METHODS AND EFFECTIVENESS OF THE DRUG REHABILITATION PROGRAMME OF A THERAPEUTIC COMMUNITY - A CASE STUDY OF THE PUSAT PERTOLONGAN, BATU GAJAH

Oleh :

No. Matrik : 35023

Chew May Loon

LATIHAN ILMIAH BAGI MEMENUHI SEBAHAGIAN DARIPADA SYARAT-SYARAT UNTUK IJAZAH SARJANA MUDA SASTERA

JABATAN ANTROPOLOGI DAN SOSIOLOGI

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SYNOPSIS :

Tujuan utama penyelidikan ini adalah untuk mengesankan metode-metode dan kesan kesan program pemulihan yang ada dalam suatu permulihan dadah dalam negara ini.

Kajian ini telah dijalankan dari 1hb Mac, 1981 hingga 27hb April, 1981 di Pusat Pertolongan, sesuatu Pusat Permulihan Dadah di Batu Gajah, Perak.

Pusat Pertolongan merupakan satu organisasi persendirian sukarela. Ia adalah satu "Therapeutic Community" yang menggunakan cara "Psiko-therapy" untuk memulihkan penagih-penagih dadah. Model program yang digunakan oleh Pusat Pertolongan adalah diadaptasi dari modal-modal "therapeutic communities" yang ada di negara-negara lain seperti Daytop Village di Amerika Syarikat dan D.A.R.E. di Filipina.

Kajian ini akan menyentuhkan tiga aspek persoalan penagihan dadah, iaitu:

1. Kuasa-kuasa motivasi dalam proses sosial penagihan dadah.
2. Metode permulihan yang digunakan oleh satu pusat permulihan dadah yang tertentu - Therapeutic Community.
3. Kesan program tersebut dan persoalan "Recidivism".

Sebagai satu perbandingan, satu usaha akan di ambil untuk membandingkan kedua-dua metode yang digunakan oleh Therapeutic Communities dan yang telah digunakan oleh "Thought Reforms Movements".

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CHAPTER ONE : INTRODUCTION

Though very little research has been done on the social processes in the rehabilitation of drug addicts in Malaysia, nevertheless the problem of drug addiction is one of the main concerns of the Malaysian government.

According to a report by the New Straits Times (June 24, 1980), a large number of the drug dependents in the country are from the working population. 62% of them are between the ages of 21 and 30 years, 30% between 18 and 21 years, 4.5% between 30 and 40 years and the rest ranges from 15 to 18 years old.

Drug abuse in Malaysia is not a contemporary problem. This problem can be traced to the mid-19th century when the Chinese immigrants to Malaysia introduced opium smoking in the country. This was only outlawed when the 'Poison and Deleterous Ordinance' and the 'Dangerous Drug Ordinance' were passed in 1952 as federal laws. At present, under the Dangerous Drug Ordinance 1952 (No. 30 of '52), any drug pushers found in possession of more than (i) 5 kg of raw opium or 1 kg of refined opium (ii) 100g of morphine or heroin or (iii) 200g of cannabis (ganja) are liable to be sentenced to death or life imprisonment by a court of law.

Drug addiction on its own is not directly the concern of the public but it is the drug related crimes which has caused public outbursts against this sub-culture.

THE RESEARCH PROBLEM :

There are several rehabilitation programmes for drug dependents in this country and a majority of them are under the administration of the Federal government. There are, however, a few private rehabilitation centres which are under the administration of private organisations.

The programmes in the government centres are markedly different from that of the private centres. While the programmes in the centres are based on the 'Semi-Vocational Training and Counselling' method, the programmes carried out by the various private centres differ significantly in terms of concepts and methodology from those in the government.

The aim of this research is to study the methods and effectiveness of the rehabilitation programme in one of the drug rehabilitation centres in the country.

SCOPE OF STUDY :

Due to the high degree of recidivism amongst rehabilitated drug dependents in the country, the more social conscious public is beginning to question the actual effectiveness of drug rehabilitation programmes. Statistically speaking, the actual rate of success in the various centres is low. As such, a large part of this exercise will be devoted to the study of the methods of rehabilitation as well as the degree of effective-

ness of a particular programme. As it is quite impossible to make a comparative study of all the different drug rehabilitation programmes in the country this study was done based on one specific rehabilitation centre - The Pusat Pertolongan in Batu Gajah, Perak.

This paper will encompass three aspect of the drug problem :

1. The motivational basis of drug addiction.
2. The structure and methods of a specific rehabilitation programme for drug dependents : The Therapeutic Community.
3. The effectiveness of the programme and recidivism. This chapter will also include a short comparision of the methods rehabilitation used in the centre with that of the Thought reform movements.

METHODS OF RESEARCH :

Data for this study were collected from the Pusat Pertolongan from the 1st of March, 1981 till the 31st April, 1981. Statistics on drug abuse were obtained from various bodies such as Pemadam, the New Straits Times and the Research Unit of Pusat Pertolongan.

The fieldwork lasted two months. During that period the researcher was given permission to stay in the rehabilitation centre and to participate in and observe all the activities there. She was given a great degree of freedom in her movements around the centre as well as in her interaction with the residents of the centre.

An ethnographic method was used in studying the rehabilitation processes as well as the interaction patterns in the centre. This method was preferred because it gave the researcher greater flexibility to observe and record details of the activities within the centre.

In order to understand the attitudes of the residents towards the programme, the researcher participated in the programme as a phase one resident for a period of three days. In this treatment phase, the newly admitted resident undergoes an orientation programme. During this period, the researcher was treated by the staff and the residents as one of the newly admitted residents in the centre.

Participation as a resident in the centre provided the researcher with important insight into the mental and physical stresses experienced by the residents. The researcher discovered that observing the programme as an outsider and participating in the programme as a resident were two very different experiences.

This also gave the researcher the opportunity to meet and communicate with the residents on an equal level. However, the researcher was not able to participate as resident throughout her stay in the centre because in her role as a general resident she was very limited in her movement and this hindered observations of other activities in the centre. Moreover, too much involvement in the programme and the activities of the residents might biased the attitudes of the researcher towards the rehabilitation programme.

PROBLEMS ENCOUNTERED DURING THE FIELDWORK :

One of the main problems encountered by the researcher during her fieldwork was the question of objectivity and self-identification. Over-involvement on the part of the researcher in the daily activities as well as the personal problems of the residents may result in the difficulty in retaining an objective view. However, non-involvement or lack of involvement on the part of the researcher meant the improbability of the researcher to obtain certain data from the residents as well as to observe certain interactions which took place among the residents and between staff and residents.

During the period of the fieldwork, the researcher was placed in an ambigious position as she was neither a staff member nor a resident. On several occasions, she was asked to assist the management as a staff member. The problem of role ambiguity resulted in some misunderstanding between the researcher and a few residents.

Initially, the researcher was faced with the problem of gaining the trust of the residents. Certain pre-conceptions held by some of the residents about University students contributed to the problems of communication. They had pre-conceptions that an educated researcher from the University is not sympathetic to their plight and cannot understand them fully.

Initially, some of the residents were suspicious as to why a university student would want to do a research in the centre. The researcher was screened and questioned informally by some residents about her views of drug dependents as well as her reasons for conducting a study at the centre. This was however settled when the researcher gave her reasons for conducting the research and when she told them her personal pre-conceptions of drug dependents. This gave more positive than negative results as the residents felt that the researcher was being frank with them and was not trying to patronised them.

As the researcher was the only outsider in the centre, the residents were aware and conscious of her presence and it was extremely difficult to play the part of an unobtrusive observer. This, however was solved later when she was accepted as part of the everyday scene. In order to blend into the community, the researcher participated in all the activities of the residents ranging from their therapy sessions to their functional activities such as functioning in the kitchen, weeding, gardening and so forth. She joined them during their free time and also at the meal table. She spent a few nights sleeping with the female residents in their cottage. Later, when the residents felt that the researcher was not putting them down, they began to be able to communicate with her on a more equal basis. However, the period spent by the researcher participating in the programme proved to be fruitful as she was treated as the rest of the residents and this increased her acceptability by the residents.

Generally, when the residents felt that the researcher did not scorn them, they gave their cooperation fully.

Since the authorities as the centre insisted that the researcher first obtained written permission from the residents before personal interviews could be carried out, she did not conduct any formal interviews. However, data obtained through informal interviews and observations at the centre were recorded in a diary.

CHAPTER TWO : STRUCTURE OF PUSAT PERTOLONGAN

Though every major hospital in Malaysia provides for the detoxification of drug dependents, they have not initiated any rehabilitation programme for their patients. Drug dependence is the result of the physical effect of the drug as well as the psychological dependence of it. It is not merely a medical problem but also a psychological problem. Simple absence of drug does not constitute rehabilitation.

In this country, there are several drug rehabilitation centres which provides 'stay in' facilities. However, most of these centres are under government supervision. There are a few private drug rehabilitation organisations, such as the Pusat Pertolongan in Batu Cajah, Malaysian Care in Kuala Lumpur and Eugene's Place in Petaling Jaya. The programmes in these centres are often different from those of the government centres. This may be due to the fact that each of these centres has a different view of drug dependency and addiction.

PUSAT PERTOLONGAN :

Pusat Pertolongan is a private rehabilitation centre for drug dependents in Batu Cajah, Perak. This foundation is a voluntary agency registered with the Registrar of Company as a non-profit organisation with the status as a foundation. The foundation is empowered to furnish residential treatment, preventive education and other services designed

to prevent the onset of drug abuse or other socially or personally deleterious conditions.

The centre is located in two different areas : the complex (where a large part of the programme is carried out) is situated in Batu Gajah. This complex occupies the premises of a former Tuberculosis hospital. The Headquarters and the Administrative body of this organisation is situated in Kampung Bercham, Ipoh. The last phase of the rehabilitation programme (re-entry) is also carried out there.

Pusat Pertolongan is actually not a centre solely for drug dependents, but also for people with personality problems. In March, 1981, there were altogether three residents who were at the centre for reasons other than drug rehabilitation. One of them was admitted by his parents because they felt that they were unable to control him. The second case is slightly retarded mentally while the third case is an alcoholic.

Table 2.1 AGE OF THE RESIDENTS IN THE BATU GAJAH COMPLEX (MARCH, 1981)

AGE	NUMBER OF RESIDENTS
Under 18 years	3
18 - 20 years	7
21 - 25 years	44
26 - 29 years	27
30 - 40 years	8
41 years and above	1

Table 2.2 STATES OF RESIDENCE OF THE REHABILITANTS OF PUSAT PERTOLONGAN (MARCH, 1981)

STATES	NUMBER OF RESIDENTS
Kedah	2
Penang	10
Perak	35
Selangor	15
Negeri Sembilan	1
Malacca	1
Johore	9
Trengganu	1
Kelantan	1
Kuala Lumpur (Wilayah Persekutuan)	15

Note : This breakdown however does not include residents who are in the 're-entry' in Ipoh. This is only a breakdown of the residents in the Batu Gajah Complex.

The turnover at the centre is quite high. There are frequent admissions as well as premature discharges requested by the family and 'splities' (residents who run away from the centre). According to the population list of the centre at the end of April, 1981, there were 114 residents in the complex and 6 residents in the 're-entry' programme in Ipoh. The residents are from various states in Peninsular Malaysia including one from Sabah. The majority of them came from four main areas, that is : Kuala Lumpur, Petaling Jaya, Ipoh and Penang. About two thirds of the residents are Chinese, the rest are Indians and Malays. As this is

a private organisation, the residents pay a fee of $300/-[1] per month for their stay in the centre. However, there are cases where the families of the residents stop payment after the initial few months while there are some admitted on 'free of charge basis', due to financial difficulties.

At present, there are ten women undergoing rehabilitation in the centre. Pusat Pertolongan is presently the only residential drug rehabilitation centre in Malaysia which admits female drug dependents. These female residents are housed in the same complex but in a separate building. They participate in the same programme as the male residents. However, there are plans to set up a separate centre for women in the near future.

Pusat Pertolongan is a therapeutic community which utilizes the concept of psychotherapy for the rehabilitation of its residents. It is presently the only therapeutic community in the country and the second one in this region, the first being the centre 'DARE' in the Philippines. Its methods and programmes are actually modified versions of Synanons[2] in the United States. Some of its staff are trained in the United States and the Philippines. Many of the staff members are former drug dependents who have undergone the programme themselves. It is believed that former drug dependents who have undergone the programme are more capable in understanding the problems of the residents.

