

# **Drug Policy Reform In Malta**

*The University Students ` View  
on the Way Forward*



## **Drug Policy Reform**

*The University Students' View on the Way Forward*

Published in August 2011



*Published By*

**Kunsill Studenti Universitarji**  
**Kummissjoni Politika Socjali (KPS)**

Students' House,  
University of Malta,  
Tal-Qroqq, Msida  
MSD 2020  
Malta, Europe

Web:  
[www.ksu.org.mt](http://www.ksu.org.mt)

Email:  
[info@ksu.org.mt](mailto:info@ksu.org.mt)

Telephone:  
+356 2134 3085

Editor: Abigail Cremona

© Kunsill Studenti Universitarji (KSU) Malta

*All rights reserved.*

## Foreword from the Editor



It is with great satisfaction that the KSU Social Policy Commission is presenting this first *Drug Policy Reform- The Way Forward*. This in- depth analysis which led to the formation of this report could not have been achievable without the extensive cooperation of the drug policy reform subcommittee members. Hence these words of appreciation go to all of them, for all their dedication and hard work! A special thanks also goes to Dr. Sandra Scicluna one of Malta's experts in this field for all her collaboration and generous help. Furthermore, it is to be immediately acknowledged that due to limitation of time and resources this report was conducted in a span of four weeks' time to be presented on the stipulated time to all student organisations on campus in the Social Policy Commission Meeting of August for discussion and approval.

It is to be reminded that in March 2010, KSU became a signatory of the European Action on Drugs, a campaign launched by the European Commission in 2009. In the view of this commitment and the lately several debates surrounding the decriminilisation of soft drugs issue, the KSU Social Policy Commission has taken this task force as another challenge serving as another step in the seeking to raise awareness about the risks of drug abuse.

It is a known fact that, drug abuse, is one of the most common risks facing Maltese citizens especially youth. Hence, this report is designed to cut through the fog of misinformation with hard facts. The presented different aspects of drug abuse ranging from the legal, medical, pharmaceutical and psychological aspects of drug abuse together with statistics and facts on the situation in Malta compared to an International level present appropriate information surrounding the subject and an accurate picture of Malta's experience with drug use and abuse. This lead to the formation of informed and researched points of views when working and writing on the several suggested recommendations.

On a final personal note, it was a lovely experience for me, to be the editor of this report and to have the opportunity to team up with varying opinions in one quest- to produce a holistic report that represents all University Students and our commitment and struggle in the fight against drugs!

Yours Truly,

**Abigail Cremona**

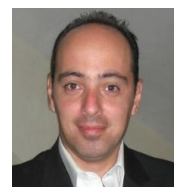
KSU Social Policy Commissioner



# The KPS Drug Policy Reform *Subcommittee*

## *The Researchers*

*Chairperson* **Oliver Cassar**



*Rapporteur/* **Abigail Cremona**  
*Editor* Social Policy Commissioner Kunsill Studenti Universitarji (KSU)



*Proof Reader* **Angelo Micallef**  
Honorary President Malta University Film Club (MUFC)



**Elena Bajada**  
President Malta University Sports Club (MUSC)



**Edward Camilleri**  
Secretary General Studenti Demokristjani Maltin (SDM)



**Rona Custo**  
Education Officer Ghaqda Studenti Tal-Kriminologija (GHSK)





**James Debono**

IT Officer Ghaqda Studenti Tal-Ligi (GHSL)



**Robert Louis Fenech**

Coordinator Moviment Graffiti



**Noel Pace**

President Malta Pharmaceutical Students Association (MPSA)



**Karen Tanti**

Coordinator Moviment Graffiti



**Daniel Vella Fondacaro**

Vice President Malta Medical Students' Association (MMSA)



**Kathryn Zahra**

Secretary General Ghaqda Studenti Tal-Kriminologija (GHSK)



## *A message from the Chairperson*

The last four weeks were quite an experience, being part of KSU's subcommittee discussing possible updates in Malta's drug-policy. Amongst other elements discussed we discussed the contrasting views on topics such as 'Switzerland's heroin maintenance programme' and the criminalization of tobacco use and alcohol rather than decriminalization any soft drugs.

Throughout the process, constant reference was made to Portugal which in 2001 became the first European country to officially abolish all criminal penalties for personal possession of particular drugs.

However the subcommittee reached the conclusion that drug addiction causes human harm and such has an impact on different families and on society in general. Such harm cannot be underestimated while investigating overall drug related problems and due to such, the subcommittee reached common views wherein basically focus was placed upon the drug addict, in particular those non-violent first time offenders that must be considered much more as a victim of addiction then being a criminal.

The fight against drugs is not just defeating the drug trafficker, thus education and rehabilitation play a crucial role within an efficient drug-policy. Mere incarceration for particular subjects is simply not the solution and there seems to be a need for new structures and alternative punishments within our criminal system. It was noted that due to certain confusions within society wherein decriminalisation and legalization are confused as being the same and not completely different the need to highlight such difference cannot be understated.



We seem to have incorrect stereotypical ideas on drugs and drug addicts and while we always associate white powder or a deviant person with 'drugs', we regularly underestimate the perception of a 'normal' youth using inhalants as a victim of drugs. Therefore we need generate a new mentality about the subject in particular by the valuable involvement of the local media. The need to understand how certain difficulties transcend different sectors of society was strongly felt. Finally, while considering Malta's limitations within a global scenario, we can further focus on the possibility of a geographical focus within our development policies by supporting education, training and enhancing possible public-private partnership within a strategy against global drug trafficking.



*Oliver Cassar*

Chairperson of the KPS Drug Reform Subcommittee



# Table of Contents

Guiding Principles	9
Guiding Definitions	10
<b>Chapter 1: The Drug Abuse situation in Malta Vs. The International Aspect</b>	<b>11</b>
- Current Situation in Malta	12
- A local Scenario	13
- Drug Use- University of Malta	14
- Drug Use- European Union	15
- Case Studies	17
Italy	17
Switzerland	19
United Kingdom	21
Portugal	23
Cyprus	24
Netherlands	25
<b>Chapter 2: Aspects of Drug Use and Abuse</b>	<b>29</b>
- The legal and Judicial Framework	30
Maltese Legal Scenario	31
- The Socio-Psychological Aspect	38
Peer Pressure and Media	38
Personality Traits	38
Wild Escapism	39
The Family Environment	40
Identity Youth and Crises	40
- The Pharmaceutical Aspect	42
Classification of drugs – Soft Vs Hard	42
- The Medical Aspect	48
The effect of Substance Abuse and Drug Addiction on the Human Body	48



## **Chapter 3: Decriminilisation of Soft Drugs- The debate: Yes vs. No**

### Aspects against

- Marijuana vs. Tobacco: How Things Stand 53
- What about Sports? 59
- Aspects in Favour 60

## **Chapter 4: Drug Treatment Available in the Maltese Islands**

### Prison Programs

- Substitution Treatment 70
- Harm Reduction 71
- Community Based Alternatives 71
- Probation 72
- Parole 73
- Drug Courts 74
- Treatment Programs 74
- Boot Camps 75

## **Chapter 5 : Recommendations- The Way Forward**

### The Introduction of a drug classification system

- A review of all national entities tackling drug abuse 80
- Harsher penalties for trafficking, cultivation and transportation 81
- Commencing to treat people dependent on drugs as patients not criminals 81
- Improvement in Restorative Justice Measures 82
- Encouraging the Introduction of Halfway Houses 82
- The setting up of a Drugs Tribunal 83
- Introducing new services for women 84
- Drug Abuse and Development 85
- Investment in Education will always remain the key to success 86
- **Concluding Remarks** 87

## *Guiding Principles*

1. Analyzing the drug situation in Malta and on a University level in comparison to the International aspect
2. Acknowledging the difference between the different classification of drugs and patterns of use
3. Commencing to treat people dependent on drugs as patients not criminals
4. Presenting a more pragmatic approach by replacing the principle of zero tolerance with the principle of harm reduction and a caring state
5. Challenge rather than reinforce common misconceptions about drug markets, drug abuse and drug dependence
6. Carefully evaluating previous drug policies to determine which are the most effective rather than sticking to an ideological perspective
7. Recognizing that this policy will be based on human rights, ethical issues and health principle aiming to reduce the stigmatization and marginalization of those who use drugs.
8. Identifying the breaking of taboo and labeling aspects to pursue an open and free debate.
9. Believing that the development and implementation of drug policies should be a one common sought shared responsibility involving the participation of the Government, NGO's and all stake holders
10. Acknowledging that the war on drugs is failing, urgent action is required and policies need to be revised now



## Guiding Definitions

### **Drug:**

Any chemical agent or mixture of agents, other than those required for the maintenance of normal health (like food), the administration of which alters biological function and possibly structure (World Health Organisation, 2009) In 1981 the World Health Organisation, in its Expert Committee on Drug Dependence (1981:227) has defined a drug as being: “any chemical entity or mixture of entities other than those required for the maintenance of normal health, the administration of which alters the biological function and possibly structure”.

### **Medication:**

Any substance with the potential to prevent or cure disease or enhance physical or mental welfare organisms.

### **Use vs. Abuse of Drugs:**

In the view of this definition, it is essential to portray that the difference between the use and the abuse of drugs is a thin line. While the use of drugs refers to its utilization through history in different parts of the world and the techniques employed to make use of the different kinds of such a drug, the abuse refers to the use of a drug outside a medical context (American Medical Association, 2009). Furthermore, according to the Black's Law Dictionary (2010), drug abuse is the detrimental state produced by the repeated consumption of a narcotic or other potentially dangerous drug, other than as prescribed by a doctor to treat an illness or other medical condition.

### **Common usage:**

The term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to any medical use. Caffeine, tobacco and alcohol which have no medical use are also drugs in the sense of being taken at least in part for their psychoactive effect

### *References*

American Medical Association (2009). *Official definition of drug abuse*. Retrieved on August 5th at 19:00 from [www.ama-assn.org](http://www.ama-assn.org)

Black's Law Dictionary (2010). *Legal definition of drug abuse*, retrieved on August 5<sup>th</sup> at 13:00 from <http://www.blackslawdictionary.com>

World Health Organisation (2009), *1981 Report on Drug dependence*. Retrieved August 5<sup>th</sup> at 12:30 from [www.who.int](http://www.who.int)



## *Chapter 1*

# **The Drug Abuse situation in Malta Vs. The International Aspect**

## *Current Situation in Malta: Statistical analysis*

Abigail Cremona| KSU

Drug use and abuse remain one of the highest concerns in Malta with the year 2009 seeing Malta as having the highest rate of heroin use in the EU (European Monitoring Centre for drug and drug addiction, 2010). In 2001 Hon. Borg stated that there were 39 people found guilty of drug trafficking with eight of these being of foreign nationality (House of Representatives, 2001: no 28043). Conversely, in 2009 Hon. Mifsud Bonnici reported that the police started procedures at the courts of Malta against 449 people related to drugs (House of Representatives, 2009: no.10137). Moreover in 2002, 147 patients were registered with overdoses at the Emergency Department of St.Lukes Hospital with the most common substances being opiates, anti-depressants and benzodiazepines with ages varying between 15 and 80 (House of Representatives, 2002, no. 37534) Further still in the year, 2009 and 2010 Hon. Mifsud Bonnici stated that 15 people were brought in front of the Gozo Law Courts accused on drug trafficking and another 23 people charged with possession of drugs. The ages varied between 16 and 57 years (House of Representative, 2010: no. 28043)

Source: Cremona, A. (2011). *Attitudes to Punishment- The Attitudes of Maltese Youth towards Punishment and Community Corrections* Dissertation, Institute of Criminology, University of Malta, Malta

## A Local Scenario

Angelo Micallef | MUFC

Malta principally has two pieces of legislation dealing with substance abuse namely the Medical and Kindred Professions Ordinance (Chapter 31) enacted into Maltese law in 1901 but amended extensively in 1985 to include a series of offences concerning the unauthorized dealing or possession of psychotropic substances, and the Dangerous Drugs Ordinance (Chapter 101) which deals with narcotic drugs and was enacted into Maltese law in 1939. This piece of legislation tackles opium, coca leaves, cannabis, cocaine, morphine and other drugs. In terms of Maltese law the unauthorized use of controlled substances will lead to a conviction for possession or trafficking once such is proved in a court of law. Possession in Maltese law is divided into two; namely possession for personal use or possession which does not seem to be one intended for the possessors exclusive use, the latter being an aggravating circumstance. The latter is further aggravated when it takes place within a 100 metre radius of a place habitually frequented by youths such as for example a school or a youth club.

Simple possession or possession for personal use is liable to a punishment of 3 to 12 months imprisonment and/or a fine of between €470 and €2,350 if triable within the Court of Magistrates. If triable within the Criminal Court the liability for punishment is somewhat higher wherein the prison sentence may range from 1 year to 10 years with the fine remaining within the same remit. Commenting on the EMCDDA website Dr. Stephen Tonna Lowell comments about the court and its attitude to crimes related to substance abuse and this when he claims, *“The Maltese courts have not shown much leniency in relation to drug-related offences, such as theft from vehicles, invariably stating that if such leniency were shown, they would be condoning more than one crime”* (EMCDDA, 2011).

Maltese legislation does not completely and altogether forget the element of treatment. Maltese procedural law dictates that the police must initiate all proceedings against an accused. This thus allows Maltese police the discretion not to prosecute where such is deemed to not be beneficial for justice. The Attorney General, upon advising the President of the Republic of Malta has a similar power of discontinuing a prosecution where such is deemed necessary. Drug offences under Maltese law may carry the punishment of enforced treatment. Interestingly in his paper Dr. Stephen Tonna Lowell further explains;

“The Conduct Certificates Ordinance (Cap. 77) does provide remedies for a conviction relating to drug offences not to be registered. This means that the conviction may not be recorded in the conduct certificate if the person convicted of the crime is not twenty-one years of age at the time of the commission of the offence or if, having regard to the nature of the crime, the circumstances in which it was committed, and the conduct of the person convicted, the court deems it proper so to direct. However, these type of offences are treated with utmost severity even in this regard” (EMCDDA, 2011)

Another piece of legislation which must necessarily be looked at is the Prevention of Money Laundering Act (Chapter 373) which law was enacted in 1994. This law is cross-referenced several times in both Chapter's 31 and 101. Chapter 373 has evolved with the passage of time including more predicate offences. Interestingly the sentence for laundering money is identical to that of drug trafficking, life imprisonment subject to the jury being unanimous in its verdict and the judge not considering such a sentence inappropriate.

## *Drug Use: University of Malta*

Abigail Cremona |KSU

In a study carried out in 2009 by Camilleri and Cefai named “Healthy Students, Healthy Lives” it was revealed that 10.1% of the university respondents confessed to the use of illicit substance abuse at least once during the last month and 17.3% during the last year. Cannabis and cocaine were listed as the drugs commonly used amongst the university students with the former having a popularity of 19.9% and the latter 9.6% (Camilleri & Cefai, 2009:51). Yet there were other drugs mentioned with heroin – deemed as the most dangerous and most addictive drug – having been used by 1% of the student population (Camilleri & Cefari, 2009).

### *Reference*

Camilleri, L., Cefai, C., (2009). Healthy Students, *Healthy Lives- The Health of Maltese University Students*, European Centre for Educational Resilience and Socio- Emotional Health, University of Malta, Malta

# Drug Use in the European Union

Angelo Micallef | MUFC

*(Selected since Malta is part of the European Union and hence what the EU does directly does to the national situation)*

The European Union does not directly regulate drug use and possession and this since the EU does not enjoy competency in this regard. This however does not mean that the European Union and the European Community before it, have been completely silent on this subject matter. The EC ratified article 12 of the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances thus leading to regulation 3677/90 in 1990 and directive 91/308 in 1991. In 1992 the Maastricht Treaty saw another leap forward. Commenting on the Maastricht Treaty and the subsequent Amsterdam Treaty Laura D'Arrigo commenting on the EMCDDA website writes;

“The Maastricht Treaty was the first European Treaty which specifically referred to the drug phenomenon. The subject of drugs was mentioned in two articles of this Treaty: Article 129 relating to public health and article K.1(4) and K.1(9) relating to the field of justice and home affairs.

