Improving Drug Rehabilitation in Prison Setting: An Implementation Research

RESEARCH REPORT

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Pusat Unggulan Kebijakan Kesehatan dan Inovasi Sosial

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ASI	Addiction Severity Index
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
BNN	Indonesia's National Narcotics Board
BNNK	Indonesia's National Narcotics Board at the city level
CITU	Correctional Implementation Technical Unit
DGC	Directorate General of Corrections
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organization
Pokja	Working Group
PWUD	People Who Use Drugs
TC	Therapeutic Community
WHO	World Health Organization

EXECUTIVE SUMMARY

Issuance of Minister of Law and Human Rights Regulation Number 12 of 2017 on drug rehabilitation program for inmates of correctional facilities started a new era in the management of prisoners who are incarcerated for drug-related offenses. The regulation aims to provide drug rehabilitation services for inmates as a part of protection of human rights. As the rehabilitation, the service encourages the inmates to recover from the biological, psychological and social aspect of dependence on narcotics, psychotropics, and other addictive substances, regain their health, and lead a more productive, higher quality life, such that they are able to socially function and reintegrate into the community.

Despite extensive effort between 2017-2019 have been carried out by the Prison DG, rehabilitation programs in correctional facilities have not been able to accommodate all inmates who upon screening were identified as moderately - severely drug-dependent, as each rehabilitation period (6 months) can only recruit a maximum of 30 participants. In addition to the limited capacity to cover more narcotics inmates to social rehabilitation services, the previous study of ARC Atma Jaya highlighted human resource availability and competence as the barrier to achieve the optimal result of the social rehabilitation for drug dependence in the correctional settings. While the human resource factor is recognized as key to successful program implementation, there has not been a single document that reports some type of capacity strengthening efforts for drug dependent social rehabilitation since 2017.

As mandated by the rehabilitation implementation guideline, there is a pressing need to have enough trained personnel to plan, manage, implement and monitor the program. Staff' competence correlates strongly with the ability to shape rehab participants toward positive behavior. Suitable vocational activities, individual and group support, and post-rehabilitation activities have been reported to result in significant behavior change, along with better adherence to the strict discipline of prison life. Several studies also report that prisoners who complete a rehabilitation program while incarcerated experience fewer relapses upon their release and are better able to reintegrate into the community than those who do not participate in a rehabilitation program.

In the absence of formal capacity building for the rehabilitation staff while the program is still implemented in the correctional setting, the AIDS Research Center of Atma Jaya Catholic University (ARC-ACJU) intended to develop a simple model for capacity building to optimize the social rehabilitation at the correctional settings. The model was developed by using implementation study, which is a study that focuses on the implementation of a certain policy, program or practice. The intent is not just to understand which program or activity works or does not work, but also to look at how and why a certain program or activity can or cannot be successfully carried out. In practice, an implementation research can look at various implementation aspects, from the process, to influencing factors, to the result of implementation. The main objective of an implementation research is therefore to test a specific health intervention by implementing it in real world settings and evaluate the outcome to inform future improvement. At the operational level, the study aimed to assess the extent of capacity building model improve the knowledge and skills of the prison staff in managing the social rehabilitation for drug dependents. Additionally, the study also assessed the impact of the social rehabilitation on the quality of life of the residents during their participation in the program.

A mixed method was used to conduct the study. A quantitative approach was used to (1) determine the direction and strength of association between the intervention model on the outcome which is knowledge and skills of the staff related to the prison-based narcotics rehabilitation program guideline. (2) assess the changes in the quality of life of the residents during their participation of the program. In addition, qualitative approach was used to understand the context and process of prison-based narcotics rehabilitation program. Prior to the study, approval was obtained from the Ethics Committee of Atma Jaya Catholic University. The study was conducted from August 2019 to January 2020 in Class II-A Prison in Magelang and Class II-A Prison in Paledang Bogor. Based on recommendations from the Directorate General of Corrections, Ministry of Law and Human Rights, the correctional facility in Magelang was selected as the Intervention Facility, while the one in Bogor was selected as the Control Facility.

Quantitative data were analyzed by descriptive analysis to describe the respondents' characteristics, the knowledge score of prison staff (pre-test, post-test I and post-test II), and the quality-of-life score of rehabilitation participants before and after the program. The quality of life is divided into four domains: physical health, psychological health, social relationship and environment and data are presented as frequency distribution tables. Further, bivariate analysis was used to determine the direction and strength of the association between the intervention model with the outcome variables. The analysis was started with the Shapiro-Wilk test to each numeric variable to test for normality. Variables that were normally distributed were analyzed using parametric test, while variables that were not normally distributed or categorical variables were subjected to non-parametric test. Quantitative data analysis was performed using STATA 14.0. While qualitative data was analyzed using a thematic analysis to identify themes and patterns in the collected data, and triangulation of informants' data. Qualitative data analysis was performed using the Nvivo 9 software.

This study shows that the intervention model which is a refreshment training on the technical guideline of the social rehabilitation for drug dependent slightly improved the technical knowledge of staff, but the improvement was not statistically significant. However, the correctional facility with the intervention model is able to implement rehabilitation program better than the facility with the standard model, which suggests that there may be contextual factors that affect staff' skill for implementing a rehabilitation program. Availability of counselors/trained staff, strong commitment and monthly monitoring are believed to play a role in the staff' ability to provide better rehabilitation services.

Qualitative data points to two contextual factors that enable better implementation of rehabilitation program in the Intervention Facility, namely trained counselor/staff and commitment of staff. Monthly monitoring which was one of the interventions performed in the study, kept staff committed to the activity, while in the Standard/Control Facility, excess workload and overlapping obligations limited staff' ability to provide quality rehabilitation service. While workload remains a common issue in both facilities, a higher level of commitment shown by staff in the Intervention Facility helped overcome the constraint. Intervention in the form of monthly monitoring also kept staff committed to adhere to the rehabilitation guideline. In the health sector, monitoring and evaluation have been proven to promote careful use of resources and adoption of best practices, as well as strike a balance between country-specific context and standardization since initial stages to ensure that the program is implemented efficiently and effectively and is reaching its target groups. Health care professionals have also relied on monitoring and evaluation to understand the relationship

between capacity strengthening and performance improvement in order to develop strategies that are focused on performance-improvement. A study on HIV service integration in Nigeria also reported the importance of monitoring and evaluation to document and measure changes in processes, service output and outcome in order to look at the positive impact of service integration.

Prison setting also plays a significant role in improving participant's quality of life. Participants in the Intervention Facility have higher quality of life scores compared to the participant in the Control Facility after completing the rehabilitation program. The study found that upon completing a rehabilitation program, participants' quality of life increased significantly in all four domains, i.e. physical and psychological health, social relationship and environment. Monthly monitoring and focus group discussion with rehabilitation staff recorded that the therapeutic community model was implemented more completely, and the rehabilitation guideline was followed more closely in the Intervention Facility than in the Control Facility. Again, this information suggests that rehabilitation was implemented better in the Intervention Facility than in the Control Facility.

Qualitative data on the experience of rehab participants supports this finding. Overall, participants in the Intervention Facility reported more positive experience throughout the program. This was seen in all aspects of quality of life. Individual, group and family counseling were one focus activity in the Intervention Facility, along with seminars on several health education topics. During interviews, rehabilitation participants in the Intervention Facility also mentioned that they felt staff had been quite responsive in providing emergency health service. In contrast those in the Control Facility expressed doubts regarding the quality of their health service. Comfort and cleanliness of cell blocks was also better in the Intervention Facility as a result of routine inspection by staff. This supports what was reported by another study about significant correlation between the quality of the built environment and individual quality of life. The social relationship between participants in the Intervention Facility was also perceived to be better as conflicts were resolved through discussions to find a solution. This demonstrates how each individual relates to one another.

Quality of life of rehabilitation participants was found to be significantly correlated with participants' compliance participation in the program. Those who had relatively complete participation in the core TC program reported a higher increase in the quality-of-life score in all four domains than participants with less complete participation. This suggests that program completion rate is one factor that is essential for improving prisoner's quality of life.

Despite the significant correlation between compliance in a rehabilitation program and improved quality of life, most prisoners in both facilities have not participated completely in the core TC program. Monthly monitoring performed by the study found no records of individual or family counseling in the Control Facility, and only 2 of 20 participants in the Intervention Facility attended family counseling sessions during the rehabilitation program. Complete participation is actually expected from all TC residents in order to help each individual end their drug dependency, achieve behavior change, assume new responsibilities and gain new knowledge about drug dependence. Limited counseling service should be made as one focus issue in rehabilitation implementation. Participants mentioned that counseling was only available with visits from a health institution or BNN. Family counseling was also not available, and the only activity that somewhat mirrored counseling was group support through morning meetings. Rehabilitation participants did express hope to receive routine counseling as sessions allow them to tell their story, gain insights and receive encouragement to change.

Aside from all the limitations of a prison-based rehabilitation program, participants agreed that the program brought about positive changes, from a closer relationship with God and more intensive worship activity, to a more disciplined, healthier lifestyle. Participants also regret having used drugs, and plan to apologize to their family upon returning home. The rehabilitation program motivates them to stop using drugs and they hope to lead a more positive life.

Based on these results, several recommendations to strengthen the narcotics rehabilitation program are formulated for the Directorate General of Corrections (DGC), Ministry of Law and Human Rights and the CITUs.

1. Review and revise the narcotics rehabilitation technical guideline that guides program implementation so that it is easier to understand and be followed by prison staff.
2. Develop a simpler rehabilitation guideline using a simpler method such as the Brief Intervention or the Narcotics Anonymous (NA) method. This will provide CITUs more rehabilitation method options to match with their need and capacity.
3. A preliminary assessment of human resources availability and preparedness is essential prior to appointment of specific CITU. The DGC can collaborate with other government institutions (e.g. BNN, Ministry of Social Affairs or Ministry of Health) and NGOs to ensure availability of adequate human resources for rehabilitation program implementation.
4. Capacity strengthening of prison staff is therefore urgently needed so that rehabilitation service can be provided following the guideline. It may be worthwhile to consider a refreshment training as a way to disseminate the content and use of the guideline to prison staff before actual program implementation.
5. Monitoring and evaluation of the rehabilitation program should engage the regional offices and the DGC should facilitate monitoring and evaluation training for its staffs and representatives from each regional office on the use of the standard M&E form.
6. Hold routine meetings with the regional office (Kanwil) and appointed CITUs as part of technical mentorship and periodic supervision.

Recommendations for the CITUs:

1. CITUs can develop a rehabilitation method that is simpler than the therapeutic community method as the simpler method (s) can be an option for an CITUs with limited capacity and a large number of drug-related inmates that may face challenges in implementing the Therapeutic Community Method.
2. Ensure a counselor is available to provide individual counseling, facilitate group counseling and family counseling as part of the TC's core program.
3. Routine coordination meetings should be organized to monitor the implementation, discuss constraints, and jointly arrive at a solution.
4. The Head of Correctional Facility is expected to be directly involved in supervising all the rehabilitation program activities, provide feedback for program improvement and to mobilize adequate funding, facility and infrastructure to support the program implementation.
5. Recruitment of rehabilitation participants should take into account each prisoner's sentence length.

CHAPTER I. INTRODUCTION

1.1 Background

Publication of a policy on drug rehabilitation in correctional facilities started a new era in the management of prisoners who are incarcerated for drug-related offenses. This policy is based on the Regulation of the Minister of Law and Human Rights Number 12 of 2017 regarding drug rehabilitation program for detainees and prisoners in correctional facilities. This regulation aims to guarantee the protection of the rights of detainees and prisoners and provide services that help these individuals recover from the biological, psychological and social aspect of dependence on narcotics, psychotropics, and other addictive substances, regain their health, and lead a more productive, higher quality life, such that they are able to socially function and reintegrate into the community [1]. The Ministry of Law and Human Rights also published an Implementation Guideline (*Juklak*) for the said regulation and appointed 128 CITUs to implement a prison- and detention center-based rehabilitation program.

Long before the *Regulation of the Minister of Law and Human Rights* Number 12 of 2017 was published, the Correctional Implementation Technical Units (CITUs) has played a critical role in the rehabilitation of people who use drugs by establishing a Drug Rehabilitation Working Group (Pokja) in each CITU. Under the auspices of Indonesia's National Narcotics Board (BNN) the working group is responsible for all aspects of the rehabilitation program, and was at that time fully funded by BNN. The program however was not free from challenges. There have been gaps in implementation, resulting in less optimum outcomes, and inability to achieve the vision of social rehabilitation.

