

# **Drug Rehabilitation and Practice Dilemmas in the Maldives**

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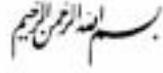
## **Abstract**

Substance misuse is a global phenomenon. However, little is known about substance misuse issues in Islamic nations or about the provision of preventative and rehabilitative services in such nations. This thesis explores the legal context of such services in the Maldives and pays particular attention to tensions between the formal policies of the National Narcotics Control Bureau and clinical practice. Findings are drawn from a review of government and service policy documents, five semi-structured individual interviews with clinical practitioners and senior administrative staff from rehabilitative services, and a three day focus group workshop with clinical staff. Findings show the lack of awareness of the legal and policy contexts for service provision and the ways in which existing policy frameworks often detract from the forging of therapeutic alliances. The primary concern raised by the analysis is the lack of involvement of clinical staff in policy formation and revision. This contributes to series of tensions and contradictions between official aims for services and the actual provision of these services. Further a range of ethical issues arose as a result of inadequate professional monitoring, training, and peer review. Recommendations are made regarding how these issues should be addressed in order to enhance the Maldivian response to increasing substance misuse.

## **Dedication**

*This thesis is dedicated to the loving memory of my father,  
Who taught me to believe in myself...  
And to my mom, who has and is always there for me.*

## Acknowledgement



*“In the name of Allah, the most Merciful, the most Beneficent”*

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# CHAPTER ONE

## Introduction

The misuse of drugs is a problem faced by many countries throughout the world (Mackie, Healy, Roberts & Ryder, 2004). Illicit drug use has serious effects on individuals and countries worldwide. On an individual level it affects people's health and livelihood, while on a national level it affects economies (UNODC, 2004). Substance abuse problems directly affect approximately 200 million people globally (UNODC, 2005). Countries in the South Asian Region have not been immune to this global phenomenon. Substance abuse<sup>1</sup> was first reported from Nepal in 1976, Sri Lanka in 1981, India 1986 and Maldives in the mid 1970's (UNDCP, 2000). Since then rates of substance abuse have been increasing in the region (Kumar & Ray, 2002). Some of the approaches taken by these countries to combat the substance (ab)use 'problem', vary from harm minimization to prohibition to partial or administrative decriminalization (Mackie, Healy, Roberts & Ryder, 2004). Specifically, I investigate the policies of the National Narcotics Control Bureau, the main organisation that is responsible for providing services to substance abusers in the Maldives, and how these policies relate to psychological interventions in practice.

This is an important focus because the Maldives is strategically located near the 'Golden Crescent'<sup>2</sup> and the 'Golden Triangle'<sup>3</sup>. Tourists travel to and from the Maldives daily, opening the country to the rest of the world as a base point for illegal shipments of precursor chemicals or large quantities of drugs meant for other countries (FASHAN & NCB, 2003). Recent reports indicate that there has

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<sup>1</sup> The term 'substance abuse' is used in this thesis to mean all the substances of abuse excluding Alcohol (this is the general method of reference in the Maldives).

<sup>2</sup> The Golden Crescent is the name given to Asia's principle area of illicit opium production, located at the crossroads of Central, South, and Western Asia. This space overlaps three nations, Afghanistan, Iran, and Pakistan, whose mountainous peripheries define the crescent. The Golden Crescent has a much longer history than Southeast Asia's Golden Triangle (Pierre-Arnaud Chouvy, 2002).

<sup>3</sup> The Golden Triangle is one of Asia's two main illicit opium-producing areas. It overlaps the mountains of three countries of mainland Southeast Asia: Burma (Myanmar), Laos and Thailand (Pierre-Arnaud Chouvy, 2002).

been an increase in a variety of substance abuse among the young Maldivians, the most prevalent being heroin (NCB, 2002; FASHAN & NCB, 2003).

Research, such as this thesis, that is designed to inform responses to increasing rates of substance misuse in the Maldives needs to take into account the importance of understanding the legal and policy frameworks and the religious/cultural context. In doing so, the present study reflects community psychology as a context sensitive sub-discipline that attempts to engage with societal concerns by looking at the wider socio-political context and how that affects local events (Foster-Fishman, Nowell, Deacon, Nievar & McCann, 2005). Heinrich & Fournier (2005) emphasise the importance of policy research in shaping and improving treatment practices and outcomes for clients. These authors stress the importance of researchers and policy makers continuing to invest in and support research that promotes a fuller understanding of policy and programme effects on treatment practices. In addition they state that research will not only advance the research-to-practice movement, but will also likely improve substance abuse treatment policy and programme administration for a diverse range of clients. This chapter covers the relevant international policy context and the local setting for addressing substance misuse in the Maldives. Specifically, it outlines international policy frameworks, the influence of the local religious and cultural setting in favouring a specific policy framework, and the organisational structure of the Maldivian National Narcotics Control Bureau (NNCB), its programmes, and underlying legislation and policies.

### **Punitive Verses Harm Reduction Responses to Substance Misuse**

Three major pieces of United Nations (UN) legislation have served as the bedrocks of modern drug policy in the international arena. The first of these was the 1961 Single Convention on Narcotic Drugs, which provided controls over opiates, cannabis, and cocaine and consolidated the administrative apparatus that had existed earlier in a variety of bodies designated by the UN (UN, 1961). The second was the 1971 Convention on Psychotropic Substances, an agreement that provided controls over manufactured drugs that had not been subject to the 1961 legislation, including barbiturates, stimulants, and hallucinogenic substances

(UN, 1971). Finally, the 1988 Convention Against Illegal Traffic in Narcotics Drugs and Psychotropic Substances provided criminal penalties for many acts that had not been considered criminal before, including consumption and possession of small amounts of named substances (UN 1988). These three conventions promote the idea that the combination of repression and prevention can eventually lead to drug free societies (Bullington, Böllinger, & Shelley, 2004). In addition to the three UN conventions, there have been several other changes in the international community's approach to regulation and control of psychoactive substances. For example, in 1972 the United States required a protocol to strengthen the provisions of the Single Convention (Bullington, 2004, 1995). The use of prohibitionist language and provisions was the result of the United States effort to bring all nations under the same control agenda (Bullington, 2004; Körner, 2004).

Evidence presented by Bullington (2004) suggested that the United States and its prohibition allies in the United Nations have effectively created and sustained a worldwide system of controls that features a strong emphasis on policies that deal with supply-side issues (production, distribution, and sales) and a much weaker commitment to demand-side features (prevention, treatment and education). Furthermore, Bullington (2004) states that the entire model was built upon the assumption that the criminal justice approach was both necessary and beneficial in combating the various harm that drugs can visit upon societies. It is worth noting that there has been significant debate regarding the success of prohibition-based policies and programmes (Bullington, 2004; Bullington et al., 2004; Jelsma, 2003 and Marshall & van de Bunt, 2001). Critiques argue that prohibition tends to take an unrealistic approach to drug issues by assuming that drug use can be eliminated through criminalisation and punitive actions.

This early commitment to prohibitionist goals remains intact today, although some nations are more tolerant of drug use than others. For example, the Netherlands made the decision to relax the enforcement of the criminal statutes against small scale cannabis sales and consumption. The German constitution guarantees that no person will be prosecuted for harming themselves (Bullington, 2004; Körner, 2004). Even within the United States there is considerable debate

about the appropriateness of current national drug policies (Bullington et al., 2004). For example, despite the protests from the federal government, twelve states effectively decriminalised cannabis during the 1970's (MacCoun & Reuter, 2001). These examples reflect how, despite the broad-based adherence to prohibition, individual states have considerable room to manoeuvre with regard to their own internal policies (Bullington et al., 2004). Krajewski (2004) and Záborský (2004) mentioned that, the previously communist countries such as Poland and the Czech Republic are under considerable pressure from the United States and other political bodies to commit themselves to the existing United Nations protocols (meaning prohibition).

Prohibition policies are subject to sustained criticisms from several quarters, including public health advocates and libertarians. Critics have noted that, despite its long-term appeal, prohibition has failed to accomplish its core objectives of eradicating substance misuse or trafficking. Given the length of time prohibition has been in force, no one can claim it is for a lack of trying (Bullington et al., 2004). Due to the failure of prohibition in countries such as Sweden there is growing acceptance of harm reduction measures in the Swedish Policy (Goldberg, 2004). Krajewski (2004) reflects on prohibition and highlights the benefit of entering the new phase of harm reduction or harm minimization, such as public health approaches that have existed for some time. However, the introduction of these has been blocked by prohibition enthusiasts who feel that these methods 'coddle' users and serve as dangerous social experiments that can easily lead to the ultimate disaster - the legalization of all substances.

The definition of harm minimisation continues to cause some debate (Boekhout van Solinge, 1999). However, it is generally accepted that harm reduction/harm minimisation is a conceptual framework that provides for individuals willing to be engaged in services to help them address their substance misuse issues, while not immediately seeking abstinence (MacMaster, 2004). This is a welfare-based approach that acknowledges that drug use is a complex aspect of the human condition and as such will not be completely eliminated. Harm minimisation initiatives do not apply a one-size-fits-all approach to either the populations using drugs or the substance being used. It allows for the development of multi-levelled

initiatives and activities (Green 2002). As such, depending on the definition of harm, harm minimisation could include a very broad spectrum of supply control initiatives and demand reduction and treatment practices. Being able to tailor harm minimisation strategies to the needs of different groups with different degrees of involvement in drug use, and groups with different risk factors, has been identified as an area requiring further debate (Stockwell, 1999).

For some time, harm reduction has informed substance abuse policies in several Western European countries, including the Netherlands, Switzerland and Germany (Macmaster, 2004; Marshall & van de Bunt, 2001; United Nations International Drug Control Program, 1997). During the early 1990's, several Western European countries began adopting harm reduction policies as their preferred method of dealing with drug-related issues. With the (re)establishment of Czech's cultural ties to the Western European region, innovative treatments and harm reduction measures were introduced relatively smoothly compared with some other Central and Eastern European Countries (CEECs) (Zábranský, 2004). This transition was facilitated by the activities of international sponsors such as the World Health Organisation (WHO), United Nations Drug Control Program (UNDCP), the European Council etc., all of whom have supported the development of a wide range of drug prevention and rehabilitative services (Hartnoll, 2003, Zábranský, 2002). It has been argued that the relatively early provision of harm reduction services available in the Czech Republic explains the success of the Czechs in minimising the importance of drug use on the local population (Zábranský, 2004).

It is clear that although current UN conventions do not leave any room for decriminalization by participating nations, there is sufficient room for differentiated national policies when it comes to the reaction towards the possession, purchase, cultivation of illicit drugs for personal use. Furthermore, it is quite clear that UN conventions (1961 & 1988) do leave room for depenalisation in member states (Ruyver, Vermeulen, Beken, Laenen, & Geenens, 2002). At this point it is timely to consider some of the complexities of substance misuse and national responses in the Maldives, an Islamic nation with religious leanings towards prohibition. The following sections document the drug situation

in the Maldives in more detail, outline current legislation, and describe the national drug institution, its policies and service provisions.

### **Drug use in the Maldives**

In order to develop effective responses to substance misuse in countries like the Maldives, it is extremely important to understand the legal and policy frameworks. Service responses to substance misuse cannot be interpreted without examining the local and political context, culture and religious practices as well as the international context for the setting of these legal and policy frameworks.

The Maldives is a small archipelago of 1192 coral islands located in the Indian Ocean, covering a geographical area of more than 90,000 square kilometres, of which the land area is only 300 square kilometres. The chain of coral islands is grouped into 26 natural atolls. However, for easy administration the country is divided into 20 atolls. Among the islands, 202 are inhabited by a total population of 270,101 people (NNCB, 2004).

According to legend, Maldives was converted to Islam by Abul Barakat Yoosuf Al Barbary, a Muslim from Morocco. Al Barbary was a Hafiz (a person who could recite the entire Qur'an from memory). After much effort he, succeeded in converting Maldivians to Islam in 1153AD. After the people embraced the Islamic faith, the Buddhist temples and idols were destroyed and Islamic customs adopted (Republic of Maldives, 1999). This conversion is directly relevant to the present research because Islam is not only a belief system; it also a way of life that unifies both the materialistic and the metaphysical (David, 2005). Shari'a (*law*) dictates the civil laws and societal norms. The Qur'an is understood to be the Word of Allah, revealed to the Prophet Mohammed, the Messenger of Allah. The Qur'an is the primary source of Shari'a (Renard, 1998). Intoxicants are forbidden in the Qur'an through several separate verses revealed at different times over a period of

years that constitute four steps towards prohibition (Syed, 2006). The first step of Qur'anic revelation regarding prohibition of wine<sup>1</sup> was:

*And from the fruits of date-palms and grapes, you derive wholesome drink or strong drink and also good nourishment (as food), (is healing for mankind). Behold, Verily in this also is a Sign for those who are wise (or who understand or who have sense or who ponder) Qur'an (16: 67)*

In this verse, a distinction was made between strong drink (which was not necessarily prohibited) and good nourishments. The verse also refers to the good judgement and rational sense of people to be able to make a decision between what was harmful and useful. This early message acted as an eye opener for staunch believers (Baasher, 1981) and set the stage for the second step/revelation,

*They ask thee concerning wine and gambling. Say: "In them is great sin, and some profit, for men; but the sin is greater than the profit." They ask thee how much they are to spend; Say: "What is beyond your needs." Thus doth Allah make clear to you His Signs; in order that ye may consider. Qur'an (a) (2:219)*

This second revelation or second step stated that, the consumption of wine was more of a sin than beneficial. However, at this stage, the consumption of intoxicants was left as a personal choice, while emphasis was placed on creating general awareness of the harmful affects of intoxicants (Baasher, 1981). This prepared the way for the third step, which was partial prohibition.

*O ye who believe! Approach not prayers with a mind befogged, until ye can understand all that ye say, ... Qur'an (b) (4:43)*

Compulsory prayers are performed five times a day (dawn, noon, afternoon, sunset and early evening). Traditional wine drinking had to be given up or reduced in order to stay sober and observe the prayers. The next step led to prohibition,

*O ye who believe! Intoxicants and gambling, (dedication of) stones, and (divination by) arrows, are an abomination,- of Satan's handwork: eschew such (abomination), that ye may prosper.*

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<sup>1</sup> At the time of the revelation of the Qur'an, wine was the only substance that was used with an addictive quality. (Syed, 2006).

*Satan's plan is (but) to excite enmity and hatred between you, with intoxicants and gambling, and hinder you from the remembrance of Allah, and from prayer: will ye not then abstain? Qur'an (c) (5:90 & 91)*

These verses confirmed that the social and religious harmful consequences of using intoxicants and called on believers to abstain. It is also important to note that, in Islam, the person who drinks alcohol (or consumes other intoxicants) is not distinguished from the person who carries it, who brews it, who sells it and who buys it: all fit into the same category (Baasher, 1981). Hence the religion prohibits not only the consumption of alcohol, but all related activities as well. In Islamic law, general acts of punishment were revealed in the Qur'an or indicated by the prophet was called a *hadd* and others are known as *ta'azeer* (acts of punishment). At the time of the prophet, punishment for alcoholics ranged from reprimanding, group scolding to lashing with palm branches (not exceeding 40 lashes). During the caliphate of Abu Bakr, the number of lashes (40) was applied to the rule of *hadd*. The was later increased to 80, by the second Caliph Omar, because of an increase in alcohol-related problems and the seriousness of these problems (Baasher, 1981). Shari'a has clearly stipulated that whatever constitutes a dependence producing drug, and which, therefore, should be regarded as harmful, should not be consumed by any Muslim. Islamic scholars have primarily formulated the definition of a narcotic substance on the original concept of wine which is defined as any substances which causes the mind to cloud and interferes with rational thinking.

As an Islamic nation, the Maldives adheres to most of the Islamic laws, whilst remaining unique and not necessarily reflecting the views of other Islamic nations. The modern Maldives is still rapidly changing to fit into the international arena, through constant changes in policies and laws. According to Mariyam Adil formulating an effective local response to substance misuse requires one to keep in mind the Islamic context, as well as regional variations in attitudes and experiences in the country, while still adhering to the international conventions (personal communication, April 2004).

## **Drug Situation in the Maldives**

At present the Maldives has the Islamic model of prohibition in place; where the use of any narcotics drug is criminalised and penalised under the criminal code. To date, no research has been done to analyse the relevance of this policy and the law on narcotics to the services that are provided and/or how they are provided including the difficulties that are faced by the existence of these policies. A reason for this lack of research may be the scarcity of information on the extent of the problem of substance abuse, a lack of mental health and alcohol and drug professionals, and a lack of resources.

In collaboration with the United Nations Theme Group on HIV/AIDS, the Maldivian government conducted a large scale situation assessment on HIV/AIDS fairly early in the epidemic, (The World Bank, 2006). One of the findings was the importance of drug abuse related sexual-behaviour (FASHAN et al., 2003). As a result of this finding, the assistance of the United Nations Office on Drugs and Crime (UNODC) was sought in preparing a detailed assessment of the drug situation in the country. A preparatory mission visited Maldives in 1999 to prepare guidelines for a Rapid Situation Assessment. UNDP Maldives funded the Rapid Situation Assessment and the report was formally released in 2003 (personal communication, Aishath Ali Naaz<sup>1</sup>, July 2005). This report provided a window into the drug abuse scenario in the country. The government in collaboration with the Foundation for Advancement of Self Help in Attaining Needs conducted the Rapid Situation Assessment on drug abuse and is now in the process of developing a master plan to address the problem (NNCB, 2004). The country even made necessary amendments to the principal legislative act of the Maldives dealing with Narcotic drugs and Psychotropic Substances in 2001, such as allowing confidential interviewing with drug users to take place for the purpose of research (FASHAN et al., 2003). This RSA report provides the most current information on drug use in the Maldives.

The report included structured interviews from two hundred and sixty four drug users, over the age of 16 years with reported drug use in the previous six months.

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<sup>1</sup> *At the time of the communication, she was the Deputy Director of Counselling of NNCB and the only Clinical Psychologist in the country and the National Consultant for the RSA Report.*

Key Informant (KI) and Focus Group (FG) discussions were also held. Most informants felt that drug abuse was increasing in the Maldives. Opiates, mainly heroin, were the drug of initiation for 43% of respondents, followed by cannabis by 34%. Commonly abused drugs (currently) were opiates and cannabis. The use of alcohol, eau de cologne, inhalants, solvents, and sedative / hypnotics were also reported. About 8% reported injecting drug use and half of them had started injecting before the age of 17 years. The findings of the Rapid Situation Assessment highlight the urgent need for development of multi-pronged strategies in the prevention and treatment of drugs users (FASHAN et al., 2003). Adverse consequences of drug use were also reported in the Rapid Situation Assessment cited above, which revealed that 94% respondents had reported legal problems after drug use, 55% of the respondents had been under police lock-up in the previous year, 38% had been jailed and 17% has been jailed in the previous one year. One-third of the respondents in the Rapid Situation Assessment reported that they could get drugs within the prison. The report suggested that there are more than 800 drug users currently in prison. A lack of any therapeutic intervention means that very little is done to motivate drug users to quit their habit. The practice of banishing drug users to different islands was felt to be counter-productive by many key informants since this only displaced the problem from one region to another (FASHAN et al., 2003). Briefly, this research documented how drug abuse is widely established in the Maldives. The Rapid Situation Assessment study also highlighted that some of the currently existing strategies and practices were ineffective and could actually be adding to the problem.

The appearance of drug abuse in Maldives in its present form coincided with the development of tourism in the early 70's, which increased the exposure of Maldivians to the outside world, and, in particular, western cultural practices. Tourism is at the heart of modern Maldivian economy and has brought new ideas and customs to the country. Admittedly, there were stories of opium abuse in the early part of the last century. However, these tended to be extremely limited (NNCB, 2004). The effects of tourism on the wider population have been minimised because of the segregation of tourists from the normal population. This has been achieved by restricting resorts to otherwise uninhabited islands. When

tourists visit local inhabited islands, they are informed about the local culture, appropriate dress code and behaviour. The Maldives, being an Islamic society, has strict legislation pertaining to drug related crimes is but at the same time, the traditionalism of its value system is under pressure from many sources. The introduction of technology (e.g. cable television, the internet) has increased the rapid introduction of foreign cultures and values.

Despite stringent drug laws and intensive efforts to prevent drug entry by several agencies, there has been growing concern about the problem of drug abuse (NNCB, 2004). In 1993, the first case of heroin was detected. With the introduction of heroin, drug abuse, particularly among young people escalated dramatically. The first major seizure of cocaine was made in September 1993 at Malé International Airport when 8 kilograms was found concealed in the false bottoms of a suitcase in the possession of a foreign national. In 1997, three Maldivians were discovered to have orchestrated an attempt to smuggle in 1,372 grams of hashish oil in seven professionally packed cans of corned beef while they were about to board a flight to Malé from Trivandrum Airport. In 1998, over 450 arrests were made on drug abuse and related offences (NNCB, 2004).

The main substances abused by Maldivians are heroin, including the crude form of heroin known as “brown sugar”, and cannabis and its derivatives. Rare cases of cocaine abuse and the use of MDMA or Ecstasy pills have also been reported. Injecting drug use is uncommon. Based on reports by the Police Headquarters and information from the healthcare sector, the prevalence of heroin injecting is estimated to be 1% of the drug abusing population (NNCB, 2004, p.5). The rapid increase in drug abuse is of great concern to health and law enforcement authorities as the majority of the drug abusers in Maldives are young people between 16 and 30 years. For a small developing country where more than 50% of the population are below 16 years of age, this is indeed an alarming trend (NCB, 2001).

## **Maldivian Law and Policies on Drugs**

The Government of the Republic of Maldives has now ratified all three of the UN conventions related to narcotic drugs, namely, the Single Convention on Narcotics Drugs, 1961 as amended by the 1972 Protocol (UN, 1961), the United Nations Convention on Psychotropic Substances (UN, 1971) and the United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances (UN, 1988). The Maldives is also a signatory to the 1990 South Asian Association for Regional Cooperation Convention on Narcotic Drugs and Psychotropic Substances. Maldives is known to contribute to international initiatives in drug control regarding both control of supply and demand reduction. The Narcotics Control Board and relevant law enforcement agencies and NGOs have been involved in drug prevention, participated in various international forums since 1997 to date (NNCB, 2004).

Official recognition of the drug problem came in 1977 when a person was arrested with 350 grams of hashish. As a result, the first principal legislative act of the Maldives dealing with narcotic drugs and psychotropic substances (Law No 17/77 - The Law on Narcotic Drugs and Psychotropic Substances) was passed the same year in order to help the legal system deal with it, and to act as a deterrent. This is the principal legislation dealing with narcotics drugs and psychotropic substances. Since the adoption of the Law on Narcotics Drugs, the many social and economic changes in the country have resulted in an increase of the magnitude and nature of the problem. Hence, the Government in 1995 introduced substantial amendments to Law No. 17/77. The First Amendment to Law No. 17/77 contains two tables; one is a list of illegal drugs and the other is a list of controlled substances. Both of these tables have been drawn up according to the schedules of the Single Convention on Narcotic Drugs of 1961 (as amended by the 1972 Protocol) and United Nations Convention on Psychotropic Substances, 1971. This Amendment makes a significant distinction between users and suppliers. Drug suppliers have been prescribed harsh punishment; there is provision for imposing life imprisonment for the manufacture, importation, exportation, sale and possession for sale of narcotic drugs. Similarly, the amendment provides for imprisonment for up to 25 years for offences of trafficking of prohibited drugs by either, cultivation, manufacture, exportation,

importation, selling, buying, giving or possession for sale of one gram or more. On the other hand, for the offence of consumption of prohibited drugs under section 4 of the law, using or possession for personal use of less than one gram, the penalty is imprisonment, banishment or house arrest for a period between 5 and 12 years, or referral to rehabilitation. After rehabilitation, offenders are released on parole for a prescribed period after which the sentence is annulled. The amendment also provides legal immunity for those who opt for voluntary rehabilitation (NCB, unknown).