Article 129 stipulated that: “(...) Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education (...).”

Article K.1. foresaw that: “For the purposes of achieving the objectives of the Union, in particular the free movement of persons, and without prejudice to the powers of the European Community, Member States shall regard the following areas as matters of common interest:

... 4) combating drug addiction in so far as this is not covered by 7 to 9;

... (9) police cooperation for the purposes of preventing and combating terrorism, unlawful drug trafficking and other serious forms of international crime, including if necessary certain aspects of customs cooperation, in

connection with the organization of a Union-wide system for exchanging information within a European Police Office (Europol)”.

The Amsterdam treaty, adopted in 1997, represented a new step forward in combating the drug problem.

It slightly changed the text of the article related to public health (article 152, ex article 129), and particularly the provision concerning drugs. Cooperation in this field is now intended to “complement the Member States' action in reducing drugs-related health damage, including information and prevention”.

Article 29, (ex article K.1) foresees: “Without prejudice to the powers of the European Community, the Union's objective shall be to provide citizens with a high level of safety within an area of freedom, security and justice by developing common action among the Member States in the fields of police and judicial cooperation in criminal matters and by preventing and combating racism and xenophobia. That objective shall be achieved by preventing and combating crime, organised or otherwise, in particular terrorism, trafficking in persons and offences against children, illicit drug trafficking and illicit arms trafficking, corruption and fraud” (EMCDDA, 2011).

Interestingly the last European Union strategy for drugs tackling the years between 2005 and 2012 dates back to 2004. The strategy called for a multidisciplinary and integrated approach to drugs. Interestingly an EC regulation had created the EMCDDA, European Monitoring Centre for Drugs and Drug Addiction and this way back in 1993, becoming fully operational in 1995.

July 1993 also saw another interesting development in that the Trevi Group of Ministers established the Europol Drugs Unit. The EU has other instruments to combat drug trafficking; one of the earliest such instruments was Joint Action 96/750/JHA. In June 2002 the Council of Minister adopted Framework Decision 2002/584/JHA namely the European Arrest Warrant and the surrender procedure between member states. This framework is currently in force in 23 member states namely Austria, Belgium, Cyprus, Denmark, Estonia, Finland,

Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovenia, Slovakia, Spain, Sweden and the United Kingdom.

Prevention and treatment are remits for member states and thus not much has been done at an EU level. This however did not stop the Council of Ministers adopting a recommendation to member states to establish the prevention of drug dependence and the reduction of related risks as a public health objective and this in June 2003.

## Case Studies-Part 1

### *Case 1- Italy*

*(Italian law has often on many matters been a source of inspiration for Maltese law)*

A law adopted in December 1975 saw Italy base its law upon the principle of non-criminalization of consumption whilst affirming the unlawfulness of possession. This law was heavily criticized and was changed by means law no 162 adopted on June 26<sup>th</sup> 1990 which law provides the legal framework for licit trade, treatment and prevention, prohibition and punishment of illicit activities. The use of drugs was regulated by means of establishing fixed quantities as the threshold between use and trafficking. A later referendum amended this law and drug use is now not mentioned as an offence. Nevertheless possession, acquisition and importation for personal use remain strictly prohibited receiving however only administrative sanctions for personal use and a prison sentence for trafficking. The formerly mentioned fixed quantities method has also been abolished and discretion is left to judicial authorities. A law signed into effect on February 18<sup>th</sup> 1999 established the National Drugs Observatory having the responsibility to develop drug policy in respect of prevention, treatment, rehabilitation and social re-integration.

Controlled substances in Italy are classified in six lists attached to a decree of March 4<sup>th</sup> 1992 and subsequent amendments. Illicit activities are punished differently according to the list in question. Lists II and IV for example are less severely punished then lists I and III. The lists are the following:



I- Includes opiates and cocaine derivatives

II- Cannabis

III- Highly addictive barbiturates

IV- Medical substances

V- Special preparation containing drugs

VI- Stimulants

Writing on punishment in the Italian legal system Silvia Zanone on the EMCDDA website writes;

“The penalty for production and/or trafficking at an individual level is of 8 to 20 years imprisonment and a fine of between €25 000 and €250 000 (table I and III drugs) and 2 to 6 years imprisonment and a fine of between €5 000 and €77 000 (table II and IV drugs) where significant quantities of drugs are involved. For smaller quantities, but larger than for personal use, the penalty is one to six years imprisonment and a fine of between €2 600 and €26 000 (table I and III) and 6 months to four years imprisonment and a fine of between €1 000 and €10 000 (table II and IV)”. (EMCDDA, 2011)

In the Italian system the police have very little if any discretion in reporting a matter to the prosecutor. Every offence reported must be registered and an investigation is then initiated by the prosecutor.

On prevention and treatment Silvia Zanone writes;

“There has been increasing involvement of the Ser.T and of the socio-rehabilitative services within the prison system. For imprisoned drug users there exists the opportunity to start or to re-start treatment and subsequently apply for an alternative measure instead of the prison sentence to complete the treatment in a therapeutic environment. The treatment service must provide the court with a declaration explaining the treatment proposed and

its suitability for the client and the court must be convinced of the client's commitment to undertake the treatment programme. Alternative measures are available for all offenders where they meet the criteria defined in the law. For drug using offenders, the focus is specifically on treatment and rehabilitation measures which address both criminal behaviour and, as importantly, drug-using behaviour which may have been an important factor in offending”.(EMCDDA, 2011).

## *Case 2- Switzerland*

*(Switzerland's drugs policy is controversial and somewhat unconventional compared to most European legal systems)*

The Swiss government has over time continued to evaluate, refine and consolidate its four-pillar counternarcotic policy focusing on prevention, treatment, harm reduction and law enforcement. Voters rejected two popular initiatives that would have significantly changed this policy, thus indicating that a national majority in support of this four-pillar policy has emerged. The Swiss Government plans to continue its heroin prescription program as a therapy form for hard-core addicts. More effective legislation and vigorous law enforcement are making it more difficult to launder money and have led to significant seizures of drug-related assets. Switzerland plans to ratify the 1988 UN Drug Convention with reservations in the near future and has already adopted legal instruments that allow it to implement the most important provisions of the convention.

Switzerland has been a party to the 1971 UN Convention on Psychotropic Substances since 1996. The government intends to conform national law to the Chemical Action Task Force (CATF) recommendations and new European Union regulations. Interestingly according to the Swiss narcotics law, cannabis cultivation is legal if the harvest is not destined for narcotics production. Cannabis farmers are even subsidized by the government as long as their plants contain less than 0.3 percent THC. About 300 tons of cannabis are cultivated annually and cannabis products have become a million franc industry. Figures on the extent of illegal cultivation are not available. However, police acknowledge that they had underestimated the seriousness of the problem.



Switzerland spends \$22 - 25.5 million annually on programs aimed primarily at the young that seek to encourage abstinence from drug use and an overall healthy lifestyle. Switzerland has always been at the forefront of new developments in treatment and rehabilitation programs. It has over 100 public and private institutions that provide drug therapy. With a budget of \$160.6 - 190 million, it has the capacity to provide therapy to two-thirds of its approximately 30,000 addicts. Regarding harm reduction, Switzerland was among the first countries to adopt a needle exchange program to combat the spread of the HIV virus. The Swiss Federal Government supports an extensive needle distribution program involving injection rooms, pharmacies, needle exchange buses and public needle dispensers. Swiss officials credit this program and other housing and employment programs with reducing the prevalence of HIV and hepatitis among Swiss drug addicts. Switzerland earmarks \$88 to 146 million annually for harm reduction.

#### References

European Monitoring Centre for Drugs and Drug Addiction (2011). *Country Profiles*, retrieved from

<http://www.emcdda.europa.eu/html.cfm/index5174EN.html#> on August 5<sup>th</sup> 2011

United Nations. (2011). *Convention on Psychotropic Substances- 1971*, retrieved from

[http://www.incb.org/pdf/e/conv/convention\\_1971\\_en.pdf](http://www.incb.org/pdf/e/conv/convention_1971_en.pdf) on August 5<sup>th</sup> 2011

## Case Studies- Part 2

Kathryn Zahra | GHSK

### Case 3-United Kingdom

*(Selected since British law has often served as a source of legal inspiration for Maltese law)*

In the United Kingdom the main law regulating drug control is the Misuse of Drugs Act 1971 (MDA); where this Act, together with other associated regulations, encompass all that has to do with the control of dangerous acts, such as: import/export, production, supply, prescription, possession and possession with the intention of selling. This act categorised controlled substances into 3 classes, whereas listed in Drug Scope (2011):

1. Class A includes cocaine, crack, ecstasy, heroin, LSD, methadone, methamphetamine, magic mushrooms (containing psilocin) and Class B drugs which are ingested. This class is considered as the most dangerous.
2. Class B includes amphetamine, barbiturate, codeine and cannabis; together with all derivatives of cathinone which were brought under control in 2010.
3. Class C includes anabolic steroids, minor tranquillizers, GBL and GHB and Ketamine.

The Misuse of Drugs Regulations require that drugs are enforced in different way by putting drugs into five different schedules, as follows.

Those drugs found within Schedule 1 are the most controlled, where it is acknowledged that these drugs have no therapeutic use and can be supplied only in exceptional circumstances under a special Home Office license. Examples include cannabis, coca leaf, ecstasy, LSD, raw opium and psilocin.

Schedule 2 and Schedule 3 drugs are those drugs that are available for medicinal purposes and therefore can be prescribed by the doctor. This makes it legal for a person to possess



drugs which fall within this category provided that these were prescribed by a doctor. Schedule 2 drugs include amphetamines, cocaine, heroin, and methadone, and morphine, opium in medicinal form, pethidine and Ritalin. These are subject to very strict regulations on record keeping in pharmacies. Schedule 3 drugs include barbiturates, Rohypnol and temazepam tranquillizers; which are subject to restrictions on prescription writing.

Those drugs which fall under Schedule 4 are divided into two parts: Part 1 drugs are made up of most minor tranquillizers and 8 other substances, making it illegal to be in possession of any of such tranquillizers without a prescription; and Part 2 drugs which include anabolic steroids, that can be legally possessed without a prescription but which cannot be supplied.

Lastly, Schedule 5 includes all drugs which are considered as the least dangerous where most of these drugs can be sold over-the-counter at pharmacies as they pose minimal risk of abuse. Although it is perhaps wise to state that when bought these drugs cannot be supplied to another person.

The penalties under the Misuse of Drugs Act are different upon the nature of the offence, that is, less for possession and more for trafficking, production or for allowing premises to be used for producing or supplying drugs. Furthermore, using the drug classification system above, the penalties given are also dependent upon the harmfulness of a drug, where Class A drugs have the most severe penalties with 7 years and and/or unlimited fine for possession; and life and unlimited fine for production or trafficking.

Table 1 Penalties given according to Misuse of Drugs Act (DrugScope, 2011)

<b>Drug class</b>	<b>Possession</b>	<b>Supply</b>
Class A	7 years + fine	Life + fine
Class B	5 years + fine	14 years + fine
Class C	2 years + fine	14 years + fine

Less serious offences are dealt with by the magistrates' courts, where the maximum sentence given is that of six months and/or a £5,000 fine; or three months and/or a fine. In this case, most drug offenders are convicted of unlawful possession.

## Case 4- Portugal

*(Selected due to the discussion raised about this particular legal model)*

In Portugal the primary law on drugs is the Decree Law 15/93 of 1993 which was amended in 1995, 1996 and partially annulled by the Law 30/2000 in 2000. This particular Decree-Law regulates and controls various aspects which surround the penalties given, medicinal prescriptions, responsibilities concerning treatment and prevention, and all that which surrounds criminal investigation and money laundering; thus making a defined distinction between what is considered as trafficking and what is considered as crimes related to the use of drugs. Portugal underwent a decision point in 1999 when the Institute for Drugs and Addiction (IPDT) was created which in turn brought about the National Strategy for the Fight Against Drugs. This prompted a series of legislative revisions which took place in 2000. Perhaps one of the revisions which caught a great deal of attention was the decriminalisation of use and possession for use of all illegal drugs, which entered into force in 2001.

All substances are classified within 6 lists that are regularly updated by decree laws. These lists are as follows:

- List 1 incorporates opiates, coca derivatives, cannabis;
- List 2 includes hallucinogenics, amphetamines, barbiturates;
- List 3 consists of preparations with controlled substances;
- List 4 tranquillisers and analgesics and
- List 5 and List 6 contain precursors.

The difference between the lists is the impact of the penalties of drug related crimes. Until the decriminalisation of drugs in 2001, drug use was an offence punishable with up to three months imprisonment or a fine. However, if the quantity found in possession exceeded three daily doses the punishment could be increased to one year imprisonment sentence or a fine. The penalties given also depended on whether the illicit substance was for personal use or for trafficking.

The decriminalisation process maintained “the status of illegality for all drugs and for using them without authorisation” (European Monitoring Centre for Drugs and Drug Addictions [EMCDDA], 2004); however it changed the punishment for illegal drug use. With the new

policy in place, any person caught with a modest quantity of drugs for personal use (which the police cannot connect to any serious offences such as sale and trafficking) will have the drugs confiscated and the case transferred to a local Commission made up of a lawyer, a doctor and a social assistant. The Commission's main aim is to treat addictions and rehabilitate the person; sanctions and penalties are not the principal aims of this phase. The control of the sale of drugs for commercial purposes still remains one of the objectives of law enforcement authorities.

The laws on trafficking play a very important role in Portugal. Portuguese law defines prosecution of drug trafficking on a number of factors. The substance involved plays a very important role where those drugs found within List 1 to List 3 attract a prison sentence of between 4 to 12 years; whilst those caught with drugs that fall under the List 4 category may get a sentence of between 1 to 5 years imprisonment. Nonetheless, the addiction state of the offender is taken into consideration, where if the offender sells drugs in order to finance his own addiction, the penalty is reduced.

### *Case 5-Cyprus*

*(selected due to the similar circumstances between Malta and Cyprus; island states members of the EU and former British colonies)*

In Cyprus the Narcotic Drugs and Psychotropic Substances Law of 1977 defines controlled substances and it contains tables which categorise all substances. Amended in 1983, 1992, 2000 and 2003; these laws include conditions on the import and export, manufacturing, possession and use of illegal substances. The first schedule of the law of 1977 classifies controlled substances in three categories: Class A Drugs; Class B Drugs and Class C Drugs. This classification system is based upon the level of harm to public health which this drugs produce as well as their potential for abuse; thus, Class A drugs have the highest abuse potential whilst Class C drugs have the lowest. The different classes are also indicative of the punishments given (European Monitoring Centre for Drugs and Drug Addictions [EMCDDA], 2004).

The use of these substances is criminalised under s. 10 of the law of 1977, which originally prohibited the use of opium, cannabis, or cannabis resin; later amended to include all

controlled drugs listed. The punishments of drugs in Cyprus appear to be very severe; where use or possession of a Class A or Class B drug is punishable with a maximum sentence of life imprisonment. On the other hand the maximum sentence given for use or possession of a Class C drug is that of 8 years imprisonment. Furthermore, the law lists that buying or getting a supply of controlled drug without authorisation constitutes an offence as well.

Following the amendments of the 1977 law in 2003, limits on the quantities for personal use were introduced, where in this manner a possession of an amount that goes beyond the threshold constitutes a presumption of trafficking. The threshold that would result in a presumption of trafficking include: 3 or more cannabis plants, 30 or more grams of cannabis or its products or 10 grams or more of prepare cocaine or opium (European Monitoring Centre for Drugs and Drug Addictions [EMCDDA], 2004). Although Cyprus Authorities are very strict on drug related offences, the amendment of 1977 laws in 1992 makes it possible for the Court to give a lesser sanction for a first time offender under the age of 25 when the offence is related to personal use only.

