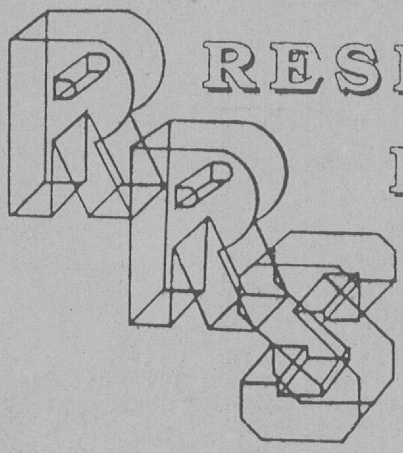

RESEARCH REPORT SERIES

28

A STUDY OF THE NATIONAL AFTERCARE PROGRAMME

Pusat Penyelidikan Dadah dan Ubat-Ubatan
(Centre for Drug Research)
U.N./W.H.O. Research and Training Centre
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A STUDY OF THE NATIONAL AFTERCARE PROGRAMME

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RESEARCH REPORT SERIES NO. 28

This study has been carried out under the Research and Development (R & D) project entitled "Penyelidikan Penilaian ke atas Program Pencegahan dan Rawatan".

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* U.N./W.H.O. Research and Training Centre on Drug Dependence and Psychotropic Drug Use.

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RINGKASAN

Pengenalan

Kajian Program Jagaan Lanjutan ini merupakan kajian susulan kepada kajian program rawatan dan pemulihan untuk penagih-penagih dadah di institusi. Kajian ini bertujuan untuk memberi kefahaman tentang Program Jagaan Lanjutan dan hubungannya dengan keseluruhan usaha rawatan dan pemulihan, serta memberi satu perihal proses penyampaian program dan analisis aspek-aspek organisasi program itu sepertimana yang dianggap oleh pegawai pemulihan.

Metodologi

Tinjauan pos ini menggunakan satu soalselidik urusan sendiri yang mana mengandungi ciri-ciri menonjol dan faktor-faktor yang didapati dari pendekatan kualitatif satu kajian kes yang awal. Responden-responden adalah terdiri dari pegawai-pegawai pemulihan yang terlibat dengan Program Jagaan Lanjutan di seluruh Malaysia.

Penemuan-penemuan

Penemuan-penemuan hasil kajian ini ialah:

- Matlamat dan objektif Program Jagaan Lanjutan yang mana adalah untuk menolong bekas-bekas penagih dadah mengintegrasikan kembali kepada masyarakat dan berfungsi sepenuhnya tanpa menggunakan dadah perlu diterjemahkan kepada komponen yang dapat diukur di mana ia dapat dilaksanakan dengan berkesan dan terkawal.

- Terdapat kekurangan sumber kebendaan dan personel untuk melaksanakan program ini dan ini mempengaruhi kecekapan dan keberkesanan kakitangan. Tambahan pula, pegawai-pegawai berkenaan harus menjalankan tugas-tugas yang tiada hubungan dengan matlamat program.

- Kekurangan kakitangan profesional yang berkemahiran menghindar perkembangan hubungan kakitangan-klien dan kejayaan penyesuaian psiko-sosial klien.

- Kerja-kerja pentadbiran merupakan sebahagian besar dari tugas-tugas pegawai, yang mana mengurangkan masa untuk interaksi dengan klien. Ini menyebabkan kekecewaan dan moral rendah di kalangan kakitangan.

- Berbagai-bagai aspek Program Jagaan Lanjutan perlu dihalusi dan dibangunkan semula supaya bekas-bekas penagih dadah dapat dipastikan mempunyai peluang yang lebih besar untuk tidak berulang (relapse).

- Penglibatan keluarga, sukarelawan dan komuniti pada amnya perlu digalakkan dan dimobilasikan.

- Satu komuniti bekas-bekas penagih dadah yang dapat menolong dalam berbagai aspek rawatan dan pemulihan adalah dicadangkan sebagai satu strategi penting dan bererti yang dapat menambahkan kejayaan program.

- Pengurusan data rekod klien yang lebih baik diperlukan untuk memperbaiki sistem kawalan dan boleh memastikan penilaian program dijalankan dengan cara yang lebih bererti di masa hadapan.

Cadangan

Adalah dicadangkan supaya kajian Program Jagaan Lanjutan di masa hadapan lebih berorentasikan tindakan. Sumber-sumber mesti diperuntukkan untuk membolehkan percubaan berbagai-bagai cara menyampaikan Program Jagaan Lanjutan di latarbelakang yang berlainan dan untuk berjenis-jenis bekas penagih dadah. Dicadangkan juga satu penilaian Program Jagaan Lanjutan dijalankan bersamaan dengan satu penilaian program rawatan dan pemulihan pada masa yang sama. Penilaian program ini mestilah termasuk penilaian bersepadu dan pembentukan.

SUMMARY OF FINDINGS

Introduction

This study of the Aftercare Programme is a follow-up of an earlier study of official treatment and rehabilitation programmes for institutionalised drug dependents. The aims of this investigation were to provide an understanding of the aftercare programme and its relation to overall treatment and its rehabilitation efforts; to provide a description of the programme delivery process and analysis of the organizational aspects of the programme as perceived by programme officers.

Methodology

This postal survey used a self-administered questionnaire which contained salient features and factors elicited in the qualitative approach of an earlier case study. The respondents are mainly rehabilitation officers involved with the Aftercare Programme throughout Peninsular Malaysia.

Findings

The major findings in this survey were:

- The goals and objectives of the Aftercare Programme which are to help recovering addicts to reintegrate into society and to be fully functioning without resorting to drugs need to be translated into measurable components that can be effectively implemented and monitored.
- There is a lack of resources both material and personnel committed to the implementation of the programme and this affect the efficiency and effectiveness of the staff members. Furthermore, the programme officers have to perform functions which have no relationship to the programme goals.
- The lack of professionally skilled staff impedes the progress of staff-client relationship and the success of client's psychosocial adaptation.
- Administrative work features a great deal in the function of the officers thereby reducing the time for interactions with their clients. This results in frustrations and low morale among staff members.

- Various aspects of the Aftercare Programme need refinement and redevelopment so as to ensure that the recovering addicts would have greater likelihood not to relapse.
- The involvement of the family, volunteers and the community in general needs to be further enhanced and mobilised.
- A supportive community of ex-addicts helping in various aspects of treatment and rehabilitation is recommended as an important and significant strategy to enhance the programme success.
- Better data management of clients' records is needed to improve the monitoring system and to ensure that programme evaluation can be done in a more meaningful way in the future.

Recommendations

It is recommended that future research in aftercare programmes be conducted which are more action-oriented. Resources must be allocated to experiment different ways to carry out aftercare programme in different settings and for different types of recovering addicts. It is also proposed that a proper evaluation of the aftercare programme should be conducted in conjunction with an evaluation of the treatment and rehabilitation programme at the same time. Programme evaluation should include both summative and formative evaluation.

CONTENTS

1. BACKGROUND TO STUDY

1.1 Introduction

The Aftercare Programme is designed as a follow-up to treatment at official rehabilitation centres to ensure that recovering addicts returning to the 'open community' can fully adjust to his/her (immediate) environment. They would be fully functioning socially and economically without resorting to drugs. These interventions also aim to enhance public understanding and awareness in order to reduce society's antagonism towards former drug dependents and to eventually facilitate their reintegration into the community.[1]

The study of the Aftercare Programme is a follow-up of two earlier studies of official treatment and rehabilitation programmes for institutionalised drug dependents.[2] In one of these studies, a preliminary investigation was carried out on the Aftercare Programme. Findings from the study indicated a correlation between the aftercare programme and drug-free status of clients* following discharge from the programme as seen from Figure 1. Thus, the aftercare programme plays a supportive role in helping a significantly large number of ex-drug dependents to maintain a drug-free life as they readjust to society.

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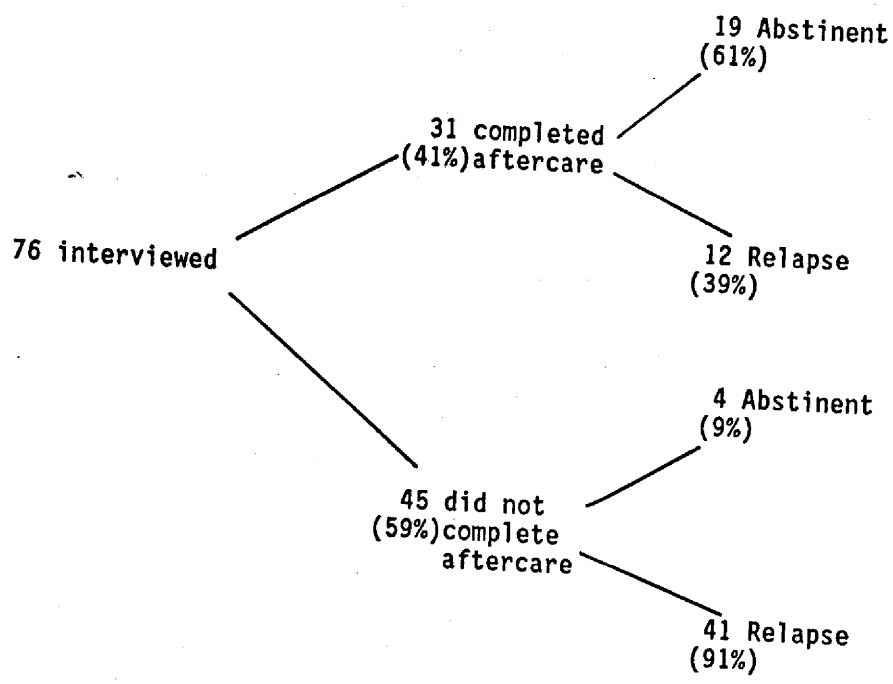
1. Bahagian Rawatan dan Pemulihan. Kertas Penerangan: Program Rawatan dan Pemulihan Dadah. (Drug Treatment and Rehabilitation Programmes: An Explanatory Paper). Paper presented at the National Seminar on Drug Treatment and Rehabilitation, Kuala Lumpur, 10-12 July 1990.

2. Navaratnam V, Foong K, Kulalmoli S. An Evaluation Study of the Drug Treatment and Rehabilitation Programme At A Drug Treatment Centre. Research Report Series No. 27. The Centre for Drug Research, Universiti Sains Malaysia, Pulau Pinang, 1992.

* Client in the text refers to an addict who has been discharged from an official treatment centre.

FIGURE 1

Drug-Free Status of Clients



Although the aftercare programme plays a significant role in drug treatment and rehabilitation, the high incidence of drop outs and the high cost of running the programmes need to be considered. The content and implementation of the programme also needs to be assessed before an outcome evaluation of the programme's effectiveness can be carried out. The purpose of this study is to provide a description of the aftercare programme and its operations so as to provide an exploratory study for further programme evaluation research.

1.2 Brief Summary of the National Drug Research Centre's Work[3]

Research involving drug treatment and rehabilitation programmes at the National Drug Research Centre at Universiti Sains Malaysia, has concentrated on three broad areas. The first area is related to the profiles of addicts seeking treatment under the government programmes such as their demographic characteristics, family background, drug addiction history, treatment history and criminality records. Detailed documentation of programmes and delivery processes as well as their organization represents the second area of investigations. The third area comprises evaluation research which aims to explore the strengths and weaknesses of programme delivery and effectiveness of the overall programme.

Information relating to the processes and outcomes of drug treatment and rehabilitation programmes are important for programme planners to develop and implement an effective national programme. Thus treatment evaluation research is an essential part of drug abuse management. Through such research, a series of recommendations have been provided and hopefully they form the basis for programme modification and further development in the coming years.

