EVALUATING DRUG REHABILITATION POLICIES IN INDONESIA

RESEARCH REPORT

2019-2020

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
Bapas	Correctional Center
BNN	Indonesia’s National Narcotics Board
BNNP	Indonesia’s National Narcotics Board on province level
BNNK	Indonesia’s National Narcotics Board on city level
DGC	Directorate of General Corrections
DIPA	Budget Implementation List
HIV	Human Immunodeficiency Virus
IAT	Integrated Assessment Team
INCB	International Narcotics Control Board
IPWL	Report Obligatory Recipient Institution
LKP	Correctional Performance Report
LPKA	Juvenile Detention Centre
NGO	Non-Governmental Organization
Pokja	Working Group
SDP	Correctional Database System
SIMKA	Personnel Management Information System
TC	Therapeutic Community
CITU	Correctional Implementation Technical Unit
WHO	World Health Organization

EXECUTIVE SUMMARY

The significant number of detainees and inmates of drug-related cases has encouraged the government, via the Ministry of Law and Human Rights (ML&HR), particularly the Directorate General of Corrections (DGC), to take strategic actions to provide rehabilitation facilities for detainees and inmates in detention centers and correctional facilities. The success of the drug rehabilitation program implementation conducted by the DGC as instructed by the Ministry of Law and Human Rights Ministerial Decree No. 12 year 2017 cannot solely rely on therapy aimed to rehabilitate inmates categorized as people with drug dependence, so that they will be able to live a more productive life in the Correctional Implementation Technical Unit (CITU). It also relies on other policies that support the drug rehabilitation program management. A more in-depth review is required to assess whether the rehabilitation policies instructed by the Ministry of Law and Human Rights Ministerial Decree No. 12 of 2017 are adequately supportive as the foundation of a drug rehabilitation program in terms of implementation and management. The results of this study are expected to provide practical recommendation in strengthening the regulations and implementation of drug rehabilitation in the UPT Pas (Unit Pelaksana Teknis Pemasyarakatan - Correctional Implementation Technical Unit - CITU)

This research sees drug rehabilitation for inmates as a health provision conducted in a CITU in Indonesia. In order to put the health efforts into action, a series of regulations have been created and utilized as guidelines and foundations for the DGC and CITU to plan and provide rehabilitation service for inmates. Therefore, to see how effective the regulation that was developed by the Ministry of Law and Human Rights, we have to look into regulations related to leadership and governance, workforce, logistics/medicines, information system, financing, and service delivery. Meanwhile, to see the extent of the drug rehabilitation, we will look into the scope, accessibility, quality, and the sustainability of the drug rehabilitation program in the future.

Based on the approach used in the analysis the various regulations are collected to describe and explain the contextual aspects such as drug-related case management and health management in a judiciary level, Government Regulations level, Presidential Decrees level, Ministerial Decrees level, or the BNN's Chief Regulation level. As for the content of the policies, it will be scrutinized from the perspectives of the Ministry of Law and Human Rights' decree about drug rehabilitation as well as a lower level regulation such as the DGC's' decree. As for the policy-making process. It will be pursued from the implementation angle which will be obtained from documents related to reports in the forms of drug rehabilitation monitoring and evaluation reports within the DGC and CITU. In the meantime, roles of related parties in drug rehabilitation policies will be identified from their roles and responsibilities for the institutions assigned to them as stated in laws and regulations. Among the regulations focused on contexts and content, there are 23 regulation documents related to drug rehabilitation from 1995 to 2019.

Basically, the drug rehabilitation program in prison settings under the Ministry of Law and Human Rights is based on adequate policies for its implementation. The policy is based on the Law on Narcotics, the Law on Psychotropic, and the following regulations in the form of Presidential Instruction, regulation of Minister of Health, Regulation of Minister of Social Affairs, BNN's Chief Regulation, and Regulation of Minister of Law and Human Rights which all are directed for drug rehabilitation service policies both for the public in general and specific populations such as prisoners. At the operational level, the implementation of narcotics rehabilitation policies for prisoners in Correctional Implementation Technical Unit (CITU) has been reflected in Regulation

of Minister of Law and Human Rights No. 12 of 2017 and the operational guidelines for drug rehabilitation program. Several aspects of health regulation such as governance, logistics and medical support, health resources, information systems, financing, and service provision, have been regulated in the operational guidelines.

The implementation of drug rehabilitation policy currently relies on social rehabilitation with therapeutic community (TC) modality. Although it has been comprehensively regulated in the operational guidelines, unfortunately the instructions of the guideline cannot be applied properly. Barriers in applying this therapeutic modality including: (1) inconsistency in the assessment process or screening to determine rehabilitation participants, (2) poor adherence in participants for engaging in therapy either due to lack of facilities and infrastructure support or due to the weak assessment system and screening, (3) limited provision of facilities and infrastructure required for a variety of therapeutic modalities, (4) limited financial fund to fully support the needs and magnitude of the problems faced by Correctional Implementation Technical Unit (CITU) and provide any necessary infrastructure and logistics, (5) unavailability of sufficient and qualified human resources, (6) limited variety of activities in rehabilitation activities, and (7) lack of documentation system to provide sufficient data to be used as the basis for the program development (services and participants).

Some strategies and recommendations that can be offered to strengthen the drug rehabilitation program at Correctional Implementation Technical Unit (CITU) are as follows:

1. Review the TC modality as the primary modality in drug rehabilitation therapy at CITU, considering that this modality requires a huge resource to be implemented consistently. It is necessary to consider a relatively simple therapeutic modality, with lower participation requirements, lower costs, facilities, and infrastructure that can be integrated with the residential nature of prisons/detention centers, and considering the period of the rehabilitation program. The application of this modality will increase the coverage of participants and is expected to be more efficient in the use of limited resources.
2. Conduct financing simulations for various therapeutic modalities that can be used for budgeting at the UPT Pas, Regional Office, and DGC levels.
3. Review the existing operational guidelines to be adjusted to the therapeutic modalities that will be applied by strengthening operational aspects through learning and capacity building. It is expected that these implementation instructions will become more feasible, effective, and acceptable for implementing staff at the Correctional Implementation Technical Unit (CITU).
4. Conduct more intensive socialization for the operational guidelines to ensure the implementers' understanding.
5. Assure the availability of regulations that support the implementation of regular and hierarchical monitoring and evaluation activities starting from CITU, Regional Office of Correction, to DGC of The Ministry of Law and Human Rights.

CHAPTER 1. INTRODUCTION

1.1 Background

For the past ten years, overcapacity of the population is a common problem that occurs in correctional facilities and detention centers in Indonesia with the number spiking by 206% in 2019. Both facilities were meant to accommodate 124.953 detainees and inmates; however, the current occupancy reached a staggering number of 258.466. This situation is rooted in the increasing number of detainees and inmates in Indonesia. From a total number of 127.995 detainees and inmates in 2007, the figure continued to spiral up to 258.466 in 2019 [1,2].

The surge in the occupancy rate of correctional facilities and detention centers is very much tied to the increase in drugs-related crimes cases that are identified as the primary cause of overcapacity in both detention centers and correctional facilities. A large number of people who use drugs have been sentenced based on Narcotics Law No. 35/2009 and placed in correctional facilities [3]. To overcome the overpopulated issues, an integrated assessment on inmates related to drugs have been stipulated in a joint decree signed by heads of several government institutions (Ministry of Law and Human Rights, National Narcotics Agency [BNN], Supreme Court, Indonesian National Police, Ministry of Health, and Ministry of Social Affairs) as “Management of people with drug dependence in Rehabilitation Centers”. From the assessment results, people with drug dependence will get clemency and will be referred to a rehabilitation center, instead of a detainment center or a correctional facility [4].

However, data continues showing that the number of people who use drugs continues to increase in the last ten years and even contributes to nearly 50% of the total population in detention centers and correctional facilities. Detainees and inmates related to drug issues categorized as users and dealers are put together in the same blocks [1,5]. It shows that imprisonment of people who use drugs may not solve drug problems, but rather create new problems due to overcrowding of the prison and may not provide opportunities to have proper drug treatment because of limited facilities in prisons [6].

A new problem that arises is the increase in cases of infectious diseases such as HIV/AIDS and other afflictions that originate from detainees and inmates who had injected drugs. Several studies conducted in detainment centers and correctional facilities in Indonesia have shown the associations between HIV infection and drug use. Prevalence survey conducted by the Ministry of Law and Human Rights on HIV, syphilis, and high-risk behaviors in detention centers and correctional facilities showed HIV prevalence was 1.1% among male and 6.0% among female inmates, while syphilis prevalence was 5.1% for male and 8.5% for female inmates. The surveys also revealed that the factor associated with HIV infection on the male population was a history of injecting drugs. Meanwhile, contributing factors for HIV infection on female

detainees and inmates include positive results in syphilis testing and experience of using drugs. Among those who have a history of injecting drugs, the percentage of female inmates and detainees who tested positive for HIV (12,0%) was close to double the males (6,7%) [7]. A prevalence survey on HIV, hepatitis B and hepatitis C conducted in a detention center/correctional facility in Bandung showed the percentage of 7,2% of the population tested positive for HIV with nearly the entire infection cases was related to injected drugs [8]. A research by the Directorate General of Corrections (DGC) of the Ministry of Laws and Human Rights Republic of Indonesia revealed a similar finding, which was the HIV prevalence among male inmates and detainees (6,5 – 7,2%) was found in a drug-related section of the facility where many were people who injecting drugs. The World Drug Report in 2019 reported that the use of narcotics, psychotropic substances, and other addictive substances is prevalent and is a constant challenge for the correctional officers. It is estimated that the percentage of prisoners who are people who use drugs reaches 30% of the total facilities' population, nearly five times the prevalence in the general population (5,56%) [9].

The significant number of detainees and inmates of drug-related cases has forced the government, via the Ministry of Law and Human Rights, particularly the DGC, to take strategic actions to provide rehabilitation or drug treatment service for people with drug dependence in detention centers and correctional facilities [5]. Drug rehabilitation services are integrated with re-education and health services as instructed in the Law No. 12 of 1995 on correctional affairs which states that one of the rights of an inmate is to receive services in health and that he or she is required to enroll in a re-education program. Furthermore, Indonesia's Law No. 35 of 2009 on narcotics regulates that people who use drugs need to undergo medical and social rehabilitations.

Some of the drug treatment and harm reduction services that have been proven to be effective in some European countries are detoxification, drug replacement therapy (Methadone Maintenance Therapy), needle exchange, drug-free unit service, and therapeutic communities (TC) [10]. However, in order for the service to be effective in fulfilling the patient's needs, it has to be based on individual assessments. Health treatments and security also play a major role for an effective rehabilitation service. The use of TC, drug replacement therapy, and drug-free unit service are already taking place in Malaysian Prisons with TC being the most effective drug rehabilitation program that has been running since 1992 [11].

Innovations in rehabilitation programs for inmates with drug-related sentences are influenced by the global paradigm that classifies people who use drugs as people who have problems with their drug addiction and therefore drug treatment and rehabilitation is a mandatory service. Support from Indonesia's Ministry of Law and Human Rights in the implementation of drug rehabilitation is stated in the Ministry of Law and Human Rights' Ministerial Regulation No. 12 of 2017 on "The Implementation of Drug Rehabilitation for Detainees and Inmates". Prior to a

direct mandate from the Ministry of Law and Human Rights to implement the rehabilitation program, CITU had been actively involved in a rehabilitation program conducted by Indonesia's National Narcotics Board (BNN) in 2015. The program ran from 2015 to 2016 in collaboration with BNN. At that time, BNN was mandated by the government to run a rehabilitation program on 100.000 people who use drugs. On BNN's 2015 report, it was reported that the number of inmates who received drug rehabilitation service was 3512 with 99,23% of them completed the rehabilitation program [12].

