CHAPTER TWO

DADAH DEPENDENCE AND PREVENTION:
THEORIES, CONCEPTS AND MODELS

INTRODUCTION

Despite more than a century of international efforts that have produced numerous policy guidelines and legal measures to curb the further spread of dadah, the traffic in and the use of the substance continues to persist. It points to a myriad of dynamics associated with the use of dadah that have produced this state of affairs. There is a need to comprehend the numerous theories, concepts and models that have been postulated to explain the reasons why people use dadah. The organisational models that are used as policy initiatives to manage, control, and prevent its further use too need to be studied. This chapter has five parts. It highlights the debate on whether dadah use is a real social problem or is merely declared to be one. It then examines the theories and concepts that are used to explain the problem of dadah use. The treatment and rehabilitation and preventive education models for dealing with dadah use are briefly reviewed. Finally, some forms of organisations that are used to manage the further spread of dadah use are discussed.
DADAH - A SOCIAL PROBLEM

According to Parton (1985), a social problem is a condition, which is defined by a considerable number of persons as a deviation from some social norms that they cherish. Accordingly, a social problem has both an objective and a subjective condition. The objective condition is described as a situation whose existence and magnitude can be verified and confirmed by impartial and trained observers. Implied in this definition is the ability to quantify a problem. The subjective condition is said to be present when there is awareness that the condition is a threat to certain cherished values. It is derived from "gut feelings" that are based upon values held by a group of people. The value judgements are the result of the upbringing and socialisation of these people or the population that constitutes the community. These values are to a great extent influenced by our philosophical and religious orientations.

Raab and Selznik (1959) view social problems as primarily problems in relationships among people. An example of a typical relationship is the need to maintain order in a society. There are formal and informal rules that govern conduct. Members of a society for example are not expected to steal or injure others and are expected to assume responsibilities. A social problem is deemed to exist when the prevailing relationships among people frustrate the attainment of important personal goals, or an organised society appears to be seriously threatened by an inability to order relationships among people. In this definition, social problems arise from three major sources:
• Historical evolution, which emphasises the broad social changes that, has occurred and are occurring in modern history.

• Sociological factors which usually highlight the social disorganisation accompanying these changes.

• Psychological factors which emphasise the personality aspects in social problems.

Horton and Leslie (1974) provide a more comprehensive definition of a social problem. They define a social problem as “a condition affecting a significant number of people in ways considered undesirable, about which it is felt something can be done through collective social action”. This definition contains the elements of “belief” or a “value judgement” that leads to a decision having to be made about a subject. It has a further element that something can be done about the problem through collective social action. A social problem thus has social origins; a social definition and it can be resolved through the resources within the society.

The extent to which the use of dadah illustrates the existence of a social problem depends on definitions made within a given society at a given time. The use of dadah for purposes of relaxation and pleasurable states as well as its use for palliative purposes has been well documented. Opium was not regarded as a major social problem until the turn of the century. Despite the addiction caused by opium it was prescribed and dispensed in patent medicines. It was a lucrative trading commodity for the British merchants. It was only after the misuse and abuse of opium had been widely publicised
that measures to control its distribution were initiated at the turn of the century (Julian, 1973).

John A. Clausen cites *dadah*, as a social problem in so far as it is believed to impair people's ability to mobilise and direct their lives (Merton and Nisbett; 1971). This view is taken, as some forms of *dadah* are believed to undermine moral restraints and lead to criminality and violence. The enforcement agencies and policy makers to secure public support have effectively used these impressions about *dadah*. For example, Goode (1972) says that behind the passage of every *dadah* law in existence is a well organised effective lobby that has convinced law making bodies and agents of social control that *dadah* use in fact is a menace to public safety and health. Howard S. Becker has coined the term "moral entrepreneurs" to describe these individuals who have taken it upon themselves to disseminate these views to public and to make sure their versions of right and wrong become law for all (Sassis, Gelles, Levine; 1991). The expressed view in this instance need not have an empirical basis. Neither does it represent the moral view of the majority of the population. To these people, the law must punish all users of *dadah*.

*Dadah* use amongst individuals sometimes does not have a sociological basis. It appears to be psychological in nature. Satinder (1980), reflecting on why there is voluntary use of *dadah* is of the opinion that individuals resort to the use of chemical substances to alter their state of
awareness. These individuals are dissatisfied with their present state of awareness. This may mean any one of the following:

- That other ways of finding satisfaction or self-actualisation are not available to some individuals.
- That other ways of finding satisfaction are progressively more difficult to attain leading the individuals to just want something different.
- That previously available ways of finding satisfaction are disappearing or losing their effectiveness.

The dynamics that bring about changes in society could inevitably also cause imbalances to occur in the self-actualisation processes of individuals. The use of dadah as an alternative means to realise their needs could be one response by these individuals. Thus, while the individual may be indulging in a voluntary act towards self-actualisation his actions nevertheless are deemed as deviant by another section of the community that does not condone such behaviour.

Conventional values such as the pursuit of wealth and occupational success and, in the more secular society, a strong belief in religious values are some of the parameters that are used to measure the worth of an individual. The use of dadah, along with other unconventional behaviour, is interpreted as a threat to this conventional way of life. This interpretation is held even if dadah does not cause serious physical harm. It is viewed as a threat to the basic moral values of the society. In the words of Julian (1973), the issue of the use of dadah can be viewed as a 'people problem'. It involves a group of people on who use dadah and another group of people in the
government who make laws to control this behaviour. On the one hand there are people who deliberately use *dadah* and on the other hand there is another group of people who act as the guardians of the non-*dadah* using community.

Several philosophical questions then arise with regards to the use of *dadah* by an individual. Referring to the work of Satinder (1980) and Vallance (1975) one is left to ponder on the following questions: Does the individual have a right to control his own destiny (including the use of *dadah*) even if he chooses to destroy himself in the process? Can the individual withdraw into an inner world and ignore the realities of the outer world? Can he live in a constant state of euphoria? Who is to define the inalienable right of the individual to pursue happiness? Should society, based upon principles of individual initiative, productivity, moderation, self-restraint, and deferred pleasure, permit individuals to devote themselves to hedonism, sensuality, and delirious experiences? Does society consider the individual who takes *dadah* as either physically or psychologically handicapped? Or is he a sick person? How much responsibility does the government have to interfere in the purely personal affairs of an individual and define permissible and proscribed behaviour? Who is to judge this behaviour? Are members of one generation to be bound by the values of another generation?

According to the libertarian view as propounded by John Stuart Mill, the only purpose for which power can be rightfully exercised over any member of a civilised community against his will, is to prevent harm to others.
His own good, either physical or moral, is not a sufficient to exercise such power (Elizabeth Vallance, 1975). The philosophical discussion that has followed this proposal by J.S. Mill raises definitional, political, jurisprudential, sociological, and legal questions. The definitional issues centre on arguments about the moral and spiritual aspects that have to be dealt within a society. At any given time a society has to maintain a moral consensus. Additionally, the spiritual development of the individual is an important aspect, which has to be carefully planned and followed and not left to chance. It is believed that a balance between these two issues is needed for the holistic development of an individual in a community.

