PROBATION AND AFTERCARE SERVICE

COLLECTED READINGS
ON
DRUGS AND DRUG ABUSE
FOR
VOLUNTEER AFTERCARE OFFICERS

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Speech by Dr Goh Keng Swee, Deputy Prime Minister and Minister of Defence, at the Launching of the NADAC Month at the National Theatre on Wednesday, 4th August 1976 at 8.15 pm.

Interest in the drug problem in Singapore has been growing over the last few years. For this reason, many people believe that the drug problem is a new one. Actually, it is a very old one and we can trace the origins to the First Opium War waged by the British on the then Imperial Government of China in 1839–42. The British Government insisted that there should be free trade of opium and this was naturally resisted by the Chinese authorities.

Since Singapore and the then Straits Settlements and British Malaya received large numbers of migrants from South China, these arrivals brought with them the habit of opium smoking.

The opium trade was quite legal in those days, the right to sell opium and run opium dens were licensed to people much in the same way as bars and restaurants are licensed to-day. But after the turn of the century, there was a public outcry for the prohibition of opium. The colonial government reacted in typical fashion. It set up a commission of inquiry when the outcry became uncomfortable. There were two such commissions of inquiry, the first reporting in 1908. It is a voluminous report in three volumes. In 1924, the British Malaya Opium Committee reported on the same subject. The 1908 report noted that a substantial proportion of revenues of the Straits Settlements — comprising Singapore, Penang and Malacca — came from the sales of opium. In 1904, 59.1% of the revenue of the Straits Settlements came from sales of opium. As late as 1934, the percentage remained as high as 40%. The prohibition of opium smoking was assessed to "have suicidial effects on the prosperity of the colony". Some beneficial side effects of opium addiction were mentioned. In those days the jungle had to be cleared for road and railway construction as well as for establishing rubber plantations. Labourers lived in what were called "coolie lines." Opium smoking after dusk set up such dense malodourous clouds of smoke that mosquitoes were repelled and workers saved from malaria.

Another reason against prohibition was the free port status of Singapore. The petition of the East India Company to the Colonial Office was quoted : "The settlement of Singapore was established as an outlet for British commerce and the preservation of its integrity as a free port has always been recognised by statements as essential to its prosperity and the full development of the objects contemplated in its formation."

In the 19th century, the principle of free trade had been elevated to the status of divine will. For instance, in the report of the first great Bengal famine, strong opposition was registered against organisation by government and charitable institutions of relief supplies to famine victims, on the grounds that this was interference with free trade. It was far better and more in keeping with the divine will that high food prices in famine areas would cause an increase of supplies through normal trade channels.

However, the Commission of 1908 was not totally bereft of social conscience. It recommended that government should suppress the use of opium in brothels.

By 1924, however, the public outcry against opium smoking had reached such proportions that the Commission recommended measures whereby consumption of opium could be reduced and that the way be prepared for eventual registration of opium smokers and rationing of supplies.

The opium monopoly continued right up to the outbreak of the Pacific war. It was managed by the Customs Department. The opium packing plant in Singapore was sited in Pasir Panjang. After the war, opium smoking was prohibited on 1st February, 1946, and the plant was closed. Its premises were used for storing rice. However, thriving business of opium smuggling developed. But with the registration of addicts and rationing of supplies introduced in 1929, the number of addicts gradually diminished as addicts died, replacements by new addicts being much less than those who died.

The current campaign against drug abuse in Singapore deals with a different situation. Unlike the old problem of opium smoking which concerns mainly old people, the present problem centres around the young. Consider the figures of young people arrested, 14–25 years of age. In 1973, the total number of such young drug takers arrested is 1,011 (16.7 per 10,000 young people of the age group concerned); in 1974, the number increases to 1,329 (or 21.3 per 10,000) and in 1975 it goes further to 2,550 (or 40.1 per 10,000).

Let us look at the 1975 figures. For that year a total of 4,201 drug abusers were arrested; so the 2,550 young drug takers, 14–25 years of age, constitute 61% of addicts arrested. And for the first half of this year, the number of young persons arrested stands at 2,166. That means incidence of drug taking has nearly doubled as compared with last year.

Why this increase? Perhaps more effective raids by the Central Narcotics Bureau may account partly for the rising rates; but given the large increases, we must believe also that more and more youths are succumbing to drugs. In the late 60s and even up to 1974, the typical drugs resorted to were ganja and MX pills; but since the beginning of 1975 hard drugs took over, the most popular of which is heroin.

In 1975, 1,725 out of 2,550 or 68% of the young drug takers arrested used heroin. There are of course drug takers unknown to us, because they escaped arrest and are unwilling to come out to seek treatment. How many of these we do not know. But the picture emerging from the known cases is a disturbing one — drug abuse appears to continue unabated, enslaving growing numbers of our nation's youths.

We know that people who take such hard drugs like heroin are certain to become addicted. Unless cured of their habit, they will eventually ruin their lives. We know that in most instance craving for drugs becomes an obsession and addicts will do anything to get regular supplies.

I will illustrate problem of drug addiction from case studies of soldiers in the SAF who have been caught taking drugs or who have volunteered for remedial treatment. This is not because soldiers are more prone to drugs than the rest of the population. In fact, the rate of drug addiction is much less. This again is not because soldiers are more virtuous than others, it is because those who are known to have a history of drug abuse are not enlisted for full time national service. However, as these records are not 100% complete, some escape notice and get enlisted.

In the SAF, since a soldier remains with us for two to two and a half years, plus whatever period he spends under detention, we are able to maintain proper records of drug takers over a long period. We have established a counselling service manned by both professional and voluntary workers, We have also made studies of their personality structure and family and social backgrounds.

The easiest way out for the army is to discharge the addict after he has served his term of detention as they are unlikely to make good soldiers. However, in an effort to help in solving this problem for society as a whole, we try to rehabilitate them. The intention is not only to reform them while they are in the army but also to help them to get secure jobs after they leave so that they can stand on their own feet, earn a secure living and become a normal responsible citizen. As this scheme started only a year age, it is too early to say whether we shall succeed.

Some addicted soldiers spent as much as $900 monthly on drugs. Not infrequently, because of a complusive craving for drugs, addicts take to theft, robbery and other forms of crime. There is a soldier who earns extra money to maintain his drug habit by working during his off days in an opium den. A recent sample study of 48 hard drug abusers in the SAF shows that about half of them had committed military offences of one type or another ranging from AWOL, sleeping on duty to gambling and theft. The majority performed poorly in training and work. Other countries provide similiar evidence of this kind. The American National Commission on Marijuana and Drug Abuse pointed out in its second report that the use of opiates in the United States, particularly heroin, makes it likely that the addict will resort to crimes such as theft and robbery to get money to buy drugs. Women resort to prostitution.

The individual and social ills resulting from drugs abuse are therefore real and costly, and are known to be so. Why then do so many people ignore these dangers? Why do they act as if oblivious to the evils.

Investigators in this area have thrown up a variety of theories. But the crucial points centre on two questions. First, what factors prompt or initiate youths into drug taking? Second, what makes them continue drug taking till it becomes a habit?

How easily a youth can be induced to drug consumption depends on the ethos of his society. In the affluent, permissive communities of the west, indulgence in marijuana and other drugs stirs no ripple of concern: on the contrary, many people who should know better extol it as life-enhancing. This is one result when people give themselves up to pursuits that are self-centred and sensation-seeking, hungering after new forms of stimulation and experience. If a people believe that the purpose of life is pleasure and enjoyment, they will be more prone to taking drugs as these provide enjoyable experience.

Happily for us, this ethos has not taken root in Singapore in a big way. But it has won the allegiance of a small group of youngsters from fairly well-to-do, western-oriented homes. They foolishly believe that everything western is good. So they eagerly submit themselves to be initiated into drugs for the sake of novel experience, of experimenting with living.

Poor influence is a strong factor here. People's behaviour tend to follow that of the group they usually associate with. If a person's best friends are taking drugs, he is likely when persuaded to follow suit. Case studies of hard drug addicts in the SAF provide supporting evidence for this. The majority of drug takers in the Army had been on drugs for an average for two years before enlistment into national service, many of them picking up their habits while in primary or lower secondary schools, at work sites or while unemployed. Almost always, their introduction of drugs was made through class mates and friends.

There are a few odd exceptions. In one case a soldier who was a morphine addict confessed that he started on marijuana when he was 15 — and by accident. He lived in an attap house in a lorong off Thomson Road. Being an introvert, he had a habit of going to a nearby Jewish cemetery whenever he was moody or upset. One evening during his Hamlet-like visit to the cemetery, he chanced up a huddled group of youths who by turn were each inhaling marijuana fumes from a bottle. The group invited him to join in and though they were total strangers, he accepted, partly out of curiosity, partly because of the lure of togetherness. So under such bizarre and macabre circumstances, another drug addict was bred.

There are of course other external influences that caused people to start on drugs. These, however, do not appear to constitute the central motivation of drug addict. Studies show that more important than external factors is the addict's psychological make-up — his personality attributes, his disposition, his way of looking at himself and the society at large. For here we may find a clue as to why some youths opt out of society's mainstream and take drugs while the majority stay within it and do not.

There exists a substantial accumulation of clinical evidence to indicate that the bulk of drug addicts possess weak personalities. They can be described as being unsure of themselves, possessing feelings of inadequacy and are subject to persistent attacks of undue anxiety. They are incapable of coping with whatever work they have to do, either as students or workers. They are unsure of their position in relation to other people including members of their family.

Such character defects or weakness are likely to get worse if the people concerned cannot get out of the rut. Because they are nervous and anxious, they perform poorly at work or school. This increase their anxiety and uncertainty, leading them to dislike study or work. They develop feelings of animosity towards society. For such people, drugs afford an escape from unpleasant reality. Narcotics like heroin generate euphoria and well-being while the effects last. Since drug taking is illegal, it has an added attraction for them as a gesture of defiance towards the society which they feel has rejected them.

A recent study of 120 hard drug abusers in the SAF confirms this general picture. Most of them are school dropouts, significantly from the English stream. Apart from their drug behaviours, they are found to be more neurotic and emotionally unstable then the average soldiers. Before national service, those who worked could not get secure employment — they hopped from job to job. Those who had held only one job before joining the army stayed on that less than a year. Drug taking merely makes them even less effective and compounds the problems.

The SAF study further revealed that as much as one-quarter of its sample had lost at least one parent; and that a smaller group had parents who were either divorced or separated. Those are physical facts, easily ascertainable, about a drug taker's family. Without doubt they have as much a bearing on the formation of the drug taker's personality characteristics as on his motivation in drug taking. No less important is the quality of family life. Is there sympathy and understanding between parents and children? Do members of the family rally to help a member who is in trouble? Do parents show an interest in the growing up and education of their teenagers? Our studies show that the family life of addicts lack these relationship of warmth and friendship which are normal in secure and happy families.

SANA is trying to go beyond symptomatic treatment to rehabilitation. The goal is to transform an addict to a responsible, useful citizen. To achieve this, to change the personality traits and outlook of an addict, counselling and other forms of aftercare are necessary.

Ultimately, our best hope is still prevention. No doubt, the incidence of drug taking is related to availability, and if we could stop drugs from circulating within our society, the problem would be solved. This is not easy to achieve. The severe punitive measures recently introduced against drug trafficking will help to reduce supplies but whether supplies will be totally stopped remains to be seen.

Efforts towards drugs prevention must therefore be supplemented in other ways. Parents have a big role to play here, They require assistance. Education in the form of moral injunctions against the evils of drug abuse will in itself help little. What is needed is practical advice — what parents could do to prevent their children from resorting to drugs, how they could detect if their children were on drugs, and if the children were confirmed to be on drugs what should they do.

In a sense, we can say that drug addicts are social casualties. One would have to exclude the foolish youths from well to do families who deliberately experiment with drugs because they believe this is the fashionable thing to do. Parents in such families who over-indulge their children have only themselves to blame if their children take to mischievious ways because they are given more money than they have common sense. This is particularly true of children who are sent overseas for education. There is no parental control, there is also plenty of money supplied because doting parents want their children to live well. Then there is the permissive environment in some western countries. A combination of these three factors has often had tragic consequences.

Children from poor families suffer from the opposite handicap. Parents drive their children hard in the hope that they will succeed in life. Many send their children to English language stream in the belief that this will open up avenues to higher professional education — doctors, engineers, economists and scientists. Those are admirable attitudes but where these aspirations bears no relation to the capacity of the child, the result would only be harmful.

It is worthy of note that a great majority of drug addicts among SAF are dropouts from the English stream. Nearly all of these are from dialect speaking families. I suspect that the feeling of inadequacy, insecurity, over-anxiety and other personality defects arose in school when the child is educated in a language which is not spoken at home. Constant parental censures merely increase his anxiety, enhance his feeling of inadequacy and make him even perform worse in school. Eventually he gives up and becomes a wrecked personality.

Parents should understand that not everyone can get four distinctions at the HSC examinations. These results are possible only to a gifted few. The rest should settle for something within their reach and there is a wide variety of occupations and careers which our economic system can provide and which will ensure adequate incomes and decent living for all who are willing to make the effort.

Two final observations. First, when I said that many drug addicts are social casualties, please do not infer from this that I am in favour of lenient and sympathetic treatment of drug addicts. Such a view is fashionable among so-called radical or liberal thinkers. Needless to say, I do not subscribe to their thinking, because I believe they are wrong. So-called progressive views applied to the treatment of criminals has led to a dangerous upsurge of crime rates, especially crimes of violence, in societies whose leaders have been foolish enough to be beguiled by these soft-headed views. As a result, innocent citizens get robbed, raped or killed by the criminals who should have been in jails.

However much we pity our addicts, they must be dealt with sternly as an example to others. Soft treatment of addicts is likely to encourage the belief among our weak minded youths that they can commit drug offences with virtual impunity. In the SAF, drug offenders are tried by court martial and sentences vary between six months to two years. When we have more professionally trained counsellors, we intend to release offenders on conditional probation before the expiry of their sentence as a method of rehabilitation. If rehabilitation fails, they return to detention. On the second point, I will venture to suggest that as more and more people live in the city and in apartment blocks, problems of psychological stresses which I have discussed are likely to be more acute and widespread. Studies of soldiers who are school dropouts and who live in the countryside show none of the character weaknesses seen in the sample of drug addicts in the SAF. In their childhood, these soldiers displayed no aptitude for study, spending their time roaming the countryside in search of spiders, crickets and other insects, birds, butterflies, fish, lizards and so on. All claimed to have thoroughly enjoyed their childhood. Parents were sympathetic, even indulgent. Their schools were Chinese village schools, not particularly well-run.

When asked whether they would not have done better if they had played less and studied more, they admitted that if they had passed their school examinations, and were able to get a university education, undoubtedly, life would had been better for them. But they said that they were not made for study and that a university or professional education was not a realistic objective. None regretted what many would consider a misspent childhood. They are all good soldiers, present no disciplinary problems, subscribe to most of the traditional ethos, including belief in the virtues of hard work, and surprisingly, also believe that they have a bright future after they leave the army. Possibly this is because they have geared their expections to a realistic assessment of their capabilities.

Speech by Mr Chua Sian Chin, Minister for Home Affairs & Education, at the Opening Ceremony of the First Meeting of ASEAN Drug Experts at the Crystal Ballroom, Hyatt Hotel, on Tuesday 26 Oct 76 at 1045 hours

The growing problem of drug abuse and drug trafficking is causing grave concern among ASEAN governments. Its seriousness and importance was underscored when the need for close co-operation among member states to combat it was included as part of the Declaration of ASEAN Concord signed by the Heads of Government at the Bali Summit in February this year. This meeting of ASEAN Drug Experts is to translate into positive action this accord to jointly eradicate this common menace from the ASEAN region. Singapore is therefore privileged and honoured to have been chosen to host this First Meeting of ASEAN Drug Experts.

2 Drug traffickers recognise no national boundaries. The activities of international drug syndicates usually cover a number of countries. It is therefore not possible to combat it successfully without the assistance and co-operation of other international and national enforcement agencies. The drug problem has also grave security implication. There is evidence that drugs have been used as a weapon for subversion either to weaken the resilience of the population, particularly the young or as a source of finance to buy arms and hire agents for subversive activities.

3 We in Singapore are now engaged in an all-out war to break the backbone of this problem. We served notice to drug traffickers when we amended the Misuse of Drugs Act in December 1975 to make the death penalty mandatory for the offence of trafficking heroin and morphine in excess of 15 grammes and 30 grammes respectively. Since then our High Court has sentenced to death 6 heroin traffickers. Another 16 are awaiting trial and if convicted will be given the death penalty. Similarly, the other ASEAN countries, if they had not done so before, have recently introduced penal provisions to sentence drug traffickers and/or manufacturers to death. But the legal provisions must be followed by effective enforcement if drug traffickers are to be discouraged from carrying on their trade. Free exchange of information and prompt action by enforcement agencies of the ASEAN countries should make it unsafe for the traffickers not only to hop from one ASEAN country to another but also dangerous to operate at all in any of the countries.

4 However, there will always be some who cannot resist temptation and greed. They will continue to traffick in drugs even at the risk of forfeiting their lives, so long as there is big money to be made. There must therefore be a sustained attack not only on the supply side but also to check the demand for drugs.

5 This means that the drugs abusers and addicts must also be arrested and put through a process of rehabilitation. This must be done at a sufficiently rapid rate to prevent further proliferation, for an addict at large has a propensity to turn on others. For example, if 1,000 addicts have potential of getting another 1,000 persons to consume drugs over a period of one year, then 690 addicts must be arrested during the year in order to keep the number of addicts the same as that at the beginning of the year. More than this number will have to be arrested if addicts who have undergone rehabilitation later go back to their drug habit.

6 This recycling or recidivism must be stopped and stopped quickly if the drug problem is to be solved at all. To achieve this successfully drastic measures are necessary. We have found from experience that there are no soft options here. Rehabilitations based on the voluntary and soft approach is ineffective. We have tried and failed.

7 Let me illustrate our experience on this. In November 1971 when our Central Narcotics Bureau was formed, morphine and heroin had hardly appeared on the scene. The drug problem then consisted of young people found consuming MX pills and ganja in growing numbers. Under these circumstances the Government decided to develop a Drug Rehabilitation Centre (DRC) at St John's Island, an island off Singapore.The main considerations was to keep the addicts away from the drugs for a period. There they were given replacement therapy, that is, drugs in decreasing dosage to help them gradually free themselves from their craving for drugs. Their daily routine at the Centre was not unlike that of a holiday camp. In fact some addicts who run short of funds for drugs volunteered for admissions to the Centre because they could then get replacement therapy.

8 In the meantime our drug problem had deteriorated rapidly. In 1972 only 4 persons were arrested for suspected heroin offences. This increased to 10 in 1973 and 110 in 1974. In 1975 there was a sharp increase to 2,263. And for the 6 months of 1976, 2,284 persons were arrested for suspected heroin offences. To stop this deteriorating situation, decision was therefore taken towards the end of 1975 to shift the Rehabilitation Centre to more spartan surroundings. A former army camp at Telok Paku was selected for this purpose. The soft approach was abandoned. A tougher and more comprehensive programme of rehabilitation was introduced at the new Telok Paku Centre. Instead of replacement therapy, addicts entering the centre are not put through the "cold turkey" treatment. The agonies of "cold turkey" withdrawal should be a constant reminder to former addicts to resist the temptation to return to drugs.

9 The inmates of the Centre have now to follow a strict daily routine so that work discipline can be instilled in them. This is to prepare them for employment upon their release. Experience shows that drug addicts who found jobs upon their release could not hold on to them because their capacity for sustained effort had been seriously impaired both by addiction as well as the leisurely tempo of life at the Centre. Now at Telok Paku the inmates are given work for eight hours a day and 44 hours a week besides other forms of activity. This work include simple assembly of electronic components, bag making and furniture polishing.

10 Another important innovation is the introduction of compulsory aftercare. This is to minimise the chances of the inmates upon their release from reverting to drug-taking. They are required to be supervised by a counselling officer and to observe certain conditions. One of them is that he is required to inform his counsellor if and when his former drug taking "friends" were to contact him.

11 Owing to the large number of former addicts who need aftercare, it is found not feasible to employ professional aftercare officers for this purpose. We have therefore devised a plan to train part-time National Servicemen in the Special Constabulary to do the counselling under the supervision of professional aftercare officers. Most of the National Servicemen selected to do this job are professional men in their civilian life. 50 have already completed their training and another 112 are now under training. At present counselling officer deals with 3 cases. The ideal is for one counsellor to deal with only one case at a time However, since those who require aftercare are expected to grow in numbers and the number of National Servicemen that can be trained is limited, the ratio of 1 counsellor to 3 cases will remain for some time. Thus, this complusory aftercare provides the continuity in rehabilitation which is absolutely vital to its success.

12 The new Telok Paku Centre has accomodation for 600 inmates, that is 480 males and 120 females. Since its operation in April this year the enrolment at the Centre has slowly been build up and to-date has reached 590 which is near its full complement. Plans are in hand to expand the present Centre. It has been estimated that there are about 8,000 addicts in Singapore. To contain the problem it will therefore be necessary also to establish additional centres.

13 Thus one of our immediate problems is that of securing adequate accomodation fast enough to cope up with the large numbers of addicts which must be rounded up to prevent their proliferation. Accomodation includes provision of special rooms for inmates undergoing "cold turkey" treatment which usually take time to build. In fact the special "cold turkey" rooms at our present Centre are still under construction and are expected to be completed by the end of December. This has caused some problems of congestion at the present temporary "cold turkey" rooms.

14 We also found that there are problems of co-ordinating in the work of rehabilitation at the Centre. This is because the work of drug rehabilitation is a multi-disciplinary one and involves a number of bodies and departments. Apart from provision of accomodation, security and instilling of work discipline the other aspects of rehabilitation include counselling and aftercare and medical attention which come under the social welfare and health departments. We are therefore considering setting up a Co-ordinating Committee to direct and co-ordinate the various areas of rehabilitation work at the Telok Paku Rehabilitation Centre.

15 I hope our Singapore experience will be of some use and help to you in your deliberations. I wish the Conference every success.

16 I now have great pleasure in declaring this First Meeting of ASEAN Drug Experts open.

THE OBJECTIVES OF ANTI–DRUG ABUSE EDUCATION

Dr Tow Siang Hwa,
Past President, Singapore Anti–Narcotics Association

Drug Misuse is a man-made disease. It causes are multiple and complex, hence its cure is equally complicated. The old saying "Prevention is better than cure" aptly applies to the drug problem. It is far easier to prevent than to cure drug addiction.

In this Campaign our primary function is summed up in three words: Prevention through Persuasion. While our words may not sink in with the hardened addict, they will find a receptive audience with the masses of children and young people, and adults who have not been infected by the drug bug. These are our target and to them our message must be beamed.

FACTORS CAUSING THE DRUG EPIDEMIC

Five years ago the President of the Association for Mental Health publicly warned of the increasing threat of drug misuse. At that time he sounded like an alarmist. Today we find that his words have been more than substantiated.

The misuse of various drugs has steadily increased, causing ripples of unease in our society. More recently, however, heroin consumption has increased at an alarming rate. It seems as though shock waves from the drug explosion in the west have now reached our shores.

What has caused this epidemic outbreak of heroin misuse? Let us briefly consider some of the factors. First is the easy availability of the drug. With the massive influx of visitors and tourists by air, land and sea, customs checkpoints are practically reduced to a formality. Drugs can be bought into Singapore with little risk of detection. The notorious "Golden Triangle" is only a few hours' flying time from Singapore. With the huge profit at stake and the ease of smuggling, international drug trafficking becomes attractive business.

Second in our consideration is the matter of demand. Restless youths are in quest of thrills and excitement, experimentation and experience. Anything to escape the pressures of school or the frustrations of broken homes and unfulfulled ambitions, anything for kicks and comfort – all these are attractive to young people. The drugs are available, everybody is trying. Would you chicken out?

A thoughtless act, a moment's pleasure and the hook is in. Then follows a life-time of misery and regrets. Once the body is conditioned to the drug, there is little hope. The mind may long for release but the body finds no escape. Hooked! Why did they ever started?

A LOOK AT THE AMERICAN SCENE

As educators we can learn much from the experience of others. Let us for a moment focus our attention on America, the great country and pre-eminent leader in almost every field of human endeavour. Its experience with the drug problem is unrivalled. In some high schools and colleges more than half the pupils have some durg experience. Why has a nation of highly intelligent, educated and affluent people taken to drugs on such a vast and unprecedented scale?

America is the land of the free. Freedom rings from east to west and from north to south. Freedom pervades thinking and action and life styles. The spirit of free enterprise inspired the building of the strongest economy in the world. "Personal freedom" ensures the rights of the individual – to speak, to consume, to live the life of one's choice. From the moment of birth, the child is given free rein to grow and develop with the minimum of parental restraint. Had not Dr Spock convinced the nation that parental control and inhibition would harm the child's normal development?

In such a milieu children grew up percociously mature, independent and without adult control. Indeed many a father had long abdicated his authority over his son, each going his own way, pursuing his own interest – the father to his clubhouse, his drinking and smoking friends while the son looked for his own excitement. Thus grew the generation gap, an ever-widening gulf between children and parents, between youths and elders.

Onto this American scene there appeared in the late fifties and early sixties the drug movement which was to enslave masses of mindless youths, sweeping the country from shore to shore. Aldous Huxley (1954) wrote a book *Doors of Perception* advocating the use of drugs "to bypass the reducing valve of the brain" and give the user "increase awareness". The promise was what restless American youths were looking for: a new experience. Timothy Leary campaigned for the free use of drugs and led millions down the slippery path of LSD tripping. With his slogan "Tune in, turn on and drop out" he built his "League of Spiritual Discovery" and "Brotherhood of Eternal Love" – one of the largest and most complex drug systems ever discovered in America.

The drug movement received its biggest impetus from the Pop-Rock revolution, with musicians such as the Beatles, Bob Dylan, Jimi Hendrix and the Rolling Stones glorifying drugs misuse in their songs and in their lives. Their electronic guitars beat out a hypnotic pulsating message across America and around the world., luring millions into the snare of misuse. At Woodstock 400,000 devotees, many with long hair and hippy trappings, drank in the rock-sex-drug message while Bob Dylan and his band piled on the heated decibels for three whole days. It was a "free-for-all" drug festival.

In the face of such overwhelming lawlessness the law itself loses effect and meaning. No amount of adult protest or enforcement officers can cope with such situation.

As drug proliferated, the climate of public opinion turned for the worse. Adult protest were weak, uncertain, divided and lacking in conviction. Against these was a large and vocal minority of pro-drug elements, clamouring for the legalization of drugs, supported by a mass of pro-drug literature and a flood of drug-oriented songs.

We must learn from the American experience. We must never allow things to go the same way. Once youths have made their minds there is little the adults can do to change them. Arguments and persuasions are simply brushed aside. If adults have their 'chemical comforts – alcohol and tobacco – why stop the young people from enjoying theirs?

OUR LOCAL PROBLEM

What is the situation like in Singapore? While ganja, methaqualone, barbiturates, morphine and opium all feature on the local drug scene, heroin heads the list by the meteoric rise in the number of abusers. Whereas there were 10 heroin arrest in 1973, 110 in 1974, the figure for 1975 was 2 263. The majority of these are below the age of 30 years with an increasing number of school children getting involved.

If the present trend is not arrested, its consequences for Singapore are not hard to imagine. The health and well being of thousands will be destroyed. Our very survival and national security will be in jeopardy.

THE ROLE OF SPEAKERS

The speaker's role is essentially that of an educator and persuader. Our business is to communicate the message of "health without drugs". We must get our facts right and information up to date. Wrong statements and muddled thinking will be disastrous. So let us learn all that should be known about the problem.

Let us adopt a sound and balanced approach, trying always to present both sides of the picture: the positive as well as the negative. While we talk of the dangers of drug abuse, let us not forget their medical uses and benefits. Let us stress the importance of healthy living and not merely the ill effect of drugs.

Let us cultivate the gentle art of persuasion, presenting our case clearly and convincingly, because we believe in it. At no time should we resort to exaggeration, misrepresentation or distortion of facts, ridicule of others or the use of scare tactics. Never talk down to an audience ; the barrier thus created will

nullify the message. On the other hand let us show genuine concern and if possible evoke in the audience a sense of self-respect and usefulness. These will pave the way for the message to get across.

BE SURE OF YOUR OWN PHILOSOPHY

The drug "subculture", as some call it, is a way of life or life style. In our efforts to combat it, we must seek to understand the outlook and aspiration of addicts. Many of them have no set purpose or aim in life. There is a vacuum in their life which they seek to fill with drugs. Pleasure there is, for a time, and then bitterness and frustration take over.

