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ALTERNATIVE SYSTEMS IN MALAYSIAN DRUG REHABILITATION: ORGANIZATION AND CONTROL IN COMPARATIVE PERSPECTIVE

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Abstract—This paper examines four drug rehabilitation systems in Malaysia from an organizational perspective. It focuses on authority structures in rehabilitation centres and their impact on rehabilitees' identities. The findings show that there are important differences between government-run and private centres in terms of administration and approach to therapy. Some policy implications are derived from a comparison of these systems.

The question of rehabilitation involves more than just the techniques of functional restoration. It also connotes the establishment of an administrative-service machinery that manages treatment programmes for various sociomedical problems. Ideally speaking, all rehabilitation organizations are concerned with the improvement of the physical and mental health of the ill and handicapped. At the sociological level of analysis, these organizations are conceptualized as social systems created to process and control defined sociomedical problems. In other words, this approach examines levels of authority and communication between administrators, medical specialists and patients in an effort to understand how rehabilitation goals are perceived and practised [1]. This paper is concerned with four drug rehabilitation systems in Malaysia [2]. It focuses specifically on social relationships within a rehabilitative environment and their impact on identity change. But first, it is necessary to describe briefly the problem of drug abuse in Malaysia.

DRUG ABUSE IN MALAYSIA

In the last decade or so, drug abuse has become a major social problem in Malaysia. A large part of this problem can be traced to the easy availability of drugs, particularly heroin prepared from opium grown in the 'Golden Triangle' on mainland Southeast Asia and processed in Thailand or even in Malaysia [3]. Yet, only less than 100 years ago, opium smoking was not considered a major social issue on the Malay Peninsula. In the late 1800s and early 1900s, opium was not only openly imported but also cultivated on farms in the Malay States. The colonial government did not raise any sanctions against such activities because they provided a sizable source of revenue in the Straits Settlements [4].

However, following the release of the League of Nations report on opium smoking in the Far East in 1930, international pressure was exerted on various governments in the region to curb this activity. In 1952, the Dangerous Drugs Ordinance was passed in Malaya which put an end to the registration of opium smokers. By the late 1960s and early 1970s, a new trend of drug abuse had emerged in Malaysia. Unlike the older opium smokers, the present generation of drug users includes many teenagers and youths who experiment with a wide range of drugs from marijuana to synthetic products. This new pattern of drug use, accompanied by an increase in drug-related crimes, has caused considerable concern to the Malaysian government [5].

It is within the context of these developments that major efforts are being made to control what is now defined as a serious drug problem. Since 1970, the Malaysian government has introduced stiffer penalties to deter drug trafficking. A national association against drug abuse (PEMADAM) was set up in 1976 with the purpose of educating the public about drug problems. Foreign experts were invited to advise the government on combatting drug problems. Various programmes to discuss and disseminate information on drug addiction were launched. Nevertheless, the drug addict population has been estimated by the government to be 76,000, so that the question of rehabilitation has become as problematic as that of deterrence. In 1975 the Dangerous Drugs (Amendment) Act was passed which legalized for the first time the rehabilitation of drug dependents. The responsibility for establishing and administering a rehabilitation programme was placed under the Ministry of Social Welfare, while drug detection and detoxification were assigned to the officials at the Ministry of Health. There are presently five government-run rehabilitation centres in West Malaysia: four on the west coast and one on the east coast [6]. Each of these five centres has the capacity to accomodate between 100 and 500 rehabilitees, most of whom are admitted via the courts for a minimum period of 6 months. Staff size at these centres ranges from 20 to 40 members, including the principal, his assistants, counsellors, nurses and instructors. Aftercare facilities are still minimal, although PEMADAM has made some efforts to pro-

vide half-way houses and day-care centres for rehabilitees in the major urban areas.

Besides these five centres, various private organizations have established rehabilitation centres throughout West Malaysia. The largest of these is Pusat Pertolongan (Help Centre) which is based in Batu Gajah, Perak, and it has a half-way house in Ipoh, Perak. It takes up to 100 rehabilitees and has 13 staff members. Several smaller centres which are Christian-based exist throughout the country but are concentrated largely in the major urban areas, particularly in the Klang Valley. These centres accept 10–20 rehabilitees and are usually run by 3–5 individuals. Traditional healers, especially the Malay *bomoh*, have also been involved in drug rehabilitation. Most of these specialists use traditional herbs and medicinal teas in the treatment of drug addicts. The existence of these alternative systems suggests that no one form of treatment monopolizes the field of drug rehabilitation. Rather, the plurality of treatments for drug addiction in Malaysia offers much insight into how an open health-care system copes with a specific sociomedical problem.