In 2017-2018, a drug rehabilitation program was independently implemented by the UPT Pas. Previously, the duration of the same program by the National Narcotics Board was three months in UPT Pas whereas now it is six months. In 2018, the DGC issued a decree, PAS-985.PK.01.06.04 year 2018, on "Guidelines to Implementing Drug Rehabilitation Service for Detainees and Inmates in CITU as an operational guideline for prison officers other parties who are involved in the rehabilitation program. At the moment, this service is spearheaded by CITU as mandated by the DGC's decree.

The success of the drug rehabilitation program conducted by the DGC and as instructed by the Ministry of Law and Human Rights Ministerial Decree No. 12 year 2017 cannot solely be measured by the success of the therapy but also relies on the policy support related to the governance and management of the program. A more in-depth review is required to assess whether the rehabilitation policies instructed by the Ministry of Law and Human Rights Ministerial Decree No. 12 of 2017 are adequately solid as the foundation of a drug rehabilitation program in terms of implementation and management. Moreover, the review is also aimed to assess the extent of the current drug rehabilitation program implementation so that obstacles and supporting factors in CITU level can be identified. The review of the program's policies implementation based on the World Health Organization's six functions of health system (or often referred to as the WHO's Building Blocks) is an approach that is used to assess the effectiveness of the rehabilitation program from the implementation and management points of view that include human resources, financing, information system, medicines/logistics, and regulations.

1.2 Research Questions

1. Has the drug rehabilitation policy developed through the Ministry of Law and Human Rights Ministerial Decree No. 12 of 2017 been able to provide an adequate foundation for a rehabilitation program for inmates in the Correctional Implementation Technical Unit (CITU) based on the WHO's Health System Six Building Blocks Framework?
2. How far has the drug rehabilitation policy been implemented by the Correctional Implementation Technical Unit (CITU)?

1.3 Research Objectives

1.3.1 General Objectives

To review policies and the program of drug rehabilitation in detention centers and prisons in terms of its implementation and governance in order to plan various efforts that can be done to reinforce future drug rehabilitation programs.

1.3.2 Specific Objectives

a. To review policies related to the implementation of drug rehabilitation programs for detainees and inmates at the Correctional Implementation Technical Unit (CITU) based on the six building blocks framework.
b. To describe the implementation of drug rehabilitation programs to inmates and to identify obstacles and supporting factors of the implementation.
c. To offer recommendations to strengthen policies and implementation of drug rehabilitation programs for detainees and inmates in the Correctional Implementation Technical Unit (CITU) in the future.

1.4 Research Significance

This research aims to reinforce a drug rehabilitation program for detainees and inmates at CITU by exploring the regulations of drug rehabilitation and the implementation of drug rehabilitation programs. Drug rehabilitation programs are one of the most important health services for inmates provided by the Ministry of Law and Human Rights. In 2020, there are 21.000 detainees and inmates who are targeted to enroll in the drug rehabilitation program at UPT Pas appointed by the DGC. The results of this study are expected to provide practical recommendations in strengthening the regulations and implementation of drug rehabilitation in CITU.

1.5. Conceptual Framework

This research is specifically using the Six Building Blocks of Health System from WHO as a conceptual framework [13]. In this framework, the health system is essentially a series of intertwined and correlating policies in creating efforts that can result in the highest level of health status for the citizens. Policies that build the health system include policies on leadership and governance, health workforce, financing, medicine, health information system, and service delivery. In Indonesia, the various main functions of the health system include health management and regulation, financing, human resources, strategic information, service, and community

empowerment as regulated in Indonesia's national health system (Presidential Decree 72 of 2012). These components can be seen below.

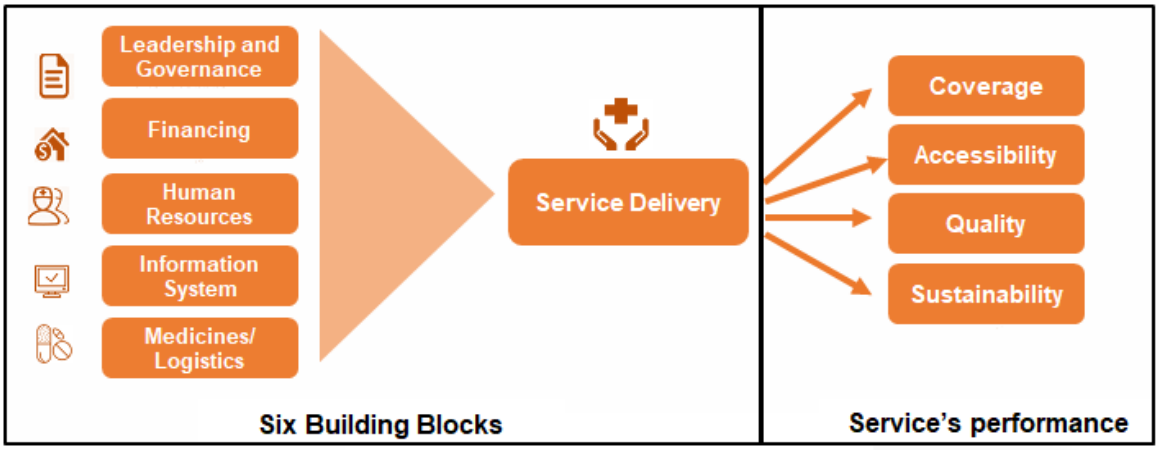

Figure 1 Conceptual Framework

Specifically, the policies related to components in the health system are as follows.

1. Policies on governance that regulate management and leadership, rules and regulations, and supervision that are needed so that the health efforts have a solid foundation and authority in the implementation.
2. Workforce policies include regulations on the availability, adequacy, and competent health workforce.
3. Policies on drugs/logistics and medical supplies are to regulate access to medical supplies and supporting facilities that support health efforts.
4. Policies on financing involve finance resources, money allocation, and purchase to fulfil health necessities.
5. Policies on health information systems that regulate strategic data gathering mechanisms through a system of documenting, reporting, quality warranty, monitoring, evaluation, researching and developing health efforts. The strategic information will be analyzed and utilized for decision-making or health effort reinforcement.
6. Policies on service delivery are policies that regulate the leadership and management of the existing health efforts.

Whether a health system will succeed or not is determined by the health status of the population who are the targets of various health efforts. It manifests in a decreasing mortality rate, illnesses, improved life quality, and decreased financial burdens caused by health issues. However, on a more operational level, the success of the health system is reflected in the health system's performance (i.e. coverage, accessibility, quality, and sustainability) as a direct effect of implementing various policies that are the components in the health system as seen in the main

indicators (i.e financing, workforce, health information system, leadership and governance, medicine and service delivery) .

According to the conceptual framework, this research sees drug rehabilitation for inmates as a health effort conducted in CITU in Indonesia. In order to put the health efforts into action, a series of regulations have been created and utilized as guidelines and foundations for the DGC and CITU to plan and provide rehabilitation service for inmates. Therefore, to see how effective the regulation that was developed by the Ministry of Law and Human Rights, we have to look into regulations related to leadership and governance, workforce, logistics/medicines, information system, financing, and service delivery. Meanwhile, to see the extent of the drug rehabilitation, we will look into the scope, accessibility, quality, and the sustainability of the drug rehabilitation program in the future.

Furthermore, in understanding drug rehabilitation policies, we cannot disregard the contextual factors in which the policies are formulated and implemented [14]. Policies and implementation of the drug rehabilitation will be influenced by: (1) the characteristics of the drug issue, policies and drug rehabilitation programs conducted by other government bodies as a prevention, follow-up, and rehabilitation, (2) the interactions of those within the policy and the drug rehabilitation implementation for inmates (3) the characteristics of the health system within the Ministry of Law and Human Rights, and (4) the existing correctional system as a context of the rehabilitation for inmates.

1.6. Methodology

This research is a policy analysis using the *Policy Triangle approach* [15]. An approach assumes that in order for a policy to be understood, it has to be looked into from four aspects (i.e context, content, process, and actors) in the developing and in the implementation. By dividing the analysis into four aspects, this policy analysis will be able to provide a complete picture of each aspect and how the four aspects are intertwined so that a comprehensive understanding of the policy can be achieved.

Based on the approach used in the analysis, the obtained data is the various regulations that can illustrate the contextual aspects such as drug-related case management and health management in a judiciary level, Government Regulations level, Presidential Decrees level, Ministerial Decrees level, or the BNN's Chief Regulation level. As for the content of the policies, it will be scrutinized from the perspectives of the Ministry of Law and Human Rights' decree about drug rehabilitation as well as a lower level regulation such as the DGC's' decree. As for the policy-making process. It will be pursued from the implementation angle which will be obtained from documents related to reports in the forms of drug rehabilitation monitoring and evaluation reports

within the DGC and CITU. In the meantime, roles of related parties in drug rehabilitation policies will be identified from their roles and responsibilities for the institutions assigned to them as stated in laws and regulations.

Among the regulations focused on contexts and content, there are 23 regulation documents related to drug rehabilitation from 1995 to 2019. This research looked into the these documents that came from the Indonesia's Law, Government Decrees, Presidential Decrees, Joint Decrees, MoU's, the National Narcotics Board's Regulation, Ministerial Decrees by the Ministry of Social Affairs, Ministry of Social Affairs, Ministry of Health, and the Ministry of Law and Human Rights as shown on the table below.

Table 1 List of Policies Related to Drug Rehabilitation Program

No	List of Policies
Laws, Government Decrees, Regulations, Presidential Decrees, Presidential Decrees	
1	Law of the Republic of Indonesia No. 9 of 1976 on Narcotics
2	Law of the Republic of Indonesia No. 12 of 1995 on Correctional
3	Law of the Republic of Indonesia Number 22 of 1997 on Narcotics
4	Law of the Republic of Indonesia Number 35 of 2009 on Narcotics
5	Presidential Decree No. 12 of 2011 about policy implementation and national strategy to prevent and eradicate illicit drug trafficking year 2011-2015.
6	Joint Regulation by the Supreme Justice, the Ministry of Law and Human Rights, Ministry of Social Affairs, Ministry of Health, Attorney General, and Chief of Indonesia's National Police about the handling of drug users and substance abuse victims into rehabilitation centers in 2014
7	Presidential Instruction No. 6 of 2018 about national action plan in preventing and eradicating drug dependence and illicit drug trafficking in 2018-2019
8	MoU between the Deputy of the BNN signed by the Directorate General of Correctional Affairs (DGC) and the Ministry of Law and Human Rights in 2018 about drug rehabilitation for detainees, inmates, and prison officers.
Policies by The National Narcotics Board (BNN)	
1	Presidential Law of the President of the Republic of Indonesia No. 23 of 2010 on the National Narcotics Board (BNN)
2	Regulations of the Head of the BNN No. 14 of 2011 about drug rehabilitation of community members
3	Regulations of the Head of the BNN No. 4 of 2015 about how to increase the ability of medical rehabilitation agencies and social rehabilitation conducted by the government or citizens

4	Regulations of the Head of the BNN No. 11 of 2014 about the management of convicts and/or drug-related people and substance abuse victims into rehab centers
5	Regulations of the Head of the BNN No. 7 of 2015 about how strategies of the National Narcotics Board 2015-2019
6	Regulations of the BNN No. 24 of 2017 about the service standard on rehabilitation for people with drug dependence
7	Regulations of the BNN No. 4 of 2018 about the Grand Design of the BNN 2018-2045
Policies by the Ministry of Social Affairs	
1	Ministry of Social Affairs Regulation No. 9 of 2017 about a national standard for social rehabilitation for people who use drugs and people with drug dependence (addicts and victims of narcotics, psychotropic, and other addictive substances)
Policies by Ministry of Health	
1	Ministry of Health Regulation No. 2415 of 2011 about medical rehabilitation
2	Ministry of Health Regulation No HK.02.02/Menkes/52/2015 about strategic plans of the Ministry of Health 2015-2019
3	Ministry of Health Regulation No. 50 of 2015 about mandatory reporting and medical rehabilitation
Policies by the Ministry of Law and Human Rights	
1	Circular Letter from the Ministry of Law and Human Rights No. M.HH-01.PK.01.06.10 of 2015 about the mechanics of the rehabilitation implementation for occupants in detention centers and prisons
2	Regulation by the Ministry of Law and Human Rights No. 12 of 2017 about the implementation of narcotics rehabilitation service for detainees and convicts
3	A decree by the Directorate General of the Ministry of Law and Human Rights No. PAS.121.PK.01.07.01 of 2017 about the establishment of Correctional Implementation Technical Unit (CITU) as rehabilitation providers
4	A decree by the Directorate General of the Ministry of Law and Human Rights No. PAS-985.PK.01.06.04 of 2018 about the guidelines to implementing narcotics rehabilitation for detainees and inmates in the Correctional Implementation Technical Unit (CITU)' social rehabilitation

To observe the implementation of drug rehabilitation, there are four documents in the form of drug rehabilitation monitoring and evaluation report in CITU. The DGC, and the Ministry of Law and Human Rights from 2016-2019 conducted in detention centers, prisons, and correctional centers (or known as Bapas). Furthermore, to give a larger context from drug rehabilitation to inmates and a response to drug-related issues during certain periods of time, information on the history of the evolution of drug-related policies in Indonesia is given to inmates.

