

CHAPTER 1

INTRODUCTION

1.1 Background and Context

The problem of drug abuse and addiction in Malaysia is seen to be a continuous and never-ending issue. Statistics released by from the officials indicate that this problem appears to be associated with the national social landscape, and a complete solution has yet to be found.

Drug addiction was classified as a chronic relapsing disease by the National Institute of Drug Abuse (NIDA), as its characterized by compulsive drug-seeking and use despite harmful consequences and by long-lasting structural and functional changes in the brain (NIDA, 2011). This classification is acknowledged by most countries in the world, including Malaysia. The classification, however, has various worrying implications which affect not only the social aspect; it also affects all aspects of national interest, such as in the economy, health, workforces and security sectors. Indeed, this phenomenon lead to the declaration of drugs as the Number One enemy of the country, contributing to an increase in healthcare cost, government expenditure, impairment of workforce productivity, and heightened crime index (Wan Shahrazad, Lukman, Roseliza Murni, Arifin, Zainah, Fauziah & Siti Fatihah, 2010; Fauziah & Naresh, 2009; and Mohd Rafidi, 2003).

This situation becomes obviously more difficult when current addiction treatment and rehabilitation efforts produce unsatisfactory outcomes. At present, prevention of drug abuse and its treatment remains the nation's greatest challenge.

Most addicts who had completed the treatment and rehabilitation program in drug

treatment and rehabilitation centers have returned to their old habits, a condition known as having relapsed (Fauziah & Naresh, 2009; Mahmud, Mohd Shuib, Lasimon, Muhamad Dzahid & Rusli, 1999; Mahmood, 1996). According to Sabri (2007), there is evidence of a high number of relapse cases, especially from inmates who have been discharged from drug treatment and rehabilitation centers. At the same time, this also reflects the effectiveness of the treatment program implemented. There is a need to reconsider the goals of treatment programs and treatment approaches in the treatment and rehabilitation centers, to make them more focused and structured (Sabri, 2007). The current situation also calls for a government review of the treatment approaches and to give health workers bigger roles in managing heroin-dependent patients (Abd Halim, 2010).

Current treatment approaches used by the government's Narcotic Addiction Rehabilitation Center (PUSPEN) solely depend on the structured treatment modality that is being practised and applied by the respective centers, a standard treatment for all inmates. These modalities include family therapy (adapted from Daytop's Therapeutic Community), work therapy, psychosocial therapy and spiritual-based therapy (Raminder & Mohamad Hussin, 2002). However, the modality's implementation methods differ according to the classification of the center (such as hard-core, highly motivated and volunteer-based center) or to the inmate's classification (such as adolescents, women and vocational). In terms of implementation, the activities conducted do not take into account the appropriateness of such modalities to the individual's treatment and recovery needs.

In 2010, under the Government Transformation Program (GTP) which was initiated by the Malaysian Premier, the National Anti-drugs Agency (NADA, also known as AADK) took a big step in gearing itself for transformation, especially in the

field of treatment and rehabilitation efforts. In July 2010, NADA launched the first-ever concept of “open-access services” as a new approach to encourage drug addicts to get treatment and rehabilitation from PUSPEN, now known as the Cure and Care 1Malaysia Clinic (AADK, 2010). These clinics practice open-access services and only accept people who volunteer to come forward for drug treatment, a vast contrast to the earlier compulsory detention of people who use drugs (Lewis, 2011). As at 2012, there were five concepts of treatment settings and drug rehabilitations introduced by AADK through the transformation programs, namely Cure and Care 1Malaysia Clinic, Cure and Care Service Centre (CCSC), Cure and Care Rehab Centre (CCRC), Cure and Care Vocational Centre (CCVC), and Caring Community House (CCH) (AADK, 2012). However, there is no guarantee that this approach will enhance treatment effectiveness because it still lacks “individually-focused” treatment. The standardized, structured and action-oriented approach still remains the core element of this concept.

1.2 Drug Treatment and Rehabilitation in Malaysia

The trend of drug treatment and rehabilitation in Malaysia shows a pattern and approach that has been changing since it was first introduced in 1975, especially in the centers run by the government. According to Raminder and Mohamad Hussin (2002) and Scorzelli (2009), the treatment provided by the rehabilitation center is based on the conventional approaches, which among others is characterized by various modalities such as therapy work, family (based on therapeutic community or also known as TC), psychosocial therapy and psychospiritual therapy. Almost all the addicts who had undergone treatment and rehabilitation did so because of the enforcement of the Drug Dependents Act (Treatment and Rehabilitation), 1983.

It began with the popular ‘tough and rugged’ concept, which stresses the application of a military-based discipline (regimented) module to treat and recover drug addicts in the rehabilitation centers (Pusat Serenti). The use of the ‘cold turkey’ method for detoxification (Abdul Rani, 2007), and a multi-disciplinary approach as treatment model (Vicknasingam & Mahmud, 2008) was the core approach used in the late 80s. A number of new modalities were introduced by the government to handle this problem. Among them are Psychosocial Therapy Modality (*Modaliti Terapi Psikososial*), previously known as Integrated Therapy Modality (*Modaliti Terapi Bersepadu*), Family Based Therapy Modality (*Modaliti Terapi Keluarga*), Vocational Therapy (*Modaliti Terapi Kerja*), Self Development Therapy Modality (*Modaliti Terapi Keinsafan Diri*) and Individual Resiliency Therapy Modality (*Modaliti Terapi Waja Insan*).

The implementation of these modalities by the rehabilitation centers is subject to the classification system introduced by NADA, which include categories such as high-propensity, soft and hardcore, vocational, and religious centers. The *Terapi Bersepadu* modality is specially for addicts placed in high-propensity rehabilitation centers which emphasize the implementation of eight major components (modules) of treatment and rehabilitation. These components are the medical treatment and health module, discipline, religious and moral education, guidance and counseling, civic and polity education, sports and recreation, vocational and skill training, and social integration (NADA, 1997). *Terapi Kerja*, *Waja Insan* and *Keinsafan Diri* modalities that are exercised in certain centers as options to *Modaliti Desa Terapi Bersepadu*, still retain these eight components as core modules but give a different emphasis that suits the concept, and this becomes the center’s orientation.

The *Terapi Kerja* or work therapy modality emphasizes vocational and skill training as key components to treat and recover drug addicts (NADA, 1997), while the *Waja Insan* modality stresses the discipline module as the key component (NADA, 1997). The *Keinsafan Diri* modality, on the other hand, gives emphasis to an Islamic religion education module as the key component to treat and recover drug addicts (NADA, 1997). The *Terapi Kekeluargaan* modality is specifically practiced in voluntary rehabilitation centers for drug addicts who come voluntarily to get treatment and rehabilitation. Although still based on a psychosocial approach, this modality stresses three strands as the core of the treatment to bring changes in the addict's life, namely, role model, peer pressure, and group support and family milieu (NADA, 1997).