A policy study (study 1) that looked at implementation of rehabilitation program documented that one reason there had been gaps in program implementation was budget inconsistency and large disparities in budget allocation. While each UPT is targeted to recruit a maximum of 30 participants per one rehabilitation period, the actual number varies from as few as 10 people to as many as 60 or even 90 people with the same budget allocation. Funding insufficiency significantly affects every component of the program; it specifically limits the manpower available to do the work, and creates ineffective monitoring and evaluation that relies exclusively on monthly reporting without any follow up. Yet, the need for a rehabilitation program is great. Monitoring and evaluation documents between year 2016 and 2019 show that despite extensive effort, rehabilitation programs in correctional facilities have not been able to accommodate all the individuals who upon screening were identified as moderately- and severely drug-dependent, as each rehabilitation period can only recruit a maximum of 30 participants. Study 1 highlighted human resource availability as one most important issue. As mandated by the rehabilitation implementation guideline, there is a pressing need to have enough trained personnel of sufficient quality to plan, manage, implement and monitor the

program. While this is recognized as key to successful program implementation, in practice there is an overreliance on staff who were previously trained by BNN who have been transferred to another position or are no longer working in correctional facilities. Throughout the period after the rehabilitation program was transferred to the authority of *Ministry of Law and Human Rights ,* there has not been a single document that reports some type of capacity strengthening efforts for rehabilitation staff in correctional facilities. Yet, adequate human resources is one key aspect of program achievement.

The Regulation of the Minister of Law and Human Rights Number 12 of 2017 article 6 states that rehabilitation service should be delivered by trained staff. Article 8 specifies that to facilitate successful social and medical rehabilitation, and provide post-rehabilitation support, rehabilitation staff require self-sufficiency training to help them be more independent in providing service [1]. The rehabilitation implementation guideline also states that high quality personnel is needed to carry out their function and role properly all the way to the post-rehabilitation program [2]. The success of the program depends on the capacity of the human resources involved.

Capacity strengthening of rehabilitation staff in the form of self-sufficiency training to enable them to manage a rehabilitation program independently becomes a benchmark for successful implementation of a prison-based rehabilitation program. Staff' competence correlates strongly with the ability to shape rehab participants toward positive behavior [3]. Suitable vocational activities, individual and group support, and post-rehabilitation activities have been reported to result in significant behavior change, along with better adherence to the strict discipline of prison life. Several studies also report that prisoners who complete a rehabilitation program while incarcerated experience fewer relapses upon their release and are better able to reintegrate into the community than those who do not participate in a rehabilitation program [4].

On the other hand, rehabilitation service also adds to the workload of prison staff who in the midst of minimal supervision and evaluation may not have the capacity to optimally manage the program [5]. In order to initiate an in-prison therapeutic community (TC) program, staff need to have a solid grasp of the regulation and rehabilitation guideline, as well as have the technical knowledge to implement the guideline. Resource limitation also often requires staff to be creative in designing innovative activities as part of program implementation, so increasing their understanding about the program is therefore important. While it is widely acknowledged that standardized facility and infrastructure, also design of tailored-interventions that are geared to meet individual needs are some of the variables that also affect the outcome of a social rehabilitation program, competent personnel are still a primary factor. In this regard competence relates to knowledge, attitude, and application of the knowledge in social life (practice). A study on knowledge-translation intervention to occupational therapists who

provide care to stroke patients reported that the therapists showed significant improvement in their ability to translate knowledge into more practical activities, resulting in overall capacity strengthening [6]. A similar study on students in Homoeopathic Colleges in India tested the students' knowledge, attitude, practice and beliefs about drug proving and many of them give evidence that having experiential knowledge provide more benefit than theoretical knowledge [7]. This suggests that desired outcomes of an intervention can be better achieved through improvement of practical knowledge.

Based on the above arguments, this study conducted interventions that consisted of capacity strengthening of rehabilitation staff, and routine monthly monitoring throughout the rehabilitation program. To strengthen capacities, a refreshment training was provided to increase the staff' knowledge about the content of the rehabilitation guideline and develop monitoring skills. The objects of the study were essentially knowledge, attitude and practice (KAP) of the guideline's content and rehabilitation staff' ability to monitor a rehabilitation program. It is hoped that having an appropriate KAP scheme and monitoring framework, the desired outcome of prison-based narcotics rehabilitation program can be achieved. As primary outcome the study measured the extent interventions improve rehabilitation staff' knowledge and skills, while improvement in rehab participants' quality of life was measured as a secondary outcome of the study. Quality of life was included as a variable in line with the objective of a rehabilitation program as outlined in attachment 1 of the rehabilitation guideline. Inmate's compliance participation in various rehabilitation program activities also strongly influenced the program's outcome.

1.2 Research Questions

- Does refreshment training improve the knowledge and skills of rehabilitation staff?
- Does compliance participation in a prison-based rehabilitation program improve the quality of life of prisoners?

1.3 Research Objectives

- To understand the relationship between refreshment training and knowledge and skills of narcotics rehabilitation staff.
- To understand the relationship between compliance participation in a narcotics rehabilitation program and improvement in prisoners' quality of life.

CHAPTER II. CONCEPTUAL FRAMEWORK

The KAP framework is used primarily to assess human behavior toward a certain topic or context [8]. As illustrated by its three components, KAP assessment identifies what an individual or a group knows (knowledge), feels (attitude), and does (practice). Knowledge is important as it affects what a person does and is obtained through a process of learning [9].

Below is a more detailed description of each component:

1) Knowledge: Knowledge is the receipt, retention and use of information or ability. Knowledge is gained through a process of understanding information and is distinguished from feelings as it is obtained through learning, and experiences. In this study, knowledge is assessed based on the amount of information that prison staff have regarding the content of the narcotics rehabilitation implementation guideline.
2) Attitude: As a psychological tendency, attitude demonstrates how an individual evaluates a certain object, based on his/her level of agreement with the object. Attitude consists of three components, i.e. cognitive, affective, and behavioral components. The cognitive component is understood as a right or wrong belief about an object. The affective component is the emotion that is directed toward an object, while the behavioral component is an individual's tendency to behave in a certain way toward an object.
3) Practice: Practice illustrates one's knowledge (increased understanding about an object) that is obtained, and a change in attitude as a result of a new belief. Practice therefore illustrates a reciprocal relationship between knowledge and attitude. This study observes the practice of prison staff in implementing the narcotics rehabilitation guideline during a rehabilitation program.

The KAP framework can be used for three objectives [8, 10]:

1. Exploration: KAP is used to gather or explore specific information about a certain population or topic for which there is limited information.
2. Test a certain hypothesis or approach: KAP is used to test an assumption or hypothesis that a certain intervention will result in a certain outcome.
3. Establish a baseline or reference value: KAP is used to build a baseline/reference value prior to any intervention so that any post-intervention changes can be measured and compared.

In this study, the KAP framework was used to understand the relationship between refreshment training and prison staff' knowledge and skills in providing rehabilitation services.

It is hoped that the KAP framework will provide evidence that interventions in the form of refreshment training are able to improve the knowledge and skills of prison staff in implementing a narcotics rehabilitation program based on an existing guideline. The main component that was tested in the study is the staff' knowledge about the guideline and the implementation of rehabilitation program by the staff (practice). The attitude component in the form of staff' perception about the rehabilitation was assessed through qualitative data. In addition, the study also looked at prisoners' quality of life as a secondary outcome.

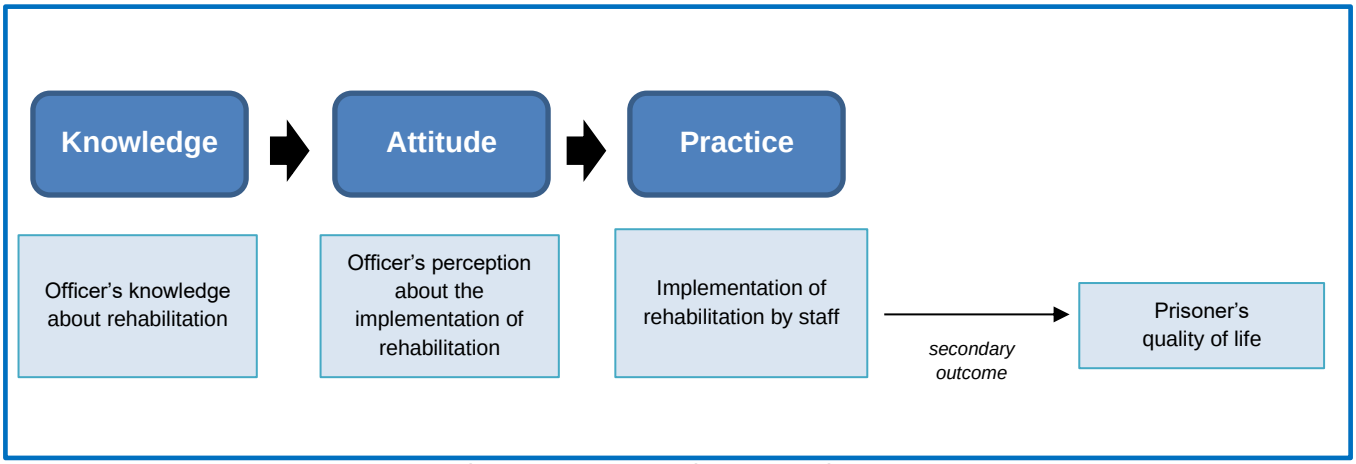

Figure 1. Conceptual Framework

CHAPTER III. METHODOLOGY

3.1 Study Design

The goal of the study was to determine the relationship between refreshment training and capacity strengthening of staff in managing and implementing a prison-based narcotics rehabilitation program, also to understand the relationship between compliance participation in narcotics rehabilitation program and prisoner's quality of life. Additionally, the study also aimed to formulate policy recommendations that can help correctional facilities improve the process and achievements of their narcotics rehabilitation program. In line with the objectives, the study was conducted as an implementation research, which is a research that focuses on the implementation of a certain policy, program or practice. The intent was not just to understand which program or activity works or does not work, but also to look at how and why a certain program or activity can or cannot be successfully carried out [11]. In practice, an implementation research can look at various implementation aspects, from the process, to influencing factors, to the result of implementation. Based on its definition, the goal of an implementation research is therefore to test a specific health intervention by implementing it in real world settings and evaluate the outcome to inform future improvement [12].

3.2 Intervention Design

Review of policies and reports of prison-based rehabilitation program evaluation found that the main issue that hampers narcotics rehabilitation program was the limited number of trained personnel and inadequate dissemination of the rehabilitation guideline's content to narcotics rehabilitation staff in the CITUs (correctional facilities/detention centers) that are implementing the program. As a result, rehabilitation service cannot be delivered in accordance with the guideline. Study interventions were therefore directed to strengthen the capacity of prison staff through refreshment training on the technical knowledge and the management of narcotics rehabilitation as detailed in the guideline.

Based on the KAP theory that was used as a conceptual framework, it was essential to review the component of knowledge and provide intervention in the form of a refreshment training that focused on the guideline. Refreshment training was hoped to improve the knowledge and skills of rehabilitation staff such that the program could improve the quality of life of prisoners who participate in a drug rehabilitation program.

Refreshment training was a short training provided to prison staff. It disseminated information about the 2018 Guideline for Implementation of Narcotics Rehabilitation Program among Detainees and Prisoners in Correctional Facilities that was issued by the Ministry of Law and Human Rights. The training consisted of two sessions, facilitated by the Directorate

General of Corrections, Ministry of Law and Human Rights and a member of the study team. Details are as follows:

a. The first session lasted for two hours and consisted of a comprehensive and thorough presentation and discussion about the guideline. Topics discussed were program goal, objectives, and target, rehabilitation assessment team, stages of rehabilitation (preliminary information, screening, rehabilitation assessment, core rehabilitation service delivery (social, medical and post-rehabilitation intervention), correctional therapeutic community (CTC), organizational structure and job description, inclusion and exclusion criteria of rehabilitation participants, recording and reporting, and rehabilitation schedule).
b. The second session was a more detailed, in-depth discussion about the flow of narcotics rehabilitation, specifically social rehabilitation, and the implementation research. The facilitator explained the recording and documentation requirement, including the study forms that staff in Intervention Facility would have to complete each month as part of the monitoring component during the six-month rehabilitation program. The second session also lasted for two hours and the study team directly interacted with the staff who were in charge of reporting and documentation in the Intervention Facility.

3.3 Study Methodology

To achieve its objectives, the study collected data using a mixed-method design. A quantitative approach was used to determine the direction and strength of correlation between (1) refreshment training and knowledge about the prison-based narcotics rehabilitation program guideline, (2) compliance participation in rehabilitation program and an individual's perception of their quality of life. In addition, qualitative data were collected to gain a thorough understanding about the context and process of prison-based narcotics rehabilitation program. The two methods are described in detail below:

3.3.1 Quantitative Method

a. Design and Measurement of Variable

To determine the relationship between refreshment training and staff' knowledge about prison-based narcotics rehabilitation program, three measurements of knowledge were performed: before and after the refreshment training (pre- and post-intervention), and at the end of the rehabilitation program. One correctional facility received the intervention and was referred to as the Observation or Intervention Facility where observations and measurements of variables would be conducted. Another correctional facility that was also implementing a narcotics rehabilitation program was

selected to be the comparison or Control/Standard Facility, and its staff' knowledge about rehabilitation was also measured. To look at compliance participation in rehabilitation and quality of life, the quality of life of all the participants in one rehabilitation cycle was measured before and after the rehabilitation program. As a comparison, the quality of life of rehab participants in another correctional facility was also measured.

