

DRUG OFFENDER TREATMENT IN THE MALDIVES

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I. INTRODUCTION

This paper is intended to describe the current situation regarding drug offences in the Republic of the Maldives, with the emphasis on how drug offenders are actually treated. An overview of drug offences in Maldives is provided first, followed by treatment practices in the Drug Rehabilitation Center. Some discussion follows.

II. OVERVIEW OF DRUG OFFENCES IN THE MALDIVES

A. Historical Background and the Current Situation

Drug trafficking and drug abuse has risen in the Maldives in recent years, largely due to increased exposure to the outside world. Drug abuse was not a problem before the mid 1970s. Though there were stories of opium abuse in the early part of this century, this was, by and large, limited to small numbers of people. The appearance of drug abuse in the present form coincided with the development of tourism in the country in the early seventies. However, it would be hasty to suggest a cause and effect relationship between the two, since the period also coincided with many other changes, including global escalation of drug abuse and increased overseas travel by Maldivians.

The Maldives lie not too far from the 'golden crescent' and 'golden triangle'; with the introduction of tourism in the early seventies hundreds of tourists began to arrive daily from Europe, Southeast Asia and South Asia. The Maldives is very well connected with the outside world by its international airport and sea ports. It is potentially vulnerable as a point for illegal shipments of precursor chemicals or large quantities of drugs meant for other countries. Official recognition of the 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 Drugs) was passed the same year in order to help the legal system deal with it, and to act as a deterrent. Commonly abused substances since then have been hashish oil and heroin. In 1996, a total of 241 cases of substance abuse were reported to the police. It is suspected that a considerable amount of drugs is smuggled into the county via sea vessels that dock at ports. However, random searches of sea vessels have detected relatively small quantities of illegal substances. The rapid increase in drug abuse is of great concern to health and law enforcement authorities. Prior to 1993, the majority of drug offenders were between the ages of 25 and 40 years.

As can be seen from the statistics of seizures made within the Maldives, the absolute volumes involved are small. Despite this, even in 2002, the Maldivian authorities reported: *"the problem of drug-related offences have now become the most frequent one faced by the Maldivian criminal courts, showing a 200 % increase in recent years. 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 of age. For a small developing country like Maldives where more than 50% of the population is below 16 years of age, this indeed, is an alarming trend (MDV, 2001)."*

Since this report was issued, it continues to be a focus of government attention.

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The main drugs of abuse in the Maldives 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 also on the rise, and while the HIV epidemic is in its early stages, this is likely to exacerbate it. Based on reports by the Police Headquarters and information from the health care sector, the prevalence of heroin injecting is estimated to be 1% of the drug abusing population.

In 1993, the first case of heroin abuse was detected. With the introduction of heroin, drug abuse among the young age group escalated dramatically. Currently the age group consists mainly of males between 16 and 25 years of age. In 1998, over 450 arrests were made for drug abuse and related offences. According to police statistics, arrests of juveniles for drug offences have increased from 16 in 2001 to 79 in 2006 and to 164 (29 percent of total juvenile arrests) in 2007. The first major seizure of cocaine was made in September 1993 at Malé¹ International Airport when eight kilograms of cocaine was found concealed in the false bottom 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 the Trivandrum² Airport. For a small country like the Maldives, this is an alarming trend. The latest statistics from the Maldives Custom Services (MCS) shows that the number drugs seizures in 2010 was nine, which included one case of heroin (360.0 grams), four cases of cannabis (4428.3529 grams) and four cases of hashish (3795.0 grams). MCS statistics also show that the main route for drug seizures was from Trivandrum to Malé, which was the route in five cases, and that most of the offenders involved are Bangladeshis. In these nine cases, the drugs were trafficked by air. 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.

The patterns and increase of drug abuse and trafficking in the Maldives appear to closely parallel the escalation of drug abuse in the region. However, certain local characteristics appear to make the drug problem in the Maldives of more serious concern. The government has responded to the growing concern of drug abuse by enacting stringent drug laws, by strengthening the supply reduction mechanisms and by setting up the Narcotics Control Board (NCB) in 1997. In addition, demand reduction activities have also been initiated by the NCB, in conjunction with other agencies.

