is the penalty of imprisonment of between seven and 13 years, plus whipping of between three and six strokes.[546] This indicates that drug law, in contradiction to the harm reduction approach, is intolerant to persistent drug dependency.

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[545] For example, World Health Organization (Western Pacific Region), *Assessment of Compulsory Treatment of People who Use Drugs in Cambodia, China, Malaysia and Vietnam: An Application of Selected Human Rights Principles*.19; Godwin, *Regional Issues Brief: Laws and Practices Relating to Criminalization of People Living with HIV and Populations Vulnerable to HIV*.17.
[546] DDA 1952, ss 39C(1) and (2).

Overall, the legal approach to compulsory drug treatment as currently implemented in Malaysia is clearly unethical, ineffective and unsupportive of the harm reduction philosophy and operation. Its practice may contribute to conflict between criminal justice and harm reduction responses, as we will see later in this chapter.

### 4.2.3 Criminal Offences in relation to Possession of Injection Equipments and Drug Residue in Syringe

#### *4.2.3.1 Possession of Injection Equipments*

Malaysia maintains criminal penalties for possession of any equipment for illegal drug consumption. The offence carries a maximum of two years' imprisonment or a fine of a maximum of RM5000.00, or both.[547] Section 10(3) of DDA 1952 provides the definition of consumption for the purpose of this offence as similar to the one given for a drug consumption offence in section 15(2) (refer to Chapter 4, Section 4.2.1.1). The illegality of equipment is subject to its characteristics and a person's intention. Thus, syringes and needles for use in injecting drugs into the human body are illegal.

The offence is committed when all ingredients of possession are proved i.e. custody or control and knowledge of the existence of the item (as previously discussed with regard to drug possession offences). In addition, the knowledge that the device is to be used for drug consumption must be established.[548] To the advantage of the prosecution, the law may presume the sufficiency of evidence for the fact that the

[547] DDA 1952, s 10(2)(a).
[548] For example, *Ong Chong Hin* v *R* [1959] 1 MLJ 96, 97.

equipment is used for that unlawful purpose based on the evidence of a police officer not below the rank of sergeant or by a senior customs officer.[549]

Having the paraphernalia law places NSEP, in principle, within an illegal, or at least uncertain, legal status. Without any immunity, the law also increases the risk of enforcement actions including arrest, raid and criminal prosecution for NSEP staff, physicians and/or pharmacists distributing drug paraphernalia, and the IDUs receiving it. Burris, while analysing the paraphernalia law in the USA, argues that conviction of the physician cannot rest on his issuing the prescription as this is dissimilar to having custody or control over the device.[550] This argument is less applicable in the Malaysian context as, besides pharmacists, physicians, particularly in the private sector, are authorised to dispense medicines and medical devices to patients.[551] This becomes a traditional system endorsed by Malaysia's National Medicines Policy and clearly varies from the practice in many countries including the UK whereby the legal right of medication dispensing is not given to health personnel other than pharmacists. Thus, where the physician's supply of injection equipment through NSEP or giving a prescription for injection equipment supply to a pharmacist working in the same setting where the physician also has access or authority of dispensing medicines and medical devices (even when not supplying the items to drug users directly), the physician could be found to have had custody and control over the injection equipment. Further, the physician fulfils the element of knowledge because he knows, or works in circumstances where one reasonably should know, that the injection items they provide will be used to inject drugs.

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[549] DDA 1952, s 37(i).

[550] S. Burris, P. Lurie, and M. Ng, "Harm Reduction in the Health Care System: The Legality of Prescribing and Dispensing Syringes to Drug Users," *Health Matrix* 11, no. 5 (2001).45–46.

[551] W.S. Sing, "Pharmacy Practice in Malaysia," *Malaysian Journal of Pharmacy* 1, no. 1 (2001).4.

Therefore, it is also reasonable to argue that the provision of injection equipment as part of an NSEP service is technically illegal for contravening this law. The clear authority of a physician to medically prescribe drugs and devices and the pharmacists to provide such a prescription may be insufficient to trigger an immunity as the criminal law should be read as placing a restriction on their authority.[552] Additionally, the strict regulations governing the prescribing of medical drugs state that medical discretion regarding drug treatment is subject to limitations (that will be discussed later in relation to MMT) even though they are inapplicable to needles and syringes. Drug users obtaining sterile injection equipment from NSEP services also commit the offence as they form the requisite intent for the offence.

It may reasonably be argued that a syringe cannot be regarded as equipment for drug consumption but instead as a legal 'medical device' under section 2 of the Medical Device Act 2012 for its original manufacture and use for disease prevention or treatment. They are provided through NSEP to control HIV and other blood-borne epidemics. However, this argument provides dubious comfort. The offence provision of section 10(2)(a) of DDA 1952 expressly mentions a 'utensil used in the preparation of opium for smoking or consumption' and hence exposes the possession of a syringe or other instrument intended for drug use as liable for criminal charge, without exemption for health care providers. No Malaysian case so far has decided on the issue of whether the public health statute of the Medical Device Act could circumvent or take precedence over the drug control statute of DDA 1952 in cases involving injection equipment supplied by NSEP for disease prevention and intended simultaneously for drug using. It is therefore

[552] Malaysia has no syringe prescription law.

unclear whether the criminal charge of possession of syringes and needles from NSEP could be decided in court that the items are medical devices based on the Medical Device Act 2012.

Further, commentators from several jurisdictions postulate that the NSEP could protect itself from criminal liability by contending that its operation involves non-commercial purposes. The provision and collection of injection equipment is conducted on a free basis, performing public health efforts. Thus, any acts related to NSEP could not be penalised by paraphernalia laws which have mostly historically been drafted to control the commercial business of drugs and paraphernalia, and not to disturb health care practice.[553] While I have found no reference to argument in Malaysia so far, it might be possible to arise given the Malaysian drug law which was originally based on the English Dangerous Drugs Acts of 1920 and 1925 and which has been drafted primarily as a consequence of the existing illegitimate trade and use of opium. However, there is less certainty about this argument as the recognised legal rule of interpretation will not recognise the objects and reasons as an ultimate basis for interpreting the true meaning and implications of the substantive legal provisions. Moreover, the impetus behind regulatory control was the belief that the acts connected to drug paraphernalia promote drug use, rather than the commercial purpose of the paraphernalia.

Some commentators in other jurisdictions advance the legal argument that NSEP staff could not be found guilty because they lack criminal intention. Their single intention is to provide health care and HIV prevention strategies, rather than condoning the

[553] For example, D. Abrahamson, "Federal Law and Syringe Prescription and Dispensing," *Health Matrix* 11, no. 1 (2001).68–69.

consumption of drugs.[554] This argument has commonsense appeal but may fail. Arguably, the staff member can clearly make out the intended offence even though they are acting for good purpose, and they are aware of the items' intended use.

We shall consider later in this chapter the extent to which the existing law relating to the possession of injection equipment is in conflict with the NSEP. The criminal law which is designed to limit access to tools for the preparation and consumption of drugs apparently contradicts the principle and objective of NSEP to ensure IDUs use clean injection equipment for each injection for the benefit of public health (particularly for the prevention of blood-borne transmission of diseases). While the NSEP distributes and advises IDUs to obtain clean needles and syringes and return the used ones for proper disposal, the law has potential to create a conspicuous disincentive for the group to comply with the advice and strategy. The ambiguous legal basis of NSEP and the fear of law enforcement and criminal penalties may hinder potential suppliers and IDUs from engaging in NSEP and carrying their own syringes. Research results indicate that the paraphernalia laws in some countries have led to the outlawing of NSEPs' establishment and ambiguous legal status, thereby discouraging its utilisation by the drug using community.[555] It is clear that such criminal law may constrain the supply and access of sterile syringe. The law may also inadvertently influence the scarcity of sterile syringes and occurrence of risky behaviour among IDUs such as the reusing and sharing of

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[554] For example, L. Ferguson, M. Perez, and S. Burris, "Syringe Exchange In Pennsylvania: A Legal Analysis," *Temple Political and Civil Rights Law Review* 8(1998).50.

[555] For example, P. Case, T. Meehan, and T.S. Jones, "Arrests and Incarceration of Injection Drug Users for Syringe Possession in Massachusetts: Implications for HIV Prevention," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 18, no. Suppl. 1 (1998).S74–S75; J.A. Taussig et al., "Syringe Laws and Pharmacy Regulations are Structural Constraints on HIV Prevention in the U.S.," *AIDS* 14, no. Suppl 1 (2000).S48.

needles. This can further perpetuate risks of blood-borne viral infections, thereby potentially frustrating the preventive goals and efforts of the NSEP.

#### *4.2.3.2 Possession of Drug Residue in Syringe*

It is clear that the current law could be interpreted to penalise someone for possessing used syringes containing the residue of an illicit drug. Such possession creates a presumption of controlled drugs. It is encompassed as 'anything whatsoever containing drugs' expressed in section 37(d).[556] The court's ruling in *Tong Peng Hong* v *PP*[557] shows that 'anything whatsoever' is restricted by the usage of the word 'containing' implying 'some measure of holding or restriction'. Thus, once it is proved that a person has control or custody of the syringe in which the drug was found, he is deemed to be in drug possession and to have knowledge of the nature of the drug.

Without any regulatory exemption, the possessing of an item containing drugs by NSEP staff or drug users could attract criminal penalty as the illegal drugs contained therein are not for legitimate medical purposes or are not being handled, or to be handled, for crime prevention. Additionally, the staff likely knows that the syringe returned to them by drug users may contain the trace, irrespective of whether the quantity of drug is visible or not. This is because the NSEP programme functions to distribute and collect syringes used for consuming drugs. Drug users also often knowingly possess a used syringe to contain trace amount of drugs. It might be possible that the accused is shielded from legal effect by the doctrine of *de minimis non curat lex* which means that 'the law

[556] DDA 1952, s 37(d).
[557] [1955] MLJ 232.

does not concern itself with trifles'. Court in *The 'Reward'*, which was among the first cases referred to the doctrine in a criminal context said:

> The Court is not bound to strictness at once harsh and pedantic in the application of statutes. The law permits the qualification implied in the ancient maxim *De minimis non curat lex*. Where there are irregularities of very slight consequence, it does not intend that the infliction of penalties should be inflexibly severe. If the deviation were a mere trifle, which, if continued in practice, would weigh little or nothing on the public interest, it might properly be overlooked.[558]

However, the case law recognising this doctrine is very limited. In *PP* v *Mohamed Ali bin Sani*,[559] the first case considering the issue of the smallness of drug quantity to establish possession, the High Court set aside the president's order and ordered a retrial when it was satisfied with the adequacy of evidence of the chemist indicating the existence of heroin in the light brown powder. This was despite the heroin's undetermined amount which had been relied on by the lower court in discharging the accused. The High Court distinguished the present case from the English case *R* v *Worsell*[560] which has been relied on by the lower court mainly due to the invisibility and in reality no drug being found by the later court. The conflicting decisions likely result from different tests by the courts; the measurability test by the lower court and the identifiability test by the High Court.

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[558] [1818] 165 ER 1482, 1484.
[559] [1978] 2 MLJ 109.
[560] [1970] 1 WLR 111.

In contrast, the Supreme Court in *PP* v *Alcontara*[561] has considered the cases of *Carver*[562] and *R* v *Worsell*[563] using a purposive approach. The court, affirming the purposive approach applied in *Loo Keck Leong* v *PP*[564], ruled that the small quantity of drugs discovered may be disregarded for falling short of the mischief at which the legislative provision was intended. Thus, arguably, the doctrine of *de minimis* could not promise a defence for the charge of drug residue possession, given very limited and mixed Malaysian courts' rulings on its application in drug cases. Some other courts might construe the legislature's intention to encompass any amount of drugs, given the absence of a statutory minimum quantity.

The law pertaining to the possession of a syringe containing drug residue may further underlie the dominance of the criminal justice approach in drug use matters and may threaten the viability of the NSEP. Aside from that offence, the provision of needles and syringes may be construed as abetting drug use and render the provider subject to criminal liability.[565] The criminalisation of trace amounts of illicit drugs has potential to result in another central tension between the criminal law and harm reduction approaches. This is because criminal law can undermine the NSEP's intent of promoting safe syringe disposal and exchange for sterile equipment. The law may cast a shadow of criminality over the practices under the NSEP, thereby potentially impeding participation in the intervention. NSEP workers, clients and other IDUs can be in legal jeopardy by carrying or possessing used syringes with trace amounts of drugs. They are vulnerable to police stop and search practices, confiscation of syringes and criminal charges for drug

[561] [1993] 3 MLJ 568.
[562] [1978] 2 WLR 872.
[563] [1970] 1 WLR 111.
[564] [1993] 2 MLJ 177.
[565] Based on DDA 1952, s 33.

possession. Discovery of a syringe may hence become a probable cause for enforcement officers to conduct further investigations and make arrests for drug use and confiscate injection equipment. By the existence of the punitive law, IDUs may avoid carrying, returning or safely disposing of the used injection items at the NSEP sites for the fear of arrest. This can influence them to reuse and/or discard the items on the streets. The law of possession of a syringe with drug residue may hence present an important barrier to the efficient operation of NSEP. We shall consider later in this chapter the extent of this impact.

### 4.2.4 Regulatory Framework Governing Prescribing, Dispensing and Receiving Methadone

Methadone remains a controlled substance classified as a Part III substance in the First Schedule of the DDA 1952, meaning that its production, supply, possession or any other dealings are all criminal offences, unless this is warranted by the regulations of the statute.[566] Despite the confirmed efficacy of methadone for drug treatment, its use has been constrained, a fact mirrored in the expansive regulations governing its use. The Dangerous Drugs Regulations 1952 permits Part III controlled substances to be used for medical purpose but with limited dealings and strict control measures for its circulation, including storing and record-keeping requirements and other requirements to control their abuse and diversion. Additionally, legitimately dealing with methadone must comply with

[566] DDA 1952, s 16.

the requirements of the Poison Act 1952 and Poisons (Psychotropic Substances) Regulations 1989 as methadone is also listed as a psychotropic substance in Part I, Group B of the First Schedule of Poison Act 1952.

The provision of methadone is further restricted by the National Policy and Standard Operating Procedures for MMT (hereinafter referred to as MMT Policy and SOP), the National MMT Guideline, MMT Dispensing Guideline and Guideline on the Endorsement of Methadone Dispensing by Assistant Pharmacists at Methadone Clinics of Malaysian Ministry of Health that set out the circumscribed situations in which methadone may be prescribed and dispensed for drug treatment.

Generally, the legislative provisions authorise the prescribing and administration of controlled drugs, including methadone,[567] by a medical practitioner[568] or under his directions for medical treatment.[569] However, unless they are specifically approved for the purpose, a medical practitioner is not permitted to prescribe methadone. Handling methadone for medical purposes is permitted only under a valid permit issued by the licensing officer[570].[571] Methadone for the administration, supply or sale to patients should be prepared by the medical practitioner himself or under his immediate personal supervision.[572] As for further eligibility to prescribe methadone, the MMT Policy and SOP require the physician to register with the MOH and obtain accreditation for the

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[567] Dangerous Drugs Regulations 1952, s 12(1); Poison Act 1952, s 21.
[568] The term 'registered medical practitioner' denotes a medical practitioner registered in the Malaysian Medical Council (MMC) pursuant to the Medical Act 1971(DDA 1952, s 2 and the Poison Act 1952, s 2). To legally practise medicine, registered practitioners must also possess an Annual Practising Certificate, as stipulated by section 20 of the Medical Act 1971.
[569] DDA 1952, s 14(2); Poisons (Psychotropic Substances) Regulations 1989, s 16.
[570] Based on the Poison Act 1952, s 2, a 'licensing officer' is a person appointed under the Poison Act 1952 and includes the Director General of Health.
[571] Poisons (Psychotropic Substances) Regulations 1989, ss 12A and 15.
[572] Poison Act 1952, s 19.

purpose from the Addiction Medicine Association of Malaysia and the Federation of Private Medical Practitioners Association. The accreditation is not granted unless the physician has undergone government-endorsed training in the management of MMT.[573] Registrants bear responsibilities for compliance with detailed prescribing requirements under the regulations and guidelines. Thus, the prescribing of methadone for drug treatment is permitted but highly restricted and extensively regulated.

Moreover, methadone dispensing is authorised but contingent on multiple conditions including prescription requirement and the dispenser's eligibility. The Regulations provide the authorisation for registered medical practitioners and registered pharmacists[574] to supply methadone for medical treatment.[575] Additionally, a licensed pharmacist is sanctioned to sell or supply methadone as a dispensed medicine.[576] They also retain the authority to compound, mix or dispense methadone with any other substance for medical uses.[577] In order to be eligible to dispense, pharmacists are required by the MMT Dispensing Guideline to obtain exposure and sufficient knowledge on medicines used in MMT.[578] The authority of dispensing may extend to a pharmacy assistant or in his absence a medical assistant in government-run health settings, but must be exercised pursuant to the regulative requirements.[579] A pharmacy assistant intending to

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573 MMT Policy and SOP, s 5.

574 Based on section 2 of DDA 1952 and section 2 of the Poison Act 1952, a 'registered pharmacist' is a pharmacist registered under the Registration of Pharmacists Act 1951. Eligible persons are registered with the Malaysian Pharmacy Board. In Sabah and Sarawak, pharmacists must also hold a qualification relating to the pharmacy profession acknowledged by the Director of Medical Services in Sabah or Sarawak. Each pharmacist must also obtain an Annual Retention Certificate to ensure that their names stay on the register, as required by section 16 of the Registration of Pharmacists Act 1951.

575 Dangerous Drugs Regulations 1952, ss 5(1) and 8(1); Poisons (Psychotropic Substances) Regulations 1989, s 11(1).

576 Poison Act 1952, s 21(1).

577 Poison Act 1952, s 12; Poisons (Psychotropic Substances) Regulations 1989, s 17.

578 MMT Dispensing Guideline, s 7.2.

579 Poisons (Psychotropic Substances) Regulations 1989, s 32.

dispense methadone has to fulfil stricter requirements under the Guideline on the Endorsement of Methadone Dispensing by Assistant Pharmacists. He must have passed specific training on methadone dispensing and acquired a Pharmacy Service Division, MOH's endorsement certificate enabling dispensing practice.[580] The approval is time limited and requires the assistant pharmacist to renew his certificate every two years.[581]

Methadone must be dispensed in liquid form and consumed under supervision. Takeaway doses are only allowed based on careful selection regarding the client's stability, reliability and progress in treatment.[582] The legislative provisions legalise the possession of methadone by those to whom it is being dispensed when it is obtained directly from a medical practitioner or under a prescription which is issued in compliance with the Regulations.[583]

The methadone is restricted to be dispensed to MMT clients. Legal rules on who could be taken on as a client stipulate that he must be capable of giving informed consent and have a chronic case of opiate dependency (regular injection of opiates exceeding two years or several failures to undertake in-patient treatment in the health care institutions and rehabilitation communities). Despite that, individuals are excluded if aged below 18, or have dependence on polysubstance non-opiate, a severely impaired liver functions test, hypersensitivity to methadone or acute medical and/or psychiatric disorders.[584] The quota

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[580] Based on Parts E and F of the Guideline on the Endorsement of Methadone Dispensing by Assistant Pharmacists, assistant pharmacists who want to train in methadone dispensing must be selected by an MMT Coordinating Officer at the state level based on fixed criteria including having confirmed employment, a minimum of three years' service, a minimum of two years' working experience in any outpatient pharmacy or specialist clinic's pharmacy, a professional attitude and conduct, and no disciplinary record.

[581] Guideline on the Endorsement of Methadone Dispensing by Assistant Pharmacists, Part F.

[582] MMT Policy and SOP, s 5; National MMT Guideline, s 3.4.

[583] DDA 1952, s 12(2); Dangerous Drugs Regulations 1952, s 6(2); Poisons (Psychotropic Substances) Regulations 1989, s 3.

[584] MMT Policy and SOP, Appendix 2, 15; National MMT Guideline, s 2.1.

of new clients is also fixed with a maximum of 20 per physician per month.[585] Their admission does not guarantee retention in MMT as the clients are subject to review and monitoring procedures including toxicological testing for drugs which make dismissal possible.[586] Drug consumption is seen as improper behaviour which can be a basis for involuntary discharge.[587]

Therefore, acts such as prescribing, dispensing, possessing, administering and consuming methadone for medical purposes are legal subject to their compliance with the relevant legislative provisions and guidelines. This offers high protection for MMT practice. The current regulatory framework shows that there is no theoretical conflict between the criminal justice and harm reduction approaches with respect to drug provision for medical impetus. The criminal justice goals and principles regarding methadone prescription are broadly consistent with those of MMT. This is in contrast to the situation with NSEP which stands in sharp contradiction to the paraphernalia law.

However, we will consider later in this chapter whether the extensive and restrictive regulatory framework has a negative impact on harm reduction and MMT in particular. The MMT efficiency may be affected by the extensive and rigid requirements and restrictions that apply to methadone provision including accreditation, licensing, duration, quota, diagnosis, clients' admission and maintenance. These restrictions are considerably stricter than the limits suggested by the international drug treaties for legitimate methadone dispensing.[588] The stringent regulations mean that physicians'

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[585] MMT Policy and SOP, s 5.
[586] National MMT Guideline, s 3.2.
[587] MMT Policy and SOP, Appendix 1, 14; National MMT Guideline, s 3.6.
[588] The 1961 Convention enumerates certain minimum conditions that must be adopted in the national regulations relating to the dispensing of Schedule 1 drugs including methadone. The conditions are:

decision on prescribing mainly hinge upon legal rather than medical considerations. These have potential to limit the physicians' attention to the diagnostic and fact-specific basis in the examination of the individuals' need for methadone. In other words, the overly tight restrictions may significantly impact doctors' attitudes and behaviour towards prescriptions and usurp their clinical discretion. The international literature shows that the strict regulation[589] of drug prescription can result in adverse consequences, including creating fear among medical practitioners of the threat of sanctions for unintended mishandling, constraining the exercise of clinical judgment and giving rise to considerable financial costs in complying with legislative requisites.[590]

The tight conditions for the participation of drug users in MMT and intolerance to their continued drug use while in the programme may cause limited accessibility and unmet demands for methadone provision including those identified in health-care settings suffering from drug dependence or serious pain from illness. The delay or rejection of service may result in drug users continuing to consume illicit drugs, particularly while in withdrawal to alleviate severe physical discomfort and craving for relief, indulging in high-risk behaviour and recourse to black market drugs.[591] The chance to gain drug users'

dispensing must be undertaken only by those with a professional practising licence or a special licence for doing so, drugs can only be moved between authorised persons and institutions, dispensing must be done upon a medical prescription, and any issued prescriptions must comply with sound medical practice and regulations for public health and welfare protection. Further requirements may be specified if considered necessary by the state to avert drug abuse and diversion (World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (Geneva: World Health Organization, 2009).79–80; the 1961 Convention).

[589] These include prescribing criteria that are specified only to drug treatment centres and to highly qualified medical practitioners in either or both government and private health settings, and rigid admission conditions that specify age limits, abstinence and random-based urinalysis during the maintenance period.

[590] R.A. Rettig and A. Yarmolinsky, eds., *Federal Regulation of Methadone Treatment* (Washington: National Academy Press, 1995).4.

[591] Babor et al., *Drug Policy and the Public Good*.190.

admission to treatment in future may vanish because they may not try again to access the service after the rejection or delay.

Obviously, despite the importance of a clear regulatory framework for controlling drug prescribing practice, providing care for clients and securing against possible unethical actions and diversion of prescribed methadone, the strictness of the current framework has the potential to erode and endanger the MMT initiatives.

It is clear that drug treatment that involves the prescribing of methadone is mandated by Malaysian law, though highly regulated and hence any medical suggestion to use methadone will be subject to careful scrutiny by law enforcement. The supply of methadone without authority may give rise to penalties under the existing Regulations including a fine and/or imprisonment. An additional or alternative liability might be for committing an infamous conduct under the Code of Professional Conduct, thereby incurring medical board disciplinary sanctions or revocation of the license.[592] Furthermore, this may leave open the possibility that a physician who possesses and supplies methadone to clients when he has no legal right could be found guilty of possession under section 12(2) DDA 1952 if caught with methadone in his possession. Once proved as having some measure of custody or control over methadone such as by physically handling drugs for the purpose of supplying to drug users, he may be deemed

[592] The disciplinary sanctions may be exercised by the Malaysian Medical Council (MMC) pursuant to the Medical Act 1971, s 29. The sanctions may be striking off or temporarily suspending the practitioner from the Register, reprimand or any of the sanctions plus suspension of application subject to certain conditions for a period or periods in the aggregate not exceeding two years (the Medical Act 1971, s 30). Moreover, the Board of Inquiry under the MOH is entitled to deal with disciplinary matters regarding medical practitioners in the public sector (N.R. Wan Abdullah, "Regulating Malaysia's Private Health Care Sector," in *Health Care in Malaysia: The Dynamics of Provision, Financing and Access*, ed. C.H. Leng and S. Barraclough (Oxon: Routledge, 2007).47).

to possess drugs and have knowledge to its presence. He may also risk the charge for trafficking or administration of drugs to others.

Trafficking of illicit drugs is a serious crime provided under section 39B of DDA 1952 and punishable with a mandatory death penalty.[593] To prove the offence of trafficking, the prosecution needs to adduce evidence relating to the physical elements of possession of the drugs in question and a further act constituting trafficking under section 2 and the mental element of intention or knowledge of the nature of the drugs.[594] The act of trafficking is defined broadly in section 2 of DDA 1952, as including manufacturing, importing, exporting, keeping, concealing, buying, selling, giving, receiving, storing, administering, transporting, carrying, sending, delivering, procuring, supplying or distributing any dangerous drugs. Additionally, section 39B includes the offering and preparatory act to do any of the enumerated acts. However, the judicial rulings indicate that the meaning of each trafficking act is dependent on the facts of a particular case[595] and should be strictly construed, considering the principle of penal statute interpretation.[596] To constitute an act of trafficking, it must be shown that it involves two parties as a minimum; a transfer or intention to transfer possession of drugs to another party.[597]

A person may also be presumed to be a trafficker when he is in possession of dangerous drugs and by virtue of the weight of the dangerous drugs enumerated in the

[593] DDA 1952, s 39B(2). The death punishment is inflicted by hanging until death pursuant to Article 277 of the Criminal Procedure Code, with the exception of pregnant women (Criminal Procedure Code, s 275) and minors (Child Act 2001, s 97).
[594] *PP* v *Zulkefle Abu Bakar & Anor*[2000] 2 CLJ 359, 372; *PP* v *Zulkipli bin Othman & Ors* [2005] 5 MLJ 170, 178.
[595] *Chow Kok Keong* v *PP* [1998] 2 MLJ 337, 338.
[596] *PP* v *Hairul Din bin Zainal Abidin* [2001] 6 MLJ 146, 156.
[597] *Ong Ah Chuan* v *PP* [1981] 1 MLJ 64, 69; *PP* v *Nik Ahmad Aman bin Nik Mansor* [2002] 2 AMR 2515, 2527.

section 37(da)(i) to 37(da)(xxv) of DDA 1952.[598] The small quantity prescribed for the trafficking shows the strict approach over the drug possession, which may implicate drug users who have such an amount in their possession even if it is for own consumption. However, the prosecution cannot invoke double presumption, relying on the presumption of possession to invoke a trafficking presumption under section 37(da) in the light of the plethora of cases on this point.[599] The rule against double presumption has been likely to be annulled by the amendment through the Dangerous Drugs (Amendment) Act 2014,[600] providing that a statutory presumption could be used together or conjunctively with

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[598] Section 37(da) of DDA 1952 provides:

> Any person who is found in possession of –
> (i) 15g or more in weight of heroin;
> (ii) 15g or more in weight of morphine;
> (iii) 15g or more in weight of monoacetylmorphines;
> (iv) a total of 15g or more in weight of heroin, morphine and monoacetylmorphines or a total of 15g or more in weight of any two of the said dangerous drugs;
> (v) 1,000g or more in weight of prepared opium;
> (vi) 1,000g or more in weight of raw opium;
> (v) a total of 1,000g or more in weight of prepared opium and raw opium;
> (vii) 200g or more in weight of cannabis;
> (viii) 200g or more in weight of cannabis resin;
> (ix) a total of 200g or more in weight of cannabis and cannabis resin;
> (x) 40g or more in weight of cocaine;
> (xi) 2,000g or more in weight of coca leaves;
> (xii) 50g or more in weight of 2-Amino-1-(2, 5-dimethoxy-4-methyl) phenylpropane;
> (xiii) 50g or more in weight of Amphetamine;
> (xiv) 50g or more in weight of 2, 5-Dimethoxyamphine (DMA);
> (xv) 50g or more in weight of Dimethoxybromoamphetamine (DOB);
> (xvi) 50g or more in weight of 2, 5-Dimethoxy-4-ethylamphetamine (DOET);
> (xvii) 50g or more in weight of Methamphetamine;
> (xviii) 50g or more in weight of 5-Methoxy-3, 4-Methylenedioxyamphetamine (MMDA);
> (xix) 50g or more in weight of Methylenedioxyamphetamine (MDA);
> (xx) 50g or more in weight of N-ethyl MDA;
> (xxi) 50g or more in weight of N-hydroxy MDA;
> (xxii) 50g or more in weight of N-methyl-1 (3, 4-methylenedioxyphenyl)-2-butamine;
> (xxiii) 50g or more in weight of 3, 4-Methylenedioxymethamphetamine (MDMA);
> (xxiv) 50g or more in weight of Paramethoxyamphetamine (PMA);
> (xxv) 50g or more in weight of 3, 4, 5-Trimethoxyamphetamine (3, 4, 5-TMA); or
> (xxvi) a total of 50g or more in weight of any combination of the dangerous drugs listed in subparagraphs (xi) to (xxiv),
>
> otherwise than in accordance with the authority of this Act or any other written law, shall be presumed, until the contrary is proved, to be trafficking in the said drug.