HISTORICAL BACKGROUND OF THE CENTRE :

Pusat Pertolongan which was founded by Encik Yakob bin Abdul Rahman[3] has its root in early 1973. At that time, Encik Yakob (then known as James Wilhelm Scholer) headed the counsel for youth problems which was attached to the Church of the Lady of Perpetual Help in Ipoh Garden. On 29-6-73, one of the parishioners who was an addict approached him for help. He was later joined by a few other addicts who came to know about it. With the help of a medical assistant, he kept these addicts at their homes and homes of their friends. As the number of people requesting for aid increased, a home was set up for them at 154, Gopeng Lane, Ipoh on 4-12-73. A board was then established to managed the place. This board and the centre was then under the supervision of the Catholic Welfare Service.

Soon Encik Yakob realised that treatment confined to detoxification and counselling alone were not sufficient. The 14-day programme produced a relapse rate of nearly 100% within 2 or 3 days. In July of 1974, Encik Yakob left for Manila where he underwent an intensive course at the Drug Addicts Rehabilitation Foundation (DARE). He implemented the system of DARE into his programme when he arrived back in Malaysia.

By this time the population of the centre had increased and a new centre in Kampung Bercham, Ipoh was rented. In June of 1975, the residents from this centre moved to a new premise also in Kampung Bercham. The new centre was built by the Ipoh Garden Building Society on a piece of land

donated by the Former Menteri Besar of Perak, Tan Sri Haji Kamaruddin. One of the main financial supporter during these times was Datuk Kim Seng Guan.

In 1975, both the Gopeng Lane centre and the Kampung Bercham centre were inadequate to cope with the growing number of residents. Another centre was then set up at 45, Gopeng Road and this centre was named Jiwa Murni. In 1975, Encik Yakob embraced Islam and hence all the three centres were severed from the supervision and control of the church.

On 27-4-75, the centre at 154, Gopeng Lane was moved to a new centre at Batu Gajah which was named Help Centre. This centre occupies the premise of a former T.B. hospital and is rented from the Malaysian Tuberculosis Association for a token rental of $100/- per year.

At the end of 1975, there were 15 female residents who were separated from the male residents and were housed at another centre in Tambun Heights, Ipoh. Thus in 1975, Pusat Pertolongan consisted of four centres : the Batu Gajah centre, No. 45, Gopeng Road, Kampung Bercham and Tambun Heights. 1976 however saw the transference and closing of pusat Jiwa Murni and the girls' centre to the Batu Gajah complex in January and October respectively.

On 19-7-77, 12 residents and Encik Yakob came to Kuala Lumpur to start a new centre called Pusat Jiwa Murni at 606, Bukit Petaling. This centre aims to admit addicts from Kuala Lumpur and Petaling Jaya areas

and to act as aftercare centre for residents whose hometown is in Kuala Lumpur or Petaling Jaya. This centre was ran in coalition with PEMADAM and acts as halfway house for government servants who had undergone rehabilitation. Pusat Pertolongan later withdrew from Jiwa Murni because of administrative problems as well as disagreement with PEMADAM. Thus till present, the Pusat Pertolongan is housed in two different centres : The Batu Gajah complex and the Kampung Bercham Headquarters.

OBJECTIVE OF PUSAT PERTOLONGAN :

One of the underlying assumptions of the therapy programme in Pusat Pertolongan is that drug abusers have certain negative traits in their character which hinders their growth as normal human beings. The aim of therapy is to eradicate these 'negative' traits and to implant corresponding 'positive' ones.

Therapists at Pusat Pertolongan believe that an understanding of the psychological make up of a drug abuser is important before further steps could be taken to rehabilitate him. Drug dependents are believed to have a certain profile. Generally, they are seen as emotionally immature individuals. They are normally self indulgent, have low levels of frustration-tolerance, low self worth, no realistic goals and little trust in themselves and in others. And it is these 'negative' traits that the Pusat Pertolongan seeks to eliminate.

Drug dependents are believed to be unable to come to terms with themselves and with reality. They have difficulties in handling or adjusting to the external stresses. This reality-gap is further widened by the inability of most drug dependents to communicate effectively with those around them especially with the non-users.

The objective of the centre is to enable an individual to achieve a certain self awareness and also an awareness of the reality and the stressful circumstances of life, so that the individual will be able to face the challenges imposed by the outside world without the help of artificial stimulants.

The centre believes that the task of any rehabilitation programme is to motivate the drug dependents to assume responsibility of helping themselves and others to bring about full recovery.

The residents of the centre have also to abide by three cardinal rules :

1. There is to be no mind altering drugs or alcohol in the centre.
2. There is to be no violence in the centre.
3. There is to be good morals amongst the members of the centre.

ADMINISTRATIVE STRUCTURE OF THE CENTRE :

The Board of Directors governs the policy making of the centre and it is ultimately responsible for the quality and directive of the found-

ation's programme. The Board of Directors also delegate the responsibility of inner affairs to the Executive Managing Director and his board of officers : the administrative manager, the programme manager and the secretary of the board.

The Executive Managing Director is accountable to the Board of Directors and is responsible for submission of monthly report to the board. He also delegates specific responsibilities to specific personel.

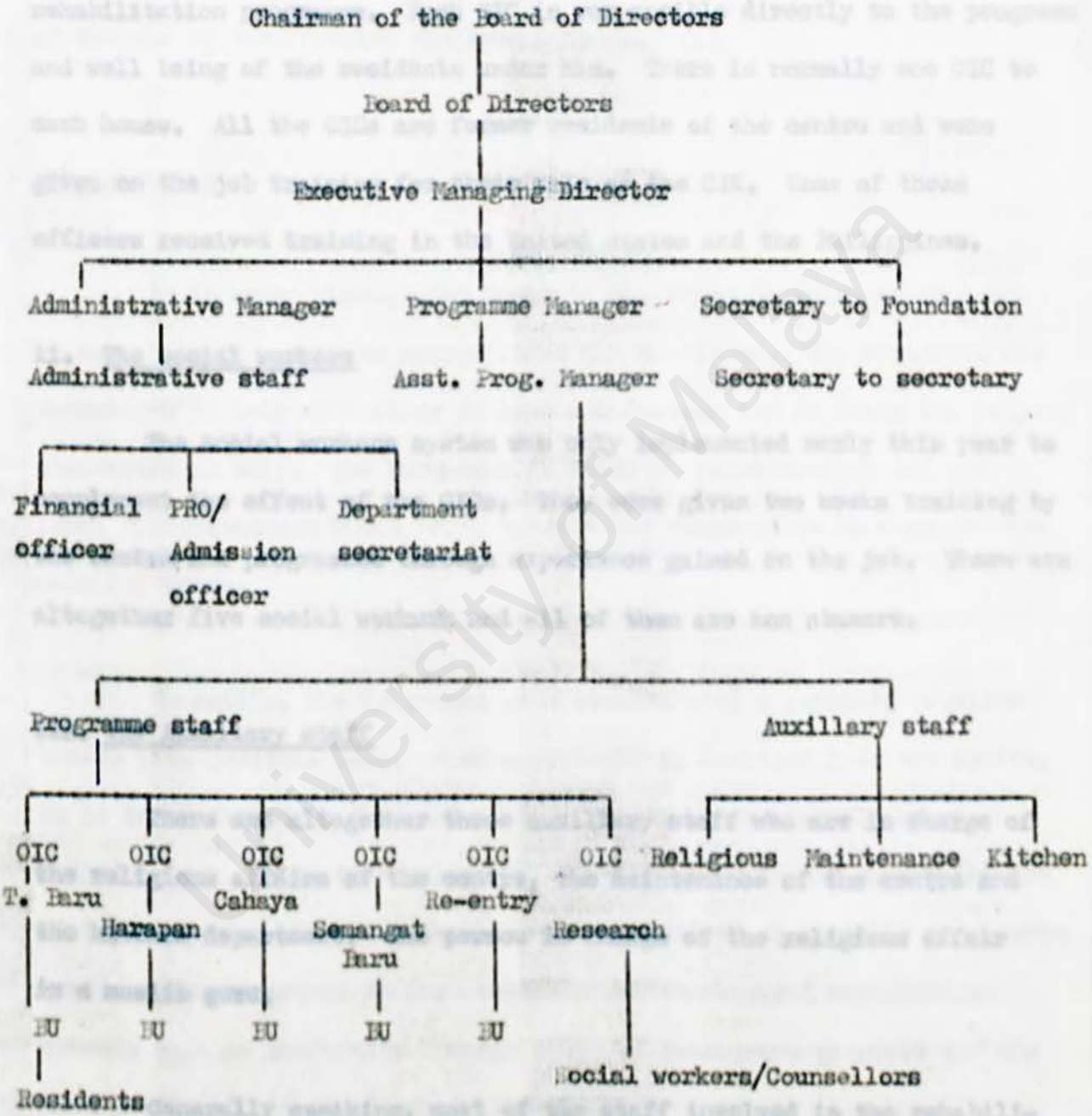
ADMINISTRATIVE STAFF :

The administrative manager is responsible for the supervision of all administrative staff. The finance officer under this department is responsible for the overseeing of the financial aspect of the foundation as well as for the day to day activities of monetary movement. The admission officer/PRO is responsible for all admission and all public visit and speaking engagement within or outside the foundation facility. The secretariat branch of this department is responsible for all the paper work of the foundation such as compiling request slips and so forth.

PROGRAMME STAFF :

The programme manager is responsible for all the activities related to the treatment of residents. He is assisted by an assistant programme manager.

Diagram 2.1



+ BU : Back-ups

i. The OIC (Officer in charge of the various houses)

The OICs are officers in charge of the various houses in the rehabilitation programme. Each OIC is responsible directly to the progress and well being of the residents under him. There is normally one OIC to each house. All the OICs are former residents of the centre and were given on the job training for their role as the OIC. Some of these officers received training in the United States and the Philippines.

ii. The social workers

The social workers system was only implemented early this year to complement the effect of the OICs. They were given two weeks training by the centre and progressed through experience gained on the job. There are altogether five social workers and all of them are non abusers.

iii. The Auxillary staff

There are altogether three auxillary staff who are in charge of the religious affairs of the centre, the maintenance of the centre and the kitchen department. The person in charge of the religious affair is a muslim guru.

Generally speaking, most of the staff involved in the rehabilitation activities are not trained professionally as such. However, most of them are former residents and former dependents who have experience in the place of academic training as well as a good grasp of the needs and

total make up of the residents. They also provide a positive model to the residents. To date, there are altogether three staff who are trained in this field. And an additional two will be sent to the United States at the end of the year for the same purpose.

THE PROGRAMME :

As in other Therapeutic Communities, Pusat Pertolongan stresses on self help as a mean to rehabilitate the residents. The residents are encouraged to help each other to grow and develop and in doing so, helping themselves as well. The programme is based on psychotherapy and gut level communications where love, honesty and responsible concern are the main key words.

Generally, the programme aims at modifying a person's negative traits into positive ones. When a resident is admitted into the centre, he is first forced to face and accept reality about himself and his deficiencies. He is then guided by his peer group in the centre and the staff to remodel his character based on 'positive' or socially acceptable traits. The programme in fact uses several behavioural modification methods such as conformity through usage of peer group pressure and the much potent effect of the 'malu phenomenon'.

The programme comprise of three main stages or 'houses' where the residents ascends from one to another gradually as his stay in the

programme increase and as he progress along the line of the programme. Progress of the person is judged by several criteria such as his consistency in his relation with his peers and behaviour towards the others and positive attitudes towards work.

The three main houses in the programme are Tunas Baru, Harapan and Cahaya. These are the three stages which encompass the 1 year treatment plan in the centre. After one year in the centre, the resident will be transfered to the 're-entry' facility called Kemajuan to undergo gradual reintergration into the normal society. This 're-entry' process takes half a year to complete and after such time, the resident will be given an honourable discharge and is deemed capable of living his own life without the supportive system of the centre. There is however one additional house in the programme which caters for the 'old programmers'. These are former residents who had relapsed after leaving the centre.

Generally, the treatment could be described as being divided into five main stages.

a. <u>Admission</u>

A new resident is admitted through the Headquarters in Kampung Bercham, Ipoh. A person will have to sign him in and pay for the first month's fee. A detailed information on his background : social, economical, environmental, educational and criminal will be taken down by the admission officer. His photograph will then be taken. After all the paper work is completed, he will be sent to the Batu Gajah complex.

b. Detoxification

Unless the person has undergone detoxification in another facility, he will have to undergo detoxification in the centre using the 'cold turkey' treatment. After about four days in the centre, he will be given a physical check up and if deemed healthy, he will be allowed to join the activities of the others.

c. Induction

During this phase, the staff makes initial evaluation of the resident based on his background. The resident will also undergo a form or orientation into the concepts of the community. He learns how to adapt himself into the programme.

d. Treatment

This is considered the longest stage. Here, the resident who is intergrated into the community will learn how to cultivate more positive personal and work habits and to strengthen himself, his self image and social relations.

e. Re-entry

(i) Re-entry phase 1 - At this stage the resident begins to reintergrates into 'normal' society. This is achieved through exposure to the wider society.