With regards to political and jurisprudential issues, the level of state intervention is governed largely by public expectations. These expectations are constantly changing. What constitutes a government activity is not rigidly defined. For any activity to be acted upon by the Government is dependent on the limits of acceptance by the public. For example, Vallance (1975) suggests that the social deviant can be forced to desist from indulging in his actions through legal sanctions. These sanctions prevent him from bringing harm to himself, maintain the pursuit of common social standards, and the acceptance of a structure of legal sanctions based on common values. Additionally, it enables the society to protect itself from the selfish use of community resources by anti-social elements.

From the sociological perspective, labelling behaviour as deviant will enable the Government to take and enforce legislative decisions on dadah
dependants in a given society. The individual concerned may not define his dadah use as deviant. It is a consequence of the act the person commits. Others judge the dadah user as a deviant through the application of rules and sanctions (Elizabeth Valance, 1975).

The philosophical debate that has been discussed above has given rise to definitional issues that continue to be highlighted. This in turn perplexes policy makers in formulating a comprehensive dadah prevention and control strategy. For example some of the questions that were discussed during the formulation of the Malaysian Five-Year Plan of Action (JKAD 5/84; 1984) are as follows. Should our policy simply inform individuals about the potential danger of dadah? Is there a need for more substantive interventions to be put forward to limit its use? Do we need to emphasise the importance of education or alternatively, should we continue to rely on criminal law as the most useful approach to control dadah. Experience shows that laws have not caused dadah use to cease. Hence, does law enforcement function as an effective instrument for dealing with dadah use and trafficking? Or is it only symbolic, and reflects an action to placate the community? Is law enforcement an approach that is the best option over which there is societal consensus?

The Malaysian dadah prevention and control policy is guided by the view that a firm stand has to be taken in terms of the development of a dadah policy (JKAD 4/84; 1984). This policy is to be reflected in strict laws and
comprehensive prevention and treatment programmes in contrast to the
dadah prevention and control programmes that are implemented in the
Western countries. Nahas and Frick (1986, Pg.4) say that the dadah policies
in Western countries have been influenced by the views of social scientists
who have formulated a permissive theory of dadah dependency based on
three erroneous assumptions. These are: -

- That dependence-producing dadah is not different from many
  other substances and that the dangers to mental and physical
  health have been greatly exaggerated. The research that
  supports this permissive view downplays the long-term
damaging physical and mental effects of addictive dadah;

- That even a young person may learn to use dependence-
  producing dadah in a reasonable and responsible manner,
  benefiting from the redeeming qualities and avoiding their
damaging effects. If is assumed here that man has become
sovereign over his body and mind and society's effort to prevent
him from using dadah is an invasion of privacy; and

- That social acceptance and commercial availability of dadah
  would eliminate the social costs associated with their illegal
  trade. This assumption underestimates the social and individual
  costs that would result from the legalisation of the dependence-
  producing dadah.

Nahas and Frick (1986, Pg. 6) then go on to state that scientific
research shows that four main properties distinguish dependence-producing
dadah from other substances. They are: -

- A pleasurable feeling which causes one who has experienced
  the feeling to use the substance repeatedly;

- Neuropsychotoxicity which is a temporary impairment to brain
  function causing an inability to interpret reality;
• While *dadah* use instigates pleasurable feeling, an abstinence of its use on the other hand causes an unpleasant and painful reaction known as a withdrawal symptom; and
• Tolerance which is a condition that requires an increased dosage of *dadah* to achieve the same level of euphoric effect. Clinical studies too have shown that an individual has limited power to control the intake of *dadah* once he has started using it habitually.

Based on the above reasons, Nahas and Frick suggest that a *dadah* prevention and control policy should concurrently emphasise measures aimed at curtailing the illicit supply of *dadah* and reducing its demand. Illicit supply could be curtailed by the strict enforcement of existing laws at the domestic and international levels. The illicit demand could be reduced through a programme of primary prevention and complemented with an enforcement programme as well as treatment and rehabilitation programme. This is the view adopted in the formulation of the Malaysian *dadah* prevention and control policy.

From the above discussion, it is observed that there are two contrasting views with regards to policy on *dadah* prevention and control. The libertarian view advocates that the individual has the right to chose what he wants to do, whereas the conservative view insists that society can sanction activity that is deemed to be harmful. The policy makers are left with the difficult task of deciding on a course of action to be taken. How is the *dadah* prevention policy then made? Is it based on anecdotal information from the community? Is it based on the opinions of medical, pharmacological, psychological, or sociological researchers who had been asked to prepare
thorough evaluations on the potential or actual dangers associated with dadah use? The answers to these questions inevitably have some bearing on the course of policy development. This course of action is influenced by theoretical orientations.

THEORIES ON DADAH DEPENDENCE

The policy making process is complicated as there are a number of theories that have been put forward to understand why people use dadah. The theoretical orientation that is adopted by the policy makers influences the policy that is decided upon. The theories are commonly classified as biological, psychological, personality, sociological, or anthropological (Segal, 1988; Akers, 1992; Mieczkowski, 1992).

Biological Theories

The biological theories explain dadah dependence is based on the responses of the body to the type of substance used. It is linked to the biological processes such as genetic, physiological, and psychological functions of the individual. The continued use of dadah makes a person accustomed to the substance. The individual becomes uncomfortable when there is abstinence from its use (Segal, 1988; Pg. 173). The user has developed a tolerance to the substance, which may require higher and more frequent doses to achieve the desired effects (Akers, 1992).
It is also observed that certain individuals have a higher propensity to use *dadah* as compared to others. Researchers such as Schuckit, Cotton and Goodwin premise that there is a genetic link to the phenomena (Segal, 1988; Mieczkowski, 1992). Their studies used alcohol using families as their samples and found that children where the parents, siblings and other family members who indulged in this habit had a higher propensity to use alcohol. The effects of the environmental factors on alcoholic behaviour were minimised by comparing this group of children with their siblings who had been adopted. However, similar studies on *dadah* using families have not yielded conclusive results (Segal, 1988).

There are other factors that are said to explain the variation in the physiological dysfunction in individuals. The first factor is said to be endogenous. This refers to the differences in the metabolism rate of *dadah* between individuals. The second factor is exogenous. This pertains to the changes that are associated with physiological functioning that result from the prolonged use of alcohol (Segal, 1988). This view is supported by the research of Dole and Nyswander (DAC, Washington; 1980). In their research, heroin was substituted with methadone as an alternative substance. It was found that metabolic changes as a consequence of the prolonged use of narcotics resulted in a need for the continued use of such form of *dadah*. This finding shows that the continued use of a psychoactive substance over a period of time causes an individual to become dependant on it. The term physical dependence is used to describe this phenomenon (please see page 15 of this study for definition). The body adapts to the psychoactive
chemicals within the *dadah*. The individual needs to use the substance at regular intervals to function normally (Akers, 1992). Failure to use the substance causes the individual to experience withdrawal symptoms or an abstinence syndrome, which is a painful process.