[599] For example, *Muhammed bin Hassan* v *PP* [1998] 2 MLJ 273, 274–75; *PP* v *Tan Tatt Eek& Other Appeals* [2005] 2 MLJ 685, 686–87.

[600] Act A1457.

another statutory presumption.[601] However, arguably, it is unlikely the courts will interpret in such a way as the terms 'found in possession' used in section 37(da) clearly permit the trafficking presumption to be activated only upon a finding of possession.

The accused, however, may rebut the presumption on the balance of probabilities that he was unaware of the existence of drugs in his possession and he was not a trafficker. The Supreme Court in *Ng Chai Kem* v *PP*[602] ruled that the accused person's challenging of the presumption of trafficking by contending that he is a drug dependent, rather than a drug trafficker, should be considered by court. The court has to consider whether the possession presumption under section 37(d) and trafficking presumption under section 37(da) are rebutted on the balance of probabilities separately.[603] If the accused successfully rebuts the possession presumption, the accused has no need to rebut the trafficking presumption. However, if he fails to challenge the presumption of possession but successfully rebuts presumption of trafficking, he will be liable for the lesser offence of possession under section 39A.

The possibility of bringing trafficking charges for the illegally supply of methadone to drug users would theoretically be possible in numerous ways. The physician's activities carried out in such prescribing may potentially denote trafficking acts, such as administering, giving, supplying and distributing. These acts are neither defined by DDA 1952 nor case law related to drugs. According to Smith, the offence's physical element happens based on the combined *actus reus* of the pharmacist's supply of drugs and *mens rea* of the physician whose intention is to illegally supply drugs to

[601] The amendment has been primarily made to overrule the court rulings against the application of double presumptions.
[602] [1994] 2 MLJ 210, 219–20.
[603] *Mohamad Radhi bin Yaakob* v *PP* [1991] 3 MLJ 169, 172.

patients.[604] The conviction for the trafficking is only secured if the prosecution adduces direct evidence to prove the offence. The trafficking presumption cannot be invoked in this case as methadone is not covered by section 37(da).

Further, as the act of giving out methadone may constitute administering, the prosecution could conceivably bring a prosecution for the administration of drugs to others under section 14(1) of DDA 1952. Upon conviction, the punishment available is a maximum of three years of imprisonment or a maximum RM10000.00 fine, or both. The offence must be proved by direct evidence regarding the act of administering drugs to another person and the recipient's tested urine found to contain drugs.[605] No statutory presumption is specified for this offence when compared to the self-administration offence.

Moreover, notwithstanding whether methadone is received on the advice of a medical practitioner for the purpose of treating withdrawal from drugs or relieving critical pain, unauthorised individuals receiving methadone face risks of criminal charges. The risk also extends to drug users receiving methadone for the purpose of reducing their drug dependency, including through MMT, but improperly complying with regulatory and guideline requirements as discussed above. The DDTRA 1983 further makes the unwarranted treatment of drug dependence illegal.[606] Therefore, unauthorised (for any of the abovementioned situations) drug users could technically be prosecuted for self-administration of drugs under section 15 DDA 1952 if found consuming methadone and for possessing illegal drugs under section 12(2) of DDA 1952 if caught with methadone.

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[604] [1986] Crim. L.R. 681.
[605] Implied by the ruling regarding the offence of self-administration of drugs under section 15 of DDA 1952 in the case of *PP* v *Chan Kam Leong* [1989] 2 CLJ (Rep) 311, 313.
[606] S 16(5).

However, they are not at risk of committing the offence of possession under sections 6, 9(1)(b), 39A(1) and 39A(2) as the drugs specified in these provisions do not include methadone.

Additionally, the law opens the potentiality that a person such as a medical practitioner prescribing methadone without authority may have secondary liability related to the offence of self-administration, consumption or possession of methadone committed by drug users. They may be criminally liable on the basis of either conspiracy[607] with drug users to administer, consume or possess methadone, or instigating, aiding or engaging with drug users in conspiracy[608] for committing any of these criminal acts. Furthermore, the unauthorised prescriber and drug user are exposed to preventive detention under the Dangerous Drugs (Special Preventive Measures) Act 1985 if they are suspected to be involved or associated with trafficking activities,[609] with or without the confiscation of property.[610]

[607] Penal Code, s 120A.

[608] All acts of instigating, aiding and engaging in conspiracy to commit crime fall under the offence of abetment and are liable for whatever punishment is specified for the abetted crime (DDA 1952, s 33).

[609] It is also possible that drug users and unauthorised methadone prescriber may be arrested without warrant and detained for investigations for the period up to 60 days under the authority of section 3 of the Dangerous Drugs (Special Preventive Measures) Act 1985 for suspected involvement or association to drug trafficking activities. They may be subsequently detained without trial or placed under restrictions for a maximum two-year term (section 6(1) and (3)). The order for detention or restriction may be issued by the Minister of Home Affairs after considering the reports of police investigation and Inquiry Officer (the Attorney General Department's officer placed in the MOHA) and being satisfied that it is necessary do so in public order interest (section 6(1)). It may be renewed for successive two years (section 11A(1)). The order and related procedures are controversial for limited due process safeguards and serious violation of personal liberty and principle of justice. The arising issues include their prolonged detention period in police custody, no court proceeding (except for procedural matters), no judicial review for the order and limited transparency of representation proceedings before the Advisory Board.

[610] The property of those who are convicted for drug trafficking under DDA 1952 or detained without trial under Dangerous Drugs (Special Preventive Measures) Act 1985 for activities related to drug trafficking may be seized and forfeited based on the authority of Dangerous Drugs (Forfeiture of Property) Act 1988. (Mainly Sections 10(5), 25, 26, 27, 32 and 33)).

The physicians and drug users facing such criminal charges may argue that they lack the required intent to commit crimes since the methadone is supplied for treating drug dependence, critical withdrawal from drugs or serious pain. This argument is seemingly possible but less persuasive as when they have intention or knowledge to do any act which is classified as a crime, even for good purpose, they could be said to be committing the crime. The other possible defence is through the application of the double effect rule which has been recognised in medical cases in some jurisdictions.[611] It denotes an ethically acceptable act is not to be regarded prohibited for its possible foreseeable but not intended secondary implication.[612] The accused may contend that the criminal effect of therapeutic acts is negated by the secondary effect of saving drug users or relieving their pain or dependence on drugs. Despite the rule's potential to challenge the conviction, this could not guarantee acquittal since it depends on the court's discretion. It seems difficult in the absence of any local decided drug case recognising its application.

Conclusively, the strict legislative controls may put medical practitioners and drug users at risk of criminal prosecution for unauthorised drug prescribing, possessing or using. This impact has also been recorded in other countries. A study in the USA, for example, documented overall 986 cases from the 1998 until 2006 that involved criminal and administrative charges against physicians pertaining to opiate prescribing.[613] The charges relate to various unauthorised actions of prescribers, such as drug illegally distributing, unlicensed activity and falsifying or failing in keeping complete medical

[611] For example, the USA Supreme Court in the *Vacco and Others* v *Quill and Others*[1997] 50 BMLR 119, 128 acknowledged the applicability of double effect rule for justifying the physician's permitting of patient's denial to life-saving treatment and considered it as different from assisting suicide.
[612] T.E. Quill, R. Desser, and D.W. Brock, "The Rule of Double Effect - A Critique of Its Role in End-of-Life Decision Making," *New England Journal of Medicine* 337, no. 24 (1997).1768.
[613] D.M. Goldenbaum et al., "Physicians Charged with Opioid Analgesic Prescribing Offenses," *Pain Medicine* 9, no. 6 (2008).741.

records.[614] The criminal provisions delineate the margins of legality for methadone prescribing and using acts by providing the strict conditions for its legal practice and room for broad inspections, investigation and criminal liabilities for unauthorised prescribing and using, even for necessities. The stringent restrictions and criminal sanctions somehow reflect the dominant criminal control over methadone provision, dispensation and use. They can deplete the efficient implementation of MMT services in certain aspects and result in stifling the growth of the interventions.[615] We shall consider later whether or not the impacts of extensive regulations on MMT occur in practice.

Overall, while the harm reduction approach is adopted in Malaysia, the laws penalising illicit drug self-administration, possession and dependency, possession of injection items, possession of trace amount of drugs in injection equipment and unauthorised drug prescribing are still sustained. While the provision of methadone is legalised, it is strictly regulated in the current legislations, regulations and guidelines. The legislative and regulatory framework has the possibility to contradict and/or produce implications on the aims and efforts of harm reduction. It may place harm reduction workers, clients and other drug users at risk of legal problems, thereby possibly discouraging or creating obstacles for them to comply or participate in harm reduction promotion and techniques for drug-related harm prevention. To what extent in practice it actually impacts harm reduction operation will be examined in section 4.4 of this chapter.

[614] Ibid.743-744.
[615] D.A. Fiellin et al., "Methadone Maintenance in Primary Care-A Randomized Controlled Trial," *Journal of the American Medical Association* 286, no. 14 (2001).1729–30; R.G. Newman, "Addiction and Methadone: One American's View," in *War on Drugs, HIV/AIDS, and Human Rights*, ed. K. Malinowska-Sempruch and S. Gallagher (New York: International Debate Education Association, 2004).275–77.

## 4.3 A Review of Government Initiatives to Encourage the Support of the Criminal Justice System to Harm Reduction Interventions

Further to their endorsement of the harm reduction approach, the Malaysian government has put in place mechanisms intended to eliminate any conflict, particularly in practice, between the criminal justice and harm reduction strategies. This section provides a brief discussion of these government initiatives.

The government has conducted law enforcement advocacy of acceptance and uptake in several manners to achieve the harm reduction's unimpeded operations. The role of the police and other criminal justice actors to implement the approach in partnership with the MOH and related bodies is depicted in the national HIV/AIDS policy documents. The National Strategic Plan on HIV and AIDS 2011-2015 expresses the integral role of law enforcement towards the maintenance of facilitating environments for HIV responses including harm reduction strategies by minimising obstacles to their efficient implementation.[616]

To ensure collaboration between public health and law enforcement agencies for HIV responses, the composition of important stakeholder committees at federal, state and district levels (namely the National Coordinating Committee on AIDS Intervention, the National Advisory and Technical Committee on AIDS and National Task Force on Harm Reduction) led by MOH includes seats for representatives from the RMP, NADA and

[616] Ministry of Health Malaysia, *Malaysia: National Strategic Plan on HIV and AIDS 2011-2015*.19, 22.

Prisons Department, health professionals and NGOs.[617] This signals a prevailing coordinating power of MOH over other enforcement agencies with regard to the harm reduction approach. This high-level coordination is significant for aligning the objectives of the harm reduction and criminal justice approaches and providing policy advice on the approaches. The coordination also potentially provides a medium for dialogues between relevant agencies to address any relevant policy and legal issues that arise.

Moreover, training related to the concepts and objectives of the harm reduction approach is provided by the MOH, with the cooperation of NGOs, to members of the police force, drug agencies and the prison department, particularly to senior officers and new recruits.[618] The training, however, does not represent a regular and comprehensive mechanism to cover all ground-level officers. Policy directives, official letters or face-to-face briefings are ordinarily disseminated by the higher level officers down the organisational hierarchy to convey policy information. But the documents and briefings, like the training, are merely focused on basic information regarding harm reduction rationales and the need for their support by not interrupting the approach's operations. As they are not detailed, arguably, the documents leave too much to the interpretation and discretion of street-level officers.

For police, there are two predominant documents relating to harm reduction interventions, namely the National NSEP Guidelines for Police and the MMT Guidelines for Police. The documents were released to guide the police in dealing with MMT and NSEP clients. The NSEP Guidelines for Police explicitly prohibit the police from

[617] Ibid.24–26.
[618] A. Kamarulzaman, "Impact of HIV Prevention Programs on Drug Users in Malaysia," *Journal of Acquired Immune Deficiency Syndromes* 52(2009).S18.

specifically targeting NSEP sites for surveillance and other enforcement activities possibly deterring drug users from accessing NSEP and safely disposing of used injection instruments.[619] The police must be informed prior to the NSEP's operation in their jurisdiction.[620] The police are only permitted to take appropriate actions in the vicinity of NSEP sites in a few situations including rising drug-related crimes, negative implications to communities and necessary operations approved by senior personnel.[621] The police cannot arrest MMT clients unless they are found to be involved in illicit drug consumption or criminal activity.[622]

Even though the guidelines have no legal effect, they provide considerable protection to harm reduction participants. The clients who are generally out of bounds to police raiding for using drugs or committing crimes are those in MMT and NSEP areas. This has been confirmed by the MOH that the police are not stopped from detaining drug users apart from the sites used by the harm reduction services.[623]

It can be argued that the mechanisms put in place by the government in order to eliminate any conflict between the criminal justice and harm reduction approaches are not comprehensive. The administrative mechanisms seemingly focus on the prevention of the interruption of street-level enforcement upon harm reduction operations. No consideration is devoted to address overall legislative provisions and penal strategies incompatible with harm reduction principles and objectives. Also, the mechanisms do not extend to

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[619] Ministry of Health Malaysia and Royal Malaysia Police, *The National Needle and Syringe Exchange Programme: Guidelines for Police* (Putrajaya, Malaysia: Ministry of Health Malaysia, 2006). Articles 4.1 and 4.4.
[620] Ibid. Articles 6.1 and 9.3.
[621] Ibid. Articles 4.3 and 5.1.
[622] Kementerian Kesihatan Malaysia, *Program Terapi Gantian dengan Methadone: Garis Panduan untuk Polis [Methadone Maintenance Therapy: Guidelines for Police]* (Putrajaya, Malaysia: Kementerian Kesihatan Malaysia, 2007). Articles 7.2 and 8.
[623] A.F. Cruez and F.A. D' Cruz, "A Shot in the Arm," *News Straits Times*, 24 March 2007.13.

instigating the extensive partnership between the public health and criminal justice systems.

It is notable that the adopted mechanisms have specific limitations. The advocacy and training are not sufficiently far-reaching because of the less systematic inclusion of grassroots police officers and of some other criminal justice actors including prosecutors and judges. In the absence of any evidence showing court officers' reluctance to be involved in harm reduction policy, this likely indicates the government's perception that the feasibility of the harm reduction approach is relatively more associated with policing and the operational activities of drug treatment agencies and prisons, rather than courts. Moreover, to date it appears there has been no system for directing law enforcement on how actually to engage effectively in wider collaboration. The international literature highlights the critical importance of multi-agency working in drug treatment and the harm reduction approach. This is encapsulated in the words of Anglin and Hser: 'Members of both systems (criminal justice system and treatment system) need to move away from adversarial stances and towards collaboration to produce the desired behaviour change in drug users'.[624] The agencies' unification and closer engagement of the different agencies are preconditions for the proper operation of harm reduction.[625] In the absence of a detailed framework and documentation, the actual practice of enforcement is still largely left to the discretion of law enforcement officers.

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[624] M.D. Anglin and Y.I. Hser, "Criminal Justice and the Drug-Abusing Offender: Policy Issues of Coerced Treatment," *Behavioral Sciences & the Law* 9, no. 3 (1991).264.
[625] M. Jardine, "Building Partnerships between Law Enforcement and Harm Reduction Programs," *International Journal of Drug Policy* 24, no. 5 (2013).378.

## 4.4 What Impact in Practice have the Legislative and Regulatory Framework and Government Initiatives had on the Operation of Harm Reduction in Malaysia

This section will examine the actual impact in practice on harm reduction of the legislative and regulatory provisions and of the government initiatives. It is important to acknowledge that the section will not present the complete extent of this enforcement, due to the absence of detailed case-by-case observation and available research findings. It is important to note that most of the enforcement data presented in this discussion is from official statistics and hence caution should be observed when relying on it. No other agencies produce the data except the government. So far, there has not been any significant debate in Malaysia about the use of the government statistical data. Additionally, the extent of data is very limited, especially regarding the charges, convictions and punishments. The approach of the government towards the availability and openness of data is probably the main contributor to this situation. The discussion of law enforcement proceeds with an account of international literature, particularly on points concerning the possible effects of enforcement.

The available evidence gives no indication that the incidence of drug use-related arrests and associated criminal sanctions has diminished since the adoption of the harm reduction approach. A high number of drug users have still been detained and subjected to urine tests. In 2008, there were 163,054 arrests by the police for the purpose of

urinalysis, growing to 246,151 in 2009 and to 368,846 in 2012.[626] Upon positive urinalysis for illicit drugs, drug dependants are frequently sent by the courts to compulsory treatment detention centres to undergo forced detoxification. The data in 2009 shows 7,123 new and 8,613 repeating drug dependants were detected. 3,047 of them were undergoing treatment for drug dependence under compulsion while 9,097 were subjected to supervision in the community.[627] In December 2013, there were 5,136 drug dependants detained in 18 rehabilitation centres around the nation while 47,161 underwent compulsory supervision.[628] Further, the records indicate a substantial number of arrests and prosecutions for the offence of self-administration of drugs. For example, as of 2009, 42,304 were arrested and 20,531 were prosecuted under section 15(1) of DDA Act 1952. The number of arrests rose to 76,812 in 2012.[629] The Attorney General lists 696 and 256 convicted cases in 2011 and 2012 respectively.[630] NADA's data also demonstrates high numbers of arrest and prosecution for drug possession; such as in 2009 whereby the arrests and prosecution under section 39A(1) were 3,823 and 1,619 respectively. Under section 39A(2), the figures were 1,715 and 1,377 respectively and under sections 6, 9 and 12, the figures were approximately 24,236 and 23,504 respectively.[631] However, in the absence of data specifically showing the possession cases involving drug users, the extent of such possession is unknown.

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[626] Agensi Antidadah Kebangsaan, *Maklumat Dadah 2012 [Drug Information 2012]*.35.
[627] Ibid.3, 37; M.R.M. Diah, E. Muniandy, and M.Y. Ismail, "Senario Penyalahgunaan Dadah bagi Tahun 2009 [Scenario of Drug Abuse for 2009]," *Jurnal Antidadah Malaysia* 5, no. 1 (2009).15.
[628] Agensi Antidadah Kebangsaan, *Laporan Dadah Bulan Disember 2013 [Report on Drugs for December, 2013]* (Kajang, Malaysia: Agensi Antidadah Kebangsaan, 2013).26, 32.
[629] *Maklumat Dadah 2012 [Drug Information 2012]*.37.
[630] Attorney General's Chambers, "Status of Latest Cases & Decisions," (2011), http://www.agc.gov.my/index.php?option=com_content&view=article&id=1285&lang=en&Itemid=63. (Last visited: 07/07/2014)
[631] Diah, Muniandy, and Ismail, "Senario Penyalahgunaan Dadah bagi Tahun 2009 [Scenario of Drug Abuse for 2009]."17–18.

The abovementioned evidence certainly suggests that despite the practice of the harm reduction policy, the criminalisation of drug use and active criminal law enforcement remain the dominant strategy. Involvement in the programmes does not shield drug users from the criminal measures. Local studies further support that clients were arrested for drug use and forcibly sent to government-run treatment centres or prisons even when already using MMT and NSEP services.[632] The decided cases such *DPP* v *Saiful Bahri Bin Abdul Wahid*[633] indicate that the judges were not ready to consider the participation in harm reduction programme either as a defence or mitigating factor to punishments for the offence of drug self-administration. In this case, the High Court upheld the lower court's judgment upon the conviction of the accused for the offence of self-administration of drugs under section 15(1) of DDA Act 1952 and a punishment of imprisonment for 14 months and supervision for three years. By emphasising the underlying principle of deterrence for the punishment and the public interest in the case of drug use crime, the court decided that the punishment was fair and just although the accused based his defence on his present involvement in MMT. All the available evidence clearly shows that the threat of criminal liability for drug users under the existing Malaysian drug law, without any exclusion to the participants of harm reduction programme, is real. This helps to support the argument that there is incompatibility between the harm reduction and criminal justice strategies in Malaysia.

To complicate matters, harm reduction programmes are being utilised as a way of intelligence gathering for drug law enforcement purposes. There is a steady flow of reports documenting instances whereby the MMT and NSEP access points continue to be

[632] For example, Norsiah et al., "Can Primary Care Clinic Run MMT Service Well?."20, 22.
[633] *DPP* v *Saiful Bahri Bin Abdul Wahid* [2012] MLJU 943.

targeted by the police.[634] Participation in the programmes is considered as a marker of illegal drug consumption and hence makes the participants subject to search and detention.[635] This is a clear disruption to the operation of harm reduction. Additional threat is the frequent information exchanges between service providers and the police. Some literature discloses that in some cases service providers have been compelled to disclose the clients' records from the registry. Registered clients may subsequently be subject to search and forced urinalysis procedures by the officers.[636] The disclosure of clients' personal details to enforcement agents appears to be evidence not only of a breach of clients' confidentiality but also a source of fear of being detected as drug users and subjected to arrest and other enforcement procedures while participating in the harm reduction programme. This may create disincentive for them to access the programme. The international evidence further supports the observation that the disclosure of clients' information by service providers to enforcement authorities may deter drug users from seeking drug treatment.[637]

Even though NSEP could theoretically be regarded as illegal under paraphernalia law, to date it appears that hardly any drug law has been invoked to challenge the service. However, the resulting ambiguity regarding NSEPs' legality may pose questions for its sustenance and expansion[638] and could disrupt the efficiency of NSEPs. It is also significant to note that the enforcement of paraphernalia law is ostensibly relaxed and

[634] For example, Kamarulzaman, "Impact of HIV Prevention Programs on Drug Users in Malaysia."S18.
[635] Ministry of Health Malaysia, *Global AIDS Response Country Progress Report 2012: Country Progress Report Malaysia*.92.
[636] For example, R.H. Needle and L. Zhao, *HIV Prevention among Injection Drug Users: Strengthening U.S. Support for Core Interventions. A Report of the CSIS Global Health Policy Center* (Washington: Centre for Strategic & International Studies, 2010).20.
[637] For example, ibid.20; D. Wolfe, M.P. Carrieri, and D. Shepard, "Treatment and Care for Injecting Drug Users with HIV Infection: A Review of Barriers and Ways Forward," *Lancet* 376, no. 9738 (2010).359.
[638] Sarnon et al., "Psychosocial Reactions of Injecting Drug Users` (IDU) towards Needle Syringe Exchange Program in Malaysia."80.

seemingly less detrimental to harm reduction measures. To date, there is no data to indicate that arrest and criminal charges are undertaken in any major way for needle and syringe possession. The police have agreed not to enforce the provision regarding possession of needles and syringes as it is difficult to prove that the equipment will be for injecting illicit drugs and that the needle or syringe belongs to the individual who carries it, unless IDUs are found using the items for self-administration of illicit drugs.[639] Moreover, I have failed to find any cases where drug users, NSEP staff or clients have ever been prosecuted and sentenced for the possession of drug residue found in syringes in the courts. This is mainly influenced by the police and prosecution's current policy to focus on actual quantifiable possession of illicit drugs. Drug residue in injection equipment is disregarded to mitigate the difficulty in laboratory testing and to avoid 'needle stick' injury to police.[640]

Although there tend not to be prosecutions under paraphernalia law, the law has nevertheless had pernicious effect on harm reduction goals and initiatives. The law continues to be applied to justify police decisions for their operational policing. Anecdotal reports reveal that NSEP workers and drug users who carry syringes and needles are often subject to harassment, frisk, detention and informal confiscation or destroying of this equipment.[641] Moreover, possession of new or used syringes is treated as a sign of illegal drug use, thereby justifying the further investigation of suspects. This is substantiated by study findings. For example, research involving 53 police officers in Malaysia discovered that roughly 53 per cent of them acknowledged seizing IDUs'

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[639] N. Mohd. Yasin, "An Overview of Malaysian Law relating to IDUs with HIV," *Current Law Journal* 2 (2002).xiii.
[640] Ibid.xiii.
[641] For example, Ministry of Health Malaysia, *Malaysia: 2010 UNGASS Country Progress Report* (Kuala Lumpur: Ministry of Health Malaysia, 2010).60.

injection instruments acquired from NSEP despite no arrest having been undertaken.[642] It is notable that this study has the limit by looking at the question of extent of law enforcement practices in relation to the possession of syringes solely through the oral testimony of the enforcement agents, rather than independent observation of their actual practice or the testimony of drug users. Nevertheless, this study does indicate the existence of contradictory criminal justice practices at the ground level despite the formal endorsement of harm reduction programmes.

Thus, it is clear that street-level law enforcement based on paraphernalia law is constantly implemented despite the fact that no criminal charges have been brought for possession of injection equipment and drug residue contained in syringes. The enforcement activity causes direct and considerable disruption to the NSEP messages and operations. The absence of prosecution is also not a guarantee of no criminal action against NSEP participants in future as the relaxation of prosecution is not for the purpose of supporting the NSEP programme. The bringing of criminal charges is more than a mere theoretical possibility in the absence of any legal exemption.

Notably, MMT service providers and clients are also not excluded from street-level law enforcement. According to some Malaysian studies and literature, they too continue to be harassed, detained and raided by the police.[643] This is so despite the MMT's legal status, given that the service's operation is governed by explicit legislative provisions and totally conducted by the medical fraternity. The international research

[642] G. Parasuraman and F. Rahman, "Police Knowledge of Needle-and-Syringe Programs and Harm Reduction in Malaysia" (paper presented at the 6th International Society for the Study of Drug Policy Conference, Kent, 30 - 31 May 2012).2.
[643] For example, Norsiah et al., "Can Primary Care Clinic Run MMT Service Well?."22; Narayanan, Vicknasingam, and Robson, "The Transition to Harm Reduction: Understanding the Role of Non-Governmental Organisations in Malaysia."315.

findings indicate that aside from direct police interference with MMT operations, the experience, mistrust and fear of police practices and conviction may dissuade drug users from accessing the treatment and potential physicians from delivering it.[644] This seems to true in the Malaysian context. The finding of Mohamed and Kasa's study in Malaysia, applying a cross-sectional survey involving medical practitioners and participants in harm reduction, demonstrates that drug users would shy away from the service if they discover that the police officers are present at the site.[645] The available evidence allows us to conclude that the conflicting law enforcement practices may impact on the accessibility to the harm reduction service. This potentially cripples the implementation of the programme and suggests a clear gap between legislative and official intentions on the hand and their actual implementation in practice, on the other hand.

To date, there is no record of arrest and prosecution for the offences of self-administration, drug dependence and possession involving unauthorised prescribed methadone. Further, I am unaware of any evidence that demonstrates that there have been criminal prosecutions of medical officers for unauthorised methadone prescribing on the basis of possession, trafficking or the administration of drugs to others offences under DDA 1952. This may be explained by compliance by medical practitioners with the strict legislative provisions concerning methadone prescribing, including on prescribers' and clients' eligibility, supported by anecdotal report and research findings.[646] This may also account for the very few prosecutions for the Poison Act 1952's violation through

[644] For example, E. Tkatchenko-Schmidt et al., "Prevention of HIV/AIDS among Injecting Drug Users in Russia: Opportunities and Barriers to Scaling-Up of Harm Reduction Programmes," *Health Policy* 85, no. 2 (2008).167.
[645] M.N. Mohamed and M.D. Kasa, "Drug Substitution Therapy: Success and Limitations of the Methadone and Buphrenorphine Maintenance Programmes," *Jurnal Antidadah Malaysia* 1, no. 1 (2007).62.
[646] For example, "Research Report. Drug Substitution Therapy: Success and Limitations of the Methadone and Buphrenorphine Maintenance Programs."52.

unauthorised methadone prescribing. The data in 2009 indicates only 46 cases of offences related to psychotropic substances including methadone, of whom one has been jailed, five discharged and acquitted, seven discharged not amounting to acquittal and the rest fined.[647]

However, the adherence to the strict eligibility requirements governing the prescription of methadone impacts MMT's missions and practice. The number of medical officers accredited for prescribing methadone is low. The data of 2009 indicates that only 631 out of 30,536 doctors obtain accreditation for prescribing methadone.[648] In 2010, Malaysia counted only 21 out of 6,442 total private clinics accredited for dispensing MMT in the country. Thus, it is clear that the practice of rigid regulation considerably inhibits the involvement of medical practitioners, particularly of those in the private health sector in the prescription of methadone. Further, the stringent restrictions have the effect of limiting the prescription of methadone in health settings. This is supported by available worldwide research results indicating fewer drug prescriptions for treating serious pain due to strict regulations.[649] Additionally, WHO study findings reveal that medical practitioners in the private sector prioritised the prescribing of less regulated substances which may be less effective than methadone such as suboxone.[650] The physicians' concerns regarding accreditation and other regulatory requirements the threat

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[647] Kementerian Kesihatan Malaysia, *Laporan Tahunan Kementerian Kesihatan Malaysia 2009 [Annual Report of Malaysian Ministry of Health 2009]* (Putrajaya, Malaysia: Kementerian Kesihatan Malaysia, 2009).275.

