NATIONAL MASTER PLAN

FOR

PILOT EXPERIMENTAL PROJECTS

Gabriel Britto
Natasha Zen
Dr.Dayal Mirchandani

February 29, 1990

National Addiction Research Centre
5 Bhardawadi Hospital
Bhardawadi Road
Andheri West
Bombay 400 058

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Natasha Zen
Dr.Dayal Mirchandani

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NATIONAL ADDICTION RESEARCH CENTRE
Floor 5, Bhardawadi Hospital
Andheri West
Bombay 400 058

Tel. 621 2661, 624 5290
Fax: 91.22.621 1658
email: narc@sangra.ncst.ernet.in

PREFACE

This paper focuses on the (re)habilitation process of addicts. Counseling, Detoxification, After-care and Social- and Vocational-integration of addicts are parts of the treatment continuum.

In India, the terms After-care and Rehabilitation are used interchangeably when referring to the Habilitation Process of addicts.

It must be noted that a large proportion of drug habitués[1] do not enter nor need to enter any formal residential rehabilitation process as they do not become dysfunctional either socially or vocationally. Most of the users of Cannabis compounds, for instance, lead fruitful lives performing all life roles and functions past the various milestones of their developmental cycle.

Whereas regular use of heroin is generally addictive, there appears to be a group of users, known as " chippers", who are able to use heroin occasionally over a long period of time without becoming addicts. In his study of heroin, Stanford University professor John Kaplan maintains:

> It is now clear that there exists a sizable population of non-addicted but regular heroin users who seem well integrated into society and in many ways indistinguishable from the rest of the population[2]

Even among heroin addicts, most of them do not enter formal treatment centres because such centres are too few, stipulate several conditions, are expensive, or are alienating; and because some of the heroin addicts quit the drug on their own through a wide variety of measures including: reverting to Cannabis compounds, switching to liquor, taking vows to specific gods/god-men, establishing satisfying new relationships, developing personally-fulfilling philosophy and meaning for their own lives or taking up jobs which demand intense emotional involvement in religious cults such as ISKCON or fellowships such as NA, to cite examples.

Finally there is one segment of those who do not enter formal treatment centres who mature out of addiction after 8 - 12 years spent in heroin clouds.

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1. habitué(s) - in the context of this paper, refers to a person habitually using/abusing drugs
2. John Kaplan, The Hardest Drug: Heroin and Public Policy, 1983.

It is equally clear to rehabilitation professionals in urban India that a small group of addicts have moved from one treatment centre to another, thus creating an illusion regards the

magnitude of the problem of long waiting lists ... playing up one centre against other ... has been one of their hobbies some parents of addicts are also perennially searching for yet another centre to dump their addicted wards for another stretch of time.

At the level of integration of addicts with their social context and society at large, for some addicts a return to the `status quo' ante-addiction is pernicious. As social workers at Shramik Vidyapeeth point out, four of their addicts were part of a gang of pick pocketeers. SPARC studies indicate that in their sample, one percent of heroin addicts had criminal records prior to the onset of addiction.

For a much larger proportion of addicts, `educational rehabilitation' is unattainable if the aim were to help them to re-enter the educational stream that they had dropped out of when they took to drugs. Some of them have remained out of school for so long that they cannot catch up and per force have to either abandon the concepts of further studies or chalk out functional training programs.

The purpose of this paper is to present in a nut shell, some aspects/arguments of different protagonists and schools of thought on the habilitation process.

Assuming that organized professional and self-help interventions could effectively assist ever greater numbers of heroin addicts, certain pilot projects are outlined for experimentation in the field.

GABRIEL BRITTO

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MANAGEMENT OF DRUG ABUSE IN INDIA
National Addiction Research Centre

The Organizational Context:

1. The Impetus:

The inspiration or reasons for the setting up of these organizations to work the field of drug abuse or to take on addiction related programs are varied.

a. International Linkage :

Services clubs such as the Giants, Rotary, Lions, Jaycees which have regular exchanges through conferences. Their counterparts abroad have supported the local initiatives in India with finance and technical inputs developed in other countries when drug abuse became a problem in India.

They have subsequently set up several counseling centers in the city. The Rotarians have moved into counseling in Madras and have set up a centre, in Punar Jeevan. The Giants have set up Forum Against Drugs (FAD) in Bombay as a coordinating body for all NGOs in the city including the Lions, the Jaycees and the Rotarians. A member of the Rotary club of Goa set up the Drug Abuse Prevention Program there in the year 1984.

Likewise, the churches and their social services organizations (like the samaritans, YMCA, The Catholic Church) which have had a long tradition of running social services institutions have begun to work in this field. They too have gained from their international contacts.

The Junior Red Cross, IOGT and such other secular specialized bodies too entered the field.

Three international conferences held in India brought in delegates from a wide range of countries with their ideas and experiences. NIMHANS has setup a research project partnership with ADAMHA, USA. The K.E.M. Hospital, Bombay has collaborated with the British Council to hold a workshop with external experts. SPARC held several workshops in collaboration with the U.S.I.S. which brought in foreign experts.

Fellowships were offered by the USIS for Indian delegates to visit U.S. based agencies, the U.N.F.D.A.C., International commission on Narcotics, Division of Narcotic Drugs, the ILO, ESCAP, WHO and various Western Governments affected by drug abuse in their countries have invited the G.O.I. to join the global struggle against this problem.

b. Field experience :

Three were some organizations which were doing community organizational work (e.g. APNALAYA, SPARC - Bombay) who came upon a new problem affecting the youth in Slums and they took on programs in this field.

The affected people :

A few ex-addicts (in Bombay SEVA DHAN - Bombay, LIFE LINE - Pune, Sahara House - Delhi, Bangalore - CAIMs, set up organizations to work in the field. Persons whose close ones were affected such as, a friend, spouse, or other family member have set up organizations (Ranganathan Foundation - Madras, Andre Faria Memorial Forum - Goa for instance).

Schools of Social Work, instruments of training service providers have taken up drug abuse work. They mainly look at curriculum development in counseling addicts and research. Pune University (Development Communication Research Project) TISS Department of Medical Psychiatry Social Work, Matru Sava Sangh - Nagpur, a School of Social Work has set up a counseling center. The school of Social Work of the Institute of Management in Solapur is preparing a city level plan and package for prevention in Solapur.

Commercial film producers and advertising agencies have been inducted to produce T.V. serials, Newspapers advertisements, hoardings ...

National Health Associations such as, Association for Social Health in India which have their own branches/chapters in different parts of India have set up counseling/detoxification centres..

Professional Associations of Social Workers in Tamil Nadu, Orissa and Andhra Pradesh have taken up training of Social Workers in low-cost media (Street Play) for drug education.