(ii) Re-entry phase 2 - This phase enables the resident to begin regular work outside. There will be increase socialisation with minimum supervision and restriction.

RELATIONSHIP BETWEEN THE STAFF AND THE RESIDENTS :

Generally, during the initial stages, the residents are not really close to the officer in charge of them. The relationship is more fear orientated as they are given 'haircut' for any mistakes they commit. However, as the resident becomes adapted to the ways of the community and learn that 'haircut' means concern, they begin to get closer to the officers. They, however are much closer to the therapists than to the social workers as most of the residents believes that only an ex addict could understand them and know what they are facing. Since all the therapists in the centre are former addicts, the residents find it easier to trust and confide in their therapists.

RELATIONSHIP BETWEEN RESIDENTS :

As there is a phase system in the programme, the more junior residents are expected to respect the more senior residents especially the phase four residents who are regarded as assistants to the officers. During function time, all the residents follow this hierachy strictly. However, in private, many of the phase four residents treats the general residents as friends more than their subordinate.

The residents are not allowed to have any form of contract amongst themselves. They are not allowed to have any form of ties, emotional or material. However, in private, there are such things as cliqueing amongst

those who are close. This is especially so amongst the phase four residents where a free exchange of money passes from one to another.

Racially, the Chinese is the majority group in the centre. As such, for convenience, the residents are divided into Chinese speaking group and the English speaking group. It has been observed that the Chinese speaking group tends to stick to each other while the Chinese from the English speaking group are more liable to mix around with the non Chinese. The Chinese speaking group also display an ethnocentric form of behaviour in the sense that most of them do not like to see a Chinese girl resident being close to a non Chinese.

FACILITIES AT THE CENTRE :

a. Vocational training

There are no provision of vocational training for the residents of the centre. Instead, the residents are instructed to carry out manual work such as weeding, repairing, gardening, cooking and other odd jobs.

There were however, during the earlier years, simple handicraft training for the residents. There were altogether four departments at that time. They were :

i. Plastic department which involves the making of simple plastic goods such as plastic tags, key chains and frames.

ii. Art department - This department was responsible for producing new designs and ideas to the other departments especially the Plastic and the Handicraft department.

iii. Carpentary department - This department was responsible for the construction of any carpentary equipment required by the centre.

iv. Handicraft department - This department produces small novel articles such as bamboo pen holders and assamwood pictures. These items were for sale in the outside market.

Apart from these departments, there was also the sales/business run by the Kemajuan residents. Under these residents, several projects were carried out. They set up popiah stalls at the Ipoh Garden Glutton Square. In 1978, the centre started a coffee house named 'DARE' in Ipoh Garden. This venture was run totally by the Kemajuan residents. However it was forced to close down nine months later due to public opinions who felt that the centre was trying to capitalize on their plight. Moreover there was also inadequate experience in such venture.

All the above departments were closed down a year or two back due to several reasons including the lack of skilled trainer, lack of funds as well as the feelings of some residents that they had been exploited.

b. Recreational facilities

The residents of the centre are given 1½ hour every evening for recreational purposes. Twice a week, they are required to attend a club meeting. There are altogether four recreational clubs : Music Club, Horticulture Club, Nature Club and Library. The residents are given the freedom to choose the club of their choice and each of these clubs has an executive committee of its own which is elected by the members of the club. For example the members of the Music Club is involve with the staging of the Metacom - a revival of Metamophorsis.[4]

For the rest of the other days, the residents are allowed either to play indoor games such as table tennis, carrom or chess, or outdoor games such as football, volleyball, basketball, sepak takraw and badminton. There are no football field or sepak takraw or badminton court in the centre. However, during the period of field work the residents themselves built a rough basketball and volleyball court. At times, the residents are also taken out to a field about half a mile away to play football. During the period of the research, there were two table tennis matches against visitors and one football match against the local Hongkong and Shanghai Bank staff.

c. Religious facilities

There is a guru in the centre and a surau for the muslim residents. A church group visits the centre every friday to give scripture lessons as well as other related activities.

d. Medical facilities

There is a medical assistant attached to the centre. This assistant visits the centre every friday and tuesday. He gives the new admission a general physical check up as well as look into the minor ailments of the residents. Any serious cases will be refered to the Intu Gajah General Hospital or the Ipoh General Hospital.

THE ARGOT OF PUSAT PERTOLONGAN :

In order to capture the essence of social interaction in the centre, it is essential to know some of the argot used there. Many of

these terms are actually adopted from the therapeutic communities in the United States especially the different 'tools of the house'.

tools of the house	:	These are actually different therapeutic techniques used to help the residents achieve their various goals in rehabilitation. Some of these tools include games, confrontation, challenges and relating.
a family	:	The residents belonging to one particular house is collectively known as one family.
splitting	:	This means running away from the centre. 'splities' are those residents who ran away.
hair cut	:	This is a verbal 'hair cut' whereby the family gives directions to the individual who had done something wrong or who has not been responsive to the learning of the programme.
hair chip	:	When a resident breaks any cardinal rules of the centre, he will be given a hair chip where his hair will be chipped physically.
short gun	:	This means the guarding of the junior residents when they have to move around.
long call/short call	:	Term used when a resident wants to go to the toilet or washroom.

comfort room : Term used to denote the washroom or toilet.

wash up : To take a bath.

personal needs : To wash one's own clothes.

pride and quality : Term used to denote a state where neatness and cleanliness are required.

learning experience : Something meted out to the residents when they had done something wrong. This aims to help the residents realise their mistakes, correct it and learn from it.

spare part : This is a form of learning experience given when the resident has broken the cardinal rules or when he is extremely unresponsive to the programme.

house cleaning : To do cleaning of one's living quarters.

ex-communicado : This person is not allowed to speak to anyone except the staff.

expeditor : This is a more senior resident who is responsible for the 'spare-parts' or any other residents undergoing learning experience. Their job is to see that these people under them do not fool around and learn from their experience.

submarine : This term refers to those residents who do things underhand or behind the backs of the other residents such as carrying tales to the officers. It also denotes a male resident who goes after the female residents in a sneaky way.

communication : To communicate is to tell the person in charge before doing something. Eg. a resident in Tunas Baru will have to communicate before washing his hands or rolling up his pants. This is considered an important aspect of the programme and if not obeyed, carries a penalty of a learning experience.

contracts : This denotes a certain relationship between two residents. Any form of relationship - material or emotional, are not allowed in the centre. Eg. the residents are not allowed to give cigarettes to each other or to share food without communicating.

Footnote

1. $300/- : With the recent change in management, the fee has been increased to $370/- due to inflation.

2. Synanon : The Synanon foundation was founded in 1958 by Charles Dederich. The original Synanon house was in Santa Monica but the foundation later opened quarters in Westport, Connecticut too. The Connecticut facilities was closed after a few years but the model was replicated under several names, often staffed by ex residents of Synanon. Synanon is today a million dollar enterprise attempting to create a small city of its own in California.

3. Encik Yakob : Encik Yakob was formerly a German Catholic brother attached to the order of Mercy. He has been in Malaysia for 18 years and has until recently been the Managing Executive Director of the centre. He returned to Germany in May of 1981 for a course of study.

4. Metamophorsis : This is actually a psycho drama presented first in 1978 by the residents of the centre. It aims to depict the past experience of a drug addict and hopes to educate the public about such matter through a musical drama which if presented well could prove to be rather touching.

CHAPTER THREE : THE MOTIVATIONAL BASIS OF DRUG ABUSE

"Why do people abuse drugs?" This question has been asked time and again and yet there is not one fixed answer to it.

In the first place, there is a need to define who exactly the drug dependents are. According to Charles Winick ('57), "the drug addict is a person with certain characteristics who happens to have selected this way of coping with his problems for a variety of reasons of which he is usually unaware. Not the least of these is his access to a social group in which drug use was both practised and valued."

Drug dependence is not simply a medical condition because it is not solely a problem of taking drugs. It also involves a state of psychic or physical dependence on drugs.

The reason for taking drugs are complex and multi-faceted. There are in fact several paths that lead to addiction and there is no one motive or set of motives which can be said characteristic of all addicts. What causes illegal drug use and subsequent addiction is still clouded with contraversy. Though there are several theories propounded as to the cause of drug abuse, non of them are accepted universally. There is no simple explanation of what circumstances - social, chemical, physical and psychological - bring about addiction. In this chapter, I will attempt to trace the various social and psychological factors that are related to drug abuse.

The sample, which comprises of 15 respondents was chosen at random. These respondents, however were selected from all the various phases in the programme. This was done to ensure maximum possible representation of all the residents in the centre. Data were collected from informal interviews with the respondents. No questionaires were used.

Table 3.1 Sexual Characteristics of the Respondents

SEX	%	No.	N
Male	87%	13	15
Female	13%	2	15

Table 3.2 Age of the Respondents

AGE GROUP	%	No.	N
18 - 20	20%	3	15
21 - 23	47%	7	15
24 - 26	27%	4	15
27 and above	6%	1	15

Table 3.3 Racial Composition of the Respondents

RACE	%	No.	N
Malays	20%	3	15
Chinese	60%	9	15
Indians	6%	1	15
Others	14%	2	15

Table 3.4 Marital Status of Respondents

MARITAL STATUS	%	No.	N
Single	87%	13	15
Married	13%	2	15

Table 3.5 Phase of the Respondents

PHASE	%	No.	N
Phase One	33%	5	15
Phase Two	20%	3	15
Phase Three	7%	1	15
Phase Four	20%	3	15
Semangat Baru (Old programmers)	20%	3	15

Table 3.6 No. of Times the Respondents have been admitted into Pusat Pertolongan

NO. OF TIMES	%	No.	N
First Time	80%	12	15
Second Time	13%	2	15
Third Time	7%	1	15

Table 3.7 No. of Attempts by Respondents to 'Kick-the Habit' at any Rehabilitation Centres, Hospital, at Home or in Jail

NO. OF ATTEMPTS	%	No.	N
First Time	40%	6	15
Second Time	40%	6	15
Third Time	20%	3	15

When asked what they perceived is the main reason for their dependence on drugs, the answer given by the respondents ranged from curiosity to peer group influence.

Table 3.8 Reasons why the Respondents use Drugs

REASONS GIVEN	%	No.	N
Curiosity	13%	2	15
To seek pleasure	13%	2	15
Peer group pressure/influence	40%	6	15
Supress problems and frustrations	13%	2	15
Seek parental attention	13%	2	15
Remove Inhibition	7%	1	15

As we can see from the above table, peer group influences and pressures plays a major role in the initiation of dependents into the drug scene. Most of the respondents under this catergory feel that it is the 'in-thing' to do because everyone in his group is doing it. And in order to be identified as a member of the group, they have to join in. Even in the rehabilitation programme itself, "peer group pressure"

remains one of the most potent 'tool' in keeping the residents in line.

Those respondents who had given curiosity as their reason said that they had often watched their friends smoking or 'shooting' drugs. And they themselves had tried it for the first time because they were curious to experience getting 'high', which was recommended by so many of their addict friends. However, what euphoric effect an individual experiences when he takes drugs depends on the meaning he assigns to the effect which in turn depends on the social definitions available to him in his social setting.

Some of the respondents abuse drugs for recreational purposes. They felt bored with their lives and enjoyed the euphoria produced by heroin, especially when it is administered by 'mainlining'. This might be due to the fact that heroin is a narcotic sedative and large doses of it can affect the hypothalimic pleasure centres and other mood control centres in the brain giving the user a feeling of euphoria. It was observed in the centre, that a majority of the residents had a tendency towards 'tripping' especially with music and songs. If given the time and chance, most of them would spend the time 'tripping' - a condition whereby they are mentally detached from reality. They are somewhere in the past or in the future. Somehow there seems a need to feel 'high' and detached from what is around them.

13% of the residents gave suppression of problems and frustrations as the reason why they use drugs. From their experiences, they felt that

heroin is a 'happy drug' which helps them to forget their problems. When a large dose of heroin is absorbed, a feeling of peace, contentment and safety envelopes the user immediately. According to Nyswander ('66), "the action of heroin on the central nervous system is that the addict feels he has eaten to his heart's content, experience full sexual satisfaction and eliminated all his anxieties".