As speakers, it is vital that we have a clear concept of the useful and productive life in which everyone has a part to play. We must be thoroughly convinced that life can be rich and meaningful without resort to drugs, and that drugs only create problems while solving none.

It is also necessary for us to adopt the right attitude towards the law which is the prime target of attack by pro-drug activists. They argue that if there were no law there would not be any drug problem. Therefore the way to remove the drug problem is to abolish the law. We need to understand and anticipate this sort of warped and perverse thinking, and take a positive stand for the law.

Let us bear in mind that the law is for the protection of innocent people, our children and youths especially. It is our duty to protect them against unconscionable and merciless traffickers whose sole aim is to wax rich on the misery of their victims. These public enemies must be apprehended and made to pay for their crimes, whether by imprisonment and caning or by death. Unless the law carries penalties that hurt how can it ever deter?

Our whole philosophy on such matters must be correctly orientated, if we are to be effective anti-drug campaigners.

EDUCATIONAL PROGRAMMES & CAMPAIGNS MAY DO MORE HARM THAN GOOD

One of the conclusions of social researches elsewhere is that educational programmes and campaigns may not achieve the desired objective of reducing drug misuse but may actually have the opposite effect. Let us examine the validity of such claims.

The first question which we should try and answer is this: What go to make a successful campaign? To my mind there are three factors. A sympathetic and receptive audience, a well-conceived message based on fact, and a good presentation by the speaker. If the audience is already sold on drugs, and drug abuse is the "in-thing", then it will be pretty difficult for us to change their minds. In fact they can become hostile and shout the speaker down, making him look foolish. With such an audience a campaign can be truly counter-productive.

A message which is not backed by solid fact and scientific evidence will not go down well with the average high school and college student, who need some pretty strong arguments to be convinced. If the message is loaded with exaggerations and scare tactics, or any inaccuracy, then it is going to back-fire. Some of the imported films and other so-called educational material which I have seen carry extremely weak messages. Some are non-committal and indecisive, and a few are even subtly "pro-drug".

Lastly, the speaker. Some have no rapport with the audience or try to talk down to them. Others fail to speak with confidence and personal conviction, or they may get their facts mixed up.

From the foregoing, it is not difficult to see why many of the American programmes were found to have done more harm than good. It is a case of "too little too late". When public opinion is already decided in favour of drugs, then no amount of campaigning or persuasion is going to work. Only recently, a high American leader said that if his son had told him that he was consuming marijuana, he would commend him for his honesty! No wonder drugs have become America's No 1 problem.

WHAT MUST WE DO ?

In the light of the foregoing, what must we do? Some have suggested that we may do more harm

with all the publicity of a campaign. I do not for a moment accept this sort of defeatist attitude and throw in the towel without even firing a shot.

I am firmly of the opinion that a vigorous and ongoing campaign at this time is vital to our entire effort to arrest the drug epidemic. The situation in Singapore is not comparable to that in America where the drug revolution was fostered. There is no "Anti-establishment" movement or vocal pro-drug faction among the student population. The climate of public opinion is still firmly against drug abuse. Adult authority is still the norm at home and in school. Our children still accept correction and guidance in the eastern tradition of submissiveness although this sort of docility may show signs of erosion at times. Nevertheless, respect for elders and for the law are still prevailing features of our society.

How about our campaign programme? You may rest assured that utmost care will be taken in our preparation of resource materials to ensure that only the truth and the best will be used. We shall avoid making those mistakes which go to nullify a campaign which we have already considereed. We shall spare no effort to make available to participants in our campaign materials of the highest quality containing a dynamic and balanced message.

It is now for you, the speakers, to prepare yourselves so that, armed with resource materials, you will be able to present a convincing message of healthy living without drugs. We need more voices speaking in unison than one message. Indeed, we want a whole chorus of voices from young and old, informing and warning all who have ears to hear. This will ensure the creation of a powerful public consensus for health and against drug abuse. This, I say, is our best and strongest weapon in our fight against drug abuse.

THE LAW OUR PROTECTION

It is also our great good fortune that we have tough laws. This is our best protection against drug misuse. The introduction of the death penalty for narcotic trafficking may appear unduly harsh to some. However, let us not be carried away be soft sentimentalism and misguided sympathy. Remember, the trafficker is out to enrich himself at the expense of young lives condemned to narcotic addiction and the "living death". Think of the thousands of youths now hooked on heroin, careers wrecked, health ruined and future lost. Think of the untimely deaths from narcotic overdose.

If we value the young lives let us give them adequate protection. When dealing with narcotics with their high stakes, and dollars are traded for lives, there is only one answer: make the penalty match the crime.

There are some whose concern is for the criminals— how to salvage them by rehabilitative mehtods. This sort of soft treatment is the surest way of encouraging crime. What criminal is worried if for his misdeeds he is assured of free food end lodging and the luxury of books, television, recreation and entertainment even behind bars?

In America, faith in rehabilitation is suffering a collapse. Even the sociologists, the champions of rehabilitation, are in retreat. Their disillusionment is such that the worth of the whole rehabilitative programme is now called into question. Lately there is a call for the punishment to fit the crime. The swing of public opinion in many areas is back to capital punishment. Ex-President Nixon said "I am confident that the death penalty can be a valuable deterrent" — in reference to drug trafficking.

As speakers, we would certainly not like to see anyone go to the gallows. Therefore, let us make it widely known that drug trafficking does not pay so that at least some of the would-be traffickers may desist from their dangerous game.

TOTAL COMMUNITY INVOLVEMENT

Our campaign calls for total community involvement. All persons in places of responsibility have a part to play. In the home — parents, in school — teachers, in places of work — the employers in society — the leaders among youths — their own peers.

Let everyone who is concerned for the continued well being and prosperity of our country join in the fight against the threat which may cripple our youths, our health and our whole economy. Everyone has a responsibility.

The responsibility is yours.

COMMONLY ABUSED DRUGS

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Nobody can deny that drugs (medicines) play a very important role in health care and currently is the basic weapon in the fight against disease. However if we turn to drugs as the solution to the problems of everyday living and concepts are even promoted or tolerated over the mass media, the trend is toward a drug-orientated society, and we should ask whether this is desirable.

Advertisements in mass media often depict the overworked executive, the harassed housewife, the tired lorry driver or the pressurised student turning to a particular product for relief or as the answer to their problem. There is also an increasing reliance on mood elevating drugs for the depressed as well as the enormous use of tranquilliser drugs for the tense. For every deviation from health, great or small, a pill is sought to the extent that it is also widely believed that good health has to be maintained by the use of drugs.

Drugs are chemicals foreign to our body and modern drugs are also potent and powerful. They have great capacity to alter our body function and correspondingly similar capacity to do harm. The ideal drug that will produce only the desired effect without causing other unwanted effects is a myth; there is no such thing as an effective and harmless drug.

If drugs cannot be used without causing some harm to the body why then do doctors prescribe them for their patients? Doctors prescribe drugs only after careful weighing of the benefits that can be derived against the potential harm that can be caused. It is only when the benefit outweighs the harm that the use of a drug is justified.

Drugs may be compared to atomic energy. When used rationally they are extremely beneficial; when used irrationally they are destructive.

DRUGS OF ABUSE

From the scientific viewpoint a drug is any chemical substance which when taken by a living organism acts to interfere with the living processes of that organism. However, the term "drug" conveys different meanings to different people. In our present local context, it is used by the public in a specific restricted sense to mean "drugs of abuse" (ie morphine, methaqualone (MX), ganja, etc) In a doctor-patient context, it is usually used to mean "medicines" taken for the relief of symptoms or to cure an illness. In this paper the term is used to refer to "drugs of abuse".

The drugs of abuse can be broadly classified into five main groups as follows:

1 Narcotics
2 Depressants
3 Stimulants
4 Hallucinogens
5 Ganja (Cannabis Sativa)

These drugs have one property in common in that they act predominantly on the brain to cause changes in mood, behaviour and perception. It is for these effects that they are misused.

NARCOTICS

Typical examples of narcotic drugs are morphine, heroin and codeine. These are derived from opium, a product of the opium poppy (papaver somniferum). Morphine and codeine occur naturally in opium whereas heroin is manufactured from morphine by chemical conversion. Other narcotic drugs with abuse potential are synthetic products, eg pethidine and methadone.

Medical uses and pharmacological actions: These drugs are potent pain relievers and used by the medical profession to relieve pain and anxiety in a patient. They are particularly effective for persistent pain associated with much anxiety. They are a great blessing in certain untreatable conditions, eg in the last stages of cancer, for even though the doctor is unable to cure the disease, he is at least able to alleviate the physical suffering and allay mental anxiety. Other uses are for the suppression of cough (codeine) and symptomatic control of diarrhoea.

Drugs are often double-edged weapons in that they can do good as well as harm. The narcotic drugs illustrate this very well. One of their actions on the mind is to produce a state of well-being tranquility, contentment and satisfaction. This complex pleasant state of mind has been called euphoria. Other effects are not so agreeable in that they also cause nausea and vomiting and, more dangerously, depress respiration. An overdose causes death due to respiratory failure.

Effects of Abuse: Nobody starts taking a drug with the idea of getting addicted to it. However, individuals vary in their susceptibility to addiction (used in the sense of "dependence" as defined by WHO). WHO's definition of drug dependence: "A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug". There is no way of knowing whether a person is dependent on a drug until the administration of the drug is stopped. If this is followed by physical discomfort or a strong yearning for the drug then dependence has developed. The degree of dependence will vary according to the type of personality, the duration and quantity of the drug used.

How is drug dependence brought about? Whenever a drug enters the body (whether taken orally or injected), the body works to get rid of the drug. This is done mainly by the liver which changes the drug to a form more easily removed by the kidneys. Frequent taking of the drug usually increases the efficiency of the body's mechanism for disposing off the drug. Therefore, larger and larger doses of the drug have to be taken in order to continue experiencing the desired effects (eg euphoria). This leads to development of "tolerance" to the drug (pharmacokinetic tolerance). Meanwhile other cells in the body, not concerned with getting rid of the drug, gradually adapt to function in the presence of the drug (cellular tolerance). Their orderly function becomes dependent on the continuous presence of the drug. If the drug supply is suddenly stopped, the functioning of these cells is deranged. Their derangement or disordered function gives rise to the withdrawal or abstinence syndrome. In the case of a narcotic addict he suffers from severe abdominal cramps, diarrhoea, muscle aches and pains, cold sweats and shivers, insomnia and mental agitation and in extreme cases suffer collapse and may die. In order to avoid this very unpleasant and uncomfortable experience the addict goes to great lengths to get his daily "fix" which is required in larger and larger amount or more frequently as tolerance further develops. This is a vicious circle, and hence the popular usage of the term being "hooked".

Drug dependence in which deprivation of the drug leads to development of the withdrawal syndrome is referred to as physical dependence. This has been described above. However, there is a second kind of dependence termed "psychological dependence". In this type there is a strong emotional craving for the drug and the person is psychologically dependent on the drug for his well-being, but suffers no characteristic physical withdrawal syndrome. The degree of psychological dependence depends largely on the personality of the drug addict and on the particular drug being used. Psychological dependence poses a more difficult problem than physical dependence in the rehabilitation of drug addicts because of the tendency to return to using the drug. The narcotic drugs induce both physical as well as psychological dependence.

DEPRESSANTS

Examples of this group are alcohol, barbiturates, methaqualone and Mandrax (MX). They exert a generally depressant action on the brain and increasing doses cause progressive loss of function until finally, when the vital centres controlling blood pressure and respiration are affected, death ensues. Barbiturates, methaqualone and Mandrax are products manufactured by the drug industry and marketed for use as hypnotics (including sleep). Alcohol is very well known and man has the most varied and ingenious ways of producing it with various flavouring, eg samsu, toddy, gin, whisky, etc.

Medical uses and pharmacological actions: These drugs have many important uses. In small doses they are used for their sedative or calming effect in anxiety states. They are widely prescribed to induce sleep. Some barbiturates are also used to control convulsions and in treating epilepsy.

Pharmacologically these drugs cause depression of brain function. The more highly developed and specialised centres are more susceptible and are first affected. This is seen particularly with alcohol because the manner in which it is taken allows the gradual manifestations of its effects. The brain cortex is first to be affected leading to a reduction of our cultivated inhibitions or restraints. Thus after one drink, there is often an apparent "stimulation" effect, the person becoming less critical of himself and consequently more communicative, more sociable and possibly in a lighter mood. As the dose is increased, the mind becomes clouded and confused, reasoning and control of emotions are affected. The nature of the response at this stage depends to a large extent on the personality and the environment. Further drinking leads to loss of muscular co-ordination (eg drunken gait), vision becomes blurred, there is slurring of speech and eventually consciousness is lost. Methaqualone is a non-barbiturate hypnotic and is available either by itself or in combination with an anti-histamine and known as Mandrax. Apart from its hypnotic action which resembles the barbiturates it seems to have also a narcotic-like effect. This effect was recently discovered by heroin addicts. Heroin addicts prescribed methaqualone for symptoms of anxiety and insomnia following withdrawal, indicated a preference for it. Persistent questioning led to the admission that the drug gave them a "buzz", meaning a positive pleasure response similar to the narcotic drugs.

The depressant drugs in general impair psychomotor performance, ie actions requiring integration of mind function and body movement, eg working with machinery, driving a car, etc. This impairment of judgement is not obvious to the person concerned, he is least able to judge the degree of impairment. Consequently he continues to drive cars, etc without appreciating his disability. Also, as he becomes less critical of himself, he is often under the delusion that his performance has improved.

A particular hazard which should be stressed is that one depressant drug enchances the action of another depressant drug, eg the effect of alcohol is accentuated by other sedatives, hypnotics, tranquillisers and even anti-histamines. Ignorance of this has caused many tragic accidental deaths.

Effect of Abuse: No other drug is abused so widely and with such great social and individual harm as alcohol. Misuse of alcohol is by far the greatest problem in drug abuse even though those who take alcohol may reject the idea that they are taking a drug. Because alcohol is generally socially accepted, many abuse it without fully realising that they are treading on dangerous ground. Frequent, excessive and prolonged use leads to tolerance and both physical and psychological dependence. (These developments apply also to the other depressant drugs). The road of alcoholism ends with delirium tremens, insanity or liver failure.

It is not generally realised that the abstinence syndrome following withdrawal of depressant drugs is even more life threatening than that caused by heroin. The abstinence syndrome suffered by heroin addicts is excruciatingly painful and tormenting but is seldom life threatening; that caused by depressants is characterized by mental excitement, hallucinations and repeated convulsions which cause death unless medically controlled.

STIMULANTS

This group includes drugs that have the effect of stimulating physical and mental activity and of providing a feeling of such stimulation to the user. Examples are amphetamines and other closely related drugs (eg methamphetamine), cocaine, nicotine and caffeine, Of these, nicotine in cigarettes and caffeine in coffee, in the quantities normally consumed are "minor" stimulants. The amphetamine type of drugs (Bensedrine, Dexedrine) are the ones drawing our attention. They are man-made drugs and their effects resemble the response to stimulation of our sympathetic nervous system.

Medical use and pharmacological actions: The amphetamines are used to treat a rare condition called narcolepsy characterized by the inability to stay awake. They are also useful in the treatment of children with hyperkinesis. This condition, which is also called minimal brain dys-function, is one in which a child shows an inability to concentrate, a deficiency in motor skills and often an abnormal brain wave pattern. These are the justifiable uses. The amphetamines have also been used in the treatment of obesity because they decrease appetite. However, after a few weeks the weight loss ceases and previous eating habits and weight gain are resumed. This is most likely due to the development of tolerance. Progressive increases in dosage to overcome tolerance is likely to add to the risk of drug misuse and habituation. This is especially so when controlled tests show that amphetamines produce euphoria more consistently in normal humans than morphine. This action partly explains the misuse of amphetamines and it is likely that the 5 billion doses of diet pills previously produced in the USA each year were used as euphoriants and could be the reason for the US Food and Drug Administration's recent action to ask manufacturers to stop production of amphetamine and related drugs, destroy existing stocks and to recall retail supplies.

The amphetamines are more potent in their effects in brain function than other drugs in this group. It is through their effects on the brain that they cause wakefulness, alertness, depress the appetite, reverse tiredness, elevate the mood with increased initiative, confidence, elation and euphoria. Prolonged use or heavy dosage is followed by mental depression and fatigue. The drug merely allows the body to draw on its reserves to produce the effects mentioned but the debt has to be paid back in full. Complete exhaustion results when the body's reserves are used up.

Effects of abuse: Whether these drugs cause long term organic damage to the body is at present unknown. The major long term toxic effect of amphetamine use is a paranoid psychosis that is often indistinguishable from a schizophrenic reaction. This can occur after continued use or even after an extremely heavy single dose. It usually disappears within a week if the individual stops using the drug.

Tolerance to most effects of the amphetamines develops rapidly and very high dosage requirements can be reached. Whether the tolerance is due to increased capacity to dispose of the drug or due to cellular adaptation to the drug is not known. The development of tolerance is not uniform, however, and the ability to withstand what would otherwise be a fatal dose does not confer tolerance to the toxic psychosis. The basic symptoms of amphetamine poisoning are extensions of its usual effects; a fatal dose ends in convulsions and loss of consciousness.

The principal adverse result of amphetamine abuse is the loss of productive activity owing to preoccupation with obtaining the drug. Physical dependence manifested as withdrawal signs is difficult to establish.

HALLUCINOGENS

Drugs from varied sources are able to disorganise brain function. These are the psychedelic or mind changing drugs. They induce a toxic state characterized by altered perceptions that culminate in hallucinations. Probably the most widely known is lysergic acid diethylamide (LSD) which is synthesized from the lysergic acid present in ergot, a fungus that grows on rye and wheat. Other hallucinogens include mescaline, an alkaloid of the peyote cactus; psyilocybin, an alkaloid from a Mexican mushroom and certain chemicals, eg 2,5-dimethoxy-4-methylamphetamine (also called STP) and dimethyltryptamine (DMT).

Medical uses and pharmacological actions: There are no recognized medical uses for the hallucinogens though some of them are tried experimentally for research and therapeutic purposes. LSD and mescaline have been used for research on mental illness and in psychotherapy. Since certain effects of these drugs mimic the symptoms of schizophrenia in some ways, it was thought that study of these effects may yield insights into the nature and causes of psychotic states.

LSD is effective when taken by mouth; this is the usual method of administration. The substance is extremely potent; to give a rough idea of its potency, a quantity equivalent of a single rice grain (about 20 mg) is enough to give hallucinations to 400 people.

The characteristic feature of these drugs is that they cause changes in sensory perception. Colours appear brighter, sounds appear louder; sometimes there is fusion of these stimuli such that "colours are heard, and sounds are seen". Walls appear to move, objects look distorted. Sometimes hallucinations occur, ie voices or objects are perceived in the absence of any stimuli. At this time, paranoid ideation and panis are common. LSD has also been used in attempts to achieve mystical understanding and are claimed to have a "consciousness-expanding" effect; the user comes to feel a sense of oneness with the universe.

Effects of abuse: The reaction of an individual to LSD will be strongly conditioned by his personality, his expectations of the drug and the environmental setting. The common adverse reactions ("bad trips") are manifestations of anxiety; feelings of depersonalization, distorted perception and hallucinatory experiences may be such that they cause fear and panic.

A possible effect following use of LSD is the "flashback", ie a recurrence of some aspect of the drug experience when the subject has not recently taken the drug. The "flashback" may last from a few minutes to several hours. The mechanism responsible is not known.

There are many reports of prolonged psychotic episodes associated with LSD use. Whether the hallucinogens cause these effects is not clear, since many disturbed people are attracted to the use of drugs and it is difficult to separate direct drug effects in someone who is about to have such a problem anyway.

Despite claims to the contrary, there is no reliable evidence that LSD causes birth defects. The early studies on this have been discredited. LSD has been shown to increase the number of chromosomal breaks in cultured white cells and in cells from skin biopsies. However other common drugs used without special concern, eg alcohol and caffeine have the same effect. There are no epidemiologic data that associate LSD with an increased incidence of congenital defects. The stress on birth defects as a possible result of the use of LSD appears to be motivated more by the desire to prevent its use than by the desire to prevent birth defects.

GANJA

Ganja is the local name for the preparation consisting of the flowering tops and leaves of the hemp plant (Cannabis sativa). Similar preparations are known in various parts of the world as cannabis, kir, bhang and marihuana. The resin from the flowering tops of the plant is called hashish which is about 5 to 8 times as potent as ganja. The active chemical substance is tetrahydro-cannabinol (THC).

Medical uses and pharmacological actions: There is no accepted medical use for this drug. It is usually smoked, but it can be taken orally. The immediate physical effects on man are mild. Heart rate is moderately increased and there is a dilation of the conjunctival blood vessels causing a reddening of the eyes. There are no changes in breathing, pupil size or blood sugar level. The drug also stimulates the appetite. If smoked the effects are experienced within minutes with peak action in 15 to 30 minutes and diminishing in 3 to 5 hours. When taken orally the effects are delayed for a few hours and may persist for up to 24 hours.

Ganja is taken for its subjective effects. It causes a subtle mood change not easily perceived by the novice. The most common mood encouraged by the drug is a sense of increased well being. Set and setting help to produce a wide range or reactions and are crucial determinants of the effects. Sensitivity to colours, sounds, taste and touch is increased. Perception of space and time is distorted in ways that can be pleasing or disconcerting. Time appears to pass very slowly. Inhibitions are relaxed similar to low doses of alcohol. Fantasy, dream-like states and sometimes hallucinations occur. This has led to their classification as mild hallucinogens. The drug also exerts the same diffused depression of the brain as the barbiturates. It can also cause a disinhibited excited state comparable to alcohol intoxication. The "high" is accompanied by ataxia (drunken gait) and impaired performance of tests of psychomotor skills.

Effects of Abuse: Significant adverse reactions to ganja are not common. They are more common when strong forms, eg hashish are used. The simple depression reaction is the mildest and most common. Its cause is not known and the reaction ends spontaneously. The drug may also trigger a psychotic break in apparently normal individuals though the risk may be higher for users who have a history of mental disorder.

Ganja appears to have the unusual property of "reverse tolerance", in that regular users are more sensitive to the drug than novices. This characteristic is known within the drug culture and is supported by a recent scientific study using radioisotope labelled THC. The conclusion was that THC may accumulate in the body, so that a regular user may already have a "basic dose" and require a smaller additional amount to obtain a psychoactive effect.

There is little evidence that physical dependence develops with the use of ganja and no significant withdrawal symptoms accompany cessation of use. If dependence of any kind develops, it is mainly psychological.

The dignity of man lies in his freedom to be able to choose what he wants to do. Being dependent on a drug takes away this freedom of choice in that the addict's well-being depends on the drug being continually available. The addict thus spends his time largely in finding ways and means to obtain the drug, thinking about the drug or under the influence of the drug. The drug controls his life to the detriment of his personal well being and social relationships. Therein lies the tragedy of drug addiction.

EDITORIAL NOTE
GANJA IS DANGEROUS

Recent reports from the WHO Expert Committee on Drug Dependence the UN Narcotics Laboratory and six other independent research centres in Europe and America have supplied sufficient scientific data to class marijuana (cannabis, ganja, pot, grass) as a "most dangerous drug". Here are the reasons for their verdict:

INITIAL EUPHORIA. The early use of ganja gives the smoker such a welcome and pleasurable sensation that he fails to detect the deterioration in mental and other bodily functions.

CELL DAMAGE. The active ingredient (THC) of ganja interferes with the body's production of DNA. (DNA is the vital genetic material that causes cell division). By slowing down the DNA process, ganja weakens the body's immunity to disease.

CHROMOSOME DAMAGE. Ganja users suffer from increased chromosome break-up when compared with non-users. Since chromosomes are responsible for transmission of hereditary characters, the long term effect of ganja smoking can cause very serious consequences.

BRAIN DAMAGE. Accumulation of the toxic contents of ganja in the Brain impairs mental function, critical judgement, appreciation of time sense, and cause unreal sensations eg hallucinations ("seeing" or "hearing things"). The ganja smoker loses ambition and interest in work. Memory is impaired, speech and thinking become disorganized.

MALE STERILITY. Production of the male sex hormone (testosterone) is reduced in male smokers to levels which may render the smokers sterile ie unable to produce children.

INCREASED CANCER RISK. Lung biopsies (ie tissue studies) reveal abnormal changes suggesting a strong resemblance to those which may eventually lead to lung cancer. These changes are similar to those seen in chronic cigarette smokers.

TOLERANCE AND ADDICTION. With continued use of the drug, its rate of excretion increases rapidly, so that more of the drug must be smoked to give the desired effect. The powerful effect of ganja on the smoker causes craving and psychological dependence so that he is compelled to go on smoking "in order to feel well, and to avoid feeling low".

In the words of one smoker: "All you do is smell it and you're back smoking. You just cannot stop!".

THE NON–MEDICAL USE OF DEPENDENCE–PRODUCING DRUGS

Dr Leong Hon Koon

DRUG OF DEPENDENCE – ACTIONS AND EFFECTS

What are drugs? Do all drugs cause addiction? Drugs are substances which when taken into the body modify one or more of its functions. From the earliest times man has used substances, generally from the plant kingdom, to alleviate pain, to arrest or cure disease, to alter the state of the mind, to induce pleasure, in religious rituals, and to cause death.

Doctors use drugs to cure disease or to alleviate dis-ease or lack of ease; and also to explore the human body, to assist them in diagnosing disease. This is the medical use of drugs. The other use, which I am talking about this evening is the non-medical use of dependence-producing drugs. Not all drugs cause addiction or dependence. Those that do affect the central nervous system, and they have generally one or more of the following properties:

They
(1) reduce anxiety and tension
(2) produce elation and feel
(3) reduce controls of behaviour
(4) alter sensory perceptions
(5) increase or depress sexual drives.

These substances have been used by man in many cultures: Peyotl or peyote from the cactus, *Lophophora williamsii,* containing mescaline was used by the Mexican Indians. Teonanactl, from the mushroom, *Psilocybe mexicana* containing psylocybin, was known to the Aztecs. Ololiuqui, the seeds of a morning glory-like plant, *Rivea corymbosa* was used by the Oaxaca Indians. Nearer South East Asia, Kratom is a tree which grows in Thailand and India, botanical name *Mitragyne speciosa,* whose freshly-plucked leaves contain the alkaloid mitragyne and are chewed by country folks who believe it gives them increased capacity for work.

All addicting drugs have one common characteristic – *psychic dependence* – a psychological compulsion to take a drug periodically or continuously to produce pleasure or avoid discomfort.

The secondary and non-essential characteristics (though important when they exist) are *tolerance,* or a diminishing effect on repeatedly taking the same dose of a drug, and *physical dependence* which is an altered but reversible adaptive physiological state brought about by repeated administration of a drug which requires continued ingestion to prevent the appearance of a self-limiting illness, that is, the *abstinence syndrome.*

The word addiction comes from the Latin "addicere" meaning to adhere to or to be stuck with; it describes the relationship of the addict and the drug he is stuck with. There is an expression "a monkey on his back". A man who is addicted to a drug is said to have a monkey on his back. Some of the early American addicts were circus people, like our own Chinese wayang actors. They noticed how in a circus act, a monkey placed on the back of a pony, is terribly difficult to shake off.

There are three properties which a drug generally has before it is considered addictive:

(1) it produces tolerance;
(2) it produces abstinence withdrawal symptoms;
(3) it produces craving.

In the simplest terms, tolerance means that if a person takes a drug, whether for pleasure or for pain, he must take more and more of the drug to get the same effects.

Abstinence withdrawal symptoms mean that after a person is addicted to a drug, then if he stops using it, he suffers symptoms like restlessness, sleeplessness, and also shows signs like running nose, muscle twitching, gooseflesh, etc., depending on the drug used.

Craving means that he has a desire for the drug, and will generally go to great lengths to obtain the drug. The Chinese word, "In Yen" in Cantonese describes this craving. The English word, "Yen". having a yen for something, comes from this word.

What are the properties, actions and effects of these drugs? World Health Organization has classified these drugs into eight classes and I shall use the WHO classification. W.H.O. also uses the term "dependence-producing" rather than "drugs of addiction". There is a good reason for this.

When we use words like "addict" and "addiction", we tend to let our emotions and feelings about the persons who use these drugs affect us. So in 1964, a World Health Organization Expert Committee recommended the use of the term "drug dependence" for "drug addiction" and "drug habituation". The term is free from any social connotations of disapproval or inferiority and is purely medically descriptive, *WHO definition of drug dependence.* A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.