To accommodate the measurement need, the study adopted a quasi-experimental design (pretest-posttest non-equivalent control group) [13]. The Intervention Facility was Class II-A Prison in Magelang and the Comparison/Control Facility was Class II-A Prison in Paledang, Bogor. Both facilities implemented the same rehabilitation methodology, but the Intervention Facility received a refreshment training as an intervention, while the Control Facility did not. Study variables (determinant and outcome) were measured in both facilities. A simple illustration of the measurement design is provided below:

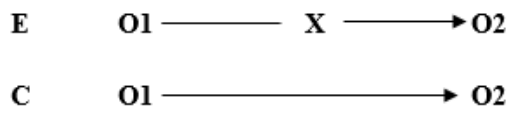

Figure 2. Pre- and Post-Intervention Design using a Comparison Group

Note:

E = Intervention group (narcotics rehabilitation staff in Class II-A Prison in Magelang)

O1 = First observation/measurement (pre-test)

X = Intervention

O2 = Second observation/measurement (post-test)

C = Control /Standard group (narcotics rehabilitation staff in Class II-A Prison in Paledang Bogor)

b. Measurement of Variable

The operational definition and measurement of each core variable are listed in the following table.

Table 1. Operational Definition of Variable

Variable	Operational Definition and Measurement
Variables at the level of narcotics rehabilitation staff	
Refreshment Training	Short two-session training on the rehabilitation implementation guideline for detainees and prisoners in CITUs that was issued by the Directorate General of Corrections, Ministry of Law and Human Rights in 2018. Variables were measured based on staff' participation in the refreshment training. Complete participation received a score of 1, while incomplete participation received a score of 0.
Knowledge of prison staff	1. Staff' knowledge about the organization and management of rehabilitation based on the implementation guideline. 2. Variables were measured based on staff' response to 25 questions about the following topics: organization and governance (11 questions), and technical management of a rehabilitation program (14 questions) starting with preliminary information, screening, rehabilitation assessment, core program, and post-rehabilitation preparation. 3. Every correct answer in the organization and governance category received a score of 9.09 (100/9), and every correct answer in the technical management category received a score of 7.14 (100/14). The possible score for officer's knowledge is 0-100. 4. The score for each aspect/component was then divided by 100 and multiplied by 3 to convert the score to a scale of 0 - 3. 5. Score 0 – 0.74 = very poor 6. Score 0.75 – 1.4 = poor 7. Score 1.5 – 2.24 = good 8. Score 2.25 - 3 = very good
Variables at the level of rehabilitation participants	
Compliance participation / completion of the core program	Participant's attendance of the rehabilitation's core program. Participation was measured by reviewing documentation of activities such as list of attendance during daily and group activities, individual counseling forms, counseling notes, and family counseling forms. Scores from the variables are categorized into: 1. Complete: when all documentation forms are complete 2. Reasonably complete: when 2-3 documentation forms are complete 3. Incomplete: when only 1-2 documentation forms are complete

Quality of life	Prisoner's evaluation or perception about four domains: physical health, psychological health, social relationship, and environment, that were derived from WHO's quality of life assessment questionnaire. The instrument consisted of 26 questions and responses were scored using a Likert scale (1-5). The score in each domain was transformed to a scale of 0-100. 1) The physical health domain consisted of seven questions that revolve around activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, pain and discomfort, sleep/rest, and work capacity. 2) The psychological domain incorporated six questions that assessed bodily image and appearance, negative and positive feelings, self-esteem, spirituality / personal beliefs, and thinking, learning, memory and concentration. 3) The social relationship domain consisted of three questions that assessed personal relationship, social support and sexual activity. 4) The environment domain contained eight questions that assessed financial resources, freedom, physical safety and security, health and social service, home environment, opportunities for acquiring new information and skills, leisure activities, physical environment and transportation.

c. Data Collection Instrument

Data collection instrument/tools were:

1) Questionnaire to assess the knowledge of narcotics rehabilitation staff about the technical information and procedure of rehabilitation in accordance with the guideline. The questionnaire contained 25 questions with the following details: preliminary information (1 question), screening (2 questions), rehabilitation assessment (4 questions), core program (6 questions), post-rehabilitation preparation (1 question) and organization and governance (11 questions). The questionnaire also incorporated questions about the characteristics of staff, i.e. age, sex, educational background and length of service in the correctional facility.

2) WHOQOL-BREF questionnaire that had been translated into Indonesian language contained 26 questions that served to assess the quality of life of rehab participants. The questions were grouped into 4 domains: physical health, psychological health, social relationship, and environment. The questionnaire also started with several questions to document the demographic characteristics of the participants (age, sex, length of prison terms, and marital status).

d. Respondent

Quantitative data were collected from two types of respondents, namely prison staff who were in charge of the rehabilitation program and prisoners from both correctional facilities who participated in a rehabilitation program. All staff and rehabilitation participants in the intervention and control facilities were recruited as respondents based on the following inclusion criteria.

Table 2. Inclusion Criteria, Exclusion Criteria and Sample Size

Study Respondent	**Inclusion and Exclusion Criteria**	**Sample Size / # of Informants**
Rehabilitation staff	**<u>Inclusion Criteria:</u>** Prison staffs 1) whose names were listed in the Decree of Prison Head regarding the Establishment of a Working Group for Rehabilitation of People who Use Drugs with a Therapeutic Community Modality in Class II-A Prison Bogor (Control Facility). 2) whose names were listed in the Decree of Prison Head regarding the Working Group for Rehabilitation in Correctional Facilities for 2019 Fiscal Year in Class II-A Prison Magelang (Intervention Facility). 3) who were in charge of program, program supervisor, program manager, specific staffs (doctor/nurse), daily activity instructor, support staff, and counselor. 4) Who were willing to be study respondents/informants. **<u>Exclusion Criteria:</u>** Prison staffs who 1) Were not directly involved in rehabilitation program implementation. 2) Were not present in the facility at the time of the study.	- 14 staff from Control Facility - 7 staff from Intervention Facility
Prisoners	**<u>Inclusion Criteria:</u>**	- 20 Prisoners

	Prisoners who 1) Were selected to participate in a social rehabilitation program in both correctional facilities. 2) Were willing to be study respondents. **<u>Exclusion Criteria:</u>** Prisoners who 1) Were rehabilitation participants but were not able to attend activities or dropped out of the program due to illness that lasted for a minimum of 1 week such that they had to be excluded from the rehabilitation program. 2) Received parole and were therefore unable to participate in a rehabilitation program to completion.	- from Control Facility - 20 Prisoners from Magelang Prison

e. Data Collection Method

Primary data were collected through a survey on the knowledge of prison rehabilitation staff before and after the intervention, and through interviews with prisoners on their quality of life, guided by a pre- and post-intervention questionnaire.

Table 3. (Quantitative) Primary Data Collection Method

Data Collection Method	Data Collection Instrument	Data Collection Period	Sample Size/ # of Informants
Survey on staff' knowledge	Questionnaire about rehabilitation staff' knowledge	At the start of the study in the Control Facility. Before and after intervention (refreshment training) in the Intervention Facility (pre-test and post-test).	- 14 staff in Control Facility - 5 staff in Intervention Facility
Interview about prisoner's quality of life (pre-test and post-test)	Quality of Life questionnaire (WHOQoL)	At the start of the study (3 months into the rehabilitation program) and after the program is completed in the Control Facility. Before and after a rehabilitation program is completed in the Intervention Facility.	- 20 prisoners from Control Facility - 20 prisoners from Intervention Facility

Secondary data provided information about the activities of rehabilitation participants as indicator of their compliance involvement in the program. Data were collected

through reviews of monitoring documents collected monthly from the Intervention Facility for a period of six months. Similar data were also collected monthly from the Control Facility for a period of three months up to November 2019. The documents collected include the following:

Table 4. Secondary Data Document

Type of Data / Secondary Document
ASSIST form, initial Addiction Severity Index (ASI) form, laboratory test result pre- and post-rehabilitation program, report on treatment diagnosis and therapy plan, daily activity attendance list, group activity form, individual counseling form, counseling notes, and family counseling form.

f. Data Collection Stages

1) Measurement of knowledge of narcotics rehabilitation staff

Measurement of staff' knowledge was performed twice in the Intervention Facility (pre-test and post-test I) and once in the Control Facility. Staff in the Intervention Facility filled in a questionnaire before and after the refreshment training which was held in August 2019, and again after the completion of a rehabilitation program (post-test II) using the same questionnaire.

2) Collection of quality-of-life data (WHOQOL-BREF)

Participants' quality of life was measured using the WHOQOL-BREF questionnaire, which was administered to all the narcotics rehabilitation participants in both intervention and control facilities. In the Intervention Facility, measurement was performed before the rehabilitation program started, while in the Control Facility, measurement was performed after the rehabilitation program had been running for three months (August 2019). Upon completion of the rehabilitation program, another measurement was carried out in both facilities followed with qualitative data collection (November 2019 and January 2020).

g. Data Analysis

Quantitative data was analyzed in two methods:

1. Descriptive analysis

Descriptive analysis was employed to describe the respondents' characteristics, the knowledge score of prison staff (pre-test, post-test I and post-test II), and the quality-of-life score of rehabilitation participants before and after the program. The quality of life is divided into four domains: physical health, psychological health, social relationship and environment and data are presented as frequency distribution tables.

2. Bivariate analysis

Bivariate analysis started with the Shapiro-Wilk test to each numeric variable to test for normality. Data was considered as normally distributed when the p-value was >0.05. Variables that were normally distributed were analyzed using parametric test, while variables that were not normally distributed or categorical variables were subjected to non-parametric test. A difference or association was considered statistically significant when the p-value was < 0.05.

- Bivariate analysis was performed to determine the difference in the characteristics of rehabilitation staff in the Intervention Facility and Control Facility. Staff' age and length of service was analyzed using the independent t-test and the Mann-Whitney U test, while staff' sex and educational background was analyzed with Fisher's exact test. Demographic characteristics of rehab participants in the intervention and Control Facility, namely age and sentence length were also analyzed with the independent t-test and Mann-Whitney U test, and chi-square test was performed on participants' marital status.
- Bivariate analysis of staff' knowledge before and after the refreshment training. The difference in the average score of staff' knowledge before and after the refreshment training (pre- and post-intervention) was analyzed using the independent t-test, while the difference in the average knowledge score at pre-intervention, post-intervention, and post-rehabilitation program was analyzed with Friedman test.
- Bivariate analysis between intervention (refreshment training and monitoring) and rehabilitation participants' quality-of-life score.

  The difference in the average quality-of-life score before and after (pre-test and post-test) a rehabilitation program in both intervention and Control Facility was analyzed using paired t-test or the Wilcoxon signed-rank test as an alternative. The difference in the post-test-pre-test average quality-of-life score between the intervention group and the control group was analyzed with the independent t-test or Mann-Whitney U test as an alternative.
- Bivariate analysis between prisoners' compliance participation in rehabilitation program and quality of life improvement.

  Bivariate analysis was also employed to determine any correlation between the characteristics of rehabilitation participants and compliance participation in the program and improvement in their quality of life. The difference in participants' average quality-of-life score based on their characteristics and compliance participation in the core program was analyzed using the independent t-test.

3.3.2 Qualitative Method

a. Measurement and Design of Variable

Through qualitative data, the study sought to obtain a deep understanding about the capacity or skills of prison staff in providing rehabilitation service after an intervention. In addition, the study also would like to know the benefit that rehabilitation participants gained from a six-month rehabilitation program. The qualitative component of the study was directed to discover whether the rehabilitation program had been implemented in accordance with the guideline, and whether participation in the program provided participants with the intended benefit as outlined in the program objectives and guideline.

b. Data Collection Instrument

1) Focus Group Discussion (FGD) with rehabilitation staff were held using a guideline that contained structured questions about: a) implementation of the rehabilitation program, stages of rehabilitation, and questions that revolve around the capacity of related manpower, b) activities in rehabilitation program from the initial phase, core phase, and post-rehabilitation preparation, and c) management of the rehabilitation program
2) The guideline for in-depth interview with rehab participants consisted of 33 questions about the prison-based social rehabilitation program. Questions were grouped into eight questions about preliminary information, screening and rehabilitation assessment, eleven questions about the period of familiarization with the prison environment (*mapenaling*), the core program and post-rehabilitation preparation, nine questions about the condition of the rehabilitation blocks, and five questions about the benefit that participants gained from the rehabilitation program. The guideline started with questions to gather demographic information, prior arrest history and health services that are available in the correctional facility.

c. Informant

A purposive sampling method was employed to select prisoners who would be informants in the qualitative component of the study. Inclusion and exclusion criteria, sample size and number of informants are detailed in the following table:

Table 5. Criteria of Informants

Type of Informants	Inclusion and Exclusion Criteria	Sample Size / # of Informants
Rehabilitation staff	Criteria: The staff: 1) Are tasked as implementers, i.e.: person in charge of the program, program	- 14 staff from Control Facility - 7 staff from Intervention Facility

	supervisor, program manager, special staff (doctor/nurse), daily activity instructor, support staff and counselor (Control Facility). 2) Attend and complete the refreshment training (Intervention Facility). 3) Are willing to be study respondents / informants.	
Prisoners	Criteria: Prisoners who: 1) Attend the 6-month prison-based rehabilitation program. 2) Are willing to be study informants. 3) Are able to express their opinion. 4) Are recommended by the rehabilitation implementation team.	- 2 prisoners from Control Facility - 2 prisoners from Intervention Facility

d. Data Collection

Primary qualitative data were collected through focus group discussion (FGD) with rehabilitation staff, and through in-depth interviews with rehabilitation participants after they completed the program. Data collection method and instrument are detailed in the following table:

Table 6. (Qualitative) Primary Data Collection Method

Data Collection Method	Data Collection Instrument	Data Collection Time	Sample Size / # of Informants
Focus Group Discussion (FGD) with staff	- FGD Guideline	- Held in intervention and control facilities upon completion of the rehabilitation program	- 14 staff from Control Facility - 7 staff from Intervention Facility
In-depth Interview with prisoners (pre- and post-intervention)	- In-depth Interview Guide	- Held in intervention and control facilities upon completion of the rehabilitation program	- 2 prisoners from Control Facility - 2 prisoners from Intervention Facility

e. Data Analysis

Data analysis started with a content analysis, continued with a thematic analysis to identify themes and patterns in the collected data, and triangulation of informants' data. Qualitative data analysis was performed using the Nvivo 9 software.