SYSTEMS OF DRUG REHABILITATION

There are presently four drug rehabilitation systems in Malaysia: government-run centres, Christian and non-Christian private centres and indigenous therapy. Data on these systems were gathered between 1980 and 1982 by 8 trained assistants who spent up to 2 months at 3 government-run centres, 4 Christian centres and 1 non-Christian private centre. They observed the day-to-day activities at the centres and conducted informal interviews with the rehabilitees and officials. Information on indigenous therapy was collected by an assistant who interviewed two Malay traditional healers.

Government-run centres

The aim of rehabilitation programmes sponsored by the government is to remove drug addicts from the street and subject them to a crash programme of counselling and various therapies in the hope that they will become reformed individuals at the end of 6 months or less. The implicit assumption of these programmes is that the identity of a drug user can be remoulded if he is placed within a drug-free environment where he can participate in 'clean', 'wholesome' activities and where he can realize his own weaknesses through counselling. Admission into government-run centres entails certain legal procedures whereby addicts are first committed by the courts under the provisions of the amended Dangerous Drugs Act (1977). This legal endorsement places restrictions on the freedom of the addict undergoing rehabilitation, i.e. absconding from a government-run centre within the stipulated period of treatment is considered a criminal offence. Following this, the addict is given a urine test and if the results are positive he is sent to the hospital for 2–4 weeks of detoxification. When he is fully recovered from drug withdrawal effects, he is transferred to a rehabilitation centre for further treatment.

Government rehabilitation programmes are structured according to four categories of treatment: (1) physical rehabilitation; (2) psychological rehabilitation; (3) vocational training; and (4) religious and moral guidance. Physical rehabilitation is premised on the assumption that the functioning of a good clean mind depends on the development of a healthy body. Thus, all rehabilitees are required to participate in early morning exercises, marching, games, gardening and various cleaning chores. Psychological rehabilitation is aimed at promoting the self-awareness of the addict through individual and group counselling. The problems and weaknesses of the addict, especially in relation to his history of drug taking, are discussed at counselling sessions conducted by psychologists or welfare officers in English, Bahasa Malaysia, Mandarin or other Chinese dialects. Occasionally, informal group counselling known as House Talks or House Meetings is held between rehabilitees in a dormitory with their housemasters. Religious and moral guidance is provided in the form of regular sermons delivered by various religious personnel. All Muslim rehabilitees are required to attend classes conduced by an *ustaz* (religious teacher) from the Department of Islamic Affairs, whereas Christian, Buddhist and Hindu rehabilitees are encouraged to attend religious classes when available. Vocational training is provided with the intention of instructing rehabilitees in carpentry, bookbinding, tailoring, woodwork, rattan weaving, painting, electrical repairs, etc. None of these classes actually provide professional training but merely opportunities for learning something useful. Recreational therapy is provided at some centres where rehabilitees participate in various recreational activities that are believed to improve their quality of life.

At the end of the treatment programme, each rehabilitee's case is reviewed by a Board of Release comprising the centre's principal, his deputy and other senior officers. Release is determined by the board's evaluation of a rehabilitee's conduct at the centre, his attitudes towards assigned activities, his relationship with other rehabilitees, his participation in counselling sessions, and his future plans. At some centres, cases for release are further reviewed by a Board of Visitors which meets about once a week. This Board comprises local notables, retired government officers and appointees of the Social Welfare Ministry. On the day of his release, each rehabilitee has to sign a bond in which he is required by law to undergo 2 years of supervision. This means that he has to report regularly to a welfare officer, to notify change of address, to avoid other addicts, and to make himself available for occasional urine tests.

Synanon imported

In 1958, Charles Dederich and his associates formed an organization in California called Synanon in an effort to re-educate drug addicts, alcoholics and juvenile delinquents. It has since grown into a large business empire in the United States and its rehabilitation programme has been exported to many countries around the world [7]. One of the Synanon-inspired programmes which reached Southeast Asia was the DARE programme (Drug Addicts Rehabilitation Foundation) in The Philippines. This programme was to become the stepping stone to a career in drug rehabilitation for Yakob Abdul Rahman, a

German Catholic priest who later converted to Islam. As a priest in Ipoh, Perak, Yakob (then known as Fr J. W. Scholer) headed the Council for Youth Problems. In 1973 he became involved in counselling drug addicts and established a rehabilitation centre under the auspices of the Catholic Welfare Service in Ipoh. When he discovered that his 14-day programme of detoxification and counselling was not sufficiently effective, he joined DARE to study its programme of treatment. In 1975 he set up two new centres in Ipoh, but with the increase in the number of rehabilitees he moved his main centre to Batu Gajah, Perak. This centre was renamed Pusat Pertolongan. By this time, Fr Scholer had embraced Islam and his rehabilitation centres were removed from the control of the Catholic Church.