WHO Classification of Dependence-producing Drugs

Firstly, the **OPIATES** — opium and its derivates, morphine and heroin; the synthetic or man-made drugs like pethidine and methadone;

Medical Uses: These drugs are medically valuable as *analgesics,* or pain killers; they relieve pain. They also produce a feeling of well-being, term *euphoria.* Taken for pain or over a long period, they produce *addiction,* with *tolerance, craving* and an *abstinence syndrome* on withdrawal. An addict has to have more and more of the drug to get the same effects. He has a craving when deprived, and shows signs and symptoms, like sweating, muscle-twitching, goose-flesh, giving rise to the expression "cold turkey", sleeplessness, etc. together known as an abstinence syndrome, when he is taken off the drug.

Secondly, the **BARBITURATES ALCOHOL GROUP:** Alcohol comes within this group. Though considered as a stimulant, it really has sedative and depressant properties. Includes tranquillisers, Nembutal and Seconal, "yellow jackets and red birds", Paraldehyde, Librium and Valium. Mandrax containing methaqualone and diphenhydramine is the drug of choice among young persons in Singapore. Mandrax is known as MX.

Medical Uses: Barbiturates have a calming effect and are prescribed by doctors for restlessness and sleeplessness, to relieve tension and anxiety. Large doses, taken for longer periods cause *addiction,* **with** *tolerance,* physical dependence and a withdrawal *syndrome.* The chronic barbiturate addict shows social and emotional deterioration and resembles the alcoholic.

Dependence is characterised by craving, moderate tolerance and a withdrawal syndrome. These drugs give elation, euphoria, a sense of well-being, lessen controls of behaviour, incoordination, (drunkeness, knocking things about, and falling down) sedation, sleep and coma. Signs of withdrawal include nervousness, sleeplessness, convulsions and delirium. Abstinence of the alcohol-barbiturates is dangerous to life.

Thirdly, the **AMPHETAMINES:** The first amphetamine (benzedrine) was synthesized in 1927. There are two categories of amphetamines-dextro-amphetamine (dexedrine) and methamphetamine (Methedrine), known as "speed". Amphetamines are stimulants; they can be used medically as an appetite suppressant to reduce weight, and in certain specific conditions like Parkinsonism. They were used by truck drivers to stay awake over long distance, by soldiers during war time when to stay awake could mean life or death. They can be abused, as in Japan, during the post-war period, when thousands of young "pleasure seekers" took it for "thrills". These are the PEP pills, the Uppies, as opposed to the barbiturates, the DOWNIES. Dependence is characterised by tolerance, craving and withdrawal is followed by sleep, hunger, apathy and depression.

Fourthly, **CANNABIS** — or marijuana, or Indian Hemp; the local preparation is called ganja; harshish is the special preparation; the present plant is *Cannabis sativa,* a plant which grows in many parts of the world, including Indonesia, India, South East Asia — even in Singapore. The preparation is also known as pot, grass, stuff, barang. The leaves and flowering tops of the plant contain the substances which produce the psycho-active effects in man. Only recently, scientists have isolated the active chemical constituents of the plant, the cannabinoids of which deltanine-trans-tetraphydrocannabinol (Delta-9-THC) is the most active.

Ganja is the name used in Singapore for the preparation of leaves and flowering tops, which is packed and sold in rolls covered with brown paper, of the size of a man's little finger. This is called a cartoo. The ganja is mixed with tobacco or rolled by itself into a cigarette with roko daun, and smoked. This is what the newspapers called a reefer. Among themselves, they call it grass, stuff, barang (Malay). Ganja, with MX (methaqualone) were the two drugs most used by young persons in Singapore, when they begin to take drugs around 1970 — 1973. Since 1974 heroin has become the main drug of abuse.

Cannabis until recently was considered to give rise to psychical (psychological) dependence, craving, but without physical dependence or a withdrawal syndrome, and with no great degree of tolerance. Recent pharmacological studies, re-evaluation, re-thinking and exchange of clinical knowledge, old and new, indicate that the distribution between psychical and physical dependence cannot be so clearly drawn; the question of tolerance requires reinvestigation. Cannabis causes increased pulse rate, elation, euphoria increased sensory awareness, in sufficient doses to hallucinations, sedation and sleep. Dangers include transient psychosis. The effects of heavy consumption are not so well documented.

Fifthly, **HALLUCINOGENS:** Lysergic acid diethylamide, LSD is perhaps the best known of the class of drugs known variously as hallucinogens, — producing hallucinations; psychoto-mimetics — giving rise to behaviour akin to madness; psychedelics — expanding the awareness of the mind, "mind manifesting", hence, their use to induce a mystic states, "instant Zen".

Substances which induce changes in the state of mind and behaviour ranging from visions to prophecy have been known to man: peyote from the cactus, *Lophorphora williamsii* containing mescaline; tecnannacatl, known to the Aztecs, from the mushroom, *psilocybemexicana,* containng psilocybin. LSD was discovered by Dr. Albert Hofman in 1938. He accidentally swallowed some of it in 1943 and found out its hallucinogenic properties. He described how he felt restless and giddy, and in a trance-like state saw fantastic visions, vividly coloured. His was the first chemically produced "trip". Other hallucinogens have been discovered. DMT, dimethyltryptamine, STP or DOM, dimethoxymethylphenethylamine, a powerful hallucinogen discovered around 1967 in San Francisco associated with the motor cycle gang, Hell's Angels; STP is a brand name, standing for "scientifically treated petroleum", but the initials also stand for Serenity, Tranquility, Peace, attributed to Timothy Leary.

Hallucinogens cause sensory perceptual distortion, ranging from greater awareness to hallucinations. Use is characterised by varying psychic dependence, tolerance and no physical dependence. Dangers include temporary madness, with possible suicide, and precipitation of chronic madness. Pharmacologically, the drug gives rise to dilated pupils, increased sweating, fever, goose-flesh. In Singapore, in some circles with tourist contact, and international travel and correspondence, hallucinogens are not unknown.

Sixthly, **COCAINE:** Cocaine comes from the leaves of a plant, *Erythroxolon coca,* which grows in Bolivia, Peru and Java. Medically, cocaine is used as a surface anaesthetic, usually as a 4% solution. In special circumstances it is also used by mouth. There are 2 ways in which cocaine can be abused. Coca leaves are chewed by Indians of the Andes, South America for its stimulant and appetite suppressant properties. Cocaine is also sniffed as a powder, or injected in solution, for its stimulant and euphoric effects. Dependence of the cocaine type is characterised by strong psychic dependence, no physical dependence and no tolerance.

Seventhly, **KHAT.** Khat is a plant, *Catha edulis,* found in Ethopia, and Arabia, whose leaves and buds are chewed to banish sleepiness and fatigue on long treks. There is craving, without physical dependence.

KRATOM: A tree which grows in Thailand and India, *Mitragyne Speciosa,* whose fresh leaves contain mitragyne and are chewed by the country folks who believe it gives them increased capacity for work.

And eightly, another class of substances, not even drugs, which have been taken to produce certain effects. These are the synthetic solvents, like toluene, used in model airplane glue.

Tobacco is not included in the list. That is what the WHO Expert Committee on Drug Dependence in its 20th Report – Geneva 1974 said –

TOBACCO: Though not listed above, it is clearly a dependence-producing substance with a capacity to cause physical harm to the user, and its use is so widespread as to constitute a public health problem. However, unlike the types of dependence-producing drug just noted, it produces relatively little stimulation or depression of the central nervous system, or disturbances in perception, mood thinking, behaviour to motor function. Any such psychotoxic effects produced by tobacco even when it is used in large amounts are slight compared with those of the types of dependence-producing drugs listed above. It is for this reason that dependence on tobacco – perhaps the most widespread form of dependence – is not given specific attention on this WHO report. Attention has been restricted to the use of dependence-producing drug capable of exercising major psychotoxic effects (WHO Technical Report Series No. 551).

Why do people take drugs? They take drugs for pleasure, for the feeling drugs give the curiosity because they have heard about what drugs can offer, for relief of tension; because they want that sense of well-being; for social reasons associated with a sense of belonging to a group; for increased enjoyment of music, sex, and phantasy. There are also a number of persons who take drugs to solve their problems. But once they are addicted they continue taking drugs to avoid the discomfort and pain of withdrawal. The state of dependence itself becomes a problem, which needs to be treated, medically in the first place; when withdrawal is dealt with, then the original causes of the drug-taking need to be dealt with; this requires, besides medical, psycho-social and perhaps other remedies.

The three main effects of drugs (dependence-producing) may be classified:

1. TOXIC – Overdose, death; liver damage, brain damage.
2. PSYCHO-TOXIC – lessened controls, drunkenness.
3. SOCIAL – neglect of work, loss of job, obsession to obtain drugs to avoid withdrawal distress, harassment by the laws, etc.

The World Health Organization has enunciated two principles of treatment:

1. drug dependents should be treated as patients, medically.
2. treatment must be based upon a study of the total personality – embracing medical, social, economic and other aspects.

Looking at drug use from the user's point of view drug dependence starts with the person who begins to use drugs and then continues to use them to the point that he presents problems to himself and to society. It is important to understand the person who is presenting problems. to himself, to his family and to people who have to deal with him – problems to himself like resorting to a black market to obtain drugs, looking for a place where he can use drugs without interference, mixing with peers who take drugs and others who do not, and having to make a choice to continue with the drug-users and drop the others. He has to ask himself questions such as: if others say drugs are bad, why does he take them.

Someone he knows has died of an overdose, yet he continues using drugs. He has to see that just after taking the drugs, when he is numb with MX, high with cannabis, or dazed with heroin, he must be able to function, walk without being caught by the police, be able to work without his employer suspecting, or his family, friends and even treatment personnel.

When members of the family begin to suspect something is wrong, he reassures them; when the father comes to know, they at first keep it in the family.

But they need help; they cannot handle the situation. Who but the family physician is best suited to offer this help?

The physician knows that intoxication gives rise to disordered behaviour sometimes resulting in death from overdose, or less severely injuries in falls, fights or accidents; or the delayed effects on the nervous system and the liver and malnutrition.

The intravenous use of drugs results in septicaemia, thrombosis, hepatitis and even malaria.

Drug withdrawal brings suffering for those using drugs that produce physical dependence. The morphine withdrawal syndrome is the best known, but it is the withdrawal from alcohol and barbiturates that is potentially life-threatening.

Psychological complications arise from the effects on and reactions of peers, family, employers, law enforcers, health and social service personnel.

The World Health Organization has advised that countries should have programmes to reduce the incidence and severity of problems associated with the non-medical use of drugs.

Let me give you the conclusions reached by a World Health Organization Working Group on Health Education Programmes for Young People Concerning Drug Abuse which met in Manila recently in November 1975; they said:

A Problem of People

Drug abuse is a problem of people, not of drugs. Drug education therefore should deal with the underlying social, cultural, psychological and environmental factors leading to problems associated with drug use, rather than drug themselves. It should include strategies for discovering alternatives to the use of drugs.

The WHO expert group said the overall objective of drug education should be to promote the responsible use of medicinal and socially accepted drugs, including alcohol, and to reduce the incidence and severity of problems associated with their non-medical use.

Education programmes for young people in this aspect should be learner-centered. It should include these basic elements: information, involvement and participation, behavioural change action and solution finding. The approach should be multi-disciplinary.

Parental Attitudes, Practices are Important

The group emphasized that parental attitudes and practices are of paramount importance in fostering awareness and realistic perception of drug issues in youth. These enable the young people to build responsible attitudes and behaviour concerning drug use. The family therefore plays a vital role in facilitating or initiating drug use or in deterring such use. Drug education must involve the home as well as the community.

PSYCHIATRIC ASPECTS OF DRUG ABUSE

by
Dr Paul W Ngui, MBBS, MRC, Psych, DPM, AM

In talking of drug abuse, one must be familiar with the various terms such as "drug addiction", "drug habituation" and "drug dependence" which have been used to describe some of the conditions resulting from the abuse of drugs.

The World Health Organization Expert Committee on Addiction Producing Drugs (1957) defined drug addiction and drug habituation as follows: "Drug Addiction" is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic).

Its characteristics include:

1 an overwhelming desire or need (compulsion) to continue taking and to obtain it by any means;
2 a tendency to increase the dose;
3 a psychic (psychological) and generally a physical dependence on the effects of the drug;
4 detrimental effect on the individual and on the society.

Drug habituation (habit) is a condition resulting from the repeated consumption of a drug. Its characteristics include:

1 a desire (but not a compulsion) to continue taking the drug for the sense of improved well being which it engenders;
2 little or no tendency to increase the dose;
3 some degree of psychic dependence on the effect of the drug, but absence of physical dependence and hence of an abstinence syndrome;
4 detrimental effects, if any, primarily on the individual.

These two terms were used to distinguish physical from psychological dependence and produced a certain amount of confusion as the degree of physical and psychological dependence varied from drug to drug and from patient to patient.

In 1964, the World Health Organization replaced the terms "drug addiction" and "drug habituation" with a single term "drug dependence". Drug dependence is a state of psychic or physical dependence resulting from repeated administration of a drug on a periodic or continuous basis. Tolerance may or may not be present. A person can also be dependent on more than one drug. Several types of drug dependence have been described. Drug dependence of morphine type, barbiturate type, alcohol type, amphetamine type, cocaine type, cannabis type, khat type, and hallucinogen type. The list is not complete for dependence on many other types of drugs and chemicals has been reported eg petrol, glue, methaqualone (MX pills) etc. The characteristics of drug dependence will vary with the agent involved, eg morphine dependence will vary considerably from that of dependence on cannabis (ganja).

Although the term "drug dependence" is generally accepted, the former terms of addiction and habituation are still useful in clinical practice to describe the various patterns of drug taking. Addiction implies the presence of physical dependence and altered physiological state brought about by repeated and continuous use of drugs, with a abstinence causing withdrawal symptoms. Habituation implies emotional or psychological dependence which is directly related to the drug's euphoric effects and its ability to remove worry.

Many factors are involved in drug addiction. There is no single cause for it. For our discussion these factors can be classified into 3 main groups:

1 The pharmacological factor
2 The human factor
3 The environment factor

The pharmacological factor lies in the addictive properties of the drug, the degree to which it can cause physical dependence. On this basis the drugs of addiction have been divided into "hard" and "soft" drugs depending on the strength of their addictive properties. The "hard" drugs include the opiate group of drugs morphine, heroin and barbiturates; the "soft" drugs include such drugs as ganja and methaqualone (MX pills). Some drugs like amphetamines and intermediate between the two not all individuals who experiment with "hard" drugs become addicted. On the other hand, there are those who become extremely dependent on "soft" drugs.

Drug addiction must be considered in relation to the human personality and his interaction with the environment. The nature of the drugs, whether "hard" or "soft" as well as the personality type, whether normal or deviant, will determine the degree, duration and tendency to relapse.

People who feel inadequate to meet the demands of society are addiction-prone, while those who have the capacity, ability and strength to handle many of life's problems are less vulnerable. The normal person is able to meet and solve the majority of his conflicts in a socially acceptable way without the help of drugs. In the case of the potential addict, he has a low tolerance for enduring discomfort, conflict, frustration, feelings of inferiority and other emotional problems. Then he experiences drugs. This could dull his feelings of inadequacy, providing him a temporary solution of a sort.

The key to addiction is in the drug's power to obliterate worry in the predisposed individual. It is this ability to obliterate worry and anxiety that causes psychological dependence.

Drug addiction may be regarded as not a disease in itself but as a symptom of an underlying psychiatric disorder, more commonly a manifestation of a personality disorder.

A classification of the addict according to personality type is accordingly useful. The following classification is practical.

1 Normal individuals, accidentally addicted.
2 Psychopathic personalities of all types.
3 Drug addicts with associated psychosis.

Opium and its derivatives, morphine and heroin, have not been surpassed as analgesics for the relief of pain. In the last century when opiates were used extensively as a panacea for all sorts of ailments, addiction was widely spread.

Many normal individuals became addicts in the process. Today it is still not unknown that such medically-induced addiction does occur. Individuals with normal personality make-up who have been given narcotics for the relief of pain in chronic illness such as cancer, can develop physical dependence provided the drugs have been administered over a sufficient length of time. In the normal person, the first experience of the drug is often unpleasant except in its relief of pain. The normal person does not experience the intense pleasure encountered by the addiction-prone individual and therefore tends to develop little or no psychological dependence. In treatment he is comparatively more co-operative and better motivated and once the physical need has been removed he has no desire to return to the drug.

Psychoneurotic personality of all types are addiction prone. The unstable, the inadequate and the immature personality who has made a marginal adjustment to life and its problems experiences immediate psychic relaxation on his first contact with drugs. With the opiates, the first experience may be so intensely pleasurable that he attempts to recapture it with repeated exposures at regular intervals and quickly becomes addicted. Barbiturates are often used as sedatives or hypnotics in the management of the neurosis and injudicious use may lead to habituation and addiction. It has also been shown that some of the tranquillizer drugs such as meprobamate, chlordiazepoxide and diazepam are capable of producing physical dependence when taken in excess. I have come across a young neurotic patient who has become psychologically dependent on diazepam injections. He has been given injections as often as three times weekly by his doctor for more than two years. He claims the injection gives him confidence lasting one to two days before he feels low again and the need for another dose.

The neurotic seeks relief from anxiety and if the drug provides immediate psychic relaxation, he may feel he has found the solution to his problems. The more the drugs are used to solve his personality problems, the more malignant the addiction. Treatment of this group is more difficult because of their personality weakness and they are less likely to be able to withstand the acute distress of the withdrawal period.

The psychopathic personalities also suffer from the results of inadequate personalities and have inferiority feelings. They differ from the neurotics by their tendency to react by aggression whereas the neurotics tend to use avoidance. They have poor character development, are frequently anti-social and lack control over their impulses. They tend to use drugs for the purposes of creating a state of elation. They are primarily pleasure-oriented individuals and show a complete disregard for social conventions. Often anti-authority they are the most difficult group to treat. The majority of drug addicts belong to these two groups.

Drug addicts with associated psychosis consist of a very small group of individuals where a psychotic illness is the precipitating cause of the use of drugs. An example is the use of alcohol in manic depressive illness. The depressive may indulge in alcohol during a depressive phase in which case the alcoholism is only a symptom of his depression.

Depressive patients have been given stimulants such as amphetamines to counter their depressive mood. This drug may be prescribed by the doctor in the form of Drinamyl, a combination of barbiturate and amphetamine, drugs which have been known to cause addiction. The use of such dangerous drugs is obsolete in the management of depressions which respond much better to the modern anti-depressant drugs available.

This classification of the addict according to personality type is from the psychiatric view point a useful one as it helps to better understand the addict as a person.

The third factor in drug dependence is the environmental factor. This includes socio-cultural factors in the environment. Studies of drug addicts in the United States show that the majority come from the lower socio-economic classes. It appears to be closely associated with social defects in society such as lack of basic opportunities, breakdown of family life and gross social neglect and indifference. Other determinants include the economics and availability of the drugs; cultural attitudes towards drugs, society's general value systems and subculture.

In the young there are strong social pressures to conform to their peer group. Drug use may provide a means of social acceptance in the social subculture. It may also provide a means of expressing hostility against parental and authority figures, rebellion against conventional social values, rejection of double standards in society and a means of escape for the inadequate from the harsh reality of a highly competitive urban society.

In dividual cases, the onset of drug dependence may be associated with a disturbing life event or precipitating factor. Such stressful life events can also act as precipitants in the causation of other various psychiatric and psychosomatic disorders; they could not cause drug dependence if at the time of the crisis the person did not have access to drugs. It is this timely offer of drugs to the addiction-prone individual in a time of crisis that eventually leads to drug dependence.

The perils of drug addiction will continue so long as there are other drug users in society who extol the use of drugs.

In summary, the factor that stands out in drug addiction appears to be the personality weakness in the individual. We all live with conflicts and tension continually. Sometimes they are frustrations due to poverty and unhappy homes, sometimes they are tensions arising from conflict in social roles, occupation, sexual adjustments, marriage and parenthood. Most of us are able to live with these tensions and adjust to them. The addict or potential addict is however unable to make the adjustment and has to depend on drugs to achieve harmony with himself and his environment.

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SAD END TO ALL DRUG TRIPS

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Although your president has given me the title of this talk as "Sad End to Some Trips", I would like to change the title to "Sad End to All Drug Trips". To continue on the trail of drug addiction will lead to a disastrous end without doubt. As in all evil, the beginning of the trip is pleasurable, but this is only short-lived. What follows is a long trail of misery, agony, painful suffering, isolation, rejection, ultimately leading to untimely and premature death.

One can get hooked to a narcotic drug even after the first try, and once hooked it becomes increasingly difficult to kick the habit as time goes on. A firmly established drug addiction is difficult to eradicate. Therefore the best advice to give is don't try, and if started, stop early.

There are many ways in which an addict can die. In fact, it is estimated that an addict has twenty times more chances to die prematurely than the general population. Death may be the result of the direct effect of administering drug into the body or indirectly because of the mind-altering properties of drugs of addiction.

DIRECT EFFECT

(A) Immediate:

1) *Acute drug reaction.* This is a common cause of sudden death among the addicts. The body reacts violently to the drug introduced which often is a hard narcotic such as heroin by injection and can happen to a new comer or a hard core addict. Death comes so quickly that the needle may still be in the vein when the victim dies. In such cases, the lungs are filled with fluid and foam can be seen from mouth and nostrils. Such an appearance was found in an 18 year old boy whose body was abandoned in the back seat of a car. He had apparently been subjected to some sort of initiation ceremony for his hair was cut before death, his pubic hair shaved, and a fresh needle mark was present in his arm. His first injection was also his last.

2) *Overdose.* A simple overdose can result from the greediness of the addict, taking in more than he could tolerated, or due to the unscrupulous dealer who wants to increase profit margin by diluting the sample with adulterants. Therefore the strength of the dose varies from sample to sample. Sometimes the addict may unknowingly purchase a pure sample of heroin. Being used to a lower dosage, the use of the pure sample may prove fatal. Another factor is that an addict may be arrested and jailed, or follow a treatment scheme for his addiction. Being away from the drug, his tolerance is lowered. Once he goes back to the habit, his normal dose may result in death.

3) *Adulterants.* Sometimes death may be due to the adulterants used in making up of the volume of the drug. These include quinine and strychrine. Or dealers and pushers may substitute one poison by another to escape the law. Such as the case of MX or methaqualone tablets. Trafficking in methaqualone carries a heavy penalty. Therefore dealers substitute barbiturates for methaqualone and make fake MX tablets. Though they possess similar pharmacological action, barbiturates taken in the same dose as methaqualone can cause death. These tablets are similar in appearance and addicts would not know the difference until too late.

(B) Delayed.

1) *Infection.* This is another common way in which addicts die. Addicts are not particular about their health and hygiene. Drug addiction leads to loss of appetite. Lack of proper diet results in malnutrition which will weaken the body's defence against infection. Further, addicts introduce infection into their own bodies by using dirty needles and utensils. These would cause ugly scars on the skin at sites of injection in skin-poppers, some result in abscesses underneath the skin. For the main-liners, infection of the veins or thrombophlebitis occur, causing thrombosis or clotting up of the veins where they inject. Foreign materials such as starch powder and other contaminants present in the drug sample may be introduced by injection and carried by blood stream to the lung, liver and brain causing foreign body granulomas. Sometimes the infection introduced is overwhelming and cause septicaemia resulting in death. Death may also be caused by tetanus or lockjaw.

2) *Transmission of communicable disease.* Addicts often use a common needle therefore diseases can be transmitted to one another such as malaria and viral hepatitis.

3) *Lung diseases.* Chronic smoking of tobacco and opium leads to a destructive incapacitating lung disease called emphysema in which the normal air cells balloon out reducing the capacity for normal function. This would lead to heart failure. Some degree of bronchopneumonia is often found in addicts, some in fatal proportion.

4) *Heart disease.* Chronic toxic action of drugs on the heart can cause sudden failure leading to fatal collapse. Bacterial Endocarditis, a disease of the heart valves is another complication of infection..

5) *Brain disease.* Meninigitis, brain abscesses, and brain damage have all been detected in addicts.

6) *Problems with pregnancy.* Abortion and premature births are common in female drug addicts. The babies are fragile and may neeed treatment for withdrawal symptoms right away.

INDIRECT WAYS

Addicts take to drugs because of their mind-altering properties. They experience euphoria, illusions, hallucinations, vision of supernatural powers lapsing into drowsiness and coma. It is these same properties that can lead to their untimely death. In their confusion they jump off buildings, flying like a bird, leaping to their death, or they may be run over by car in the streets, drowned and met with other accidental deaths. In their derilious state, girls are raped and even murdered.

Chronic abuse of cannabis and heroin leads to psychosis, depersonalisation, disorientation, and a paranoid state. In periods of depression the addicts may feel a sense of hopelessness, of inability to achieve great things in life and commit suicide.

In withdrawal of the narcotic drugs, the addict undergoes such pain, agony and misery that is beyond imagination. In desperation, they would rather die and commit suicide or they may simply die from exhaustion. Not all drug trips are pleasant. Some trips are nightmares. What is more important is that this harrowing experience can recur later even though no drugs are used. Recent research had shown that repeated high dose of drugs can produce an irreversible metabolic lesion causing changes in genetic and other biological factors affecting the probability of experiencing adverse drug effects.

I can go on with the list. Many pages and books can be and have been written about the myriad of combination and ramification of problems of drug addiction. Every year, between 10 to 15 die in Singapore from effects of drug addiction. If this habit spreads as it is spreading now without checking, the death toll will go up. Many hundreds more are suffering and incapacitated. It has been estimated that a confirmed heroin addict is likely within five years of the various complications. It is your duty to go out and advise that the momentary pleasure derived from drug addiction does not compensate the prolonged misery and agony that is certain to follow ultimately leading to a tragic end..

PATTERNS AND SOCIAL CONSEQUENCES OF DRUGS ABUSE AND THE REHABILITATION OF DRUG ADDICTS

Mr K V Veloo
Chief Probation and Aftercare Officer

I PATTERNS OF DRUGS ABUSE

There are significant differences in becoming involved with drug abuse. A recent study† on drug offenders placed on probation indicate that these differences or patterns of drug use can be related to their activating factors. The Second Report of the National Commission on Marijuana and Drug Abuse* provides a framework to discuss the patterns of drug use.

(a) Experimental Use

2 Experimental drug use, as local studies and experiences have shown, is primarily motivated by curiosity or the desire to experience a new feeling. Initiation usually occurs in a social situation through association with users. Drug pushers are most wary of supplying drugs to someone whom they do not know. Therefore, the first drug experience is usually obtained in an encounter at a party. The Probation Study found, for instance, private parties, nightclubs, discotheques and coffee houses were the foci of initial drug experimentaion.

(b) Social Use

3 Experimentation can lead to social use. In social use the peer group desires to share an experience perceived by the group as both acceptable and pleasurable. Often the group contributes towards the purchase of the drug. One of its members purchase it. A meeting place is arranged. The group share the drug among the members. The "togo-stag-group" is an outstanding example among adults. The only difference is we do not make sufficient educational effort to discourage the use of alcohol because it is widely available and perhaps we believe that it is socially acceptable. Social use can and had led to more severe forms of drug abuse.

(c) Situational Use

4 In the situational use, there is a limited use of drugs. It may vary in frequency as in social use of drugs. The only difference is that the intensity and duration varies according to the situation or circumstances. The use is motivated by the perceived need or desire to achieve an anticipated effect. Situational use is often identified with students. They may use drugs to prepare for examinations. Military personnel sometimes use drugs to help them withstand the stress of combat situations. However all forms of medication in response to a particular task or situation fall under this category. Pharmacological advances have given us a variety of new drugs in the struggle against pain and illness. Many people in society have learned to expect, and even demand immediate relief from emotional or physical discomfort. Many of us are often unwilling to endure mild discomfort if there is a drug available to subdue pain and distress. Situational use of drugs can become a serious feature of our society and can lead to other forms of serious drug abuse.

† Research Papers, Vol IV, Probation & Aftercare Service, Singapore.

* Drug Use in America: Problem in Perspective. Second Report of the National Commission on Marijuana and Drug Abuse.

(d) Compulsive Use

5 Compulsive use of drugs are often the sustaining cause of personal and family problems. It produces physiological or psychological dependences. Motivation to continue use at this level stems from various reasons, but generally, from a sense of aimlessness and the fear of unwanted withdrawal reactions. It is primarily psychologically motivated and reinforced. All normal considerations of personal and social values, and integrity are nothing before this compulsive need of drugs.