Various problems and content of policies in general and operational regulations above are then categorized based on the components of six building blocks of the health system that includes leadership and governance, workforce, medicine/logistic, health information system, financing and service delivery. Meanwhile, to observe the implementation and performance of the drug rehabilitation program, we used CITU' monitoring and evaluation's reports from 2016- 2019.

CHAPTER II. RESULTS

2.1 The Development of Drug Rehabilitation Regulations in Indonesia

The design of prevailing ministerial or institutional policies for drug rehabilitation is influenced by the regulation on narcotics at the international and national levels. One of the international agreements ratified by a number of countries is the Single Convention on Narcotic Drugs. This convention was the outcome of The United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs held in New York from 24 January to 25 March 1961. The signing of The Convention began on 30 March 1961 where Indonesia took part in signing along with 96 other countries and also proposed conditions to change protocols in the agreement [16].

Indonesia's commitment in the effort to eradicate illicit drug trafficking is revealed by the enactment of the ratification of The Single Narcotics Convention of 1961 along with the proposed protocol for the amendment to Law No. 8 of 1976 [17]. The protocols of The Convention gave a larger portion to the enforcement and regulations on treatment and rehabilitation for people who use drugs. It also strengthens the role and position of the International Narcotics Control Board (INCB) in monitoring and enforcing the resolutions stated in The Narcotics Single Convention of 1961 in order to lower illicit drug trafficking. A more specific regulation in treatment and rehabilitation in The Convention is stated in 36-letter articles (a and b) that emphasized on giving alternative consequences which were the treatment and rehabilitation and social reintegration for people who use drugs[16].

The Narcotics Single Convention of 1961 then became the beginning of the existence of legislations related to narcotics in Indonesia at the time when illicit drug trafficking in the early seventies were on the rise, considered a threat to national stability. This situation was followed by the Presidential Decree No. 6 of 1971. The decree was meant for the Head of the National Intelligence Coordination to coordinate to prevent and eradicate issues and violations in the society such as counterfeit money and drug crimes [18]. Five years later, the House of Representatives successfully passed Law No. 9 of 1976 about narcotics. It was the first law about drug policies passed by the New Order government. In the law, the regulations on rehabilitation are stated on articles 33-34 about treatment and rehabilitation for people who use drugs and the efforts to overcome the issue and to encourage the participation of rehabilitation centers [19].

Indonesia’s involvement in the international convention for eradicating illegal drugs in 1988 was a part of the country’s commitment in the drugs and psychotropic substance issues. The regulations on treatment and rehabilitation in the convention are stated in articles 3 section (4b), section (4c) and section (4d) about violation and the sanction where people with drug dependence have to undergo treatment and rehabilitation and social reintegration [20]. The ratification result of the convention was then passed into Law No. 7 of 1997 that also detailed post-treatment,

rehabilitation, and social reintegration in the main points on crimes and sanctions [21]. However, long before Indonesia ratified the convention, the Indonesian Penal Code ratified in Law No. 8 of 1981 also mentioned the treatment for people who use drugs although article 21 section(4b) of the penal code only talked about penal law for people who use drugs. The article directly referred to Law No. 9 of 1976 on narcotics [19]. In the description of the article 21 section (4b), this law emphasizes on the defendants who use drugs placed in treatment and care [22].

The passing of Law No. 22 of 1997 on narcotics was a form of concern on the government's part for the rising number of illicit drug trafficking and its impact on national stability. Because of this, Law No. 5 of 1976 was deemed irrelevant and a new law needed to pass. Law No. 22 of 1997 passed at the same time with Law No. 5 of 1997 about psychotropic which was ratified on 11 March 1996. In implementing articles of how a change took place from article 20 of the psychotropic abuse [24, 25].

From a legal standpoint, every law, every product of narcotics or psychotropic drugs and also international conventions always contained rehabilitation. The same thing happened when Law No. 5 of 1997 on psychotropic drugs passes. In the law, there are regulations on treatment and rehabilitation stated in regulations (2), chapter 39 and section 50 already (1 and 2) stated observation for medicals to medical rehabilitation centers run by the government or citizens [26]. The same thing is found in Law No. 22 of 1997 on narcotics that contain regulations on rehabilitation which was article 48 section (1, 2) and article 50 that clarifies that social rehabilitation of former people who use drugs are done in social rehabilitation institutions appointed by the Ministry of Social Affairs [27].

Law No. 35 of 2009 on narcotics as a replacement for Law No. 22 of 1997 on narcotics also explicitly states regulations on treatment and rehabilitation. One of the four objectives of narcotics laws on article 4 is the warranty for medical and social rehabilitation for people who use drugs. The obligation to undergo medical and social rehabilitation is also stated in article 54. If article 54 speaks about medical and social rehabilitation, then article 56 section (1 and 2) is about (1) medical rehabilitation for people with drug dependence done in a hospital appointed by the Ministry of Health, (2) medical rehabilitation that can be done by a government institution or citizens after approval from the ministry. Article 58 also contains social rehabilitation (can be run by government or citizens) [28]. The implementation of medical and social rehabilitation are regulated by Ministerial Decree from the Ministry of Health and Ministry of Social Affairs as stated in in article 59.

From Law 35 of 2009, several laws related to medical and social rehabilitation emerged, particularly the ones about medical and social rehabilitation such as Presidential Decree 25 of 2011 on mandatory report for drug dependents and Ministerial of Social Affairs Law No.8 of 2014 on social rehabilitation rules who faces the law inside the institution. Moreover, there is the

Ministry of Social Affairs Regulation No.16 of 2019 on social rehabilitation national standard. Ministry of Health Regulation No. 4 of 2020 on the implementation of the institution that dealt with acknowledgement of recipients who are required to report. As a government institution that covers all CITU in Indonesia, the Ministry of Law and Human Rights also has regulation No.12 of 2017 on rehabilitation programs for inmates and detainees.

Law No. 25 of 2011 refers to article 55 section (3) of Law No. 35 of 2009 on narcotics concerning the underage and adults with drug dependence who are required to report. The law assigned some facilities as the institution that accepts the report which are medical centers, hospitals, and rehabilitation centers appointed by the government [29].

Furthermore, placing people who use drugs in a rehabilitation center during their sentence period is further validated by Supreme Court Circular Letter No. 4 of 2010. Medical and social rehabilitation sentences from the judge to the defendant refers to the evidence from the Supreme Court Circular Letter. Medical and social rehabilitation centers meant in the Circular Letter are the ones managed and supervised by BNN [30]. In 2011, the Supreme Court issued another Circular Letter No. 3 June 2011. The letter informed all heads of high court that guests to the Court and High Court to sentence people who use drugs with medical and social rehabilitation sentences. This can only be done to those who have been convicted in drug-related charges, those who are arrested and proven innocent, and suspects in drug-related charges who are waiting for their sentence, or those who are proven innocent, and suspects who are still in the investigation or prosecution phase. This Circular Letter emphasizes the previous letter about placing people who use drugs in rehabilitation during the judicial period [31].

The Attorney General highlighted the issue of people with drug dependence during and after the judicial period. This problem was solved when the Attorney General issued a Circular Letter No. 22 of 2013 to all attorney generals across Indonesia, signed on 15 February 2013. The main point of the letter is placing people with drug dependence in medical and social rehabilitation centers. The letter also ordered people who use drugs or with drug dependence to rehabilitate themselves outside the prison during the judicial period and propose for a placement in a medical and social rehabilitation center as per regulated by the law [32].

Joint regulation No. 465 year 2014 about placing people who use drugs or with drug dependence in a rehabilitation center signed by 7 heads of rehabilitation centers make the support stronger for people who use drugs and with drug dependence to receive rehabilitation treatments while awaiting trial and after receiving a sentence. The joint regulation states that placement of those who use drugs and with drug dependence in rehabilitation centers are based on laws and ministerial regulations [33].

The existing of the joint regulation from several government bodies coincided with the new era of handling and controlling narcotics in Indonesia even though it still refers to the Law No. 35

of 2009. The war on drugs that have continued to be fought since 2015 gave birth to new ministerial regulations regarding the battle against drugs. The large number of people who use drugs in prison is a problem in the facility due to the fact that the facilities do not accommodate the occupancy. This condition triggers the existence of the Ministry of Law and Human Rights Regulation No. 12 of 2017 on rehabilitation for inmates and prisoners. This regulation eventually became the legal standard for rehabilitation guidelines in 2018.

2.2 Narcotics Rehabilitation Regulation for Inmates

2.2.1 Leadership and Governance

The leadership and governance domain is the supporting pole of the implementation of rehabilitation programs in prisons. Leadership and management involve regulation, strategic policies, and accountability and contains aspects of networking/collaboration, vision, target, principles, directions, monitoring, and evaluation. Rehabilitation service needs a set of regulations, policies, and a management system that allows the operation to run as intended.

a. Principles of Policies

The medical and social rehabilitation program as the first step of treatment and as a way to handle drug dependence is a mandatory for people who use drugs as stated in the Narcotics Law No. 35 year 2009. In terms of preventing and eradicating drug use and stopping illicit drug trafficking, the National Narcotics Board was established with the rehabilitation department. Another task for the BNN is to provide capacity building for drug treatment and rehabilitation programs. One example of their work in rehabilitation is to increase the board's medical and social rehabilitation ability in centers run by the government or non-government organizations. In Law 35/2009 it is stated that the facilitator of a medical rehabilitation can be undertaken in appointed hospitals whereas social rehabilitation can be done in government facilities or communities. The government's rehabilitation institutions have different models such as one stop center, homes, or centers.

Implementation of drug rehabilitation program in CITU is officially regulated in the Ministry of Law and Human Rights Regulation No.12 of 2017 followed by the existence of operational guidelines of program implementation for detainees and inmates. There are four objectives of rehabilitation program for detainees and inmates based on the Ministry of Law and Human Rights' Ministerial Regulation No. 12 of 2017, 1) to provide service and protection to the detainee's/inmate's rights, 2) to heal and maintain the inmate's health condition in biology, psychology, and social away from drug addiction , 3) to increase productivity and life quality of the inmates and detainees, 4) to prepare the detainees/inmates to return to their roles in society [4].