## *Case 6- Netherlands*

*(selected due to being one of the first countries to go for an alternative legal model on drugs)*

The European Monitoring Centre for Drugs and Drug Addictions (European Monitoring Centre for Drugs and Drug Addictions [EMCDDA], 2004) identifies how the main drug law in the Netherlands is the Opium Act of 1919 which was the result of Netherlands' participation in the 1912 International Opium Convention in The Hague. This framework makes up the basis for the present legislation. This Act was amended in 1976 determining the current version; where the amendment made a distinction between 'hard' drugs and 'soft' drugs as based upon a scale designed upon medical, pharmacological, sociological and psychological data. The 1976 Opium Act distinguished between drugs which carried serious risks (unofficially called 'hard drugs') and cannabis products (unofficially referred to as 'soft drugs').

Said Act also includes provisions which cover drug trafficking and within the Penal Code measures are listed which cover the confiscation of assets and prosecution of money

laundering activities. Whilst arresting and sentencing those individuals who are found in possession of small quantities of any drug for personal use is not a priority for law enforcers; there are legal measures which offer the possibility that these users are sent to undergo treatment through “suspension of detention pending trial” (European Monitoring Centre for Drugs and Drug Addictions [EMCDDA], 2004). The year 2001 saw the introduction of a new law which enabled courts to send addicts with a criminal history to at least two years of intensive treatment at a special institution. In 2004, ‘Placement in an Institution for Prolific Offenders’ came into effect. Conversely, this act included all prolific offenders and it was not restricted to addicts. Since then, the 2001 law was incorporated within the 2004 law mentioned above.

The national drug policy of the Netherlands is decentralised at the local level, where drug related nuisance, including closing down premises where illegal drugs are sold, are dealt with by mayors. This local drug policy, is coordinated between the mayor, the Chief Public Prosecutor and the chief of police in what is referred to as tri-part consultations.

The categorisation within the Opium Act between ‘hard drugs’ and ‘soft drugs’ is broken down further, in order to allow different penalties for the different Schedules as seen below (Schedule I holding the harshest penalties).

Schedule I for those drugs which present harmful risks is divided into three:

- Ia: including opiates, cocaine and cannabis oil (amongst others);
- Ib: codeine;
- Ic: amphetamines and LSD.
  
- Schedule II is divided into two:
  - IIa: including tranquillisers and barbiturates;
  - IIb: including cannabis.

Drug use per se does not constitute a crime within legal terminology, yet there are situations where the use of drugs is strongly prohibited, such as use of drugs in schools. It is in the competency of the responsible authorities involved to enforce such regulations and not the central government. Law enforcement main priorities are not focused upon the individual use but are rather directed at investigating and prosecuting the production and international

trafficking of drugs. Any person found in possession of less than 0.5grams of Schedule I drugs will generally not be prosecuted although police will confiscate drugs and consult a care agency. Conversely, a maximum of 5 grams of cannabis will not lead to investigation or prosecution.

With the separation of the market between hard and soft, coffee shops emerged as the sales channels for cannabis under strict conditions. These locations are an attempt at keeping the youth population, away from much more dangerous drugs. The sale of small quantities of cannabis is technically an offence, but there are no proceedings instituted unless one of the criteria used by the Prosecutor General is broken. These criteria, as mention in the European Monitoring Centre for Drugs and Drug Addictions (2004) website, are as follows:

1. Not more than 5 grams per person should be sold in any transaction and the coffeeshop should not keep a stock of cannabis which exceeds 500 grams.
2. No hard drugs are to be sold.
3. Drugs should not be advertised.
4. The coffeeshop must not cause nuisance.
5. Said coffeeshops are not allowed to sell any alcohol.
6. Minors are not admitted inside the premises nor sold any drugs.

Possession of cannabis or other drugs for commercial purposes is considered to be a more serious offence than simple possession for personal use. The maximum penalty for possession with the intent of selling is 1 month imprisonment and/or a fine of €3,350 for an amount of cannabis which does not exceed 30 grams. On the other hand, if the substance is not cannabis, the maximum penalty will vary from a one year imprisonment sentence and/or a fine of €6,700 for a small quantity; up to 8 years imprisonment and/or a fine of €67,000 for the production of these substances. The maximum penalty can be increased by one third if the same crime has been committed more than once.

A distinction is made between drug users and traffickers. Drug users who are caught committing a crime are placed in an institution meant to provide care and treatment; whereas in 2006 the maximum penalty for Schedule II drug dealing was increase from 4 to 6 years of



detention or a fine. Within the original Opium Act the penalty for hard drug trafficking can be between 12 to 16 years and in contrast the penalty for importing or exporting quantity of cannabis is 4 years imprisonment sentence and/or a fine of €67,000.

### *References*

Drug Scope. (2011). *Drug Scope.*, retrieved from <http://www.drugscope.org.uk/resources/faqs/faqpages/what-are-the-uk-drug-laws.htm> on August 7, 2011

European Monitoring Centre for Drugs and Drug Addictions [EMCDDA]. (2004). *Country Profiles*: EMCDDA retrieved from <http://www.emcdda.europa.eu/html.cfm/index5174EN.html> on August 7th, 2011



## *Chapter 2*

# **Aspects of Drug Use & Abuse**

# *The Legal & Judicial Framework*

James Debono | GhSL

The legal aspect in Malta is enshrined in the Health Care Professions Act 2003, the Medicines Act 2003, the Department of Health Ordinance 1937, and the Dangerous Drug Ordinance 1939. The latter is mainly divided into four parts according to the substance in question and another two parts which deal with external trade and general matter. The substances mentioned include Raw Opium and Coca Leaves, Prepared Opium, Indian Hemp, Cocaine, Morphine and others. Moreover, it bestows three schedules each delineating lists of illegal substances in Malta as well with exemptions and preparations.

## **Comparative Law**

Before tackling each and every substance one has to keep in mind that in Malta we classify the different stages related to drugs under two main categories which are possession and trafficking.

In UK the most common offence is possession of a controlled drug which means the joint or past possession of a common pool of drugs. No offence arises if you are found in possession of a drug that you didn't know was on your person but that must be proven later in court. By law, the police have to prove that you knew that you had the drugs on you.

In the case *Khalif Id Ahmed vs Avukat Generali* 15th October 2010 the court pointed out the different legal aspects dealing with drugs in the Maltese scenario

“To limit oneself to plants, our law, in the Dangerous Drugs Ordinance, targets specifically the opium poppy (*papaver somniferum*), the coca plant (*Erythroxylum Coca*) and the cannabis plant. However it cannot be said that any other drug which is listed in the schedule to either the Dangerous Drugs Ordinance or the Medical and Kindred Professions Ordinance (or regulations made thereunder), and which may occur naturally in some other plants, automatically renders that other plant “illegal”, whether for purposes of possession (simple or aggravated) or for purposes of trafficking (which includes importation and cultivation).

Therefore, there is a distinction between possession, which may be aggravated in certain circumstances, and trafficking which incorporates importation and cultivation of plants. Comparatively, in Italy, possession, provision or consummation of drugs in whatever the quantity are all acts which are punishable by law. It is the quantity of the substance in question which determines whether the person is trafficking or not, risking from one to twenty years imprisonment.

Detenere, cedere o consumare tali sostanze, non importa in che quantità, sono comportamenti puniti dalla legge. In particolare, possedendo più di una quantità massima prestabilita, si diventa spacciatori e si rischiano pene da uno a vent'anni di carcere, secondo la gravità. Il consumo è comunque punito con sanzioni amministrative (il ritiro della patente, del porto d'armi, del permesso di soggiorno, ecc.) revocabili se l'interessato si sottopone a programma terapeutico, di cui si è certificato il buon andamento.

### **Maltese Legal Scenario**

#### *Raw Opium*

In Malta, the first scenario presented in the DDO refers to the Raw Opium and the law specifically states the no person shall cultivate the opium poppy or cocoa plant. Conversely, in the case of Prepared Opium Article 5 affirms that no person shall import or else export such substance from Malta. Furthermore it asserts as well that:

If any person -

- (a) manufactures, sells or otherwise deals in prepared opium; or
- (b) has in his possession any prepared opium; or
- (c) being the occupier of any premises permits those premises to be used for the purpose of the preparation of opium for smoking or the sale or smoking of prepared opium; or
- (d) is concerned in the management of any premises used for any such purpose as aforesaid; or
- (e) has in his possession any pipes or other utensils for use in connection with the smoking of opium, or any utensils for use in connection with the preparation of opium for smoking; or



(f) smokes or otherwise uses prepared opium, or frequents any place used for the purposes of opium smoking,  
he shall be guilty of an offence against this Ordinance.

### *Prepared Opium*

Thus, as one may note the law clearly points out the different circumstances where one may be found guilty because of connections with Prepared Opium. The punishment of committing an offence against the DDO is underlined in article 22 of the same ordinance.

### *Indian Hemp*

Part III of the Ordinance tackles the Indian Hemp which is commonly known as the Cannabis plant. Article 7 specifies the prohibition of importation and exportation of any resin from such plant whilst the following Article deals with other situations where liability may arise because of Indian Hemp.

If any person -

- (a) has in his possession (otherwise than in the course of transit through Malta or the territorial waters thereof the resin obtained from the plant Cannabis or any preparations of which such resin formed the base; or
  - (b) produces, sells or otherwise deals in the resin obtained from the plant Cannabis or any preparations of which such resin formed the base; or
  - (c) cultivates the plant Cannabis; or
  - (d) has in his possession (otherwise than in the course of transit through Malta or the territorial waters thereof) the whole or any portion of the plant Cannabis (excluding its medicinal preparations); or
  - (e) sells or otherwise deals in the whole or any portion of the plant Cannabis (excluding its medicinal preparations),
- he shall be guilty of an offence against this Ordinance.

In the case *Police vs Jason Savary* 4th August 2011, one may find an example of possession of the Indian Hemp. "In view of the guilty plea submitted by the accused and after having



considered Section 8(d) of Chapter 101 of the Laws of Malta, the Court finds the accused guilty of the charge brought against him.”

With regards to *Cocaine and Morphine* as well as other similar substances the Dangerous Drugs Ordinance Act Part 4 specifies in article 9 that

“the Minister responsible for public health may make rules for controlling the manufacture, sale, possession and distribution of those drugs, and in particular, but without prejudice to the generality of the foregoing power, for

- (a) prohibiting the manufacture of any drug to which this Part of this Ordinance applies except on premises licensed for the purpose and subject to any conditions specified in the licence; and
- (b) prohibiting the manufacture, sale or distribution of any such drug except by persons licensed or otherwise authorized under the rules and subject to any conditions specified in the licence or authority; and
- (c) regulating the issue by medical practitioners of prescriptions containing any such drug and the dispensing of any such prescriptions; and
- (d) requiring persons engaged in the manufacture, sale or distribution of any such drug to keep such books and furnish such information either in writing or otherwise as may be prescribed; and
- (e) controlling or restricting the possession of or dealing in any such drug while in transit through Malta.



## **Part IV – Dangerous Drug Ordinance**

It is Part 5 of the DDO which tackles the notion of trafficking of drugs. Particularly, Article 13 states that:

(2) No dangerous drugs shall be exported from Malta unless the consignor is in possession of a valid and subsisting export authorization relating to such drug granted under this Ordinance.

(3) No dangerous drug shall be imported into Malta unless the person to whom the drug is consigned is in possession of a valid and subsisting import authorization granted in pursuance of this article.

(4) Every dangerous drug imported into Malta shall be accompanied by a valid and subsisting export authorization or diversion certificate.

The only exception relates the Article 15 which highlights the notion of dangerous drug transit:

15. (1) No person shall bring any dangerous drug to Malta in transit unless -

(a) the drug is in course of transit from a country from which it may lawfully be exported, to another country into which such drug may lawfully be imported; and

(b) it is accompanied by a valid and subsisting export authorization or diversion certificate, as the case may be.

## **Liabilities and Penalties related to Drug Offences**

As we have seen the different instances when a person contravenes or commits offence against the Dangerous Drug Ordinance, it is apt to focus on the offences and penalties arising from such acts. The latter are clearly cited in Article 22 which states:

22. (1) Any person -

(a) who acts in contravention of, or fails to comply with, any provision of this Ordinance; or

(b) who acts in contravention of, or fails to comply with, the conditions of any licence or permit issued or authority granted under or in pursuance of this Ordinance; or

(c) who for the purpose of obtaining, whether for himself or for any other person, the issue, grant or renewal of any such licence, permit or authority as aforesaid, makes any declaration, or statement which is false in any particular, or knowingly utters, produces or makes use of any such declaration or statement or any document containing the same; or

(d) who in Malta aids, abets, counsels or procures the commission in any place outside Malta of any offence punishable under the provisions of any corresponding law in force in that place, or who with another one or more persons conspires in Malta for the purpose of committing such an offence, or does any act preparatory to, or in furtherance of, any act which if committed in Malta would constitute an offence against this Ordinance; or

(e) being a citizen of Malta or a permanent resident in Malta, who in any place outside Malta does any act which if committed in Malta would constitute an offence of selling or dealing in a drug against this Ordinance or an offence under paragraph (f); or

(f) who with another one or more persons in Malta or outside Malta conspires for the purposes of selling or dealing in a drug in these Islands against the provisions of this Ordinance or who promotes, constitutes, organises or finances the conspiracy, shall be guilty of an offence against this Ordinance.

Punishments under the DDO are tackled into two different courts which are the Criminal Court and the Magistrate Court. In the Criminal Court aspect punishments are divided into selling and dealing which are punished by a term four to ten years imprisonment when the verdict of jury is not unanimous and Possession which is punished by a term from twelve months to ten years plus fine (multa) of between €465.87 and €23,293.73

On the other hand, in the Magistrates' Court, selling and dealing are punished by a term of imprisonment from six months to ten years plus a multa of between €465.87 and €11,646.87. The punishment for possession – three months to twelve months plus multa between €465.87 and €2,329.37 (Lm1000)

On the other hand, in the Magistrate Court, selling and dealing are punished by a term of imprisonment from six months to ten years plus multa between €465.87 and €11,646.87. The

punishment for possession – three months to twelve months plus multa between €465.87 and €2,329.37 (Lm1000)

For trafficking, the offender is punished with life imprisonment plus forfeiture of property. Court may order treatment and moreover probation and suspended sentences may also be given in case of possession.

Factors such as age, the previous conduct, the nature, quantity and equipment used and other circumstances will be taken in consideration to determine whether the penalty of imprisonment for life would be an appropriate punishment or not. The same applies where the verdict of the jury is not unanimous. In those instances, the Court may sentence the offenders, which would be convicted to the punishment of imprisonment for a term not less than four years but not exceeding thirty years in addition to a fine of not less than 2,329.37 euro but not exceeding 116,468.67 euro.

Other case-scenarios such as when the person convicted (unless charged jointly with someone else over 16 years of age) has not attained the 16 years of age shall be construed as a reference to the Juvenile Court. One the aggravations mentioned in article 22 is when the offence is committed within 100 metres of the perimeter of a school, youth club, centre or a place frequented by young people. Other aggravations included when the offence consists in the sale, supply, administration or offer of doing such acts to a minor, woman with child or person following a rehabilitation programme from drug dependence. In such cases the punishment shall increase by one degree.

In the case of plant cultivation in a field, garden or similar place, the court may order (in addition to any other punishment) order the forfeiture in favour of Government of the immovable property in question.

As it is aptly cited in the EMCDDA 2010, the penalty for a drug offence in different EU member states officially varies according to the class or harmfulness of the substance involved, as defined by lists which are established in or directly linked to the laws. For example, in Bulgaria, Cyprus, the Netherlands, Portugal, Romania and the United Kingdom, the law requests the prosecuting authorities to distinguish between types of drugs for any offence; in Spain, Latvia and Malta, the penalty is only varied for a charge of drug



trafficking. Moreover, one has to point out that in our Maltese scenario the system allows the prosecutor to choose the court for the trial, which will also affect the range of sanctions available.