Professional support organizations which offer technical service, such as center for Youth and Social Development offer burgeoning small media and youth organizations training on a whole range of subjects such as account-keeping, reporting, technical information on drugs.

Youth wings of political parties and allied organizations who conduct rallies, protest marches, conferences (Youth Congress (I), Anti-Narcotic Cell, Shiv Sena and other parties).

Individuals (highly connected, sometimes highly qualified) have either registered organizations I.C.E. Delhi) or have resurrected moribund organizations (Kashi Club, Varnasi). These organizations have no prior experience in the NGO Sector as such but have begun drug abuse work from the start and do only addiction-related work.

2. Types of Agencies:

a. State Governments :

Most of the State Governments have ignored this problem except perhaps Maharashtra, U.T. of Delhi, while the Health Department of Maharashtra has attempted to incorporate it into three district level projects on community mental health. The Welfare department of Maharashtra is planning to allot some buildings from the Social Housing schemes for drug abuse work. They also liaison with the Central Welfare Ministry for processing projects.

The DDA (Delhi Development Administration) has allotted space/buildings to NGOs for drug abuse work (More information to be obtained).

b. Correctional Administration :

The Imphal Central Jail, The Yeravada Jail, in Pune, the Tihar Jail in Delhi have set up either counseling/detox centres or a separate ward for addicted inmates in their jails. One of them has invited an NGO to run the program within the Jail premises. Children's reception homes, lock ups in police stations are yet to take up the issue.

The Police department of Delhi has mobilized their NGO to provide detox, follow-up and use the setting for getting information on the peddlers, apart from rehabilitating addicts.

c. Local Governments :

The Bombay Municipal Corporation, Nasik Municipality, Nagpur Corporation, Barmer and three other local governments have become involved in Drug Abuse work. B.M.C. has provided space to several NGOs for the purpose, Nasik Administration held a week long blanket campaign drugs and started a detox and follow-up center with local contributions. The Central Government has funded six corporations in a small way.

d. Mental Hospitals, General Hospitals, Commercial Hospitals Clinics and Non-profit NGO Hospitals.

e. Some mental hospitals have begun a separate ward for addicts. The general hospital which great addicts, allot 3 - 5 beds in their psychiatric department. However, a considerable number of such hospitals are averse to admitting addicts due to DAMA, recidivism and other administrative problems in treating addicts.

f. There are a few private commercial Hospitals such as the APOLLO group of hospitals which have started separate trusts/ NGOs, (APOLLO started ADDART for e.g.) or keep a separate ward. Similarly, several psychiatric and general nursing homes treat addicts. These are expensive.

g. General Practitioners :

Whose clients are close to their clinics often get patients whom they treat with nutrient fluids and sedatives; knowing little about addiction.

ESIS Practitioners, Industrial Psychologists, Welfare Officers, Unions, Union support organizations ... have no orientation whatsoever to this problem.

h. Journalists :

A few journalists have taken keen interest in drug abuse and have written columns on a regular basis in the media. So have several psychiatrists and social workers. But the quality of reporting, scrutiny of data available are very week and they need perspective and training.

i. Religious Leaders :

They have either no clue to this problem or they are responding by setting up extremely costly rehabilitation centres to cater to a token number of addicts.

Some Comments:

A. One of the important phenomena in the field of drug is the birth and death of several organizations or branches of organizations.

The DAIRRC for instance started a day-care center at Dongri in Bombay and closed it down a year later apparently for want of funds. SPARC started a day-care center with the Cooper Hospital at Vile Parle and ran it for a year and four months. The arrangement was that the therapist would be selected, appointed and supervised by the Department of Psychiatry which would provide the space for group therapy and individual counseling sessions. This arrangement broke down for a variety of reasons and therapist was relocated into SPARC research program. Nirmala Niketan started out on preparing a manual for parents through conducting training programs for parents. Apparently, it has not pursued the objectives for want of timely release of grants by NISD. While SPARC has successfully partnered HOPE in Bangalore for research and training activities with the SNDT University for with Women's Graduate Union for running a Brief Strategic Family Therapy center for addicts ...

It can be said that by and large, SPARC has learnt through trial and error, the parameters of networking and partnering with other organizations. Its attempt to partner with the another agency failed due to the iadequacies of the staff member of SPARC assigned for the task.

b. There is a tendency to call anti-alcohol work addiction work because there is money for drug abuse programs today and very few grants are available for the prevention of alcoholism since most of the State Governments make their revenue by the taxes on alcohol and most political parties consider issuance of license as one of the post-election bonanzas for their party activists.

c. Cross Subsidy:
The Vivekananda Education Society at Calcutta supports its drug related work through the surplus generated by their schools. Kripa and Seva Dhan charge fees at their rehabilitation centres patients to maintain the centres and when poor addicts approach them they raise sponsors for their treatment period. No one is turned away for wants of money. The T.T. Ranganathan Clinical , Research Foundation charges fees for 45 out of 50 beds which are mostly paid for under the State Employees Insurance program of the industries. However it maintains five beds for poor patients who cannot afford to pay the the fees. Their after-care center is fully paid for by the Ministry of Welfare, G.O.I.

d. The seeds of youth-to-youth programs can be seen in several organizations such as the SPYM, 'Motivation' - St. Xavier's college, Calcutta, Adam, Madras.

Another trend one sees in the emergence of organizations working in the field of drug abuse in India deserves attention; viz.. governmental organizations registering a separate body under the Societies Registration ACT to deal with the problem of drug abuse. The Institute of Mental Health (Kilpauk, Madras), the Institute of Mental Health (Yeravada, Pune), the Municipal Corporation of Nasik.

e. Women Writers:
There is another phenomenon of women writers getting involved in the field of drug abuse. Mrs. Sugathakumari is a well-known poet-author from Kerala who successfully spearheaded the environment movement through powerful poems and mobilization of scientists and concerned citizens to prevent the degradation and denudation of the Silent Valley virgin forests. Subsequently, she visited a mental hospital to write about women patients with mental health problems, policy makers, concerned citizens and the courts. A committee was set up to review the condition of mental hospitals in Kerala and the government brought about several changes in the funding and administration of all the four government-run mental hospitals in the State of Kerala. Inspite of these reforms Mrs. Sugathakumari and her colleagues felt the need for setting up a transit home for women in distress and they called it appropriately 'Athani' (Roadside pillars erected for people to place their headload on the pillars and to take rest in the vicinity. These pillars are a common sight along the highways in rural Tamil Nadu and Kerala). When drug abuse became a serious de-addiction project, Mrs. Sugatha Kumari set up a community counseling project. Both Athani and Bodhi are projects of the NGO called 'Abhaya', headed by Mr. Surendranath and Mrs. Sugathakumari. In principle, Abhaya does not accept foreign donation and so they have not applied for registration under Foreign Contribution Regulation Act. They find it very difficult to raise 10% contribution to government grant.

