XIIITH WORLD CONGRESS OF REHABILITATION INTERNATIONAL
HELD AT TEL AVIV, ISRAEL

13th to 18th June, 1976

"Rehabilitation of Drug Addicts in a Correctional Setting"

by

T.G.P. Garner, Esq., J.P.,
Commissioner of Prisons, Hong Kong.
(Also Hon. Secretary, The Hong Kong
Society for Rehabilitation)

Introduction

Addiction to drugs and more specifically addiction to a narcotic drug, particularly heroin, creates within a community a problem which from long standing experience we know is difficult to tackle. What is generally not realised is that such problems, especially the major ones, will always be reflected within the prison community, although not always directly related to the offence for which a person is committed to prison. A Prison Service, or in the light of the emphasis now being placed on the rehabilitation of offenders, a 'Correctional Service', has an important role to play in tackling such problems which must be done with vigour and determination for, although the safe custody of offenders is placed first in the order of priority, the fact that one day almost all offenders will be released makes it necessary to concentrate on problems which can be successfully tackled while the offender is in custody. This will increase the extent of the contribution which the service makes to the community.

In Hong Kong, addiction to narcotic drugs has been a problem for the Prison Service almost from the very first day that the service was created and while the pattern of addiction has changed, the resulting difficulties and all that goes with them have not. In the 50s and 60s the presence of addiction to narcotics amongst persons admitted to prison was a constant 90%, irrespective of the type of offence for which they were committed. At that time some 50% were admitted for offences involving narcotics mainly for possession of small amounts. With such a high proportion of addicts within the prison community, it was apparent that if the Prison Service was to function efficiently in its aim of rehabilitation, then it had no choice but to become involved in the treatment of addiction. If it neglected to do this, then the rate of recidivism was going to be very high, probably over 90%.

Programmes of treatment have been drawn up in a number of countries where drug addiction prevails to treat prisoners who are found to be addicted to drugs. Treatment usually takes place within the confines of a prison and this is an encouraging first step. However, it is at best makeshift, for such specialised treatment programmes cannot be carried out efficiently inside an institution which is generally geared to the custody and reformation of offenders of a completely different type and lacks a totally orientated staff trained for a treatment programme in the drug field.

Intervention for Treatment

The treatment of the addict, particularly the narcotic addict once he comes within the ambit of the Prison Service, is a point when it can be considered appropriate for community intervention. If we accept, and it is doubtful that many will disagree, that once an addict has broken the law, this presents an opportunity for intervention to take place. Of course, it can be argued that if the possession of a drug is not considered a criminal offence, then intervention cannot come about, most certainly not in this way. Be that as it may, I am not aware of any country that has approved the possession of heroin other than when it has been authorised by a physician; therefore, under such circumstances, intervention can be considered appropriate in the interest of the community and the individual. A point to emphasise is that many persons come before the courts on a criminal offence other than a drug offence and are found to be drug dependent; at least this is the case in Hong Kong. In such cases, the question of intervention for treatment must be considered, particularly if it is determined

/that .....

that the offence stems from the problem of addiction. The position, therefore, is, that in any community where the problem of drug addiction, particularly narcotic addiction, exists, this problem will be reflected within the prison community, and unless the authorities are prepared to tackle it, a golden opportunity for doing so at the time when intervention can be deemed to be appropriate will be wasted.

It is sometimes argued that such an approach being a compulsory one can have little value. Those who take this line fail to understand the positive role that the Prison Service can and does play. Few will disagree that drug addiction presents a problem of public health and we are all aware that in matters of public health particularly if it involves, for instance, smallpox or cholera, intervention is considered right and proper in order to isolate for treatment those who are affected. Such action is considered necessary on humanitarian grounds not only in the interest of the individual but also to protect the community. Why then should we ignore drug addiction? Does the fact that it is considered more difficult to treat rule this out? One fact which cannot be ignored is that within the field of treatment for drug addiction, there cannot be a compulsory approach at least in the sense implied; it is compulsory only, in that the individual is taken, without his consent, to a treatment centre where the process of instilling motivation can commence. Ultimately, it is the individual under treatment who will decide whether or not he or she will revert to drug use; thus the period for which they are detained can be used to encourage them to make a decision which will enable one to live within the community after discharge without dependence upon drugs.

Period of Institutional Treatment

Addicts are people and like people they differ from each other in many ways, except of course in their desire for drugs and the symptoms they exhibit when they go through withdrawal. With this in mind, it follows that there cannot be a fixed period of time laid down for a programme of treatment, either for the treatment of the withdrawal syndrome, such other medical treatment which may be required, the necessary physical build-up, or the many other facets of the programme. Individual addicts will respond over varying periods of time mainly depending on their attitude and the period of time it takes the staff to persuade those who are reluctant to become involved in treatment or, to put it another way, show motivation. Persuasion, finesse and understanding are all important at this stage. Of all the factors involved in the treatment process, motivation is one of the most important; whether this stems from a desire to be rid of addiction simply because one is tired of it, whether it is through pressure from the family, or being afraid of the law does not particularly matter. What does matter is the recognition that motivation is essential even if only to cause one to make an attempt to try; for at least this provides a foundation, weak though it may be in the beginning, on which to build.

This and other factors make it difficult to set a stipulated treatment period at the end of which one could reasonably expect an addict to be at the peak of response. The alternative then is an indeterminate period for treatment based on a realistic minimum and an acceptable maximum with the aim of keeping the average period for the majority as short as possible. In Hong Kong many addicts take heroin by a method commonly known as 'Chasing the Dragon' (1) which also involves the use of barbiturates based roughly on a mixture of 3 parts barbiturates to 1 part heroin (2). The result is that many suffer from dependence on heroin complicated by a dependence on barbiturates requiring treatment for dependence on both types of drug. Experience has shown that most addicts with treatment rapidly overcome the symptoms of heroin withdrawal, but it takes longer to overcome their dependence on barbiturates, the most common symptom being that of insomnia. Thus the treatment for the withdrawal period for an addict in Hong Kong can take anything from 5 days to 4 weeks.

In an effort to determine the period of time required for treatment, the Prison Service, over a period of 10 years, gave treatment to convicted prisoners found to be drug dependent on admission to prison for the length of their sentence irrespective of their offence. Sentences ranged from several weeks up to a maximum of 3 years; however, allowing for a 1/3 remission of sentence for good behaviour given under the law for those serving a sentence of more than 1 month, the actual time served ranged from weeks to a maximum of 2 years. The number involved in this fact-finding exercise was in excess of 15,000. This eventually led to the conclusion that a minimum period of 6 months to a maximum of 18 months was the most appropriate period required. Recognising that after-care also plays an important role in the rehabilitation of the addict and bearing in mind the large number involved, it was decided that a compulsory period of 12 months after-care should follow release after treatment.

Consequent upon the drafting of the necessary legislation, an ordinance was enacted in Hong Kong which provides the courts with an alternative to all other options including imprisonment for a drug dependent person who has been found guilty of a drug or other related offence and this came into operation in January 1969. For the first 5 years following the enactment of this ordinance, the average length of stay in a drug addiction treatment centre worked out at 9 months. However, from 1974 and for the past 2 years, this period has been progressively reduced, until it is now approximately 7 months and presently we are seeking an amendment to the ordinance to lower the minimum to 4 months and the maximum to 12 months. (Information on persons admitted for treatment between the years 1972 and 1974 can be found in tables attached as an appendix to this paper.)