Another widely held view of the biological theories is that *dadah* use is an emotional disorder. There are a number of psychological explanations that vary according to the orientation of the theoretician. A psychoanalyst sees the process of injecting *dadah* as a "phallic autocratic" act (Mieckowski, 1992). (The injecting process involves drawing some blood into the syringe and then partly injecting it. This is repeated a few times before the addict finally injects fully the contents of the syringe). The cognitive-behaviourist oriented theoretician using the sociological perspective views *dadah* use as a response to unresolved problems of living (Akers, 1992). The daily stress encountered that is not met with adequate coping skills results in the use of *dadah* as a means of escape. As such the *dadah* users are seen as people with defective personalities and have character disorders. Research is now in progress to define an "addictive personality" (Mieckowski, 1992). Some characteristics of an addictive personality that have been identified include a lack of self-control, has low self-esteem, lacks ability to plan for the future and is often depressed. From this discussion it can be concluded that whatever the theoretical orientation, psychological theories primarily see the problem of *dadah* use as an intrapsychic one. This means that there are flaws in the psychology of the individual.
While there are convincing arguments for a psychological reason for *dadah* use, it does not wholly explain the phenomenon. Stevens argues that even if there is an emotional flaw, what has been its root cause (Mieczkowski, 1992). Has the use of *dadah* caused the personality problem or vice-versa? If the problem lies within an individual, why is that other family members are not affected similarly. Alternatively, why are there differences in the responses to emotional problems by people with similar characteristics? (Bassis, Gelles, Levine; 1991). This has led researchers to look for other alternative explanations to *dadah* use.

**Sociological Theories**

The sociological theorists propose that the use and effect of *dadah* is not contingent on the pharmacological properties alone of the substance. They believe that the sociological factors that surround the individual could also cause *dadah* use. Zinberg and Harding (1979) use the terms "set" and "setting" to describe these sets of factors. The term "set" refers to the mental and emotional state of the individual at the point of the initiation or decision not to use *dadah*. Cohen (1998; Pg. 190) says that the decision to use or not to use *dadah* takes place in either one of the following two situations:

- When a *dadah* user is suffering, and realises the suffering is *dadah*-related; or

- When a non-user has so much going for him that perceived *dadah*-related risks threaten the present state of comfort.
The "setting" refers to the immediate and the larger social environment in which dadah use or abstinence from its use occurs. The sociological theories hence attempt to explain dadah taking behaviour from the social, cultural and psychological variables that influence it (Akers, 1991). This section will summarise some of the more significant sociological theories that have been advanced to explain dadah use.

One sociological theory attributes dadah use to a condition of normlessness or the loss of accepted social rules within a society. Emile Durkheim (1951; Pg. 241-276) describes this condition as an anomie. In his groundbreaking work on suicide he attempts to show that one of the causes of suicide is the breakdown of small, traditional communities and the rise of modern, urban, ever-changing social structures. As a consequence there are many inconsistencies and ambiguities that arise in the social stricture of a society. The individuals who are unable to keep with these changes resort to alternative behaviours to cope with the situation. This includes non-conformation to the accepted rules and regulations of that society.

In Malaysia, a seven year study by M.P Deva (1978) of dadah use among those seeking treatment at the University Hospital, University of Malaya found that a large number of them were from the rural areas. As the country underwent rapid economic and social development in the 1970s and 1980s, it resulted in the rural population moving to the urban areas to seek employment. In most instances these people did not have a support system in
the form of family members on whom they could rely upon to help them in
times of need. This caused a situation of anomie to arise. As they were
unable to cope with the demands of their new lifestyle, some of them resorted
to the use of dadah to help them overcome the stress that followed. This
Malaysian study supports Durkheim’s theory.

While Durkheim theorised that a condition of anomie leads to deviant
behaviour, Merton (1968) says that the social norms and the attainment of
societal goals in a society create deviance. The social and cultural system of
a society has its own goals that are to be pursued. The social system also
prescribes the use of legitimate means to attain these goals. Consequently, a
society, which has high expectations, will also have a built-in high failure rate.
For example, the society admires success and condemns failure. There are a
number of ways individuals can attain these prescribed goals. Merton has
derived five classifications to group individuals and how they attain these
goals. These are:

- The conformist who accepts both the desired goals and the
  socially approved methods to attain them.

- The innovators are those who are willing to achieve
  conventional goals, but, will resort to unconventional methods
  so long as they succeed.

- The ritualists are the opposite of innovators. They are
  compulsive about following rules and in the process lose sight of
  their goals. Complying with means to attain these goals
  becomes an end by itself.

- The retreatists on the other hand have given up on the goals
  and means of achieving them.
The rebels are those members of the society who reject both the values and norms of their society. They substitute the original goals and means with new ones.

Using the above categorisations, Merton classifies psychotics, vagrants, chronic drunkards and dadah dependants as retreatists who have rejected both the larger success goals of society and the legitimate means to attain them.

Building on Merton’s work Cloward and Ohlin describe dadah dependants as double failures (Mieczkowski, 1992). They have failed at being conformists and at being innovators. Cloward and Ohlin further state that this situation creates an avenue for illegitimate opportunities (Bassis, Gelles, Levine; 1991). One such illegal activity is trafficking in dadah. Cloward and Ohlin found that the trafficking of dadah in a society would favour a particular group within that society which is already in control of it earlier. The group will have knowledge about activities associated with dadah trafficking and its use even if they are not involved directly. The illegal activities over time come to be seen as legitimate undertakings.

While Merton, Cloward and Ohlin view the dadah dependants as being retreatist; Ed Preble (an anthropologist) found the contrary. In his study on dadah addicts in New York he found that they practised a sub-culture of their own (Mieczkowski, 1992). They pursued a deviant career in this subculture. The size of the dadah habit, the ability to hustle and cheat and their adherence to the value structure and normative dictates of their fellow dadah
dependants is used to judge success in this subculture. They use *dadah* to belong to a group as against the need to escape from the pain of living. Subsequent studies by Preble show that the lifestyle of a street *dadah* dependant is a complex and vibrant one. The findings of Preble show that there is a parallel social culture with its own norms and values that is practised by the *dadah* dependants.

The social learning theory states that deviant behaviour as one that is learned (Akers, 1991; Bassis, Gelles, Levine, 1991). According to this theory people learn to abuse alcohol or use *dadah* just as they learn to earn a living. The use of *dadah* is a socially influenced behaviour, which is acquired and sustained through a learning process. The behaviour is learned from the prevailing conditions in a society or through modelling on the behaviour of others (Akers, 1991). It is a vicarious learning process by observing others. As such the deviant behaviour is a result of socialisation.

The social learning theory states that the probability a specific behaviour will occur or increase is contingent on the actual or anticipated reward or positive consequence/reinforcement, and the avoidance of punishment or negative reinforcement/consequence (Bush and Iannotti, 1985; Bassis, Gelles, Levine; 1991). For example, the pharmacological properties of *dadah* may adversely affect the dependant but he deems the euphoric effects as a positive reinforcement. Alternatively, direct punishment and lack of rewards reduce this behaviour. The ‘cold-turkey’ withdrawal used in the treatment and rehabilitation a *dadah* dependant is a form of adverse
consequence on the individual for his *dadah* taking behaviour. The social learning theory, hence has implications for the prevention and control of *dadah* within a society. The policy makers can use social controls to prevent and control its future use within a society.

The third set of sociological theories known as labelling theory states that deviance arises when a group of people who act as the rule makers label those who break these rules as deviants (Bassis, Gelles, Levine; 1991). The label that is given causes the individual to embrace the deviant lifestyle and involve him in a deviant career. This consequently leads to the creation of a deviant subculture that is distinguished by deviant norms, values and lifestyles. Once people are labelled as deviants, their respectability is taken away. They are assigned to a "devalued" category.