B. Survey Results

In order to prepare a National Master Plan for Drug Abuse Control, the government sought UNODC support for a detailed assessment of drug abuse in the Maldives. A preparatory mission visited the Maldives in 1999, with financial support provided by UNODC, to prepare guidelines for the Rapid Situation Assessment survey (RSA). UNDP Maldives funded the RSA as a project and the report was formally released in 2003. This report is a window into drug abuse in the Maldives.

The RSA employed a combination of quantitative and qualitative methods, including primary interviews with drug users, interviews with key informants, focus group discussions and ethnographic observations of drug use sites. Secondary data from the Maldives Customs Services and on treatment referrals to the NCB complemented the information obtained from primary sources. The atolls of Maldives, Miladhunmadulu Dhekunuburi, Faadhipolhu in the north and Addu Atoll in the south, were selected for the RSA, based on higher reported drug use in these sites. The assessment included interviews with 1,058 respondents connected with drug use directly or indirectly. Four hundred and seventy-one potential drug users were contacted, of whom 204, above the age of 16 years and reporting drug use in the previous six months, were interviewed on a structured interview schedule. A total of 111 key informant (KI) interviews and 49 focus group interviews, covering 443 persons, were conducted. In-depth interviews were carried out with 13 drug users. Interviewing 19 family members of drug users assessed the burden on families. Secondary data was available on 2,304 persons arrested by the Drug Control Bureau and 547 clients referred to the NCB. Thus, drug related information was obtained from 3,909 individuals. Most KI as well as focus group respondents felt that drug abuse was increasing in the Maldives. The Drug Control Bureau’s data on arrests revealed a peak in arrests during 1998, coinciding with the highest number of seizures of brown sugar. Reports of drug related seizures and arrests indicate that opioids, especially ‘brown sugar’, hashish oil and other cannabinoids are the most commonly available drugs in the Maldives. KI from the north reported the

¹ Malé is the capital city of the Maldives.

² Trivandrum, also known as Thiruvananthapuram, is the capital of the Indian state of Kerala.

frequent abuse of 'cola water' (eau de cologne) and 'Dunlop' (glue, an inhalant). Cannabis, pharmaceuticals, alcohol, ecstasy (MDMA) and use of the local oshani for intoxication were also reported. Drugs of initiation were mainly opioids, primarily brown sugar (43 per cent) and cannabinoids (34 per cent). A smaller number of respondents, especially from the atolls, had initiated drug use with 'cola water' (5 per cent), alcohol (12 per cent), or sedatives/hypnotics (4 per cent). Primary drugs used in the previous month were opioids (76 per cent) and cannabinoids (12 per cent).

In the survey, what is alarming is that drugs users were mainly in their early twenties and the mean age of the respondent was 21.4 years (15 to 42 years). Almost half of the respondents were under 20 years of age; 32% were 20-24 years of age; and 13% were 25-29 years of age. The opioid (heroin) and cannabinoids (hashish) are the most frequently used drugs. The most common reason for initiation was peer pressure (38%), followed by desire to experiment (26%). The findings of RSA highlight the urgent need for development of multi-pronged strategies in the prevention and treatment of drugs users.

Malé, the capital of Maldives, with only 130,000 residents, is a small city but one of the most densely populated in the world. This makes it more difficult for former drug users to avoid re-encountering old drug haunts. There is not a single street in Malé where you will not see a person dependent upon drugs. Their number has increased a great deal during the past few years. One in 100 adults in the Maldives struggle with substance abuse.

On 19 January 2010, UNODC signed with the Government of the Maldives the ever first country-specific technical cooperation project for the Maldives, called "Strengthening the national response to combat drug abuse in Maldives". The project will provide technical assistance to strengthen the national response on drug use prevention and treatment through a series of capacity-building measures both with the Government and civil society under the framework of the United Nations Development Assistance Framework. UNODC has in the past provided technical assistance to the Government of the Maldives; in 2008 they developed and launched the first national "Drug Control Master Plan 2008-2012".