The programme of treatment at Pusat Pertolongan is based on many similar techniques developed by Dederich and his associates at Synanon. In general, rehabilitation involves progression through four stages or 'houses' over a period of $1\frac{1}{2}$ years. The three major houses—Tunas Baru, Harapan, Cahaya—are located in Batu Gajah while the final house—Kemajuan—is based in Ipoh. An addict admitted into the centre for the first time is sent to Tunas Baru for 45 days or more. Then he is transferred to Harapan for 3–4 months, after which he spends 6 months or more in Cahaya. He is required to spend his last 6 months in Kemajuan where he is prepared for re-entry into the larger society. However, individuals who had absconded from the centre and ex-rehabilitees who have returned to drugs but who now wish to undergo the treatment programme again are assigned a shorter stay at the centre. These ex-programmers (as they are called at the centre) spend a minimum period of 45 days at Tunas Baru and an indefinite period in the other houses depending on the officers-in-charge. All ex-programmers are required to spend a short time in Semangat Baru, an alternative house created specially for them.

The rehabilitation programme follows a five-phase system which emphasizes the gradual assumption of increasing responsibility. Phase One rehabilitees are housed in Tunas Baru where they receive cold turkey treatment while undergoing withdrawal. Tunas Baru is a maximum security house as rehabilitees there are believed to harbour a great urge to abscond. They are guarded by senior rehabilitees all the time and are given limited freedom in their activites. After they have recovered sufficiently from the pains of drug withdrawal, they are taught the rules of the programme. Rehabilitees graduate to Senior Phase One and Junior Phase Two in Harapan where they are exposed to an Intensive Therapy Community Programme. In this programme, they are expected to apply the 'tools of the house' that they have learned in Tunas Baru. They are given more responsibilities, such as guarding Phase One rehabilitees or running a department. Senior Phase Two and Phase Three rehabilitees are placed in Cahaya where they are given more freedom than their counterparts in Tunas Baru and Harapan. They are expected to be uninhibited in discussing their problems with other rehabilitees. Phase Four rehabilitees in Cahaya are required to serve as 'back-ups' for 2 months, i.e. they assist the officer of each house in administrative and therapeutic matters. These senior rehabilitees are given a ten dollar allowance every week and occasional leave. When the rehabilitees enter Kemajuan, they are expected to be physically and psychologically stable. At Kemajuan they are gradually weaned from the treatment programme and introduced to work in the outside world. They are encouraged to develop closer ties with their families and are allowed home leave.

The 'tools of the house' that rehabilitees learn and apply at Pusat Pertolongan form the major techniques in treating drug addiction. Basically, these techniques involve the development of a style of social interaction that accentuates candidness, self-criticism, guilt by association and authoritarianism. It is believed that self-recognition of individual weaknesses, achieved through the application of these techniques, implants in a drug addict the impulse to seek non-drug alternatives in dealing with various problems. In other words, these techniques are used intensively to restructure the moral interpretations of a drug addict. The heart of the rehabilitation programme is centred on 'The Game.' This involves several hours of uninhibited verbal exchange among twenty or more rehabilitees. The Game is held twice a week with four different groups from Phases One, Two, Three and Four. Each Phase is divided into a Chinese-speaking and an English-speaking group, and is moderated by a therapist/officer. The Game is conducted with only three rules: (1) no violence or threats of violence; (2) no walking out and (3) no breaking the seal of the Game, i.e. participants cannot use their Game experiences outside 'The Game'. Participants in the Game are permitted to verbally attack others, even those from other Phases. A Game usually involves a rehabilitee confronting another for various reasons. The latter is expected to explain and defend himself without the help of his colleagues who decide the outcome of the case. Gaming instills in the rehabilitees a posture of guardedness since they must be prepared for sudden hostilities from others. However, 'Contract Games' which are planned by several individuals to humiliate a particular rehabilitee are forbidden [8].

The Christians' cure

It is not known exactly when Christian drug rehabilitation centres were first established in Malaysia, but probably some of them predate the government-run centres which were first built in 1975. In the late 1970s, at least 8 Protestant Christian rehabilitation centres were established in the Klang Valley in Selangor. All these centres operate independently of the government-run centres but their activities are monitored by the Ministry of Social Welfare. Each Christian centre depends on private donations and financial aid from local churches to continue functioning. Although each Christian centre is aware of other such centres in the area, there is relatively little or no contact between them. Despite occasional meetings to exchange ideas on rehabilitation, each centre prefers to keep to its own programme.