[648] World Health Organization (Western Pacific Region) and Ministry of Health Malaysia, *Good Practices in Asia: Scale-Up of Harm Reduction in Malaysia*.26.

[649] For example, C. Beyrer et al., "Time to Act: A Call for Comprehensive Responses to HIV in People who Use Drugs," *Lancet* 376, no. 9740 (2010).555; S.A. Husain, M.S. Brown, and M.A. Maurer, "Do National Drug Control Laws Ensure the Availability of Opioids for Medical and Scientific Purposes?," *Bulletin of the World Health Organization* 92, no. 2 (2014).112–13.

[650] World Health Organization (Western Pacific Region) and Ministry of Health Malaysia, *Good Practices in Asia: Scale-Up of Harm Reduction in Malaysia*.27.

of law enforcement scrutiny upon methadone prescribing are said to account for this practice.

Moreover, the strict selection criteria have significantly affected the number of those who can gain admission to the MMT. Methadone has commonly not been provided to ineligible persons even in the event of critical withdrawal, pain and emergencies. Records in 2011 show that there are only 44,428 of 170,000 estimated drug users registered for MMT services.[651] The research also shows that a high number of drug users have been put on a long waiting list. The situation in Malaysia is a worry since harm reduction services have not reached even half of the targeted drug users.[652] This is further exacerbated by the premature termination of those admitted to MMT for specific reasons including taking illegal drugs while undergoing the MMT.[653] The actual number of active MMT clients in 2012 was 27,756. The limited admission into the programme could also be traced in other nations. For example, around 85 per cent of those whom MMT might assist remained untreated in the USA, as a result of rigid dispensing regulations.[654] Thus, the implementation of stringent limitations on methadone medication heightens the MMT's inability to accommodate the high demand of drug users. Clearly, the imposition of strict admission criteria threatens and damages the effectiveness of MMT.

The ways in which Malaysia's criminal justice operations affect harm reduction rationale and programmes can also be traced in closed settings. Drug users who are

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[651] Ministry of Health Malaysia, *Global AIDS Response Country Progress Report 2012: Country Progress Report Malaysia*.34.
[652] Ibid.34.
[653] N. Mohamad et al., "Better Retention of Malaysian Opiate Dependents Treated with High Dose Methadone in Methadone Maintenance Therapy," *Harm Reduction Journal* 7, no. 30 (2010), http://www.harmreductionjournal.com/content/7/1/30.2. (Last visited: 10/09/2013)
[654] B.J. Rounsaville and T.R. Kosten, "Treatment for Opioid Dependence: Quality and Access," *Journal of the American Medical Association* 283, no. 10 (2000).1337.

detained in police custody, government-run treatment centres and prisons (for drug-related crimes or other crimes) have limited access to harm reduction services due to dominant abstinence-based policy. While NSEP is not offered in any criminal justice settings, MMT is provided for a limited number of inmates in prison institutions and compulsory drug centres. The data in 2008 shows that there were only 42 (out of 16,749) drug-using inmates (or approximately 22 per cent of the total prison population) receiving MMT in three out of 31 prisons in Malaysia.[655] The numbers of prisons providing MMT programmes increased to 18 by the end of 2010 but the number of inmates admitted for the service is still very low.[656] MMT was provided in only two government-run rehabilitation centres, involving 21 inmates in 2011 and 40 inmates in 2012.[657] There appear to be several obstacles to the prison-based MMTs' efficient operation. The services are not yet standardised through policy mechanisms and they face significant challenges which include sporadic involvement of inmates and prison staff in anti-MMT hyperbole and 'lock down' times when prison officers bar movements within prisons.[658] The evidence demonstrates that the inclusion of drug users in compulsory rehabilitation centres or prisons blocks their voluntary participation in harm reduction services.[659]

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[655] World Health Organization (Western Pacific Region) and Ministry of Health Malaysia, *Good Practices in Asia: Scale-Up of Harm Reduction in Malaysia*.37; Agensi Antidadah Kebangsaan, *Maklumat Dadah 2012 [Drug Information 2012]*.25.
[656] Ministry of Health Malaysia, *Global AIDS Response Country Progress Report 2012: Country Progress Report Malaysia*.34.
[657] S. Kaur, "Transformation Journey of Treatment and Rehabilitation Programs in Malaysia: Compulsory to Open Access Services," (Kajang, Malaysia: National Anti Drug Agency, 2012).23.
[658] J.A. Wickersham et al., "Implementing Methadone Maintenance Treatment in Prisons in Malaysia," *Bulletin of the World Health Organization* 91, no. 2 (2013).125–26.
[659] For example, T.M. Hammett et al., "'Social Evils' and Harm Reduction: The Evolving Policy Environment for Human Immunodeficiency Virus Prevention among Injection Drug Users in China and Vietnam," *Addiction* 103, no. 1 (2008).142; Norsiah et al., "Can Primary Care Clinic Run MMT Service Well?."22.

Moreover, the effectiveness and credibility of the government's drug programmes are challenged by numerous seminal works and research, mainly for the high rate of drug consumption and relapse, and their absolute reliance on abstinence.[660] Based on international and national assessments, residents of Malaysia's compulsory treatment centres also experienced physical violence, mistreatment and medical neglect.[661] Additionally, the research by Mohamed found that drug users, while undergoing mandatory examination procedures for channelling them to residential treatment, have been affiliated with practices including unreasonable arrest, improper medical evaluation of drug dependency, limited medically-assisted treatment and non-adherence to due process.[662] Such findings are significantly troubling for human rights violations and health-related harms. Emerging research has found a relationship between enforcement abuses and the incapability of drug users to decrease adverse drug-related health risks.[663] These studies unanimously suggest that the excessive use of force or ill treatment upon drug users has an impact on their subsequent health.

As shown in this discussion, both the applicable legislative and regulatory framework obstruct harm reduction measures by raising legal problems for harm

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[660] United Nations Asia Far East Institute for the Prevention of Crime and the Treatment of Offenders (UNAFEI) and Research Division of the Research and Training Institute, Ministry of Justice Japan, *Research on the Trends in Drug Abuse and Effective Measures for the Treatment of the Drug Abusers in Asian Countries - An Analysis of Innovative Measures for the Treatment of Drug Abusers* (Tokyo: UNAFEI, 2005).31, 34; Md. Isa et al., *Laporan Kajian mengenai Undang-Undang Rawatan dan Pemulihan di antara Malaysia, Negara ASEAN, United Kingdom, Kesatuan Eropah (EU), Jepun, Korea, India, China dan Australia serta Pelaksanaannya [Report of Study: The Laws of Treatment and Rehabilitation in Malaysia, ASEAN Countries, United Kingdom, European Union (EU), Japan, Korea, India, China and Australia and Their Implementation]*.6.

[661] For example, World Health Organization (Western Pacific Region), *Assessment of Compulsory Treatment of People who Use Drugs in Cambodia, China, Malaysia and Vietnam: An Application of Selected Human Rights Principles*.19.

[662] Mohamed, "Mandatory Assessment of Drug Users in Malaysia: Implications on Human Rights."229–31.

[663] For examples, S.K. Koester, "Copping, Running, and Paraphernalia Laws: Contextual and Needle Risk Behavior among Injection Drug Users in Denver," *Human Organization* 53, no. 3 (1994).290–93; H. Cooper et al., "Characterizing Perceived Police Violence: Implications for Public Health," *American Journal of Public Health* 94, no. 7 (2004).1115–16.

reduction staff and clients and other drug users, thus eroding their engagement with harm reduction activities. Further, both would contribute to drug users' health risks and behaviours, thereby contravening harm reduction's objectives and efforts. International literature suggests that drug laws and enforcement elevate drug-associated health risks.[664] They could generate fear among drug users which consequently drives them to engage in behaviours prejudicial to public health. It has been reported that the fear of police interaction causes IDUs' disinclination to carry injection equipment and hence leads them to borrow or take discarded syringes.[665] This has been confirmed by the findings of studies including by Sarnon et al.[666] A substantial body of studies from many countries has also demonstrated that to evade police interference and arrest, IDUs have increased their risk of acquiring or transmitting infectious diseases and overdose by involving themselves in practices including syringe sharing;[667] obtaining the services of street-based injectors who likely administer multi-person injections;[668] unsafe disposal of needles and

[664] For example, L. Maher and D. Dixon, "Policing and Public Health: Law Enforcement and Harm Minimization in A Street-Level Drug Market," *British Journal of Criminology* 39, no. 4 (1999).495–505; L. Beletsky et al., "Syringe Confiscation as an HIV Risk Factor: The Public Health Implications of Arbitrary Policing inTijuana and Ciudad Juarez, Mexico," *Journal of Urban Health* 90, no. 2 (2013).293–94.

[665] For example, Koester, "Copping, Running, and Paraphernalia Laws: Contextual and Needle Risk Behavior among Injection Drug Users in Denver."290–92; T. Rhodes et al., "Situational Factors Influencing Drug Injecting, Risk Reduction and Syringe Exchange in Togliatti City, Russian Federation: A Qualitative Study of Micro Risk Environment," *Social Science & Medicine* 57(2003).46–47, 50.

[666] N. Sarnon, I. Baba, and Z.A. Hatta, "Program Pertukaran Jarum dan Picagari (NSEP): Cabaran Mengurangkan Tingkahlaku Berisiko Pengguna Dadah Secara Suntikan [Needles and Syringes Exchange Program (NSEP): Challenges in the Reduction of Injecting Drug Users' Risky Behaviour]," *E-BANGI* 2, no. 2 (2007), http://pkukmweb.ukm.my/e-bangi/papers/2007/nurulhuda07.pdf.8–9. (Last visited: 09/12/2013)

[667] For example, C. Latkin et al., "My Place, Your Place and No Place: Behavior Settings as a Risk Factor for HIV-Related Injection Practices of Drug Users in Baltimore, Maryland," *American Journal of Community Psychology* 22, no. 3 (1994).421; R.N. Bluthenthal et al., "Collateral Damage in the War on Drugs: HIV Risk Behaviors Among Injection Drug Users," *International Journal of Drug Policy* 10, no. 1 (1999).32–33; Beletsky et al., "Syringe Confiscation as an HIV Risk Factor: The Public Health Implications of Arbitrary Policing inTijuana and Ciudad Juarez, Mexico."293–94.

[668] For example, A.L. Ball, S. Rana, and K.L. Dehne, "HIV Prevention among Injecting Drug Users: Responses in Developing and Transitional Countries," *Public Health Reports* 113, no. Suppl. 1 (1998).175.

syringes;[669] associating with fatal overdose risk by relocating their injecting sites;[670] and dangerous drug storing, particularly in body cavities.[671]

Further, the fear drives IDUs to rush the injecting process and consequently exposes them to several harms including bacterial infections or even drug overdose. International empirical evidence shows an association between hurried injecting and risky behaviour including sharing and reusing drug paraphernalia and abandoning sanitary measures such as cleaning used syringes with bleach.[672] Criminal legal measures have an influence on drug-related risk behaviours as they may become significant contributors to the spread of communicable diseases and health harms. Numerous investigations show that HIV prevalence in many countries is associated with law enforcement.[673] Additionally, growing macro analyses classify laws, policies and their enforcement as key structural factors in creating the 'risk environment' for the production of health risks.[674]

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[669] For example, D. Weatherburn and B. Lind, "Heroin Harm Minimisation: Do We Really Have to Choose Between Law Enforcement and Treatment?," *Crime and Justice Bulletin: Contemporary Issues in Crime and Justice* 46(1999).7; W. Small et al., "Impacts of Intensified Police Activity on Injection Drug Users: Evidence from an Ethnographic Investigation," *International Journal of Drug Policy* 17, no. 2 (2006).91.

[670] For example, S. Darke and J. Ross, *Heroin-Related Deaths in South Western Sydney: 1992-1996* (Sydney: National Drug and Alcohol Research Centre, 1998).33; K. Dovey, J. Fitzgerald, and Y. Choi, "Safety Becomes Danger: Dilemmas of Drug-Use in Public Space," *Health & Place* 7, no. 4 (2001).328–29.

[671] For example, A. Heinemann et al., "Body-Packing as Cause of Unexpected Sudden Death," *Forensic Science International* 92, no. 1 (1998).7–8; S. Havis and D. Best, *Drug-Related Deaths in Police Custody: A Police Complaints Authority Study* (London: Police Complaints Authority, 2003).14.

[672] For example, R.S. Broadhead et al., "Safer Injection Facilities in North America: Their Place in Public Policy and Health Initiatives," *Journal of Drug Issues* 32, no. 1 (2002).338; C. Aitken et al., "The Impact of a Police Crackdown on a Street Drug Scene: Evidence from the Street," *International Journal of Drug Policy* 13, no. 3 (2002).200.

[673] For example, H.J. Albrecht, "The Role and Impact of Law and Enforcement in Reducing the Harms of Injection Drug Use and HIV/AIDS," in *War on Drugs, HIV/AIDS, and Human Rights*, ed. K. Malinowska-Sempruch and S. Gallagher (New York: International Debate Education Association, 2004).72.

[674] For example, S.A. Strathdee et al., "HIV and Risk Environment for Injecting Drug Users: The Past, Present and Future," *Lancet* 376, no. 9737 (2010).270; L. Beletsky et al., "The Roles of Law, Client Race and Program Visibility in Shaping Police Interference with the Operation of US Syringe Exchange Programs," *Addiction* 106, no. 2 (2011).362–63.

Overall, despite the support from the leadership of law enforcement agencies for harm reduction programmes and police guidelines and instructions to prevent the conflicts between the harm reduction and criminal justice approaches, significant conflicts still arise in Malaysia. The available aforementioned evidence suggests that the conflicts arise principally from the law enforcement practices. Punitive sanctions, coercive drug treatment and highly regulated drug prescribing have not been significantly reduced. Unsupportive and disruptive policing activities on the streets against drug users including those participate in harm reduction programmes such as raids, crackdowns and arrests are still common and dominant practices. This indicates that law enforcement discretion is not being exercised to support the operation of harm reduction, and that there is lack of real or genuine commitment of the criminal justice system to the harm reduction approach. This, according to the international evidence, leads to significant conflicts between the two approaches. The local evidence, though limited and not precise on the issue, does suggest that serious conflict remains. The threat of criminal law enforcement, whether real or perceived, tends to impede the efficiency of the harm reduction programme by posing legal risks and barriers to the approach's optimal availability and accessibility, and impacting drug users' human rights and health risks which would serve to counter harm reduction objectives and initiatives.

## 4.5 Is the Conflict between the Harm Reduction and Criminal Justice Approaches Unique to Malaysia and How Significant is the Conflict?

We have seen that conflicts between the harm reduction and criminal justice approaches are evident in Malaysia. This raises some relevant important questions, namely, are these conflicts exclusive to Malaysia or do they also emerge in other nations? Secondly, how significant are these conflicts in Malaysia? These two questions will be addressed in the following sections.

### 4.5.1 Is the Conflict Unique to Malaysia?

This section will look at the question whether conflict between the criminal justice and harm reduction strategies is unique to Malaysia and give a general overview of the conflicts, if any, that occur in other parts of the world, but will not examine every jurisdiction in depth. In this discussion, the various countries are classified based on general similarities of the conflict's nature. This should not be understood to indicate that each of the countries shares specific characteristics as regards policies, laws and strategies.

Despite policy commitment to harm reduction mainly due to the HIV/AIDS epidemic, significant theoretical and practical clashes between the harm reduction and criminal justice approaches, like in Malaysia, have been documented in many countries in

Asia (including Indonesia, China and India),[675] the Middle East (including Iran, Lebanon and Morocco),[676] Sub-Saharan Africa (including Kenya and Tanzania),[677] Central Asia (including Kazakhstan, Turkmenistan and Uzbekistan)[678] and Eastern Europe (including Ukraine and Poland).[679] The general picture that emerges in many of these countries is that though the law enforcement authorities recognise the legality of the harm reduction policy, they are less committed to the approach and to effective collaborative efforts. They regularly apply strategies including arrest, seizure of illicit drugs, confiscation of paraphernalia and sanctions in a deterrence mode. For example, despite the legal endorsement of the harm reduction approach through HIV laws and the government's advocacy in Vietnam, there are conflicting street-level policing practices and penal measures against drug users including mandatory abstinence-oriented drug treatment.[680] This is significantly influenced by the prevailing aim of supply and demand reduction and drug law enforcement. The conflicts are thus more about the practical exercise of enforcement discretion as efforts have been made to integrate harm reduction, but the efforts are hindered by the practices of the enforcement personnel.

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[675] Lawyers Collective HIV/AIDS Unit, *Legal and Policy Concerns related to IDU Harm Reduction in SAARC Countries: A Review Commissioned by UNODC*.72; Needle and Zhao, *HIV Prevention among Injection Drug Users: Strengthening U.S. Support for Core Interventions. A Report of the CSIS Global Health Policy Center*.20, 26.

[676] C. Stoicescu, ed. *The Global State of Harm Reduction 2012: Towards an Intergrated Response* (London: Harm Reduction International, 2012).106–10.

[677] D. Wolfe and K. Malinowska-Sempruch, "Seeing Double: Mapping Contradictions in HIV Prevention and Illicit Drug Policy Worldwide," in *Public Health and Human Rights: Evidence-Based Approaches*, ed. C. Beyrer and H. Pizer (Baltimore: Johns Hopkins University Press, 2007).334–35; Stoicescu, *The Global State of Harm Reduction 2012: Towards an Intergrated Response*.121.

[678] United Nations Office on Drugs and Crime Regional Office for Central Asia and Canadian HIV/AIDS Legal Network, *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.39–40,58–61, 71–72, 88–89.

[679] T. Zabransky et al., "Harm Reduction in Central and Eastern Europe," in *Harm Reduction in Substance Use and High-Risk Behaviour*, ed. R. Pates and D. Riley (West Sussex: Wiley-Blackwell, 2012).301–03, 311–16.

[680] M. Jardine et al., "Harm Reduction and Law Enforcement in Vietnam: Influences on Street Policing," *Harm Reduction Journal* 9: 27, no. 1 (2012), http://www.harmreductionjournal.com/content/9/1/27.1–3. (Last visited: 06/01/2013)

In some jurisdictions, conflicting enforcement actions have still occurred even though the government's advocacy efforts have been accompanied by legislative changes to address relevant legal issues. For example, 17 states in the USA, including the state of Rhode Island, have amended their paraphernalia laws to legalise NSEP and/or deregulate syringe distribution and possession. Considering the existence of inconsistent law enforcement practices in some part of states, the researchers suggest that the amendment and/or deregulation has not necessarily resulted in policing discretion being supportive of NSEP.[681] The persisting inconsistency may be caused by the government's failure to better promulgate new policy and statutory guidance and by the ground level enforcement actors' application of discretion in ways that impede harm reduction efforts. As seen earlier in this chapter, the general picture in these countries would appear broadly similar to the position in Malaysia.

Arguably, the experiences in much of Western European and Oceania countries including the UK, Portugal, Australia and New Zealand show relatively fewer conflicts than other countries such as Malaysia. This is attributed to their recognition of the treatment approach for drug users and to the sustained partnership between law enforcement and health agencies,[682] and would appear to confirm the importance of multi-agency working in relation to harm reduction interventions as highlighted above.

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[681] L. Beletsky, G.E. Macalino, and S. Burris, "Attitudes of Police Officers towards Syringe Access, Occupational Needle-Sticks and Drug Use: A Qualitative Study of One City Police Department in the United States," *International Journal of Drug Policy* 16, no. 4 (2005).268; S. Burris et al., "Addressing the "Risk Environment" for Injection Drug Users: The Mysterious Case of the Missing Cop," *Milbank Quarterly* 82, no. 1 (2004).139.

[682] R. Atun and M. Kazatchkine, "Translating Evidence into Action-Challenges to Scalling Up Harm Reduction Programmes in Europe and Central Asia," in *Harm Reduction: Evidence, Impacts and Challenges*, ed. T. Rhodes and D. Hedrich (Luxembourg: European Monitoring Centre for Drugs and Drug Addiction, 2010).96; A. Wodak et al., "Policy and Practice in Harm Reduction in Australasia," in *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice* ed. R. Pates and D. Riley (West Sussex: Wiley-Blackwell, 2012).409–11, 415–18.

Enforcement officers continue aggressive punitive measures to disrupt drug production and distribution but adopt a minimalist criminal approach to drug users. They support harm reduction measures in a handful of ways such as avoiding enforcement against service participants, diverting drug users to treatment centres through drug courts and police stations, and engaging directly in service delivery. For instance, through the UK Drug Referral Scheme, police stations have been used for drug agencies to provide assistance and referrals to suitable treatment programmes. The provision of methadone and buprenorphine to offenders who are already in drug substitution programmes is also carried out at police stations in Australia.[683] Additionally, many nations have adopted policy, legislative and enforcement changes to accord with the harm reduction approach. The above practices reflect a more far reaching commitment and determination to support harm reduction by governments and the enforcement sector.

In the Netherlands, enforcement practices display a high dedication to public health and to the principles and praxis of harm reduction and hence greatly reduce the conflicts between the approaches.[684] They have adopted harm reduction as one of the integral aims of enforcement and show great commitment to the goal by perpetually undertaking collaborative actions and tailoring measures around drug use, production and distribution. Harm reduction receives extensive emphasis in drug policies and laws. Harm-oriented classification of illicit drugs into those with 'tolerable' harm (soft drugs) and 'intolerable' harm (hard drugs) to the users' health appears the essence of Dutch drug policy. Even if the policy and practice may potentially lead to unimpeded harm reduction

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[683] G. Monaghan, "Harm Reduction and the Role of Police Services," in *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice* ed. R. Pates and D. Riley (West Sussex: Wiley-Blackwell, 2012).64–65.

[684] Ghodse, *Ghodse's Drugs and Addictive Behaviour A Guide to Treatment*.73.

programmes, it is not without risk. This may significantly cause slippage in prohibitionist-based goals and strategies to address drug prevalence. Thus, it is unsurprising that indefinite drug maintenance and drug dependency problems persist in the Netherlands.[685]

However, in other countries where government has given steadfast exclusive concentration to repressive anti-drug policy based on prohibition and criminalisation, there appears to be an uphill battle between the approaches. This can be found in the majority of states in the USA and some nations in Eastern Europe such as Russia, Tajikistan and Turkmenistan.[686] In these countries, harm reduction policy receives little or no support from governments and the link between government health and law enforcement agencies is almost non-existent. For example, in the USA, while criminal justice-oriented prohibition is heavily focused in national drug strategies, the harm reduction approach is constantly objected to by the federal government.[687] Thus, it is difficult, if not impossible, to implement robust harm reduction measures. Considering the ultimate weight of the federal and state governments to primary preventive measures, abstinence-oriented treatment and stringent law enforcement, the constant antagonism towards the harm reduction approach is understandable. The enforcement authorities exercise a punitive approach against those consuming illicit drugs, thereby decreasing access for any type of intervention, treatment or harm reduction.

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[685] Bowser, Word, and Seddon, *Understanding Drug Use and Abuse: A Global Perspective*.137, 139.

[686] Stoicescu, *The Global State of Harm Reduction 2012: Towards an Intergrated Response*.86; J. Buxton, *The Political Economy of Narcotics Production, Consumption and Global Markets* (London & New York: Zed Books Ltd., 2006).162–64; W.E. Butler, *HIV/AIDS and Drug Misuse in Russia: Harm Reduction Programmes and the Russian Legal System* (London: International Family Health, 2003).332–33; Atun and Kazatchkine, "Translating Evidence into Action-Challenges to Scalling Up Harm Reduction Programmes in Europe and Central Asia."96–98.

[687] L. Moore and A. Clear, "History and Context of Harm Reduction in the United States," in *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice* ed. R. Pates and D. Riley (West Sussex: Wiley-Blackwell, 2012).374–75.

In short, it is clear that the conflicts between criminal justice and harm reduction approaches are not a problem unique to Malaysia. The attempts here to provide a general picture of conflicts in other countries go some way to show the position of Malaysia's conflict levels. Malaysia is apparently stronger than in some other countries, especially those that totally reject harm reduction approach, due to its clear endorsement of the approach. However, Malaysia still experiences significant conflict, particularly arising out of limited effective multi-agency partnership and the lack of enforcement discretion towards supporting it. This shows a lack of integration of both approaches in Malaysia when compared with some other countries such as the UK where collaboration among multiple agencies and a positive exercise of enforcement discretion are more prevalent. The fact that conflict can be found in multiple jurisdictions should help set the agenda for further assessment including comparative analysis which is currently lacking.

### 4.5.2 How Significant is the Conflict?

Given the conflicts arising from the concurrent implementation of law enforcement and harm reduction, the debate on drugs in Malaysia broadly reflects the governing assumption that there is compatibility between both approaches. In that vein, this section explores this issue and considers the significance of conflict between the two approaches and some of its implications for harm reduction policy and practice, taking into account both local and international perspectives.

Any conflict between these approaches in Malaysia is rendered by some as trivial. They argue that hostile law enforcement operations are rare and hence do not negatively impact the successful expansion of the harm reduction approach nationwide. Any challenges to the programmes are within the government's control through policy guidelines and other mechanisms geared towards collaborative efforts from relevant agencies. This kind of view seemingly plays down the significance of conflicts between drug policies, thereby overlooking the pivotal importance of maintaining consistency between different elements of drug policy.

Worse than that, the government, the supporting media and public in general seemingly close their eyes to the realities of the situation in Malaysia, and conclude that there is no practical contradiction between the approaches. According to them, both policies are mutually reinforcing in the drive towards controlling the drug problem. Considering the government's constant advocacy initiatives and smart partnership between relevant authorities, the harm reduction approach is assumed to be practiced harmoniously nationwide within the continuing prohibition framework.

It is implausible to presume that the policy guidance and other measures will be realised in practice. Within the face of repressive law enforcement in the Malaysian context, it is clear that the emerging conflicts are more than symbolic and insubstantial, and thereby demand attention. The evidence noted in this chapter shows that criminal law and its enforcement practices against drug use and its related activities are in obvious conflict with harm reduction efforts. The contradictions should not be treated as trivial as they are thwarting the objectives of harm reduction and hindering its practices.

The inconsistent and counterproductive legal provisions and practices indicate that the different intrinsic philosophical frameworks of the criminal justice approach and harm reduction as a public health approach in Malaysia have not been properly reconciled, particularly with respect to the principles, objectives, strategies and priorities in addressing drug problems. This argument shows that unless reconciliation of the two approaches is made, the different theories of both policies at international and national levels will continue to contribute to the discordance between them.

What is meant by reconciling is to redefine or adjust the aims and purview of each harm reduction and criminal justice approach with reference to a principled approach and embodying policies and strategies to build partnership between the two regimes. More discussion regarding ensuring the compatibility between both drug responses is provided in Chapter 5. It is worth mentioning that the notion of 'balancing' is avoided in order to resolve the conflicts between the approaches despite its wide use in political and legal debate. This is because balancing can be a problematic metaphor in the criminal justice sphere for its potential for abuse. It has always been applied as a 'rhetorical device' to justify changes without appropriate support or sufficient attention and resolution to conflicting accounts.[688] The lesson of criminal justice is also that the balance is tipped by the prediction of future threats with high uncertainty and pursued on the claimed impetus for safeguarding the factional interests of community and victims at the expense of individual liberties.[689] Moreover, despite its advantage in driving the examination of what is being balanced including values, interests and rights and their subsidiary aspects such

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[688] Ashworth, "Crime, Community and Creeping Consequentialism."229.
[689] L. Zedner, "Securing Liberty in the Face of Terror: Reflections from Criminal Justice," *Journal of Law and Society* 32, no. 4 (2005).511–14.

as the basis and weight or priority of every factor, it is barely to be a useful guiding tool for decision making. As Zedner argues, this is because the calculations to the commensurability of the supplementary factors are convoluted by distribution (the interest of majority versus that of small minorities) and temporal dissonance (known interest versus future uncertainty).[690]

It is worth bringing to mind some important points regarding the criminal justice and harm reduction approaches. The criminal justice approach aims to contain drug supply and consumption through prevention, treatment and punishment. Preventive measures are devised to thwart the occurrence of future drug use while treatment serves to address the drug using habit by seeking to stop physical and psychological dependence on drugs. Treatment is usually predicated in the punishment matrix and is mainly based on coercion and severe penalties upon relapse. The other primary strategies are law and its enforcement via police actions, prosecution and punishments, usually in the form of incarceration.