The implementation of drug rehabilitation by CITU is stated in regulation by DGC of the Ministry of Law and Human No. PAS.121.PK.01.07.01 of 2017 on the appointment of the CITU to facilitate rehabilitation for detainees and inmates with drug-related cases. There are 128 CITU as implementers. The CITU consist of 79 prisons, 44 Bapas, 1 hospital (Pengayoman Hospital). Narcotics rehabilitation operational guidelines issued by DGC specifically states that rehabilitations are conducted by operational teams whose members are chosen via decision letters issued by the provincial regional government [12].

b. Networking

A number of policies on narcotics rehabilitation show that the responsibility for the implementation of the program does not fall on one institution only. The polarized authority for program implementation can be traced from Presidential Decree 12/2011 on policy implementation and national strategy to prevent and eradicate illicit drug trafficking year 2011-2015 that instructed the participation of multiple government bodies in bringing the program forward such as the Ministry of Health, the Ministry of Social Affairs, the BNN, the National Police, and a community-based rehabilitation. With this policy, rehabilitation service was executed by the ministries above with the BNN and the community. The authority to build the capacity of a medical and social rehabilitation institution, organize an integrated information management system for people who use drugs, and also data-recording on the condition of medical and social institutions was on the three government institutions. The Presidential Decree showed that no other government institution was involved. This was then followed up with the three institutions issued three separate policies that supported the same program (narcotics rehabilitation). The Ministry of Health issued a Ministerial Regulation 2415/2015 on medical rehabilitation, the Ministry of Social Affairs issued a Ministerial Regulation 26/2012 on standards of social rehabilitation, and the BNN issued the BNN's a Chief's Regulation about standards of rehabilitation service.

In prevention and eradication of drug dependence and illicit drug trafficking program in 2018-2019 that was instructed in the Presidential Decree 6/2018, there were a few adjustments made. BNN acted as the main authority in the rehabilitation program in collaboration with 17 related government institutions. The Ministry of Social Affairs and the Ministry of Health were still an important part of the program from making the regulations, managing the rehabilitation, up to the installment of an integrated rehabilitation information system. Furthermore, the Ministry of Law was also mandated in the making of sustainable regulations and in the making of a nation-wide and integrated rehabilitation information system.

With so many institutions involved in the rehabilitation, a policy is needed to regulate the format of the collaboration of the institutions. First, there is collaboration with the Supreme Court, the Ministry of Health, the Ministry of Social Affairs, the National Police, and the BNN that was

documented in the Joint Regulation on Addicts Management in 2014. The policy emphasizes coordination from related institutions in the healing, recovery, and aftercare of drug treatment and synergized in implementing the rehabilitation program in the investigation level, the trial level, and the scanning level. One of the collaborations that was created with the institutions was the establishment of Integrated Assessment Team (IAT), a team consisting of doctors from the health institution and a legal team from the National Police, the BNN, General Attorney, and Ministry of Law. In the assessment and analysis, the doctor team and the legal team worked side by side. The doctor team was assigned for medical and psychosocial assessment and analysis and gave recommendations for therapy plans and drug rehabilitation programs. The legal team was tasked with an in-depth analysis on illicit drug trafficking and drug precursor with investigators in charge of the cases [3]. The assessment result would be used as a consideration in sentencing.

In the leadership and governance of the rehabilitation in CITU, the BNN collaborated with the DGC. In 2018, a joint decree was issued by the BNN and the DGC in the matter of drug rehabilitation for inmates, detainees, and prison officers. To ensure a successful rehabilitation program in prisons, the BNN was assigned with facilitating the capacity improvement by the rehabilitation operational officers, capacity upgrade, materials and visual tools, providing manpower and accommodation for addiction counselors, and exchanging information and data on narcotics rehabilitation. The DGC officers were assigned with appointing CITU that will be in charge of the rehabilitation, preparing officers to be the addiction counselors and assessment officers, preparing facilities that met the minimum standard, and preparing a rehabilitation information system for inmates and detainees.

2.2.2 Drug Rehabilitation Program

a. Description of the Narcotics Rehabilitation Service

Rehabilitation for people who use drugs has been arranged since Indonesia issued narcotics laws in 1976. The rehabilitation was conducted by rehabilitation institutions appointed with a Presidential Decree [34]. Next, those who use drugs were required to undergo medical and social rehabilitations as instructed by the Narcotics laws amended in 1997 and 2009 [27,28]. As of 1997, medical rehabilitation has been provided in hospitals and is a direct responsibility of the Ministry of Health whereas social rehabilitation is within the authority area of the Ministry of Social Affairs. However, due to a slight change in the new narcotics laws, social rehabilitation is now the responsibility of government institutions and the community who organize it. Article 127 of the Act No. 35 year 2009 emphasizes that every person who uses drugs or anyone who has been proven as people with drug dependence is required by law to undergo medical and social rehabilitation.

Drug rehabilitation programs have also been the responsibility of the BNN as stated in the Government's Decree No. 23 of 2010 that specifies the role of the BNN, which is to increase the ability of medical and social rehabilitation institutions, by government or by citizens [35]. Based on the Presidential Decree No.12 of 2011, the Ministry of Health, the Ministry of Social Affairs, and the BNN are authorized to facilitate rehabilitation of narcotics [36]. The Ministry of Law, the National Police, the Supreme Court, and the Attorney General are then the next to be involved in narcotics rehabilitation based on the Joint Regulation on the Management of Narcotics Addicts and Substance Abuse in Rehabilitation Centers [37].

According to the Ministry of Law and Human Rights Regulation No. 12 of 2017, rehabilitation of narcotics is defined as a series of integrated rehabilitation process that include medical and social rehabilitation for inmates, detainees, and prison officers and post-rehabilitation services for clients in the prison facilities (inmates and officers) for physical and mental recoveries and to help those who use drugs or with drug dependence to heal, and to be productive, and socially functional in the society as they were before [38]. Based on reviews on two BNN's policies, there are two terms of rehabilitation which are continuous rehabilitation and drug addiction rehabilitation. The first term, continuous rehabilitation, refers to the narcotics rehabilitation of members of the society conducted by the BNN. The second term, drug addiction rehabilitation, means a series of efforts that aim at the recovery of people who use drugs that include early admittance, medical and/or social rehabilitation, and post-rehabilitation [39, 40].

Based on the definitions of various policies and regulations, (issued by The Ministry of Law, the BNN, the Ministry of Health, and the Ministry of Social Affairs), drug rehabilitation program consists of three services which are medical rehabilitation, social rehabilitation, and post-rehabilitation. As stated on written policies issued by the four institutions, and as instructed on Indonesia's Regulation No. 22 of 1997 on narcotics and addictive substances, medical rehabilitation refers to a process of an integrated treatment to liberate addicts from a dependency on narcotics. Social rehabilitation is defined as a process of integrated recovery activities (physical, mentally, and social) that help the addicts return to society and resume social responsibilities.

Post-rehabilitation refers to a phase of a social rehabilitation conducted by the BNN as advanced guidance in the form of mentoring, enhancement in skills, and productivity support aimed to maintain sobriety and to build the ability to adapt to different social environments, and to instill independence [41]. Based on the agreement between the BNN and the Ministry of Law in 2018, post-rehabilitation is defined as more detailed as a series of services that are advanced guidance in mentoring, enhancement of skills, and productivity support given to former addicts in their medical and/or social rehabilitation so they are able to maintain their sobriety and adapt independently in their social environment [42].

Providing inmates and detainees with rehabilitation programs began in 2015 where 62 prisons were mandated to run a narcotics rehabilitation (social rehabilitation) based on a Circular Letter issued by the Ministry of Law and Human Rights. Stated in the letter that the Ministry of Law and Human Rights cooperated with the BNN to support the government's program, "rehabilitation for 100.000 people who use drugs". The letter explained the rehabilitation mechanics for inmates and was the guideline in the implementation that was completed in 3 months (12 weeks) at the time [43].

Drug rehabilitation programs for detainees and inmates were then regulated by the Ministry of Law and Human Right Regulation No. 12 of 2017 and in the same year the DGC appointed 128 CITU (prisons and Bapas) to provide drug rehabilitation programs. Seventy-two prisons were appointed to implement social rehabilitation, five were appointed to give medical rehabilitation, seven were appointed to implement both medical and social rehabilitation, and 44 Bapas were tasked with giving post-rehabilitation services [44]. In 2018, the decree No. PAS-985.PK.01.06.04 of 2018 was issued by DGC of the Ministry of Law and Human Rights about the guidelines in the execution of narcotics rehabilitation for detainees and inmates that was to be conducted within a period of six months [45].

b. The Target and Flow of Narcotics Rehabilitation Program

People who use drugs are the targets of the drug rehabilitation program as stated in the regulations. Based on the operational guidelines of the rehabilitation, the targets of the program (medical rehabilitation, social rehabilitation, and post-rehabilitation) are detainees and inmates who use drugs or with drug dependence.

Before the operational guidelines were issued in 2018, the flow of narcotics rehabilitation in detention centers and prisons were regulated by a regulation issued by the Ministry of Law and Human Rights in 2015. Drug rehabilitation program was done within 12 weeks (3 months) in three steps: 1) physical and psychological evaluation for two weeks, 2) social rehabilitation for eight weeks, and 3) preparations for the post-rehabilitation for two weeks. Inmates who will participate in the program will be selected through assessment. Inmates who are eligible for the program are those who: 1) have 3-6 months remaining in their prison time or in the process of applying for a parole, on a parole prior to their release, or in a process of an early release; 2) selected based on article 127 and/or related to Law No. 35 of 2009 on narcotics, or are officially diagnosed as drug users in the assessment.

Referring to the operational guidelines, there are four steps in the rehabilitation process that participants must follow. They are preliminary briefing, screening, narcotics rehabilitating assessment, and rehabilitation (medical, social, and post-rehabilitation) [5]. Preliminary briefing

is given in the process of induction to the prison environment that includes educating participants on the negative effects of drugs, introduction to the available health services and rehabilitation, and educating participants about the illnesses caused by drug dependence. The next step is screening which is meant to identify the substance used and the risks of substance abuse [5].

Participants with screening results that show “low” risks will be educated on the negative impact and risks of drug dependence, “moderate” risks will be given addiction counselling , and “high” screening results will be transferred to the next assessment by the assessor team [5]. Assessment is an evaluation to identify the client’s condition caused by the drug use in terms of medical and social aspects [7]. Rehabilitation screening results will be used as the reference for the rehabilitation services consisting of medical rehabilitation, social rehabilitation, and post-rehabilitation [5]. The steps of the drug rehabilitation program of BNN and the Ministry of Law and Human Rights are nearly similar.

The flow on drug rehabilitation program in the BNN consists of admittance, rehabilitation, and post-rehabilitation. Admittance includes observation and assessment using a comprehensive instrument and a medical screening when deemed necessary. The types of rehabilitation are medical rehabilitation, social rehabilitation, and post-rehabilitation. The rehabilitation process includes assessment, planning of the rehabilitation program and the inpatient/outpatient program. Assessment is done in the admittance process and also during and after the rehabilitation program. Meanwhile, post-rehabilitation is done after completing medical and/or social rehabilitation that is proven with a treatment result statement letter and a certificate stating the completion of the rehabilitation program [46].

c. Narcotics Rehabilitation Program

This policy review shows that there are effective methods that can be used in the rehabilitation program (medical rehabilitation, social rehabilitation, and post-rehabilitation).

c.1 Medical Rehabilitation Method

Medical rehabilitation defined in several policy documents is given as an urgent treatment for narcotics-related conditions, detoxification, and symptomatic therapy, comorbidity therapy, methadone therapy, or non-methadone therapy. Detoxification and methadone therapy are explained in great detail in the Ministry of Health’s policy. Detoxification is defined as a medical intervention process aimed to help people with drug dependence overcome withdrawal symptoms and the body’s dependency on the substance caused by the sudden cut-off in drug use. Methadone therapy is a long-term treatment (at least six months) for client who are dependent on opiate by substituting to agonist synthetic opioid (methadone) or a partial agonist opioid

(buprenorphine) administered orally or sublingually by trained doctors as outlined in the national guidelines [48, 51].