The thrust of the Christians' rehabilitation programme is more redemptive than therapeutic. In other words, drug rehabilitation is not merely considered as a means of directing an addict away from

drugs but also arousing his interest in spiritual goals. Despite a lack of communication between these centres, each follows a standard programme of rehabilitation which is broadly divided into three stages. The first stage comprises the admission and 'cold turkey' treatment of the addict. Throughout his withdrawal period, the addict is not given any medication but is comforted only by prayers and the attention of his counsellor and fellow rehabilitees. After he has recovered from his withdrawal symptoms, the addict is introduced to the programme and is expected to adhere closely to the norms of the centre. He is also isolated from the outside world by his superiors who restrict his communication with friends and relatives. In the second stage, the rehabilitee is encouraged to give testimonies, participate in bible studies and attend chapel services. The emphasis is on the practice of a new lifestyle and the strengthening of religious commitments. At some Christian centres, the test of discipleship is focused on participation in street-witnessing where rehabilitees are required to proselytize strangers, drug addicts and prostitutes into the Christian faith. In the final stage, the rehabilitee is given more freedom in his movements and contacts with the outside world. He is encouraged to seek full time employment and may even decide to embark on a career of drug counselling.

During his period of rehabilitation, the addict is constantly watched and evaluated by the counsellors (many of whom are former addicts) and his peers. The ability to perform well in various chores and to impress others with advancement in spiritual matters are two means to a successful career in the centre. The progress of each rehabilitee is publicly marked on a large wall chart where points gained connote more rewards and acquisition of seniority, while points lost imply more restrictions and less respect. The ratings are made largely by the chief counsellor and his staff. Evaluations are based on various criteria such as the rehabilitees' submissiveness to the counsellors, attitudes towards work, relationship with other rehabilitees and spiritual growth. Occasionally, the counsellors may give a particular rehabilitee extra points to boost his morale and also to serve as model for others.

Counselling is considered a vital aspect of the rehabilitation programme. It is usually conducted on an *ad hoc* basis in the privacy of an office. The rehabilitee is encouraged to express his feelings to the counsellor who subtly combines spiritual and mundane approaches to solve problems. In addition to individual counselling, the entire group may gather once a week at Family Time to discuss and settle various problems. These group counselling sessions are intended to provide a safety valve in dissipating unreleased tensions among feuding rehabilitees. Public confessions and apologies are prescribed means of discharging pent-up emotions at the weekly meetings. Many of these practices resemble those developed at Pusat Pertolongan—this is not surprising because some of the founders of the Christian centres were originally rehabilitees there. However, unlike Pusat Pertolongan the religious elements in the Christian programme provide the major bonds for cementing relationships between the rehabilitees. Compared with the government-run centres, the Christian rehabilitation programmes are more personal and individually oriented. Since Christian centres admit only a select number of people, there is a greater likelihood for the formation of more intense face-to-face relationships among the rehabilitees.

Indigenous therapy

The services provided by the Malay traditional healer (*bomoh*) in drug rehabilitation must be considered as equally important to the other forms of treatment described above. In general, the principles adopted by *bomohs* in drug rehabilitation are similar to those followed by the various centres. The processes of detoxification and attitude-change are central to the *bomohs'* method of treatment. However, a major difference lies in the *bomohs'* explanation of causation in drug abuse. For the Western-trained therapists, drug abuse can be attributed to a wide range of psychological and sociological causes. *Bomohs* accept these explanations in addition to their belief that drug dependency is linked to spirit possession. They believe that it is not only important to re-educate a drug addict but also to exorcise him of drug spirits (*hantu dadah*) that are in control of the addict's psyche. Exorcism is conducted by inscribing Koranic verses in ink on a patient's body and chanting these verses to drive out the malignant spirits. The patient must be sufficiently recovered from his withdrawal symptoms before exorcism can be performed [9].

The practice works on two levels. Firstly, drug exorcism is a ritual that symbolizes the termination of a wayward habit and the restoration of a clean lifestyle. The exorcised spirits represent the residue forces of drug experiences that are potentially capable of re-igniting an addict's cravings for drugs. The exorcism ceremony provides in essence a symbolic release of the addict from the vestiges of these remaining desires and restores some confidence in his own abilities to cope with future temptations. On another level, the spirits are assumed to be real in the sense that they actually inhabit the addict's body, forcing him to submit to the urges for drugs. The addict is not considered the guilty party but the injured party, overwhelmed by the will of the spirits. Exorcism in this case is literally a cure to oust the evil spirits from the addict's body.

Exorcism is only one stage in the rehabilitation technique employed by *bomohs*. Most *bomohs* treat their patients by first administering herbal medicine to induce vomiting or defecation. This is meant to purge the body of all toxic substances. The second stage of treatment involves rest and ingestion of more herbal medicine prepared by the *bomoh* for the restoration of the patient's strength. After exorcism has been performed, the patient is given religious instructions to reinforce his psychological defenses against drug temptations. The names of various Islamic saints are invoked and repeated to symbolically form a protective barrier around the patient. Some *bomohs* include *mandi bunga* (bath of flowers) in their treatment. This is a traditional method for treating various ailments. A talisman (*timah hitam*) is usually slipped into the water for ritual purification before the patient is bathed. This treatment is applied for 10 days in succession.