The government acknowledges that there is a room for medication in the field of drug treatment and rehabilitation in Malaysia. According to Rusdi, Noor Zurani, Muhammad and Mohamad (2008), the results of treating drug addiction in Malaysia is not promising and poor, and this is due to several reasons. Among these reasons is the medical therapeutic approach which has been totally ignored by the policy despite strong evidence that addiction to drugs is a medical condition. The national drug substitution task force was then set up to review the treatment policy and provide input in the management of addiction in Malaysia, mainly to control the problem of the spread of HIV, especially among heroin addicts. The task force suggested introducing the implementation of methadone maintenance therapy by 2000. However, only in 2005 did the government agree to accept and implement a drug substitution therapy with the use of methadone as a new approach to dealing with drug addiction (Rusdi et al., 2008). This therapy was implemented together with the needles-and-syringe exchange program and the free condom grant to drug addicts,

both of which aim to reduce the spread of HIV virus based on the concept of harm reduction (Abdul Rani, 2007). It is still practiced throughout the country by the Ministry of Health.

In 1998, the government experimented with the use of an antagonist drug as adjunct therapy, but the experiment failed. That pilot study sought to discover the effectiveness of the use of naltrexone as an adjunct treatment among the addicts of the opiate (Abdul Rani, 2008). The results of the study indicated that the subjects (drug addicts) on naltrexone only showed slightly better results than the control group (Vicknasingam & Mahmud, 2008). Then in 2001, the government allowed the use of the buprenorphine drug as maintenance treatment but this was also eventually stopped because of the problem of misuse and abuse (Vicknasingam & Mahmud, 2008).

In 2010, the government began an initiative to implement a more “friendly” approach to eradicate drug addiction problems through the AADK Transformation Program as part of the Government Transformation Program (GTP) and National Key Result Area (NKRA) initiatives (AADK, 2010 & 2011). Through these transformation initiatives, AADK is seen as moving towards providing more open treatment and rehabilitation services that meet the client’s satisfaction, needs, preferences and recovery needs. AADK intends to materialize the organization’s vision and mission by providing services that are felt by society and are best for its wellbeing. Among these initiatives are:

- (1) To provide services to all individuals who have drug dependence problems;
- (2) To give an option to drug addicts to voluntarily come for treatment;
- (3) To approach clients by using an outreach program;
- (4) To cooperate with smart and strategic partners;

- (5) To give an awareness of the danger of drugs from the aspect of health;
- (6) To detect and detain those who refuse to voluntarily come and get the treatment;
- (7) To improve the treatment program by providing clinical care service; and
- (8) To introduce and expand the drug substitution therapy program (methadone maintenance therapy).

(AADK, 2012, Cure & Care Model in Malaysia, pp. 23 – 25)

Designated as the AADK Transformation Program, all AADK approaches have been comprehensively modified and integrated, and are consistently strengthened by cooperation between the government and civil society in a nationwide attempt to eradicate the abuse of drugs. In the context of drug treatment and rehabilitation, the transformation program that received more attention was the implementation of open access services through the introduction of Open PUSPEN, later known as 1Malaysia Cure & Care Clinic. This approach allowed the drug addicts to voluntarily come forward and apply for the services. They were also no longer subject to the procedures and processes of law enforcement. The addicts were screened and assessed for the severity level of addiction to determine the treatment placement stage, whether by residency (inpatient) or out-patient, treatment package period and program intervention that fit their recovery needs; introduced to the medical module through drug substitution therapy and psychiatric treatment; and given recovery support services, such as referral and advocating, as well as a co-dependency consultation service (AADK, 2010).

This clinic was officially launched on 1st July 2010 as an option for drug users and drug addicts to voluntarily come forward for treatment and rehabilitation service.

The option is also open to any family members who need treatment for their co-dependency problems. One PUSPEN center, namely PUSPEN Sungai Besi, Kuala Lumpur, was chosen to pioneer this approach, and from the date of commencement of operations, the name 'PUSPEN Sungai Besi' was changed to 'Klinik C&C 1Malaysia', an abbreviation of Klinik Cure and Care 1Malaysia (AADK, 2010). The essence of this approach comprises the following aspects:

- (1) Customer or client can choose what service or program will meet his/her commitment and recovery needs;
- (2) Customer or client is not limited only to the drug user or addict; the program is also open to every member of society on all levels, whether family members, employer or any individual who are affected by the addiction problem (co-dependency);
- (3) No pre-requisites are imposed on the customer or client who comes forward or applies for the services, and information on their particulars will not be disclosed;
- (4) Customer or client that is being or has get service are not subject to legal binding; and
- (5) The services are available seven days a week, except for public holidays.

All types of services offered or applied for by the customer or client will be listed under one out of the seven (7) client placement levels, namely:

- (1) Residency (inpatient) – for the period of one month, three months or six months
- (2) Outpatient – according to client suitability
- (3) Detoxification with or without medication – for the period of two

weeks

- (4) Drug substitution therapy – according to client suitability
- (5) Daycare
- (6) Short service (on the spot) – complaint, advisory and intervention services
- (7) Referral and advocacy services

Another transformation initiative also initiated by AADK was the categorization of PUSPEN into three systems, which are the Triage Center, Hard-core PUSPEN, and One PUSPEN for addicts who have undergone treatment and rehabilitation because of a court order (mandated). The triage center sorts, separates, sifts and selects the client. The center functions as a screening and assessment center for placement of the customer or client to the rehabilitation center that meets the stated criteria for One PUSPEN or Hard-core PUSPEN. Hard-core PUSPEN is the placement center for inmates who are identified (triaged) as having criminal records, are repeated cases, or who have low motivation to be cured. One PUSPEN is the center for inmates who have high-propensity and motivation, are repeated cases but not more than twice, have no criminal records, no chronic diseases or are not physically disabled, and have full support from family members or employer (AADK, 2010).

To entertain the drug users in the community setting and to meet their treatment and rehabilitation needs, AADK introduced a Cure and Care Service Center (CCSC) and Caring Community House (CCH). CCSC is an institution which been handled more openly and in a much more conducive manner so that it can play an important role in accelerating a client's recovery process, and help him/her to live a healthy life without drugs. Operated as a daily-activity center, half-way house and

drop-in center, CCSC provides treatment and rehabilitation services to the target group. This includes guidance and counseling, support group therapy, community rehabilitation program, work placement, referral and advisory services, and drug substitution therapy. It is also a resource center, and contains sports and recreation facilities. On the other hand, CCH is a facility which is run by a group of ex-addicts with support from local community members, and its roles include being a temporary and permanent settlement center, drop-in center, and intermediate house for cases or former addicts with no shelter or who need peer support (AADK, 2010).

Until 2012, the AADK transformation program processes were seen as non-static. In fact, the program developed and was intertwined with the introduction of new programs characterized by an approach called the "Cure and Care Model". According to AADK (2012), the Cure and Care Model approach became the basis for all service settings offered by AADK, particularly the service for drug treatment and rehabilitation. This model contains three main elements that differentiate it from the previous approach even when half of it was a rebranding effort especially for the psychosocial modality. Firstly, this model emphasizes the concept of voluntary service in which the clients (drug addicts) come of their own will there is no compulsion and no pre-conditions imposed on the clients to get the service. Moreover, there is also no legal ties. Secondly, the model introduces new elements in the scope of its services. These are: clinical treatment and medication, methadone replacement therapy, reference and support services, and the basic scope of service which encompasses inpatient and outpatient treatments. Thirdly, this model classifies the treatment components and drug rehabilitation into two main components, namely, clinical and psychosocial.