6 Whether a person's initial drug-using behaviour was experimental, social or situational and whatever the sources of the early reinforcements, escalation to intensified or compulsive patterns can occur and create serious social consequences. There is little one can do to help him recover completely from his drug abuse.

II SOCIAL CONSEQUENCES OF DRUG ABUSE

7 The Straits Times on 28 Jan 76 carried a caption: "TWO JAILED FOR THEFTS BLAME IT ON DRUGS". One of them, Yin Mun Poh, aged 26 years, in his mitigation pleas said that as a result of his heroin addiction:

a) his wife left him;
b) he gave up a promising future which included a scholarship offer from the Industrial Training Board; and
c) he spent a lot of money on heroin and suffered much.

8 Yin Mun Poh's account of the consequences of drug abuse is not unique or dramatic. Those engaged in the rehabilitation of drug addicts have heard it over and over again. He was lucky. His heroin addiction came to the fore. He would at least receive attention for his drug dependence in prison. Others like him could have well ended up in a ditch either with an overdose of drugs or with some attendant complications of compulsive drug abuse.

9 Not long ago, an attractive 16 year old girl appeared before me. She told me how drugs had ruined her life. She was from a middle-class family and a respectable neighbourhood. She had been an excellent student. Her conduct and behaviour were good. Her attendance was regular. Her parents were proud of her and so were her teachers.

10 She was hooked on MX pills. By the time she reached Secondary IV, her marks went down. Her attendance was irregular. She was pulled up by her principal for persistent breaches of school regulations. Her parents began to nag.

11 One day she decided to give up school and her home. The following day her parents found the loss of jewellery and cash in the home. Three months later, she was picked up in a brothel in the association of a a secret society member. He was a heroin addict himself. He had lived on her immoral earnings. She had by then graduated to ganja and was experimenting with heroin. Equally serious was that she was suffering from venereal disease. She was not fully aware of its consequences. She had sought treatment from a back-lane medicine pedlar.

12 She too was fortunate. She was picked up in time. She was referred to the correctional agencies. Her account, though tragic, is a fact. But it is neither unusual nor uncommon. We have heard it before. We will continue to hear it again.

(a) Its Effects on Society

13 The major social consequences of drug abuse is the threat to public safety. This arises from drug abusers resorting to crime to finance purchases in the illicit market. Female drug abusers resort to prostitution and bring with them other attendant social problems like increase in the incidence of venereal diseases and unwanted pregnancies.

14 More importantly, from the standpoint of prevention and control of illicit drug traffic, an unrehabilitated drug addict becomes the principle focal point of contamination of the innocent and the recruitment of a growing number of new users.

15 The next person he recruits or fall prey to his friendly and beguiling persuasions could well be your son, your daughter, your sister, your brother, or anyone close to you or to me.

16 Drug abusers cost the society millions of dollars. The average heroin addict, for example, spends about $35 a day; some even more. This means about $1,000 a month or $12,000 a year. In 1975, the number of arrest of heroin addicts was in excess of 2,200. The total cost of heroin for these addicts could have been in the region of $26.4 million per year in the streets. The large majority of the drug addicts, because of their low educational status or lack of skills, are often found in low-salaried jobs. They therefore resort to crime, largely indulging in acquisitive types of offenders. Society as a whole loses out.

17 The cost of maintaining enforcement, health, social and rehabilitative services to control and prevent drug abuse and treat drug addicts is by itself exorbitant. We have already a growing problem of dealing with crime and delinquency. Drug abuse now further drains our scarce resources.

(b) Its Effects on the Family

18 Heroin addicts, whether they are single or married, create difficulties both to themselves and their families. Their preoccupation with drug abuse, their alienation from stable social relationships (possibly to avoid detention or family disapproval) and their inability to sustain personal and family situations. Their drug induced behaviour reduces the cohesiveness and ability of the family to function effectively.

19 Yin Mun Poh's case is an example where his drug induced behaviour led to marital discord and separation.

20 But I know a 23 year old married woman. She sought my assistance to resolve her problem with her husband, a drug addict. One does not question love. It simply does, she thought. She married him against her parent's consent. A child was born. She set up her own home in a HDB flat.

21 Life was not pleasant after marriage, at least after the second year of marriage. Her husband kept late nights. He found difficulty in getting up early for work. He absented himself from work, and soon lost his job. He became difficult to get along. He took her pay, but did not manage the household budget. He was disinterested in her and his child. He walked in and out of the home as he liked. She pawned her jewellery. She obtained financial assistance from her parents and when her parents began to question, she borrowed. She invited further trouble.

22 One day, she found her husband had been picked up for heroin addiction. She loved him. His apologies and assurances made her go along with him. He was released after treatment. But it was short-lived. He had gone back to drugs. He became even more aggressive and demanding. He wanted money to purchase his drugs from the illicit market. But, there was no money. The wife too had lost her job for being irregular at work arising from her domestic problems. He went a step further. He invited his male friends to his home. He made subtle allusions that she should entertain them in bed. Fortunately, for her, he was picked up again. Time to time he was committed to prison.

23 She asked me to help her make a decision: whether to leave him for good and return to her family — start life afresh.

24 The family is particularly susceptible to the social consequences of drug abuse: it not only reflects but magnifies other attendant social problems like financial hardship, marital difficulties, children's educational and behaviour problem, rejection by members of the family, etc. Social dislocation and demoralisation creep in, in a family where one or more members are drug abusers, in particular, where the drug addict is also the head of the household.

(c) Its Effects on School and Employment

25 The relation between drop-outs and drug abuse is a subject of great concern. There is growing evidence that drug abusers constitute a higher proportion of drop-outs even among the above-average students. The development of personality may be fostered or retarded by the way in which a child is able to respond intellectually to the demand by the school.

26 The case of the sixteen year old girl quoted earlier is a typical example of the deteriorating effects drug abuse can have in the conduct, progress, attendance and performance in the sports field, in school. Various shades of extortion and thefts in school can often be the result of drug abuse. It sometimes happens that professional drug pushers assume control over the student-drug abusers. They either encourage or coerce them to push drugs or indulge in other criminal activities that are of benefit to them.

27 Most drug abusers who were hooked on drugs in school find themselves at a disadvantage in the employment field. Because of their low educational status and a lack of marketable skill, they have to take on low-salaried jobs, even though they could be of average or above average intelligence. Substantial number of them remain idle on leaving school for long periods or work intermittently for considerable lengths of time. They are preoccupied by the ways and means of getting their next fix. They have therefore neither the time nor the inclination to form stable work habits or relationships or the desire to put in their best in their jobs. Their low self-esteem and their inadequacies alienate them further from their work-mates and their surroundings.

28 The major concern from the standpoint of drug induced behaviour in the field of employment is the social loss in terms of productivity, social and economic functioning as manifested by unemployment, absenteeism and decreased performance. Singapore cannot afford such a loss. It is dependent on its manpower resources.

III REHABILITATION OF DRUG ADDICTS

(a) The Need for Rehabilitation

29 Drug abuse has become a domestic social problem. What alarms us most is that the young have taken to heroin. The heroin trip is a voyage to nowhere. Indeed, it can be a voyage of no-return.

30 Whatever the weaknesses of the drug addicts or the faults of their parents, we have to get them rehabilitated. And, we have to act quickly, failing which the problem can create a catastrophic break-up of the fabrics of our society.

31 Many drug addicts do want to give up their drug abuse just like many others who resolve time and again to give up cigarettes or that bottle of beer. It is incumbent on society to help those who have the self-expressed desire to kick the habit. And those who do not want to do so, will have to be compelled to do so. Where social persuasions and precepts fail, the full impact of the legal sanctions must apply without compunction.

(b) Treatment

32 Treatment of drug addicts differ not only in the method but also in objective. One method is to maintain the drug addict with a minimum maintenance dosage. This can help to reduce illicit drug traffic to some extent. But the addict, having obtained his supply from his doctor to prevent withdrawal symptoms, could still get an additional dosage in the streets to obtain his sense of euphoria.

33 The second method tries to help the drug addict by withdrawal from his dependence by gradual reduction of his dosage of drugs. The objection to this method is that some addicts misuse the opportunities of treatment by seeking admission to treatment centres only to obtain assisted withdrawal in order to reduce their tolerance and enable them to resume their habit again on a minimal and less costly level.

34 The third method involves substitute drug therapy such as methadone maintenance. Despite its relative effectiveness, there are reasons to believe that it does not really cure but merely transfer the addict's dependence from one drug to another.

35 Withdrawal is also done "cold-turkey" with little or no supporting medical treatment. It is an agonizing process for the addict, characterized by severe twitching, shaking, sweating, vomiting, abdominal cramps and, in some cases, severe hallucinations. The aim is simply to allow the drug addict to fight his way through withdrawal and in the course experience suffering. It is felt that the agony and fear of the withdrawal experiences will always remain in the addict's mind and, perhaps, help him from the temptations of further drug abuse.

36 In Singapore drug addicts on opiate drugs are confined in the Drug Rehabilitation Centre for purpose of withdrawal and convalescence. This is only the first stage of the total rehabilitative process. After withdrawal is complete, the second stage of social care begins. This stage prepares the drug addict for return to the community. It gives him time to develop behaviour patterns that do not centre around drug taking. The third stage, which is vital, involves assisting the discharged drug addict to reintegrate himself in the community through supervision and personal care. Under this form of aftercare, which begins from the day the drug addict is admitted to the centre, supervision will include periodic testing of drug use through urinal analysis.

37 Aftercare is a form of corrective management of offenders who are released from a penal or corrective institution. Its main objectives in the context of rehabilitating drug addicts are:

a) to help the drug addicts to lead a drug free life; and
b) to arrest his criminal tendencies, if any.

38 In an attempt to help drug addicts understand why they used drugs and to encourage abstinence Aftercare Officers use a variety of techniques. They set limits, give information and even direct advice, recognise positive achievements, and attempt to enlist the family's co-operation. There is an emphasis upon the Aftercare Officer's readiness to give immediate practical help as difficulties arises. Employment is of great importance. Any period of idleness is an invitation to readdiction. The Aftercare Officer finds it essential to get the drug addict involved in constructive leisure activities. With the drug addict it is not a matter of referring him to a community centre or sports clubs. Most drug addicts are non-competitive and lack motivation or self-confidence. Consequently, Aftercare Officers have to become directly involved.

39 The attitude of family members are crucial to success in helping the drug abuser. The Aftercare Officer will spend time in alleviating the problems in the family which could be the conditioning factors for the drug addict's involvement in drugs. The root of the drug problem is often found in damaging family relationships that may persist and tend to preserve the addict's need for drugs.

c) Uphill Task of Rehabilitation

40 The history of the treatment and rehabilitation of heroin dependent persons has been a series of largely unsuccessful efforts. Medication and "cold-turkey" can be effectively employed against the physical component. They are, however, of little assistance in dealing with the psychological reinforcement component and in preventing the frustrating relapse rates. On the other hand, psychiatric, psychological and social work techniques have not completely succeeded in solving the psycho-social aspects of the problem and in arresting the relapse syndrome.

41 Some dependence may be incurable and the function of treatment and rehabilitation must invariably be to minimise the anti-social behaviour attending compulsive drug abuse. In other circumstances, even though an addict's basic adjustment problem is not fully eliminated, success can be claimed, if it has achieved enough reduction of the problem so that it is no longer crippling to the drug addict and his family and a liability to society.

SOCIAL FACTORS OF DRUG ABUSE

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INTRODUCTION

1 Several factors are held responsible for the current drug scene in Singapore. A commonly quoted cause is the adoption of the "pop-culture" by some of our mindless youth.

2 The alcove of youth from the adult community and the evolvement of "pop-culture" in the West has become increasingly an intrinsic part of modern industrial and urban way of life in this part of the world. This "pop-culture" is characterized by loose morals and social values, slovenly appearance and unabashed practices. It has developed its own norms and values which counter the accepted ways and desired goals of the larger society. It is amplified by its permissiveness in sexual activities, outlandish styles in clothing, unkempt hair styles and convulsive dances to the brawling music of electric steel-guitars. Those who subscribe to this "pop-culture" elect to be alienated from the rest of the community. They seek refuge in a niche of free sex and drugs.

3 The "pop-culture" which was relatively localised in the West took to unprecedented proportions with the emergence of the Beatles in the United Kingdom and the Rolling Stones in America. Whether their appearances were accidental or causative of the "pop-culture" is not exactly known but there is no doubt that their influence precipitated the overflow of the "pop-culture" to other parts of the world. Singapore was no exception.

4 It is true that Singapore has not assumed the magnitude of the problem as in the West. While it is creating a catastrophic break-up of the fabrics of certain societies, we are now feeling the impact of certain aspects of "pop-culture" and its attendant social problems. An affluent society may be able to withstand its pernicious consequences but a small developing country like ours, which is dependent on its manpower resources, cannot afford to be complacent. We must keep constant vigilance and take preventive measures against this "pop-culture" from gaining a foothold within our society.

5 The youth to-day enjoy greater freedom from traditional norms of behaviour and greater influence than the youth of yesterday. The breakdown of the classical family structures through rapid social change and the accelerated growth of industrial and urban programmes, have given rise to inter-generational conflict and tension. The emancipation of women from the drudgery of household chores and the fear of unwanted pregnancy through the advance in birth-control techniques have precipitated a greater occupation with sex without regard to social or religious persuasions. Large segments of our population are so self-conscious and so puzzled by their own sexual behaviour.

SOCIAL VALUES & AUTHORITY PATTERNS

6 The social values and authority patterns which were once held high in our society are now being disparaged by some of our youth. The day-to-day forms of authority we have respected in the home, school, church and community are being fretted away by youth. Their principal concern appears to be a highly individualised self-interest. Self-assertion seems to be the modern aspiration. The work ethic, the basis of our viable society, is also derided by our youth. Some simply think that society owes them a living. This is manifested by the increase in criminal activities and the growing membership of the "pop-culture". The main concern of some of these youths who deviate from the norm is that the individual owes little loyalty or obligation to authority and to traditional and personal values. We see these manifestations in hostile attitudes toward existing institutions and excessively tolerant views in matters of sexual morality, disobedience of the laws and in use of drugs. It is increasingly fashionable for them to question and attack the basic elements of our society. Religion has become irrelevant and our system of criminal justice, repressive.

7 The home, the school, institutions of higher learning and religion and the community itself are our reference points. They mould our character. There must be respect for these as there must be respect for our national goals and aspirations.

RELIGION

8 Traditionally religious institutions have also served as an important mechanism for articulation of social and moral values of society. In recent years, however, the extent and rapidity of change has placed a great stress on all our basic institutions, and, particularly, on religion. There appears to be a lack of spiritual values among our youth. This is not merely because the majority of people do not go to church, temple or mosque, but because of the general temper of society and standard of morality. Most people would affirm some sort of belief in God, but are unable to relate it to their daily lives. It is clear that all things being equal, a home with a religious atmosphere is a good safeguard against moral delinquency.

9 Certain forms of commercialised amusements are also factors in the causation of drug abuse. In terms of the number participating, commercial enterprises reach more people and exert a far greater influence than communist-oriented forms of recreation and amusements. Of these, the cinema, perhaps, draws the largest number of the younger sections of our population. Films depicting crimes of violence and passion or of sex have morally harmful influences on conduct. Though admittedly most of the films on crime contain a moral philosophy of "good triumphing over evil" or "crime does not pay", it is the means in achieving the end result that affects the impressionable young. On the other hand, some of the Malay and Indian films which often verge to the point of sentimentality sometimes inadvertently exhort suicide as a desirable virtue to solve personal problems, thus encouraging an escapist attitude among our young.

10 Among the mass media, the newspaper and television can be singled out for special mention. Newspapers by virtue of their detailed reporting of incidents of drug abuse and the proceedings of the court, inadvertently become responsible for an increase and sophistication in drug abuse by teaching the techniques of drug abuse, by making it seems common, attractive, profitable and even exciting.

PHARMACOLOGICAL ADVANCES

11 Pharmaceutical companies by their commercialism and lavish advertising of "quick-relief" patent medicines create a pattern among youth for the consumption of medicines for minor aches and pains. This pattern of self-administration of drugs without medical consultation may well lead to other forms of drug abuse. Indeed, when the mother picks out a couple of aspirin or panadol tablets from the first-aid chest and swallows them in the presence of her young or alternatively medicates her child, when he complains of headache or abdominal pains, she is in fact creating difficulties for herself and her child. The child may well accept the idea that it is an obvious way to deal with his physical ailments. This may lead to a susceptibility for drug abuse when he grows up and is confronted with emotional problems.

12 Enormous pharmacological advances have also given us a multitude of new drugs in the struggle against pain and illness. Since powerful drugs have become widely used, many people in our society have learned to expect, and demand immediate relief from discomfort, emotional or physical. Many of us are often unwilling to endure mild discomfort if there is a drug available to subdue distress.

PREDISPOSING AND PRECIPITATING FACTORS

13 In dealing with the causation of delinquency and drug abuse, one may recognise two sets of factors:- predisposing and precipitating factors. The former makes a person vulnerable to deviant behaviour such as crime and delinquency, suicide, mental illness or drug abuse. The other, the precipitating factors trigger off the first step in the wrong direction.

14 The predisposing factors of juvenile delinquency or drug abuse can best be understood in relation to the background of the individual offender and the social milieu in which he lives. The child is not only born with a constitutional equipment, certain biological and psychological characteristics and capacities, but he is also born into a social world in which culture, social organisation, social relations and activities exist. It is in the process of interaction between the child and his social environment that acquired characteristics develop. Children always live and act in association with others. They are members of family, play, school and other groups. These primary groups condition a child's behaviour.

15 The complex variables of the individual and the social environment in which his behaviour occur, makes it difficult to identify the separate causative factors of juvenile delinquency or drug abuse. Even one isolated act of delinquency and drug abuse is often complicated by a multiplicity of predisposing factors. They may occur conjointly in such a way giving the impression that one factor by itself is the decisive cause. Judged by experience, there is no single cause or predisposing factor to drug abuse. In a given case, one factor may stand out above others, but usually a number of conditions contribute in one way or another to drug abuse. But one thing is certain: almost any child can withstand the strain and stress of one or two handicaps in life, but if he has certain physical and mental handicaps, comes from a large family, lives in a blighted neighbourhood, has quarrelling or drunken parents, engages in street trades and is subject to undesirable community influences, he is more likely to indulge in delinquency or drug abuse and get into conflict with the law.

PREDISPOSING FACTORS

16 The family, the school and the peer groups are among the important social groups involved in the development of the attitudes and habits of the child. They are the first groups in which the child lives and they are essential in the formation of his social nature.

(a) Home and Family

17 The significance of family life lies in the interactions and inter-relationships among various individuals who compose the family. The family is the repository of customs, usages and tradition. Anything that affects the family adversely may have direct repercussions on the individual and thereby the Community. The normal family is the most effective agency of social control and has long been regarded as the best insurance against delinquency and drug abuse. A broken family due to divorce, desertion, separation or death, or a family which functions inadequately as a social unit, cannot fully discharge its duties and responsibilities towards the children. It must also be recognised that though a family may not be disrupted physically, it may nevertheless be broken through insecurity and emotional disturbances. Family dysfunctioning or disorganisation is a disintegrating process and the disrupting factors that lead to a broken home have more adverse effects than the actual break, such as divorce, desertion or death.

18 Parents with large numbers of children often create difficulties both for themselves and for their children. It is not always possible to provide equal and sufficient material and emotional content to a large family of children. The parents themselves become nervous, irritated and quick to project their frustrations upon their children or quarrel among themselves.

19 Extensive employment of the mother in a community which shifts towards the nee-local pattern of family arrangements is one of the conditioning factors that is related to delinquency and drug abuse. Where there is lack of provision for the care and supervision of the young, children are often left to fend and shift for themselves. Parents working overtime have neither the time nor energy to participate fully in the home. Defective discipline, lack of supervision and dissatisfaction with home routine, especially if accompanied with a loss of the sense of parental interest and responsibility produce unhappy homes for the children.

20 The lack of moral standards or where double standards are practised within the home have been recognised as contributing to misconduct and misbehaviour of children. If there is no recognition of the difference between right and wrong, no value placed on self-control, no consideration for others or in the acceptance of family and individual responsibility, it is hard for the child to acquire the qualities of good citizenship.

21 Defective discipline is another factor that has to be considered. Discipline may be defective if it is unjust, lax, too strict or inconsistent. Over indulgence or molly-coddling may produce behavioural problems as do overstrictness and severity. Lack of co-operation between parents or differences in their methods of discipline confuses the child. Frightening children is a negative way of affecting discipline and nagging them only alienates them from the home. Favouritism and injustices lead to the loss of respect for parents and not infrequently to grudge against parents or the more favoured siblings. Homes which are dull and uninteresting, with nothing to stimulate or interest the children, may drive them on to the streets which become more attractive. Lack of understanding on the part of the parents is also a critical factor in the adjustment process of young people particularly during adolescence. The cumulative effects of this give rise to such symptoms as: for autonomy or recognitions, for achievement, control or novelty; or other serious trouble.

(b) School

22 A child spends up to ten formative years in school under the watchful eyes of teachers. The schools have the major responsibility for the education and training of children. Many functions formerly placed almost entirely in the family have been transferred to community institutions, like the school. Schools of course cannot help to overcome the undesirable influence of homes and of community conditions. But they can do much in preventing maladjustment through programmes for the promotion of healthy social and emotional development and for the fostering of good adjustment.

23 The relation between school drop-outs and drug abuse is a subject of great concern. There is indication that mentally retarded students and slow learners constitute a higher proportion of drop-outs than students who make average or better grades. Critical schooling situations occur at any stage from kindergarten to the end of schooling. The developments of personality may be fostered or checked by the way in which a child is able to respond intellectually to the demand made by the school. School learning can have unfavourable or even traumatic effects, unless it is adapted to the developmental levels of the students. It is therefore important that teachers understand the developmental needs and interests of children and the experience which they have outside the school. One very real task teachers have is to counteract the effects of an emotionally unwholesome home or community environment. Unless the school provides support for the emotional stability and growth of low achievers, they may develop frustrations and feelings of insecurity — and begin to search for some solutions to their status problems. Drug abuse is one easy alternative open to children who experience status deprivation in school. Dropping out of school also offers a solution to this problem and is not necessarily confined to those lacking intellectual ability.

24 The school has a great role to play in guiding the young, discovering the early signs that point to disturbance or maladjustment or disaffection and seeing that these problems, if beyond their capacity, receive the necessary attention and services and thus prevent the developments of tendencies that mature into delinquency.

(c) Peer Group and Delinquency Gangs

25 How often Probation Officers have heard parents say that their children were getting on well until they get mixed-up with some boys in the neighbourhood. Drug abuse, according to one viewpoint, is a matter of intimate relationship with a group engaged in this behaviour.

26 The breakdown of the family creates a vacuum in society which draws children in similar circumstances and enhances the importance of the peer group which raises its head in the form of a gang.

27 The gang takes several forms. There is the play group which is formed by youngsters brought together merely because they have nothing else to do. They get together for the sake of play. Nearly all children have their playmates, friends and companions both within and without school. Play groups are normal and exist to satisfy basic needs and provide opportunity for friendship and response.

28 Sometimes an innocent play group may develop into an anti-social gang. A remark of some adults makes the youngsters realise that their play is a source of annoyance to the adults. They then try out a new game — that of intentionally annoying the adults. They find that there is much more fun and excitement. Initially, its activity is limited to hooting, making noise and the like but soon the gang expands its activity to include vandalism and petty thieving. It then assumes another form — the delinquent gang. It sometimes happen that shady adults assume control of the delinquent gang and encourage the youngsters to participate in criminal activities and drug abuse that is of benefit to them. Sooner or later the members of the delinquent gang find themselves drawn into the membership of secret societies.

29 There are hardly any local in-depth studies of sufficient stature on the structure and functions of play groups, delinquent gangs and secret societies. It is common knowledge, however, that the delinquent gangs and the secret societies are deeply involved in drug abuse and in pushing drugs. The informal education of the streets is often more influential than what they receive elsewhere. Home often plays a very small role in the life of these gangs. Except to eat and sleep, they are rarely at home. The gangs help in making out of the members, chronic truants from school and undisciplined employees.

30 The factors underlying ganging are complex. A youngster may choose a delinquent gang for the sense of belonging and security he derives from being with those of similar ethnic or socio-economic

background. Another may join for protection or for monetary rewards. For some the attachment helps to mitigate the feelings of inferiority or anxiety growing out of parental affection. However, the underlying causes appear to be inadequate family life, poverty, deteriorated neighbourhood, ineffective religious persuasions and lack of organised leisure activities.

PRECIPITATING FACTORS

31 Whether a person's initial drug-using behaviour was experimental or situational, and whatever the source of the early reinforcements, escalation to intensified or compulsive patterns should be viewed primarily as an increasing reliance on drugs in the conduct of the user's alienation frequently precede the initiation of drug use. The early phase of an individual's chronic use pattern may be prompted largely by peer group influence. Subsequently, a sense of aimlessness and the fear of unwanted withdrawal reactions may be dominant factors in maintaining a chronic behaviour pattern. All these suggest the impossibility of identifying precipitating "causes" of drugs use and listing them in order of importance. At best, we can only sketch reasons why some individuals may feel a need for drugs and identify some factors which tend to reinforce drug-using behaviour.

(a) Availability

32 Youthful experimentation with forbidden drugs such as alcohol and tobacco is a well-recognised part of growing up. We do make an educational effort to discourage the potentially harmful and risk-laden experimentation with these drugs. The important question is why now with those other drugs? One reason is simply that these other drugs are, perhaps, for the first time widely available. Second, the need is there. The need for self-coping device: the need to transcend ordinary life because it is meaningless or on a more mandane level, boring. Among youth, the new wave of drug experimentation scenes primarily relates to this reach for meaning.

(b) Personal Dissatisfaction

33 Many young people grew up in some affluence. They grow up in circumstances where their labours are not needed to put bread on the table and where they are not taught values to which they can with enthusiasm commit themselves. They therefore seek to find their own meaning in life. Sometimes this search is made far from their own family background and in ways which are harmful and socially unacceptable. Indeed, a sense of purposelessness and meaningless in living contributes more to the attractiveness of drug taking than any other single factor. Many of our young are bored despite the apparent case of their lives.

(c) Low Status Image

34 Of chief interest over the long term is whether the recent cycle of increased youthful experimentation will leave behind a significant number of intensified and compulsive users. Failure to rise and to prosper may become more than an disappointment of material ambitions; it can become a sign of personal impotence. The individual who thus sees himself as a potential failure, whose achievement or future prospects do not measure up to his self-concept, may begin to feel a pressure to reconcile the difference between what he is and what he should be. For some the results may be an attempt to avoid the painful reality by substituting a new one. And if this change can be achieved with the aid of chemicals, the person is likely to become a drug dependent person.

CONCLUDING COMMENTS

35 Drugs has the capacity to destroy the Will. The relationship between drugs and "will" is reflected in the casual relationship to drugs and almost every type of anti-social behaviour. Drugs are related to sexual excesses, crime and prostitution.

SOME CAUSES OF ADOLESCENT PROBLEMS

Mr S Vasoo
Dy Director, Singapore Council of Social Service

Adolescent in many countries are searching for various means to see how their needs could be met constructively. It has also become evident today that the needs of the young expecially in urbanised societies have been domonstrated through varying forms of social expressions with a view to alert the existing social systems to accommodate to their needs. However, limited success has been achieved in the countries of the region. Does this indicate that the overall social planning in these countries has now considered needs of its youthful population? Does it imply that those concerned, that is, the school system, the family and other related organisations have tended to tackle problems of the adolescents in a piecemeal manner by providing services to deal with the symptoms rather than the cause of their problems?

Singapore has become a highly urbanised society and over the last two decades, tremendous social changes have taken place. Our adolescents are being exposed to various kinds of social and educational opportunities which are not available in many countries around the region. Our urban and industrial development have provided a wide range of social and economic activities for our adolescents to be involved.

In a highly urbanised society of ours where there is orderly progress and stability, many of our adolescents are coming to grip with the strains and pressures of change and are capable of adjusting to the demands placed upon them by various social institutions. However rapid industrialisation and social changes have certain implications on the lives of our adolescents expecially in such areas as orientation to work, organisation of their leisure activities, social responsibilities to the community, relationship with their families, sexual and moral values and participation in community development. Many of our adolescents are able to adjust satisfactorily and find a sense of equilibrium in these areas but there are some who are unable to do so and are grabbing with the realities of our social situation.

The schools today have been subjected to a lot of criticisms for those adolescents who have become casualities of social changes. On one hand the school system tends to view that the problems of some of the adolescents are due to the lack of parental guidance. The parents on the other hand feel that the school is there to guide their children. Who are to be assigned the blame for the problems faced by some adolescents?