13% of these respondents said that they had initially used drugs to gain attention from their families, especially their parents. One of the respondents came from a family of 10 children. He said that after smoking ganja for the first time, he went immediately to tell his mother about it. He enjoyed all the fuss his family made. Attention, may be the reason why some of the residents purposely go against the centre's rules. Some of them said that without some excitement such as getting some learning experiences, life in the centre would be very boring. Moreover, most of the residents are very good at the performing act such as the psycho-drama, singing and dancing.

One of the girls I interviewed said that she smoked heroin for the first time to remove inhibition towards physical contact with the opposite sex.

Though several reasons were given about the motivational basis of drug addiction, it must be stressed that the reasons for initial use of drugs differs from those related to continual use.

Environmental factors play an important role in a person's involvement in the drug sub-culture. The chances of a person being exposed to drugs depend to a large extent on his association with groups which use drugs. A person's attitude and behaviour is often influenced by his peer group. A majority of the drug abusers were introduced to drugs by their friends.

Table 3.9 How the Respondents were Introduced to Drugs

	%	No.	N
Introduced to it by friends	80%	12	15
Sought for drugs themselves	7%	1	15
Introduced by relatives	13%	2	15

80% of the respondents were introduced to drugs by members of their peer group - in some cases, their classmates and their colleagues. 7% sought for drugs themselves. This particular respondent said he took drugs initially out of curiosity because he had heard so much about it. 13% of the respondents were introduced to drugs by their relatives, who were mainly their cousins.

It is stressed that familial background plays an important part in drug addiction. According to some of the studies made in the ghetto and slump areas of the United States, most of the drug abusers came from financially deprived homes, broken families and are normally inadequately educated. However, statistically, this study show otherwise. Only 20% or 3 of the respondents came from broken homes.

Table 3.10 Financial Situation of the Families

FINANCIAL SITUATION	%	No.	N
Above average	33%	5	15
Average	40%	6	15
Below average	27%	4	15

Table 3.11 Educational Level of the Respondents

STANDARD OF EDUCATION	%	No.	N
Primary	13%	2	15
Lower Secondary	27%	4	15
Upper Secondary	60%	9	15

Here we can see that more than half of the respondents received upper secondary education. In fact, on an overall, all the residents in the centre had received some form of education. Many of them, in fact, I found could write remarkably good speeches for seminars and poems. A majority of the respondents came from average families. This I can safely say represent a fair picture of the entire population in the centre. However, with regard to social class background, the range of the social class background of the residents in the centre is very wide - ranging from royalties to professional to working class.

Table 3.12 Age of Initiation into Drugs

AGE	%	No.	N
15 years and below	13%	2	15
16 - 17 years	53%	8	15
18 - 20 years	27%	4	15
21 - 25 years	7%	1	15

With reference to the table above, it is found that the age at which the respondents are initiated to drugs corresponds with that of the western studies such as those done by Erich Goode ('72) and Richard L. Rachin ('75). Most of the respondents began their addiction around early and mid-teens when they are still emotionally and psychologically immature.

These statistics seem to imply that drug abusers do not necessary come from the lower strata of the society - financially or educational wise. As I have mentioned before, it is impossible to draw a clear boundary as to the environmental and social background of drug dependents. Drug abuse is a widely disperse phenomenon and the members of this sub-culture cannot be put into a 'neat package' for convenience sake.

CHAPTER FOUR : THE STRUCTURE OF THE REHABILITATION PROGRAMME AT PUSAT PERTOLONGAN

THE PROGRAMME :

The 1½ year therapy programme emphasies on character-building of its residents through gradual but constant reinforcement of certain basic values and traits which are centralized on three main values - Honesty, Trust and Responsible Concern. The importance of these values are constantly stressed in the centre throughout the entire programme. It is the belief of the therapists that these qualities could be absorbed into a resident's total character through practise, self-realization and the guidance of the others in the community, especially the senior residents.

The therapists also believe that a certain 'pure' environment has to be maintained so as to encourage maximum learning and absorption on the part of the residents. In other words, to create an ideal learning environment which is quite different from that in the outside world. Values such as trust, honesty, concern and love are stressed amongst the residents.

There are three stages in drug rehabilitation. First, the resident learns about himself and acquires the ability to analyse and accepts himself totally. Then, the programme seeks to eliminate all 'negative' traits and attitudes of the residents. Finally, when this is achieved, the person is encouraged to give responsible concern as to help other residents, especially the juniors

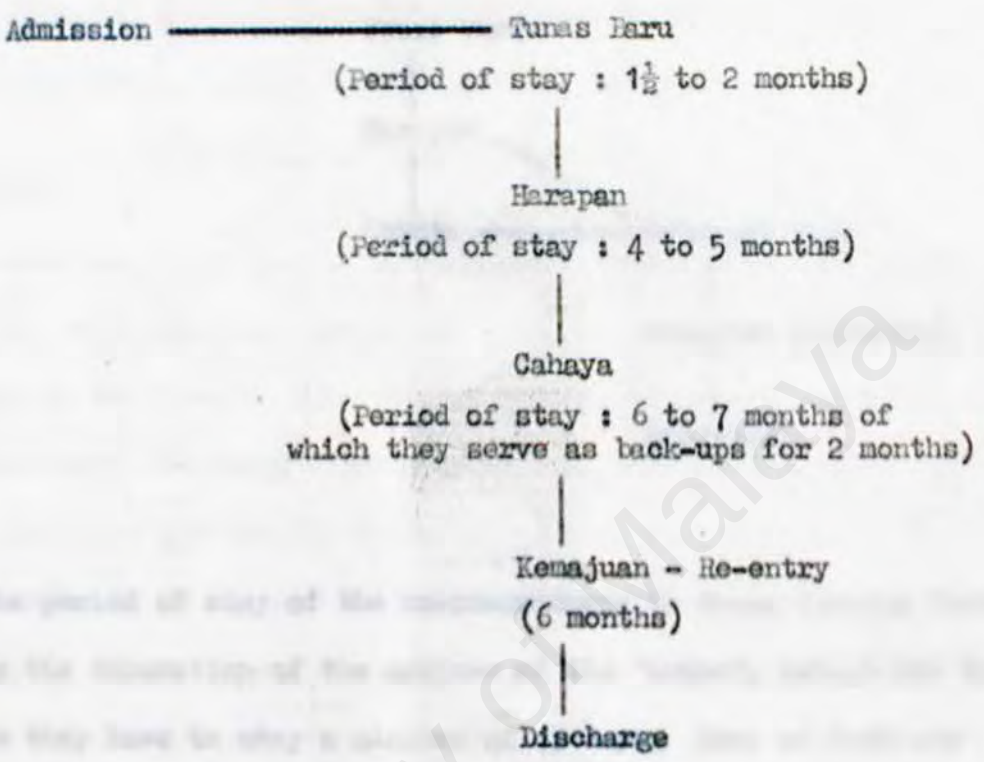
However, before all these aims could be achieved, the therapists feel that the social mask of the drug dependent has to be penetrated and exposed. This means that a resident has to see himself clearly and realize his mistakes before he could be helped. In order to help the residents open up and expose his inner, self, 'tools of the house' are used. These therapeutic tools will be discussed later in this chapter.

STRUCTURE OF THE PROGRAMME :

The structure of the programme is such that every resident has to go through four stages or 'houses' before they can be said to have completed the programme. These four stages are spanned over a period of 1½ years.

The three major 'houses' - Tunas Baru, Harapan and Cahaya are based in the Batu Gajah centre while the final 'house', Kemajuan is based in Ipoh. All the three 'houses' - Tunas Baru, Harapan and Cahaya are actually progressive 'houses' which are linked to one another. Their programmes are actually a continuation of the other so as to enable the residents to develop gradually, corresponding to their period of stay in the centre. When a person is first admitted into the centre, he goes to Tunas Baru for a period of 45 days or more. Then he is transfered to Harapan for a period of 3 to 4 months. After that, he is transfered to the stage three 'house'. He will normally be here for a period of 6 months or more, of which he will serve as a "back-up" during the last

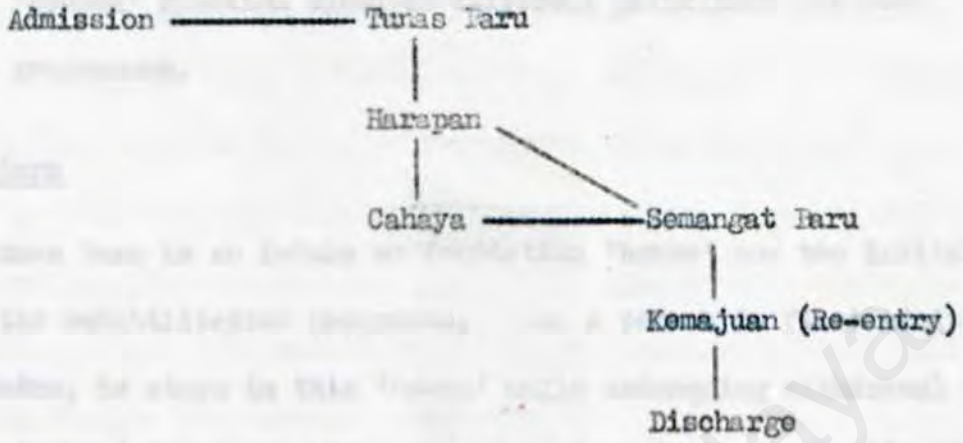
Diagram 4.1 Structure of the Programme



two months or more. The period of stay in the various 'houses' is however different for different individuals and depends on the reports of the officers of the various 'houses'.

The structure above however applies only to new residents. Ex-programmers who had fallen back to drugs go through another slightly different programme.

Diagram 4.2 Structure of Programme for Ex-Programmers



The period of stay of the ex-programmers in these various 'houses' is left to the discretion of the officer of the 'house', except for Tunas Baru where they have to stay a minimum of 45 days. Some of them are transfered straight from Harapan to Semangat Baru (the alternative house which is created specially for them) while the others go to Cahaya before entering Semangat Baru. Generally, their stay in the various 'houses' are shorter than that of a new resident.

Each of these 'houses' are under their respective officers. These officers, who are trained as therapists by the centre, conducts therapy sessions in their respective 'houses'. They are responsible for the development and welfare of each and every resident. Each officer is assisted by at least two senior phase four residents, in the running of the 'house'. These phase four residents or 'back-up' take care of the 'house' and its residents throughout the day and at times even conduct therapy sessions. The back-ups normally receives daily instruction from the

officer of the 'house' which they are in charged of. All the five different 'houses' function based on different principles and have different programmes.

a. Tunas Baru

Tunas Baru is an intake or foundation 'house' and the initial stage of the rehabilitation programme. When a person is first admitted to the centre, he stays in this 'house' while undergoing withdrawal using the 'cold-turkey' treatment where cold baths are taken constantly to suppress the crave for drugs. After his withdrawal and when he is deemed healthy enough, he is allowed to join the 'family' where he will be given a family name. This is to symbolise a new beginning. In this house, they are not put under any physical stress as they have just undergone withdrawal and are normally very weak. At this stage, they are taught discipline, the basics of the programme and the 'utilization' of the 'tools of the house'. They are given seminars on the profiles of drug addicts, how to use the 'tools of the house' and so forth. There are discussions on how the programme is run and the rules of community life. This serves as the orientation period into their year long stay in the complex.

This is a maximum security 'house' as the residents are believed to harbour a great urge to 'split' (run away). They are guarded everywhere they go by the senior residents and are given limited freedom in all their actions. They do not participate in many of the outdoor activities. Strict discipline is stressed and any show of insubordination is immediately confronted and corrected by using the therapeutic 'tools' and group pressures.

b. Harapan

Pusat Harapan is the second stage 'house' and residents here undergo the Intensive Therapy Community (ITC) programme. The residents are expected to know the programme and the 'tools of the house' well enough to be able to apply them effectively. In this 'house', they are built up emotionally, mentally and physically through very tight schedules and self discipline. The residents of this 'house' are divided into various departments for various activities.

The departments are : Commo Department, Horticulture Department, Maintenance Department, Agriculture Department and the Kitchen Department. The Commo Department is responsible for the paper work of the 'house', such as preparing the name lists, memos and requisitions. The Horticulture Department is responsible for the gardening activities of the centre. The Agriculture Department is responsible for the working of the plots allocated to them, while the maintenance crew helps the maintenance head of the centre to carry out odd jobs like weeding, repairing work and so forth. The kitchen crew is responsible for the preparation of all the meals for all the residents in the complex. They have to see to the preparation and the distribution of all the meals for the entire complex during the five week days as well as the cleanliness of the kitchen.