Mrs. Sivasankari, Madras:
She identified the emerging problem of drugs, interviewed some addicts and wrote a serial in a popular Tamil weekly with a large circulation. Later it was released as a book which was in turn made into a television serial in Hindi of which thirteen parts were shown on the national network and then stopped. In the meantime, with the offer of the Ministry of Welfare of support to her prevention work, she registered a Society, Agni. Agni has printed leaflets and stickers, produced a film, conducted signature campaigns ... It has also participated in a research study on the rate of incidence of addiction among the slums of Bangalore and Madras cities organized by the Apollo Hospitals Pvt. Ltd.

f. Churches:
Church - based organizations were among the first to respond to the problem of addiction in the country apart from Padmashree Narayan Singh Manaklao at Jodhpur. The Samaritans in Calcutta set up a center to addicts eighteen years ago, which has now grown into a full fledged residential rehabilitation center for addicts. The Jesuits have assisted alcoholics and addicts in a center at Bandra, Bombay since 1979. Asha Bhavan in Goa has been supporting Pallotine Priests who provided the premises for both the rehabilitation centre run by Seva Dhan in Goa.

Likewise, the YWCA and the YMCA networks have provided space and funds to different organizations such as the Seva Dhan and DAIRRC, the Lions clubs ... The Marthoma Church created a day care center in collaboration with DAIRRC in Bandra, Bombay. The Xavier Institute of Communications, in Bombay produced the first slide program 'No Sugar Tonight', which has been re-produced as a video-cassette. The Sisters of St. Paul have produced a film in collaboration with Seva Dhan 'Is Anybody Listening Sir'. Kripa is one among the oldest rehab centres for alcoholics and addicts. It is now setting up rehab centres in different parts of the country.

Charismatic personalities are characteristic of any set of NGOs and organizations. The field of drug abuse is no exception. Here one finds a professor of Hindi from Bihar going to his home town in Rajasthan for the summer vacations. He witnesses a function in which several peasants and farmers are being given loans for the purchase of cattle. In order to enhance their incomes. After a year, he sees that none of them have retained their assets purchased from the loans and most have squandered it away on opium-drinking. He resigns his job of teaching Hindi in Bihar and sets up an organization to work with opium drinkers of Rajasthan in 1979.

Though Mr. Narayan Singh Manaklao remains central to the functioning of his organization, it has acquired proper organizational apparatus and is professionally managed with the guidance of industrialists and others in their governing body. His movement is attaining maturity. However, the same cannot be said of all organizations headed by charismatic personalities. While many of the latter type of organizations in this field are able to enthuse volunteers for specific activities or programs, they remain essentially a single-person organization with all the strengths and weaknesses of such organizations. The training needs and possibilities of offering training to such organizations would naturally vary.

h. The Ministry of Welfare has a large program for the development of women and children and has funded several NGO in the country. It is logical to expect that some of these organizations with explicit goals of child/women's welfare or development would be inducted into the field of drug abuse which has also become a central program of the same Ministry at the Central Government level. Their training needs in this field would be different from those of youth organizations.

ANNEXURE:

ON TRAINING MANUALS AND MATERIALS :

The ILO has prepared a kit for drug abuse prevention in the workplace. The WHO has produced a handbook for community health workers in the field drug abuse. The NIMHANS has produced a manual for community mental health workers which has incorporated drug abuse as one of its chapters. The TTR clinical research foundation has developed a manual for community workers and this manual has been published by the Ministry of Welfare, Government of India. The Spicer Memorial College, Pune, is preparing a handbook for teachers to facilitate them to incorporate drug abuse while teaching biology, botany, bio-chemistry ... without

expanding the size of the text books or the number of hours or teaching.

The ILO is launching a action project in the SAARC region for developing a manual on the vocational integration of addicts.

The UNESCO is reported to have produced a manual for youth workers on drug abuse prevention.

The ESCAP is engaged in developing curriculum for community workers through a workshop process in India and would probably set up some field projects to test the validity of such a curriculum.

Through the seven projects being set up by the GOI in collaboration with the UNFDAC, the several manuals are expected to emerge in the next two or three years.

SOME PROBLEM AREAS :

The are practices of some organizations in the field which require public debate :

Very few organizations declare the fee they charge. The public has a right to know the fees and services provided. Some of the organizations declare that they provide free services but on account of the number of persons seeking admissions, waitlist ..., corruption, speed money to skip the queue enter the scene. Some justify the high fees by saying that it is not paid by the patient anyway but by the sponsors or the companies. Some parents prefer to go to costly treatment centres because they want good services. It is not at all clear to us what is the best treatment in terms of medication for addicts. There are organizations which charge just two rupees per detoxification and there are also organizations which apparently charge anywhere from Rs. 9,000 to 35,000 for a ten day detoxification in the country which in strict terms should not cost beyond Rs. 300. In the ultimate analysis, it is the economic principle of demand and supply that will rule the roost and so some organizations have systematically begun training general practitioners of medicine in detoxification of heroin addicts. Thus, if in each area where a counseling center is located, about 200 general practitioners are trained in detoxification of addicts, then, it is possible for the counselors to identify addicts in early stages, to detoxify addicts on out-patient basis or in their homes. Naturally there will be some addicts who require hospitalization or in-patient care. Their proportion to the total number of addicts who seek help is very small. In this manner, the load on the de-addiction centres can be reduced. There is already a small manual for detoxification of patients addicted to heroin type of drugs.

Prevention of Drug Abuse in India

A Status Paper with Outlines for Pilot Experimental Projects

National Addiction Research Centre
5 Bhardawadi Hospital
Bhardawadi Road
Andheri West
Bombay 400 058

PREVENTION OF DRUG ABUSE

PREVENTIVE MEASURES

The general objective of any demand reduction activity is to control use/abuse of all illicit drugs, specific drugs and the number of new cases of illicit use.

Attainment of the goal is dependent on formulation and implementation of activities focusing on four specific areas; preventive, treatment, (re)habilitation and social/vocational-integration.

Preventive measures are undertaken under the assumption that informational approach, educational programmes, personal developmental programmes, health educational programmes and community based intervention can control the problem through culture specific methodology of intervention.

PREVENTION IN INDIA

Philosophy:

The preventive measures in India are based on the philosophy that addiction to drugs is a new phenomenon that can be tackled by magnifying the adverse effects of drug use and abuse.

Concepts:

Prevention concepts are restricted to modification of the behaviour of the user, high-risk groups; identification of users/abusers by the family, friends,concerned individual and providing information on the treatment facilities.

Strategy of Intervention:

The organisations involved in the field of prevention have adopted the fear or scare approach to deal with the behaviour pattern of the users and abusers, the psychological inclination of the high-risk population and to encourage the involvement of support groups.