Unlike punitive criminal justice, the harm reduction approach moves the focus away from drugs themselves to their adverse consequences to oneself and others. The harm reductionists' arguments point out that harm reduction interventions are not constructed to decrease the absolute numbers of drug users. Des Jarlais, for instance, points out: 'Drug use leads to individual and social harms through many different mechanisms, so a wide range of interventions is needed to address these harms […] It is not always necessary to reduce nonmedical drug use in order to reduce harms'.[691] Thus,

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[690] Ibid.516, 532.
[691] D.C. Des Jarlais, "Editorial: Harm Reduction-A Framework for Incorporating Science into Drug Policy," *American Journal of Public Health* 85, no. 1 (1995).11.

its achievement is evaluated in terms of actual effects, by the decrease of drug consumption and its related harms, not by the decline of drug use prevalence.[692] The harm reduction framework which is based on pragmatism and voluntariness forms a large part of antagonism to the extensive criminalised prohibition.[693]

This stance of this thesis regarding the existence of tensions between the harm reduction and criminal justice approaches clearly challenges the opposite perspective of the conceptual congruity between the approaches. Perhaps the most important view regarding the compatibility is the statement of the UNODC that harm reduction complements, rather than contradicts, other interventions under the prohibition framework. It is clearly stated: 'Harm reduction is often made an unnecessarily controversial issue as if there was a contradiction between prevention and treatment on one hand and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary'.[694] UNODC observes that neither the prevention, dependence treatment or harm reduction in isolation can effectuate drug strategy but together they can shape a combined approach to reduce the harmful effects of drug use and eliminate the epidemic of blood-borne diseases.[695]

Similarly, too often harm reduction policy is viewed reciprocally related to the prevention of drug use, treatment and law enforcement in a four-tier drug policy framework. As stated by MacPherson, the model 'seeks to bring together the diversity of

[692] For example, Nadelmann, "Common Sense Drug Policy."172.
[693] C. Reinarman and H.G. Levine, "Real Opposition, Real Alternatives: Reducing the Harms of Drug Use and Drug Policy," in *Crack in America: Demon Drugs and Social Justice*, ed. C. Reinarman and H.G. Levine (Berkeley, California: University of California Press 1997).349–50, 356–57.
[694] United Nations Office on Drugs and Crime (UNODC), *Reducing Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach. Discussion Paper* (New York: United Nations, 2009).iii.
[695] Ibid.3.

views and issues surrounding substance misuse so that we can build a consensus for action'.[696] Some, for example Kendall and Weir, suggest that the harm reduction approach is not antagonistic when it is made as an umbrella strategy in the four-pillar framework[697] while many regard harm reduction as a complementary fourth tier of four pillars under the drug policy model. By way of illustration, as stated by the MOH, British Columbia, regarding the position of harm reduction in Canada, 'harm reduction is an essential part of a comprehensive response to problematic substance use that complements prevention, treatment and enforcement'.[698] The model suggests a consistency with the harm reduction approach to other responses to drug problems including prevention, treatment and law enforcement under a larger prohibitionist policy. While positing the harm reduction approach within the four-tier framework together with other vital policies has merits as a means of endorsing it as an important drug policy, it is not convincing enough to conclude that there is no conflict among the policies.

It is here acknowledged that the harm reduction idea is not a polar opposite to the traditional criminal justice approach. Philosophically, there are some similarities and mixed linkages between both approaches, including their deep roots and shared concerns on the health and welfare of drug users and the principle of social interest protection. Harm reduction could form as a paramount approach not to supplant but to be aligned with other drug approaches in addressing drug use problems. Hwang affirms this asserting that: 'harm reduction strategies are intended to complement, rather than replace,

[696] D. MacPherson, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver* (Vancouver: Vancouver's Coalition for Crime Prevention and Drug Treatment, 2000).30.
[697] P. Kendall and E. Weir, "Substance Abuse: Tempering the Debate," *Canadian Medical Association Journal* 162, no. 12 (2000).1687.
[698] British Columbia Ministry of Health, *Harm Reduction: A British Columbia Community Guide* (Victoria: British Columbia Ministry of Health, 2005).3.

more traditional means of treatment'.[699] However, unless there is a reconciling measure to the dissimilar principal goals, principles, methods, priorities, practices and understandings of drug use between criminal justice and harm reduction, the assumed compatibility-approaches, irrespective of whether it is anchored in a four-pillars framework or not, is less compelling. The non-reconciled theoretical differences lead to conflicts. Scholars such as Caulkins likewise consider that the goals of criminal justice and harm reduction approaches are in agreement with each other as it is not inevitable that the former's achievement will counteract the latter's success. However, the selecting of goals may be in conflict as a result of different preferences and other differing aspects.[700]

The arguments for the consistency among drug approaches in the four-pillar model provide insufficient justifications on why and how far the compatibility among the approaches is attained by being put together in the framework. This is a flaw, particularly due to the remaining higher weight of law enforcement, including for funding. The four-pillars, as one activist depicted, are 'a tree trunk (law enforcement) and three toothpicks'.[701] The theoretical pitfall of consistency among the approaches is further shown by practical conflicts. For example, the 2003 police crackdown on IDUs in Vancouver has disrupted harm reduction accessibility and increased risky behaviour.[702] This shows that the four-pillar framework tends to be a political adjustment but fails to lead to extensive reconciliation among drug responses.

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[699] S.W. Hwang, "Homelessness and Harm Reduction," *Canadian Medical Association Journal* 174, no. 1 (2006).50.
[700] J.P. Caulkins, "Law Enforcement's Role in Harm Reduction Regime," in *War on Drugs, HIV/AIDS, and Human Rights*, ed. K. Malinowska-Sempruch and S. Gallagher (New York: International Debate Education Association, 2004).306–07.
[701] Human Rights Watch, *Abusing the User: Police Misconduct, Harm Reduction and HIV/AIDS in Vancouver* (New York: Human Rights Watch, 2003).2.
[702] Small et al., "Impacts of Intensified Police Activity on Injection Drug Users: Evidence from an Ethnographic Investigation."88–91.

The notion of the philosophical compatibility of the criminal justice and harm reduction approaches is also problematic as it may disregard the insights for investigation, weighing and seeking solutions to the conflicts of both methods. To juxtapose the contrasts between the harm reduction approach and other drug approaches towards addressing the policy barriers, Jourdan advocates for harm reduction to be posited in contradiction to other drug policies.[703] Arguably, the practical tensions are considerably symptomatic to inconsistent ideological underpinnings of the approaches and thereby require strategies to reconcile both theoretical and praxis aspects.

There is also much to learn from the incidents involving tensions between drug responses in Malaysia. Criminal justice may run into significant discrepancy to the harm reduction approach where there are non-reconciled different philosophical principles and the implementation of both approaches. It seems that there is a need to shift away from assuming the general compatibility between drug approaches in international and national contexts. Instead, a reoriented focus should be on reconciling the philosophical and practical gaps and conflicts.

However, the criminal justice practice is central to the conflict. Even if criminal justice emerges to be theoretically contradictory, both responses are not necessarily antithetical in practice in any country (as shown in Chapter 4, Section 4.5.1) as policy guidance may caveat this for harm reduction interventions. The practical contradiction will occur when criminal justice authorities do not take into account a harm reduction perspective and apply discretion to support the approach as evidenced in the Malaysian

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[703] M. Jourdan, "Casting Light on Harm Reduction: Introducing Two Instruments for Analysing Contradictions between Harm Reduction and 'Non-Harm Reduction," *International Journal of Drug Policy* 20, no. 6 (2009).515.

case. This indicates the core influence of criminal justice responding to the compatibilities. The challenging Malaysian criminal justice response, characterised by pervasive policing surveillance, imprisonment and coercive treatment of drug users is influenced by several main factors which will be discussed in the next section.

To sum up, generally there are differences in the underlying concepts of criminal justice and harm reduction approaches which contribute to the contradiction in both international and national contexts. Dissimilarities do not mean the impossibility of reconciliation, particularly with respect to practice at national level which is a relatively more important determinant of actual conflicts. In Malaysia, there are substantial philosophical and practical conflicts between the two responses, with no significant reconciliation undertaken upon the different theories and praxis.

## 4.6 What Factors Lie behind the Exercise of Police Discretion as It relates to Harm Reduction in Malaysia

Criminal justice actors *are* commonly conferred vast discretion when deciding what incidents to become involved in and how to deal with them. The discretionary power in the Common Law system of criminal justice is not limited to police but extends to others actors including prosecutors and even judges.[704] As discussed before, the evidence shows that when it comes to drug use, the police in Malaysia tend to exercise their discretion in

[704] P. Stenning, "Discretion," in *The SAGE Dictionary of Policing*, ed. A. Wakefield and J. Fleming (London: Sage Publications Ltd., 2009).85.

ways that impede harm reduction programmes. In view of this, it is important to look at a possible explanation of why the police officers have seemingly been reluctant to move away from the strict enforcement. There follows a discussion of several important factors affecting the exercise of police discretion in relation to harm reduction based on available evidence in the Malaysian context, while taking some account of the international literature on policing.

### 4.6.1 Lack of Knowledge or Scepticism about Effectiveness or Morality of Harm Reduction Interventions

Positive depictions of the potential of harm reduction measures are likely tempered by the poor knowledge and misinterpretation of Malaysian enforcement personnel about the principles and local utility of harm reduction. Some local empirical results highlight this attitudinal factor whereby they are either ignorant or doubtful of harm reduction operations. The findings of a study by Ibrahim indicate that there is unawareness and lack of knowledge among the police officers of the NSEP despite the widespread of distribution of the Guidelines for Police in relation to the programme.[705] Research by Parasuraman and Rahman further found police officers still had limited knowledge regarding harm reduction approach and its imperatives although they had already attended relevant training.[706] The available findings are unsurprising, considering the lack of local scientific evidence indicating the effectiveness of harm reduction services

[705] Ibrahim, "Needle Syringe Exchange Program in Malaysia."35.
[706] Parasuraman and Rahman, "Police Knowledge of Needle-and-Syringe Programs and Harm Reduction in Malaysia."3.

(as previously shown in Chapter 3), officers at ground-level not being involved in initial policy planning and limited communication (as discussed in Chapter 4, Section 4.3).

Additionally, a few research studies suggest that many Malaysian police officers see harm reduction services as encouraging and enabling drug use and are negative towards ways of handling drug use problems other than the traditional abstinence-based approach. In Rahman and Parasuraman's study of 53 low to mid-level RMP officials, approximately half of the respondents think that NSEP condones the consumption of illicit drugs.[707] This accords with the findings of studies in South East Asia showing that the street-level officials' pessimistic viewpoints regarding the morality of harm reduction programmes inhibit their support.[708] These studies suggest that many officials have less commitment to supporting harm reduction and also relates to an ideological issue.

The attitudinal factor is likely coherent as intuitively how individuals conduct themselves, including how they exercise discretion, ensues from their attitudes. However, the studies on this influence upon the ways in which police perform produce inconsistent findings. Mastrofski et al. found that the police's positive belief regarding community policing contributes to their significantly less likelihood of arrests.[709] Riksheim and Chermak's comprehensive review of the studies in the 1980s reports the presence of individual determinants.[710] These studies lend support to the attitude-behaviour linkage and would suggest that difference in actions flows from variance in attitudes. By contrast,

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[707] Ibid.2.

[708] For example, V. Sychareun et al., "Defining and Redefining Harm Reduction in the Lao Context," *Harm Reduction Journal* 9, no. 1 (2012).6; T.H. Khuat et al., "Harm Reduction and "Clean" Community: Can Viet Nam have Both?," *Harm Reduction Journal* 9, no. 1 (2012), http://www.harmreductionjournal.com/content/9/1/25.8. (Last visited: 03/01/2015)

[709] S.D. Mastrofski, R.E. Worden, and J.B. Snipes, "Law-Enforcement in a Time of Community Policing," *Criminology* 33, no. 4 (1995).557.

[710] E.C. Riksheim and S.M. Chermak, "Causes of Police Behavior Revisited," *Journal of Criminal Justice* 21, no. 4 (1993).376.

some studies indicate weak or no support for the link between attitudes and police actions. A study by Worden found that the attitudinal indicators including attitudes towards their role, legislative constraints and citizenship only weakly relate to police practices.[711] Terrill and Mastrofski also found no link between attitudes and the police's exercise of coercion.[712] Such negative results likely led claims in the literature that the personal belief and attitudes of the police provide little guidance to explain police decision-making.

The impact of the police's attitudes on their behaviour is therefore inconclusive, considering the mixed results of these studies. More research is therefore needed to examine connections between both variables. Current Malaysian research has started looking at the circumstances regarding police behaviour towards harm reduction and detects its consistency to the police's individual knowledge, belief and attitudes. Thus, there is clearly an opportunity for additional studies to examine this attitudinal explanation.

### 4.6.2 Perception of Priority for Drug Fighting Responsibility

The promotion of harm reduction measures is also believed to be competing with the task of combating drugs, thereby causing dilemmas in Malaysian police works. The evidence indicates that the enforcement authorities frequently think that they should give

[711] R.E. Worden, "Situational and Attitudinal Explanations of Police Behavior: A Theoretical Reappraisal and Empirical Assessment," *Law and Society Review* 23, no. 4 (1989).687–90, 701–03.
[712] W. Terrill and S.D. Mastrofski, "Situational and Officer-Based Determinants of Police Coercion," *Justice Quarterly* 19, no. 2 (2002).239.

precedence to the task concerning prohibition-based drug control.[713] Implicit in this is the officers' viewpoints that drug control is their utmost responsibility, leading them to abandon or only provisionally consider public health measures. This is expected given the officers' long immersion within prohibition-oriented strategies. This indicates that the connection of police enforcement against the harm reduction to perception issue. It accords with the research findings showing the implication of officers' belief and attitudes on their decisions as discussed above.

Further, despite there being no specific evidence in the literature on the influence of police personality to Malaysia's contradictory police practices, the aforementioned evidence of police priority to strict enforcement enables its possibility to be seen. The presumption is also driven by the 2005 Royal Commission Report revealing the cultures and negative traits among Malaysian police that connect to prevalent abuse of powers and public trust.[714] Additionally, there is international literature supporting the association between police personality and drug use enforcement. Lough, for instance, in highlighting to some extent the incompatibility between the criminal justice and harm reduction approaches as understood and practised in Australia, considers that repressive actions against drug users are somehow counterweighted by the personality characteristics of police.[715] This argument is consistent with seminal works and studies showing that police

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[713] Narayanan, Vicknasingam, and Robson, "The Transition to Harm Reduction: Understanding the Role of Non-Governmental Organisations in Malaysia."312.
[714] Royal Commission, *Report of the Royal Commission to Enhance the Operation and Management of the Royal Malaysia Police* (Kuala Lumpur: Percetakan Nasional Malaysia Berhad, 2005).3, 302, 339.
[715] G. Lough, "Law Enforcement and Harm Reduction: Mutually Exclusive or Mutually Compatible," *International Journal of Drug Policy* 9, no. 3 (1998).171.

behaviours are contributed by their distinct personality.[716] However, this subject gets scant focus in the recent empirical assessments.

The notion of police personality suggests the homogeneity of traits among police individuals. It, for Berg, connotes the consolidation of characteristics and behaviours which are stereotyped to police officers. The characteristics frequently cover 'a desire to be in control of the situation, assertions, cynicism, authoritarian attitude, a wish to be aloof from citizens, an increased solidarity with other police officers and a tendency to be physically aggressive'.[717] Scholars, however, differ in their arguments pertaining to the roots of police personality. Some contend that police personality is dispositional. The personal traits of individual officers pre-exist before their entry into the police force.[718] Of these certain personality characteristics, they are recruited. This is realised through pre-occupational screening processes. Some others argue that police personality builds from an employment socialisation process.[719] This means that the personality attributes are acquired by officers throughout the course of their work. Moreover, there appear to be scholars claiming that police personality is a product of police culture. Organisational culture comprises 'values that are common to most of the organisation's members'.[720] According to Reiner, 'cop culture' embodies 'mission/action/cynicism/pessimism, suspicion, isolation/solidarity, conservatism, machismo, racial prejudice and

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[716] For example, A. Twersky-Glasner, "Police Personality: What is It and Why are They Like That?," *Journal of Police and Criminal Psychology* 20, no. 1 (2005).65.
[717] B.L. Berg, *Policing in Modern Society* (Boston: Butterworth Heinemann, 1999).297.
[718] P. Bonifacio, *The Psychological Effects of Police Work: A Psychodynamic Approach* (New York: Plenum Press, 1991).147.
[719] R.P. McNamara, "The Socialization of the Police," in *Police and policing: Contemporary issues*, ed. D.J. Kenney and R.P. McNamara (Westport, C.T.: Greenwood Publishing Group, 1999).4–5.
[720] S. Kelman, *Making Public Policy: A Hopeful View of American Government* (New York: Basic Books, 1987).152.

pragmatism'.[721] In other words, the police subculture is a trait of police occupation that influences elusive police personality. This stance assumes a considerable similitude among officers. Arguably, it is less plausible to specify a single basis for the formation of police personality. Considering the interrelations of all notions, it is fair to say that police personality stems from congruent pre-employment individual attributes and develops through occupational experiences and police culture.

While there are supports to police personality, there appear few studies failing to find its evidence.[722] Some research found variance in personality among police officers.[723] The notion is also rejected by some scholars based on several grounds. Firstly, the police attributes are regarded as being basically undistinguishable from non-police. This reflects the objection to the notion of the distinctive traits of the police. Secondly, police personalities may become less prevalent as a result of specific efficient measures. According to Wortley, traditional police personalities could be lessened by effective strategies including the promotion of professional conduct, training and recruitment requirements.[724] Presumably, this contention suggests that police personalities are unfixed and subject to moderation and hence it is not strong enough to conclude whether it might account for differences in actions among officers. It is hard to accept these claims, considering the capabilities and opportunities of police to constantly exhibit distinctive

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[721] R. Reiner, *The Politics of the Police*, Fourth ed. (New York: Oxford University Press, 2010).118–31.
[722] For example, J. Mahanta and S.V.K. Kathpalia, "Personality Dimensions of Police and Other Officers in Criminal Justice Administration," *Journal of Police Science and Administration* 12, no. 2 (1984).213–15.
[723] For example, B.A. Sanders, "Maybe There's No Such Thing as a "Good Cop" – Organizational Challenges in Selecting Quality Officers," *Policing: An International Journal of Police Strategies & Management* 26, no. 2 (2003).324–25.
[724] R.K. Wortley, "Measuring Police Attitudes Toward Discretion," *Criminal Justice and Behavior* 30, no. 5 (2003).540.

traits consistent to their different role, nature of occupation and ways of applying authorities.

To sum up, the link of police personality to their behaviours has been widely examined with mixed evidence but this should not discount the potential connection between these variables. It has also been supported by compelling arguments. The determinant's influence deserves more studies to confirm its validity. Therefore, it is here argued that the police practices in the Malaysian context of drug use are considerably attached to their perception and presumed personality. The existence of such factors and connection to conflicting enforcement actions needs confirmation through further research. However, arguably, it is not strong enough to believe that the beliefs and personality, if they exist, will confirm police behaviours. The attitudes are just a part of the overall picture due to their subjectivity to other considerations.[725]

### 4.6.3 Performance Targets and Policing Policy

The Malaysian literature demonstrates that the police's decisions on the streets are considerably affected by their performance targets or quotas which are usually based around law enforcement.[726] Thus, while harm reduction is implemented, intense focus on drug control is still covered under the target's commitment. Similarly, the performance settings become a major issue for policing in numerous countries including England and

[725] T. Newburn and R. Reiner, "Policing and the Police," in *The Oxford Handbook of Criminology*, ed. M. Maguire, R. Morgan, and R. Reiner (Oxford: Oxford University Press, 2012).811.
[726] Khuat et al., "Harm Reduction and "Clean" Community: Can Viet Nam have Both?".7; Parasuraman and Rahman, "Police Knowledge of Needle-and-Syringe Programs and Harm Reduction in Malaysia."2–3.

Wales.[727] Much can be learned from the available evidence that despite its being claimed essentially as one component of central performance controlling to heighten public services' effective delivery, the target-setting may lead to negative implications. One detrimental consequence connected to the police is the primary emphasising of enforcement practices to crimes of greatest opportunity of detection. It is for this reason that researchers including Patrick and Chatterson consider shifting the prioritising of severe offences to small crimes as part of adverse outcomes from the target's overuse.[728] It might become an easy way for the police to cope with the pressures from the quota imposition. This shows that the commitment to target attainment can have a pernicious effect upon police discretion regarding low-level criminality. It is therefore unsurprising that drug users in Malaysia are continuously targeted by the police as they seemingly constitute 'low lying fruit' to meet the performance quotas. More significantly, there is no evidence showing the account of supporting harm reduction operations within the quota regime. This further explains the police's harassment upon the participants of services.

The focusing on minor crimes for reaching quotas is problematic for its danger of the 'gaming'[729] of system which is an antithesis to ethical ideals. By devoting high preference to actions that directly contribute to performance indicators, it propagates costs to other policing purposes and hence constitutes a 'skewing'; a type of 'gaming'.[730] From

[727] R. Patrick, "Performance Management, Gaming and Police Practice: A Study of Changing Police Behaviour in England and Wales During the Era of New Public Management" (Ph.D. Thesis, University of Birmingham, 2009).3–5.
[728] Ibid.267; M. Chatterton, *Losing the Detectives: Views from the Front Line* (Surrey: Police Federation of England and Wales, 2008).iii.
[729] This refers to the floridness for working's operating towards achieving target at all expenses.
[730] Aside from skewing, other conduct categories considered gaming include: cuffing, which involves unwarranted fixing of crime records; stitching, which relates to using illegal methods to obtain evidence; and nodding, which regards colluding with criminals to getting discovery through unjustified techniques. (Patrick, "Performance Management, Gaming and Police Practice: A Study of Changing Police Behaviour in England and Wales During the Era of New Public Management."15).

the resulting gaming, it is possible to argue that the rigid centrally set-targeting could ruin the police's professional standards and eventually impair not only policing efficiency but also harm reduction accessibility. Contributing to the tension of the enforcement officers in Malaysia is the national 'Drug Free Nation' target to be achieved by 2015, the National Key Result Area (NKRA) which includes decreasing street crime and the Government Transformation Programmes (GTP) that direct governmental sectors towards providing high quality services to society. These policies are emphasised within the police's vision and framework. The inconsistent departmental goal and demands provide insight about the potential impact of organisational context on police's decision-making concerning drug control and harm reduction efforts. In contrast to attitudinal determinant that intrinsically attaches to individuals, the organisational determinant accords department. However, it impacts officers' behaviour.

Evidence from a handful of research demonstrates that police's discretionary behaviours may be affected by the organisational context in which it happens. The work on this factor has been pioneered by Wilson. He introduced three distinctive categories of police agencies. First is the watchman-type agency. By aiming to achieve order maintenance, this agency undertakes law enforcement upon major crimes while neglecting offences of a minor nature. Second is legalistic-type which is connected to strict the law enforcement principle and practice based on wide regulations and procedures. It has autonomy from communities but subjects to being centrally controlled. Third is service-type agency. In this organisation, they focus on community-based policing and implement non-law enforcement problem-solving techniques. There are

lesser degrees of bureaucracy and controlling in this agency than legalistic-type.[731] Conversely, Wilson's model suggests that differences in police agency patterns influence divergences of enforcement actions including arrests, whereby more will be actualised in legalistic-type agency than others.

Wilson's typology is applied by some studies including Smith and Klein and Mastrofski, focusing on the organisational characteristics and their influence on police decisions.[732] The findings supporting the impact of organisational features include size, bureaucracy, supervision level, professionalism and policies on discretionary decision making of police are also discovered by other studies such as Monkkonen.[733] Further, there appear to be research results demonstrating the link between this determinant and specific police cases. The findings of Smith's study, for example, indicate higher arrests particularly in cases involving youths and disputes by officers from the legalistic police division than other units.[734] This shows the significant influence of organisational structures on police arrests.

However, the organisational determinant does not go unchallenged. Few studies found non-existent or minimal relationships between organisational features and police decision making.[735] Several study results also indicate that policing is based principally

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[731] J.Q. Wilson, *Varieties of Police Behaviour: The Management of Law and Order in Eight Communities* (Cambridge & Massachusetts: Harvard University Press, 1968).140–225.
[732] D.A. Smith and J.R. Klein, "Police Agency Characteristics and Arrest Decisions," in *Evaluating Performance of Criminal Justice Agencies*, ed. G.P. Whitaker and C.D. Phillips (Beverly Hills: Sage Publications, 1983).92; S. Mastrofski, R. Ritti, and D. Hoffmaster, "Organizational Determinants of Police Discretion: The Case of Drinking-Driving," *Journal of Criminal Justice* 15, no. 5 (1987).388.
[733] E. H. Monkkonen, *Police in Urban America* (New York: Cambridge University Press, 1982).147.
[734] D.A. Smith, "The Organizational Context of Legal Control," *Criminology* 22, no. 1 (1984).30–32.
[735] For example, R.H. Langworthy and M.J. Hindelang, "Effects of Police Agency Size on the Use of Police Employees - A Re-Examination of Ostrom, Parks, and Whitaker," *Police Studies* 5, no. 4 (1983).17, 19.

on other factors, including situational context rather than organisation role.[736] Thus, the organisational impact is claimed by Chappell et al. as exaggerated in literature.[737] Overall, there are supporters of the organisational indicators of police behaviours from a fair amount of existing studies. However, its degree raises calls for further empirical studies. There appears to be some evidence for supporting the impact of organisational characteristics including vision, administrative policy and work controls to practices against drug use and harm reduction in Malaysia. This should be validated by further empirical research which is a clear gap.

### 4.6.4 Contradictory Criminal Laws

Further, for some critics, the Malaysian police's contradictory enforcement exercises are contributed by conflicting drugs laws. Kamarulzaman and Razali, while describing the challenges to Malaysian HIV strategies, express: 'The existence of the current laws makes it difficult for police particularly junior officers to reconcile the strict zero tolerance policies with the newly introduced harm reduction measures'.[738]

This illustrates the point that problematic police practices are related to criminal legislation. It seems plausible since the punitive prohibition-oriented laws against drug

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[736] A.T. Chappell, J.M. Macdonald, and P.W. Manz, "The Organizational Determinants of Police Arrest Decisions " *Crime & Delinquency* 52, no. 2 (2006).302–03.
[737] Ibid.302.
[738] A. Kamarulzaman and K. Razali, "Malaysia," in *Public Health Aspects of HIV/AIDS in Low and Middle Income Countries: Epidemiology, Prevention and Care* ed. D.D. Celentano and C. Beyrer (New York: Springer Science & Business Media, 2008).495.

users are sustained and have not been amended to accommodate the integration with harm reduction as discussed earlier.

However, some literature on policing highlights that law exerts no significant influence upon police actions since they can evaluate and determine their way of responding to a specific situation. According to Manning, police always apply 'situational rationality that takes into account the particular times and places of events, rather than a set of firm rules, regulations, or laws'.[739] This argument tends to suggest that the main determinant of police decisions is contextual. The other implicit idea from this stance is that in choosing reactions to encountered realities on the streets, officers employ enormous discretion.

Despite the discretion owned while encountering specific situations, it is clear that the police are not totally disconnected from the underlying framework of law. The law becomes an elementary groundwork or structural predisposition orienting the police in interpreting and resolving responses to the circumstances. This is supported by many commentators.[740] The law is employed primarily to understand the confronted events as they emerge and judge the need and approach of reactions.

The legislative provisions also have ties with enforcement based on their related roles. The law constitutes the main reference regarding enforcement work and its limitations. It designs the principal obligations, procedures, rooms of flexibility and restrictions upon enforcement. Thus, the law arises as the foundation of actions.

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[739] P.K. Manning, "Information Technologies and the Police," in *Modern Policing* ed. M. Tonry and N. Morris (Chicago: The University of Chicago Press, 1992).357.

[740] For example, R.F. Groeneveld, *Arrest Discretion of Police Officers: The Impact of Varying Organizational Structures* (New York: LFB Scholarly Publishing LLC, 2005).7.

Additionally, the law provides legality and justifications for enforcement practices. According to Herbert, 'officers invoke not just the bare dictums of the legal code in their actions, but the broader value of preserving a legally defined social order. This provides a powerful normative pull on officers'.[741] This shows that the law could be the officers' mediums for certain enforcement objectives or outcome attainment.

Considering the role and permissiveness of Malaysian drug law to enforcement actions, it is not surprising that the actions against drug use including penal surveillance, detention and sanctions are continuing. It is also possible to render the contradictory criminal laws as a catalyst for organisational demands relating to strict drug control and for officers to translate their attitudes against drug use and harm reduction into practice. Newburn and Reiner state: 'The (police) culture is generated and sustained by the problems and tensions of the police role, structured by legal and social pressures'. Thus, the laws arguably may become the most important structural factor supplementing the organisational and individual accounts for enforcement practices in drug use context. Further, the existing drug laws have influence on clashing criminal justice practices by considerably conveying inconsistent signals. This thereby contributes to the officers' perception of conflicting tasks. At one hand MMT and NSEP are highlighted as crucial public health interventions for drug users but on the other hand punitive drug laws remain unchanged.[742]

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[741] S. Herbert, "Police Subculture Reconsidered," *Criminology* 36, no. 2 (1998).353.
[742] Canadian HIV/AIDS Legal Network, *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS. Sterile Syringe Programs* (Ontario: Canadian HIV/AIDS Legal Network, 2006).6; Ministry of Health Malaysia, *Global AIDS Response Country Progress Report 2012: Country Progress Report Malaysia*.92.

Despite the arguments supporting the law's impact upon policing practice, yet extensively missing from the current international and national research, is the attention to this aspect. The available research reveals the connection of laws to officers' behaviours include Chaney and Saltzstein. The study's findings demonstrate that the state and city laws in the USA which demand the arresting of domestic violence perpetrators has a strong linkage with the police's arrest in the event of violence and its threats.[743] More research should be conducted to expound the lacking empirical results regarding this aspect.