Not many *bomohs* actually specialize in the treatment of drug addiction. However, in Kuala Lumpur there are at least two *bomohs* who have built their reputations on drug rehabilitation. One *bomoh* practices in a small office in the heart of the city. Addicts consult him on an individual basis and are largely treated as outpatients. He does not charge a fixed fee for his services. The other *bomoh* (originally from Java) operates a small clinic in an urban village on the outskirts of the city. His methods are more elaborate and he charges each patient a fee of M$400 for an entire course of treatment lasting about 10 days. Both claim to be specialists in drug rehabilitation because of their allegedly consistent successes in curing drug addicts. Other traditional folk healers, such as the Chinese sinseh and the Indian Ayurvedic practitioner, have also been reported to be involved in drug rehabilitation, but we do not have sufficient information on their practices to compare with those of the *bomoh* [10].

ORGANIZATION AND CONTROL IN REHABILITATION SYSTEMS

An understanding of how the above systems work entails a comparative analysis of the varying levels of power in rehabilitation centres and their corresponding effects on the rehabilitees' identities.

Power and privilege

The chief executive of formal authority in a government-run centre is the principal who is not only responsible for its overall administration but also its liaison with various government departments and hospitals. However, the principal cannot fully exercise his formal powers without vital feedback from his subordinates. In a sense, his subordinates, particularly his senior welfare officers, wield greater formal powers in the day-to-day supervision of the centre since they are in constant contact with the rehabilitees. Within this structure of formal authority, there are various built-in constraints that limit the powers of the officials. First, the principal virtually has no power in formulating policies for drug rehabilitation. He merely follows orders from the Ministry of Social Welfare. Secondly, the principal and his officers do not always decide the fate of individual rehabilitees. An external body—the Board of Visitors—comprising government appointees reviews each case on a regular basis. Thirdly, all officials expect transfer orders from their superiors at any time during their term at a rehabilitation centre. This means that their authority in a specific area may be abruptly terminated, leaving a vacuum in policy implementation.

Unlike the tight hierarchial structure in government-run centres, the private centres are relatively less constrained by external decision-making bodies. The centre at Batu Gajah and various Christian centres are more self-contained and relatively free of government interference. In this regard, the director of a private centre has relatively more freedom to formulate rehabilitation policies.

The status hierarchy at the formal level is replicated to a certain extent among the rehabilitees. At the government-run centres, senior rehabilitees are accorded higher rank than their juniors by the staff. This is clearly evident in the grading system at some government-run centres where recently admitted rehabilitees are given red badges to distinguish them from the senior rehabilitees who wear green and yellow badges. Junior rehabilitees are usually given menial chores to perform, such as cleaning the premises and kitchen work. A rehabilitee's status is also easily identified by the length of his hair. Junior rehabilitees usually wear their hair short whereas senior rehabilitees are allowed to grow their hair long. This overt ranking system only forms the surface of an elaborate informal power structure, known as the *Taikor* or *Abang* system [11] where some seniors exercise considerable *de facto* power over the juniors. This system of control is self-perpetuating in the sense that senior leaders relinquish their power to others when they leave the centre. Within this system, the informal leaders exact deference and respect from the juniors by intimidation and physical violence [12].

In the private centres, senior rehabilitees are also given more privileges than the juniors. They enjoy greater freedom of movement and are even required to supervise the activities of the juniors. Unlike the government-run centres, the authority wielded by seniors in the private centres is usually legitimated by the director. In other words, informal control is minimized by a system of custodianship where selected seniors receive orders from the director in the day-to-day management of the centre. As appointees of the centre, the privileges they receive are not exacted by force but are part of the reward system sanctioned by the formal authorities. This may partially account for the lower incidences of physical violence at the private centres.

The relationship between the formal and informal structures may be analysed on two levels—the public and private. At the government-run centres, the formal authorities often strive to maintain a clear distinction between their status and that of the rehabilitees. The public image that is presented emphasizes the status distance between the officials and rehabilitees. Norms of deference are observed by the rehabilitees, as seen in their public behaviour—they are expected to address the principal as *tuan* (sir) and the officers as *encik* (mister). Many rehabilitees regard a deferential front as necessary for maintaining good relations with the officials so that no blemishes appear on their records. Officials always claim to be alert to the infringement of formal rules by rehabilitees operating with the *Taikor/Abang* system. In reality they turn a blind eye to these practices. Since officials cannot exercise formal control over every aspect of the rehabilitees' activities, they see the practical need to come to terms with them so that disruptions in the status system are minimized.