To assign blame to the school is just being short sighted because the school environment has little control over the family's function. To assign blame to the family is equally short sighted because the family's function has become so diversified through urbanisation. What is more important now than ever before is to see how the family and the school can jointly co-operate to tackle some of the problems faced by our adolescents.

Let me now isolate some major areas that our adolescents in schools could be fallible and these areas have attracted much concern among parents, educators and others who are called to provide solutions to deal with the problems of our school going population.

DRUG AND THE ADOLESCENT

We have heard so much about the issue of drug abuse among young people. The problem of drug taking is not confined to adolescents who are out of school, but the school going adolescents who can also be vulnerable to it. It is widely known that some adolescents from schools have been involved in drug taking and if this is a danger that the school is posed, then teachers have an important role to play in discontinuing this social menace from spreading into the schools.

Adolescents who abuse drugs are people with problems and they think that the use of drugs will resolve whatever underlying problems faced by them. This illusory thinking is predominant amongst the youngsters and the satisfactions they desire after consuming drugs tend to reinforce their action.

It is not difficult to identify an adolescent who is abusing drugs particularly heroin which is commonly consumed by those who are involved in drug taking. What is important here is how the teacher is going to handle the case who is either abusing drugs or suspected of taking drugs. In any attempt to help pupils who are confronted with this problem, it is necessary for the teacher to understand the profiles of his pupils and establish a close relationship with them. This rapport can emerge if there is a sincerity and genuine concern for the overall welfare of the pupils. The teacher who takes a positive interest in his pupils and listen sympathetically to their problems will eventually succeed in helping them to deal with their drug problems. The task will be simple provided the teacher himself is willing to take the challenge.

ACHIEVEMENT AND THE ADOLESCENT

It must be admitted that the school is a competitive area for the adolescents. The principle of meritrocracy applies in the school system too. Some pupils will make the grade; others will just make it; whilst some others may find it difficulty despite their efforts. Imagine what will be the implications on an adolescent's self-image if he fails to succeed in school. What will his parents and his school colleagues think of him?

Failure in school performance is something which most adolescents like to avoid if possible but the human situation is such that there will be some who because of varying reasons are less endowed to make the grade. Those who failed have reacted in different ways to cope with their failure. Anxiety and depression were commonly faced by them and in some extreme cases suicide resulted. The school will perpetually have to contend with a group of pupil who will face this dilemma. Therefore teachers must develop a high level of sensitivity so as to be able to spot out those pupils who require assistance to overcome the aftermath of being branded failures. In fact most of the pupils who fail to make the grade need some kind of support from the teachers. Perhaps these pupils could be helped to discover their other hidden potentials.

PERSONAL PROBLEMS AND THE ADOLESCENT

Adolescence is a stage during which one searches for his identity. It is during this period that he could be vulnerable to social problems which may arise as a result of others with whom he relates. Not all adolescents are able to resolve his personal problems which are precipitated by extra-familial or familial conflicts. As a result some adolescents indicate their problems at the school setting through various overt behaviours such as trauncy, naughtiness, aggression, withdrawal and attention seeking. All these overt behaviours which appear to be unacceptable to the school system, are symptoms of other underlying problems. They are smoke signals indicating a request for help. A teacher who is alert to these symptoms expressed by his pupils, will therefore be able to intervene and assist them. A show of concern by the teacher to pupil with personal problems is perhaps the first step towards helping them to resolve their difficulties.

PEER GROUPS AND THE ADOLESCENT

Adolescent peer groups are likely to be formed in schools. Most peer groups are positive but there are some which are negative and can cause a lot of heartaches for the teachers. Negative adolescent peer groups tend to defy authority, test the tolerance limits of their teachers by bullying other pupils, and indulge in anti-social activities like smoking, defacing properties etc. Amongst the members of these negative peer groups, one will find several leaders. Disciplining these leaders is an easy task but does not solve the problem. What seems to be important here is for the teacher to work with the so called leaders of the negative peer groups. In doing so, the teacher can help not only the leaders to change but the members of the group as well.

LEISURE AND THE ADOLESCENT

Many of our adolescents in schools are enjoying long vacations and holidays. Some are able to use their leisure constructively whilst others really do not know how to spend their leisure usefully. What kind of leisure activities are our adolescents involved in? You would have probably witnessed that some of them have become 'night birds' and they are attracted by exotic programmes of the night clubs and coffee houses.

All these sources can breed problems for the adolescents. They can become high and dry after the nights outings to these places. Anti-social values are picked up by the young mind at these so called exciting places. Furthermore the discriminate giving of pocket money by parents to these young further enhance their propensity to spend lavishly.

We also witness that a large number of school going adolescents do not have any attachments to social organisations after school hours. This group of adolescents abstain from using the youth provisions which have been set up in the community. With the establishment of urban centres and housing estates, the formation of unattached adolescents have been indirectly accelerates. The unattached adolescents idle away their time and participate in leisure activities which are anti-social. One of the commonest activities indulged in is drug taking. Drug taking is becoming an in-thing amongst this group of adolescents and there is always a tendancy in them to pollute other curious youngsters with their decadent activities.

The unattached adolescents are vulnerable to social problem because they remain divorced from the main stream of youthful acitivities. Many youth organisations within the neighbourhoods have either attempted seriously to work closely with the school to reach to these youngsters or assess how they can plan constructive social and recreational programmes for these unattached adolescents. How can the school involve youth related organisations to plan constructive leisure programmes for these adolescents who may benefit by participating in activities of these organisations?

SEX AND THE ADOLESCENT

Our adolescents in schools are exposed to various influences of the developed western world. They tend to assimilate values of the industrialised world without assuming whether these are relevant to our society. Much have been said that our adolescents ape the promiscuous sexual behaviour of the west. Just ponder a moment on our adolescents perception to the question of sex.

The increase in venereal disease amongst adolescent although not as alarming, is one social indicator that some of our young are unable to discern what positive moral values to adopt. They have to rely on second hand information regarding sexual matters and so often these adolescents are misinformed or ill-informed about it. What can be done especially for higher secondary students regarding this important issue. We know parents and at times teachers shun away this sensitive topic when approached by adolescents. If we are to prevent the proliferation of promiscuous behaviours amongst adolescents then some positive steps have to be taken to prepare them.

COMMUNICATION AND THE ADOLESCENT

Many problems faced by adolescents are due to the breakdown in communication between their parents and them and between them and the school systems. The so called "generation gap" is actually caused by the lack or miscommunication between the adolescents and those in authority. The adolescents are faced with an adult world that has double standards, hypocrisy, disgust and lack of Integrity. As a result, they go against those in authority because they are told what is expected of them and not shown how to do them. What we should be concern about in bridging the communication gap between the school and adolescents is to see what channel of formal and informal communications are available within the school system, the more it will encourage the adolescent especially those who face personal and interpersonal conflicts to discuss with the teachers.

CONCLUSION

Industrialisation and urbanisation in our society has certainly brought about changes in the aspirations and expectations among our adolescents. Many adolescents will pass through the doors of our schools whose primary objective is to teach them the art of living and to be capable of coping with the stress and strains of living.

Hundreds of adolescents will be taught by the teacher in his life-time career. You are trusted with the responsibility to enable all these individuals to be useful citizens and to develop their best potentials. Many of them can adjust and adapt within the school system and benefit most from it, but there are some who will be unable to do so because of social and psychological impediments. This group of pupils equally poses the challenge to the teacher and in order to help these pupils the teacher must humanize the school system to establish services that will cater to their needs.

PROBATION AND AFTERCARE SERVICE

THE PRINCIPLES OF PROBATION

In any profession which hopes for status and responsibility a basic ethnical code is essential. To work without this is like steering a ship without a chart or compass. Fortunately most probation officers have high principles, and the following are current practices and acceptable, but the reasons for our actions now need clarification.

Probation methods may change but certain rules governing the relationship between persons, because they touch more fundamental beliefs about the nature and dignity of man, have a permanent basis. Yet this rules need not be restricting. Within themselves they may bring firstly security, then freedom, spontaneity and progress. But their acceptence does not increase responsibility. With this in mind, the following principles are offered:

PRINCIPLE I

Probation is and effective and economic method of dealing with offenders and is therefore an integral part of the maintenance of law and order.

Law and order are essential for the protection and continuance of the State. Probation is among the most successful methods of treatment for offenders, firstly because it deals with an offender in his normal environment and secondly because he can be helped to adjust within his family, for the basic unit of our community.

But the offender also continue to live and work in the community and the cost of probation is obviously much lower than institutional management.

PRINCIPLE II

Probation is performed in an authoritarian setting and this fact must be accepted and used constructively.

Probation aims to assist persons so that ideally they will not offend again. It is suggested elsewhere that obligations exist between probationer, probaton officer and court. The probation officer has a duty to see that the probationer complies with the rules, but within limits he may use his discretion.

The probation officer will not help his probationer if he ignores the authoritarian aspect of his job. The probationer may well be helped to come to terms with authority through his contact with the probation officer.

If the probation officer cannot accept the authority he must not ignore it. He is employed to use it. If this burden is too heavy, he should work in another setting.

The Probation of Offenders Rules requires the probation officer to ensure that the probationer understands his rights and obligations under the order and complies with the requirements of the order.

Probation often necessitates a somewhat delicate balance between help and the use of authority but here also lies its strength, it is between two necessary requirements of a successful society.

PRINCIPLE III

Probation has a limited objective, that of helping a person become a responsible law-abiding citizen.

A person who is responsible supports himself and his dependants where necessary, solves his problems (or asks others to help him solve them) in ways which do not injure him or others. Moreover, he accepts and discharges his duties and responsibilities as a citizen and obeys the rules of the society in which he lives. Probation is not intended to help him make the fullest use of his abilities. Of course, society would be enriched if this could so achieved but it is still not the aim or purposes of probation. Indeed, the probation officer may attempt to develop abilities in the probationer's interests (perhaps to help him solve his problems) but the development of ability or personality for its own make is not within the terms of reference.

The probation officer is primarily intending to help the probationer reach the point where he is a normally responsible person. If he succeeds in taking the probationer further, this is commendable but nevertheless incidental to the main purpose.

PRINCIPLE IV

When a person is placed under the supervision of a probation officer by a court each party has rights, responsibilities and obligations.

A defendant over 14 years is asked if he accepts a probation order and if he agrees to its conditions. By this acceptance, he is bound to keep to the conditions or face the consequences. He is asked to make an effort towards his rehabilitation and if he fails to do so and his general conduct deteriorates, or he commits a new offence, action may be taken against him. Thus, some responsibility is implied.

The probation officer is employed to see that persons placed under his supervision keep to the requirements of the probation order and become law-abiding citizens. The use of discretion is acknowledged but there are limits. The probation officer is asked to use the appropriate resources and where necessary, to seek the co-operation of other people or organisations in the reformation of the probationers. The probation officer should offer all possible assistance to the court and report to them with skill, accuracy and objectivity. He has a duty to help or to seek the help of others or refer elsewhere when asked to do so.

PRINCIPLE V

The probation officer's work with offenders and others is based on an intrinsic belief in the value of every human being and his capacity for growth and change.

If one believes that a man is incapable of change, then there is no purpose in trying to help him do the impossible. On the other hand, if one believes that a man can change, whether it is because he is maturing, or for self-preservation, each time he offends, the situation will be reviewed again for signs of change or hope.

Unless the probation officer has a progressive view of man, he is engaging in hopeless and purposeless activity, trying to mend something beyond repair. But, in addition, the probation officer should believe that others may be to able to repair even if he cannot.

PRINCIPLE VI

The probation officer should respect the needs and feelings and the privacy of mind of offenders and others with whom he has contact.

A man's mind contains his hopes, fears, secrets, his past and present thoughts. Within his mind he is free to think what he will and he cannot break laws by doing so. He has no guarantee that by disclosing information he will be better off, but even if he does he must be allowed to make his own decision. His mind in effect is refuge of his personality, and contains his most private secrets. But one may say that when an individual breaks the law he becomes liable to be punished or otherwise dealt with by society. This is because the continuance of society depends among other things, on its members keeping to the rules it has made and which it believes to be essential. But by breaking the law, does the individual become a person for whom there must be no respect, no concern? And does it help him if there is no respect for him?

If you respect his need for privacy is it not reasonable to consider also his feelings. The probation officer would not be entitled to bring about unnecessary discomfort or mental suffering. Nor should he use a relationship to gratify his own ends or curiosity at the expense of assaulting another's self respect.

PRINCIPLE VII

A person is free to make his own decisions, and it is the probation officer's ultimate aim to enable him to make responsible decisions.

Many problems have a range of possible solutions but because the relationship between probation officer and probationer is somewhat unequal the probation officer may attempt to influence the probationer into accepting his solution. But has the probation officer any right to exert undue influence when the issue of right and wrong is not involved? What proof has the probation officer that his answer is always the only correct one?

In helping a probationer, the probation officer can discuss which decisions are likely to be unfeasible or less desirable, which are beyond his abilities or others' abilities to assist him. The probation officer may show these courses of action which are likely to bring the probationer most benefit but throughout he tries to help him exercise and use his intellect so that eventually he can make up his own mind, generally solve his problems unaided and by legitimate means.

PRINCIPLE VIII

It is essential to be just and to show integrity in relationships.

There is no substitute for truth and honesty. Anything less reflects upon the integrity and personal standards of the individual. But it is often argued that means are justified by the (good) ends they seek to attain. Even if they were reached (and this is rate) would it be right to injure others on the way. The probation officer could also use coercion or other unfair means: for example, lies, half truths, bluff or practice or take part in deception, but doing harm is wrong in itself and may bring distrust, suspicion and disrespect. It is not possible to teach morality by immoral methods: bad means may corrupt those who use them. Moreover, they may be misunderstood and their results, unforeseen. A man has no right to tell another to be honest but not practice this virtue himself.

PRINCIPLE IX

A person under supervision or in contact with a probation officer has a right within certain limits, to make statements in confidence and on the understanding that the information will not be divulged.

There are occasions when a person wishes to take a probation officer into his confidence. The information is likely to be two groups: (1) concerning an offence committed either inside or outside the home, or (2) about some aspects of the person's life, for example his parentage or his plans. Information in the first group may come infrequently and it may concern an offence of long ago, or involving others. Every aspect of the situation should be considered, expecially the effect on the person. But first it is necessary to discover whether an offence has actually been committed or whether the person is really seeking punishment or merely trying out the probation officer.

In some probation areas special arrangements are in force. In all cases the officer has to use discretion, but where another is likely to suffer injury or is in danger, the probation officer may have to take action. Confidentiality is not an excuse to condone a serious offence but it is a principle which enables a person to speak freely. The probation officer should put his position clearly before a person discloses a confidence.

In his relations with other people particularly, other social workers, the probation officer may disclose confidential information. We should do this with the probationer's knowledge and usually with his consent, unless there are very good reasons for not doing so.

The criteria should be what action should be taken and what effect will it have on the probationer and/or his relatives and the community. The probation officer is not a judge as to whether a person is guilty or otherwise of an offence. On the other hand, he must keep to reality and ask "Am I shielding this person from reality by coming between him and the law?"

PRINCIPLE X

The probation officer has a primary responsibility to use his time in pursuance of his statutory duties which have priority over other social work he may do.

A probation officer's work is roughly divided between what he has to do and what he may do. With the former he has no choice, with the latter he can choose. But in each case, he should make a responsible decision. He must first use his time effectively in the interests of those who are his responsibility because the immediate consequences for them are possibly quite serious. If he fails to help, they may be deprived of freedom or subject to other drastic measures.

This is not to say that other work, for example matrimonial conciliation, has no purpose or that marriage break-down have no repercussions — those may in fact have far reaching effects and cause delinquency. Though this is a possibility, it is not a certainty. But there are other organisations to deal with these sorts of problem.

PRINCIPLE XI

The probation officer must, in the interests of his probationer and the courts, increase his skill and understanding by studying and co-operating in research and gain knowledge of delinquency and its treatment.

Knowledge about human behaviour increases as various individuals and organisations conduct research, some of which is helpful to the probation officer. By developing his skill, the probation officer can become more helpful to his probationer, the court and society generally. The probation officer should seek new knowledge and weigh its usefulness against his setting and experience.

THE REHABILITATIVE ASPECTS OF PROBATION MANAGEMENT

"Supervision" in probation sometimes offers the comfortable illusion that strict surveillance by itself or "compulsion" of having to report regularly to the Probation Officer was good for the offender and would somehow encourage discipline in other aspects of his social functioning. Supervision in probation is sometimes disparagingly dismissed as an effort to secure employment or accommodation for the offender. Whilst regular reporting and surveillance of the activities of the offender are significant to prevent him from committing further offences during his period of probation, they only contribute to an outward conformity rather than to an inner progress toward maturity. The mere provision of employment by itself without supportive supervision is not a guarantee that he will not offend again. If the offender had the natural ability to walk into the Employment Service to obtain a job, the interest in activity programmes of the Community Centre or the thrift to open up a Post Office Savings Bank, he would not have been involved in criminal activities in the first place.

In probation management, there is inherent a concept of sequence of cause and effect, based on the knowledge of human growth and development and criminal behaviour. Suppose our probationer is a young married man who has committed theft, the Probation Officer who deals with the offender will not label the problem as "theft". Instead he will see it as being a combination of several more basic problems. The young man for instance may have come from a depressed and dislocated family background; he could have a health problem like chronic asthma that causes emotional depression or incapacity on the job; he may be severely burdened with debts because of poor management; he and his wife may have marital problems arising from sexual incompatibility; his children may be low-achievers in school or he may have any of various long-standing problems. So here we have a cause and effect sequence which looks like this in the mind of the Probation Officer; the young man has problems, a combination of health, financial, marital and emotional difficulties. It is possible that because of these problems or some portion of them, he might have committed theft. In other words, his offence is symptomatic of his deep-rooted problems and his inability to resolve or cope with them by himself.

In the sequence, supervision in probation management becomes a dynamic situation for resolving problems rather than the mere negative enforcement of authority and surveillance. By helping the offender to resolve his personal and family problems, the Probation Officer enables growth and change in the offender, and thereby his rehabilitation.

The Probation Officer is concerned with problems of social dys-functioning in the offender. His task is to help the offender who in the face of stress and difficulty has not been able to meet the demands of the society in which he lives. The Probation Officer achieves this in a variety of different but interrelated ways. He improves the unsatisfactory material environmental conditions in which the offender lives by enabling the offender to use the social services available effectively. He brings about modifications in the attitudes of the individual concerned and improves family functioning and the relationships which may be the aggravent of difficulties. In effect the Probation Officer with his training, experience and skills, aims to bring the benefits of the social services to bear on specific cases of human needs. He seeks to find ways in which the offender and his family can be helped over difficulties which they are facing. He establishes a bond of confidence and trust with the offender. Within this close relationship, he attempts to modify the behaviour of the offender which is socially unacceptable. He finds ways of helping the offender to meet the demands of society. Of course, where the Probation Officer realises that the offender is not taking advantage of the supervision or taking the Probation Officer for a ride, he will exercise his authority. He will not hesitate to use his authority fully when the occasion demands, but the most effective kind of authority he carries comes not so much from the law that backs him as from his stature as a strong helping person. It cannot be assured that all offenders will naturally respond to supervision. There are bound to be failures. A primary requisite for change is the self-expressed desire to make good. It is this, that the Probation Officer seeks to strengthen from the first moment.

Let us look at an actual case study. A boy aged 14 years, was placed on probation for a year for the offence of theft of bicycle. The Probation Officer in the course of his social investigation into the personal and family background of the offender found that:—

a The boy's father died when the boy was about 12 years old. After the father's death, considerable deterioration took place within the family situation. The boy's mother who was completely dependent on the boy's father found herself inadequate to meet the changed circumstances. She left too much to fate. The children were all young and there was no one to fall back on for support. The situation was aggravated by the mental retardation on one of his sister. Another sister had undergone a major operation and two other sisters were at home. The mother was illiterate and had not sent her daughters to school. She was on public assistance. The children were undernourished and in need of medical care.

b The boy who was the eldest, was an intelligent student, but had not made use of his capabilities fully. He had an excellent record in his primary school. In his secondary school (he was in Sec 2 when he committed his offence), his progress had deteriorated. His form teacher who had no knowledge of the boy's home background, observed that the boy was quiet in class, indifferent to his work and irregular in his attendance. He was always in arrears in his supplementary fees.

c The boy's version of his offence was that he needed a bicycle. His school was about 8 kilometres away from his home. Sometimes he did not have bus fares for school. Often he felt envious when other boys in school had their own bicycles. He said he stole the bicycle on a sudden impulse.

d The Probation Officer in "diagnosing" the problems observed that much of the problems arose from the depressed conditions of his family.

It became clear to the Probation Officer that unless he helped the family to alleviate its problems, any amount of good work with the boy would be futile. The offender was not an isolated person living in a vacuum, even though he had offended and was on probation. His problems could rarely be those seen outside his family environment.

In this particular case, the Probation Officer initiated the following actions and with the involvement of the boy and his family saw them through.

a The immediate action taken was to get the boy back to school. Instead of sending him to his previous school, which was 8 kilometres away, a school in his neighbourhood was found for him. The Probation Officer enlisted the services of a school teacher to help the boy with his lessons. The Probation Officer kept regular contact with the boy's form teacher and principal. His conduct, progress and attendance were checked every month.

b The family was on public assistance. Obviously, it was not enough to manage the household budget. The Probation Officer obtained the assistance of a voluntary agency which provided the family with monthly rations and clothing. The voluntary agency even went a step further and donated a bicycle to the boy.

c The Probation Officer then proceeded to deal with the boy's four younger sisters.

i The Probation Officer realised that the sister who was mentally retarded was a source of irritant at home. He arranged for her to be examined by a psychologist. It was found she was trainable. He got the help of a voluntary association for retarded children to train the girl. The association agreed and also provided for the girl's transport.

ii The girl with a major operation was referred to the Paediatric Unit to find out her fitness for school. It was found that she had undergone heart surgery. She was certified fit for school but would not be able to participate in games or physical exercises. She was helped to enter a school in the neighbourhood.

iii The youngest daughter aged five, who was problematic in a sense that she was demanding and broke into traumatic fits was helped to enter a kindergarten. She liked it and her behavioural problems became much less.

iv The eldest daughter, aged nine years, was overaged for school. The mother wanted the girl to help her with the household chores. The mother herself was diagnosed as having hypertension. She was helped to receive medication. The Probation Officer impressed upon her the need for her daughter to get some form of rudimentary education. She agreed to send her daughter to the children's centre.

d The unresolved problem at that stage was to find proper accomodation for the family which was living in a makeshift shack within the compounds of a firm dealing with iron-scrap. Fortunately for the family, the firm was ordered to shift its business elsewhere as the place was required for urban redevelopment. The Probation Officer sought the sympathy of the firm which agreed to provide accomodation.

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THE ROLE AND FUNCTIONS OF THE PROFESSIONAL PROBATION AND AFTERCARE OFFICER IN THE DRUG REHABILITATION CENTRE

K V Veloo, Chief Probation and Aftercare Officer

THE ROLE OF AFTERCARE

Aftercare in the context of the Drug Rehabilitation Centre, is concerned with the personal care and supervision of those released from the Centre. Its main objective is to help the discharged inmate to lead a drug free life and help him to re-establish himself in the community as a useful and law-abiding citizen. A person who had been living under conditions of restraint and deprivation of drugs is at a great disadvantage in trying to fit into ordinary life again, even if he had not the added disadvantage of the disapproval of the community. The efforts of the institutional programme will be minimised, if the discharged inmate is allowed to return to drug dependence or crime mainly due to his inability to adjust to normal living in society after his release. The active intervention of aftercare can therefore have great significance in determining whether he will be able to withstand the temptations of drugs and the demands placed on him by the community. Aftercare to meet these expediencies can offer a purposeful continuation in the open environment of the institutional treatment. It is in this context that the present thinking of aftercare is that it should begin as soon as the drug-dependent person enters the Drug Rehabilitation Centre.

THE ROLE AND FUNCTIONS OF THE AFTERCARE OFFICER

2 The Aftercare Officer in the Drug Rehabilitation Centre will be dealing with the inmate at two stages of rehabilitation:

a) one, undertaken in the Drug Rehabilitation Centre; and
b) two, when the inmate leaves the centre on discharge for a final period in a freer form of treatment.

SERVICES UNDERTAKEN IN THE DRUG REHABILITATION CENTRE

3 For convenience, the services undertaken in the Drug Rehabilitation Centre by the Aftercare Officer could be broken down to three distinct but interrelated stages:

a) services offered at intake;
b) during custody; and
c) immediately prior to discharge

4 The Aftercare Officer would interview the inmate on admission. This initial interview by the Aftercare Officer is very necessary for the inmate at a time when he is incapacitated and stripped of all freedom to act. The unanticipated entry into the institution, where the inmate is subjected to an authoritarian rule will without doubt, create in him feelings of frustration and hostility towards society generally. Thus the initial interview with the Aftercare Officer will give the inmate an opportunity to give vent to his aggressive feelings.

5 The initial interview is also important as the inmate is acquainted with the role of the Aftercare Officer and the services he will offer. Secondly, the inmate is interviewed with the purpose of collecting data from which a social report on his family and personal background is prepared. The primary purpose of social investigation is to obtain accurate information about the inmate and his interpersonal situation or social environment. The focus here is to assist the institutional staff to gain a clear understanding of all of the relevant aspects of the inmate's life. This enable the centre to determine an appropriate rehabilitative programme that best suits the inmate. The secondary purpose of the investigation is to provide the Aftercare Officer with the kind of knowledge about the inmate that is useful in developing a plan of treatment or

rehabilitation. This contains some tentative goals to be achieved on behalf of the inmate as well as a commentary on how these are to be accomplished. Thus, the social report becomes an integral part of the Centre's total services. Thirdly, at this interview and subsequently, the Aftercare Officer will try to identify the more immediate personal and family problems. He will make tentative assessment of the structure and financial position of the family and if he detects a social breakdown in the family, he will without delay step in to alleviate the immediate problems. Fourthly, this interview would also be the starting point of the detection of the inmate's problems which resulted in his admission to the centre. His personal, social and emotional problems, if any, would be tentatively assessed. All these facts would assist the Aftercare Officer to arrive at a provisional diagnosis of the inmate's problems and the likelihood of his responding to sound treatment.

b) During Custody

6 Though many aspects of the rehabilitative process are in the hands of the Centre's staff who come into contact with the inmates daily, this does not in any way lessen the burden on the Aftercare Officer. The Aftercare Officer's aim and objectives are in no way different from those of the other members of the staff, and he together with them forms a team.

7 While in custody all problems of inmates arising out of their inability to adjust to an atmosphere of restraint, or an inability to "get along" with fellow inmates, the rehabilitative staff or personal behaviour problems which result in non-conformity, will be some of the instances in which the Aftercare Officer will intervene to offer a helping hand. It is not hoped that the Aftercare Officer would be used by the inmates as an instrument for "getting them out of trouble", for this will not be anywhere near his function.

8 It is of great importance to state here that all inmates will view the Aftercare Officer as a person who constantly maintains their relationship with the external world. The efforts of the Centre's staff will be minimised if there is no person who can work with the problems emanating from inmate's external world. Moreover, the treatment of the inmate has to be done in relation to the family and the environment to which he has to be ultimately integrated on his release. This brings the Aftercare Officer to the arena of family welfare work. Besides maintaining regular contacts with families, he may be called upon to see them more frequently where there are serious social breakdowns.

c) At Discharge

9 A person who is admitted to the centre obviously does not come there of his own choice. This conglomeration of individuals, who have got out of step with society resent living together in a closed community, which is a foreign world to them and in no way permits them the use of discretion in their actions. A person who goes through a period of stay in the centre would lose some sense of direction to live a normal life on his release unless he is given assistance and guidance during the initial period of integration. This has been considered to be one of the causes of a person returning to a life of drugs on release. The efforts of officers handling the aftercare services, who had no contact with the inmate during his stay in the centre and as a result were only vaguely aware of the problems of the inmate, would not alter the position very much. The present view that aftercare service starts the day an individual is admitted to the centre would envisage placing the aftercare service in the hands of the very person who assisted the individual during the period of incarceration. Thus for the total and ultimate rehabilitation of the drug addict, the Aftercare Officer would have to follow up after discharge till the individual is ready to stand on his own.