Under section 4 of the law, first-time drug offenders below 16 years of age, can have their sentences suspended for three years and be handed over to the National Narcotics Control Bureau. Based on the recommendation of the 'Committee for Identifying Substance Abusers that Fit Into The Criteria Of Requiring To Undergo Treatment By Law, and How Treatment Should Be Carried Out'<sup>1</sup> users are referred for rehabilitation. After the person completes the period of rehabilitation to the satisfaction of the Committee, and does not commit any further offence within these three years, the person's sentence can be deemed to be fully served and s/he 'released' from the treatment and rehabilitation of NNCB. However, if the person for any reason is unable to complete this period of rehabilitation successfully, s/he is then handed over to the Department of Corrections. Also, under the law on drugs, the person who uses drugs can make self-refer to the rehabilitation assessment committee of NNCB and request treatment. The committee decides on treatment and checks whether the person has other pending legal sentences for banishment, house arrest or jail. Presence of a legal sentence prevents the person from opting for voluntary treatment.

At present, there are no clear national policies on substance abuse<sup>2</sup>. NNCB (2005) reports that a review of past practices indicated that an ad hoc, fragmented approach is in place regarding drug issues. The report states that greater coordination among concerned agencies was needed. Furthermore the report argues that evidence-based approach is needed in formulating policies, strategies

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<sup>1</sup> Hereafter referred to as the 'Committee'

<sup>2</sup> Alcohol is not included in the law on drugs. It is controlled under the law of Islamic Shari'a.

and actions. NNCB (2005) suggests that, the organization itself has to set up a mechanism to ensure greater coordination among concerned agencies as well as to strengthen data gathering, research and evaluation and inform dissemination capacities in order to enable planning and implementation of evidence-based practices.

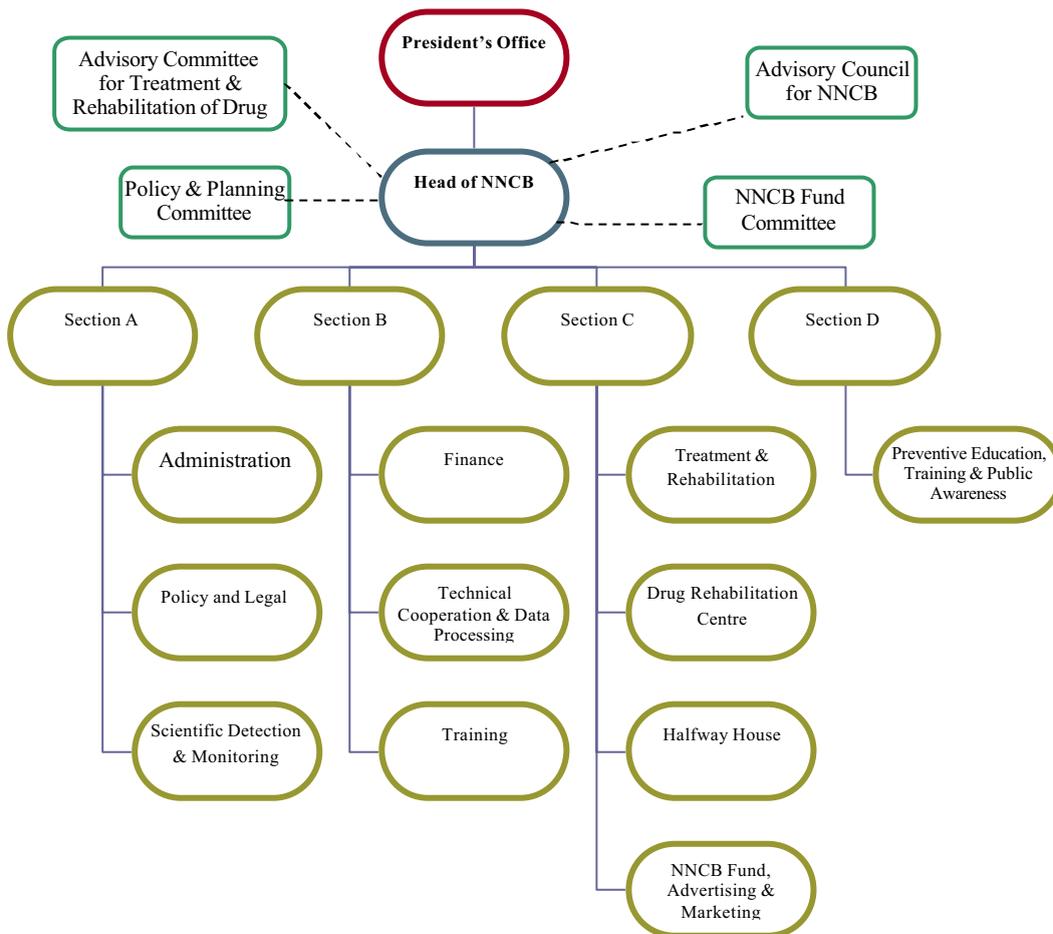
#### *Relevant Institutions and Services*

The Government of the Republic of Maldives has stated publicly its determination to bring about a reduction in the demand for and the supply of illicit drugs. This was reinforced with the establishment of the Narcotics Control Board (NCB) on the 16th November 1997. NCB is responsible for coordinating demand reduction efforts, management of rehabilitation programmes, and maintaining communication with national and international drug control and law enforcement agencies (NCB, 2001). Many workshops and training programmes have been carried out recently with the cooperation of various international agencies to increase awareness among government officials. Customs officials and operational staff from regional airports / seaports met in May 1999 to exchange information on trends of drug smuggling within the region (NNCB, 2004).

The establishment of the Narcotics Control Board through a Presidential Decree on the 16<sup>th</sup> November 1997 has strengthened the efforts aimed at addressing the issues of drug control. The Narcotics Control Board is primarily responsible for the co-ordination of demand-reduction and awareness building programmes, maintaining communication with international drug control agencies and management of rehabilitation programmes. Further amendments to the law in 1995 brought the management of the Drug Rehabilitation Centre, previously under Ministry of Health, directly under NCB. The Drug Control Bureau of the Police Headquarters, together with the Maldives Customs Service, are responsible for seizures of illicit drug in the country (NCB, 2004). The Ministry of Health plays an important role in demand reduction issues. The main policy-making body for the AIDS control programme is the National AIDS Council, a multi-sectorial body of government institutions and NGOs (Ministry of Health, 2002).

On 14 October 2004 The President's Office (2004) abolished the Narcotics Control Board and in its place was instigated a National Narcotics Control Bureau (NNCB). The National Campaign taskforce to Combat the Drug Problem was incorporated into the new NNCB. Although broadly divided into Sections A, B, C and D, NNCB generally functions in smaller units each having their own responsibilities

**Figure 1: Organization Chart of the NNCB**



Adapted from NCB (2004a) Narcotics Control Board. *Handbook*. Author.

The aims of the NNCB are to;<sup>1</sup> (1) create awareness among the people of the Maldives on the misuse of drugs/narcotics substances. These programmes are to be conducted in collaboration with other relevant agencies for the capital and other atolls. (2) Provide rehabilitation services for people who are abusing narcotic substances and be fully involved in integrating these people back to the

<sup>1</sup> This is a rough translation of a report issued by the President's Office on 14 October 2004.

community as useful citizens. (3) Liaise with international bodies to combat the drug problem. (4) Be involved in stopping the drug trafficking and sales into and within Maldives in coordination with other relevant government bodies and (5) be involved with the NGO's and other bodies and agencies that are working in this area, and provide assistance if and when required. Currently, there are 208 staff employed by the NNCB. Of these 43 are strictly clinical, including a psychiatrist, a clinical psychologist, a medical officer, programme coordinators, and counsellors. Programmes and services ranging from detoxification, residential rehabilitation, out patient and community rehabilitation to public awareness are supported by various administration staff. Given the current situation of the Maldives, the NNCB has declared its full commitment to providing multi-faceted programmes.

A detoxification centre was opened in February 2004. So far there are 135 clients and they are following treatment in the community. The government is in the process of expanding the services for more clients. To date, there is only one detoxification programme in existence in the country, which is run by the NNCB, with the help of the Ministry of Health and the Indhira Gandhi Memorial Hospital (IGMH<sup>1</sup>). Other illegal detoxification takes place quite frequently by the IGMH, other private clinics and hospitals. The law as yet does not provide for detoxification by other agencies.

The Drug Rehabilitation Centre<sup>2</sup> (DRC) was officially opened in 1997. Currently, a total of 70 males and 8 females are being given residential treatment for drug dependence. There are 76 clients in community rehabilitation. The clients are mostly referred from the court system but the number of voluntary clients has increased significantly. There has been an emphasis on promoting voluntary treatment. In both residential and non-residential treatment, the clients receive comprehensive drug education and psychotherapeutic intervention. Some of the therapeutic programmes included in the daily programmes are anger management, drug education, and problem solving skills and overcoming depression. In

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<sup>1</sup> *The main/major hospital in the Maldives situated in the capital Male'.*

<sup>2</sup> *The Drug Rehabilitation Centre is located on an inhabited island, about 10 kilometres from the capital, Male' and can currently accommodate about 120 clients (104 Males, 16 Females).*

addition, a structured daily physical exercise programme is implemented, and various educational and skills workshops are held regularly (NCB, 2004).

There are 12 outreach programmes established in 11 atolls in the country. These programmes are run in collaboration with the Ministry of Health and IGMH. NNCB coordinates the country's only rehabilitation programme, from the Drug Rehabilitation Centre. They follow the Therapeutic Community model of treatment. The programme's main aim is to motivate the inmates to help each other and promotes a family milieu concept with the help of written and unwritten philosophies. A scheduled programme in improving the spiritual awareness among the residents is also emphasized in this. Counsellors are trained from NISD/Sri Lanka, Daytop/USA, Pertapis Halfway House/Singapore, TTK/India and Pengasih/Malaysia (NCB, 2004).

A number of continuing Drug Awareness Programmes which are aimed at various sectors within the community are conducted or organized by the Narcotics Control Board. These include; an annual education programme that is conducted for parents of school children of below thirteen years in schools of Male' and other atolls; Life skill classes and drug awareness programmes for students of grade 8 and above in Male' and other atolls. The Atoll Awareness Programme aims to cover the entire Maldives within the next three years, with programmes conducted in every inhabited island in the country. These awareness programmes target atoll and island chiefs, healthcare workers, teachers and island committee chairpersons. Eleven atolls have so far been covered under this programme. Television and Radio advertisements about the dangers of drugs are routinely shown and information is available to the public by the NNCB.

Workshops and training programmes are being organised to ensure that necessary skills are given to officials of law enforcement authorities, counsellors and staff of NGOs. The development of youth counsellors for the atolls is also a major concern. The NNCB has also started a training course for counsellors to overcome shortage of staff in this area. In the area of tertiary prevention, the Narcotics Control Board is rehabilitating the affected individuals. There is a plan to upgrade the facilities at its halfway house. It should be noted that, even though

on paper, most of the programmes are integrated into each other, in practice there is only limited overlap from one programme to the other. The transition from the residential to the community setting is set up without a halfway house or a programme to facilitate the change.

In recent years, the substance abuse field has emphasised the importance of adopting evidence-based treatment as a means to improving both the quality and accountability of treatment (Grella, Hser, Teruya & Evans, 2005). Lamb, Greenlick and McCarty (1998) advocate the research-to-practice movement in drug and alcohol abuse treatment as a means to improving the effectiveness and efficiency of treatment. Some of the reasons suggested for the gap between research and practice in the area of substance use include (a) researchers' reliance on statistical significance versus clinical significance, (b) reliance on efficacy trials versus effectiveness studies, (c) lack of research training for clinicians, (d) a communication gap between researchers and clinicians, (e) time constraints that are primarily due to paperwork obligations, (f) supervisors' lack of training and experience, (g) lack of resources in treatment centres, and (h) lack of contact between researchers and clinicians (Campbell, Catlin, & Melchert, 2003; Lamb et al., 1998; Thompson, 2002). In the Maldives research findings have not been used within treatment programmes. NNCB (2005) acknowledges that the past experiences with demand reduction activities had documented the need for the development of new programmes in line with best practices followed in the region and worldwide. However, the lack of technical expertise available in the country was presenting a problem and priority was being focused on developing human resources. The need for ongoing research was also pointed out, in order to understand the changing patterns and trends of substance abuse and also assess the impact of the programmes being implemented so that evidence based programmes could be developed (NNCB, 2005).

#### *Specific NNCB Policies*

Policy is complex and dynamic, and the term embraces a range of different aspects (Keeley & Scoones, 1999:4). Carter (1994) suggests that official documents (policies) provide a valuable window into state processes. Documents

constitute artefacts containing insights into the surrounding nexus of underlying cultural classifications that gives life to the art of the state. Further, policy and policy making is conditioned and shaped by the political, social and economic *environment*, as well as historical factors and is not implemented solely by policy makers in government offices (Pasteur, 2001). A range of *institutions*, such as the legal system, and *organisations* such as NGOs or bureaucracies, mediate a messy relationship between policy and practice. This is the interface where policy and practitioners meet. One has to be aware of the fact that statements of policy intent can only be put into practice if they are translated into measures, such as laws, regulations, programmes or projects that facilitate implementation. Such measures may be put into place without referring to any specific policy statement. Conversely, policy statements can exist which are not supported by policy measures, which may mean that the government or ministry is not fully committed to the policy change (Shankland, 2000). This seems to be the case for the NNCB policies.

For this research it was initially hard to determine what exactly a policy was and which documents should be included. There was no single term for policy in the *Dhivehi* (language of the Maldives) terminology. The closest is ‘Gavaidhu’, a term loosely used for procedure, rules, conventions, protocol and procedures. In order to narrow down to the policy documents a decision was made to restrict the documents to the ‘*gavaidhu*’ of the organisation. This meant that, only the documents finalised by the NNCB and also the Committee as *gavaidhu/policy* were used. The distinction of official and unofficial policy made for the purpose of this research is that, only the documents finalised by the NNCB and the committee were regarded as official policy. The documents used as procedures, rules and general guidelines that has not been finalised by the NNCB as a *gavaidhu* is considered unofficial policy. These documents were usually used as measures of policy implementation rather than policy itself.

It is important to briefly review these policies because, in addition to influencing the way people construct themselves and others, policies can also become a ‘code’ of society (Shore & Wright, 1997). Prohibition is one of the core codes within the drug discourse in the Maldives. This code incorporates the conflict between our

desire for both individual autonomy and social cohesion (which requires submission to authority) as well as the related themes of chaos versus social order.

Policy 1: Committee Policy – (Policy On Treating Substance Abusers): The ‘Decision making committee on identifying the substance abusers who fit the legal criteria for treatment, (hereafter known as the ‘committee’) is the main body that governs the programmes of the NNCB and its clients. Policy 1 outlines the responsibilities of the committee. The Committee is charged with designating the type, manner, and location, and length of treatment for individuals. The Committee is also responsible for making decisions regarding the completion of treatment, or the failure to complete treatment, as well as penalties for client offences while in treatment. The Committee is authorized to hand over the client at any stage to the authorities and to terminate their rehabilitative period. This group is also responsible for monitoring and evaluation of the programmes run by NNCB. Each of the responsibilities stated above is accompanied by a brief guideline on how to make the decision. The guidelines and procedures in the policy are straightforward and easy to follow (see Appendix A).

Policy 2: Policy On Clients: This policy is divided into two sections under the headings of, ‘clients in the Drug Rehabilitation Centre’ (DRC) and ‘Clients in the Community Rehabilitation Programme’ (CRP). The main components in both these policies revolve around specifying client behaviour while in programme, the consequences of not attending programmes, abusing drugs or smoking cigarettes. In addition the policy for the CRP clients include guidelines for behaviour regarding work attendance, getting married, family visits, partaking in community activities, and not evading NNCB and its supervisors. All these specific sections concentrate on the consequences that the clients will have to face, and stresses the importance of getting permission for any of the above activities prior to getting involved. There is no mention of client rights in these policy statements (see Appendix B).

Policy 3: Policy On House Arrest Clients: This policy focuses on the clients that are waiting to go to DRC, often for extended periods extends from less than a month to more than a year. The components of this policy include, provisions for

going outside their house, approved places and times, pre-approved parents or guardians that clients are allowed to go out with, use and abuse of medication and drugs, attending programmes at NNCB, working to earn a living, and positive urine tests. While under house arrest, clients are not allowed to go outside the house other than to pray to the nearest mosque within a specified time frame, attend special prayers. In case of a medical emergency the client is allowed to go to a medical facility accompanied by a pre-approved guardian without notifying NNCB if it is after hours. If the client needs to work due to financial status, permission is granted if the place of work is registered; the job offered does not require the client to go into the community and can be done within the premises of the workplace. During the course of the job, if the client is required to venture into the community or to a nearby island, prior permission is required from NNCB. The consequences of breaking any of the rules in this policy or getting a positive urine results in the client being transferred to jail for the awaiting period (see Appendix C).

Policy 4: Policy on Client Behaviour Maintenance the Rehabilitation Centre:

The main aim of the introduction of this policy is to make clients undergoing their rehabilitation treatment in DRC more acceptable to society and to make them worthy of respect by the community and the society. The objectives of the policy were stated as teaching the clients to possess the determination and aim to lead a drug free life; respect and perform the obligatory requirements of the religion; exhibit good conduct and attitude; be on time; love parents and relatives; do at least two types of skill and handiwork and become a healthy individual. The tools for achieving the above objectives were stated as; obeying orders/rules, performing the compulsory religious obligations, not smoking tobacco, personal hygiene and general cleanliness, conduct and attitude, use of the centre /facilities/belongings, restriction on things that could be brought into the centre, access to medical treatment, writing letters and communication outside the facility, family visits, phone calls, and urine tests. These tools appear to have little connection with the stated objectives. These tools enforce a rule, or prohibit an action. The prohibition of a behaviour or action doesn't necessarily teach obedience. For example, phone calls to the family were allowed only once a week and that is only if the client maintained good behaviour without any mishap for

that whole week. A family visit is not allowed if certain conditions are not met. Permission depends on an assessment for the client's progress. But the criteria for this progress are open to interpretation. Being penalised with family visits contradicts the objective of learning to 'love parents and relatives'. This is just one example of theory not being followed in practice (See Appendix D).

Policy 5: Policy On Clients Sent For Community Rehabilitation: This policy dictates the conduct of the people undergoing community rehabilitation programme. The CRP is where the clients are treated while they live with their families and are exposed to the community. Whilst, in this programme, clients are expected to conduct themselves to the best of their abilities with the aim of getting the best results. This policy overlaps with the policy on clients, and deals with the same subject matter. This policy also states that the inability to adhere to the policy would be considered as a refusal to complete treatment and the proper action would be taken against the client (See Appendix E).

Policy 6: Policy Regarding People Who Wish To Undergo Drug Rehabilitation Programmes Overseas: This policy describes the procedure for obtaining permission to get treatment from overseas countries. The NNCB grants permission if certain criteria and conditions are met, both from the client who is requesting permission and the centre the client wants to go to. The people who are granted permission are limited to clients who are already in the DRC or to clients who are already in CRP. This excludes clients who had disregarded the notices of NNCB, already had a positive urine test result, had been or have to be referred to the Committee or refused counselling at any stage. After getting treatment from a centre overseas, the client is supposed to submit all the documents regarding the client's treatment from that centre. After reviewing these documents, the NNCB rules on whether the client has completed treatment as stipulated under law 17/77 or not. The policy also covers non completion of treatment; clients not returning back and the period given for treatment in these cases (see Appendix F).

In summary, the above mentioned policies, predominantly focuses on prohibiting action or behaviours. They prescribe punishments or consequences for breaking rules. Some of these policies contradict each other, while others lack internal

consistency. For example, the policy designating the committee's responsibility states that this body is supposed to make all decisions regarding all matters relating to the clients of NNCB. However, the policy on clients (see appendix B) states that, clients are to be referred to the Ministry of Defence for investigations. While clause 10 of the same policy states that, if the client gets intoxicated on the premises of DRC then the client be referred to the committee.

### **The Present Study**

The primary aim of this thesis is to show that there are inconsistencies in the approach prescribed by the law and the policies to address drug misuse and service provisions in the Maldives. The thesis will examine whether there is a need for change in the legislature and the policy relating to the drug misuse and as a result reformulate service provisions and professional practice guidelines. Clearly it would be too much for one thesis to explore all the policies of all the relevant organisations. Therefore, the thesis concentrated on the policies of NNCB, which is the main organisation responsible for substance abuse service provision in the Maldives. Despite the somewhat restricted focus, this thesis makes a novel contribution to academic and professional knowledge of links between legislation, policies and practice in a Muslim nation state. To date there is a limited literature on these issues even in Western countries such as the United States. This has created some dilemmas in that the research had to draw together material from a range of fields in order to address this gap in the rehabilitative psychology literature.

The substance abuse treatment field has long been characterised by inconsistencies, eccentric practices based on individual experiences, instinct, different styles of communicating and or on myth. The gap between the treatment approaches or practices that research has shown to be effective and what is actually done or practiced in substance abuse treatment programmes or agencies is enormous (SAMHSA, 2003). Lamb et al (1998) and Campbell et al (2003) called for connecting practice to research as highlighted previously. One scientist estimated that 19% of medical practice was based on science and the rest on "soft-science" or opinions, clinical experience, or "tradition." It is likely that even less

of substance abuse practice is based on science, given the state of the art of substance abuse research and practice (SAMHSA, 2003). Evidence-based practice basically means that service providers have an opportunity to improve services and at the same time make these treatment programmes efficient and cost effective (Institute of Medicine, 1998). The assumption made here is that, what is proposed by evidence-based practice will actually work. The need exists for practitioner since; they need to know what the most appropriate care is; need for scientific research and findings; adhere to standardized practice and keep up with the changes in technology (ATTC, 2003). Governments, hence the policy makers and funding agencies have started putting a greater emphasis on outcome improvement and accountability, this is indicative of the need for practitioners to incorporate evidence based practice and increase their awareness. Another important need is that client retention is tied to positive outcomes, if based on evidence based practice; practitioners may be able to engage client in treatment for longer (ATTC, 2003a).