Appendix

Drug Addiction Treatment Centres Ordinance

The Drug Addiction Treatment Centres Ordinance provides for the rehabilitation of persons found guilty of criminal offences who are suffering from addiction to a dangerous drug. It is worthy of note that intervention for treatment in a drug addiction treatment centre will only take place following a finding of guilt and providing that the court is satisfied, in the circumstances of the case and having regard to the character and previous conduct of the individual, that it is in the individual's interest and the public interest that one should undergo a period of rehabilitation in an addiction treatment centre. This option is open to the court in lieu of imposing any other sentence and a criminal conviction will not be recorded unless the court orders that this must be done. Prior to the signing of an order for detention for treatment, the court considers a report by the Prison Authorities regarding the suitability of such person for treatment, taking into consideration the availability of places in the treatment centres, and all other relevant information necessary including previous medical, family, and other background history. Staff skilled in the various fields investigate and assist the court in compiling these reports for which the court will remand a person in custody for a period not exceeding 3 weeks to enable the report to be prepared.

The Ordinance stipulates that a person in respect of whom a Detention Order is made shall be detained in an addiction treatment centre for not less than 6 months and not more than 18 months from the date of the order, as the Commissioner of Prisons may determine, having regard to the health and progress made by such person and the likelihood of remaining free from addiction to any dangerous drugs on release. When submitting the suitability report, the Prison Authorities indicate within the report whether or not a previous Detention Order has been made so that the court is made aware if a person has previously received treatment in a treatment centre.

/Treatment .....

In planning a treatment programme, of equal importance for consideration is the setting within which treatment will take place. There exists in some countries a very strong emphasis on the need to take precautions to keep the environment within the institution drug free, in other words to prevent the trafficking of illicit drugs into the treatment centre. While one can fully appreciate the need for such action, in adopting such precautions, there is a tendency for the institution to develop a more prison like atmosphere than a treatment centre, which is to be deplored. A person under treatment will himself determine whether he is going to remain drug free upon release, this being so he will find it extremely difficult to reach a favourable decision with any firmness of conviction if, during the treatment programme, he is not sufficiently trusted and there is an obvious lack of confidence emphasised through the kind of environment in which he finds himself. There is also the question of the environment in which the staff must work; the wrong environment will affect their ability to influence those requiring treatment to accept the basic principles leading to the creation of motivation, for motivation cannot be built up in an atmosphere of distrust. It is therefore crucial for the institutional setting in which the treatment programme will be carried out to be as open as possible not only to enable those under treatment to live within conditions more favourable to community life, but also to fully demonstrate that the greatest effort within the treatment programme will have to be exerted by themselves rather than having to rely on others. Naturally, there will be differences within the treatment group, for instance new admissions will contain a large element of those who are lacking motivation and must be kept separate for at least a little time from those who have been within the programme longer. However, such differences can be minimised and formally accepted as part of the overall treatment process.

Given that the addict is a person who has a complication of both physical and psychological dependence, and in the light of the knowledge borne of experience that physical dependence is a factor which is much more readily and easily overcome, we are left with the problem of psychological dependence. To treat the psychological dependence factor, one does not necessarily require a classical psychiatric setting. Based on the Hong Kong experience, we believe that the less hospital orientated the setting, the better. In the absence of a total medically orientated programme, one does not build up a doctor/patient relationship whereby the addict who fails the treatment programme can readily blame the doctor for failure to provide adequate treatment, hence an escape mechanism for relapse. The need for medical services and care is, of course, essential and must not be minimised. This will include treatment for those who may be suffering from any illness or disease apart from addiction or some form of psychiatric illness. However, treatment for the latter can be accomplished by transfer to an institution specialising in such treatment following which the person concerned can be returned to the centre. The treatment programme must be directed in such a way that the addict realises beyond any doubt that he himself is responsible for making most of the going. The facilities which are provided and the assistance given by the staff are but aids to assist him to do so. To this end a regular daily routine, coupled with work mainly of a physical nature, aimed at cultivating good work habits is essential. Insofar as is possible, such work should take place outside of the treatment centre perimeters involving community projects through which those under treatment can demonstrate their usefulness to the community and at the same time take pride in being gainfully employed, the results of which can be seen and enjoyed by all. Afforestation is but one example of the type of work which can be usefully performed. Recognition of the need to rebuild family relationships and to prepare the individual to stand up to the stresses and strains of life which will have to be faced upon release are all important. The eventual aim is to implement a programme unsophisticated in scope but which covers the various stages in-depth.

Due to the poor physical condition of many addicts on admission, one would think that it is necessary for long periods to be spent either in the hospital or in idleness. However, this is not the case. Physically, recovery is rapid and unless an addict is suffering from other medical complications, he soon becomes fit for work and this does much to help restore badly needed self-respect and triggers recognition that he is making progress. Psychological treatment aided by individual and group counselling assisted by welfare and after-care services, good work therapy, plus a wide range of recreational activities, are all necessary facets of the programme.

It is essential that the person under treatment is made aware at frequent intervals how his response to treatment is viewed. To this end a board of review should be established before which he can appear and in addition to being informed of his progress he has the opportunity to state his own views and assessment of his situation.

Trial periods of absence away from the centre also help and, if used as a privilege, create incentive. In Hong Kong such periods, usually covering 48 hours, are very seldom abused and urinalysis determines if one has engaged in any drug activity while away from the centre.

Another very important factor in the treatment process, and probably the main one, involves the calibre of the staff. A treatment programme can be carried out in buildings, new or old, lavish or cramped, but ultimately it is the staff who hold the key to its success. The creating of a favourable environment encompassing a spirit of hope which can be recognised by new arrivals is essential. This can only come about through the staff acting as a team with the firm conviction that what they are doing is right, worthwhile and capable of achieving success. It is well known that man can influence man for bad; one often forgets that the reverse is also true, that he can exert and exercise a good influence. This means that the staff must take a much greater interest in their respective duties over and above that which is expected of them if measured by financial remuneration alone. Problems, particularly emotional ones, coming at the end of a day or prior to a member of the staff going off duty, cannot be thrust aside and left to wait until the next day; they must be tackled immediately, partly at least, for by so doing there is much to be gained; if not, much can be lost.

Age groupings and previous criminal history must also be taken into account in planning treatment programmes. Most certainly narcotic addiction and crime is interlinked and cannot be ignored. We have also discovered that the treatment of those under 21 can be much more meaningful when they are segregated from the older age groups. We have currently a programme for this particular group which we are watching with great interest. So far all signs point to the probability that we will achieve better results than those we have achieved with adults. The physical stamina and the various interests of young persons are different to those of adults and must be catered for, and the potential for leadership steered in the right direction.

Persons with minor criminal histories must be segregated from those with long criminal histories, for there is usually a larger percentage of hard core addicts in the latter group compared to the former. Such segregation is practised in Hong Kong and results prove that we have adopted a correct approach.

We do not consider the addict to be a complicated person, difficult though his problems may be. Many are genuine in their desire to achieve a drug free status but lack the necessary determination and resolve to carry it through - a human weakness. It is all the more important because of this for the staff to step in and help stiffen that resolve by ways which only man can help man.

