Review Article

Treatment and Rehabilitation of Substance Use Disorder: Significance of Islamic Input in Malaysia
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Abstract
Drug addiction is a chronic relapsing disease which can be treated. Treatment, however, is dependent on many variables; the drug of choice, severity of drug use, individual and personality characteristics such as religiosity; community and environmental factors, familial and social support, employment and many more. Many countries used the supply and demand reduction strategies, nonetheless some are successful, and some are not. The advent of HIV-Aids among IDUs forces treatment specialist to look at other alternatives. Harm reduction offer pragmatic approaches though sometimes controversial avenues to provide solutions to the HIV and substance users. Drug Substitution Therapies for people using opioids have proven to be more effective with other non-medical approaches such as contingency management, behavioral interventions and spiritual/religious enhancement. This paper reports the experience of Malaysia in its approach to SUD treatment and providing Islamic religious input to treatment and rehabilitation programs in government and non-government facilities.

Keywords: drugs; addiction; treatment; rehabilitation; drug policy; Islam. Mahmood

Introduction
Treating a chronic relapsing disease is not a simple undertaking. It involves the illness itself, behavioural and psychological components, belief system and spirituality.1 Many treatment providers reported significant relapse rate among those undergoing treatment, especially for addiction to psychoactive substances. McLellan et. al² reported that illnesses like asthma and hypertension have 50-70% relapse rate; type I Diabetes has 30-50% relapse rate; drug addiction exhibit a relapse rate of 40-60%. However, all this illness especially drug addiction can be treated with a combination of treatment modalities and approaches.¹³

There are basic principles to drug treatment that treatment providers must understand to provide treatment and rehabilitation. One important fact is that no single treatment is appropriate for all individuals. Effective treatment attends to multiple needs of the individual, not just his or her drug use. In addition, treatment and service plans must be continuously assessed to ensure that plan meets the person’s changing needs.¹

When a client is ready for treatment, remaining in treatment for an adequate period is critical for treatment effectiveness. Many believe that medical detoxification can help, however it is only the first stage of addiction treatment and by itself does little to change long term drug use.² Counseling and behavioral therapies are critical components of effective treatment for addiction.²,3⁰ Medication is an important element of treatment for many patients. Treatment should provide assessment for HIV, TB and other infectious diseases.²⁶ It is also important to know that recovery can be a lifelong process with relapses and require multiple treatments.¹

Drug Addiction in Malaysia
The drug problem in Malaysia was identified since the pre-independence days. Most of the drug addicts used opiates, specifically opium that was brought in from China and the Golden Triangle area. In the 60’s, influences from the ‘hippie’ western culture reached the shores of Malaysia with marijuana and other psychedelic drugs preliminarily used by the American servicemen.

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The 70’s saw the advent of heroin and morphine into the country, and drug addiction reached an epidemic proportion. In 1983, drugs and drug addiction is declared a national security problem. National drug treatment program was set up to provide mandatory treatment to drug dependent. Many Compulsory Centers for Drug Users (CCDUs) was set up to provide treatment, which was largely based on psychosocial and military model, where not much focus was given to addiction treatment and treatment of other ailments. It was until the 1990’s that drug addiction is accepted as a chronic relapsing disease. Drug addicts are accepted as patients that must be treated and alternatives to treatment are given, however still limited. Supply and demand reduction approach was adopted as the national anti-drugs strategy then. In the past decade, on the average we identified 32,000 drug addicts in the country (55% - 60% relapse users) each year. This has reduced significantly in the past years to about 22,811 cases and around 14,489 cases in 2007. Further reductions in the numbers caught every year also demonstrate that the present strategies undertaken by the Malaysian government has taken effect.

Supply reduction

Usually, the first approach to drug control is supply reduction, simply put, the supply of the psychoactive substance to the affected population must be intercepted and terminated. Supply reduction focuses on law enforcement activities to suppress or disrupt production and the distribution of drugs. Legal measures used by all countries to control or eliminate the availability of illicit drug. Some supply reduction strategies employed are (i) Source-country control such as crop replacement and destruction; (ii) Interdiction of supply into end countries; (iii) Police enforcement of supply and possession; and (iv) Regulatory policies to restrict prescription of opioids.