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3. Foong K, Chee KL, Navaratnam V. Treatment Research in Malaysia. Paper presented at the National Seminar on Treatment and Rehabilitation, Kuala Lumpur, 10 - 12 July 1990.

1.3 Objectives of the Study

The objectives of the study are:

1. to provide an understanding of the aftercare programme and its relation to overall treatment and rehabilitation efforts;

2. to provide a description of the programme's delivery process and of problems encountered;

3. to be an exploratory study for constructing a research design for a full evaluation study on the effectiveness of the aftercare programme at the national level;

4. to provide an analysis of the organisational aspects of the programme as perceived from the programme officers' perspective rather than from the addicts' perspective.

This study is a sequel to an earlier effort which uses a case study approach[4]. The latter study was essentially more qualitative in approach and relied significantly on personal observations and participations in actual activities at the offices. The study provided invaluable insights to the actual work practices and problems faced by the officers.

As stated earlier, there is a strong evidence that clients who do not drop out have a much lower recidivism rate. The case study provided some clues as to the reasons clients dropped out of the programme and why desired results were not achieved. A number of shortcomings were revealed that had implications on the success of the programme. Several of these shortcomings were associated with problems faced by the staff which include inadequate training, lack of physical amenities, heavy work load, role conflicts and lack of family and community support.

4. Chiang PH. A Case Study on the Aftercare Programme. National Drug Research Centre, USM, Penang, 1990. (Unpublished report).

1.4 Methodology

The qualitative approach used in the preliminary case study paved the way for the construct of a survey instrument. The self-administered questionnaire has a total of 52 items and focused on four main areas of inquiry which are related to: (i) the features of the rehabilitation office, (ii) work activities, (iii) use of community resources and (iv) effectiveness of the aftercare programme as gauged by the officers.

In January 1991, a total of 117 questionnaires were mailed or handed out to potential respondents who are rehabilitation officers in charge of aftercare delivery. They represented all officers involved in the aftercare programme in the whole of Peninsular Malaysia. Eighty six officers responded which gives a 73% response rate which is good for a postal survey.

Since this study was concerned with the actual implementation and operation of the aftercare programme, the elements that had to be accounted for include programme's goals/objectives, delivery approach, staff involved in delivery, staff-client ratios, job descriptions, delivery process and assessment of client's progress.[5]

5. Posavac EJ. Carey RG. Programme Evaluation: Method and Case Studies, Prentice Hall Inc., Englewood Cliffs NJ, 1980.

2. THE AFTERCARE PROGRAMME

2.1 Introduction

In drug abuse treatment, aftercare refers to "interventions designed to permit the client's effective integration/reintegration into society... and aftercare activities can be viewed as a first line of defense against return to drug use".[1] Its main aim is to prevent recidivism among recovering addicts and to reinforce treatment measures.

The aftercare programme is one component of the overall drug treatment and rehabilitation programme. The treatment and rehabilitation of drug dependents can be described as a continuum of function which necessitate comprehensiveness of the rehabilitation approach. Boey[2] affirms: "It was clear to the committee that every component in the continuum of the total rehabilitative process must be effective and view itself as an integral part of the total process of rehabilitation, with a common objective for the prevention of recidivism. For example, supervision and aftercare cannot by themselves achieve remarkable success if the seeds of rehabilitation are not sown within the drug rehabilitation centres. The contrary is also true. The efforts of the drug rehabilitation centres could be withered away for lack of supervision and aftercare."

The aftercare programme can be considered as a continuation phase of the treatment and rehabilitation with its focus shifted from the clinical environment of a rehabilitation centre to the previous social sphere of a client. The client may have successfully kicked his habit in the centres but following discharge, moves back into an environment that has helped to create the addiction. In that sense, it is a challenge for the client to work at overcoming the causes of addictive behaviour and re-learn strategies and techniques to stay clean and enjoy normal life.

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1. Nelson JE, Pearson HW, Sayers M, Glynn TJ, (eds). Guide to Drug Abuse Terminology, US Department of Health and Human Services (DHHS), Research Issues 26, 1987.

2. Boey LP. Treatment and Rehabilitation - The Aftercare System in Singapore, SANA, Not dated.

2.2 Issues in Recovery and Relapse[3]

Addiction is not only a disease; for most addicts it is also a way of life within a distinct subculture. Recovery is not just cessation of drug use; usually it demands adjustments to a new way of life within the culture of the larger community. They need guidance, new skills, new contacts so that they cease being an 'immigrant'.

First, there is drug craving, which can remain strong for many months following physiological withdrawal and which may surface upon one's discharge from a drug-free environment (even if a person has spent years in it). Craving appears to be largely the result of drug conditioning and is stimulated by a host of settings and events that a recovering person must gradually learn to handle or avoid altogether.

Next, there is a need for a new social network to replace old associations. There are significant social risks and skills involved, and a recovering person often greatly fears being known as an ex-addict. So telling about oneself, usually a principal way of becoming known to new friends, becomes charged with anxieties.

There are adjustments to drug-free activities and satisfactions. These adjustments constitute a learning process which can lead to needless doubt and despair. This is not only in relation to responses to pleasure but also to pain and stress. A newly drug-free person can easily feel his pain is abnormal, become discouraged, and of course, resort to drugs.

Interpersonal intimacy rather than dependence is needed but it is difficult for the recovering addict to initiate and sustain such relationships. Many past relationship are deeply damaged, so family and friends may be hard to approach.

Risks of slipping are great as drugs are still widely available. If a slip occurs, how one responds and with what help and resources, critically affects whether a full-blown relapse will ensue.

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3. Zackon F, McAuliffe WE, Ch'ien JMN. Addict Aftercare: Recovery Training and Self Help, National Institute of Drug Abuse, DHHS, 1985.

All these challenges must be managed as the person begins to assume, and catch up with, other conventional tasks of life: employment, education, paying bills, and so on.

For many ex-addicts, stress and dissatisfaction will slowly but surely erode their resources, and temptations will exceed their control. Especially painful are the relapses of people who have made sincere and sustained efforts; their return to drugs can deeply hurt and confuse the family, counsellors, and friends who have stood by them and encouraged them so long. But without finding safety and comfort in a new world, one can stay as an immigrant only so long before returning to the old habit.

2.3 Philosophy, Goals and Objectives of the Aftercare Programme

The goal of the aftercare programme is to rehabilitate the recovering addict within the open community (after a period of treatment and rehabilitation at the centres) so that they are independently functioning in their family and society without resorting to drugs. The three broad objectives are to ensure that recovering addicts: (i) remain drug free, (ii) function as productive and useful members of society, and (iii) be reintegrated into society.[4]

The philosophy of the programme took its cue from approaches and efforts in the United States which focused on the individual (or client). The existing aftercare programme is modelled after the Client Management System and has been in operation in Malaysia since 1978/79 with the cooperation of consultants from the National Institute of Drug Abuse, US. This approach is to help addicts overcome their drug dependence on an individual basis, to alleviate, resolve and prevent such problems that undermine the adequacy of their daily life functioning. Where necessary, family members and significant others are brought into the therapeutic process.[5]

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4. Bahagian Rawatan dan Pemulihan. Kertas Penerangan: Program Rawatan dan Pemulihan Dadah. (Drug Treatment and Rehabilitation Programme: An Explanatory Paper). Paper presented at the National Seminar on Drug Treatment and Rehabilitation, Kuala Lumpur, 10-12 July 1990.

5. Gilbert N, Specht H. Handbook of the Social Services, Prentice Hall Inc., Englewood NJ, 1981.

2.4 Structure and Organization of the Aftercare Programme

The Ministry of Home Affairs took over the planning and implementation of drug treatment and rehabilitation programmes from the Welfare Ministry in 1983 when the government realised that the drug problem demanded greater attention. A division within the Ministry, the Drug Treatment and Rehabilitation Division, was set up to coordinate all levels of programme planning in treatment and rehabilitation efforts. All directives with regards to drug treatment and rehabilitation including the aftercare programme come from the headquarters in Kuala Lumpur. This is to ensure uniformity of programmes in all states. The detailed planning of activities in relation to programmes is undertaken by officers in each state.

The aftercare programme is compulsory for all ex-addicts following their discharge from the treatment centres where they are institutionalized for a period of up to two years. It is statutorily provided in Act 283 Part 4, Item 13 and 14, and Part 5, Item 20 and 21 of the Drug Dependents (Treatment and Rehabilitation) Act 1983. Section 13(1) of the Act states, "A drug dependent who has been discharged from a Drug Rehabilitation Centre shall immediately upon such discharge, undergo aftercare by a Rehabilitation Officer or such other person as the Director-General may designate for a period of two years."

There are two components of the aftercare programme: the institution based services and the field services. This function is carried out by 14 State Rehabilitation Offices and 47 District Offices with a total of approximately 150 officers.

Under the institution based services, clients who face rejection from their family members and have no proper place to return to, can apply to stay in residential centres (known as Aftercare Centres) where they will be further assisted to readjust to society. They will also be trained in a range of activities to develop new skills. The institution based programme is for a period of six months. After the initial six months stay-in, they are sent back again to the community where they undergo the one and a half years aftercare programme.

The field service component is for a duration of two years and is structured upon social support, follow-up and a phase system and involves public institutions (eg. charitable, religious bodies), government agencies (Drug Rehabilitation officers, police, hospitals), family and relatives, neighbours, volunteer organizations (eg Drug Rehabilitation Committees), and the individuals concerned.

Presently, the Aftercare Centres also function as Re-entry Centres for trainees in the Rehabilitation Centres who are to be discharged soon and as Halfway Houses for those who are discharged from the rehabilitation centres and are undergoing the aftercare programme.

2.4.1 Social Support

Social stigmatisation of drug dependents can affect the reintegration process adversely and affect recovery. Such prevailing negative attitudes discourage ex-addicts who themselves are shunned, rejected and given very little opportunity to prove themselves as worthwhile members of the community. Interventions are aimed at the community in order to enhance public understanding and awareness and thus to reduce society's antagonism towards former drug dependents and to eventually facilitate their reintegration into the community.

2.4.2 Follow-Up

Follow-up is a process of evaluation of client's progress. It can be done by letters, procedures (e.g. urine testing), or home visits. It should increase or reinforce effectiveness of a previous programme. It serves to monitor clients' progress and provide the agency with an evaluation of the therapeutic process, effort and effect.

2.4.3 Tasks and Activities in the Phase System

In theory, the two year duration of the aftercare programme is divided into eleven levels. At each level there are specific tasks and associated activities that will be performed by a team comprising caseworkers, supervision and job placement officers on an individual basis known as task-oriented casework. These guidelines are laid out in the official manual,[6] and ideally, each officer is assigned to manage 23-25 cases at any one time.

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6. See Chapter 2 Ref. 4

The casework method is based on two basic assumptions of the individual: (i) the person lacks resources for alleviating the problems and (ii) the person lacks skills for alleviating the problems. The goals of casework is to: (i) release/change a client's negative emotional state, (ii) increase understanding of themselves and situation, (iii) better able to make important decisions and (iv) better able to implement the decisions. The success of a case depends on a great deal on a caseworker's ability and skills to deal with a client and motivate him to solve his problems.

The tasks for the officers include getting prepared for the client and his problems, gathering information, building a supportive relationship, defining and negotiating a working arrangement, creating action plans, implementing action plans, and evaluating the work and deciding on next steps till the client is fully independent within a two year time frame.

