SOCIETAL REACTION TO DRUG ADDICTION

Latihan Ilmiah Bagi Memenuhi
Sebahagian Daripada Syarat-Syarat
Untuk Ijazah Sarjana Muda Sastera
Dalam Antropologi Dan Sosiologi

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SUMMARY OF THE STUDY

The study deals with societal reaction to drug addiction. Basically, the study provides a comprehensive account of the kinds of drugs used, deals with the reactions and opinions of the 30 respondents and attempts to evaluate the effect of societal reaction on the drug addict. It also provides a study of the Rehabilitation programme of the Centre.

The author probed into six potential areas of labelling. These included the family, relatives, neighbours, non-addict friends, working colleagues and public agencies and institutions. It was discovered that all six potential sources of labelling were more likely to have negative societal reactions rather than any positive outlook on the problem of drug addiction and of addicts. An attempt is made to perceive to what extent the negative societal reactions or labelling affects the respondents of the study.

In evaluating the rehabilitation programmes of the Centre, the author attempts to assess arbitarily the good points and weaknesses of the programmes. Its basic emphasis on character modification is relevant to the problem of drug addiction. This is because it gets to the root of the problem - the drug addict himself.

Finally, from the gathered data and the further analysis of it, the author draws conclusions as to the success of the programme and how it impinges on societal reaction and its effects on the drug addict.

ACKNOWLEDGEMENTS

I am greatly indebted to the inmates and staff of Pusat Pertolongan, Batu Gajah, Ipoh for their cooperation in the gathering of data for this study. I would also like to express my thanks to the President of Pusat Pertolongan, Encik Yacob Abdul Rahman, for giving me permission to interview the respondents and staff and to utilise the facilities of the Centre.

I would further like to thank Encik Hadi Zakaria, my supervisor, for his guidance on the project and the effort he made on ploughing through my draft and making recommendations.

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CHAPTER 1

INTRODUCTION

Whilst this a study of societal reaction on drug addiction, it is necessary to know something about the drugs abused. The following is an informative account of the various drugs abused by individuals.

Drug is defined as:

(i) A substance used as a medicine or in making medicine for internal or external application.

(ii) A substance recognised in an official pharmacopoedia or formularily.

(iii) A substance intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals.

(iv) A substance other than food intended to affect the structure or function of the body of man or other animals.[1]

From the above definition of drugs, drugs abused could be defined as drugs that are misused to the apparent detriment of society.

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[1] Webster's Third New International Dictionary, (London: G. Bell and Sons Ltd.), p. 695.

Addictive drugs are defined as:

"drugs that caused physical changes in the body, perpetuating their use".[2]

This means that tolerance is established in the addict and he needs increasing doses of the drugs to hold off withdrawal symptoms or to attain the same degree of satisfaction from its use.

The Types of Drugs that are Abused in Our Society

The popular drugs that are misused are alcohol, marijuana, amphetamine, opium, morphine and heroin.[3]

Marijuana

Marijuana is known locally as ganja or grass and is most widely used. It is classified legally as narcotic but medically as hallucinogen drugs.[4] If it is properly used, marijuana has useful medical purposes. It could be used as an anaesthetic in surgical operations, to relieve pain in labour and child birth. However, nowadays it is totally discarded as a medical devices in favour of drugs that are more predictable and medically superior.

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[2] Laurie, Peter, Drugs, Medical, Psychological and Social Facts. (Middlesex, England: Penguin Books Ltd., 2nd edition, 1971), p. 9.

[3] In this study of drug abuse and addiction, alcohol is not considered.

[4] The term 'narcotic' refers to opium and pain-killing drugs made from opium, such as heroin, morphine, paregoric and codeine. Several synthetic drugs such as bemerol and polophine are also classed as narcotics. Cocaine and marijuana are classified legally but not chemically as narcotic drugs.

Marijuana is obtained by crushing or chopping dried leaves and flowering shoots of the female hemp plant - 'cannabis sativa'. Marijuana may be smoked as cigrattes or mixed and ingested with food or liquids. Its subjective effects are sudden, unexplainable hilarity (e.g. giggling), feeling of contentment and relaxation and distorted perception. However, in contrast to its 'high', marijuana user also has its 'downs' that is the user may suddenly shift from a state of gaiety to that of depression and anxiety.

A stick of ganja or marijuana sold illegally can cost around $2.00 to $3.00. It is not an addictive drug.

Amphetamine

Amphetamines are commonly known as pills or mx's locally. There are many brands of amphetamines available locally. The most common of them that are abused are Benzedrin or better known as 'bennies'.

Amphetamine stimulates the central nervous system and produces euphoria, energy, alertness and endurance. Whilst it does not produce physical dependence, a tolerance develops and larger and larger doses are required to achieve the desired effect. Mx pills cost about $1.20 each illegally. Amphetamines are classified as stimulants.

Heroin, Opium, Morphine

All of the above are narcotics and are dangerous and highly addictive. They are also 'totally escapist' drugs in the sense that the relief and 'high' experienced from use of them encourages and reinforces their repeated use.

Opium has been used for centuries in Asia and Africa as an euphoriant. It is taken from the unripe seed capsules of the opium poppy. Morphine (an active chemical in opium) is extracted from opium. In turn, heroin is a semi-synthetic derivature of morphine. It is simple and inexpensive to produce and is more potent than morphine or opium.

Morphine is used medically as a effective pain-killer, whereas opium and heroin have no medical value.

Opium and morphine are used through smoking. There are however, several ways of taking heroin. It may be mixed with tobacco and smoked, sniffed, 'chased', or in extreme cases of addiction, injected directly into the blood-stream.

'Chasing' is a slang word for inhaling the fumes of heroin as it is melted over a small fire. In a serious case of addiction where the addict needs plenty of heroin to maintain the euphoria, injection of heroin is usual since wastage does not occur. Injection of heroin is also more effective as the heroin passes directly into the blood-stream.

Of the three drugs, heroin addiction is more widespread in our society. It is sold illegally in powder form in small tubes. Prices are $3.00 for ¼ tube, $6 for ½ tube and $9.00 for a full tube. Opium and morphine are cheaper than heroin.

Table 1.1 Retail Price of Specific Drugs

Drugs	Price Per lb.
Raw opium	$200 - $250
Morphine	$2,000 - $2,500
Heroin No. 3	$2,500 - $3,000
Heroin No. 4	$6,000 - $8,000

Source: Zainal Adzam bin Abdul Ghani: Social and Legal Aspects of Drug Abuse in Malaysia, Graduation Exercise, Law Faculty, University of Malaya.

Heroin is also the most destructive drug. Results of heroin addiction is withdrawal symptoms when it is discontinued. Withdrawal symptoms are anxiety, body aches, abdominal and other muscular cramps and vomiting. However, withdrawal symptoms are not as serious as they thought to be. Anxiety and tenseness arises from the individual's expectations of undergoing great physical pain during withdrawal. Withdrawal symptoms appear in addicted person about 18 hours after the drug has been discontinued. The

drug also depresses certain areas of the brain and may reduce feelings of hunger, thirst and sex drive. Because heroin addicts do not usually feel hungry, they often lose a considerable amount of weight and their hospitalisation may include treatment for malnutrition.

Heroin addiction may be remedied medically by drug substitution (one of the drugs is methadone). The non-medical cure for heroin addiction is abstinence. Addicts which can be kept under supervision and without drugs for around 7 days or so could be restored to normal metabolic state. It may take another 3 months of rest, good food and exercise to get back to normal health.

The drug problem in Malaysia is serious. The tables below show the amount of drugs seized by law enforcement agencies and the number of individuals prosecuted for drug offences.

Table 1.2 Seizure of Drugs by All Law Enforcement Agencies in Malaysia in Kilograms

Year	Raw Opium	Prepared Opium	Morphine	Heroin	Ganja	Ganja Plant#	Psycho-tropic Pills*
1970	2,248.415	39.575	64.921	0.208	1,446.738	4,418	2,349
1971	1,360.964	42.07	7.542	0.928	3,819.167	10,191	1,524
1972	1,340.818	29.995	78.755	2.644	1,282.298	5,621	11,419
1973	2,391.345	57.982	77.589	19.023	1,004.689	47,401	45,254
1974	1,227.782	24.444	9.535	26.47	396.073	5,141	29,728
1975	826.253	84.546	28.546	85.9	415.43	84,324	57,112

Refer to the number of plants seize.
* Refer to the number of tablets seize.

Source: Zainal Adzam bin Abdul Ghani: Social and Legal Aspects of Drug Abuse in Malaysia, Graduation Exercise, Law Faculty, University of Malaya.

Table 1.3 Success of the Preventive Branch of the Royal Malaysian Custom and Excise in Relation to Persons Prosecuted on Drug Offence

Year	No. of Persons Prosecuted	No. of Persons Convicted	Fines	Fines Paid
1974	46	29	$22,000	$19,000
1975	43	29	$10,400	$ 5,500
1976 (Up to March)	11	6	$ 1,150	$ 1,150

Source: Zainal Adzam bin Adbul Ghani: Social and Legal Aspects of Drug Abuse in Malaysia.

The Study

Scope

The study is based on certain aspects of the 'labelling' theory or 'societal reaction' theory. The societal reaction theory deals with two fundamental problems: the social production of deviance and the effect of labelling on behaviour.

Aims

1) To find out whether the inmates experienced any negative form of labelling before admission into the rehabilitation centre.

2) If so, what was the extent of labelling, the sources of labelling and how does it arise.

3) How they could avoid being so labelled.

4) The effects of being so labelled and their response to the label.

5) (a) To find out the methods of drug rehabilitation.

(b) To find out the attitudes of the inmates towards the rehabilitation programmes.

(c) An evaluation of the rehabilitation programmes.

Source of Data

The data for the study was obtained from the inmates and staffs of the Pusat Pertolongan, a rehabilitation centre in Batu Gajah and Kampung Bercham, Ipoh. This centre was chosen on the basis that:

1) it has a sizable population of ex-drug addicts.

2) it has a rehabilitation program.

Methodology

The methods of data collection comprise of interviews, questionnaires and non-participation observation. A sample was taken from the total population of 175 inmates. Since senior inmates may have different attitudes towards the rehabilitation programmes as compared to more junior inmates, a stratified random sample was taken according to the 'houses' of rehabilitation. (There are altogether 6 'houses' of rehabilitation, refer to Chapter 5).

A simple random sample was taken from each stage of rehabilitation and the subsamples add up to 25 persons. Name of all inmates in each house was taken and the required subsample was

chosen by the lottery method. Altogether 4 inmates were chosen from each house with the exception of 5 inmates from the most senior house (Pusat Kemajuan).

However, the nature and intensity of labelling may differ according to sex. Since at the time of the study there were only 5 female inmates, all the girls were included into the sample which then totalled 30 (7.14% of the population).

Stratified random sampling was used because the centre was divided into 6 'houses' of rehabilitation. Each house has separate identities and therefore subsamples are needed.

For data collection, open-ended questionnaires were used because it allows the respondents to talk freely about their past experiences. It also permits the respondents to answer in their own terms and in their own frame of reference. Interviews and non-participation observations were used for gathering data on the centre's rehabilitation programmes. Lastly, interviews was used to gather information on the inmates attitudes towards the programmes.