In all matters of treatment of difficult problems we must expect failures, for failure is not always the fault of the person under treatment. In some cases, he does not fail the programme, the programme fails him. Treatment is accumulative and a second programme can build upon the first. For instance, if an addict under treatment has already been instructed on the effects of the drug, he does not require the same instruction over again. Therefore, during the second treatment, a more varied approach is called for which takes into account that he is not receiving treatment for the first time. The foundation on which to work has, to some extent, already been laid and should not be wasted by going over old ground unless such a step is considered absolutely necessary.

After-Care

After-care is a continuation of the treatment process within the community after release from the centre. However, the term 'after-care' suggests that this commences only after release, which is not the case. In a true treatment setting, the matter of release will be considered almost from the time the person commences treatment. There is much to be done to prepare him or her for the day when they will once again be back in the community and more than likely return to the same environment from whence they came, a fact of life which cannot be ignored.

The building up of a solid foundation of confidence and friendship between the person who will be under after-care, his family, and the social worker is a task which takes time and calls for tact and understanding for such a foundation must be built prior to release. Employment prospects must be investigated and a job found prior to discharge; this should be the concern of all involved. Discharge to idleness can put a treated addict 50% or more back on the road to re-addiction.

The practice of requiring former drug dependants under after-care to return and report to an office in order to monitor progress leaves much to be desired. This does not inspire confidence or signal friendship on the part of the social worker. The social worker has him for a client, so why then should the social worker not go to visit him. To monitor progress one requires not only the means for determining if the client is drug free, but also a check on family relationships; this is much more easily ascertained by social workers on home visits rather than have the client call in at an office.

After-care by the Prison Service in Hong Kong is carried on for a 1 year period. There is nothing magic in the period of 1 year except this carries them over the crucial first 6 months during which time they are more vulnerable to relapse.

To carry after-care through for too long a period can be frustrating to the client, particularly if he is doing well and has settled down in the community. We have therefore determined that a 1 year after-care follow up with provision for early termination, if considered desirable, is the most economical period bearing in mind that relapse usually occurs with the largest number within the first 6 months. A longer period than 1 year is not considered economically justified in view of the resulting minimal gain.

Of significant benefit to the treated addict following release from a treatment centre is the availability of such facilities as Half-way Houses and social clubs. The former can act as a bridge for those who need to be eased back into the community and the latter can be utilised during leisure time, particularly important during the early months following release after treatment. At most, however, the use of such facilities must be for a limited period for the eventual aim is to assist the former addict to overcome and forget the days and years of his dependence on drugs.

/The .....

The idea of life long membership of an alumni association or the gathering of former addicts on a regular basis with a fanfare of publicity to celebrate overcoming their dependence is not, in my opinion, a wise policy. Former addicts must be encouraged to reintegrate into society and not stand aloof because of their former dependence. A man of today who has overcome his addiction will not want to have this fact continuously before him for the rest of his life.

Conclusion

In this paper, I have endeavoured to outline by way of a thumb nail sketch the department's approach to the treatment of drug dependants in a correctional setting. It does not cover all that is being done or how it is being done other than what I consider to be the more essential points.

An indication of the size of the problem that the Prison Service must deal with in Hong Kong is best illustrated by the following statistics: Since 1st May, 1972 (a period of 4 years) a total of 12,707 cases (male) have been remanded in custody for a suitability report for admission to a drug addiction treatment centre. Of this figure only 1,990 (15.66%) were found not to be addicted to drugs and therefore were rejected. In addition, a further 3,333 cases were either found unsuitable or were refused admission in view of the lack of available accommodation. In all some 7,318 cases were found suitable out of a total of 10,717 confirmed addicts (68.28%) and of that total 6,732 were ordered by the court to be detained for treatment. Currently, the service maintains 4 drug addiction treatment centres, 3 for males and 1 for females, with normal accommodation for 1,189. At the present time, these centres are holding 1,481 made up of 1,432 males and 49 females, an overcrowding factor of 24.56%.

The proof of the programme's success must, of course, be measured in terms of results achieved. Since the introduction of the programme in January 1969 some 8,296 men and 342 women have been discharged from the treatment centres. At the end of the 1 year follow up after release, the drug free rate stands at 59.92% for men and 69.69% for women.

On the basis of a 10% sample followed up for 3 years, the figure stands at 40.13% for men. The percentage for women cannot be measured accurately as only 19 have completed the 3 year period; however, we do know it is higher than the male percentage. The criterion for determining success is a drug free status, stable employment, good family relationships and no additional criminal offence.

Not included is the 13.55% (males) who have been reconvicted for a criminal offence but who still retain a drug free status. When added to the above percentage, 40.13% increases to 53.68% drug free 3 years after treatment. Those engaged in the treatment field will, I am sure, consider this a remarkable achievement.

You will recall that in the introduction to this paper I stated that in the 50s and 60s the presence of addiction to narcotics amongst admissions to prisons was a constant 90%. Today the figure has dropped to 63%. During the same period in the 50s and 60s, 50% plus were admitted for offences involving narcotics mainly possession; today only 15% are admitted for possession (excluding trafficking, dealing etc.). Included in that 15% are many who have previously been convicted for dealing in drugs and serious crimes of violence. While we cannot afford to be complacent about the present figures, there are good grounds for believing that we have made genuine progress during recent years.

/The .....

The department has reason to be confident of the approach that it has pioneered and although it can be termed a compulsory one it has achieved a higher success rate than other programmes in the voluntary sector, this despite the initial lack of motivation on the part of many admitted for treatment. The results achieved indicate at least one reasonably successful approach to the problem of drug dependence; no one would claim it is the total answer but at least an approach in the right direction - a foundation on which to build.

The availability/scarcity of drugs, particularly narcotics within a community, will have a distinct bearing on the degree of success achieved, so too will the attitude of members of the community, particularly parents, teachers, employers, and members of law enforcement agencies. The problem of treatment for drug addicts is difficult but the staff of the Prison Service in Hong Kong have proved it is not impossible.

Explanatory Notes:

(1) 'Chasing the Dragon'. Heroin is mixed with a quantity of barbitone which is placed on a piece of tin foil, and heated by means of a lighted taper or candle placed under the tin foil. The resulting fumes are inhaled through a small tube usually made of paper or bamboo. The mixture of heroin/barbitone will run in various directions on the tin foil with the result that the fumes will rise in an undulating manner resembling the tail of a dragon, hence the term 'Chasing the Dragon'.

(2) Addicts 'Chasing the Dragon' usually purchase the heroin/barbitone already mixed in prepared packets. The amount of base powder (barbitone) can be used in any quantity which the smoker desires.* (It is known that approximately 15-25% of the barbitone is broken down by heating during the process of chasing the dragon, although the exact amount which is decomposed will certainly vary with the habits of the individual.) However, there is no doubt that a number of addicts who 'Chase the Dragon', have a combined heroin/barbiturate addiction.

* Pharmacological Investigation and Evaluation of the effects of Combined Barbiturate and Heroin Inhalation by Addicts. Dr. Carl C. Gruhzie, M.D., Ph.D., Pharmacologist, University of Hong Kong.