Clinical elements in this model offer treatment service through the seven main components of the clinical and medical methods. These components are: (1) medical detoxification; (2) replacement therapy treatment using methadone; (3) screening test for human immunodeficiency virus (HIV); (4) hepatitis B and C; (5) clinical treatment and minor cases; (6) follow-up treatment to the hospital; and (7) health psychoeducation. The psychosocial component stresses the content of the programs that are set to change addictive behavior, provide the skills to prevent relapse, give knowledge about rehabilitation, and give self-confidence. All these involve seven content elements listed as early recovery, relapse prevention, social support, counseling and guidance, psychoeducation, religion and spirituality, and family programs (AADK, 2012).

All these transformation efforts represent a quantum leap by AADK and they sparked a phenomenon on treatment and the drug rehabilitation systems available in Malaysia (AADK, 2011). As a result, many achievements and effects were observed, some of which are listed below:

- (1) AADK succeeded in fulfilling the aspirations of stakeholders and the community, and the benefits of the service was felt by the community;
- (2) It was successful in assisting the government to reduce the rate of street crime which involved drug addicts;
- (3) Clients' access to the service increased;
- (4) Society is more open as there is a lessening of the stigma attached to drug treatment and rehabilitation, and a continuing increase in clients' voluntary commitment to come forward to receive treatment;

- (5) AADK's approach and transformation program received worldwide recognition, especially as the best role-model in open-access service; and
- (6) The tagline for the services – "*Kami prihatin dan kami sedia membantu*" ("We care, we serve") – has affected the rehabilitation program provided; at the same time, AADK was able to introduce a comprehensive and systematic treatment model by combining psychosocial and medical programs.

1.3 Group Treatment in Drug Treatment and Rehabilitation

Groups which are organized around therapeutic goals can enrich members with insight and guidance, provide positive peer pressure and reinforcement, and teach new social skills. They can also be used as change agents with the presence therapeutic forces such as affiliation, confrontation, support, gratification, and identification. In short, group therapy can provide a wide range of therapeutic services, comparable in efficacy to those delivered in individual therapy (Center for Substance Abuse Treatment, CSAT, 2005).

Yalom (1995, in Connors, Donovan & DiClemente, 2001) stated that the use of a group delivery format capitalizes on the operation of a number of "curative factors" associated with groups as a format of treatment. Some features of group treatment can provide and contribute to the behavior change process (Kaufman, 1994; Velasquez, Maurer, Crouch & DiClemente, 2001; CSAT, 2005; Washton & Zweben, 2006), including the following:

- (1) Groups provide positive peer support and pressure to the members to abstain from the drug use.

- (2) Some important aspects of life and social skill training, such as communication, feedback and assertive, occur more powerfully in a group setting. Learn and relearn processes happen inclusively.
- (3) Groups provide members with the opportunity to change their social networks, and to develop a meaningful support system that can enhance their recovery process.
- (4) A group supports and directs an individual towards a commitment to recovery, a fundamental ingredient in the process of behavior change.
- (5) The group members' roles and influence, through modeling, experience sharing and feedback, sometimes have more impact than a therapist. A group can serve as a mirror to the members regarding their values and abilities.

The history of group treatment activities in drug treatment and rehabilitation centers in Malaysia (PUSPEN) can be traced through the implementation of the Curriculum and Procedure for the Implementation of Counseling Activities in Drug Rehabilitation Center, which was circulated in 1998 (AADK, 1998). According to this circular, two group activities were to be implemented for all inmates, namely, group counseling, and group guidance and development program, which includes a didactic and experience sharing session. Other than being the means of providing more comprehensive and efficient treatment activities for the inmates, these group treatments also aimed to decrease the supervision ratio between the counselor and the client (AADK, 1998). Among the features of these two group treatments were: the prescribed curriculum and procedure for the activities of the treatment; group membership arranged according the treatment phase without taking into consideration the client's readiness-to-change level and recovery needs; and the frequency of the

activities that are not tailored to the client's recovery needs but are conducted to satisfy the fixed schedule, which is once a month for group counseling and twice a month for the group guidance and development program (AADK, 1998).

AADK introduced the Cure and Care Model from 2010 to replace the existing approach at that time, through a transformation program that maintained the use of group technique as the main delivery method of service, particularly in the implementation of psychosocial components at Cure and Care Rehab Centre (CCRC) (AADK, 2011). The use of group technique could be found in the implementation of skills and physical training module, sports and recreation, marching and physical activities, early recovery, relapse prevention, religion and spirituality, support group and family program. Differences in previous approaches were apparent in the group development method (process of group membership selection) which was completely dependent on the matching method based on stages of change. However, the content in the module for all these groups remained the same, which meant that there was no difference between those who were in the early stages and later stages of change.

Group development, arrangement and activities should be subject to the client's readiness for change and recovery needs. Barrie (1991) notes that difficulties often arise in the group setting when the members' aims and needs are widely divergent, a situation which occurs when individual or people from different stages in the recovery process are mixed together in a group. In such a case, some problems between members may happen, and these may include disagreement on the status of problem identification, treatment goals, and characteristics of the members such as denial versus acknowledgment of the addiction problem, and resistance versus commitment to the treatment programs. The use of separate groups for clients in the early and later stages of change should be emphasized, which the group members

encompass same characteristics of the clients, share common features that all members have problems with, and more importantly, that they are in the same readiness-to-change level, early stages of change.

The curriculum and module prescribed for the group should also seriously take into consideration the client's readiness to change, according to the stage-based group approach proposed by Connors, Donovan and DiClemente (2001), an approach which attempts to match the group interventions to the group member's stages of change. As the majority of the inmates in PUSPEN are in the early stages of change, which are the pre-contemplation and contemplation stages of change (Abdul Halim, 2010; Najwa, Sabitha & Mahmood, 2008; Abdul Halim, Mohd Rafidi & Jailani, 2006; Mohd Rafidi, 2003), they should be treated where they are. This is because most pre-contemplators come for treatment as a result of external influences and are not themselves committed to the treatment, and the contemplators are still in the ambivalent state of changing behavior. Thus, a primary goal of the group which handles these clients is to increase their awareness of their substance-related problem and move them on to the next stage where they can begin to see a need for a change (from pre-contemplation to contemplation) and begin to prepare to make a change (from contemplation to preparation) (Connors, Donovan & DiClemente, 2001).

The most frequent activities conducted to promote change for these clients' stages of change are carried out by a psychoeducational alcohol or drug information group (Connors, Donovan & DiClemente, 2001). The objectives of this group are to help identify problems related to the addiction, to maintain/enhance a commitment to change addictive behavior, and to teach methods of resolving addiction problems. Besides providing information, this approach offers clients an opportunity to reassess their situation and consider the extent to which substance use or abuse plays a part in

their difficulties in a variety of life areas. A goal is to increase the individual's motivation for change by demonstrating the link between these difficulties or negative consequences and their alcohol or drug use (Barrie, 1991).

1.4 Statement of the Problem

The question raised now is why addiction behavior is so difficult to treat. Various approaches and modalities have been introduced by the government, but the problem still remains unsatisfactorily resolved. Most studies show that the majority of addicts (50% to 90%) who have completed treatment programs will return to their old habits (relapse) after discharge from drug rehabilitation centers (Abdul Halim, 2010; Scorzelli, 2009; Sabri, 2007; Abdul Rani, 2007; Reid, Adeeba & Sangeeta, 2007; Mohd Rafidi, 2003; Mohamad Hussin, 2003; Mohamad Hussin & Mustafa, 2001). That the drug treatment and rehabilitation struggle is on the rise is supported by statistics issued by the National Antidrug Agency for 2005 to 2009 which shows that average 53.65% (out of 98,196 addicts) cases detected are relapse cases. The details are shown in the table below.