In measuring the extent of labelling, 6 sources of labelling were considered, labelling from:

i) parents.
ii) relatives.
iii) neighbours.
iv) non-addict friends.
v) working colleagues.
vi) public institutions and agencies.

The extent of knowledge of the respondents' addiction and the nature of the reactions by the above sources were investigated. For example, a respondent which had experienced much labelling would be known to take drugs by all or most of his non-addict friends and lost of friends would be inevitable. Attitudes of the respondents towards rehabilitation would be classified in terms of favourable, unfavourable or indifference. By gathering the attitudes of the respondents and through non-participation observation, the author would make an evaluation of the rehabilitation programmes.

Problems in Data Collection

Firstly, there was the problem of reliability. Some respondents tend to give distorted answers to too personal questions. In some cases, responses may also be exaggerated.

Secondly, there was the problem of response. Although the majority of the respondents were extremely co-operative, a handful resisted personal questions.

Attempts were made to overcome the problem of reliability and response with the use of cross-interviews and asking the same questions again in a more indirect manner (which is one advantage of using open-ended questionnaire).

Theoretical Framework

The Labelling Theory

Until recently in the study of deviance, little attention has been paid to societal reactions to deviance. The study of deviance had then focused on several theories regarding social-structural forces thought to produce deviance. Most of these theories regarded deviance as behaviour which violates a common cultural value system or norms shared by most citizens. And that this deviance disrupts social equilibrium. However, with the introduction of the labelling approach or societal reaction approach, deviance is seen as problematic and a matter of social definition, because the standards or norms which are violated are not universal or unchanging. Since its introduction, the labelling approach to crime has been receiving the heaviest attention in theoretical and research literature.

The approach rejects genetic, psychological or multi-factoral accounts of crime which stress the absolute nature of the causes of criminality or deviation. Labelling theorists stress on the nature of social rules and the labels aimed at individuals which contradicts such rules. They are interested in the social production of deviance and the effects of labelling on behaviour. With regard to the latter aspect, labelling theorists feel that deviance is the result of social judgement imposed on persons by a social audience.

The pioneer of the labelling approach is Tennenbaum. In 1938, Tannenbaum published a statement that was to become a landmark of what is now known as either the labelling or societal reaction perspective.

> "The process of making the criminal is a process of tagging, defining, identifying, segregating, describing, emphasising, making conscious and self-conscious, it becomes a way of stimulating, suggesting, emphasising and evoking the very traits that are complained of".[5]

The next major development in the labelling perspective is found in Lemert's book Social Pathology (1951). One major distinction introduced by Lemert is that between primary deviation and secondary deviation. These concepts reflect his concern with deviance as a social process and with the impact of societal reactions on the individual. In dealing with primary and secondary deviation, Lemert has two main problems in hand.

1) How deviant behaviour originates.
2) How deviant acts are symbolically attached to persons and the effective consequences of such attachment for subsequent deviation on the part of the person.

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[5] Frank Tannenbaum, Crime and the Community, (Boston: Ginn 1938), p. 19.

For Lemert primary deviation is:

> "assumed to arise in a wide variety of social, cultural and psychological contexts, and at best to have only marginal implications for the psychic structure of the individual ..... Secondary deviation is deviant behaviour or social roles based upon it, which becomes a means of defence, attack or adaptation to the overt and covert problems created by the social reaction to primary deviation".[6]

Lemert further defines secondary deviation as:

> "..... a special class of socially defined responses, which people make to problems created by the societal reactions to their deviance".[7]

An example of a deviant which progress from primary deviation to secondary deviation would help clarify Lemert's concepts. Heavy drinking of alcohol, for example, would be initially attributed to a variety of personal reasons, for example, death of a loved one, feeling of failure, group pressures, escapism and many other reasons. As long as heavy drinking can be tolerated and incorporated into an otherwise non-deviant image, the deviant behaviour will remain primary and have little or no consequences for the individual or those viewing his or her behaviour. This is often true as in our society. Heavy drinking could be easily concealed. A good example would be the social drinkers.

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[6] Edwin M-Lemert, Social Pathology: A Systematic Approach to the Theory of Sociopathic Behaviour (N.J.: McGraw-Hill, 1951), pp. 75-76.

[7] Lemert, Human Deviance, Social Problems and Social Control, 2nd ed., (New York: Englewood Cliff, Prentice Hall, 1972), p. 63.

On the other hand, should drinking draw adverse reactions from others, it is possible that drinking can eventually attributed not to the original cause but to new problems created by those unfavourable reactions. At this point, deviance becomes secondary. For example, the social drinker may lose control of himself and behave in such an obvious way that others began to react unfavourably towards him. He may then increase his drinking as a means of defence, for example, he may alienate himself and drink more heavily.

The causes of primary deviation according to Lemert are wide and varied. And according to Howard S. Becker, another profound labelling theorist, most people experience impulses to deviate but secondary deviation is different in the sense that the original causes of the deviation recede and give way to the central importance of the disapproving, degradational and labelling reactions of society.

However, not all primary deviance escalates to secondary deviation. The possibilities of development of secondary deviance are as follows:

1) primary deviation.
2) societal penalties.
3) further primary deviation.
4) stronger penalties and rejections.
5) further deviation which may involve hostilities and resentments focusing on those doing the penalising.

6) Crisis reached in the tolerance quotient which results in formal actions by the community stigmatising of the deviant.

7) Strengthening of deviant conduct as a reaction to the stigmatisation and penalties.

8) Utimate acceptance of deviant social status and efforts at adjustment on the basis of the associated role.[8]

In his book The Outsider (1963), Becker argued that there is no automatic, fixed and invariant relationship between behaviourial act and societal reactions to the conduct as deviant.

> "Behaviours that would be identified publicly as deviant varies in accordance with time at which they occur, the place where they transpire, and the individuals who observe the conducts".[9]

For instance, in wartime the taking of life may be identified as one's patriotic duty. However, killing for personal gain or revenge in time of peace would bound to draw adverse reactions from society. Also prior to the introduction in the United Kingdom of the breathalyser test, it was legal to drive with a certain amount of alcohol in the blood. However, with the introduction of the test, it was suddenly illegal to drive when

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[8] Lemert, Social Pathology, p. 76.

[9] Howard S. Becker, The Outsider, (New York: Free Press of Glencos, 1963), p. 22.

alcohol content in the blood reaches a certain limit. Hence, people with a particular amount of alcohol in their blood-stream would be labelled as drunken drivers by the police or courts of justice.

Becker goes on to emphasize the distinction between rule-breaking and deviance, noting that many people who are rule-breakers do not receive a deviant lebel, while others who have committed no rule-breaking acts may be mistakenly labelled deviant.

> "Deviance ..... is the product of a process which involves responses of other people to the behaviour ..... whether a given act is deviant or not depends in part on the nature of the act and in part on what other people do about it. ..... yet it might be worthwhile to refer to such behaviour as rule-breaking and reserve the term deviant for those labelled as deviant by a segment of society".[10]

For those rule-breakers which are not labelled, Becker calls them 'secret deviants'. One of Becker's major contribution is his stress on the temporal patterning of deviant behaviour, arguing that sociologists ought to pay particular attention to sequential model of deviance. That is the orderly changes in the action of people over time. Here he offers the concept of deviant careers and career contingencies as an explanation of career development.

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[10] Ibid., p. 14.

Career contingency is a factor or a set of influences which results in the movement of a career from one position to another in a career pattern. Deviant career is caused by the processes and variables which sustain a pattern of deviance over a lengthy period of time. According to Becker, the most crucial step in the process of building a stable pattern of deviant behaviour is the experience of being caught and publicly labelled as a deviant.

Hence it is clear that the labelling theorists are concerned with social attributes and how these attributes affect the way others respond to an act of primary deviance. Being labelled deviant by a social audience or agencies of social control can change one's conception of self and lead the individual to deviant roles. In this case the labelling theorists are influenced by George Mead. Labelling theorists said that the self is a social construct, that the way which we act and we see ourselves as individuals are the result of the way in which other people act towards us. Therefore, if people see us as somewhat strange or different, then we are likely to begin to thinking of ourselves as different.

Originally, the word 'stigma' was used to refer to obvious physical deformities or marks, however in the labelling approach, it refers to any attribute of a person which can be negatively evaluated. According to Erving Goffman, the term 'stigma' is used

to refer to an attribute that is deeply discrediting. He stated that there are three different types of stigma.

First, there are abominations of the body - the various physical deformities.

Next, there are blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs and dishonesty, these being inferred from known record of, for example, mental disorder, unemployment, suicidal attempts and racial political behaviour.

Finally, there are the tribal stigma of race, nation and religion, these being stigma that can be transmitted through lineages and equally contaminate all members of a family.[11]

Labelling theorists state that once a person is stigmatised as a result of being labelled a deviant he would be seen as untrustworthy and alienated. Thus, labelling effectively limits the deviant's contact with the legitimate world and make contacts with the illegitimate appear as more acceptable alternatives. Also the deviant may alter his or her self-concept and so assume a deviant role. Labelling as such could lead to a deviant career and the final step is movement into an organised deviant group which provides support for deviant behaviour.

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[11] Erving Goffman, Stigma (Penguin 1968), p. 14.

For example, an individual who is openly labelled a homosexual may be alienated from society which sees him as abnormal. He may then use his label agressively to fend off adverse criticisms of a heterosexual society. Therefore, he would socialise with his own homosexual peer groups and thus assume a deviant role resulting in the development of a deviant career.

Once an individual is labelled as deviant, his or her deviant status will act as a master status which will determine how others will act towards him or her across the entire range of social interactions which have no relation to his or her deviant behaviour at all.[12] For example, homosexuals would be discriminated when they seek employment. Labelling theorists assume that once a person is labelled as deviant, he would be permanently treated as a deviant by others and that his deviant status would be irreversible.

The study by Richard D. Schwartz and Jerome H. Skolmick[13] on the effects of a Criminal Court record on the employment opportunities of the unskilled, confirmed the fact that once an individual is labelled as deviant, he would be put into an

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[12] Walter R. Gove: The Labelling Perspective: An Overview in W.R. Gove: The Labelling of Deviance (ed), (New York, John Wiley and Sons, 1975), p. 13.

[13] Richard D. Schwartz and Jerome H. Skolmick, "A Study of Two Legal Stigma" in Howard Becker (ed), The Other Side, Perspective on Deviance, (London: Callier-MacMillan, 1964), pp. 105-110.

unfavourable social context such that his or her deviant role would be permanent.

In the study, four employment folders were prepared. In all the folders the applicant was described as a thirty-two years old single male of unspecified race, with high school training in mechanical trade, a maintenance worker and handyman. The four folders differ only in the applicant's record of criminal involvement. The first folder indicated that the applicant has been convicted and sentenced for assault, the second stated that he has been tried for assault and acquitted, the third also tried and acquitted but with a letter from the judge certifying the finding of not guilty and thus reaffirming his innocence. The fourth folder made no mention of any criminal record.

A sample of 100 employers was used forming 4 groups of 25 employers each. The 4 groups were shown different employment folder and was asked whether the employers would use the man as described in the folder.