In short, the available literature provides an indication of the potential role of criminal law as an explanatory factor in the Malaysian police's drug controlling practices. It is essential to empirically examine the extent of law's influence upon enforcement actors' ways of defining and responding to drug taking and harm reduction operations.

To summarise this section, it has been highlighted that there is interplay between individual police officers' knowledge, belief and attitudes, and organisational and legal factors that may explain their exercise of discretion in relation to harm reduction approach in Malaysia. Arguably, even though the officers' attitudes can be used to understand the contradictory enforcement practices, the attitudes are not the whole story. The realisation of attitudes is to some extent contributed by codicillary organisational and legal structures. This analysis marks a need for a further study pertaining to the gulf between localised harm reduction and law enforcement actions by a range of actors such as police, prosecutors, judges and prison officials to refine the existing evidences and show the real picture.

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[743] C.K. Chaney and G.H. Saltzstein, "Democratic Control and Bureaucratic Responsiveness: The Police and Domestic Violence," *American Journal of Political Science* 42, no. 3 (1988).763.

## 4.7 Conclusion

This chapter has demonstrated the persistent and dominant prohibition-oriented legal response to drug use through penal instruments in Malaysia despite the implementation of harm reduction. There appear drug laws which have the clear potential to contradict the harm reduction principles and objectives and to impact the approach's operation. These laws have not been changed to keep step with the adoption of harm reduction approach. To date, no statutory exemption or protection has been provided for harm reduction providers and clients. Conflicting criminal law, however, is not the main problem facing the Malaysian harm reduction approach. Rather, it is law enforcement practices, particularly ground level actors' use of discretion and how they respond to drug users that is where the tension really arises in Malaysia. Inconsistent street-level policing activities are still widespread. This reflects the fact that police officers have not used their discretion in ways to support the harm reduction approach. There is limited commitment on the part of the criminal justice system to the harm reduction approach. The government's collaborative efforts and administrative arrangements are limited in scope and seemingly emerge as a political compromise rather than a genuine effort to avoid conflict between both approaches. Even though there is limited evidence in Malaysia, it seems to point in the same direction as the international evidence in suggesting that inconsistent or antagonistic law enforcement practices create more than a symbolic problem. Rather, the evidence suggests that there is a significant clash, between the criminal justice and harm reduction approaches. The present contradictory law and particularly its enforcement practices directly and indirectly erect formidable obstacles to

the promotion and effective practice of harm reduction. They have the clear potential to restrict drug users' accessibility to the services, to reduce the involvement of medical personnel and to exacerbate health risks. The analysis in this chapter also reveals that the conflicts between the approaches are not a problem exclusive to Malaysia. They also occur, though in different ways, in other nations. It is fair to argue that the conflicts in Malaysia are clear and significant. At present, the approaches are not reconciled sufficiently. The way the police officers exercise their discretion to impede the harm reduction interventions is associated with knowledge, belief, attitudes, organisational and legal factors.

This analysis of impact and factors of an incompatible criminal justice approach in Malaysia is based on limited available evidence. Additional research is needed to gain deeper insights into the impacts and roots of this incompatibility in a Malaysian context and to elucidate existing research findings. The effects of the courts' operation on harm reduction practices are also a clear gap in the body of knowledge. The possible reason for this is that the courts are not part of public health measures and the examination of their operation and impact needs extensive investigation.[744] This aspect merits further research.

In light of the legislative, practical and operational incompatibilities between the criminal justice and harm reduction responses in Malaysia, we should consider whether both approaches can nevertheless be pursued at the same time, and the appropriate ways for addressing the conflicts. These issues will be the focus of the next chapter.

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[744]S. Belenko, "The Challenges of Conducting Research in Drug Treatment Court Settings," *Substance Use & Misuse* 37, no. 12-13 (2002).1655.

# CHAPTER 5

# RECONCILING HARM REDUCTION AND CRIMINAL JUSTICE APPROACHES: TOWARDS A CONCEPTUAL ANALYSIS

## 5.1 Introduction

The theoretical and practical incompatibility between harm reduction and criminal justice approaches to drug use as they are currently understood and practised in Malaysia demands affirmative solutions. This chapter seeks to examine whether or not these conflicting approaches can be reconciled. In considering this question, the chapter proceeds from the belief that before recommending specific concrete mechanisms and initiatives with the goal of harmonising these approaches, it is first essential to determine whether these two approaches can genuinely be pursued together and reconciled, at the conceptual level. Without giving careful consideration to this major issue, it is unlikely that any concrete initiatives will be properly formulated and even less likely that they will be properly implemented. The question has been the subject of an extensive debate, which I will review as part of this chapter. Therefore, this chapter gives consideration to three key relevant aspects: first, the feasibility of the harm reduction approach within a larger prohibition-based drug policy; second, its relationship to the criminal justice approach; and third, its workability alongside an abstinence-oriented goal. It is hoped that these considerations will provide the possible rightful position in which harm reduction and criminal justice approaches may properly be reconciled under a prohibition

framework in seeking to ensure the effective functioning of both, and to prevent conflict between them.

## 5.2 The Feasibility of Harm Reduction Approach within a Prohibition Framework

As previously discussed in Chapter 4, the prohibition framework with its conflicting criminal justice approach has inhibited efficient harm reduction practices. To complicate matters, the punitive regime has also failed to curtail drug problems and has had other unintended negative implications. The negative consequences of prohibition on the harm reduction initiatives, failure and other adverse effects of prohibition have instigated the issue of whether or not harm reduction policy is feasible within a prohibition framework. This section will discuss this issue with consideration to the relevant issue of the viability of the prohibition policy, particularly in relation to public health approach for drug users.

Notably, the Malaysian experiences with illicit drug supply and use show that the prohibition framework is less successful in reducing such behaviour despite its long term appeal. Considering the high volumes of arrested drug users and traffickers, a considerable body of research suggests that Malaysia's prohibitive control strategies are largely ineffective.[745] This parallels the failure of the 50-year-old global prohibition

[745] For example, Harring, "Death, Drugs and Development: Malaysia's Mandatory Death Penalty for Traffickers and the International War on Drugs."405; Md. Isa et al., *Laporan Kajian mengenai Undang-Undang Rawatan dan Pemulihan di antara Malaysia, Negara ASEAN, United Kingdom, Kesatuan Eropah (EU), Jepun, Korea, India, China dan Australia serta Pelaksanaannya [Report of Study: The Laws of*

regime since the 1961 Convention to substantially suppress illicit drug supply and demand. Both have expanded to all continents. Exhaustive evidence shows that the drug market level across the globe has risen significantly over last few years.[746] The UNODC's estimate in 2012 shows substantial drug consumption worldwide; somewhere between 162 million to 324 million.[747] In their report on illegal drugs markets round the world from 1998 to 2007, Reuter et al. conclude that 'We find no evidence that the global drug problem was reduced during the UNGASS [UN General Assembly Special Session on Drugs] period [from 1998 to 2007]. For some nations the problem declined but for others it worsened and for some of those it worsened sharply and substantially'.[748] Thus, the ability of the criminal justice approach to attain its goals in drug supply and consumption contexts, other than retribution, is contestable.

Beyond its consequences upon the harm reduction approach, public health and human rights as demonstrated in the previous chapter, the punitive regime, whether international or domestic, has also resulted in other widely acknowledged impacts on security, safety and economy. Critics including Nadelmann and Keefer et al. point out that prohibition has left in its wake increased crimes due to several reasons such as drug use and supply criminalisation, acquisitive crimes to pay for drug habits, systemic crimes of violence linked to illicit drug enterprises and highly profitable drugs as a result of its

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*Treatment and Rehabilitation in Malaysia, ASEAN Countries, United Kingdom, European Union (EU), Japan, Korea, India, China and Australia and Their Implementation]*.8.

[746] For example, P. Reuter and F. Trautmann, eds., *A Report on Global Illicit Drugs Markets 1998-2007* (Brussels: European Communities, European Commission-Trimbos Institute-RAND Europe, 2009).11; P. Reuter, "Main Report: Assessing Changes in Global Drug Problems, 1998-2007," in *A Report on Global Illicit Drugs Markets 1998-2007*, ed. P. Reuter and F. Trautmann (European Communities, European Commission-Trimbos Institute-RAND Europe, 2009).23–25.

[747] United Nations Office on Drugs and Crime (UNODC), *World Drug Report 2014* (New York: United Nations, 2014).1.

[748] Reuter and Trautmann, *A Report on Global Illicit Drugs Markets 1998-2007*.53.

inflated price in black markets.[749] It also fosters corruption among enforcement agents.[750] These accompanying crimes lead to the impairment of public safety.

Moreover, criminal justice approaches including law enforcement, prosecution and incarceration cost vast amounts of public money.[751] In Malaysia, it was estimated in 2008 that there was MYR177 million spent annually in tackling the drug problem.[752] By contrast, the wealth of the illicit drug industry contributed by prohibition is enormous. The global illegal drug trade is worth USD320 billion annually or 0.9 per cent of total trade.[753] Aside from the health risks discussed in the previous chapter, prohibition may also exacerbate the health hazards of overdoses or poisoning from adulterated drugs as there is no control over their potency and purity.[754]

The ongoing debate regarding the viability of the prohibition policy contains a number of different strands. Some commentators voice support for the intensification of stricter law enforcement and criminal penalties, alongside expanded economic opportunities[755]. The stringent enforcement strategies are seen more essential and appropriate than other lenient measures including harm reduction methods to effectively

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[749] E.A. Nadelmann, "Drug Prohibition in the United States: Costs, Consequences, and Alternatives," *Notre Dame Journal of Law, Ethics & Public Policy* 5, no. 3 (1991).790–93; P. Keefer, N. Loayza, and R.R. Soares, "Drug Prohibition and Developing Countries: Uncertain Benefits, Certain Costs," in *Innocent Bystanders: Developing Countries and the War on Drugs*, ed. P. Keefer and N. Loayza (Washington: Palgrave Macmillan & World Bank, 2010).18–23.
[750] Pryce, *Fixing Drugs: The Politics of Drug Prohibition*.107.
[751] Ibid.96–97.
[752] J. Ali, S. Hassan, and N.A.A. Karim, "Kos Ekonomi Penyalahgunaan Dadah [Economic Costs of Drug Misuse]," *Jurnal Antidadah Malaysia* (2010).9.
[753] United Nations Office on Drugs and Crime (UNODC), *2005 World Drug Report*, vol. 1 (Vienna: United Nations, 2005).17.
[754] Keefer, Loayza, and Soares, "Drug Prohibition and Developing Countries: Uncertain Benefits, Certain Costs."15.
[755] For example, E. Koch, "Legalizing Drug-Use: Is it the Only Realistic Solution-No " *ABA Journal* 75(1989).37; L.L. Thye, "Iltizam Perangi Dadah [Efforts to Fight Against Drugs]," http://www.utusan.com.my/utusan/info.asp?y=2011&dt=0419&pub=Utusan_Malaysia&sec=Rencana&pg=re_09.htm.10. (Last visited: 02/04/2012)

tackle the serious drug use problem. This thesis argues that the case for more aggressive criminal justice measures is far from persuasive. They will not offer a solution due to their undetermined success. Indeed, increasing the harsh features will bring greater risks of detrimental implications including thwarting harm reduction strategies, and increasing, both human right violations and state expenditures. Further, drug dependency disempowering reasonableness is behind the compulsion to seek drugs and hence cannot be simply blocked by imposing harsher punishments.[756]

There are also commentators who suggest the adoption of a firm emphasis on an exclusively public health goal. This would involve the application of approaches for promoting health or minimising harm rather than the traditional criminal justice approach. A notable supporting argument is that drug use is more of a public health issue than a criminal justice issue, and it therefore necessitates public health methods.[757] The primacy of the public health aim over the criminal justice aim is also advocated based on critical widespread HIV/AIDS and effectiveness of the former over the latter to control drug use and the prevalence of HIV/AIDS.[758] In addition, commentators such as Caulkins and Reuter advocate for primary importance to be given to total harm reduction aim and strategies for handling drug dealing and its harmful consequences.[759] This means that paramount attention is given to the achievement of a decrease in drug-related harms. Moreover, the argument is presented to support harm reduction policy through the change of drug policy and law based on its effectiveness to mitigate drug-related harms. For

[756] Bowser, Word, and Seddon, *Understanding Drug Use and Abuse: A Global Perspective*.178.
[757] For example, Gostin, "Drug Dependency and HIV."175.
[758] Ibid.152.
[759] J.P. Caulkins and P. Reuter, "Setting Goals for Drug Policy: Harm or Use Reduction? ," *Addiction* 92, no. 9 (1997).1149.

instance, the Burnet Institute calls for the modification of local laws to facilitate the expansion of an effective harm reduction approach.[760]

Exclusive focus on the public health or harm reduction paradigm is not likely to be beneficial. It ignores the fact that the criminal justice approach, as Seddon emphasises, is also grounded on public health.[761] Further, unless strong justifications are given to support this type of conceptualisation, it is inappropriate to connect drug use issue and drug policy and law exclusively to public health matters. An exclusive focus inevitably loses sight of other harms attributable to illegal drug use and other concerns including public order and welfare which should also be considered in developing drug policy and laws. Additionally, the public health sector's credibility to fully tackle drug problems without any engagement with criminal justice initiatives is doubtful; the problem is too complex for a one-dimensioned approach.

It is also unreasonable to just rely on the harm reduction goal and efforts to reduce negative drug taking's effects to address drug problems. The harm reduction approach, even effective, is not a complete answer to the prevalence of illicit drug use. Even though it assists with stabilising drug dependants for drug treatment and contributes to minimising drug consumption, it itself is incapable of curing and eliminating drug dependence (refer to Chapter 3, Section 3.3). Merely emphasising mitigating of drug-related harms through MMT and NSEP might contribute to undefined drug maintenance and long-standing dependency. Moreover, the harm reduction approach has some other

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[760] Burnet Institute, *Harm Reduction in Asia: Progress towards Universal Access to Harm Reduction Services among People who Inject Drugs* (Melbourne: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific, 2010).18.
[761] T. Seddon, *A History of Drugs: Drugs and Freedom in the Liberal Age* (Abingdon: Taylor and Francis, 2010).134.

limitations in relation to control the wider drug problem, including less consistent participation from the drug-using population and subjectivity of its efficacy to wide and free accessibility and integration into national health services.[762]

Furthermore, many who argue for a stronger focus on public health principles frequently call for the implementation of a decriminalisation[763] or legalisation[764] regime, in which harm reduction and other public health measures could be enhanced to reduce drug-related harms. The decriminalists' arguments, supported by research findings, also directed towards the advantages of reform including rising attendance in drug treatment and mitigated health harms from drug consumption including blood-borne disease infections and mortality.[765] Supporters also argue that decriminalisation would lead to a decline in associated crimes attributable to eradicated proceeds of the illegal drug market and financial burden of criminalisation scheme.[766] Invariably, based on utilitarian accounts, the legalisers argue that benefits of the reforms would include: the improvement of drug users' health and quality of life; a wide availability of drug treatment; protection of civil liberty via reduced state interference in individual behaviour; reduction of health risks from drug use; reduction in crime levels including drug trafficking and acquisitive crimes; and reduced costs of law enforcement.[767]

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[762] Bowser, Word, and Seddon, *Understanding Drug Use and Abuse: A Global Perspective*.179.
[763] For example, K.L. Schmoke, "An Argument in Favor of Decriminalization," *Hofstra Law Review* 18(1990).506, 523.
[764] For example, N. Mamber, "Coke and Smack at the Drugstore: Harm Reductive Drug Legalization: An Alternative to a Criminalization Society," *Cornell Journal of Law and Public Policy* 15, no. 3 (2006).644.
[765] For example, C.E. Hughes and A. Stevens, "What can We Learn from the Portuguese Decriminalization of Illicit Drugs?," *British Journal of Criminology* 50, no. 6 (2010).1014–15, 1017.
[766] For example, Schmoke, "An Argument in Favor of Decriminalization."518–19; D. Maloff, "Review of the Effects of the Decriminalization of Marijuana," *Contemporary Drug Problems* 10, no. 3 (1981).316–21.
[767] S.B. Duke and A.C. Gross, *America's Longest War: Re-Thinking our Tragic Crusade Against Drugs* (New York: eReads, 1999).259–67; Nadelmann, "Drug Prohibition in the United States: Costs, Consequences, and Alternatives."798.

Decriminalisation and legalisation are unpromising drug models. Withdrawal from global prohibition is not easy as it is controlled by the international drug treaties. There also appears less clear description regarding their working operations and no convincing justifications suggesting their greater efficacy and benefits over the prohibition regime. Most arguments for the positive effects of legalisation are likely grounded on guesswork owing to insufficient or compelling evidence. Considering the facts and history, decriminalisation or legalisation could also bring increased overall levels of drug use along with associated health risks, medical costs and other social and economic damages to individuals and societies. According to Goldstein and Kalant, the removal of criminal penalties against drug-related acts is associated with the easy availability of drugs which likely triggers growing consumption.[768] This is also supported by analyses such as by Kleber and Rosenthal showing significant increase of marijuana and cannabis use from 1984 and 1996 in the Netherlands which practises decriminalisation policy.[769] By contrast, evidence from other countries finds little effects of decriminalisation on drug consumption rates.[770] Rosmarin and Eastwood, based on their assessment of global practices of decriminalisation, concluded that the prognosis of soaring drug consumption is false.[771] This seemingly suggests that there is somehow an agreement among the commentators that there is an increase in drug use by the adoption of decriminalisation policy, though, they differ regarding the extent of the increase. Thus,

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[768] A. Goldstein and H. Kalant, "Drug Policy: Striking the Right Balance," *Science* 249, no. 4976 (1990).1516.

[769] H.D. Kleber and M.S. Rosenthal, "Drug Policies Should Not be Based on the Harm Reduction Model " in *Drug Legalization*, ed. S. Barbour (San Diego: Greenhaven Press, 2000).129.

[770] R. Room et al., *Cannabis Policy: Moving beyond Stalemate* (New York: Beckley Foundation & Oxford University Press, 2010).viii; E. Single, P. Christie, and R. Ali, "The Impact of Cannabis Decriminalisation in Australia and the United States," *Journal of Public Health Policy* 21, no. 2 (2000).173; Hughes and Stevens, "What can We Learn from the Portuguese Decriminalization of Illicit Drugs?."1008, 1017.

[771] A. Rosmarin and N. Eastwood, *A Quiet Revolution: Drug Decriminalization Policies in Practice Across the Globe* (London: Release, 2012).14.

this thesis argues that the decriminalisation or legalisation likely results to at least small increase in drug use. It is therefore possible to contend that even though drug policy alternatives might minimise negative consequences, this benefit may be offset by the cost of any resultant rising drug consumption. This could be supported by the MacCoun and Reuter's macro analysis framework[772].[773] Additionally, in the absence of definite assessment, the effectiveness of any drug policy to achieve greater total harm reduction is unknown and hence any call for making preference to any lenient alternatives over prohibition on this contention is unpersuasive.

The ineffectiveness of prohibition and its negative consequences on the harm reduction approach do not mean that states should abandon prohibition, but rather requires improvement. It is imperative to give thoughtful consideration to various drug use costs aside from just negative health effects. There are numerous roles and goals of drug policy and law and multiple principles including social order, human rights and social justice if the overall public interest is to be served. Accordingly, public health should not be treated as the only pivotal principle to underpin drug policy and law. Integrating all of the above goals within a broader aim of public good under a sustained prohibition-based framework potentially becomes a precondition to effective drug policy planning and implementation.

It is urgently necessary to affirmatively integrate the harm reduction approach as a crucial response to drug use to achieve public health aims, as one of the goals within a

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[772] The recommended framework for assessing drug policies is: Total Drug-Related Harm = Harmfulness (average harm per dose) x Prevalence (number of users) x Intensity (number of doses per user).
[773] R.J. MacCoun and P. Reuter, "Assessing Drug Prohibition and Its Alternatives: A Guide for Agnostics," *Annual Review of Law and Social Science* 7(2011).63.

wider prohibition regime. Properly understood, harm reduction may be seen to complement rather than contradict supply reduction and demand reduction strategies under the prohibition framework. Moreover, utilisation of the harm reduction paradigm to handle drug use problems would enhance the efficacy of treatment and preventive strategies. This would positively impact drug users' health and welfare and diminish the negative implications from fixed dependence on criminal justice methods. This revised understanding of the role and place of the harm reduction approach within a broader prohibition framework would also help to give harm reduction greater political credibility and thereby enable fuller implementation.

In short, the harm reduction response should be pursued as an important constituent of overall drug policy within a prohibition framework, rather than merely a national response to the HIV epidemic or as a minor component of drug policy. This way is more credible towards mitigating drug-related harms and drug use prevalence rather than intensification of punitive measures on the one hand or adopting sole emphasis on harm reduction policy or public health principle, either within or without the prohibition framework, on the other hand.

## 5.3 Further Thought on Relationship between Harm Reduction and Criminal Justice Approaches: A Conceptual Analysis

Due to the conflict between the harm reduction and criminal justice approaches in Malaysia, it will be worthwhile to consider some issues including whether either of the

approaches should be dropped to avoid future conflicts or whether both could be reconciled in order to efficiently handle drug use problem and if so, how?

The discussion will begin with a consideration of the main strands of philosophical approaches to the legitimate utilisation of criminal law and public health measures; legal liberalism, legal paternalism, legal moralism and public health in articulating the jurisdiction of every criminal justice approach and public health approach including the harm reduction approach upon drug use and their relative strength. This is imperative to determine which approach has the rightful claim of domain over drug use and hence must be pursued.

*(i) Legal Liberalism*

Legal liberalism demarcates limits on the criminal law's domain. At its core, competent individuals have liberty to act without interference on the grounds of autonomy. The autonomy refers to 'people possess free will and must be allowed, to the maximum extent possible, to make free choice'.[774] The freedom of action, however, may be subjected to state's restriction if its exercise is harmful to others. This constitutes the essence of 'harm principle' which sketches a requisite ground for criminalisation. In his essay 'On Liberty', John Mill, the influent contributor to the harm principle, mentions:

> The only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others.

[774] C.M.V. Clarkson, H.M. Keating, and S.R. Cunningham, *Clarkson and Keating Criminal Law: Text and Materials* vol. 7 (London: Sweet & Maxwell, 2010).9.

> His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear […] because in the opinion of others to do so would be wise or even right.[775]

Joel Feinberg further elucidates on Mills' principle: 'It is always good reason in support of penal legislation that it would be effective in preventing (eliminating, reducing) harm to persons other than the actor (the one prohibited from acting) and there is no other means that is equally effective at no greater cost to other values'.[776]

What is important to note is, on liberalism, neither harmless, self-harm nor morality are sufficient to justify state interference. A utilitarian harm-oriented approach requires the state to present relevant evidence concerning a relation between the conduct in issue and its harming effects to anybody except the actor. This, according to Feinberg, extends to the threat of harm.[777]

Feinberg, however, limits the harm principle's application to 'wrongful harms' being 'thwarting, setting back, or defeating of an interest' (of other person)[778] that 'violates the other's rights'.[779] The interest consists of aspects which enable individual chances for enjoying or pursuing his life.[780] Feinberg points out that 'only setbacks of interest that are wrongs, and wrongs that are setbacks to interest, are to count as harms in

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[775] J.S. Mill, "On liberty," in *Man and the State: The Political Philosophers* ed. S. Commins and R.N. Linscott (New York: Random House, 1859/1947).144.
[776] J. Feinberg, *The Moral Limits of the Criminal Law: Harmless Wrongdoing*, vol. 4 (New York: Oxford University Press, 1988).xix.
[777] *The Moral Limits of the Criminal Law: Harm to Others*, vol. 1 (New York: Oxford University Press, 1984).11.
[778] Ibid.33.
[779] Ibid.34.
[780] A.P. Simester et al., *Simester and Sullivan's Criminal Law: Theory and Doctrine*, Fifth ed. (Oxford and Portland: Hart Publishing, 2013).646.

the appropriate sense'.[781] Wrongful harm provides a factor for criminalisation. Merely defeating the others' interest without infringing their rights or vice versa may not be legitimately criminalised. The criminal liability is however defensible by the presence of victim's consent as no personal interest is wrongfully set back. [782]

Furthermore, for Mill, the harm principle is qualified for persons of sufficient competency to make informed choices and act deliberately. The incompetent persons including those with mental illness and children are subject to paternalistic intervention. Mill states: 'It is perhaps necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties […] Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury'.[783] Therefore, the state could decide and take actions on behalf of persons of diminished capacity to secure their interests, safety, welfare or health.

Unlike Mill, Feinberg has not specified the harm principle as the only justifiable 'liberty-limiting principle'. He added a profound offence principle which recognises the proper criminalisation of seriously offensive behaviours. As claimed, 'if these unpleasant experiences are intense or prolonged enough […] or if they recur continuously or occur at strategically untimely moments, they can get in the way of our interests'.[784] It is the commonly unacceptable conduct which happens in public and impacts uncomfortable feeling justifies liberty restriction. According to Feinberg, 'it is always a good reason in support of a proposed criminal prohibition that it would probably be an effective way of

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[781] Feinberg, *The Moral Limits of the Criminal Law: Harm to Others*, 1.36.
[782] Ibid.35–36.
[783] Mill, "On liberty."145.
[784] Feinberg, *The Moral Limits of the Criminal Law: Harm to Others*, 1.46.

preventing serious offence (as opposed to injury or harm) to persons other than the actor, and that it is probably a necessary means to that end'.[785]

The application of harm and offence principles will lead the state to scrutinise criminalisation issues from a consequentialist lens. However, the related difficulty with both principles is the problem of determining these terms' meanings, given no sound clarification provided by their proponents. The vagueness of the term 'harm', according to some critics, may possibly lead to wider deductions about its application.[786] Therefore, arguably, the criminal sanction for harm prevention should be limited in serious circumstances.

*(ii) Legal Paternalism*

Legal paternalism allows the use of penal legislation where conduct harms the actor oneself. The label paternalism characterises the belief that 'it is always a good reason in support of a prohibition that it is probably necessary to prevent harm (physical, psychological, or economic) to the actor himself and there is probably no other means that is equally effective at no greater cost to other values'.[787] There is legitimate ground for the state, under this theory, to interfere with personal liberty for protecting the safety, welfare or other interests or values of the person concerned regardless of his values, interests and goals. Paternalism agrees with liberalism by their requirement of harm inflicted to a person. It, however, clashes with liberalism for its sanction of self-harm

[785] Ibid.12.
[786] For example, Simester et al., *Simester and Sullivan's Criminal Law: Theory and Doctrine*.650–51.
[787] Feinberg, *The Moral Limits of the Criminal Law: Harm to Others*, 1.26–27.

criminalisation. The obvious examples of paternalist regulations include the law punishing an attempt to commit suicide and the law punishing the omission of motorbike riders to wear helmets. The latter example demonstrates that according to paternalism, the control over individual action could extend to the act of posing a risk of harm upon himself, such as the risk of more grievous injury in accident of which the helmetless cyclist freely assumed.

The comment against paternalism mainly lies on its inconsistency to the liberal notion of autonomy. Even if paternalist legislation is not detrimental to people's lifestyle as in the case of the helmet wearing requirement, it indeed involves the infringement of personal liberty to freely act in accordance to his own desires and preferences, including to undertake self-regarding action.[788] For this reason, it seems fair to say that before the legislators decide to criminalise behaviours on paternalist grounds, they need to provide a prudent basis for their intervention, including a valid reason why its promotion of actors' safety and welfare could offset their autonomy.

### *(iii) Legal Moralism*

Legal moralism holds the legitimacy of criminalisation of certain acts based on immorality *per se*. It embraces the belief that 'it can be morally legitimate to prohibit conduct on the ground that it is inherently immoral, even though it causes neither harm nor offence to the actor or to the others'.[789] Notably, unlike liberalism and paternalism

[788] Simester et al., *Simester and Sullivan's Criminal Law: Theory and Doctrine*.657–58.
[789] Feinberg, *The Moral Limits of the Criminal Law: Harmless Wrongdoing*, 4.xix–xx.

principles, moralism does not subject the utilisation of criminal law upon any adverse effects or infringement of rights of particular persons.

An attempt to qualify the criminalisation against immorality has been made by Lord Patrick Devlin, annexing it to the deep social disgust at a particular action. Considering moral values as a vital component of society's structural framework, Devlin has suggested the prohibition of its breach to conserve the social structure. Warranting morally repugnant conducts, for him, will potentially cause devastation of social fabric and ultimately society's dissolution and anarchy.[790] It is suffice to say that in relation to the justification of criminal law's use, Devlin's critical consequentialist-based concern is the law's effects to the preservation of society but not the conduct's effects.[791]

Devlin's view is problematic, considering the inconclusive basis of disgust for criminalisation. There is no clear link between immorality and depth of disgust. Disgust, for Hart, is also potentially influenced by 'ignorance, superstition or misunderstanding'. Further, there is insufficient evidence for confirming Devlin's consequentialist-based hypothesis regarding the effect of immorality to society's dissolution.