3.4 Study Location and Timing

The study was conducted from August 2019 to January 2020 in Class II-A Prison in Magelang and Class II-A Prison in Paledang Bogor. Based on recommendations from the

Directorate General of Corrections, Ministry of Law and Human Rights, the correctional facility in Magelang was selected as the Intervention Facility, while the one in Bogor was selected as the Control Facility.

3.5 Ethics Approval

This study collected data and information from respondents and informants, and as required for all researches involving human subjects, the study complied with ethical research principles. This included consideration of the potential risks and benefits to study participants, reinforcing confidentiality, and upholding the principles of autonomy and respect for human rights. Prior to the study, approval was obtained from the Ethics Committee of Atma Jaya Catholic University, the Directorate General of Corrections, Ministry of Law and Human Rights, and Head of the correctional facilities where the study was expected to take place. Written informed consent was also obtained from each study respondent/informant following an explanation about the study, the risks, rights and obligations of respondent/informant.

3.6 Informed Consent Procedure

All the study respondents and informants received an explanation about the study objective, the risk and benefit of taking part in the study, and the time that will be spent to complete questionnaires, attend FGD and participate in an in-depth interview. Respondents and informants who were willing to participate in the study were requested to sign an informed consent form. As compensation for their time, respondents received lunch and snacks at the amount of IDR 50,000 after the pre-intervention questionnaire and after the post- intervention questionnaire. Informants who agreed to participate in an in-depth interview received a souvenir at a value of IDR 50,000, while informants who attended an FGD received IDR 150,000 as compensation for their time.

3.7 Study Limitation

The number of rehabilitation staff who participated in the study was very small resulting in low precision and possibly a large bias. The result of the analysis may therefore not reflect the actual situation, and readers will need to take this into account in interpreting the difference in staff' knowledge as reported by the analysis.

Prisoners' baseline quality of life in the two facilities (control vs intervention) was not assessed in the same condition. In the Control Facility in Bogor, the quality of life was assessed three months after the rehabilitation program started, unlike the Intervention Facility in Magelang, which did the assessment before the program started. This can create bias in data measurement. Any difference in the baseline quality of life between the two facilities might be due to the different timing in measurement. The timing might also influence the way prisoners

in the Control Facility completed the post-intervention test, resulting in bias in the pre- and post-intervention measurement between the Control and Intervention Facility. Readers will therefore need to take this issue into consideration in interpreting the study result.

CHAPTER IV. RESULTS

4.1 Situation of the Narcotics Rehabilitation Program in Correctional Facilities in Indonesia

Indonesia has started to implement a narcotics rehabilitation program, consisting of medical and social rehabilitation, in correctional facilities/detention centers since 2002. The National Narcotics Board (BNN) facilitated capacity strengthening effort of staff, also vocational activities, and provided support for medication and laboratory screening test kits. Initial activities started with a social rehabilitation program using the Therapeutic Community (TC) method and the Criminon program in narcotics prison that had been built in several provinces. As part of the medical rehabilitation program, in collaboration with BNN, the Ministry of Health appointed several prisons/detention centers to be satellite facilities for methadone maintenance treatment (MMT). Rehabilitation service was also integrated with other health service for diseases such as HIV AIDS and Tuberculosis (TB).

Up to year 2016, prison-based rehabilitation program received support from BNN, who provided capacity strengthening training for rehabilitation personnel, as well as funding for appointed correctional facilities/detention centers. Rehabilitation program implementation was also considered as one performance indicator of BNN and up to year 2016, 60 CITUs provided social rehabilitation service to 4440 prisoners. In addition, 2619 individuals received post-rehabilitation support in correctional centers (*Bapas*).

In 2017, with the discovery of illegal drug distribution in correctional facilities/detention centers, BNN withdrew its support to the prison-based rehabilitation program. In recognition of the need for rehabilitation service, the Ministry of Law and Human Rights took the initiative to implement the rehabilitation program independently, and issued a Regulation of the Minister of Law and Human Rights Number 12/2017 on narcotics rehabilitation program in correctional facilities. The regulation was followed with a Decree of the Directorate General of Corrections that appointed 128 CITUs to implement a narcotics rehabilitation program (medical, social rehabilitation and post-rehabilitation support) for incarcerated drug offenders. A guideline to implement the rehabilitation program was also developed and is still used until today.

The majority of correctional facilities/detention centers provide social rehabilitation service instead of medical rehabilitation, and the existing guideline specifies that the therapeutic community (TC) model, or the criminon program be implemented accompanied with post-rehabilitation support. The TC method seems to be the method of choice in most facilities, primarily in facilities whose staff had received TC training from BNN. The initial TC method that BNN implemented was a three-month program, but the Ministry of Law and Human Rights then extended the program to six months and specified it in the guideline. Medical and social rehabilitation program is followed by post-rehabilitation support in

correctional centers (*Bapas*) that assume a community research (*litmas*), mentorship, coaching and supervision role in the medical and social rehabilitation process. The role of *Bapas* in community research is not documented in rehabilitation program implementation.

Based on the Regulation of the Minister of Law and Human Rights Number 12 of 2017, the TC method mandates screening of all prisoners. Those who are determined as low risk will receive some brief interventions, while those of moderate to high risk will undergo a subsequent assessment to determine the type of rehabilitation service (medical vs social) each individual will receive. Medical rehabilitation consists of methadone maintenance treatment, and test for comorbidities, i.e. physical illness (HIV/AIDS, TB) or psychological/mental disorder. Symptomatic treatment is provided as needed, and referral is made for individuals with mental health issues. Once the individuals are considered stable, they will receive symptomatic therapy or social rehabilitation. After completing a social rehabilitation program, all participants continue with a post-rehabilitation program.

The targeted and actual number of CITUs that implement a rehabilitation program and the target and actual number of program participants is monitored each year and is incorporated as one performance indicator of the Directorate of Health Care and Rehabilitation. In 2016 the performance indicator was the number of CITUs that provided special health and rehabilitation service, and of the 67 CITUs that were appointed to provide social rehabilitation service, 60 did provide the service. However, none of the 9 CITUs that were appointed to provide medical rehabilitation managed to provide the service. Cumulatively 4,440 of the targeted 5,450 individuals completed a rehab program. The following year, when BNN's support for the operational cost of the rehab program was withdrawn, most correctional facilities lacked funds to implement the program, such that the number of rehabilited prisoners decreased to 2,563 individuals.

In 2018, after the rehabilitation program was taken over by the Ministry of Law and Human Rights, the number of program participants increased slightly though still below the targeted number. Among the 128 appointed CITUs, 62 provided rehabilitation service to a total of 2,735 prisoners. The majority, 2,360 individuals, participated in a social rehabilitation program, while the remaining 154, and 221 individuals received medical rehabilitation and post-rehabilitation service respectively. The following year, in 2019, CITUs managed to rehabilitate 6,171 prisoners, exceeding its target of 6,000 prisoners. This was possible because additional 21 CITUs that in the Directorate General of Corrections Decree were actually not appointed to provide rehabilitation, started implementing a rehabilitation program for their inmates.

Competent prison staff in adequate number is key to successful implementation of narcotics rehabilitation in correctional facilities. The guideline specifies doctor, nurse and addiction counselor as medical rehabilitation service providers. Addiction counselor will also

be needed for a social rehabilitation program, along with a program manager, and a health worker (doctor or nurse). In practice, monitoring and evaluation show that most CITUs do not have specific assessment personnel or addiction counselors. Under the Ministry of Law and Human Rights' program, capacity strengthening training for prison staff has never been reported.

4.2 Impact of Intervention on Staff' Knowledge and Skills

1. Demographic Characteristics of Rehabilitation Staff

Study respondents consisted of 5 rehabilitation staff in the Intervention Facility, and 14 rehabilitation staff in the Control Facility. Demographic characteristics included age, sex, educational background and the length of time the staff have worked in the correctional facility. A descriptive statistical analysis is listed in the table below.

Table 7. Demographic Characteristics of Rehabilitation Staff

Characteristics of Rehabilitation Staff	Classification	Control Facility (n=14)		Intervention Facility (n=7)		p-value
		n	%	n	%	
Age (year) Mean (SD)		41. 71 (9.76)		44.43 (8.96)		0.545[a]
Age group	≤ 40 years old	8	57.14	2	28.57	
	> 40 years old	6	42.86	5	71.43	
Sex	Male	9	64.29	5	71.43	0.572[b]
	Female	5	35.71	2	28.57	
Educational background	Health	7	50	2	28.57	0.324 [b]
	Non-Health	7	50	5	71.43	
Length of service (year) *Mean (SD)*		10.14 (8.74)		17.14 (10.09)		0.107[c]

Note: [a]Independent t-test; [b]Fisher's exact test; [c]Mann Whitney test

Table 7 shows that the majority of staff, 64.29% in the Control Facility and 71.43% in the Intervention Facility, were male. In the Control Facility, half of the staff had a health-related educational degree, while the other half came from a non-health background. In the Intervention Facility, the proportion of staff with a non-health background was higher at 71.43%. On average staff in the Intervention Facility had worked for 17 years, longer than the length of service of staff' in the Control Facility (10 years).

As shown by the p-value > 0.05 in Table 7, differences in the staff' age, sex, educational background and length of service were not significant. This confirmed that rehabilitation staff in the Intervention and Control Facilities were comparable.

2. Knowledge Score of Rehabilitation Staff

a. Pre-intervention (Baseline) Knowledge Score in Intervention vs Control Facility. Baseline knowledge of staff in both facilities was measured, which in the Intervention Facility would need to be performed before staff received a refreshment training. Simultaneously the knowledge of staff in the Control Facility was measured. The results are compared and detailed in the Table below:

Table 8. Baseline Knowledge of Rehabilitation Staff in Control and Intervention Facilities

Baseline Knowledge of Rehabilitation Staff	Control Facility (n=14)		Intervention Facility (n=7)		p-value[a]
	Mean	SD	Mean	SD	
Total score (0-200)	134.86	18.85	124.71	26.51	0.322
Knowledge classification (0-100)					
Technical knowledge	63	7.97	60	17.01	0.671
Organization and governance	71.86	15.09	64.71	15.16	0.320

Note: [a]Independent t-test

Table 8 shows that staff in the Control Facility had a higher average knowledge score (134.86) than staff in the Intervention Facility (124.71). The staff were measured on two categories of knowledge. First, they were assessed on how well they knew the technical stages of a rehabilitation program, from preliminary information, screening, assessment, core program to post-rehabilitation support. This first category of knowledge is basically the content of the guideline that *Ministry of Law and Human Rights* published. The second category focused more on the organization and governance of a rehabilitation program, the goal and objectives, health information system, also the tasks and responsibilities of each officer. On average staff in the Control Facility scored higher, namely 63 and 71.86 in the technical knowledge and organization-governance knowledge respectively, than the staff in the Intervention Facility who received an average score of 60 and 64.71 in the first and second category respectively.

Independent t-test analysis showed that the score differences, either the total score, technical knowledge as well as organization-governance scores, were not significant ($p > 0.05$) and it can be concluded that staff in both facilities had a similar level of knowledge regarding a rehabilitation program.

b. Knowledge Score in the Intervention Facility at Baseline (Pre-Intervention), Post-Intervention 1 and Post-Intervention 2

Knowledge of staff in the Intervention Facility was measured three times, before the refreshment training or pre-intervention (pre-test), after the refreshment training or post-intervention 1 (post-test 1), and after the rehabilitation program or post-intervention 2 (post-test 2), which was basically after the intervention ended. The result is detailed in the Table below.