In addition to (1), in Hong Kong narcotic drugs are also taken in other ways:

(a) Firing the ack ack gun. A few granules of heroin are placed on the tip of a cigarette, which is then smoked, held in a vertical position by the smoker to prevent the heroin from falling off. This method is used by the majority of addicts when they first begin to take heroin.

(b) Playing the mouth organ. This is a variation of 'Chasing the Dragon' by using a match box cover to inhale the fumes instead of a small tube. The reason for this is to inhale as much of the fumes as possible which is particularly difficult for a beginner trying to 'chase the dragon' using a small tube.

(c) Opium. This can be taken two ways - either smoked with a pipe, or taken orally in the form of a pill.

(d) Heroin pill. This can be taken two ways - either smoked with a pipe, or taken orally in the form of a pill.

(Heroin). Other methods used include intravenous, subcutaneous or intra-muscular injection.

APPENDIX

TABLES

Universe of the Study

A total of 4,313 male and 182 female drug addicts who have completed a full treatment programme in the Prisons Department's drug addiction treatment centres between 1972 - 1974 are the subject of this study. This represents a 100% coverage of the treatment centres clientele during that period. Table 1 shows the breakdown of addict population in terms of sex and time reference.

TABLE 1

ADDICT POPULATION 1972 - 1974

	Male	Female	Total
1972	1,321	50	1,371
1973	1,374	45	1,419
1974	1,618	87	1,705
	4,313	182	4,495

Method of Data Collection

Data has been collected via personal interview; every addict being interviewed upon admission to a treatment centre by interviewers carefully selected and trained for the task. Although the interview is essentially a standardised and structured one, provision is made for the use of discretionary non-directive probes as it is recognised that pertinent and reliable information from inmates usually demand the technique of indirect questioning and mild-mannered cross examination (unless rapport exists).

Wherever possible, cross reference is made with official records to ensure the accuracy of certain information.

TABLE 2 (Male)

AGE GROUPS

Age	Number	Percentage
14-15	11	0.3
16-20	626	14.5
21-24	922	21.4
25-29	726	16.8
30-34	383	8.9
35-39	395	9.2
40-44	459	10.6
45-49	389	9.0
50-54	241	5.6
55-59	113	2.6
60 & Over	48	1.1
Total	4,313	100.0

(Female)

14-15	1	0.5
16-20	35	19.3
21-24	51	28.0
25-29	29	15.9
30-34	10	5.5
35-39	5	2.7
40-44	19	10.5
45-49	14	7.7
50-54	12	6.6
55-59	4	2.2
60 & Over	2	1.1
Total	182	100.0

TABLE 3 (Male)

PLACE OF BIRTH

	Number	Percentage
Hong Kong, Kowloon and New Territories	1,854	43.0
Canton, Macau and Adjacent Places	1,052	24.4
Sze Yap	545	12.7
Chiu Chau	595	13.8
Elsewhere in Kwangtung Province	97	2.2
Elsewhere in China	131	3.0
Other Asian Countries	38	0.9
Non-Asian Countries	1	-
Unknown	-	-
Total	4,313	100.0

(Female)

Hong Kong, Kowloon and New Territories	97	53.4
Canton, Macau and Adjacent Places	37	20.3
Sze Yap	12	6.6
Chiu Chau	7	3.8
Other Places	29	15.9
Total	182	100.0

TABLE 4 (Male)

EDUCATION ATTAINMENT

	Number	Percentage
No Schooling	672	15.5
Lower Primary	1,053	24.4
Upper Primary	1,853	43.0
Lower Secondary	634	14.7
Upper Secondary	94	2.2
Post Secondary & Above	7	0.2
Total	4,313	100.0

(Female)

No Schooling	61	33.5
Lower Primary	51	28.0
Upper Primary	55	30.2
Lower Secondary	15	8.3
Upper Secondary	-	-
Post Secondary & Above	-	-
Total	182	100.0

TABLE 5 (Male)

OCCUPATIONAL STATUS

	Number	Percentage
Unemployed *	1,066	24.7
Farmers, Fishermen etc.	94	2.2
Miners, Quarrymen etc.	-	-
Service, Sport & Recreation Workers	594	13.8
Transport & Communication Workers	169	3.9
Clerical & Sales Workers	418	9.7
Craftsmen & Production Workers	1,270	29.4
Unskilled Labourers	693	16.1
Administrative, Technical & Professional Workers	9	0.2
Total	4,313	100.0

(Female)

Unemployed **	105	57.9
Housewife	29	15.9
Service, Sport & Recreation Workers	17	9.3
Clerical & Sales Workers	9	4.9
Craftsmen, Production Workers & Labourers	21	11.5
Others (not specified)	1	0.5
Total	182	100.0

* 29 or 0.7% of the males listed as unemployed admitted engaging in homosexual practice for financial gain.

** 79 or 43.5% of the females listed as unemployed admitted engaging in prostitution.

TABLE 6 (Male)

DAILY INCOME

	Number	Percentage
Nil	1,037	24.0
Less than $5	-	-
$5 to less than $10	36	0.8
$10 to less than $15	214	5.0
$15 to less than $20	484	11.2
$20 to less than $25	716	16.6
$25 to less than $30	586	13.6
$30 to less than $35	456	10.6
$35 to less than $40	223	5.2
$40 to less than $45	225	5.2
$45 & Over	336	7.8
Total	4,313	100.0

(Female)

Nil	55	30.2
Less than $5	1	0.5
$5 to less than $10	2	1.1
$10 to less than $15	8	4.4
$15 to less than $20	17	9.3
$20 to less than $25	13	7.1
$25 to less than $30	9	5.0
$30 to less than $35	8	4.4
$35 to less than $40	7	3.9
$40 to less than $45	9	5.0
$45 & Over	53	29.1
Total	182	100.0

TABLE 7 (Male)

AGE AT COMMENCEMENT BY AGE GROUPS

Age at Commencement	Age Groups Under 30		30 & Over		Total	
	No.	%	No.	%	No.	%
14 - 15	235	(5.5)	36	(0.8)	271	(6.3)
16 - 19	1,161	(26.9)	79	(1.9)	1,240	(28.8)
20 - 24	712	(16.5)	404	(9.4)	1,116	(25.9)
25 - 29	177	(4.1)	515	(11.9)	692	(16.0)
30 - 34	-	(-)	448	(10.4)	448	(10.4)
35 - 39	-	(-)	298	(6.9)	298	(6.9)
40 - 49	-	(-)	226	(5.2)	226	(5.2)
50 - 59	-	(-)	21	(0.5)	21	(0.5)
60 & Over	-	(-)	1	(-)	1	(-)
Total	2,285	(53.0)	2,028	(47.0)	4,313	(100.0)

(Female)

14 - 15	15	(8.3)	1	(0.5)	16	(8.8)
16 - 19	54	(29.7)	5	(2.7)	59	(32.5)
20 - 24	41	(22.4)	14	(7.7)	55	(30.3)
25 - 29	6	(3.3)	11	(6.0)	17	(9.3)
30 - 34	-	(-)	11	(6.0)	11	(6.0)
35 - 39	-	(-)	11	(6.0)	11	(6.0)
40 - 49	-	(-)	9	(4.9)	9	(4.9)
50 - 59	-	(-)	4	(2.2)	4	(2.2)
60 & Over	-	(-)	-	(-)	-	(-)
Total	116	(63.7)	66	(36.3)	182	(100.0)