## **Reference**

Minister of Justice and Home Affairs. (2011). 1939 Dangerous Drugs Ordinance, Chapter 101 retrieved on 6<sup>th</sup> August at 18:00 from [www.mjha.gov.mt](http://www.mjha.gov.mt)



## *The Socio-Psychological Aspect*

Abigail Cremona | KSU

Drug abusers may be without knowing sending to society a very important message that something is terribly wrong. Far from realizing their childhood dreams, many users seem to prefer destroying themselves by turning to mind numbing drugs (NIDA, 2008). Thus, what lies behind the socio-psychological aspects that lead an individual to resort to the consumption of drugs?

### **Peer Pressure & Media**

According to EURAD (2007), peer pressure and media feature as a main socio-psycho aspect that leads to drug abuse. Their studies suggest that television remains the most important source of information about drugs while Coleman and Hendry (1999) in their studies stress that peer pressure and social pressure continue to be the most important reasons for young people initial involvement in the drug scene.

The media is not teaching children to cope with the stress of problem solving, according to Miceli (1995). These messages are in conflict with messages of competition rise in school, the economy system and society in general. Hence pressure is created with some victims not having developed the necessary skills to cope with.

### **Personality Traits**

Studies showed that personality identity formations such as low self-esteem, anxiety, depression and lack of self-control correlate with certain patterns of drug use (Miceli, 1995). Moreover, the National Institute on Drug Abuse (2009) in the studying of young adults and drugs consider that the most personality dimension linked with drugs is the lack of traditional values. He interprets that as rebellious behaviour and resistance to social structure, disregard to social expectations and a willingness to participate in deviant behaviour can lead to such abuse (Miceli, 1995). During the many years of treating drug abuses by traditional psychiatry,



O'Brien and Henican (1993: 7) came up with a possible explanation of drug addicts users which illustrates that;

“the number one factor in the understanding of drug addiction is the realization that drug abuse is not in itself a disease but merely a manifestation of underlying psychological or emotional problems. The addict's basic problem is immaturity. Addicts are emotional infants locked up in adult bodies. Whatever their chronological age, most of them are fundamentally unable to cope with the day-to-day stresses of adult world”.

### **Wild Escapism**

For people who suffer emotional immaturity, any demand or challenge or difficulty in life presents itself as a monumental threat. Such people will try to eliminate stress at almost any cost. O'Brien and Henican (1993:20) describe that drug abusers are continuously running away either from home or from treatment failing to realize that the primitive responses of fighting and running away do not solve any problems. Such users do not want to accept any more the fact that pain and suffering are normal in everyday living. They turn towards drugs without thinking about the significance of pain and suffering (Miceli, 1995).

In effect, in his book “Co-dependency- How to break free and live your own life”, Stafford (1991) points out that any adolescent growing up in an addicted home can become used to not having his needs met. This in turn can bring about the feeling that he is not justified in having these needs. The child can become so sure that he is to blame for everything, that he has caused the problem, that he can become a scapegoat, resorting to drugs and turn towards a self-destructive behavior (Stafford, 1991:20). In effect US President elect Barac Obama in his biography admitted that he used marijuana during his teenage years to “push questions of who I was out of my mind” (The Boston Globe, 2007).

## **The Family Environment**

According to Maslow's Hierarchy of needs, belonging to a family, a group is an important basic need. It is through the family each individual is socialized into the culture roles and norms of the type of society (Becker, 1973). Parents pass on values attitudes to their children. The adolescent requires parental help and support to establish self-control, control of sex impulses of anger and other emotional states (Spiteri, 1996).

Moreover sudden changes in family structures can lead to dislocation and stress (Zammit, 1997). Drastic changes in the family structure that may affect the adolescents behaviour and get caught in the risk of drug abuse and its false impressions of feeling pleasantly high (Zammit, 1997). Family functioning has a great relevance to the occurrence of drug use. Within the family there are certain dimensions such as the maintenance of discipline, control, parental, supervision, family cohesiveness, attachment to parents, communication patterns that if these are negative the risk of developing anti-social behaviour and substance abuse increase drastically (Spiteri S, 1996).

## **Identity Youth and Crises**

According to Erikson (1994) generally drug abuse has its origins in adolescence. According to Stanley Hall this can be due to the fact that adolescence is a period of heightened "storm and stress" due to being a transitional stage of development between childhood and adulthood representing a period of time during which a person experiences a variety of biological changes and encounters a number of emotional issues (Arnet, 1999).

Further still according to Erikson (1994) drug abuse from early adolescence can be linked to the normal process of growing up, experimenting with new behaviors without experiencing properly the elements of social bonding which according to the social bonding theory of Travis Hirschi includes attachment to families, commitment to social norms, institutions, involvement in activities, and the belief that these things are important (Marsh, 2006).



In Erik Erikson's (1994) stages of psychosocial development, the emergence of an identity crisis occurs during the teenage years in which people struggle between feelings of identity versus role confusion. Furthermore in his book "Identity Youth and crises" (1994) he proposes that there are three stages in drug use. The first is the use of legal drugs as alcohol. The second involves the use of marijuana as a gate way drug which is also primarily peer-influence. The third stage involves the stepping of other illegal drugs.

Therefore after taking all these points into consideration, it can be viewed that many psychological reasons such as curiosity and the desire to fit into a social group or as a tool for escapism problems and challenges of growing up are common reasons leading to drug abuse (Becker, 1973). Finally as proposed by Travis Hirschi in his Social Control Theory people relationships, commitments, values, norms, and beliefs can be beneficial tools to help people meeting their needs (Marsh, 2006).

## References

- Arnet, J.J. (1999). *Adolescent Storm and Stress reconsidered*. The American Psychological Association, Vol. 54, No. 5, 317-32.
- Becker, S. (1973). *Outsiders- Studies in Sociology of Deviance*. London, Collier Macmillan Publishers.
- Erikson, E.H. (1994). *Identity, Youth and Crises*. London, Norton and Company Inc.
- Europe Against Drugs, (2007). *EU Drug Policies*. Retrieved on August 6th 2011 at 18:00.
- Hendry, L.B., Coleman, J.C. (1999). *The Nature of Adolescence- Third edition*, London, Routledge Press.
- O'Brien, W.B., Henican, E. (1993). *You can't do it alone- The Daytop way to make your child drug free*, Simon & Schuster Publishers.
- Marsh, I. (2006). *Theories of Crime*. Routledge, USA and Canada.
- Miceli, P. (1995). *Drugs, alcohol and the family- a study in relationship*, Diploma in Youth Studies, Malta, University of Malta.
- National Institute on Drug Abuse- NIDA (2008), *InfoFacts:Marijuana*, retrieved on August 6th 2010 at 17:00 from [www.nida.nih.gov/infofacts/marijuana.html](http://www.nida.nih.gov/infofacts/marijuana.html).
- Spiteri, S. (1996). *Family functioning as a factor in drug abuse*, Diploma in Youth Studies, Malta University of Malta.
- Stafford, D. (1991). *Co-dependency- How to break free and live your own life*. London, Judy Piaktus Publishers Ltd.
- Zammit, G. (1997). *Dysfunctional families and drug misuse*, Diploma in Youth Studies, Malta, University of Malta.
- 2007, November 21, *Obama gets blunt with N.H. students*, The Boston Globe, retrieved on August 5th 2007 at 20:00 from [www.boston.com](http://www.boston.com)



# *The Pharmaceutical Aspect*

Noel Pace | MPSA

## **Classification of drugs – Soft Vs Hard**

This is a highly volatile classification system as there are no guidelines on how to distinguish between a so called soft and so called hard drug. Classification can be based on various amounts of factors which from a professional point of view neither should be given more importance than the other. These can be based on: damage to the body, abuse liability, addiction, costs, mode of administration, duration of effect, time for onset and many more factors (UN, 2011).

There are contrasting schools of thought and most of the classification is based on personal opinion from drug users and abusers.

The common trend for classification as hard/soft drugs is the following:

**Hard Drugs:** seriously liable to disable the individual as a functioning member of society (psychological, physical dependence). Hard drugs are highly addictive (for instance, heroin, morphine, cocaine) (Grotenhermen, Russo, 2002).

**Soft Drugs:** there can be psychological dependence, but little or no physical dependence (for instance, valium, marijuana) (Grotenhermen, Russo, 2002).

The distinction between hard and soft drugs is not very well defined as such while some drug classification systems consider nicotine a hard drug because it is addictive, other classification systems disagree on the basis that nicotine is legal. Alcohol is classified as a soft drug, but can be considered a hard drug if it is taken in large amounts. MDMA (ecstasy) and LSD are very controversial and tend to lie in between because while not very addictive, they can do a lot of harm. Psilocybin (magic) mushrooms are considered to be soft drugs as they have no record of addiction (Grotenhermen, Russo, 2002).

One can also make a difference between 'hard use' and 'soft use':

- Hard use- drug is central to the individual's life
- Soft use- incidental, recreational
- Another difference with regards to drug abuse is 'continuous use' and 'occasional use':
  - Continuous use- true dependence: opioids, cocaine
  - Intermittent/Occasional use: recreational
  - Alcohol can be both

(Grotenhermen, Russo, 2002)

It is easier and more reasonable to classify drugs according to their pharmacological classification. Hard / Soft are wide terms and can serve as loopholes whereas using pharmacological classification this is less likely to occur and future drugs can be easily classified due to their chemical structures (Grotenhermen, Russo, 2002).

The lack of a proper classification system undermines confidence in distinguishing between drugs and from the start this cripples any health education campaign initiatives structures (Grotenhermen, Russo, 2002).

### **Rational scale to assess the harm of drugs of potential misuse**

A scale was developed to make up for unscientific and poor classification systems of drugs. This system is based on the harm done to the human body, dependence and harm done to society. This system goes beyond classifying drugs in two categories (Hard and Soft drugs) which can be an easily biased classification with many gray areas (Blakemore, King, Nutt, Saulsbury. 2007).

Such a scale can be applied to emerging new drugs contrary to the "soft vs hard drug" classification system where it would be difficult to place a new drug into one category or the other (Blakemore, King, Nutt, Saulsbury. 2007).

Table 1: Table showing the different types of harm drug misuse can cause



<b>Physical Harm</b>	Acute
	Chronic
	Intravenous harm
<b>Dependance</b>	Intensity of pleasure
	Psychological dependence
	Physical dependence
<b>Social Harm</b>	Intoxication
	Other social harm
	Health-care costs

(Blakemore, King, Nutt, Saulsbury. 2007).

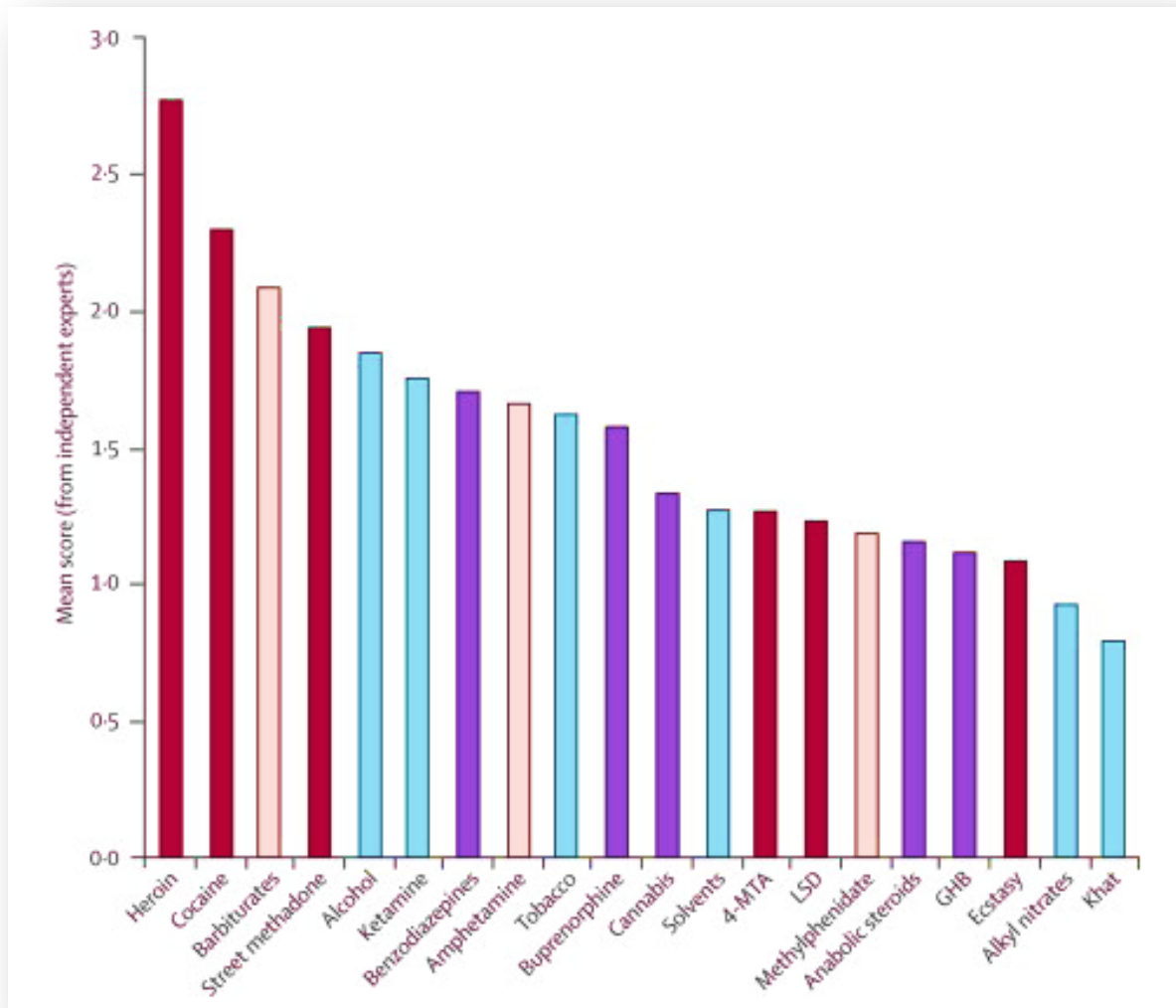
Drugs which are administered by the intravenous route were generally ranked high in harm, not solely because they received high scores for the third Physical harm parameter (i.e. ; intravenous harm) and the third Social Harm parameter (i.e.; Health-care costs). Values for such drugs were elevated in the remaining fields (Blakemore, King, Nutt, Saulsbury. 2007).

Table 2 portrays the results of study on a selected amount of drugs using the above parameters of harm.