10 It is also at the last stage of the inmate's detention that the work of the Aftercare Officer becomes pronounced. He makes an intensive effort to establish a strong professional relationship with the inmate as institutional staff slowly move away from the inmate without a catastrophic break-up in their relationship. The success of aftercare depends on the bond of confidence and trust among the Aftercare Officer, the inmate and his family. A discharged inmate usually returns to live with his family. The chances of successful aftercare would be greatly enhanced if during his period of custody some welfare work had been done with the family to prepare it for his eventual return and to enable the family to give some encouragement and worthwhile support to him on his return home. It may be desirable to offer social casework support to a disturbed family where, perhaps, the Aftercare Officer may find that the younger brothers are showing behavioural problems or the family is in financial distress..

11 It is also during this last stage of his detention that the Aftercare Officer discusses with the inmate his discharge arrangements. Prospective employers are interviewed and employment arrangements are further discussed with his family. Where an inmate has no home to return to, alternative arrangements are

made. It may involve seeking help from other social agencies. The trainee may need help to get a copy of his Birth Certificate, his Identity Card and such other things that are important to him. When discharge arrangements are finalised, a report will be made to the relevant authorities for a consideration of his release, if he is found suitable. It must be emphasised that during all this activity, the institutional staff will be constantly consulted on the Aftercare plans for and on behalf of the inmate.

SERVICES UNDERTAKEN ON RELEASE FROM THE CENTRE

12 The second aspect of the Aftercare Officer's role is a significant one. When an inmate is released, he comes under the supervision and personal care of the Aftercare Officer who had previously dealt with him during his period of detention. Such supervision in an environment of freedom is a purposeful continuation of the treatment and training undergone in the custodial situation. It will be fruitless if what had been done at the centre is left to wither for lack of positive aftercare service for the discharged inmate. A discharged inmate coming out of the centre will have both material and emotional problems even though some of these problems may have been resolved partially or wholly during the training period. It is a common experience for a discharged inmate to take some time to settle down in a new situation of freedom. It is important that during this period he can turn to some one whom he knows and trusts and to discuss his doubts and anxieties. It is therefore interesting to note that the term "supervision" does not adequately describe the role and functions of the Aftercare Officer.

13 Supervision in aftercare sometimes offers the comfortable illusion that strict surveillance by itself was good for the discharged inmate and would somehow encourage discipline in other aspects of living. Whilst surveillance of the activities are significant to prevent him from recidivating, it can, if carried out without sensitivity and understanding, lead to outward conformity rather than to an inner progress toward maturity and abstinence from drug abuse or dependence. The mere provision of employment by itself without support and guidance is not a guarantee that he will not offend again. If the discharged inmate had the natural ability to walk into the Employment Service to ask for a job or the interest in the activity programmes of the Community Centre or the thrift to open a savings account in the Post Office Savings Bank, he would not have in the first place be attracted to the abuse of drugs.

14 In aftercare treatment, there is inherent a concept of sequence of cause and effect, based on the knowledge of human growth and drug abuse behaviour. Suppose our discharged inmate is a young married man, the Aftercare Officer will not label his drug dependence as an "offence". Instead he will see it as being a combination of several more basic problems. The young man for instance, may have come from a depressed and dislocated family background; he would have a health problem like chronic asthma that causes emotional depression or incapacity on the job; he may be severely burdened with debts because of poor management; he and his wife may have marital problems arising from sexual incompatibility; his children may be low-achievers in school or he may have any of various long-standing problems. So we have a cause and effect sequence which looks like this in the mind of the Aftercare Officer: the young man has problems, a combination of health, financial, marital and emotional difficulties. It is possible that because of these problems or some portion of them, he took to drugs. In other words, his drug dependence can be symptomatic of his deep-rooted problems and his inability to resolve or cope with them by himself.

15 The Aftercare Officer is concerned with problems of social dysfunctioning in the discharged inmate. His task is to help the discharged inmate who, in the face of stress and difficulty, has not been able to meet the demands of the society in which he lives. The Aftercare Officer achieves this in a variety of different but interrelated ways. He improves the unsatisfactory material environmental conditons in which the discharged inmate lives by enabling him to use the social services available effectively. He brings about modifications in the attitudes of the individual concerned and improves family functioning and the relationships which may be the aggravant of difficulties. In effect, the Aftercare Officer with his training, experience and skills aims to bring the benefits of the social services to bear on specific cases of human needs. He seeks to find ways in which the discharged inmate and his family can be helped over difficulties which they are facing. He establishes a bond of confidence and trust with the discharged inmate and within this close relationship, he attempts to modify the behaviour of the discharged inmate which is socially unacceptable. He finds ways of helping the discharged inmate to meet the demands of society. Of course, where the Aftercare Officer realises that the discharged inmate is not taking advantage of the supervision or taking the Aftercare Officer for a ride, the Aftercare Officer will exercise his authority. He will not hesitate to use his authority fully when the occasion demands, but the most effective kind of authority he carries comes not so much from the law that backs him, if he has it, as from his stature as a strong helping person. It cannot be assured that all discharged inmates will naturally respond to supervision. There are bound to be failures. A primary requisite for change is the self-expressed desire to make good and it is this that the Aftercare Officer seeks to strengthen from the first moment.

IDENTIFICATION OF DRUG ABUSERS

General Symptoms of Drugs Abuse*

Abrupt changes in school or work attendance, quality of work, grades, discipline, work output.
Unusual flare-ups or outbreaks of temper
Withdrawal from responsibility
General changes in overall attitude
Deterioration of physical appearance and grooming
Furtive behaviour regarding actions and possessions
Wearing of sunglasses at inappropriate times (to hide dilated, or constricted pupils)
Continual wearing of long-sleeved garments (to hide injection marks)
Association with known drug abusers
Unusual borrowing of money from parents or friends
Stealing small items from home, school, or employer
Attempts to appear inconspicuous in manner and appearance (to avoid attention and suspicion)
May frequent odd places without cause, such as storage rooms, closets, basements (to take drugs).

*This outline may help you identify persons abusing drugs by enabling you to recognise symptoms and signs of drug abuse. Obviously, no one symptom should be considered an indication of such abuse. Also, it should be remembered that some of these symptoms could indicate normal adolescent variability or other health problems. In other words, SYMPTOMS ARE NOT PROOF' CONCLUSIONS SHOULD BE BASED ON FACT, NOT ASSUMPTIONS.

SYMPTOMS OF ABUSERS OF SPECIFIC DRUGS

The Glue Sniffer (or User of Other Vapor-Producing Solvents)

Odor of substance on breath and clothes
Excess nasal secretions, watering of eyes
Poor muscular control
Drowsiness of unconsciousness
Increased preference for being with a group, rather than being alone
Plastic or paper bags or rags, containing dry plastic cement or other solvent, found at home or in locker at school or at work.

The Depressant Abuser (barbiturates, tranquillizers, "downs")

Symptoms of alcohol intoxication with one important exception: no odour of alcohol on breath
Staggering or stumbling
Falling asleep inexplainably
Drowsiness; may appear disoriented
Lack of interest in school and family activities

The Stimulant Abuser (amphetamines, cocaine, "speed", "bennies", "ups")

Pupils may be dilated (when large amounts have been taken)
Mouth and nose dry; bad breath; user licks his lips frequently
Goes long periods without eating or sleeping
Excess activity; user is irritable, argumentative, nervous, has difficulty sitting still
Chain smoking
If injecting drug, user may have hidden eye droppers and needles among possessions

The Narcotic Abuser (heroin, morphine)

Lethargic, drowsy
Pupils are constricted and fail to respond to light
Inhaling heroin in powder form leaves traces of white powder around nostrils, causing redness and rawness
Injecting heroin leaves scars, usually on the inner surface of the arms and elbows, although user may inject drugs in body where needle marks will not be seen as readily
Users often leave syringes, bent spoons, bottle caps, eye droppers, cotton and needles in lockers at school or hidden at home.

The Marijuana Abuser

In the early stages of intoxication, may appear animated with rapid, loud talking and bursts of laughter. In the later stages, may be sleepy or stuporous
Pupils usually are dilated
Odor (similar to burnt rope) on clothing or breath
Remnants of marijuana, either loose or in partially smoked "joints" in clothing or possessions
Usually user in a group, at least in early habit of smoking

Note: Unless under the influence of the drug at the time of observation, marijuana users are difficult to recognize; infrequent users may not show any of the general symptoms of drug abusers.

Marijuana is greener than tobacco. Cigarettes made of it (called "joints"; "sticks" or "reefers") are rolled in a double thickness of brown or off-white cigarette paper. Smaller than a regular cigarette, with the paper twisted or tucked in at both ends, the butts (called "roaches") are not discarded but saved for later smoking if not consumed at initial usage. Marijuana also may be smoked in a pipe (very small bowl, long stem) or cooked in brownies and cookies.

The LSD (or STP, DMT, THC) Abuser

Users usually sit or recline quietly in a dream or trance-like state.
Users may become fearful and experience a degree of terror which makes them attempt to escape from the group
Senses of sight, hearing, touch, body, image and time are distorted
Mood and behaviour are affected, the manner depending upon emotional and environmental condition of the user
Users may have unpredictable flashback episodes without use of the drug

Note: It is unlikely that persons using LSD or other hallucinogens will do so in school, at work, or at home at a time when they might be observed. At least in the early stages of usage, these drugs generally are taken in a group situation under special conditions designed to enhance their effect.

LSD is odorless, tasteless and colorless. It may be injected, but usually is taken orally in impregnated sugar cubes, cookies, or crackers.

PROBATION AND AFTERCARE SERVICE

BASIC COUNSELLING CONCEPTS

Experience has shown that respect is the key to success in working with offenders. The offender will not be open to effective counselling, advice or help until he respects and trusts you as a person.

Given the goal of establishing a suitable relationship with the offender how may this be achieved? The matter is not one of hard and fast rules. Every case has much that is unique in it, and cannot be handled according to set rules alone. Your own imagination, judgement and initiative are also involved.

Discussed below are some basic counselling concepts to provide the basis on which you may organise your personal experience of working with offenders.

Empathy

Simply putting yourself "in his shoes"'.

Simple Language

For effective communication, use simple language. Discuss matters on a level the offender can understand.

Example

Set a good example. Be careful of your mannerisms. If you are gaining his respect, he will emulate you.

Advice

Most offenders have received much advice from parents, relatives, teachers, friends, police officers, magistrates and other. Thus do not be in a hurry to offer more advice. You may be lumped together with others who advise, and resented. Advice will only be accepted after a relationship of trust has been established. If premature, it will hinder such a relationship and become self-defeating. Never give advice which the offender's circumstances make it impossible for him to follow. To do so reveals that you lack empathy and do not really understand his position.

Listening

A basic requirement in counselling is the ability to be an interested listener. It may be difficult, but genuine listening is a way of showing concern. Remember that listening is not just keeping quiet when the other person speaks, it is making a genuine effort to take in what is said. Do not concentrate only on what *you* are going to say next.

At the same time, do not be a naive and over-credulous listener. Check the facts when you can. Many offenders can take you for a ride, and may habitually lie as a matter of habit. However, to a careful listener the truth will emerge. However do not put the offender off with excessive disbelief.

Exaggerating or lying can also be a way in which offenders let off steam, and get things off their chest. Within limits this is good for them. Be ready for such set-backs. Be human. You can show your feelings with control if you hear an obvious lie of bad behaviour. But do not lose your temper with an offender. If you do, he will believe that he has made you reveal your true self and that your professed desire to help is phoney.

Respect the Offender

Respect the worth and dignity of the offender. There is no room for narrow prejudices. Basically, you must like the person in order to help him. What the offender may tell you may shock you. He may have a different set of values and have been exposed to an environment foreign to you in many respects. Try therefore to think of them objectively without either judging or condoning. If you dislike the offender or have personality conflicts which cannot be resolved, do not hesitate to request that you be taken off the case. This is far more honourable than struggling under irremovable pressure and prejudices. Remember that the welfare of the offender should come before your own pride in the matter.

Do not expect explicit thanks either from the offender or his family. Even if the offender feels gratitude, he may not know how to express and communicate it. Though your work may not be rewarded by open thanks, it is in the long run appreciated, probably more than you or we shall ever know.

Actions not words

The offender readily recognises your sincerity or lack of it. It is not so important what you say, but how you say it. You must be honest. Never make a promise or a threat that you cannot back up. Do not let him down even in apparently small things like showing up for appointments and being on time.

Inspirational

Be enthusiastic and show your leadership. Think positively regardless of the shortcomings of the offender. Exploit his strengths and strengthen his weaknesses. Do not expect overnight miracles. When things have been wrong for years with the offender, they do not get corrected in a few weeks. It takes time. Even if progress is visible, there will be frequent setbacks.

Persistence is an important part of counselling. It shows the offender that you will not give up on him. He himself may expect disappointment. When he realises that you are genuinely interested in helping, this may well serve as a turning point for him.

Know the offender

Get all the information you can from him either from his probation records or by direct contact. At some point you may want to take advantage of the information. Keep an open mind on the offender especially before meeting him and getting to know him. Avoid forming fixed and premature opinions, until you have done much discerning listening and gathered all the background information on him.

Respect Confidentiality

Whatever you know about an offender must not be divulged or discussed with anyone except a person or agency authorised by the department to receive such information. Violations of this is not only highly unethical but it will destroy the relationship with the offender, if discovered. Confidentiality, however, does not include keeping known infringements of the Probation Order a secret from his Probation Officer. However easy it may be seen to do so, in the long run sweeping such things under the carpet does the offender a disservice. He may learn to think that he can always get away with a violation. You may be sacrificing everything to win his friendship but will end up losing his respect. You must report all breaches of the Requirements of his Probation Order immediately to his Supervising Probation Officer. You must be sure to tell the offender if there is anything you feel you must report to your supervisor. If the offender feels you have gone behind his back unfairly, he will naturally resent it. In discussing with the offender possible or unproven breaches, be honest and firm when you disapprove. This is not inconsistent with being helpful and friendly. After all, if you do not stand for something in his eyes, there are very few others who will.

Relationship with Parents.

While your relationship with the offender is obviously foremost in your mind, you must also realise that he has other important relationships as well, with his parents, peers, teachers, employers etc. Give some careful thought and attention to these, too. It is often found that much of the problems of the offender can be traced back to poor family conditions. Your work may thus involve helping the family to alleviate some of its problems. Move with care when you are dealing with the family. Discuss your plans with your supervisor before you take any action in family problems and relationships.

Spiritual

Most offenders have some concept of good and the effect of the spiritual realm upon their lives. Use these concepts in character building in suitable cases. Do not force your own denomination or beliefs upon them. Do not expect all offenders to show an interest in spiritual matters.

DOs AND DON'Ts

DO. . . .Establish friendly working relationship with the person with whom you are working.

DON'T . . .Exercise or use authority that is vested in the Probation Officer

DO. . . .Accept the individual "as he is".

DON'T . . .Compare his values with yours.

DO. . . .Talk on his level

DON'T . . .Talk above the probationer's ability to comprehend and effectively communicate with you.

DO. . . .Help solve financial problems.

DON'T . . .Loan money.

DO. . . .Notify Probation Officer of any pending court appearances of probationer.

DON'T . . .Appear in court on behalf of probationer without knowledge and consent of Probation Officer.

DO. . . .Provide empathy.

DON'T . . .Provide sympathy.

DO. . . .Exercise patience, wisdom, and understanding. Sometimes positive results do not appear on the surface until a much later time.

DON'T . . .Become discouraged.

BASIC COUNSELLING MODEL

Stage	Subsidiary Stages	Counselling's Role
1 Establishing rapport		Putting client at ease and creating an open channel of communication.
2 Ventilation		Listening to the client and encouraging him to talk.
3 Understanding the Problem		Helping the client to come to as full and understanding of his problem as possible.
4 Decision-making	A Is the client really aware of the nature of his problem? (See Stage 3 above). B What are the various possible solutions? And what are their advantages/ disadvantages? C What is the best solution for this client and what are its implications if adopted? D How can the chosen solution best be put into operation?	
5 Terminating the interview		To summarise the progress made. And if appropriate, to go over any plans made for implementing decisions made. To arrange future interviews.

Note: The interview need not necessarily go through all five stages. It can end, as the arrows show, after Stage 2 or Stage 3 or during Stage 4.

This table is taken from John Shaw's Basic Counselling (1973)

LISTEN TO AND REALLY HEAR ANOTHER HUMAN BEING

COUNSELLING: A HELPING RELATIONSHIP

1 COUNSELLING: A HELPING RELATIONSHIP

This brochure is designed to present the story of counselling, although it is difficult to capture on paper the dynamic quality of the profession. Every time two people come together, each with his unique feelings and personality, the result is a kaleidoscope of perceptions and emotions as each interacts and shares with the other. This relationship ,which is the essence of the process of becoming, represents the basis of counselling.

Counselling, a profession of service to others, originated in the Judeo-Christian commitment to the brotherhood of man. Counselling recognises that we each have within us something of value to share with others. A counsellor is sometimes seen as an all-power authority who solves other people's problems or makes decisions for them. He is not. The counsellor is a thinking, feeling, caring individual who has developed the capacity to share his knowledge and skills with those who need help.

The close, human relationship counselling requires the depth and breadth of warmth, openness, and mutual trust that is deeper than simply technical knowledge or intellectual competence. The Counsellor may function in one-to-one relationship, or he may work with groups. He may work in schools or other educational settings; rehabilitation centres or hospitals; public employment offices; community mental health centers; or in some public or private agency working with the physically, educationally, emotionally, or culturally different child and adult. Although the locale may change and the technical skills necessary to function in a specialized setting may differ, the counselling relationship remains essentially the same. It is a form of verbal and non-verbal communication among people, built on the elements of caring for, giving to, and helping others.

Counselling is a challenging profession for individuals who wish to work in a constantly changing situation and who genuinely enjoy working with people. It seeks mature individuals who know themselves and who feel that they have something to share with others. The personal regards are great, although usually intangible. The rewards come from the satisfaction of assisting people in making wise choices for the future; helping individuals work through personal concerns that might have prevented them from living rich, full lives; and being an involved yet unbiased listener in a world in which the people's need often remain unheard.

2 THE COUNSELLOR AND THE COUNSELLEE: WHO ARE THEY?

If we can accept the concept of individuality, then we can recognize that each person has needs, concerns, feelings, and problems that are unique to him in his personal life. Although the counsellor cannot provide a panacea to all individuals, he can mean a great deal to many individuals. He attempts to assist those who come to him for help in whatever professional setting he happens to be.

Who are the people counsellors work with?

Individuals seeking to identify educational, vocational, or personal goals.

Individuals and groups who are living satisfactory lives but who aspire to something better.

Youngsters attempting to adjust to the myriad pressures of family, peer group, school, and society.

Handicapped individuals learning to live fully with their disabilities.

Couples trying to maintain their marriages.

Senior citizens who feel that they have lost their place in society.

Individuals confronting conflicts between their own personal beliefs and standards and those held by people who are important to them.

Young men and women in Job Corps centers who are striving to make a new way of life for themselves.

College students searching for identity in an anonymous society.

Students in Upward Bound programs, striving toward a brighter future through education.

Lonely, forgotten persons who need someone to care about them or someone to care about.

In each case, the counsellor operates on two levels. He has certain specialized knowledge and skills that enable him to assist others in understanding themselves and their world in order to make the wisest decisions about their futures. The counsellor is also concerned with feelings. He must be capable of helping others to better understand their emotional natures as real and valued parts of themselves, as uniquely and appropriately part of them as their rational natures.

3 COUNSELLING AND THE HELPING PROFESSIONS

The counsellor has much in common with other helping professions, particularly the social worker, the psychologist, and the minister. He has a similar backgound in the behavioral sciences; he deals primarily with people in need of help; in many settings he functions as a member of a professional pupil personnel or rehabilitation team working toward a common goal; and he should have similar personality characteristics of warmth, self-understanding, intelligence, security, and a willingness and ability to become involved with others in a close, personal relationship.

The counsellor focuses upon the needs of the individual rather than upon the expectations of society. Counselling is his primary commitment and responsibility.

The social worker usually has a major concern with the environment of his client.

The psychologist frequently is concerned with diagnosis and/or treatment of the abnormal personality.

Although the counsellor has much in common with others, he nevertheless remains an individual with a special function, who must be able to understand and demonstrate his uniqueness if he is to be successful.

The counsellor is also an agent of change. He is more than a passive observer of the lives of others. Rather, he is an active participant, a catalyst designed to facilitate the development and growth of the individual through the counselling process. Defining the counsellor as an agent of change does not mean to imply that his aim is to change the individual to fit society. It means that at times he may become actively involved in the counselee's life in order to facilitate the modification or removal of barriers to change within the counselee's immediate environment.

4 WHAT IS COUNSELLING?

As with most behavioral sciences, counselling represents a large body of knowledge, the meaning of which depends heavily on the individual counsellor's philosophy of counselling and of life, his background, and his professional preparation. As an emerging profession, counselling has not yet developed a precise description of the counselling process. For this reason, each counsellor entering the profession is encouraged to conduct research whenever possible.

Despite the current lack of a precise definition of what counselling is and does, counselling continues to emerge as a full-pledged partner in the helping professions. On going research helps us

increasingly to understand the process of human interaction. Even at our present limited state of development, however, there are certain things we know about the counsellor and the counselling process.

Counselling involves non-judgmental, non-evaluative listening. This does not mean to imply that the counsellor is an emotionally sterile person. It means that although he is aware of his personal biases, he can interact with a counselee by not judging him and by assisting him in making his own judgements and developing his own values through the development of self-awareness and self-trust.

Counselling is almost synonymous with confidentiality. Under normal circumstances whatever occurs in the counselling relationship remains confidential between the participants in that relationship and will not be revealed to others without the permission of the counsellee.

Counselling involves the concepts of right and wrong or good and bad only when perceived through the eyes of the counsellee in terms of his own values. Although the counsellor may interpret the law, religion, and the socio-cultural modes of society to the counsellee, his primary obligation is to help him weigh all possible alternatives and then to reach a decision that is right for the counsellee. This does not mean that the counsellor encourages anarchy but rather that he helps the counsellee reach for freedom within the limits set by society.

Counselling involves a sensitivity to the needs and feelings of others, an understanding of the forces that operate within and around each individual, an empathy that enables the counsellor to see life through the counsellee's eyes, a humility with regard to his own frailties and limitations, and a degree of security and sophistication that enables the counsellor to help those he can help and to refer to others those he cannot help.

Counselling means involvement. Although the counsellor cannot serve all, he can mean a great deal to some. The counsellor must be able to interact as an equal with other human beings.

He must be able to trust the counsellee, to share himself with the counsellee, and to become involved with the counsellee's life in the same way that he asks the counsellee to trust and share with him.

Counselling means listening to and really hearing another human being. The counsellor must be receptive to the most subtle signs of distress. He must be able to sense when people are in trouble and be able to reach out to them. In the complex impersonal society in which we live, the counsellor must become the individual who cares enough about others to provide a source of warmth, empathy, and security for them. For many, the counsellor may represent the final refuge.

5 WHERE DOES COUNSELLING TAKE PLACE?

Counselling can take place virtually anywhere. Where the counsellor works depends on the types of problems and counsellees with which the counsellor feels most comfortable as well as on the extent of his background and preparation. With the increasing shortage of counsellors in the country today, the demand for counsellors in all settings far exceeds the supply. (It is estimated that this shortage will reach 40,000 within the next five years).

Counsellors with masters' degrees are working as school counsellors on the elementary and secondary level; as counsellors in college and university counselling centers; as rehabilitation counsellors in public and private rehabilitation centers, agencies, and hospitals; and as individual and group counsellors in specialized settings designed to serve the needs of the culturally different, such as Job Corps centers and Head Start programs. In short, counsellors work wherever people go for help.

Although the setting and clientele may vary greatly, the counselling process remains relatively constant. It may be a long-term service, solving a specific concern. It may be supportive in a situation that cannot change, or directive in assisting an individual to make a decision. It may be educational in planning for further study, vocational in investigating career opportunities, or personal-social in assisting the individual to look at himself and at his interpersonal relationships.

THE AMERICAN PERSONNEL
AND GUIDANCE ASSOCIATION

SOME SPECIFIC AREAS OF ASSISTANCE

Ways to assist the offender are only limited by the combined efforts and imagination of the Volunteer Probation Officer and his Supervisor, the Probation Officer. It may be just doing what you would do for a friend. Sometimes all it takes to redirect the life of an offender is a timely suggestion, a little encouragement or some practical assistance. Below are some ways in which you can help the offender. These suggestions are not all inclusive and are intended to point out a few areas of concentration. You may be involved in any combination of these areas and in a host of other areas as well.

Employment

You can help generate interest and motivate the offender to participate in vocational training. Upgrade his underemployment by obtaining a marketable skill. Identify his vocational interest and aptitude through discussions and testing through community resources. Assist in the actual enrollment and follow up of the offender. Make contacts with the training school or firm, family and others to encourage course completion.

Find him a suitable job, if he is unemployed. Encourage job stability, punctuality and regular attendance, proper notice for job changes and other responsibilities connected with maintenance of regular employment.

Education

You can help him to maintain class attendance, good conduct and consistent progress in his work. Where necessary, you can provide tuition to the offender. You can help him to complete his schooling. For instance, if the offender has dropped out at Sec III, your immediate goal will be to help him complete his Sec IV probably by encouraging him to enrol in the Adult Education Board.

Spiritual Guidance

Religious and spiritual growth can provide the ingredients for rehabilitation. Character guidance and moral values which are grounded in religious beliefs can help strengthen the offender's ability to withstand temptations, strain and stress. You can encourage regular attendance and activities in various places of worship within the offender's religious upbringing and persuasions.

Hobbies, Arts and Crafts

You can help direct his youthful energies into useful pre-occupations or leisure pursuits. You can broaden the scope of his interest in hobbies, arts and crafts. You may, for instance, have an interest in rebuilding old cars and the offender may have a similar or parallel interest. You can work together on such projects.

Personal

One of the foremost qualities of a good Volunteer Probation Officer is the ability to be an interested listener. There is much therapeutic value in merely allowing an offender to talk out his problems and needs. You can point out his strengths and weaknesses. The offender needs to experience success to bolster his ego, instill pride and inspire greater achievement.

Good influences change attitudes. You can encourage personal hygiene, improvement in physical appearance and good grooming, in particular the need to keep short hair. You can help him with his residential arrangements, budgeting and finance. Encourage him to be thrifty and to save part of his earnings. Much of the problems of the offender lie in his inability to budget his expenses.

Discuss the health hazards of smoking, alcohol, drug abuse and promiscuous association with prostitutes. Help him to stop smoking, if he smokes or to give up drugs, if he is on them. Help him to plan his family, if he is married.

Sporting and Cultural Activities

You can develop the interest of the offender in sporting, cultural and social activities by associating him with youth clubs, community centres and sports associations. It is good to develop other areas such as art and music. Many have not the advantages of exposure to fine arts. You may wish to bring him along with you to the library, museum or an exhibition of art display, etc. You may wish to take him along for a picnic with your family or to a show. Such matters as the offender visiting your home, meeting members of your family or friends or having dinner with you will have to be decided by you on an individual basis.

Family Relationships

You can improve family structure and relationships. Always secure family assistance and involvement in all your plans for the offender.

Changing habits, outlooks and attitudes is a long arduous task. It takes extreme patience. Progress may be slight in some cases, while other individuals have the capacity for greater reform. In all cases you may meet with some frustration, discouragement and disappointment. But if you continue to give your goodwill, understanding and opportunity to the offender, you would soon find that your efforts are manifested in the form of delayed action.

A GUIDELINE ON 'MORAL AND ETHICAL VALUES' FOR THE DEVELOPMENT OF THE OFFENDER

INTRODUCTION

In order for man to live in harmonious adjustment with one another, man must be willing to defend the values that are basic for human fulfilment and co-operative living. To want others to treat us with consideration and respect, this must first be followed by a desire on our part to treat others in a manner that we would want them to treat us. In the belief that man has a great capacity for self betterment, an attempt is made at drawing a guideline for Probation & Aftercare Officers to impart moral and ethical values essential in the development of the offender.

AIMS AND OBJECTIVES

2 This guideline aims at achieving the following objectives in respect to the offender:

i To teach the importance of distinguishing between right and wrong and to impart the rules of right conduct;

ii To teach the importance of upholding justice and respect for law and order;

iii To promote an understanding and respect of religious beliefs and customs of each ethnic group;

iv To promote the idea of tolerance, goodwill and understanding in the concept of harmonious living;

v To foster a sense of respect for the dignity of labour;

vi To promote an understanding of the relationship between self and others, in particular one's duty towards the state;

vii To foster consciousness and loyalty to the State.

3 To achieve the aims and objectives, the guideline will trace the moral and ethical values essential for the development of the offender in relation to his network of social relationships:

i the family
ii the neighbours
iii his friends
iv his education
v his employment
vi his religion, and
vii his nation.