Table 1.1

The total of case detected based on case status

Year	New cases		Relapse cases	
	No.	%	No.	%
2005	15,389	46.91	17,419	53.09
2006	10,381	45.51	12,430	54.49
2007	6,679	46.10	7,810	53.90
2008	5,939	48.08	6,413	51.92
2009	7,123	45.27	8,613	54.73
Average	9,102	46.35	10,537	53.65

(Source: AADK (2010), *Maklumat Dadah 2009*, p.10)

According to Prochaska, DiClemente and Norcross (1992), Connors, Donovan and DiClemente (2001), and DiClemente (2006), most addicts fail to maintain their recovery after completing the rehabilitation program. This is due to the fact that most of the existing treatment programs practiced were action-oriented rather than carried out in accordance with and to fulfill the requirements of an addict or an addict's recovery needs. The three studies mentioned above proposed that the counselor or therapist should develop treatment programs and systems that are responsive to the process of change. Thus, the techniques and strategies that engage specific processes of change should be matched to the current stage of change and the dynamic processes and markers of that stage. Shifts in stage status can take place during the actual treatment session, outside the session, or even after the treatment has ended. In order to make shifts, the client and the therapist or counselor responsible to promote stage-appropriate tasks and must perform the task for making the transition possible. There is a critical need to review the treatment approaches applied in the treatment and rehabilitation of drug dependants in the nation.

Malaysia still practices modalities that are so-called action-oriented-based approaches, where inmates must undergo the structured programs/activities scheduled for them, and they are also required to fulfill certain targeted sessions of activities, whether individually or as group treatment. There is no module that matched the addicts' treatment and rehabilitation needs. In general, all addicts are required to go through standard activities/programs, which is the usual routine in their previous treatment experiences even though they have previously been in the treatment, such as in the case of readmissions. A comparative study on best practices in treatment and rehabilitation conducted by Abdul Halim et al. (2010) asserted that the orientation of treatment and rehabilitation adopted by the centers neglect the critical component of

readiness to change amongst the inmates. For that reason, most studies show that the majority of addicts who underwent treatment and rehabilitation in PUSPEN were in the early stages of change and remained status quo after they were released or discharged (Abdul Halim, 2010; Najwa, Sabitha & Mahmood, 2008; Abdul Halim, Mohd Rafidi & Jailani, 2006; Mohd Rafidi, 2003). They were not treated in a way they should have been. Treatment and rehabilitation of addicts must be conducted based on the principles of treatment proposed by the National Institutes of Drug Addiction (NIDA). According to NIDA (2006), matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

Although AADK introduced various changes through the transformation program, including introducing and practicing the Cure and Care Model as the core service through five types of service settings, the condition only managed to fulfill half of the total rehabilitation requirements. The fact that "they were not treated in a way they should be" has yet to be completely practiced. The researcher's analysis found that this model is still based on the concept of 'action-oriented', especially in the pre-prepared module of the psychosocial component. By implementing this component, all clients will go through the process and program (which have the same content in respect of the duration of the treatment and rehabilitation) without needing to match the rehabilitation needs (program content) to on the clients stages of change. Service orientation for all of these psychosocial components also do not differentiate between the clients' status of whether they were new or relapsed addicts, the level of or addiction severity and the clients' personal rehabilitation requirements.

Since the majority of addicts who undergo treatment related to drug addiction

appear to be in the pre-contemplation and contemplation stages (Abdul Halim, 2010; Najwa, Sabitha & Mahmood, 2008; Abdul Halim, Mohd Rafidi & Jailani, 2006; Mohd Rafidi, 2003), it is important to understand the nature of pre-contemplators and contemplators, and what therapeutic processes might enable clients to move on through the processes of change into the preparation, action and maintenance stages (the later stages). Pre-contemplators are the individuals who are satisfied with, or at least unwilling to disrupt, a current behavior pattern, the stage in which there is a little or no consideration of change of the current pattern of behavior in the foreseeable future (DiClemente, 2006). While contemplators are theorized to have high levels of ambivalence, and some have postulated that these individuals lack the necessary motivation to change (Reid, 2007), ongoing examines the current pattern of behavior (instability) and the potential for change in a risk-reward analysis (DiClemente, 2006).

It is necessary to insist that one of the basic fundamental principles of the helping profession is to begin where the client is, and this approach necessitates exploring the client's readiness to change as part of the assessment process and throughout the treatment. If a counselor or therapist gets ahead of a client by administering interventions improperly matched with the client's readiness to change, treatment may be prematurely terminated or high levels of resistance may be encountered during therapy, or at least the client resists against change. To begin with where the addict is, there must be some idea or space of efforts to create and generate some intervention program to help drug addicts. One of the promising theoretical foundations that could be used and has been proven practical is the Transtheoretical Model of Behavior Change (TTM). Prochaska and DiClemente (1984) proposed the TTM to advance their belief that individuals move through several stages of change when attempting to alter specific target behaviors (Reid, 2007). According to Noar,

Benac and Harris (2007), the TTM suggests that because individuals' attitudes, strategies, and skills differ at varying stages of the change process, interventions should be uniquely tailored to those stages, sensitive to where individuals are in the change process, and interventions tailored to those stages are likely to be the most effective in moving individuals forward through the stages.

With the popular concept of TTM of "doing the right thing at the right time", Velasquez, Maurer, Crouch and DiClemente (2001) suggested that any intervention development should consider three key factors to be included to encourage successful transition through the stages of change as proposed by Prochaska and DiClemente (1984). The processes of change, decisional balance, and self-efficacy were the primary factors that predicted an individual's ability to transition through various stages of change. The processes of change (POC) are the internal and external experiences and activities that enable individuals to move from stage to stage. They are the engines that create and sustain the transitions through the stages and facilitate successful completion of the stage task (DiClemente, 2006) while decisional balance refers to the process of cognitively appraising the benefits and costs associated with behavior modification. Self-efficacy refers to an individual's self-perceived confidence in his or her ability to make change occur (Reid, 2007).

The various tasks identified in the stages of change transition provide a dynamic framework for examining the interactions of important factors in addiction and recovery, especially in the dimension of change. According to DiClemente (2006), by incorporating the process and its dimension, for this study – the stages of change, self-efficacy and decisional balance (markers of change), will lead to address four main deficits in many current studies. First, many studies fail to make critical distinctions among change dimensions in the questions addressed and types of

populations studied. Most studies (such as Fauziah et al., 2010; Wan Shahrazad et al., 2010; Najwa et al., 2008; Callaghan et al., 2008; Duvall et al., 2008; O'Connor, 2007) recruited their samples to represent the entire population in all stages of change, instead of representing one or two stages. It can affect the relevancy to the study of the phenomenon of interest among participants who present different stages. The second deficit is that studies often examine inappropriate or unlikely end points that may have little variance in some populations, seriously limiting the ability of the studies to find predictors or differences among treatment and control groups. The third deficit involves the lack of process research and measures that focus on how, not whether, this or that result was found (DiClemente, 2006). The research most often measures only prevalence of use and not stage status or movement of the population through the stages of addiction or recovery. According to Longabaugh & Wirtz (2001), treatment research often fails to measure important critical markers and processes of change that could explain how a treatment did or did not operate as expected.