Actvities Undertaken:

In the country out of 161 organizations working in the field 105 organizations have undertaken information based preventive measures to deal with addiction.

The informational approach is implemented through talks,group discussions, lectures,group discussions,seminars,workshops,distribution of pamphlets and leaflets, poster, essay and elocution competition, holding public meetings, conducting walkathons, morchas, exhibition,

street plays and producing films and audio-visuals. The organizations which utilize audio-visuals, posters, pamphlets and talks etc. form the majority and workshops and seminars are conducted by thirty organizations. At present a large number of information based programs are based on fear or scare approach in isolation, in order to tackle the problem. There is a lacuna of conducting other forms of preventive measures along with awareness building programs.

There are several groups in the field of drug abuse today, who believe in preventive campaigns.

a. Political parties and their cells for the control of Narcotics.

b. Concerned individuals with perhaps the rudiments of an organizational shape (some are in the process of registering their organizations).

c. Registered NGOs.

d. City administration with the Public Health Department taking the initiative.

e. Public sector and private sector industrial houses.

f. Prohibition Department.

g. Films division.

h. Television.

i. Radio.

a. Political Parties:

The Anti-Narcotics cell of the Congress party has been active in different parts of the country, organizing mass meetings, cycle morchas to the offices of the Commissioner of Police to put pressure on them to control trafficking. They also arrange talks and exhibitions on college campuses.

It is not enough if one or two political Parties enter the campaign. Heroin trade should become a common platform for all Parties. Each has to act as a watchdog of the other and to conduct joint campaigns.

Rotarians, Lions, Jaycees and Giants have promoted a similar series of lectures and exhibitions targeted at the college youth, conducted mostly in English. The DAIRRC has initiated a campaign against drug abuse in the slums in Bombay.

b.Public and private sector Industries :

Bharat Petroleum; Rashtriya Chemical Fertilizers, Hindustan Petroleum and a few other public corporations have also supported campaigns through hoardings and films. The films "Manas" and "Sankalp" have been sponsored by the Corporate Communications Department of Bharat Petroleum and have been widely used in English, Hindi and Marathi. In the private corporate sector, one sees the Ad club of India taking a leading role. They had launched a nation-wide competition with awards of Rs. 2,00,000/- and have developed prototype campaign material for seven segments of target-audience in all media. This preparatory work for campaigns has been titled "FAIDA". (However this entire campaign was based on evoking fear psychosis and it has remained in their godowns).

Groups like "Enterprise" in Bombay and some other groups have developed street plays on drug abuse. Though the actors are middle class youth, they have adopted several folk lores in their plays which appear to be more proximate.

A student group in Calcutta,"Motivation",launched a campaign against drugs and also undertook referral functions.

It would be more practical to mobilize the slum youth to develop programs, document them, analyze and understand their appeal to their peers from their response to these performances.

It is with this thrust that organizations such as Apnalaya, "SUPPORT" and "SVP" (Bombay), have facilitated the local youth to come together and develop and perform street plays on drug addiction in the slums.

d.City Administration:

The mobilization of the entire administration of the city of Nasik and their week-long blanket campaign in all parts of the city using multi-media is another important development in this field. The participation of leading labor unions, ex-addicts, the poor, the unemployed as well as college students was a special characteristic of this campaign. This unique model can be an example for the administrators in other cities. (More details can be had from the Secretary, Public Health Department, Government of Maharashtra).

The Nasik city administrators had also mobilized resources for setting up a detoxification facility and follow-up unit.This is necessary, for creating public awareness on dealing with the drug problem, without providing the necessary treatment and follow-up facilities, would lead to mass frustration and endanger credibility, The Rotarians in Madras too, found that running campaigns alone is not enough. They have thus set up a counseling center (Punar Jeevan) for addicts. In Bombay, the Lions too are running two counseling centres for addicts and they conduct a detoxification camps.

The principle must be : No awareness campaign should be conducted without providing appropriate service facility. We do not want to repeat the situation after the T.B. campaign when patients were given cough syrups and sent away.

Critical Factors In Preventive Measures:

Differential pattern of Drug Abuse:
The problem of Heroin/Brown Sugar addiction is predominantly an urban phenomenon except in North Eastern India, the border villages in North West India and in the fishermen' colonies on the coastal tip of Southern India.

It has also become clear that the problem of Drug Abuse varies of from city to city. In 1987, pervasive use of crude Heroin was seen in Bombay, Pune, Goa and Delhi. Heroin had also made significant inroads into Calcutta, Madras, and Kashmir while the soft drugs such as ganja, bhang, charas), were dominant in Cuttack, Bhubaneshwar, Hyderabad, Coimbatore and the tribal areas. On the other side, we have Imphal and Ukhrul were white Heroin is injected, a mode of consumption reported practically nowhere else.

Demand reduction activities should be State-specific/city specific depending upon the configuration of the drugs of abuse, profile of abusers... opium drinkers of Rajasthan are of a higher age group than heroin users of Bombay. Thus the appeals for prevention have to be differently selected. Even within a State, variations are visible as illustrated in the following report of two rapid studies.They indicate a need for bottom up planning of demand reduction activities. At the time of the present writing, all planning is done centrally at the national level by a small group of overworked administrators for whom drug abuse is one of twenty odd subjects to dispose of(See annexure).

Socio-economic Factors:

Preventive activities should be formulated after an analysis of the social customs of the area or target population. In our country use of natural forms of drugs has been prevalent for centuries and an attempt to ignore or avoid it would lead to the justification of patchwork attempts by publicity and non-professional individuals.

In certain parts of the country the basic necessities of existence would be a major problem than addiction. And addiction to soft forms of drugs is the only way for the population to deal with stress and continue their cycle of life. Invariably this fact has been utilised by individuals with vested interest to market synthetic forms of drugs.

Addiction to heroin has found to be related directly or indirectly to urbanisation and thus dealing with the problem should consider the role of other resultant problems of industrilisation.

Culture:

When preventive measures utilise audio-visuals, films, posters and pamphlets, under the assumption that gestures, symbols and style of communication to be universal would result in disfunctional interventions. It is vital to formulate the activities after analysis of the culture and customs by experienced anthropologist and linguist.

Limitations of Present Intervention:

Informational approach is not effective in modifying the behaviour patterns of users/abusers. Thus scare or fear approach can be justifiable as an excuse for publicity, funds and effortless professionalism. Through fear/Scare technique would negate the impact of the programme on high-risk population as the messages conveyed are contradictory to the reality and even factual data may be ignored by the target population.