SELF

4 Self is the end product of social interactions within the community. Self is shaped in accordance with the practices of the environment in which self lives, and is therefore responsive to new adjustments and values. Thus the inculcation of proper values in the offender would lead him to become a socially useful and law-abiding citizen.

i **Self-Awareness**
Sense of responsibility;
Sense of righteousness;
Truthfulness, diligence;
Sense of justice and respect;
Recognition of his weaknesses and strengths;

ii **Self-Respect**
Honour, trustworthiness, reliability;
Self discipline, self refrain;
Maintaining a high standard in whatever is to be done;
Thrift and budgeting within means;

iii **Self-Control**
Avoiding fickleness, irresolution;
Accepting and learning from mistakes;
Presence of mind, avoidance of panic;
Constant effort made to succeed in spite of difficulties or previous failure (perseverance).

SOCIAL RELATIONSHIPS

5 An individual does not live by himself. He lives in the midst of and with others. Owing to this myriad of social relationships, the individual is expected to respond and act in accordance to the stimuli he receives from others. However, there are certain expectations of how the individual should act within his network of relationships.

i The Family

The family exists to satisfy the needs of its individual members and to perform essential tasks from the point of view of society. The family is important in the life of the individual because it gets him first, keeps him longest. In our society the family furnishes the basic environment for personality development.

The following are a set of values the offender should possess in respect to his family.

Filial Piety
Honour due to parents;
Obedience to parents;
Gratitude to parents;
Respect for parents;

Co-operation in the Family
Understanding and appreciation of family problems and needs;
Contribution to household budget;
Keeping the family informed of his activities;
Discussing his problems and needs with the family;
Developing honesty, tolerance and patience within the family;

Harmony in the Family
To be sensitive to each others feelings;
Refraining from hurting other members in the family by action or speech;
Respect and tolerance of each others faults;
Respect for each member's possessions;

Thrift in the Family
Exercising care and appreciation of useful things;
Discouraging waste and coverting of the possessions of others;
Respect for the household savings;

ii The Neighbours

Good neighbourliness means a happier and healthier neighbourhood for an individual to grow up in. Neighbours also form an essential group in the social network of an individual's interaction and growth. In order for good neighbourliness to prevail, there is the need for the individual and his neighbour to behave in an acceptable manner which will promote neighbourliness.

Values in promoting neighbourliness
The importance of helpful/close neighbours;
Promoting tolerance and understanding amongst neighbours;
Encouraging mutual respect and help to each other;
Being courteous and avoiding conflicts;
Showing care and concern for neighbours and their properties;

iii Friends are another very important "others" in the development of the individual. As the saying goes, "A person does not live alone, he lives in harmony with his family and friends". Friendship provides the bond between two or more individuals which gives meaning and worth to all other experiences and which goes through a process of give and take. In this light, an attempt is made here to highlight the values in friendship.

Friendship
The danger of choosing friends at random;
Encouraging the differentiation of the positive and negative qualities in friends;
The need for mutual sincerity, straight forwardness and respect for friends;
The need also for the individual to be firm in his own convictions so that he is not easily influenced by the behaviour of his friends;
The need to sanction unacceptable behaviour of friends besides showing consideration; understanding and helpfulness;

iv Education

This aspect of development is an ongoing process in which an individual gains knowledge, insight, forms attitude and develops skills in school or college. Informal education arises from day to day experiences or through relatively unplanned or undirected contacts with communication or mass media. The stress both is on the values of both formal and informal education.

Learning from Experiences
The learning value of pleasant and unpleasant experiences;
Examples of personal friends;
Advice from colleagues, elders, based on their experiences;

Formal Education
The value of formal education and respect for teachers;
Recognition and appreciation of the opportunity for formal education;
Cultivation of reading habit;

v Employment

By the time an individual graduates from childhood into late adolescence or early adulthood, he has to be prepared to assume his role in the labour market.

The economies of a country is vital in providing social and political stability. As our population is relatively young and as there is the need to inculcate responsible work sense, and proper attitude towards all forms of "labour", there are certain values which have to be upheld in the interest of a responsible and healthy work force.

Employer–Employee Relationship
The need to respect company policies and goals;
Having mutual respect and co-operation;
Adhering to the principles of benefits for employers and employees;
Having interest in raising the quality of products which will thereby affect the company and ultimately the country;

Expectations on Employees

Offender should respect the dignity of labour and to understand that each piece of work goes a long way in contributing to the growth of the nation;
They should show discipline and initiative in their work, should observe safety precautions;
They should not fight shy of new challenges or learning experiences;
They should shoulder responsibility and do more than a fair share of their work;

vi Religious Beliefs, Customs and Traditions

These are part of the scene in which an individual grows up. They are important qualities in the development of a multi-racial, multi-lingual and multi-religious society. The promotion of harmony demands a certain expected behaviour from the members of the society.

The need to respect each other's religions, as they teach good for all;
The need to tolerate each other's religious beliefs and practices;
The recognition of the corrective values and guidance of religion, customs and traditions upon our daily lives;

vii The Nation

The Nation may be defined as a society of people united by a common culture and consciousness. The vital binding force of the nation is invariably derived from a strong sense of its own history, its religions and its cultures. The ultimate characteristics of a nation are its unique heritage, religion, liberty, independence and shared historical experience. Singapore became an independent nation in 1965. The following are considered as significant national ethical and moral values for Singaporeans.

Nation Building

The need to live and work harmoniously with fellow countrymen in the continual promotion of a multi-racial, multi-religious and multi-lingual society;
The importance of setting national priorites before personal gain;
The importance of labour, dignity of work and discipline in the economic progress of the nation;
The concerted efforts of members of the nation in curbing noise and air pollution;
The awareness of consequences of uncontrolled population growth and the importance of family planning in stabilizing the population growth;
The need to uphold the Five Principles of the State; namely, peace, democracy, progress, equality and justice and to play the part in national defence in a bid to uphold these principles;
The awareness that each individual has a vital role to play in nation building and thereafter in preserving what they have built;

Public Spiritedness

The need to cultivate and to express concern and public spiritedness to their fellowmen and in their duty to society;
The importance of respect for law and order of the Country and to know that each individual in respecting the laws would help make the society a safer place to live in;
The need to build a concerned and caring attitude for fellow citizens by responding to public appeals and call for voluntary help for the less fortunate members;
To play their part in promoting and maintaining a clean and green city.

CONCLUSION

Conflict of values occur in our daily lives. We make judgement of situations and events based on our knowledge, temperament, experiences from foes and friends, teachers and elders. In this realization, an attempt is made to list the essential values beneficial in the development of a good citizen, especially as our behaviour and action ultimately have a great bearing on our future, the future of our community and our country.

Though this is what this guideline is striving for, the methodology of imparting these values will invariably differ from one Probation and Aftercare Officer to the next.

REACHING OUT TO DETACHED YOUTH

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INTRODUCTION

Young people can contribute immensely in the rehabilitative and preventive programmes in drug abuse. Because of their youth they can easily relate and make a breakthrough to work with drug abusers and those who are vulnerable to drug taking. What is more important at this stage is for young volunteers to identify youths who will be prone to drug abuse problems in their own neighbourhood where the volunteers live and interact with others. It is also important for volunteers to review systematically the needs of "vulnerable youths" in the context of the changing needs of the young people who form more than half of our population. Such a review is necessary because more and more youths are getting out to work, maturing earlier and acquiring responsibilities at an earlier age. At the same time youths have to cope with various demands of their environment. All these changes make it necessary for our young volunteers to establish new and imaginative ways in order that they can reach out to work with those youths who are drug abusers. I personally feel with vast potential lies in the area working with youths who chose to be "detached" from the main stream of youth activities in their respective communities. What we should be concern as youth volunteers is how we could reach out to the many detached youth in the community, particularly those who are living in various public housing estates. Many youth organisations and youth groups do not attract and work with detached youths who are perhaps most vulnerable to drug abuse. Moreover, there is a lack of concerted effort in planning and setting up of appropriate programmes to involve the detached youths. It is here where youth para-counsellors can contribute most by trying to programme for the detached youths.

THE DETACHED YOUTHS

The term detached youths is used to identify groups of young people who abstain from utilizing normal youth service provisions which have been set up in their community. They are youths who for some reasons or another are detached from youth organizations and prefer to gather in small loose groups indulging in activities that are unacceptable to people in their neighbourhood. We may wonder why they abstain from the use of the services. Several reasons seem to be obvious, such as the lack of adequate programmes to attract them, their low self-image or they may be demanding and troublesome.

The establishment of urban centres and newtowns have directly accelerated the formation of detached youth groups. This process is inevitable because of the lack of social organizations which specifically meet the needs of youths. Few social amenities exist to elicit their participation and ultimately we find groups of youths loitering without any particular interests.

There are some characteristics which are peculiar to the detached youths. Although these characteristics are also commonly associated with anti-social youths, it does not necessarily make the detached youths anti-social.

a FLUIDITY

Their membership is fluid because of diverse interests amongst the members. Many small loose groups are formed on the basis of attraction to some influential youths who appear to be extroverted and tough. Such loose groups also facilitate a high mobility of membership because of different experiences provided in these groups.

b PEER AFFILIATION

There appears to be strong peer influence in the formation of detached youth groups. Most of them are of the same age group and they come from the same neighbourhood. It is a well known fact that peers amongst young people either in their adolescence or post-adolescence provide a source of support and identity reference. It is common to find this phenomenon amongst detached youths but some inherent danger exists in their membership being polluted by some youths who have deviant behaviours. When this happens, peer members who are "marginally disorganised" in their roles, become easily encouraged to delinquency. Shaw, in his study confirmed that peer groups under the adverse influence of some individuals with negative social out-looks leads these groups to organised delinquent activities.

In our work with many detached youth groups, it is found that at least one or two members in each these groups have criminal records. It therefore makes the groups more disposed to anti-social behaviours.

c EDUCATIONAL ATTAINMENT

Most of the detached youths are either doing poorly in school or have left school for varying reasons. Many of those who have left school have some primary education, some a few years of secondary education and a few have completed secondary education with poor grades. Their poor educational attainments seems to suggest that there are other underlying problems besides those faced in their school. Also, their inability to stay in school have given them more free time which indirectly lead them to form loose groups in their community.

d EMPLOYMENT STATUS

Seasonal employment is common amongst the youths. This is partly due to their poor ability to adjust to work. They indicate interest in work but do not make an active attempt to keep their jobs. There is also an incompatability between the types of jobs they prefer and their abilities to do them. It is during the periods of unemployment that they seek devious ways in acquiring an income.

e DRUG EXPERIENCE

Many of the detached youths have experimented with drugs. Quite a number of them use drugs frequently. The common drugs consumed by them are "ganja", "MX" pills and "Heroin". These drugs are expensive and the youths jointly contribute small sums of money so as to purchase them. This reduces excessive expenditure and a number of them will have an opportunity to taking these drugs which may otherwise be beyond their means to obtain. In fact, drug experience amongst these youths are incidental to their personal problems. Other youths who have no exposures to drugs, can be encouraged to taking drugs when they are associated with them.

THE CURRENT SITUATION

There is no evidence of any single youth service agency which has embarked on a comprehensive programme to reach out to organize the detached youths. Youth organizations which are primarily set out to cater for youths, find it troublesome and time consuming to devise a programme for detached youths. Moreover, there is a lot of mixed feelings about such youths. It is often considered unworthy to work with them. If the objectives of youth services are to be fully realized, it is not only necessary to organise "respectable youngsters" but also to satisfy the needs of detached youths. At the same time, the general public must be convinced that this investment is in the long run worthy.

AVAILABILITY OF RESOURCES

There are some resources in our new towns but those who hold such resources are unable to utilize them effectively to meet the needs of youths in general and those of the detached youths in particular.

Social amenities are also lacking in new towns and many youths find few places that they can go and participate in some useful social activities. Some activities are being organised but it does not seem to attract many youths.

INITIATING A SERVICE FOR DETACHED YOUTHS

When initiating a service for detached youths it is necessary to consider several factors, which are important to the success of such a service. Pertinent factors, like deciding the localities where it can be initiated, the types of manpower required, the methods of intervention and the types of programmes, have to be thoroughly explored before the service could be started.

a LOCALITY

As more new towns and communities are established in Singapore, a service for detached youth becomes necessary. This is because of the large number of youths who remain unorganised, as they have to make a number of social adaptations to their new environment. To minimise the stresses that may accompany these adaptations, it is essential to provide guidance and developmental services for these youths. Unless some attempts are made to service the detached youths their problems will continue to increase in different dimensions.

b TYPES OF MANPOWER

The quality and the number of staff account for the effectiveness of a service for detached youths. In most existing youth organizations the staff are experienced in working with "normal youths". This experience though necessary is insufficient for work with the detached youths because it demands a different expectation and insight. The staff must be prepared to get into various areas where the youths are found and to begin work.

Some skilled manpower is required to work with detached youths. Since it is expensive to engage many of them, it will be useful to train groups of young volunteers to carry out the work. Young volunteers can be a good alternative source of manpower, provided they are supervised carefully by skilled personnel in their work with detached youths.

METHODS OF INTERVENTION

It is necessary to study the common places where detached youths congregate before attempting to organise them. This method is useful because it reduces time and effort, normally required for work with them.

Contacts with detached youths are made by the youth worker as soon as their place of congregation is located. It is initially difficult to create rapport with them because they are suspicious of the motives of the worker. The continued presence of the worker makes it possible for him to establish some relationship with a few of them and this could bring the whole group closer to him.

Another alternative to contact these detached youths is to provide a meeting place and some facilities which would attract them. Once the initial contact is made it is left to the abilities of the youth worker to build up and maintain positive relationships with them.

Finally, when contacts are established the youth worker must assess the needs of the detached youths and to motivate them in fulfilling these needs through various programmes.

PROGRAMMING

The programmes which are to be initiated with the detached youths must interest them. The objectives of such programmes are geared towards modifying some of their behaviours and to provide developments of their potentialities. It must be borne in mind that programmes should not become an end in itself but as a means of working with the detached youth on their problems. Many formal and informal programmes such as these could be considered.

a INDIVIDUAL COUNSELLING

Some detached youths may have personal problems relating to family, school, work, friends, the law etc. Such youths may need individual counselling to resolve the problems they face.

b GROUP COUNSELLING

Many members in the detached youth groups have common social difficulties like drug abuse, poor self-image, inability to use resources, poor leadership, and lack of leisure activities. These youths could be encouraged to discuss in their groups some of their common frustrations and be assisted in seeking remedies to them. The youth worker can also offer his leadership and resources during the group counselling sessions.

c SOCIAL ACTIVITIES

It is necessary to deviate attractive social activities. The usual traditional activities such as football, table tennis, basketball should not form the central core of the activities that are to be planned. Social activities planned outside their immediate environment will supply young people with the means of experiencing new situations. Camping, hiking, travelling etc, could provide such an experience. Youth workers have to attempt at co-operating with other voluntary and statutory organizations in using their resources to plan for effective social activities.

CONCLUSION

Our youth volunteers must constantly appraise its works in the light of rapid changes that affect the lives of youths. They must move from a traditionally oriented approach to one with pragmatic idealism. This means that the parochial approach, whereby youth volunteer work is confined within the agency, is replaced by a dynamic approach which reaches out to them in their respective neighbourhoods.

Youth volunteer services like fields of work related to the development of human potentialities, must continue to reflect on its achievement and to meet the changing aspirations of youths. It is advocated that a detached youth work service is included in the framework of our youth volunteer service programmes.

SOCIAL CASEWORK

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In recent years society has felt an increasing concern for its members whose well-being is temporarily or permanently threatened by circumstances outside themselves – making it difficult or impossible for them to achieve satisfying relationships in family and social life. As we know this concern has led to the development of both Government social services and voluntary organisations. Many of these are generalised services which are designed to prevent such problems from arising at all – or to enable the person concerned to deal with himself if they do arise. In the first category are, for example, many of the health, welfare and educational services. In the second are the financial grants, which help the individual to meet problems during illness or unemployment and, of course, the medical and employment services, whose aim is social rehabilitation. There are many people, however, who for various reasons cannot make constructive use of these services without help; equally they are unable to solve or come to terms with their social and family problems by their own efforts. They need individualised help to enable them to do so and the giving of such help either at a time of crisis or on a long-term basis has become the province of the social case-worker.

The case-worker is different from the official administering a general social service. The help the social worker gives is specially adapted to the needs of each individual and is given through the medium of a personal relationship developed for that purpose. So, to the case-worker every person whom he deals is unique – though his needs, when broadly classified, may be identical with hundreds of others but he will be given individualised study and attention as the case-worker attempts to help him in the solution of his problems.

Social case-work is based on the belief in the intrinsic value of each human being and on his capacity for growth and change. How to use the individual's capacity for growth and change depends on some understanding of the nature of both man and the society in which he lives. This understanding, which is still incomplete, is derived from many disciplines – anthropology, sociology, medicine and psychiatry, but also from the study of social-work practice over the years. With this knowledge, case-workers have been able to formulate certain principles on which to base their methods of work. To gain a clear understanding of people – their social situations, and the part that can be played in helping them. This knowledge also helps case-workers to enter into and use conscious and controlled relationships with individuals as the means by which growth and change may be encouraged.

I propose, in the first place, to attempt to set out a few basic principles of case-work and give you some idea of its methods. In the second lecture, to consider the special application of these principles and methods to the main field of work in which probation officers are concerned – the supervision of persons who have been placed under their care by the Court.

The Basis of Social Case-Work

As I have already said, case-workers are concerned with those who have suffered, or are likely to suffer, some form of social breakdown and who cannot solve their problems alone. Case-work, therefore, is a problem solving process – it is a partnership, in which the case-worker and client engage together in a professional relationship focused on the needs of the client – a partnership in which the case-worker places his personality, his knowledge and skill at the service of another (the client) who, for the time being, cannot face and deal with his difficulties and problems alone. Now their relationship is not a cold, clinical, and business-like affair, but is made warm and living by the reality of the social worker's concern for the client and his appreciation of him as a person who is worthy of help. Since case-work is based on the belief in the intrinsic value of each human being and on his capacity for growth and change, one of its principles must be regard for the client's right to self-determination. Therefore the help that is offered should be such as to leave the client not more dependent, but better able to manage his own affairs, in this way increasing and not undermining his self-respect and self-confidence. There is a growing recognition of the importance of helping a client to understand his own problems so that he can make good by his own efforts, rather than by having ready made plans forced upon him or by attempting to conform to a way of living he cannot maintain without the support of the case-worker.Case-work is the response of one human being to another in need. It is centred on the client in his relationships with his family and with society.

The relationship upon which case-work depends is professional in nature, and it should provide clients with a medium within which they can find themselves — particularly that part of themselves which they are uncertain about or afraid to face alone. Within the framework this relationship provides, they can test out ideas and plans for the future — in fact the case-worker himself provides a reliable environment. He holds the difficult situation — brought by the client — tolerating it until the client is able to find his way through or learns to tolerate it himself. This should provide the client with the much-needed support both in his situation and in his efforts to change. If the case-work relationship is geared to the uniqueness of the individual, the client will allow the case-worker to explore aspects of his life which, in normal personal relationship, might remain concealed for a considerable time, maybe for all time.

Since the case-work relationship has its beginning when the case-worker and client first meet, treatment itself starts with the making of the social diagnosis. Now a fundamental requirement in this situation is the worker's acceptance of the client as he is, in whatever sort of situation he happens to be, and whatever his behaviour. It is the case-worker's acceptance which makes it possible for the client to express his feelings, which is a very necessary preliminary to his being able to change them. Acceptance, however, does not mean that the case-worker condones the client's behaviour but it stems from his respect for, and his sincere desire to help another human being in trouble. This kind of acceptance involves as it is said "beginning where the client is" — that is, with his concern about his immediate problem. Social worker and client must consider the steps necessary for working together towards the solution of the problem, and the client's periods of time which will be entirely devoted to him. It is, of course, important that any plans they make, however tentative, should be realistic and their achievement possible within the potentialities and limitations of both client and case-worker. Initially, the client and case-worker may be working towards quite limited goals and it is only as their relationship develops that the client's readiness and capacity to take steps to solve his more fundamental problems can be tested. These will probably be related to the strength of his desire to change and to improve. Both social diagnosis and case-work planning are, therefore, evolving processes, always tentative and liable to modification.

You know that problems are seldom simple — nor do they come singly — but you also know that energy can be wasted and frustration is almost inevitable if a broad frontal attack is made upon them. It is by recognising a particular aspect of the problem in which client and worker can make a start that the client gains sufficient confidence to proceed. The case-worker has to decide what line to take in the light of his initial diagnosis, bearing in mind the capacity and willingness of the client. In the same way that problem breeds problem, so may a solution of one problem help with recovery in others.

Problem-solving takes a great deal of time and what matters is not that the case-worker should see the solution to the problem and take the initiative in reaching it, but that he should enable the client to proceed to an agreed goal at his own pace. It is therefore important for the worker to form an early assessment of the client's capacity for growth and change and to gear his contribution accordingly. If, for instance, full of enthusiasm and a desire to put things right, the worker rushes ahead, he may arouse such anxiety in his client that the relationship will break down and treatment fail. At all stages, therefore, the worker must move in alongside, and keep in step with the person he is trying to help, moving at a pace which is within the client's capacity in helping him to solve his problems.

If we wish to examine more closely the principles of social case-work, two fundamental questions immediately come to mind which lead to the heart of this subject. First — what do case-workers mean by this concept of acceptance? Shouldn't we let people know when we think they are doing the wrong thing? Doesn't one have to maintain one's own ethical standards? Isn't it insincere to pretend to agree when one does not? Second — what about this idea of self-determination? Don't we often know what is best for the client, what he ought to do and why then shouldn't we tell him what to do?

These at least set us on the way of examining two major assumptions in social case-work. What case-workers mean by acceptance, and why have we come to believe in it? First of all, it is necessary to understand that acceptance refers to the feeling one has toward another. It is a feeling of warmth, of positive good will, of a wish for the well-being and happiness of another person. We know that it is easy to have such feelings toward someone who is likeable, who appeals to us, who is friendly to us, who behaves in a way that we can easily understand, and towards which we naturally feel sympathetic. But our clients, no more than other people, are consistently like that. There are those who always see themselves, in a favourable light, are always misunderstood — never at fault. There are those who lie and cheat. There are those who impulsively throw over their responsibilities. There are those who offend against the law — who we call offenders. Now I am not saying that one comes to like any of these ways of behaving, nor that a case-worker never has feelings of irritation, even anger, at some of the behaviour of his clients. But what I am saying is that in order to help another person through the case-work method there must be sufficient understanding of why people act in this way, of the suffering that either precedes and causes the behaviour, or else flows from such behaviour, to overshadow whatever feelings of irritation or anger we experience and be replaced by warm feelings of good will and understanding. Unless this exists we have little or nothing to offer our clients.

This attitude of acceptance of another person is quite different from approval of his behaviour. There are many times when we think our client is in the wrong, and his behaviour is unwise. To put it even more strongly sometimes that his behaviour is criminal or disgusting. Very frequently it is just because we think his behaviour is so that we should like to be able to help him to modify it through case-work.

I should emphasize that this attitude of acceptance does not mean giving up of one's own personal code of ethics. It is not by any means a denial of values in behaviour. A sense of values the case-worker must have. Rather it is a separation of judgements about values from feelings toward a person. We have used the term "non-judgemental" to describe this aspect of acceptance. I suggest that it would be more accurate to use the term "non-condemnatory" because the worker will always have an opinion, a judgement, about his client's behaviour, but what he must not allow himself to do is to have feelings of condemnation towards his client because in his judgement the client is in the wrong. This is really a translation into case-work terms of the old religious admonition to "hate the sin but love the fellow sinner". Indeed, it is only as the case-worker is able to feel the client's problem as a common human problem that is or very easily could be his too, that true acceptance is possible.

Of course it would be insincere to pretend to agree, or to approve, when we do not. There is nothing more important than honesty in the relationship between worker and client — as with any two people. But one does not have to express agreement or approval to a client in order to demonstrate acceptance. Very frequently no expression of our opinion is called for at all, and the important thing is for the client to arrive at his own thinking rather than to be told ours. At other times it is quite possible effectively to raise questions about the advisability of a course of action that the client is pursuing within the framework of an accepting relationship. Indeed, it is in this situation that our questions have the best chance of moving the client to a re-examination of his own thinking.

What about self-determination, the second principle that raises so many perplexing issues? The word itself is misleading. It carries an emphasis on self and on independence which is sometimes interpreted to mean the right of the individual to pursue his own ends always — in any situation — with ruthless disregard for the rights or well-being of others. Nothing could be farther from the true meaning of the concept. Self-responsibility might be a better term, for we are trying to describe the client's primary responsibility for the conduct of his own affairs. Wisely used this includes his consideration of the rights and needs of others. But if he is to use this right wisely he must have the opportunity to exercise it. This principle assumes that all people do have a measure of choice in the conduct of their own affairs, that behaviour is not mechanistically controlled. Therefore I believe that the case-worker should promote rather than hinder the exercise of this choice, and indeed that only in extreme situations should it be interfered with.

In actual practice this is a very difficult principle. There are few things harder to do than to restrain oneself from dominating other people, particularly when it seems so obvious to us that we could lead their lives so much better than they can themselves: The case-worker's first question about this principle almost inevitably is — don't people have to be stopped from doing anti-social acts. And of course the answer to this question is that in extreme instances they do have to be controlled. The right to direction is never an absolute. At times we must take a protective role. A person may be too sick mentally or physically to take responsibility for himself, or his behaviour may be so harmful to himself or to others that measures must be taken to restrain him. With children obviously this principle is subject to limitation because in many respects the child has neither the knowledge nor the maturity necessary for the complete conduct of his own affairs.

This then becomes a matter of judgement. We must decide when the principle of determination is superseded by the necessity for protection, or direction or control. Here lies a great pitfall. It is a temptation to decide too readily that protective care or control is needed. The criteria can be so stretched as to make a farce of the principle. The burden of proof, it seems to me, lies upon the worker to demonstrate that protective or directive care is necessary. It should be used only when other approaches have been tried without success and the situation is so serious that a change must take place. Even in the extreme example of a seriously psychotic patient it is often possible, as we know, for the patient to take responsibility for his own voluntary commitment to a hospital. If this can be achieved it creates a more favourable atmosphere for psychiatric treatment. Furthermore, the fact that it is necessary for us to take responsibility for one facet of a person's life does not mean that his entire life need be under our supervision. If in a parole situation we of necessity control certain aspects of the parolees's life — we might exclude certain neighbourhoods as places to live, certain occupations, we must enforce certain regulations about his companions, his recreation, and so on — but even within such strict limits as these, there are areas of life that need not be controlled by the parole or probation officer. There are areas that can be made free for choice even within such regulations. The more these are used by the officer, and the more the officer confines himself to the limitations that are unavoidable, the greater is his success with the parolee likely to be. I do not mean by this a weak or sentimental attitude where authority is necessary, but rather sufficient internal strength on the part of the probation officer to free him from the need to use authority unnecessarily.

Our next question about the client's right to conduct his own affairs really goes to the heart of the matter. Do we not in reality often know what is best for the client, and why should we not tell him what to do? In the first place it happens less frequently than we sometimes suppose that we do know what is best for the client. Usually our surest way to find out what is best for another person is to listen to his thoughts as we encourage him to explore the question for himself. Perceptive questions and comments, turning his attention to aspects of his problem which may have escaped him are necessary. But by the time he has really expressed his own thoughts and feelings fully enough for us to have a worthwhile opinion about what it is wise for him to do, he should have equipped himself with this same knowledge. He may not yet be ready to accept his own conclusions but then neither would he be ready to follow our advice. Then the obstacles or barriers to his willingness to acknowledge what he knows becomes the next question to be explored. He will be far readier, to look at his lack of response to his own ideas, than at his reluctance to accept ours. This is not to say that a case-worker never gives advice. There are times when we have knowledge of situation that is beyond the client's knowledge. This is particularly true in employment matters, often in educational and vocational matters, sometimes in aspects of marital affairs. There are times when direct suggestions and direct advice about these things are very much in order but advice that is given in an atmosphere of freedom for the client to reject the advice is quite different from the same advice given with the condition that the client is under an obligation to accept and act upon it.