Of the 25 employers shown the 'no record folder', 9 gave positive responses. The group shown the 'convict folder' only 1 gave positive response. Finally, the group of employers approached with the 'accused but acquitted' applicant, only 3 offered jobs.

The findings showed that conviction is a powerful form of labelling which leads to status degradation. The individuals accused but acquitted of assault had almost as much trouble finding a job as the one which was convicted. Hence, labelling is also

applicable to those who had experienced court procedures, regardless of whether they are guilty or not.

Labelling theorists are in a way pessimists in that they argue that correctional institutions such as prisons, rehabilitation centres, training schools and criminal justice institutions such as the criminal court actually push individuals further into crime. They also state that such institutions have several negative consequences on the deviant like 'Labelling'. Also people with higher status are more likely to fend off unfavourable reactions from others and thus avoids secondary deviations.

Summing up, the labelling perspective differs from the normal approach to the study of deviance by concentrating on the effect of societal reaction on deviants instead of studying deviance as the violation of social norms or legal norms. In this aspect the labelling perspective claims to explain why certain persons and not others are labelled as deviant. They argued that once a person has been labelled the person would experience a inferior status which further leads him into criminality. Thus he or she would develop a deviant self-image based on the image received through the reactions of others and once deviance becomes secondary, it is irreversible.

Operational Framework

The concept of secondary deviant would be applied. According to Lemert (1951), being labelled would change one's conception of self and lead the individual to a deviant role and finally into a deviant career. In this aspect, the author would find out whether the respondents have develop any form of secondary deviation.

CHAPTER 2

PUSAT PERTOLONGAN: IT'S HISTORICAL BACKGROUND

Pusat Pertolongan has its roots in early 1973 and was founded by Encik Yacob Abdul Rahman (then known as James Wilhem Scholer).

In early 1973, the Church of Our Lady of Perpectual Help of Ipoh Garden, Ipoh formed various counsels concerning the formation of action group to care for the needs of its parishioners. Encik Yacob volunteered to head the counsels concerning youth problems and advisory. Very soon between May and June 1973, a group of volunteers interested in counselling of youths was formed and with the help of Datuk Dr. M. Mahadevan, lectures and evening sessions were formed to look into problems concerning youths.

On 29th June 1973, an addict approached Encik Yacob and asked for his help. Soon the friends of the addict came to know about Encik Yacob and they also requested for his help. Encik Yacob together with the medical assistant provided by Dr. Mahadevan kept the addicts in their homes and homes of their friends. However, the number of addicts soon became too numerous and hence on 4th December 1973 Encik Yacob setted up a home for them in No. 154, Gopeng Lane, Ipoh.

A Board was soon established to run the place and the Board of Members of the Parish Counsell was formed. The Board and the centre at Gopeng Lane came under the Catholic Welfare Service.

However, Encik Yacob realised that treatment confined to detoxification and counselling was not sufficient as the relapse rate among the addicts was almost 100%. Therefore in July 1974, he left for Manila and underwent an intensive course from the Drug Addict Rehabilitation Foundation (D.A.R.E.) and he implemented the therapeutic methods of D.A.R.E.

At the same time the population at the centre had increased and a new premise in Kampung Bercham, Ipoh was rented to cope with the growing population. In June 1975, residents of the Kampung Bercham premise were transferred to a new premise, also in Kampung Bercham. The new Bercham 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.

However in 1975 both the centre at Gopeng Land and Kampung Bercham were inadequage to cope with the growing admission of addicts. Another centre in No. 45, Gopeng Road was opened and it was named Pusat Jiwa Murni. In 1975, Encik Yacob embraced Islam and hence all the 3 centres were severed from the supervision and controls of the Church.

In 27th April 1975, the centre in No. 154, Gopeng Lane was moved to a new and bigger centre in Batu Gajah, Ipoh. This new centre is called the Help Centre or Pusat Pertolongan. Also at the end of 1975 there were 15 female residents and to separate them from the male residents, another centre in Tambun Height, Ipoh was opened.

Hence at the end of 1975, Pusat Pertolongan consist of 4 centres in Batu Gajah, No. 45 Gopeng Road, Kampung Bercham and Tambun Height.

1976 saw the transferred and closing down of Pusat Jiwa Murni and the girl's resident to the main centre at Batu Gajah on January and October respectively.

On 19th January 1977, 12 residents of the Pusat Pertolongan together with Encik Yacob (its Director) took a night train from Batu Gajah to Kuala Lumpur to start another centre. The new centre is located at No. 606, Bukit Petaling and incidentally it was also called Pusat Jiwa Murni. This centre is meant to admit addicts from the Kuala Lumpur and Petaling Jaya area and to act as an after-care centre for inmates whose home-town is in Kuala Lumpur and Petaling Jaya.

This centre was also run in coalition with PEMADAM (Persatuan Mencegah Salahguna Dadah, Malaysia) and also acts as an half way house for government servants who leaves the centre in the morning for work and return later in the evening.

However due to administrative problems and disagreements between the Pusat Pertolongan and PEMADAM, Pusat Pertolongan withdrew from Pusat Jiwa Murni in late 1977. Therefore up till the time of the study, Pusat Pertolongan consist of the main centre in Batu Gajah and another centre in Kampung Bercham.

Although initially the Pusat Pertolongan was purely a drug rehabilitation centre, it is now a rehabilitation centre for youths who need social help. Since its foundation, the centre's population had increased tremendously. It had a population of only 66 residents

during its pioneering year in 1973 and its population increased to a record of 460 in 1975.

The following tables showed the centre's population, the respondent's age and marital status, the racial composition of the respondents and the type of drugs used by the respondents.

Table 2.1 Age Groups of Pusat Pertolongan's Population from 1973 to 1977

Age in Years	Year				
	1973	1974	1975	1976	1977 (Up to May)
14 - 18	15	35	67	11	8
19 - 23	35	59	172	63	52
24 - 28	14	121	137	67	76
29 - 33	2	70	58	17	25
34 - 38	0	5	26	7	15
Total Population	66	290	460	165	170

Source: Census Sheets, Research Department, Pusat Pertolongan.

Table 2.2 Racial Composition of Pusat Pertolongan's Population from 1973 to 1978

Race	Year					
	1973	1974	1975	1976	1977 (to May)	1978 (to March)
Malays	4	13	97	55	45	41
Chinese	43	226	287	87	106	102
Indians	12	25	61	18	15	22
Others	7	26	15	5	4	10
Total	66	290	460	165	170	175

Source: Majallah Malam Tauliah, Pusat Pertolongan.

Table 2.3 Types of Drugs Used by the Resident from 1974 to 1977*

Type of Drugs Used	Year			
	1974	1975	1976	1977 (to May)
Heroin	167	375	154	163
Morphine	83	50	5	4
Opium	12	10	1	1
Ganja	9	1	0	0
Canabis	0	0	4	1
Mx	15	8	1	0
Dethidine	1	6	0	0
Non drug users	3	10	0	1

* Figures for 1973 are not available.

Source: Majallah Malam Tauliah, Pusat Pertolongan.

Table 2.4 Marital Status of Resident from 1973 to 1974*

Marital Status	Year			
	1974	1975	1976	1977 (to May)
Married	15	30	10	28
Single	275	430	155	142
Total	290	460	165	170

* Figures for 1973 are not available.

Source: Majallah Malam Tauliah, Pusat Pertolongan.

CHAPTER 3

SOCIAL BACKGROUND AND DRUG ABUSE CHARACTERISTICS OF ADDICT RESPONDENTS

Social Background of Respondents

A sample of 30 (17.1% of the population) respondents was taken from the total population of 175 inmates. Tables 3.1 and 3.2 show the sex and racial composition of the respondents.

Table 3.1 Sex Characteristic of Respondents

Sex	Sample Size	Population Size
Male	83.3% (25)	97.1% (170)
Female	16.7% (5)	2.9% (5)
Total	100% (30)	100% (175)

Table 3.2 Racial Composition of Respondents

Race	Sample Size	Population Size
Malays	23.3% (7)	23.4% (41)
Chinese	70.0% (21)	58.3% (102)
Indians	6.7% (2)	18.3% (32)
Total	100% (30)	100% (175)

Table 3.3 shows the marital status of the respondents recpectively.

Table 3.3 Marital Status of Respondents

Sex	Married	Single	Total, N=30
Male	3.33% (1)	80% (24)	83.33% (25)
Female	0	16.67% (5)	16.67% (5)

The age of the respondents ranged from 17 years to 30 years with a mean of 23 years and a standard deviation of 8.9 years.

Table 3.4 Frequency Distribution of Respondent's Age

Age in Years	Frequency (f)	Mid-Point of Interval (x)	fx	d	fd	$(fd)^2$
17-18	1	17.5	17.5	-3	-3	9
19-20	10	19.5	195	-2	-20	400
21-22	4	21.5	86	-1	-4	16
23-24	4	23.5	94	0	0	0
25-26	4	25.5	102	1	4	16
27-28	5	27.5	137.5	2	10	100
29-30	2	29.5	59	3	6	36
	N=30		$\Sigma fx=691$		$\Sigma fd=-7$	$\Sigma(fd)^2=577$

$$\text{Mean, } \mu = \Sigma fx/N$$

$$= 691/30$$

$$= 23.03 \text{ years.}$$

$$\text{Standard Deviation, } S = i\sqrt{\frac{\Sigma(fd)^2 - \left[(\Sigma fd)^2 / N\right]}{N-1}}$$

(i is the size of the class interval)

$$\therefore S = 2\sqrt{\frac{577 - \left[-7^2 \div 30\right]}{30-1}}$$

$$= 8.9 \text{ years.}$$

Prior to their admission to the centre, 26.7% (8) of the respondents were working. Out of these, 4 are government servants and 4 are private employees. The rest of the residents (73.3% or 22) were unemployed before admission. However, out of these respondents, 10 had once been working during the time they were on drugs, and 5 were schooling prior to admission.

Drug Abuse Characteristics of Respondents

In the study all the respondents were heroin addicts. However they had tried a variety of other drugs before getting addicted to heroin. Two reasons were given by the respondents for changing to heroin, one was for a better 'kick':

> "I was introduced to heroin by a friend, before that I was on ganja for 2 years. I tried it and found that the kick was much better ..... I started off (with heroin) real heavy. After 2 weeks I began to have running nose and felt weak without heroin. I was then having withdrawal symptoms without realising it".

The second reason was that ganja was getting harder to obtain at times. It is obvious that the pushers were concentrating on the more profitable heroin business rather than the less lucrative ganja.

Table 3.5 Type of Drugs Taken by Respondents

Drugs	Respondents in %
Ganja	83.3 (25)
Amphetamine	43.3 (13)
Alcohol	6.7 (2)
Opium	36.7 (11)
Morphine	3.3 (1)
Heroin	100 (30)
N=30	

The number of years the respondents were involved in drugs (ganja, amphetamine, alcohol, heroin, opium and morphine) ranged from 1 to 8 years with a mean of 3.8 years and a standard deviation of 3.9 years.