The BNN added that medical rehabilitation services also must have psychosocial intervention services (counselling, motivational interviewing, behavioral and cognitive therapy, and prevention to relapse), urine test, and periodical evaluation. Facilities used in a medical rehabilitation include hospitals, public health centers, specific rehabilitation centers for medical rehabilitation [28]. Also required are absolute medical rehabilitation available in detention centers/prisons/hospitals, assistance that include symptomatic therapy, psychosocial intervention, and supporting medical rehabilitation services such as methadone therapy, accompanying condition or medical complication therapy, psychiatric comorbidity therapy, and drug-related emergency treatment. However, medical rehabilitation services can only be provided by CITU where the clinics have official operational permit [5].

c.2 Social Rehabilitation Method

Policy analysis results show that CITU (prisons/detention centers/Bapas) conduct social rehabilitation programs more than medical rehabilitation programs [19]. There are three methods of social rehabilitation: TC, *Criminon*, and brief intervention [5]. TC is the most frequently used social rehabilitation by the Ministry of Social Affairs, the BNN, and the Ministry of Law and Human Rights. This method can be modified based on the patients' needs. One reason why this method is highly used is that it has been proven to be effective and it has successfully helped people who use drugs endure their treatment, particularly those who take part in the program from beginning to end [48].

Social rehabilitation programs provided by the BNN consist of the minimum service and the optional service. Minimum service includes assessment, motivational and psychosocial diagnosis, and psychosocial intervention. The optional service is divided into treatment and foster care for underage clients, vocational training and entrepreneurship mentoring, mental and spiritual guidance, religious guidance, resocialization guidance, periodic substance use monitoring, and referrals [17].

Based on the guidelines to drug rehabilitation programs by the Ministry of Law and Human Rights, an absolute social rehabilitation method is available in prisons and youth detention centers as prison-based TC and brief intervention. TC is modified by considering the needs of the inmates within the duration of six months. TC consists of physical and psychological evaluation for two weeks, a core program consisting of three phases (younger, middle, older) for 19 weeks that focuses on behavioral change, and preparation for the post-rehabilitation phase lasting for three weeks. Psychosocial intervention can also be given in the core program. The brief intervention method is a series of principally different interventions but it still uses conventional therapy. The duration for this is approximately 15 minutes (5 minutes – 1 hour) per session. The materials for

the brief intervention consist of eight themes (basic education, drug education, nutrition, hygiene, personal safety, trauma coping skill, communication skill, and art therapy) given for 45 days and repeated in forty-sixth meeting [5].

c.3 Post-Rehabilitation

Social and medical rehabilitation program in CITU (detention centers/prisons/youth detention centers/hospitals) is followed by post-rehabilitation in Bapas so that clients are sober, productive, and socially functional. The post-rehabilitation services in Bapas are provided according to the center's role as the CITU that conducts research, guiding, mentoring and supervising, coordinating, and providing post-rehabilitation services as a continuous rehabilitation process which also serves as the last interactive service for the clients on the last phase [11]. Post-rehabilitation service is given as group meetings, self-development seminars, family group support, or professional service facilities [5].

Technically, post-rehabilitation services are given in Bapas [5]. However, participants who live far from Bapas can enroll in the program at a group home belonging to the provincial office of the BNN under the supervision of Bapas' Community Guides. The BNN has three post-rehabilitation services, which are the intensive post-rehabilitation service (inpatient), regular post-rehabilitation service (outpatient), and advanced rehabilitation service. In the advanced rehabilitation phase, the clients are back in the society fully functional in their own social roles with a series of continuous supervision and guidance in the advanced guiding service [22].

d. Facilities

From the operational guidelines of program rehabilitation, the medical rehabilitation program needs an examination room, a counselling/ psychosocial intervention room, and medical Standard Operating Procedure for medical rehabilitation service. Social rehabilitation program needs: 1) special block for rehabilitation participants; 2) administration room; 3) clinic; 4) multifunction room; 5) vocational room; 6) recreational room; 5) praying room; 6) kitchen. Bapas also needs a room for post-rehab service [5]. Facilities needed for narcotics rehabilitation conducted by the BNN and the Ministry of Social Affairs are specified in more details than the necessities for narcotics rehabilitation in CITU as written in BNN Regulation No. 24 year 2017 and a Ministerial Regulation No. 9 of 2017 [17,49].

Facilities that must be available for social rehabilitation are: (a) office area consisting of managerial room, staff room, meeting room, living room, documentation room, data and information room, library, bathroom, kitchen, (b) technical service room consisting of dormitory, facilitator room, diagnostic room, psychosocial counselling room, observation room, production installation room, exercise and physical guidance room, mental and social guidance room, craft room, and art room; (c) public service area consisting of dining room, study room, praying room,

health room, hall, security post, living room, storage room, bathroom, parking lot, and facilitator's room; (d) social rehabilitation equipment consisting of office support room, communication device, lighting, clean water and water installation, supporting equipment for participants, technical support equipment, (e) transportation consisting of office transportation and participant transportation, and (f) clothing and food for participants.

The BNN divides necessities based on the type of rehabilitation. Medical rehabilitation requires basic medical devices (stethoscope, blood pressure meter, thermometer, scale, first aid kit), non-medical equipment (chair, examination table, clipboard, key) stationery, examination and counseling room, and urine sample room. There are also other facilities such as advanced medical devices (EKG, resuscitation device, minor surgeries kit, and sterilizer, patient's room, detoxification room, overnight stay room, detoxification room and/or isolation ward, vocational room, sports facilities, praying room, office, pantry, vehicle. Social rehabilitation needs minimal necessities, which are examination/assessment/ counseling room, office, (chair and exam table, cupboard with keys), and stationery. Advanced facilities such as dormitory, isolation ward, counselor room, isolation room, and an examination table, a cupboard with keys to record rehab sessions, stationery, and computer), advanced facilities such as dormitory, client's bedroom, isolation room, counselor room, common room, dining room, praying room, operational vehicle. Post-rehab services are done at the BNN provincial office facilities consisting of administration room, counseling room. For intensive post-rehab sessions, counseling is done in a program home consisting of an administration or in a counseling room. For intensive post-rehab sessions, the sessions are done in a group home consisting of a bedroom, bathroom, kitchen, and filing cabinet.

e. Target and Accomplishment

The decree of DGC of the Ministry of Law and Human Rights, as stated in No. PAS.121.PK.01.07.01 of 2017 shows that every CITU (prisons, detention centers and Bapas) are given a target to provide narcotics rehabilitation programs (medical, social, post-rehabilitation) to at least 30 persons. The national target for rehabilitation programs in 2018-2019 stated in the operational guidelines are as follows: 6.000 inmates/detainees, with the following composition: 1) medical rehabilitation: 250 participants; 2) social rehabilitation: 3.750 participants; 3) post-rehabilitation: 2.000 participants. Every year, 30 inmates who become participants are expected to join the rehabilitation program (10 for medical rehabilitation, 10 for social rehabilitation, and 10 for post-rehabilitation).

2.2.3 Management of Human Resources

Proportions and competencies of health workers in implementing drug rehabilitation programs are already included in the policy documents of the four rehabilitation implementing agencies, namely Ministry of Social Affairs, Ministry of Health, BNN and Ministry of Law and Human Rights [4, 16, 17, 19]. Narcotics rehabilitation policy patron in prisons currently refers to Regulation of Ministry of Law and Human Rights No. 12 of 2017 concerning the implementation of narcotics rehabilitation services for inmates. But in 2015, there was a circular about the mechanism of implementing rehabilitation for prisoners who use drugs in prisons and detention centers. This circular is used as a reference for the implementation of rehabilitation prior to the existence of operational guidelines. The implementation of rehabilitation in detention centers is carried out by *Pokja* (Working Group) consisting of program managers, counselors / assistants of counselors, medical / paramedical officers, psychology officers / social workers, security officers, and administrative officers.

In the Regulation of Ministry of Law and Human Rights No.12 of 2017, the need for human resources in the rehabilitation implementation in prisons is adjusted to the stages of narcotic rehabilitation which are divided into four stages, namely preliminary information, screening, narcotics rehabilitation assessment, and provision of rehabilitation services (medical rehabilitation, social rehabilitation and post-rehabilitation) [4]. Health personnel or workers are required in the initial information socialization related to any adverse effects of drugs, introduction of health services and available narcotic rehabilitation and comorbidity of drug dependence. ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test) screening process version 3.1 is carried out by trained doctors, nurses or trained prison officers. The following stage is rehabilitation assessment conducted by doctors or psychologists, corrector representation and corrector counselors who have received training.

Availability of doctor / psychologist plays a central role in rehabilitation assessment since it includes establishment of diagnoses, assessment of medical problems and preparation of therapeutic plans. Similar to Regulation of Ministry of Law and Human Rights No. 2415 of 2011 on Medical Rehabilitation, composition of the assessment team consists of psychiatrist, forensic specialists, doctors and psychologists from medical rehabilitation facilities or skilled health workers trained in the field of drug impairment. Roles and responsibilities of health workers, namely doctors, nurses, psychologists, addiction counselors continue to provide medical and social rehabilitation services to the post-rehabilitation stage [16].

The role of involvement in the implementation of narcotics rehabilitation programs is more directed to health workers, such as doctors, psychologists, and nurses. It can be seen in Regulation of Ministry of Law and Human Rights No. 12 of 2017 that health workers, especially doctors and nurses are required at every stage of rehabilitation, ranging from screening

implementation, medical rehabilitation services, social rehabilitation services to post-rehabilitation. Health workers serve a central role since drug rehabilitation programs are included in the healthcare division in prisons. If referring to the implementation instructions for the rehabilitation of narcotics for inmates, the tasks that must be carried out by health workers include narcotics assessment and are responsible for carrying out medical rehabilitation. Whereas in social rehabilitation services, addiction-skilled doctors and nurses act as special service officers who have responsibility for scheduling health services and rehabilitation services, recording and reporting health progress of rehabilitation participants and also joining health seminar activities [4].

In the implementation of social rehabilitation in prisons, health workers are assisted by prison officer representatives who have joined rehabilitation training and are appointed as program managers / instructors. Also, involvement of social workers, clergymen enables them to carry out activities in social rehabilitation. Implementer composition of social rehabilitation in Regulation of Minister of Social No. 9 of 2017 concerning National Standard for Social Rehabilitation for Addicts and Victims of Abuse of Narcotics, Psychotropic and Other Addictive Substances, is also slightly different, namely consisting of social workers, social welfare workers or volunteers, addiction counselors, nurses and additional support staff such as psychologists, skill instructors and clergyman [19].

In the framework of the 100,000 resident rehabilitation program, rehabilitation officers are required to have joined an internship at BNN for two months or training in the field of drug impairment, such as narcotics assessment training and rehabilitation training. These requirements are needed to build any necessary competencies in achieving successful implementation of rehabilitation programs. In the attachment to BNN Regulation No. 24 of 2017 concerning Rehabilitation Service Standards for Narcotics Addicts and Narcotics Abuse Victims, it is listed the necessary competencies to be owned by officers in rehabilitation services consisting of general competencies, special competencies of doctors and health workers, and special competencies for social and behavioral sciences. General competence consists of: a) basic knowledge of substance use and prevention of substance use and prevention of recurrence, b) assessment skills and therapeutic / intervention plans, c) basic counseling skills and psychosocial interventions, d) case management skills, e) educational skills for client families, f) basic knowledge of legal aspects related to narcotics. Whereas specific competencies for doctors and health workers are: a) detoxification management skills, b) narcotics emergency management skills, physical comorbidity and psychiatric management skills, d) pregnancy care skills for female clients, e) management skills of Methadone and / or Buprenorphin Maintenance Therapy Program. Finally, specific competencies for social and behavioral sciences include: a) vocational governance and entrepreneurship development skills, b) mental, physical and spiritual guidance

skills, c) care and parenting skills for child clients, d) re-socialization guidance skills, e) crisis management skills, and f) supervision and monitoring skills.