C. Legal Framework

As per Section 2 of the Maldives Law on Narcotics, planting, production, import, export, selling, buying, giving, possession, with the intention to sell and being an accomplice in any such activity involving illegal drugs is a crime and attracts life imprisonment. With regard to precursor chemicals, we are fortunate that there is yet no manufacturing or production of illicit drugs taking place in the Maldives. The drug problem in the Maldives is presently restricted to the smuggling of regionally available opiate and cannabis derivatives and the increasing abuse of the same. Section 2 and Section 3 of the Law on Drugs prohibit the manufacture, in any form, of prohibited drugs in the Maldives. It also prohibits the manufacture of controlled substances in violation of the law. These provisions also make the importation, supply, possession and sale of chemicals for the manufacture of narcotic drugs and controlled substances punishable on the same basis as the offence of trafficking. Further, with the absence of chemicals and related industries, the regulation of the importation and use of precursor chemicals would not be very complex.

In the Maldives, where there is no manufacturing, cultivation or production of illicit drugs, the government's anti-drug policy is aimed at stopping narcotic drugs, psychotropic substances and precursor chemicals from entering the country. As Maldives is not a producer of any type of drugs, there has never been any case of illegal exportation of precursors or any other type of chemicals used for illicit manufacture of narcotic drugs or psychotropic substances. There is also no visible threat in the near future of any smuggling of these chemicals for the manufacturing of illicit drugs. Nevertheless, the geographical location and the formation of the country makes the Maldives an ideal place for a potential trafficker with an eye for new places to be used as diversion points of illegal shipments of precursor chemicals or large quantities of drugs intended for another country.

III. TREATMENT IN THE DRUG REHABILITATION CENTRE

A. Drug Rehabilitation Centre

The Drug Rehabilitation Centre (DRC) was established in 1997. It is based on a small island called Himaffushi. It runs under the Department of Rehabilitation Services, as well as under the Department of Medical Services, which in turn comes under the Ministry of Health.

1. How to get Treatment in the DRC?

There are two ways to get treatment in the DRC. One is on a voluntary basis and the other is if the patient is sentenced by a court to undergo rehabilitation. A committee appointed by the president determines the fitness of the patient to go to the DRC. This is true for both voluntary as well as sentenced patients.

2. Aim and Objectives

The aim and objectives of DRC are as follows:

- Rehabilitation of substance abusers under the Therapeutic Community module;
- Providing life skills, coping skills and training;
- Conducting seminars;
- Preparing the substance abusers in such a way that they help each other, creating a family environment with some written and un-written philosophies;
- Creating awareness of the dangers of illicit drugs and their harmful effects.

3. Structure of the Drug Rehabilitation Centre

The DRC comprises of the clinical division, administrative department, medical department, security department and special services department.

- Clinical division: entirely managed by the counsellors;
- Administrative department: takes care of the administrative matters of the whole facility;
- Medical department: comprises a doctor and two nurses. The medical staff looks after all the health related aspects of the patients in the facility;
- Security department: involves maintaining security all around the facility and also taking care of any violence that might erupt within the facility;
- Special services department: is in charge of maintaining cleanliness and taking care of all maintenance work in the facility.

All departments mentioned above work together in perfect coordination as a team for the benefit of the patients in the facility. Each counsellor assumes the role of the Staff on Duty [SOD] on a rotating basis. The SOD communicates with all the departments to run the programme.

4. Description of the Programme

On reaching the DRC, the patient is assessed by the doctor in charge and undergoes detoxification as and when required. After detoxification, the patient goes to the intake and screening unit, where they are sensitized about the centre and its treatment approaches by the intake counsellors, as well as the senior patients in the therapeutic community module (TC). Then they are incorporated into the TC setup. TC followed in DRC is a highly structured programme aimed principally at behavioural modification of the patients. The treatment methodology is based on four structures and five pillars of TC. Here they go through what is called as the 'primary phase' and later the 're-entry phase'.

(i) Primary phase: Consists of Six Stages

Stage 1:

- Duration is 40 days.
- Young member: The patient is referred to as young member, and is taught the written and un-written philosophies of TC; he or she attends life skills classes, religious classes, sports and recreation activities, literacy classes for illiterate patients, general education classes and so on.

Stage 2:

- Duration is 21 days.
- Departmental Crew: will do the cleaning, arrange the tools, stationery and other belongings.

Stage 3:

- Duration is 21 days.

- Ramrods: they are put in charge of paperwork.