Table 3.6 Frequency Distribution of Years Spent on Drugs by the Respondents

Time on Drugs in Year	Frequency
1 - Under 2	2
2 - Under 3	9
3 - Under 4	6
4 - Under 5	7
5 - Under 6	3
6 - Under 7	1
7 - Under 8	2
N=30	

The length of drug addiction (time since first recognition of addiction) ranged from ½ to 7½ years which is long enough for labelling to take place. The mean is 3 years and the standard deviation is 4.4 years.

Table 3.7 Frequency Distribution of Length of Addiction of Respondents

Length of Addiction in Years	Frequency
½ - Under 1½	4
1½ - Under 2½	9
2½ - Under 3½	9
3½ - Under 4½	3
4½ - Under 5½	2
5½ - Under 6½	1
6½ - Under 7½	2
N=30	

The drugs available in the local black market are not cheap. A very heavy heroin addict may easily spend between $50.00 to $80.00 (5½ to 9 tubes) on heroin daily. In the study, the respondents spent an average of $29.40 (3½ tubes) on heroin daily, the standard deviation is $42.30 (5 tubes) and the range is from $6.00 to $80.00 (½ to 9 tubes).

Table 3.8 Frequency Distribution Showing the Amount of Money Spent by the Respondents on Drugs

Amount Spent on Drugs Daily, in Dollars	Frequency
5 - 14	4
15 - 24	8
25 - 34	11
35 - 44	4
45 - 54	0
55 - 64	1
65 - 74	1
75 - 84	1
N=30	

The respondents spent an average of 5.7 months in the centre with a standard deviation of 11.4 months. The range is 1 month to 14½ months. The average duration of stay in order to graduate from the centre is 8 months. The longest possible duration of stay would depend on the progress of the inmates and their willingness to participate in the centre's programmes.

Table 3.9 Frequency Distribution Showing the Length of Time Spent by the Respondents in the Centre

Time in Months	Frequency
1 - Under 3	9
3 - Under 5	7
5 - Under 7	4
7 - Under 9	4
9 - Under 11	3
11 - Under 13	2
13 - Under 15	1
N=30	

Table 3.10 Summary of the Drug Abuse Characteristics of the Respondents

Characteristic	Mean	Range	Standard Deviation
1. Age (in years)	23	17 - 30	8.9
2. Total time spent on drugs (in years)	3.9	1 - 8	3.9
3. Length of addiction (in years)	3	½ - 7½	4.4
4. Daily cost of addiction (in dollars)	29.4	6 - 80	42.3
5. Time spent in the centre (in months)	5.7	1 - 14½	11.4

CHAPTER 4

LABELLING AND ITS EFFECTS ON THE RESPONDENTS

Data in this chapter was obtained by interviewing 30 inmates from the Pusat Pertolongan. A deviant like the alcoholic, may easily be seen as a social drinker. Drug addiction, on the other hand, has no socially acceptable outlets and the physical and withdrawal symptoms of addiction are not so easily concealed.[14] Supporting a drug habit also means that the addict may often need to raise money, legally or illegally.[15]

The aim of this chapter is to discover the intensity, nature and consequences of labelling or societal reactions on the respondents. Six possible sources of labelling were investigated: family, relatives, neighbours, friends, working colleagues and public agencies and institutions.

The Family

The respondents are young, averaging 23 years of age and only 1 is married. All of them are still staying with their parents. As they have face to face contact with other members of their respective family daily, it is inevitable that sooner or later every member of the family would come to know about their involvement with drugs.

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[14] William E. McAuliffe, Beyond Secondary Deviance: Negative Labelling and Its Effects on the Heroin Addict, in Walter R. Gove, The Labelling of Deviance (ed), (New York, John Wiley and Sons, 1975), p.223.

[15] Ibid., p. 234.

All the respondents admitted that every member of their respective families knew about their habit. However, this only occurred when they had developed dependency on drugs. Prior to the respondents addiction, their habits were easily concealed by their being extremely cautious. Buying and taking of drugs were done in the utmost secrecy. The respondents usually take drugs out of the house or in the privacy of their rooms.

The average length of drug dependency in the sample is three years. However, it was only after a year or more before any of the respondents family members began to find out about it. At that stage, their increasing drug addiction meant a possible desperate approval for financial support or outright thieving of family possessions. Of course, this would lead to arousal of suspicion and the inevitable revelation. Furthermore, withdrawal symptoms may become harder to conceal. The following was one example:

> "I was on drugs (heroin) for three years and most of the times were spent out of the house. Physically I was thin and pale, when my parents suspected that things were missing from the house they became suspicious. Finally, I was caught taking drugs in my room".

The parents immediate reactions was that of shock and disbelief followed by long confrontations with the respondents on the dangers of drugs.

The most negative reactions experienced by the respondents were outright rejection by their respective families. In the sample, 36.7% (11 males and 2 females) of the respondents experienced this.

Out of these respondents:

(i) 6 were rejected by their parents.

(ii) 2 were rejected by the father only.

(iii) 3 were rejected by both parents and siblings.

Rejection by the parents (fathers and mothers) meant threatening to disown them. In three cases, the respondents' parents threatened to inform the police. In one case, the parents made good their threat. Parental rejection resulted in adverse psychological upset of the respondents. Family ties were strained because of the constant nagging and harassment. One respondent felt that he was being treated like a child by his parents. The respondents believed that their parents lacked faith and trust in them and this worsen the relationship.

Threat of violence was rare and was only evident in two cases. The respondent's father threatened to beat him if he did not stop the habit immediately. One respondent's mother repeatedly threatened to commit suicide.

Confinement of the respondents within their homes were also often effected by the respondents' parents. All of the respondents admitted that at one time or the other they were told to stay at home and were put under strict parental control and supervision. One respondent said that a daily schedule was prepared by his parents stating that a certain time must be allotted to his studies and certain friends were barred from the house. They even followed him whenever he went shopping or to the movies as they distrusted him where money matters were concerned.

Much pressures were applied on the respondents by members of their family in the form of constant nagging and complaints. Most respondents said that nagging, complaints and advices from their respective family were a daily affair.

However not all reactions were negative. Prior to their admission, 50% (15) of the respondents had been sent for treatment by their parents:

(i) 9 had been sent for medical treatment in hospitals or clinics.

(ii) 3 to bomohs.

(iii) 2 to rehabilitation centres.

(iv) 1 respondent was sent to his uncle's house for treatment on a self-withdrawal basis.

With the exception of one respondent who had been admitted to the Pusat Pertolongan, the treatment of the rest of the respondents were unsuccessful. The 9 respondents who had been sent for medical treatment only succeeded in stopping drugs temporarily. All of them relapsed as soon as medical treatment was terminated. Only one of the three respondents who had been treated by bomohs claimed to have been cured temporarily. Another respondent which had been admitted to a drug rehabilitation centre in Kuala Kubu Baru did not succeed in terminating his addiction as he claimed that the centre does not have an effective rehabilitation programme. Cigarettes has been freely available at the centre which in turn led to the smuggling of drugs in the form of cigarettes into the centre. The respondent who went to stay with his

uncle, lacked the will-power to stop drugs and he ended up cheating his uncle to obtain money to buy drugs.

Consequences of negative Familial Reactions

Frustration, anxiety and complete lost of hope were experienced by the respondents due to the negative reactions. One respondent became so frustrated that he frequently abused his sister who used to hide or throw away his drugs. However, such outbursts of violence by most other respondents were rare. Two respondents reported an increased in their taking of drugs due to depression and anxiety. However, the rest of the respondents did not increase their doses as a result of negative reactions.

Another significant consequences of negative reactions was the respondents attempt to stop taking drugs. In the sample, 90% (27) of the respondents had tried at least once to stop drug abuse by abstinence. Some of the respondents avoided taking drugs by moving out of their house to friends' or relatives' house. They were usually located in another town where drugs were not easily obtainable.

However such withdrawal methods had 100% relapse rate as the temptation to fall back on drugs were great. Moodiness, depression and lack of will-power intensified the temptation to resume the habit. Instigation and pressures from the respondents' addict friends also played an important factor in the relapse.

Seven of the twenty-seven respondents had had been to treatment in drug rehabilitation centres prior to their admission into

Pusat Pertolongan. Such treatments were also unsuccessful as some centres lack a proper treatment programme and these respondents lacked the discipline and will-power to stop drugs then. Therefore some of the respondents were prematurely discharged and some absconded from the centres.

Reasons given by the respondents as to why they had tried to stop taking drugs were that they were fed up of the constant pressures they had to face not only from their respective families but also from friends and relatives. Many respondents also felt that they needed a change after all these years in the dark. As one respondent puts it:

> "I really felt bad because my father intended to send me to Europe for further studies. Instead I got busted (jailed) twice for pushing. When I got out of jail my parents were depressed and worried. Finally, I realised that I couldn't carry on like this anymore".

Relatives

In contrast to the respondents' families, not all the members of the respondents' relatives knew about their involvement with drugs. This is obvious, since their next-of-kins were numerous and so it is not possible that all would know about it.

From the sample,

(i) 36.7% (11) respondents were known by most of their relatives to take drugs.

(ii) 40% (12) said that only a few of their close relatives had any knowledge about it.

(iii) 13.3% (4) said that none of their relatives knew.

(iv) The remaining 10% (3) were in doubt as to whether their relatives knew.

The relatives' knowledge of the respondents' drug addiction hinged on the degree of intimacy of relationship between the two parties. The closer the relationship increased the likelihood of the relatives knowing about it. In fact, relatives were usually informed by the respondent's family. Only one parents attempted to conceal the fact of his son's drug addiction. They felt that revealing it would merely disgrace the family.

Reactions of the respondent's relatives towards them inevitably depended on the bond between the respondent and his relatives. More often, close kinfolk proffered advice and sympathy. No rejection by close kinfolk was reported. Distant relatives, however, avoided contact with the respondents or as one respondent reported were totally indifferent.

Consequences of 'Next-of-Kin' Reactions

The reactions of relatives did not have much effect on the respondents. This is due to the fact that most of the reactions of relatives ranged from sympathy to total apathy and indifference. Negativity is obviously not going to produce any positive effects on the respondents. However, where-ever concern and sympathy was proffered, it played a minor part in the subsequent attempt by the respondents to give up drugs. As such, it was significant that 20% (6) of the respondents resided with their relatives during their efforts to fight drug addiction.

Neighbours

The sample survey showed that:

(i) 26.7% (8) of the respondents said most of their neighbours knew they were drug addicts.

(ii) 46.7% (14) respondents said a few of their neighbours knew.

(iii) 16.7% (5) claimed that their neighbours had no knowledge of their drug involvement.

(iv) The remaining 10% (3) were in doubt as to whether their neighbours knew, but felt that they probably suspected it.

'Know-aboutness' (a term used by Goffman, 1963) of the respondent's involvement with drugs by their neighbours was possibly through the respondent's physical characteristics and behaviour. Noticeable physical characteristics are, for example, loss of weight and paleness. Suspicious behaviour like the buying of drugs from local 'pushers' fueled gossip and rumours among the neighbours.

Five respondents were apparently able to conceal their habit from their neighbours. They took drugs in utmost secrecy and dressed and behaved decently in the presence of their neighbours. One respondent almost completely avoided his neighbours by secluding himself in his room after work. A female respondent not only behaved decently and normally in public but also publicly avoided her friends who were addicts. Drugs were bought through these friends. As such, none of her neighbours knew about her involvement with drugs.