2.2.4 Financing

The joint regulation on handling people who use drugs into rehabilitation institutions in 2014 shows that rehabilitation costs are sourced from each of the organizing institutions that are obtained from APBN funds. Medical rehabilitation costs for defendants who have been decided by the court are charged to the Ministry of Health's budget, social rehabilitation costs are charged to the Ministry of Social Affairs' budget, medical rehabilitation costs and / or social rehabilitation for a people who use drugs who are still in the judicial process are charged on the BNN's budget [4]. Aside from the State Budget, the source of social rehabilitation financing from the Ministry of Social Affairs can come from community contributions referring to Regulation of Ministry of Social Affairs No.9 of 2017 while sources of funding for rehabilitation organized by BNN can be obtained from private parties / NGOs with the scheme of *Public-Private Partnership* referring to BNN Regulation No. 4 of 2018.

In the context of the prison, the implementation of the drug rehabilitation program was newly started in 2015. In the period of 2015-2017, drug rehabilitation was managed by BNN, so the source of funding for rehabilitation in prison was from BNN's Budget Implementation List (DIPA). The existing of Regulation of the Ministry of Law and Human Rights no 12 of 2017 is an expansion of governance in the implementation of rehabilitation services in prison. Since it was managed by the Ministry of Law and Human Rights in 2018, the source of funding was from the Ministry of Law and Human Rights' DIPA. According to the standard costs for drug rehabilitation output at the CITU' listed in the 2018 Drug Rehabilitation Guideline, the budget allocation for 30 prisoner-care services is 73,880,000 IDR. If the budget allocation per inmate is calculated, it is only 2,462,667 IDR during 6-month rehabilitation.

2.2.5 Management of Drugs and Logistics

Policy / regulatory documents discuss only a few issues on necessary medicines and logistics for implementing rehabilitation. It is not yet found any policies that regulate the procurement of medicines in the context of medical rehabilitation. The availability of other logistics such as urine test kits (UT kits) is provided by each CITU organizer through APBN funding (DIPA). Based on the standard costs for drug rehabilitation at the CITU attached to the 2018 operational guidelines, it is known that UT kits are available for medical rehabilitation (20 for screening, 10 for follow-up assessment, and 10 for final assessment), social rehabilitation (20 for screening, 10 for follow-up assessment, and 10 for final assessment), and post-rehabilitation (10 for final assessment). In addition, there are instruments used in the rehabilitation program consisting of

ASSIST at the screening stage, ASI for initial and final assessments, therapeutic plan forms, reports development, and correctional research form [11].

2.2.6 Management of Health Information System

The Regulation of Ministry of Law and Human Right specifically mentions the information system of drug rehabilitation organized by CITU (prisons or guard hospitals). The Head of the CITU (detention center, prisons, juvenile detention centre/LPKA and hospital) must report on the drug rehabilitation process that is carried out by the CITU in stages and regularly [4]. Head of Prison, Head of Detention Center, Head of Bapas, Head of LPKA and hospital must give reports on the rehabilitation process to the DGC in stages. The report must contain the implementation of drug rehabilitation, targets and achievement of drug rehabilitation services, availability of supporting facilities and infrastructure, human resources, budget sources and realizations, constraints and efforts to overcome the obstacles [4].

The operational guidelines of drug rehabilitation for detainees and inmates describe specifically the specific reporting forms in 12B, 12C, 12E forms, and client service forms used in documenting the implementation of drug rehabilitation in prison. Reporting from the CITU is carried out regularly once in a month to the Regional Office at the provincial level.

Meanwhile, the management of monitoring and evaluation activities as a form of strategic information management is carried out by each CITU and / or is carried out jointly with other agencies that collaborate with the organizing agency. The Ministry of Law and Human Rights through the DGC monitors and evaluates three indicators, namely 1) implementation of drug rehabilitation, 2) targets and achievements of narcotic rehabilitation, and 3) effectiveness of drug rehabilitation [4]. Monitoring of the implementation of drug rehabilitation services at the prison is carried out in stages by DGC at Regional Office and from Regional Office to the CITU [10].

2.3 Implementation of Drug Rehabilitation Regulation

2.3.1 Implementation of Narcotic Rehabilitation

Based on the Regulation of Ministry of Law and Human Rights No. 12 of 2017, the rehabilitation program for inmates with drug dependence issues are basically using therapeutic modalities, namely residential / inpatient therapy using TC method. The implementation of drug rehabilitation programs for inmates is also integrated with HIV/AIDS prevention programs. In addition to using the TC method, therapy and rehabilitation of narcotics dependence in prisons and detention centers have also used detoxification and withdrawal therapy, emergency therapy, and outpatient therapy, relapse prevention therapy and post-treatment therapy. However, various therapeutic modalities have been integrated into the TC method currently.

The implementation of drug rehabilitation was developed initially to be aimed at expanding access and increasing coverage of medical rehabilitation and social rehabilitation programs. For this reason, the DGC decided to take strategic steps, including prison setting for social rehabilitation based on proposals from regional offices, and changing inmates criteria for participants in social rehabilitation programs in prison, not only those from criminal articles 127, but as well as other general criminal articles that meet the criteria for addicts based on the results of medical assessments. In addition, there was also a synchronization of rehabilitation services in Bapas with post-rehabilitation services by the Head of Institution. DGC also cooperates with the Ministry of Social Affairs to reach any prison that do not obtain BNN supports, and propose funds for Medical and Social Rehabilitation Therapy activities for people with drug dependence through DIPA on 43 prisons, as well as periodically monitor their implementation There is also a coordination with the Ministry of Health in the context of proposing prisons that can carry out medical rehabilitation services as a Report Obligatory Recipient Institution (IPWL).

In prior, the implementation of drug rehabilitation services still relies greatly on technical support and funding from BNN. Only a few prisons (mainly narcotics prisons) have independent narcotics rehabilitation activities, but the amount is indeed not as large as funding support from the BNN. In early 2017, BNN stopped technical support and funding in early 2017 therefore most prisons were unable to implement such activities. In 2018, out of 128 CITU appointed as rehabilitation implementers, only 33 UPT Pas had a budget for DIPA. Nevertheless, rehabilitation services must still be implemented at prison in accordance with their existing capabilities. CITU is expected to collaborate with relevant agencies, namely BNNP / BNNK, social services, health offices and NGOs.

The TC method implemented based on the Regulation of Ministry of Law and Human Rights No, 12 of 2017 and it has a service which all participants go through the screening process, if the participant has a low risk then there will be a brief intervention. Whereas for participants with moderate and high risks will be assessed. After the assessment, it will be determined whether the participant needs to receive medical rehabilitation or social rehabilitation. If the participant must receive medical rehabilitation, the maintenance therapy will be carried out. In addition to maintenance therapy, participants will also be examined for comorbidity, such as physical ailments (HIV-AIDS, TB) or psychological / mental disorders, if they have mental disorders, participants will obtain a referral. In addition, participants can also show symptomatic therapy as a part of medical rehabilitation. If the participant is stable, the participant can get symptomatic therapy or social rehabilitation. After participating in social rehabilitation, participants will continue with post-rehabilitation.

The implementation of drug rehabilitation programs usually is initiated by socialization and provision of a number of information related to narcotic dependence in the form of communication,

information and education (KIE). The KIE socialization was only held in 2019. Data showed that out of 12 prisons visited by DGC, there were only 9 prisons implementing the KIE socialization before screening process to be participants in drug rehabilitation.

Urine test kits and special blocks for drug rehabilitation participants are the facilities and infrastructure needed for the rehabilitation program. Urine tests are used for screening and rehabilitation assessments for narcotics dependency. Therefore, urine tests are required in sufficient quantities for each month. Procurement of narcotics urine tests is carried out by the DGC. The distribution of urine test (UT) kits to CITU was last carried out in 2017 by DGC. Based on the monthly report on the Condition of Facilities and Infrastructure of Health Care and Rehabilitation, there were only 2 CITU always having sufficient urine test stocks. Other CITU faced unavailability of UT kits.

Another aspect of service provision that can show how far the implementation of the drug rehabilitation regulation is the reporting aspect. Normatively, the reporting for monitoring and evaluation of drug rehabilitation in prison/ detention centers consists of several sources of data in stages. The data sources used in 2016 and 2017 were taken from: CITU monthly report, DGC's archives, monitoring data (*Bintorwasdal*), and Correctional Database System (SDP). Slightly different, in 2018 and 2019, the data were taken from: Correctional Performance Report (LKP), DGC's archives, extracts of Monitoring and Evaluation instruments, data from verification results of Regional Office B06 and B09 performance target data and SDP data. SDP provides data on the number of prisons and detention centers, as well as the number of narcotics cases. While the reports provided by the officers are composed of several types of forms.

The forms that were consistently mentioned in the 2016-2019 monitoring and evaluation report were 12C Form (Monthly Report on Drug Dependency Rehabilitation Services) and 12E Form (Monthly Report on the Condition of Facilities and Infrastructure of Special Health Care Services and Rehabilitation Activities). But, there were also forms that were only mentioned in certain years, including: 12D Form (Monthly Report of CITU Data that Implements Drug Rehabilitation) in the 2016 report; *Bintorwasdal* report (Guidance, Monitoring, Supervision and Control) in 2017; *Watkesrehab* 12B Form (Semester Report on the State of Officers and the needs of Health Service Officers and Narcotics Dependency Rehabilitation) in the 2019 report. On the other hand, problems related to the low level of recording and consistent reporting were presented and reported in 2016-2019.

In 2017, out of the measured 9 prisons and detention centers, no one managed to achieve the recording and reporting target score. The highest score achieved by one detention center had a score of 9 out of 15. Then in 2018, out of the 128 CITU appointed as implementing rehabilitation of narcotics, only 81 (or 63%) CITU reported their activities. Then for reporting at the regional level, there were 26 regions whose reporting is below 60%, and the national average report

fulfillment was only 36%. Turning to the 2019 data, out of the 32 regions assessed for the reporting system, only 7 regions reported reporting rates in the range of 75% to 100%.

It is illustrated that the majority of prisons and detention centers have not sent monthly rehabilitation reports in a timely and appropriate format. DGC itself stated in the monitoring and evaluation reports in 2016, 2017 and 2019, that there were two possible causes. The first possibility was due to complexity of the report form format. Secondly, it was caused by ineffectiveness of socialization when there was any revision of the forms, and ineffectiveness of tiered monitoring from the center to CITU.

2.3.2 Performance of the Drug Rehabilitation Program

a. Coverage and Accessibility

Each year, it is recorded the number of targets and coverage of the CITU which implement the drugs rehabilitation program. Based on the Performance Agreement of DGC in 2016, the performance indicator for Directorate General of Health Care and Rehabilitation in 2016 was the number of CITU operating special health care and rehabilitation. Determined target in 2016 was for 15 CITU. This target was met by the existence of 60 UPT Pas implementing social rehabilitation. Meanwhile, the target of prisoners taking rehabilitation was 5.450 participants. However, in 2017, there was a decrease in the number of inmates taking the medical and social rehabilitation into 2563 participants. Meanwhile, the number of CITU having operational cost of drug rehabilitation program was 29 CITU; this number also decreased from 2016. This situation happened because the operational fund of drug rehabilitation programs in prison supported by BNN was stopped in 2017, so most of the prisons have no budget to implement the rehabilitation program.

In 2018, there was also an increase on the number of inmates taking rehabilitation. There were 154 participants of medical rehabilitation, 2.270 social rehabilitation and 311 participants of post-rehabilitation, totally there were 2.735 participants taking the rehabilitation. Out of 128 appointed CITU, there were only 81 CITU reporting their activities, while there were 27 CITU taking screening process, 46 CITU taking assessment and 63 CITU implementing rehabilitation. Such numbers increased again in 2019 with 6.171 rehabilitation participants.

The DGC cooperates with several agencies to improve the ability to carry out drug rehabilitation programs in prisons and detention centers. Since 2015, BNN has assisted in training activities for prison officers. In 2016, there were 67 CITU in collaboration with BNN, in the form of socialization of rehabilitation programs, assessment training, assistance of addiction counselors, as well as organizing social rehabilitation services for inmates.