Stage 4:

- Duration is 21 days.
- Head of Department [HOD]: they organize department activities.

Stage 5:

- Duration is 21 days.
- Co-coordinator of the Department [COD]: coordinates with the Staff on duty [SOD] to formulate the action plan and arrange daily activities in the facility.

Stage 6:

- Duration is 21 days.
- Older member in house: they help the SOD to run all the programmes and various departments.

(ii) Re-entry Phase

In this phase, the patients learn about relapse prevention and other important life skills, like problem solving and decision making. Also, the importance of self-help groups among the patients is stressed and they are made to realize their importance in the journey of recovery. Especially in this phase, the counsellors check the readiness of the patient to face and live in the community and teach them to take ownership of themselves or 'self-ownership qualities'. After the counsellor, clinical supervisor, and the patient feel and agree upon the readiness of the patient to face the community, he or she is released from DRC and referred to the Community Service Centre.

5. Community Health Centre or 'Halfway House'

The Community Service Centre or 'halfway house' comes under the authority of the DRS. Here the patient is monitored regularly by community centre counsellors in the community and is offered help readily whenever needed. Urine checks are conducted on a routine basis in order to assess and help in maintenance of the patients' recovery in the community.

6. Discussions

The treatment period provided in the rehabilitation centre is six to eight months, which is too short a period in the absence of a re-entry programme for the addict as they return to the community. Patients are in danger of relapse without a sustainable aftercare programme. Even if the patient is 'cured' however, with no aftercare available in the Maldives, he or she will often just go back to his or her island and face the same social conditions that contributed to his or her addiction in the first place. Although they may be out of rehab, they are unable to kick the habit for good.

The need to use more and more drugs, coupled with the debilitating highs and lows, makes securing a paying job all the harder for users, at a time when they need more and more money to pay from their addiction. Many users turn to crime - petty theft and robbery - or turn to dealing. One of the major reasons why few break out of their addiction however, is a systematic failure in the Maldives to help users kick their addictions.

One thing that is certain is that brown sugar addiction is disastrous in the Maldives. Action in the Maldives is reaching epidemic proportions and the government, concerned authorities, the community and NGOs need to take serious action in tackling the drug supply problem as for the past 12 years the country has been working only to address the demand, with the result being the present huge disaster to the Maldives.

How can we help drug addicts? This question could be answered better by posing another question: why do people use drugs? People come into drug addiction for myriad reasons like peer pressure, recreation, experimental use, and a way of escape from reality. The reasons are endless. This gives us a clear indication that merely treating the drug problem is not enough. Rehabilitation calls for an entire change in the addict's lifestyle. This is where Cognitive Behavioural Therapy (CBT) comes into place. Counselling occupies the

core of CBT. Counselling helps the addict/client recognize how drugs affect his or her health and lifestyle, and encourages the client to reject drugs and maintain abstinence, developing spiritual and psychosocial skills to be relied upon as a way of life.

Proper counselling and rehabilitation, in addition to drug treatment, can definitely help the drug addict in his or her all-round development, leading to a life free from banned substances.

IV. CONCLUSION

In this paper, an overview is provided, followed by one author's³ views on the probable cause of this rising number of people getting into addiction. There are quite a few factors to be taken into account. The Maldives being unique in culture and lifestyle, we need to have a fair idea and a detailed understanding of its religious and cultural preferences. It has had many rulers from across the world and consequently, it has developed its own unique lifestyle, with a mixture of different cultures. Although the predominant religion is Islam, the Maldivian lifestyle has been westernized to a greater degree than many other Muslim countries, the main reason being tourism. The Maldivian economy is driven by tourism, leading to its exposure to western culture, which has emerged as one of the major factors for people getting into drug addiction. This has led to drug trafficking. The Maldives, being connected to all parts of the globe by tourism, makes it an important hub for drug trafficking.

The author would like to stress upon the need to open more drug rehabilitation centres to cater to the rising drug addict population. Speaking of the treatment provided in these rehab centres, more training programmes have to be conducted on a regular basis and more qualified professional staff need to be recruited. The community must also be educated about and sensitized to this problem. It is our important duty to educate them on the ways to deal with addicts in their respective families and communities.

³ Hassan Zilaal.

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