The fourth deficit is the lack of experimental research to evaluate the effectiveness of stages-matched interventions in behavior change, especially in the field of drug treatment and rehabilitation. Sutton (2001, 2005) stated that most research designs for the application of TTM in the movement of behavior change can be divided into four types. They are cross-sectional study (comparing people in different stages); examination of stage sequences; longitudinal prediction of stages transitions; and experimental studies of matched and mismatched interventions. His literature review found that there was no published study on alcohol and drug use that used any of the last three types of research designs.

The same goes for the literature review by Riemsma, Pattenden, Bridle, Sowden, Mather, Watt dan Walker (2002) which systematically reviewed researches

which studied the effectiveness of interventions based on a stages-of-change approach to promote individual behavior change. They found that there was no stages-based approach studies conducted that focused on the effectiveness of matching intervention on drug addicts. A similar concluding remark was made by Lua, Talib and Selamat (2011) who stated that they could not find any concrete evidence to support their finding on the low readiness for change and recovery among drug addicts in Malaysia due to the lack of behavioral studies, particularly among illicit drug abusers in our country.

TTM recommended that the most appropriate intervention strategy for the groups of these stages (pre-contemplation and contemplation) is through psychoeducation, either individually or in groups. The main objective of this intervention is to increase the addicts' awareness of their addiction problem and the drug-related problems which they are experiencing. This is to enable them to move to a higher stage of change, and to see the need for change; to educate them about the negative effects of addiction; and to explore the concerns and conflicts that arise between drug use and personal values. In addition, the addict should be provided with information which is related to his/her addiction problem and the potential problems that might arise (Velasquez et al., 2001).

This approach has been proven to be effective and is widely applied (Griffith, 2006) in many fields such as health, behavior and cognitive, including substance abuse and treatment of drug abuse (Richards, 2012; Elliot & Walters, 1997; La Salivia, 1993, Aguilar, DiNitto, Franklin & Lopez-Pilkinton, 1991). Nevertheless, based on the researcher's observation, the psychoeducational therapy approach in treatment and rehabilitation programs has not been given due attention. There is also no research conducted to test the psychoeducation matching strategies based on early

stages of change according to the TTM model. This study on the effectiveness of psychoeducational group therapy that emphasizes the element of processes of change through its stages, self-efficacy and decisional balance, will be able to examine and identify the core treatment approach in addiction.

1.5 Objectives of the Study

This study has several main objectives. The first objective is to examine the effects of psychoeducational group therapy to motivate change among drug addicts who are participating in treatment and rehabilitation programs and are classified as being in the early stages of change. One specific module based on the TTM theory (guided by stages of change construct, change processes and markers of change in TTM) was developed by the researcher. The module was developed by using “Model Pembinaan Modul Sidek” (MPMS) and it has been tested for reliability and validity in the Malaysian context. It carries the concept of group therapy by applying specific psychoeducational intervention to assist in enhancing motivation and promoting changes in addicts who are at the early to the later stages of change.

In Malaysia, there is no written evidence that shows the application of psychoeducational group therapy approach as the intervention method used to treat and rehabilitate the drug addicts. As a comparison for examining the effectiveness of psychoeducational group therapy, the researcher will use an experimental design as a research method that includes the pretest-posttest control group designs (Campbell & Stanley, 1963; Chua 2011). This will be done by establishing a control group which is a group that will not receive any psychoeducational group therapy treatment. The differences between the two groups, the experimental group (received treatment) and

the control group (did not receive treatment), would determine the effects of the treatment studied.

The second main objective of this research is to compare the effects of psychoeducational group therapy on drug addicts who are at the early stages of change with different treatment experiences. The two categories of drug addicts' treatment experiences for Malaysian drug addicts who are participating in treatment and rehabilitation programs are the naive addicts and the experienced addicts. The results of the study show that there was a huge difference in the scores between the two categories of drug addicts for all types of independent variables measured. Both categories also show the differences in the treatment received. Comparisons between the effects of treatment on the two categories of treatment experiences must be carried out in order to determine whether the treatments are effective in assisting the drug addicts who are at the early stages of change for both categories of treatment experiences, or it could be effective for only one category of treatment experience.

The third main objective of this research is to identify how long the effects of psychoeducational group therapy on the addicts who are at the early stages would last. All addicts would be given psychoeducational group therapy, which is inclusive of 15 structured sessions. If the findings of the research prove that the treatment has a time-delay effect, it would show that the treatment must be continued or the addicts given follow-up treatment. One new investigation must be done to complete the follow-up intervention treatment to the addicts which is suitable to the requirements for treatment and rehabilitation services for the rest of their lives.

In conclusion, the objective of this study is to evaluate (effectiveness) the use of Psychoeducational Group Therapy plus the usual treatment (PGT) and compare the results with the usual treatment-only group (CG) among addicts in the early stages of

change (pre-contemplation and contemplation), and with the inclusion criterion (treatment experiences) in a drug treatment and rehabilitation center.

The dependent variables for this research are the stages of change (SOC), self-efficacy (SE), and decisional balance (DB). In detail, the objectives of this study are:

- (1) To measure the treatment effect of PGT and compare this with CG on the addict's SOC, SE, and DB among treatment-naïve addicts;
- (2) To measure the treatment effect of PGT and compare this with CG on the addict's SOC, SE, and DB among treatment-experienced addicts;
- (3) To compare the treatment effect of PGT between treatment-naïve and treatment-experienced addicts on the addict's SOC, SE, and DB;
- (4) To measure the time-delayed effect of PGT treatment on the addict's SOC, SE, and DB among treatment-naïve and treatment-experienced addicts.

1.6 Hypotheses

To answer research objective (1), six hypotheses were developed, three of which were to affirm assumption of treatment effect of PGT on **treatment-naïve** (PGTN) addicts, and three other hypotheses served to reveal the comparison of treatment effect of PGT between the treatment group (PGTN) and the comparison group (CGN).

Hypothesis 1a: There is no significant difference in SOC between pre-PGTN and post-PGTN addicts.

Hypothesis 1b: There is no significant difference in SOC between post-PGTN and post-CGN addicts.

Hypothesis 2b: There is no significant difference in SE between pre-PGTN and post-PGTN addicts.

Hypothesis 2b: There is no significant difference in SE between post-PGTN and post-CGN addicts.

Hypothesis 3a: There is no significant difference in DB between pre-PGTN and post-PGTN addicts.

Hypothesis 3b: There is no significant difference in DB between post-PGTN and post-CGN addicts.

In a nutshell, the illustration of hypotheses used to answer research objective (1) is related to the research design (explained in detail in Chapter 3) and are presented in the following Figure 2.3.