Erich Goode (in Bassis, Gelles, Levine 1991; Pg.163) has identified six stereotypes to label deviants. These are: -

- Exaggeration when focus is on an extreme form of deviant behaviour and assumes it is typical of all individuals who fit into this category.

- Centrality which says that a specific behaviour becomes a preoccupation and consumes most of the persons waking hours and dominates his/her thoughts.

- Persistence which means that once a deviant always a deviant.

- Dichotomising that characterises either/or form of thinking. It does not admit the possibility that an individual can move back and forth between conventional and deviant behaviour.
- Homogeneity, which states that all deviants, is basically alike.
- Clustering where deviance is seen as a package deal. It is not seen as an isolated trait or activity.

Using Goode's classification, a dadah dependant is stereotyped as one who is incorrigible. He will be an addict forever. His main preoccupation is to satisfy his need for dadah. He is seen as a thief, a 'con man' and a peddler of the substance to sustain his habit. The consequent effect of labelling may result in further isolating the individual. The society's attempt to control dadah may make matters worse rather than successfully control its use. Studies by Schur (1971) and Lemert (1972) suggest that some dadah users look upon themselves as irrevocable deviants. They then become deeply involved in the subculture that supports the lifestyle and have difficulty to abstain from the habit.

The situation that is described above is not true in some societies. Braithwaite (in Akers, 1992) in his studies of the Caribbean communities found that in a social atmosphere that accepts the social deviant, the act to label the deviant evokes a sense of shame and remorse. The consequent feeling of guilt motivates the deviant to seek treatment and rehabilitation. The social acceptance by the community helps to reintegrate the individual rather than isolate him. This social situation thus is a more positive approach to prevent and control dadah use in a community.
A fourth sociological theory seeks to explain *dadah* use from the cultural perspective. Some of the factors that are deemed to influence *dadah* use are found in the cultural environment such as the despair of living in slums, social pressure from friends, a disturbed family environment, a sense of frustration and anger about social conditions, and poverty (Segal, 1988). This can cause according to Erich Goode a situation of "selective interaction" (Akers, 1992). The potential user is attracted to join the *dadah*-using group as he not only shares similar views on the substance, but also, may include religious and social alienation, sharing similar political opinions, and being deprived of opportunities to attain societal goals. In other words, the individual is attracted to the subculture that constitutes this group of people. A continued process of socialisation and living in this subculture acts to reinforce *dadah* use by that individual.

From the above discussion it is observed that the disease models and the sociological aspects only partially explain the causes of *dadah* use. This lays the groundwork for other possible explanations for *dadah* use.

**Psycho-Social Theories**

Ausubel (1958) in his study on child development has synthesised the role that biology, psychology and the environment plays in the developmental process of the individual. He came to this conclusion after studying the preformation or pre-deterministic approaches. These approaches state that the basic properties and behavioural capacities of man such as his personality,
values and transformation over his life span are pre-formed at birth and unfolds sequentially with little modification with increasing age. This thinking according to Ausubel is flawed. With the exception of some motor functions, there is little basis either logically or empirically for the belief that any psychological functioning is performed at birth and is completely independent of subsequent environmental experiences.

Ausubel also found that the ideas put forth by movements such as humanism, behaviourism, situational determinism and varieties of cultural relativism, that down play genetic factors and give pre-eminence to the role of the environment are also flawed. These approaches do not take into consideration the selective pre-dispositions, limitations, capacities and potentialities that lie within the individual. There are also intercultural differences that are conditioned by the background experiences of the individual, family and the sub-culture of the individual.

Arising from the above, Ausubel proposes that human development is a product of a continuous interaction between various stimulating factors and a prevailing growth matrix consisting selective pre-dispositions both to undergo change and to respond to the environment in a particular way. This model attempts to combine the role that innate factors such as genetic inheritance and the external factors such as the environment and socialisation processes play in the development of the individual. According to this approach the internal factor that encourages the use of dadah is the response of the body to the euphoria producing properties of the substance. The
external factors that supports *dadah* use are the environmental and social processes that either reward this behaviour or stifle it. The concept of the "set" and the "setting" that is advanced by Zinberg and Harding to explain *dadah* taking corresponds to the model that is proposed by Ausubel. *Dadah* use is thus enhanced or prevented through the interplay of both the internal and external factors.

Isodor Chein and Richard and Shirley Jessor (NIDA Monograph No. 30, 1980) in their respective research found that addicts and those individuals who exhibit deviant behaviour are characterised by certain personality deficiencies (psychological) and hostility to society (sociological). The addicts demonstrated a low panic and frustration threshold, distrust of the fellow human beings and their interpersonal relationships are defined in terms of conning, manipulating and pushing other people around. The personality disorders also do not enable them to establish close and prolonged friendly relations and have a sense of futility, expectation of failure, general depression and are easily frustrated. Chein further found that among the influencing conditions that precipitated this include the family, lifestyle of the peers and the social environment of his place of domicile. These findings by Chein demonstrate that both the psychological and social factors act jointly to create situations that cause *dadah* sung behaviour.

Richard and Shirley Jessor (NIDA Monograph No. 30, 1980; Pg. 102 to 109) have made a broader application of the social-psychological theory of problem behaviour and development in youths to explain *dadah* use among
them. Consequently they have proposed the problem behaviour theory to explain the phenomenon. According to these researchers, the conceptual structure of this theory consists of the personality system, the perceived-environment system and the behaviour system. The personality system has its main constituents the values, expectations, beliefs, attitudes, orientations towards self and others. These are cognitive features and indicate the social meaning and social experience. The main components of the environment system include the supports, influence, controls, models and expectations of others. These factors act with the personality factors and provide a logical meaning to the actions of the individual. The behaviour system emphasises socially learned purposes, functions rather than the physical restrictions it imposes. To Jessor and Jessor behaviour is the outcome of the interaction of the personality and environmental influences.

In conclusion it is observed that the numerous theories that have been put forth to explain the use of dadah provide only an insight into its complexity. These theories however do not comprehensively explain the phenomenon. Consequently, this restricts the development of the policy imperatives that are needed to address the issue. The main features of the theories are summarised in Figure 1.
### Biological Theories
- Genetically inherited
- Metabolic rates for *dada* ingestion that differ among individuals
- Adaptation/Development of physical tolerance
  - Avoid pain (from withdrawal)
- Psychological deficiencies
  - Low self esteem
  - Anxiety/stress

### Sociological Theories
- Breakdown of social structures and changes in socio-cultural values
  - Achievement of goals
  - Being successful
- Learned behaviour
  - Environment
  - Modeling
  - Positive and negative enforcement
- Labeling of behaviour by society
- Environment
  - Slums/squatter colonies
  - Selective interaction/socialization

### Psycho-Social Theories
- Personality deficiencies that have biological origins
  - Low anxiety/stress threshold
  - Psychological limitations
- Cognitive features
  - Values
  - Expectations (individual)
  - Beliefs
  - Attitudes
  - Orientations towards self and others.
- Environment
  - Support
  - Influence
  - Controls
  - Models
  - Expectations of others
- Behaviour
  - Socially learned processes.