Table 9. Knowledge of Rehabilitation Staff in the Intervention Facility

Knowledge of Rehabilitation Staff	Pre-test (n=5)		Post-test 1 (n=5)		Post-test 2 (n=5)		p-value[a]
	Mean	SD	Mean	SD	Mean	SD	
Total Score (0-200)	129	24.11	127.4	39.01	116	23.74	0.107
Knowledge classification (0-100)							
Technical knowledge	59.4	11.5	63.6	18.12	67.80	10.62	0.099
Organization and governance	69.6	15.31	63.8	21.27	48.2	18.91	0.094

Note: [a]*Friedman test*

As shown in Table 9, on average staff showed an increase in their technical knowledge, from 59.4 at pre-test to 63.6 at post-test 1 and 67.80 at post-test 2. Their knowledge on the organization and governance of rehabilitation program however did not increase, and in fact slightly decreased.

Analysis showed that the knowledge scores before and after the refreshment training and after the rehabilitation program were not significantly different, which may be caused by the small sample size. This indicated that the intervention did not improve the knowledge of rehabilitation staff in the Intervention Facility.

3. Knowledge and Practice Score of Rehabilitation Staff

Practice or the actual implementation of rehabilitation program was scored based on completeness of monthly reports that were submitted and confirmation of the information with rehabilitation staff through a focus group discussion. To compare the knowledge score and practice score, the technical knowledge score was divided into five stages: preliminary information, screening, rehabilitation assessment, core program, and post-rehabilitation preparation, while the organization-governance score reflected the extent rehabilitation staff understood what they needed to include in the monthly reporting. The practice score was therefore based on the quality of monthly reports that were submitted such as adherence to the instruction in completing the activity forms and the detailed information provided in the form.

Knowledge and practice was scored on a scale of 0-3. A score between 0 - 0.74 would mean that staff had very poor knowledge and practice, and sequentially scores between 0.75 - 1.4, 1.5 - 2.24, and 2.25 - 3 would represent poor, good and very good

knowledge and practice. A score comparison between the Control and Intervention facilities is detailed in the Table below.

Table 10. Knowledge and Practice Score of Rehabilitation Staff in Control and Intervention Facility

No	Stage	Control Facility		Intervention Facility	
		Knowledge Score	Practice Score	Knowledge Score	Practice Score
1	Preliminary Information	0.86	1	2.14	1
2	Screening	2.46	1.42	2.79	2.92
3	Rehabilitation Assessment	2.05	0.8	1.61	1.61
4	Core Program	1.83	1.12	1.9	1.29
5	Post-Rehabilitation Preparation	0.86	1.27	0.43	1.51
6	Organization and Governance	2.16	0.59	2.07	1.51
Average Final Score		1.7	1.03	1.82	1.64

The scores in Table 10 demonstrate that rehabilitation staff in both facilities had good knowledge as shown in the final score of 1.82 for the Intervention Facility and 1.7 for the Control Facility. The level of overall understanding about the rehabilitation guideline was slightly higher in the Intervention Facility but the Control Facility scored higher on specific topics such as rehabilitation assessment (2.05), post-rehabilitation preparation (0.86) and organization and governance (2.16). However, a good knowledge score does not guarantee good implementation. In both facilities, the practice score was lower than the knowledge score (1.7 vs 1.03 in Control Facility, 1.82 vs 1.64 in Intervention Facility), and comparison of the practice score indicated that the Intervention Facility implemented the rehabilitation program (1.82) better than the Control Facility (1.03). That was evident in the reports from the Intervention Facility which were more complete and detailed even though the information may still not fully describe the situation/challenge that clients faced.

4.3. Compliance vs Quality of Life: Impact of Rehabilitation Program on Participants' Quality of Life

1) Demographic characteristics of rehabilitation participants

The study recruited 40 rehabilitation participants to be respondents, 20 from each correctional facility. Their demographic characteristics are described in Table 11 below.

Table 11. Demographic Characteristics of Rehabilitation Participants

Characteristics of Participants	Classification	Control Facility (n=20)		Intervention Facility (n=20)		p-value
		n	%	n	%	
Age (year) Mean (SD)		30.65 (6.67)		35.45 (9.27)		0.068[a]
Age group	≤ 30 years old	10	50.00	6	30.00	
	> 30 years old	10	50.00	14	70.00	
Length of Prison Terms (months) Mean (SD)		56. 35 (15.16)		61.55 (5.35)		0.113[b]
Length of Prison Terms	≤ 60 months	13	75.00	3	15.00	
	> 60 months	7	35.00	17	85.00	
Marital status	Single/divorced	12	60.00	7	35.00	0.113[c]
	Married	8	40.00	13	65.00	

*Note: [a]Independent t-test; [b]Mann Whitney test; [c]Chi-square test; *p value <0.05*

As shown in Table 11, on average rehab participants in the Intervention Facility were older than 30 (35.45 years), were sentenced to a longer prison time than than those in the Control Facility, and were already married. Statistical tests however showed that the observed differences were not statistically significant (p-value = 0.068, 0.013 and 0.113 for age, length of prison terms and marital status respectively). This indicated that study respondents in both facilities had similar characteristics in terms of age, length of prison terms and marital status.

2) Pre- and post-intervention quality of life in both facilities

Rehabilitation participants in the Intervention Facility had their quality of life measured before (pre-intervention) and after (post-intervention) the rehabilitation program. In the Control Facility, measurement was performed three months into a rehabilitation program (pre-intervention) and at the completion of the program (post-intervention). Pre- and post-intervention quality-of-life scores in both facilities are detailed in the following table.

Table 12. Pre- and Post-Intervention Quality-of-Life Score of Rehabilitation Participants in Control and Intervention Facilities

Quality-of-Life Score	Mean	SD	95% CI	Min-Max	p-value
Control Group					
Domain 1. Physical health (score 0-100)					
Pre-intervention	49.90	9.97	45.23-54.56	38-69	**0.049[a]***
Post-intervention	44.5	8.98	40.34-48.75	25-63	
Domain 2. Psychological health (score 0-100)					
Pre-intervention	60.7	10.75	55.66-65.73	38-81	0.592 [a]
Post-intervention	62.3	11.34	56.99-67.61	44-81	
Domain 3. Social relationships (score 0-100)					
Pre-intervention	43.15	11.57	37.73-48.56	19-56	**0.021[b]***
Post-intervention	33.75	10.81	28.69-38.81	19-56	
Domain 4. Environment (score 0-100)					
Pre-intervention	45.8	13.13	39.65-51.94	25-75	0.451[a]
Post-intervention	43.85	9.41	39.44-48.25	25-56	
Intervention group					
Domain 1. Physical health (score 0-100)					
Pre-intervention	41	10.91	35.89-46.10	25-63	**0.001[a]***
Post-intervention	57.4	8.01	53.65-61.15	38-69	
Domain 2. Psychological health (score 0-100)					
Pre-intervention	48.8	11.79	43.28-54.32	19-69	**0.001[a]***
Post-intervention	71.05	7.5	67.54-74.56	50-81	
Domain 3. Social relationships (score 0-100)					
Pre-intervention	46	10.38	41.14-50.86	19-69	**0.005[a]***
Post-intervention	55.85	9.68	51.32-60.38	31-75	
Domain 4. Environment (score 0-100)					
Pre-intervention	37.95	10.26	33.15-42.75	13-50	**0.001[a]***
Post-intervention	70.6	12.01	64.98-76.22	31-81	

Note: [a]Paired t-test; [b]Wilcoxon test; *p-value <0.05

Table 12 lists the quality-of-life score of rehab participants in each facility as measured using the WHOQOL-BREF questionnaire. The quality of life is divided into four domains: physical health, psychological health, social relationship, and environment with a range of score between 0-100 for each domain.

In the Control Facility, a statistically-significant difference (p-value <0.05) was seen in the pre- and post-intervention score for physical health and social relationship domain. However, the post-intervention average quality-of-life score at completion of the program was actually lower than the pre-intervention score which was measured after the program had been running for three months. In the Intervention Facility, significant differences (p-value <0.05) were seen in

the average score in all domains and the post-intervention scores were higher than the pre-intervention scores.

3) Post- and pre-intervention quality-of-life score difference between the Intervention and Control Group

The impact of intervention on rehabilitation participants' quality of life was assessed based on the post- and pre-intervention average score difference between the intervention group and the control group. The result is presented in the following table.

Table 13. Comparison of Post- and Pre-intervention Quality-of-Life Score Difference between Intervention and Control Facilities

Quality-of-Life Score (Post-intervention – Pre-intervention Difference)	**Control Facility (n=20)**		**Intervention Facility (n=20)**		**p-value[a]**
	Mean	**SD**	**Mean**	**SD**	
Domain 1. Physical health	-5.35	11.37	16.4	14.34	**0.0000***
Domain 2. Psychological health	1.6	13.14	22.25	9.63	**0.0000***
Domain 3. Social relationship	-9.4	16.38	9.85	13.86	**0.0003***
Domain 4. Environment	-1.95	11.33	32.65	12	**0.0000***

Note: [a]Independent t-test; *p-value <0.05

The score difference at pre- and post intervention in the Intervention Facility, when compared with that in the Control Facility shows that rehab participants in the Intervention Facility reported an improved quality of life in all domains, and based on the p-values, the improvements were statistically significant. This indicates that the study intervention did have an impact on improving the rehabilitation participants' quality of life. Participants in the Control Facility on the other hand, experienced reduced physical health, social relationship and environment after the rehabilitation program.

4) Relationship between demographic characteristics, compliance participation in a rehabilitation program and post-pre-intervention score difference

The relationship between participants' demographic chacteristics, their compliance participation in a rehabilitation program, and improvement in their quality of life is presented in the following table.

Table 14. Relationship between Participants' Demographic Characteristics, Complete Participation in the Core Rehabilitation Program and the Pre-Post Intervention Score Difference

Variables	Classification	n=40	Quality-of-Life Score (post-intervention – pre-intervention)							
			Physical health		Psychological health		Social relationships		Environment	
			Mean (SD)	p-value	Mean (SD)	p-value	Mean (SD)	p-value	Mean (SD)	p-value
Age				0.611[a]		0.362[a]		0.791[a]		0.548[a]
Age group	≤ 30 years old	16	4.69 (16.86)	0.801[b]	10.94 (16.01)	0.746[b]	-2.81 (16.35)	0.387[b]	12.75 (23.06)	0.529[b]
	> 30 years old	24	6.08 (17.21)		12.58 (15.37)		2.25 (18.87)		17.08 (19.77)	
Length of prison terms				0.774[a]		0.928[a]		0.216[a]		0.427[a]
Length of prison terms	≤ 60 months	16	1.69 (18.37)	0.245[b]	5.81 (12.41)	0.039[b]	1.12 (16.94)	0.798[b]	6.25 (20.79)	**0.029*[b]**
	> 60 months	26	8.08 (15.65)		16 (16.15)		-0.375 (18.79)		21.17 (19.38)	
Marital Status	Single	19	3.68 (17.25)	0.518[b]	9.53 (14.88)	0.357[b]	-2.37 (15.91)	0.389[b]	13.00 (22.99)	0.507[b]
	Married	21	7.19 (16.75)		14.09 (15.98)		2.57 (19.55)		17.47 (19.27)	
Correctional Facility	Intervention	20	16.40 (14.34)	**0.0000*[b]**	22.25 (9.63)	**0.0000*[b]**	9.85 (13.86)	**0.0003*[b]**	32.65 (12.00)	**0.0000*[b]**
	Control	20	-5.35 (11.37)		1.60 (13.14)		-9.40 (16.38)		-1.95 (11.33)	
Participation in core program	Less complete (score 2)	27	-1.15 (16.28)	**0.0001*[b]**	5.85 (13.89)	**0.0000*[b]**	-4.48 (18.25)	**0.014*[b]**	8.04 (20.15)	**0.0008*[b]**
	Quite complete (score 3-4)	13	19.38 (6.48)		24.54 (10.10)		10.00 (12.73)		30.53 (13.34)	

Note: [a]Simple linear regression; [b]Independent t-test; * p-value<0.05

The above table shows that there was no significant correlation between the demographic characteristics of rehab participants (age, sentence length and marital status) and their post-pre-intervention score difference in almost all domains. The only significant correlation was seen between the environment domain and length of prison terms, which means that participants' quality of life for the environment domain significantly correlates with their sentence length, ≤ 5 years or > 5 years.

Table 14 also shows that interventions caused significant improvement in quality of life in all domains in the Intervention Facility. In the Control Facility, prisoners actually reported reduced quality of life. The degree of participation in the core program of rehabilitation also significantly correlated with the quality-of-life improvement and participants who had relatively complete participation reported higher improvement in their quality of life compared to those with less complete participation. The degree of participation reflects participants' compliance with the rehabilitation program, so compliance participation correlates with improved quality of life.

4.4 Perception of Rehabilitation Staff about Rehabilitation Program Implementation

Implementation of a rehabilitation program in correctional facilities depends greatly on the staff who carry out and monitor the day-to-day activities. It is therefore important to gauge

the extent prison staff understand and implement the rehabilitation program from participants recruitment to implementation of core and post-rehabilitation program, challenges and barriers, as well as the general situation of the correctional facility, human resources preparedness, facility and infrastructure. Staff' perception about the rehabilitation program was gathered as primary data through a focus group discussion with rehabilitation staff in Class II-A Prison in Paledang Bogor (Control Facility) and Class II-A Prison in Magelang (Intervention Facility).