Some specific activities are to (i) ensure the ex-addicts are drug free via urine testing, (ii) hold counselling sessions with ex-addicts (individual as well as group), with the family and employers, (iii) visit homes/places of employment to ensure that rules are followed; and have discussions with people close to the ex-addicts, (iv) secure jobs/training for ex-addicts (v) plan and organize economic activities/projects, (vi) organize their involvement in welfare, charitable and sporting activities in their residence, and (vii) assist them to solve problems associated with their welfare.

The overall key activity in the aftercare programme is counselling. While many of the aftercare activities are used to monitor a client's progress, the counselling process is the means to motivate a client towards attitudinal and behavioural changes that will lead to continuing abstinence from drugs. When a client comes with a problem, the rehabilitation officer will try to help the client solve the problem. Solving the problem means to equip a client with coping skills to readjust to his surroundings without resorting to drugs. Home visits are also seen as essential and an integral part of the programme as it allows a caseworker together additional information and to build up relationship with his client and family. Frequent and surprise urine testing is routinely used to ascertain the drug-free status of clients and to reinforce conformity to goals expectations.

There is also a need to involve other significant persons in the therapeutic process, in particular family members, neighbours, and to a certain extent the community. At the community level, there is a need to increase readiness of people to accept recovering addicts and also to contribute toward a client's readjustment into society.

The particulars and progress of each client are recorded in a personal file on designated forms. All matters pertaining to the client such as results of urinalysis, social report, official correspondence are kept in that file for record keeping and future reference. Clients have to abide by a series of conditions under the aftercare programme. If not adhered to, they are sent back to the rehabilitation centres for further 'treatment'. Clients who cannot be traced will be considered as having absconded from the programme.

2.4.4 Outcome Measures

The activities mentioned earlier serve to monitor the progress of a client and ensure that he is really on his way to a totally drug free lifestyle. At the end of the two year aftercare programme, it is anticipated that the client will be integrated, fully functioning at home and in society without resorting to drugs. Some of the measures used are: drug-free urine on testing, good interaction with the family, functioning well in school or place of employment and acceptance by the community.

3. OVERVIEW OF WORK PRACTICES AT THE REHABILITATION OFFICES

3.1 Introduction

The rehabilitation office is both the starting and exit point for all cases (mandatory or otherwise) referred to the official drug treatment and rehabilitation programmes. To gain a clearer insight into the operations of the rehabilitation offices, it is important to have an overview of the general work patterns, time spent in the performance of such tasks and activities as well as an idea of work loads.

The function of aftercare services is provided by a unit within the framework of state and district rehabilitation offices. There are no well-defined work roles and functions in the various work areas. Generally the rehabilitation officer who deals with admission cases, is also the supervision officer, counsellor, aftercare officer, community organiser, part time clerk and typist, and an administrator.

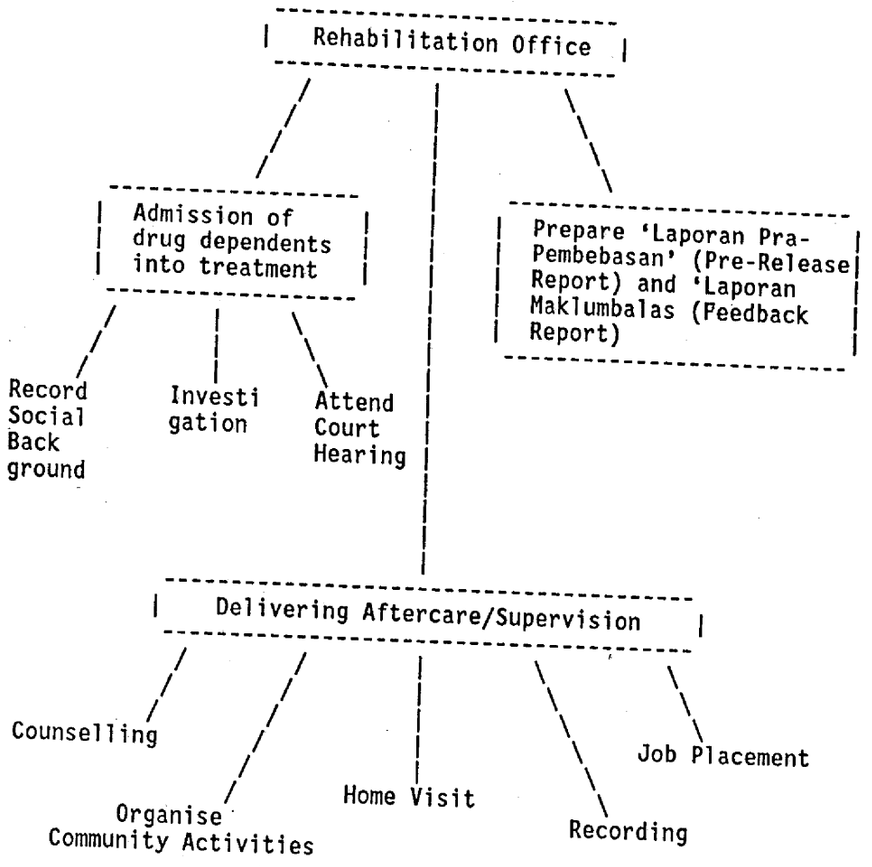
The work process involves admitting drug dependents into treatment programmes and delivering supervision and aftercare as well as a host of related work (See Figure 2). A brief description of specific tasks and activities performed by the officers in relation to intake, aftercare, supervision and work related to the Rehabilitation Centres is presented here to get an overview of work patterns and activities. Most of the rehabilitation offices have a similar work flow but where the office also doubles up as either a halfway house or aftercare centre, there are additional tasks of administrating these centres.

3.2 Activities Related to Admission

A majority of drug dependents are in treatment by mandatory order, very few cases are voluntary. Any person suspected of using drugs can be detained by the police and produced in court to be charged within a period of 14 days. During this time, a urinalysis is done to ascertain his drug taking status. If the result is negative, he will be released. Otherwise, the police will inform the rehabilitation officer to process the case.

FIGURE 2

Work Process Chart At The Rehabilitation Office[1]



1. Chiang PH. A Case Study on the Aftercare Programme, National Drug Research Centre, USM, Penang, 1990. (Unpublished Report).

Each case is registered by the rehabilitation office, and the officer has to interview the drug dependent to obtain information on his background at the police station lock-up. The officer also has to locate his family and to visit them with the purpose of assessing the addict's family background and of discussing the proposed course of treatment suited to the drug dependent.

The officer is required to make a recommendation to the magistrate to either admit the addict into a treatment centre subject to availability of space or where possible to be placed under supervision. The rehabilitation officer also has to accompany the drug dependent to court with the necessary documents. Generally, the magistrate gives a rehabilitation order based on the officer's recommendation.

The officer has other work to do when clients are committed voluntarily. These clients can choose to receive treatment at the centres or be placed under supervision. The client does not have to appear in court and a different set of documents are prepared for his admission or supervision. The social report assessment has also to be completed.

All drug dependents have to undergo detoxification before they are admitted into the centres or placed under supervision. Voluntary clients are detoxified at general hospitals whilst those under mandatory order will undergo detoxification on admission to the rehabilitation centres.

3.3 Activities Related to Supervision and Aftercare Programmes

Supervision is a preferred alternative to treatment at the rehabilitation centres but this depends on a number of factors. Volunteer cases or new addicts can undergo supervision if their family is supportive, or they are either studying or working and their environment can support their abstinence from drugs.

There are a lot of similarities between activities in aftercare and supervision. In fact, the manual states that the tasks and activities are similar. Most officers do not differentiate between the two in terms of emphasis and effort. Records, however, are kept separately. Some officers pay more attention to supervision cases while others prefer to deal with aftercare clients.

Counselling is an important component of both these programmes. Family members of clients can also come together with the client for family counselling. The duration and frequency of such sessions will depend on the respective officers and their clients.

The officers will also visit the homes of their clients to meet with the family and see how their clients are settling in their respective homes. Family members who are more cooperative will encourage the officers to visit regularly, at least once a month.

Urine tests are conducted regularly to determine the drug free status of clients. If the result of the urinalysis is drug positive, the client is given a chance to be detoxified at the hospital and if the client relapses again then legal action may be taken against him. The frequency of urine testing again depends on the respective officers. After the sample is collected, the officer has to send it to the local or district hospital for testing and collect the results a few days later.

Records of each client i.e minutes of each counselling session, records of home visits, results of urine tests and others, are maintained in a file.

3.4 Other Related Work

As a member of the Drug Rehabilitation Committee, the respective rehabilitation officer has to take the initiative to plan and organise activities for the clients at the community level. They also make the necessary contacts and various other arrangements to facilitate the client's reintegration into society. This again will take up time as there are meetings to attend and administrative work to be done in relation to this committee.

In 1991, the Ministry introduced new work practices to enhance utilization of its services. Under the Extension Services, extra time has been set aside for clients to meet the officers outside of normal working hours. This service is available for a few days each week at present.

The sub-centres service brings the officer to a designated place closer to his clients. For instance one of the officer from the Balik Pulau office will be stationed at a sub-centre at Bayan Baru, which is approximately eight miles away. This service is offered once a week during working hours.

These two work practices were introduced for the convenience of clients who may have problems of meeting the officers during normal working hours and for those who live far away from the rehabilitation office.

Focused Group ('Tumpuan Gerakan') is another organised activity to enable all the officers to meet with their clients and families in one area. This is to enable the officers to exchange information and ideas on case management as they are from different districts and engage in common goals.

3.5 Work Related to Clients in the Rehabilitation Centres

After admission of a client to a rehabilitation centre, the counsellor at the centre will request the respective rehabilitation officer to prepare a structured Feedback Report (Laporan Maklumbalas). This report is used by the counsellor as a basis for his counselling sessions. In order to prepare the report, the rehabilitation officer will have to meet the client's family to get the required information.

Rehabilitation officers are also encouraged to visit their clients in the centres and also their family members. This is rarely done due to time constraints. A few, however, will drop by the client's home if they are in the vicinity while handling other cases.

The Pre-Release Report (Laporan Pra-Pembebasan) is another report that has to be submitted by the officer to the counsellor. This report is an assessment of the client's family and future options open to him and contains information about the condition and readiness of the client's family to receive him back after his discharge from the centre. The report is done at the end of a client's stay at the centre.

3.6 Activities and Work Processes

The general pattern of tasks and activities described above is fairly typical in all rehabilitation offices though their frequency varies from office to office. The performance of these tasks and related activities can be referred to as the work process in the rehabilitation offices. (Refer to Appendix 1 for an outline of overall activities).

An earlier study provides in-depth information with regards to the frequency of activities and tasks performed within a month by two officers from different offices.[2]

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2. ibid.

Table 3.1 summarises the overall tasks and activities performed in a one-month time frame and variations in the frequency of their activities. Time constraints and work loads influence the performance of these activities. The staff have to schedule the time among the various tasks listed above. All these varied tasks and activities are time consuming and consequently, time allocated for essential tasks like direct work with clients can be much less or displaced by other routine activities.

Direct work with clients[3] is approximately 39% for Officer A and 44% for Officer B of total activities. The rest of the time is allocated to work related with other agencies and a bulk to administrative work for client management or office administration.

Administrative work is inevitable due to the broad scope of work and lack of support staff. The officer is in constant contact with various institutions: police authorities, hospital staff, treatment and rehabilitation centres, courts, voluntary organizations and individuals. This administrative work is related to case management: official correspondence, liaising with other agencies, organising and attending meetings, formal and informal discussions, etc. and then take up a considerable amount of time.