The membership of these departments are on a rotating basis and changes every week. Each department has a department head who is responsible for his members and the completion of the task allocated to them. These departmental heads are also on a rotating basis and changes every week to give everybody a chance at leadership. However, it

is normally the senior residents of the 'house' who are given the job.

c. Cahaya

Normally, after five months in the programme, the residents would have reached the final 'house' in the programme. The residents here are considered matured and to have understood themselves and their problems. Here, the therapy sessions are conducted to prepare them for re-entry into wider society. Seminars given here are concerned with life in the outside world and the problems they will meet with, when they go out.

In Cahaya, the residents are more individualistic, each one doing his or her work. They are expected to be able to express themselves, their feelings, their problems and their guilts without much probing from their fellow residents.

The residents of Cahaya are given the most freedom in movement as they are allowed to move around without being guarded by the senior residents. They are also given the choice of recreational activities. They are no longer under any 'protective shield' and it is up to them to make the right decisions. For example : if a resident who is banned from smoking decides to ignore the ban and smokes, he will be allowed to but he will also have to face whatever learning experiences which will be dealt out to him for breaking the ban.

d. Semangat Baru

This 'house' is created specially for residents who had fallen back to drugs. At the time of the fieldwork, there were around 8 residents in this 'house'. There is no fixed programme in this 'house'

and the members are given much freedom. They are allowed, for example, to go downtown or to go jogging outside the centre. However, they still have to abide by the rules of the centre. Occasionally, they have therapy sessions in the evening.

When a former resident is re-admitted, he is normally sent to Tunas Baru and then to Harapan before joining Semangat Baru. However, the time taken to go through these two 'houses' is relatively shorter than that of the average resident. However, towards the end of the fieldwork, there was news that a new system would be implemented in the 'house', including a special programme for its residents.

e. Kemajuan

This 'house' is located in Ipoh with the headquarters of the centre. After completing one year of the programme in Batu Gajah, the residents are transfered to Kemajuan for 'de-orientation' and preparation for re-entry into society. However, the transference of a resident to Kemajuan is not necessarily fixed according to the period of time a resident spends in Batu Gajah. The decision whether a resident will be transfered to Kemajuan depends to a great deal on his officer and also on his performance as a 'back-up' in the centre.

This re-entry stage is not exactly a 'house' like all the other four 'houses' because though it has an officer in charge, it does not have any form of programme or therapy. However, if required, personal, family and vocational counselling will be provided by the officer of the 'house'. There are two phases under this stage. When a person is newly transfered to Kemajuan, he is considered to be a phase one resident and

he is not allowed to go out unless accompanied by a more senior member. He has to work in the centre doing jobs such as gardening, cooking or administrative work. After two months in Kemajuan, he will move on to phase two where he is allowed to work outside the centre but he has to stay in. He is also allowed to go out alone.

The residents here are given much more freedom and they are permitted to stay out until 1 am. However, they still have to abide by certain regulations, such as no drinking, no drug taking and they are also not permitted to mix with the residents who had 'splitted' or those who had been discharged prematurely. They are also encouraged to form close ties with their families and are allowed to go home on leave.

The re-entry stage is seen as a very important stage because the environment in Batu Gajah centre is very different from the outside world. If a resident is released without gradual 'de-orientation', the resident may experience great difficulties in re-adjusting to the wider society and may not be able to handle his freedom. Here, the residents are given freedom step by step until they are totally free from the programme itself.

THE PHASING SYSTEM :

This programme is also broken up into five different phases with phase one in Tunas Baru, senior phase one and phase two in Harapan, senior phase two and phase three in Cahaya and phase four as back-ups. Each phase has its own concepts and criteria and promotion in this system

depends on whether the individual is able to fulfill the criteria set up by each phase.

The division of the residents into the various phases helps to chart their development in the programme and to give the residents something to look forward to and to work for. As the residents moves from one phase to the next, he is supposed to be moving closer to his goals. Moreover, along with these phases comes certain priviledges, with those in the higher phases getting more. For example : a phase four resident is allowed to go out once a week, he is allowed to keep $10/- every week to buy his own essentials, he is allowed to wear watches and other jewelleries and a female phase four resident is allowed to use make-up.

The criteria used to judge whether a resident can be transfered to the next phase or not does not depend on intelligence or fluency of language but more on the emotional growth of the individual as indicated by his external behaviour and attitudes such as his sincerity, his consistency and his effort.

a. Phase One

In this phase, the resident learns about community life and how he could fit into it. He learns about the rules and regulations of the programme and the method of social interaction in this programme. A phase one resident is housed in Tunas Baru and Harapan (as senior phase one).

b. Phase Two

In phase two, the residents learn how to apply all that they had learned in phase one. Here, they are given more responsibilities such as guarding phase one residents, 'expediting', functioning as departmental heads. They are given more trust and less supervision. They also learn about self control. Junior phase two can be found in Harapan while senior phase two in Cahaya.

c. Phase Three

A phase three resident is expected to be able to intergrate all the positive qualities acquired in the previous phases in order to function as a wholesome person. Phase three residents are given more responsibilities and chances at leadership. They are given the chance to take care of the 'family' on a rotating basis. They are expected to be able to assimilate more data and utilize them constructively and productively as well as to improve their self-discipline.

d. Phase Four

This is actually a pre-re-entry stage. The phase four residents are required to take care of 'families' and this acts to strengthen their determination and their frustration tolerance. They are given more freedom and are allowed to go out to town and even to Ipoh during their off day. There is also a deeper level of self discovery through the giving of directions to those residents under their care. They are expected to have high levels of behaviour and integrity to act as a model for the more junior members. They are also given a chance at financial management as they are allowed to have $10/- allowance every week.

e. Phase Five

This is the re-entry phase whereby the residents prepare to leave the therapeutic community support system for the society outside. There is a complete withdrawal of therapeutic tools and sessions. Here, they are independent physically, psychologically and financially. They learn how to manage their time and money and are exposed to the various aspect of society. They learn here to search for alternatives to drugs. This phase enables them to make a gradual but complete break from the therapeutic community system and to survive on their own.

Table 4.1 Period of stay required for promotion to phase indicated

PHASES	PHASE 1	PHASE 2			PHASE 3			PHASE 4			RE-ENTRY		
Minimum and Maximum Period		Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max
Length of stay - in months	completion of detoxification	3	4	5	6	8	10	9	12	15	12	16	20

N.B. The phases are structured to fit into the 1½ year programme.

METHODS OF REHABILITATION :

The objective of the programme is to enable every individual resident to achieve self-awareness, to eliminate all the negative traits and to prepare them to face the challenges and obstacles imposed by reality.

In order to achieve these aims, the residents are taught how to use and learn from the various therapeutic 'tools of the house'. These 'tools' are again adaptation from the various therapeutic communities in the United States, especially the Daytop Village in Staten Island.

a. Emotional Interview

Here, a new resident is interviewed by the rest of his 'family' before he is allowed to join the 'family'. During this interview, he has to tell everyone present about his addictive history and his social, familial and educational background. He has also to answer whatever questions the members of the 'family' might choose to ask him. This is to help the resident to learn how to trust the others with his past experiences.

b. Morning Meeting

This is a meeting of all the residents during which the individual and the group's mistakes of the previous day are brought out. The emphasis is on honesty, trust and responsible concern. The morning meeting is supposed to help the residents increase their self awareness and emphasizes the need to correct their negative traits.

c. Relate, Challenge and Confront

In short, this is called RCC by the residents. To relate, is to open one's innermost feelings and thoughts to another resident or to the group. It is believed that this can help the individual resident to release his negative feelings and to seek guidance. For example : A might be hurt by something B had said and he has thus formed a grudge

against B. He can either request for a game with B or relate to B by telling B how much his action had hurt his feelings.

A confrontation is a direct inquiry by one resident to another so as to ascertain the motives behind one's behaviour, be it positive or negative. For example : a person may be confronted for not making his bed or for being aggresive. A fixed pattern has to be followed for confrontation. An example of confrontation :

A : Can I confront you?

B : Yes.

A : Why is it that you always use my soap?

B : I haven't got mine yet.

A : I understand, but don't you think it is very rude that you didn't ask my permission?

B : Yes.

A : Please ask me before you use it the next time. Taking things for granted is very bad. Do you accept the confrontation?

B : Yes, I accept. Thank you.

A : Your are welcome.

If a confrontation is accepted, that particular confrontation will be entered into the 'pull up' board. Each 'house' has its own 'pull up' board whereby all the confrontations which took place between its members will be entered. This serves as a record and check list for the officers and back-ups of the 'house'.

Sometimes a person gets confrontated so many times that he gets confused. Moreover, it is best to accept confrontations whether the confrontation is right or wrong. This is the maxim amongst the residents.

A challenge is similiar to a confrontation but it is less formal. Challenge is used when a person is not very sure whether the subject of the challenge is right or wrong.

d. Seminars

Largely educational and stimulating a free flowing exchange of ideas, seminars are discussions that center around the basic values and experiences applicable to the rest. They could be led by the residents or by the staff. A resident may be told to give a seminar as his learning experience. For example : A resident who uses vulgar language very often may be asked to give a seminar about 'why it is wrong to use vulgar language'.

e. Learning experiences

The learning experience serves as a constant reminder of a mistake of negative attitude and makes the resident more aware so as to correct them. It also serves to drive home the point in a deeper and more dramatic manner. The staff in the centre is emphatic that this is not any form of punishment. It is believed that the learning experience helps to strengthen the resident's ability to accept things and situations and to handle stress.

Formally, the centre followed the type of learning experiences used in the therapeutic communities in the United States which includes

the usage of signs which are worn around the necks of the residents, such as 'I am lazy', 'Please confront me', 'I need help' and so forth. However, sometime before the fieldwork commenced, the government placed a ban on such learning experience as it was felt that the residents should not wear any form of 'punishment' on their person.

The learning experience is not limited to physical objects carried on their person. It may take the form of a situation. A person is not only told of his mistakes but is also made aware that his actions have consequences that he cannot escape from. For example : A resident who is untidy or dresses untidily could be given a learning experience whereby he has to appear in long pant, long sleeve shirt, shoes and tie for every meal.

When a resident shows good responses to his learning experiences and when his officer feels that the message is understood, he will then 'lift' (remove) the learning experience.

f. Spare-part

The spare-part is a form of learning experience given to residents who have broken any of the cardinal rules or committed extreme forms of insubordination. When a person is reduced to a spare-part, he is something like the family's servant and has to be responsible for all the chores such as setting the meal table, washing up the plates and so forth. He is not allowed to wear any form of footwear and his attire consists of short pants and tee shirt. He is not allowed to walk and has to jog around. He is normally under an 'expeditor' who makes sure that he does

not fool around and learns from his experiences. This form of learning experience is very strenous both mentally and physically. For those who still do not learn from this form of learning experience, will be made an 'ex-communicado' whereby, in additional of being a spare-part, he is limited in all his movement and he is also not allowed to speak to any of the residents.

g. Hair cut

This is a verbal reprimand or a tongue lashing given to a resident by members of his 'family'. Mistakes or negative attitudes are forcefully pointed out to the individual, and directions are given to him in an equally forceful manner. Vulgar language may be used, ways and means are used to break down the subject concerned. This may include bringing back memories of past experiences or family problems which they know will hit the subject the hardest. The type of haircut, its intensity, subtlety or crudeness depends upon the offences and the nature of the offence. A haircut is always moderated by a 'back-up' or the officer of the 'house'. A 'patch-up' or moral boosting from the rest of the 'family' usually follows. The haircut is used when the less dramatic tools of the 'house' fails to correct an attitude.

h. Hair chip

When a resident breaks any of the cardinal rules, he will be shaven bald. However, at present, anyone who breaks the cardinal rules will be given a hair chip whereby his hair will be chipped either by his officer, the programme administrator or he himself is asked to do it.

i. General Assembly

When a resident has absconded from the centre or has violated one of the cardinal rules of the centre, he is subjected to a general assembly. He is probed and questioned as to why he had committed the offence. If those present accept his reasons, they will give him directions which may take the form of explanations or haircut. General assemblies are attended to by all the residents in the complex, no matter what 'house' they belong to.

j. House Meeting

This is conducted either by the residents or by the staff members when the 'house' is guilty of general negative attitudes such as sliding back, lack of confrontation, taking things lightly, lack of discipline, and disregard for 'house' rules by the majority of the members. In Cahaya, however, the residents can use this opportunity to voice out any dissatisfaction against the management.

k. Probe

The probe is an intensive confrontation/interrogation made on a resident by a panel of his peers trying to probe into his past life experiences, upbringing and conditioning that may have some bearing on his present attitudes, tendencies and outlooks.

l. The Game

The heart of the rehabilitation programme is centered on the game. The game is composed of around 20 people who are seated in a circular

formation. The membership of each group depends on the phase of the residents. The game is held twice a week on Tuesday and Friday. There are four different games at one time : the phase one game, phase two game, phase three game and phase four game. Each phase game is again divided into two games : the Chinese speaking group and the English speaking group. Cantonese, Hokkien and Hakka are the dialects used in Chinese speaking game. Eight games are held simultaneously. Each game is moderated by a therapist/officer. The game has no rules except three:

a. No violence or threat of violence.

b. No walking out.

c. No breaking of the seal of the game (this means that whatever that had past in the game is not allowed to be repeated to a non-participant).