TABLE 8 (Male)

PERIOD ON DRUGS BY AGE GROUPS

Period	Age Groups Under 30		30 & Over		Total	
	No.	%	No.	%	No.	%
Less than 1 year	478	(11.1)	105	(2.4)	583	(13.5)
1 - 2 years	695	(16.1)	157	(3.7)	852	(19.8)
3 - 4 years	496	(11.5)	191	(4.4)	687	(15.9)
5 - 6 years	294	(6.8)	192	(4.5)	486	(11.3)
7 - 9 years	232	(5.4)	243	(5.6)	475	(11.0)
10 - 14 years	86	(2.0)	412	(9.6)	498	(11.6)
15 - 19 years	4	(0.1)	316	(7.3)	320	(7.4)
20 - 24 years	-	(-)	205	(4.8)	205	(4.8)
25 - 29 years	-	(-)	96	(2.2)	96	(2.2)
30 - 39 years	-	(-)	92	(2.1)	92	(2.1)
40 & Over	-	(-)	19	(0.4)	19	(0.4)
Total	2,285	(53.0)	2,028	(47.0)	4,313	(100.0)

(Female)

Less than 1 year	25	(13.7)	2	(1.1)	27	(14.8)
1 - 2 years	42	(23.1)	6	(3.3)	48	(26.4)
3 - 4 years	25	(13.7)	2	(1.1)	27	(14.8)
5 - 6 years	9	(4.9)	4	(2.2)	13	(7.1)
7 - 9 years	13	(7.1)	7	(3.8)	20	(11.0)
10 - 14 years	2	(1.1)	16	(8.8)	18	(10.0)
15 - 19 years	-	(-)	14	(7.7)	14	(7.7)
20 - 24 years	-	(-)	8	(4.4)	8	(4.4)
25 - 29 years	-	(-)	4	(2.2)	4	(2.2)
30 - 39 years	-	(-)	3	(1.6)	3	(1.6)
40 & Over	-	(-)	-	(-)	-	(-)
Total	116	(63.7)	66	(36.3)	182	(100.0)

TABLE 9 (Male)

AGE AT COMMENCEMENT BY CAUSATION

Age at Commencement	Causation															
	Cure for Illness		Association with Addict To Gain Acceptance		Curiosity		Improve Sexual Capabilities		Long Hours of Work		Pleasure/ Pastime		Depression		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
14-15	8	(0.2)	107	(2.5)	81	(1.9)	10	(0.2)	7	(0.2)	57	(1.3)	1	(-)	271	(6.3)
16-19	76	(1.8)	403	(9.3)	351	(8.1)	108	(2.5)	77	(1.8)	208	(4.8)	17	(0.4)	1240	(28.8)
20-24	80	(1.9)	376	(8.7)	307	(7.1)	124	(2.9)	122	(2.8)	88	(2.0)	19	(0.4)	1116	(25.9)
25-29	68	(1.6)	192	(4.5)	122	(2.8)	103	(2.4)	150	(3.5)	41	(1.0)	16	(0.4)	692	(16.0)
30-34	82	(1.9)	131	(3.0)	43	(1.0)	50	(1.2)	112	(2.6)	21	(0.5)	9	(0.2)	448	(10.4)
35-39	67	(1.6)	81	(1.9)	25	(0.6)	35	(0.8)	65	(1.5)	18	(0.4)	7	(0.2)	298	(6.9)
40-49	75	(1.7)	38	(0.9)	14	(0.3)	13	(0.3)	68	(1.6)	7	(0.2)	11	(0.2)	226	(5.2)
50-59	9	(0.2)	5	(0.1)	-	(-)	-	(-)	6	(0.1)	-	(-)	1	(-)	21	(0.5)
60 & Over	-	(-)	1	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	1	(-)
Total	465	(10.8)	1334	(30.9)	943	(21.9)	443	(10.3)	607	(14.1)	440	(10.2)	81	(1.8)	4313	(100.0)
(Female)																
14-15	-	(-)	4	(2.2)	10	(5.5)	-	(-)	-	(-)	-	(-)	2	(1.1)	16	(8.8)
16-19	11	(6.0)	14	(7.7)	30	(16.5)	-	(-)	-	(-)	2	(1.1)	2	(1.1)	59	(32.5)
20-24	6	(3.3)	19	(10.4)	24	(13.2)	-	(-)	1	(0.5)	3	(1.6)	2	(1.1)	55	(30.3)
25-29	7	(3.8)	3	(1.6)	4	(2.2)	-	(-)	1	(0.5)	-	(-)	2	(1.1)	17	(9.3)
30-34	5	(2.7)	1	(0.5)	4	(2.2)	-	(-)	1	(0.5)	-	(-)	-	(-)	11	(6.0)
35-39	6	(3.3)	-	(-)	3	(1.6)	-	(-)	2	(1.1)	-	(-)	-	(-)	11	(6.0)
40-49	5	(2.7)	2	(1.1)	-	(-)	-	(-)	1	(0.5)	-	(-)	1	(0.5)	9	(4.9)
50-59	3	(1.6)	-	(-)	-	(-)	-	(-)	1	(0.5)	-	(-)	-	(-)	4	(2.2)
60 & Over	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)
Total	43	(23.7)	43	(23.7)	75	(41.2)	-	(-)	7	(3.8)	5	(2.7)	9	(4.9)	182	(100.0)

TABLE 10 (Male)