The coverage and accessibility of services in drug rehabilitation for inmates also seem to be related to unfavorable financing policies. In 2016, the total planned DIPA CITU budget was 426,476,000.- IDR, with an absorption rate of 70% (300,406,960.- IDR). Whereas in 2017, the total planned DIPA CITU budget was 954,180,000.- IDR, with an absorption rate of 75.7% (722,140,630.- IDR). In 2018, there is no data of the total budget and its absorption, but it turned out that the main problem in the rehabilitation process in 2018 is the absence of a drug rehabilitation budget at the CITU as implementers of the drug rehabilitation program. In prisons with low rehabilitation participants, it is found that the available budget is insufficient to meet rehabilitation targets.

In 2019, the total drug rehabilitation budget available in the CITU was 2,507,681,000 IDR. There were 84 of the 128 appointed CITU as implementing drug rehabilitation services have a rehabilitation budget in the DIPA. Out of the 84 CITU, only 40 CITU have budgets that are in accordance with the Standard Costs for Medical Rehabilitation, Social Rehabilitation, Post Rehabilitation. This number increased from 2018 which only 33 CITU had rehabilitation budgets. Even though some of the CITU implementing rehabilitation have allocated narcotics rehabilitation budgets, the available budget is still below the determined targets.

b. Quality and Sustainability

Overall, the quality of service can be seen from the compliance of the implementation of various documents that have been established for the implementation of drug rehabilitation in prison. Monitoring and evaluation used to determine compliance of rehabilitation officers by monthly report. The monitoring and evaluation of drug rehabilitation programs has been carried out since 2016-2019. There are three forms of monitoring and evaluation activities carried out, namely: first, from the results of monthly report recapitulation and the visit of DGC to CITU for drug rehabilitation. The monthly reports referred to are 12C Form and 12E Form, which also function as a medium for recording and reporting the implementation of CITU drug rehabilitation program. Considering the lack of recording and reporting from CITU, it also leads to less monitoring and evaluation activity. The second is the visit of the representatives of the DGC and the Directorate of Care and Health to the Regional Office and CITU which implement drug rehabilitation. Then the third is monitoring budget absorption by Personnel Management Information System (SIMKA) application.

In the 2017 Monitoring and Evaluation Report, there were only nine prisons or detention centers visited. The assessment used the Bintorwasdal instrument which was actually intended for CITU implementing medical rehabilitation. However, out of the nine selected locations, there was only one prison that carried out medical rehabilitation, this also led to less valid monitoring and evaluation assessment. It can be seen from the results showing that only one prison could

successfully reach a score of 15 (target score) in three of the five aspects. Then in 2018, the monitoring and evaluation assessment in 23 regions used a percentage of 0-100%, while the number of CITU visited was 17 CITU. From the results of monitoring and evaluation to 23 regions, it was grouped into three categories, namely: green indicates the top 10 rankings, yellow indicates 13 middle ranks, and red indicates the 10 lowest ranks.

In terms of the assessed aspects during monitoring and evaluation, there are differences in mentioning aspects in the report from year to year:

- In 2016: institutional governance (human resources, organization, governance), coordination and synchronization, infrastructure and services;
- In 2017: human resources, facilities and infrastructure as well as the process of implementing drug rehabilitation services, even though they are budgeting, preparation and reporting elements. The number of *Bintorwarsdal* and quality of human resources, conditions of facilities and infrastructure, budget availability, service processes, reporting, and the achieved outputs;
- In 2018: process of counseling, screening and assessment, coordination with security officers and recording data;
- In 2019: HR, budget, facilities and infrastructure (urine tests and special blocks), service processes (screening and assessment), output (or budget), and reporting.

The explanation above shows the use of different aspects of monitoring and evaluation in the past four years, it also can be seen inconsistent indicators used to measure the achievement of monitoring and evaluation year to year. Some use the percentage of 0-100%, others use the score 0-15. ; b) there were only a few prisons, detention centers and regional offices visited by representatives of the DGC; c) differences in writing conclusions (Monev Reports in 2017 and 2018 presenting conclusions based on UPT Pas or region, while the Monev Reports in 2016 and 2020 presenting Monev results per aspect).

Aspects that also determine the quality of service are compliance with assessment and screening instruments and used application of inclusion criteria. Increasingly compliant to use the assessment including applying specified inclusion criteria will determine the accuracy of will-be-rehabilitated participants. Results of the Monev showed that discussions on the use of assessment and screening instruments were only available in 2018 and 2019 data. In 2018, it was reported that from eight regional offices assessed, only four had achieved the target score in the aspects of screening and assessment. In 2019, related to the use of forms as a measurement and screening tool, it is reported more specifically based on 3 categories of assessment. Totally, there were 12 reported prisons, and the following are the results:

- Use of *informed consent* to prisoners before implementing the rehabilitation: 8 prisons achieve target scores
- Use of screening form: 10 prisons achieve target score
- Use of assessment form: 9 prisons achieve target score

Another aspect that can determine the quality and sustainability of drug rehabilitation programs is availability and competence of prison officers carrying out their duties and responsibilities. In 2015, there were 480 officers who had joined training from BNN. In 2016, it was recorded that 46 officers joined training as assessors and 474 joined social rehabilitation training. This training was given by BNN in 2015. There were also 69 officers who joined methadone training. However, it is not known whether the officers who joined training were the same people who joined training from BNN. There were also problems related to human resources in 2016. The arising problem was the unfulfilled need for doctors, nurses, trained addiction counselors in prison and detention centers who carry out medical and social rehabilitation services as well as trained instructors and addiction counselors in Bapas who have been appointed as implementers of post-rehabilitation services.

If referring to the operational guideline of drug rehabilitation for inmates, medical rehabilitation programs are carried out by doctors, nurses and addiction counselors. Social rehabilitation programs are carried out by program managers, health workers (doctors or nurses), and addiction counselors. In 2019, based on the results of monitoring at the central level through the Personnel Information System (SIMPEG), data on the number of trained officers in prisons showed 45 apprentices, 252 instructors, 30 addiction counselors, 5 assessment officers. This number has decreased because officers who have joined training from BNN have been transferred or no longer work in prison. It can be seen that there were several prisons that have collaborated with other agencies. It is known that in 2019, 32 CITU collaborated with BNN, 16 CITU cooperated with NGOs, and 35 CITU collaborated with other organizations (Ministry of Health, Health Office, Hospitals, Ministry of Religion, Islamic Boarding Schools, Rehab Centers, Social Affairs, Universities), but it is unknown whether the collaboration also includes support of human resources from related institutions. This data also shows that CITU implementing drug rehabilitation still lacks assessment staff and addiction counselors.

The quality and sustainability of services also depends on the facilities and infrastructure that can be provided by prisons / detention centers to carry out drug rehabilitation. In the guidelines, it is stated that rehabilitation participants should be placed in a separate block from other residents. This is done in order to prevent rehabilitation participants' interactions with other inmates, which might motivate rehabilitation participants not to use narcotics and follow rehabilitation until completion. Based on monthly report data on the Conditions of Facilities and

Infrastructure of Health Care and Rehabilitation, there are only 40 CITU that have special blocks for narcotics rehabilitation participants.

In general, detention centers and prisons have difficulty in providing special blocks for rehabilitation participants because the number of inmates has exceeded capacity. By an average of 30 rehabilitation participants per detention / prison, so far, there has been very inefficient provision of special blocks for inmates in general. Therefore, the quality of the results is often not as expected. Other facilities and infrastructure that also influence the quality of rehabilitation results are limited UT kits stock, unavailability of special rehabilitation blocks and post rehabilitation services. These problems have actually been found since 2016 to 2019. Specifically, in 2019, there were specific reports regarding urine test stocks. Monthly Report on the Condition of Health Care Facilities and Infrastructure and Rehabilitation (*Watkesrehab* 12B form) from January to September 2019 showed that only two CITU always had sufficient urine test stock. It was stated that the last shipment of urine tests was in 2017. Other CITU faced a vacancy in the urine test stocks. It was possibly caused by the last delivery in 2017. Whilst the urine test stock is only sufficient for ± 3.5 months.

There have been efforts to improve the quality of drug rehabilitation and at the same time be able to support the sustainability of services in the future through the development of cooperation with other institutions beyond prison or detention centers. In 2018, it was noted that the DGC urged the heads of regional offices to collaborate with BNNP / BNNK, social services, health offices and NGOs in the context of optimizing drug rehabilitation services at CITU. The results of the Monev also showed that assistance from partners or third parties led to high achievement of targets for implementing narcotics rehabilitation, although there was still insufficient internal budget. It was recorded 5 CITU in collaboration with BNN, 9 UPTs with NGOs, and 5 with other organizations so totally, there were 19 CITU. In 2019, there were 84 CITU, with details: 32 CITU collaborated with BNN, 16 with NGOs, and 36 with other organizations.

CHAPTER III. DISCUSSION

Indonesia already has sufficient policies to support the implementation of drug rehabilitation. Various laws in Indonesia related to drugs always regulated provisions regarding rehabilitation. In other words, the rehabilitation policy can never be separated from drug policy. There are also several policies related to social rehabilitation and medical rehabilitation, referring to Law No. 35 of 2009 on narcotics, article 127 paragraph (3) indicates that each person who used drugs is required to receive social rehabilitation and medical rehabilitation. Even before Law No. 35 of 2009 on narcotics was established, rehabilitation policies have also been presented in Law No. 5 of 1997 concerning Psychotropic article 37 and Law No. 22 of 1997 on narcotics article 45, and was further clarified in article 48. The articles provide guarantees for people who use drugs to receive treatment at the social or medical rehabilitation center.

The implementation of drugs rehabilitation also already has strong policies support such as Ministry of Health Regulation No. 2415 of 2011 regarding the medical rehabilitation standards, Ministry of Social Affairs Regulation No. 16 of 2019 concerning national standards for social rehabilitation, and Ministry of Law and Human Rights Regulation No. 12 of 2017 concerning drugs rehabilitation for prisoners and detainees at CITU. Each of these ministers' regulations has produced an operational guideline for each institution to carry out drug rehabilitation following the mandate of Law No 35 of 2009. However, in the Ministry of Law and Human Rights Regulation No. 12 of 2017, there are no regulation references related to drug rehabilitation guidelines or standards either mentioned by the Ministry of Health, the Ministry of Social Affairs, or Regulation of BNN's Head. This situation creates the impression that drugs rehabilitation policies at CITU are separated from other agencies' rehabilitation standards. Even though the operational guidelines for drug rehabilitation in CITU referred to the Decree of DGC No. PAS-30.PS.01.07.01 concerning medical rehabilitation therapy standards, but there is no policy regarding the social rehabilitation standards.

This study also found there is inconsistency in strategic and operational policies that give barriers to the implementation of drug rehabilitation programs in prisons. The inconsistency relates to the disparity between rehabilitation budget allocations and the targets. Decree of DGC of 2017 stated that each prison must reach the target of 30 inmates participating in the social rehabilitation program, while the DIPA budget listed in operational guideline 2018 was only available for ten inmates to undergo social rehabilitation programs. In reality, several prisons even have 60 and 90 inmates in their rehabilitation programs, even though the DIPA budget is only intended for ten inmates for every prison that has rehabilitation programs.

Referring to the implementation process that can be seen in the 2016-2019 Monitoring and Evaluation documents, the drug rehabilitation program at CITU has not been able to

accommodate all inmates that should enter the drug rehabilitation program based on their screening results. The limited number of participants for drug rehabilitation programs, as stated in the operational guidelines (30 participants per six-month period), causes not all inmates with moderate to severe screening results or positive urine test results can participate in the rehabilitation programs organized by prisons or detention centers. There is no data reported for the proportion of inmates who have completed the rehabilitation program from the number of detainees and inmates who should have participated in the drugs rehabilitation programs based on screening results taken by each CITU. However, the high proportion of detainees or inmates involved in narcotics cases and BNN findings related to illicit drug trafficking in several prisons/ detention centers shows fewer inmates can participate in drug rehabilitation programs than those who should participate in the rehabilitation program.