It is a verbal free for all and anyone with a grudge against another can use this opportunity to attack the person concern. One can also 'game' another person from another phase or group by requesting through the moderator. A person can be 'gamed' for anything from using vulgar language to the breaking of the rules.

Example of a game :

A might 'game' B for talking behind his back. A might ask B why he does that and that, will be followed by a stream of tongue lashing. After that B will try to explain or defend himself. All the while, the rest will not interfere and will only listen, until it comes to a stage where the rest are sure as to who is in the wrong. If by this stage, the party who is wrong still do not admit that he is wrong, group pressure

will be put on him to admit his mistake and to apologize. This resembles a court in that, witnesses may be brought in to clarify the situation.

The game is a highly individual thing and only the two persons concerned are really involved. Contract games are not allowed. A contract game is when a group of people get together to 'game' someone for their own reasons or spite, and they had planned the entire procedure beforehand. Another kind of game is the encounter game. This is used when the misunderstanding between two persons is so great that they want to thrash it out amongst the both of them. During an encounter game, two persons may lash at one another verbally, bang the table and so forth but they are not allowed to use physical violence or threat of violence.

m. Guilts and Contracts

This session is held when the management feels that there are a lot going on which they might not be aware of. During this session, all the members of the family will have to admit whatever guilts they have committed and the contracts they have had with another resident. Contracts are not allowed to be formed in the centre as this is believed to be a deterrent factor in their growth.

n. 'I like you, I don't like you' Session

During this session, all the residents in a 'family' will be focused on, one by one. The rest of the 'family' tells the subject what they like about him and what they dislike about him. This is to enable all the residents to know what the others thought about them and to have a cleared insight into themselves.

o. Prospect Chair

When a person is put on prospect chair, he is isolated from the rest of the members of his 'family'. He will not participate in all the activities of the 'family'. When a person is newly admitted into the centre, he will be placed on prospect chair so as to give him more time to think about his past experiences and to confront himself on his past behaviour. Sometimes, prospect chair is also given to a resident as a learning experience if the officer feels that that particular resident is confused and needs some time to think about his mistakes. Prospect chair can also be requested by the residents themselves if they feel that they need some time to think.

Apart from these therapeutic 'tools of the house' which are used very often to help the residents achieve their aims, several activities are also carried out on specific occasions with specific aims in mind.

i. The 'track' and the 'caterpillar walk'

These two activities were held once in Harapan when it was found that the residents were sliding back and did not trust one another. In the 'track', all the participants are blind folded and are led through bushes and drains by the sound of a whistle as well as calls of directions by their fellow residents. Then the residents were told to stand up on the edge of a table and to fall backward with the assurance that his fellow residents are there to catch him when he falls.

The 'caterpillar walk' stresses on team work whereby all the participants sits down on the ground and they are held on to the person

in front of them, by curling their legs on to the stomach of the person in front. They are then asked to move over a distant and up a small hill. They had to use their hands in order to move and everyone has to move at the same time because if one stops, the whole line cannot move.

ii. Music 'tripping'

This is held during the night and was held three times by Cahaya in the period of two months. All the residents are allowed to bring out their mattress to the garden and to lie down. Music and songs will be on at full blase and the residents are allowed to 'trip'. This is to introduce to them an alternative method for relaxation and to get 'high' and to 'trip'.

iii. The tribal game

The tribal game was held once during the research period. The tribal game was held to boost the spirit of the residents and to establish cohensiveness within the residents. All the residents in the centre took part in the game. The residents were divided into six 'tribes' namely Honesty, Perseverance, Trust, Concern, Determination and Discipline.

Songs too play an important role in the therapy of the residents. The residents are taught songs which stresses on love and brotherhood. These songs are used normally to boost the morale of those residents who had undergone a particular strenous learning experience. It is called 'reaching out' with songs. The whole ritual includes each resident reaching out and hugging the subject while the song is being sung.

'The Creed' of the centre which is taught to all its residents is sung every night before curfew hour. This song was written with special reference to the residents. It stresses on the various concepts used in the programme. It starts with the line 'We are here because, there is no refuge finally from ourselves'.

CHAPTER FIVE : THE EFFECTIVENESS OF THE PROGRAMME

The actual effectiveness of the Therapeutic Communities in the rehabilitation of drug dependents has been questioned and debated over by many people especially in the United States where therapeutic communities remains one of the strongest institution in the rehabilitation of drug dependents. Is this method of rehabilitation effective as claimed by many of its supporters? Is this a 'cure' for each individual drug dependent?

THE PROGRAMME OF THERAPEUTIC COMMUNITIES AS COMPARED TO THOUGHT REFORM MOVEMENTS :

Therapeutic Communities subscribe to the theory that drug dependents have certain personality deficiencies. They are seen as immature, irresponsible, unstable and incapable of handling of feelings. The programme stresses on character modification and aims to bring about a radical change in the individual in terms of his behaviour, attitude, feelings and intellect.

Several 'tools' are used by means of ridicule, caricature, exasperation, coercion, repetition and various verbal tactics and learning experiences in their aim to overcome the psychological blocks of the residents.

In many ways, the programme of the centre are thought reformatory and are relatively similar to the various thought and behaviour modification

movements such as the Ideological reforms carried out by the Communist Chinese.

The term 'brainwashing' has been seen negatively by many because of its negative political connotation. However, I must stress here, that this is not a discussion on the moral aspect of the methods used by these movements. It is merely an effort to identify the various components in the two methods and their similarities.

The term 'brainwashing' is derived from the Chinese Colloqualism 'hsi nas', which literally means to wash the brain. The Random House Dictionary of English Language defines brainwashing as "a method of systematically changing attitudes or altering beliefs originated in totalitarian countries, especially through the use of torture, drugs or psychological stress techniques". This is followed by a second defination which states that "any methods of controlled systematic indoctrination especially one based on repetition and confusion can be seen as brain-washing".

According to Margaret O.Hyde ('74), brainwashing normally involves 4 phases which are in sequence although they may overlap. The 4 phases are:

1. Assault
2. Calculated kindness and leniency
3. Confession
4. Re-education

In the case of prisoners of war, certain conditions are stimulated to enable 'brainwashing' to be carried out effectively. Firstly, the person has to be put in a position where it is necessary to make a choice between co-operation or starving, torture or being killed. If the initial attempts fail, living conditions may be made harsher. However, if a person co-operates, he will be rewarded.

After co-operation, the subjects are asked to indulge in self-criticism. Co-operation normally produces guilt feelings in a great majority of the subjects. The use of harsh treatment alternated with friendly treatment puts the subject in a state of confusion. At this stage, worn out by physical mistreatment and emotional confusion, the person is in a state where ideologies can usually be indoctrinated with little resistance. One effective method used in reforms of this nature is group pressures. According to Robert J. Lifton ('62), the prisoners in the Chinese Communist prisons are subjected to extreme group pressures to conform, whereby rejection and extreme physical discomfort will result from any form of insubordination while co-operation will be rewarded with "open-arm" acceptance into the group.

This does not mean that the residents of the centre are submitted to similar living conditions or extreme torture as in the case of the prisoners of totalitarian countries. There are however certain subtle similarities between the two.

In the early years, the form of therapy used in the centre was the "Attack Therapy", which was imported wholesale from D.A.R.E. of the Philippines. This form of therapy is highly stressful both mentally and physically. The residents may have to undergo extreme physical fatigue by attending marathon games which may extend over a few days or at least 48 hours non-stop. Or some may be required to stay in a pit filled with waste. Thus it is either to co-operate or face extreme unpleasantries. However, in recent times, the therapy is more of "Love Therapy" where love and responsible concern are emphasized. The residents are given more time to rest with afternoon naps at least once a week unless the entire house undergoes a "stress programme".

In the centre, the residents are subjected to group pressures to conform and to co-operate. Residents who are not co-operative will face a variety of learning experiences which ranges from 'hair-cut' to 'spare-part'. The hair-cut and the game are quite effective 'tools' as it can either help a person understand himself more or break him down psychologically. The spare-part on the other hand is both demanding mentally and physically. He is expected to function in the kitchen as early as 5.30 in the morning and is deprived of certain priviledges such as sleeping on beds, eating at the table and so forth.

A resident is also required to confront himself or in other words to critisize himself and his past. He has to learn to accept the fact that he has several negative qualities and that it's his own fault that he is addicted. When this accomplished, he will then be indoctrinated

with new positive attitudes through learning and practising.

In the centre, the token-reward system is also carried out. Co-operative residents are promoted faster than those unresponsive ones. The residents of a house are responsible to one another. If all the residents of a house are responsive to the programme, then they will be rewarded but if a large number of its members are unco-operative, the entire 'house' will be placed on a stress schedule. Peer pressure is often used to force unco-operative residents to conform. In this case, 'tools' ranging from confrontation to family haircut many be used.

Here, the Hard-Soft method is also used. After a resident has undergone certain stressful experiences eg: spare-part, he will be given a morale boosting through the use of songs. The members of the family will reach him out one by one to welcome him back into their fold.

However, no extreme isolation is imposed as in the case of the totalitarian countries. An unresponsive resident may be placed on the prospect chair where he is expected to confront himself and his attitudes. A resident on prospect is not allowed to speak to the other residents unless with the permission of the management. The prospect is also not allowed to take part in any activities and even takes his meals apart from the family.

No two residents are allowed to have any form of 'contract' - emotional or material. According to the management, any form of 'contract'

may lead to guilt feelings and this may be the initial source of 'splitting'. However, there are such things as "close-friends" amongst the residents. They somehow realize the need to have someone to be close to in the programme. Moreover, many of them feel that it is difficult to go through the programme 'alone'. Is this form of treatment programme effective in rehabilitating drug abusers?

EFFECTIVENESS AND SUCCESS RATE :

Defination of effectiveness. How do we define effectiveness and success rate? How can we measure success rate? - in terms of time or numbers? Rehabilitation of drug dependents is an extremely unstable phenomenon. There is no permanent guarantee that a rehabilitated addict will not relapse again. There have been cases of rehabilitated addicts relapsing after staying straight for 5 to 10 years.

Do we consider a person as rehabilitated after he completes the programme? If that is the case, what happens if he relapses after a few months or even a year? Thus do we give a time limit of 5 years, 10 years or even 15 years before we consider a person rehabilitated? It is thus very difficult to project this on a long term basis and for this exercise, I will limit myself to the short term effects as the research period of 2 months renders it quite impossible to consider anything beyond that.

EFFECTIVENESS :

It is difficult to measure success-rate statistically as only a comparatively small number of the residents completes the entire programme. A majority of the residents 'splits' or leaves after a few months in the centre while some were taken home prematurely by their respective families.

Of those who had completed the programme, a number of them are working in the centre as therapists. As there are no after-care facilities, it is quite problematic trying to trace the progress of the ex-residents especially when they had returned to their home states.

About half a year ago, some form of after-care plan was drawn up whereby questionaires were sent out annually to ex-residents in order to keep track of their progress. As this system is still new and there is no guarantee that the respondents will answer the questionaires, there is no statistics to measure success rate as such.

Personally I believe that the effectiveness of this programme depends a great deal on the individual residents themselves. Conceptually I would say that this programme encompasses certain important variables in the rehabilitation of drug dependents. The programme is able to understand the intrinsic components behind drug abuse and it is able to a certain extent resocialise a drug abuser by introducing to him certain socially acceptable characteristics.

had been pressured into conforming and as such, there remains the possibility that he may leave the centre without experiencing any radical change in attitude.

Many residents feel that it would be easy to 'flow' through the programme. Normally, often two or three months in the programme, the residents would have learnt the ways of the programme and could adjust quite well to it. Some of them said that the easiest way out is to accept all that is "thrown" to them. For example, one of the residents was confronted very often and she always accepted the confrontations. I happened to hear one of the confrontations.

Confrontator : Can I confront you?

Subject : Yes.

Confrontator : Do you accept?

Subject : Yes, thank you.