Human Resources Competencies

To obtain a picture about the competency of prison staff who are at the forefront of program implementation, the study tried to map the competencies of human resources who were involved in the rehabilitation program, specifically any capacity building opportunities that were provided to staff. The study found that though some training and internship program were available, they were not specific on the technical aspect of rehabilitation, and so most rehabilitation staff had never received training or participated in an internship about rehabilitation. Individuals who had relatively good training or internship experience were mostly BNN's counselors who work at correctional facilities on a contract basis. Other staffs, like medical staffs, rely on their experience with rehabilitation programs from five years ago when rehabilitation services were actively provided in correctional facilities. The actual portrait about the human resources capacity is illustrated in the following statements:

> *"Regarding experience with social rehabilitation, one time Pak Roni sent me to a training at BNN, a residential social rehabilitation program for more than 1 month. But in terms of educational background, I actually have a Bachelor's degree in public health. In the social rehabilitation program, I am the program manager" (IDR-Control).*
>
> *".....So for coaching, we are the only staffs. That's the situation in the coaching and health section, and none of us in that section have received any training. So to do the task in our position, we simply….., like for example the program manager, he should've done an internship first. Also the instructor should be trained first. In the end, since we don't have any…., we just follow the existing structure" (HFH-intervention).*
>
> *"There was never any training, never during my position as a rehab staff. Therefore, this is my first experience. I just follow along, because I haven't had any experience. I follow my colleagues" (AF-intervention).*
>
> *"..... I'm here as a staff for the reporting. At that time I was put in the section of Islam religion. During the time I was there, I never attended any training. So, well.. the information was from them, it's to fulfill the section about Islam, about muslim (HKM-intervention).*

Since the rehabilitation program was taken over by the Ministry of Law and Human Rights, capacity strengthening of rehabilitation staff had never been provided. As a result, the current personnel, in the Control Facility as well as the Intervention Facility, do not have the experience

or capacity to implement a rehabilitation program. Inadequate quantity and quality of personnel are acknowledged by staff. Medical teams also had never received any rehabilitation-specific training. Focus group discussions revealed that staff who had access to rehabilitation-specific trainings seemed to be those from outside the correctional facility such as counselors who are BNN's staffs. Lack of counselors as key front-line workers is one critical issue that rehabilitation staff highlighted. Clients need support with their drug dependence to prevent them from returning to their previous habit once the rehabilitation program ends, and counseling for problemsolving is a necessity. Counseling should be provided by a counselor and a psychologist/psychiatrist but currently correctional facilities are not yet able to meet program requirements primarily due to budget limitation and other constraints. In an effort to fulfill the requirements stated in the guideline, despite delays, the Control Facility collaborated with a hospital to gain access to a counselor for their rehabilitation program.

> *"We also do not have a counselor to do counseling. So we finally asked a counselor from the hospital to help, but only for the last session. Since the timing was late, we had to have the counseling separately. Before that there was no counseling" (RN-control).*

> *"But after we are no longer linked with BNN, we have no counselors at all. Yes, that's the difficulty that we have (MP-control).*

Lack of counselors becomes a critical human resources issue and a rehabilitation program without a counselor is constrained in its ability to respond to clients' needs. This is what occurred in the Control Facility. FGD participants acknowledged that funding limitation makes it difficult for them to recruit counselors. In the end, the rehabilitation program did not include a counseling component, but consisted of mostly vocational activities, relying on existing personnel for program continuation. Staff in the Control Facility also perceive that during the six-month rehabilitation program, only one session of individual counseling is mandated by the guideline. In contrast, the Intervention Facility worked with a counselor from BNN of Temanggung in Central Java and arranged for the counselor to make weekly visits and provide counseling. FGD with the Intervention Facility staff revealed that the weekly visits could shift slightly due to the counselor's overlapping obligations, but in general, the Intervention Facility successfully solved the issue of counselor's inavailability and managed to provide routine counseling for rehabilitation participants. Prison staff and the counselor also developed a good relationship and could complement one another in their work.

> "…..*I'm the only counselor at BNN Temanggung, I live quite a distance, and I can only come here once a week. One time I couldn't come here for 2 weeks. A good thing friends could participate and help substitute for me in group activities" (FB-Intervention).*

Screening of Rehabilitation Participants

Different correctional facilities perceive screening differently. The Control Facility screened all inmates using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Prior to rehabilitation, participants would undergo a general assessment (not ASSIST) to categorize them into mild, moderate, and severely drug dependent. Clients who were considered as fulfilling the criteria for a rehabilitation program would undergo a laboratory drug screening test before being transferred to rehabilitation-specific cell blocks.

> *"Eerrr, for the rehab screening, we use ASSIST, Sir. We usually use that ASSIST not as we're about to start a rehab, no we don't use ASSIST …, but it's for new prisoners, when they just arrive here, then we use ASSIST. That's our screening. For the rehab, we don't use ASSIST but we go directly to a general assessment" (RN-control).*

A different procedure was observed in the Intervention Facility. All new prisoners would undergo mandatory screening using the ASSIST form. ASSIST and laboratory testing were also used as part of rehabilitation screening to divide clients into the category of mild, moderate, or severely drug-dependent based on the scores of ASSIST components.

> *"As a start we have stages. First, we do screening. Screening is also done when a new prisoner just arrives, we usually do a health check up, TB screening and substance-use screening. Then we were considering that we are not going to involve detainees since first of all detainees will still have to go in and out to attend court" (HFH-intervention).*

Both Control and Intervention Facilities had similar reservations regarding enrolling detainees, even severely-dependent individuals, into a rehabilitation program based on the consideration that court attendance would interfere with the rehabilitation process. Even with prisoners who had received their sentence and would not be going in and out to attend court, efforts to match the rehabilitation program period with the sentence length ran into various challenges. Unexpected occurrences such as reduced sentence period, remission, etc. frequently resulted in rehabilitation program interruption or drop outs.

> *"We cannot ensure the resident will be released right after he finishes the rehab program. Sometimes he's already freed before the rehab program finishes. Just like the situation now, we started with 30 participants, now we're down to 20. So some got out right in the middle of rehab. We cannot be sure about that. That's the dilemma. If we enroll those who are sentenced for more than six months, the dilemma is that it will be a long time before they are released, so what are we going to do with them after they finish rehab?" (SD-control).*

Recruitment dilemma was more frequently experienced by the Control Facility that had also experienced a program failure in the past when none of the rehabilitation participants completed the program. This emphasized the importance of taking into account the length of prison terms, remissions and other conditions in recruiting rehab participants.

Core Program

Based on the rehabilitation guideline, the core program of rehabilitation used the therapeutic community (TC) method, which to staff in the Control Facility was understood as a method for structuring discipline and instilling a sense of responsibility in the participants or residents. Discipline was enforced and rules were incorporated into what is termed a 'walking paper'. This literally meant a book that residents constantly carried wherever they go during the introduction phase within the rehab complex. The walking paper contained various rules, from discipline to the philosophical foundation of rehabilitation for residents to understand and internalize during the TC program. A credo was included which was the residents' belief in the program they were participating in, also a pledge for residents to read out loud together. The pledge aimed to build togetherness, so that residents would support one another in the rehabilitation process, and adopt other values that can increase their feeling of self-efficacy.

> *"The content is more on instilling discipline, for example discipline with time, the way to store their clothes, also hygiene, it's how they need to assume responsibility. Basically, social rehabilitation therapy is you helping yourself, helping other people in order to help yourself. That's what we emphasize" (IDR-control).*

Similar to staff in the Control Facility, the Intervention Facility's staff also perceived the therapeutic community (TC) method as a process of rule enforcement and discipline. TC residents would be treated differently from inmates in the general cell blocks, and would be required to follow all the protocols that have been set before they were transferred to rehab-specific cell blocks.

> *"So we pressure them to truly understand everything in the walking paper, the one you saw earlier. So we really coach them to review all the lessons, even memorize them. I guarantee these 20 people know these by heart ever since that time…., 3 weeks ago Febri and I were looking for ways to solidify their understanding. (HFH-intervention).*

Participants of a rehabilitation program would have to be ready for the outcome, which is a change in their daily habit. There might be some things that they had in the general cell blocks that would be more limited in the rehab cell blocks. The intent was to change behavior for the better, as shared by two resource persons:

> *"The hope is that what we tell them all this time will be remembered. At least we give them slightly more knowledge, and then, well… change their behavior" (MP-control).*

> *"So it's basically changing someone's behavior, make it better. Later, maybe those good habits here can continue outside" (RN-control).*

In the Control Facility, before starting the core program, participants went through an administration process to ensure and document that they had fulfilled the requirements for participating in a rehabilitation program. The Intervention Facility implemented a different

system. In the first month of rehabilitation, participants underwent a detoxification program, during which they would not be permitted to make contact with individuals outside the program, including their own family members. Participants also received an orientation about the tasks and rules of rehabilitation that they needed to comply with throughout the program.

> *".....then in the next process, we have a detox period. During the first month, they would not be allowed to receive visitors and make contact with their family. So it's kind of like a period of contemplation. They also need to know the rules in rehab, what the rehab cell blocks are like. We introduce to them this cell block has a different rule from the other blocks" (HFH-intervention).*

The Control Facility did not include a detoxification program, and participants directly followed activities that rehabilitation staff had prepared starting with information about the rehabilitation program before going into a specific cell block for an introductory session about the program. In the specific block, participants also directly followed staff' direction about the rules and other details.

One key difference between the control and Intervention Facility's core program was in counseling. The Intervention Facility provided routine counseling in the form of individual and group counseling, as well as family support group activities. The facility collaborated with the Temanggung District-level Narcotics Board (BNNK) to provide individual counseling once a month.

> *"Okey, that is one of our activities, and then individual counseling is given once a month, Sir. But this is a constraint, pardon me, I'm the only counselor at BNN Temanggung, I live quite far, I can only come here once a week. One time I couldn't come here for 2 weeks. Luckily colleagues could take part and fill in for me in the group activities" (AW-intervention).*

A counselor's task was not limited to provide individual counseling but also to provide psychoterapy, facilitate group therapy, and conduct almost all the activities that are outlined in the rehabilitation guideline such as CRGM, page, static. Group activities included seminar, group counseling, morning meeting, support group, and sports activities. Recreational activity included movie watching sessions every Saturday after which participants would be requested to make a summary of the movie. There was also handicraft class as one vocational activity.

> *"We have a lot of group activities for example a seminar. A seminar, both from the structural people or by the participants themselves. Materials would be provided by the instructor or counselor. Then we also have group sessions like therapy group… for example the other day Bro Febri taught about CRGM, and then page, static" (HFH-intervention).*

The Intervention Facility also worked with one university and invited a guest speaker on legal issues as a form of education for prison staff and rehabilitation participants. In addition

participants were required to attend religious and routine prayer sessions, read the Al-Quran and memorize prayers.

The content of the core rehabilitation program in both Control and Intervention Facilities was in general similar as both facilities followed the guideline. The implementation however varied, due to a variety of manpower constraints. As observed in the Control Facility, morning meetings, seminars and vocational activities were relatively good, but individual and group counseling as well as family support group activities were barely implemented as a result of counselor inavailability.

> *"Addiction counselor. There were several who agreed to help, but in reality, they came once and never came back (IDR-control).*

The core rehabilitation program consisted of three phases. The first phase, termed *younger member,* focused on introducing participants to the TC method, helping them adapt to the environment, and be informed about the rules and norms during rehab activities. The second phase, *middle member,* aimed to facilitate individual development to conform to societal norms and to understand the relationship between the rehabilitation program with life in the real world. The third and last phase, *older member phase,* facilitated training on leadership, responsibility, interpersonal skills and understanding of various life aspects. In implementation, resource limitations did not make it possible to divide participants into the different stages, so all participants took part in the same activities, and there was no clear separation between activities of the different phases. In the end, participants would be categorized into the different phases based on how much they were able to "memorize" information and adhere to the procedure and discipline applied in the program.

> "*So responsibility is something we put forward, either through those memorizations that are taught from that walking paper we talked about earlier. So it's basically since… what is it called… since addiction is an illness, it's said that it's a chronic illness, there's a disconnect in the brain, something like that. So we try to push them, we push them through memorization, etc. That's what we haven't done" (IDR-control).*

Another form of activity in the Control Facility's core program was group counseling held as a seminar on addiction with a doctor as a resource person. This activity was performed very minimally. Aside from the activities mentioned, the core program in both Control and Intervention Facilities was mostly religious in nature, and focused on vocational and group activities. In the absence of individual and group counseling, the Control Facility provided spiritual support such as daily prayer sessions, prayer memorization, and reading the Holy Book, interspersed with sports and vocational activities like hairdressing, handicraft-making skill training, etc.