Public communication between the officials and rehabilitees at the private centres appears to be more egalitarian. Officials and rehabilitees normally address each other as 'brothers' and 'sisters.' The public image of mutual cooperation and understanding is cultivated through the ideology of self-examination and information-sharing. The distinction between the formal and informal power structures at the private centres appears to be less clear-cut, blurred largely by

a tendency of all concerned to believe in the ideology of individual upliftment through team-work. Moreover, the cooptation of seniors into the formal structure reduces the possibility of clandestine group formation. Despite this facade of fraternal relations, the officials and seniors exact compliance through therapy sessions focusing on confessions and self-criticisms. When rehabilitees can no longer tolerate the tension between these methods of rehabilitation and the professed ideology of egalitarianism, they abscond from the centre.

Indigenous therapy, on the other hand, offered by *bomohs* and other folk healers has not been organized on the same scale as the government and private centres. Addicts seeking treatment from indigenous healers do not experience similar constraints since therapy is not conducted within the confines of a total institution.

Forms of control

Formal control in government-run centres is exerted through a rigidly structured reward–punishment system. Rehabilitees who demonstrate a ready compliance with the centre's rules are rewarded with the opportunity to participate in short holidays away from the centre. Model rehabilitees are sometimes given an early discharge from the centre. Infringement of rules usually results in loss of cigarette rations and postponement of release from the centre.

Cigarette rationing is used as a method of control because cigarettes have acquired high value as an item of economic exchange in some government-run centres. Since rehabilitees are not permitted to carry cash, they use cigarettes as a currency for all social transactions. The authorities at some centres have legitimized cigarettes as an item of consumption to reduce problems of tobacco smuggling. Cigarettes have become such an important commodity that the rhythm of life at some centres depends on their daily distribution. Each rehabilitee receives a fixed number of cigarettes a day from the authorities. Many of them use their rations to form cigarette partnerships as a type of investment.

Deferment of release from a government centre is often considered by many rehabilitees as a harsher form of punishment than cigarette rationing. Many of them feel a loss of face when they are kept in longer than expected. To be detained longer than usual while their fellow rehabilitees are released on schedule often produces a heightened sense of anxiety among those being punished. These rehabilitees would stay away from others and avoid all social activities until their release from the centre.

The authoritarian methods of control at the formal level are replicated to a certain extent at the informal level. Most rehabilitees entering a government-run centre are subjected to initiation rituals characterized by violent beatings. The aim of these rituals is to impress upon the new rehabilitee his inferior status in the social hierarchy at the centre. The most common method of initiation is 'star lighting' where a rehabilitee is hit several times on his forehead with rapid flicks of the first finger and thumb. These rituals are usually conducted at night or in secluded areas such as bathrooms and toilets. Kangaroo trials are occasionally conducted in secret by seniors against rehabilitees who have breached rules in the *Taikor/Abang* system. Although the authorities are aware of these informal methods of discipline, they are powerless to act because the victims usually do not wish to testify against their tormentors. There is a general code of silence among the rehabilitees who are aware of the unpleasant consequences of informing on their tormentors.

On the other hand, the private centres employ more subtle methods of control that are built into the rehabilitation programmes. The authorities at these centres use shaming techniques to exercise psychological control over the rehabilitees. Game therapies and group counselling at these centres are essentially attempts at inculcating a sense of worthlessness in rehabilitees. Those who seek to rebuild their self-images develop dependent relationships with counsellors and senior peers for support and recognition. The manipulation of rehabilitees' self-esteem tends to reduce the need for overt disciplinary measures at these centres. Stern punishment such as expulsion or withholding leave occurs only in extreme cases of insubordination. Although the senior–junior system is condoned by the authorities in the private centres, no violent methods are used to maintain status differences among the rehabilitees. This is because senior rehabilitees appointed to supervise juniors in the private centres are accountable for the latter's welfare, unlike the seniors in the government-run centres who have no legitimate standing as supervisors. In addition, the ideology of brotherly affection emphasized by the authorities in Pusat Pertolongan and the Christian centres places certain constraints on the use of physical violence, whereas this ideology is not even given lip service in the government-run centres.

Impact on identity

Ideally speaking, drug rehabilitation is a process of inducing voluntary change in an addict's identity. In actuality, this identity change is dependent upon an addict's experiences in a rehabilitation centre. At the government-run centres, rehabilitees quickly develop cynical attitudes when they discover that the authority structure there instills fear and mistrust. The maintenance of the status quo through a system of punishment at the formal and informal level is likely to intensify their 'survival instincts' than to promote a sense of camaraderie. Under such circumstances, the rules of survival on the streets are seen to be equally applicable in a government-run centre.