	Physical harm				Dependence				Social harm			
	Mean	Acute	Chronic	Intravenous	Mean	Pleasure	Psychological dependence	Physical dependence	Mean	Intoxication	Social harm	Health-care costs
Heroin	2.78	2.8	2.5	3.0	3.00	3.0	3.0	3.0	2.54	1.6	3.0	3.0
Cocaine	2.33	2.0	2.0	3.0	2.39	3.0	2.8	1.3	2.17	1.8	2.5	2.3
Barbiturates	2.23	2.3	1.9	2.5	2.01	2.0	2.2	1.8	2.00	2.4	1.9	1.7
Street methadone	1.86	2.5	1.7	1.4	2.08	1.8	2.3	2.3	1.87	1.6	1.9	2.0
Alcohol	1.40	1.9	2.4	NA	1.93	2.3	1.9	1.6	2.21	2.2	2.4	2.1
Ketamine	2.00	2.1	1.7	2.1	1.54	1.9	1.7	1.0	1.69	2.0	1.5	1.5
Benzodiazepines	1.63	1.5	1.7	1.8	1.83	1.7	2.1	1.8	1.65	2.0	1.5	1.5
Amphetamine	1.81	1.3	1.8	2.4	1.67	2.0	1.9	1.1	1.50	1.4	1.5	1.6
Tobacco	1.24	0.9	2.9	0	2.21	2.3	2.6	1.8	1.42	0.8	1.1	2.4
Buprenorphine	1.60	1.2	1.3	2.3	1.64	2.0	1.5	1.5	1.49	1.6	1.5	1.4
Cannabis	0.99	0.9	2.1	0	1.51	1.9	1.7	0.8	1.50	1.7	1.3	1.5
Solvents	1.28	2.1	1.7	0	1.01	1.7	1.2	0.1	1.52	1.9	1.5	1.2
4-MTA	1.44	2.2	2.1	0	1.30	1.0	1.7	0.8	1.06	1.2	1.0	1.0
LSD	1.13	1.7	1.4	0.3	1.23	2.2	1.1	0.3	1.32	1.6	1.3	1.1
Methylphenidate	1.32	1.2	1.3	1.6	1.25	1.4	1.3	1.0	0.97	1.1	0.8	1.1
Anabolic steroids	1.45	0.8	2.0	1.7	0.88	1.1	0.8	0.8	1.13	1.3	0.8	1.3
GHB	0.86	1.4	1.2	0	1.19	1.4	1.1	1.1	1.30	1.4	1.3	1.2
Ecstasy	1.05	1.6	1.6	0	1.13	1.5	1.2	0.7	1.09	1.2	1.0	1.1
Alkyl nitrites	0.93	1.6	0.9	0.3	0.87	1.6	0.7	0.3	0.97	0.8	0.7	1.4
Khat	0.50	0.3	1.2	0	1.04	1.6	1.2	0.3	0.85	0.7	1.1	0.8

(Blakemore, King , Nutt, Saulsbury, 2007)

Graph 1: The following is a graph showing the mean score for harm caused by misuse of a range of illicit drugs and five legal drugs (alcohol, tobacco, Miraa, solvents and alkyl nitrites) and ketamine was used as a reference drug.



(Blakemore, King, Nutt, Saulsbury, 2007)

Another method of classification which could be applied is according to their chemical structure and pharmacological properties. This allows newly marketed drugs to immediately raise an alarm if they have similar chemical structures to existing illicit drugs and an immediate course of action to be taken (Maisto, Galizio, Connors, 2011)



## *References*

Blakemore C., King A. L., Nutt, D., Saulsbury, W.( 2007) *The Lancet- Development of a rational scale to assess the harm of drugs of potential misuse*, Vol. 369 Issue, Pgs 1047-1053.

Grotenhermen. F., Russo, E.B., (2002). *Cannabis and Cannabinoids: Pharmacology, Toxicology, and Therapeutic Potential*. The Haworth Press. Binghamton, NY

Maisto S. A. , Galizio, M., Connors, J. G., (2011). *Drug Use and Abuse*, 6<sup>th</sup> ed.

United Nations Office on Drugs and Crime (2011). *War on Drugs- Report of the Global Commission on Drug Policy* retrieved on 6<sup>th</sup> August at 18:00 from [www.unodc.org](http://www.unodc.org)



# *The Medical Aspect*

Daniel Vella Fondacaro|MMSA

## **The effect of Substance Abuse and Drug Addiction on the Human Body**

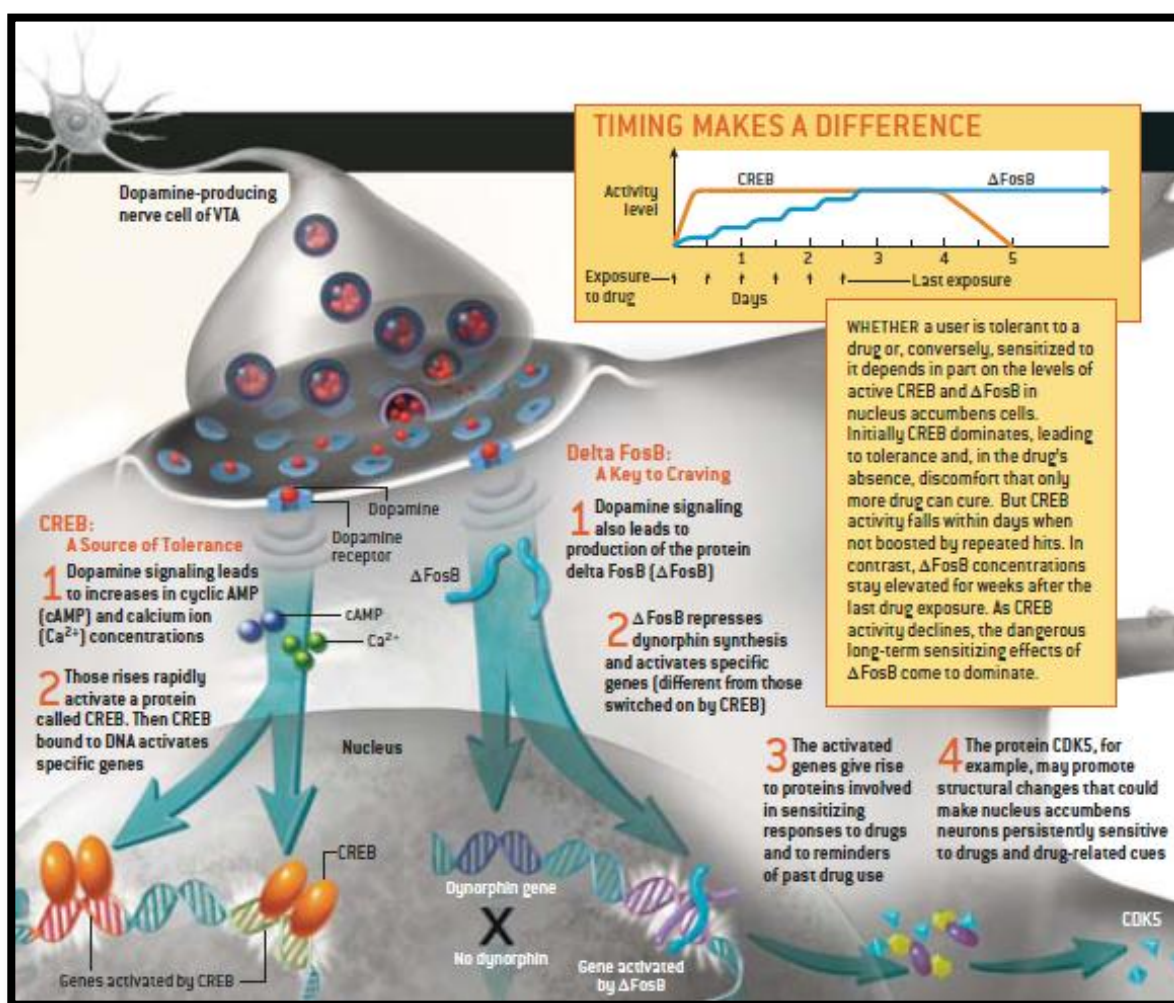
A drug is a chemical. These chemicals induce a change in the way our body works (physiological change) to be classified as a drug. If the drug was taken as medical treatment (prescribed by a medical doctor) the physiological changes that do occur should be mostly beneficial and are necessary. On the other hand, if the drug was taken abusively (in excess and without actually needing it) the physiological changes that occur to the human body may be harmful, especially with excessive use. Drugs were discovered thousands of years ago and some say that by the late Stone Age drug use was already present.

One has to keep in mind that there is a significant difference between a drug and a medicine. A **drug** is a chemical substance of known structure, which is not a nutrient or an essential dietary substance, which produces a biological effect upon administration. A **medicine** is a chemical preparation, which can consist of more than one drug, and produces a therapeutic effect upon administration. As such medicines usually contain other substances such as stabilizers and excipients which make the medicine more convenient to use (Rang, P., Dale, M., Ritter, Flower, J.M., (2007). *Rang and Dale's Pharmacology* (6<sup>th</sup> e.d). Philadelphia: Churchill Livingstone).

Many drugs of abuse are used to **boost the activity of the brain's reward system**. For a brief period after taking the drug, everything seems just right, however not only does the euphoria end, adaptations in the reward system will elevate the thresholds for that drug, meaning that a larger amount of the same drug is needed to achieve the same effect upon subsequent use. This concept is called drug tolerance. Drug tolerance occurs due to an increase in the levels of a substance called CREB, within the ventral tegmental area of the brain (dopamine-secreting cells) and the nucleus accumbens (dopamine-sensitive cells). CREB promotes tolerance. After sustained use of the drug the threshold of the reward system is raised to such an extent that the individual abusing the drug will need the drug in their system to feel 'normal', and will have the severe side-effects of dependence if the drug is not

taken regularly (dynorphin is a protein secreted due to CREB levels and depresses the reward system in the body).

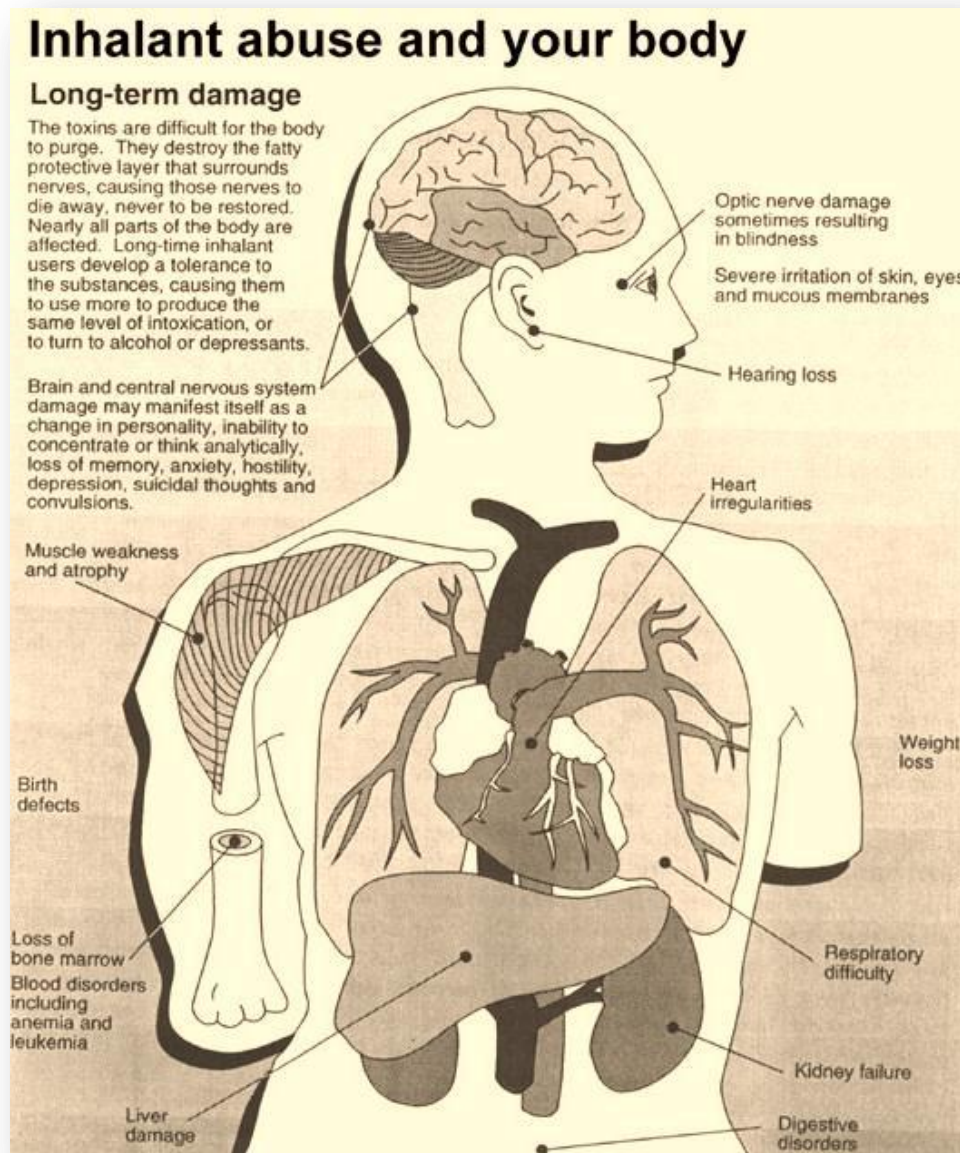
When the person stops the drug intake, CREB levels decrease after a few days. However, a very dangerous chemical hits in,  $\Delta$ FosB. This chemical is responsible for craving when the individual is 'clean' of the drug.  $\Delta$ FosB levels stay elevated for weeks after the last drug exposure.



(Nestler, Malenka, 2004)

Therefore, all drugs that cause a boost, followed by tolerance in the brain's reward system may be considered as drugs of abuse. Lately, a lot of awareness increased with regards to inhalant abuse. Gasoline, glue compounds etc. may be inhaled and can be the source of addiction, especially in teenage social circles where it is not very known that such inhalants

can promote a similar negative effect as other drugs of abuse. Drugs of abuse are often classified as hard and soft drugs.



(New England Inhalant Abuse Prevention Coalition)

Psychological dependence is the first to appear (depression and emotional distress when the drug is stopped) and is entirely subjective. Psychological effects may occur during experimentation in subjects that are deceptively told that they are being given a drug that has certain properties (e.g. stimulant) even if the preparation they are given has no such effects. Physiological/physical dependence implies continued exposure and adaptive changes in the body that cause tolerance to the particular drug. Thus, withdrawal symptoms occur if the drug



is not taken (Bennett, P.N., Brown, M.J., (2008). *Clinical Pharmacology* (10<sup>th</sup> e.d). Philadelphia: Churchill Livingstone).

Drug abuse can also happen with prescribed drugs. 'Non-medical use, misuse, and abuse of prescription drugs are defined as 'the use of prescription medications without medical supervision for the intentional purpose of getting high, or for some reason other than what the medication was intended' (Office of National Drug Control Policy Executive Office of the President, 2007). Some people think that abusing with prescribed medicine is not as dangerous as 'street drugs'. In reality, prescribed drugs are still chemicals that promote a physiological change in the body, and therefore their abuse can be as harmful as that of 'street drugs'.

#### References

Bennett, P.N., Brown, M.J., (2008). *Clinical Pharmacology* (10<sup>th</sup> e.d). Philadelphia: Churchill Livingstone

Nestler, E.J., Malenka, R.C., (2004). *The Addicted Brain*. Scientific American

Rang, P., Dale, M., Ritter, Flower, J.M., (2007). *Rang and Dale's Pharmacology* (6<sup>th</sup> e.d). Philadelphia: Churchill Livingstone

The New England Inhalant Abuse Prevention Coalition retrieved from  
<http://www.inhalantprevention.org/coalition/background/intro.html> on August 10<sup>th</sup> 2011 at 20:00



## Chapter 3

# Decriminalisation of Soft Drugs

## *The Debate Yes Vs. No*

*As the debate on decriminalisation is a highly polarizing debate and one that generates a whole plethora of arguments on both aspects, the subcommittee felt that it would be prudent to present arguments on both sides of the coin. To this effect this chapter presents two articles with arguments which are often found in studies, with such arguments being on both sides of the coin.*

# *Aspects against the Decriminalisation of Soft Drugs*

Edward Mario Camilleri | SDM

***Reason 1: Prohibitive drug laws have a successful track record suppressing illicit drug use since they were introduced more than a century ago.***

Although alcohol has currently user rates as high as 80-90% in populations over 14 years of age, and tobacco has historically had current use rates up to 60% of adult populations, yet the percentages concerning adult populations currently using illicit drugs in Organization for Economic Co-operation and Development (OECD) countries are generally below 1% of the population excepting for cannabis which varies between 3% and 10%. (Drug Free Australia's Arguments against Drug Legalisation).