Since there is a lack of support staff, clerical work such as typing, filling forms, maintaining records and filing system, is also done by the officers. At the end of each month, they have to post monthly statistics on clients' status to the Headquarters. The officers are used to the routines, but such administrative tasks take time away from direct work with clients.

It is also common for an office to be closed when officers go out to attend meetings, make home visits, or attend to court or police cases. This usually occurs where there are less than two officers managing the office.

The roles and functions of the rehabilitation officers are too varied, and the effective and efficient management of the aftercare programme is subject to interplay of priorities of these roles and functions. The skills, capabilities and resources of individual officers are strained as they attempt to fulfill the work expected from them in the various functions and areas.

3. Based on Category 1, 2 and 3 from Table 3.1

TABLE 3.1

Frequency of Activities and Tasks Performed in a Month by Two Officers From Different Rehabilitation Offices

	Type of Activity	Officer A %	Officer A n*	Officer B %	Officer B n
1.	Attend to/counselling clients	9.8	(6)	28.8	(15)
2.	Attend to clients' family/ New clients	16.4	(10)	5.8	(3)
3.	Home visits	13.1	(8)	9.6	(5)
4.	Court visits (for rehabilitation order)	6.6	(4)	9.6	(5)
5.	Hospital visits (Send urine samples, collect results)	6.6	(4)	5.8	(3)
6.	Meetings and Administrative Work	4.9	(3)	3.8	(2)
7.	Update files/prepare reports	18.0	(11)	9.6	(5)
8.	Handle police cases	8.2	(5)	15.4	(8)
9.	Discussion with police authority	3.3	(2)	2.0	(1)
10.	Home visits to make social reports	4.9	(3)	-	
11.	Meetings/official functions/ correspondence	8.2	(5)	9.5	(5)
	Total	100.0	(61)	100.0	(52)

* n refers to numbers of times an activity is performed.

4. PHYSICAL SETTING AND FEATURES OF THE OFFICES

4.1 Profiles of the Offices

Due to the ad hoc nature of the establishment and implementation of drug treatment and rehabilitation programmes in the country, the planning and commitment of resources to the offices were predictably limited.

As seen from Table 4.1, 36.6% of the respondents from Big Towns[1] and 43.6% from Small Towns surveyed are operating in other government agencies, for instance, welfare and district offices. The situation is slightly worse in Small Towns. The others have only one room or two rooms for office space, with a small proportion having access to more than two rooms. Even those occupying one, two or more rooms do not have much privacy as the officers have to share the space with their own colleagues.

This lack of privacy does not provide a conducive environment for the officers to interact with their clients. In most cases, what the client has to say could

TABLE 4.1

Physical Setting of Offices

	Big Towns %	(n)	Small Towns %	(n)
One small space on sharing basis	36.6	(15)	43.6	(17)
Office - one room	34.1	(14)	35.9	(14)
Office - Two rooms	19.5	(8)	10.3	(3)
Office- More than two rooms	9.8	(4)	10.3	(4)

Missing = 6

1. We have categorised these sets of data according to the size of towns: Big Towns (eg. Kuala Lumpur, Johore Bharu) and Small Towns (eg. Alor Gajah, Muar) for comparison purposes.

not be stated in privacy. This lack of confidentiality hinders any systematic effort by the officer to work with the client. Where offices share space with other government agencies, this not only creates a great deal of inconvenience but also subjects the clients to public scrutiny and stigmatization which does not enhance their self-esteem.

The lack of resources is also evident in some offices where the officers have to rely on the good will of other agencies for the use of phones, stationery, etc. Considering the large amount of liaison work with other agencies and support work with clients and their families, it is remarkable how they cope with such inadequate communication facilities such as telephones. Others lament the lack of duplicating machines to distribute circular letters or bulk materials and resources to support their work.

With regards to location of the offices, (See Table 4.2) it can be noted that more than half of the officers (51.2%) agreed that the present location of their offices is not conveniently accessible to their clients. The main reasons cited were the lack of proper public transportation and the distance. Clients lack motivation to see the officers if the office is located too far away from their homes, schools or workplaces.

TABLE 4.2

Suitability of Office Location

	Big Towns %	(n)	Small Towns %	(n)
Yes	45.2	(19)	51.3	(20)
No	54.8	(23)	48.7	(19)

(Missing = 5)

To counter problems of inaccessibility, sub-centres were set up and service hours extended but a lack of staff and overload with cases greatly impedes the potential benefits of these services. Sometimes there is no staff to man the main office when the officer services the sub-centres or goes on home visits. This highlights further the lack of staff and resources to implement the aftercare services.

4.2 Supplementary Services

In terms of number of areas serviced by each office (See Table 4.3 A), a significant proportion of offices in the Big Towns have four and more areas to service. A slightly higher proportion of those in the Small Towns operated more sub-centres compared to in Big Towns.

A slightly greater number of offices in the Small Towns function as Aftercare Centres in contrast to those in Big Towns. The situation was again reversed for extension hours service: more offices in Small Towns offered extended hours services compared to those in Big Towns.

TABLE 4.3

Supplementary Services

	Big Towns % (n)	Small Towns % (n)
A. Number of areas serviced		
One area	50.0 (19)	66.7 (26)
Two to three areas	29.0 (11)	28.2 (11)
More than three areas	21.0 (8)	5.1 (2)
(Missing = 9)		
B. Number of sub-centres		
None	54.3 (19)	39.4 (13)
One centre	20.0 (7)	36.4 (12)
More than one centres	25.7 (9)	24.2 (8)
(Missing = 18)		
C. Function as aftercare centre		
Yes	15.0 (6)	26.3 (10)
No	85.0 (34)	73.7 (28)
(Missing = 8)		
D. Extension hours services		
Yes	68.3 (28)	81.6 (31)
No	31.7 (13)	18.4 (7)
(Missing = 7)		

Table 4.4 summarises four main indicators of workloads in the rehabilitation offices, namely supervision cases, aftercare cases, police cases and voluntary cases.

As seen from Table 4.4, the number of supervision cases by office was slightly higher in Small Towns while the number of aftercare cases was higher in the Big Towns. The bulk of police cases were processed in Big Towns. This is consistent with the higher incidence of drug dependents in Big Towns. The numbers indicated for voluntary admission were predictably small underscoring the involuntary committment of many of the clients into treatment and rehabilitation programmes.

TABLE 4.4

Office Workloads

	Big Towns % (n)	Small Towns % (n)
Number of supervision cases		
< 60 cases	41.0 (16)	24.3 (9)
60 - 120 cases	20.5 (8)	37.8 (14)
> 120 cases	38.5 (15)	37.8 (14)
(Missing = 10)		
Number of aftercare cases		
< 26 cases	30.8 (12)	37.8 (14)
26 - 50 cases	30.8 (12)	21.6 (8)
> 50 cases	38.5 (15)	40.5 (15)
(Missing = 10)		
Number of police cases		
< 63 cases	30.6 (11)	34.3 (12)
63 - 130 cases	16.6 (6)	28.6 (10)
> 130 cases	52.8 (19)	37.1 (13)
(Missing = 15)		
Number of Voluntary cases		
< 3 cases	42.9 (15)	31.4 (11)
3 - 20 cases	28.6 (10)	54.3 (19)
> 20 cases	28.6 (10)	14.3 (5)
(Missing = 14)		

However, in comparison with the case study, the figures in this survey were surprisingly low. In the case study, supervision cases were reportedly as high as 1,200 and aftercare cases in the region of 200-300. Obviously, there is either a misrepresentation of data in manual compilation of statistics or the numbers reported in this study represent individual caseloads rather than office caseloads.

4.3 Staffing

A majority of respondents are rehabilitation officers (see Table 4.5) with a few field officers and other staff. 52.4% (n = 22) of staff in Big Towns had more than six years experience compared to 69.2% (n=27) in Small Towns.

TABLE 4.5

Staffing

	Big Towns % (n)	Small Towns % (n)
Profile of Respondents		
Rehabilitation officers	92.9 (39)	89.7 (35)
Field Officers	4.8 (2)	7.7 (3)
Others	2.4 (1)	2.6 (1)
(Missing = 5)		
Years of Service		
< 3 years	26.2 (11)	20.5 (8)
4 - 6 years	21.4 (9)	10.3 (4)
7 - 9 years	47.6 (20)	61.5 (24)
> 10 years	4.8 (2)	7.7 (3)
(Missing = 5)		

All of the officers have some formal training, either short-term in-house training courses or long-term programmes at some institution. Some of the officers have been seconded from the Welfare Ministry when the Ministry of Home Affairs took over in 1983. Occasionally, short term courses in counselling are offered to the officers to upgrade their skills and further equip them for their roles as counsellors.

In terms of staff, many offices are short-handed and lack staff for effective administration of the offices and client management.

Though we did not survey on the aspect of gender, more than 60% of the rehabilitation officers are reported to be women. There are certain limitations they face in the course of their work such as supervising collection of urine samples, accompanying addicts or going for home visits to sensitive areas of high incidence of drug addiction and criminal activity.[2]

A few officers have the services of ex-army personnel to assist them in rudimentary tasks that require less skills usually on six months attachment. These assistants do not have formal training but learn on the job. Those who are around longer are sent for short courses. They help to ease the burden of the officers but they may not be able to carry out those tasks skillfully or effectively.

The survey also looked at other support staff in the offices and Table 4.6 summarises some main findings. A slightly higher proportion of offices in Big Towns have at least one field officer. None of offices in the Small Towns have clerks or typists and the situation in the big towns is only marginally better. This was also true in terms of office boys as support staff. None of the offices in the Big and Small Towns reported drivers on their staff.

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2. Osman M.S. Strategi dan Program Pemulihan Dadah Masakini (Current Drug Treatment Programmes and Strategies). Paper presented at the National Seminar on Drug Treatment and Rehabilitation, Kuala Lumpur, 10-12 July 1990.

TABLE 4.6

Support Staff in the Rehabilitation Offices

	Big Towns %	(n)	Small Towns %	(n)
Field Officers				
None	58.4	(24)	65.6	(21)
One	22.0	(9)	34.4	(11)
Two	19.5	(8)	0	(0)
(Missing = 13)				
Clerk/Typist				
None	97.6	(40)	100.0	(32)
One	0	(0)	1	(0)
Two	2.4	(1)		(0)
(Missing = 13)				
Office Boys				
None	95.1	(39)	100.0	(32)
One	0	(0)	0	(0)
Two	2.4	(1)	0	(0)
Three	2.4	(1)	0	(0)
(Missing = 13)				

4.4 Personal Workloads

A further examination of the data related to individual workloads indicated the following results (See Table 4.7). The number of clients serviced by individual officers in Big Towns and Small Towns were not significantly different. The situation was also true for home visits.

Officers in Big Towns reported spending more time on administrative work. About 41% of them spent at least 24 hours out of a 46 hours work week attending to administrative matters. More time spent on administrative work means less time spent on direct work with clients.

TABLE 4.7

Achieved Case Workloads by Officer

	Big Towns %	(n)	Small Towns %	(n)
No. of clients serviced in past week				
10 and less	41.5	(17)	46.0	(17)
11 - 20	43.9	(18)	32.4	(12)
> 20	14.6	(6)	21.6	(8)
(Missing = 8)				
No. of home visits in past week				
< 5	61.0	(25)	56.8	(21)
6 - 10	22.0	(9)	21.6	(8)
> 10	17.1	(7)	21.6	(8)
(Missing = 8)				
Number of hours spent on administrative work				
< 12 hours	18.0	(7)	39.5	(15)
13 - 24 hours	41.0	(16)	44.7	(17)
> 24 hours	41.0	(16)	15.8	(6)
(Missing = 9)				

This suggests that direct work with clients which are of higher priority are being replaced by administrative work and procedures. It can also create a sense of frustration in the officers when they find themselves doing more paperwork than attending to their clients.