The most common reaction by the neighbours was the ascribing of stereotyped traits to the respondents. 70% (21) of the respondents

said that their neighbours viewed drug-addicts as dirty, immoral, useless and considered them thieves or thugs. The respondents' neighbours avoided them as far as possible for fear of police harassment and that the respondents would pressurise them for money. Only three respondents had sympathetic neighbours.

Consequences of Negative Reaction by the Respondents' Neighbours

Although there were considerable negative reactions towards the respondents by their neighbours, the respondents managed to neutralise such reactions by ignoring or avoiding their neighbours. Since most of the respondents were not very close to their neighbours, this sort of labelling does not have very much effect on the respondents.

Friends[16]

Almost all of the respondents were known to their non-addict friends as addicts. Out of the thirty respondents in the study,

(i) 60% (18) were known as addicts by all of their non-addict friends.

(ii) 30% (9) said most of their non-addict friends knew.

(iii) 6.7% (2) were known to take drug by a few of their non-addict friends.

(iv) 3.3% (1) said none of them knew.

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[16] In this section only labelling from the respondent's non-addict friends were taken into account.

'Know-aboutness' of the respondents' habit among their non-addict friends was high because of the majority of the respondents did not bother to conceal their addiction from friends. This is because it is difficult to conceal the symptoms and effects of taking drugs when the respondents were in the drugs when the respondents were in the company of their non-addict friends.

Initially, they had been on good terms with their non-addict friends. It was not uncommon for the respondents to discuss their personal problems with friends, even the fact of their experimentation with drugs. Therefore many of the respondents' non-addict friends knew that they were on drugs even before the respondents became addicted to it.

Only three respondents took the trouble to conceal their involvement with drugs. These respondents wanted to maintain a good relationship with their non-addict friends. One of these respondents was a junior executive in a reputable firm and he could not afford to be labelled as an addict by anyone. As a result, two of these respondents were only known to take drugs by a handful of close non-addict friends.

One respondent succeeded in concealing his addiction from all his non-addict friends. This was because he had then been schooling and was also an active student. All the time his non-addict friends only knew him as a heavy smoker.

Rejection is the most common reaction by the respondents' non-addict friends. All (29.6% or 29) of the respondents who were known by their non-addict friends as addicts had lost non-addict friends at

one time or another. The remainding one respondent did not lose any non-addict friends because of his addiction as none of them knew that he was on drugs.

Most of the respondents felt that their friends had discarded them because these friends considered them hopeless and untrustworthy. Some respondents suspected that their friends were even afraid of them. A respondent's comment reflected the above situation:

> "Who would want to mix with an addict? They think that all addicts are nothing but trouble ..... they are afraid that they would get 'hooked', arrested or something else may happen to them if they socialise with addicts".

The dilemma of estrangement or alienation was mirrored in the words:

> "People think of addicts as different from normal people, the way they dress and behave ..... that addicts had no respect for anything".

Therefore, it is significantly implied that drug addiction leads to a serious degradation of social status of the drug addicts.

Fortunately, most of the respondents did have a handful of close non-addict friends. This small circle of close friends were sometimes persuaded to give some financial help and were generally sympathetic. Financial help was also coupled with advice on terminating their drug addiction.

On the other hand, other non-addict friends usually tried their best to avoid the respondents. Theirs was chiefly a fear of drug involvement and also being pestered for financial aid. As one respondent

puts it:

> "Most of my friends (non-addicts) were afraid of me because I tried to introduce them to take drugs as I was 'pushing' drugs at that time".

Consequences of negative Reactions by Non-Addict Friends

The inevitable result of labelling from non-addict friends was the severing of friendship ties between the respondent and his non-addict friends. The respondent usually starts off with many non-addict friends but is gradually alienated as his involvement with drugs escalates.

The respondents felt out of place with their non-addict friends as their interests differ (the respondents become quite obsessed with drugs alone). For example, the respondents would feel rather embarrassed whenever he or she have withdrawal symptoms or the urge to take drugs in the company of non-addict friends. Avoidance by their non-addict friends also gave the respondents an inferiority complex to socialise with them.

Working Colleagues

Prior to the respondent's admission into the centre, 26.7% (8 males) of the respondents were working:

(i) four respondents were government servants; and

(ii) four were private employees.

Another 33.3% (7 males and 3 females) of the respondents had left their jobs prior to their admission into the centre.

All of the eighteen respondents who had been working, had tried to conceal their addiction from their working colleagues and employers. This arose out of a fear of losing their jobs. These respondents concealed their addiction during working hours by taking drugs secretly in any vacant place, rooms and usually in toilets.

But not all of the respondents managed to conceal their addiction successfully. Under the influence of drugs, they soon began to lose interest or slacken in their work.

(i) Four of the respondents were known to take drugs by most of their working colleagues.

(ii) Five said very few knew.

(iii) Out of these nine respondents, six said their employers knew. Four of them are government servants and two were private employees.

(iv) Seven of the respondents had managed to keep it a secret from both their working colleagues and employers.

(v) The remaining two respondents were not sure whether any of their working colleagues or employers knew.

Reactions from working colleagues resembled reactions of non-addict friends towards the respondents. Many of the respondents were estranged from their working colleagues as a result of their addiction. This is because their working colleagues feared involvement with them would mean lost of their jobs should their employers come to know about it. But a handful of close working colleagues were sympathetic and continued maintaining a relationship with the respondents.

Employers of five respondents suggested that they either stop taking drugs or resign. As such, four respondents who are government servants were sent to the Pusat Pertolongan for rehabilitation by their respective government departments. The remaining respondent lacked the will-power to stop taking drugs, so he resigned. One respondent was fired by his employer because he was caught stealing office equipments.

Significantly, the seven respondents whose working colleagues and employers remained in ignorance of their addiction managed to get along fairly well with their working colleagues. These respondents felt out of place with their colleagues after working hours. As such, there was little contact apart from office hours.

Consequences of Being Negative Reactions by the Respondent's Working Colleagues

Negative reactions from the respondent's working colleagues resulted in the severing of friendship between the respondents and their working colleagues. This had led the respondents to alienate themselves and therefore they had only minimal relations with their working colleagues.

Public Agencies and Institutions

Of the public agencies which the respondents were known to, the police is the most common. 46.7% (14) respondents had had contacts with the police. 13 respondents were 'picked up' by the police on suspicion of either buying, selling or the taking of drugs. One respondent was 'picked up' for house-breaking. All except one respondent

were released due to lack of incriminating evidence. This particular respondent was jailed for 'pushing'.[17] Out of these 14 respondents, only 5 of their parents knew about their contact with the police. Their non-addict friends, relatives and neighbours knew very little or nothing at all about their involvement with the police.

Only 3.3% (1) of the respondents was brought to court. This respondent, at the time of the study, was awaiting a court-case for extortion. Only his parents knew about it.

10% (3) of the respondents had been treated for drug addiction by the general hospital, 3.3% (1) by a private hospital, 16.7% (5) by private clinic. Also 23.3% (7) of the respondents had been for treatment in drug rehabilitation centres. The treatment undertaken by these respondents were only known to their parents and a few close friends.

Consequences of Being Labelled by Public Agencies and Institutions

Labelling of the respondents by public agencies and institutions does not occur frequently. Furthermore, most labelling were rarely made known to the respondent's relatives, parents, neighbours or friends. The respondents also had adopted the addict label long before their being labelled by such agencies and institutions. Hence when the respondents

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[17] Prior to the incorporation of Section 39B to the Dangerous Drugs Ordinance, 1952 by the Dangerous Drug (Amendment) Act 1975, there is no single offence of trafficking as such. The only provision is Section 9(1) (c) in Part III which prohibits any persons from manufacturing, selling or dealing in prepared opium. Subsection (2) of Section 39B provides the punishment of death or the alternative life imprisonment which includes the mandatory punishment of whipping on conviction.
This respondent was convicted before the Drug Amendment Act, 1975.

appeared before such agencies and institutions, it was the respondents who admitted the deviant label rather than having it ascribed to them. Therefore, such labelling had little or no effect on the respondents.

Table 4.1 Knowledge of Respondent's Addiction by Their Family, Relatives, Neighbours, Non-Addict Friends and Place of Work

Extent of Knowledge	Family %	Neighbours %	Non-Addict Friends %	Place of Work %	Relatives %
All know	100		60		
Most know		26.7	30	22.2	36.7
Few know		46.7	6.7	27.8	40
Nobody know		16.7	3.3	38.9	13.3
Not sure of it		10		11.1	10
They know					
Total	100 N=30	100 N=30	100 N=30	100 N=18*	100 N=30

* Only 18 of the respondents had had been working.

Table 4.2 Agencies to Which Respondents Were Known

Agencies	% Known N=30
Police	43.3
Jail	3.3
Criminal court	3.3
General hospital	10
Private hospital	3.3
Drug rehabilitation centre	23.3
Private clinic	16.7

Conclusion

The process of labelling are:[18]

(1) the act of identifying someone as a person who engages in a given type of behaviour, and placing the label on that person as one who does that type of thing (or desire to do it, or even has a strong but repressed and latent potential for doing so).

(2) the act of categorising the type of behaviour (not necessarily the individual) as bad, evil, sinful, antisocial: in short, of requiring some isolation, punishment or treatment.

Kitsue identifies two factors: identification by another and differential (or negative) treatment, as being necessary in order that a person be labelled deviant.[19]

The extent to which others are aware of deviance has been described by Goffman under the simple term 'known-aboutness'.[20]

Therefore from the analysis of the six sources of labelling, the respondents were subjected to much labelling. Female respondents tend to experience the same type of labelling as their male respondents.

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[18] E. Sagarin and R.J. Kelly, Sexual Deviance and Labelling Perspectives in W.R. Gore, The Labelling of Deviance, (New York, John Wiley and Sons, p 1975), p. 246.

[19] Ibid., p. 246.

[20] Ibid., p. 246.

However, as these female respondents did not have any contact with public agencies like the police or rehabilitation centres prior to their admission into the Pusat Pertolongan, they did not experience any labelling from this quarter.

The general pattern was that almost anyone who knew about the respondents' addiction either rejected or avoided them and also pressurised them to stop taking drugs. The respondents' response to negative reactions was to alienate themselves and socialise increasingly with their addict friends.

A fundamental distinction made in the labelling theory is that between primary deviance and secondary deviance. Primary deviance may caused someone to be labelled as a deviant, in this context, the respondent who becomes addicted to drugs was labelled a drug addict. Subsequently, deviant behaviour of the respondent resulting from being placed in the above deviant role is termed secondary deviance. Lemert notes that,

> "Primary deviation is assumed to arise in a wide variety of social, cultural and psychological contexts ..... Secondary deviation is deviant behaviour or social roles based upon it, which becomes a means of defence, attack or adaptation to the overt and covert problems created by the societal reaction to primary deviation".[21]

The respondent who is labelled as a drug addict faces problems created by the societal reaction against his deviance. Societal reaction comes in term of societal sanctions against drug abuse. It is concretised

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[21] E.M. Lemert, Human Deviance, Social Problems and Social Control, (Englewood Cliffs, N.J., Prentice Hall, 1967), p. 17.

in current laws which reduce availability and which makes illegal drug abuse. The respondents in response to societal reaction adapts himself by resorting to secondary deviance. Adverse societal reaction means that the deviant has now no legal financial means to support his drug addiction. Secondary deviance in terms of trafficking of drugs, theft, robbery and cheating becomes necessary in order to sustain his commitment to a primary deviance - drug abuse.