In the European Union, Sweden spends the second highest percentage of GDP after the Netherlands, on drug control. The United Nations Office on Drugs and Crime (UNODC) stated that when Sweden reduced spending on education and rehabilitation in the 1990s due to higher youth unemployment and declining GDP growth, illicit drug use rose. However, restoring expenditure from 2002 again sharply decreased drug use as student surveys indicate. In 1998, a poll run by SIFO of 1,000 Swedes found that 96% wanted stronger action by government to stop drug abuse, and 95% wanted drug use to remain illegal (NSW Bureau of Crime Statistics and Research, 2001).

A 2001 Australian study of individuals between the age bracket of 18-29 by the NSW Bureau of Crime Statistics and Research suggested that prohibition deters illicit drug use. 29% of those who had never used cannabis cited the illegality of the substance as their reason for never using the drug, while 19% of those who had ceased use of cannabis cited its illegality as their reason (NSW Bureau of Crime Statistics and Research, 2001).



In the United States, Alaska's experiment with legalization in the 1970s led to the state's teens using marijuana at more than twice the rate of other youths at a national level. This led Alaska's residents to vote to re-criminalize marijuana in 1990 (U.S. Department of Justice, 2003).

***Reason 2: The US Drug Enforcement Agency's 2008 Marijuana Sourcebook argues that recent research supports the gateway hypothesis that certain drugs (such as cannabis) act as gateways to use of harder drugs.***

This can be either because of social contact or because of an increasing search for a better high. Proponents of this theory cite studies such as that of 311 same sex twins, where only one twin smoked cannabis before age 17, and where such early cannabis smokers were five times more likely than their twin to move on to harder drugs (Office of National Drug Control Policy, 2008).

.

***Reason 3: Advocates of drug prohibition argue that particular drugs should be illegal because they are harmful.***

For instance, Drug Free Australia argues "That illicit drugs are inherently harmful substances is attested by the very nomenclature of the 'harm reduction' movement." The U.S. government has argued that illegal drugs are "far more deadly than alcohol" saying "although alcohol is used by seven times as many people as drugs, the number of deaths induced by those substances is not far apart. According to the Centers for Disease Control and Prevention (CDC), during 2000, there were 15,852 drug-induced deaths\*; only slightly less than the 18,539 alcohol-induced deaths." (US Drug Enforcement Administration, Centers for Disease Control and Prevention (CDC), 2000)



*(\*In this report, the phrase 'Drug-induced deaths' include all deaths for which drugs are the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. A drug includes illicit or street drugs, as well as legal prescription drugs and over-the-counter drugs.)*

A 2010 report by the DEA entitled Speaking out Against Drug Decriminilisations has stated that:

- Marijuana is far more powerful than it used to be. In 2000, there were six times as many emergency room mentions of marijuana use as there were in 1990, despite the fact that the number of people using marijuana is roughly the same. In 1999, a record 225,000 Americans entered substance abuse treatment primarily for marijuana dependence, second only to heroin—and not by much”
- According to the National Institute on Drug Abuse, “Studies show that someone who smokes five joints per week may be taking in as many cancer-causing chemicals as someone who smokes a full pack of cigarettes every day.”
- Marijuana contains more than 400 chemicals, including the most harmful substances found in tobacco smoke. For example, smoking one marijuana cigarette deposits about four times more tar into the lungs than a filtered tobacco cigarette.
- The short-term effects are also harmful. They include: memory loss, distorted perception, trouble with thinking and problem solving, loss of motor skills, decrease in muscle strength, increased heart rate, and anxiety. Marijuana impacts young people’s mental development, their ability to concentrate in school, and their motivation and initiative to reach goals.



- Harvard University researchers report that the risk of a heart attack is five times higher than usual in the hour after smoking marijuana (U.S. Drug Enforcement Administration).

***Reason 4: In the United States, illegal drugs already cost \$180 billion a year in health care, lost productivity, crime, and other expenditures and that number would only increase under legalization because of increased use.***

The U.S. government began the Drug Use Forecasting (DUF) program in 1987 to collect information on drug use among urban arrestees. In 1997, the National Institute of Justice expanded and reengineered the DUF study and renamed it the Arrestee Drug Abuse Monitoring (ADAM) program. ADAM is a network of 34 research sites in select U.S. cities (California Police Chiefs Association Conference, 2010).

The DUF research indicates that:

- Frequent use of hard drugs is one of the strongest indicators of a criminal career.
- Offenders who use drugs are among the most serious and active criminals, engaging in both property and violent crime.
- Early and persistent use of cocaine or heroin in the juvenile years is an indicator of serious, persistent criminal behavior in adulthood.
- Those arrested who are drug users are more likely than those not using drugs to be rearrested on pretrial release or fail to appear at trial.

***Reason 5: Criminal behavior can importantly be the direct result of drug use which can cause emotional/brain damage, mental illness and anti-social behavior.***

Psychoactive drugs can have a powerful impact on behavior which may influence some people to commit crimes that have nothing to do with supporting the cost of their drug use. The use of drugs changes behavior and causes criminal activity because people will do things

they wouldn't do if they were rational and free of the drug's influence. Cocaine-related paranoia is an example. If drug use increases with legalization, so will such forms of related violent crime as assaults, drugged driving, child abuse, and domestic violence (Office of National Drug Policy Control).

## **Why should Malta say no to the decriminalisation of soft drugs?**

(Calleja, 2011)

1. Each year between 10 and 12 people die of a drug overdose.
2. More than half of cannabis users who seek outpatient treatment in Malta are daily users.
3. Malta is one of three European countries where 40% of drug-related deaths occur among those under 25.
4. Just below 15% of drug-induced deaths in Malta are among those aged 40 or older, whilst 7% of those seeking treatment for their addiction are aged between 40 and 59 years.
5. About two non-fatal overdose cases are admitted to Mater Dei Hospital every week
6. Over 900 children of drug addicts need support to ensure they do not follow in their parents' footsteps.
7. Between 800 and 1,000 drug users use Sedqa's services at any one time.
8. Women face issues that are unique to their gender, including prostitution, sexual abuse and domestic violence.

In July 2011, a survey conducted by the Euro Barometer confirmed that drug use in Malta is amongst the lowest levels in the European Union. Whilst 5% of youths in the EU member states said that they had made use of an illicit substance in the previous month, the figure in Malta was only 0.3%. (Camilleri, 2011)



## References

Calleja, C. (2011) , *Decriminlise Drugs? No way, says Government in wake of global report*, Times of Malta published on 3/6/11

California Police Chiefs Association Conference (2010), retrieved from <http://www.whitehousedrugpolicy.gov/publications/factsht/druguse/>

Camilleri, C. (2011) *Low drug use amongst Maltese young people – EU Study*, The Times, 12/7/11

Drug Free Australia's Arguments against Drug Legalisation, retrieved from [/http://www.drugfree.org.au/fileadmin/Media/Global/Taskforce\\_Arguments\\_for\\_Prohibition.pdf](http://www.drugfree.org.au/fileadmin/Media/Global/Taskforce_Arguments_for_Prohibition.pdf)

NSW Bureau of Crime Statistics and Research, (2001) retrieved from [http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll\\_bocsar.nsf/vwFiles/mr\\_cjb58.pdf/\\$file/mr\\_cjb58.pdf](http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/mr_cjb58.pdf/$file/mr_cjb58.pdf)

Office of National Drug Policy Control,

Retrieved from <http://www.whitehousedrugpolicy.gov/publications/factsht/crime/index.html>

U.S. Department of Justice, (2003) retrieved from [http://www.justice.gov/dea/demand/speakout/speaking\\_out-may03.pdf](http://www.justice.gov/dea/demand/speakout/speaking_out-may03.pdf)

U.S. Department of Justice, (2008) retrieved from [http://www.justice.gov/dea/statistics/Marijuana\\_2008.pdf](http://www.justice.gov/dea/statistics/Marijuana_2008.pdf)

U.S. Department of Justice, (2003) retrieved from <http://www.justice.gov/dea/demand/speakout/index.html>

U.S. Drug Enforcement Administration retrieved from [http://www.whitehousedrugpolicy.gov/news/speech10/030410\\_Chief.pdf](http://www.whitehousedrugpolicy.gov/news/speech10/030410_Chief.pdf)



## *Marijuana vs. Tobacco – How things stand.*

Elena Bajada | MUSC

Firstly, it is essential to highlight that, the idea of decriminalizing soft drugs is hypothetical to the extent that one may not generalize and say that such decriminalization will lead to a general reduction in the amount of people who take marijuana in general. It is true that practices in other societies may formulate a general idea of what can happen, however, one cannot generalize and conclude that every society will be effected in a likewise manner (American Journal of Public Health ,1995).

Let us start by saying that legal drugs are typically used before illegal drugs, often before they become legal for the youthful user. Marijuana is already the first illicit drug used. If decriminalized, its use might often precede rather than follow use of alcohol and tobacco (Neuropsychopharmacology, 2011). Legal drugs can be said to be used more regularly than illicit drugs, their use persists longer, and they are less often given up in young adulthood. This is true for cigarettes as well as alcohol, despite the public campaigns to persuade smokers and alcoholics to quit or moderate (American Journal of Public Health, 1995).

### *Decriminalising tobacco never helped anyone right?*

The consequences of the criminalisation of marijuana are uncertain. It might displace tobacco and alcohol in the sequence in which drugs are introduced. On the other hand, young adult use of this drug might well increase once use is not stigmatized as illicit (The Cannabis rescheduling petition, 2006).

However, we might be willing to tolerate somewhat more adult drug use if crime were markedly reduced. This trade-off between the harmful physical effects of increased use of marijuana and the possible reduction in crime might not be necessary if criminalization could be limited to those aged 21 or older, because, from studies that were carried out it results that persons who initiate use after the age of 21 rarely use drugs frequently or heavily, however, unfortunately we do not know how to



protect adolescents from the use of drugs that are legal for adults, as shown by the high frequency of underage drinking and smoking (The Cannabis rescheduling petition, 2006) .

## *What about Sports?*

Through its long term experience in the sports field, the Malta University Sports Club holds true that one can hardly say that all athletes are non smokers. In Malta at least, a good number of people who actively practice sports are smokers. Tobacco already puts in jeopardy the performance abilities of sportsmen. The aim of sports (amongst other things), as is known to all, is the maintenance of a certain level of fitness of the body that is healthy. In simple terms, the use of tobacco, marijuana, or any other drug, be it a soft drug or a hard drug, can never be of aid to anyone who practices sports. To put it simply, decriminalization of drugs can never go hand in hand with sports, simply because such decriminalization admits of the use of drugs, and the health levels that sports seeks to promote can never be enhanced by drug usage (Teens Health, 2011)

### **Providing a solution**

The solution, although drastic (if the main objective at hand is that of the protection of the health of youth and adults alike) would be to ban tobacco. Since many youngsters never use drugs other than legal drugs, declaring tobacco use illegal would protect a lot of youngsters even if tobacco remained available illicitly. Banning tobacco should also shorten the typical smoking career of those who use it, assuming illegal tobacco use will follow the pattern now seen for use of other illicit drugs. Legal drugs are used before illicit ones. Therefore, banning cigarettes might postpone the age at which they are first used (American Journal of Public Health, 1995).



Since number of years of heavy smoking plays an important role in the health consequences of smoking, a shorter smoking career would offer great health plusses. Although decriminalization appears to be attractive because the adverse consequences of illicit drug use today probably stem more from the drugs' illegal status than from their chemical properties, the risks of exposing any more people to these drugs, which would occur with decriminalization or even worse, legalization, are large. Banning cigarettes appears a less risky next step (Teens Health, 2011).

#### References

American Journal of Public Health (1995). *The Natural History of Substance Use as a Guide to Setting Drug Policy*. Vol. 85, No. 1 retrieved from <http://ajph.aphapublications.org/cgi/reprint/85/1/12.pdf>

Neuropsychopharmacology (2011). *Acute Marijuana Effects on Human Risk Taking*, retrieved from <http://www.nature.com/npp/journal/v30/n4/abs/1300620a.html>

Teens Health. (2011). retrieved from [http://kidshealth.org/teen/drug\\_alcohol/drugs/know\\_about\\_drugs.html](http://kidshealth.org/teen/drug_alcohol/drugs/know_about_drugs.html)

The Cannabis rescheduling petition. (2006). retrieved from [http://www.drugscience.org/sfu/sfu\\_gateway.html](http://www.drugscience.org/sfu/sfu_gateway.html)

## *Aspects in Favour of Decriminalising Soft Drugs*

Karen Tanti & Robert L. Fenech | Moviment Graffiti

Decriminalisation is an approach advocated by many groups and implemented in various countries. It is very different from legalisation, which permits the legal and therefore regulated selling and buying of substances. Decriminalisation removes criminal penalties for simple possession (no criminal record, no prison sentence), allowing resources allocated to fighting drugs to be used in more useful ways. Decriminalisation can be an effective solution to the drug problem in Malta, because:

### ***Reason 1 : Decriminalisation does not mean that drug use will increase***

According to a 2009 annual report by the European Monitoring Centre for Drugs and Drug Addiction, the Dutch are among the lowest users of marijuana or cannabis in Europe, despite the Netherlands' policy on soft drugs being one of the most liberal in Europe, allowing for the sale of marijuana at "coffee shops", which the Dutch have allowed to operate for decades, and possession of less than 5 grams (0.18oz). (Stevenson-Reed, 2009)

In 2001, Portugal became the first EU country to introduce decriminalization of drugs. In the following years, a study was carried out to assess the outcome. "In the five years after personal possession was decriminalized, illegal drug use among teens in Portugal declined and rates of new HIV infections caused by sharing of dirty needles dropped, while the number of people seeking treatment for drug addiction more than doubled." (UN Report, 2011)

An editorial in The Economist argued that:

“fear [of legalisation] is based in large part on the presumption that more people would take drugs under a legal regime. That presumption may be wrong. There is no correlation between the harshness of drug laws and the incidence of drug-taking: citizens living under tough regimes (notably

America but also Britain) take more drugs, not fewer. Embarrassed drug warriors blame this on alleged cultural differences, but even in fairly similar countries tough rules make little difference to the number of addicts: harsh Sweden and more liberal Norway have precisely the same addiction rates.”

(The Economist, March 5th 2009)

It should be realised by policy-makers that prohibition of a drug or the lack thereof is only one factor in usage rates. Culture, socio-economic background and situation, peer group, and other factors are all just as, if not more, significant, factors in youth drug experimentation and drug use rates. Pursuing a drugs policy mainly based on prohibition is faulty reasoning.

### ***Reason 2: Decriminalisation frees up police and court resources***

Decriminalisation leads to less police focus on small quantities of drugs; thereby freeing up resources that can be used to tackle more serious crimes (violent assault and corruption linked to drugs are two that easily come to mind). Victimless crimes should be treated as such. Even the clinical director of the government agency Sedqa has called for decriminalisation due to prisons being too full, while still not giving addicts the treatment they need.

### ***Reason 3: Decriminalisation removes the stigma of conviction and leads to crime reduction***

Despite the fact that most drug offenders are non-violent, the stigma attached to a conviction can prevent employment and education. (Beck and Harrison, 2001) Unable to find work, many people may turn to a life of crime in order to get some money. Therefore, decriminalizing soft drugs would decrease crime rates as drug users would not have to turn to illegal means to buy drugs and earn money. David Boyum and Mark Kleiman in their review



of drug control policies stated that, “Making marijuana legally available to adults on more or less the same terms as alcohol would tend to reduce crime...” (Boyum and Kleiman, 2002).