The implementation of social rehabilitation in prisons or detention centers has not been implemented based on the guidelines issued by the DGC. Most CITU only implement social rehabilitation, not medical rehabilitation. The social rehabilitation program used the TC method that has been practiced since the narcotics rehabilitation program in prisons was still fully supported by BNN. The TC method in prison is an inpatient rehabilitation program that provides intensive and positive (supportive) to rehabilitate people who use drugs. The TC method in prisons is principally different from other rehabilitation methods regarding its use of groups/ communities as the agents of change, in which rehabilitation administrators and participants interact to affect attitudes, perceptions, and behaviors related to drug use [50]. The basic social learning model in TC is also strengthened by varieties of additional services, including family, education, vocational, physical, and mental health support. The TC method has been implemented in various settings such as prisons, hospitals, and rehabilitation institutions for alcohol and drug dependence problems [51].

Currently, the TC method is seen as a primary option in social rehabilitation programs implemented in prisons or detention centers, although in the operational guidelines, there is a brief intervention method as another option. TC is a social rehabilitation method commonly used by the Ministry of Social Affairs and the BNN, so the prisons are more familiar with implementing it because their officers already receive training from the BNN. Drug rehabilitation, which initially lasted for three months under the BNN's responsibility, subsequently became six months following the Ministry of Law and Human Rights' operational guidelines. In addition to the changing duration of social rehabilitation, participants screening method that initially used article 127 (Law No. 35 of 2009 on narcotics) changed to screening using forms (ASSIST version 3.1) and urine test for drugs use (inspection), even though in practice there were still many CITU still using article 127 in the screening process. This situation shows the lack of socialization for the operational guidelines to each CITU appointed as the implementing unit.

TC is also the Ministry of Social Affairs' primary choice for social rehabilitation implementation because it has been proven to be qualified after being implemented in several rehabilitation institutions. However, the different settings of CITU from other rehabilitation institutions make TC standards organized by the Ministry of Social Affairs can not be directly applicable. Based on the operational guidelines, prison-based TC is the only available social rehabilitation service in the prisons or correctional centers and can be modified based on inmates' needs. However, its implementation showed that TC is not being modified to inmates' needs. This gives an impression of one-size-fits-all therapy without considering the client's needs. As a part of health services, focusing on patient needs should be seen as a priority, as stated in BNN's Chief Regulation No. 24 of 2017, social rehabilitation should be modified to patient needs based on the assessment results. The use of TC often can not give inmates adequate ability to address the primary issue of their drug addiction problems. Prison itself is associated with the discipline system and hierarchy of power [52]. Whereas from the findings of previous studies, it shows that TC effectiveness was determined by the readiness and willingness of individuals to change and overcome their drug addiction problems, not only because of pressure and obligation to participate in rehabilitation programs [11, 53].

Another principle of drug rehabilitation is program sustainability. It is instructed that each stage of rehabilitation should be able to deliver effectively in the recovery process and create change in client behavior (BNN's Chief Regulation No. 24 of 2017). Operational guidelines of drug rehabilitation for inmates have also mentioned social rehabilitation, starting from assessment to post-rehabilitation program (aftercare). However, in its implementation, only a small number of inmates continued to post-rehabilitation programs. This condition displays poor synergy between prisons and Bapas in providing post-rehabilitation programs. It is also necessary to optimize Bapas as an administrator for the after rehabilitation program, because previous study showed TC supplemented by post-rehabilitation services (aftercare) can significantly decrease recapture cases in periods of up to 4 years after being released from prison [54], and it can help inmates not use drugs again and help them find employment. In social rehabilitation, the ability of rehabilitation officers serves as the foundation of TC's success. The principal therapy in TC is the community/group itself which consists of peers, environment, and rehabilitation officers as role models for the recovery process. Interaction between participants and rehabilitation officers is expected to create changes in inmates' attitudes, perceptions, and behavior [50]. In its implementation, program managers must provide orientation to all rehabilitation officers and rehabilitation participants to clarify expectations regarding TC to prevent confusion and misunderstanding in the implementation. All rehabilitation officers must receive training to attain full control of the rehabilitation implementation [55]. Rotation of health workers in prison settings is not frequent as other staff due to the limited number of health workers in DGC. If the rotation

happens then the staff may only move from one prison to another prison but their assignment is more likely the same as their previous assignment. This rotation model actually is an advantage in terms of maintaining the technical skills of the health workers in prisons. Staff who have been trained in certain technical skills would still work in the same department.

Based on the 2016-2019 monitoring and evaluation report, the rehabilitation program still encounters barriers regarding the lack of trained human resources in prisons. Although the instructions related to human resources are clearly stated in the operational guidelines, the monitoring and evaluation report in each year always states barriers about the availability of human resources in prisons. So far, the rehabilitation held in prisons still depends on the officers who have previously received training from BNN. Many of these officers no longer work in prison or have been transferred. In addition to the officers' availability, another problem is related to their capability to administer rehabilitation. It is unknown whether rehabilitation officers have received other training besides the training from the BNN, including training about the rehabilitation implementation according to operational guidelines. The rehabilitation program greatly depends on the availability of trained staff and their understanding of the operational guidelines. In line with the findings in this study, another study shows that the lack of understanding from officers about the importance of TC method is a problem in Indonesia's drug rehabilitation program [56]. Recommendations of the TC implementation in several prisons show that the main issues are the recruitment and training of rehabilitation officers. The Ministry of Law and Human Rights should consider providing policies that guarantee capacity improvement for the prison officers in drug rehabilitation programs in 128 CITU (prisons and detention centers)

The explanation above shows that the TC method in the context of social rehabilitation in prison was not carried out according to its principles. The drug rehabilitation program in prison was not optimal, which could lead to the client's ineffectiveness recovery process. Whereas some research shows that TC is an effective rehabilitation method fitted with a prison setting to reduce recurrence, reduce the likelihood of inmates to be detained again (re-arrest and re-incarceration). Inmates can also feel the benefits, especially in vocational programs, educational therapy, life skills training, counseling services, religious services, and health services [57, 58, 59].

In addition, the declining performance of narcotics rehabilitation in CITU due to the discontinuance of funding support from BNN and inadequate funding are other barriers in the implementation of drug rehabilitation in prisons. Inadequate financial support caused the monitoring and evaluation program for CITU (prisons/detention centers/Bapas) can not be performed optimally. Monitoring and evaluation of drug rehabilitation from 2016-2017 depends on the recording and reporting taken by the CITU to DGC through monthly reports and monitoring data (*Bimtorwasdal*) and correctional database system data (SDP) in 2018-2019, added by data from the Regional Office. The policy study shows that the responsibility to report on the narcotics

rehabilitation process at the CITU should be carried out regularly; it also shows there is still a need to optimize tiered reporting.

From a technical point, there is an inconsistency of the form's name used for documentation and reporting in a particular year within monitoring and evaluation reports. Different formats will inevitably impact both rehabilitation officers and readers' understanding. Changing the form's format every year makes rehabilitation officers have to learn new formats continually, thus it can hamper the documentation and reporting activities. This may be one of the causes concerning the low documentation and recording reports. Different monitoring and evaluation formats will certainly lead to difficulty in evaluating the development of prison documentation and reporting in each year. Inconsistency of the documentation and reporting format can lead to the lack of data collection from the rehabilitation program. Thus the outcomes and results of TC methods in the rehabilitation program cannot be evaluated [57].

CHAPTER IV. CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

Basically, the drug rehabilitation program in prison settings under the Ministry of Law and Human Rights is based on adequate policies for its implementation. The policy is based on the Law on Narcotics, the Law on Psychotropic, and the following regulations in the form of Presidential Instruction, regulation of Minister of Health, Regulation of Minister of Social Affairs, BNN's Chief Regulation, and Regulation of Minister of Law and Human Rights which all are directed for drug rehabilitation service policies both for the public in general and specific populations such as prisoners. At the operational level, the implementation of narcotics rehabilitation policies for prisoners in CITU has been reflected in Regulation of Minister of Law and Human Rights No. 12 of 2017 and the operational guidelines for drug rehabilitation program. Several aspects of health regulation such as governance, logistics and medical support, health resources, information systems, financing, and service provision, have been regulated in the operational guidelines.

The implementation of drug rehabilitation policy currently relies on social rehabilitation with therapeutic community (TC) modality. Although it has been comprehensively regulated in the operational guidelines, unfortunately the instructions of the guideline cannot be applied properly. Barriers in applying this therapeutic modality including: (1) inconsistency in the assessment process or screening to determine rehabilitation participants, (2) poor adherence in participants for engaging in therapy either due to lack of facilities and infrastructure support or due to the weak assessment system and screening, (3) limited provision of facilities and infrastructure required for a variety of therapeutic modalities, (4) limited financial fund to fully support the needs and magnitude of the problems faced by CITU and provide any necessary infrastructure and logistics, (5) unavailability of sufficient and qualified human resources, (6) limited variety of activities in rehabilitation activities, and (7) lack of documentation system to provide sufficient data to be used as the basis for the program development (services and participants).

In general, drug rehabilitation purposes have not been achieved by the current program because the success of the program is measured only from the number of inmates who have received the rehabilitation. Indicators related to fulfillment of the rights, health needs, rehabilitation and improved quality of life and readiness to re-entry to social life have not been developed as the indicators to measure the effectiveness of the drug rehabilitation programs.

4.2 Recommendations

The findings have shown the performance overview and various limitations related to the implementation of drug rehabilitation programs in CITU from various aspects of the policies. Overpopulation basically is the main barrier for the rehabilitation program at the prison setting because of the huge number of inmates who should be rehabilitated on one hand and limited resources including facilities, budget and staff on the other hand. This barrier is the negative consequence of the implementation of drug policy that still favors to lock people who use drugs in prisons rather than in rehabilitation centers. The recommendation of this study will not address the issue due to it beyond focus of the current research that emphasizes the technical aspect of rehabilitation policy in the prison setting. Therefore, some strategies and recommendations that can be offered to strengthen the drug rehabilitation program at CITU are as follows:

1. Review the TC modality as the primary modality in drug rehabilitation therapy at CITU, considering that this modality requires the support of distinct facilities and infrastructure, the intensity of the service provided, and qualified health care workers, participants with high severity problems, large funding per person and complex documentation system. On the other hand, with this large resource requirement, it will limit the inmates' coverage and accessibility as rehabilitation participants because of limited cost provided. Thus, it is necessary to consider a relatively simple therapeutic modality, with lower participation requirements, lower costs, facilities, and infrastructure that can be integrated with the residential nature of prisons/detention centers, and considering the period of the rehabilitation program. The application of this modality will increase the coverage of participants and is expected to be more efficient in the use of limited resources.
2. Conduct financing simulations for various therapeutic modalities that might be applied at the CITU so that it can estimate financing needs by considering the effectiveness of the therapeutic modalities to be applied. This funding simulation can be used for budgeting at CITU, Regional Office, and DGC levels.
3. Review the existing operational guidelines to be adjusted to the therapeutic modalities that will be applied by sharpening operational aspects through learning that has been obtained in implementing narcotics rehabilitation so far. It is expected that these implementation instructions will become more feasible, acceptable for implementing staff at the CITU and effective.
4. Conduct more intensive socialization for the operational guidelines to ensure the implementers' (in CITU and Regional Office of Law and Human Rights) understanding. Hence, they are able to perform drug rehabilitation consistently with operational guidelines as the service standards set by the DGC. If there are specific technical skills that must be

possessed by CITU officers, it is necessary for appropriate training to ensure the quality of service.

5. Ensure the availability of standardized forms for monitoring and evaluating rehabilitation programs that refer to the operational guidelines for drug rehabilitation. Assure the availability of regulations that support the implementation of regular and hierarchical monitoring and evaluation activities starting from CITU, Regional Office of Correction, to DGC of The Ministry of Law and Human Rights.

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