To be both evidence based and useful, policy must balance the strengths and limitations of all relevant research evidence with practical realities of the clinical settings (Gray, Haynes, Sackett, Cook & Guyatt, 1997). This is seen as problematic because of limitation in both the evidence that is available and in the policy making. Even though clinical practice guidelines help practitioners, the expertise, resources and effort required to ensure that they are scientifically sound as well as clinically helpful are often lacking (Haynes & Haines, 1998). National healthcare policies are formed by a range of non-evidence based factors including historical, cultural and ideological influences. Furthermore, when these policies encourage practitioners to perform procedures that are not evidence-based, the unnecessary work acts as a barrier to the implementation evidence based practice (Haynes & Haines, 1998). Evidence can be used by individual practitioners to make policies, but few practitioners have the time and skill to derive policies from research evidence. The difficulties in developing sound policies are perhaps the greatest barrier to the implementation of research findings (Haynes & Haines, 1998). The next step is applying evidence based policy at the right time, right place and right way. Barriers exist at the local and individual level. The lack of training; complexity of guidelines/policies; organisational barriers to change; lack

of continuing education; lack of interventions to improve quality among practitioners have been identified as some barriers (Grilli, & Lomas, 1994). In the Maldives this lack of skills and evidence based practice becomes transparent in the policy formulation process due to lack of trained professionals and lack of evidence based resources and research. As a result, the policies do not reflect evidence based practice and creates a barrier to practitioners who try to implement evidence based programmes.

A serious of ethical tensions arise from current Maldivian drug legislation, which classifies drug taking behaviour as a criminal offence and hence punishable by incarceration. A person, who is not currently registered with the NNCB as a client does not get the privilege of confidentiality, and in fact, people, including counsellors, doctors and other clinical people, are supposed to report to the authorities, people who abuse drugs or face criminal charges themselves. This would likely cause conflict between professional ethics and practices and legal obligations. Another issue of concern is that, once a person volunteers for rehabilitation and registers him or herself as a client of NNCB, he or she will be given legal immunity as long as he or she stays on the programme without relapsing. If the client relapses, then s/he would be sentenced without any further chances at rehabilitation and s/he would have a permanent police record. Hence, people are reluctant to seek treatment unless they are caught using drugs. This would likely create conflicts of interest. The service providers want more people to be motivated and volunteer for treatment, since motivation counts a lot towards a successful treatment (Böllinger, 2004), but conflicts arise when service providers have to report to the authorities when these clients relapse or gets a positive in the random urine test. The trustworthiness of the counsellors and the clinical staff as a whole is undermined. The only non-governmental organisation (NGO) operating in the field of addiction and treatment, are required to report the names of their clients to the authorities for their records. The validity of this claim is not known. But if this is the case, this is a serious issue to be concerned about charging the clinical staff with performing the dual functions of treatment and control increases the possibility of treatment failure (Böllinger, 2004).

Coercion is promoted in policy as necessary in order to initiate the process of treatment. In many cases clients are seen as being compliant with such coercion. Böllinger (2002) argues that this compliancy may simply represent a rather preliminary tactical and realistic adaptation to the situation, and have no realistic adaptation to the situation and therefore have no real behavioural post release implications. The ultimate goal for rehabilitation should be to regain and retain the highest possible level of autonomy in order to maximize participation. Thus, Cardol, De Jong & Ward (2002) suggest that respect for autonomy and the process of enabling it should be built into the definition of rehabilitation. In controversial cases of serious violent crimes, coerced treatments may well be legitimate. However, such coercion does not seem to be appropriate with regard to substance abuse, which is as much an illness as a crime (Böllinger, 2004).

A code of ethics is the identifier that most directly defines a profession for its stakeholders (Tarvydas & Cottone, 2000). This code and the processes used to enforce it, serves as a manifesto for how the members of the profession defines appropriate practice. Currently NNCB does not have a professional body to regulate practice. As a result there is no code of ethics or peer supervision processes to monitor practice and ensure standards. There is an urgent need to review this lack of a code of ethics, in view of the recent increase in the service provision in the country and the associated problems of ethics. This thesis will explore a range of ethical dilemmas faced by practitioners due to limitations in policy and the lack of ethical guidelines.

### **The Researcher, the Service and Policy Development Process**

The amendment of the law 17/77, law on narcotics and psychotropic substances, in 1995 required people to be trained to provide treatment services to substance abusers. In 1996, five people, including the researcher, were trained as counsellors by the Ministry of Health. This job included setting up the first ever drug rehabilitation service in the Maldives. This was a challenging undertaking given that most of the counsellors were fresh out of school, equipped only with a certificate in counselling from Sri Lanka and no relevant experience. The Drug Rehabilitation Centre was initially set up within a secluded corner of the jail.

Within eight months, the mini-rehabilitation centre was moved out of the jail-setting into the new building where it stands now. With this move, the President's Office created a new organisation called the Narcotics Control Board and shifted the treatment centre and the counsellors to this newly created organisation. Two counsellors, including the researcher, were sent to Malaysia and India for further training. Upon their return, they were expected to expand the services to include awareness programmes within Male' (the capital city), and in the surrounding islands. These included education programmes like life skills, both in the school setting and outside.

A larger number of counsellors were then trained to cope with increased client numbers. The researcher was awarded a scholarship to New Zealand to do a bachelor's degree in psychology. Upon her return she was expected to provide supervision to the new counsellors, deal with difficult clients, help establish new programmes and manage the community rehabilitation programme while providing inputs, supervision and feedback to the drug rehabilitation centre. During that year (2003), it was increasingly difficult to provide the supervision and expertise that the counsellors needed. This was due to the lack of time, knowledge and experience. After a year of trying to juggle everything the researcher decided to undertake further studies and research possibilities for refining service provisions. Issues surrounding the tenuous nature of links between policies and the work counsellors actually do became a core concern. The researcher had always tried to instil a strong code of ethics in the new counsellors that were being trained, but kept getting overruled by senior staff on several issues of misconduct. The need to address such tensions emerging from the gulf between policy and practice become increasingly apparent.

### **Objectives**

The aim of this study is to investigate the policies of the National Narcotics Control Bureau (NNCB), and how these policies relate to psychological interventions in practice. The study is focused on investigating the difficulties faced by clinical staff on the National Narcotics Control Bureau as a result of the existing policies and the Law on Narcotics (17/77). The investigation progressed

through an engagement with practitioner's perspectives on the adequacy of services these staff members were involved in providing, and the restrictions practitioners and managers identified.

The next chapter outlines the information gathering process and methods. It reviews the general approach of the research including interviews, focus group and the document collection; data analysis and addresses the issues raised during the research. Chapter three presents the findings. The main themes that emerged from the findings are; policy awareness, relevance and feasibility; the rights of staff and clients; committee responsibilities, membership, meetings and ethics and NNCB and accountability and power. These themes are discussed with relevance to practitioners and wider implications of these findings are looked at. The final chapter discusses key findings in more detail with a view to recommendations for improving policies and drug rehabilitation services in the Maldives. This chapter also looks at the therapeutic alliance and best practices and suggests the 'Four Pillar Strategy' as an alternative approach.

## CHAPTER TWO

### Method

#### General Approach

This research utilizes a mixed methodology consisting of a review of policy documents, focus group discussions and semi-structured interviews. The integrated qualitative method was employed because it provided access to practitioner perspectives (Bouma, 2000), and offers empirically-based insights into the interpretations and meanings practitioners give to events they experience (Patton, 1999; Rudestam & Newton, 1992). This strategy also responds to the ethical issues that arise in research regarding relationships between researchers and health professionals and the need for rapport with the participants (Flick, 2006).

Ethnographic content analysis (ECA) refers to an integrated method, procedure, and technique for locating, identifying, retrieving, and analyzing documents for their relevance, significance, and meaning (Altheide, 1996). A rationale for an ECA is that, sampling procedures are informed by theory while constant comparison and discovery are used to delineate specific categories as well as narrative description. Situations, settings, styles, images, meanings and nuances are key topics in the analysis of new documents (Altheide, 1987). This method was utilised for the reasons that the document analysis was partly done in the focus group and the individual interviews. The participants' perceptions about the documents were recorded and later utilised in the document analysis. The main themes were categorised and later discussed with the participants to reconfirm that the cultural context and the situational (work) context was properly portrayed in the analysis.

Focus groups are carefully planned discussions where the objective is to learn about the perceptions, feelings, attitudes, and ideas of participants regarding a given research topic (Cohen, 2000; Kahan, 2001). The group is relatively small (6-15 people) and conducted in a non-threatening and informal manner. The

identifying characteristic of a focus group is the interaction among the participants as the discussion follows the general outline structured by the moderator. The method is at first sight deceptively simple. It is a way of collecting qualitative data, which essentially involves engaging a small number of people in an informal group discussion, 'focused' around a particular topic (Wilkinson, 2004). Focus groups take advantage of an interactive group situation to provide in-depth information and allow the participants to reveal information they consider most relevant.

Individual interviews are among the most widely used methods of data generation in the social sciences (Gubrium and Holstein, 2002). Researchers generally agree that semi-structured interviews can elicit accounts of subjective experience. A semi-structured format was chosen because the researcher knew all the participants and had a previous working relationship with them. Semi-structured interviews provided the flexibility of asking open ended questions as well as the opportunity to vary questions and ask more spontaneous questions as the discussion developed. Although semi-structured interviews were used, background information and current news and recent changes in NNCB were researched prior to sitting down with the participant. This preparation was needed since, semi-structured interviewing meant that the researcher had to be aware of the issues and be ready to improvise on the spot (Wengraf, 2001).

### **Conducting the Research**

In Mid 2004 an e-mail was sent to the NNCB expressing my interest in undertaking research in substance abuse. The expression of interest was very general and included an interest in evaluation of the current method of Therapeutic Community utilised by the Drug Rehabilitation Centre. An e-mail was received from the NNCB confirming their interest in the research and further discussion via email revealed that a more beneficial research would be something relating to institutional contexts for service delivery. During a visit to the Maldives in April 2005, the researcher met with the chairperson of the NNCB. An opportunity emerged to explain the current research topic and ask for assistance and permission to use the resources of NNCB such as the hall/group therapy rooms in *Greenge* (place where the community rehabilitation services is provided,

and the workplace of most of the counsellors) to conduct the focus group, white boards and other related resources like photocopying and so on. Permission was granted to use these resources to conduct the research. Full co-operation was promised on the behalf of the NNCB.

### **Documentation**

Documents were requested from the NNCB in December 2004. An email was sent to the organization expressing interest in the area and asking for assistance in obtaining policy documents that were relevant to the study. NNCB sent policy documents that they thought would be useful, recent research reports, and manuscripts outlining programmes. The documents used in this research are the law on narcotics and psychotropic substances, the internal policies of the NNCB and some research reports. These documents were requested, since they were the only documents available from NNCB that related to the practice and provision of clinical services. Policy documents were the only documents that fit the definition of '*gavaidhu*' that was formulated for the purpose of this research. These documents/policies were requested, with the idea of re-familiarizing myself with these policies. More importantly, from informal conversation with potential participants it was understood that most of the participants had not seen most of these documents. Specific documents requested were; Law 17/77 (law on narcotics and psychotropic substances); Policy 1: Committee Policy – (Policy On Treating Substance Abusers); Policy 2: Policy on Clients; Policy 3: Policy on House Arrest Clients; Policy 4: Policy on how the behaviour should be maintained by clients who are undergoing treatment in the rehabilitation centre; (6)Policy 5: Policy on clients sent for community rehabilitation; and Policy 6: Policy regarding people who wish to go undergo drug rehabilitation programmes overseas.

### **Focus Group**

Participants of the focus group were given a detailed description of the study prior to conducting the group discussions, both verbally and in the form of invitation letters to the participant (see Appendix G & H), and "Participants wanted for research" notice (see Appendix I). Each participant was provided with

information regarding; the aim of the study, the procedure, confidentiality issues, the researcher's responsibilities, the right to withdraw at any time and the use of the data. Participants had the opportunity to consider the risk to their anonymity and other issues that were raised before confirming their consent in writing (see Appendix J). Where participants were not comfortable with giving written consent, a verbal agreement or email consent to participate was considered as formal informed consent. An opportunity was taken to meet with several clinical staff members to talk about the research. At this meeting they provided valuable insight into the current problems they were facing in relation to the programmes of NNCB. This included the recent shift in management and the rapid changes that the organisation was going through. After ethical approval was obtained, all the information regarding the research (see Appendices G to L) was sent to the main contact people in the NNCB and were distributed to all the counsellors and relevant clinical staff. Expressions of interest were sent back to me via e-mail and through MSN Messenger. These potential participants offered suggestions for what they would like to discuss in the focus groups.

Prior to travelling to the Maldives in June 2005, one focus group was set up for the counsellors working in Male. Just prior to the departure, notification was received via an e-mail that most of the clinical staff were going to be out of the island working in an outreach programme. Travel arrangements could not be changed at the late notice, but negotiations with some participants ensured that several remained in Male' for the focus group.

Focus group sessions included eight participants; six females and two males, ranging in age from 20 – 30 years. The group had experience dealing with clients in the community rehabilitation programme, the outreach programmes, the house arrest programme and conducting several awareness programmes. They have been variously trained in India, Sri Lanka, Malaysia, Singapore, Australia and the USA. Their education level ranged from basic counselling certificates to university degrees. The period of their service to the NNCB ranged from one year to over seven years (this excludes the contract counsellor who had just joined the organisation three months ago). The focus group sessions were held on three days for approximately three hours per day. An additional period of time was spent

with each participant, ranging from six hours to twenty hours. This time was spent discussing cases and talking about how to improve services. These discussions helped to inform the analysis of policy documents and focus group and interview accounts.

Prior to the start of the focus group, the research was explained again and participants were given the opportunity to clarify issues and ask questions. A quick check was made to make sure that the participants had all the relevant information that was sent and copies were made available to participants who needed them. This information was provided to the participants, both in English and Dhivehi, since participant preferences varied. The option of keeping some of the information completely confidential was explained to participants. However, there were no instances where the participants felt that any particular information that was shared should be deleted.

To guide the discussion I used a schedule of main themes (Appendix K): participants' understanding of the existing policies of NNCB and the law, the difficulties faced because of the existence of these documents, the methods used to overcome these difficulties, and suggestions from the participants. Caution was taken not to suggest any possible alternatives, leaving this exercise for the participants. Sufficient encouragement was given to the participants to generate issues that were important to them. At the end of the focus group participants were informed that they would be assigned aliases to protect their identity. Participants were enthusiastic about the research and wanted to know how the findings of the thesis would be used. They were reassured that a copy would be made available to them, once it was finished.

I recorded my thoughts and reflections after each session, with my impressions of the participants and how the group went. The transcripts of the sessions were produced in English and emailed to the participants in order to verify the information as well as the translation. No major concerns were raised regarding the transcripts.

### **Individual Interviews**

I approached three senior staff members and described the project in detail. All three expressed interest in participating. Two of the three wanted their names to be kept confidential; the third person did not make any requests. Arrangements were also made via telephone to conduct individual interviews with two counsellors. The participants of the individual interviews were three senior staff members of NNCB and two counsellors who worked in the Drug Rehabilitation Centre (DRC). The senior staff members were two males and a female between the ages of 30 to 45. These three participants are Maldivians and these participants had worked in the organisation as senior staff for at least five years, and had experienced working in the clinical section with clients and clinical staff. The two counsellors were Maldivian females aged between 20 and 30, whose experience in DRC ranged from 3 to 7 years.

The interviewees were given a detailed description of the study prior to their interviews. Both verbally and in the form of invitation letters (see Appendix G & H). Each participant was provided with information regarding; the aim of the study, the procedure, confidentiality issues, the researcher's responsibilities, the right to withdraw at any time and the use of the data. Participants had the opportunity to consider the risk to their anonymity and other issues that were raised before confirming their consent in writing (see Appendix J). For participants who were not comfortable with giving written consent, a verbal agreement was considered as consent. An interview schedule (see Appendix L) was used to guide the conversations around several thematic topics. A flexible approach was taken in order to adjust questions according to relevance to each participant. The main themes for the questions were participant understandings of the existing policies of NNCB and the law, the difficulties faced because of the existence of these documents, the methods used to overcome these difficulties, and suggestions from the participants. The main themes for the senior staff members varied slightly and included inquiries about the administrative difficulties and the involvement in the policy formulation process and the extent of their input.

Three senior staff members were interviewed in their offices located in NNCB in July 2005. The setting was agreed upon by both parties, since these settings were both private and provided the necessary confidentiality without many interruptions. Two counsellors were interviewed in Greenge, which is the operating site of the Community Rehabilitation Programme and the intake setting for the Detoxification Programme. The interviews spanned two to four hours. Additional time spent with each participant ranged from three to fifteen hours. This time was spent discussing organisational developments over the past year and half and service delivery issues. My thoughts and reflections were recorded after each interview including the impressions of the interviews and the participants. Significant non-verbal behaviour of the participants was noted, including the tone of voice and body language.

All interviews were conducted in Dhivehi, on the request of the participants, although some of the participants used a lot of English. The interviews were transcribed into English, taking care not to alter the meaning or context. Participants were given copies of their transcripts in order to verify the information and the translation. All participants wanted their personal information kept completely confidential. Additional caution was taken to comply with their request of complete anonymity when conducting and transcribing the interviews and the focus group (Bouma, 2000). The researcher personally did the transcripts/summaries and in compliance with ethical approval from the Department of Psychology Ethics Committee the digital information was kept on a personal laptop with passwords, both to the files and the laptop itself.

### **Data Analysis**

Data gained from the policy review, the focus group sessions and individual interviews were analysed using thematic analysis (Flick, 2006). Thematic analysis is explained by Kitzinger and Barbour (1999, P.16) as drawing together and comparing discussion of similar themes and examining how these related to the variation between individuals and between groups. A four step thematic analysis was conducted (Aronson, 1994). Step one involved collecting the data, transcribing it and identifying preliminary themes. Step two involved categorising

all the extracts from the transcripts that related to each theme. The identified themes were then developed further by grouping the specific themes conceptually so as to explore overlaps in issues and various other synergies. The third step involved combining and cataloguing related patterns into new sub-themes emerging from ideas or experiences recounted in the focus group sessions and interviews, or noted by the researcher following episodes of data collection. The final step involved building an overall interpretation or argument based on the themes.

## **CHAPTER THREE**

### **Findings and Discussion**

Practitioners work on a wide range of drug service. Many practitioners will argue that each day they test their programmes in the most demanding research environment – with their clients. In doing so they are constantly refining their technique in order to provide the optimal approach possible within the constraints of the outcomes established as viable for that programme (Evans, 2001). This expertise of the practitioners needs to be nurtured and their views sought when carrying out research. If a systematic partnership could be created between the practitioner and the researchers, the ultimate outcome will be improved practice, policy and service (Smith, Bingman, Hofer, Medina, & Practitioner Leaders, 2002).

The analysis of accounts collected through the focus groups and the interviews are presented in the following four sections. Section one explores the content of policies and issues of awareness, relevance and feasibility. Section two explores the rights of clinicians and clients. This involved concerns regarding the lack of procedures guiding practice and ethics. Section three investigates governance and committee structure. Section four documents issues surrounding National Narcotics Control Board, accountability and power. This section also presents further concerns regarding the board's governance of rehabilitative practice. These themes all relate to the question of policies and the feasibility and implementation of regulations for service provision

#### **Policy Awareness, Relevance and Feasibility**

Only a few participants showed any awareness of the existing policies of the organisation. The implications of these policies and how it affects the practitioners are discussed in this section. The relevancy of the policies and keeping them up to date was another issue that came up during the discussions. The remainder of this section will look at the need for consultation on implementation and enforcement

of policies in order to ensure that this is more than a paper exercise, recognition that these issues place practitioners and clients in different and difficult situations, and lastly, the importance of consultation in developing workable policies as a way forward.

Discussions with participants were based around whether existing policies of the NNCB were adequate in terms of supporting service provision. It is not surprising that this issue was important to discussants. However, only a few of the participants were aware of the organisation's policies. Most participants were not aware of the policies relating specifically to clinical practice. A typical statement was:

*Arisha: I know that one (policy) exists, but don't know what it is about and its contents.*

This general lack of awareness extended to senior staff and contributed to operational problems, including a lack of consistency in treatment and decision making. The decisions staff made in practice were not based on the existing regulatory frameworks. Some procedures were not followed by all staff, either because of the lack of awareness and knowledge of policies and procedure or perhaps because of a lack of perceived relevance. For example, the official procedure for granting clients the right to go to work dictates that the client present a letter requesting permission to go work along with a job offer and contact details of the employer. NNCB staff are then supposed to assess the validity of the job offer and the suitability of the job for the client before granting permission. However, when permission was asked by a client, sometimes a staff member gives permission on the spot without checking the suitability of the job.

Initially it was simply difficult to focus the group discussion on the policies due to participants' lack of awareness regarding their content. We had to spend time reading and discussing policy documents and then meet again to discuss content. It was by unanimous decision of the group that we went on to discuss the content of the policies and try to identify the issues that concerned the group. What emerged at this time was a sense in which staff perceived a necessity to familiarise themselves with official policies because they felt they were simply irrelevant to daily practice as reflected by the example below.

*Shaasha: the committee policy does not concern us*

*Amir: yeah, and anyway it is something confidential.*

*Researcher: do you all know that it exists?*

*Raya: yeah we do, but we don't know what they do....*

The above example was a typical comment from the participants regarding the awareness of some policies. These comments were made when I inquired about the committee policy. I considered this policy (committee policy, see Appendix A) was one of the most important policies that affected the work of the participants and that it would have a major influence on the clinical decisions and practice and services of NNCB. Participants were not aware of how much this policy influenced them as practitioners and their clients. The policies does influence their work but not in ways that the participants thought it did.

All the participants were aware of how important the committee was. The idea that, the Committee could be held accountable and answerable to past and present actions was a novel idea to the participants. The participants could not imagine the Committee being asked to explain 'why' they took such a decision. For some reason, the Committee was perceived to be an untouchable body. The participants also took time grasping the concept that, the committee was governed by a policy and set of rules which needed to be followed.

After further conversation, the participants were able to make the connection between the committee policy and how exactly they as practitioners were affected.

Participants thought that current policies had limited relevance to present day service practices, and that these "outdated" policies should be 'scratched' and new, more relevant, policies put in their place. They invoked the general importance of clear policies, while also questioning the relevance of current policies. In the following example, participants discuss the newly opened drop-in service.

*Shaasha: the drop-in centre will stop working next week ...because there is no doctor in the drop-in centre.*

*Amir: there are no written procedures for the drop-in centre*

*Raya: there is no policy either*

*Aisha: it was started suddenly*

*Shaasha: there was no discussion with us about starting this programme. And we didn't know. So let's talk about something we know about.*

*Raya: We need proper procedures and a policy for the drop-in centre.*

Participants pointed to the relevance of having a procedure or policy for the programme, while also proposing that the NNCB did not need a policy or procedure for the House Arrest clients (see Appendix C), because that programme is not currently in service and even if it was, the policy was a little outdated. The clinical staff were not consulted about the development of this drop-in service. They were only told to report for work in the evenings at a certain time. No explanation was given on what was going to happen in the programme or what their jobs were to be, and who would be running the centre or who the clients would be. All participants expressed their frustrations about not knowing what they were supposed to be doing, and suggested perhaps it would have been sensible to have consulted them in the planning phase and if not, then at least given them proper briefing on what they were supposed to be doing. The participants gave this as an example to reflect on how most of the other programmes were started as well. They strongly suggested that these programmes should have a policy or something similar that they or anybody else could refer to as a guideline.