Moralism, except Devlin's moralist principle, does not require empirical evidence, given its purely deontological nature. Thus, it may likely accelerate the state's promulgating of criminal law which satisfies and advocates the citizens' rooted moral perspectives. However, moralism singly represents an unsubstantial ground upon which to invoke criminal law. The cases against moralism rest on the undetermined scope of morality and its contradiction to the autonomy principle. There appears the problem of

[790] P. Devlin, *The Enforcement of Morals* (New York: Oxford University Press, 1959/1965).9.
[791] R.J. MacCoun and P. Reuter, *Drug War Heresies: Learning from Other Vices, Times and Places* (Cambridge: Cambridge University Press, 2001).67.

discerning agreed moral values due to people's diverse opinions in a society with various religions, cultures and ethnicities. Moreover, the nature of the morality perspectives is such that they alter in consonance to changing times. Additionally, criminalisation involves unavoidable deprivation of personal liberty. Thus, defensible infringement via criminalisation arguably calls for more compelling grounds, rather than solely moralism.

*(iv) Public Health*

The public health principle emphasises the promotion and protection of community's health as a basis for government actions. Public health, according to the Institute of Medicine, is 'what we, as a society, do collectively to assure the conditions for people to be healthy'.[792] Larry Gostin defines public health law as:

> Public health law is the study of the legal powers and duties of the state, in collaboration with its partners (e.g., health care, business, the community, the media, and academe), to ensure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population), and of the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary, and other legally protected interests of individuals. The prime objective of public health law is to pursue the highest

[792] Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988).19.

possible level of physical and mental health in the population, consistent with the values of social justice.[793]

Therefore, the primary focus of public health is on populations rather than individuals. It obliges the government initiatives to improve the health and wellbeing of populations. It also broadens the legitimacy base for actions including promulgating and exercising legislations to attain public health targets.

Consistent to its emphasis on wider population-oriented viewpoints concerning causes and risks of health problems, including environmental determinants, public health places importance on individual, community and environmental changes through broad-based means for the purpose of halting or decreasing health threats. The Ottawa Charter for Health Promotion, endorsed by WHO, specifies five important types of actions for promoting populations' health: developing public policies supporting health, creating conducive environments for health, strengthening community action, building the skills of individuals or society and re-orienting health services.[794] Hence, public health reorients the thinking and ways to deal with health-related issues.

The public health basis has been challenged for its potential violation of the affected individuals' liberty. This issue commonly arises in relation to coerced-based interventions including compulsory testing, treatment and quarantine in the name of public health imperative. Voluntary measures are also contestable for their discriminatory

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[793] L.O. Gostin, *Public Health Law: Power, Duty, Restraint*, Second ed. (Berkeley: University of California Press, 2008).4.

[794] World Health Organization, *Ottawa Charter for Health Promotion* (Ottawa: World Health Organization & Canadian Public Health Association, 1986).6–7.

coverage.[795] The state's unjustified encroachment of the private zone for public health purpose may potentially occur. While contemporary public health acknowledges voluntary cooperation, deviating from coercive public health authority or 'police power' prioritised during the 20th and early 21st centuries, the government is still free to determine the breadth of power ambit and need of coercive interventions. This is contributed by the lack of specific guiding criterions or clear ethics framework in applying the health-oriented strategies.

Therefore, it is argued here that entire reliance upon the public health rationale is insufficient to justify coercive health measures. It should be circumscribed for serious health risks after taking into account other alternatives and interests. Arguably, its necessity must be subjected to case-by-case assessment based on principles of criminalisation due to their overlaps of the state's coercive power and other priorities such as safety and human rights. This is important to ensure that positive outcomes of health measures are harmonised with individual liberty burdens.

Having considered the jurisprudential foundations of criminal law and public health strategy, this thesis will now seek to refine the perspectives on whether drug use fits the principles and specify the appropriate areas of both approaches in responding to the conduct.

Many liberalists have the view that adults have an individual liberty to use drugs, backed by their autonomy to engage in any self-destructive behaviour. Drug consumption is deemed normal behaviour and primarily harmful only to oneself, rather than to others

[795] L.O. Gostin and Z. Lazzarini, *Human Rights and Public Health in the AIDS Pandemic* (New York: Oxford University Press, 1997).44–45.

and hence the restriction on personal freedom to take drugs represents an unjustifiable intrusion of liberty. Thomas Szasz defends the libertarian perspective on drug using by the following statements:

> I believe that we also have a right to eat, drink, or inject a substance-any substance-not because we are sick and want it to cure us, nor because a government-supported medical authority claims that it will be good for us, but simply because we want to take it and because the government-as our servant rather than our master-does not have the right to meddle in our private dietary and drug affairs.[796]

It seems right to take the opposite perspective to the liberal ideas. Drug taking cannot possibly only impact its actor. The conduct's resulting intoxication risk damages to others. For example, driving under the influence of drugs can endanger passengers and other road users. The behaviour also considerably causes a burden on family, society and economy. For instance, habitual drug using may lead to abandonment of family-members' obligations, financial cost of public health services and reduction of workers' productivity.[797] One argument rejecting the claim is that drug consumption's consequences to others are indirect and hence not wrongful harms.[798] The potential response to this is that considering the liberal criteria, the effects to others may sanction criminalisation if they involve the infringement of moral rights including drug users to exercise responsible parenthood to children. Alternatively, harms or risks of harms to

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[796] T.S. Szasz, "The Morality of Drug Controls," in *Dealing with Drugs: Consequences of Government Control*, ed. R. Hamowy (San Francisco: Pacific Research Institute for Public Policy, 1987).349.
[797] Pryce, *Fixing Drugs: The Politics of Drug Prohibition*.32–33.
[798] For example, P. Smith, "Drugs, Morality and the Law," *Journal of Applied Philosophy* 19, no. 3 (2002).236.

others, irrespective of whether they are direct or not, if serious enough to the public good, could press state into action. However, it might be contested, given the vagueness of the harm term to public interest. Therefore, this justification should be associated with more other justifications.

Additionally, there is no merit in the liberalist case of sidestepping drug-related damages to the users. Drug consumption in many circumstances risks great self-harms and hence may become an acute factor for state concern and interference. A sea of evidence leaves little space for ambiguity that illicit drug consumption is physically hazardous, causing health-related harms including diseases, damage to organ systems, mental impairment and drug overdose. For instance, using opiates including morphine and heroin may pose critical or life-threatening health risks such as nervous and respiratory problems, constipation and dependency.[799] Drug taking is also fraught with psychological effects such as depression, anxiety and hallucinations. Further, it may cause unintentional sufferings including drug-related vehicle accidents.[800]

However, the state's prohibition, arguably, cannot rest on contended drug-related crime. The arguments for drug-crime relation which are frequently based on evidences of substantial connection between criminals and drug using numerically could be challenged using the common reason model. Seddon, by considering the UK's history of drug use, shows the relation of drug use and crimes to socio-economic disadvantages and social exclusion contexts.[801] This thesis is persuasive, given the socio-economic problems including poverty and low academic qualification among criminals and drug users in

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[799] Ghodse, *Ghodse's Drugs and Addictive Behaviour A Guide to Treatment*.76–79.
[800] S.B. Duke and A.C. Gross, *Rethinking Our Tragic Crusade Against Drugs* (E-Read Kindle, 1999).4.
[801] T. Seddon, "Drugs, Crime and Social Exclusion: Social Context and Social Theory in British Drugs–Crime Research " *British Journal of Criminology* 46, no. 4 (2006).690–93, 695–96.

many countries.[802] Additionally, Goldstein's explanatory typology of drug-crime connection[803] is questionable mainly for an uncertain direct causal link. The causality of violence to drug's 'criminogenic' property is not well presented given its weak evidence, as suggested by multiple reviews.[804] The 'systemic crime' which involves violence in illicit drug dealings and conflicts controlling is also indirectly correlated to drug taking, but instead linked to the drug market's illegal features. It is also fair to say that the 'economic-compulsive crime' of drug users arises from less affordability in fixing drug habits, rather than intrinsically attributable to drug taking. However, considering evidence upon account of economic-compulsive crimes to fund drug use in some circumstances,[805] the acceptable approach would be diversion into a drug treatment scheme as practised in drug courts.

Notably, despite being less risky or dangerous to self or others, some drugs are classified as illegal. Based on experts' rating of the harms of major abused drugs in Nutt et al. research, illegal drugs including ecstacy, LSD and bubrenorphine presented the least harms to users and other persons with the last score between 7 to 9 respectively out of 100.[806] In Malaysia, these illicit drugs are listed together with more harmful drugs discovered by Nutt et al. including heroin (55) and cocaine (27) in Part III of First

[802] This is prevalent in Malaysia. (For example, Yaqin, *Law and Society in Malaysia*.177; A. Sidhu, "The Rise of Crime in Malaysia: An Academic and Statistical Analysis," *Journal of the Kuala Lumpur Royal Malaysia Police College* 4(2005).16–17).
[803] P.J. Goldstein, "The Drugs/Violence Nexus: A Tripartite Conceptual Framework," *Journal of Drug Issues* 15(1985).493–98.
[804] For example, J.B. Kuhns and T.A. Clodfelter, "Illicit Drug-Related Psychopharmacological Violence: The Current Understanding within a Causal Context," *Aggression and Violent Behavior* 14, no. 1 (2009).75.
[805] For example, T. Bennett and K. Holloway, *Understanding Drugs, Alcohol and Crime* (Berkshire: Open University Press, 2005).92.
[806] D.J. Nutt, L.A. King, and L.D. Phillips, "Drug Harms in the UK: A Multicriteria Decision Analysis," *Lancet* 376, no. 9752 (2010).1559–61.

Schedule, DDA 1952 (Refer to Annexure I). Therefore, their use seems inadequate to invoke the legal paternalism.

The view regarding self-harms of drug using is also challenged by the argument that the conduct does not invariably imperil the user. In multiple incidents, most users do not suffer the harms.[807] Such argument has been usually raised to accommodate less focus of legal interventions against recreational users, given no apparent individual and social damages from their under control consumption.[808] Arguably, this selective criminalisation may constitute disproportionate application of criminal justice principles and practice. Further, employing social conflict theory,[809] this could bring class conflicts and perpetuate social inequality. This is because recreational using is commonly annexed to a wide range of social structure covering the upper- and middle-class while critical consumption and dependence on drugs are predominant among the less powerful poor, led by political and economic structural situations.[810] Drug use controlling in USA has been connected to social divergence when it targeted the black ethnic and economically disadvantaged with drug consumption generally swelling across diverse social groups.[811]

Additionally, it seems true that whole drugs are not uniformly perilous and in certain circumstances, their consuming does not entail great harmfulness. This is because drug use effects vary as a result of many factors such as types and dosage of drugs used, using techniques, frequency and settings. Therefore, the initial or recreational level of use

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[807] For example, Duke and Gross, *America's Longest War: Re-Thinking our Tragic Crusade Against Drugs*.168.

[808] E. Goode, "The Sociology of Drug Use," in *21st Century Sociology: A Reference Handbook*, ed. C.D. Bryant and D.L. Peck (California: SAGE Publications, Inc., 2007).421.

[809] T.B. Bottomore and M. Ruben, eds., *Karl Marx: Selected Writings in Sociology and Social Philosophy* (New York: McGraw-Hill, 1964).178.

[810] Goode, "The Sociology of Drug Use."420–21.

[811] J. Fellner, "Race and Drugs," in *The Oxford Handbook of Ethnicity, Crime, and Immigration*, ed. S.M. Bucerius and M. Tonry (New York: Oxford University Press, 2014).194–207.

does not necessarily mean that significant harms will happen. Despite this, there are still harms or at least potential risks of harms involved in every drug taking. The probability of harms may strengthen the case for equal paternalistic protection, compatible to Feinberg's harm principle.

Furthermore, many have defended certain drugs of which the most cited are cannabis and psychedelics for their potential benefits. It is true that certain illicit drugs may bring benefits if properly taken. Cannabis, for example, has been shown by scientific evidence to have therapeutic values including for critical pain. This has been confirmed by numerous large reviews.[812] Therefore, assessment of harms relative to benefits is important. The government may permit the use of certain illicit drugs for needs related to their significant benefits while controlling them to prevent harm. Arguably, this is more tenable than fully prohibiting or legalising it. To facilitate ascertaining which drugs may require control and its extent, the government may provide a systematic categorisation of illegal drugs accounting a range of dangerousness and risks, harm degrees' different determinants, relative importance of costs versus benefits and use and dependence tendencies based on evidence.

Moreover, the government may enforce drug use control against minors, teenagers and those suffering mental incapacity by virtue of their deficient capability for reasoned actions. The state intervention is important for protecting their interests and wellbeing. This argument finds consistency with Mill's exception principle. However, it is worth repeating (as discussed previously in Chapter 4, Section 4.2.2) that the compulsive state actions, including compulsory drug treatment for drug dependants solely on the basis of

[812] For example, L.E. Zimmer and J.P. Morgan, *Marijuana Myths Marijuana Facts: A Review of the Scientific Evidence* (New York: Lindesmith Center, 1997).17.

the resulting reasoning incapacity from drug dependency, is unjustifiable. This is because the contradictory scientific evidence indicates that drug dependants retain their ability of autonomy and self-determination. Nevertheless, it is argued that drug dependence which is at the highest level that may be reached from initial drug use and harmful to oneself and others may reinforce the justifications for the state control over drug use. As in the issue of drug-related harms, the criticism is that not all drug using is followed by drug dependence and hence the generalised prohibitive measures against drug users are morally objectionable.[813] The defence is that despite different expediency to reach dependence, almost all drug users are potentially depending to drugs and hence in concern, the prevention of which may therefore substantiate the control against drug consumption.

Furthermore, the moralistic appeal of drug prohibition presupposes the intrinsically moral failing of drugs. Drugs are rendered as evil and sinful in themselves and their taking is intolerable. This can be illustrated by the signatories' statement in the 1961 Convention that they are 'conscious of their duty to prevent and combat this evil [narcotic drugs]'.[814] Drug prohibition is defended by the moralists as a moral imperative. A major drawback of this argument is its neglect to scientific lens regarding drugs' chemical nature and physical and psychological harms to people. Unless being consumed or taken into humans' body, the drug itself does not impact any damages or benefits and hence should not be subjected to moralistic judgment.

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[813] For example, P. De Marneffe, "Against Drug Legalization," in *The Legalization of Drugs*, ed. R.G. Frey (New York: Cambridge University Press, 2005).152–54.

[814] The 1961 Convention as amended by the 1972 Protocol, Preamble.

The stance of this thesis is however on the immorality of using illicit drugs for illegitimate purposes. The behaviour, rather than the drug itself, is a vice that has profound effects on human excellence, perfectionist ideals and quality of life. It is the philosophers including Aristotle and Plato who taught the conceptions' values. Drug consumption effects human disordered lives, thereby making its actor unfit to virtuousness or ideal pursuit. Further, drug using potentially undermines society and state. Drug takers becomes ill and slave to their lust to drugs and may hence neglect their responsibilities, disregard societal standards and ethics, and undermine efforts to construct civilisation in the state.[815] Consequently, this could lead to the state's destructive security and equilibrium. Moreover, in the Malaysian context, drug consumption is contrary to perpetual national culture and religious beliefs. The shared morality of drug use is well-documented in numerous literatures.[816]

Notably, some prohibitionists' argument evoking the wickedness of consuming drugs centres on the conduct's harms, rather than its inherent wrongfulness. This argument suits neatly into consequentialist types and is impurely moralistic. Wilson, for example, makes empirical claim in favour of drug control by utilising several terms such as 'enslaves the mind' and 'destroys the soul' which denotes harm to individuals:

> Even now, when the dangers of drug use are well understood, many educated people still discuss the drug problem in almost every way except the right way. They talk about the 'costs' of drug use and the 'socioeconomic factors' that shape that use. They rarely speak plainly– drug use is wrong because it is

[815] Pryce, *Fixing Drugs: The Politics of Drug Prohibition*.21–22.
[816] For example, Zulkifli et al., *Study on the Impact of HIV on People Living with HIV, Their Families and Community in Malaysia*.87.

immoral and it is immoral because it enslaves the mind and destroys the soul.[817]

Therefore, arguably, Husak mistakenly asserts that Wilson's arguments for drug prohibition are underpinned by religious notion.[818]

The purely moralistic arguments are reasoned to support the immorality of using drugs. Thus, the contradictory views are unconvincing. The liberalists including Husak suggest that drug taking per se is not morally wrong but instead a warrantable way of gratification.[819] As contended, the moral disapproval of drug using is unpersuasive to justify drug prohibition as unaccompanied by acceptable explanations, given most merely relate to religious accounts inconsistent to cognition, inadequate evidence of causal link between drug use and societal impacts and involve consequentialist basis.[820] It is acceptable that the activities for pleasure are generally not wrong. However, even also for recreational purpose, using drugs is immoral due to its adverse impact to human conduct, society and state. Moreover, as in the Malaysian case, the immorality of drug use has grounded as established social norms and values. The moralistic belief is of deontological issue and hence is non-empirical evidence-related.

However, even drug use amounts to immoral behaviour, immorality alone cannot be the appropriate rationale for punishing its actor. It seems imprudent to criminalise conducts simply for their moral failing. It bears repeating the improper merely compliance to legal moralism, given unfixed sphere of morality and its clear

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817 W.J. Bennett, J.J. DiIulio, and J.P. Walters, *Body Count* (New York: Simon and Schuster, 1996).140–41.
818 Husak, "For Drug Legalization."80.
819 Ibid.74, 76.
820 Ibid.78–82.

inconsistency to individual freedom principle. Therefore, the criminal sanction should be backed by more persuasive justifications in addition to that moral repugnance. This secures justice and compromise between personal autonomy and common interests.

Further, drug consumption may come within the ambit of public health. It is undoubtedly a public health problem, considering its adverse implications for individual and public health. Extensive evidence shows that drug using contributes to serious effects to physical and mental health including fatalities and modified brain function.[821] Many acknowledge that drug use is a chronic and relapsing disorder, similar to other chronic health conditions handled by medical practitioners.[822] It is also linked to severe communicable diseases including AIDS and HCV. Moreover, it also influences growing medical care and drug treatment expenditures. All this thereby seems sufficient to invoke a public health approach. This is further supported by increasing empirical findings on the approach's effectiveness in minimising drug taking and its harmful consequences.[823]

The approval of a public health approach to drug use problems would mean that the latter should be dealt in congruity with the prism of the wider public health method. Therefore, as a public matter, it needs to be handled by the government through wide ranging techniques aimed at decreasing both drug-related harms and overall drug use prevalence. Unless combined with social and environmental measures, the strategies for

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[821] Ghodse, *Ghodse's Drugs and Addictive Behaviour A Guide to Treatment*.52–53.

[822] G. Bevan, "Problem Drug Use the Public Health Imperative: What Some of the Literature Says," *Substance Abuse Treatment, Prevention, and Policy* 4, no. 21 (2009), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2805619/pdf/1747-597X-4-21.pdf.1–2. (Last visited: 07/12/2014)

[823] R.K. Chandler, B.W. Fletcher, and N.D. Volkow, "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety " *Journal of the American Medical Association* 301, no. 2 (2009).1844–45.

personal behavioural changes including drug treatment are seemingly inadequate. The comprehensive interventions potentially benefit drug user and community health.

However, concentrating solely on the public health approach makes other issues connected to drug use such as safety and welfare unaddressed. This is unlikely realised by those arguing for the state's exclusive adoption of the public health approach for drug users.[824] As believed, this approach would be more effective than punitive measures including imprisonment for addressing drug use and its health effects to the actor and population. It is worth repeating (it has been discussed in Chapter 5, Section 5.2) that this sort of claim is less compelling for its lack of attention to not only varied priorities relevant to drug consumption but also the concomitant public health province of criminal law.

The provisional summary of this thesis is that almost all illegal drug using may present individual and societal harms and risks even though their degrees might differ. More adverse effects of certain drugs than others are affected by various factors. The degree could be reflected in an appropriate drug classification. The behaviour is also against Malaysia's social norms. The damages, risks of harms and immorality could justify the inhibition of all levels of illegal drug use inclusive of experimental, recreational, regular, heavy and dependence status and any means towards the consumption including drug possession, except for legitimate purposes connected to their significant benefits. This seemingly suits the principles of liberalism, paternalism and moralism. Simultaneously, it may sufficiently belong in the public health realm, given resulting personal and public health consequences. In other words, both criminal justice

[824] For example, J.F. Mosher and K.L. Yanagisako, "Public Health, Not Social Warfare: A Public Health Approach to Illegal Drug Policy," *Journal of Public Health Policy* 12, no. 3 (1991).308–09.

and public health have the rightful claim of jurisdiction over drug use and thus neither of them could simply be dropped. Nonetheless, the unclear lines for the ambits of both approaches may impact unresolved conflicts. Therefore, for addressing the conflicts between them, it is argued that it is critically necessary to reconcile or harmonise between both approaches by redefining or adjusting the purviews and aims for every approach for drug use with reference to a principled approach.

Before any further discussion, this thesis would make clear a value judgment regarding drug use. This thesis disagrees with the argument that drug use should be treated as a normal conduct but needs focus to its immediate problems and harms in accordance to the neutral stance of many harm reductionists.[825] This normalising is less compelling as the way how the drug use problem is gestated may significantly shape the policies and strategies to tackle it. Schuster claims that the conceptualisation of drug using constitutes the strong influence of its policy.[826] Influenced by Martin's formulation of moral-therapeutic conception related to mental health[827], this thesis proposes that combined moral-health viewpoints should apply to drug taking, given its justified position on moral, medical and public health issues. Arguably, using drugs is a complex issue which is insufficiently explained and tackled by one theory, given its limitations including narrow perspectives regarding the influences to drug dependency and appropriate approaches. The joined conceptions may disband the moral-disease or health dichotomy which drives towards contradiction between both. While considering drug

[825] For example, Erickson et al., *Harm Reduction: A New Direction for Drug Policies and Programs*.8; Keane, "Critiques of Harm Reduction, Morality and the Promise of Human Rights ".232.
[826] C.R. Schuster, "Comments on MacCoun," in *Choice, Behavioural Economics and Addiction*, ed. N. Heather and R.E. Vuchinich (Oxford: Elsevier Ltd, 2003).404.
[827] M. W. Martin, *From Morality to Mental Health: Virtue and Vice in a Therapeutic Culture* (New York: Oxford University Press, 2006).3.

users' sickness, it may ensure their liability for options and accountability for wrongdoings. Every drug use stage relates to choices and even dependence to drugs develops from chosen initial recreational using. The linked angles are important to trigger complementary criminal justice and public health methods instead of either of both to manage the drug use problem. It may avoid absolute medical interference and sickness excuses for wrongful acts based on the disease model or total punitive responses deriving from the moral model.

For the purpose of redefining or adjusting spheres for each criminal justice and public health approach, this thesis makes particular reference to Andrew Ashworth and Jeremy Horder's minimalist principles that furnish a yardstick for the use of criminal law; covering deontology, consequentialism and human rights aspects. The principles are as follows:

(a) respecting human rights safeguards;

(b) acknowledging the right not be susceptible to state punishment;

(c) making the criminal law as a strategy of last resort, considering the serious wrongfulness and harms of behaviour; and

(d) avoiding the utilisation of counterproductive criminal law.[828]

In applying Ashworth and Horder's criteria and public health principle, it seems that problematic drug use[829] and dependence should not initially be criminalised but instead provided with voluntary-based drug programmes following medical and public health models and comprising harm reduction services, drug treatment, testing and

[828] Ashworth and Horder, *Principles of Criminal Law*.31–35.
[829] This refers to drug use which clearly results into problems or negative effects.

education. When diagnostic criteria of problematic drug use or dependence are unmet, it is justifiable for the government to offer preventive and behavioural changing strategies other than drug treatment such as educational programmes including to initial or casual users, given its potentiality to develop to problematic use. The interventions may be combined with other supporting services recognising multiple modalities to address social and welfare issues among the drug using population. All the interventions must be underlined with the goal of public good as discussed before. The non-coercive approach is more humane, less intrusive to personal rights and credible to address the conduct and its varied harms and risks than the usual penal measures including incarceration.

But, it may be justified to employ criminal compulsion against those who failed to engage and committed in such programmes voluntarily. This would become a reliable mechanism to attain harm reduction, behavioural change and recovery of extensive portions of drug consuming population towards attaining the public good aim. The threat of coerced observed programmes may also become an efficient way to instigate voluntary participation. This means that criminal law is utilised as a method of last resort, only in the failure of other non-restrictive initiatives to attain both pressing personal and public health or security objectives in a drug use context.

It is also suggested that the state coercion is immediately applicable where drug using is committed in public and known by others. This satisfies Feinberg's profound offensive principle and the social norms in drug use's wrongfulness. Furthermore, criminal control could operate against any drug users who intentionally, knowingly or recklessly expose substantial harms or reasonably anticipated risks of harm including HIV and other blood-borne diseases to others through their involvement in dangerous

behaviours such as unprotected needle-sharing. This argument is clearly consistent with the harm principle. The liability should be irrespective of drug using level and proof of the victim's consent, given sanctity of life principle. Specific modalities for behavioural changes and harm reduction conjunctive to coerced drug programmes could be considered in pursuit of public health and security. Considering the connection of drug consumption to acquisitive crimes and drug possession for personal use, it is also justifiable for the government to provide diversion to a drug treatment programme as an alternative to the latter's original punishments. However, this choice should only be limited to problematic drug use or dependence and non-violent relations. Moreover, incarceration-based treatment could still be provided for other inmates unqualified for the diversion scheme but who satisfy drug dependence criteria. This may fit the integrative moral-therapeutic model.

All criminal compulsions must only be exercised after some lesser restrictive methods to control harmful or unwanted behaviours have been found insufficient or unworkable. The methods between voluntary measure and criminal way may possibly encompass prism of persuasion, warning, court enforceable proceedings and civil penalties based on Ayres and Braithwaite's generic business regulatory pyramid.[830] Seddon convincingly advocates for potential deployment of regulatory mechanisms for drug responses including treatment and other services for drug users. Regulatory lens incorporating normative and non-normative could contribute transformative policy direction and medium to harness insights of scholarship from varied disciplines.[831]

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[830] I. Ayres and J. Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (New York: Oxford University Press, 1992).35.

[831] T. Seddon, "Regulating Health: Transcending Disciplinary Boundaries," *Health Care Analysis* 21, no. 1 (2013).48–51.

Additionally, the selection of methods should be case-by-case considering several factors including the extent of devastating harms, regularity and persistency of conducts. This is important to secure fairness, proportionality and criminal law's role as a last mean to maximise the applicability of harm reduction and other drug measures.

If criminal control is truly necessary in exceptional circumstances, it must be undertaken in strict compliance with certain fundamental conditions. Coercive measures need to be exercised in facilities and techniques of acceptable quantity that is neither under-inclusive nor over-inclusive and quality which is aligned with objective evidences. As suggested by Ashworth and Horder, in case of no preferred or poorer implications than other techniques, the criminal strategies should be withdrawn. Additionally, they should strictly respect and fulfil human rights including freedom from discrimination. Further, they are subjected to the principles of health-care ethics such as informed consent, confidentiality of health status, fair procedural standards and due process. Rather than being extensive, it is necessary that the period of criminal compulsion is ended when the requirements for initial liability do not exist anymore. Drug users should be treated with respect, dignity and concern like a family member who does not undertake self-control. Criminal justice agents should aim to educate them and appeal their self-controlling ability, rather than to punish. These are consistent to the key standpoints of Griffiths' Family Model of criminal process.[832] Full observance to the basic criteria would add value to criminal law's justification, proportionality and justice and lead directions for reconciliation between diverse interests in the criminal justice procedure.

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[832] J. Griffiths, "Ideology in Criminal Procedure or A Third "Model" of the Criminal Process," *Yale Law Journal* 79, no. 3 (1970).370, 373–74, 384, 389, 410–11.

Therefore, echoing multiple theoretical sources, this thesis puts forwards the applicability of criminal law and public health approaches for drug use and has redefined their coherent specific terrains over drug use with reference to a principled approach. This may address a blurring line and conflicts between them. The primary focus should be devoted to drug programmes and behavioural interventions including harm reduction measures offered on a voluntary basis to tackle health and safety issues related to drug use. Criminal justice measures should be vigilant and adhere to certain basic constraints to conserve justice, proportionality, human rights and good health practice. The clear specified domains and roles of both approaches moving to address drug use under the umbrella goal of public good would advance multiple interests including personal and public health, welfare and safety, than merely correspond to moral concerns.

Nonetheless, the redefining of the provinces of each public health and criminal justice approach should not deter the mainstreaming of a partnership across the two regimes. It is pertinent that both systems serve as ‘carrot’ and ‘stick’ together in order to achieve the shared goal of public good. For example, law enforcement officers could provide information and assist in referring drug users to drug treatment and other public health programmes, including harm reduction services and ensure accessibility to the interventions in criminal justice settings such as prisons, probation and pre-trial detention. Interagency collaboration could be mobilised by constructive means including a systematic cooperative framework, constant liaison, useful information exchange, transformation in management, changes in operational objectives, training, organisational, and behavioural-change processes.

A need also exists to make appropriate and responsive policy and legal changes towards realising all the aforementioned options in order to ensure consistency between harm reduction and criminal justice approaches. Equally critical, an important priority must be given to the improvement of legislative and regulatory provisions related to the distribution and possession of needles and syringes and methadone prescribing and use to mitigate the barriers or risks they could pose to MMT and NSEP. The primary step should include enacting legislation to specifically legalise or authorise the harm reduction measures and exclude their practices from criminal liabilities.[833] Such legislation should provide a clear and fixed acknowledgement of the interventions and clarify the vagueness concerning their legal status, in addition to protecting them from enforcement actions that may limit their promotion, extension and efficient operation.