PRESENT REASON GIVEN FOR TAKING DRUG BY CAUSATION

Present Causation	Causation											
	Cure for Illness		Association with Addict To Gain Acceptance		Curiosity		Improve Sexual Capabilities		Long Hours of Work		Pleasure/ Pastime		Depression		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Relieve Depression	9	(0.1)	3	(0.1)	1	(-)	26	(0.6)	-	(-)	35	(0.8)	36	(0.8)	110	(2.5)
Physical Dependence/ Compulsion	361	(8.4)	1056	(24.5)	662	(15.3)	371	(8.6)	460	(10.7)	316	(7.3)	37	(0.9)	3263	(75.7)
Pleasure	3	(0.1)	99	(2.3)	139	(3.2)	5	(0.1)	2	(0.1)	52	(1.2)	-	(-)	300	(7.0)
Relieve Reality Pressure	2	(-)	3	(0.1)	3	(0.1)	2	(-)	1	(-)	1	(-)	4	(0.1)	16	(0.4)
Long Hours of Work	1	(-)	12	(0.3)	4	(0.1)	-	(-)	114	(2.6)	-	(-)	-	(-)	131	(3.0)
Sexual Capabilities	3	(0.1)	2	(-)	8	(0.2)	11	(0.2)	3	(0.1)	2	(-)	-	(-)	29	(0.7)
Relief of Pain	79	(1.8)	26	(0.6)	1	(-)	3	(0.1)	17	(0.4)	-	(-)	-	(-)	126	(2.9)
Association with Addict	5	(0.1)	132	(3.0)	120	(2.8)	17	(0.4)	10	(0.2)	13	(0.3)	-	(-)	297	(6.9)
Relieve Boredom	2	(-)	1	(-)	5	(0.1)	8	(0.2)	-	(-)	21	(0.5)	4	(0.1)	41	(0.9)
Total	465	(10.8)	1334	(30.9)	943	(21.9)	443	(10.3)	607	(14.1)	440	(10.2)	81	(1.8)	4313	(100.0)
							(Female)									
Relieve Depression	2	(1.1)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	2	(1.1)	4	(2.2)
Physical Dependence/ Compulsion	23	(12.6)	28	(15.4)	50	(27.5)	-	(-)	-	(-)	2	(1.1)	4	(2.2)	107	(58.9)
Pleasure	-	(-)	-	(-)	1	(0.5)	-	(-)	-	(-)	2	(1.1)	-	(-)	3	(1.6)
Relieve Reality Pressure	4	(2.2)	-	(-)	1	(0.5)	-	(-)	2	(1.1)	-	(-)	-	(-)	7	(3.8)
Long Hours of Work	-	(-)	1	(0.5)	-	(-)	-	(-)	2	(1.1)	-	(-)	-	(-)	3	(1.6)
Sexual Capabilities	-	(-)	-	(-)	1	(0.5)	-	(-)	-	(-)	-	(-)	-	(-)	1	(0.5)
Relief of Pain	9	(4.9)	3	(1.6)	3	(1.6)	-	(-)	-	(-)	-	(-)	1	(0.5)	16	(8.8)
Association with Addict	2	(1.1)	7	(3.8)	10	(5.5)	-	(-)	2	(1.1)	-	(-)	-	(-)	21	(11.6)
Relieve Boredom	3	(1.6)	4	(2.2)	9	(4.9)	-	(-)	1	(0.5)	1	(0.5)	2	(1.1)	20	(11.0)
Total	43	(23.7)	43	(23.7)	75	(41.2)	-	(-)	7	(3.8)	5	(2.7)	9	(4.9)	182	(100.0)

TABLE 11 (Male)

PEER ASSOCIATION AT TIME OF FIRST TAKING DRUG

	Number	Percentage
Friends of the same sex	3,811	88.3
Friends of opposite sex	4	0.1
Friends of both sexes present	37	0.9
Spouse	93	2.2
Lover	58	1.3
Relatives	39	0.9
Alone	238	5.5
Others	33	0.8
Total	4,313	100.0

(Female)

Friends of the same sex	70	38.5
Friends of opposite sex	42	23.1
Friends of both sexes present	14	7.7
Spouse	4	2.2
Lover	26	14.3
Relatives	9	4.9
Alone	10	5.5
Others	7	3.8
Total	182	100.0

TABLE 12 (Male)

PREVIOUS DRUG BY CURRENT DRUG USED

Previous Drug Used	Current Drug Used: Heroin		Opium		Heroin/Barbitone		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Heroin	1,168	(27.1)	43	(1.0)	1,195	(27.7)	4	(0.1)	2,410	(55.9)
Opium	266	(6.2)	207	(4.8)	431	(10.0)	1	(-)	905	(21.0)
Heroin/ Barbitone	272	(6.3)	18	(0.4)	704	(16.3)	-	(-)	994	(23.0)
Other	1	(-)	-	(-)	3	(-)	-	(-)	4	(0.1)
Total	1,707	(39.6)	268	(6.2)	2,333	(54.1)	5	(0.1)	4,313	(100.0)

(Female)

Heroin	106	(58.2)	-	(-)	25	(13.7)	-	(-)	131	(72.0)
Opium	7	(3.8)	5	(2.7)	2	(1.1)	-	(-)	14	(7.7)
Heroin/ Barbitone	18	(9.9)	-	(-)	13	(7.1)	-	(-)	31	(17.0)
Other	6	(3.3)	-	(-)	-	(-)	-	(-)	6	(3.3)
Total	137	(75.3)	5	(2.7)	40	(22.0)	-	(-)	182	(100.0)

TABLE 13 (Male)

PREVIOUS METHOD BY CURRENT METHOD USED

Previous Method Used	Current Method Used: Ack Ack		Chasing the Dragon/Mouth Organ		Injection		Opium Pipe		Oral		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Ack Ack	1,000	(23.2)	1,216	(28.2)	109	(2.5)	42	(1.0)	-	(-)	2,367	(54.9)
Chasing the Dragon/ Mouth Organ	31	(0.7)	745	(17.3)	231	(5.4)	18	(0.4)	-	(-)	1,025	(23.8)
Injection	-	(-)	2	(-)	11	(0.3)	-	(-)	-	(-)	13	(0.3)
Opium Pipe	211	(4.9)	444	(10.3)	39	(0.9)	186	(4.3)	10	(0.2)	890	(20.6)
Oral	4	(0.1)	1	(-)	-	(-)	-	(-)	13	(0.3)	18	(0.4)
Total	1,246	(28.9)	2,408	(55.9)	390	(9.0)	246	(5.7)	23	(0.5)	4,313	(100.0)

(Female)

Ack Ack	77	(42.3)	13	(7.1)	3	(1.6)	-	(-)	-	(-)	93	(51.2)
Chasing the Dragon/ Mouth Organ	2	(1.1)	33	(18.1)	26	(14.3)	-	(-)	-	(-)	61	(33.5)
Injection	-	(-)	2	(1.1)	6	(3.3)	-	(-)	-	(-)	8	(4.4)
Opium Pipe	2	(1.1)	2	(1.1)	2	(1.1)	3	(1.6)	-	(-)	9	(4.9)
Oral	7	(3.8)	1	(0.5)	1	(0.5)	-	(-)	2	(1.1)	11	(6.0)
Total	88	(48.4)	51	(28.0)	38	(20.9)	3	(1.6)	2	(1.1)	182	(100.0)

TABLE 14 (Male)

AGE BY VOLUNTARY ATTEMPTS AT ABSTINENCE

Age	Voluntary attempts at abstinence: 0		1		2		3		4		5		6		7		8		9		10 & Over		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Under 16 years	5	(0.1)	5	(0.1)	1	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	11	(0.2)
16-19	331	(7.7)	113	(2.6)	9	(0.2)	2	(-)	2	(-)	1	(-)	1	(-)	-	(-)	-	(-)	-	(-)	-	(-)	459	(10.7)
20-24	598	(13.9)	292	(6.8)	97	(2.2)	42	(1.0)	17	(0.4)	18	(0.4)	6	(0.1)	6	(0.1)	5	(0.1)	1	(-)	7	(0.2)	1089	(25.2)
25-29	299	(6.9)	169	(3.9)	85	(2.0)	45	(1.0)	32	(0.7)	27	(0.6)	19	(0.4)	14	(0.3)	8	(0.2)	5	(0.1)	23	(0.5)	726	(16.8)
30-34	151	(3.5)	82	(1.9)	35	(0.8)	17	(0.4)	24	(0.6)	10	(0.2)	14	(0.3)	4	(0.1)	12	(0.3)	9	(0.2)	25	(0.6)	383	(8.9)
35-39	148	(3.4)	76	(1.8)	33	(0.8)	27	(0.6)	27	(0.6)	14	(0.3)	9	(0.2)	13	(0.3)	8	(0.2)	9	(0.2)	31	(0.7)	395	(9.2)
40-49	260	(6.0)	158	(3.7)	78	(1.8)	59	(1.4)	44	(1.0)	30	(0.7)	29	(0.7)	27	(0.6)	19	(0.4)	20	(0.5)	124	(2.9)	848	(19.7)
50-59	104	(2.4)	62	(1.4)	29	(0.7)	20	(0.5)	22	(0.5)	12	(0.3)	17	(0.4)	10	(0.2)	12	(0.3)	10	(0.2)	56	(1.3)	354	(8.2)
60 & Over	16	(0.4)	10	(0.2)	6	(0.1)	2	(-)	3	(0.1)	-	(-)	3	(0.1)	1	(-)	1	(0.1)	2	(-)	4	(0.1)	48	(1.1)
Total	1912	(44.3)	967	(22.4)	373	(8.6)	214	(5.0)	171	(4.0)	112	(2.6)	98	(2.3)	75	(1.7)	65	(1.5)	56	(1.3)	270	(6.3)	4313	(100.0)