Efforts on reducing the supply of drugs into Malaysia were initiated way back before the independence of the country to control the import, sales and use of opium then. Several laws were enacted with consequences for involvement in drugs such as trafficking, using or abusing is severe. There are five main Acts that govern the law on Drugs in Malaysia.

First is the Dangerous Drugs Act 1952 - The major legislation in relation to drug control in Malaysia. This Act is very extensive covering aspects of offences, procedures and evidence. It provides for mandatory death sentence for drug trafficking offences. Second is the Dangerous Drugs (Special Preventive Measures) Act 1985 – The DDA-SPM aimed at enhancing the effectiveness of countermeasures taken by the relevant authorities against those who are involved in drug trafficking. It empowers the government to detain anyone suspected of being a trafficker without having to bring the suspect to any court of law. Thirdly; Dangerous Drugs (Forfeiture of Property) Act 1988 – The DDA-FoP empowers the relevant authorities to trace, freeze and forfeit assets of convicted drug traffickers. Forth, the Poisons Act 1952 - Controlling the import and sale of “poisons” which refers to any substance specified in the Poisons List and includes any mixture, preparation, solution or natural substance containing such substance other than an exempted preparation or an article or preparation included for the time being in the Second Schedule of the Act. Many precursors to ATS are controlled by this Act. Fifth is the Drug Dependents (Treatment and Rehabilitation) Act 1983 that provides for both mandatory treatment and rehabilitation of any person who have been certified as drug dependent as well as for voluntary treatment and rehabilitation. The period of treatment and rehabilitation at rehabilitation center is for two (2) years. This institutional treatment and rehabilitation is followed by aftercare for another two (2) years.

Finally, is the Anti-Drugs Agency (AADK) Act 2004 – An Act specifying the role of National Anti-Drugs Agency (NADA) in Malaysia, empowers NADA for enforcement These laws were enacted from 1952 up to 2004 and several agencies, primarily the Royal Malaysian Police, were given the authority and mandate to implement these laws. It overlaps with the second strategy, which is demand reduction in the 80’s to manage and reduce the drug problem in the country. To date, there are no major changes made to these laws, however, some shift in policy on treatment and rehabilitation of drug offenders are evident.

Demand Reduction

Prior to introducing medication for the treatment of drug use and abuse in Malaysia, the authorities placed significant amount of effort to reduce the demand towards these illicit substances.
Demand reduction refers to efforts aimed at reducing public desire illegal and illicit drugs i.e. reduce use and abuse of, and demand for, narcotic drugs and psychotropic substances. Demand reduction seeks reduction of abuse directly through prevention and treatment. First, demand reduction approach provides training and capacity building to prevent the onset of substance use and abuse; Secondly, prevention is achieved by intervening at “critical decision points” in the lives of vulnerable populations to prevent both first use and further use; Thirdly, it provide effective abstinence-based treatment programs for drug dependents; Forth, it broaden education and increase public awareness of the consequences of drug use/abuse; Fifth, it builds coalition to mobilize local and the international community; and finally it promotes research on the effectiveness of these and other programs.

In general, the practice of demand reduction covers family, school, workplace and the community. Prevention in family and school settings such as basic knowledge about substance use and misuse, life skills, positive relationships, early intervention program, preventive screening. Prevention at workplace basically includes program such as drug-free workplace policy & guidelines, employee participation, voluntary and random testing, drug and addiction counseling, early intervention, treatment and rehabilitation. Continuous or random monitoring are often builds into the human resource policy of the organization.

Community-based prevention program is often the most difficult because it covers a plethora of setting, sub-cultures, ethnic backgrounds and other variables. What is often done is mobilizing community leaders and members to be aware of the drug situation; collaborative effort with enforcement agencies to reduce the demand for drugs; and a multitude of drug free community efforts.

In Malaysia, there are several efforts being undertaken by the government and community alike to provide institutional-based treatment. There are 12 abstinence-based Cure and Care Clinics that provide voluntary drug treatment; 28 mandatory treatment centers all conducted by government and 30 treatment centers operated by the NGOs and private sector.

There is also community-based rehabilitation program in 93 districts in the country that focus on individual, group and family counseling, health and welfare services, FA, NA, AA meetings, job placement, religious programs and career development of the affected population. This includes 18 government halfway houses and service center; 4 main drug related NGOs providing community-based outreach, relapse prevention and career development programs; support and assistance from more than 50 civil societies to aid in the reentry of recovering drug dependents into society.