One of the main problems of the centre is the rehabilitation of old programmers. These residents had undergone the programme before and they are very well versed with the programme. Some of these residents are highly manipulative and to many of them, the programme is like playing a game of chess with the staff. They play their moves and amuse themselves by predicting the various steps taken by their therapists. It was even found once that some of these residents had brought back with them drugs and pills during one of their trips out. But incidences of this nature seldom occurs undetected. The very nature of the community which stresses heavily on honesty makes the offenders or even people who

know about it very guilty. Sometimes these form of guilts bears on them so much that they had either to open up their guilts or to 'split'. However, at present there are plans to set up a special treatment plan for these old programmers.

Drug abusers have the tendency to rely on things (eg. drugs) or people or on relationship. There is the question as to whether the residents are truly rehabilitated or is it merely a matter of transfering their dependencies on drugs to the centre. The way of life in the centre is highly addictive. The residents are protected from their outside problems. Unlike their addictive life outside, they do not have to worry about where they will be getting their next shot and so forth. Every waking hour in the centre is kept occupied and this ensures that they will not indulge themselves in thinking about their lives outside. After a few months, they become alienated to the wider society and way of life outside. Thus it could be disastrous to release a resident straight into the wider society without gradual re-entry. In the case of the 'splities', the re-entry to society is so sudden that many of them feel lost and are unable to cope up with the situation. They begin to worry and become frightened. This may be the reason why most of the 'splities' relapse (in fact, all the residents who had 'split' during the research period relapsed) as drugs are the only familiar avenues opened to them after leaving the centre. Initially, most of these 'splities' harbour the urge to return to the centre. There is always the question of whether the centre really helps every individual resident to eradicate the need to depend on something - material or emotional, or for residents, a matter

of transfering their dependencies to a new object. This may be the reason why many of the residents in the re-entry facility drinks heavily though it is prohibited.

The rehabilitation programme in the centre is based on certain "Psychological tools". All the residents will invariably learn how to use these 'tools' and can become highly manupulative or subtlely co-ercive - even more so then when they were still on drugs. It is thus dangerous if a resident relapses as he has now in his hands various methods to manipulate people psychologically.

Most of these problems may be related to the fact that the residents may not have learned and understood the programme well. This may be due to the fact that the centre does not have sufficient staff to run the programme effectively. Due to financial and other problems, most of the staff are para-professionals who are paid comparatively low salaries. On the average, each therapist takes charge of around 30 residents. It is extremely difficult for one therapist to deal with 30 residents though he is assisted by the back-ups and social workers. The programme requires the therapists to "breakdown" the image of every resident and to build it up again, ingraining in them positive attitudes. The 'tools' of the house are very effective as it can break down a person's resistance and self-esteem. It is not an easy task trying to rebuild a person's confidence and to remould his character. Any lack or failure in doing so may result in some psychological scar in a person's character.

The ratio of one therapists to 30 residents is high. It is almost impossible for one therapist to deal effectively with 20 residents as far as Psycho-Behavioural therapy is concern. Each individual has his own social and environmental background and there can be no one specific way of handling everybody. Though each resident has a counsellor and a treatment plan, I feel that it is still insufficient.

The number of dropouts in the centre, as in other therapeutic communities is very high. The way of life in a therapeutic community is regorous and may not be acceptable to all. Many may be turned-off by the deliberate humiliation, the game and so forth. They are unable to orientate themselves to the life style in the centre.

The lack of after-care facilities too may in a way hamper the effectiveness of the programme. Though half a year is allocated for the re-entry process, not every resident is able to adjust to the wider society within that period and many may still face social or psychological problems.

RELAPSE/RECIDIVISM :

The researcher did not conduct any interviews concerning the above topic. This effort is derived from her interactions with the old programmers and 'splities' who had returned to the centre.

When asked why they had relapsed after undergoing rehabilitation, some of them gave the answer that they did it at a moment of weakness. They felt that they had not really learned from the programme and were not prepared. As such, they gave in to temptations, even though they were aware of the consequences. Many of them felt that they took drugs the first time after rehabilitation, thinking that they would be able to resist further offers.

These residents also felt that the drug experience is heavenly and unforgetable. They likened it to the 'first love' where memories of the experience and the urge will always be there and it is up to the individual to resist the temptation. One resident felt that there was actually nothing wrong with taking drugs, except for the fact that it leads to criminal activities. This particular subject had been in and out of various institutions 23 times.

After they had been released, most of these residents relapsed after mixing with their former peer group members (junkie friends). At the beginning, they just stopped to greet their addict friends. Later, they began visiting these friends thinking that they were strong enough to resist any offers. Soon, their addict friends began to offer them 'spiked cigarettes' and sooner or later, all of them accepted the offer. To these residents, one important variable in recidivism is their move to rejoin their addict friends, which according to them, may have started initially through innocent greetings. However, these subjects feel that the temptation to take drugs is ever present and it is up to them to reject any offers by their addict friends.

CHAPTER SIX : CONCLUSION

IMPLICATION OF STUDY :

There seems to be no one set of motives or social patterns in drug abuse. It is more, the result of a complicated interaction between all these factors. Each drug dependent therefore has to be evaluated as an individual with his own motives and social background.

Much has been stressed on the role of psychological factor in drug abuse. Drug dependents are believed to have certain negative traits which contributed to their addiction. They are seen as immature, insecure, have low tolerance, low self-worth, criminal tendencies and so forth. However, there is no clear evidence to show that there is any fixed set of characteristics - psychological or physical which can be said to be universal to all drug dependents. It is not even clear as to whether these traits are really the result of drug addiction or vice-versa.

Initiation to drug abuse, is more a matter of being in the wrong situation, at the wrong time, with a wrong group of people. A person, who has a psychological and a predisposing inadequacy, when facing a crisis is given a timely offer of drugs - is more likely than not, to accept the offer. According to the finding of this study, one of the most important factors in the social processes of drug abuse is the role played by the peer-groups, especially amongst teenagers and people in their early twenties. A person who has access to drugs or drug users has a greater

chance of getting involved with the sub-culture.

Rehabilitation of drug addicts depends to a great extent on the individual addict. In my opinion, a person who is determined to rehabilitate will be able to do so. A rehabilitation programme, can only provide supportive measures such as vocational training, counselling, therapy and so forth to guide the residents along the way.

However, though a programme could only provide supportive aids, it is essential as it is almost impossible for drug dependents to overcome their psychological and physical dependence on drugs by themselves. In this light, Pusat Pertolongan can be seen as having effective machineries in guiding its residents in their endeavour to resocialize into the wider society. The therapists at the centre allegedly understand the various processes involved in drug addiction and are in the position to help the residents. But, the very nature of a therapeutic community alienates its residents from the real life situation and many of its residents may face the problem of re-entering society.

The very nature of the methods used by therapeutic communities have been questioned by many scholars and professional therapists. As mentioned before, the methods of rehabilitation in the centre resembles to a certain extent to that of the Thought Reform movements. Does anybody has to right to remould another person ideologically? Many may feel that this is morally wrong. However, if this method of rehabilitation is effective, then why not?

The fact that the centre has a high rate of 'splities' - who invariably fall back to drug abuse shows that many of its residents were not able to adjust to extreme change of life style in the centre. Moreover, the fact that co-operation and exemplary behaviour are indications of successful participation in the programme may be deceiving. It may simply imply that the residents had been pressured to conform and this does not constitute any form of rehabilitation.

RECOMMENDATION :

One thing sadly lacking in Pusat Pertolongan, as in most of the other rehabilitation centres is an efficient after-care unit. After 1½ years in the programme, a resident is discharged and many of them return of their hometowns. These ex-residents may in time come to need moral and social support from the centre. As such, a specific facility should be established to cater the needs of these ex-residents.

The absence of vocation training facilities is a setback to the rehabilitation programme. To increase the effectiveness of the programme, efficient vocational training should be provided for those residents who are unskilled. By vocational training, I do not mean the form of vocational which are provided by many centres at present. The training provided should be able to equip the residents well enough to compete in the job market when they leave the centre.

In all the government drug rehabilitation centres of this country, no facilities are made available for women addicts. According to Datuk Dr. Wan Ismail Wan Mahmood, the PEMADAM information committee chairman, during the recent 'conference of non-governmental organisation on drug use, prevention and control' (National Echo - 5th November, 1981), this is due to the fact that the number of women addicts in Malaysia is comparatively lower than that of the male addicts. This however, in my opinion, is no reason at all as the problem does not disappear just because it is comparatively smaller than the other. Moreover, there is no substantial evidence to indicate that the number of women addicts is actually lower than that of the male addicts. The problem of women addicts has not been highlighted as most women addicts can support the habit by prostitution and this is normally considered by the public to be not as serious as theft or robbery and is tolerated to a certain extent. In fact, on 31st October, 1981, according to the matron of the women section of Pudu Jail, Kuala Lumpur, out of a total of 98 women inmates, 83 were on drug charges.

A centre, I feel should be set up for the women addicts in the country. Female addicts often encounter more problems than their male counterparts. They are faced not only with the stigma of being an addict but also with the stigma of being associated with prostitution. Thus, they have to overcome the stigma of not only being an addict but also as a social outcast. In the centre, none of its female residents, up to the research period has completed the entire programme. Todate, only 3 female residents reached phase four. Most of them 'split' or were

discharged by their families before completing the programme. This might be due to the fact that the programme may not be suitable to their needs. As such, efforts should be made to draw up a comprehensive treatment plan for the female addicts as they are faced with an almost different set of problems and situations from the male addicts.

One problem, I feel facing the question of recidivism, is societal rejection faced by the ex-addicts. Common stereotype has projected the drug addict as a 'long haired, dirty, untrustworthy and criminally inclined person'. Drug abuse is seen as a sub-culture whereby members of the wider society are reluctant to get involved with.

Drug abusers are further alienated from the non-users when people attribute to them a set of psychological make-up which is said to be typical of all drug abusers. They are said to be immature, criminally inclined, have low self-esteem and so forth. As such, drug addicts face not only social and legal stigma but also psychological stigma. Moreover, addicts themselves feel inferior to non-users. They are very conscious about their past, which are normally associated with criminal activities. All these factors create a wide gulf between the users and non-users. An ex-addict may find it difficult to cross this gulf and for this reason many ex-addicts may return to the drug sub-culture which would accept them. I feel that efforts should be made to encourage public and governmental awareness of these ex-addicts and to extend to them whatever help possible.

WEAKNESS OF THIS STUDY :

1. This study faces certain limitations in its scope as it is based on data obtained from one centre. Thus only prevailing problems and the rehabilitation efforts of that particular centre are highlighted. Moreover, the findings of this research may not be applicable to all drug dependents. These residents are undergoing rehabilitation and they may differ in some ways from those who are still 'hitting the street', in their perception of the drug sub-culture.

2. The statistics given in chapter three are derived from a sample of 15 respondents chosen at random. As this sample is very small, it may not reflect the entire population of the centre.

APPENDIX 1

FIELDWORK EXPERIENCE :

My initial impression of the centre was that of a holiday camp with shady trees and loud music blasting out from the loud-speakers.

The residents were initially very curious about me, the nature of my research and my views about drug addicts. Most of the residents seemed anxious to know about my opinion of drug addicts and initially, I found it some-what difficult to answer the questions. Moreover, the residents believed that University students are all proud and would not see their side of the story. However, after some pondering, I decided to tell them my frank pre-conception of drug addicts. But I explained to them that I have had no contact with drug abusers before and that my view is based on contemporary public opinions of drug addicts. And I assured them that I would keep my mind open during the course of the study.

During the first week or so, there were some barriers between the residents and I. Both the residents and I came from two very different social "world". Moreover, the residents had this pre-conception that only an addict could understand another addict and a "straight" can never enter the social "world" of an addict. To overcome this problem, I joined all the activities of the residents ranging from therapy sessions to working activities such as cooking, weeding, washing-up and so forth. I joined them at meal-times and during their leisure hours. The time I spent

sleeping with the female residents at their cottage also proved to be fruitful as I was able to communicate well with them.

However, the 3 days I spent participating as a phase one resident in Tunas Baru proved to be the most important step in breaking down the barriers between the residents and I. During that period, I was treated like another resident and this gave me the opportunity to communicate with the other residents on a equal basis. In fact, I had to show respect and obedience to those residents from higher phases especially the phase four residents or "back-ups". In order to do away with the "University researcher" image, I decided not to carry around my note books and tape-recorders. Instead I made mental notes. Whenever I was in doubt of certain things or concepts, I often asked the advice of the residents and this seemed to close the gap between us.