One of the biggest concerns raised by all the participants was that the current policies were neither implemented, enforced nor followed. Some policies were perceived to 'look good on paper', while not reflecting daily practice. As a result frontline staff had to face the clients and their families and try to sort out the mess created as a result of not following proper procedures or policies. The following extract illustrates participants' concerns regarding a lack of guidelines for community reintegration. The policy in context relates to the community clients<sup>1</sup>:

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<sup>1</sup> 3. Unless there is written consent from NCB or unless the client is accompanied by a parent or guardian he or she is not allowed to go anywhere other than the places specified below

- a. Join the congregation for prayer at the mosque closest to the client's home.
- b. Go to a place on the direction of NCB.
- c. Place of work where the client has a job, with prior consent from NCB (Appendix E)

*Shaasha: ...I think we (as an organisation) are responsible for setting up our clients to take the fall. We set them up to be caught by the law. My suggestion is, make a re-entry programme. Bring them to the community, to a halfway care. Then release them with complete freedom into the community. This would be in the best interest of the clients. Because right now there is no way we can make a follow up on the client. If we see the clients on the road alone, there is nothing we can do about it. So therefore why make policies and laws on things that we cannot reinforce or enforce?*

*Musthaq: What is actually happening is if there is a policy, then you can set up the client. As in get him back into the “system” (back to jail).*

*Shaasha: That is not the reason why we should have policies for. The reason should not be to put the client in a tight spot. Our aim is to rehabilitate the clients and make them useful citizens of the community right?*

The participants showed concern over how hard it was to adhere to the policy on clients sent for community rehabilitation (see Appendix E). The policy had a clause which stated that they could only go outside into the community with a parent or guardian. Since we are talking mostly about young adults, adults and sometimes older people, this did not seem a feasible clause to be kept in the community client’s policy. Most participants agreed that this would be next to impossible to follow for the clients, since most of them did not have parents or guardians in Male’, and even if they did, they would be too busy to run up and down with them to places in the busy capital where each had their own lives and families to look after. Therefore, the participants questioned keeping policies that were not feasible. The participants quite strongly equated these policies with ‘setting up the clients to fail’, and trying to keep them in the system or get them back into the system. Participants proposed that if NNCB was to genuinely help these clients, then they should perhaps refrain from making policies that were not feasible and which they were not ready to implement. It is common knowledge that almost all the clients do go outside their respective residences on their own.

Participants further queried why policies were produced if they were not implemented.

Some of the senior staff also faced the problem of lack of implementation on the committee's part. In the following extract a participant mentioned how a policy was not being implemented and that there was nothing service staff could do about it.

*Sadiq: ...Let's say they (a client) went against the treatment policy, they refused treatment<sup>1</sup>, in that case a sentence should be carried out, it should be enforced, the client should serve time in jail. This is how it should be. However, what happens now is that when they refuse treatment and when it is time for them to be sent to jail they are actually on the streets living as they like. This means that the law is not being implemented as it supposed to be. Because of this shortcoming in the law even the good clients who had been following the programme properly thus far suddenly doesn't want to continue with it. They want out of the programme and hang out with their friends. For these reasons the people are coming from there too.*

*Sadiq: ...Their point is (some of the committee members decide) that it is better to send some clients to the rehab rather sending them to jail. If they are sent to jail then once their sentence is carried out they will simply go back into the community. So they want to avoid that. That is something that is being done very illegally. In reality the whole treatment is not achieving its goals because of lapses like this on our part. Because we chose not to follow procedure or policy.*

A serious problem faced by staff, due to the lack of implementation of the legislation<sup>2</sup>, was that clients were able to take the 'easy way out'. If clients refused

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<sup>1</sup> 4.7. Individuals who met the criteria as mentioned in 1.1, but did not take that opportunity to go for treatment should NOT be recommended for treatment (Committee policy, see Appendix A)

<sup>2</sup> 13 (b) If curative treatment has not been received as determined by and at a level acceptable to the committee stated in (c) of Section 11 of this Law, or if [the said person] commits an additional

treatment (three years of rehabilitation), they were released with no charges in some cases, without serving the six year jail sentence. As a result, more clients were opting to take this 'shortcut'. This served as a root for discontent among clients who were already in compulsory rehabilitation. This conflict arose when committee members took action that was in conflict with the committee policy, and according to this participant, were also in serious conflict with the legislature.

The issue of consultation with clinical staff came through to some extent. This was particularly of concern to some members as they were the staff who have to conduct programmes and were faced with associated practical dilemmas. Hence the practitioners believed that their input should be considered and valued since they were involved in and responsible for the daily provision of the services. The following quotes describe an incident where a client committed an offence before starting rehabilitation and the counsellor had to report this incident, which resulted in the client being terminated from the programme and in addition sent to serve a six year jail sentence.

*Shaasha: My problem was, this client was progressing so well and was keen to get out of drugs and she was honest, and yet she had to suffer.*

*Amir: The aim and objective of treatment has been lost in that case. Our aim should never be to arrest the client and make her go through like this.*

*Shaasha: Because she was terminated from here, she had to face 6 years in jail and a house arrest sentence, she had a little baby to think about and I know she did not have it easy in jail. But she took the baby with her to jail. [She was sent to jail after the birth of the baby]*

*Amir: She was taken to jail because she was terminated from here.*

The admission of a crime or offence to a counsellor cost the client, in terms of a jail sentence and the termination from treatment. The focus group did not bring

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*offence within the period of the sentence passed on the said person, the sentence passed on the said person shall be immediately executed (Law 17/77, Attorney General's Office, 2006).*

out this issue of client counsellor confidentiality. There is not enough data to determine the reason whether it was because of the clinical staff's helplessness in this matter or whether the issue of confidentiality has been resolved. The participants have a fair grasp of the concept of confidentiality. It was because of the organisation's outlook on the issue of confidentiality as a trivial issue that the participants felt helpless.

Currently existing policies do not differentiate between the offences committed prior to client starting treatment in NNCB and offences committed after treatment. The lack of this differentiation has caused some clients to lose their chance to get treatment and they have been sentenced to jail for a crime/offence committed for something that was done before they were brought in for treatment. And there is no differentiation between a primary crime (a crime unrelated to the drug using behaviour) or a secondary crime (related to abusing behaviour like, small time robbery, vandalism and so on). The focus group thought that if they were going to be brought in for treatment, then their former sentences and crimes would be dealt with before they came into rehabilitation, rather than having to go in the middle of the treatment period.

From these accounts it is safe to conclude that the lack of awareness of current policies and legal obligations among clinical staff contributes to implementation problems. The participants/practitioners being unaware of the policies meant that; they as practitioners were not able to provide the best possible service to the clients. The practitioners had had no input into the decision making process of the committee. There was no consultation between practitioners and the policy makers.. This means that, there is a readiness to change from the practitioner's side, and an urgent need for change exists within the organisation. Proper consultation with key stakeholders needs to happen, and new policies need to be drafted with the old ones being re-evaluated for consistency and relevancy. The concerns regarding relevance and feasibility were caused by a lack of review of the policies with the fast changing framework of NNCB. One of the main issues that need to be put across to the organisation is that of the rights of staff and clients. Currently there is no document or policy to regulate this issue. The following section will look at this issue in detail.

## **Rights of Staff and Clients**

The issues of staff rights, client rights and confidentiality emerged repeatedly. Participants' concerns related primarily to the rights of clinical staff and other staff involved in the day-to-day dealings of clinical issues; the rights or lack of rights granted by the NNCB to its staff; the rights or lack of in the legislation; the right of clients, both granted by the NNCB, its policies and the Committee. Of considerable concern throughout were the limits of confidentiality because of certain legal restraints imposed on the NNCB.

Participants in the focus group were quite concerned that there were no written staff rights. Having a written document would allow the staff to know what their rights are and legal limits of practice. Clinical participants saw this as something that would provide them with protection from senior staff, as well as from clients. The need exists here for a professional body to monitor and provide ethical guidelines. Such a body would provide support to its members in return for the commitment of its members to act ethically in the provision of professional services. Members would have the responsibility to adhere to the code of ethics, the laws, regulation and policies which are professionally relevant to their working environment. Members would be accountable to both the public and their peers, and, therefore, subject to complaint and disciplinary procedures. Such a code of ethics would not be a static document, but revised over time in the light of continuing development of ethical knowledge and emergence of consensus on challenging ethical issues (Canadian Counselling Association, 1999). The section will look at the situation in NNCB, the difficulties and dilemmas faced by practitioners.

Client files were accessible to most staff of NNCB, which most of the participants believed should not happen. Participants believed that since these contained sensitive confidential information, they should be made available only to staff directly involved in the process. Participants conveyed the perception that current practice could contribute to breaches of confidentiality. They provided examples of this happening. After clients begin the programme their notes are kept with the clinical staff. These notes are not kept under lock and key. When the time comes for assessments or committee reviews, information about the client can be

obtained for their personal use, such as gathering background information of a client for the use of somebody outside the organisation:

*Musthaq: they (committee members) gossip a lot, and the client's suffer from this, and confidently is breached a lot.*

*Aisha: and sometimes they ask about where the clients are from, who's son it is and if they know, then they start talking about such a good family or such a bad family or stuff like that and base their judgments on those aspects rather than the client. Clients with powerful family connections have a lot of advantageous over their lesser peers.*

*Amir: and for working clients, sometimes they stress on finding out were exactly they are working or who their boss is rather than, the progress the client has made by joining the workforce.*

*Musthaq: those questions are more to satisfy their curiosity than for anything else. And that is not ethical. I think when we present the case to them, we should take out the personal details.*

Sometimes this unnecessary information is used to determine the future of the client. For example, the fact that a client was well-connected might get them a faster release. NNCB needs to dictate stricter guidelines for committee members in terms of ethical behaviour and proper procedure for decision making. There is a need to keep the committee discussion limited to issues of relevance only. Issues outside the agenda need to be kept out. The members need to be of a higher professional standard and adhere to some sort of ethical principle or guideline provided either by NNCB or an outside body. Members acting outside policy guidelines and ethical practices need to be held accountable to prevent such abuses from happening.

Some staff use client files to gather information for their personal use or for use by someone else outside the process, although it was felt that this did not occur very frequently. When the file goes to the committee, the information is sometimes again abused by the committee members. For example, they might use the information in the files, to determine who the parents are and base their

decisions on that factor, or look at the previous crimes and or if they know o the client through a friend or someone, use their prejudgement of the client to base their decisions on. Having a professional body to dictate ethical issues would solve this dilemma. For example the Canadian Counselling Association (1999) states that access to records only be provided after written consent from the client or only when required by law. Also, if an ethical body was established, the files could have access restricted to members of this body.

From an individual interview with a Drug Rehabilitation Centre clinical staff, the issue of protection to the staff or rather the lack of protection emerged. This staff member was concerned that there were no policies or procedures that gave staff any sort of protection from clients. This staff also pointed out that in the event of any sort of illegal activities or when a client tried to breach security there was no way that the client could be physically touched in order to restrain the client. The staff do not have any rights to restrain a client when they turn violent.

*Liusha: If a client turns violent and starts bashing up the windows and doors, there is nothing we can do, if that client wants to go outside, nobody can touch him, if two clients get into a fight there is no authority given to staff to restrain them. Basically there the guards cannot touch them. We have no rights to physically touch them at any time.*

There is no rule/guideline or procedure for a course of action in case of client turning violent or harming another client. The staff have no idea how to act in a situation like this and feel at a loss. This particular participant felt that, the clients cannot be touched at any time, due to legal reasons, but was unable to link this thought to a legal document or NNCB policy. Other participants interviewed from Drug Rehabilitation Centre expressed the same frustration.

Participants often referred to the lack of a procedure for complaints, either for clinical staff or clients. The staff members are not sure where to take their complaints. Most of the focus group members did not know whether they were supposed to talk to their section heads, or NNCB head, or the committee. In the case where one of their immediate bosses was involved in an incident, they were

at a loss of what to do. None of the clinical staff felt comfortable talking to any of their senior bosses since they felt that confidentiality would not be maintained and that no action would be taken anyway.

*The counsellors cannot complain about clinical/treatment related issues because it would not be liked by the NCB heads. The understanding given to the counsellors were that these were internal matters and that it should not be discussed in the committee (focus group)*

*Raya: they should be made clear on how to go about it. (The complaint procedure)*

The above quote was about taking complaints to the committee. It was believed that such a complaint would result in a lot of unnecessary tension. An example that was discussed in the focus group involved a client who was forced to do ‘special favours’ for a senior staff (a direct quote cannot be provided here because of the sensitivity of the case and confidentiality issues). The counsellor was not able to complain to the staff directly because it was obvious that the staff member would use their influence to make matters worse. This counsellor did report to the immediate boss. However, the boss decided to support the senior staff member instead of the client. The counsellor could not take the problem to the committee because of fear of repercussion from senior NNCB personnel. There was a loss of morale among the clinical staff due to several such staff misconducts that were not dealt with.

The issue of confidentiality was mentioned in almost all the topics that were up for discussion, both in the focus groups and in most of the individual interviews. There were several incidents reported by participants where there was a serious breach of confidentiality and in these instances it was always the clients and the junior staff that had suffered. Often clients had to wait longer for their releases or sometimes even their treatment terminated and sent to their sentences. The junior staff faced lesser consequences like being ignored by the senior staff, verbal confrontations with clients and family, sometimes leading to physical and abuse from clients

*Raya: especially since Azeza started going in to those meetings (Committee meetings). And anyway, if somebody wanted to*

*look up some confidential information then there are ways to do it easily in NNCB.*

*Shaasha: for some reason its ok for her (Azeeza) to give out so called confidential information to the clients and their parents. But if we do it, we get warnings, its not fair.*

*Amir: yeah because she is (a senior staff), there is nobody to tell her off*

*Musthag: and someone like Ashiya did something, then it was because she didn't know any better. My question is how come a different set of rules apply to her (Ashiya) and Azeeza?*

Raya was referring to the easy access of confidential information to almost any staff who worked at NNCB. That is client's personal information was easily accessible to staff not directly involved in the treatment process. It was also further discussed that a lot of the staff in NNCB did not take confidentiality very seriously. It was suggested that "they didn't know any better" or "had no idea of the seriousness of the issue". Or simply, "issues like this got lost in the system", as there was no repercussion for breaches of confidentiality.

If a service provider such as a counsellor used drugs, then they would get a life sentence (maximum sentence), which is 25 years<sup>1</sup>. There would be no choice of treatment. Some of the counsellors thought that this was reasonable since they were trying to make other people stop using drugs. But others thought that it was not reasonable and they also deserved a chance.

*M5: if a person working in the field like us, if we ever to get arrested, we would get the maximum sentence.*

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<sup>1</sup> *Awarding of maximum penalty stated in this Law*

*(c) A person assigned by the government with the task of preventing the use of narcotics drugs and psychotropic substances and stopping the trading in the same.*

*(j) A person that administers health-related curative treatment by nature of his or her employment, or a pharmacist using his or her position, or using influence [of those positions] to commit an offence.*

*(k) Commission of [an] offence at a school or at a place where teaching is engaged in, or at a centre where health-related curative treatment is given, or at a centre where curative treatment is given to persons who, under this Law, are determined to be given curative treatment from among persons who use narcotic drugs and psychotropic substances, or at a social centre, or at a centre designated for sports activities or for entertainment, or at a centre for the police or the armed forces, or at a centre specialized for the execution of legal sentences.*

*M2: that's not fair*

*M3: I am even not sure that we should be included in that.*

*M1: Well yeah, in a way its good, we should be responsible and not get into drugs.*

*M4: yeah practice what you preach? but 25 years!*

*M2: We are only human, we should get the chance for rehabilitation too.*

Practitioners currently get awarded the maximum sentence under section 13 of Law 17/77 (see Appendix M). Some of the participants thought that this was just and fair, since they as practitioners should act as the responsible adults they were. The other view was, even though they were practitioners, they were not immune to human conditions and that they should have the right to treatment, should one of them get into drugs.

During the focus group participants discussed just how organisation-oriented they were and encouraged to focus on the committee's needs rather than the clients.

*Amir: that is a very important issue, all the clients should know what their rights are.*

*Raya: I think they should be told what their rights are by the NCB.*

*Shaasha: all the policies/rules and procedures are made to protect and enforce the rights of NCB. They have not thought about the clients' rights at all.*

*Raya: they are all based for NCB*

In the above example the, staff shows disillusionment with the system. Especially the lack of NNCB's commitment to protect their clients. This could have the negative effect of practitioners losing faith in the system and start ignoring set rules and procedures. In fact, some 'bending' of the rules do happen to accommodate this lack of commitment from the NNCB's part.

Most of the clients come to the rehabilitation after being in the jail, sometimes straight from the jail cell to the centre. Nobody is assigned from the NNCB to brief the client about what is to be expected when they enter the rehabilitation centre, in terms of what their rights are and what they can expect from NNCB as

an organisation. According to the data, this is something that has not been happening and urgently need to happen. The participants pointed out that, when the procedural briefing was given about the rights of the NNCB and its policies, it would be easy enough to include what the clients can expect from them in return.

The usual procedure is that when a client comes for the initial interview to the NNCB (prior to sentencing), some of the procedure is explained before the client signs a form stating that they are volunteering for rehabilitation. What is explained quite thoroughly is what is expected of the client: how they should behave and what they should wear. What is expected of the client is explained very clearly, but omitted from the briefing is what to expect from NNCB, and what their rights are as a client.

When the client gets sentenced to rehabilitation, the forms filled in and the procedures explained do not include a bill of rights, or a complaint procedure.

*Shaasha: you have to agree that, sometimes there are clients who are very regular in coming to session and miss out on the sessions because of the carelessness of the counsellors. It's the clients right to have something done about it. But how many documents exist here about what can be done in a situation like this? How many documents exist outlining the rights of the clients? NCB doesn't have any. Show me anyone if you can. The clients in Rehab don't have any and neither does the clients in community rehab. But counselling is done, and counsellors exist for the rights of the clients. But counsellors have their rights and NCB has their rights.*

Some of the participants got quite agitated by the lack of a complaint procedure that was fair and transparent to all. Sometimes, if a client does not have the 'proper connection', even if the client, is regular in attending the programmes and progressing well, s/he does not get the opportunity to even inquire or complain, if s/he missed out on counselling sessions and classes, because of the carelessness of the counsellor. The blame always lay on the client's shoulders. There was no system in place that put the responsibility on NNCB to oversee or supervise the

clinical staff and evaluate their performance. When things go wrong, it was always the client's fault as shown by the following extract.

*Musthaq: There should be a complaint procedure or policy or something like that.*

*Raya: they should be made clear on how to go about it. (the complaint procedure)*

*Shaasha: if the clients don't attend an NCB programme, it describes what should be done to the client. But if a client comes and doesn't get the services s/he deserves then there is nothing there written or otherwise, on what can be done to rectify the situation or get the client his/her rights.*

*Musthaq: what the client should or can do, its their own responsibility, they should find their own ways to do it.*

*Shaasha: no, they should have a client bill or rights or something, here. We have to have a written policy on it. NCB should be responsible for it.*

Because there is no formal procedure client complaints and ill feelings are directed at the clinical staff. This can create more stress and instability in the already frail client-counsellor relationship. Almost all the participants of this research had expressed frustration over this matter. An example discussed when a client came in for a counselling session, the client could not find out who the counsellor was. The client was not notified of who would be responsible for the client's case management at all. The client came regularly once a day for a week to find out who the counsellor was then once a week for another two weeks and then stopped coming altogether. When the time came for the client to be discharged, which meant his/her treatment period was going to expire, the committee and NNCB decided that since the client had not attended a counselling session or a class, the client was not fit to be released.

This raises serious issues of undermining the therapeutic alliance, from the NNCB as an organisation and at an individual level from the practitioners. MacGuire (2004), stresses the importance of the therapeutic alliances in offence-focused work. A study by Fiorentino, Nakashima & Anglin (1999), suggests a positive effect in employing a therapeutic alliance between the practitioner and the client.

MacGuire also states that effort and skill of the practitioners is one variable through which motivation and change in individuals occur. Furthermore Shorr(1989 cited in MacGuire, 2004) argues that for successful implementation of rehabilitative programmes, there needs to be a climate created by skilled, committed professionals respectful and trusting of the clients they serve, regardless of the precepts, demands and boundaries set by professionalism and bureaucracies. In most cases, preoccupation with programme components implied that in the process of information distribution the importance of staff skill may be underemphasized (MacGuire, 2004). Some of the skills mentioned in Trotter (2000) cited in Macguire(2004) are; building a working alliance characterised by trust within clear boundaries; motivating to change and helping to build upon a sense of empowerment; and understanding the local context and making adaptations accordingly.

### **Committee Responsibilities, Membership, Meetings and Ethics**

The major body governing the NNCB's clinical programme is the decision-making committee on identifying the substance-abusers who fit under the Criteria Of Requiring Undergoing Treatment By Law, And How The Treatment Should Be Carried Out (In short referred to as the Committee). This section will look at participants' accounts regarding the responsibility and role, membership, meetings, and ethics of the committee.

Committee responsibilities have been defined in the Committee Policy as: (1) Make a decision on who needs to undergo rehabilitation/ Treatment as stipulated by the law - that is basically deciding who goes and who doesn't. (2) Make decisions on how this treatment is to be carried out for each individual – deciding to which phase of the treatment the individual will go to. That is residential, halfway or community. (3) Monitor the treatment programme on a regular basis – monitor the DRC, CRP and any other treatment programmes run by the NNCB. (4) Make a decision on who has completed the treatment – review the client's case and decide whether the client has completed the treatment and was fit to be released back to the community (5) Make a decision on who is to be terminated from the programme – decide whether the client had shown enough progress to be released, and if not then make the decision to terminate and send the client back to

their sentences which ranges 6 years in jail to 18 years. (6) Make a decision on how the individual will be penalised for committing an offence/crime during the treatment period – this includes offences within the treatment centres and outside the centres and programmes. They also have to make a decision on whether to refer the case to the police or not.

Almost all the participants questioned the responsibilities and exact role of the committee. Accounts invoked the proposition that the staff of NNCB have little to no confidence in the abilities of the committee to carry out the tasks assigned in its policy. When reading this policy Arisha stated:

*“(reading again to what I was pointing to) they are not following this clause. (Reading a little bit and commenting that there were not following the responsibilities) All they are into is admission and discharge”.*

In this quote, the participant was reading the above described responsibilities of the committee policy (see Appendix A). This extract presents a typical response to the discussion of the responsibilities of the committee. Most of the participants who commented on the policy had little or no confidence in the committee that, the committee was carrying out their responsibilities. The following section will provide an in-depth description of the committee responsibilities.

Before the court sentences a person for abusing drugs, their case is sent to this committee and it is this committee’s responsibility to advise the courts on whether the person needs to be rehabilitated or not as mentioned in the committee policy, as described in (1) above. Although there is a psychiatrist present on the committee usually, no psychiatric evaluation is done before making the decision. No psychological assessment is done, and none of the committee members meet the person. They base their decisions on their criminal history sent by the courts and the police; and on the family history, educational history and the substance abuse history taken by a junior clinical staff (which usually involves filling out a form). The data showed that, most of the participants did not feel that this was a fair method of evaluating the client for treatment. They felt strongly that the committee was in no position to carry out (2). The participants were of the strong opinion that individual case plans for treatment should be made by the clinical staff themselves. As for carrying out (3), it has been some years since a board

member had visited any of the treatment facilities or reviewed any of the treatment programmes.