The supply and demand reduction strategies have contributed significantly to the reduction in numbers of drug dependents caught by the authorities. Figure 1 shows that among the heroin addicts in the country, the number detained every year has reduced from 23,723 in 1995 to 7,963 in 2006, just about one year before DST is in full use in Malaysia and up to 2013 (Figure 2), the total number of drug addicts has declined significantly.

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Figure 1: Number of heroin offenders from 1995-2006

Figure 2: Number drug addicts in Malaysia from 1970 – 2013

**Harm reduction**

The introduction of harm reduction in Malaysia comes with the realization of the limitations of supply and demand reduction approaches that was practiced since the 70’s to mid-2000. In short, harm reduction is “policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their
families and the communities".11,11 There are many approaches that can be include as harm reduction practice among others are advocacy and ‘capacity building’ which is conducted through forum, seminar, media, training study tour, research and publication.11,12 Most of the services provided under the umbrella of harm reduction are client-friendly; it uses the multi-sectoral and community-based approach to implement harm reduction; it establishes Practical Guidelines and SOPs to guide implementation on the ground; it emphasizes on ‘evidence-based’ program implementation, effective monitoring and tracking program.11 There are several outcomes to harm reduction practices among others are reduction of substance use, not sharing needles (recipient of NSEP program); greater concern towards one’s health; decrease in illegal activities, longer retention in treatment programs; gain employment and increase in income. Figure 3, for example, demonstrated significant reduction in the engagement of illegal activities after six and 12 months of OST13. Figure 3 also shown marked improvement in reducing drug use; reduction in HIV risk behavior; and reduction in illegal activities.14.

Harm reduction comes to effect with the HIV-Aids epidemic. Two categories of affected population were given focus; the sex industry and drug addicts.15 For sex workers, primarily interventions are preventive education and condom distribution.11 For drug addicts, Drug Substitution Therapy (DST) and Needle Syringe Exchange Programs (NSEP) were introduced.11,15,16,17 These initiatives werealso introduced in Malaysia to curb the HIV epidemic and drug use.10

**Medical Treatment to Drug Addiction**

Malaysia does not practice harm reduction approaches such as OST and NSEP during the supply-demand reduction era. However, on 13 Jan 2005, the Deputy Prime Minister announced in the National Council for the Eradication of Drugs (MTMD) meeting that the use of Methadone to treat drug dependents has been endorsed by government.4 MMT program started in October 2005. For Phase 1, it is conducted in 8 hospitals, 2 health clinics, and 8 private clinics which involved 1,240 opiate dependents in 4 zones (north, south, east and west) of peninsular Malaysia. Soon to follow is the NSEP program. New HIV cases were brought down since first detection in 1986 (Figure 4).10

![Figure 4: Percentage of HIV cases among IDU and Sexual](image)

Since then, more opiate users and addicts are given the Methadone Maintenance Therapy. Other substitutes were also provided such is Buprenorphine / Subutex and Subutex + Naloxone (Suboxone). However, these are substitutes for opiates, whereas no medication is available for other substance of abuse.16

Many studies found that giving substitutes together with behavioral and psychosocial interventions yielded better results.18,19 Harm reduction initiatives that are supported by counseling, especially motivational in nature can shape a person’s behavior change to a specific target.19 A person on Methadone Maintenance Therapy (MMT), for example, given the proper counseling can direct his behavior to finding better jobs, engaging in community activities or take care of his health, aware of his medications as compared to a person that is on MMT alone. This also includes spiritual input, i.e. to enhance him to perform his religious duties according to his faith.20,21 What is important is that harm reduction initiatives can put a user on a platform where other services that can enhance abstinence to be provided to him in the long run.11 Religiosity seems to be one of the important factors that are present in recovering drug users that has maintained abstinence for a long time.21,22

**Islamic Religious input**

It is very clear that many religions of the world oppose to the use of intoxicating substances.22 Among those clearly spoke out this opposition is Islam, who is against the use of any drugs except...
for those which are medically prescribed. The Holy Quran states “O you who believe! liquor, gambling, idols and divining arrows are but abominations and Satanic devices. So, turn wholly away from each of them that you may prosper. Satan desires only to create enmity and hatred between you by means of liquor and gambling and to keep you back from the remembrance of Allah and from Prayer. Will you then desist?” (Verse 5:91-92). Prophet Muhammad pbuh said, ‘Every intoxicant is Khamr (alcohol) and all Khamr is Haram (unlawful or not permitted)’. The very argument that was used against such intoxicating substances is that all drugs enable people to escape from real life which would mean that they cannot serve Allah SWT. As such, people who use any type of non-medicinal substance will have to return to the path of Allah SWT.