The management had given unlimited freedom to me during my stay in the centre. However, I was requested to inform the management of whatever information I received from residents. This placed me in a very difficult position. And after about a week in the centre, I was tested by some of the residents who had broken some rules. For example - a female and male resident broke the rule of the centre when they had a midnight rendezvous and they told me about this. Soon love-letters were passed in my presence. Other residents began to confide in me about the 'contract' they made such as the 'money contract' amongst some phase 4 residents. Till now, I am still uncertain as to whether the residents were really confiding in me or whether they were testing me. I was

called up often by the management, who enquired about my views of the centre and whether I found out anything from the residents. I refrained from answering saying that certain information were confidential and that I was not in the position to reveal. Fortunately the management did not really insist on this issue. In fact, I got into some problems with some of the 'back-ups' when I refused to tell them certain things which their residents told me. They felt that I was in their way interfering with their work. I had to be very careful not to get involved with all the 'un-approved' activities of the residents (for eg. - a resident once approached me to pass a letter to another resident. Passing of letters between residents are not allowed) and at the same time not reveal any of these activities to the management.

The management also requested that I obtain a written approval from the residents before interviews could be carried out. And this was difficult as many residents were quite reluctant to sign any form of agreement. After the few initial interviews, the rest of the interviews were carried out informally. In fact, the data from most respondents were collected over a period of time through daily interactions with them.

One thing which I had to be careful when I received information from the residents was the authenticity of the information. Most drug addicts pride themselves on their skill at manipulating and they feel that they can easily take a "straight" for a ride. In fact, many residents warned me that some residents may not trust me enough to tell the truth or they may just do it for fun. For example - one female

I spoke to during my first week in the centre gave me an entire different account when I interviewed her again near the end of the research period. In order to reduce the risk of wrong information, most interviews were carried out near the end of the research period. And in order to ascertain the authencity of the information, most information received were counter-cheched with other residents, the staff or I would re-interview the person again at a later date.

In general, I was able to integrate into the community quite easily because I am a girl and am comparatively younger than most of the residents. The residents may have felt less threatened. I tried to behave naturally as if I was interacting with normal members of the wider society and not with a group of different or deviant people. I reminded myself often to be open and not be biased by common stereotype of drug addicts and this may have influenced my attitude and behaviour towards the residents.

APPENDIX II - PLATES

Plate 1 : The Pusat Pertolongan's complex in Batu Gajah

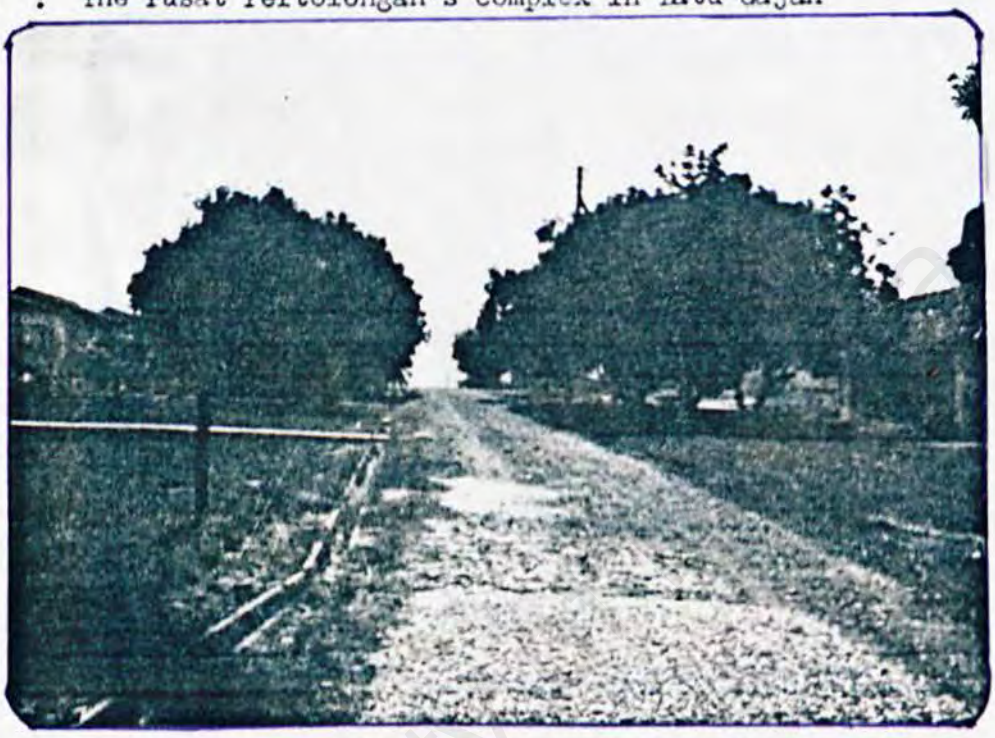


Plate 2 : Kemajuan - The Headquarters of Pusat Pertolongan. It is situated in Kampung Bercham, Ipoh. Kemajuan also houses the Re-entry facility

Plate 3 : The cottage for Women Residents

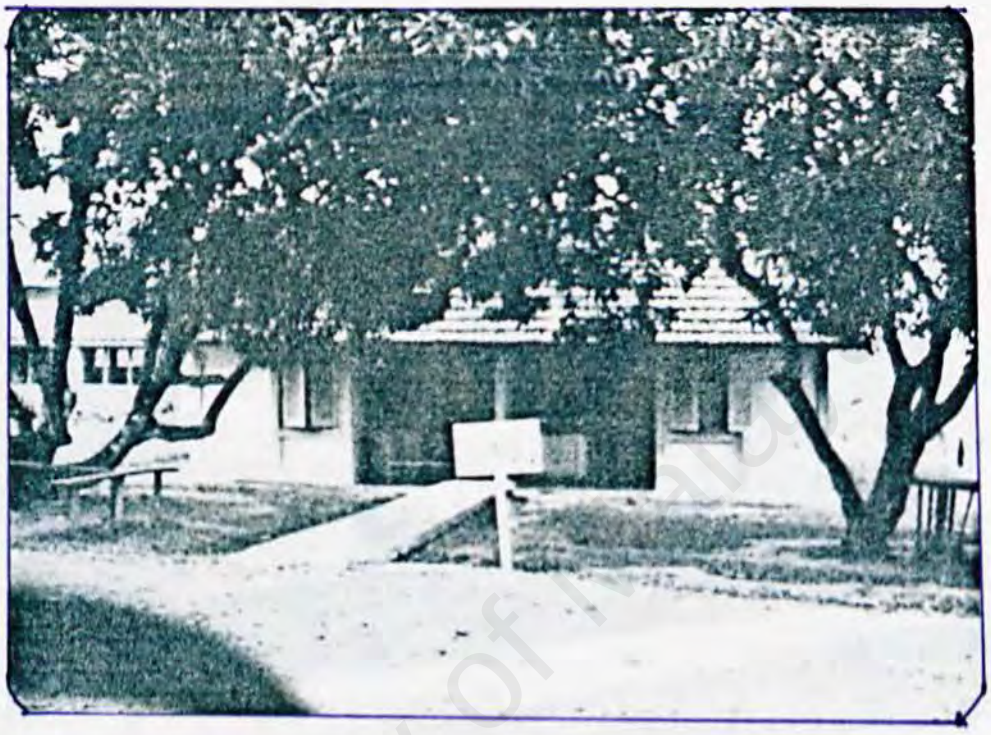


Plate 4 ; The surau in the Batu Gajah Centre

Plate 5 : The various concepts stressed in the programme

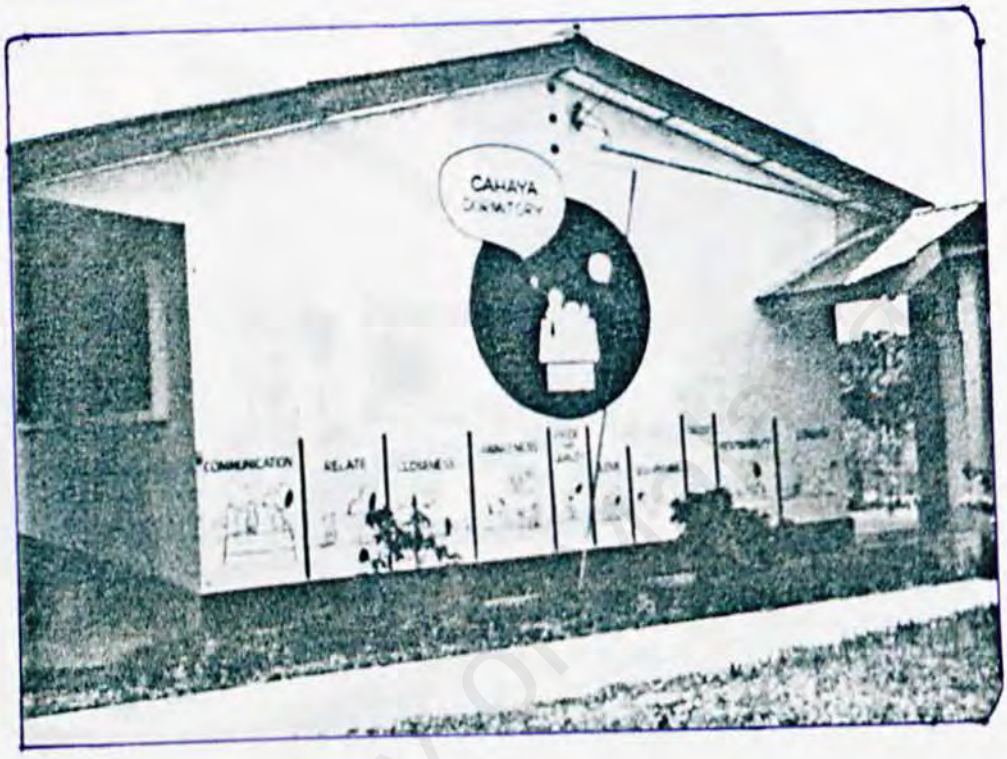


Plate 6 : Maintenance crew at work, repairing the roof of Tunas Baru

Plate 7 : Some of the residents undergoing their learning experience - jogging around the centre.

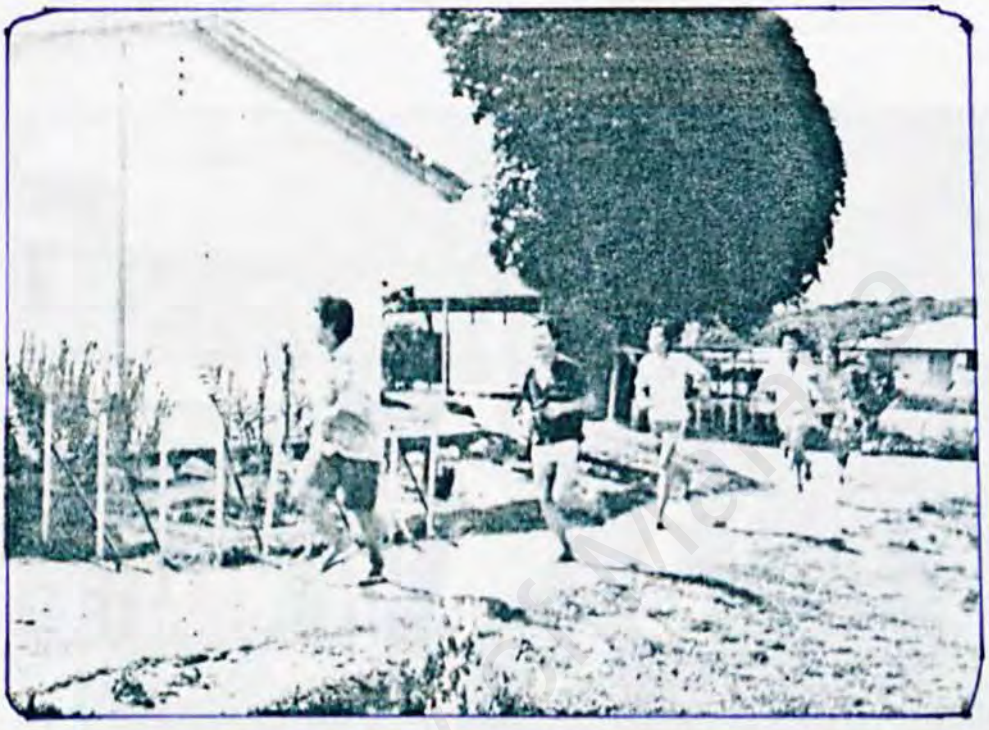


Plate 8 : The residents playing volleyball in the evening. The volleyball court was constructed by the residents themselves.

Plate 9 : The selection parade for "Miss Pusat Pertolongan '81" contest. This was one of the events of the Tribal Game. All participations of this 'beauty' contest are males.

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