All respondents had committed forms of deviance other than that of drug-taking, i.e. secondary deviance. They admitted they had repeatedly stolen things from their respective homes. Goods stolen were quickly sold to anyone who are willing to purchase it. The respondents also cheat their respective families, relatives and friends. Cheating takes the form of borrowing money without due repayments or by using lies to persuade someone to lend them money. Beside this, 16.7% (5) of the respondents had been involved in house-breaking, 6.7% (2) were extortioners and 46.7% (14) were former 'pushers'.

Only 26.7% (8) of the respondents were working prior to their admission into the centre. Another 33.3% (10) had had been working but left their jobs prior to their admission. The remaining 40% (12) were not working. Therefore, soon after the onset of addiction, the respondents would quickly exhaust their personal resources such as income, savings and personal belongings as drug taking is a very expensive habit.

When personal resources were gone, the respondents' desire for drugs led them to depend heavily on illegal resources (for example, drug-trafficking or thieving) as legal access to drugs were closed.

By doing so the respondents in turn creat further undesirable social identity and lebels. Many friends were lost and near the end of their drug career, the respondents even chose to stay away from their addict friends. Addict friends which were once depended upon were now considered to be a problem as the respondents would be obliged to share drugs with them, a condition which they could no longer afford.

At the very end of their drug career, many respondents were so financially and socially depleted that they had to turn to drug-trafficking (a very risky venture) or cheaper form of opiates like crude opium and morphine. Finally, the constant labelling and the risk of being arrested and personal health were too great. The respondents began to 'bottom-up' and decisions to give up drugs were made. This is because the respondents had the choice of conforming to social sanction by giving up drugs.

CHAPTER 5

PUSAT PERTOLONGAN: ITS METHODS AND APPROACH OF DRUG REHABILITATION

In this part of the study, a detailed study and analysis of the Pusat Pertolongan approach to drug rehabilitation is given. The aim of this chapter is to show how one of our local drug rehabilitation centres treats drug addiction.

Pusat Pertolongan: A Therapeutic Community

The centre's program was adapted from the treatment program of Drug Addict Rehabilitation Foundation (D.A.R.E.) in Manila, Philippines in July 1974. D.A.R.E. in turn had its roots in Daytop (Drug Addicts Treated On Probation) village which is an offspring of the successful American treatment centre Synanon.

Synanon is an informal self-help community of addicts and ex-addicts and was founded in Southern California in 1958 by an ex-alcoholic member of Alcoholics Anonymous in the United States. Synanon apply the cultural reorientation approach to rehabilitation which is concerned with weaning people away from illegal or criminal activity by changing their perspectives.

Synanon like most other self-help organisations have rejected using professionals like psychologists and psychiatrists to help solve their individual problems. They believe, in general, these professionals have not been successful, and that their presence would prevent the growth

of the kind of group solidarity which they believe to be necessary for a successful operation.

Synanon's primary concern is that the specific behaviour of their members conforms to the norms and values of the group or community. In 1966 it had 450 members. An addict who enters the centre must first undergo withdrawal treatment. He is then required to live in the community for a minimum of two years.

The central features of the treatment are the seminars. In the seminars the members meet in groups of eight or twelve for one and a half hour three times a week. And they subject each other to the most vicious criticism, abuse and ridicule. The members of each seminar are rotated so that all in the community interact with one another.

Since most characteristic personality problems of addicts are that they cannot bear stress and criticism, the daily discovery that one can be criticised and still live on would be a most important lesson. In this way the aim of the seminars was to provide the members with a positive and realistic frame of society to live in. The members are required to work and are paid a small amount of pocket money. Members who do not seem to be benefiting from the community are given the choice of expulsion or trial by their peers. If they do not conform to the program, the men who are guilty have their heads shaved and the women have to wear a placard round their necks as punishment.

In many ways the program of the Pusat Pertolongan is similar to those of Synanons. However, much modifications and additions were made, both through trial and error and through the long process of adaptation of the

program to conditions here.

The inmates refer to their centre as a therapeutic community.[22] That is they are a group of people living together as an extended family sharing common ideals and goals. All the inmates have accepted that they are not perfect and are seeking new insight into themselves in order to promote growth and maturity to the individuals as well as the group.

The Therapeutic Community (T.C.) of Pusat Pertolongan makes use of local cultural values. The T.C. concept is very similar to the Malaysian value of 'gotong royong' and cannot exist without the mutual help of all inmates and staff members. Although the centre believes in the need for developing necessary agricultural, industrial and technical skills, the emphasis is on attitudes. The centre strongly proposes that one can achieve whatever he has set his mind on achieving, if he possesses the right attitudes.

All inmates in the centre were accepted into the T.C. as immature, irresponsible, emotionally unstable and incapable of handling their feelings. Therefore, all inmates are composed of people who define their difficulties as stemming from a common problem. Therefore, the T.C. aims to bring about a radical change in the individual in term of his behaviour, attitudes, feelings and intellect.

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[22] The concept of therapeutic community was first attempted in England by Maxwell Jones. The Therapeutic Community used the 'sick-model' of the client with the notion that psychic change takes place best in a setting that represents a miniature of the outside world.

The methods of treatment in the T.C. are similar to those of D.A.R.E. and Synanon. In the T.C. the inmates are subjected to much physical and emotional stresses. The learning process makes good use of the 'malu' phenomena. Shame is a powerful tool in the Malaysian society which can be used to compel people to conform. Strong authoritarian methods are used in the T.C. which are similar to parental rule in the Malaysian family. It is in fact very much like the average Malaysian home where the children are subjected to strong corrective pressures. Staff and officials of the T.C. are seen as substitute parents and behave in very much the same way. Peer group pressures are also used as a tool for conformity in the T.C.

In the T.C. each inmate has a defined status and function, starting at the bottom on the onset of admission. If he or she fails or refuse to participate in the program he/she would be "shot down" to a lower rank. On the other hand, the inmates who progress fast and are willing to 'grow', are rewarded with promotion to a higher rank.

In short, the programs of the T.C. emphasizes attitude, personality and character building and these are reinforced by the teaching of various handicraft, agricultural and administrative skills.

The Tools of the Therapeutic Community

Although the rehabilitation process of the T.C. are divided into 4 stages consisting of 6 houses which the inmates would have to go through, the methods of treatment or the 'tools' in each 'house' are the same. The only difference in the tools of each 'house' lies in their intensity and

frequency of application. However each 'house' differs administratively and has different functions all of which are also part of the treatment process. Therefore, before a discussion on the various stages of rehabilitation, an insight into the 'tools' of the houses would be most helpful.

The various tools of the T.C. are:

1) 'Relate, Challenge and Confront'.
2) Seminars.
3) Learning Experience.
4) The Game.
5) Probe.

1) 'Relate, Challenge and Confront'

To 'relate' is to open up one's innermost feelings and thoughts to another inmate or to the group. An inmate relates in order to seek guidance and release from negative feelings. For example, someone may relate that he or she feels like running away from the centre. Relating of positive feelings are also encouraged.

A 'confrontation' is a direct inquiry by one inmate to another or by a group to an inmate. The aim is to ascertain the rationale and motives behind one's behaviour, be it positive or negative. For example, one may be confronted for isolating himself or herself from the group, or for being too aggressive in his or her involvement.

A 'challenge' is similar to confrontation but is less formal. An inmate could challenge another inmate any where and any time.

Relate, confrontation and challenges are given to test, strengthen as well as giving advice and guidance to an inmate. Such activities would also allow the rest of the inmates to learn from each other's mistakes or achievements. Except for challenges, relate and confrontation are done under the directions and supervisions of the staff[23] or officials[24] of the houses.

2) Seminars

Seminars are largely educational discussions dealing with topics ranging from Bible study, English lessons, politics, health education and music appreciation. Inmates given the opportunity to voice their personal problems, opinions or suggestions. These seminars are usually led by an inmate or a staff, and as it is informal, it could be held any where; in the various 'houses', under a tree or in the canteen.

3) Learning Experience

When inmates are not benefiting from the T.C. programs or are refusing to learn they are given a learning experience. The 'learning experience' attempts to strengthen the resident's ability to accept situations and to handle stress. There are various forms of 'learning

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[23] Staff would be referred to inmates which had 'graduated' from the centre. They are experienced programmers and are employed by the centre.

[24] Officials are senior inmates which have had gone through most of the programmes and are selected on basis of their leadership and personality qualities.

experience': using placards, or hair cuts, or others termed as "spare parts", 'out casts'.

a) Placards

Placards are hung around the inmate's neck. The nature of the inmate offence is inscribed on it, and an additional note calls upon other inmates to confront the bearer. In this way, other inmates could learn from mistakes of others. Placards are used for minor offences like laziness, irresponsibility or using vulgar words. Occasionally, having an untidy room means that the particular inmate has to wear a rolled up blanket around his neck to show the nature of his offence. If the whole house is not progressing, all its inmates have to wear placards and promenade around the centre in front of the other inmates.

b) 'Spare Parts'

A 'spare part' is slang term for an inmate, who loses certain privileges and he may also be confronted by other inmates. Minor offences warrants this learning experience.

c) Out Cast

Out casts are inmates who refuse to learn or boycott the T.C. programs. Out casts are isolated from other inmates until they are willing to participate.

d) Hair Cut

Hair cut is a form of punishment for heavier offences like fighting, smoking cigarettes or drugs and very bad behaviour. The hair cutting ceremony starts off by a tongue-lashing given to the inmate by a panel (usually five inmates) headed by a staff. Mistakes and negative attitudes are forcefully pointed out to the individual. After this a patch of hair is cut off from the head of the inmate. However, if the inmate still refuses to learn from his or her mistake, he or she would be shaved bald. However, the latter is rarely necessary. The purpose of the hair cut is to remind inmates of their mistakes whenever they look into the mirror or comb their hair.

With the obvious exception of the 'hair cut', deterrent learning experiences are lifted whenever an inmate had learnt from his mistakes.

4) The Game

The heart of the rehabilitation program is centred on the game. It is carried out by usually 8-13 inmates seated in a circular formation. The game is verbal free for all seminar. The inmates emotions, attitudes, personality, character, weakness and strong points are subjected to discussion, probes, analysis, ridicule, praise and scorn. An individual is subjected to confrontation until he has fully exposed himself which is often emotionally painful. The game is also a setting for pouring out hostile feelings among inmates and making effective use of confrontation to make inmates respond.

In the game, no sides are taken, each inmate is equally vulnerable to attack irrespective of rank. The purpose of the game is to make the inmates see and know themselves and one another as they truly are. By opening up the inmates come to realise the types of help they needed and this usually becomes a way to foster cooperation, love and understanding among inmates. The rules of the game include,

a) the barring of violence or even threat of violence.

b) no walking out during the game.