***Reason 4: Decriminalisation is based on pragmatism and is in tune with the individual right of liberty***

Many people, including some non-drug using religious groups, argue that the war on drugs is itself immoral. The Argentine Supreme Court declared in a 2009 landmark ruling that it was “unconstitutional to prosecute citizens for having drugs for their personal use. It stated that “adults should be free to make lifestyle decisions without the intervention of the state”. (theguardian.co.uk, September 13th, 2009)

In 2007 Richard Brunstrom, the Chief Constable of North Wales, one of Britain's most senior police officers, said "If policy on drugs is in future to be pragmatic not moralistic, driven by ethics not dogma, then the current prohibitionist stance will have to be swept away as both unworkable and immoral, to be replaced with an evidence-based unified system aimed at minimization of harms to society." (The Independent, 2007)

The UK drug policy reform group ‘Release’ believes that the stigma attached to drug use needs to be removed. Release's actions have included challenging such stigmatization with its "Nice People Take Drugs" advertising campaign. From the ‘Release’ website: Rather than committing ourselves to the fantasy of a drug-free world—something that never has existed and never will—we should educate and regulate to restrict their negative effects. Whether this happens through a reinterpretation and reconfiguration of the present structure, or requires a more radical overhauling of institutional and juridical arrangements, remains to be seen. (Release, 2011)



***Reason 5: Both profession and public opinion is shifting to support it***

According to Transform Drug Policy Foundation, over the past decade there has been strong shift in public opinion in favour of drug policy reform. This shift has taken place despite successive government's reluctance to consider or debate the subject, or even call to for an independent inquiry. (Transform Foundation, 2011)

Professionals working in the field of drug abuse are also becoming critical of the war on drugs. Stephen Rolles (2010), writing in the British Medical Journal, argues:

“Consensus is growing within the drugs field and beyond that the prohibition on production, supply, and use of certain drugs has not only failed to deliver its intended goals but has been counterproductive. Evidence is mounting that this policy has not only exacerbated many public health problems, such as adulterated drugs and the spread of HIV and hepatitis B and C infection among injecting drug users, but has created a much larger set of secondary harms associated with the criminal market. These now include vast networks of organised crime, endemic violence related to the drug market, corruption of law enforcement and governments.”

In the UK various professional committees have come to that same conclusion, such as the Police Foundation, the Home Affairs Select Committee, the Prime Minister's Strategy Uni, the Royal Society of Arts and the UK Drugs Policy Consortium. (Stephen Rolles, British Medical Journal 2010)

Both the editor of the British Medical Journal as well as the former president of the Royal College of Physicians have also supported these conclusions, along with many others all over the world.

The UN Global Commission on Drugs, that in June 2011 declared that the war on drugs had failed and set forth several recommendations encouraging experimental models of drug regulation, including decriminalisation, was made up of such noteworthy figures as the former Presidents of Mexico, Colombia and Switzerland and Brazil, the Secretary General of the United Nations, former Secretary of State of the US and former European Union High Representative for the Common Foreign and Security Policy, as well as the former State Secretary at the German Federal Health Ministry. That such a diverse group of politicians coming from different backgrounds and political climates agree on a needed change is worth taking note of, to say the least. (UN Report, 2011)

### ***Reason 6: Selling to Minors***

The use of drugs by minors is much more difficult to control with drugs prohibited. To effectively regulate the sellers of drugs so as to ensure that they only sell drugs to adults, drugs must be legalized, and the sellers licensed. With drugs prohibited, sellers are "underground" and therefore nearly impossible to control. (UN Report, 2011)

### **Why should Malta decriminalise soft drugs?**

From the local end, a fundamental discussion on drug laws were called for by Sedqa's clinical director George Grech, who called for an "urgent" debate on decriminalisation (Times of Malta, December 11th, 2010) and Caritas director Mgr. Victor Grech, who appealed for drug users not to be sent to prison (Time of Malta, June 25th, 2005 and July 1st, 2011). The fact that they represent the government and the Church's agencies dealing with drug abuse shows that those in most in touch with the realities of drug abuse in Maltese society and therefore better able to analyse it have already realised there are fundamental flaws in the system and have urged discussion. Prison rights activist Fr Mark Montebello O.P. has also shown support for decriminalisation (MaltaToday June 13th, 2011).



## References

- Allen J. Beck and Paige M. Harrison A., Prisoners in 2000, Bureau of Justice Statistics, U.S. Department of Justice, Washington, D.C. August 2001 and Boyum, D. A., and Mark A.R. Kleiman. 2002. "Substance Abuse Policy from a Crime-Control Perspective". In Crime: Public Policies for Crime Control, ed. James Q. Wilson and Joan Petersilia, 331- 382. Oakland, California: Institute for Contemporary Studies.
- Brown, J.; Langton, D. (October 2007). *Legalise all drugs: chief constable demands end to 'immoral laws*
- Editorial, The Economist,. (2009). *How to Stop the Drug Wars*, retrieved from [http://www.economist.com/node/13237193?story\\_id=13237193](http://www.economist.com/node/13237193?story_id=13237193)
- Jenkins, S. (2009). *The War on Drugs is Immoral Idiocy*, retrieved from <http://www.guardian.co.uk/commentisfree/2009/sep/03/drugs-prohibition-latin-america>
- MaltaToday. ( 2011). *Resistance to drugs decriminalisation dictated by greed*, retrieved from <http://www.maltatoday.com.mt/news/national/resistance-to-drugs-decriminalisation-%E2%80%98dictated-by-greed%E2%80%99>
- Release: Drugs, Law and Human Rights, 2011
- Rolles, S. (2010), "An alternative to the war on drugs", British Medical Journal June, 3rd 2010 retrieved from <http://www.bmj.com/content/341/bmj.c3360.full>
- Stevenson, R. (2009). *Dutch among lowest cannabis users in Europe*-report and Report of the Global Commission On Drug Policy, 2011.
- Times of Malta, (2005). Call for fast-track justice for drug offenders, June 25<sup>th</sup>
- Times of Malta (2011).Sedqa doctor calls for debate on decriminalisation of drug use,
- Times of Malta. (2011).Caritas calls for drug court, retrieved from <http://www.timesofmalta.com/articles/view/20110701/local/caritas-calls-for-drug-court.373250>
- Transform Drug Policy Foundation, 2011
- Unites Nations (2011). *War on Drugs*, Report of the Global Commission On Drug Policy retrieved from [www.globalcommissiondrugs.org](http://www.globalcommissiondrugs.org)



## Chapter 4

# Drug treatment currently available in the Maltese Islands

Rona Custò | GhSK

*The treatment of drugs in Malta is delivered by Sedqa, the National Drugs Agency, the Substance Abuse Therapeutic Unit, the Dual diagnosis Unit and the Corradino Correctional Facility - funded by the government.*

*NGOs: Caritas and OASI Foundation (Gozo) - partially funded by the local government.*

***Types of treatment:***

Different types of treatment classified into four main categories: outpatient community services, rehabilitation residential programmes, detoxification treatment and substitution maintenance treatment.

Together these offer Community Outpatient Services, offering long/short term support (EMCDDA, 2011).

- ✓ Rehabilitation programmes
  
- ✓ Residential programmes:      Caritas – Dar il-Vittorja (females) residential
  - Caritas - an 18 month residential programme (San Blas - males)
- ✓ Sedqa also offers another residential programme (Santa Marija)
  - OASI – residential programme (male)

OASI also have the services of a half-way house for clients wishing to seek rehabilitation skills before re-entering the community. These usually last between 2-6months (EMCDDA, 2011).

***Prison programmes***

Caritas offers a 2 year residential programme (PIP) - Dar Sant'Anna (males) Prisoners serving a prison sentence who have a drug addiction problem can apply to serve their last 2 years at the Prison inmate programme. This is a service offered by Caritas where they offer a residential programme in a homely atmosphere in Bahar ic-Caghaq. Only individuals already

serving a custodial sentence are eligible to apply. While on this programme clients are gradually allowed more leave to be able to pursue work opportunities and also gradually reinstate themselves in the community. This service is available for males only (Caritas, 2011).

➤ S.A.T.U.

The Substance Abuse Therapeutic Unit (SATU) is a Unit within the Department of Correctional Services. This Unit is for sentenced male individuals with a documented history of substance abuse. It is aimed at those who voluntarily request to attend a rehabilitation problem to address their addiction.

Inmates with a history of substance abuse who are eligible for prison leave under prison regulations and who are currently serving a sentence are offered the opportunity of applying to attend a rehabilitation programme. They are then processed by the Prisoner Substance Abuse Assessment Board (P.S.A.A.B.) prior to transfer to one of the three rehabilitation programmes available on the island. This service is available for male prisoners only (EMCDDA, 2011).

Eligibility: individuals currently serving a sentence of more than six months and less than two years.

➤ Substitution treatment

The SMOPU – Substance Misuse Outpatient Unit (detox) is a centralised methadone treatment unit in Malta. The Craig Hospital in Gozo offers the same services.

In 2005, take-home methadone prescriptions were introduced, and in 2006 treatment with buprenorphine began, in addition to methadone. Buprenorphine is given as a take-home dose, and is available by prescription from either SMOPU or a general practitioner. In Malta,

substitution treatment is mainly initiated and administered by treatment centres, and only a few general practitioners offer substitution treatment (EMCDDA, 2011).

Sedqa also offers a detoxification centre in its inpatient centre of Dar l-Impenn. (stay is usually of app. 6 days)

➤ Harm reduction

Free syringes to drug users:

Malta has the policy of handing out free syringes to drug users in a campaign aimed at reducing the risks of infections and diseases spread through the use and sharing of already contaminated needles. These new unused needles are given free of charge to anybody asking for them at any health centre in Malta. This is a harm reduction practice which started in the 1980's and as published in The Times in Feb'11, today health centres hand out an average of 844 syringes a day, mostly from Floriana, Cospicua and Paola (The Times, 2011).

## **Alternatives to custodial (prison) sentences**

➤ Community based alternatives

Penal systems around the world are seeing an increase in the use of community based alternatives. A report by the Walmsley (2009) shows that “more than 9.8 million people are held in penal institutions throughout the world” and thus the need to look for alternative measures to incarceration is one of the main reasons why other options are sought. However investing in community-based alternatives should not only be seen as a means of decreasing prison populations, which is already a pressing matter present in many countries, but community corrections “...should also be concerned about correcting injustices, social problems and advocating for improved social environments that foster pro-social behavior in some instances” (Evans, 2004). It is important to set a clear definition in order to contrast



between punishment and corrections. Punishment is defined as a retributive reaction to an offender's violation of the law as well as a deterrent. On the other hand, corrections seek to reduce law violations through education and correcting unlawful behavior (Butts, 1995).

The benefits of such community service based alternatives lie also in the rates of recidivism where studies show that these were reduced. Butts (1995) maintains that leaving the offenders to work and receive treatment in the community will make it much easier for the offenders to adapt themselves to society once the correction period is over and thus "...this is thought to reduce the likelihood of recidivism". As Martin (2003: 27) states, "[T]he overall conclusion from a broad reading of the available literature is that for reducing recidivism, treatment and rehabilitation are more likely to be successful than surveillance and enforcement", and this is one of the principal theories behind correctional sanctions that involve treatments, such as attendance centre programs, probation as well as intensive supervision. This is relevant in a broader sense to drug related offenders as aiming to treat the offender, but also as an individual with a more specific need for community attention and rehabilitation.

Available alternative orders include;

➤ Probation

Probation is a period of time where a criminal offender is supervised by a probation officer. During this time, the offender must regularly report to the officer and must not commit any other offenses. Probation has two major functions. First, probation protects the community by monitoring the offender. Secondly, probation assists the offender in abiding by the law. There are four different types of probation. Intensive probation is the type of probation where the offender is closely monitored often by GPS monitoring or home detention. Offenders under standard probation are required to report to probation officers biweekly, monthly or quarterly. Offenders under unsupervised probation do not have direct supervision by an officer.



Informal supervision is supervised or unsupervised probation without having been found guilty of a crime

➤ Community Service Order

A Community Service Order requires doing unpaid work in the community. It can be given to someone aged 16 or over convicted of an imprisonable offence if the offender consents and may be between forty (40) and two hundred & forty (240) hours duration. Probation Officers organise what work is to be done and ensure offenders attend and work to standards. The range of work carried out by the offender is varied, for example; assisting at social clubs for older people or people with disabilities, painting and decorating work, gardening and landscaping.

➤ Parole

In criminal justice systems, parole is the supervised release of a prisoner before the completion of their sentence in prison. This differs from amnesty or commutation of sentence in that parolees are still considered to be serving their sentences, and may be returned to prison if they violate the conditions of their parole. A specific type of parole is medical parole or compassionate release which is the release of prisoners on medical or humanitarian grounds. Conditions of parole often include things such as obeying the law, refraining from drug and alcohol use, avoiding contact with the parolee's victims, obtaining employment, and maintaining required contacts with a parole officer.

Some justice systems, such as the United States federal system, place defendants on supervised release after serving their entire prison sentence; this is not the same as parole. In Malta, even though past initiatives included the introduction of suspended sentence (1990) the remission of sentence and prison leave (1995), the introduction of the Community Service

Order (2002), the amendments to the Probation of Offenders Act (2002), proposals were put forward in the White Paper on Restorative Justice (2009), proposing the introduction of Parole, further recognizing that the Penal Justice System should serve to protect the society and to reform and reintegrate offenders (MJHA, 2009),

➤ Drug Courts

Drug courts are specialist courts available only to offenders involved in drug-related crimes. The difference of such courts to the traditional systems is that they offer a more holistic approach to the problem of drug related offences.

They were first introduced in the US in 1989 and are now used extensively to divert drug and substance abusers into treatment rather than prison. Their main function is to coordinate public resources and facilitating speedier processing of cases to help break the cycle of criminal behaviour associated with drug abuse. Research indicates that drug courts have been successful in the reduction of recidivism related to drug use and crime as well as improving the outcome of existing substance abuse treatment programmes (Office of National Drug Control Policy, 2011).

Drug courts are designed to utilise a non-adversarial model of intervention to facilitate and manage substance abusing offenders' access to, and participation in, appropriate treatment and rehabilitative services. The judge is directly supported by a case management team comprising defence and prosecution, probation and treatment service providers in a cooperative and collaborative approach to case management of substance abusing offenders. Eligibility is for drug or alcohol dependents and for those who are commonly charged with offences which are drug-related such as possession or other offenses which are determined to be caused or influenced by the addiction. The sittings are presided by a Judge who is supported by a whole team which are responsible to evaluate and examine each individual's case. These sittings are held in open court (King, Pasquerella, 2009).

➤ Treatment Plans

Treatment plans vary according to participants' individual clinical needs. In addition to substance abuse treatment, services often include mental health treatment, family counseling, vocational counseling, educational assistance, etc. The drug court's case management process is enhanced by the use of dedicated personnel whose roles are recognisable and consistent. The use of dedicated personnel enables those officers to provide expert support in these specialist roles, which in turn promotes consistency of service within the drug courts.

In the US, no other programme has been found to be as effective as the drug courts. They were found to drastically reduce recidivism, be cost effective as well as help offenders successfully complete rehabilitation programmes whilst more effectively reintegrate themselves into the community (Huddleston & Marlowe, 2011).

In Malta no such programme exists but has been proposed by Caritas as an alternative to long court proceedings, punishment and imprisonment. So far however no structure or model has been proposed to be implemented in the Maltese Criminal Justice system.

**Policy Shift to Treatment:**

*A balanced approach of prevention, enforcement, and treatment is the key in the fight against drugs.*

As the 2002 National Drug Strategy observes, "What the nation needs is an honest effort to integrate these strategies." In the U.S. criminal justice system there has been a shift to provide treatment for non-violent drug users with addiction problems, rather than incarceration. The criminal justice system actually serves as the largest referral source for drug treatment programs (US Department of Justice, 2003).