Malaysia, being an Islamic country placed emphasis in spiritual rehabilitation in most of its social, behavioral and correctional programs. This can be seen in all government programs and many others operated by NGOs and private institution.

For government-based programs, most of the educators, teachers, counsellors and therapist are being supplied by the Department of Islamic Development, Malaysia (JAKIM) and the State Religious Council / Authorities. Thus, teachings of Islamic religion and good values are done by certified religious teachers. Also, drug rehabilitation programs obtain assistance from local religious leaders, Ulama, Imams of the mosque to interact with residents in the center to prepare them to re-enter society.

At the triage department of government treatment centres, drug dependents are detained for 2 weeks following the court order for assessment, evaluation and relocation. Minimum religious inputs are provided here because of the short detainment period. Religious teachers from JAKIM encouraged detainees to perform their 5 times obligatory daily prayers in their holding rooms. Assessments were conducted by JAKIM officers on religious understanding, knowledge and practice starting from the Syahadah covering all the basics Islam.

Following up at the rehabilitation institution, there are assessment and evaluation done to match clients’ needs and interest according to the requirements of the basic knowledge and values of Islam. Religious inputs provided at these centers, among others are, mandatory prayers, reading the Quran, sunat prayers, zikir and learning of the hadith, celebrating Islamic events, religious classes and talks and a choice of careers pertaining to religious practice.

There are several spiritual enhancement program at the government drug treatment institution that includes the followings: (i) Spiritual and self-introspection; (ii) Religious educational classes such as Tauhid, Fiqh, Akhlak, Al-Quran, Al-Hadis; (iii) Learning the stories of Prophet Muhammad S.A.W., the caliphs & sahabat; (iv) Subuh and Maghrib religious programs and talks; and (iv) the religious test (tasmi”) in order to qualify for advancement to the next phase of treatment.

There are also annual Islamic program and celebrations such as; celebrate the beginning and year end Do’a at the beginning of Islamic calender year (1st Muharram); Maulidur Rasul (12 Rabi’ul Awwal); Isra’ Mi’raj (27 Rejab); Nisfu Sya’ban (15 Sya’ban); Ihyaa’ Ramadhan (1-30 Ramadhan); Nuzul Al-Quran (17 Ramadhan); ‘Aidl Fitri (1 Syawal); and ‘Aidl Adha (10 Zulhijjah). Celebrating these programs are often done with family members and significant others in order to facilitate family’s involvement, care and concern to the treatment program.

There are also special programs that are included in the Islamic activities calendar of the nation. These are Islamic current issues Forum (with RTM); Jenazah course; Nasyid competition (religious songs); Hafazan al-Quran program; Tilawah Al-Quran program; and Friends of the Mosque (a joint-program with JAKIM).

Spiritual-based relapse prevention program in community setting

When recovering drug users left the institutional drug treatment program, most of them still need guidance to re-enter their society. Many will use the government facilities, such as the drop-in and community service-centres (CCSC), community courses and other community-based programs to gain the confidence. Here, there are a multitude of programs that they can follow, one of which is the religious program (See Table 1).

Most of the community-based program also contains the followings: (i) taqwa enhancement program; (ii) solat program; (iii) capacity building and enhancement; (iv) spiritual and religious recovery mentoring; (v) visits of the community religious leaders; (vi) Imam & Muadzin workshop; and (vii) dakwah methodology courses. These were often done with collaboration of the local religious heads in the community.
What is the outcome of these inputs? National Anti-Drug Agency (NADA), in its implementation documents stated that the desired outcomes would be clients that perform religious practice in their everyday life; clients practice Islam as a way of life; religion can deviate clients away from negative life influences and decisions; there are some improvements on the clients’ physical, social and spiritual quality of life. The question is how to measure these outcomes in a short time frame.