TABLE 14 (Cont'd)

(Female)

Voluntary attempts at abstinence

Age	Nil	1	2	3	4	5	6	7	8	9	10 & Over	Total
	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %
14-15	1 (0.5)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	1 (0.5)
16-19	18 (9.9)	5 (2.7)	5 (2.7)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	28 (15.4)
20-24	27 (14.8)	22 (12.1)	4 (2.2)	4 (2.2)	- (-)	- (-)	- (-)	- (-)	- (-)	1 (0.5)	- (-)	58 (31.9)
25-29	12 (6.6)	10 (5.5)	5 (2.7)	1 (0.5)	1 (0.5)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	29 (15.9)
30-34	6 (3.3)	1 (0.5)	3 (1.6)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	10 (5.5)
35-39	3 (1.6)	- (-)	2 (1.1)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	5 (2.7)
40-49	19 (10.4)	8 (4.4)	5 (2.7)	- (-)	1 (0.5)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	33 (18.2)
50-59	7 (3.8)	5 (2.7)	1 (0.5)	1 (0.5)	1 (0.5)	- (-)	- (-)	- (-)	- (-)	- (-)	1 (0.5)	16 (8.8)
60 & Over	1 (0.5)	- (-)	1 (0.5)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)	2 (1.1)
Total	94 (51.7)	51 (28.1)	26 (14.3)	6 (3.3)	3 (1.6)	- (-)	- (-)	- (-)	- (-)	1 (0.5)	1 (0.5)	182(100.0)

TABLE 15 (Male)

REASON FOR ABSTINENCE

	Number	Percentage
Not applicable	1,912	44.3
Scarcity of drugs	221	5.1
Cost too much	51	1.2
Pressure by family	345	8.0
To retain employment	147	3.4
Problems of health	409	9.5
Afraid of law	1,197	27.8
Detention/Imprisonment	31	0.7
Total	4,313	100.0

(Female)

Not applicable	94	51.7
Scarcity of drugs	1	0.5
Cost too much	9	4.9
Pressure by family	38	20.9
To retain employment	-	-
Problems of health	24	13.2
Afraid of law	16	8.8
Detention/Imprisonment	-	-
Total	182	100.0

TABLE 16 (Male)

TRIAD/GANG ACTIVITY

	Number	Percentage
Not applicable	904	21.0
Former Member	136	3.2
Passive Member	1,964	45.5
Active Member	1,250	29.0
Office Bearer	59	1.3
Total	4,313	100.0

(Female)

Not applicable	174	95.6
Former Member	3	1.7
Passive Member	4	2.2
Active Member	1	0.5
Office Bearer	-	-
Total	182	100.0

TABLE 17 (Male)

FIRST OFFENCE BY PRESENT OFFENCE

First Offence	Present Offence: Against Lawful Authority No.	%	Against Public Morality No.	%	Against the Person No.	%	Against Property No.	%	Against the Penal Code No.	%	Against Local Laws No.	%	Narcotic Offences No.	%	Total No.	%
Against Lawful Authority	9	(0.2)	-	(-)	-	(-)	30	(0.7)	3	(0.1)	1	(-)	136	(3.2)	179	(4.2)
Against Public Morality	-	(-)	3	(0.1)	-	(-)	6	(0.1)	-	(-)	-	(-)	12	(0.2)	21	(0.5)
Against the Person	1	(-)	1	(-)	6	(0.1)	24	(0.6)	5	(0.1)	-	(-)	107	(2.5)	144	(3.3)
Against Property	24	(0.6)	1	(-)	4	(0.1)	364	(8.4)	17	(0.4)	7	(0.2)	1077	(25.0)	1494	(34.6)
Against the Penal Code	2	(-)	-	(-)	1	(-)	7	(0.2)	10	(0.2)	-	(-)	29	(0.7)	49	(1.1)
Against Local Laws	7	(0.2)	-	(-)	-	(-)	73	(1.7)	6	(0.1)	12	(0.3)	508	(11.8)	606	(14.1)
Narcotic Offences	17	(0.4)	1	(-)	5	(0.1)	167	(3.9)	10	(0.2)	4	(0.1)	1616	(37.5)	1820	(42.2)
Total	60	(1.4)	6	(0.1)	16	(0.3)	671	(15.6)	51	(1.2)	24	(0.6)	3485	(80.8)	4313	(100.0)

TABLE 17 (Cont'd)

(Female)

First Offence	Present Offence: Against Lawful Authority		Against Public Morality		Against the Person		Against Property		Against the Penal Code		Against Local Laws		Narcotic Offences		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Against Lawful Authority	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	2	(1.1)	2	(1.1)
Against Public Morality	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	2	(1.1)	2	(1.1)
Against the Person	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	1	(0.5)	1	(0.5)
Against Property	-	(-)	-	(-)	-	(-)	3	(1.6)	-	(-)	2	(1.1)	14	(7.7)	19	(10.4)
Against the Penal Code	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)
Against Local Laws	-	(-)	-	(-)	-	(-)	2	(1.1)	-	(-)	5	(2.7)	43	(23.6)	50	(27.5)
Narcotic Offences	-	(-)	-	(-)	-	(-)	2	(1.1)	-	(-)	1	(0.5)	105	(57.7)	108	(59.4)
Total	-	(-)	-	(-)	-	(-)	7	(3.8)	-	(-)	8	(4.4)	167	(91.8)	182	(100.0)

TABLE 18 (Male)

TYPE OF PREVIOUS CONVICTION

(a) Inmates with previous convictions

	Number	Percentage
Not applicable	575	13.3
Previous convictions	3738	86.7
Total	4313	100.0

(b) Previous offences based on those who had previous convictions, i.e. 3738 = 100%