*Sadiq: Yes. On the third time his case is to be taken to the committee for their decision. Let's say we are at this stage and the committee reviews all the treatments he has undergone. Upon review they decide to terminate the treatment. When this decision is reached, it is one that the committee made and not the counsellor. I think a decision by the counsellor is also important. Because the client will be working very closely with the counsellor. To the committee the client is just a report. This is what he did and so on. The counsellor makes the presentation. Based on this report the committee makes its decision.*

Regarding (4) and (5), the participants were of a mixed opinion. Some felt that the clinical staff got to present the case to the committee before the committee took the decision to release or terminate the client. The decision can then be based upon what was presented to the committee. The other participants felt that this was not totally right. They felt that it should be up to the client and the counsellor as their case managers to decide whether the client is fit to move on to the next stage of treatment or whether the client has finished the treatment and achieved all the client could from any of the programmes at NNCB. These participants did not have a problem with the committee rubber stamping their decision, but strongly felt that the 'decision' to say the client has completed or failed the treatment should remain with the clinical staff.

There were also mixed opinions on point (6). Most of the participants felt that any decision taken regarding misconduct should be consistent and fair, regardless of who the client is. Data also showed that what was more important to the clinical staff was that, the consequence faced should match the offence committed and that it should not matter who (as in how connected the client was ) committed the offence. Data also showed that the clinical staff wanted previous offences to be dealt with before they come to rehabilitation and that, the client should not be penalised for the same offence again and again.

The issues relating to the Committee members, and their role were a major issue of concern for all the participants. The issues raised ranged from the members of the committee to the questioning of the need for the existence of such a committee.

*Arisha: 'it is not workable, the committee is full of redundant people, the committee is full of people who are not capable of performing these functions, the committee is not involved in professionals, the committee is not fit to judge whether the client is fit for treatment or not, so this is a redundant committee. In other words the committee should not be there'*

The data strongly suggests that the participants did not believe that the current members were able and capable to run the committee. The current members were not seen as 'professionals' in the area of treatment. They were not even considered knowledgeable in the field. The current membership is described and discussed below.

Currently the membership includes representatives from; The Ministry of Defence and National Security, (as of now the membership has been changed to the Police Services since the creation of this service); Representative from the Ministry of Health; Representative from Ministry of Women's Affairs and Social Security; Representative from the Office of the Attorney General and a Representative from the Narcotics Control Board. The role and the capabilities of these members were questioned and discussed by the participants. One participant states;

*"(I don't) see a need for a person from the Ministry of Defence and National Security. If you want to be realistic. I don't see a need at all. (Why is that?) That is because well what will a person from the Defence ministry do on a committee that is providing treatment. That is my question. I mean when the client's case is brought to the committee, it has already been reviewed to see what kind of crime or crimes he or she had committed, whether there is an ongoing case or investigation and so on. All these are already looked at. Then why do we need someone from the Defence Ministry? There is no need exactly. Well he's not from the Defence*

*anymore. He is from the Police Services now. But still we don't even need a person from the Police Services." (sadiq).*

The members who attend the meeting are neither experienced in the field of treatment/addiction nor have the knowledge of the issues concerned. This was a major concern since the major role of the committee was to advise the NNCB on their treatment issues and make crucial decisions regarding NNCB clients. The current law prescribes that the members represent the Ministry of Defence and National Security, Ministry of Women's Affairs and Social Security, the Ministry of Health, and the Attorney General's Office (Attorney General's Office, 2006). Previously the law (before it got amended) stated the occupation of people who could be members of this committee, for example, a lawyer, a medical doctor, a psychologist and so on. After the amendment the levels of the people were taken out and only the offices remained.

Sadiq went through the people who came to these meetings and stated that most of these people were not relevant to be on the committee. And some of these people had no relevant qualifications and no experience or knowledge of the issues that are dealt in the committee. Because of the lack of a guideline, even administrative people were being nominated into this committee. The following section will provide an overview of the committee meetings, the decision making process and how these decisions are relayed to the clinical staff.

All these members are nominated by the respective government offices. They each nominate three members out of which, one member attends the meeting. Who attends the meetings depends on the availability and time constraints of the three nominated members of each office. NNCB currently does not provide any guidelines or criteria on who should be included in this list. As a result, sometimes non-relevant, unqualified people for the job are nominated and present in the meetings. NNCB currently does not have a membership in the committee, other than the administrative person who goes into the committee and the head of the clinical section.

*Sadiq: It's alright to have someone from the administrative side to do admin work. But we (NNCB) really do need someone from the treatment side to be on the committee. (Information*

*deleted to protect anonymity), let's say for instance Azeeza, she can be there. But what I am saying that the one who makes all the decisions with respect to the clients should be someone from this area. This person should be on the committee to present the clients' cases on their behalf. The presentations that Azeeza makes now are not good. It will and does not have a positive impact on the clients.*

The policy of the committee gives some guidelines as to how to make a decision regarding clients. But there is not enough data to determine whether these guidelines are enforced or followed. It is the opinion of most of the participants that these guidelines are not followed.

The meetings are held regularly, but data showed that, most of the time was spent on irrelevant issues. The minutes of the meetings used to be kept, but this has not been happening for some time now. There is nothing done to rectify the situation.

*Raya: they can't decide \*\*\*. How many times have we taken up this issue? But it has never made it to the minutes of the meeting and the minutes are never circulated.*

*Aisha: since Hassan(real name not used to protect anonymity) left, we never get to see the minutes, I don't think that it is updated since he left, I don't even think it is done properly. We don't get the proper details anymore*

As a result a lack of documentation, the committee decisions get delayed being relayed to the necessary parties, if at all this happens.

*Amir: But all these stuff is not communicated to the counsellor. Only a little of it trickles down to the counsellor, all these decisions are already made or to be made by the committee, and one day the client shows up and says that s/he is getting married tomorrow. Or I am going to leave the island/country tomorrow.*

And sometimes these decisions get relayed directly to the clients without informing their counsellors. The participants mentioned several instances where this happened. Because of this the clinical staff have a hard time monitoring the progress and 'sticking' to the case management plan.

*Dhooma: sometimes the board decides that the clients only have to sign in once a month. The decision might have been made more than one month ago, but the clients have not been notified of it, and they would have been coming regularly once a day. It's not because they haven't managed to get hold of the client. I think it's the right of the client to know about decisions made about him/her.*

*Sarah: sometimes because it has become a problem to the counsellor and the counsellors have called up the clients and notified them. And then what happens is that, when they change that then the signing section would say that they weren't notified or they didn't notify them.*

*Aisha: and after the committee releases them from the programme, or after they have been terminated from the programme, they have not been notified, and it is only known after the parents come in and talk to the bosses.*

Sometimes these decisions taken regarding clients are not relayed to clinical staff at all. This happens either due to the lack of knowledge about these decisions or due to the lack of documentation or sometimes due to slow processing of the administrative staff. The clinical staff felt that serious decisions such as terminating the client from treatment or releasing the client should be relayed immediately to the clinical staff and then to the clients. And changes in the administrative procedures such as the change in 'signing' are not notified to the proper administrative sections, it is the clinical staff and the clients that have to take on the added stress and confusion. On top of this stress and conflict, the practitioners have to face daily ethical dilemmas where the committee is concerned. The following sections discuss the ethics of the committee in view of the findings from the research.

Participants reported that the Committee members were not entirely ethical when they came to making decisions regarding clients. It is not clear what the protocol of conduct for the committee members are or whether they have to abide by certain rules when it came to confidentiality or code of conduct. It is also not clear whether they have to face any consequences for breaking confidentiality. None of

the existing documentation or written down procedure showed how to handle misconduct by committee members. One of the participants stated;

*Sarah: Once I was presenting a case to the committee, I was giving the family history saying that he has been married for 18 years and has this many kids. This committee guy was just munching on something and looked at me after I had finished the history and asked me whether the client was married. Just how mad do you think I will be? One other member was talking about how his water pipe had burst the other day, another person was talking about something else. When they realized that I had finished presenting my case, they decided that this client should be terminated from treatment!*

*Raya:” yeah they go eenee meene myni mo, yeah s/ he is terminated s/he is released.*

This was an example of a case that was presented to the Committee. The participant was describing how inattentive the members were and how uninvolved they were in the client issues. Their lack of regard to the issues and the consequence of terminating the client without even properly listening to the case presentation was a constant source of frustration to the counsellors. The participants felt that, this continues to happen because of a lack of professionalism on the members' part and also due to the lack of accountability. So far, no one has contested a decision the committee members have made. It is not even clear whether a decision could even be contested. This lack of an appeal process seems to be a significant breach of the rules of natural justice.

As a result, the members had never been made answerable for any decision or made accountable. It seems that the structure or the qualities of membership needs to be changed to include a more comprehensive, treatment based and focused members in it. At the moment data shows that there is climate of pessimism, discontent, lack of direction and uncertainty for the clinical staff.

*Musthaq: they gossip a lot, and the client's suffer from this, and confidentiality is breached a lot.*

*Aisha: and sometimes they ask about where the clients are from, who's son it is and if they know, then they start talking about such a good family or such a bad family or stuff like that and base their judgments on those aspects rather than the client. Clients with powerful family connections have a lot of advantages over their lesser peers.*

*Amir: and for working clients, sometimes they stress on finding out where exactly they are working or who their boss is rather than, the progress the client has made by joining the workforce.*

*Musthaq: those questions are more to satisfy their curiosity than for anything else. And that is not ethical. I think when we present the case to them, we should take out the personal information*

Sometimes, the committee members seem to be focusing on irrelevant issues as shown by the example above. There is a strong need for the members to base their decisions on the qualities and the achievements made by the client themselves rather than who they are related to or employed by. The clinical staff strongly suggested making a 'committee ethics' or at least a code of conduct for these members where they were made answerable to these kinds of non-relevant inquiries or a document restricting these members to ask questions that were relevant to the position they had in the committee as in which office they represented. In general there seems to be a lack of adherence to the currently existing policy of the committee and also a strong need to make a governance structure to prevent the uncertainty and the ethical problems.

The main findings regarding the Committee were that the current membership was not sufficient to run this committee. Membership needed to be expanded to include more treatment focused members, with experience and knowledge in the field. The need for proper guidelines and structure is important to the proper functioning of this committee. A more coherent policy which includes the ethics and conduct of the members were needed could cater to the much needed changes. Responsibility of the individual members and the accountability of their decisions

were big issues, since these members were equipped with the authority and power to make major decisions for the clients of NNCB.

### **National Narcotics Control Bureau: Accountability and Power**

This study is based on this one organisation NNCB, which is the major service provider for substance abusers. Apart from the issues described above, this thesis will highlight some of the prominent issues that came up regarding NNCB. Some of them directly related to existing policies or a policy deficiency while some went deeper into the core of the functioning of the organisation. The main issues that will be looked at in this section are; issues of accountability, the documentation process and power struggles, staff code of conduct and ethics, clinical staff and lack of consultation with them and the Drug Rehabilitation Centre.

A major concern the participants mentioned were the issues of accountability. The participants face the lack of accountability on the part of senior staff on a day to day basis. One participant mentioned,

*Sadiq: Well to be honest with you, the way things are running right now... Mariyam doesn't really know what is going on. Or how things should be. She wants things to be run her way. But even then she is doing things one way one day and another the next day. What happens then is that there are a lot of negative things happening because of this. Azeeza and Arisha are there to support her in running it like this. Because of that, even though there are laws and policies and such, since we are a government agency there is nobody to prosecute her. So things are going from bad to worse day by day (in this extract, no real names have been used in order to protect anonymity).*

According to the participants, there seems to be a lack of accountability within the NNCB, in much the same way as there is little accountability within the committee,. Because of this lack of accountability and lack of being questioned regarding a decision, a lot of the decisions are taken unfairly towards clients as some previous examples have shown. A reason pointed out by the participants for this was that perhaps people in charge of running this organisation were unaware

of the issues involved and are out of touch with the needs of the organisation as a whole. There is enough data to determine that, most of the staff at a senior level are not entirely sure of what the existing policies are and of its content. In one instance an informal conversation with a very senior staff revealed that, although s/he was aware of the policies and the legislature, s/he was adamant on deriving own conclusions and meanings from these documents to suit his/her need. These data seem to suggest that there is a strong need for a change in these policies and legislation.

Deriving their own meaning was not limited to the senior staff, a few junior staff seem to be mirroring their senior colleagues on ‘bending’ the rules to suit their need or just deriving their own meaning..

*Musthaq: No we can use those policies in certain instances that are advantageous. We don't have to strictly follow it all the time. Just those times that are advantageous.*

*Musthaq: we don't have to follow it all the time, we can bend it*

*Raya: no we can't bend any rules. If you want to bend it then it should give that way in the rule itself.*

*Musthaq: no there might be situations that might arise, that we could bend it.*

*Shaasha: your boss cannot give you that authority since there is a specific policy and you cannot bend the rules and clauses to suit your needs neither can the boss. If you can bend rules to suit certain clients then that means there is room for discrimination. We certainly wouldn't want a policy like that.*

*Shaasha: All I am saying is that none of the bosses should have the authority to change a written policy just when it suits a need or when they feel like it. A policy should remain as it is, and as it was written until it is officially changed.*

There were mixed views on staff ‘bending rules’ to suit their needs. Some of the participants were of the view that it was acceptable to bend the rules as long as staff think they are doing the right thing. Other participants thought that it should not be done at any time, even though bending the rules would benefit themselves or the clients. The staff who were into the practice of ‘bending the rules’ to suit

their need seems to be doing so to get around the unworkable, unfeasible policies, and while the others advocate against ‘bending rules’ there is enough data to suggest that most of the participants on occasion bent the rules and policies of the organisation to suit their need at that time. All of the participants did agree that certain policies should change and the others should just be abolished in order for them to do their work more efficiently.

A participant shared a case with the group to illustrate her claim that NNCB was negligent and should be made accountable for serious blunders made by them. The participant also mentioned that, the root to the problem lie due to a lack of consultation with the clinical staff.

*Shaasha: this was unfair, and I won't let up on this case. I will always have this case and will talk about the unfairness whenever I get the chance. (Details of the case has been excluded, in order to protect the identity of the client and the participant), the client was treated very unfairly. In this case, NCB was very negligent towards the client. The proper channel of communication did not exist. And vital information was not relayed to the counsellor even though the counsellor was right there and had been communicating her concerns regarding the client to NCB. The client was handed to the cops without letting the counsellor have a chance to talk to the client, and that same day the client committed suicide in the holding cell. The counsellor felt very strongly that, NCB should be held responsible and accountable for the client's death.*

*Shaasha: I want something in the policy, to reflect cases like this and where the clients could fight for their right and counsellors ask about stuff like this. Something that should be fair.*

In the above example, the information that was not relayed to the counsellor included the result of the urine test, that the client was being referred to the authorities, and that the client was going to be taken then and there while the counsellor was present in the same building but without notifying the counsellor

and without giving enough opportunity for the counsellor to prepare the client for what was coming. The client was very fragile mentally and this issue was explained to the senior staff, and also the counsellor's concern of the client being suicidal was shared with the senior staff.

In cases like this the clinical staff felt that consultation regarding client's issues should be held by NNCB at all times. And that when the NNCB 'mess up big time' like this, they should be held accountable and an independent inquiry be made. The general attitude was that just because the client did not commit suicide on NNCB premises, NNCB should not be 'let off the hook' easily. The clinical staff felt that they should have a forum to voice their concerns and thoughts regarding these sorts of sensitive issues of gross unfairness on NNCB's part. And most important of all, that NNCB should be held accountable for such actions, and an independent body should investigate these issues.

This section is basically focused on issues raised by documentation and the power struggles that exist within the organisation and outside it. The main problem with documentation was, that the process and the paper trail was too long and too complex, when it came to getting proper permission and that there was a lack of documentation when it came to senior staff putting their decisions on paper. One participant states:

*Raya: to go out of the island. You have to get a written permission. By the time you finish even saying written permission the client would have already left the island. This is a real problem. The client will come and tell Azeza and then go. There is nothing written down. The counsellor works here and the permission is given verbally by the clinical head in the head office. So we don't know where he is or whether he got permission or not. All we know is the client does not show up for counselling sessions, does not show up for signing. When the client does show up, they insist that they had permission in the first place.*

Data showed that there were several instances of not keeping proper documentation that lead to confusion. Whether this is a lack of compliance from

the people involved or whether the expected documentation is too much cannot be determined from the data gathered. Documentation concerned ranged from simple things like, the client records to more complex issues like permission granted to leave the island or country to urine test results. These issues involve the clients and the organisation on a deeper level in instances like negligence on NNCB's part to keep track of their clients via documentation and their crucial information such as the client's progress throughout the three year period.

The following section will give an overview of the power struggle that exists within the organisation. From the data gathered, there seems to be a power struggle on three areas. One area is between the NNCB, other involved government offices and the policies and legislature that are relevant; secondly between the senior staff and the junior/clinical staff; and on a third area, between NNCB and its clients.

The struggle between NNCB and related organisations like the Attorney General's office and the Police services, on the one hand and the legislature and the law on the other suggests that there is a strong need for change. At the moment, data shows that the current legislation did not allow for clients to come in for treatment except under article 11 and 12 (see Appendix M). In effect, NNCB is acting illegally providing treatment for users and is liable under the current Maldivian law.

*Sadiq: What is happening is that, the President's Office, the Attorney General's Office and the NNCB all want these people off the streets and in treatment. It doesn't matter how it's done, or whether the whole treatment collapses. That is what's happening. They believe they are the ones who are making the laws and also implementing them so they are above it. No one can prosecute them. Law is insignificant to them as is the committee. Even Mariyam wants the committee to be what she calls "flexible". Flexible in the sense when she wants a client to be given treatment, it shall be done. That's how she wants it. They most definitely would have been rejected. So they decided to forego the committee and commence their treatment. This*

*happened between NNCB, the Police and the Attorney General's office.*

This participant's concern was that, because of this decision by NNCB and the other organisations to act outside the law, if anything happens, then it would be the clients who are suffering. Even if these organisations had the need to act, before the new law passed, it was suggested that there be some form of amendment, act or a policy in place put in place for the protection of the vulnerable clients. Unforeseen problems, such as how to distinguish between the 'legal clients' and the 'illegal clients', came up briefly in one interview. The major problem was, that these clients are not offered any protection under the law, and at any time can be sent to jail. The other problem is that these clients, even if they commit an offence or drop out of treatment, NNCB cannot hold onto them or ask them to come back, since they are not officially registered with the NNCB and the 'Committee' has no knowledge of them. This issue has created some conflict within the clinical staff and also between the clinical staff and the 'legal clients'.

Constant undermining of the junior staff by the senior has led to a lot of frustration and loss of morale amongst the junior staff. Several of the participants stated that, in many instances, the senior staff dismissed valid issues and concerns presented by them. One participant states:

*Sarah: Even if a procedure exists in the policy it doesn't work that way. I once had a client who had 7 positive urine test results, I inquired about it from the scientific detection unit but the head said to leave the client be. And not to follow the usual procedure. She presented it to the committee and got the client released.*

This participant went on to describe the consequences of this action taken by the senior staff without giving consideration to the bigger picture. The participant mentioned that, as a result, all the clients who came to know of this incident had to be given explanations as to why there was a different action taken towards that specific client. It was also noted that, this senior staff took no responsibility in the end or helped in offering a plausible explanation to the clients. What ended up happening was that, a lot of clients lost trust in this participant, and blamed this participant regarding this case.

The participants pointed out several incidents where they thought that some of the senior staff deliberately went out of their way to undermine the clinical staff. Some thought that it could be a case of the senior staff trying to reaffirm the seniority over the clinical staff. There has not been enough data to determine any of these claims. A more senior clinical staff explains the problem as:

*Arisha: The problem is that some redundant people have been kept in some redundant position. And there is a power struggle here. And dirty politics works here and nepotism works here and we have to get educated people who understand what is a policy what does it do and how it provides and people need to be first educated on what is a policy and the acceptance of the policy should come from the staff and the administrative structure has to be revamped or whatever so that the policy can be implemented.*

There is not enough data to conclude that, there are redundant people who have been kept on. But the other issues brought out by this participant have been mirrored by most of the other participants as well.

There were several instances where, the participants shared stories/ cases of when there have been conflicts between staff and clients. There were some cases of physical/sexual abuse and mental abuse reported by participants. Cases as these were always hushed up and the client terminated or released to ‘get rid of the problem’. And most of the time it is the clients that have suffered. On a less severe level, the general attitude of staff towards clients are not, all friendly and most of the time they are just ‘put up’ with.

There have been several incidents where the staff have been known to act unethically towards the clients. Sometimes it is neglecting their duties other times it has gone beyond moral ethics, such as sexual and mental abuse of clients. One participant states,

*Amir: Once, one of my female clients was blackmailed on this issue and forced into sexual favours for a friend of an NCB boss, because she was special to that boss at the moment,*

*her initial tests were not counted, but the minute she refused those favours, she was sent off.*

Here the participant was talking about, a client who, initially, had positive urine tests. This client was kept on because she was doing a 'favour' to one of the senior staff's friend. The minute she refused to keep on doing it, her positive results started being counted.

The general attitude from the senior staff interviewed revealed that, there was no existing staff code of conduct/ethics. One perceived reason was that, if a staff conduct/ethics were to be enforced, there would not be enough people who would come to work in the organisation. It was felt that then it would be too restrictive and people would get scared to work in such a place. A second reason was that, the senior staff did not want to deal with these issues of misconduct and were almost in denial that these things could happen in the organisation. A third reason was perhaps that, it was perceived by some senior staff that these sorts of conduct or misconduct among staff were almost expected of them and it was acceptable to an extent. There is not enough data to determine whether this is the attitude of the entire senior staff of the organisation, but there definitely is enough data from the junior staff to show that this was not acceptable to them. This was an interesting fact since most of these junior staff are clinical staff such as counsellors and some of the misconduct have happened between counsellors and clients.

#### *Clinical staff, consultation and responsibilities*

The lack of consultation with the clinical staff came up constantly in some individual interviews and in the focus group. The main concern was that, because of the lack of consultation, the treatment process was not running according to 'therapeutic methods' and that the whole process was getting mixed up with a difference of opinion on how things should be run. An added stress identified by the participants was the lack on knowledge of clinical procedures of the administrative staff. These issues have come in different context and settings. Sometimes it had been brought to the attention of the senior administrative staff, but to date there had been no constructive solution put forward to resolve this issue.

*Aisha: We are not even able to give our suggestion to the committee regarding our clients, even though we have a suggestion section. They take it as we are dictating to them. Sometimes it is felt that the clinical section head makes a lot of decision without consulting the committee even.*

*Amir: It doesn't matter what is written there.*

*Aisha: nowadays the decision is already made when it comes to us.*

Equal opportunity for all the clients was lacking, because of the way some of the policies were worded, and because of the lack of knowledge of these documents. The lack of consultation with the clinical staff meant that the authority to decide on most of the issues rested with the administrative staff. It was suggested that, if a clinical input was given regarding the issues involved, perhaps a more fair unbiased system would exist. The participants believed that this lack of consultation contributed to the problem of discrimination that was happening. Another suggestion the participants put forward was, perhaps decision making should not exist with just one person when it came to client issues.