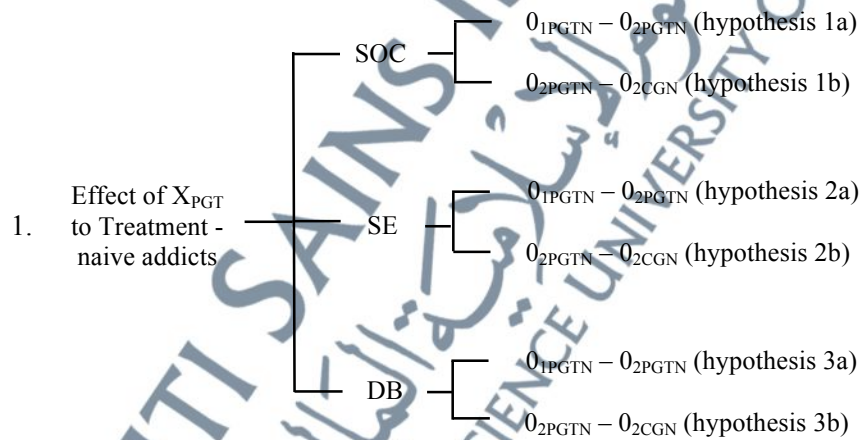


Figure 1.1: The association of hypotheses and research design for research objective (1)

To answer research objective (2), six hypotheses were developed, three of which functioned to examine the treatment effect of PGT on **treatment-experienced** (PGTE) addicts, and three other hypotheses to determine the comparison of treatment effect of PGT between the treatment group (PGTE) and the comparison group (CGE).

- Hypothesis 4a: There is no significant difference in SOC between pre-PGTE and post-PGTE addicts.
- Hypothesis 4b: There is no significant difference in SOC between post-PGTE and post-CGE addicts.
- Hypothesis 5a: There is no significant difference in SE between pre-PGTE and post-PGTE addicts.
- Hypothesis 5b: There is no significant difference in SE between post-PGTE and post-CGE addicts.
- Hypothesis 6a: There is no significant difference in DB between pre-PGTE and post-PGTE addicts.
- Hypothesis 6b: There is no significant difference in DB between post-PGTE and post-CGE addicts.

In a nutshell, the illustration of hypotheses used to answer research objective (2) is related to the research design (explained in detail in Chapter 3) and presented in the following Figure 1.2:

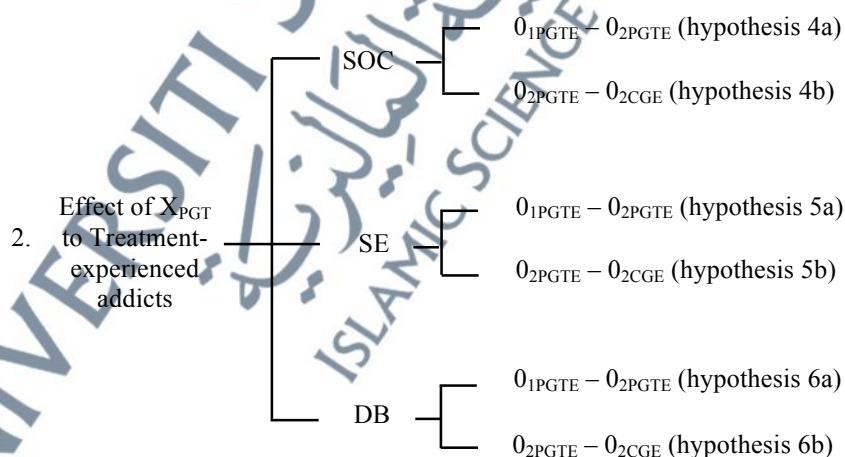


Figure 1.2: The association of hypotheses and research design for research objective (2)

To answer research research (3), three hypotheses were developed to ascertain the difference in effect of PGT between two treatment groups (PGTN and PGTE) on addicts' SOC, SE, and DB.

Hypothesis 7: There is no significant difference in SOC between post-PGTN and post-PGTE addicts.

Hypothesis 8: There is no significant difference in SE between post-PGTN and post-PGTE

Hypothesis 9: There is no significant difference in DB between post-PGTN and post-PGTE

In a nutshell, the illustration of hypotheses used to answer research objective (3) is related to the research design (explained in detail in Chapter 3) is presented in the following Figure 1.3:

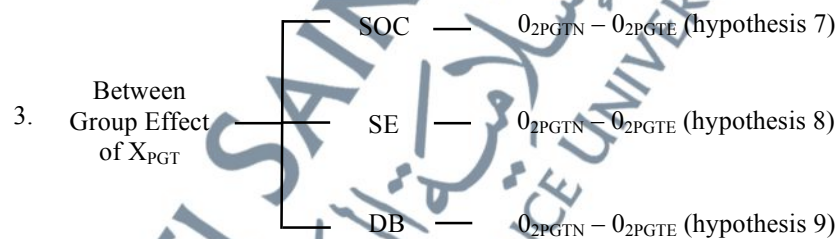


Figure 1.3: The association of hypotheses and research design for research objective (3)

To answer research objective (4), nine hypotheses were developed. Three of the hypotheses functioned at asserting the time-delayed effect of PGT on treatment-naive (PGTN) addicts; three hypotheses were to identify the differences in the treatment effect of PGT on treatment-experienced (PGTE) addicts; and three other

hypotheses to identify the difference in the time-delayed effect of PGT among treatment-naive and treatment-experienced addicts on the addicts' SOC, SE and DB.

Hypothesis 10: There is no significant difference in SOC between post-PGTN and follow-up-PGTN addicts.

Hypothesis 11: There is no significant difference in SE between post-PGTN and follow-up-PGTN addicts.

Hypothesis 12: There is no significant difference in DB between post-PGTN and follow-up-PGTN addicts.

Hypothesis 13: There is no significant difference in SOC between post-PGTE and follow-up-PGTE addicts.

Hypothesis 14: There is no significant difference in SE between post-PGTE and follow-up-PGTE addicts.

Hypothesis 15: There is no significant difference in DB between post-PGTE and follow-up-PGTE addicts.

Hypothesis 16: There is no significant difference in SOC between follow-up-PGTN and follow-up PGTE addicts.

Hypothesis 17: There is no significant difference in SE between follow-up-PGTN and follow-up PGTE addicts.

Hypothesis 18: There is no significant difference in DB between follow-up-PGTN and follow-up PGTE addicts.

In short, the illustrations of hypotheses to answer these research objective (4) that are related to the study (explained in detail in Chapter 3) are listed in Figure 1.4.