5. IMPLEMENTATION AND DELIVERY OF PROGRAMMES

5.1 Introduction

The treatment and rehabilitation programmes have been established since 1975; from 1975 to 1983 under the Ministry of Social Welfare and since 1 May 1983 under the Ministry of Home Affairs. The developments have been largely in response to accommodating the drug dependents in rehabilitation centres with the setting up of more treatment centres. It was interesting to note that in the same period there was relatively less emphasis on supervision and aftercare programme and activities.

Much of the preliminary research conducted by the National Drug Research Centre indicate that the functions in treatment and rehabilitation centres were better defined and supported. This is a stark contrast to work at the rehabilitation office and to the aftercare programme in particular. In this chapter, results from the survey are examined and discussed in relation to current work practices.

5.2 Programme Delivery

Although the conceptual model of the aftercare programme incorporated the need for specialised staff to handle case work, supervision, job placement and community activities, the realities of scarce resources have forced all these tasks and responsibilities on to the rehabilitation officers. The ideal work ratio of an officer working on 23 to 25 cases cannot be implemented. There are increasing cases in supervision and aftercare but the numbers of officers have not increased proportionately.

Generally, the extensive and multiple roles assumed by the officers affect the quantity and quality of services. Client management is intermittently interrupted when other demands on the office's time crop up; for instance, handling of cases following intensified police raids or organising some prevention campaigns, and so on. The officers have to temporarily set aside their tasks of delivering the aftercare programme.

The system of administering the aftercare programme cannot be implemented according to schedule. The officer may have planned sessions with a client but they are not strictly adhered to or followed through. There is too much concern with getting on with routines and lack emphasis on content and rationale behind the activities.

Although guidelines are given and there are standard forms for recording, "visits to the rehabilitation offices revealed great variations"[1]. Some officers are more organised in case management of clients while others do not even use the provided forms; they cite too much paperwork as an excuse. Some of the guidelines, however, lack clarity as they only spell out tasks and activities but fail to provide the rationale for these activities.

Record keeping is no longer an assessment and information tool. It is more of a burden to the officers, taking up time, yet hardly of use to their work. An officer has no way of knowing a client's progress without having easy access to the records. In some cases, client records are poorly maintained.[2] Even if records were properly maintained, no effort is put into summarising these records to monitor clients' progress and evaluate officers' handling of cases.

5.2.1 Management of Aftercare in Relation to Supervision

Although the guidelines state that activities pertaining to supervision and aftercare are similar, only 13.6% of officers were sure of that (Table 5.1). Some of them commented that they prefer to concentrate on aftercare cases, the clients coming out from the rehabilitation centres need more support. There was no general consensus that either supervision or aftercare cases were easier to manage.

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1. Chiang PH. A Case Study on the Aftercare Programme, NDRC, USM, Penang, 1990. (Unpublished Report).

2. ibid.

TABLE 5.1

Officers' Opinions on Differences Between Supervision and Aftercare Programme

	%	n
Yes, many differences	6.2	(5)
Yes, some	35.8	(29)
Only a few	44.4	(36)
Not at all	13.6	(11)

(Missing = 5)

5.2.2 Relationships with Other Agencies

The officers have to work closely with other agencies and institutions involved in prevention, treatment and rehabilitation efforts. The extent and nature of these working relationships can affect their work achievement.

Officers were asked to relate their experience in working with other agencies; Table 5.2 gives a breakdown of officers' opinions on this point. Overall, there is a need to review these relationships so as to not overburden the officers.

TABLE 5.2

Problems Encountered Working with Other Agencies

	%	n
Yes, many problems	9.8	(8)
Yes, some	24.4	(20)
Only a few	45.1	(37)
Not at all	20.7	(17)

(Missing = 2)

This particular question drew a substantial number of comments from the respondents. Most had problems with police authorities and had faced delays in getting urine test results from the hospitals. The processing of police cases has to be done as soon as the officers are notified and thus other work has to be temporarily suspended. However, instead of the two week remand period provided for in the Act, some officers are given last minute notice to process admission cases. Other times, due to the delay in receiving urine test results, all necessary documents to admit the client which had been prepared were discarded because the result turned out to be negative.

Sometimes, the delays in getting urine test results from the hospital can be as long as three to four weeks. The officers cannot take immediate action and consequently cannot follow through a case even if the urine test is positive. There have been cases whereby dates set for court hearings were incorrect, and the officers were sent on a wild goose chase. The officer also have to liaise with the rehabilitation centres to check for availability of place for the client.

Overall, there needs to be greater coordination and cooperation between these agencies to facilitate the officer's job performance and achievement.

5.3 Emphasis on Aftercare Activities

Table 5.3 summarises the emphasis of officers on the key components of aftercare activities. There is more emphasis on counselling activities, and to a lesser extent home visits and community activities.

TABLE 5.3

Emphasis on Aftercare Activities

	A great deal %	n	A certain level %	n	A little %	n	Not at all %	n	Missing
Counselling	33.3	(27)	51.9	(42)	12.3	(10)	2.5	(2)	5
Home Visits	23.2	(19)	54.9	(45)	19.5	(16)	2.4	(2)	4
Community Activity	6.7	(5)	22.7	(17)	38.7	(29)	32.0	(24)	11

Each component of the aftercare activities will be discussed in detail below.

5.3.1 Counselling

The frequency of counselling sessions for each new client is scheduled in the quidelines, i.e. weekly, the first 3 months, fortnightly the next 9 months and monthly in the second year. This is rarely adhered to and it depends on the officer and his work commitments, his clients and other circumstances. Some officers only monitor their clients after a three month absence.

Although counselling is the most emphasised activity in aftercare, it can be noted from Table 5.3 that at least 15% of respondents reported paying little or no emphasis to counselling activities.

Most counselling sessions are of a short duration. About 26% of respondents reported sessions of 25 minutes and less, with 36% between 26 and 39 minutes. These findings were in line with the earlier preliminary study on aftercare programme.[3] About 64% held group counselling sessions for an hour or less.

TABLE 5.4

Duration of Individual Counselling Sessions

	%	n
< 26 minutes	266.2	22
26 - 39 minutes	35.7	30
> 39 minutes	38.1	32

Missing = 12

Counselling sessions have been observed to be rather superficial as typified by a counselling session recorded during the case study.

Counsellor:	How are you?
Client:	Fine
Counsellor:	Do you have any problems?
Client:	No problem
Counsellor:	How is your family? Any problem getting along with them?
Client:	No problem. Family is fine

3. Navaratnam V, Foong K, Kulalmoli S. An Evaluation Study of the Drug Treatment and Rehabilitation Programme At A Drug Treatment Centre. Research Report Series No. 27. The Centre for Drug Research, Universiti Sains Malaysia, Pulau Pinang, 1992.

Some counselling sessions are mere conversations lacking indepth probing by the officer. A majority of clients are admitted involuntarily and view the tasks of meeting the officer as an order. Their intentions for coming to the counselling sessions is to fulfil the conditions of the aftercare programme rather than to talk about themselves and to be helped. The officers, hampered by conflicting demands and time constraints, tend to put less effort and time in direct interaction with clients.

The objective of counselling is really to work with the client to overcome specific problems which they face so as to equip them with appropriate coping skills. This could be due to the high expectations on outcome goals placed on the officers whereas in reality many lack the professionalism needed to handle their clients.

A closer examination of the staff profiles in relation to their level of skills and years of service highlighted several shortcomings.

As seen from Table 5.5, only 7% of respondents felt very confident and competent to deal with their clients. At least 31% felt they had little expertise to counsel their clients.

TABLE 5.5

Level of Counselling Expertise

	<4 years	4-6 years	7-9 years	>9 years	All
	% (n)	% (n)	% (n)	% (n)	% (n)
More than sufficient	5.6 (1)	6.7 (1)	8.9 (4)	0.0 (0)	7.1 (6)
At a certain level	50.0 (9)	60.0 (9)	68.9 (31)	57.1 (4)	62.3 (53)
A little	44.4 (8)	33.3 (5)	22.2 (10)	42.9 (3)	30.6 (26)
Not at all	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0 (0)

(Missing = 1)

TABLE 5.6

More Training Needed to Handle Clients Better

	<4 years	4-6 years	7-9 years	>9 years	All
	% (n)	% (n)	% (n)	% (n)	% (n)
Yes, a great deal	61.1 (11)	46.7 (7)	44.4 (20)	42.9 (3)	48.2 (41)
To a certain extent	33.3 (6)	33.3 (5)	44.4 (20)	57.1 (4)	41.2 (35)
A little	5.6 (1)	20.0 (3)	11.1 (5)	0.0 (0)	10.6 (9)

(Missing = 1)

A number of long term service staff (10 and more years) seems to have had less exposure to training in counselling. None of them had more than four times training compared to 13% of the 4-6 years and 18% in the 7-9 years category (See Table 5.7)

TABLE 5.7

No. of Training Courses in Counselling Undertaken

	<4 years	4-6 years	7-9 years	>9 years
	% (n)	% (n)	% (n)	% (n)
< 3 times	82.3 (14)	33.3 (5)	20.0 (9)	28.6 (2)
3 - 4 times	17.7 (3)	53.3 (8)	62.3 (28)	71.4 (5)
> 4 times	0.0 (0)	13.3 (2)	17.8 (3)	0.0 (0)

(Missing = 7)

Some expressed reservations on the quality of training sessions over quantity. The quality of training in counselling was considered to be average.[4]

Some of the problems encountered in counselling were related to untrustworthy/ unresponsive clients, lack of privacy, lack of expertise and skills, case overload and lack of family/community cooperation. Many clients are reluctant to be followed up and they sometimes miss sessions with the officers. Because of their inconsistent behaviour and attitudes, the officers are wary and tend not to trust them.

5.3.2 Home Visits

Home visits are mostly done on monthly basis. Some officers will visit a client more often when there is a crisis i.e. the family is facing some problems with the client and needs help. Others only follow-up with their clients after an absence period of three months.

In the survey 59% of respondents managed to do up to five home visits, 23% six to ten visits and 18% more than 10 visits in the past week.

TABLE 5.9

Home Visits Done In Past Week

	%		n	
< 2	23.2	> 58.6	19	> 48
3 - 5	35.4		29	
6 - 10	23.2		19	
> 10	18.3		15	

(Missing = 4)

4. Chiiang PH. A Case Study on the Aftercare Programme, National Drug Research Centre, USM, Penang, 1990. (Unpublished Report).

Most officers (See Table 5.3) agree that home visits are important as they provide an opportunity to work directly with the family members. They are aware that the family is an important factor that can contribute to the successful rehabilitation of the client. Some of the clients' families are very supportive and cooperative and even encourage the officers to frequent their homes whilst others are very uncooperative. Compared with the amount of emphasis placed on other components of aftercare activities (see Table 5.3), 23% paid a great deal of attention to home visits after counselling activities.

Officers can only claim up to a maximum of $100 per month as transport allowance for home visits and travelling expenses. Consequently, this discourage the officers from conducting more home visits even if they have the time.

5.3.3 Urine Testing

Here again, officers use their discretion in determining if a urine test needs to be done. In the initial stages of the programme, urine tests are to be carried out more frequently; they are gradually decreased over a period of time but this schedule varies from officer to officer. A respondent raised the issue that being a female hampers effective monitoring of a client during collection of urine sample.