5) Probe

The probe is an intensive confrontation or interrogation made on an inmate by a panel of his or her peers to throw light on his past life, experiences and upbringing that may have some bearing on his present attitudes and outlooks.

The T.C. of the Pusat Pertolongan is divided into 4 stages consisting of 6 houses. Each house has a separate identity with distinctive administrative programs and functions.

Stage 1 - Pusat Tunas Baru

The first house of the T.C. is called Tunas Baru. It is an intake house, the initial stage of rehabilitation. Being a 'nursery house', the inmates of the house need to be handled in tactfully. The family (or inmates of the house) are guided and helped in order to get them ready to face more challenges in the second house which is Pusat Cahaya.

Treatment

All new intakes must be given detoxification for them to withdraw from drugs. The method is drug-abstinence and inmates under detoxification are isolated in separate rooms. Detoxification usually takes about 4 to 5 days and after this, 'probes' are given to find out more about the new inmates and hence recommend appropriate treatment.

Treatment includes application of the 'tools of the house' and projects like gardening, fishing, football, etc. Since it is an intake house where the inmates are detoxified, there would be the occasional threat of violence and refusal to participate in the program. Therefore, a patient and understanding approach is implemented. More counselling is done (usually in the form of seminars and sometimes games) and tough learning experience is met out only when found necessary. Besides the 'tools of the house', morning meetings are conducted six times a week. During the meetings, the negative attitudes of the residents are pointed out to the whole family. Discipline is strictly maintained through the use of the various 'tools of the house'.

As the family shows signs of progress, more trust is given and seminars, 'games' and sometimes lunches are held outdoors to make the inmates feel less isolated. Sometimes if the family is very cooperative, fishing tripsto the nearby mining pools are organised.

Management

The house is under a staff member known as the Officer In Charge (O.I.C.) assisted by an officer known as the House Coordinator. Besides this, there are Chief Expeditors and several Assistant Expeditors, kitchen, detoxification, maintenance and the health crews. The 'tools of the house'

are implemented by the O.I.C., House Coordinators and the various expeditors when necessary. All members of the management are inmates with the exception of the O.I.C. who is a graduate from the T.C. The management crews are taken from the second stage house (Pusat Cahaya) because they had had experience in Tunas Baru.

Stage 2 - Pusat Cahaya

Pusat Cahaya is the second stage house where the 'family' are being built up emotionally, mentally and physically to get them ready for the third stage which consists of 3 houses (Pusat Harapan, Pusat Cahaya and Metamorphosis Commune).

Treatment

Treatment programs are very similar to those of Tunas Baru, that is, the application of the 'tools of the house' and work and recreational projects. However, the treatment are far more intensive than in any other houses. The aim is to correct personality and character disorders in order to bring about radical changes in the inmates. The programs include learning experiences, the instruction of honesty, trust, responsibility, manners and a willingness to change.

'Tools of the house' are conducted 5 times a week, more often if necessary. The emphasis is on counselling and therefore seminars are daily affair. This is because the family faces a lot of stress and work and they might find it hard to handle various problems. Work therapy is also more intensive. At the time of the study, a Cahaya garden project had just been completed, a football field has been made for the T.C. and the Cahaya living

quarters were washed, cleaned and painted.

Management

Management organisations are the same as that of Tunas Baru with the exception of the detoxification crew. However, the management crews are given more responsibilities and trust and work-load is often heavier. Management officers are either from the third or fourth stage house.

Stage 3 - Pusat Harapan

Pusat Harapan (sometimes known as the Central Office) is part of the administrative headquarter of the Pusat Pertolongan. Its function is purely administrative.

Treatment

In the treatment programs, work therapy is equally as important as the 'tools of the house'. The administrative function includes the handling of admissions and discharges, typing, paper work, printing, accounting, public relations, liasons with other houses, sentry duty and the recording of all daily events and happenings. All these administrative works are done by the 'family'. There is also a research centre which is responsible for all written articles and circulars and the constant revision and improvement of the therapeutic programs.

Since the family is often engaged in administrative work, there is little time for work projects. However, the 'tools of the house' are not neglected. In this aspect the application of the 'tools' is done in a more

mature way, the inmates are expected to know their mistakes and weak points. Also all inmates are expected to take a positive view towards the house programs and must be willing to 'grow'.

The residents of Pusat Harap are selected from the outgoing residents of Tunas Baru who are proficient in paper and clerical work.

Management

Head of the management is the Officer In Charge who is a staff responsible for the overall programs. Assisting the O.I.C. is the House Coordinator who is an inmate. Because of the house administrative nature, there are various departments each under an Officer. They are the secretariat, finance, research, public relation, printing and kitchen departments. The management crews are all selected from within the Pusat Harapan or the final stage house Pusat Kemajuan.

Metamorphosis Commune

This is the most recent of all houses being formed on December 1977. The purpose of the creation of this house was to form a family to practise for a choir and play (called metamorphosis, and hence the family was named after this play) to be presented on the Pusat Pertolongan Graduation Day at Ipoh Town Hall on 7th January 1978. Therefore the Metamorphosis Community is based on artistically talented inmates pulled up from among all other houses, disregarding their respective length of stay in the T.C.

Treatment

Treatment programs are the usual application of the 'tools' of the house but more emphasis is placed on work therapy. Work therapy in this house are the constant rehearsing and practising for choir or drama. Since its formation, the family had to practise every day as all the scenes of the play and the singing have to be perfected. The play "metamorphosis" is about the life history of an ex-addict. The aim of the play is to show society, in a dramatic form, what can be done to fight drug abuse.

Metamorphosis Commune is a 'moving family' travelling around the country to show to society the importance of fighting drug abuse and to publicise the Pusat Pertolongan treatment programs. It also is a fund raising campaign since donations are collected during the staging of plays. Funds collected go towards the development of the centre. As noted at the time of this study, the commune had already staged its play and presented the choir at the Pusat Pertolongan Graduation Day, Batu Gajah Convent Girls' School, Batu Gajah Chinese Temple, Taiping Prison and at the University of Malaya. At the time of the study, the commune was planning to stage two more plays in Penang and Pahang.

The aim of this type of work therapy is to give the family members more responsibility and to expose them to outside life. Since its foundation, the 'tools of the house' are seldom applied due to the good discipline and the inmates' preoccupations with work therapy.

Management

The organisation of the Commune management is similar to that of Tunas Baru with the exception of a detoxification crew and expeditors. However the Officer In Charge and House Coordinator have more responsibilities as they have to make the necessary arrangements and preparations for the staging of plays, transport and lodgings.

Pusat Industry

Pusat Industry is another third stage house which obtains its residents from Pusat Cahaya. Residents are chosen because of their skills and interest in pratical work.

Treatment

Treatment are based on both work therapy and the application of the 'tools of the house'. For work therapy, Pusat Industry have different departments consisting of:

a) Plastic Department

The products of this department range from crest key chains, plastic picture frames, name tags and plastic trophies. New intakes into this department are given training and supervision by its senior members.

b) Art Department

This department produces painted posters, sign boards, paintings and interior decorations. It also coordinates with other departments by providing them many new resigns and new ideas, especially the handicraft and plastic departments.

c) Carpentry Department

Produces chairs, tables, cupboards, book shelves and various carpentry work which also include the varnishing and reconditioning of old furnitures. This department is very useful as its products are relevant to the extensions of the Pusat Pertolongan. Residents who are interested in carpentry work are given training by the more skilful and experienced members.

d) Handicraft Department

This is a small department with a few residents who have had past experience in this field. They produce products like bamboo pen holders, assamwood key chains and assamwood pictures.

e) Horticulture Department

This department purchases plants and grows many species of plants. These plants are for decorative purposes and quite often the plants are given to other houses.

f) Other Departments

This comprise of the administrative and clerical departments which is wholly responsible for all paper work of the house. The maintenance department upkeeps the house and the kitchen department is responsible for marketing and cooking of food for the family.

Work in Pusat Industry is similar to that in outside life. All residents are expected to be responsible and independent where work is concerned.

However, the importance of the 'tools of the house' are not to be neglected. Seminars, games and meetings are important sessions that help

the residents to understand the benefits of a working therapy house. After working hours, the residents are given the chance to relax and to confront and probe into each others problems, frustrations and ideas.

Management

As usual, the head of the administration is the Officer In Charge who is a staff and is assisted by the House Coordinator, an inmate of the house. Below them are the various departmental heads. Management crews are selected from within the Pusat Industry or the Pusat Kemajuan. Unlike the rest of the houses which are located in Batu Gajah, Pusat Kemajuan is located in Kampung Bercham, Ipoh.

Stage 4 - Pusat Kemajuan

It is a final stage house in which all inmates must pass through in order to be a graduate of the Pusat Pertolongan. As such it is a house consisting of the most senior inmates with a deeper understanding of the T.C. program.

Treatment

Work therapy is a major part of the treatment program. Kemajuan is a business house. The house is an agent for a popular fruit drink and inmates are required to do door-to-door selling of this product. The house had also set up two food stalls in Ipoh Garden Gourmet Square. Also at the time of the study, a restaurant to be run by the house was under construction in Ipoh Garden.

The aim of this house is to provide the inmates with an exposure to society, programming them for a gradual re-entry into society. The second aim is to provide supplementary income, if possible. All members of the house are by now highly responsible and mature individuals. They are given much trust and freedom in the sense that they are allowed to handle money.

In the application of the 'tools of the house', the game and learning experiences are used more than the rest of the tools. Instant learning experience is given without hesitation should intolerable attitudes surface. Hair cuts are conducted in a counselling-like approach instead of the usual forceful approach. Residents also had to relate to the whole family before curfew at the end of the day.

Management

Management is headed by an Officer In Charge who is a staff member and assisted by the House Coordinator, who is an inmate. Directly under them are the heads of the sales, accounting and finance administrative, maintenance and kitchen departments. All officials are chosen from within their own house.

By the combining efforts of the 'tools of the house' and work therapy, inmates would then be able to develop a positive attitude towards life and are taught many responsibilities so that they might be independent and responsible when they graduate from the centre. In the centre, almost all duties are carried out by the inmates. There are only 12 staff members in the centre at the time of the study.

The conditions for graduation are based on a merit system. All new inmates start at zero. Stage 1 residents are rated 1 to 7, Stage 2 from 8 to 12, Stage 3 from 13 to 15 and Stage 4 from 16 to 18. After Stage 4, inmates are allowed to leave the centre on probation. Upon reaching a rating of 20, an inmate is a qualified graduate. All inmates must pass through all the stages in order to qualify for graduation. Any inmates who are not benefiting from the programs are shot down to a lower rank. A cooperative inmate would spend an average of 2 months in each stage.

However, the concept of graduation does not apply to government servants and students. Such inmates are rushed through all phases of the programs as quickly as possible and discharged.

The Respondent's Attitudes Towards The Rehabilitation Programs

The views of the Stage 1 respondents differed greatly from the Stage 2, 3 and 4 respondents. Since the programs are new to Stage 1 respondents, they are not very sure about its relevance and importance. Out of the Stage 1 inmates being interviewed, 3 did not give any opinions saying that they had yet to understand the programs. One Stage 1 respondent was not sure whether the rehabilitation program would be beneficial but expressed a willingness to participate.