Prevention cannot be achieved through information-dissemination nor by evoking fear of death, impotence ... Such strategies have failed elsewhere and we have no empirical evidence of their success here. This is one area where professionals and policy makers need not attempt to re-invent the wheel but learn from the evolution of preventive strategies in the West where enormous human and monetary resources have been invested for the purpose.

Media professionals are largely drawn from the commercial advertising world. Their principal thrust has been to sell some product.Theirs is an attempt to bring about a positive attitude towards a new product and to make the viewer/audience accept that product or adopt a new procedure. Similarly, most of the family planning campaigns are intended along the lines of promoting the concept of a small family norm and to adopt family planning measures.

On the other hand, the current thrust of the anti-drug campaigns seek to bring about a negative attitude toward socially accepted drugs such as alcohol, tobacco, charas, ganja, bhang, opium, and also against the not-so-accepted brown sugar/heroin.

Here, the differentials of commercial advertising and social advertising need to be understood when preparing the campaign against drugs. Promotional campaigns aimed at developing a positive attitude towards a drug free life is more akin to commercial advertising than when they attempt to evoke antipathy to drugs.

We can introduce participatory production-processes. Poster, essay, speech and drama competitions... among youth is a useful exercise to generate ideas and to gain insight into the vocabulary range of the youth population in different cities at different levels.

Campaigns must motivate people to come for early treatment, to promote abstinence and lead a drug-free life.

It is clear then that each state has to develop its own action-plan depending on the particular pattern of drug abuse in that state.

DIMENSIONS OF PREVENTIVE MEASURES

Preventive measures are various depending on the area of focus and target population. Inspite of these differences there are certain principles to be adhered to, which would determine the effectiveness of these programmes.

GENERAL PRINCIPLES:

These measures cannot be carried out in isolation from control on trafficking of the specified drug(s). Countries that cultivate poppy need to focus on crop substitution; methodology of cultivation, its cost-effectiveness, scope for international market and its role in facilitating trafficking.

Demand reduction activities have to be varied: Area-specific/drug specific, culture-specific and cost-effective.

The first step in planning, designing and implementation of the program is the selection of objectives, depending on pattern of use and related problems.

Effective measures have to be sustained and planned on a long term basis.

Those involved in demand reduction need to co-ordinate their activities with clearly defined roles.

PREVENTIVE PROGRAMMES

Prevention programs may be either motivational or deterrent in nature. Motivational programs focus on competence development. Deterrent programs emphasize the harmful consequences of drug use to the user; Suppressive measures against illegal cultivation, manufacturing/ distribution and enforcement of controls on pharmaceutical products.

Alternatively, measures for prevention can be of three types: informational, educational and community measures.

Prevention concepts:

It is evident from studies that knowledge by itself cannot bring about a change in attitude. Even if a particular intervention process manages to achieve this goal, it does not mean that change in attitude will head to a change in behavior pattern.

Information approach can be targeted at various groups:

policy makers in the department of revenue, education, health, welfare, labour and tourism, the media personnel, labour welfare and personnel officers, law enforcement officials, organizations working in social problems, educationists, agronomists, the funding organizations, action groups, youth, teachers and parents.

Prevention through information should offer balanced knowledge about the effects of drugs, nature and extent of the problem, relationship of drug abuse to other social problems, physical, psychological social and economic costs of illicit use to the individual(1), symptoms of addiction, help available and their drawbacks, initiatives which can minimize harmful effects of drugs, the need for crop substitution, legal status/changes required in the law, the extent to which the law has been utilized to curb supply, to stigmatize and to marginalize addicts, the marketing strategies utilized in order to substitute soft drugs with harder forms for higher profits, the role of NDPS Act in facilitating the marketing strategy of the traffickers, the circumstances under which an abuser resorts to peddling, the inhumane facilities provided to the vulnerable groups in the correctional settings and options available to them.

Information programs should have pre and post evaluation. Analysis of the reports and articles on the program with regard to their frequency and content are necessary measures along with awareness building programs.

Educational Measures:

1) Programmed teaching approaches
2) Integrated drug educational program
3) Health educational programs and
4) Programs for personal development.

Programmed teaching in drug addiction can be carried out through short term Courses, study circles, individual studies/postal courses. Such courses per se cannot change attitudes and behavior but their utility will depend on the content, the context and by whom the matter is presented within the broad framework of the academic curriculum. The topics covered in the course should be sequential and the use of appropriate audio visuals might create a better impact. Emphasis being laid on responsibility for one's own decisions and rational attitudes toward use or abuse of drugs. A caution however is necessary. Taking responsibility for one's actions and the right to make decisions are not highly respected values in our country where authoritarian life style is emphasized in all institutions whether it be the family, the school, or political parties or industrial establishments...

Before venturing into developing courses for the youth or students, it is vital that a course for the trainers of youth should be conducted.

Trainers should have skills for modifying the course according to the requirements of their particular setting. The selected trainers should be those with whom the students are able to relate. Individual study/postal courses should take into account the age, level of awareness of trainees. The availability of trained individuals in the vicinity is important to clarify doubts.

Study Circles:

The group participation approach might have advantage over inflexible pre-determined courses. It will capture the interest of the target group, facilitate their critical thinking and clarify their doubts. Opting for participatory approach indicates the preferance for non-authoritarian life-styles and democratic norms. It will also improve inter-personal skills and communication between the trainer and learners. This approach also has the advantage of working out personal problems of trainees as they surface in discussions.

Integrated Educational Program Within The Curricula:

Drug education program will have to be a part of the regular curriculum in the educational institutes. It will have to be continuous, it can be implemented through illustrations and discussions during lectures on biology, law, chemistry, civics and allied subjects.

It would require a specially prepared curriculum and teaching materials, trained teachers and oriented administrators for program co-ordination.

Health Education Program:

Health refers to mental, physical and social well-being. Health education is a necessary component of health promotion. Drug education is more effective when integrated with general health education programs.

It can be targeted at health education workers, youth/ students, community workers, and trainers of youth. When its prototype is developed, it is vital that a multi-disciplinary team of professionals should be involved. They should test the appropriateness of teaching materials and curricula for each of the target age groups, their experience with drugs...

The cost of the activity will be minimal where there is already a health educational system. In India we have the Central and State Health Education Bureau with technical staff, equipment...

Programs for personal development:

Personality development programs are based on the assumption that drug abuse is a symptom of maladjustment and/or personality characteristic or contradictory social values, social goals, injustice and lack of creative activities. The emphasis is on the individual who uses or is likely to use drugs, rather than on creating awareness on drugs in general. They facilitate him to re-examine or clarify his values, or encourage him to accept positive ones or to have better insight into himself, or to utilize his interest and need to take part in activities that can improve his self-esteem and to prevent alienation. These programs should not be undertaken to modify him to suit the society but should enable him to stand by his views, to have faith in his abilities and to develop inner strength to deal with what might result from discrepancies between his goals and that of the society.