Pre-scheduled urine testing has a limited use when clients are aware of being tested. As urine testing can only identify users who have consumed drugs within the last 24-hours, spot checks are necessary to counter-check drug-free status of clients. From Table 5.10, it can be noted that only 34% of the respondents conduct spot checks on their clients. As mentioned earlier, action can be taken against a client if his/her urine is found to be positive but some officers just 'close an eye' especially towards elderly clients and those who do not cause trouble. One of the officers remarked, 'as long as they do not give trouble to society and their family, just let them be' (paraphrase). Some officers see further action as burdens that will only be a waste of resources.[5]

5. ibid.

TABLE 5.10

Spot Check Urine Testing on Clients

	%	n
Yes, often	33.7	29
Yes, sometimes	48.8	42
Yes, rarely	14.0	12
Not at all	3.5	3

Majority of the officers (93.0%) have to send the urine samples to general hospitals or district hospitals for urinalysis and some have to collect the results. Some also face delay of up to 3 - 4 weeks in getting the results; this affects the officers' follow-up with a client.

TABLE 5.11

Required to Send Urine Samples to Hospital/Office For Testing

	%	n
Yes	93.0	80
No	7.0	6

About 43% experienced problems getting the urine samples (Table 5.12). Insufficient bottles are a common problem, some had difficulties with clients and lack amenities like a fridge to store the samples. Sometimes the local hospitals where they send samples to, lack testing facilities and they have to go to a bigger town hospital to get the samples analysed.

TABLE 5.12

Problems Getting Urine Samples

	%	n
Yes	43.0	37
No	57.0	49

5.3.4 Job Placement

Clients who face difficulties in getting employment may seek the help of officers. The officers do not recommend clients to specific jobs but advise or encourage them to seek jobs whenever they know of vacancies. The officers believe that getting employment is not really a big problem provided the clients are willing and are not choosy. Officers should liaise with employers to involve them in the aftercare programme but this is hardly done. This is one inherent weakness in delivery and needs to be re-emphasised as relapse is also related to the inability of client to secure a job.

5.3.5 Work with the Community

To a certain extent, the officers have to take the initiative to organise community activities to involve their clients and foster interaction with the community. This however, is not frequently done. Only 7%, of respondents (See Table 5.3) paid a great deal of attention to community activities, involving clients with the community through some activity or service.

Part of the key to successful rehabilitation of the client is the acceptance of the community at large, yet the officers are unable to do more in this area. Some of the officers felt that there needs to be more awareness in the community because many do not accept the ex-addicts and there is a sense of hostility against them. The lack of positive encouragement from this group is likely to steer the ex-addicts towards their old friends and old habits.

5.3.6 Other Related Work

When clients do not turn up for a period of time (for e.g. four months) an officer is required to take action against them. Some officers do not resort to any action as this requires additional time and effort. The officer can report to the police if clients are found with drugs, and they can be incarcerated for a duration of six months to three years. The ex-addicts have to continue the aftercare programme following discharge if they have not completed it. A small number of these cases that cannot be traced is considered as abscondment.

5.4 Staff Relationship with Clients

The attitudes and personality of an officer can affect his/her relationship with a client. Clients are more open and cooperative with officers who are friendly and who take an interest in them. An officer has to work at building a relationship with his/her client and that takes time and effort.

Some officers express a lack of trust in the clients, and find the clients resistant. The client's inconsistent attitudes and behaviour frustrates the officers' efforts to help them. Sometimes the clients are unresponsive and this could be due to their unwillingness to go through the programme and the stigmatisation from the people in the community.

Often the officer is caught in a role-conflict. Part of this conflict also contributes to the client's attitude of uncertainty towards the officer. The client will not open up freely and report they are on drugs and need help for fear that he/she will be reported by the officer. The officers themselves are caught in this double-bind of having to act out the role of a counsellor as being caring and understanding, and that of a disciplinarian, strict and uncompromising.

Table 5.13 summarised the extent of role conflicts experienced by the officers. The foremost role-conflict was the roled disciplinarian versus counsellor.

TABLE 5.13

Officers' Experience of Role-Conflicts

	%	n
Not at all	21.3	16
A little	6.7	5
Yes, to a certain extent	42.7	32
Yes, a great deal	29.3	22

(Missing = 11)

The frustrations caused by heavy workload and low morale may be a root cause of some officers' indifferent attitude towards their work and clients. They are forced to adopt a discriminatory practice of giving more time to those whom they feel are more genuine and responsive. It is not effective to concentrate on all clients assigned to them, since some don't want to be helped and there are limited resources.

6. USE OF COMMUNITY RESOURCES

6.1 Introduction

In many social settings, volunteers are contributing their skill, energy and time to reinforce the work of professionals. The mounting drug-related problems cannot remain a government concern alone but requires a multi-prong input from the private sector, non-governmental agencies, the community and individuals.

The role of the volunteer is no longer just to fill time but includes activities requiring greater skills and accountability on the part of the volunteer. With respect to the drug treatment and rehabilitation programmes, some of the main areas of involvement include counselling, drug education and prevention activities nation-wide, and residential programmes.

6.2 Profiles of Volunteers

PEMADAM's (Society for the Prevention of Drug Abuse in Malaysia) involvement in drug abuse prevention and rehabilitation efforts goes back to 1976 when it was established to assist government agencies and like-minded groups to tackle the dadah (narcotic drug) problem.[1]

Since then there has been a series of changes to the roles that PEMADAM assumed, and of late they have been given the responsibility of assisting in aftercare services, prevention and information/education activities.

Since 1981 there are [illegible] over 2,858 PEMADAM volunteers from all levels of society. The issue of the effectiveness of PEMADAM volunteers was raised and some reasons offered for their ineffectiveness:-

i. The training sessions do not equip the volunteers for what is expected from them.

ii. Some of the volunteers are not interested in counselling.

1. Anti-Dadah Task Force. Narcotics Report 1990. Report of Anti-Dadah Task Force.

iii. Those who have been trained are much involved in other activities.

iv. There is no initiating agency to encourage the volunteer to be active in counselling services.

v. Volunteers are not clear on PEMADAM's role and what is expected of them.[2]

The Drug Rehabilitation Committee was established as a legislative requirement with the objective of supporting recovering addicts undergoing supervision or aftercare programmes. This move springs from the opinion that drug addiction problems have their roots in society. The society, therefore, needs to play a positive role to assist recovering addicts' welfare and reintegration into the community. There are approximately 83 Drug Rehabilitation Committees established since 1987 in 'sensitive areas' (high incidence of drug problems and related criminality). The committee members are prominent members of the local community and also involve the rehabilitation officers. The function of the Committee is to supplement PEMADAM's role.[3] Until till end of 1990, a total of 130 committees has been established in 'high-risk' localities throughout the country.

The third main group of volunteers are individuals who offer their services to the rehabilitation offices.

Currently, most of the volunteers are involved in counselling the ex-addicts in the various drug treatment and rehabilitation programmes. PEMADAM volunteers are given three different levels of training in counselling. The level of skills that individuals offer is variable and they do not receive any specialized training in counselling.

To overcome deficiency in volunteers' knowledge and skills, a training programme has been launched both in drug abuse prevention and aftercare. The objectives of the training are:- (1) upgrade knowledge and awareness on

2. ibid.

3. Osman MS. Strategi 5 Tahun PEMADAM. Kertas Kerja Program Rawatan dan Pemulihan Dadah: Satu Pendekatan Baru Mengenai Peranan PEMADAM (Pemadam's 5 Year Strategy). Working Paper of the Drug Treatment and Rehabilitation Programme: A New Approach for the Role of Pemadam). 5 September 1987.

the dangers and threat of drug abuse to self, family and society as a whole, (2) upgrade and provide skills by providing knowledge on primary and secondary prevention strategies, and (3) provide management skills towards better drug abuse prevention efforts.[4]

6.3 Current Patterns of Volunteer Utilization

Table 6.1 gives the level of volunteer involvement in counselling ex-addicts. 43% of the officers reported the involvement of PEMADAM members in counselling activities, 52% specified members of the Drug Rehabilitation Committee and only 20% stated involvement of individuals.

TABLE 6.1

Volunteers Involved in Counselling of Ex-Addicts Reported by the Officers

	Yes		No	
	%	(n)	%	(n)
PEMADAM Members	43.2	(35)	56.8	(46)
Drug Rehabilitation Committee Members	51.5	(66)	18.5	(15)
Individuals	19.8	(16)	80.2	(65)

(Missing = 5)

On closer examination on the level of effectiveness of each group of volunteers, Table 6.2 tabulates the ratings of effectiveness by the officers. The contributions to the programme are as follows: 17% of the officers considered PEMADAM members to be very effective, 23% indicated the Drug Rehabilitation Committee members, and 13% the individuals.

4. See Chapter 6 Ref.. 1

TABLE 6.2

Officers' Opinions on Effectiveness of Volunteers' Involvement

	A Great deal	To a certain extent	A little	Not at all
	% (n)	% (n)	% (n)	% (n)
PEMADAM members (Missing = 51)	17.14 (6)	25.71 (9)	42.8 (15)	14.29 (5)
Drug Committee Members (Missing = 20)	22.73 (15)	33.33 (22)	40.91 (27)	3.03 (2)
Individuals (Missing = 70)	12.50 (2)	25.00 (4)	50.00 (8)	12.5 (2)

TABLE 6.3

Officers' Opinions on Other Roles of Volunteers

	%	n
Socio-Economic activities	60.3	41
Reintegration activities	38.2	26
Assistance in aftercare	17.4	12
Informants	10.1	7
Religious Activities	8.7	6
Preventive Activities	5.8	4

(Missing = 18)

The officers' were asked on the future roles in which volunteers could assume apart from counselling. A summary of the major roles identified by the officers are presented in Table 6.3.

Many officers tend to agree that volunteers could play a major role in helping the recovering addicts in socio-economic activities. These include helping the recovering addicts secure employment, overcome any difficulties in that area and initiate viable economic projects.

The second key area was reintegration activities: initiating more social activities to bridge the gap between recovering addicts and the community/family and fostering clients. This, in their opinion, could contribute greatly towards the client's self esteem and confidence as many are not accepted by the community, not even by their own families. Some of the other roles suggested were assisting in administering aftercare, acting as informants, religious instructors to clients, and engaging in preventive activities.

The objectives of the aftercare programme pertaining to reintegration of ex-addicts, to a large extent, are to be assumed by non-government agencies and volunteers. Although there are written guidelines, in reality there is no agency to coordinate efforts between the various groups. Again the rehabilitation officers are expected to play a major role in liaising and linking with external groups and agencies.

There are also no guidelines on the utilization and monitoring of volunteers, particularly with regards to involvement in counselling activities. Volunteers' involvement and their level of skills and expertise needs to be ascertained before they are co-opted into programmes to ensure their input to the programme is beneficial. The evaluation of services of volunteers needs to be undertaken to determine the impact of such services on overall treatment and rehabilitation programmes. Although volunteers' involvement is critical where there are limited resources, there should be some principles to monitor their input.

6.4 Involvement of Ex-Addicts

There is a growing trend within drug treatment and rehabilitation programmes of staff recruited from people who have recovered from drug dependency. "The advantage of this labour pool is that it is readily available, it appears to be effective, the individuals have an immediate rapport with the clients, they tend to be street wise and less gullible, and they constitute a relatively inexpensive labour source."[5]

The results indicate a positive affirmation of the role of ex-addicts in drug programmes and services. Table 6.4 lists the various roles identified by the officers. It is important to realise that ex-addicts are good examples to the clients and form a positive peer pressure group. Some officers expressed that ex-addicts are better equipped to deal with clients and are more insightful to the needs and problems faced by them and will be in a better position to offer advice and counsel. Since the ex-addicts have more in common with the clients, and are more familiar with the problems and setbacks of the recovery phase, the officers felt they were far more effective in dealing with the clients and sharing information and tips to overcome their difficulties. Ex-addicts also have a better acceptance from the clients.