Post-Rehabilitation Preparation and Program

Preparation for post-rehabilitation program was performed differently in the control compared to in the Intervention Facility. The Intervention Facility would administer the ASSIST without any laboratory screening, based on a consideration that throughout the rehabilitation program, participants were put in separate cell blocks, not mixed in with the general blocks. All of them would therefore be assumed to have a negative drug screen. ASSIST would be performed in accordance with the guideline as an evaluation method and to determine participant's interest in a post-rehabilitation program. Meanwhile the Control Facility would perform laboratory screening on the participants and a regular assessment (not ASSIST) similar to the initial assessment done for recruiting participants. Staff did acknowledge that all rehabilitation participants had a negative drug screen prior to entering the rehab-specific cell blocks, and they would not be exposed to any substances during the program, so laboratory screening served to evaluate and ensure consistency in all participants. In addition, an assessment served as a form of evaluation on the participant's progress.

Post-rehabilitation activities that most participants in the Control Facility took part in were seminars, vocational and religious activities, which were monotonous. Assessment actually revealed a good mix of interests and talents among participants, but the facility's ability to provide various skill-development support was very limited. Involving the correctional centers (*Bapas*) to follow up on the participants' interest and talent as part of post-rehabilitation program was constrained by limited facility and infrastructure.

In the Intervention Facility, post-rehabilitation activities would be monitored by rehabilitation staff. Participants worked on craft projects, or read addiction-related materials that would direct them to counseling. A rehabilitation instructor would prepare a report documenting participants' progress and submit it to a supervisor. This post-rehab report would complement a pre-rehab report that should be prepared at the start of the rehabilitation program as required by the guideline. Reports would be prepared by the instructor and not by the community research (*litmas*) unit.

> *"In the beginning and at the end. So it depends on the sentence period. When they first joined the program, we would prepare an initial report, and when they're close to be released there is parole, JP, conditional leave, we will have another report, so you can see there. The progress of what we do here can be seen" (AW-intervention).*

Similarly, the community research (*litmas*) unit in the Control Facility did not prepare pre- and post-rehabilitation reports even though the guideline actually specifies that reports be prepared by *Litmas*. Leveraging the correctional center (*Bapas*) to follow up on interests and talents of participants as part of post-rehabilitation activities was difficult due to *Batas*'s limited facility and infrastructure.

Perception of a successful rehabilitation program varied among staff. Some followed the guideline's statement about the goal of social and medical rehabilitation, namely abstinence and behavior change. Abstinence would be based on a negative drug screen, even though before entering rehab, participants have had a negative drug screen. Behavior change was assessed by the way participants took up responsibility over themselves in day-to-day activities, their polite behavior, willingness to accept criticism and diligent participation in religious activities.

> *"If you go back to the goal of rehabilitation as stated in the Guideline, the first is total abstinence. In terms of total abstinence, I dare to guarantee that it's a 100% success. The last urine tests were all negative. The second one is behavior change". (AW-intervention).*

Discussion with the rehabilitation team in the Intervention Facility revealed that the rehabilitation program had been implemented following the guideline, though not all activities stated in the guideline were conducted. Limited facilities, and human resources were still the main constraint in the effort of improving prisoners' quality of life. The key finding is that based on the rehabilitation service standard that was applied, Magelang and other correctional facilities have not met the requirement to be a social and medical rehabilitation institution.

Barriers in program implementation

Focus group discussions revealed that one of the challenges in following the rehabilitation guideline was that prison staff had little comprehension about the therapeutic community program and its curriculum. The terminologies and language used in the program guideline were perceived as foreign and hard to comprehend, and prison staff found it difficult to translate the program curriculum into day-to-day activities and some program activities may in fact be misleading. Staff' technical competence to apply or visualize the curriculum was very limited, compounded by a low commitment to rehabilitation program in the midst of overlapping obligations. This also related to the limited resources that have been allocated to the program despite the need that was much greater like for counseling activity that is actually the main component of a TC program.

Overall, rehabilitation service with the TC method in the Control Facility has not met the expected standard, from the facility and infrastructure, to human resources competencies, and funding support. The Intervention Facility faced similar challenges, except for counseling service which was provided quite intensively and routinely in the Intervention Facility. Lack of comprehension about the guideline was a constraint as the guideline used a lot of psychological terms that rehabilitation staff found difficult to understand. To prepare information that rehabilitation participants would understand, prison staff had to search for materials online themselves.

The biggest barrier was resource limitation despite the need that was relatively large. The rehabilitation program would also benefit from having several rooms for several processes, but space in correctional facilities is limited. Most rehabilitation staff were also responsible for other tasks and the dual role limited their ability to focus on the program.

4.5 Perception of Rehabilitation Participants about the Program

4.5.1 Demographic Aspect

The study team interviewed four participants of a social rehabilitation program. Two of them were from the Control Facility, and the other two were from the Intervention Facility. All four respondents have used drug in the past and were imprisoned for drug-related offenses. The four respondents also directly enrolled into a rehabilitation program when they first arrived at the correctional facility. Respondent 1 underwent a drug screen after he had been in the facility for a few months, and when his drug screen was positive, he enrolled into a rehabilitation program. Respondent 2 took the initiative to register and took an assessment for a rehabilitation program in January, and was finally able to enroll in a program in April or May.

> *"When I first arrived, I wasn't given a urine test. I had it, and then when I was at the kitchen, that was after a year, then I had a urine test and it came back positive" - Respondent 1- Control.*

> *"That was my own initiative because I had intended to participate in a rehabilitation. So I registered, then there was an assessment by a nurse."- Respondent 2 – Control.*

> *"I first heard that there would be a rehab activity [I was told] Everyone was told about it, some wanted it, some refused. I myself would like to participate."- Respondent 3 – Intervention.*

A similar situation was reported by the two respondents in the Intervention Facility. Both of them were offered a rehabilitation service, and they took the initiative to register. Respondent 3 shared that during the assessment, his drug screen result was negative. Respondents mentioned that when they first arrived at the correctional facility, they did not enroll in any program. Midway through their sentence, some were offered rehabilitation service and agreed to register, while others did so because they had been using drugs while in prison. All respondents had to wait a few months after the initial assessment before they would start a rehabilitation program.

4.5.2 Psychological Health

Actual rehabilitation activities in the Control Facility consisted of a good mix of individual and group activities. Some examples included routine morning exercise, prayer meeting and religious sermon, also memorization of a specific book in the Qur'an, seminar on drug and substances, or a specific health topic. There were also group activities such as a creativity contest on creating useful items from recycled products, gardening, movie nights, music concert. Participants could also sharpen some skills such as haircutting skills, etc. Individual or family counseling was limited, but group counseling was quite routinely held. One participant mentioned that the most routine activity he was involved in was religious activities.

> *"Gardening.. perhaps several times I think, while to learn to be a hairdresser, all of us are still learning that until now."- Respondent 1 – Control.*

> *"Spiritual activity, that's done daily."- Respondent 2 – Control.*

The reverse was seen in the Intervention Facility. Activities would revolve around individual, group, and family counseling, also seminars on drug and health-related topics. Respondents shared that BNN played a large role in the rehabilitation program, in counseling sessions as well as in the seminars. Fridays would typically be filled with religious activities, while Saturdays would be spent on vocational training (e.g. skills to turn recycled products into a useful item). Outside those structured activities, rehab participants would engage in some sports activities like table tennis, etc.

> *"The counseling is like what we are doing Ma'am, one-on-one. Some of the questions could be a bit sensitive, some were sensitive. The counseling questions could come from BNN,"- Respondent 3 – Intervention.*

> *"It was about therapy, motivation in life, how to resist temptation, something like that. An example is what I said earlier, hang out with a different crowd so that we won't use drugs anymore, and then we talked about the emotional aspect, psychological aspect."- Respondent 4 – Intervention.*

4.5.3 Physical Health

In general rehabilitation participants in both facilities believed that health services provided in the rehab-specific cell blocks were quite satisfactory, and were considered as the best that could be obtained in a correctional facility. Rehabilitation participants in the Intervention Facility added that health provider's response to emergencies was usually quick, but one convict from the Control Facility mentioned that he had doubts about the quality of the drugs used.

"Personally, when I look at the prison's condition and environment, maybe this is the best that can be done by the clinic here, currently, this is the best for us. They handle cases quite well."- Respondent 3 – Intervention.

"I wonder what those generic drugs are for, well, I will go to a doctor when I feel really ill. That's my personal opinion, I don't know about others, but when it comes to medicine in prison, you know how things are"- Respondent 1 – Control.

4.5.4 Environment

The study also looked at the environment in the facility, specifically the level of comfort in cell blocks. Participants agreed that the rehab-specific blocks were better than the general cell blocks. Crowding in the general cell blocks made the cells cramped and dirty, and with up to 40-50 inmates per room, finding a space to sleep could be a challenge. The study observed that the specific cell blocks were cleaner and neater, and had better sleeping facility, which according to one rehab participant in the Intervention Facility was because staff routinely monitored the cleanliness and neatness of rehab participants' room. Rehab participants mentioned how the general cell blocks were generally larger and more in quantity but were less comfortable than the rehab cell blocks.

"Very, very different. If we weren't in rehab, we would sleep like sardines."- Respondent 1 – Control.

"We have what is called the RoomGI session. It's basically a checking, an inspection of our room, its neatness, our diligence to clean it, its cleanliness. I think it's very comfortable, specifically in the rehab block, it's because we prioritize cleanliness, and neatness. "- Respondent 3 – Intervention.

4.5.5 Social Relationship

Another aspect the study looked at was the process of adaptation when participants first started a rehabilitation program. Since rehab participants were housed in a specific cell block, they had more opportunities to interact with one another, including with individuals they did not know beforehand (in the general cell block). With 20 participants and numerous group activities, intensive interaction could result in argument and conflict and participants had different views about this. One participant from the Control Facility saw this as a result of one troublemaker who often triggered physical altercations, while a participant from the Intervention Facility highlighted that conflicts are common occurrences which could be handled and resolved.

"Things basically became physical, there was always somebody who said this and that. Somebody always did. There was this one guy, he was totally nuts. In my opinion, he actually was not suitable to enroll in rehab since he was here for a criminal case"- Respondent 1 – Control.

"In a family, it's natural to have clashes, to have differences of opinion. There has never been a problem that can be considered as having an overall impact, no there's none. Each time there's a problem, a warning, or anything that needs to be discussed, then we sit down together and talk"- Respondent 3 – Intervention.

One significant difference that rehabilitation participants needed time to adapt to was the strict scheduling and the demand to participate in various activities. Participants felt regulated and restricted, unlike in the general cell blocks where they did not have to wake up early at a specific time each morning. Routine activities were seen as boring and participants felt restrained by the strict schedule as discipline was a priority in the rehab blocks more than in the general blocks.

"The first thing I felt back then was obviously I needed to adapt to the schedule, I usually wake up at 07.00, then for the morning gathering I need to wake up early, participate in rehab activities, so at first it was boring, boring,"- Respondent 3 – Intervention.

Those constraints were overcome with time and participants acknoweldged gaining positive impacts from the activities. Later, the strict schedule was felt as an added value for improving their self-discipline. Communication also improved following the routine morning meeting and inter-personal communication seminar, for example in communicating aspiration and handling confrontations. One participant from the Intervention Facility felt the activity helped him to be more confident, and less nervous to speak in public. Religious activity was also felt as giving a positive impact as a solution to negative thoughts that participants sometimes experienced.

"For me, during the time I'm in rehab I've been waking up earlier, I pray more diligently, my behavior and attitude also change. In terms of attitude, we become more appreciative of people, also the way we talk to people is different. We used to just blurt out whatever is in our mind, that's all,"- Respondent 2 – Control.

"I couldn't accept it, I couldn't stand being regulated, do this, do that, those were not important for me, why bother participating in this kind of rehab, if I'd known, I wouldn't have participated, I wished I hadn't, so at first I regretted participating. But over time, they were right, in rehab I become better, that's what I mean…."- Respondent 1 – Control.

4.5.6 Similarities and Differences in Experience

The four domains above demonstrated the different experience participants in the control and Intervention Facility had during rehabilitation. In the psychological health domain, the Intervention Facility focused on counseling to support the psychological need of participants, and participants in the Intervention Facility responded more positively to the health service provided, primarily services in the event of a health emergency. In the environment domain, staff' routine inspection of rooms helped maintain a clean and comfortable living space. Socially, the Intervention Facility was better able at addressing conflicts through discussion and resolution. All the differences indicate that rehabilitation participants in the Intervention Facility had a more positive experience than those in the Control Facility.

Aside from differences, there were similar experiences as well. Participants reported being positively impacted by rehabilitation activities, from structured and religious activities, training and communication seminar, to craft and creative skill development. Improved discipline, better communication, religious worship activity and sharper vocational skills were some of the positive impacts reported. They were seen as helping each individual in their self-development journey. Vocational skills also helped each participant explore potential income-generating activity for their future livelihood.

On the other hand, vocational skills training was limited as it mostly focused on arts and crafts such as working with recycled products, newspaper or the skin of *durian* fruit. Quite frequently, training would be facilitated by an inmate who is already skilled in the activity. Other options for skills development were limited. Most importantly, as one participant mentioned, training was provided only for the production aspect, while to successfully turn a skill into an income-generating business, a whole range of skills is needed from material preparation to marketing, calculation of profit margin, and others. As a result, the vocational skill training was felt as merely an activity to keep participants busy during rehabilitation but turning the skill into livelihood would be an unrealistic expectation.