Moreover, many rehabilitees in the government-run centres had been arrested in drug raids and admitted on an involuntary basis. It can be assumed that involuntary rehabilitees have no wish to be reformed in the first place. Their general attitude is to endure 6 months of treatment and return to their old habits as soon as they are released [13]. Counselling is usually not taken seriously by these rehabilitees. Most of them attend counselling sessions because they do not want tainted records [14]. Given these hardened attitudes and limited rewards for identity change in government-run centres, it is unlikely that rehabilitees will experience radical transformation in their personalities.

The support system that is crucially needed to

maintain an addict's reformed identity is not adequately developed in government rehabilitation programmes. Upon release from a government-run centre, each rehabilitee is required to report periodically to a welfare officer for an interview and urine test. When a rehabilitee fails to keep his appointment with the officer, several reminders are sent until the case is dropped. There are few facilities to track the movements of a rehabilitee and his activities. Aftercare programmes to monitor changes in his attitudes and behaviour are either non-existent or poorly managed. Without this support system, identity change among rehabilitees is easily ruptured by reexposure to the drug scene [15]. This problem is also evident in indigenous therapy since most traditional folk healers do not have sufficient resources to monitor their patients' progress after treatment has ended.

Compared with the rehabilitees at government-run centres, those admitted to Pusat Pertolongan and the Christian centres generally volunteer for treatment. This implies that they are more motivated to seek changes in their identities and more receptive to the programme of treatment. More importantly, identity change is facilitated by an authority system that emphasizes the subordination of individual identities to a larger group identity. The blurred distinction between formal and informal authority at the private centres tends to promote a sense of community that is maintained regularly through small group interactions. Under these conditions, rehabilitees experience an intense pressure to shift their frame of reference to that of the overall community. The effects of this 'conversion' process are somewhat lasting, as evident in small groups of ex-rehabilitees from Pusat Pertolongan who meet regularly to play Synanon games, or some rehabilitees from the Christian centres who become missionaries. This larger group identity is reinforced by networks of ex-rehabilitees who continue to maintain ties with the private centres and their counsellors. Some rehabilitees have even refused to leave the private centres upon completion of their treatment. They live on the centres' premises but work elsewhere in the day. In other words, the private centres also function as reference points for ex-rehabilitees who are adjusting to the outside world. However, there is no record of such developments in the government-run centres. The weaker ties in the government-run centres can be partly attributed to their highly differentiated status system which tends to inhibit the formation of a superordinate identity among rehabilitees.

CONCLUSION

The comparison of these four drug rehabilitation systems reveals significant differences in their organizational structures and therapeutic approaches. The government-run centres are largely organized as extensions of an administrative machinery with minimal concern for individual action or innovation. The authority structures in these centres typically reflect the bureaucratic hierarchies of government departments. Individual innovation is not overtly tolerated in this rigidly stratified system and is usually manifested as an 'underground' phenomenon (as in the *Taikor/Abang* system). An uneasy compromise exists between the formal and informal levels of authority that maintains the overall status system. On the other hand, the organizational structures of Pusat Pertolongan and the Christian centres are relatively more open and independent in function. Organizational decisions are made with minimal external interference, so that commitments are centralized from within than from without the centres. The cooptation of rehabilitees into the authority structures in these centres reduces somewhat the problem of alienation in systems of total control. These organizational comparisons are however not applicable to the various forms of indigenous treatments which are presently practised on an individual rather than institutional basis.

These organizational differences are paralleled by diverse therapeutic approaches to drug rehabilitation. At the government-run centres, the notion of therapy is not sharply distinguished from disciplinary control. This is characteristic of a system that gives priority to the detection of rule infringement than to individual attitude change. Counselling is provided at these centres but its function is overshadowed by the punitive ethos of the system. The therapy programmes at Pusat Pertolongan and the Christian centres are more person-oriented, designed specifically to alter an addict's outlook through emotional manipulation and continuous indoctrination. The apparent openness of these centres provides an ideal environment for intensive face-to-face interaction required for radical attitude change. Similarly, the healer–patient relationship in indigenous therapy develops on an individual basis but is more susceptible to abrupt disruption since it has no organizational referents. Patients consulting indigenous healers are not institutionally committed and have no obligation to return for further treatment.