Source: Writer's own computation from literature review
TREATMENT AND REHABILITATION MODALITIES

There are a number of treatment modalities that have been derived to treat dadah dependants. These modalities are influenced by the theoretical orientations of their proponents. The treatment modalities attempt to address certain aspects of the person who is a dadah dependant. This section will discuss three major modalities that have been used universally. These modalities are used specifically for the treatment of one type of dadah namely heroin. But the same principles of treatment could be applied to the other types of substances that are grouped within the dadah cluster. The treatment modalities discussed are (i) the maintenance programme, (ii) detoxification programme, and (iii) dadah-free therapeutic communities.

The Maintenance Programme

Maintenance programme uses a substitute drug to assist dadah dependants to overcome their habit. The programme has its inspiration from the biological theories of dadah use. In a maintenance programme a substitute drug (also known as a congener) is used to assist a dadah dependant to suppress his craving for dadah and relieve the withdrawal symptoms. It is taken orally. The drug primarily used in the maintenance programme for heroin addicts is methadone. It has similar pharmacological properties to heroin. Methadone blocks narcotic withdrawal and its effect lasts for twenty-four hours. In comparison, the effects of heroin last for approximately three to four hours. Theoretically, the longer acting effect of
methadone allows the addict to be “stabilised” or maintained on a daily oral dose (Leavitt, 1995).

Maintenance programme has been the mainstay of the British effort to control the use of heroin in Great Britain. Physicians in that country can prescribe heroin to those dependants on this form of dadah. It enables the heroin addicts to sustain their habit in a controlled manner (Zinberg, 1984). However, not much have been written about this “British model” of dadah use prevention and control. Similarly, the use of methadone as a substitute to heroin has been extensively used in Great Britain. The efficacy of this form of treatment was only tested in the United States in the 1960s.

Vincent Dole and Marie Nyswander are some of the researchers who have experimented with the use of methadone as a substitute drug in the United States. Their research is extensively discussed in a report prepared by the Drug Abuse Council, Washington (DAC; 1980). They found that heroin dependants maintained on methadone appear more alert, energetic, and interested in constructive social activities. In contrast, heroin dependants are difficult to stabilise, became lethargic after injecting heroin, and undergo withdrawal as the effect of the heroin wears off. These findings led Dole and Nyswander to propose that the repeated use of heroin cause biochemical change in the body that requires indefinite therapy with an opiate substitute. Once the patients are stabilised on a fixed dose of methadone, they can then be offered counselling, job training, and various other forms of intensive
support to facilitate the development of a life free from heroin (Senay and Renault, 1986; Leavitt, 1995).

A major consideration in the promotion of a methadone-maintenance programme is the treatment goals. It is been well documented that the continued abstinence from dadah by the addict is not an easily realisable goal (Vaillant, 1966). A methadone-maintenance programme enables the individual to function and is productive within the community. He is able to form and develop relationships, which are crucial for subsequent rehabilitation. The process to socialise and to live within social groups is fraught with difficulties especially after having had been very individualistic while being addicted to heroin.

Methadone-maintenance has been a controversial modality since its inception. Critics argue that substituting one narcotic form of dadah with another is morally wrong. It also does not treat the causes of addiction. Research shows that methadone does not produce long-term cures (Leavitt, 1995). The individual has to be given a daily dosage. This inconveniences the individual. Simultaneously, an efficient system to maintain and manage the records of the patients, handling and storage of the substance has to be maintained. Others argue that methadone-maintenance only addresses opiate addiction and none of the other dadah categories (Stephens, 1987).

Defenders of this modality, on the other hand, argue that methadone is a therapeutic tool. It keeps the client in treatment long enough to enable
other forms of interventions that address the psychosocial aspects of addiction. Proponents of methadone-maintenance programmes also show that coping with the use of narcotics form of dadah is an important task in and of itself. By retaining the client in treatment allows alternative interventions to be made to deal with other forms of dadah use (Stephens, 1987; Leavitt, 1995). It can be concluded that maintenance programme has some merit in that it allows the addict to be retained in treatment.

Detoxification Programmes

Detoxification is the second major approach to treat heroin addiction. The detoxification programme has two primary goals. These are (i) to withdraw the individual as rapidly as possible from dependence on dadah and (ii) to provide some form of outreach. Detoxification can be viewed as an important first step to involve the compulsive dadah dependant in a more comprehensive, long-term therapy. Some dadah dependants volunteer to participate in long-term treatment programmes after being detoxified (Hiding Place; 1990). The “freedom” from the pain associated with dadah use motivates the individual to want to be permanently free from it.

Traditionally, detoxification takes place in a hospital (DAC; 1980). The DAC has identified a number of reasons why detoxification from dadah must be accomplished in an in-patient medical setting. First, there are some types of dadah from which physiological withdrawal can be life threatening. Chronic dadah use usually makes a dadah dependant physically weak. Secondly, in
many cases the patient is too intoxicated to supervise his or her own withdrawal. As withdrawal is a painful process, such patients cannot be trusted to avoid taking dadah for palliative use. Thirdly, is the reality that other dadah dependants usually surround the highly motivated patients. They encourage them to continue using dadah. Finally, there are many individuals whose dadah use may be the consequence from a disrupted family life or from other forces within their immediate environment. Individuals who want to detoxify themselves need some form of isolation to become dadah free. Only after successfully detoxifying themselves can they return to their family and their community and attempt to cope with their problems that may have caused dadah use in the first place.

In Malaysia, the detoxification programme is performed on heroin addicts who are sent directly to the treatment and rehabilitation centres and those who seek voluntary detoxification at government hospitals. In both instances, a “cold-turkey” approach (the term used to describe drug free treatment) is used. Symptomatic treatment is administered only if the individual has other physiological diseases that need to be treated (Mohd. Shariff Osman; 1990)

The Therapeutic Community (TC)

The TC approach for treatment and rehabilitation of dadah dependants is of fairly recent origin. The first programme was Synanon. It was founded by Charles Dederich and is based in California. The founder was himself an
ex-alcoholic. He theorised that “the addict can change his deviant behaviour by voluntarily joining a strongly disciplined, but loving pseudofamily and re-experiencing the process of growing up” (Smith and Gay, 1988; Pg. 10). The TC approach views the dadah as one having a social deficit. The treatment programme attempts to provide social skills to the inmate. The individual goes through a programme that requires a collective effort for its upkeep. The group therapy and encounter sessions develop self-discipline to assist the individual to remain dadah-free and accept responsibility.

The TC can be distinguished from the other dadah treatment modalities in two fundamental ways. First, the TC offers a systematic treatment approach. The treatment perspective is on the dadah-use disorder, the person, recovery, and right living. Second, the primary therapist and teacher in the TC is the community itself. There is a purposive use of the community as the primary method for facilitating social and psychological changes in individual. This consists of the social environment, the peers, and the staff members who act as role models. The activities are designed to produce therapeutic and educational changes in the participants. The participants themselves play the role of agents of change and are part of the change process itself.

Some of the more important features of the TC model of treatment identified by De Leon (NIDA Monograph 144, 1994) are as follows:

- The individual contributes to the daily life of the community;
- The members of the community are the source of instruction and support. The individual learns through observation and role modelling. He has to give genuine reactions to the processes he undergoes.

- The educational training, and therapeutic activities occur in groups which provides for personal growth in a social context and through social intercourse;

- There are shared norms and values;

- Social structures and systems are used to maintain the TC and provide training in specific skills and accepting responsibility; and

- Development of open communication and maintaining relationships.