	Not Applicable		1		2		3		4 & Over	
	No.	%	No.	%	No.	%	No.	%	No.	%
Possession of dangerous drugs	1063	(28.4)	1041	(27.9)	542	(14.5)	306	(8.2)	786	(21.0)
Smoking dangerous drugs	2495	(66.7)	717	(19.2)	232	(6.2)	142	(3.8)	152	(4.1)
Selling dangerous drugs	3716	(99.4)	21	(0.6)	1	(-)	-	(-)	-	(-)
Trafficking dangerous drugs	3665	(98.0)	70	(1.9)	3	(0.1)	-	(-)	-	(-)
Manufacturing dangerous drugs	3737	(100.0)	1	(-)	-	(-)	-	(-)	-	(-)
Dealing with dangerous drugs	3723	(99.6)	14	(0.4)	-	(-)	1	(-)	-	(-)
Against property	1373	(36.8)	891	(23.8)	486	(13.0)	288	(7.7)	700	(18.7)
Against person	3478	(93.0)	227	(6.1)	23	(0.6)	7	(0.2)	3	(0.1)
Immoral earnings	3723	(99.6)	14	(0.4)	1	(-)	-	(-)	-	(-)
Soliciting	3730	(99.8)	6	(0.2)	-	(-)	1	(-)	1	(-)
Prostitute	3733	(99.9)	4	(0.1)	-	(-)	-	(-)	1	(-)
Triad	3266	(87.4)	438	(11.7)	30	(0.8)	1	(-)	3	(0.1)
Others not specified	2197	(58.8)	796	(21.3)	263	(7.0)	176	(4.7)	306	(8.2)

TABLE 18 (Cont'd)

(Female)

(a) Inmates with previous convictions

	Number	Percentage
Not applicable	63	34.6
Previous convictions	119	65.4
Total	182	100.0

(b) Previous offences based on those who had previous convictions, i.e. 119 = 100%

	Not Applicable		1		2		3		4 & Over	
	No.	%	No.	%	No.	%	No.	%	No.	%
Possession of dangerous drugs	16	(13.4)	45	(37.8)	19	(16.0)	10	(8.4)	29	(24.4)
Smoking dangerous drugs	90	(75.7)	21	(17.6)	5	(4.2)	3	(2.5)	-	(-)
Selling dangerous drugs	115	(96.6)	4	(3.4)	-	(-)	-	(-)	-	(-)
Trafficking dangerous drugs	118	(99.2)	1	(0.8)	-	(-)	-	(-)	-	(-)
Manufacturing dangerous drugs	119	(100.0)	-	(-)	-	(-)	-	(-)	-	(-)
Dealing with dangerous drugs	118	(99.2)	1	(0.8)	-	(-)	-	(-)	-	(-)
Against property	91	(76.6)	18	(15.1)	3	(2.5)	1	(0.8)	6	(5.0)
Against person	111	(93.3)	7	(5.9)	1	(0.8)	-	(-)	-	(-)
Immoral earnings	94	(79.0)	15	(12.6)	3	(2.5)	-	(-)	7	(5.9)
Soliciting	75	(63.0)	9	(7.6)	6	(5.0)	4	(3.4)	25	(21.0)
Prostitute	108	(90.8)	5	(4.2)	3	(2.5)	-	(-)	3	(2.5)
Triad	113	(95.0)	6	(5.0)	-	(-)	-	(-)	-	(-)
Others not specified	97	(81.5)	9	(7.6)	5	(4.2)	-	(-)	8	(6.7)

TABLE 19 (Male)

AGE AT COMMENCEMENT BY AGE AT FIRST CONVICTION

Age at Commencement	Age at First Conviction															
	14-15		16-19		20-24		25-29		30-34		35-39		40-49		50-59		60 & Over		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
14-15	112	(2.6)	111	(2.6)	19	(0.4)	11	(0.3)	8	(0.2)	4	(0.1)	4	(0.1)	2	(-)	-	(-)	271	(6.3)
16-19	237	(5.5)	679	(15.7)	255	(5.9)	30	(0.7)	22	(0.5)	15	(0.3)	23	(0.5)	5	(0.1)	1	(-)	1240	(28.8)
20-24	146	(3.4)	219	(5.1)	485	(11.2)	150	(3.5)	49	(1.1)	16	(0.4)	18	(0.4)	6	(0.1)	-	(-)	1116	(25.9)
25-29	29	(0.7)	83	(1.9)	117	(2.7)	260	(6.0)	133	(3.1)	43	(1.0)	23	(0.5)	3	(0.1)	1	(-)	692	(16.0)
30-34	9	(0.2)	24	(0.6)	48	(1.1)	63	(1.5)	166	(3.8)	101	(2.3)	35	(0.8)	2	(-)	-	(-)	448	(10.4)
35-39	1	(-)	13	(0.3)	28	(0.6)	29	(0.7)	33	(0.8)	118	(2.7)	68	(1.6)	8	(0.2)	-	(-)	298	(6.9)
40-49	-	(-)	3	(0.1)	13	(0.3)	22	(0.5)	18	(0.4)	17	(0.4)	127	(2.9)	24	(0.6)	2	(-)	226	(5.2)
50-59	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	1	(-)	3	(0.1)	16	(0.4)	1	(-)	21	(0.5)
60 & Over	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	1	(-)	-	(-)	1	(-)
Total	534	(12.4)	1132	(26.2)	965	(22.4)	565	(13.1)	429	(9.9)	315	(7.3)	301	(7.0)	67	(1.6)	5	(0.1)	4313	(100.0)

TABLE 19 (Cont'd)
(Female)

Age at Commencement	Age at First Conviction															
	14-15		16-19		20-24		25-29		30-34		35-39		40-49		50-59		60 & Over		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
14-15	6	(3.3)	7	(3.8)	1	(0.5)	1	(0.5)	1	(0.5)	-	(-)	-	(-)	-	(-)	-	(-)	16	(8.8)
16-19	13	(7.1)	28	(15.4)	10	(5.5)	6	(3.3)	2	(1.1)	-	(-)	-	(-)	-	(-)	-	(-)	59	(32.5)
20-24	8	(4.4)	10	(5.5)	22	(12.1)	8	(4.4)	5	(2.7)	1	(0.5)	-	(-)	1	(0.5)	-	(-)	55	(30.3)
25-29	1	(0.5)	3	(1.6)	-	(-)	7	(3.8)	3	(1.6)	-	(-)	3	(1.6)	-	(-)	-	(-)	17	(9.3)
30-34	-	(-)	1	(0.5)	2	(1.1)	-	(-)	4	(2.2)	4	(2.2)	-	(-)	-	(-)	-	(-)	11	(6.0)
35-39	-	(-)	-	(-)	1	(0.5)	-	(-)	4	(2.2)	4	(2.2)	2	(1.1)	-	(-)	-	(-)	11	(6.0)
40-49	-	(-)	-	(-)	-	(-)	-	(-)	1	(0.5)	2	(1.1)	5	(2.7)	1	(0.5)	-	(-)	9	(4.9)
50-59	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	1	(0.5)	2	(1.1)	1	(0.5)	4	(2.2)
60 & Over	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)	-	(-)
Total	28	(15.4)	49	(27.0)	36	(19.8)	22	(12.1)	20	(11.0)	11	(6.0)	11	(6.0)	4	(2.2)	1	(0.5)	182	(100.0)

TABLE 20 (Male)

NUMBER OF PREVIOUS INSTITUTIONAL SENTENCES

	Number	Percentage
Nil	1,664	38.6
1	848	19.7
2	432	10.0
3	266	6.2
4	180	4.2
5 - 10	623	14.4
11 & Over	300	6.9
Total	4,313	100.0

(Female)

Nil	93	51.1
1	33	18.2
2	9	4.9
3	10	5.5
4	8	4.4
5 - 10	20	11.0
11 & Over	9	4.9
Total	182	100.0

END