> *"My current skill is only cutting newspaper, then I got tired, and then for the fun of it I made something. For personal use I think it won't be a problem, I can display it at home. Yes, later when I'm bored at home, I can make one just for fun. To commercialize it, well I haven't thought of it. Why would I want to do that, unless it's promising then yes I want to, but what if it's not promising,"- Respondent 1 – Control.*

Rehabilitation participants also stated their expectation from the program. One participant in the Control Facility hoped that the rehabilitation program only recruited individuals who truly need rehabilitation as he knew one participant who was doing time not for drug-related offenses. Participants in the Intervention Facility hoped for more rehabilitation staff and an improved facility. In general participants hoped for higher engagement with

counselors from outside the facility such as from BNN, and more seminars that focus on drug and health issues that are beneficial for them.

CHAPTER V. DISCUSSION

This is the first study that looks at the impact of refreshment training and monitoring on knowledge and skills of narcotics rehabilitation staff in a prison setting in Indonesia. Outside Indonesia a similar experimental study looked at how training on the therapeutic community (TC) treatment model and a course on managing organizational change affected rehabilitation service. The result shows that training positively impacted implementation of the rehabilitation program [14].

This study shows that refreshment training in the Intervention Facility resulted in a slight increase in the average knowledge score on program management. Program implementation in the Intervention Facility also improved as shown by more complete and higher quality reporting. Complete reporting illustrates that the Intervention Facility had followed the rehabilitation guideline and implemented the TC treatment program better than the Control Facility that mostly relied on seminar, vocational skill training, morning meeting and religious activities. A key finding from the study is the critical role of counselors in rehabilitation and the importance of capacity development of rehabilitation staff. Engagement with a counselor from the district BNN to perform monthly visits to the Intervention Facility was useful to facilitate counseling and therapy as core components of the TC treatment.

Qualitative data points to two contextual factors that enable better implementation of rehabilitation program in the Intervention Facility, namely trained counselor/officer and commitment of staff. Monthly monitoring which was one of the interventions performed in the study, kept staff committed to the activity, while in the Control Facility, excess workload and overlapping obligations limited staff' ability to provide quality rehabilitation service. While workload remains a common issue in both facilities, a higher level of commitment shown by staff in the Intervention Facility helped overcome the constraint. Intervention in the form of monthly monitoring also kept staff committed to adhere to the rehabilitation guideline. In the health sector, monitoring and evaluation have been proven to promote careful use of resources and adoption of best practices, as well as strike a balance between country-specific context and standardization since initial stages to ensure that the program is implemented efficiently and effectively and is reaching its target groups [15]. Health care professionals have also relied on monitoring and evaluation to understand the relationship between capacity strengthening and performance improvement in order to develop strategies that are focused on performance-improvement [16]. A study on HIV service integration in Nigeria also reported the importance of monitoring and evaluation to document and measure changes in processes, service output and outcome in order to look at the positive impact of service integration [17].

The setting in correctional facilities is one factor that greatly influences prisoners' quality of life (Table 13), and interventions indirectly improved the quality of life of individuals who

participate in a rehabilitation program (Table 12). This study shows that after a rehabilitation program, the quality-of-life score of participants in the Intervention Facility increased in all domains (physical and psychological health, social relationship and environment). On the other hand, participants in the Control Facility reported reduced quality-of-life score in three domains (physical health, social relationship and environment) even after a rehabilitation program. Statistical test (Table 11) confirmed that interventions through refreshment training and monitoring did improve rehabilitation participants' quality of life in all domains as shown in the average quality-of-life score difference between the Intervention Group and the Control Group. This indicates that without targeted intervention that specifically focuses on capacity strengthening of rehabilitation staff, rehab participants may not necessarily see improvement in their quality of life after they complete a rehabilitation program.

Qualitative data on the experience of rehab participants supports this finding. Overall, participants in the Intervention Facility reported more positive experience throughout the program. This was seen in all aspects of quality of life. Individual, group and family counseling were one focus activity in the Intervention Facility, along with seminars on several health education topics. During interviews, rehabilitation participants in the Intervention Facility also mentioned that they felt staff had been quite responsive in providing emergency health service. In contrast those in the Control Facility expressed doubts regarding the quality of their health service. Comfort and cleanliness of cell blocks was also better in the Intervention Facility as a result of routine inspection by staff. This supports what was reported by another study about significant correlation between the quality of the built environment and individual quality of life [18]. The social relationship between participants in the Intervention Facility was also perceived to be better as conflicts were resolved through discussions to find a solution. This demonstrates how each individual relates to one another.

Another factor that was identified as important in quality-of-life improvement is compliance participation in a social rehabilitation program. The study shows that participants who had relatively complete participation in the TC core program experienced a higher increase in their quality-of-life score than those with less complete participation. The score increase was significant and was observed in all domains (physical and psychological health, social relationship and environment). This finding is consistent with what was reported in a retrospective study in Australia that followed 193 therapeutic community residents. The study recorded a higher increase in psychological and quality-of-life scores over time. A similar increase was seen among participants who completed the TC program, which shows how TC program completion affects individual well-being in a significant way [19].

Despite the significant correlation between compliance participation in a rehabilitation program and improved quality of life, most prisoners in both facilities have not participated completely in the core TC program. Monthly monitoring performed by the study found no

records of individual or family counseling in the Control Facility, and only 2 of 20 participants in the Intervention Facility attended family counseling sessions during the rehabilitation program. Complete participation is actually expected from all TC residents in order to help each individual end their drug dependency, achieve behavior change, assume new responsibilities and gain new knowledge about drug dependence [20].

Limited counseling service should be made as one focus issue in rehabilitation implementation. Participants mentioned that counseling was only available with visits from a health institution or BNN. Family counseling was also not available, and the only activity that somewhat mirrored counseling was group support through morning meetings. Rehabilitation participants did express hope to receive routine counseling as sessions allow them to tell their story, gain insights and receive encouragement to change.

The therapeutic community model itself emphasizes a psychosocial approach to change behavior and attitude, foster emotional growth, promote hope, as well as improve the management skills of clients [21]. Therefore, individual and group counseling, also group therapy are key activities and the TC model relies greatly on availability of counselors and trained personnel. As observed in the study, trained staff are currently still limited and counseling therefore have to rely on BNN's support. Counseling is known to help people who use drugs overcome their psychological issues [22] and considering the prevalence of mental health illness that tends to be higher among prisoners than among the general population, mental health becomes an important issue that requires attention [23, 24].

Vocational skills such as hairdressing, gardening, craft creation from recycled products and others are positive new skills that rehabilitation participants appreciate. However, there is an impression that the skill only provides short-term benefit and cannot be an income-generating activity. Prison-based rehabilitation program does not just change behavior and individual mindset about drug use, but also provides a clearer idea about future profession or employment [25]. It is therefore important that more attention be given to vocational training modules and incorporate materials that foster managerial and marketing skills to build participants' marketing capacity. Experience with formal salaried work will also help inmates continue to be employed post-rehabilitation or post-incarceration to facilitate their re-entry process into the community [23, 24].

Aside from all the limitations of a prison-based rehabilitation program, participants agreed that the program brought about positive changes, from a closer relationship with God and more intensive worship activity, to a more disciplined, healthier lifestyle. Participants also regret having used drugs, and plan to apologize to their family upon returning home. The rehabilitation program motivates them to stop using drugs and they hope to lead a more positive life.

CHAPTER VI. CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This study shows that refreshment training slightly improved the technical knowledge of narcotics rehabilitation staff, but the improvement was not statistically significant. However, with intervention, the correctional facility was able to implement an improved rehabilitation program, which suggests that there are contextual factors that affect staff' skill for implementing a rehabilitation program. Availability of counselors/trained staff, strong commitment and monthly monitoring are believed to play a role in the staff' ability to provide better rehabilitation services.

Prison setting also plays a significant role in improving participant's quality of life. Participants in the Intervention Facility have higher quality of life scores compared to the participant in the Control Facility after completing the rehabilitation program. The study found that upon completing a rehabilitation program, participants' quality of life increased significantly in all four domains, i.e. physical and psychological health, social relationship and environment. Monthly monitoring and focus group discussion with rehabilitation staff recorded that the therapeutic community model was implemented more completely, and the rehabilitation guideline was followed more closely in the Intervention Facility than in the Control Facility. Again, this information suggests that rehabilitation was implemented better in the Intervention Facility than in the Control Facility.

Quality of life of rehabilitation participants was found to be significantly correlated with participants' compliance in the program. Those who had relatively complete participation in the core TC program reported a higher increase in the quality-of-life score in all four domains than participants with less complete participation. This suggests that program completion rate is one factor that is essential for improving prisoner's quality of life.

6.2 Recommendations

The study shows that refreshment training slightly increases staff' technical knowledge about the rehabilitation program. The study also shows that there are contextual factors that play a role in improving the implementation of the rehabilitation program, and that prisoners' compliance participation in a rehabilitation program is associated with their improved quality of life. Based on these results, several recommendations to strengthen the narcotics rehabilitation program are formulated for the Directorate General of Corrections (DGC), Ministry of Law and Human Rights and the CITUs.

Recommendations for the Directorate General of Corrections, Ministry of Law and Human Rights:

7. Review and revise the narcotics rehabilitation guideline (*Juklak*) that guides program implementation so that it is easier to understand and be followed by prison staff. Needed refinement includes use of simpler terminologies, and fewer psychological terms that are unfamiliar and difficult to understand so that staff can better interpret and translate the content of the guideline into workable program activities.
8. Develop a simpler rehabilitation guideline using a simpler method such as the Brief Intervention or the Narcotics Anonymous (NA) method. This will provide CITUs more rehabilitation method options to match with their need and capacity. Once the guideline is developed, all CITUs should be sensitized on the guideline's content and use.
9. Take into account the availability of rehabilitation staff in specific CITUs before appointing the unit as implementers of a rehabilitation program since proper implementation requires a detention center/correctional facility to have a program manager, a daily activity instructor, an assessor, and an addiction counselor. A preliminary assessment of human resources availability and preparedness is essential prior to appointment of specific CITU. The DGC can collaborate with other government institutions (e.g. BNN, Ministry of Social Affairs or Ministry of Health) and NGOs to ensure availability of adequate human resources for rehabilitation program implementation.
10. Ensure all rehabilitation staff in appointed CITUs have the capacity to implement the rehabilitation program in accordance with the guideline, starting from screening, initial assessment, to core program activities (individual counseling, family counseling, and group therapy), to post-rehabilitation preparation. Capacity strengthening of prison staff is therefore urgently needed so that rehabilitation service can be provided following the guideline. It may be worthwhile to consider a refreshment training as a way to disseminate the content and use of the guideline to prison staff before actual program implementation.
11. The DGC, Ministry of Law and Human Rights should develop a standard form to monitor and evaluate the implementation of social, and medical rehabilitation, and post-rehabilitation program in line with the guideline. Monitoring and evaluation of the rehabilitation program should engage the regional offices (*Kanwil*) and the DGC should facilitate monitoring and evaluation training for its staffs and representatives from each regional office on the use of the standard M&E form. Monitoring and evaluation is also expected to enable CITUs ensure complete participation of all rehabilitation participants in rehabilitation activities.
12. Hold routine meetings with the regional office (*Kanwil*) and appointed CITUs as part of technical mentorship and periodic supervision. This can take place once a month at a

minimum through direct visits or virtual meeting (e.g. using the zoom application). One objective of the meetings will be to identify constraints that are experienced in program implementation and discuss support that the DGC and regional office can provide to overcome the constraint.

Recommendations for the CITUs:

6. CITUs can develop a rehabilition method that is simpler than the therapeutic community method such as the Brief Interventions or the Narcotics Anonymous (NA). These two methods can be an option for an CITUs with limited capacity and a large number of rehabilitation participants that may face challenges in implementing the Therapeutic Community Method.
7. Ensure a counselor is available to provide individual counseling, facilitate group counseling and family counseling as part of the TC's core program. Appointed CITUs that do not have an addiction counselor can recruit an external counselor from the Provincial/District BNN or NGO using funds from respective correctional facility/detention center.
8. Build commitment of prison staff by strengthening their understanding about the main task and function of each officer in the rehabilitation program. Routine coordination meetings should also be organized to monitor the implementation, discuss constraints, and jointly arrive at a solution.
9. The Head of Correctional Facility is expected to be directly involved in supervising all the rehabilitation program activities and provide feedback for program improvement to all the staffs. The Head is also expected to mobilize adequate funding, provide facility and infrastructure to support the rehabilitation program implementation.
10. Recruitment of rehabilitation participants should take into account each prisoner's sentence length. Those with a shorter sentence length (close to being released) should be prioritized for a rehabilitation program and it is hoped that program completion can coincide with the individual's release date so that participants will not need to return to the general cell blocks for a long time before their release.

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