The target group of these programs will be youth/students,ex-addicts, those who have slipped, relapsed but have not become re-addicted. They might call for changes in the existing system. They would prevent the socialization process from creating a stagnated stream of future generation. They activity should be undertaken along with community approaches such as adventure groups and action groups.

Programs can also be training for assertiveness, for value-consciousness, for rational decision making, to acknowledge, to acknowledge one's decision making in public without feeling uncomfortable about the decision made. They promote inviduality and and support individuals becoming responsible about their decisions. But it might not necessarily lead a drug abuser to abandon the use of mind-altering substance or prevent experimentation.

The above programs would strengthen decision making skills, inter-personal skills, ability to anticipate drug offer situations and self perception.

These programs will not be restricted to intellectual aspects associated with use or abuse of drugs, but would also involve focusing on the feelings associated with use or abuse and drug offer situations.

The important conditions for these programs are :

Periodical assessment of the cost-effectiveness of the program and involvement of an international consultant and members of the affected population who left drugs on their own and are capable and interested in facilitating professionals involved in the field to take a critical view of the methodology of interventions.

These programs would require extensive resources, time and energy in the formulation and subsequent training of others to implement the

program. They cannot be substituted by posters, campaigns,etc. which might be less labor intensive, provide more publicity for those social figures who thrive on them being less accountable in terms of their utility and cost-effectiveness.

It is important to realize that the utility of campaigns, poster competitions, talks, films, audio-visuals and commitment models is minimal when conducted without being followed by community-based programs. Preventive measures conceptualized by professionals tend to aim at satisfying their need to modify the behavior patterns of the affected population to the needs of the society. The affected population consists of a percentage of individuals who feel the need to rebel against society and their best option to express their discomfort about the societal values,hypocrisy,lack of creative options etc.,and they might prefer not to accept the goal set for them by the society and their representatives. Preventive measures also need to include programs that offer alternate forms of activities and facilitate the targeted population to tackle the problems of the society and change society.

It is evident that preventive activities should not be restricted to campaigns but should involve community approaches and educational programs.

Drug abuse campaigns must communicate to the target population in as many languages as are found in each city . Since addicts were found in all language groups (SPARC reports). Here again, drug abuse campaigns can benefit from the lessons in the Family Planning campaign, its leaders and the established infrastructure.

In the Family Planning campaigns, only persuasive, facilitative, and educational strategies have been used. But in drug abuse, particularly, after the 1985 Act and its amendment of 1988, legal sanctions are attendant upon drug abuse. Hence, power strategies have been used which can be built into the campaign.

Drug free values need to be introduced in the educational system, not as a separate subject but used as illustrative material in subjects and topics that touch upon those aspects of personal and social life of individuals covered in educational curricula.

The program on drug abuse should not be prepared and transmitted nationally. Otherwise, we would be introducing more advanced forms of drug abuse in areas which are till now accustomed only to charas and ganja.

It is a fact that only a few abusers begin addiction with brown sugar. Most of them have been on tobacco and/or alcohol and/or charas/ganja for years. Thus, though not all smokers are likely to take charas or ganja or brown sugar, we still do not know precisely the characteristics of those who do graduate to higher-order drugs. In

We need to set up a national program to periodically monitor through rapid research techniques such as "sounding" in all urban areas, the patterns and trends in drug abuse and provide this research data bank to the media people and the practitioners and professionals and volunteers who help in the actual work.

All media programs, including TV and radio should target their audience and use appropriate time slots depending on their target audience. For example any program aimed at adolescents would be missed, if projected for 8 p.m. in cities like Bombay. The anti-drug campaign can be projected when serials, popular among the youth, are relayed. Anti-Drug Abuse campaigns can also be published in popular youth magazines, and programs can also be made to educate the parents regarding the signs and symptoms of addiction and the causes and need for a support system.

Media people ought to remember that even the most effective preventive education program aimed at students, sustained for many years, can tackle only a third of the problem since addiction occurs for the majority only after they have left the portals of education. A considerable number of the addicts have either never entered school or have dropped out at the primary level itself.

Thus, the scope of preventive action needs to be broadened. The vocabulary, idiom and setting, dress, demeanor of media presentation should be tailored to the non-students, the marginalized youth.

Any reduction in drug-use or abuse may probably be more due to family or community pressures, political mobilization, increasing costs of Heroin and deaths or addicts, than due to our anti-drug campaigns, which often have a negative impact.

a. Heroin/Brown Sugar, being new, is not known but is feared.

   Our campaigns may remove the fear. An exaggerated stress on the negative aspects, if made in a sensational form, might evoke curiosity rather than aversion for drugs among the youth.

b. Public campaigns aimed at publicity and fanfare may tend to push abusers to more clandestine locations.

c. The increasing invisibility of the problem is certain. But we need to clarify the specific impact of our campaigns.

Some countries appear to have come to terms with the drug trade and have laid the burden of addiction squarely on their youth. Campaigns such as "War on Drugs" have gradually yielded to "just say No" programs. Journalists and other media personnel should not end up

the absence of a clear understanding of these parameters which might help us to predict which smoker would switch to higher-order drugs, we should NOT use the TV. Damage caused by a program projected to an unintended audience of children or villagers who have never heard of brown sugar cannot be remedied.

English/Hindi programs on brown sugar on the national network of the TV must be stopped at once as the use of drugs follows varied patterns in our country.

The infrastructure has to be developed for regrouping transmissions. Programs on Heroin should be broadcast only in Delhi, Bombay, Pune, Goa, the North-East, Calcutta and Madras. Other areas should be included only upon empirical evidence of Heroin use in those cities.

The injectable mode of consumption of drugs is common in the case of Fortwin, Pethidine, Brown Sugar and White Heroin. However, use of Pethidine and Fortwin occurs only sporadically, except in Tamil Nadu and Kerala. Not more than 1.6 % of brown sugar addicts have ever resorted to injecting brown sugar in Bombay, Delhi, Goa, Madras or Calcutta.

Thus, media programs and all publicity (except in the North-East) including exhibitions and posters should not depict injections or the injectable mode of drug consumption because it is like educating people on a mode of addiction that usually comes on after several years of "chasing" brown sugar.

The impact of presenting a well built, tall young man as a hard core heroin addict, indulging in criminal, homicidal activities needs to be studied. We are trying to show a hard core addict losing all values in desperation for funding his habits. Heroin addicts with rare exceptions become very sick in six months time. We see brown sugar addicts with respiratory problems, anemia, infections and loss of weight and it is farcical to see perfect models acting as hard core heroin addicts in the nationally transmitted anti-drug program.

On the other hand, there are regular consumers of charas/ganja for over thirty years or more whose physical health has not broken down, though their achievement orientation may have become blunted.