The treatment process begins by first isolating the client from the environment that caused his dadah addiction. He is then put through a self-help programme that requires the individual to participate in a number of planned activities. Therapy at a TC is further facilitated through encounter groups. These sessions make the individual aware of specific attitudes and behavioural patterns that should be modified. Individuals also learn how to identify feelings and express them appropriately. They learn to manage these feelings constructively through the interpersonal and social demands of a communal life. The emphasis is on an honest expression of feelings.

Research of the TC programme by De Leon shows that there is a correlation between the length of time spent in treatment and abstention from dadah (NIDA Monograph no. 144, 1994). The longer an individual stays in the community enables him to stay away from dadah longer than the individual who leaves early. De Leon found that individuals who stayed for
more than nine months showed a higher motivation to stay *dadah* free. Some of the individuals who have completed the TC programme have gone on to establish therapeutic communities of their own. There are two inferences that can be made. Firstly, *dadah* addiction is not an incurable condition. Given the right conditions, the individual can overcome his addiction. He can then continue to live a productive life. In some instances he is able to assist others to overcome their addiction.

Secondly by isolating of the *dadah* dependant from an environment which causes him to use *dadah* enables him to evaluate his life. It gives him the opportunity to make decisions in an environment that is free of his usual distractions. The research conducted by De Leon shows a correlation between the time spent in a therapeutic community and the ability of the rehabilitated inmate to abstain from using *dadah*. It was found that the longer the length of time the individual is isolated from the environment that caused his *dadah* problem enables him to strengthen his resolve to stay free of the substance.

Despite the positive findings by De Leon there are however some drawbacks of the TC modality. Firstly, it is a long-term residential programme. This poses a problem to some of the residents. They tend to leave the programme early. The highest numbers of dropouts experienced are in the first three months of the programme (De Leon in NIDA Monograph 144; 1994). It is human nature not to live in isolation. The individuals who abscond feel that the brief time spent at the TC is sufficient for them to stay
free from *dadah*. That is until they relapse. The number of dropouts from the TC programme begins to decline rapidly after six months and plateau's after nine months. De Leon further found that approximately 15 percent of individuals who diligently follow the programme's activities stay longer than nine months and beyond. It can be concluded that in the long run, the TC as a treatment modality is beneficial to a small group of people who are willing to stay in relative isolation.

Secondly, the treatment process is based on allocating a considerable amount of time to provide the resident with personal attention. It is said that the modality benefits only one person in ten who seek help (Senay and Renault; 1986). This precludes the involvement of a large number of persons seeking treatment at any one time.

Thirdly, it is found that there is a preponderance of younger and single persons who seek treatment and rehabilitation at a TC (Senay and Renault, 1986). This phenomenon could be due to the older *dadah* dependants having a steady job, being married and having to support their families. A long-term residential treatment programme may not serve them well. If they are confined to a TC, they will not be able to work and provide for the needs of their families. As such, the single and younger *dadah* dependent who does not have many personal commitments is more likely to seek treatment at a TC as compared to an older one.
Fourthly, there is the focus on the expression of genuine feelings in all inter-personal communication. This may be difficult for some individuals to understand. The individual may develop defence mechanism for his psychological problems and inability to express his feelings (Salasnek and Amini, 1986; Young, 1992). The individual may consequently resolve to please his mentors. This includes accommodating to the demands made on him by his mentors for the duration of the stay at the TC. There is no actual initiative on the part of the inmate to resolve his problems. In such situations a more personalised individual form of psychotherapy may prove more useful to assist the inmate. He will be better prepared to face life in a group setting, as he is able to deal with individual difficulties separately.

From the above discussion, it is observed that the proponents of the TC model of treatment and rehabilitation are influenced by the socio-psychological theories. The individual is deemed to lack social skills. He has low self-esteem, and is easily swayed by others. While at the TC, the individual learns how to deal with life through a communal type of living. The encounter sessions help the individual to develop self-confidence. He is then better prepared to face life outside the TC. In conclusion, it is observed that despite the drawbacks, the TC model provides a holistic approach to treatment. It combines a drug-free detoxification process with social and psychological rehabilitation.
PRIMARY PREVENTION MODELS

From the above discussion it is observed that treatment and rehabilitation programmes seek to reduce or eliminate dadah use. Primary prevention programmes on the other hand aim at the reduction, delay or prevention of dadah use before it has become habitual or becomes dysfunctional (Polich, Ellickson, Reuter and Kahan, 1984). The programme focuses on trying to keep young people from ever starting at all or shifting from infrequent use to regular use. The programme targets the general population or adolescents that is in no imminent danger of developing a problem. Primary prevention activities seek to alter the environment or the individual so that a dadah related condition or problem would not develop.

Schools have been identified as the main area of action for the primary prevention programme. There is considerable debate about whether schools should play this role particularly at a time when there is renewed concern about academic standards. The truth remains that schools offer the most efficient access to a large number of children or adolescents who are the targets of health and social programmes as compared to community-wide general information programmes. Several different types of prevention approaches have been conducted in school settings. These approaches can be divided into three prevention models namely (i) cognitive or information dissemination model; (ii) affective education or individual deficiency model; and (iii) social influence or pressures model (Botvin, 1995). These
approaches that typically involve classroom activities and are undertaken either alone or in combination with school-wide activities are discussed below.

**Cognitive or Information Dissemination Model**

The dissemination of factual information about *dadah* to educate students of the consequences of involvement in the use of and the trafficking in *dadah* is the most commonly used approach. It is assumed that adolescents use *dadah* because they lack information about the negative effects and therefore have neutral or maybe even positive attitudes towards trying it. The solution then is to provide information to students about the different types of *dadah* and their negative consequences. The adolescents are given accurate information about all types of *dadah* and its effects on the human system. Students learn about the dangers in terms of the adverse health and the legal consequences. The information programme also defines various patterns of *dadah* use, the pharmacology of *dadah*, and the process of becoming an addict. This model assumes that the factual information enables an individual to make rational decisions to use or not to use *dadah* (Botvin, 1995).

Even though, this model is the most widespread approach used, research shows that it is not totally effective. An evaluation of the approach by Dryfoos shows that it has an impact on the knowledge and attitudes of the individual, but, does not affect his behaviour (Botvin, 1995). An increase in knowledge about the negative consequence about *dadah* use has no impact
on either curbing its use, intention to use, or the behaviour of those already using it (Nahas and Frick; 1986). On the other hand studies by Swisher, Crawford, Goldstein, and Yura, show that these approaches may lead to increased use of dadah (Botvin, 1995). The curiousity of the target audience may be stimulated to use dadah to verify the authenticity of the information that is given to them. The curiosity of the individual to experiment may be further aroused if he observes that there are individuals who have not been adversely affected despite using dadah.

The above findings do not mean that the information dissemination approaches are without merit. The aetiology of dadah use is complex and multi-factorial. This has been enumerated in the discussion on causal theories to explain dadah use. The lack of knowledge on dadah is only one of the many factors that causes its use. For some knowledge at the cognitive level is a sufficient deterrent not to use substance.