Why do I put all this stress upon self-direction? Because I believe it is one of the greatest dynamics of the whole case-work approach. Because I believe that the soundest growth comes from within. Because the aim is to release the individual's own life energy to take hold of his situation. Because I believe there is within man a capacity for grasping the realities once he comes to understand them. Because I believe he is more satisfied with decisions he arrives at through his own thinking, even when those decisions are painful ones. Because I believe that the more he exercises his own capacity for decision making, for learning to see reality, the more that capacity will grow, and the more he will be able to continue to do it after his association with the case-worker has ended. Case-workers have seen that somehow in this process energy is released, fears are reduced, self-confidence and self respect grows, and people become better able to manage their own affairs. But for this growth from within to occur there must be freedom — freedom to think, freedom to choose, freedom from condemnation, freedom from coercion, freedom to make mistakes and to learn from those mistakes. That is what is meant by self-determination in case-work practice.

It is absolutely impossible to make a person develop understanding about himself against his will. The client must want to gain this understanding of himself and be prepared to try and find a solution to his problems. In other words, the help we offer is the product of our general knowledge of personality and social conditions, of our understanding of this individual and his situation, and of our value system. The help the client uses must be consistent with his own hopes and ambitions for himself.

Another principle of case-work is that men are more likely to act wisely towards others, and themselves, when they can be helped to understand themselves and others. In other words, action based on knowledge is superior to blind obedience. With this in mind we seek constantly to broaden and deepen our clients' understanding of their situations, of other people, of their own feelings and reactions. This is a slower method for immediate results than that of giving active direction, but we believe that in the long run the client will act more wisely and will achieve more lasting ability to manage his affairs as his ability to understand them grows. We believe that he will achieve the greatest measure of improvement if he can be helped to gain a greater knowledge of his situation, his associates, and himself.

But why do we care about these things? Why do we go to all this trouble? Why do we have such a thing as social work anyway? Are there not some even more fundamental assumptions than these that underlie our casework practice? Yes, I think there are. Fundamental to all else is the belief that human life is precious; that the individual has the right to grow and develop and achieve the highest degree of happiness or satisfaction in life of which he is capable. This in turn, we believe, depends upon his ability to function in respect of his intellectual, physical, emotional and spiritual capacities. We believe, too, that there are inter-relationships between the well-being of one person and that of another — that man cannot live well for himself alone. The lives of individuals are so intertwined that one person can only be helped as he is seen in relation to the others with whom he is closely associated. He can only steer his own course successfully as he considers it in relation to others. Indeed the very existence of social work itself is an expression of this belief. It rests upon the idea that one individual has responsibility for improving the welfare of another. Collectively through social institutions we carry out this responsibility. Otherwise we would believe in the survival of the fittest and would not waste our time looking after those who are weak and have fallen behind in the race. But we are slowly coming to realize that there is no sharp line between the fit and the unfit, that the concept of the survival of the fittest to human results ultimately in destruction for all.

We also believe that in their essential value as human beings all men are equal. This has many implications. Social work does not discriminate between races, or nationalities, between rich and poor, between educated and uneducated, in the quality of service it gives. Even though in the lives of our countries — and I speak only for my own — this ideal has been very imperfectly achieved, social work itself can be found in the vanguard of those who seek to break down the inequalities between men and to offer opportunities and services which will in some measure compensate for their deprivations.

Related to this is also our belief in the value of diversity. Social work does not strive for uniformity. Rather, we believe that many patterns of life are possible and useful and that each individual will fashion his own particular solution to his problems and find a way of life that will meet his needs. In fact we welcome this diversity because we believe it enriches life for all of us as well as giving greater play to each person's creativity. So in our work we seek to free the individual to find his own way of life, not to imitate ours. In training situations we encourage the social work student to keep his own spontaneous and natural way of relating to people, of expressing himself, rather than to imitate the style of his teachers. A certain amount of imitating he will of course do, but this we regard as a stage of development which he may need to lean on until he can establish his own characteristic ways of working. It is for this reason that we tend to discourage observation of interviews of more experienced workers. This assumption applies also to diversity in the practice of case-work in different countries. Much as we can learn from each other in sessions such as these, it would be a very great mistake to think that either training or practice can be identical in different countries. Individual variations there must be. We can learn only so much from each other. Whilst we should try to integrate what we learn from each other into the peculiar fabric of our own culture and situations, we must never slavishly copy. The strange part of it is that the freer we are to do this the more we are likely in reality to learn and, in turn, to contribute.

THE INTERVIEW AND THE SOCIAL CASE RECORD

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These are the tools which the social worker uses both in diagnosis and in treatment.

THE INTERVIEW

I am going to confine myself to discussing only one kind of interview that is used by a social case worker. I am not going to discuss the fact finding public opinion poll kind of interview, nor the psychotherapeutic, or analytic, or psychiatric interview which is the province of skilled practitioners in these fields. In the social workers' interview, fact-finding, attitude evaluation, diagnosis and treatment are all ingredients. It is through it that we are going to get some of our objective data, but more important we are going to get feeling about what the situation means to the client — and more and more this is where our material lies. There is an inner and an outer approach to every problem we want to know particularly what the difficulties and stresses are, and we want to know what they mean to the client, and we want to use our understanding and our personality in getting movement and progress on a case. As social workers we want to give a sense of confidence and ease, we want to convey warmth and interest, and we want in establishing a professional relationship, which is essentially different from friendship or family guidance and advice, to give the feeling of our acceptance of the client and his actions.

There seem to be certain ways of going about interviewing which can be distinguished as producing the best results. There are two certain faults which we all make at some time and looking back we may wonder why we didn't get far then. No technique, no system of interviewing, however, takes the place of, or is any use at all without, a depth of understanding, a warmth, a liking for people, together with the capacity to communicate that sense of warmth and tolerant understanding to the client without of course becoming emotionally involved, or unprofessionally friendly — that isn't our role.

The interview of the social case worker, is a professional conversation. From it he hopes to collect information, but it is more that, for in itself it is a part of treatment. Your client will learn to trust you, will expand, will perhaps regain confidence in the assurance, that you at least are non moralising, non judgemental — that you accept him at his own valuation, to understand and to tolerate behaviour that other people are shocked by, and may gradually through the relationship be led to a solution of his own problems. He will do this to the degree that you can convey these things to him. Therefore, to be a good interviewer, you must yourself be free (or if that is impossible be aware of prejudices of your own).

You must be an "accepting" kind of person — not accepting low standards or immoral behaviour, or the flaunting of society's codes — but accepting that this person with you, acted in this way, with his environment, and his personality and his background, and understanding it. Your client is at a disadvantage usually when he sees you — hostile to authority, humiliated by the position he is in, and he may be angry and defiant. The interviewer must accept that — he may recognise in it anxiety and insecurity — he must not be disturbed if he meets hostility at times, first to himself as representing authority.

You must be accepting in that you don't take sides, don't side with husband against the child, eg you are detached. You listen to the story from the tellers point of view.

WHAT ABOUT THE FOCUS OF THE INTERVIEW?

It should be private, and quiet and comfortable. The client should feel that he has your full and undivided attention, that while he is with you, you are ready and anxious to consider his problems seriously not interrupted by phone calls or urgent discussions by other members of the staff. This is made much

more possible if an interview takes place by appointment — a definite time made, and preferable a time set. The client knows, if you are seeing him regularly, that there is a certain time set aside, and he mobilises his thoughts to express them in that time. He doesn't feel he is "encroaching" — he knows when the interview is at an end (not that painful, uneasy, inability to go, even though he wants to). This is also true of Home Visits, that should also be by appointment. Social workers are not detectives concerned with human relationships and are not doing detective work, not wanting to "catch out" but to see the "real situation" — and there is nothing more real than the prepared interview! There is no reason why you shan't see them and they wish you to. I'd like to see much more interviews at home with appointment. It is ordinary courtesy. They have thought over problems and are ready for you and they aren't distracted (and have no excuse to be distracted by attending to other things). We have done it with foster home surveys, with mental hospital visits, with ordinary case work visits. Far from people being out, they stay on to see you. If you don't write before, when you call you can say "Is it convenient? Can I come back?"

ARE YOU GOING TO INTERVIEW AT HOME OR IN OFFICE?

This I think has to be thought out afresh for each case. Every interview must have a purpose. Not casual "dropping in" because you are in the neighbourhood. (Just easy way of earning your living!) Is this the moment? Should you leave her to think things out, or take the initiative, will the client think you don't trust her if you visit? What movement do you expect, what do you want to know?

So always the choice has to be made of office interview and Home Visit. Some time ago we used to think of H V as essential — we must see client in his own setting, and that was true when case work was largely a matter of altering material conditions; of environmental and economic manipulations (wanted to see rent books, pawn tickets, etc) when housing, furniture, etc are part of the approach, you certainly must visit. Where the problem is more one of attitudes, the necessity of a H V is not so obvious. Though one must say that in the "diagnostic" process one gets clarity from a home visit. Relationships in the home — toward the children — the relatives. The standard of the home in relation to the neighbourhood — the sort of the home.

However in a treatment situation, and where emotional problems are the matter at issue, one must always think whether the worker-client relationship may be endangered by a H V too soon. Tension may be created.

One must base one's decisions partly on the nature of application or investigation, partly on personality of client. Let me illustrate:—

1) Sometimes the client comes to the office to seek help, to discuss a problem, he may not want to reveal everything. He may not want you at once to penetrate his defences until a closer bond has been built; he may want to present himself in a certain light, and doesn't want yet revelations about home situation. One must take all into account and must not let him feel he has let himself down. Wait until you know he accepts you. Ask his permission and make an appointment.

   Since the important factor in any social problem is not so much its size as the client's attitude to it, the social worker's understanding of it will only be furthered by the client's ability to reveal his hopes and fears about his problem, and his drive towards its solution. The extent to which he can do this depends on the relationship built up between client and social worker, and in emotional problems, problems of changing attitudes, nothing should imperil this relationship; with a too hasty wanting to know too much.

2) Case may be referred by another person or another agency, and client doesn't really accept responsibility for such a referral. You want him to be positive and constructive — active with his own situations. He is uncertain, passive — if after perhaps a first explanatory interview, you will confine the client in a passive dependent attitude. "Though I'd just wait till the lady came". You confine him in a dependent, passive attitude instead of positive active participation. It might be better to make provision for client to return for further interview when he has thought it over.

3) It may be that where really hostile feelings (even though subconsciously they exist) — may be carried over from attitude to parent, to subsequent authority — they can be dealt with better

in neutral impersonal atmosphere of office rather than in emotional, host and guest atmosphere of home where they can't be discussed.

4) Need for another member of family – say father – to participate. Perhaps he should take an active part in the case. He should go to office and have a talk about foster child or own child. Not just wait till he is visited or hear it second hand from the wife. And you have got to give him the chance of that kind of positive, and healthy movement in the situation.

5) The aged, the infirm, the sick, the timid, the retiring; all need a positive expression of our interest in them, they are afraid of a rebuff, they are lacking an impetus to make the visit, and they have to be visited, but you may want to give them the initiative and let them come to you.

6) In general, then, visiting for interviews is valuable in the initial stages in diagnosis, and is valuable throughout where the workers seeing the whole family and setting aims at dealing with the material and environmental circumstances. Where treatment is concerned with adjustment of emotional attitudes, with emotional problems worked through together by client and worker step by step (perhaps with the adjustment approaching the material problem) there is a lot to be said for office interview.

POSITIVE VALUES

Often the client has to be away from the distractions and tensions of the home and the children and the mental difficulty, to see her emotional problem clearly (she can talk about her children more easily when away from them). Value of impersonal atmosphere. Sometimes the home too can offer distractions, which allow her to evade the emotional issues.

If he has to come to the office, keep appointments; he comes prepared to talk about what he has thought over, and he is making a constructive active step towards it.

FIRST INTERVIEW

If we do initiate visits or H V's we must do certain things – make an appointment if possible. Say who we are, and why we've come, and go straight to the issue. Our job as social workers is to talk about the problem in hand, *not* make a social call. "I want to discuss Johnny with you, as you know he is coming up to court on Monday". "The doctor wanted me to see whether you needed any help over treatment, etc". "I've come from the Child Guidance, I thought you might like to know what we do – whether you can give me help in understanding Mary's behaviour".

In this first interview, you will want to :

1) Establish rapport. Enter into a relationship with client. A certain kind of relationship – quite different from an ordinary friend.

2) Relieve tension if necessary and appropriate (you may do this by just skilled listening)

3) Find out the nature of the inquiry or the problem

4) Make clear the role of the organisation or dept.

Later on you will want to assemble all the facts, and see their significance.

But in the first interview, you will be unwise to try to get the full social history.

Just establish rapport, ease the tension, perhaps clarify a little. Not too much at first. You must protect the client against being too expansive about his own feelings, and thus involving himself in a relationship *he cannot shoulder.* You must at first listen, without too much probing, not over curious, otherwise your client goes away and never comes back. He may have said more than he can ever face you again with (a common experience). You get too much, too soon, and he never returns.

The worker must guard against encouraging too deep confidences, pressing for information, and also must eschew any appearance of being over optimistic, or minimising the problem or finding a ready solution, not immediately reassuring so that you shut off the real things and the true anxiety. There is nothing so galling as for someone to treat a problem you've worried yourself sick over, lightly. "I'm sure you'll soon be absolutely better". "Oh, he'll grow out of it"; "Pull yourself together", "worse things have happened than having your own son aged 10 appear in Court on a charge of arson!" "We'll get round it for you". "I'm sure everything will turn out alright".

Don't probe, or arouse conflicts and anxieties, which you can't cope with. Your interview will be a "prompted narrative" — but don't prompt at first issues which seem sore *eg the ones never mentioned.* Not omissions. Note what people talk about first.

In the course of the first interview you must beware of arousing too much anxiety. For example, in the course of the story, if you attempt to interpret at all, the parent may suddenly see *his* own responsibility for a situation eg a child's behaviour is "all my fault".

There is great danger throughout of interpreting without knowing what you are doing. "Can't I let her see that it is her own possessiveness that makes the child put up defence of illness, etc". Avoid then the easy reassurance, the ready solution, the too quick identification, the over-sympathetic attitude. Steer a course between extreme professional detachment and rich human sympathy.

After the first interview the client should go away feeling more confident, feeling relief at having talked — and seeing things clearer just for having been listened to unemotionally; perhaps with a very skilled interviewer and a client with good insight, seeing in a single interview what the base of the problem is. Sometimes in short interviews you can point the way, but some cases may need a bit of help.

You want at the end of an interview for the person to go away seeing the problem in a new light — and you want them to see it in a favourable light, with confidence that they are understood. The client should feel his co-operation is needed and welcomed.

END OF INTERVIEW

At the end, one must decide, if you are going to continue (if it is open to the client to choose if he comes back or not (eg not if a client is on probation or parole, or a ward of state) on some assessment on a tentative basis as to whether long time contact is necessary. The question of whether you close the case is important in first interview. Inexperienced workers tend to close too soon and see only the *expressed,* request; need of a job, whereas it is the anxiety if they could do it if they got a job. Legal advice on a separation order from husband — whereas it is the deep distress at her failure to keep him that needs exploring. Students often close too soon. You may recapitulate the various points in the discussions. You may survey with him the various possibilities, and then leave the way open to further interview. Do not *advise* or *moralise* or point out, beyond perhaps some line of enquiry or action on his own over some of the points in which he wants advice — doubtful at this stage.

Thereafter, each subsequent interview can be regarded as an episode in a process of adjustment during which the initial problem may become modified, and new observations are made.

One wants to begin at the point where the client is and wants always to be concerned with how it looks like to him — his attitude to it. Get a person to describe his experiences — "and how did you feel about that?" This can be gauged, not so much, or not at all, by direct questions but by noting what subjects are too painful to talk about, what points he is garrulous on; when emotion is aroused, when over-emphasis is placed, and when a problem is minimised. As one gets the social history in the subsequent history, one begins at the present problem and works back. Listening and thinking, and working out the set of related facts that seem to you to present a possible diagnosis.

How have they met things in the past? What stresses have they given way under? What were early experiences and what did they mean to the client? What are the *positive* and good things you can work on? What are the negative? How far can the client help himself? How far can he accept interpretations which will suggest themselves perhaps in the process of one session.

HISTORIES

A social history is important. Live isn't disjointed episodes but a flow. We begin at the now and work to what happened to bring "now" about. From surface to deeper levels. We must always wonder how much is occasioned by present conditions in which the clients' behaviour is normal reaction, and how much is part of life patterns in which the main trends were shaped early and are part of the whole personality.

There is a connection between an occurrence in the family, or socially, with the mother's own attitude, with the child's behaviour. The client comes back and says "I've been thinking. I think I've been expecting too much of him at school just because I never got the chance of the education I wanted myself, and I don't believe I have given him the right amount of attention since the second baby came".

The to and fro. Take responsibility at first, perhaps, then, push the initiative back to the client. A constant exploring around the point is needed.

The skilled interviewer is seeking always the inflections, nuances meaning. He is observing as well as listening, noting behaviour, tone, fear, hesitation, dependency on worker, hostility to worker (eg coming late or not at all) which may be. In the interview one is learning *subjective* facts. There will be other ways of getting objective ones.

GETTING THE FACTS ESTABLISH THE RELATIONSHIP

If one grasps the focal point and asks about wages, rent and so on, financial problem about school, teacher's attitude, and so on, don't skate around. If child problem, it is an issue. Ask relevant questions boldly. The client is received.

It is important to get enough factual material to facilitate understanding of the present situation and what the person has done about it. We want the current situation, its onset, what precipitated it, how the client managed in the past, something about other people in his story. The interview can motivate, teach, secure information, help client bring out things which are blocking him. It helps to provide an opportunity for observing a person's behaviour. It is the only way to get understanding of attitudes and feelings – the reaction of this individual to his situation.

ALL SOCIAL HISTORIES WILL INCLUDE :

1) Identifying date – face sheet
2) A statement of the problem
3) A description of the present situation for which the individual seeks help, gained from various sources
4) A life history of the client, and other members of family involved, (perhaps to 2nd generation)
5) The personality of the person involved
6) The client's feeling and attitudes to problem
7) Worker's impressions
8) Points for consideration and approach :
   a) positive feature
   b) negative feature
9) Plan return, if any.

RECORDING

The purposes of keeping social case records are usually defined as practice, administration, teaching, and research. The dominant consideration is that of practice, service to the client. The professional record is the case worker's tool. It shows the relevant facts accurately, and concisely. Even more important it shows, as nothing else can, what the client is feeling and thinking. It should show the worker's interpretation of these facts. It should be a full continuous record, which other people can consult – can weigh up the evidence and see if they come to the same conclusion. In order to get the full picture from which you can make deductions, each case record should be an accurately written description based on careful observation of the client's situation and the worker's performance in it; preferably accompanied by the worker's analysis and interpretation of the case.

The interpretation of the worker should be based on the primary evidence contained in the record, not upon hunches, – not new material, but actual interpretation based on recorded data. This provides a check on the bias on one's judgements, or flaws in it. It gives one a chance of going back and saying where are we trying to go? Are we getting there? Why not? What does it all add up to? Are there any areas unexplored? Are there points we have overlooked? This kind of interpretation should be based on primary and stated evidence. It should be separated off from actual data and observed behaviour and made clear that it is the worker's interpretation. The material on which the interpretation is based should be descriptive and not coloured by worker's own judgements and prejudices: "Dreadful mother", "shocking home", "bad type", "shiftless creature". These have no place in the record but they show the worker's bias. Description of the home, of the behaviour of the children, of the manner of behaviour, should be employed, rather than the use of terms like neurotic, nervy, mentally defective, and so on. The worker's impression should be put at the end of an account based on the evidence only, so that others could interpret.

In so far as these are judgements by the client, it should be made clear that it is the client's view, and it is this attitude which is important eg mother said no child was a child of Satan, husband a waster, or mother-in-law said she was a "bit sub-normal". These attitudes and ideas must be attributed to the source, and not accepted as the worker's own view. (eg husband appears as monster from wife's account, when he finally is seen he is a mild well mannered man with quite a different story) These are important in a record as *attitudes.* The worker's own impressions must be separated.

In writing, screening takes place partly through forgetting, partly through process of consciously omitting what seems unimportant. Selectivity in observing is parallelled by selectivity in recording. To give the essence of the matter represents professional competence of a high level. You omit the self-evident, the insignificant, the familiar, the repetitive.

The final task of the social worker and the other specialists is to sift out from a mass of facts collected all these which seem to bear on the problem, and to select the theory of interrelationship which seems to offer the most comprehensive explanantion.

THE UNIT RECORD

Keeps the continuous account of the data, the client's attitudes, the worker's performance and helps the reader to see the whole picture. There are 2 main methods of recording the date, narrative and summary.

NARRATIVE

The main body of the record will be written in narrative, in chronological order, written by the case worker, of the client's situation and its changes throughout treatment. It is not only for use to others, it is an aid to the worker's memory and an aid to thinking, and a tool in supervision. Case work performance is improved by giving an account of it, set down as soon after an interview as possible. One must acquire the habit of careful observation and accurate written description.

The narrative may be written in sections under topics, eg after home visit, with the worker's impressions and interpretation, kept distinct. A process record is a kind of verbatim account mixed with narrative.

SUMMARY

As the case builds up, one wants frequently to draw the threads together for purposes of diagnosis and treatment, and must *summarise* the situation to date. It is important that this should be done. There is a variety of purposes. From the beginning a Social History presents the picture to date. Recording is not simply an outline of interviewing.

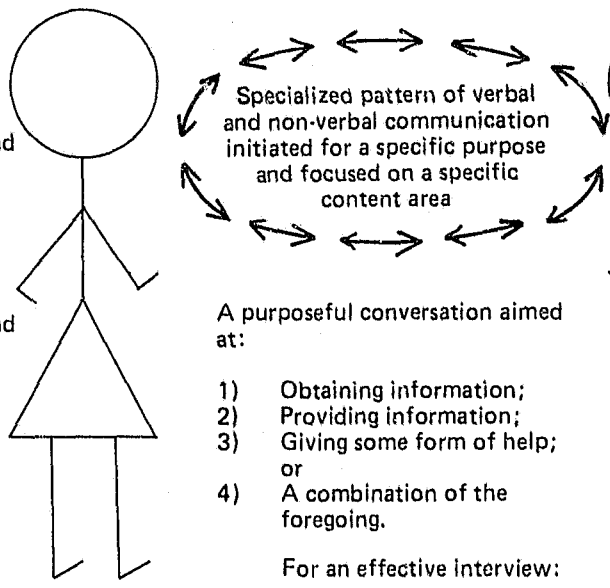
A Diagnostic Summary is for discussion in case conferences. There may also be a Summary for special purposes – for magistrates, for doctor, for psychiatrists – and a *General Summary* made at intervals, such as Calendar interviews, or at the conclusion of a treatment phase.

Finally there is a *Referral Summary* and a Closing Summary written on a separate paper.

There is no model for summaries; much depends on what you are investigating, and for whom they are meant.

INTERVIEWING SKILLS

Professional interview – the total and medium through which problem-solving is effected and the helping process is experienced



Has own cultural, social and personal background

Has own experiences in relationships

Holds certain attitudes/ feelings about problems and people with problems

Has own cultural, social and personal background

Has previous experiences in relationships with people/ agencies

Has feelings about his problem(s) and seeking help

Holds certain expectations of agency/helping person

A purposeful conversation aimed at:

1) Obtaining information;
2) Providing information;
3) Giving some form of help; or
4) A combination of the foregoing.

For an effective interview:

The worker must possess:

- An interest in and a caring attitude for people
- Knowledge of culture, personality, role
- Skills in listening, observation, use of setting, recognising ambivalence, meeting resistance, establishing rapport, use of authority, use of silence.

The interviewee must:

- Feel he is respected
- Feel and see the worker has time for him
- Experience his situation is being understood the way he views and reacts to it
- Experience being helped through problem-solving activity in the interviewing process through questions, comments, and non-verbal signs of support, etc.
- He helped to want to be self-directing and to undertake responsibility
- He helped to follow through with solutions

THE HELPING PERSON – SOME BASIC PRINCIPLES

The helping person can best serve his clients, whether individual or groups, if his philosophy of action is based upon the following principles:

1 **An accepting attitude** – convinced that other people have worth – optimistic about human nature.

2 **Begin where people are** – Start at his level of understanding – starting where he is rather than where you think he should be.

3 **Individualise** – see clearly the circumstances which surround the person in his living.

4 **The client must want help** – he may ask for a different kind of help or express it differently than you would – the first task may be to help him express his need.

5 **Help in small doses** – deal with one problem at a time, or with part of a problem.

6 **Find his strengths** – recognise that he has strengths – find and use them.

7 **Set realistic goals** – client and helper must not expect too much too soon – reduces overwhelming frustration.

8 **Client makes the decisions** – the helper is a consultant, not an authority.

9 **Deal with real problems** – the client must see the problems as real ones, specific and important.

10 **Measure progress** – client, assisted by helper, evaluate progress from time to time – recognise gains.

11 **Set specific goals** – determine what is to be done – specific tasks to be undertaken.

12 **Programs deal with needs** – program methods and contents are in harmony with a group's needs.

13 **Pay attention to communication** – expect misunderstanding and work to reduce it – careful communication is not left to chance.

14 **Be careful with authority** – the helper must acknowledge that he is an authority and use it in healthy and positive ways – do not diminish self respect of the client.

15 **Strive for continuity** – the client must be able to count on a continued relationship with a helper – helper must be trusted to be there.

16 **Know your limitations** – sometimes the helper cannot help – helper must know when and be able to get more adequate help for the client.

"How can you hurt a person more than not to help him?"

– Anonymous

Adapted from DYNA-HELPS (249)
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SOME CRITERIA FOR EVALUATING PROGRESS

Criteria for evaluating progress cannot be separated from the entire concept of treatment planning. A plan for treatment must be formulated upon an analysis of specific problem areas which the client exhibits, and goals relative to these problem areas should be set. One may conceive of a long-range goal for the total personality rehabilitation, but plan toward short range goals of more modest proportions so that progress is assessed by measuring movement toward these goals.

Although the design of treatment is specifically created to accommodate a single individual, certain standards of conformity can be used as measures of skill in the management of daily life. Our task is to assist our clients to achieve a life management which precludes destructive acts (both self and society directed) particularly those acts which bring them into conflict with society's laws. If, in fact, we strive for greater goals with our clients, ie deeper insight and growth, this may be said to be the icing that frosts the cake.

What, then, constitutes the areas of our concern, universal to all clients, both juvenile and adult, and what are some of the specific criteria for each?

1 **Stability** — The noticeable consistency of activities, behaviour, interests, intentions.

   a In work
   b In school
   c In residence
   d In relationships to important others

2 **Responsibility** — Willingness and ability to assume obligations.

   a Toward self
   b Toward family (especially important in masculine roles regarding financial obligations)
   c Toward job
   d Toward school (attendance and homework)
   e Toward society (debts, laws)
   f Toward probation orders (reporting, restitution, etc.)

3 **Reality Orientation** — The ability to evaluate objectively events, goals and persons.

   a Practical planning
   b View of others
   c Goals for self
   d Insight into and handling of his own personality problems

4 **Self-Image** — A state of self-acceptance and self-like necessary to move away from destruction and toward self-growth, as evidenced in:

   a Personal appearance
   b Reduced tension
   c Verbal expressions of realistic and appropriate confidence
   d Worthwhile companions and associates

5 **Independent Action and Thought** — Self-determination based on strength and confidence in making decisions relative to work leisure time activites, companions, goals, self-development.

6 **Self-Expression** — The ability to express feelings, beliefs, and share confidences with the Probation Officer. An evidence of trust in others. The development of ability to relate meaningfully to appropriate persons.

7 **Authority Concepts** — An acceptance of the necessity for law and order and a willingness to maintain a pattern of life within the limits set by the law.

a Better attitude toward probation process and DPO
b Diminishing number of law violations
c Reasonable attitude toward law enforcement agencies and officers

Hostile attitude may be reflected by open aggressiveness towards authority or may be disguised as a meek, passive manner. A healthy attitude toward authority lies at neither extreme, permits the healthy questioning of authority and its rules, when appropriate.

8 **Companions, Associates and Important Others** — Choice of associates reflects feelings of self-worth since they are predicated upon an ability to identify with such companions. An individual may seek his "double" in his close companies, people who feel as he does, act as he acts, see themselves as he sees himself. Such associations are a mirror in which he sees the areas of his personality which are of most importance to him. Therefore poor companions bespeak the feeling that he is worthy of no better association; improved companions announce a growing development of self-worth. These guideposts apply to mate selection as well.

9 **Identification with American Culture** — Acceptance of the US way of life without losing pride in the culture of his forebears.

10 **Creativity and Commitment** — Adoption of a way of life which provides a healthy outlet for self-expression.

11 **Relationships with Important Others** — This category is especially important to juveniles. It is the ability to form relationships which are appropriate with:

a Parents or mate and other close family members
b Teachers
c Peers
d Employer
e Probation Officer

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