However, all of the stages 2, 3 and 4 (86.7% or 26 of the respondents) had a positive view towards the program. Most said that for the first time in their lives they were in contact with reality. The programs enabled them to acquire a sense of responsibility, honesty,

trust and mutual understanding. Everyone in the centre learned to respect each other. All staff and officers are referred to as 'abangs' or brothers by other inmates. Laziness and vulgar vocabulary were eradicated by learning experience.

The cardinal rule of the centres helped to maintain the existing spirit of the respondents. The cardinal rules were:

1) No drugs or any other forms of intoxication.
2) No violence or threat of violence.
3) Good moral.

The positive attitudes of the respondents were reinforced by the fact that many had tried to stop drugs on their own but failed. At the centre they had begun to realise that the social and emotional aspects of drug rehabilitation were most important.

When asked whether the treatment would help to prevent their being labelled as addicts when they leave the centre, the respondents were doubtful. Almost all of the respondents were not sure whether rehabilitation would prevent a continued labelling as drug addict. However, they are confident that with the help of the rehabilitation programs they would be able to prove to society that they could be normal law abiding citizens. As such, labelling may be less likely to occur when they rejoin society.

Only one respondent felt that rehabilitation program was ineffective in preventing relabelling of inmates. This respondent stated that although the program was good, it was not given enough publicity. Many members of the public were not aware of what is

going on inside the centre. He reiterated that many phase 4 inmates were discriminated by members of the public when they went out to sell their products. He noted that the degree of labelling experienced by inmates had been immense.

Evaluation of the Treatment Programme

The treatment programme of the Centre emphasizes character modification. This is apparently positively accepted by most of the respondents. Modifying the respondent's character would strengthen his ability to fight against relapses. It would to some extent, mentally prepare him to fend off any further drug involvement or negative societal reaction, when he leaves the Centre. The use of the various methods of 'learning experience' is commendable since they are fairly informal and allow for 'gotong-royong' spirit enhances unity against a common foe - drug addiction. The intense, searing interaction and voicing of views liberates the drug addict and provides the means by which he may understand himself through others. The program succeeds if the drug addict is able to interact with others in their community, which is representative of our Malaysian society.

The rehabilitation programme does, however, have some weaknesses. (i) it is difficult to measure the respondent's progress; and (ii) the Centre lacks a vocational training programme.

(i) The fact that cooperativeness and exemplary behaviour are indications of successful participation in the program may be deceiving. It may simply imply the

inmate has been pressurized to conform. As such the possibility remains that inmates may leave the Centre without any radical change in their character. This may be especially true in the case of the government servants who are rushed through the programmes.

(ii) Majority of the respondents complained that the Centre does not have a vocational training programme. The inmates are only trained in handicraft skills, simple carpentry and home gardening. The crux of the issue is that only those who are interested are sent to Pusat Industry for the above training. It must be noted that twelve respondents did not have any working experience prior to their admission. In these cases, vocational training is required to provide them with the appropriate skills. The graduate of the Centre who is faced with unemployment may experience frustration. And this may lead to recidivism.

Despite the above flaws, the Centre's rehabilitation programme is being developed in order to ensure better treatment. In the early years, the Centre had a very authoritarian rehabilitation programme that stressed on punishment. Fortunately, the present programme is tempered with years of experience and the element of patience and understanding.

Conclusion

All the respondents in the study had undergone negative societal reaction and labelling. Labelling adds fuel to the problems of the respondents. Not only does society frown on drug addiction and the addicts but it levers social sanctions. The social sanctions either restrict or deny any financial support of addiction and the accessibility of drugs. The marked lack of any positive reaction can only mean that the respondent retrogrades increasingly. Further deviation results from the obsession to find even illegal means to pay for their habit. Desperation increases until the respondent 'bottoms-out' forcibly or willingly and seeks treatment.

The Centre's program has been able to a great extent, to understand the intrinsic dements behind drug addiction. Its emphasis on attitudinal and character modifications allows the respondent to infuse confidence in himself by learning more about himself and achieving a sense of self respect. Character modification in this sense may minimise the possibility of a relapse. It possibly reduces the effects of the stereotyping of the drug addict and provides immunity against further stereotyping of the respondent who emerges from the Centre as an ex-drug addict.

Recommendations

1) A drug rehabilitation centre should not only provide for actual physical drug withdrawal and character modifications but should also have a vocational training program. Rehabilitated inmates must have the necessary skills to obtain suitable jobs. Pemadam (Persatuan Mencegah Salah Guna Dadah, Malaysia) for instance, has a halfway house in Kuala Lumpur - it provides some vocational training to ex-drug addicts to enable them to readjust comfortably into society. This, however, is still a relatively recent venture.

2) Drug rehabilitation must draw wide community support in order to be fully effective in the society. Schools, public and private commercial sectors and government agencies in supporting the above may encourage more drug addicts resorting to drug rehabilitation. Just as important, is the responsibility and willingness of government and private commercial sectors to help ex-inmates find suitable employment. Employers who had initially dismissed those who were drug addicts should take them back if and when they are cured. A positive attitude towards ex-drug addicts would help them to become normal citizens.

Limitations of The Study

The study focuses on respondents who were at the time of the study undergoing rehabilitation. A study of labelling would be more compact and complete if it considered not only respondents which are undergoing rehabilitation but also those who are not being rehabilitated and those who have been rehabilitated. Drug addicts that have not undergone rehabilitation may react differently to labelling. In the study, one major consequence of labelling was the eventual decision of the respondent to undergo rehabilitation. Labelling of addicts that have not been rehabilitated may have different consequences. The author is not at liberty to state the different consequences since he was unable to interview any of them.

In the study, the author was only able to make an arbitrary evaluation of the effectiveness of the Centre's rehabilitation programme. A follow-up study of ex-inmates of the Centre is necessary to make an accurate evaluation.

Suggestions For Further Study

To throw more light on the labelling perspective of drug addiction and the methods and degree of effectiveness of drug rehabilitation in Malaysia, the following studies are recommended:

1) A study of labelling and its consequences on drug-addicts which had not been rehabilitated.
2) A study on the life-style of drug-addicts which has not experienced any form of labelling or those who has experienced only minimal amount of labelling. This

would be useful in understanding more fully the labelling perspective of drug addiction.

3) A study of inmates who had undergone complete rehabilitation at the Pusat Pertolongan or any other rehabilitation centres, so as to evaluate the effectiveness of the centres rehabilitation programmes. And to find out whether they had been relabelled and if so, how it affects them.

Plate 2. A sample of the productivity of the Art Department.

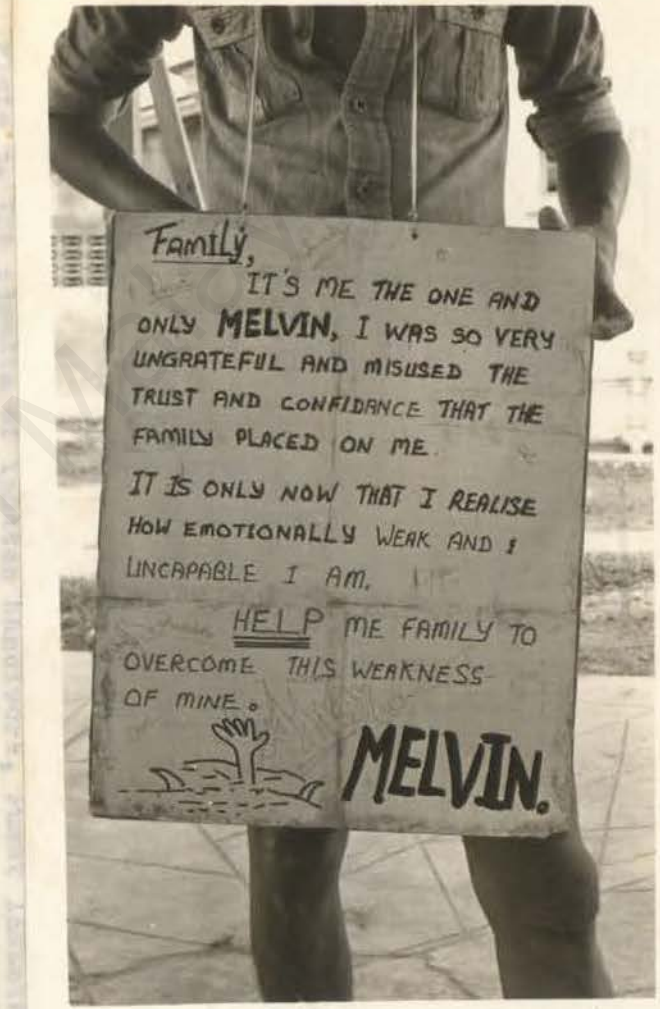

Plate 1. A form of learning experience: wearing a placard.

Plate 3. The results of inmates handiwork, Pusat Industry.

Plate 4. Creativity is encouraged as noted in the making of assam wood plaques.

Plate 5. A part of the rehabilitation programme: seminars are carried formally (Plate 5) and informally (Plate 6).

Plate 6.

Plate 7. A sample of the group learning experience - they are required to promenade around the centre.

Plate 8. Pusat Kemajuan, Kampung Bercam, Ipoh.

Plate 9. Rehabilitation does not exclude recreation (Plate 9 and Plate 10).

Plate 10.

Bibliography

1) Becker, Howard S., The Outsider, Perspective On Deviance. London: The Free Press of Glencoe, Collier-MacMillan Limited, 1964.

2) Chambliss, William J. and Mankoff, Milton. Whose Law, What Order? (ed) New York: J. Wiley, 1976.

3) Gibbons, Don C. and Joseph F. Jones. The Study of Deviance, Perspective and Problems. N. Jersey: Englewood Cliffs, Prentice-Hall, 1975.

4) Gove, Walter R. The Labelling of Deviance (ed). New York: John Wiley, 1975.

5) Johnson, Elmer. Crime, Correction and Society, 3rd ed. Homewood, I.E., Dorsey Press, 1974.

6) Laurie, Peter. Drugs, Medical, Psychological and Social Facts. Penguin Books Limited, Middlezex, England, 2nd ed., 1971.

7) Lemert, Edwin M. Human Deviance, Social Problems and Social Control. 2nd ed., New York: Englewood Cliff, Prentice-Hall, 1972.

8) _____ Social Pathology: A Systematic Approach to the Theory of Sociopathic Behaviour. N. Jersey: McGraw-Hill, 1951.

9) McCaghy, Charles H. Deviant Behaviour. New York: MacMillan Publishing Co. Inc., 1976.

10) Rock, P. and McKintosh, Marie. Deviant and Control (ed). London: Tavistock Publications, 1974.

11) Scarpitti and McFarlane. Deviance (ed). Mass., Addison-Wesley Publishing Co., 1975.

12) Traub and Little. Theories of Deviance (ed). Itasca, I.U., Peacock Publishers Inc., 1975.

13) Tylor, Ian., Walton, P. and Young, Jack. The New Criminology. London: Routledge and Kegan Paul Limited, 1973.

14) Wolk, Donald J. Drugs and Youth. National Council for the Social Studies, Washington, 1971.

Periodical

1) Majallah Malam Tauliah, Pusat Pertolongan.