But this is not true for the society as a whole. The inability of some individuals to make accurate decisions has prompted Nahas and Frick (1986) to warn us about the dangers associated with the assumption that dadah use can be averted through information programmes alone. They cite clinical studies that show that the interference in the brain mechanism associated with pleasure and reward causes an individual to have limited power to control dadah use. A purely information based programme is unable to prevent an individual from using dadah.
Affective Education or the Individual Deficiency Model

This model emerged as an important approach in the 1970s. This model assumes that the problem of substance use lies within the adolescent himself. He uses *dadah* to compensate for a lack of self-esteem or because they lack adequate tools for making rational decisions (Polich, Ellickson, Reuter and Kahan, 1984: Botvin, 1983, 1985). The intervention approach advocates increasing social competence and self-efficacy to avert using *dadah*. Social competence here includes the ability to disagree, to refuse, to make requests and to initiate conversations with others. "Self" - is defined as "the conviction that one can successfully execute behaviours to produce desired outcomes" (NIDA Monograph No. 63, 1985: pg. 16). The individual has to be well schooled with the right social skills to be able to achieve these personal qualities.

The individual deficiency model emphasises the development of cognitive and behavioural skills, which are flexible and situation specific. On the cognitive level students learn decision-making and problem-solving skills. This prepares them to avoid peer pressure situations that involves participation in an activity with negative consequences without isolating the individual. They still remain friends. Only the negative behaviour is avoided. The students also learn techniques to help guide them through high-risk situations. Finally, the students learn interpersonal skills that help them to implement specific decisions that they have made. These skills are learned through a combination of instruction, modelling, feedback, social
reinforcement and behaviour rehearsal. Wherever possible group processes are used to enhance the learning processes. To further enhance the learning process, adult group leaders are invited to teach the adolescents systematic decision making procedures for handling difficult situations. The adult group leaders share their own experiences as adolescents and how they countered these difficult situations (Botvin, 1985).

The training programme involves the use of both verbal and non-verbal assertive behaviours. The assertive skills involve learning what to say (example include no-statements, requests, refusals) and how to say it. The non-verbal skills include eye contact, loudness of voice, facial expressions, distance (between the individual and his counterpart) and other forms of body language (Botvin, 1983). The affective education programme stimulates the individual to think rationally before making a decision.

Though this approach is more comprehensive than the information-dissemination model, it has several weaknesses. These include (Polich, Ellickson, Reuter and Kahan, 1984; Botvin, 1995):

• A focus on narrow and incomplete set of etiologic determinants. The programmes set out to change the self-concept of the individual through short-term programmes are not adequately supported by research.

• The use of ineffective methods to achieve stated programme goals(such as the use of experiential games and classroom activities rather than skills-training methods. The programmes fail to link general skills in communication or decision making with specific dadah using situations.
• A lack of domain-specific information related to dadah use, and
• The inclusion of 'responsible use' norm-setting messages that may be counterproductive.

The disappointing results found in the cognitive and affective models for dadah use prevention have encouraged researchers to increasingly focus on the social pressures model that influence dadah use. The research in preventive education is now increasingly grounded in the social learning theory of Bandura and the problem behaviour theory of Jessor (Botvin, 1985).

**Social Influence or Pressures Model**

The underlying assumption of this approach is that adolescents use psychoactive substances because they succumb to the social influence from their peers and the media (Botvin, 1995). This model recognises the vulnerability of adolescents who are in a transitional stage between childhood and adulthood. There is an increased tendency for them to emulate adult behaviour to appear grown up. This includes dadah use. The adolescent is subjected to subtle external influences such as the media and the actual behaviour and attitudes of key people such as his family members, friends and other peers that shape his own attitudes and behaviour. Hence, the approach that purely scares adolescents on the negative consequences of dadah is debunked when the peers who use the substances portray a functional life style (Cohen, 1988). The social-skills approach acknowledges
dah-taking behaviour and attempts to develop skills to resist the temptation to use it by a non-user.

Secondly, research also shows that some adolescents may actually want to use dah. They are not yielding to pressure from their peers. Dah has an instrumental value. It helps the individual to deal with anxiety, low self-esteem, or to feel comfortable in social situations (Cohen, 1988). These individuals too need to be equipped with skills to avoid the use of dah to resolve their problems. In this instance the social skills training prevention approach features teaching personal self-management to enable an individual to deal with a situation that could lead to dah use.

Social skills training programme thus has two distinct features. These are (Botvin, 1995):

- They focus on increasing the resolve of young people against negative social influences, and
- Provide the skills to resist these influences.

There are a number of terms that are used to describe these approaches. These include the following:

- Social influence approaches because they target the social influences promoting dah use.
- Refusal skills which feature teaching the students how to refuse offers to use dah; and
Social resistance skills where students learn practical approaches to resist social influences to use *dadah*.

Richard Evans from the University of Houston pioneered this approach. His work is grounded on the findings from research that is being conducted on persuasive communication theory. Using these observations, Evans devised an approach that provides a form of psychological inoculation towards messages that promote *dadah* use that are encountered by adolescents. They are gradually exposed at first to the weaker persuasive messages and then progressively moving on to the stronger forms. For example, an adolescent is taught that smoking is not associated with maturity. It is the ability to resist smoking, which indicates the maturity of an individual.

The students are also provided with information that is derived from feedback and tests on the actual prevalence and incidence rates of *dadah* use. This dispels the mistaken notion that other adolescents too indulge in the act. It aims to show that there are other non-*dadah* using adolescents. In other words, the adolescent learns about and becomes aware about the occurrences in his environment. To further enhance the learning process, the adolescents along with the adult facilitators or teachers, can participate in a survey of *dadah* use. This participatory approach heightens awareness of the adults and the adolescents on the actual rate of substance use (Botvin, 1995).
There are several other skills that are taught. These include decision making and problem solving skills, cognitive skills to resist inter-personal and media influences, skills to enhance self-esteem, coping strategies to deal with stress and anxiety and general assertive skills. The adolescent learns communication and social skill to give and receive compliments, conduct a conversation, and indulge in friendship creation. These skills are taught through a combination of instruction and demonstration methods, feedback, reinforcement, and behavioural rehearsal (both in the class and outside the class) and through specific assignments.

The pioneering work by Evans has led other researchers to expand on it. Botvin (1985) has developed a programme that consists of three components. The first component is the substance-specific. This component describes the long- and short-term consequences of dadah, incidence and prevalence of dadah use in the community and materials concerning media pressures and advertising appeals to use psychoactive substances.

The second component contains the personal skills that are needed by the individual. These include decision-making skills that are designed to develop critical thinking and responsible decision-making; anxiety and techniques to cope with stress and basic principles of personal behaviour change and self-improvement.
The third component is the social skill component. This component contains materials designed to improve the general interpersonal skills. Elements of this component include material concerning effective communications, general social skills, conversational skills, interpersonal relationships that focus relationship among the genders and verbal and non-verbal skills. From the above it is observed that the life skills training approach that is proposed by Botvin synthesises the information and affective aspects with the living skills that an individual requires for his daily functioning to provide a comprehensive programme for the prevention of dadah use among adolescents.

Cohen (1988) adds yet another dimension to the social influence approach for dadah prevention. He suggests that preventive education programmes need to emphasise the causes of dadah use. These programmes then focus to develop and communicate alternative attitudes, strategies, techniques, institutional changes and life styles that could diminish the desire to use dadah. He theorises that an individual's decision to abstain from using dadah is that an alternative is available that makes him feel better. Preventive education strategies that focus on providing these alternatives need to be developed. These strategies address the various sensory stimuli and include aspects on personal growth and development. Cohen also proposes a shift in the focus of education away from intellectual development to the development of the emotional supports of an individual (Goleman, 1995). An individual with a high intellect is not necessarily immune to dadah
and vice-versa. The use of *dadah* has permeated into the whole social fabric and is not confined to any particular group of people. Thus, an individual who has better emotional supports will be able to resist using *dadah* better than one who is emotionally insecure.