According to the U.S. Department of Justice, Drug Enforcement Administration, (2003:3);

“Any successful treatment program must also require accountability from its participants. Drug treatment courts which are a good example of combining treatment with such accountability are given a special responsibility to handle cases involving drug-addicted offenders through an extensive supervision and treatment program. Drug treatment court programs use the varied experience and skills of a wide variety of law enforcement and treatment professionals: judges, prosecutors, defenses counsels, substance abuse treatment specialists, probation officers, law enforcement and correctional personnel, educational and vocational experts, community leaders and others, all focused on one goal: *to help cure addicts of their addiction, and to keep them cured.*”

***Drug treatment courts are working.*** Researchers estimate that more than 50 percent of defendants convicted of drug possession will return to criminal behavior within two to three years. Those who graduate from drug treatment courts have far lower rates of recidivism, ranging from 2 to 20 percent. That’s very impressive when you consider that; for addicts who enter a treatment program voluntarily, 80 to 90 percent leave by the end of the first year. Among such dropouts, relapse within a year is generally the rule”.

➤ Boot camps

Boot camps are the modern alternative to the military school. It was during the 1990s that boot camps gained popularity (Layton MacKenzie, Gover, Styve, & Mitchell, 2001). Boot camps use a very similar system to that used within the military; where participating individuals need to wear uniforms, are given names such as “platoons” or “squads” and have marching duties enforced within their routines. Even though both physical fitness and training are given a great deal of importance, education is considered a must. Boot camps tend to be surrounded by an element of controversy.

Those who are in favour of the use of boot camps argue that the atmosphere in these camps helps the inmates by providing discipline and the lack of possibility of getting involved into criminal activities. Some individuals see these places as safe environments where young people are safe and cannot get into any trouble. Conversely, those who argue against boot camps believe that the 'confrontational environment' used within these camps is the exact opposite of what youth would need. Those against boot camps also state that the techniques used at these camps; "may cause juveniles to fear the correctional staff, which would create a negative environment for therapy and educational achievement" (Layton MacKenzie, Gover, Styve, & Mitchell, 2001).

It is quite common to find that boot camps are used for those individuals who have a substance abuse problem. Together with shock incarceration programmes, boot camps are used as therapy to help people who fall victims of drug abuse. Within said boot camps, substance abuse programmes are given, focusing on educating the abuser on the harm and other series implications such substances may have on their physical, mental and social state. Furthermore, in order to help the individuals overcome a drug problem; these boot camps focus on instilling a variety of skills.

These skills are intended to teach the client means on how to cope with life's stressors. Some of these skills include "development of motivation and commitment (to overcome dependence), development of life skills (e.g., fiscal management, communication skills, constructive use of time), AIDS education and prevention and relapse prevention strategies" (Cowles, Castellano, & A. Gransky, 1995). No such programmes are available yet in Malta.

### References

Butts, Jeffrey A. (1995). *Community-based corrections*. In The Encyclopedia of Social Work, 19th Edition, Vol. 1, pp. 549-555. Washington, DC: National Association of Social Workers. Retrieved on 9th December 2009, from <http://jbutts.com/pdfs/encycsocwork1995.pdf>

Cowles, E. L., Castellano, T. C., & A. Gransky, M. (1995). "Boot Camp" Drug Treatment and Aftercare Interventions: An Evaluation Review. US Department of justice.



Drug Courts. (2011). Retrieved August 2011, from Office of National Drug Control Policy:  
<http://www.whitehousedrugpolicy.gov/enforce/drugcourt.html>

Drug treatment overview for Malta. (2011). Retrieved August 2011, from European Monitoring Centre for  
Drugs and Drug Addiction: <http://www.emcdda.europa.eu/data/treatment-overviews/Malta>

Evans, D. (2004). *Why community corrections matters*. Corrections Today, 66(6), 6-19.

Health centres hand out 844 syringes daily to drug addicts. (2011, February 15). The Times .

Huddleston, W., & Marlowe, D. (2011). *Painting the Current Picture: A National Report on Drug Courts and  
Other Problem-Solving Court Programs in the United States*. National Drug Court Institute.

Layton MacKenzie, D., . Gover, A. R., Styve, G., & Mitchell, O. (2001). *A National Study Comparing  
theComparing theEnvironments of Boot Camps WithTraditional Facilities for Juvenile Offenders*. US  
Department of justice.

Martin, G. (2003). *The effectiveness of community-based sanctions in reducing recidivism*. Corrections Today,  
65(1), 26.

Probation Services. (2011). Retrieved August 2011, from Ministry for Justice and Home Affairs:  
<http://www.mjha.gov.mt/Page.aspx?pageid=136>

Services. (2011). Retrieved August 2011, from Caritas Malta: <http://www.caritasmalta.org/?m=services>

Walmsley, R. (2009). *World prison population list* (eighth edition). International Centre for Prison Studies.



## *Chapter 5*

# **Recommendations**

## **The Way Forward**

Even though it might be concluded that drug use is still a modern problem in Maltese society, especially amongst youth, it is to be acknowledged that our country has made a significant progress in fighting drug abuse and drug trafficking. In this view, the United Nations Global Commission War on Drugs Policy (2011) emerged as an eye opener that the war on drugs is failing, urgent action is required and that policies need to be urgently revised. Now is the time to strengthen our efforts by firstly identifying that breaking down the taboos surrounding the issue of drugs, removing labeling aspects, whilst also pursuing an open and free debate are paramount.

Finally, a set of recommendations will be proposed as potential actions for the way forward with the hope that social policy makers and the respective authority will take them into consideration. These recommendations are founded upon two fundamental beliefs;

- *Whilst a balanced approach of prevention, enforcement, and treatment is the key in the fight against drugs*
- *the development and implementation of drug policies should be a one common, sought shared responsibility, involving the participation of the Government, NGO`s and all stake holders*

### *1. The Introduction of a drug classification system*

- Whilst acknowledging the difference between the different classification of drugs and patterns of use, Malta needs to work within European Union's frameworks for an independent study to be conducted so as to provide official legal guidelines of classification for different kind of drugs and substances of abuse. Such guidelines must then be kept regularly updated in order to reflect any new trends.

## *2. A review of all national entities tackling drug abuse*

- An increase in investment in research, along with analysis of different policies and programs, is also essential for a helpful, sustainable and updated drugs policy. A review of all national entities who tackle drug abuse in some way should be carried out within a period of 4 years thus ensuring that all recommendations emanating from this review, and which are deemed to ensure better tackling of trafficking, cultivation and transportation whilst ensuring a more reparative approach towards drug abusers, should be put into place and functioning by 2015. At the same time an open debate on drugs in society must be enhanced.

## *3. Harsher penalties for trafficking, cultivation and transportation*

- Sentences for trafficking, cultivation and transportation should be made stricter. This should be complimented with increased investment in law enforcement on these areas, particularly trafficking.

- Where trafficking is linked to organized crime, law should consider such as being an aggravating circumstance. Imprisonment sentences for possession for personal use should be removed and such cases should instead be tackled in a manner so determined by the multidisciplinary expertise of the Drugs Tribunal. This while establishing better and updated metrics, indicators and goals to measure progress that can be more realistic in offering clearer views within the subject.

- Monetary penalties inflicted on drug traffickers should serve to finance drug rehabilitation centers while seizure and disposal of any vehicles used in the process of drug trafficking should be passed to law enforcers and used in the fight against crime instead of being left in derelict areas.

#### *4. Commencing to treat people dependent on drugs as patients not criminals*

- It is being noted that although a disciplinary system is surely required, a young person (first-time offender) of about 15 years old must be treated much more as a victim of drug abuse than as a criminal with all the related repercussions.
  
- Youths with drug abuse problems should have more specific rehabilitation programmes which take into consideration the causes of the drug abuse within their (the youth's) environment.

#### *5. Improvement in Restorative Justice Measures*

- **Probation services** need to be strengthened, while the **Parole system** and the Victim Offender Mediation programmes should be put into practice.
  
- Better working conditions and more human resources should also be considered for the officers involved in such valuable work, sometimes within dangerous environment. Having to deal with persons traumatised in various ways should call for professional stress management programmes.
  
- More varied and more target specific types of programmes, especially vocational programmes, would be more beneficial to better help the different number of persons affected by the problem of drug abuse coming from different backgrounds. Research should be carried out to enhance a new mentality acknowledging the victims of drug abuse whilst proposing new political updates where required.

## *6. Encouraging the Introduction of Halfway Houses*

- The introduction of halfway houses would be ideal for youths with problematic social background; in particular for those whose parents or close relatives also have a 'history' of drug abuse. In this manner, specific attention can be given to these youths whilst in a 'secure' environment. These premises should be beneficial for a more gradual reintegration into the community whilst aiming to lower the risk of recidivism. It must be noted that this recommendation is aimed at those youths who have already served a custodial sentence, or who have successfully completed a residential rehabilitation programme.

## *7. The setting up of a Drugs Tribunal*

- A Drugs Tribunal should be set up and this since such a specialized judicial fora would allow for multidisciplinary expertise to be better utilized, thus improving the chance that the sentence meted out would have long term benefits for the accused. Such Drugs Tribunal should be able to hand limited imprisonment sentences and/or fine / amenda, particularly when dealing with recidivists. However, the aim of the tribunal should always remain that of using multidisciplinary specialization for the benefit of the accused and ultimately of society in general.

- The introduction of a Drug Tribunal in Malta would provide an alternative process in the criminal justice system for eligible non-violent drug offenders which focuses on treatment and allows successful defendants to avoid prison time and a criminal record. With a proper infrastructure, this introduction can offer rapid judiciary system with alternative punishments.

- On the other hand, the system must take note to empower the process for a 'proper rehabilitation' of drug victims to be reintegrated successfully into society whilst avoiding the possibility that they would be sent to prison on 'insignificant' criminal charges which had been pending for years. This would limit the risk of 'ruining' valuable efforts from various entities / NGOs and professionals to achieve a successful rehabilitation for the victim.
  
- Drug Tribunals are being recommended instead of a Drug Court as in the USA model (federal state) as it is believed that these courts will imply a strict approach, whilst what is being recommended is a more 'flexible approach' with victims of drug addiction; in particular young offenders.
  
- A Drug Tribunal is surely a much more effective method of justice as it can show a certain degree of 'compassion' to the victims. It also gives an opportunity for a second chance in life, while as a structure; it will cost taxpayers substantially less money and enhances public safety.

## *8. Introducing new services for women*

- It is recommended that specialised programmes, including residential services, be offered to women with drug abuse problems. Drug abuse in women tends to come with other complications such as unexpected pregnancies and a link to prostitution. With the help of dedicated staff and a required framework, women can be assisted to overcome their addiction, live healthy lives and when needed, raise healthy babies as well.

## *9. Drug Abuse and Development*

- Drug use, trafficking and the strategies used to tackle these problems, can be linked with development policies as drugs have a negative impact on the poor and most vulnerable people in society. This link has often been neglected in the past and is not adequately tackled within global policies and strategies aimed at achieving the Millennium Development Goals (MDGs) by 2015. Drug control responses in countries of origin have traditionally taken the form of crop bans and eradication, and criminalization of producers, while often overlooking alternative development measures.

- Education and vocational training should have more importance in development assistance in order to provide the people involved in the drug industry with possibilities for an alternative employment. Furthermore, public-private partnerships should be fostered in order to provide incentives for the private sector to enlarge and employ persons coming out from the drug industry in developing countries. While noting that Malta's development assistance has sub-Saharan Africa as its geographical focus, Malta could consider providing further assistance in relation to education/training and public-private partnership to the countries of the Sahel region, which is one of the main drug trafficking roots to Europe.

## *10. Investing in Education will always remain the key to success*

a) To invest further in educational programs in *schools* (especially secondary and sixth form schools which can also be carried out in collaboration with Students Organisations on campus) through media and health awareness campaigns so as to integrate the concept of harmful substance abuse and skills on self-empowering and assertiveness.



Educating the *public* especially youth and *educational institutions* would encourage the individual to say 'no' to peer pressure by strengthening the individual's self-control and self-esteem. Within such a scenario, it is important that young first-time users, experimenting with drugs, would be spared to be 'labeled' as criminals by undergoing bureaucratic criminal procedures, having a stigma of a criminal record and experiencing a prison environment.

c) To inform the public on the actual biological effects of *methadone therapy*. As a consequence, the public would have a true picture of methadone therapy and decreases the 'medical myths' regarding methadone.

(There are several rumours going on with regards to the methadone effects on the body. Such 'medical myths' include: 'Methadone weakens your bones', 'It is difficult for methadone to be metabolized by the liver', and 'Methadone causes people to use cocaine'. In most cases, these rumours are not true and will push away heroin addicts from starting methadone treatment. During school and public campaigns, many individuals seem to be unsure about how methadone works. Thus, tackling this issue would be of public benefit)

d) At the same time the government must ensure that our *law enforcers* and other related authorities are continuously trained and kept updated upon different trends within the subject.

# Concluding Remarks

It is worth noting that the presented recommendations are also backed up by a recent study carried out by Cremona (2011<sup>1</sup>) where 1078 Maltese youth participated in a questionnaire varying between the ages of 18 and 35.

As suggested in the recommendations section, the majority of these Maltese youth also believe that better approach towards alternative to imprisonment aimed at rehabilitation methods is beneficial. If effect), 87.9percent (738 respondents) of the respondents affirmed that they believe “rehabilitation works” supported by a majority of 497 females and 241 males. When this is compared with international findings, as stated by Roberts and Hough (2002) although public knowledge of community penalties tends to be poor there is considerable evidence that people support rehabilitative measures.

Furthermore as indicated in the below table, in this study when asked which punishment is the most suitable, while for drug addiction 50.5% of the participants opted for probation, for drug addiction 52.6% of the participants chose prison.

	<i>Reprimand</i>	<i>Fine</i>	<i>Compensation</i>	<i>Probation /Community work</i>	<i>Prison</i>	<i>Boot camps</i>	<i>Death Penalty</i>
<i>Drug Addiction</i>	11.1%	6.8%	3.3%	50.5%	7.4%	20.7%	0.2%
<i>Drug Dealing</i>	1.3%	12.6%	4.6%	11.8%	52.6%	12.7%	4.4%

In addition a mainstream of 91.0percent (779 respondents) upholds that “the government should concentrate on investing in restorative justice measures” while 81.7percent affirmed that the government should “not invest in the building of another prison”. In effect, a strong

---

<sup>1</sup> Cremona, Abigail (June 2011). *Attitudes to Punishment-The Attitudes of Maltese youth towards punishment and Community Corrections*, Institute of Criminology, University of Malta.

majority of 62.5percent (549 respondents) youth believe that parole should be introduced in Malta with support coming from a majority of 367 females and 182 males (Cremona, 2011)

With regards to the Introduction of Halfway houses a majority of 69.9percent (604 respondents) comprising 478 females and 228 males sustain that the “government should invest in the building of halfway houses”. In addition, the introduction drug court was also a supported measure with an outstanding 94.8percent (832 respondents) emerging from a record of 550 females and 282 males preferences.

Finally, when confronted with choosing the best method for the way forward as a successful means of enhancing public knowledge, as stated in the recommendations “educational campaigns” was the most selected with 93.3percent (806 respondents comprising of 532 males, 273 females) reaffirming the widely known status that education is the key to success.

Thus after studying the stated recommendations, statements and taking into consideration various different considerations on a closing remark, the KSU Social Policy Commission believes that it is amply evident that Malta's drug policy severely needs a better approach. Such can only be possible by first and foremost having a drug classification system and by tackling all national agencies tackling drug abuse. KSU also believes that a drugs tribunal should be set up and a wholesome review on crimes directly related to drug abuse should take place. Naturally all of this also requires huge improvements in the current rehabilitative services available as well as introducing new services for women.

The overall spirit of this report is that of embracing a more pragmatic approach something which is essential in replacing the principle of zero tolerance with the principle of harm reduction and a caring state. Together we need to challenge rather than reinforce common misconceptions about drug markets, drug abuse and drug dependence while continuing to carefully evaluate previous drug policies to determine which are the most effective rather than sticking to an ideological perspective.

*The KSU Social Policy Commission truly hopes that the relevant authorities will acknowledge the hard work that was endured by several students coming from different organisations with different beliefs and thus take into consideration the suggestions and recommendations put forward in this report.*