In addition, the drug law needs to be amended to decriminalise the distribution and possession of injection equipment provided by the NSEP service and other authorised dealers or sellers such as physicians and pharmacists.[834] This is crucial to ensure that the criminal prohibition, while being requisite to combat the illegal distribution or sale of injection instrument, will not represent an impediment to prescribing such items for legitimate public health purpose. It is further advisable not to make the possession of injectable items a legally sufficient ground for law practices such as search and urinalysis for drug use and the equipment itself as admissible evidence in the court trials involving

[833] The sample of such legislative provision can be found in Article 21(1) of Vietnam's Law on the Prevention and Control of HIV/AIDS 2006 that states: 'Harm reduction intervention measures to prevent HIV/AIDS transmission shall be implemented among target groups with risky behaviours through programs and projects suitable to socio-economic conditions'.

[834] This has been done in other countries such as Australia. Regulation 4 of South Australia, Controlled Substances (Exemptions) Regulations 2004 excludes the offence of drug paraphernalia possession as stipulated in section 31(1)(c) of the Controlled Substances Act 1984 from 'a person having in his or her possession a syringe or needle for use in connection with the administration of a drug of dependence or a prohibited substance'.

the offences, including drug consumption. This policy and legal modification will remove any threat of policing and legal liabilities for the NSEP operators, staff and clients for supplying, possessing or using needles and syringes. In addition, it would be preferable to make explicit in the legislation that the possession of syringes and other related materials that contain illicit drug traces have exemption as the criminal offence of the possession of a controlled substance.[835] Any drug residue contained in injection articles should also not be considered as admissible evidence with respect to drug-related offences. This legal reform would encourage IDUs to bring their used needles and syringes to be disposed of at the NSEP sites without concern for arrest or prosecution and assist a decrease in risky behaviour, such as syringe sharing. It would also ensure that health-care practitioners dealing with the used injection equipment are secure from the risks of criminal liability.

Furthermore, the regulations for prescribing methadone should be sustained for the imperatives including providing guidance for operations, ensuring medical standards and clients' autonomy and safety and minimising methadone diversion. However, the policies and legislation on methadone must be reformed to ensure that the provisions governing important aspects (including the eligibilities of prescribing physicians and clients, staff-clients ratios, licensing, dosing, duration of prescribing, confidentiality, take-away, withdrawal or discharge of treatment, improper prescribing and continued illegal drug taking) are really rational, necessary and facilitative to greater clinical discretion. It

[835] The example of the provision to decriminalise the possession of trace amounts of controlled substances could be found in section 38(2) of the Tasmania, Australia, HIV/AIDS Preventative Measures Act 1993. It states: 'A person who is in possession of any trace element of a substance that is contained in a syringe or needle is not, by reason only of that possession, taken to have committed an offence under the Misuse of Drugs Act 2001 or Poisons Act 1971'. Though the Public Health (Miscellaneous Amendments) Bill 2015 repeals the HIV/AIDS Preventative Measures Act 1993 (but the Bill is not yet enforced), the similar provision relating to the decriminalisation of possession of drug residue is included under amended Tasmania, Australia Public Health Act 1997; under section 56K(2).

is advisable that the restrictive regulations, guidelines and practices are made in accordance with international drug treaties, and with relevant resolutions and suggestions of international bodies such as the WHO. To reemphasise the discussion in Chapter 3, section 3.3, it is vital to note that the control of diversion, abuse or non-directed ingestion could be achieved by the mechanisms other than severe legislative restrictions upon methadone provision. These may include proper training for health-care workers on a consistent basis and systematic quality assurance and monitoring systems(for example, duly keeping the client registers, prescribing and dispensing, transferring records to the national central databank and inspections by enforcement officials). Additionally, consideration should be given to ensure methadone availability, accessibility and use in a sound and controlled manner in absolute emergency such as to relieve critical pain or reduce serious drug dependence or opiate withdrawal in the course of normal health care or inpatient treatment in health settings.

It is not easy to address the conflicts between the public health and criminal justice approaches, given their considerable philosophical differences. Therefore, I do not claim that my overall suggestions in this chapter will definitely put the tensions between the two responses to rest. However, the agendas I recommend are promising ways, which should make it possible to mitigate the contradictions and their negative impacts upon the harm reduction policies and practices. Despite potentially being challenged, I argue that the recommended options are more meaningful, comprehensive and concrete than other means such as discretionary enforcement, litigation and diversion to treatment strategies.

It is imperative to pinpoint that the discretionary arrangement methods including the police working agreement and prosecutorial pre-trial discretion may afford at times a

mean through which law enforcement agencies' approval and cooperative efforts towards harm reduction approach could be enhanced. The police are capable of undertaking discretionary efforts such as avoiding to enter into harm reduction facilities and from making arrests on those who take drugs in small quantities. The prosecution could avoid proceeding with criminal charges against the acts of harm reduction interventions, despite their violations of drug legislation. This option has been implemented productively in other nations such as England and Iran[836]. This seemingly influences some scholars to advocate the use of discretionary arrangements in establishing harmonious practices of the criminal law and harm reduction policies.[837] However, this avenue suffers from a variety of potential drawbacks. The administrative enforcement arrangement can be subject to disregard or violation for its no legal effect. The research findings reveal many situations in which the administrative arrangement is breached.[838] The findings suggest that such arrangements are difficult to implement without the significant support of the police or other enforcement officials. Another possible problem is that this avenue makes those involved in harm reduction services rely upon political and enforcement disposition. The administrative arrangement could be potentially altered in accordance with the shifts in political winds and enforcement management and strategies.[839]

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[836] There is prosecutorial and judicial directive in Iran to circumvent the enforcement of laws that otherwise undermine the harm reduction operations. (E.M. Razzaghi et al., "Profiles of Risk: A Qualitative Study of Injecting Drug Users in Tehran, Iran," *Harm Reduction Journal* 3, no. 1 (2006), http://www.harmreductionjournal.com/content/3/1/12.11). (Last visited: 02/09/2015)

[837] For example, C. Spooner, M. McPherson, and W. Hall, *The Role of Police in Preventing and Minimising Illicit Drug Use and Its Harms* (Canberra ACT: Commonwealth of Australia, 2004).8.

[838] For example, the study by Klein in Canada found that the seizure of syringes from NSEP clients still happened despite the existence of police administrative arrangement. (A. Klein, *Sticking Points: Barriers to Access to Needle and Syringe Programs in Canada* (Toronto: Canadian HIV/AIDS Legal Network, 2007).21).

[839] For example, the change of government that favours a total abstinence paradigm in drug interventions in Germany has led to the substantial reduction of prison-oriented NSEPs; from seven to only one. (Cook and

Moreover, broadening discretion is not always necessarily a good thing. I would suggest that discretion without statutory and structural changes is problematic if it is to be embedded in a harm reduction approach. For example, the government in England and Wales are looking at trying to reduce or reform police powers of 'stop and search' because broad police discretion has led to problematic outcomes, despite the official directives. The same can be said for police use of out of court disposals such as cautions. In England, these have been used widely due to police discretion. The government has since been introducing statutory guidelines and new legislation to try to limit their use. I hence further argue that the discretion the police have is liable to be used to thwart the harm reduction approach, as evidenced in Malaysia. Additionally, reliance upon enforcement discretion to sidestep what might otherwise be regarded as law contravention would result into a lack of uniform law enforcement policy and practice. Therefore, depending on the police, prosecutorial and even judicial discretion would not be a sufficient, sustainable and effective means of addressing the conflicts between the public health and criminal justice approaches. As Elliott et al. contend, 'dependence on 'lenient' interpretations of particular provisions would be too tenuous a basis on which reforms could be founded and criminal sanctions avoided.'[840]

Furthermore, it is undeniable that litigation potentially brings the lawfulness of harm reduction interventions to the forefront and defends those against prosecution. Existing literature demonstrates that public health advocates have resorted to litigation mostly based on the defence of necessity and in seeking a judicial declaration that larger

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Kanaef, *The Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics*.53).

[840] R. Elliott, I. Malkin, and J. Gold, *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues* (Toronto: Canadian HIV/AIDS Legal Network, 2002).39.

public health interests outdo drug legislation. The use of the necessity doctrine has been accepted by the courts in several cases, in some countries such as the USA. This was related to the supply of sterile injection items, particularly for curtailing the debilitating HIV/AIDS transmission crisis[841] and for the provision of unlawful substances, particularly for reducing serious pain[842]. Additionally, the precedence of public health law empowering the measures for public health imperatives over contrasting drug laws to legitimise the harm reduction approach has been judicially recognised in some decided cases.[843] Arguably, the future of litigation in securing the harm reduction approach remains uncertain. The battle waged in the courts is not only costly and lengthy but also far from providing immunity before involving in the harm reduction programmes. In addition, litigation is an indefinite tool for justifying these measures, considering the disagreements amongst courts (for example in USA and UK) regarding its viability.[844] Even when the courts do uphold the harm reduction approach, the declaratory judicial decisions are unable to fully ensure that the total law enforcement, especially street-level operations, favour and support the harm reduction programmes. Again, this goes back to the crucial point of discretion.

I also contend that the strategy of diversion to treatment, either through arrest referral[845] or drug courts[846] in isolation (as implemented in numerous jurisdictions

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[841] For example, *People* v *Bordowitz* [1991] *588 N.Y.S.2d 507*, 155 Misc. 2d 128.511.
[842] For example, *Jenks* v *State of Florida* [1991] 582 So. 2d 676.680.
[843] For example, *Spokane County Health* District v Brockett[1992] 120 Wash.2d 140, 839 P.2d 324.327.
[844] For example, the court in *Commonwealth* v *Leno*[1993] 415 Mass. 835, 839-840, *616 N.E.2d 453*.456.arrivedat a differing conclusion regarding the justifiability of medical necessity for NSEP operation, which violates syringe laws. This is predicated mainly on the reasoning that there are no situations of imminent or real danger to the public. Also, many courts including English Court of Appeal in *Quayle and Others* v *R* [2005] EWCA Crim 1415,89 BMLR 169.170. rejected the doctrine of necessity to be invoked for someone has possession of, for therapeutic supplying and/or use of illegal drugs.
[845] This scheme involves referencing drug-using offenders to drug programmes via the arrest point within police custody sites. Edmunds classified an arrest referral service into three models; 'information',

including the UK, USA, Canada, Australia and Brazil) cannot adequately address the conflicts between the public health and criminal justice approaches. Both strategies seem to be ideal ways of connecting drug treatment and harm reduction services. The courts exemplifying problem-solving justice, as Donoghue rightly describes, is 'a window of opportunity' for intervening in the lives of those who are most in need of treatment.[847] The regime is potentially well positioned to aid public health policies and operations, considering their large contact with drug users. The diversion to treatment method is, however, not without challenges. Considering the dissimilar philosophies, objectives and cultures between the criminal justice and treatment and rehabilitation regimes, the clashes between the people involved may still occur. The efficient practices and targeted outcomes of both arrest referral and drug courts rely substantially on acceptance and commitment among police and judges that are conditioned on organisational and behavioural shifts. This makes the process of increasing the enthusiasm of relevant people more complex.

Additionally, the treatment mandated, particularly by drug courts, is still strongly linked to the drug control criminal prohibitionist framework. It is clearly embraced by the threat of criminal penalties. Hunter et al. claim that 'the most unsatisfactory outcome of the collaboration would be one where the criminal justice system is always the dominant partner so that harm reduction and health goals are always subservient to those of

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'proactive' and 'incentive'. Within the first model, the police officers simply provide essential information about drug programmes to those who pass through custody. The second model involves drug workers undertaking a preliminary confidential assessment of detainees and giving advice and referral to appropriate drug services. The third model involves incentives to motivate the detainees to get treatment services. (M. Edmunds et al., *Arrest Referral: Emerging Lessons from Research* (London: Home Office, 1998).IV-V).

[846] The courts are specialised in handling drug-related offences and offer an option between treatment and prison to offenders.

[847] J. Donoghue, *Transforming Criminal Justice?: Problem-Solving and Court Specialisation* (London: Routledge, 2014).24-25.

enforcement and crime reduction'.[848] Therefore, the strategy is not really treatment or therapeutic oriented but criminal justice oriented. Moreover, the arrest referral and drug courts are subject to basic questions of fairness and equity. There are obvious risks in terms of inequality in intensity of diversion and disparity in relevant operational matters such as types of drug programmes connected to the schemes. Arguably, there is the wider issue about to what extent judges are involved in making similar decisions concerning a defendant's personal, social and health circumstances in traditional courts.

In short, my suggested options could provide relatively more extensive, useful and practical tools to harmonise the tensions between public health and criminal justice approaches for drug use, rather than other ways including discretionary enforcement, litigation and diversion to treatment strategies.

## 5.4 Can Harm Reduction Approach Work Effectively alongside an Abstinence-Oriented Goal?

The harm reduction approach can be unified with the abstinence-oriented paradigm on the basis of consecution of protection for drug users. As discussed in Chapter 2, Section 2.5, the integration of both paradigms is beneficial and practical for the augmentation and stability of drug use management and treatment within the criminal justice and public health systems. However, there is an important question whether the harm reduction

[848] G. Hunter, T. McSweeney, and P.J. Turnbull, "The Introduction of Drug Arrest Referral Schemes in London: A Partnership between Drug Services and the Police," *International Journal of Drug Policy* 16, no. 5 (2005).345.

approach can work effectively alongside an abstinence-oriented goal. Specific attention is given to the key issue of whether the abstinence-oriented goal should be a fundamental end target or a recommended but unnecessary aim in drug treatment. This issue must be addressed as it is one of the critical determinants of the compatibility between the criminal justice and harm reduction approaches.

Numerous commentators classify the abstinence orientation as an alternative to the harm reduction paradigm, rather than a necessary requirement for drug responses. The main justification forwarded is that abstinence is practically unrealistic for individuals who are unready or unable to quit consuming drugs. Christie et al. explicitly note that 'abstinence could be an eventual outcome and is consistent with harm reduction; however, abstinence is not a condition of the harm reduction approach'.[849] Whilst Riley et al. express:

> That is not to say that harm reduction and abstinence are mutually exclusive but only that abstinence is not the only acceptable or important goal. Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic ones to be achieved in steps on the way to risk-free use or, if appropriate, abstinence, it is consequently an approach which is characterised by pragmatism.[850]

In line with the abovementioned views, the UK Drug Policy Commission (UKDPC) also refers to abstinence as an optional goal for drug treatment. Even though

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[849] Christie, Groarke, and Sweet, "Virtue Ethics as an Alternative to Deontological and Consequential Reasoning in the Harm Reduction Debate."53.

[850] D. Riley et al., "A Brief History of Harm Reduction," in *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice* ed. R. Pates and D. Riley (West Sussex: Wiley-Blackwell, 2012).10.

recovery is acknowledged as one of the central aims for drug treatment to achieve 'health, wellbeing and quality of life', it is not singly confined to ending drug consumption but to suffice with 'voluntarily sustained control over substance abuse'. For UK Drug Policy Commission (UKDPC), medical drug maintenance is also inclusive as an acceptable count of recovery.[851] This exemplifies the UK reformulated recovery model which has pragmatic perspectives on drug controlling responses. Entrenched in this model is the extensive width of recovery beyond staying free from drugs and hence a likely departure from the crux of disease model tenets. While recognising the authenticity and benefits of abstinence, the model is flexible towards the attainment of abstinence. As concluded in the 2010 monograph on recovery-based MMT, the question whether MMT is to be continued or ended is determined by individuals.[852] Additionally, the strict pursuit of abstinence is seen as potentially leading to several negative implications for the harm reduction approach. These include restoration of MMT with residential rehabilitative services and specification of limited drug maintenance period.[853] Obviously, the arguments in favour of the harm reduction paradigm accept a certain flexibility regarding the aim of recovery eventually. The proponents of this stance regard drug users' participation to reduce drug-related harms and control over their drug-using habit is a minimally acceptable case, given their belief that the abstinence may be inappropriate or useless for certain people. This view likely rejects the importance and prospect of future abstinence-based measures towards achieving reduction of drug use.

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[851] UK Drug Policy Commission, *The UK Drug Policy Commission Recovery Consensus Group: A Vision of Recovery* (London: UK Drug Policy Commission, 2008).6.

[852] W.L. White and L. Mojer-Torres, *Recovery-Oriented Methadone Maintenance* (Chicago: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center, 2010).5.

[853] Hunt, "Recovery and Harm Reduction: Time for a Shared, Development-Oriented, Programmatic Approach?."163.

By contrast, some commentators have taken the view that abstinence is an essential end outcome for drug treatment, mainly based on the inability of the harm reduction approach to stop the drug using habit. This goal is I said to parallel the hope of most people with a drug using problem. In a study evaluating the target of drug users entering drug treatment in 33 settings in Scotland, McKeganey et al. state that various drug programmes must be concerned to achieve abstinence than merely to decrease adverse effects from drug consumption.[854] The researchers claim that abstinence is the aspiration of almost all drug users, as shown in their research findings in which 56.6 per cent of nearly 800 respondents voice abstinence as their ultimate target for accessing the drug programme.[855] This study has limitations including there being no examination of how the respondents interpret abstinence and also the likelihood that the responses from prisoners who constitute a high proportion of respondents are driven by the abstinence-oriented drug treatment offered to them in prisons. However, the finding indicates the presence of those among the drug using population who want abstinence. The results of this study are frequently applied by the 'new abstentionists' to justify the reorientation of recovery from illicit drugs. (Previous discussion about this group's concern for abstinence can be found in Chapter 2, Section 2.5.) The insistence on abstinence is to some extent consistent with the conservative recovery-oriented model discourse, particularly among researchers and drug dependence professionals in the USA.[856] It largely echoes the disease model as enshrined in the models such as the 12-step and Minnesota Model given

[854] N. McKeganey et al., "What Are Drug Users Looking for When They Contact Drug Services: Abstinence or Harm Reduction?," *Drugs: Education Prevention and Policy* 11, no. 5 (2004).434.
[855] Ibid.425–26.
[856] A.B. Laudet, "What Does Recovery Mean to You? Lessons from the Recovery Experience for Research and Practice," *Journal of Substance Abuse Treatment* 33, no. 3 (2007).245.

its consideration upon absolute abstinence from drugs to solely denote recovery for drug dependency as a chronic and progressive disease.

This thesis argues that abstinence should be sustained as the eventual goal of drug treatment. The entire range of harm reduction techniques should also be emphasised to assist and secure drug users' health and wellbeing until they are ready or able to attain and maintain abstinence. Clearly categorising decrease of drug-related harms as a short-term goal and abstinence as a long-term aim merits consideration. The importance and a wide array of benefits from every paradigm would enhance the capability and efficacy of drug use management and treatment in criminal justice and public health settings as explained before. Turning attention to the two paradigms is also worthwhile for attaining the congruity between them. It is notable that a considerable account of progression towards abstinence while adopting harm reduction strategies in drug interventions is embedded in the Gradualism and Stages of Change models of respectively Kelogg and Prochaska et al.[857] Exponents of these models find the harm reduction paradigm alone as troubling for giving little positive prospect for drug users. The arguments for 'abstinence-eventually' are driven by the significance of transitions towards the achievement of actual demand reduction, rather than merely mitigation of negative effects from drug taking. This is vital for the achievement of abolished or decreased prevalence of drug use.

The unification of both paradigms may influence a more creditable, inspirational and cogent drug treatment framework than the exclusive pursuit of either paradigm. An abstinence goal may frame a clear eventual target for substance users. It avoids their indefinite maintenance on substitute drugs and hence mobilises them to return to a drug-

[857] Kellogg, "On "Gradualism" and the Building of the Harm Reduction-Abstinence Continuum."243–46; Prochaska, Diclemente, and Norcross, "In Search of How People Change."1103–04.

free life. Arguing against a neutral stance on the achievement of abstinence, Kellogg says that 'The problem with neutrality is that it runs the risk of encouraging stagnation, of not fostering a kind of therapeutic or healing momentum'.[858] Abstinence constitutes, as Ghodse suggests, an achievable result for most substance dependants despite the chronic nature of dependence.[859] Harm reduction measures could function to stabilise drug users towards achieving cessation from drug consumption. Moreover, the politically credible justification of the harm reduction approach could be enhanced if the approach serves the goal to reduce the prevalence of drug use. The incorporation of the abstinence-based target into the harm reduction approach will not negatively impact the latter provided certain key rules are safeguarded. For example, the 'abstinence-eventually' goal should not subject harm reduction interventions to time limitation or other inappropriate constraints when the services are demanded by clients. The programmes should be maintained until the clients have capability for embracing abstinence.

Though it is strongly argued here that there should be a clear focus on the abstinence orientation together with the harm reduction paradigm, abstinence should not be positioned as an urgent, immediate and rigid endpoint. Consideration should be given to the physiological, psychological, cognitive and behavioural characteristics of each drug user while assessing the needs, appropriateness, adequacy, time span and other aspects of the interventions and processes towards cessation from drug using. In other words, all matters related to drug management and treatment must be considered on a case-by-case basis. This is because, as discussed in Chapter 2, Section 2.5, drug users vary in many aspects including their state of motivation and their ability to abstain from drugs at that

[858] Kellogg, "On "Gradualism" and the Building of the Harm Reduction-Abstinence Continuum."244.
[859] Ghodse, *Ghodse's Drugs and Addictive Behaviour A Guide to Treatment*.253–54.

time. A range of strategies and modalities of treatments must also be made available throughout the course of treatment to better tailor to personal needs. Moreover, the relapse to drug use as a natural occurring phenomenon should be considered as a part of the long-term treatment process and a basis for reviewing the approaches and their relevant aspects. Appropriate techniques as the routes to their developed skills for resisting illicit drugs, constructive behaviours and increased wellbeing in multiple life domains must be strengthened. The failure to be abstinent from drugs due to inability as evidenced by medical analysis, treatment staff certification and others must be considered as an exemption from the requirement of achieving abstinence. There are those who are truly unable to abstain or sustain abstinence as discussed before. Arguing in the North American drug court context, Werb et al. makes the perspective clear that emphasising abstinence and denying relapse puts the participants with critical drug dependence in a position with a huge potentiality for failure.[860] This thesis agrees that the emphasis on abstinence is valuable and advantageous, but it could be unworthy and inimical for drug users who are incapable to abstain from drugs. It is hence impractical and implausible to urge this subset of the drug using population to cease from using drugs.

In summary, abstinence should be incorporated as an eventual but not instantaneous and inflexible goal in drug treatment while attention must also be accorded to other paradigms, especially harm reduction. This is essential in order to develop more justifiable, viable and effective drug use interventions towards ensuring a healthy, productive and drug-free life for drug users. But, the attainment of abstinence and other aspects relevant to drug treatment need to be dealt with on an individual basis.

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[860] D. Werb et al., "Drug Treatment Courts in Canada: An Evidence-Based Review," *HIV/AIDS Policy & Law Review* 12, no. 2/3 (2007).15.

## 5.5 Conclusion

This chapter has provided possible approaches towards ensuring appropriate compatibility between harm reduction and criminal justice approaches in Malaysia. Important contentions are made, particularly concerning the rightful positions of the harm reduction approach in connection to the prohibition framework, the criminal justice strategy and the abstinence-based goal.

Despite the ineffectiveness and negative effects of the prohibition framework including upon harm reduction interventions, the former should be sustained while significantly adopting the latter as an important component of overall drug policy towards attaining the public good of a reduction of drug-related harms and the prevalence of drug use. This is more credible than implementing more aggressive punitive strategies or absolute focus to harm reduction or public health paradigm within prohibition or alternative drug frameworks. Moreover, due to the rightful claim of jurisdictions of criminal law and public health approaches over drug taking, reconciliation between the two must be made by redefining the purviews and aims of both approaches with reference to a principled approach. The ultimate strategy must be providing voluntary drug programmes and behavioural interventions including harm reduction services. Criminal justice interventions could be enforced in certain cases, particularly drug users' intractability to participate or less commitment, drug consumption in public settings or related to risky conduct and inefficacy of less restrictive methods. However, they must be circumspect and satisfy certain essential restrictions to preserve justice, proportionality,

human rights and good health practice. All interventions must be intensified towards achieving the underlying goal of public good. Further, harm reduction and abstinence may be integrated based on specific safeguards as respectively a short-term and long-term goal. This could benefit a drug treatment system by pragmatically progressing towards stabilisation through drug maintenance and a drug-free life.

All these paradigm shifts may reconcile not only differing primary goals, methods, priorities and practices of two drug responses but also multiple interests including private interest, public health and public safety. To effectuate the suggested theoretical frameworks, appropriate adjustment to policies, law and its enforcement practices is worthy of consideration.

# CHAPTER 6

# CONCLUSION AND RECOMMENDATIONS

## 6.1 Introduction

This final chapter consolidates the constituent elements from past chapters and in so doing, links the research findings to the original purpose of research in seeking to critically examine the justifications for the harm reduction approach in Malaysia, its compatibility to the existing criminal justice approach and ways of finding reconciliation for both approaches if there are conflicts between them. In addition to summarising the study findings, the chapter also provides some observations regarding the experience of researching this field and identifies some knowledge gaps and recommendations that are relevant to the field. Furthermore, the chapter briefly discusses the limitations of the research and gives some suggestions for further research and work.

## 6.2 Conclusion and Recommendations

This thesis is designed to contribute to our knowledge with respect to the justification of the harm reduction approach for drug users and its compatibility with the criminal justice

approach. Before summarising the main aim, questions, findings and suggestions of this study, it may be worthwhile to note the experience of studying this field.

Reviewing the available limited literature in Malaysia shows that there appears an employment of either exclusively social science or exclusively legal methods in exploring the issues concerning the harm reduction approach. This research went beyond that dichotomy to use a socio-legal approach in order to widen our understanding and to give a more comprehensive picture of some major issues. This approach enables the researcher to explore the historical, legal, social and political contexts in which the harm reduction approach was initiated and implemented. Additionally, based on this method, the researcher could examine the relevant debate and moral, ethical and scientific justifications for harm reduction strategies. Applying a socio-legal analysis is also pertinent in critically assessing how the drug control law works in practice, the extent of its congruity to the harm reduction approach and other relevant issues such as whether the government mechanisms developed to prevent clashes with mainstream criminal justice strategy actually impact on the operation of harm reduction. Therefore, the socio-legal methods are useful tools for the researcher to undertake a more effective assessment of justifications of the harm reduction approach and its compatibility with the criminal justice approach.

Further, the application of the socio-legal approach in this research gave valuable insights into varied concerns and questions to be considered for further analysis in Malaysia. These include limited local evidence regarding the imperatives and benefits of MMT and NSEP and the impact of and explanations for antagonistic criminal justice

practices. These issues should be examined using socio-legal methods so that more comprehensive findings and outcomes can be achieved.

This thesis is the first in Malaysia to examine the main justifications of the harm reduction approach from varied philosophical and scientific perspectives and its consistency with criminal law and enforcement practices. Substantial consideration is given to the main supporting and opposing arguments because they have the value of disclosing potentially crucial questions and coherent concerns related to the imperatives of the harm reduction approach and its compatibility with the criminal justice approach. This is an important departure from the general tendency in Malaysia (and perhaps in other settings) to disregard careful and sufficient examination of the issues addressed in this thesis and the emerging controversies in this field. Thus, this thesis constitutes a significant original contribution to the body of knowledge in this area. It further intends to serve as a foundation for further assessment in this area, considering the worth of exploring further compelling rationales for the harm reduction approach and effective options to harmonise its relation to the criminal justice approach against drug users.

In terms of substance, the examination of the Malaysian literature reveals that, in general, consideration has been devoted to the imperatives of the harm reduction approach from a scientific perspective. This is unsurprising given that the harm reduction approach is commonly understood and promoted by the Malaysian government as a pragmatic response to HIV/AIDS virus transmission and other drug-related harms. There is an absence of serious attention to the ethical and ideological judgments to the approach. This leaves relevant normative issues without sufficient attention, including the ethical

underpinnings of the harm reduction approach and its congruity to abstinence-oriented paradigms within drug prohibition policy.

Despite the focus on the consequentialist concerns regarding MMT and NSEP in Malaysia, gaps still remain concerning the evidence base for these strategies. There is scant data on the effectiveness of both interventions in decreasing the transmission of HCV virus and their cost-effectiveness in reducing HIV spread. Also, largely missing from current study is a focus on the economic benefits of MMT and NSEP for HCV prevention. There is also a lack of local evidence regarding the issue of minimising non-opiate drug consumption and the financial efficiency of MMT in managing opiate dependence. Additionally, a lack of evidence is discovered pertaining to the impact of NSEP on HIV infection and prevalence, drug taking patterns and frequency and referral of drug users to drug treatment and other health interventions. Furthermore, there is very limited evidence on the unintended effects of harm reduction services, including the transmission of messages encouraging drug use, the recruitment of new drug takers and the increase of involvement in criminality and the hazards of discarded needles and syringes in public settings.

Moreover, the existing local materials and literature provide an inadequate focus on the issue of compatibility between the harm reduction and criminal justice responses in Malaysia. Although several commentators in Malaysia give some overview of several inconsistent legal rules and enforcement practices, none has provided detailed scrutiny or study of the issue of conflicts between both approaches and related issues such as the nature, significance and impacts of conflicts, if any, on the operation of harm reduction, and the individual, institutional and environmental factors that influence criminal justice

actors including police, prosecutors, prison officials and judges and on possible ways to address the tensions in theory and practice.