At a more philosophical level, of the three senior staff interviewed, one pushed the medical model, one a prohibitionist model and the other decriminalisation. These were three very different models and the junior clinical staff were being caught in the middle of it. The focus group did not have any problems with the current existing model, (which was a mixture of prohibitionist model with a therapeutic community model) since it was moving toward decriminalising and making treatment accessible to all. But because the senior staff could not agree how and what should be in effect in the programmes, there was serious conflict at the higher level. All three people are at a level to influence future policies of NNCB at an organisational level and also affect a National policy and when it was decided to make one. Currently, one of these staff is involved in drafting the new Law concerning treatment of substance abusers. And there is an obvious lack of consultation with the people who are actively working in the field.

The participants also brought up the issue of lack of transparency and communication within the organisation. The lack of transparency meant that, there

was a deliberate attempt to keep some of the information exclusive to the senior staff. The focus group participants and some of the individual interviewees were of the opinion that, this was a major cause of opportunity for discrimination against the clients in relation to decisions taken by the senior staff. If the decision making process were made more visible to staff as well as the clients concerned, the participants believed that there would be less opportunity for discrimination and misconduct from the staff. Data also suggests that more members would like information made available both to staff and clients, especially information regarding themselves (clients and staff). A general improvement of communication within the organisation and also between itself and the clients was suggested as another solution to this problem.

A prominent issue faced by the clinical staff was that, they were ‘made’ responsible for all the issues related to their clients, whereas they thought that they should be held responsible for only the counselling sessions, inclusive of family counselling and skills classes. The participants did not see that having to call up their clients repeatedly for non attendance for signing and urine tests should be their responsibility, especially, since there were specific sections in NNCB to carryout these tasks. As counsellors have to be ‘two faced’ – be an authoritative figure as well as their counsellor, the counsellors were not able to maintain a healthy ‘therapeutic’ relationship with the clients. One participant states:

*Raya: And the supervisors (guards) they make a list and go around the houses to get the clients, but we have no idea who is on the list, if we did then it would make our job easier, and we would know at what stage the process is at. And after being told to come in to NCB by these supervisors some don't turn up and we don't know who it was that didn't turn up either. In the end we don't know whether the client had been notified at all or that the client had been notified and chose to ignore and not come in. Also sometimes the police might take the clients, and we wouldn't know this either, we get no notification at all. It all becomes muddled up and confused. The only way we find out is, when we call their house, their parents tell us that that client had been taken to the police*

*and has been there for this number of days. There should be some procedure for this too, if the police take them, then they have to communicate to NCB. Then we can update the case and state that the client was in police custody. Then again we also have to think about, what would happen to the client once s/he was released, would s/he come back here or go to a sentence or what. Right now, I have no way of knowing what would happen to a client when s/he was released from the police, whether the client keeps the status of an NCB client, or whether the client would be referred to the courts or what. And they expect us to keep track of all of this!*

In instances like the above example, the counsellors are questioned when something regarding a client goes wrong. The participant was stating that during the whole procedure of going to find the client, the progress is not reported. The participants were questioning whether, they as counsellors or clinical staff even need to know all the ongoing administrative work that went beyond the therapeutic relationship regarding the client. Perhaps if they were not made accountable for that, then there would be no issues relating to the counsellors not knowing the progress of those actions mentioned by the participant.

Another issue raised was that, the clinical staff had to conduct awareness programmes that took them all over the country, leaving little time for preparing the material and also little time to inform the clients that they would not be available and not enough time to hand the client over to another counsellor. Even if they were able to do it, the counsellor who took over the client might have to go off the following week, and they were having a hard time keeping track of the clients. There was nobody there to keep track of what was happening to the clients and their affairs, when the counsellors were rostered like this. In other words, no supervision was given to the counsellors. The following quote gives a good idea of what the priority is like.

*Dhooma: They might send the counsellor for 10 days to conduct some programme, and then the coming week to conduct a training programme, the next week to some other island, without any breaks in between. We might not get to come in*

*to office for a month or more, or get to come in for a sec or two. I don't believe that this is right.*

The participant was describing the typical schedule of a counsellor, and how little the administration thought about how a client might be disadvantaged when the counsellor is unavailable. This issue of neglect of clients was becoming very apparent to most of the counsellors, but they were unable to do anything about this since there was nobody who provided supervision to the counsellors and hence nobody who understood clinical issues like that.

The data discussed above is applicable to the clinical staff working in the residential setting as well. In addition some of the issues faced by them were; lack of supervision or lack of professional staff to help them in their work; and lack of supervision from the 'committee'. Another important issue mentioned by these participants was a lack of guidelines or procedures for the medical staff working in the DRC. Currently a doctor and nurse works in the setting itself. But the doctor is not given an orientation or a set of rules or guidelines to operate in the centre. The participants mentioned that the doctors who came to work there repeatedly undermined the work of the counsellors and there was no collaboration with clinical staff on sensitive client issues. They suggested that, perhaps somebody should provide some sort of guidelines or at least orient provide an orientation to the culture and also the culture of substance abusers and their behaviour.

### **Chapter Summary**

From the analysis of the data collected, it can be safely concluded that there is a serious lack in knowledge relating to existing policies. The result is that the services of the organisation are run inefficiently. While there was a lack of proper procedures, guidelines and policies to run the programs, the data also showed that, there was an urgent need to review these policies which did exist. In addition, there was a lack of adherence to the currently existing rules and policies from both the staff of NNCB and its clients. This lack of observance of rules created the context for serious, ethical dilemmas that were faced by the practitioners, which affected both staff and the clients. A further need was for a staff and client rights.

Issues regarding the Committee involve the membership, meeting and the ethics. The findings assured an urgent need existed for an evaluation of this body and its membership and responsibilities to the NNCB. These issues will be reviewed in the next chapter

## **CHAPTER FOUR**

### **Conclusion**

This thesis has documented inconsistencies and serious injustices in the approach prescribed by the Maldivian law and related official policies to address drug misuse, and service provisions in the Maldives. I have examined whether there is a need for legislative and policy change, and the reformulation of service provisions. Findings support the need for such change. This chapter will review the key findings from the previous chapter and then move on to a focus on recommendations for improving policies and services in the Maldives based on the key findings from the analysis.

Analysis of participant accounts revealed that there is a lack of knowledge of existing policies and their content among those providing services and clients. As a result, current programmes are not carried out as intended or in the most efficient or proper manner. There is a lack of proper policy or rules of procedure to govern them. A need for the review of the policies was a major issue brought out by almost all the participants including the lack of provision of service for alcohol abusers. At present there are no services provided for this group of people, for the reason that the legislation and the policies of NNCB have no provisions for treatment for alcohol consumption. As mentioned in Chapter One, all intoxicants are treated as the same in Islam. Maldives being a Muslim nation, perhaps need to adjust the legislature or policy where alcohol and drugs could come under the same law and make provision accordingly for treatment.

The lack of dialogue between clinical staff, policy makers and legislators supports the proposition that policies need to be reflective of practice and uniformly applied. Change is crucial because the rights of the staff and clients are currently exacerbated by a lack of communication and issues with the NNCB. A key factor for enabling evidence based best practices has been identified as communication. The lack of communication between these two parties have been identified as a

major reason the gap between treatment approaches and practice (Campbell et al., 2003; Lamb et al., 1998).

Additional issues addressed in this chapter relate to the limitations of NNCB policies and the lack of adherence to the existing policy concerns. These concerns were evident from the accounts of staff from the levels of the organisation. There was a general lack of awareness of the policies in question and associated lack of adherence, and perceived lack of relevance. Currently there was no code of conduct of ethics to govern the practice of the clinical staff or any other staff. This resulted in violations of client rights were happening within the organisation with no accountability, nor any authority to address these issues. Tarvydas & Cottone, (2000) states that a code of ethics is the identifier that defines a profession for its stakeholders. Furthermore, the coercion for treatment and the classification of substance abuse as a crime in the legislature treatment decision as looked at in Chapter One adds onto this problem of ethics and the dilemmas of therapeutic alliance. This will be discussed later in this chapter.

The issues surrounding the Committee seems to revolve around, the irrelevant membership and perceived unethical conduct of committee members and a general lack of accountability. The NNCB seems to be exhibiting a power struggle within each level of the organisation, inclusive to the clients. In the case of NNCB there was a lack of accountability and a careless attitude towards documentation. A lack of consultation with the clinical staff existed, with little or no communication between the administrative staff and these practitioners. To add on to the above mentioned issues, there was a lack of transparency within the organisation. These issues support the need for change that is felt by all participants in order to address the split between the currently existing policies and practice. These issues are addressed in the following section.

Issues of policy practice split emerged inductively and in particular through conduct of the focus group sessions when it became apparent that those practicing did not know about the policy or legal contexts for their work. This issue of the relationship between theory and practice is a recurrent theme in psychological research (Hill, 1994; Jeutleson, 2002). The bridge building perspective claims that

scholars not only can but also have an obligation to contribute to practice (Jentleson, 2002). Conversely, the independence perspective argues that scholars should keep policy makers at a distance (Hill, 1994). There are particular risks to this bridge building (Booth, 1997). When research produces useful ideas, it is mainly the responsibility of the scholar to initiate the interaction between practitioners. The greater the internal differentiation and thus the degree of specialisation, the greater the frequency of exchange with practitioners (Eberwein, 1994 cited in Eriksson, 2006). Schools of public policy are particularly useful for communicating research-based ideas to future and in some cases active practitioners (Eriksson, 2004). The need to address this gap became apparent during the course of this research. Currently there is little research done in the area of substance abuse in the Maldives, and the findings of this research are not related back to the practitioners. Therefore, formulating a best practice based on a Maldivian model is both difficult and unrealistic given the lack of research and lack of evaluation of existing models of treatments, for example, the prohibitionist model versus the harm reduction model, as discussed in Chapter one. The Maldives has not yet embraced any harm reduction strategy nor evaluated the possible strategies for an implementation of such a program. At the same time it is confusing for a practitioner to choose a best practice, because, strict traditional prohibitionist model is not followed and enough resources on other existing models are not made available in a form that could be understood and applied to practice. In the following section, the concept of therapeutic alliance and best practices are discussed.

### **Therapeutic Alliance and Best Practices**

The treatment of substance abusers poses serious challenges to practitioners. One of the most important of this is maintaining a positive therapeutic alliance with the clients<sup>1</sup>. If practitioners succeed in communicating the spirit of acceptance, collaboration, respect, goodwill and optimism to their substance abuse clients, the process of treatment will be enhanced (Newman, 1997). A look at the qualities

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<sup>1</sup> *The concept of therapeutic alliance started with Freud. Freud took for granted the need to first establish rapport as part of developing alliance with the patient, as an essential part of effective treatment. Later Bordin, developed on it and set the stage for later developments and measures of therapeutic alliance (Luborsky, Barber, Siqueland, MacLellan, & Woody, 1997).*

mentioned above, shows that NNCB is gravely lacking in therapeutic alliance. First of all, the practitioners find it hard to maintain proper communication with the clients, due to a general lack of open communication channels within the organisation. Even though the practitioners/clinical staff accept the clients as they are, data showed that it was hard for the clinical staff to convey this general acceptance of clients because of the restrictive and prohibitionist stance of the law. Clinical staff find it hard to get the collaboration and trust from clients in such an environment. Naturally without these factors, goodwill is non-existent and it is hard for the clinical staff to exhibit optimism (Newman, 1997). At the moment, there is little to no therapeutic alliance between the clinical staff of the NNCB and its clients. The need to foster this positive alliance is greatly felt by practitioners who participated in this research. It is recommended that NNCB can facilitate the formation and maintenance of a positive therapeutic alliance between staff and clients by consistently adhering to a code of conduct or ethics and facilitating such principles as working with the clients as a team, providing clinical rationales in a clear fashion and eliciting feedback from the clients. Being aware of the stance of NNCB on issues, at the same time as being aware of the needs of the clinical staff, as well as checking the client's own belief systems is believed to be helpful to the therapeutic alliance process (Newman, 1997).

As data shows, when new policies are enforced or implemented it would be useful if they were subject to forum discussions. Most of the participants suggest that if they were initially consulted on the formulation of policy more comprehensible and representative policies would be developed and implemented. The lack of consultation with practitioners has left NNCB with policy documents that are not appropriate for implementation, documents that do not reflect current practice and best procedures. There needs to be an open channel of communication between the necessary stakeholders (Campbell, Daoud, Catlin, & Abelson, 2005). Evans (2001) states the importance of input by practitioners in establishing research proposals that aim to improve the quality of service to clients. His argument is that, since there is a wide range of drug services available for the community, practitioners who deliver these services should contribute to the research design and implementation (Evans, 2001). Aronson (1993) affirms that increasing the

involvement of service–users in public policy reflects the drive to ensure that policies and programmes are more appropriate for meeting service-user needs.

Until very recently, the NNCB did not have a policy section/department where existing policies were reviewed and new policy formulated. After the recent establishment of this section, NNCB has yet to undertake the job of evaluating the existing policies. Currently, it has been reported that there is a serious lack of staff in that section (personal communication, Aishath Mohamed. March 2006). Formulating this department is seen as a step forward. However, there is a need for NNCB to equip this section with qualified professionals and back them up with proper resources. Furthermore, NNCB needs to look at participant and practitioner inclusion when formulating new policies or evaluating old ones. There is a need to produce policy documents that are relevant and feasible. Fostering cooperation and understanding between the practitioners and the administration would help ensure that the commitment to policy changes are shared. This might address likely resistance to change.

### **Policy Recommendations**

With the adherence to the UN conventions, the Maldives adopted the prohibitionist stance promoted by countries such as the United States. The prohibitionist stance fitted with the Islamic Shari’a, and as a result, no effort was made to look for other alternatives. At the time of the UN conventions, although substance abuse was reported (UNDCP, 2000), it was not classified as a problem by the Maldivian government. After the ‘drug problem’ did start to emerge in the late 1980’s the law was amended (in 1995) to incorporate a drug rehabilitation service. This move showed that the Maldives no longer strictly adhered to the prohibitionist stance. Rather, we started moving away from a strict prohibitionist stance to providing treatment to users. This amendment did, however, retain the prohibitionist language of users being labelled as criminals and had harsher sentences for ‘traders/dealers’. The law at that stage did allow a one time chance for rehabilitation. If there was a relapse on the part of the client, no more opportunities were given. A later amendment to the law provided the substance abuser with two more opportunities for rehabilitation for convicted substance

abusers and also the unique opportunity to enter rehabilitation without having a police record (the opportunity to volunteer). The alarming increase in the substance abusing population (FASHAN et al., 2003) has raised a need for research on culturally acceptable options that would not conflict with the Islamic Shari'a.

It is understandable why local researchers would hesitate to suggest harm reduction strategies or methods (Goldberg, 2004) as a solution to the substance abuse problem. It is perceived that harm reduction methods would be in direct conflict with Shari'a. That is implementing harm reduction strategies would probably mean accepting substance abuse as not a legal problem and there is the belief that this would enhance the belief that substance abuse is not prohibited in Shari'a.

Substance abuse is a problem in other Islamic countries as well. The major categories of the substances abused in these countries include opium and its derivatives, cannabis, khat, alcohol and certain manufactured psychoactive derivatives (Baasher, 1981). With the exception of alcohol there is no reference to any of the drugs mentioned above in the early Islamic era, and there is no direct mention of either of them in the Qur'an or the *hadith/sunna* (sayings and practices of the Prophet). In later periods in history, the lack of this reference in the Qur'an and *hadiths* has created dilemmas with regard to the use of dependence-producing drugs. Baasher (1981) states that, it is not unusual to come across a person from Sudan or Egypt who abuses some sort of substance with the firm conviction that it was not wrong to indulge in the use of these drugs because they have not been prohibited by Allah, since they were not mentioned in the Qur'an. This attitude seems to have filtered into the Maldivian culture as well. Alcohol is *haram* (prohibited) and while misuse of other substances is not a good thing to do, it is not considered haram. This belief is upheld because the legal system currently prescribes 40 lashes-*hadd* for people who consume alcohol and is not included in the Law on Narcotics and Psychotropic substances.

It is worth noting that Islamic shari'a has clearly stipulated that whatever constitutes a dependence-producing drug and which, therefore should be regarded

as harmful, should not be consumed by any Muslim. There is no data available to determine the cause of this split in the legislature between general substances of abuse and alcohol. However, since the Maldives is trying to comply with Islamic doctrine, it would be useful to look at the model that was first implemented in Islam. The model gave due consideration to the prevailing ecological factors and a step-by-step system of gradual desensitization, persuasion and effective community involvement (Baasher, 1981). The Four Pillar Model discussed below prescribes an acceptance of substance abusers and employ methodology that would not directly contradict with the shari'a.

*An alternative approach*

'Four Pillar Strategy' suggested by Heed (2006) is realistic and applicable to the Maldivian situation. The Four Pillars Drug Strategy is a plan for reducing drug-related harm. It consist of;

Pillar one, harm reduction – reducing the spread of deadly communicable diseases, preventing drug overdose deaths, increasing substance users' contact with health care services and drug treatment programs, and reducing consumption of drugs in the street;

Pillar two, Prevention – using a variety of strategies to help people understand substance misuse, the negative health impacts and legal risks associated with substance use and abuse, encouraging people to make healthy choices, and providing opportunities to help reduce the likelihood of substance abuse, including affordable housing, employment training and jobs, recreation and long-term economic development;

Pillar three, Treatment – offering individuals access to services that help people come to terms with substance misuse and lead healthier lives, including outpatient and peer-based counselling, methadone programs, daytime and residential treatment, housing support, and ongoing medical care; and,

Pillar four, Enforcement – recognizing the need for peace and quiet, public order and safety in the country by targeting organized crime, drug dealing, drug houses, problem businesses involved in the drug trade, and improving coordination with health services and other agencies that link drug users to withdrawal management (detoxification), treatment, counseling and prevention services (city of Vancouver, 2006).

In Heed's vision, the police and other enforcement agencies have a leadership structure that is responsive to emerging concerns and focus on immediate problems where solutions are available. The police are involved in addressing the issue of reducing the supply of drugs, suppressing or disrupting the drug scene and maintaining order on the street. At the same time, the enforcement agencies are supposed to accept addiction as a health issue. My experience shows that, almost everybody in the Maldives has scoffed at the idea of 'drug abuse' being a disease. The Attorney General's Office (2004, p.21) states that drug abuse is generally perceived as a crime rather than a health issue. This criminalisation has led to widespread stigmatization and social exclusion, leaving the substance abuser with a criminal record, expulsion from school or workplace, and further difficulties in obtaining employment. The general public and the relevant organisation has accepted that people abusing substances face innumerable health issues. Therefore selling the idea of a harm reduction approach to substance abuse to the general public and some of the enforcement agencies as a health issue is perceived to be more probable.

Heed (2006) continues that these enforcement agencies address different levels of the drug field. At one level they refer the substance abusers to the health and social services, and on the other level, these enforcement agencies are to actively pursue the profit oriented traffickers and expect the courts and corrections to play a role in dealing with these subjects. This scenario is similar to what is supposed to be happening now in the Maldives. A couple of simple adjustments/amendments to the law and policies would make this procedure work. Currently the substance abusers are taken into the legal system and processed through the courts. Instead, if they could be referred directly to the NNCB or any other agency involved in providing similar services, then the problem of

stigmatizing the substance abusers as criminals would be dealt with. If the stigma could be gradually removed, then the general public would be more susceptible to more health focused treatment options for substance abusers.

In a small country like the Maldives public opinion should be taken into consideration. As it is, the problem of drugs is widespread in the Maldives (Attorney General's Office, 2004; FASHAN et al., 2003; NCB, 2004, 2001, 2000 & NNCB, 2004) and almost everybody is affected by it. Currently the law states "Any person found to be in possession of any narcotic drugs and psychotropic substance, in excess of one gram, shall be deemed to be in the business of trading in narcotic drugs and psychotropic substances" (Attorney General's Office, 2006. p.1). The penalty for trading is currently life imprisonment. To fit into the *Four Pillar System*, or even a harm reduction approach, the Maldivian Law needs to allow people who are addicted to any substance the opportunity to be treated. There needs to be a differentiation between addicted traffickers/dealers/traders and traders who deal just for the profit. Heed (2006), proposes that the addicted trafficker who lies in between the above mentioned two groups, be dealt by the police. The reasoning behind this statement being that, typically persons in this category are chronic offenders, with long histories of trafficking related behaviour. However, they can still refer the addicted traffickers to treatment, but continue to deal with the individuals who resist detoxification and treatment and refer them to the legal system. An integrated approach like this would need the cooperation of organisations and offices such as the NNCB, the Police Services, the National Security Services, The Maldives Customs, Immigration and the Department of Penitentiary and Rehabilitation to mention a few. All these agencies have meaningful roles and contribute to the overall solution.

Persisting with the prohibitionist model and arresting our way out of this drug problem is not a solution (Heed, 2006). There is a need to be proactively involved in the situation and work towards a common goal of addressing the drug problem in the Maldives. There is a greater need to stop the problem before it starts, and if that cannot be done, then stop people who are already abusing substances. Similarly, if that cannot be sufficiently addressed then the priority becomes reducing the harm substance abuse is going to bring them, and to the society.

This would mean that there is a need to accept and respect that substance abusers are part of the general population and that they are people too, and people need to believe that they can lead useful lives (Heed, 2006). As a nation, there is the need to accept the notion that the solution to the drug problem is not beyond reach, and at the same time have to accept that the drug problem developed gradually not overnight, and therefore a solution cannot be found overnight. Presently, the Maldives lacks proper services for the current requirement. There is only one rehabilitation centre in the country, there is no network for community-based outreach for those who cannot or do not want to access treatment centres, the existing drug rehabilitation centre which is fully government-funded is currently running 40% below capacity resulting from obstacles posed by the Anti-Narcotic Act (Attorney General's Office, 2004). This acknowledgement of obstacles arising from the legislature is seen as a need for change. Since the National Criminal Justice Action Plan (Attorney General's Office, 2004), suggests establishing a comprehensive system of care for substance abusers which is needs-based and client led. And that this care system should address issues such as pre-treatment, motivational counselling and other harm reduction measures, detoxification and treatment, rehabilitation and aftercare, and follow-up and social-reintegration.

### **Reflections on the Research**

This research contributes to the developing and rapidly changing NNCB by canvassing input from clinical staff who need to be central to any 'informed' and workable plans for change in services. The thesis makes a novel contribution to academic knowledge regarding links between legislation, policies and practice in the Maldives that may be of relevance to other Muslim countries. As noted above, a lack of previous research on these issues created difficulties. It was difficult to predict the outcome of this research. An associated weakness of this research was that the research had to adapt a lot of Western ideas and research to support a locally focused research. As a result, all the data was compared with Western literature and ideas, which provided some general insights, was at other times less

relevant. The lack of previous research has also provided an opportunity to explore and draw together material from a range of fields.