A study at 10 community-based Cure and Care Service Center (CCSC) in 2013 showed that there are positive changes perceived by the clients after they undergo at least 12 months of religious programs as part of their rehabilitation (Table 2).

### Conclusion

The inclusion of religion and spirituality into drug treatment has been found to have positive effect onto the lives of the residents and clients. From an increase in church attendance that was associated with reduction in cocaine use, to regularly performance of one’s religious obligations, such a positive effect, though not widespread has help to improve the quality of life of recovering drug addicts.

There are studies that showed good outcomes to the religious programs conducted in Malaysia; however there are also many studies that showed little change over a longer period of time.

These studies also pointed out those religious inputs must be conducted together with other evidence-based drug treatment modalities. Those who conduct the religious program in isolation have shown to be of little effect as compared to those conducted with other programs such as detoxification, behavioural interventions, therapeutic communities, and later MMT and other OSTs. From these studies and a multitude of unrecorded experiences conducting the religious programs, there are lesson that can be learnt from Malaysia.

Since many drug users/addicts have limited knowledge on religion, much less practicing it, many treatment experts belief that religion is quite ‘alien’ to the lifestyle of a drug addict. Relearning religion and religious values is imperative, and it has to be done at a slow pace.

Treatment providers and specialists also commented that rejection, non-commitance, non-adherence to programs and negative defense mechanism are common especially among the hardcore addicts. Acceptance is much higher with younger clients and those who do not experience severe dependency. This would act as a good group to start a religious program.

Introduction of religious teachings should be at the level suitable to the subjects’ needs and preparedness. Education should start at the appropriate level rather than if they know everything. Inputs that are too high or complex would only be met with rejection. Thus, teaching religion, its values and practice without proper assessment of the client’s needs is counterproductive. The Severity of Addiction matrix (ASSIST) can be used as a guide for placement of clients into specific program. Peer-educators can be used to guide clients into the

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**Table 1: Some of the Community-Based Islamic Programs and its Expected Outcomes**

<table>
<thead>
<tr>
<th>No.</th>
<th>Program/Activities</th>
<th>Objective</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Taqwa</td>
<td>Provide continuous religious classes to recovering drug addicts and their families, besides group meetings to enhance recovery</td>
</tr>
<tr>
<td>2</td>
<td>Islamic art and culture</td>
<td>Provide Islamic entertainments, arts and culture for recovering drug addicts</td>
</tr>
<tr>
<td>3</td>
<td>Dhohry camp</td>
<td>To provide an intensive program to study Quran and Hadith</td>
</tr>
<tr>
<td>4</td>
<td>Mosque as foster homes</td>
<td>To aid recovering drug addicts and their families in the recovery process by using the spiritual approach</td>
</tr>
<tr>
<td>5</td>
<td>Friends of the mosque</td>
<td>To encourage recovering drug addicts to be closer to the mosque community. It can act as a “sanctuary demanding for them when they need the community”</td>
</tr>
<tr>
<td>6</td>
<td>Volunteer work in the community mosque</td>
<td>To encourage recovering drug addicts to be closer to the mosque community; preparing them to be reengaged back in the community</td>
</tr>
<tr>
<td>7</td>
<td>Outreach to urban drug addicts</td>
<td>Outreach work to recovering or drug addicts &amp; families in the community</td>
</tr>
</tbody>
</table>

**Table 2: Measuring outcomes at 10 CCSCs.**

<table>
<thead>
<tr>
<th>Model</th>
<th>Post</th>
<th>Pre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model A</td>
<td>68%</td>
<td>31%</td>
</tr>
<tr>
<td>Model B</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Model C</td>
<td>70%</td>
<td>30%</td>
</tr>
</tbody>
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programs, and at the same time to avoid coercion. Also, the use motivation-enhancement techniques to move clients up the ladder of religious values and practice are more effective rather than following a structured and fixed program. Guidance and counseling is necessary to motivate clients towards religion, its values and practices. Clients who reject religious teachings can and will influence others to reject the program in many ways. There must be allocations for group discussion sessions on their experience learning/relearn religion – what are the ups and downs. Encourage clients to choose what they want to learn with a given menu. Assess their achievements and give reports/encouragement.

Finally, adhere to the Principles of Drug Addiction Treatment (PODAT). If religious/spiritual is to be used as primary treatment, medical & behavioral must be integrated to provide holistic drug treatment.

References