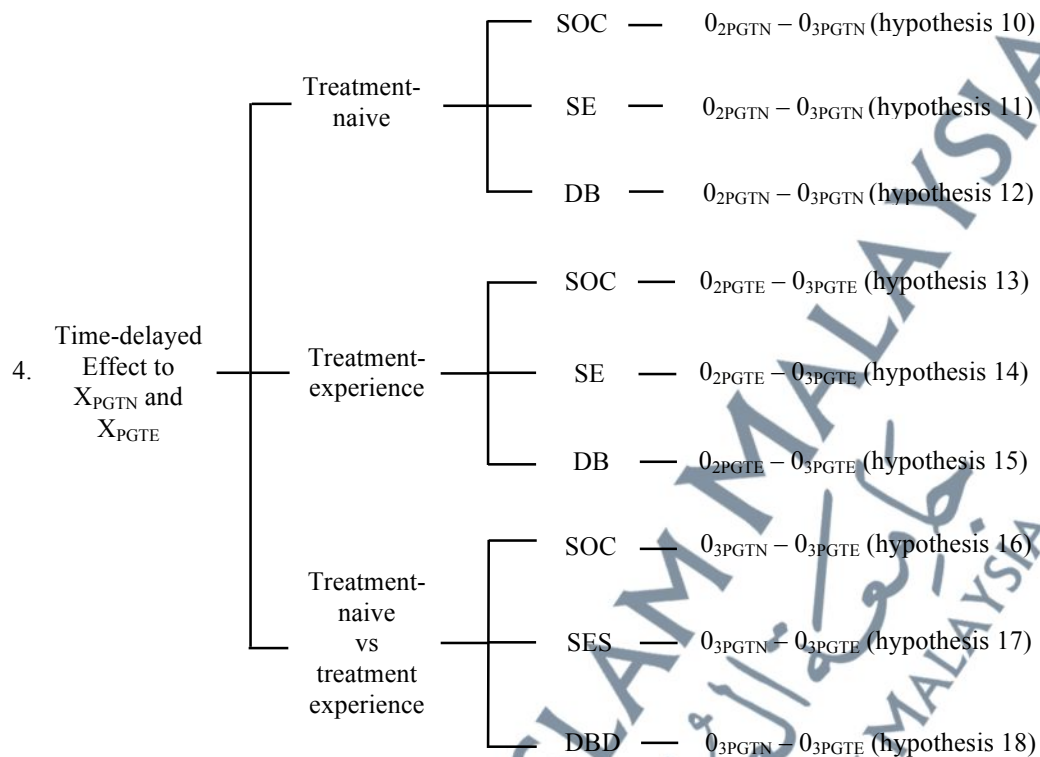


Figure 1.4: The association of hypotheses and research design for research objective (4)

1.7 Significance of the Study

This research not only intends to study and identify the effectiveness of the psychoeducational group therapy to enhance the addict's stages of change, self-efficacy, and decisional balance, this study also intends to present a model of recovery management that is more focused on the treatment and recovery needs of an addict, based on the concept of stages-matched intervention. This model that fits with the addicts' stages of readiness to change will be able to move client change towards a more positive attitude, and shy away from again being trapped by addiction or relapse.

A comparative study was also done to identify the effectiveness of the model on an

addict's treatment history, which included the treatment-naïve and treatment-experienced addicts.

Based on this model, addicts who are identified as staying in the early stages of change can be helped to progress to the later stages of change and maintain the recovery processes, further maintaining the behavioral change and drug-free lifestyle. To achieve this purpose, this model stresses the use of intervention strategies that match the stages and change processes, which were experienced by the addicts using the psychoeducational group therapy approach. This model is different from the present approach implemented by AADK, which stresses the standardized and action-oriented treatment and rehabilitation program for all addicts without regard to the addict's stages of readiness to change.

The findings of the research indicate that AADK, as the leading and focal agency in managing the drug addiction problem in the country, is expected to provide treatment and rehabilitation programs and activities that are more pragmatic and systematic, based on the client's readiness to change and stages of change. In terms of identification and fixing the placement criteria, this model also recommends a method that is more congenial, arranged and comprehensive. Based on the suggestions and proposals in the later part of this study, AADK can decide on the placement criteria for the rehabilitation centers or community with reference to the addict's readiness-to-change levels or stages of change. This model recommends that the placement of an addict should fulfill his or her treatment needs according to his/her current stages of change, and support and help should then be given as needed by the addict.

The study's findings can also increase the awareness of rehabilitation officers that psychoeducational group therapy needs to be carried out to significantly enhance the effectiveness of the treatment and rehabilitation efforts to help addicts. This is

because counseling techniques that used to be practiced are not necessarily effective in moving an addict to change. The psychoeducational technique will provide the knowledge and skills to the addict, especially on the effects and causes of addiction. Using this model, rehabilitation officers will be able to identify and carry out their responsibility and role to help push an addict to change, based on the proposed intervention strategy and assignments and according to the readiness to change level of the addict. The officer can also adapt accordingly to an addict's treatment history, whether he/she is a treatment-naïve or treatment-experienced addict.

The main construct of this psychoeducational group therapy model is based on the processes of change experienced by the addicts who are in the early stages of change, as proposed by TTM that highlights the use of the change process as the basis for stages of change and is the 'key' to the addicts' change (DiClemente, 2006; Connors, Donovan & DiClemente, 2001; Prochaska, Norcross & DiClemente, 1994). Drug addicts individually go through different stages and processes of change. In other words, each stage of change has its own change process. The results from this study could inspire and provide ideas to rehabilitation professionals to use the constructs of change process as the main content in their intervention programs. It is not limited to only group therapy; the method can be applied to individuals and larger groups. There are similar implications for change processes construct for other stages of change such as preparation, action, and maintenance (later stages of change) and it can be the essence of intervention programs for the groups.

1.8 Assumptions

The primary assumption of this research is that psychoeducational therapy, which uses the processes of change as the main module, can play an important role in

promoting motivation and change among addicts who are in the early stages of change. The truth behind the concept “do the right thing at the right time” and “the matching of stage and process is a key to change” is the essence of this module which is based on the construct of The Stages of Change (SOC) and The Processes of Change (POC) in The Transtheoretical Model of Behavior Change (DiClemente, 2006; Velasquez et al., 2001) to promote motivation and change.

In order to support the findings of these researches, a construct in the same theoretical framework was used to explain how a situation happened such as The Markers of Change (MOC). These theoretical opinions stated that the markers of change (self-efficacy and decisional balance) play significant roles as markers of development in the early stages of change as well as being a mechanism to explain an individual’s self-confidence in carrying out certain behaviors, and predictors are crucial to every stage of action and long-term success (DiClemente, 2006). In short, the increase in motivation and change happens when the decisional balance of the clients become pros to change and self-efficacy also increases.

Lastly, this research model is based on the three main TTM constructs (SOC, POC and MOC) with a group therapy approach and psychoeducational strategy. This approach is widely used in the Western world and may be used in the local setting for drug treatment and rehabilitation, especially in preparing and implementing alternative interventions as well as the complement to group of addicts who are at the early stages of change.

1.9 Limitations and Delimitations of Study

The making and implementation of the therapy module for the psychoeducational group in testing its effectiveness on the drug addicts is limited to

the target group which was represented by drug addicts who were participating in institutional treatment and rehabilitation programs and they were all at the early stages of change known as the pre-contemplation and contemplation stages. Comparisons of the effects of the treatments which were highlighted were limited to the usual treatment or Cure and Care for CCRC (CCRC Model) conducted at CCRC Jelevu, Negeri Sembilan. Since the researcher did not have the authority to limit the access of the addicts in the experiment group to the treatment provided solely by him, these addicts also received the treatment as usual, which was mentioned earlier. The addicts in the control group received only the usual treatment.

In order to view the effects of treatment as a whole, the researcher particularized the target research group to only two groups of addicts who were receiving treatment and rehabilitation. These two groups were represented by addicts who enrolled and received the rehabilitation service for the first time (naive addicts) and the addicts who joined and received the treatment for the second time or more (experienced addicts). The frequency of joining and receiving rehabilitation in this research refers to the treatment experience.

Addicts who were involved in this study were selected based on several pre-determined criteria before the research were conducted. They were addicts who were at the early stages of change and had been in the treatment for at least 14 days to six months. They were also Malays aged between 30 to 49 years old with a minimum of education at secondary school level and the period of addiction was between five to ten years. These criteria were established in order to maintain the homogeneity factor and to control the extraneous variables which could influence the research results if they were not managed.