However this thesis was able to reflect the situation of Maldives and where exactly Maldives stood in an international context in the arena of drug policy framework. Being the small country it is, it is of some comfort that Maldives was not that far lagging behind the developed countries in moving away from a prohibitionist model towards a more harm minimisation focused model. This is indicated by a proposed change to the law on narcotics to accommodate access to treatment centres regardless of how many times a person has accessed treatment before. This new draft also proposes opening the service provision to NGOs. Perhaps a service provision for alcohol abuse would not be too far behind. Being a from Muslim nation and coming from that background, I find it easy as a researcher to understand why the state is hesitant to acknowledge a problem in this area. Making a service available would be acknowledging a problem, hence leading to conflicts of whether making a service available would be saying that it is ok to abuse alcohol. As a practitioner, it is easy to acknowledge that there is a serious need in that area, and this need should be reflected in policy itself. This leads to the split in policy and practice. As reflected in this thesis, there are a number of ways to address this issue. As a researcher and a practitioner, I feel that, addressing the issues of consultation and communication would help promote best practice and at the same time address the issue of the split and gap. This brings me to the one of the core reasons why I took on this project, the issue of ethics. The need for a professional independent body to monitor the practitioners as well as the need for a regulatory body to supervise and inspect the service providers and evaluate the services.

To conclude, this thesis has investigated the need for NNCB to adapt its policy to the changing requirements of practitioners and clients. It has also shown that The Maldives needs to keep up with the rest of the Islamic community as well as the world in order to be able to provide best practices. Findings suggest that further research needs to be carried out in the area of policy feasibility and change within substance misuse services in Islamic nations.

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# Appendices

**APPENDIX A: POLICY ON TREATING SUBSTANCE ABUSERS**  
**(Committee Policy)- as translated**

**1. Name of the Committee:**

Decision making committee on identifying the substance abusers who fit under the Criteria Of Requiring Undergoing Treatment By Law, And How The Treatment Should Be Carried Out.'

**2. Members:**

Representative from the Ministry of Defence and National Security

Representative from the Ministry of Health

Representative from Ministry of Women's Affairs and Social Security

Representative from the Office of the Attorney General

And Representative from the Narcotics Control Board

**3. Responsibility / Role**

- 3.1 Make a decision on who needs to undergo rehabilitation/ Treatment as stipulated by the law.
- 3.2 Make decisions on how this treatment is to be carried out for each individual.
- 3.3 Monitor the treatment programme on a regular basis.
- 3.4 Make a decision on who has completed the treatment. (Refer to 2)
- 3.5 Make a decision on who is to be terminated from the programme.(refer to 2)
- 3.6 Make a decision on how the individual will be penalized for committing an offence/crime during the treatment period.

**4. Making a decision on recommending individuals for treatment.**

- 4.1 Treatment could only be given for substance abusers as stipulated under the Law 17/77 article 11 (from court referred clients only). And as under article 12 – where people volunteer themselves for treatment. People from both categories can go for treatment based on this committee's decision.

- 4.2 Before making a decision, the individual's criminal history for the past 5 years should be looked at. This includes sentenced served, serving and to be served. All the records/cases held by Office of the Attorney General's Office, Ministry of Defence and National Security, Criminal Court and Department of Corrections should be examined. If these records are deemed not satisfactory by this committee, treatment can be denied.
- 4.3 An initial interview should be done via the Narcotics Control Board on each individual before a decision regarding the individual is reached.
- 4.4 After examining the records mentioned in 1.2, interview mentioned in 1.3, the police statement from the investigating officer signed by the individual, and signed form requesting to undergo the treatment programme, a decision is made on who should receive treatment.
- 4.5 In the interview stated in 1.3, if a person under the age of 18 signed the form NOT wanting to go for treatment. The committee has the authority to recommend to send this individual for treatment.
- 4.6 Individuals who had already completed this programme and people who were terminated from the programme should NOT be recommended for treatment again.
- 4.7 Individuals who met the criteria as mentioned in 1.1, but did not take that opportunity to go for treatment should NOT be recommended for treatment.
- 4.8 In the case of individuals whose cases get referred back to the committee after a new offence (where the person was not recommended for treatment), the new case should be looked at before reaching a decision.
- 4.9 Individuals who had a previous history of selling or importing drugs should not be recommended for treatment.
- 4.10 Individuals who had once completed their treatment programme as a volunteer and individuals (volunteers) who were terminated from the programme should not be recommended for treatment.

## **5. How to provide treatment**

- 5.1 Residential rehabilitation – based in the Drug Rehabilitation Centre
- 5.2 Halfway house – this is the stage where the client is kept before the client rejoins the family and the community.
- 5.3 Community rehabilitation – based in the community with the family.

- 1.1.1. An assessment report on each individual should be sent to the committee every 90 days.
- 1.1.2. Individuals who are recommended for treatment would start in the residential programme – Drug Rehabilitation Centre. Those clients that respond to the programme and show steady progress in the programme will be reviewed by a committee of counsellors. Those clients recommended by the counsellor’s committee for community rehabilitation will be reviewed by this committee and approved.
- 1.1.3. As mentioned in ii), the reports reviewed by the counsellor’s committee should be submitted to the NCB. The head of NCB or person in charge of NCB at the time will review the case and transfer the individual to the halfway house for a period not extending 30 days.
- 1.1.4. The head of NCB or the person in charge at the time has the authority to transfer clients from the Halfway house to the Community Programme provided that these clients are progressing well in the programme.
- 1.1.5. A progress report from the individual’s counsellor should be presented to the committee of clients who have progressed enough to leave the community programme and clients whose sentences are due to finish in 30 days. The committee will review the report from the counsellor and their case file before making a decision on whether the individual has completed treatment or not.

**6. How to treat individuals who do not complete the treatment as per their agreement.**

- 5.4 After reviewing the assessment reports, if the committee feels that the individual is not progressing well or not adhering to the treatment agreement, the committee should terminate the individual from the treatment programme. And the individuals who were referred through the court would return/resume their sentence as stipulated by Law 17/77, article 13b. If the reason why the individual was terminated happens to be something that could be classified as an offence or a crime, then that offence/crime should be reported to the relevant authority.
- 5.5 If an individual does not complete the treatment stipulated under Law 17/77 article 12, then this case should be referred to the relevant

authority. If the reason why the individual was terminated happens to be something that could be classified as an offence or a crime, then that offence/crime should be reported to the relevant authority as well.

Note:

- The referred services of the Halfway House in section 5 in this policy has not established yet. This part of the policy will come into action when the services start.
- From individuals referred to this committee, based on their age, health, type of drug abused and level of addiction; the committee can decide for the individual to skip a stage of the treatment programme mentioned in Section 5 of this policy.

As amended on 28 June 2004.

## **APPENDIX B: POLICY ON CLIENTS - *as translated***

### **Clients in the Drug Rehabilitation Center**

1. A positive urine result (either in the random urine check or when it is checked on their return trip from male' to the centre).
  - 1.1. Clients excluding Young members
    - a) First time – Demote one level
    - b) Second time – suspension of privileges for a month
    - c) Third time – Refer to the committee for a decision
  - 1.2. Young member
    - a) First time – Suspension of a privilege for a month. ( The privilege that is most cherished by the client)
    - b) Second time – Suspension of privileges for a month.
    - c) Third time – refer to the committee for a decision.
2. In the instance where a client tries to bring in any drug/substance mentioned in the law, and any drug/substance which is illegal to import to the Maldives to the centre, will be referred to the Ministry of Defence for investigation.
3. In the instance where a client tries to bring in tobacco or any other prohibited item to the centre ;
  - 3.1. First time – written warning given (signed)
  - 3.2. Second time – refer to committee for a decision.
4. In the instance where a client tries to bring anything which is not allowed in the centre without the permission of the Narcotics Control Board.
  - 4.1. First time – written advice (signed)
  - 4.2. Second time – warning (signed)
  - 4.3. Third time – refer to the committee for a decision.
5. Not attending the mosque for prayers.
  - 5.1. First time – verbal advice
  - 5.2. Second time – written advice (signed)
  - 5.3. Third time – written warning (signed).
  - 5.4. Fourth time – refer to the committee for a decision.
6. Not attending the classes
  - 6.1. First time – written advice (signed)
  - 6.2. Second time – written warning (signed)
  - 6.3. Third time – refer to the committee for a decision.

7. not attending morning meeting and other activities
  - 7.1. First time – verbal advice
  - 7.2. second time – written advice (signed)
  - 7.3. Third time – written warning (signed) and the suspension of some privileges for a month.
  - 7.4. Fourth time – refer to the committee for a decision.
8. Vandalism on the premises of the Drug Rehabilitation Centre.
  - 8.1. Pay for the damages and issue a written warning (signed)
  - 8.2. If the damages are not paid for, refer the case to the committee for a decision
  - 8.3. If there is a repetition of this offence, refer to the committee for a decision.
9. Stealing or damaging another client's property
  - 9.1. Pay for the damages and issue a written warning (signed)
  - 9.2. If the damages are not paid for, refer the case to the committee for a decision.
  - 9.3. If there is a repetition of this offence, refer to the committee for a decision.
10. Getting intoxicated in the premises of the Drug Rehabilitation Centre (DRC).
  - 10.1. Refer to the committee for a decision.
11. Smoking (cigarettes) within the premises of DRC
  - 11.1. First time – written advice (signed)
  - 11.2. Second time – written warning (signed)
  - 11.3. Third time – refer to the committee for a decision
12. Going outside the premises of the DRC in breach of its rules and regulations
  - 12.1. First time – written warning (signed)
  - 12.2. Second time – suspension of some privileges for a month
  - 12.3. Third time – refer to the committee for a decision
13. Inciting violence within the premises of the DRC
  - 13.1. Refer to the committee for a decision
14. Being unduly rude to staff of DRC
  - 14.1. First time – written advice (signed)
  - 14.2. Second time – written warning (signed) and the suspension of some privileges for a month.
  - 14.3. Third time – refer to the committee for a decision
15. Harassing other clients in the DRC
  - 15.1. First time – verbal advice

- 15.2. Second time – written advice (signed)
- 15.3. Third time – written warning (signed) with the suspension of some privileges for a month.
- 15.4. Fourth time – refer to the committee for a decision
- 15.5. If the harassment occurred against a member of the opposite sex , refer to the committee without going through the above mentioned steps.
- 16. If a male client, grows is hair long, dye the hair, grow their finger nails, body piercing and wears unacceptable cloths
  - 16.1. Notify him of the changes needed (signed)
  - 16.2. If the changes are not brought, refer to the committee
- 17. Committing an offence/crime under the Shari’ah and Law
  - 17.1. Refer to the committee for a decision
- 18. Not going to the DRC on the scheduled day
  - 18.1. In the presence of the parent/guardian get a written statement from the client (signed) Send him to the Centre on the first available ferry and suspend some of the privileges for a month.
  - 18.2. If this offence is repeated, refer to the committee for a decision.
- 19. Using any medication in violation of any of the exiting policies of the Narcotics Control Board (NCB)
  - 19.1. First time – written advice (signed)
  - 19.2. Second time – written warning (signed) with the suspension of some privileges for a month.
  - 19.3. Third time – refer to the committee for a decision.

### **Clients in the Community Rehabilitation Programme**

- 1. A positive urine test
  - 1.1. First time – Refer the ‘special counselling’ programme
  - 1.2. Second time – suspend all the privileges and send the client to DRC for a period no less than a month.
  - 1.3. Third time – refer to the committee for a decision
- 2. Ab/using a narcotic drug
  - 2.1. Refer to the committee for a decision
- 3. Taking any kind of medication without prior approval of the NCB
  - 3.1. First time – written advice (signed)
  - 3.2. Second time – written warning (signed)
  - 3.3. Third time – refer to the committee for a decision

4. Working without getting prior approval from NCB
  - 4.1. First time – written advice (signed)
  - 4.2. Second time – written warning (signed)
  - 4.3. Third time – refer to the committee for a decision.
5. Going out of the house in violation of any of the exiting policies of the Narcotics Control Board (NCB)
  - 5.1. First time – written advice (signed)
  - 5.2. Second time – written warning (signed)
  - 5.3. Third time – refer to the committee for a decision.
6. Not signing in at NCB
  - 6.1. First time – written advice (signed)
  - 6.2. Second time – Sending the client back to DRC with the suspension of all privileges for a period not less than a month
  - 6.3. Third time – refer to the committee for a decision
7. Not attending the classes
  - 7.1. First time – written advice (signed)
  - 7.2. Second time – written warning (signed)
  - 7.3. Third time – refer to the committee for a decision.
8. Not attending the counselling sessions
  - 8.1. First time – written advice (signed)
  - 8.2. Second time – written warning (signed)
  - 8.3. Third time – refer to the committee for a decision.
9. Hiding from supervisors
  - 9.1. First time – written advice (signed)
  - 9.2. Second time – refer to the committee for a decision
10. Smoking cigarettes
  - 10.1. First time – written advice (signed)
  - 10.2. Second time – written warning (signed)
  - 10.3. Third time – refer to the committee for a decision.
11. Taking part in sports, tournaments and social events without getting prior approval from the NCB
  - 11.1. Refer to the committee for a decision
12. Getting married without the approval of the NCB
  - 12.1. Refer to the committee for a decision
13. Leaving the island without prior permission from the NCB or evading NCB.
  - 13.1. Refer to the committee

14. Committing an offence of crime in violation of the existing policies of the NCB, which is not included in this policy
  - 14.1. Refer to the committee
15. After the client had been in the community rehabilitation programme for six months, if the client is progressing well, the commissioner of NCB or the person in charge at the moment in NCB has the right to grant the client a leave of 3 weeks to visit the client's family in the home island.
16. Evading the NCB when asked to come in
  - 16.1. Refer to the committee

Note: In the DRC there are eight levels. "Young members" refers to the new clients that are just starting the programme. During the first 8 months if these clients complete all the programmes that are intended for the young members, they progress to the next level. Other than the first level (young members) the other 8 levels have a duration of 3 weeks each to complete that level before progressing to the next level.

*\* (signed) – the document is signed by both parties;*

*NCB/DRC – to confirm that the advice/warning was given*

*Client - to legalize the document saying that s/he received the advice/warning.*

- **As amended on 28 June 2004.**

## **APPENDIX C: POLICY ON 'HOUSE ARREST' CLIENTS- *as translated***

1. Clients who have been sentenced for treatment under the NCB, while they wait for a place in the DRC, they are not allowed to go out of their house other than to places that NCB has given permission. They should only go to these places, in accordance with the conditions specified by NCB.
2.
  - 2.1. In the event that a client has to seek medical advice/attention, they should obtain permission from the NCB and go to the hospital or clinic with a parent/guardian. Prescription for medicine should be shown to NCB and permission obtained before using the medication.
  - 2.2. If a client needed urgent medical attention during non-working hours (of NCB), the client can go to the hospital or a clinic, accompanied with a parent/guardian. If any medication was prescribed, it should be taken. However, as soon as NCB re-opens, the prescription should be brought in to NCB to get permission for further use of the medication.
  - 2.3. Medication mentioned other than in 2.1 and 2.2 should not be used at any time.
3.
  - 3.1. To perform the 5 obligatory prayers in Jama'at (congregation), the client can go to the nearest mosque. For Friday prayers and other special prayers like the Eid prayers, the client can go to the nearest mosque that is performing that prayer or to the Islamic Centre. During the Ramadan, client can attend the Tharavees prayers in the closest mosque to his/her home. The client should not leave the house for prayer 20 minutes before the prayer time and should be back in home after 30 minutes after the prayer.
  - 3.2. The client should be on time for counselling sessions.
  - 3.3. The client should attend urine tests within an hour of notification.
  - 3.4. The client should take the shortest route to the destinations intended mentioned in 3.1, 3.2, 3.3, and 2.1. The client should not stop to talk to people, take any detours and go into places, en route to the above mentioned destinations. The client should always remember that s/he is in rehabilitation and respect the social etiquettes when on the road.
4. The clients should come in to sign in the registry on their designated days.

5. The clients who are under house arrest till they get a place in the DRC, can find work from places that are not too public, close to home under the following rules
  - 5.1. If they find a suitable job, they should inform NCB in writing, the name of the place and the job title and description of the job offered.
  - 5.2. Permission will only be granted if the place of work is registered, the job offered did not require the client to go into the community and can be done within the premises of the workplace.
  - 5.3. If the client is required to go to another part of male', villingili, Hulhule, Thiliafushi, Hulhumale', Funadhoo, as part of the job, the client should have obtained prior permission from the NCB.
6. The clients who are waiting to go to DRC are sent for House arrest, to the care of a parent/guardian. Therefore the parent/guardian should comply with the procedures and respect the policy. If a parent/guardian should find out that the client is breaking the rules, it is the responsibility of the parent/guardian to inform NCB of the incidence.
7. If a client is found breaking a rule, or gets a positive urine test, the client will be transferred to Jail for the awaiting period.
8. 3 and 5 will not be applicable to clients who don't have to go to any of the places mentioned above as part of their job.

**APPENDIX D: POLICY ON HOW THE BEHAVIOUR SHOULD BE  
MAINTAINED BY CLIENTS WHO ARE UNDERGOING TREATMENT  
IN THE REHABILITATION CENTER.- *as translated***

The main aim of the introduction of this policy was to make the clients who were undergoing their rehabilitation treatment in DRC, more acceptable to the society and to make them worthy of respect by the community and the society. The objectives of the policy were stated as;

- Learning to possess the determination and aim to lead a drug free life.
- Learning to respect and perform the obligatory requirements of the religion.
- Learning to have a good conduct and attitude.
- Early to rise early to bed – learning to.
- Learning to always be on time
- Learning to love your parents and relatives
- Learning at least two types of skill and handiwork
- Becoming a healthier individual.

Even though the objectives were stated as above, the tools on achieving the objectives were stated as; obeying orders/rules, performing the compulsory religious obligations, not smoking tobacco, personal hygiene and general cleanliness, conduct and attitude, use of the centre /facilities/belongings, restriction on things that could be brought into the centre, access to medical treatment, writing letters and communication outside the facility, family visits, phone calls, and urine tests.

Introduction

This policy has been introduced to make the clients who are undergoing their rehabilitation treatment in DRC, more acceptable to the society and make them worthy of respect by the community and society.

Objective

If the clients followed this policy of individuals who are in the treatment programme the following objectives could be achieved.

- a) Learn to possess the determination and aim to lead a drug free life.

- b) Learn to respect and perform the obligatory requirements of the religion.
- c) Learn to have a good conduct and attitude.
- d) Early to rise early to bed.
- e) Learn to always be on time
- f) Learn to love your parents and relatives
- g) Learn at least two types of skill and handiwork
- h) Become a healthier individual.

How the client should behave.

**1) Obey orders**

- a) Obeying orders is always one of the most important things in a residential centre like this
- b) The person giving the order is whether a Senior Official, Security Officer or a Guard, if they give the order using that rank, the client should obey that order.

**2) Perform the compulsory religious obligations**

Performing the 5 compulsory daily prayers, fasting, and reciting the Holy Qur'an is something all the clients should do regularly

**3) Staying away from Tobacco use**

Use of Tobacco is banned in this centre

**4) Cleanliness**

- a) Every client should be clean. During work time and other times, the client should give importance to his/her body, the clothes s/he is wearing and the place that s/he lives in
- b) All the male clients should have a hair cut one every month
- c) All the clients should shave their beards and moustaches. If a client wants to keep them, then it should be neatly trimmed.
- d) Nails and toenails should always be cut and neat. There should be no finger nails that should be grown longer, be it one finger or not.
- e) Male clients should not wear necklaces ear rings or other types of jewellery.
- f) Clients should not dye their hair any colour other than to use black dye to cover the grey hairs

**5) Conduct and attitude**

- a) Conduct and attitude is the determinant of good and bad in human beings. Therefore in a rehabilitation centre like this, the clients should exhibit these values.

- b) Within the premises and out the premise of the centre, raising your voice, shouting and using slang and bad language is not allowed.
- c) The clients should not call out to people going pass the centre, should not use abusive language, whistle or harass them at any time.

**6) Use of the centre and its belongings**

- a) The clients who come get rehabilitated should use the things in the centre with utmost care and know that these things are there to help them.
- b) If the clients break anything because of their carelessness, they should take the responsibility for replacing them.
- c) If the a client breaks something on purpose and with the intention of causing damage, then that case will be investigated proper measures taken.

**7) Things that can be and can not be brought into the centre for personal use.**

- a) The things that the clients bring into the centre should be brought in with the permission of NCB. During checks, if a prohibited item is found on a client, it will be assumed that this has been brought into the centre without the permission of NCB. Proper measures will be taken against the client. The type of this item will be taken into consideration.
- b) Listed below are things that the clients are prohibited from bringing into the centre at all times
  - i) Tobacco and tobacco products
  - ii) Lighter, matchbox, or things that can be used to ignite fire
  - iii) Coil (for boiling water ), cookware that requires electricity or gas
  - iv) TV
  - v) Communication equipment (walkie-talkies, mobile phones, etc.)
  - vi) Anything that can be used in the production of a substance that can be abused or any product that can be abused.
- c) Expensive items like receivers, cassette players, radios, Cameras and other such items excluding a regular wristwatch and a rormal pocket radio, proper permission should be obtained from NCB. Permission will only be granted for this type of only at the discretion of NCB. And these items could only be taken out of the Centre after obtaining proper permission from DRC.
- d) You as a client cannot giveaway your belongings, other than food items without obtaining prior permission from DRC.

- e) Any food item that needs cooking can only be brought into the centre after obtaining prior permission from the NCB.

#### **8) Medical treatment**

- a) Every client going through rehabilitation in the centre should have disclosed the history of all their existing medical problems. All the existing medical records and prescriptions should be handed in to the centre when they are admitted.
- b) During the treatment period, the client can only get treated at hospitals/medical centres and clinics that are approved by the NCB.
- c) In special circumstances where the client seeks medical treatment/attention from a non-approved provider (refer to 8b), special written permission should be obtained from NCB prior treatment.
- d) In getting treatment from any of the above mentioned (8b & 8c), the client should hand in the form to the doctor before the doctor attends to the client. The form is made about the client by NCB.
- e) If the client is receiving treatment as mentioned in 8c, the client should get the prescription approved by the NCB before starting any medication.
- f) Medical certificates obtained from any hospital other than Indira Gandhi Memorial Hospital (IGMH) will not be accepted by NCB.
- g) The client should not at any time obtain medication on their own, over the counter or otherwise. The clients should only use medication as mentioned in 8b or for prescriptions only.

#### **9) Writing letters and communications**

Since every drug abuse is influenced by outside forces, NCB takes the responsibility of minimising these outside influences on the client upon itself. Therefore the NCB and the DRC has to have some rules when clients send letters outside the centre and when clients receive any letter. The rules are as follows

- a) All the correspondences (letters) should be made through the NCB. The letter should not be sealed.
- b) Any correspondences to the client should be made via NCB. These letters will be checked before the clients receive them.
- c) Any mention of DRC or any client residing in DRC should not be mentioned to anyone who is not concerned.

#### **10) Participating in the programmes**

When working with people who have an addiction, DRC has to prohibit some things and order the clients to obey rules. According to this, arrangements

have to be made for each individual client. The clients have to participate in all the normal programmes conducted in the DRC. The progress of the client and the ease of living in the centre will be based on how the client is performing in the centre and how much involvement is given by the client.