The above comparisons suggest that the private centres are more effectively structured for drug rehabilitation than the government-run centres, considering the former's record of low physical violence and sustained control over rehabilitees' emotional experiences. There are two plausible explanations for these differences in rehabilitation effectiveness. Firstly, the private centres are more selective in the admission of rehabilitees and therefore have better control over rehabilitees' motivation for change. On the other hand, government insensitivity to the problem of involuntary treatment is likely to produce superficial results in the motivation levels of rehabilitees. Secondly, authority relations in the private centres are less bureaucratized than those in the government-run centres. This implies that close rapport between staff and rehabilitees is more likely to develop in the private centres than in the government-run centres. In view of these differences, policy-makers need to redefine the government's approach to drug rehabilitation. A critical evaluation of admission policies and organizational accountability in the government-run centres is required for the improvement of their rehabilitation programmes. This entails a careful consideration of the differences between voluntary and involuntary rehabilitees and the appropriate administration of rehabilitative treatments. In other words, policy-makers concerned with the effectiveness of drug rehabilitation should give more

consideration to the complex interplay between individual motives and authority structures than to the mere question of confinement and treatment.

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1. For an example of this approach, see Crooq S. H. and Ver Steeg D. F. The hospital as a social system. In *Handbook of Medical Sociology* (Edited by Freeman H. E., Levine S. and Reeder L. G.), pp. 274–314. Prentice-Hall, Englewood Cliffs, N.J., 1972. See also Goffman E. *Asylums*. Penguin, Harmondsworth, 1961.
2. Malaysia comprises a peninsula (West or Peninsular Malaysia) and two states—Sabah and Sarawak (East Malaysia)—in Borneo. In this paper, I am concerned only with West Malaysia, the population of which is approx. 55% Malays, 34% Chinese, 10% Indians and 1% Others (Aborigines, Eurasians and Europeans).
3. Further discussion of the drug problem in this region can be found in Spencer C. P. and Navaratnam V. *Drug Abuse in East Asia*. Oxford University Press, Kuala Lumpur, 1981.
4. Total opium revenue collected between 1921 and 1925 amounted to nearly M$68 million (Proceedings of the Legislative Council of the Straits Settlements, 1925).
5. Several studies have already been conducted on drug abuse in Malaysia, e.g.: Deva M. P. A seven-year study of opiate dependence in Malaysia. *Med. J. Malaysia* **32**, 249–254, 1978. Navaratnam V. and Spencer C. P. A study on socio-medical variables of drug-dependent persons volunteering for treatment in Penang, Malaysia. *Bull. Narcotics* **30**; 1–7, 1978. Navaratnam V., Lee B. A. and Spencer C. P. Extent and patterns of drug abuse among children in Malaysia. *Bull. Narcotics* **31**, 59–68, 1979. Tan E. S. and Haq S. M. Drug abuse in Malaysia. *Med. J. Malaysia* **29**, 126–130, 1974.
6. Another centre located on the west coast built at a cost of M$6 million is expected to be ready in December 1984.
7. See Ofshe R. The social development of the Synanon cult: the managerial strategy of organizational transformation. *Soc. Anal.* **41**, 109–127, 1980. Yablonsky L. *Synanon: The Tunnel Back*. Penguin, Harmondsworth, 1967.
8. In addition to 'The Game', there are various forms of interaction with specific names and rules, such as 'haircut', 'spare part', 'learning experience' etc. For a further description of these Synanon-type rehabilitation methods, see the author's unpublished report, The social processes of drug use and rehabilitation in West Malaysia. Submitted to the Institute of Advanced Studies, University of Malaya, 1983.
9. In the case of one *bomoh* from Kuala Lumpur, his method of exorcism includes inscribing Koranic verses on the bodies of Muslim patients and Buddhist–Hindu magical diagrams on the bodies of non-Muslim patients.
10. Further descriptions of traditional Malay treatment of drug addiction can be found in Heggenhougen H. K. and Navaratnam V. A general overview on the practices relating to the traditional treatment of drug dependents in Malaysia. National Drug Dependence Research Centre, Universiti Sains Malaysia, Penang, 1979.
11. *Taikor* and *Abang* mean elder brother in Cantonese and Malay respectively.
12. Physical violence at these centres has resulted in two deaths in 1982 and 1984.
13. Some rehabilitees had expressed to us their eagerness to resume drug-taking as soon as they were released. They claimed that they can never forget the euphoria associated with drug-taking. We discovered that many of them continued to receive drug supplies from unidentified smugglers in government-run centres.
14. Observations of some group counselling sessions revealed that many rehabilitees quickly became bored by the same routine of delivering public confessions and receiving staid advice from the counsellor. Occasionally, hand gestures were made behind the counsellor's back to signal others to terminate the discussion.
15. Government officials have admitted that there is a high rate of recidivism among rehabilitees from government-run centres. For instance, the Deputy Information Minister has claimed that most of the 102,000 addicts arrested up to November, 1984 have returned to their drug habits following release from government-run rehabilitation centres (*The Star*, March 18, 1985). However, there is as yet no systematic study of drug recidivism in Malaysia and this should be given priority in future research.