TABLE 6.4

Officers' Opinions on Roles for Involvement of Ex-Addicts

	%	n
Providing assistance in aftercare, etc.	64.7	44
Preventive activities	27.9	19
Social activities	26.5	18
Informants	2.8	6
Socio-Economic Activities	5.9	4

(Missing = 18)

5. Gilbert N, Specht H. Handbook of the Social Services, Prentice Hall Inc., Englewood Cliffs NJ, 1981.

Some officers asserted that ex-addicts could also assist in the day to day running of the rehabilitation offices and some monetary incentives need to be given to encourage their involvement and participation. This will also build-up the ex-addicts confidence and provide them with some sense of security as some of them had difficulties getting employment.

Although the general consensus for involvement of ex-addicts was very positive, there were also reservations on the sustainability of such a programme. Some are of the opinion that ex-addicts could not be trusted and there were a lot of risks involved. Only 10% (n = 8) of the officers were confident that the ex-addicts involvement would be highly effective (Refer to Table 6.5).

TABLE 6.5

Effectiveness of Involvement of Addicts

	%	n
Yes, very effective	10.0	8
Yes, to a certain extent	63.8	51
A little	23.8	19
Not at all	1.3	1

(Missing = 7)

However, in view of current successes reported overseas on the effectiveness of self-help groups in relation to various treatment modalities, the plan to incorporate ex-addicts in treatment and rehabilitation programmes needs to be reviewed and formulated.

"The newly detoxified or treated person feels like a new immigrant in a strange environment where s(he) has to struggle against all kinds of temptation and pressure for him/her to slide back to drug use. If the individual is associated with a new reference group which can provide timely intervention and support, (s)he can recover from relapse episodes rather promptly without returning to a deviant life style or a sub-culture of addiction and crimes."[6]

Parallel support to all forms of treatment holds significant potential. Residential treatment clients live in an artificial environment that provides for all their needs. This institutionalisation can result in individuals losing touch with the demands of independent living. Participation in an off-site self-help group could be a useful approach to resolving this problem, because clients could interact with persons who are living in and coping with society, This could also prepare clients for re-entry by allowing them to establish a social network apart from the institutional setting.[7]

Self-help groups serve as a highly effective form of aftercare for persons leaving treatment programmes. Members have coping techniques that help reinforce a clean lifestyle and often help each other through times of crisis. In addition, self-help groups can reduce both the incidence and severity of relapse.

Community-based rehabilitation with a supportive network of ex-addicts will contribute greatly to recovering addicts' prognosis. Recovering addicts acquire a distinct sub-culture with its special needs and problems. Ex-addicts who have fully recovered can play a key role to motivate and encourage them. The ex-addicts' message to the recovering addict will be one of hope and assurance of recovery.

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6. Zackon F, McAuliffe WE, Ch'ien JMN. Addict Aftercare: Recovery Training and Self Help, National Institute of Drug Abuse, DHHS, 1985.

7. National Institute of Drug Abuse. Non residential Self-Help Organizations and the Drug Abuse Problem: An Exploratory Conference. NIDA Research Report Series, 1978.

7. ISSUES ARISING FROM THE IMPLEMENTATION OF THE AFTERCARE PROGRAMME

7.1 Effectiveness of the Aftercare Programme

The goals of the aftercare programme is to ensure that clients are independently functioning in their family and society without having to resort to drugs. In a previous study, the findings suggested that there is an association between completion of aftercare programme and drug-free status of subjects[1]. (See Figure 1 of Chapter 1 for further details).

It is important that the officers are able to monitor and check a client's progress to evaluate current therapeutic effort and also if necessary to redirect the effort.

Table 7.1 and 7.2 indicates the officers' responses to how well they monitor their clients and whether they are able to determine if their clients could readjust to society after a 6 months period in the aftercare programme.

TABLE 7.1

Monitoring Clients' Progress

	%	n
Extremely satisfactory	1.2	1
Satisfactory	32.9	27
Not very satisfactory	58.5	48
Not at all satisfactory	7.3	7

Missing = 3

1. Navaratnam V, Foong K, Kulalmoli S. An Evaluation Study of the Drug Treatment and Rehabilitation Programme At A Drug Treatment Centre. Research Report Series No. 27. The Centre for Drug Research, Universiti Sains Malaysia, Pulau Pinang, 1992.

TABLE 7.2

Possibility of Clients Adapting to Society after six months

	%	n
Yes, more or less all cases	8.4	7
Yes, just a few cases	66.3	55
Not at all or a few cases only	25.3	21

(Missing = 3)

The level of client monitoring and tracking is generally poor (Table 7.1), with 66% reporting dissatisfaction at their efforts. The range of criteria used as a means of monitoring their clients were more reflective of client's attitudes and behaviour. Most relied on individual assessment and there was little evidence of a structured reporting scheme whereby officers could monitor progress of all their cases.

About 8% are confident that most of their clients would adapt to society after a period of six months and 66% could do so for just a few cases (Refer to Table 7.2).

Officers were also asked to determine the effectiveness of the Aftercare Programme. The results are as follows (See Table 7.3).

TABLE 7.3

Opinions on Effectiveness of Aftercare Programme

	%	n
Don't know/Not sure	12.0	10
Not at all effective	1.2	1
Not very effective	37.3	31
A little effective	41.0	34
Very effective	8.4	7

(Missing = 3)

At least half of the respondents expressed doubts on the effectiveness of the programme. On the other end, 8% of respondents felt that the programme was very effective. Part of the uncertainties reflected by the officers can be attributed to the fact that they are unable to monitor client's progress (i.e. achieving expected outcome goals etc). Other reasons could be the officers' ambiguities of expectations in the goals and objectives of the aftercare programme. This in turn can be linked to a lack of clarity in procedures and lack of skills and knowledge to put the therapeutic process in practice. The criteria for measuring effectiveness were not precise. Very few of the responses were in accordance to results/outcomes of programmes.

Some officers relied significantly on frequency of clients' attendance in various activities as an indicator. Other responses bordered on vagueness and were not related at all to outcome measures. Some of the more accurate responses were reiteration of overall goals and objectives of the rehabilitation programmes namely (i) free from drugs, (ii) accepted by family and community, (iii) not involved in crime (iv) productive and responsible member of society. There were a few who did not offer any explanation why they felt the programme was effective.

The objectives of the aftercare programme are broad and ambiguous. Officers are uncertain of measures to validate their clients' progress and go by quantifiable measures for e.g. frequency of reporting and involvement in activities.

We tried to identify factors that could be correlated to perception of effectiveness of programme but there was not much variations due to the small sample size. One significant variable was related to the officers' ability to monitor client's progress. Those who were able to monitor and check clients' progress better, rated the programme to be more effective. This in turn can be linked to officers' knowledge base and skills in relation to the therapeutic process and outcome goals.

With regards to the duration of the aftercare programme, most (84%) agreed that the duration was adequate to provide the service.

7.2 Problems Encountered in the Delivery of the Aftercare Programme

The Aftercare Programme serves to ensure that ex-addicts continue to maintain a drug free lifestyle following discharge from the rehabilitation centres. As discussed in Chapters 3 to 5, there are deviations in work practices and these may be the result of operational problems encountered by the officers carrying out their tasks. Table 7.4 highlights the major problems encountered by the officers in their work.

TABLE 7.4

Problems Encountered in Delivery of Aftercare

		Yes % (n)	No % (n)
1.	Heavy Workload	85.4 (70)	14.6 (12)
2.	Clients' Unresponsive Attitudes	84.1 (69)	15.9 (13)
3.	Lack of Amenities	75.6 (62)	24.4 (20)
4.	Lack of Counselling Skills	67.9 (55)	29.6 (24)
5.	Perceived Role Conflicts	62.2 (51)	36.6 (30)
6.	Time Constraints	48.8 (40)	50.0 (41)

7.2.1 Heavy Workload

At least 85% of the respondents identified heavy workload as a major problem. They are also in charge of admission, supervision and miscellaneous prevention and rehabilitation activities and the day to day running of the office. Administrative work occupies a bulk of their work. On top of that they have caseloads

that well exceed manageable levels. Though there are guidelines to follow, actual work practices show a great variation. For instance a new client is to meet the officer weekly for first 3 months but this is not carried out due to constraints mentioned above. Sometimes even clients who dropped out are not traced immediately.

There is also a need to take into account home visits, community work, extension hours service, sub-centres, servicing more than one area and lots of administrative meetings and protocol.

7.2.2 Clients' Unresponsive Attitudes

Most of the clients have been admitted to the treatment centres involuntarily, thus many are not the least motivated to change their ways. Officers find it hard to work with clients, especially with repeated offenders and there is a general sense of frustration on the officers' part. They often find that clients are untrustworthy.

7.2.3 Lack of Amenities

The lack of private office space and privacy is demoralizing and creates a burden for the officer to work with clients. Where interviews take place at a police lock-up the client is made to feel very insignificant and stigmatized and this affects the relationship of the officer and client.

Insufficient facilities also hamper smooth delivery of services. It is very difficult to offer services when there are no back-up facilities. Some offices are not equipped with phones, necessary stationery and equipment (e.g. clean urine bottles) for them to carry out their tasks. They also lack financial resources for organising activities.

7.2.4 Lack of Counselling Skills

Many feel inadequate in the role of counselling clients and achieving outcome goals specified in the therapeutic relationship. Although all have some basic training, the skills training is lacking. There are also language

barriers between officer and client which need to be overcome. Counselling of clients with drug dependency problems is no mean task, the officers need to equip themselves before they can take on the clients and their problems effectively.

7.2.5 Perceived Role-Conflicts

The most common area of role-conflict for the officer was the dual role of being a disciplinarian and counsellor. As a disciplinarian, the officer has to act 'tough' with the client and ensure that he is not on drugs otherwise he will need to take action against him. On the other hand, being a counsellor means having to build a trusting relationship with the client, providing care and understanding. Assuming such conflicting roles affects the quality of the working relationship and causes his client to mistrust him. This duality creates a great deal of conflict for the officer and he may not able to carry out his tasks effectively.

7.2.6 Time Constraints

Too many role expectations of the officer can lead to a failure in job performance and effective interventions. Apart from juggling tasks and activities day to day, the officer has to respond to other urgent tasks that need his attention, for instance admission of cases following police raids. Too much time is spent on administrative work and this is not taking into account administrative meetings and travelling time to do home visits, attend to court cases, and so on.

7.3 Critical Success Factors in Programme Implementation

In the implementation of any programme, there are critical factors which are important in ensuring the success of the programme. Rehabilitation officers were requested to identify factors which they perceive as crucial to the success of the aftercare programme. (See Table 7.5A). According to the officers' assessment, factors related to family and community involvement are comparatively more important. This is in line with extensive empirical findings that social support following relapse and recovery is an important factor. The family's acceptance of, and support provided to, the recovering addicts is the first step towards readjustment. Family relationships are generally strained and tense because of the ex-drug dependant's past history. He is likely to return to old friends if the family continues to shun him. The community also has a significant role in helping the recovering addict in terms of providing job opportunities and developing positive social climate/ relationships that would replace old associations thus facilitating the recovery and readjustment process.

The next group of factors which are considered to be also important are related to aspects of case management, namely, counseling skills, type of clients and caseload. Other programme factors such as programme administration, physical facilities and duration of supervision are relatively less critical for the programme's success as perceived by the officers.