Drug induced psychosis is possible not only in the case of LSD, brown sugar but also charas and ganja. However, to what extent it has been brought out by drug consumption requires clinical research.

While creative writers and professional media persons and performing artists have an extremely important role in the Anti-Drug Abuse campaigns, the programs need to be developed on the basis of their grass root level experiences/exposures and the empirical data needs to be built up.

putting the entire blame of addiction on youth and their parents; nor should they make it an individual problem of the affected people when in reality it is a systemic problem.

Community Campaigns:

Turning to community campaigns, we may again cite the examples from the peripheral areas.

In the Jammu and Kashmir region, we have the United Falah Aam committees (at Urdu Bazaar, at Gantmullah and at Badami Bagh, Sopore, Baramulla District); the Samaj-Sudhar Committee at Punipora Tarzoo, Sopore and the Welfare Committee at Dalgate as examples of local mobilization.

The TMNL Youth council at Ukhrul has included drug abuse as one of the themes of deliberation in its annual general council meetings normally attended by over a thousand youth (see SPARC : a note on non-institutional forms of campaign).

Such community efforts are also seen in the metropolitan cities though on a smaller scale.

Ways must be found to sustain such popular participation and we have to emphasize the role of established organizations, who do not take on the work themselves but facilitate the affected people themselves to take up the issue.(A pilot project to set up area resource centres in different parts of the country for the purpose has been proposed in the final section of this master plan under the heading 'Supportive Projects').

The emphasis is on utilizing the forces in the community to tackle the problem, facilitating them to act as support groups, involving them in preventive activities, the process of social re-integration, in facilitating them to understand the merits and demerits of the present preventive activities,the lacunae in terms of treatment facilities, alternate forms of activities available, the options available and the method of implementation, the funds available for various activity, need for accountability among professionals, the role of community in sustaining the activities of groups that are involved in tackling the problem, understanding the need for a committee that will create accountability. Such a committee should consist of professionals, committed individuals, ex-addict professionals open to assessment of their own work, community leaders, members from social organizations working in other fields.

The term community does not mean people from a specific geographic region but people in the neighborhood, village or town who are concerned about the quality of life in their locality. The community will be the best force that can bring about a change in the attitude of the society towards the marginalised force, in questioning the

State machinery tackling the possibility of curbing the problem through coercion and authority, when its attempts on these lines have till today have not managed to curtail the activities of the underworld nor create a harmonious existence among people. Probably coercion might succeed in throttling the marginalised section of the society in the name of justice and welfare of the people as the they are not equipped like the underworld to deal with the powerful, rigid, hypocritical system called society.

It is a romantic Western concept that such caring communities exist in the developing countries such as India. Our own experiments in rural development, panchayatiraj, community development, cooperative movement, electoral politics, communal conflagrations, tribal movements, peasant revolts, cohesive communities have been rent asunder by the structural inequalities and political mobilization processes set in motion by the democratic institutions of India.

It is in this context that we need to look at the types of organizations working with the poor in the country. These grass-root workers have insights into the methodology of coalescing distinct, often divided populations along the lines of primordial sentiments into a common area of concern, overcoming the obstacles posed by the political and other vested interests which thrive on divided communities. It took even the industrial and commercial groups well over fifty years in India to emerge as a single entity under the banner of Federation of Indian Chamber of Commerce and Industry. This formation was preceded by the chambers of commerce and Industry grouping under language, caste and other divided considerations. It will take mature community work to bring in the poor on a common platform of dealing with the problem of drug abuse.

Besides, drug abuse is a problem which affects all classes. The tendency is to enter into multi-class mobilization. From a review of mass movements in the country where the rich and the poor have been simultaneously mobilized for a common cause. It is the poor who bear the brunt of the movement-making while the elite groups within the movement walks away with the benefits of the Movement, whether it is the freedom movement under Mahatma Gandhi, or the non-brahmin movements under Periar in Tamilnadu or the Phule's movement in Maharashtra or the Assam Movement or the Farmers' movements under Sharad Joshi or other Agrarian leaders. Only token benefits trickle down to the masses who lose out on the control of the movement planning and negotiations.

Thus, sectroal mobilization is indicated as the key word for community work. Even when multi-class mobilization is taken up, the organizers have to consciously train the poor in leadership skills, in setting up communication systems in their constituencies, include them in negotiations, giving them access to information on the problem and assisting them to generate data on the problem through community self-surveys and through analysis of existing data from all sources.

It is surprising that none of the government funded deaddiction centres nor the counselling centres employ even a single community organizer as a part of the treatment team. It is even more surprising that there are practically no community development organizations being funded to take up drug abuse work. This is one set of organizations which not only have the theoretical framework of social development and social problems for tackling the problem of drug abuse, but actually have created communities out of disparate individuals and mutually antagonistic groups which stay divided on real or imagined or propagated reasons for staying divided for survival. The collective insights these organizations have built up through years of working with Community based Organizations should be capitalized upon. The principle is building upon what is available within the system. The simplistic notion that giving a van and even appointing a social worker as part of the counselling and deaddiction centres would not by themselves give these institutions the community orientation that is so thoroughly missing in them.

Before venturing into community-based approaches or facilitating or strengthening already prevalent community based programs. The steps to be taken in order to ensure that program activities are facilitated and impact made realistic are; identification and mobilization of resources which already exist which include youth organization, the media, voluntary organizations, welfare organizations, educational institutions, industrial sectors, labor unions, religious organizations, leisure activity and facilities; the assessment of the size and characteristic of the problem in the community; the development of mechanisms for co-ordination existing services and those which might be developed in the future; establishment of mechanisms for obtaining funds, volunteers, facilities and technical expertise.

Building an Integrated Community

Broad Objectives:

1. To help communities at large to understand, social, political economic factors that create and sustain problem of drug abuse.

2. To create public debate and positive atmosphere towards indentification of drug affected persons and creation of a support network.

3. To equip and train community volunteers to gain control over health care techniques.

   a) Identification, referral detoxification, treatment, follow-up - specific to drug abuse.
   b) Develop skills of analysis and application (survey - analysis - action - feedback).
   c) To develop and sustain area resource centers.
   d) To act as trainers for spread of anti-drug education and action.

4. To develop strong local forums/groups of concerned individuals, organization/political representatives, in order to mobilize public opinion and provide support to community groups and maximize use public/community resources.

5. To interact with and lobby for change in legal, administrative environment with reference to adopting new approach towards drug abuse.

Assumption

Information:

- Patterns and variations in the spread of drug abuse are not yet understood.