For the researcher to view the effects of the treatment, three main variables, namely, the stages of change, processes of change and markers of change (self-efficacy and decisional balance) in the TTM construct were used as the benchmark of increase in motivation and changes that occur. The fourth construct of TTM, which is the context of change, was not taken into account since all respondents were in a controlled situation and were not directly influenced (no direct interaction) by outside elements, as intended by this construct (DiClemente, 2006).

1.10 Operational Definitions of Terms

The terms used in this research are defined as follows:

1.10.1 Stages of change

The 'stages of change', also known as 'stages of readiness to change', is the term used to mark an individual's status in intentional behavioral change. The stages depict a person's movement through the process of change in terms of the motivational and temporal aspects needed to create a successfully sustained pattern of behavior (DiClemente, 2006). The road that leads individuals to change an established behavior pattern is divided into five stages of change, namely, pre-contemplation, contemplation, preparation, action and maintenance. In this study, only the pre-contemplation and contemplation stages will be considered.

1.10.2 Processes of change

The 'processes of change' represent the internal and external experiences and activities that enable an individual to move from one stage to the next stage. According to DiClemente (2006), when an individual engages in these processes, they provide the means for the individual to accomplish the stage 'tasks', and the processes

create and sustain movement through the stages. Ten processes of change are identified in TTM, and these are divided into two categories: cognitive/experiential process, and behavioral process. The ten processes are consciousness raising, emotional arousal, self-reevaluation, environmental reevaluation and social liberation (cognitive/experiential process), self-liberation, stimulus generalization or control, conditioning or counter-conditioning, reinforcement management, and helping relationship (behavioral process). In this study, these processes of change will be used to generate an input (strategies and tasks) for the psychoeducational group session, and are limited to five processes of change which occur in the early stages of change (DiClemente, 2006; Connors, Donovan & DiClemente, 2001; Velasquez et al., 2001), namely, consciousness raising, emotional arousal, self-reevaluation, environmental reevaluation and social liberation.

1.10.3 Self-efficacy

‘Self-efficacy’ is the term used to describe an individual’s confidence in performing a specific behavior. It is a unique insight into describing efficacy expectations (Can I do it?), and the role of efficacy self-evaluations in predicting performance of a behavior (Bandura, 1997). Self-efficacy seems a stronger and more important predictor once the individual begins to engage in behavior change and as a predictor of maintenance of that change (DiClemente, 2006). Self-efficacy in this study will refer to the self-belief of the inmates in their ability to make or engage in behavior change.

1.10.4 Decisional balance

‘Decisional balance’ is the term used by the TTM to describe the process of decision-making based on the decision-making model by Janis and Mann (1977), on how an individual weighs the pros and cons of change in making a decision to take an action. Decisional balance is one of the markers of change, a signpost that identifies where a person stands in making change (DiClemente, 2006). The decisional balance process, which influences the addicts to come to a decision, depends on the weightage, whether or not the pros to behaviors (or cons to change), or pros to change (or cons to behaviors) are identified.

1.10.5 Psychoeducational group therapy

Psychoeducational groups are groups designed to combine interpersonal interaction and didactic information, often topical or focal, which means that they present and process information on a particular issue. Most group counselors this researcher has worked with report that groups sized between 8 and 12 members can remain therapeutic, while larger groups are more likely to resemble a class (Ingersoll, Wagner & Gharib, 2002). Psychoeducation is a didactic style of teaching psychologically relevant information (Velasquez et al., 2001). The Center for Substance Abuse Treatment (CSAT, 2005) states that psychoeducational groups are designed to educate clients about substance abuse, and related behaviors and consequences. The major purpose of psychoeducational groups is to expand the client’s awareness and to motivate him/her to enter the recovery-ready stage. In this study, the technique of psychoeducation will be applied to the group as a therapy.

1.10.6 PGT Module

The psychoeducational group therapy (PGT) module in this study is a module that consists of structured group therapy sessions or 15 sessions developed by the researcher based on the TTM model, particularly the process of change construct which is matched with the rehabilitation requirements of the target group in the research, which comprised the addicts who were at the early stages of change, namely, the pre-contemplation and contemplation stages. This module is also known as the stage-match intervention approach (DiClemente, 2006; Connors, Donovan & DiClemente, 2001; & Velasquez et al., 2001). All respondents in the experiment groups (PGTN and PGTE) underwent the module as a whole, according to the arrangement of the sessions, without even one exception for a single session. A detailed explanation of the PGT module will be clearly explained in the next chapter.

1.10.7 Treatment as usual

‘Treatment as usual’ in this research refers to the treatment input and rehabilitation (program) that is compulsory for all addicts (known as ‘clients’) who are participating in or going through drug treatment and rehabilitation in CCRC. In this scope of the study, ‘treatment as usual’ refers to the CCRC Model (Cure and Care Model for CCRC) which encompasses ten main programs that include health treatment, early recovery (6 sessions), relapse prevention (18 sessions), religion and spirituality (48 sessions), social support group (9 sessions), family program (2 sessions), guidance and counseling (at least 4 sessions), skills and vocational training (3 sessions), sports and recreational and physical activities (72 sessions) for 6 months.

1.10.8 Treatment experience

‘Treatment experience’ in this study is the term used to refer to the number of times that an inmate enters the drug addiction treatment facility (PUSPEN). According to Neale, Robertson & Bloor (2007), treatment experience is the time frame for which previous treatment is measured (e.g. “ever had previous treatment” or “had previous treatment a certain number of years”). In this study, two groups of inmates will be classified according to their treatment experience. The first group is the treatment-naive group which consists of the inmates who enter the facility for the first time and do not have any previous treatment experience. The second group is the treatment-experienced group which consists of the inmates who enter the facility to undergo treatment for the second time or more.

1.10.9 Inmates

‘Inmates’ in this study refer to the individuals who undergo treatment and rehabilitation at CCRC. While AADK in Halim (2010) defines inmates as individuals who are in the process of treatment and rehabilitation at the centers as ordered by the court or who entered the centers voluntarily, in this study, inmates refer to those in the orientation stage (after 14 days) and first phase (first six months in the CCRC) of the treatment and rehabilitation program in the centers (CCRC).

1.12 Chapter Summary

This chapter explained the background to drug addiction issues in Malaysia which require attention and careful action in order to prevent them from becoming worse and unmanageable. Various initiatives and efforts delivered by many authorities, particularly the government through AADK, were discussed but the

expected results remain elusive. One of the problems highlighted by the researcher is the absence of a management system for rehabilitation requirements that is based on the recovery of addicts who are going through a treatment and rehabilitation program and the rehabilitation service orientation which is more action-oriented has inspired the researcher to pursue this study.

As a result, four main research objectives were stated by the researcher to be achieved through this study. These objectives will be explained in depth later through the development of the four specific research objectives and four research questions. The researcher produced 24 hypotheses to be tested based on the four research questions. Of these 24 hypotheses, six were allocated for the first research question, six for the second research question, three to answer the third research question, and the last six hypotheses to answer the fourth question. The findings of this research are envisaged to contribute significantly to the current knowledge of practitioners in rehabilitation centers, particularly AADK and professional rehabilitation centers in Malaysia.