In general, the above ranking of the critical factors are almost the same for all the subgroups of officers (See Table 7.5 B to 7.5 D). There are some variations. In particular, officers in small towns do find the administration of the office to be somewhat more important than their counterparts in bigger towns.

There needs to be a greater emphasis on working with the recovering addicts' families and active involvement of the community. In general the first two factors have to a large extent been neglected due to work overload and time constraints, and where possible, the input and involvement of other agencies and non-governmental organisations will need to be co-opted.

More effective case management, in particular the counselling aspect, has to be stressed. There are many conflicting agendas on rehabilitation officers' efforts but the role of direct work (ie. counselling) with clients should not take a back seat to other matters especially administrative tasks. Outcome goals and expectations in the therapeutic process need to be correlated to inputs to enhance delivery and consequently its effectiveness.

TABLE 7.5

Critical Success Factors

	Family's Acceptance	Community Involvement	Counseling	Client Type	Case Load	Admin/ Manage	Physical Facilities	Duration	Missing	
	%	%	%	%	%	%	%	%		(n)
A. Total (N = 83)	60.2	54.2	50.6	44.6	39.8	38.6	32.5	9.6	3	
B. Location										
Big Town (N = 40)	65.0* (26)	60.0* (24)	52.5 (21)	42.5 (17)	42.5 (17)	27.5* (11)	35.0 (14)	12.5 (5)		
Small Town (N = 38)	52.6 (20)	50.0 (19)	50.0 (19)	47.4 (18)	39.5 (15)	47.4 (18)	31.6 (12)	5.3 (2)		
Unknown (N = 5)									3	

TABLE 7.5 (Cont.)

	Family's Acceptance	Community Involvement	Counseling	Client Type	Case Load	Admin/ Manage	Physical Facilities	Duration	Missing
	%	%	%	%	%	%	%	%	(n)
C. Caseload									
< 120 cases (N = 47)	59.6 (28)	55.3 (26)	55.3 (26)	38.3* (18)	40.4 (19)	34.0* (16)	40.4* (19)	12.8 (6)	7
> 121 cases (N = 32)	68.8 (22)	50.0 (16)	50.0 (16)	53.1 (17)	37.5 (12)	43.8 (14)	18.8 (6)	6.3 (2)	
D. Duration of Service									
< 6 years (N = 33)	69.7* (33)	54.6 (18)	45.5 (15)	36.4* (12)	33.3* (11)	30.3* (10)	30.3* (10)	12.1 (4)	3
> 6 years (N = 50)	54.0 (50)	54.0 (27)	54.0 (27)	50.0 (25)	44.0 (22)	44.0 (22)	34.0 (17)	8.0 (4)	

7.4 Suggestions by Officers to Improve Aftercare Programme

1. It was strongly felt that there needs to be a clearer demarcation of roles and functions of the officers involved in the various areas of rehabilitation work and to create separate divisions for managing the programme.

2. There is also a need to increase the number of officers as well as support staff to strengthen programme input and offset the current heavy workload.

3. Some felt that current legislation needs to be improved and enforced so that clients will follow through the aftercare programme.

4. Competence in counselling was strongly advocated and officers suggested improvements in contents of counselling training sessions.

5. An overall improvement in facilities, amenities and resources is essential. Funds allocation needs to be increased so that more activities and projects can be initiated for clients.

6. There needs to be more involvement from and acceptance by the local community. Job placement opportunities and provision of capital need to be increased. A structure similar to sheltered workshops for the disabled need to be created as income generating opportunities for the clients.

7. A greater level of cooperation and coordination between agencies to facilitate the above, exchange of information, quick action and enforcement of relapse cases and on overall rehabilitation efforts.

8. DISCUSSIONS AND CONCLUSIONS

8.1 Introduction

Completion of the Aftercare Programme can provide recovering addicts a road to recovery provided the programme is implemented as planned. However, the results from the survey point to severe weaknesses in the delivery of the aftercare system. It is essential that these weaknesses be corrected so that resources directed into the programme will fully benefit the clients and be cost-effective.

8.2 Approach

The original programme proposed case work approach in which stresses are placed on individualised attention and counselling to promote client's independence and readjustment. This is actually hampered by organisational and administrative constraints. In view of increasing supervision and aftercare cases, the number of officers involved in the therapeutic effort is dismally small. A ratio of 23 - 25 cases per officer has been recognised as ideal for case management; anything beyond that will affect staff's effective performance. Currently, various work functions and many conflicting agendas impede officers from carrying out the programmes effectively.

There does not appear to be enough consistency and systematic approach in handling aftercare cases as this often conflicts with other demands and priorities on the officer's time.

Any approach to help the recovering addicts individually perhaps needs to be supplemented by a supportive network of ex-addicts. This type of self-help group involves members in giving support to each other and in sharing experience. The group provides support, reinforcement, sanctions, and norms. It extends the power of the individual, provides peer help, and provides mutual feedback. A recovering addict tends so be stigmatised and alienated. However, within the group, he can relate to and find support and help from others who have had similar problems.[1]

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1. National Institute of Drug Abuse. Non Residential Self-Help Organisations and the Drug Abuse Problem: An Exploratory Conference, NIDA Research Report Series, 1978.

8.3 Shortcomings of Interventions in the Programme

The interventions outlined in the programme have not been fully implemented. These shortcomings weaken the effectiveness of the programme considerably by failing to follow-up recovering clients in a systematic manner.

Interventions often fail to take into consideration the client's vulnerability to risk situations. Each day and moment in their lives are filled with threatening and tempting events which can influence them to go back to old norms and habits of addiction. Any amount of exposure to treatment and rehabilitation is no guarantee of success. The recovering client has a fragile self-esteem and is constantly aware he may fail.

The odds are stacked higher when society is unable to accept the recovering addict. Social stigma of drug addiction is an indelible mark and very few have reached a level of self-esteem to stand up to others, to accept themselves and their past, and be open about it. It is tragic that many of their genuine attempts to be accepted are thwarted when people come to know that they are ex-addicts. In that sense, we are still a long way from our objectives. As long as societal attitudes remain negative, the ex-addict's journey to a normal life will remain obstructed and doomed to failure.

We need to re-examine our efforts directed towards the community and even towards agencies working with ex-addicts. With little effort directed at such attitudes, the success of the programme will remain limited.

These problems are not new and have been reiterated again and again at many levels both by administrators and officers.

Counselling activities lack professionalism. Dealing with drug dependency cases is complex and requires a high level of training, experience and effort. Furthermore, counsellors cannot be expected to be effective if they have so many interchangeable roles.

A specialised curriculum with specific reference to the whole recovery process (as well as to avoid lapses) needs to be built up in the training of counsellors. Total abstinence as a goal is an ideal, as research shows that lapses and relapses are part and parcel of the recovery process. It is thus important to equip counsellors to help their clients to anticipate slips and lapses.

Many issues dealing with relapse and recovery remain obscure. Routine activities take precedence while the rationale behind the programme activities remains vague. Thus goal expectations are also ambiguous so that subsequently officers cannot always redirect their clients.

Job placement activities are also a weak element in the list of interventions though its importance cannot be overestimated. Further structural support, perhaps from the community, will be needed to help ex-addicts acquire job skills and find employment opportunities to prove themselves and gain self-esteem in the process.

Community awareness and involvement remains low. A serious problem affecting treatment effectiveness is the social stigma which drug users and ex-addicts bear. Studies into stigma management and methods for changing public and employers' attitudes are needed. Studies are also needed on how to gain community support. Supportive communities can facilitate job placement and social reintegration while encouraging treatment recruitment and cooperation.

The follow-up system is poorly implemented. This insufficient follow-up of client's progress impairs evaluation efforts for improving the therapeutic process.

The guidelines for therapeutic efforts in particular case management need to be clarified and not left to individual interpretation and operation.

8.4 Better Data Management

None of the clients' records are grouped in such a way that they can be easily used for evaluation. It is an uphill task to plough through the files just to retrieve basic information at any one time. Although having better records is time-consuming and involves resources, the overall benefits will increase. The officers will have a better picture of their overall efforts and can periodically review their clients' progress.

8.5 Challenges in Relapse and Recovery

Successful rehabilitation depends not only on programmes but also on personal risk factors, but the one factor shown by extensive research to be the most important is social support following rehabilitation. There is a high risk of failure if a client is not prepared for reintegration with a supportive social network.

Another important question concerns the recovering addict who is fully functioning as a productive and useful member of society but is not totally drug free. What is his status then? Recovering addicts may occasionally have 'slips'. View of a client's slip as a sign of failure has to be re-examined in the context of recovery and relapse issues. It may be necessary to re-examine the present objective "totally drug-free" and come up with more realistic objectives.

Relapse into drug-taking behaviour is a frequent occurrence and is due to a number of factors. Clients may need to be prepared for a lapse. If they become aware of how this may occur, that is in their individual circumstances, the client will be able to repeat previously effective strategies or look at alternatives. The main message from a social worker must be that this lapse is only temporary, emphasize the success[2] and that forward movement is always on the agenda.

Self-help groups are a viable adjunction to the rehabilitation efforts in drug dependency. Ex-addicts can play a positive role in rehabilitation work, this has to be reviewed and implemented at the various treatment and rehabilitation levels.

In recognizing the multifaceted causes of dependence, it is important that a combination of different professionals, including ad hoc consultants, are most appropriately placed to deliver an efficient client service. Specific on the job training for officers and counsellors working with recovering addicts is vital. There has been a growth of knowledge in theory and practice in the last ten years, but there is no mechanism to evaluate and incorporate current approaches into the field.

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The aftercare system is a necessary, even a vital component of treatment and rehabilitative efforts, but many organisational and administrative barriers affect its overall effectiveness. There is a need to restructure the programme to ensure that the interventions are more effective and that goals are better met.

The path of intervention is never easy but continuous monitoring, feedback and redirection of therapeutic efforts will ensure that the impact of aftercare programme will be greater. It is hoped that the weaknesses and deficiencies identified will be addressed gradually and resources will be committed to restructure and strengthen the programme.

8.6 Future Research Direction

There are many experimental models which have been successfully adopted into aftercare. There is enough expertise to draw up an experimental programme, and given adequate resources, to implement it successfully.

It is recommended that future research in aftercare programmes be conducted which are more action-orientated. Resources must be allocated to experiment different ways to carry out aftercare programme in different settings and for different types of recovering addicts. Mere replications of existing offices under the current programme's philosophy is not likely to have high pay off in terms of cost-effectiveness.

Finally, a proper evaluation of the aftercare programme should be conducted in conjunction with an evaluation of the treatment and rehabilitation programme at the same time.

APPENDIX 1

Work Flow At The Rehabilitation Office

AREA	TASKS AND ACTIVITIES
Intake/Admissions	Interview drug dependent in lock-up Social Assessment Report Visit family Prepare documentation and recommendation Accompany drug dependent to court Register drug dependent Check for availability of places at centre (transfer if necessary) Await results of urine testing Send clients for detoxification
Supervision	Similar to Aftercare
Aftercare	Prepare family for client's return Work out treatment plans and goals Counselling - indepth Home visits Urine testing Job placement Community activities Progress reports to Treatment and Rehabilitation Centre Deal with immediate problems of clients (accommodation, etc) Work with family and community Maintaining case records
General	Extension service Sub-centre Focused group ('Tumpuan Gerakan') Administrative and Clerical Work Prevention activities, talks, etc. Liaising with HQ - preparing official monthly statistics and other related matters Raids on Beggars ('Serbuan Pengemis')

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