**11) Going out of the premises of DRC and not participating in the programmes.**

- a) Any client undergoing treatment in the area is not allowed to step out of the premises of the DRC without getting prior permission from the office.
- b) During a programme where the DRC has planned outside the premises, the client should not move away from the area at any time.
- c) Full involvement from the client in the programmes conducted by DRC is expected. Clients who do not participate in these programmes without a valid reason will not be considered to be clients in the programme.
- d) As mentioned in 11c, a valid reason is considered to be a reason which the client given prior notification to and accepted by the DRC.
- e) If a client does not participate in the programmes without a valid reason as mentioned in 11c, the period that is spent in non-participation will not be counted as time spent in treatment. And, some of the privileges and other services will not be provided by DRC and these will be determined by the discretion of DRC.
- f) As mentioned in 11b, when working outside the premises of DRC, the clients should not communicate with people who are not involved in the programme and should not exchange anything or develop any relationship with these persons.
- g) The clients should take care to carry out their duties on top of the programmes that they are involved in. If a client fails to attend to the rostered duty, then steps mentioned in 11e will be taken.

**12) Sleeping and waking**

Going to bed early and waking up early are described in human beings as good habits. Therefore in a centre like this where people come to get rehabilitated, special attention is given to this issue.

- a) At DRC the lights go out for the night at 11pm. Clients are expected to get up 15 minutes prior to the dawn prayers. For special occasions or to allow for natural incidences these times can be changed temporarily and DRC will make the necessary changes.
- b) Clients are not to talk, laugh and joke, play songs/music or make any such loud noises during the sleeping time specified in (a) above.

### **13) Meeting family members**

- a) The earliest a DRC client can be sent to Male' to meet with his family members is 3 months. Permission may only be granted after a written request is made to DRC and after assessing the client's progress.
- b) The earliest that a family member can come to Himmafushi and meet with a client is two weeks if this was the first treatment that the client was undergoing. Permission may only be granted upon assessing the client's progress.

### **14) Talking to family members on the phone**

- a) The clients will be allowed to talk to their families on the phone, two weeks after their treatment commences. The duration of the call should not be more than 10 minutes.
- b) DRC will first call the respective family member at the specified number. Family members who are allowed to call the client will then call DRC and will be allowed to talk to the client as specified in (a).

### **15) Items to be obtained in order to participate in the DRC programme**

In addition to the normal clothing, the clients have to obtain the following items. This is in order to participate in various programmes run at the centre.

- 1 pair of track pants
- 1 pair of shorts
- 1 white T-shirt (with a round neck)
- 1 pair of sneakers (suitable for running in)

### **16) Items given to the clients for personal use**

- a) Clients who are not financially well-off may be given some items of clothing and toiletries by DRC. This is only after a written request is made to the DRC and only after NCB has investigated the claim and deems the parent/guardian financially incapable of supplying the afore-mentioned items.

### **17) Action to be taken to improve a given situation or to improve the centre itself**

- a) If there is any grievance over a programme conducted by the DRC or about a service of the DRC or an employee of the DRC, this matter should be brought to the attention of the head of the NCB by correspondence. Such letters do not have to be opened as specified in policy "10a" and will be considered as secret letter.

- b) Suggestions on improving and expanding the services provided by the centre must be made to the group leaders. The group leaders will in turn pass on these suggestions to the heads of NCB during their meeting with them.
- c) If there is a reluctance or objection to writing a letter as specified in “a” above then a request can be made to meet with the head of NCB and it shall be granted.

**18) Checking of possessions**

There is no room for secrecy in a centre where people are being shielded from and treated for narcotics. Therefore, at the discretion of DRC and in the interest of keeping the clients safe, body searches, searches of possessions and searches of their rooms can be conducted.

**19) Testing of Urine**

- a) Since every client being treated at DRC is to be kept away from drugs and controlled substances urine tests can be conducted at the centre’s discretion.
- b) Should a client test positive for drugs or controlled substances then the client is to be immediately handed over to the Ministry of Defence and National Security for further investigation. His treatment at DRC can only be resumed if the investigation conducted by the ministry clears him or her and if he or she is handed back to NCB.

**20) The obstruction of anything specified in this policy**

Should any one try to obstruct the work of an NCB or DRC employee as specified in this policy then, immediate action will be taken against that person.

***As amended on the 18<sup>th</sup> of June 2000.***

**APPENDIX E: POLICY ON CLIENTS SENT FOR COMMUNITY  
REHABILITATION- *as translated***

This policy dictates to the conduct of the people undergoing community rehabilitation programme. The CRP is where the clients are treated while they live with their families and are exposed to the community. While they were in this programme they were expected to conduct themselves to the best of their abilities with the aim of getting the best results. This policy overlaps the policy on clients, and talks about the same things. This policy also states that the inability to adhere to the policy would be considered as a refusal to complete treatment and the proper action would be taken against the client.

**Introduction:**

This policy dictates the conduct of the people undergoing community rehabilitation. The community rehabilitation programme is one where the clients are treated while they live with their families and are exposed to the community. This programme is of significant importance in the drug rehabilitation process. Whilst the clients are undergoing this programme they are expected to conduct themselves to the best of their abilities with the aim of getting the best result.

1. A client who is participating in this programme is expected to attend and participate in any event specified in the programme on time. Should, for any unforeseen circumstance, the client is unable to attend the Narcotics Control Board must be notified immediately.
2. The skills and experience gained while participating in this programme must be used while the client is living in the community. The outcome of using these skills and experience must be revealed during the counselling session.
3. Unless there is written consent from NCB or unless the client is accompanied by a parent or guardian he or she is not allowed to go anywhere other than the places specified below.
  - a. Join the congregation for prayer at the mosque closest to the client's home.
  - b. Go to a place on the direction of NCB.
  - c. Place of work where the client has a job, with prior consent from NCB.
4. The client is not to leave the island without the prior written consent from the NCB.

5. Smoking of any kind is prohibited.
6. Participating in sports competitions or social activities whether it is as a means of income or for some other reason, should be approved by NCB in writing prior to the event.
7. If the client wants to do any of the activities listed below then a written consent must be sought from the NCB;
  - a. Marriage
  - b. Becoming a member of a club or association
  - c. Becoming a shareholder of a company
  - d. Registering a club or association
  - e. Registering a business
8. If the community rehabilitation is being undertaken in one of the atolls then wherever it is specified that the client has to seek written permission or consent "from NCB", the client can write to the local NCB centre. If there is no such centre, then he or she can write to the most senior counsellor on the island.

The inability to complete the above-mentioned points will be considered as refusal to complete the treatment. If the client is slacking in any of the points mentioned then action will be taken against the client.

I have read and understood the rules regarding the clients who are undergoing community rehabilitation and I agree to abide by these rules and will persevere to a useful member of my family and the community.

## **APPENDIX F: POLICY REGARDING PEOPLE WHO WISH TO UNDERGO DRUG REHABILITATION OVERSEAS- *as translated***

This policy describes the procedure of obtaining permission to get treatment from overseas countries. The NNCB grants permission if certain criteria and conditions are met, both from the client who was requesting permission and the centre the client wants to go to. The people who are granted permission is limited to clients who are already in the DRC or to clients who are already in CRP. This excluded clients who had disregarded the notices of NNCB, already had a positive urine test result, had been or have to be referred to the Committee or refused counselling at any stage.

After getting treatment from a centre overseas, the client is supposed to submit all the documents regarding the client's treatment from that centre. After reviewing these documents, the NNCB rules on whether the client has completed treatment as stipulated under law 17/77 or not. The policy also covers, non completion of treatment, not coming back and the period given for treatment in these cases.

### **1. Procedure on obtaining permission**

The NCB can give consent to clients who wish to undergo drug rehabilitation from overseas if the following conditions are met:

- a. The overseas centre is one approved and recognised by this board
- b. Document proving that a placement has be sought and obtained from this overseas centre
- c. Document from the party financing the whole treatment
- d. Sign an agreement that says that the client agrees to undergo treatment in this overseas centre
- e. A progress report on the client from the overseas centre must be submitted to this board once every three months
- f. Should the client wish to return to the country during the duration of his or her treatment then he or she must seek written consent from NCB before attempting to do so.
- g. After obtaining the permission, if the client comes to the country during the treatment, the client has to come to and inform NCB within three days of his or her arrival.

- h. Upon completion of the treatment, the client must submit documents from the overseas centre stating the fact that he or she had completed the treatment and the treatment given to the NCB within three days of his or her arrival.

## **2. People given permission for such treatment**

Permission to seek treatment from abroad can only be granted to either clients who are already in the drug rehabilitation centre or to people who are already undergoing the community rehabilitation programme.

This excludes clients who have disregarded the notices of this board, been tested positive for drugs in their urine tests and had been or have to be taken to the committee or refused to receive counselling and had been or have to be taken to the committee.

## **3. Completing the treatment**

- a. Upon reviewing the documents prescribed in rule 1(h) above, the committee will only view the treatment as having being completed, if the committee feels that the level and duration of the treatment is adequate.
- b. Upon reviewing the documents prescribed in rule 1(h) above, should the committee feel that the client has not completed the treatment satisfactorily and if the client wishes to undergo further treatment abroad then permission to do so may be granted for a duration the committee feels suitable so long as the duration, including the duration of the previous treatment, does not exceed the period prescribed in rule 5 of this policy. The client may also be allowed to complete his or her rehabilitation in the country.
- c. Should a person undergo treatment abroad without following the protocol prescribed in this policy then he or she will not be seen as having completed the treatment under the law 17/77.

## **4. Failure to complete treatment**

- a. If the clients who went abroad for treatment had not completed their treatment, the board will look at the reasons for their incompleteness given in the reports/ documents mentioned in 1(f), and the committee will decide on whether the client will continue his/her treatment from NCB or not.
- b. Clients who do not come back after treatment or send their reports as mentioned above in this policy will be referred to the committee for a decision.

**5. Period of Treatment**

- a. For clients seeking treatment from abroad, only a period of one year would be granted.

**6. Terms of reference**

- a. The 'committee' referred in the above policy is the committee specified in law 17/77 article 11(b).
- b. Board refers to Narcotics Control Board
- c. Centre refers to the Drug Rehabilitation Centre.

21/05/2003.

## APPENDIX G: LETTER OF INVITATION

### Attachment 2

*Ihsana Ageel*  
4/237 Old Farm Road  
Hillcrest  
Hamilton

*Ph: (07) 856-2532*  
*E-mail: [ia3@waikato.ac.nz](mailto:ia3@waikato.ac.nz)*  
*[Ihsana@yahoo.com](mailto:Ihsana@yahoo.com)*

18 April 2004

Dear Sir/Madam

My name Ihsana Ageel and I am a graduate student at the University of Waikato. As part of my graduate degree, I am completing a thesis that is of considerable interest to me titled "Drug Law and Policies in the Maldives". The aim of this study is to examine whether there is a need for change in the legislature and the policy relating to the drug abuse in terms of service provision in the Maldives.

In order to successfully complete this project, I am requesting that a poster advertisement for the research be placed on your notice board and or somewhere, where, the clinical staff would be able to see it. I also request that these documents be sent to the Drug Rehabilitation Centre based in K. Himmafushi, the halfway house located at Greenge, and also be made available to the clinical staff working in the main office of the NNCB.

I have included my name and contact details in the advertisement. I welcome any queries regarding my research by either you or members of your staff. The best way to contact me is via e-mail, [ia3@waikato.ac.nz](mailto:ia3@waikato.ac.nz) / [ihsana@yahoo.com](mailto:ihsana@yahoo.com).

This study is part of a University of Waikato graduate course, which is being supervised by Dr Darrin Hodgetts and Dr Neville Robertson. Should you have any concerns regarding this research please contact Dr Hodgetts on (07) 856 2889 ext 6456, e-mail [dhdgetts@waikato.ac.nz](mailto:dhdgetts@waikato.ac.nz) and Dr Robertson on (07) 856 2889 ext 8300, e-mail [scorpio@waikato.ac.nz](mailto:scorpio@waikato.ac.nz) from the University's Psychology Department. Please note that there is a time difference of +7 hours to +8 hours depending on the daylight saving.

Please find a copy of the project proposal and 'participants wanted' notice appended.

Thank you for your assistance.

Yours sincerely,

Ihsana Ageel

## APPENDIX H: LETTER OF INVITATION

### Attachment 3

*Ihsana Ageel  
4/237 Old Farm Road  
Hillcrest  
Hamilton*

*Ph: (07) 856-2532  
E-mail: [ia3@waikato.ac.nz](mailto:ia3@waikato.ac.nz)  
[Ihsana@yahoo.com](mailto:Ihsana@yahoo.com)*

5 May 2005

Dear Sir/Madam

My name Ihsana Ageel and I am a graduate student at the University of Waikato. As part of my graduate degree, I am completing a thesis that is of considerable interest to me titled "Drug Law and Policies in the Maldives". The aim of this study is to examine whether there is a need for change in the legislature and the policy relating to the drug abuse in terms of service provision in the Maldives.

In order to successfully complete this project, I am requesting for your participation in my research. I would need 1-2 hours of your time to conduct an individual interview, which I mentioned in my visit to you in late April.

**Your responses are confidential.** Your name and any other identifying information received will remain confidential at all times. Your name will not be used in any report. ***You will also have the right to withdraw from the research at any stage, for any reason and without penalty or prejudice.***

I welcome any queries regarding my research by either you or members of your staff. The best way to contact me is via e-mail, [ia3@waikato.ac.nz](mailto:ia3@waikato.ac.nz) / [ihsana@yahoo.com](mailto:ihsana@yahoo.com).

This study is part of a University of Waikato graduate course, which is being supervised by Dr Darrin Hodgetts and Dr Neville Robertson. Should you have any concerns regarding this research please contact Dr Hodgetts on (07) 856 2889 ext 6456, e-mail [dhdgetts@waikato.ac.nz](mailto:dhdgetts@waikato.ac.nz) and Dr Robertson on (07) 856 2889 ext 8300, e-mail [scorpio@waikato.ac.nz](mailto:scorpio@waikato.ac.nz) from the University's Psychology Department. Please note that there is a time difference of +7 hours to +8 hours depending on the daylight saving.

Please find a copy of the project proposal notice (Attachment 1) and copy of main areas of interview (attachment 6) appended.

Thank you for your assistance.

Yours sincerely,

Ihsana Ageel

## APPENDIX I: PARTICIPANTS WANTED NOTICE

### Attachment 4

### **Participants Wanted for Research**

Hi, my name is Ihsana Ageel. I am a graduate student in psychology at the University of Waikato, New Zealand. I am looking for volunteers to participate in my research project, who are willing to take part in a focus group discussion and or an interview.

The aim of this study is to examine whether there is a need for change in the legislature and the policy relating to the drug abuse in terms of service provision in the Maldives.

This study is focused on investigating the issues faced by the clinical staff of the National Narcotics Control Bureau (NNCB), as a result of the existing policies and the Law on Narcotics (17/77). Investigations would be done by looking into the adequacy of services these staff are involved in providing and the restrictions they face.

In order to explore the issue, this project will use a qualitative approach and information will be gained through three key methods. This will include an investigation into the relevant policies and the Law, focus groups and narrative interviews that I hope to conduct face to face, but may have to be conducted over the phone due to the geographical location of interviewees.

In this research, I would require approximately two, 2-3 hour sessions with those who volunteer for the focus groups, and two, one hour sessions for the individual interviews.

If you are interested in this research, you can e-mail me your name and contact details to [ia3@waikato.ac.nz](mailto:ia3@waikato.ac.nz) or [ihsana@yahoo.com](mailto:ihsana@yahoo.com) or call me at 07-856-2532.

**Your responses are confidential.** Your name and any other identifying information received will remain confidential at all times. Your name will not be used in any report. ***You will also have the right to withdraw from the research at any stage, for any reason and without penalty or prejudice.***

This study is part of a University of Waikato graduate course, which is being supervised by Dr Darrin Hodgetts and Dr Neville Robertson. Should you have any concerns regarding this research please contact Dr Hodgetts on (07) 856 2889 ext 6456, e-mail [dhdgetts@waikato.ac.nz](mailto:dhdgetts@waikato.ac.nz) and Dr Robertson on (07) 856 2889 ext 8300, e-mail [scorpio@waikato.ac.nz](mailto:scorpio@waikato.ac.nz) from the University's Psychology Department. Please note that there is a time difference of +7 hours to +8 hours depending on the daylight saving.

**APPENDIX J: CONSENT FORM**

University of Waikato  
Psychology Department  
**CONSENT FORM**

**PARTICIPANT'S COPY**

Research Project: **Thesis Research**  
Name of Researcher: Ihsana Ageel

Name of Supervisor (if applicable): Dr Neville Robertson and Dr Darrin Hodgetts.

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's  
Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

University of Waikato  
Psychology Department  
**CONSENT FORM**

**RESEARCHER'S COPY**

Research Project: **Thesis Research**  
Name of Researcher: Ihsana Ageel

Name of Supervisor (if applicable): Dr Neville Robertson and Dr Darrin Hodgetts.

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's Name : \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

## APPENDIX K: FOCUS GROUP SCHEDULE

### Attachment 5

#### Focus Group

The general areas that would be explored are;

- Participants' general knowledge of the legislation
- Ways in which policies allow for and enhance rehabilitative services
- Ways in which policies restrict rehabilitative services
- Issues practitioners face in relation to specific policies
- Gaps between policies and practice
- Do you think we need new policies or change existing ones.
- If participants could rewrite or reproduce policies what would they do

The policies in question are;

- Law on Narcotics and psychotropic drugs 17/77.
- The policies of the National Narcotics Control Bureau
  - Policy on 'House Arrest' clients
  - Policy on clients going through the detoxification programme
  - Policy on clients going through the residential rehabilitation programme
  - Policy on clients going through the halfway house programme (if this program is in service)
  - Policy on clients going through the community rehabilitation programme
  - Policy on clients in the outreach community based programme
  - Policy on clients who are working while in the community programme
  - Policy and the service description of the role of the 'Advisory Council to the National Narcotics Control Bureau'.
  - Policy and the service description of the role of the 'Committee On Deciding Which Substance Abusers Fit Into The Criteria Of Requiring To Undergo Treatment By Law, And How The Treatment Should Be Carried Out.'

## APPENDIX L: INTERVIEW SCHEDULE

### Attachment 6

#### Individual Interview

Narrative interviews will be used to follow up individual thoughts that arise from the focus groups, and also to utilise the ideas and thoughts of some of the personnel not included in the focus groups.

From the people who were not included in the focus group, I wish to explore

- The administrative difficulties implications of specific policies
- Understandings of and role in the policy formation and revision process
- The difficulties they may encounter in running the rehabilitative programmes namely
  - Detoxification centre
  - Drug rehabilitation centre
  - Community rehabilitation
  - Or any other programme identified by the interviewee.
- The difficulties faced in making policies or incorporating these into the existing programmes.
- The process of making a policy

**APPENDIX M: THE LAW ON NARCOTIC DRUGS AND  
PSYCHOTROPIC SUBSTANCES, ARTICLE 11 – 14 (p 8 -10).**

*Giving curative  
treatment to  
persons that use  
narcotic drugs  
psychotropic  
substances.*

- 11.**
- (a) From among persons who use narcotic drugs and psychotropic substances, the affairs of giving curative treatment to those that have to be given the same under this Law shall be looked after by the Narcotics Control Board. In addition, the policies and criteria for the provision of curative treatment to those that, under this Law, have to be given the same from among persons who use narcotic drugs and psychotropic substances, shall be determined by the Narcotics Control Board in consultation with the Ministry of Defense and National Security, Ministry of Women's Affairs and Social Security, the Ministry of Health, and the Attorney General's Office.
  - (b) From among persons who use narcotic drugs and psychotropic substances, the determination of those persons that have to be given curative treatment under this Law, and the manner in which curative treatment to those persons shall be determined by a committee comprising [representation from] the Ministry of Defense and National Security, the Ministry of Health, the Ministry of Women's Affairs and Social Security, and the Attorney General's Office.
  - (c) If commission of an offence of use of narcotic drugs and psychotropic substances has been proven against any person to the legal system, the court that passed sentence on the said person must inform the Narcotics Control Board of the same without delay. If the person against whom an offence of use of narcotic drugs and psychotropic substances has been proven is not a person who is due to serve, or is serving, a sentence of a jail term, banishment or house arrest as penalty for another offense that had been proven against him or her, the Narcotics Control Board must submit [the person's case] to the committee stated in (b) of this Section to determine whether or not the said person has to receive curative treatment under this Law.

*Persons who seek curative treatment voluntarily.*

12. When a person who uses narcotic drugs and psychotropic substances in contravention of this Law, before the use [by the person] of narcotic drugs and psychotropic substances is exposed [i.e., publicly and to legal agencies], submits his or her wish to seek curative treatment to the Narcotics Control Board, if the said person is not a person against whom a sentence of a jail term, banishment or house arrest has been passed and is due to serve, or is serving, said sentence as penalty for another offence that had been proven against him or her, if the committee stated in (b) of this Section determines that the said person has to receive curative treatment under this Law, if the said person receives [said] curative treatment as determined by the said committee and at a level acceptable to the said committee, without commission of additional offences, the identity of the said person must not be publicly disclosed. In addition, the said person cannot be prosecuted under (a) of Section 4 of this Law. However, if curative treatment is not obtained [by said person] as determined by the said committee and at a level acceptable to the said committee, the said person shall be prosecuted under (a) of Section 4 of this Law.

*Completion of curative treatment.*

13. (a) The person receiving curative treatment in accordance with section 11 of this Law receives treatment determine by the committee stated in (c) of that Section and at a level acceptable to the said committee, without commission of additional offences within the period of the sentence passed on the said person, the sentence passed on the said person shall not be executed.

*Non-completion of curative treatment.*

- (b) If curative treatment has not been received as determined by and at a level acceptable to the committee stated in (c) of Section 11 of this Law, or if [the said person] commits an additional offence within the period of the sentence passed on the said person, the sentence passed on the said person shall be immediately executed.

*Deferring execution of sentence.*

14. (a) If the person that committed an offence stated in Section 4 of this Law was a minor who had not attained 16 years of age, and if it was the first such offence proven against the said minor, the

Qaal'ee shall decree that the sentence passed against the [said] minor shall be deferred for a period of 3 years. And if the minor was someone against whom the offence of the use of narcotic drugs or psychotropic substances has been proven, the committee stated in (b) of Section 11 of this Law shall determine that the said minor should receive curative treatment, and the [said] curative treatment shall be administered to the said minor.

- (b) If the person that committed an offence stated in (a) of Section 4 of this Law was a person who had attained 16 years of age, and if it was the first such offence proven against the said person under this Law, and if it has not been determined that the said person has to receive curative treatment as stated in Section 11 of this Law, if the [said] person spends [i.e. serves] half of the period of the sentence that had been passed on him under Section 4 of this Law within the penalty of the sentence without committing an additional offence, the execution of that period of the sentence that remains unexecuted shall be deferred for the period of the [said] sentence.

*Commission of an offence during the period of deferment of execution of sentence.*

15.

- (a) If the [relevant] person does not commit another offence within the period of the sentence that is deferred in accordance with Section 14 of this Law, the sentence that has been passed on the said person shall not be executed even at a later time.
- (b) If it is proved that a person, within the deferred period of the sentence that had been pronounced on him or her, has committed another offence, the Qaal'ee shall decree that the deferred sentence shall immediately be executed or that the deferred sentence be executed subsequent to the execution of the sentence that has been passed with regard to the commission of the latter offence.