Extensive reference to global literature and materials enables me to study the harm reduction approach as more than a purely legal issue and assess the issues relating to its justifications and congruity to the criminal justice approach in its wider social, political and legal context. Generally, the international literature acknowledges the need for the adoption of the harm reduction approach. The substantial literature on the harm reduction approach reveals the debates surrounding the rationales of MMT and NSEP. In terms of substance, however, several knowledge gaps can be identified with respect to the justifications of both programmes. Despite growing interest in the ethical and theoretical impetus of the harm reduction approach, limited attention is paid to relevant important issues such as the approach's consonance to religious perspectives, consistency between human rights norms as an important ideological basis for the approach and community good principle, and Asian values and the compatibility between harm reduction and abstinence-based paradigms. In terms of scientific justifications for harm reduction interventions, there is still a lack of assessment regarding the efficacy and financial-efficacy of MMT and NSEP for the control of HCV transmission and their unintended negative results such as symbolism of drug use promotion, the increased number of new initiates to drug consumption, needles and syringes discarded in public places and crimes. Further, research on the cost-effectiveness of MMT in managing opiate dependence and on the issue of mitigating dependency of non-opiate drugs such as ATS is scarce in many countries, with the exception of the UK and USA.

Although extensive international studies have examined the legal and regulatory framework enabling or clashing the harm reduction strategies in local context, there is limited comprehensive evaluation of the compatibility between harm reduction and criminal justice approaches which extends to consider how the law is actually deployed and how it actually impacts upon harm reduction policy and measures. The limitation is particularly apparent in relation to the prosecutors' and courts' practices. Moreover, there is generally scant investigation regarding the knowledge, beliefs, attitudes, motivational, organisational and structural causes of the behaviours of enforcement officials affecting harm reduction interventions. There is also limited research regarding effective ways to bring about reconciliation between harm reduction and criminal justice approaches or addressing the theoretical and practical conflicts between both approaches.

In achieving the aims of this thesis, an attempt was made to address the following central questions. Firstly, whether Malaysia should implement the harm reduction approach for drug users or not? Secondly, if so, whether the harm reduction approach in Malaysia is compatible with the existing criminal justice approach against drug users or not? Thirdly, if there are conflicts between both approaches, is there a way of finding a reconciliation between them or must one or other of these approaches be abandoned? Some may believe that addressing these research questions will only be beneficial to the Malaysian audience. This is untrue as the interdisciplinary and comprehensive approaches applied in this thesis in examining the research questions suggest that this thesis is useful for the audience not only in Malaysia but also in other nations. By way of illustration, Chapters 2 and 3 provide a holistic understanding of normative, philosophical and

scientific imperatives of harm reduction approach in the light of relevant debate and evidence at Malaysian and international levels.

With respect to the first research question of whether Malaysia should implement the harm reduction approach for drug users or not, this research reached a positive conclusion, considering its philosophical and scientific justifications to be sufficient. It is notable that an important point to emerge from this study was the significance of considering different justifications for the harm reduction approach and not relying solely on scientific judgments. Attention must also be given to the ethical and philosophical issues, so that more comprehensive rationales for harm reduction can be established. In this thesis, the arguments are deliberately focused on 10 important aspects covering both ideological and scientific justifications of the harm reduction approach. The discussion in Chapter 2 indicates that none of the main ideological arguments against the harm reduction approach is persuasive enough to warrant discarding the approach. In defending the harm reduction approach from ethical criticisms, this thesis suggests the worth of the approach through several normative bases. The response is anchored principally in public health as it suits the prevention for diseases and health risks under the traditional public health and health promotion under the new public health. It also meets the utilitarian analysis for its effectiveness in contributing good for individuals and society. These ideological bases are further reinforced and counterbalanced by the approach's connection to the protection of human rights of health and freedom from inhuman and degrading treatment.

The resistance to the harm reduction approach, particularly in Malaysia, also brings forward the claim regarding its contradiction to Islamic values, principally on the

grounds that it assists and encourages sinful, illicit drug taking. In response to this contention, this thesis argues for the permissibility of MMT based on the Islamic principle of '*hajiyyat*' (needs) given its use in drug dependence treatment while NSEP on the Islamic dictums of '*darurah*' (necessity) and '*al-∂arar al-ashadd yuzalu bi'l-∂arar al-akhaff*' (a greater harm is eliminated by tolerating a lesser harm) considering the emerging dangers to life in terms of HIV transmission and drug dependence. Another main argument against the harm reduction approach lies on the premise of the approach's incongruity to abstinence orientation adopted within drug prohibition policy given its ultimate attention to mitigation of drug-related harms. Accordingly, this thesis argues that in spite of different focuses, the two paradigms are not wholly exclusive and contradictory, and suggests that there are possibilities for collaboration between the approaches and for regarding them as providing a continuing framework for protection of drug users. Additionally, this thesis finds that opponents of harm reduction are mistaken in believing that the harm reduction approach contravenes the international drug control conventions based on its divergence from the main thrust of law enforcement policy. In giving effect to this point, this thesis stresses the presence of interpretative leeway to legitimise the harm reduction practices within the confines of drug treaties. For example, as the 1961 and 1971 Conventions allow the production, distribution or possession of controlled substances exclusively 'for medical and scientific purposes',[861] the undefined phrase 'for medical and scientific purposes' is interpretable to warrant the methadone prescribing for decreasing opiate dependence. Embracing all these ideological aspects would strengthen the theoretical bases for the harm reduction approach.

[861] The 1961 Convention, Article 4(c); the 1971 Convention, Articles 5 and 7.

The analysis provided in Chapter 3 further suggests that the implementation of MMT and NSEP is justifiable based on their effectiveness and cost-effectiveness in reducing drug use and its harmful consequences. The available evidence nationally and internationally convincingly shows that both measures are efficacious in decreasing drug consumption, HIV-risk behaviours and the viral infection incidence among drug users. The interventions also yield economic benefits, given their cost-effectiveness and cost-saving in the control of drug use and HIV pathogen transmission. The efficacy and economic efficiency for the domains are adequately solid to defend the availability of MMT and NSEP although there is a lack of evidence to support their protective and financial returns in the prevention of HCV transmission. This may call for the consolidation of varied interventions to improve and enhance the desirable outcomes, rather than the abandonment of harm reduction programmes. Further, there appears no evidence indicating their unintended adverse impacts including symbolism of drug using promotion, rise in drug consumption initiation, criminal acts and needles and syringes litter in public places.

It is important to recognise that the effectiveness of strategies is not put into question by the existence of several negative empirical findings because there are clear explanations for these contrary results and in general the strength of the overwhelming evidence points in the opposite direction. This weakens the opposing contention that harm reduction strategies are ineffective, economically inefficient and have adverse effects. Such arguments are also unsupported by credible and conclusive evidence. The scientific bases would supplement the ideological imperatives in entailing strong credentials for harm reduction practice.

Having identified the justifications for the implementation of the harm reduction approach for drug users, this research moved on to respond to the second question of whether the harm reduction approach in Malaysia is compatible with the existing criminal justice approach against drug users. The present widespread assumption and official position is that the two approaches are compatible. However, this thesis has argued that the official position is mistaken. It is important that the question of compatibility be verified by an extensive empirical research. Unfortunately, at this moment very limited empirical research has been conducted on this issue in Malaysia. At present, it is impractical and ineffective to do the extensive study although this research recognises its impetus. At present, the prospect of conducting such research in Malaysia is still limited, given the substantial methodological limitations as explained in the Introductory Chapter. However, considering my experience, informal discussion and the limited local literature and evidence, taking into account the international evidence, this thesis argues that there are significant conflicts between the harm reduction and criminal justice approaches as they are currently understood and practised in the Malaysian context. The conflict is not necessarily driven by the existence of legislative and regulatory framework relating to drug use that is contradictory in principle and/or has potential to affect the harm reduction objectives and operation. Rather, the conflict arises from law enforcement practices, predominantly street-level policing including raids and crackdowns. This is where the source of the tension actually lies in Malaysia. Disruptive ground-level enforcement practices somehow mirror the lack of genuine commitment on the part of the criminal justice actors to support the harm reduction approach, and this is reflected in the exercise of their discretion. State initiatives, such as training and guidelines, likely constitute a

political compromise intended to prevent obstruction of the operation of the criminal justice process, rather than genuinely support the operation of harm reduction.

It is pertinent to note that the conflicts between the two approaches are not a unique issue in Malaysia. They are also evident in other jurisdictions, although with varying degrees of seriousness. The general comparative analysis applied tends to reinforce the thesis's argument that the conflicts in Malaysia are led by limited effective multi-agency collaboration and lack of enforcement discretion exercised in such a way as to support harm reduction. This thesis therefore argues that the conflicts between these approaches in Malaysia are rooted in an incomplete understanding of the conceptual and theoretical basis of the approaches on the one hand, and in an incomplete appreciation of the gap between official policy and actual enforcement in practice, on the other hand.

This thesis further considers the possible main explanations for the failure of police discretion to support the harm reduction approach in Malaysia, including the attitudes, lack of knowledge, misunderstanding and negative perceptions of harm reduction held by criminal justice actors, strength of commitment to punitive response against drug use embodied in the criminal justice system and failure to understand that both approaches can be implemented together. Therefore, it is coherent to conclude that the existing conflicts between harm reduction and criminal justice responses are crucially contributed by the dominance of the latter to undermine the former's objectives, availability, accessibility and efficiency and exacerbate certain effects, particularly health and human rights risks which will counter the harm reduction initiatives.

Despite the limitations of this research, it provides an important basis for further research. The issue of compatibility between the two approaches, the explanations for and impact of conflicts, the perceptions of the harm reduction approach, all deserve further extensive investigation. This thesis argues that both approaches can be implemented harmoniously, provided that a proper basis for reconciliation is established. The chance of genuine collaboration between both regimes is low until we achieve a clearer conceptual and theoretical understanding of the two approaches and a deeper understanding of the gap between official policy and actual enforcement.

In addressing the final question concerning a way of finding reconciliation between the harm reduction and criminal justice approaches if there are conflicts between them, this study reached (as highlighted in Chapter 5), the following main conclusions. Firstly, the harm reduction approach is feasible to be incorporated as an important component of overall drug policy under the maintained larger drug prohibition policy. This will help to ensure the political acceptability, efficiency and consistency of the harm reduction approach to the supply and demand reduction principles and strategies including the criminal justice approach working towards the public good pursuit of minimisation of drug-related harms and drug use prevalence. This thesis contends that the incorporation of the harm reduction approach represents a more credible option to contribute to the outcomes rather than an intensification of punitive strategies or an absolute emphasis on harm reduction or public health policy for drug use, either within prohibition or alternative drug frameworks as suggested by the commentators.

Secondly, echoing relevant philosophical underpinnings for the criminal law and public health approaches (comprising the harm reduction approach), it can be argued that

each approach has the rightful claim of jurisdictions over drug use. Therefore, this thesis suggests that neither of these approaches can simply be abandoned when there are conflicts between them and suggests that they can be reconciled by redefining or adjusting their terrains with reference to a principled approach. This is crucial to avoid any blurring of the lines between them. In applying Ashworth and Holder's minimalist principles, this thesis argues that principal attention must be tailored to appropriate drug interventions including harm reduction services on a voluntary basis. Criminal justice interventions could be implemented in certain cases including when drug users are headstrong or less committed to take part, consume illicit drugs in public settings or simultaneously engage in behaviours related to drug use that expose harms or risk of harms to others. Nevertheless, this thesis contends that they should only be enforced in subsequence of the failure or insufficiency of less restrictive means based on Ayres and Braithwaite's generic business regulatory pyramid[862] and in compliance to certain fundamental constraints to protect justice, proportionality, human rights and good health practice. All interventions must be aligned with the goal of public good and partnership between the public health and criminal justice regimes. All the agenda this thesis forwards must be supported by suitable changes in relevant policies, law and regulations.

Thirdly, harm reduction and abstinence could be unified in drug treatment systems as respectively short-term and long-term objectives under a continuing framework of protection. However, the consolidation must be subject to some safeguards, including avoiding making abstinence an immediate and inflexible goal, considering other appropriate interventions and dealing with the achievement of abstinence and other

[862] Ayres and Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate*.35.

aspects related to drug treatment on an individual basis. The unification of both objectives would assist in building more viable, efficacious and compatible multi-component measures in both criminal justice and public health settings for handling drug use and its harmful effects.

In the light of the discussions throughout this thesis, several recommendations are presented below:

**Recommendation 1:** It is critically important for the ethical and philosophical rationales behind the harm reduction approach to be firmly created and sustained to enhance the credentials of the approach. The ethical and ideological underpinnings of the harm reduction approach should be articulated in policy documents and drug discourse and maintained within a clear framework for its practices.

**Recommendation 2:** The state must conduct an open and transparent public approach which increases awareness and knowledge regarding the conception, practice, philosophical and scientific imperatives, related issues and future direction of harm reduction policy and strategies. This can be effectuated by education, communication and information through potential mediums such as extensive government documentation and mass media sources. A mitigation of oppositions and intense attacks against the harm reduction approach and services may be expected to follow from this strategy.

**Recommendation 3:** Harm reduction programmes must be developed within socio-cultural and religious framework. The services should be community-oriented and responsive to social, cultural and religious values and concerns. This could be achieved through the commitment and appropriate initiatives of the government such as engaging

community councils, community-based organisations, religious scholars, religious institutions, NGOs and representatives from the drug-using population at the levels of planning, implementation and evaluation, mapping and assessing needs and limits embodied in cultural and religious values for the harm reduction practices and providing attention to important concerns raised by local communities. This would offer a potential route to garnering broad public support and ensuring the fit of harm reduction designation and development to local climates.

**Recommendation 4:** The importance of harm reduction interventions as part of the protection of human rights of health and freedom from inhuman and degrading treatment should be explicitly endorsed and enforced by the UN General Assembly, the UN bodies, the Commission of Human Rights and all member states. The government must make efforts to fulfil their human rights obligation of implementing harm reduction measures for drug users at a realistic standard in consonance to the economic faculty of the country.

**Recommendation 5:** More supportive interpretation of the international drug control conventions to the legality of harm reduction policy and practices should be globalised and supported by the UN system and signatory countries. Attention must also be provided to initiate strategies towards revising and amending the drug treaties to explicitly warrant the harm reduction approach and measures. This would give a clearer and stronger basis for their legitimacy under the international law.

**Recommendation 6:** Considering the clear ideological and scientific rationales of MMT and NSEP, their availability and accessibility need to be substantially extended throughout Malaysia. The relative less sufficient local evidence for the efficacy and cost-

effectiveness of the services must not be used as an excuse to quit or limit the programmes. Their imperatives based on overall evidences including from international sources are compelling for their urgent practice. The programmes should be scaled up by the state to provide sufficient coverage to drug users in all urban and rural areas and in closed settings, including prisons. The measures must be targeted at those in need beyond the IDUs. For enhancing the accessibility, important attention should be paid to the relevant aspects such as policies for equitable access, efficient delivery modes, location and time of service. Additionally, specific initiatives to reach hard-to-reach drug using subpopulations including women and minors must be central to government efforts.

**Recommendation 7:** The government must constantly support and apply effective techniques to realise the feasibility, efficiency and efficacy of harm reduction interventions. This must cover the means to maintain the infrastructure of the services including adequate funding, trained workforce, training and logistics and developing a better monitoring and evaluation system for the programmes. This should be coupled with strategies to ensure their efficient and effective operations such as assurance of management and programmatic system (including quality surveillance, strategic information and clinical guidelines), sufficient supply of methadone, adequate methadone dosing, sufficient quantity of sterile needles and syringes, duration of service and retention of clients. The state should further encourage and support research assessing the harm reduction measures, their effectiveness, cost effectiveness and societal impacts in the national context. This should be accompanied, if necessary, by appropriate modification and improvement to the programmes.

**Recommendation 8:** To make a difference, MMT and NSEP must be integrated as parts of an important constituent of a comprehensive approach for drug users. The well-integrated strategy could comprise varied harm reduction services in conjunction with other interventions including education on risk reduction, disposal of used injection equipment, non-pharmacological drug treatments, inter-programme referral networks, schemes to eradicate stigma and marginalisation among drug users and health and social services which could ideally be suited to drug use dynamics and the needs of individual drug users. These must be implemented where feasible to enhance the acceptability and efficacy in handling drug use (not limited to opiate drugs) and its multiple harmful effects (including HCV infection).

**Recommendation 9:** The government must adopt the harm reduction approach as a paramount component of a whole drug control policy under the sustained larger drug prohibition framework. Thus, harm reduction policy and strategies must be streamlined together with supply and demand reduction policies and strategies including the criminal justice approach within the national drug response towards achieving the public good aim of reducing drug use prevalence and drug-related harms.

**Recommendation 10:** The government could adopt three levels of actions against drug use and dependency. The initial level should be specified for the provision of voluntary drug treatment and behavioural interventions including harm reduction services for drug users. The secondary level might include the regulatory mechanisms to maximise the applicability of the drug treatment and behavioural interventions such as persuasion, warning, court enforceable proceedings and civil penalties. This may be undertaken for the cases, particularly the intractability of drug users to participate or less commitment in

voluntary programmes, drug consumption in public places or engagement with behaviours in connection to drug use that expose harms or risk of harms to others. The last level may involve the criminal justice interventions in the event of failure or insufficiency of the secondary level of action.

**Recommendation 11:** Recommendation 10 must be aligned with the government steps to enhance the partnership between the public health and criminal justice systems and suitable policy and legal shifts. Thought should also be given to reform the policy and legislation to explicitly legitimise the harm reduction interventions, decriminalise the provision and possession of injection items given by the NSEP programme and other authorised distributors and possession of drug residue contained in injection equipment. While the regulatory provisions and guidelines related to MMT should be retained, it must be ensured that they are truly rational, necessary and supportive of the exercise of higher clinical discretion.

**Recommendation 12:** The state must update national policy and strategies for drug use to distinctly support harm reduction as a pertinent paradigm in drug use, dependency and relapse interventions in public health and criminal justice settings. It could be consolidated as a short term orientation with abstinence as a long term goal under the framework of consecution of protection. Nevertheless, the harm reduction and abstinence achievement and other aspects of drug programmes must be dealt with flexibly on a case-by-case basis.

## 6.3 Limitations of the Research

Although this study sought to examine the justifications and compatibility of the harm reduction approach with the criminal justice approach within a socio-legal sphere of analysis, there are several relevant aspects that require detailed analysis but which are beyond the scope of this thesis. These aspects include: the imperatives of harm reduction in specific settings such as prisons and for drug using subpopulations such as children and women;, varied factors such as social, cultural, political, economic, individual and organisational factors impacting on drug use problems; the efficacy, cost-effectiveness and efficiency of harm reduction programmes; the methodological validity and strength of data related to the scientific justifications of MMT and NSEP; environmental determinants of criminal justice practices against drug users; and the perceptions and experience of the law and of harm reduction held by clients, drug users and law enforcement actors.

## 6.4 Avenues for Future Work

Many salient areas in which further assessment regarding the harm reduction approach and interventions, their worth and (in)consistency with the criminal justice approach should be done to broaden and improve the current knowledge base. Some research issues which deserve to be explored are briefly provided as follows. Future evaluations should

look specifically at how to link harm reduction measures including MMT and NSEP to values and philosophical imperatives and other relevant ideological issues, the scientific supports of the programmes for reducing drug taking and varied harms, possible unintended effects and means to address them in case of discovery, eligibility requirements for service providers and clients and strategies to prevent methadone diversion. The other area that deserves further research is the theoretical and operational (in)compatibility of the harm reduction approach with criminal justice response in many jurisdictions. This should engage data collection beyond statistics to achieve information concerning the actual nature and scale of criminal justice practices that include the prosecution and court operations. In addition, more study is important to examine the related aspects, particularly impacts, reasons of supporting or hindering law enforcement and options to address any conflicts between harm reduction and criminal justice approaches.

Further, more research is needed on the efficacy and economic-efficacy of harm reduction techniques, including MMT and NSEP for a particular subpopulation of drug users such as women and children and different settings including prisons, the programme components such as intensity and access points and clients characteristics which implicate in the desirable outcomes of the services, their relative effectiveness in relation to social, political and economic variables, effective interventions for reducing non-opiate drug dependency and optimal methods to consolidate and coordinate other programmes particularly education, abstinence-based drug treatment, behavioural and psychosocial interventions with multi-components of harm reduction measures and additional

protective and financial returns of such combined approaches and effective ways to enhance the partnership between harm reduction and criminal justice actors.

## 6.5 Conclusion

In this thesis, the argument is for an approach to the research process that begins with the examination of the justifications for the implementation of the harm reduction approach and moves on to consider the compatibility between the harm reduction approach with the criminal justice approach against drug users in Malaysia and ways of finding reconciliation for both approaches if there appears conflicts between them. It is hoped that the study findings embodied within this thesis will enhance the knowledge in the field, contribute to the scholarly debates in Malaysia and in the broader international arena and foster further research in the field. The shelf-life of this thesis will be finite if it is intended to produce a complete analysis in the field, given its potential developments and changes in the future. Nonetheless, the hope is that some of the arguments and recommendations of this thesis will have continuing relevance. The conclusions and suggestions which have been presented represent an attempt to provide significant bases for the harm reduction approach and possible pathways for pursuing its efficient and effective operations in harmony with criminal justice practices.

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# ANNEXURE

## FIRST SCHEDULE

[Sections 2, 11 (1) and 17 (3)]

### PART I

Raw Opium
Coca Leaves
Poppy-Straw
Cannabis

### PART II

Prepared Opium
Cannabis
Cannabis resin and substances of which such resin forms the base

### PART III

Acetorphine
Acetyl-alpha-methylfentanyl
Acetylmethadol
Alfentanil
Allylprodine
Alphacetylmethadol
Alphameprodine
Alphamethadol
Alpha-methylfentanyl
Alpha-methylthiofentanyl
Alphaprodine
2-amino-1-(2, 5-dimethoxy-4-methyl) phenylpropane
Amphetamine
Anileridine
Benzethidine
Benzylmorphine
Betacetylmethadol
8-beta-11-dihydroxy-delta-9-tetrahydroxycannabinol
8-beta-hydroxy-delta-9-tetrahydrocannabinol
Beta-hydroxyfentanyl
Betahydroxy-3-methylfentanyl
Betameprodine
Betamethadol

Betaprodine

Bezitramide

Butorphanol

4-bromo-2, 5-dimethoxyphenylethylamine (2C-B)

Cathinone

Clonitazene

Cocaine

Codoxime

Concentrate of poppy-straw (the material arising when poppy-straw has entered into a process for the concentration of its alkaloids, when such material is made available in trade)

delta-8-tetrahydrocannabinol

delta-9-tetrahydrocannabinol

Desomorphine

DET, N, N-diethyltryptamine

Dextromoramide

Diampromide

Diethylthiambutene

Difenoxin

Dihydroetorphine

Dihydromorphine

Dimenoxadol

Dimepheptanol

2,5-Dimethoxyamphetamine (DMA)

Dimethoxybromoamphetamine (DOB)

2, 5-Dimethoxy-4-ethylamphetamine (DOET)

Dimethylthiambutene

Dioxaphetyl butyrate

Diphenoxylate

Dipipanone

DMHP, 3-(1,2-dimethylheptyl)-1-hydroxy-7,8,9, 10-tetrahydro-6,6,9-trimethyl-6H-dibenzo [b,d] pyran

DMT, N, N-dimethyltryptamine

Drotebanol

Ecgonine

Ethylmethylthiambutene

Eticyclidine, N-ethyl-1-phenylcyclohexyl-amine

Etonitazene

Etorphine
Etoxeridine
Etryptamine
Extract or tincture of cannabis
Extract or tincture of coca leaves
Extract or tincture of opium
Fentanyl
Flunitrazepam
Furethidine
Gamma hydroxybutyric acid (GHB)
Heroin
Hydrocodone
Hydromorphinol
Hydromorphone
11-hydroxy-delta-8-tetrahydrocannabinol
11-hydroxy-delta-9-tetrahydrocannabinol
Hydroxypethidine
Isomethadone
Ketamine
Ketobemidone
Levomethorphan
Levomoramide
Levophenacylmorphan
Levorphanol
(+)-Lysergide, (+)-N-N-diethyllysergamide (d-lysergic acid diethylamide)
Mescaline, 3,4,5-trimethoxyphenethylamine
Metazocine
Methadone
Methadone-Intermediate
Methamphetamine
5-Methoxy-3, 4-methylenedioxyamphetamine (MMDA)
4-methylaminorex
Methyldesorphine
Methyldihydromorphine
Methylenedioxy-amphetamine (MDA)
3,4-Methylenedioxymethamphetamine (MDMA)
3-methylfentanyl

1-methyl-4-phenyl-4-piperidinol propionate (MPPP)

3-methylthiofentanyl

4-methylthioamphetramine (4-MTA)

Metopon

Monoacetylmorphines

Moramide-Intermediate

Morpheridine

Morphine

Morphine Methobromide and other pentavalent nitrogen morphine derivatives, including in particular the morphine-N-oxide derivatives, one of which is Codeine N-oxide

Morphine-N-oxide

Myrophine

N-ethyl (MDA)

N-hydroxy (MDA)

N-methyl-1-(3,4-methylenedioxyphenyl)-2-butanamine

Nicomorphine

Nimetazepam

Noracymethadol

11-nor-delta-9-tetrahydrocannabinol-9-carboxylic acid

Norlevorphanol

Normethadone

Normorphine

Norpipanone

Oxycodone

Oxymorphone

Para-fluorofentanyl

Parahexyl, 3-hexyl-1-hydroxy-7,8,9,10-tetrahydro-6,6,9-trimethyl-6H-dibenzo [b,d] pyran

Paramethoxyamphetamine (PMA)

Pethidine

Pethidine-Intermediate-A

Pethidine-Intermediate-B

Pethidine-Intermediate-C

Phenadoxone

Phenampromide

Phenazocine

1-phenethyl-4-phenyl-4-piperidinol acetate (PEPAP)

Phenomorphan
Phenoperidine
Piminodine
Piritramide
Propheptazine
Properidine
Psilocine, Psilotsin, 3-(2-dimethylaminoethyl)-4-hydroxyindole
Psilocybine, 3-(2-dimethylaminoethyl)-indol-4-yl dihydrogen phosphate
Racemothorphan
Racemoramide
Racemorphan
Remifentanil
Rolicyclidine, I-(1-phenylcyclohexyl) pyrrolidine
Sufentanil
Tenocyclidine, 1-[1-(2-thienyl) cyclohexyl] piperidine
Tetrahydrocannabinols, 1-hydroxy-3-pentyl-6a, 7,10,10a-tetrahydro-6,6,9-trimethyl-6-H-dibenzo [b,d] pyran
Thebacon
Thebaine
Thiofentanyl
Tilidine
Trimeperidine
3,4,5-Trimethoxyamphetamine (3,4,5-TMA)

The isomers, unless specifically excepted, of the drugs in this Part whenever the existence of such isomers is possible within the specific chemical designation;

The esters and ethers, unless appearing in another Part, of the drugs in this Schedule whenever the existence of such esters or ethers is possible;

The salts of the drugs listed in this Part, including the salts of esters, ethers and isomers as provided above whenever the existence of such salt is possible.

## PART IV*

Acetyldihydrocodeine

Codeine

Dextropropoxyphene

Dihydrocodeine

Ethylmorphine

Nicocodine

Nicodicodine

Norcodeine

Pholcodine

Propiram

The isomers, unless specifically excepted, of the drugs in this Part whenever the existence of such isomers is possible within the specific chemical designation;

The salts of the drugs listed in this Part, including the salts of the isomers as provided above whenever the existence of such salts is possible.

*As amended by PU (A) 69/81.*

## PART V*

## PREPARATION FOR THE EXPORT OF WHICH EXPORT AUTHORIZATIONS ARE NOT REQUIRED

1. *(Deleted)*.

2. Preparations of cocaine containing not more than 0.1 per cent of cocaine calculated as cocaine base and preparations of opium or morphine containing not more than 0.2 per cent of morphine calculated as anhydrous morphine base and compounded with one or more other ingredients and in such a way that the drug cannot be recovered by readily applicable means or in a yield which could constitute a risk to public health.

3. Preparations of diphenoxylate containing, per dosage unit, not more than 2.5 milligrammes of diphenoxylate calculated as base and a quantity of atropine sulphate equivalent to at least 1 per cent of the dose of diphenoxylate.

4. Pulvis ipecacuanhae et opil compositus

    10 per cent opium in powder

    10 per cent ipecacuanhae root, in powder

    well mixed with 80 per cent of any other powdered ingredient containing no drug.

4A. Preparations of difenoxin containing, per dosage unit, not more than 0.5 milligrammes of difenoxin and a quantity of atropine sulphate equivalent to at least 5 per cent of the dose of difenoxin.

4B. Preparations for oral use containing not more than 150 milligrammes of dextropropoxyphene salts per dosage unit or with a concentration of not more than 2.5 per cent in undivided preparations.

5. Preparations conforming to any of the formulae listed in this Part and mixtures of such preparations with any material which contains no drug.

**As amended by PU (A) 164/74, 233/74, 242/81, 151/2001.*