The main areas of action from the above discussion can be summarised into a cube as in Figure 2. The prevention programme consists of the domains of intervention, the foci of intervention and the target groups of the prevention programme. The domains of intervention are the psychological, social and personal domains. The focus of intervention is the behaviour, personality and the environment of the individual. The target groups for prevention programmes are the individual, family peers and other social institutions in the community. Each domain and focus of intervention will have its specific activities that target the different groups.

Secondly, it can be concluded that research to develop specific activities for the preventive education programme to influence society not to indulge in *dadah* use is still continuing. There are still no long-term preventive education activities that have been identified to ensure that *dadah* use can be resolved. The solution may require a combination of the above approaches to successfully educate the society not to use *dadah*. 
FIGURE 2: PREVENTIVE EDUCATION MODEL

ORGANISATIONAL STRUCTURES FOR IMPLEMENTATION AND CO-ORDINATION

Many countries have bodies to co-ordinate and implement national level dadah control and prevention activities. From history it is observed that the organisation structure has varied from country to country. In some countries where opium is produced for licit use, the function of control is vested with the Ministry of Finance. In other countries, the responsibility is entrusted with the Ministry of Health. In some others, the Ministry of Social Welfare plays this role. These administrative arrangements create in their wake a number of problems. The prevention and control of dadah also involves other functions. These include planning and development, education, justice, law enforcement, foreign co-operation, and finance. The effort requires the involvement of a number of different agencies working together to plan strategies for dadah prevention and control. But in most countries, inter-departmental co-ordination and co-operation however remains a problem. The Ministries and departments have strong traditions of acting independently resulting in a lack of communication among them. Whereas it may seem easy to suggest the need for a national co-ordination body to be set-up, it is difficult to establish the general principles, which guide its composition and function. However, a number of structures have evolved that merit a closer examination.

The adoption of the Shanghai Convention in 1912 saw the development of the enforcement model for dadah abuse prevention and
control. It uses as its basis the legal model. The legal model places great
importance on defining the moral and juridical limits of the medical use of
some types of *dadah* such as opium. There are rules and laws against the
non-medical use of *dadah*. The law enforcement actions are thus highlighted
(Edwards and Awni, 1980). This model evolved primarily in the United
States. With the passage of the Harrison Act of 1914 to regulate narcotics
use it eventually saw the setting up of a national level enforcement agency.
After a number of name changes, this agency today is referred to as the Drug
Enforcement Agency (Akers, 1992). The enforcement model has remained
one of the main areas of action due to the portrayal by certain groups and the
media that the use *dadah* has to be regulated through the strict enforcement
of laws.

As research by sociologists and medical practitioners on the causes
and consequences of *dadah* use began to increase and the findings were
made known, this knowledge led to a rethink on the efficacy of a wholly
enforcement oriented approach to *dadah* abuse prevention and control.
Consequently, some countries resorted to the setting-up of a commission of
inquiry (Edwards and Awni, 1980). This commission is especially useful
during the initial stages of a government taking prevention and control
measures. The commission is an independent body with specific terms of
reference. It inquires into the nature of the problem and makes its
recommendations. While the commission is an independent body, the
authority that creates decides on either to accept its recommendations or to
ignore them. Should the latter occur, then the time, money and effort spent by the commission to do its work is wasted.

The discussion on the theories on the causes of dadah use shows that it is a multi-dimensional problem. There is a need for a concerted and co-ordinated effort that requires the involvement of a number of agencies. This requirement has led some countries to form a co-ordination committee (Edwards and Awni; 1980). The co-ordination committee is usually located in a government agency. The co-ordination committee symbolises an effort to co-ordinate the prevention and control effort at a single level of government. As such the committee could be an inter-ministerial, inter-agency or inter-departmental in its composition. Its members may comprise permanent members from the various agencies. The eventual composition is determined by the terms of reference of the committee. While the committee type of organisation draws expertise from a number of agencies, its major drawback is that it does not have its own funds to implement programmes. The agencies that constitute the committee are expected to provide funds for this purpose. This situation eventually causes problems as the participating agencies have their individual objectives. This may constrain them from making the allocations for the prevention and control programme.

Some countries have a narcotics board or a national commission to plan, implement and co-ordinate efforts at the national level (Edwards and Awni, 1980). The membership of the commission is drawn from the relevant
departments and agencies of government. It may also include individuals and representatives from non-governmental organisations as members. Whereas the committee type of structure is located in a government agency without a full-time secretariat staff, the commission is usually supported by a full-time secretariat. There is a group of core staff who undertakes the responsibility of the day-to-day operations. The commission reports directly to a specific authority, which is determined by the government. The commission exercises greater autonomy than the inter-agency committee. This allows it to make some decisions on actions to be taken. While the commission has some level of independence, its efforts can be frustrated, as it is unable to integrate its activities wholly with the other national level agencies. It is also administratively more costly to maintain.

The more developed countries have developed yet another organisation to undertake *dada'ah* prevention and control programmes. This mechanism is usually found in countries with a federal system of government and is referred to as a national institute of *dada'ah* abuse control or a similar type of organisation (Edwards and Awni, 1980). This organisation are a number of functions. It serves as a resource centre, prepares guidelines on programme planning and implementation, allocate funds for research, prevention and control efforts which focus on preventive education and treatment and rehabilitation and provides directions for prevention and control efforts. It could also function as a large programme agency primarily involved in the assessment of the *dada'ah* use situation, research, documentation,
administrative counselling centre, or act as a clearing house that compiles and makes available materials and services that are not available or cannot be provided by others. To undertake such a diverse set of functions requires the organisation to employ manpower from a wide range of expertise to be fully operational. Based on these functions the organisation requires a large financial input to function. It is thus not surprising that this form of organisation is found mainly the developed countries that are able to finance its operations.

An ideal model for the management and control of dadah then would be one that creates an integrated operating system by linking together all activities related to dadah in the country, has authority and commands proven leadership. It also has to be sensitive to the political and administrative issues, which will enable it to secure support for its proposals. The coordination mechanism needs to define its authority, responsibility, and organisational structure so as to effectively organise resources, collect and disseminate information, and has at all times a comprehensive picture of the nature and extent of the problem. It needs to be able to assist to formulate, plan, and guide the implementation of prevention programmes and be able to advise the legislative body. The organisation thus has to be a multi-disciplinary in its structure to successfully execute its varied functions and role.
CONCLUSION

From the discussion it is observed that the dadah problem is a multi-dimensional phenomenon. It is an area of study that has only drawn the serious attention or researchers recently and, as such, there is still no one specific generic theory, concept or model to initiate efforts to control and prevent dadah use and addiction. Existing policy imperatives, too, are often questionable, especially from the enforcement aspect, despite creditable achievements by various government mechanisms to check or control the spread of dadah problem. Nevertheless the reality remains that dadah use and dadah trafficking are very serious problems that will continue to drain a country's resources which, otherwise, could have been channelled to other alternative uses. More importantly, it will continue to threaten the existence of human society as dadah health-related issues persist and moral misgivings dominate decaying family, community and social values.