- Within the country, state, city/village there is a varied pattern of drug abuse. Traditional forms of opium consumption, use of Ganja, Charas etc. on an everyday basis and currently the use of heroin/brown sugar etc. reveals the need for deeper understanding of causation, availability of drugs, its spread among urban rural communities, role of addiction in personal life and potential for addiction among certain sections of the poor.

- Opium/heroin addiction is a group/community phenomena often with social and cultural sanctions which need to be reviewed.

- Drug addiction as a phenomenon is a complex web which eccompasses and destroys established belief and value systems.

Process

Assumptions:

Key persons in the community and families of affected persons have an intrinsic understanding of the causes of drug addiction and how it affects the individual, family and community.

Every drug addict is a person first and a member of his/her community therefore his/her responsibility extends towards community.

Addiction is a group phenomenon.

Training would be an outcome of an assessment which identifies clearly the following:

a) directly affected persons
b) indirectly affected persons
c) support/interested members
d) area/community resources
e) key communicators
f) members of the drug abuse chain
g) extent availability of drugs in the community
h) belief and customs
i) role of drug use in current life style; patterns of addiction.

- acceptance of the drug abuser and his/her integration in community.
- community members - especially those affected would be the best persons who can define community goals/vision

ANNEXURE

PILOT PROJECT : 01: **DEVELOPING PEER LEADERS FOR PREVENTION**

Project Justification:

Effective preventive measures are participatory. Innovations are necessary since preventive measures are limited to poster campaigns, walkathon morchas. We have to assess the effectiveness of "Just Say No" campaigns (which simplify the problem of addiction to intra-psychic factors). We need to develop training programs for interested, capable youth to assist their peers in tackling isolation and alienation associated with addiction. A properly designed pre-project and on-going training program for volunteering youth leaders would increase the probability of tackling addiction given the paucity of resources and trained personnel.

"My friend gave me" is an soft-heard phrase in our interviews with addicts when discussing their initiation into drugs. Friends are also cited as significant sources of support for giving up addiction by former addicts. Establishing a satisfactory new relationship has been an important milestone in the total recovery of many addicts. Thus training peer leaders can be an important step towards prevention of first experimentation with drugs. Such trained peer leaders will be our important local resource to identify drug abuse among colleagues.

The specific advantages of relying on peers as prevention agents are:

a. Being of the same age group, they speak the same idiom and language.
b. They are going through similar difficulties and joys arising out of the roles and functions they have to perform in their stage of the developmental cycle.
c. They are in daily contact.
d. They know each other's lives:happy moments, sad events, how each one responds to different situations. They reach out to each other in crisis and they have fun together.

Peer leaders can be chosen from a group of friends in a given institution/community or a trained youth can be placed in an already existing group of friends provided that the trained youth is compatible with the group he is entering.

Community Project - Goals

1. To ensure that "community management" mechanisms are set up to deal with social addiction (drug and alcohol).

2. To ensure voluntary treatment and integration of abusers in community processes.

3. To generate action processes which in turn increase community participation and decision-making of key issues in the environment.

4. To increase the use of public resources, establishing mechanisms of direct feedback and dialogue with the local, city, state governments.

5. To build and strenthen "shared" community assets and co-operative structures.

6. To increase interaction building federations of settlement committees of the poor in cities/towns sub regions and regional level.

7. To train ex-abusers and youth as a cadre of change agents in the community.

ON-GOING/ PROPOSED PROJECTS

The UNFDAC funded Project in Delhi:
This project has been conceived both as a step toward sharpening the technology of communication in the Indian context and at the same time to develop community participation in the management of drug abuse in a city.

Jagran, a non-governmenal organization based in Delhi has been using their mime plays to act as catalysts to rouse community consciousness to convince individuals that they have options available in solving their essential problems and to create in immigrants the self concept of being potential initiators of a progressive change for the better. Among the issues handled are untouchability, nutrition, balck marketing drug abuse,dowry, sanitation, family planning, evils of alcoholism etc. In view of the drug problems, JAGRAN has been working in educating and motivating the slum dwellers in Delhi on the harmful effects of drug abuse as prevalent today in the slum colonies. The method of JAGRAN has been through the Pantomime theatre which involves the local people of the resettlement colonies to act as animators.

The project aims :

i) to produce through surveys and communication with people in the resettlement areas, pantomime plays that aim both at primary and secondary prevention target groups.

ii) to train animators, in contacting slum dwellers, transcribing their discussions into new ideas for plays development mimes, rehearsing them intesively and performing them.

iii) to evaluate the first year of project implementation to assess the impact of the project.

The two main activities of the project will be the selection and training of a group of animators who will work in the slum areas, and secondly the production of plays. These two activities are closely inter-related and part of a particular methodology that JAGRAN has developed over the last decade.

The animators play a key role both through their contacts with slum dwellers but also through the development of ideas into plays and through the actual rehearsals and performance of the pantomime plays.

In the following pages, a few pilot projects are outlined to be launched by under the UNFDAC-GOI drug demand reduction programme in India.

FUTURE NEEDS:

1. Informational approach need to be targeted at support groups.
2. Intergrated Educational programmes have to be formulated and implemented.
3. Health educational Programmes involving community level health workers have to established depending on the needs of the specific region.
4. Organisations involved in prevention should network with other orgaisations involved in treatment, (re)habilitation, social integration and law enforcement.
5. Each city have to develop an action plan specific for their region.

Immediate Objective: one
To evaluate the role of peer leaders in prevention of drug abuse addiction.

Output	Activities
An action group consisting of peer leaders trained in preventive education.	- Selection of a group of youngsters who are interested and capable.
	- Assessment of the selected trainees knowledge of drugs and attitudes towards drug abuse and abusers.
	- Orientation of the group on various aspects of addiction, types of preventive measures and their drawbacks.
	- A sounding study-interview with small groups of addicts, law enforcement officials and key informants carried out lay by the group.
	- Formulation of subgroups to conduct following activities:
	Sub-group A - Documentation of organizations working in the field and assessing their lacunae or shortcomings.
	Sub-group B - in-depth interviews with addicts who discontinued treatment and their view about support systems
	Sub-group C - interview with support groups with the view of creating a dialogue between support groups, affected population and the group of trainee-peer-leaders.
	Sub-group D - study of legal aspects of addiction and relevance/the drawback of NDPS Act.
	Sub-group E - Independent survey of the problem in a given educational institution
	- Formulation of policies for the institution and conducting dialogues with administrators of the institution.
	- Facilitation of the peer-leader trainees to identify drug offer situations, tutorials and assignments on review of

literature drug offer-situations encounter meetings with recovered addicts on drug-offer situations and on ways of coping with it in a positive manner.

- Value clarification program for the peer-leaders trainees.

- Role play on drug offer situations.

- Training in leadership functions.

- Collation of all information collected and forming guidelines for further field work-specifically for preventive work with various target groups.

- Assisting one or two of the sub-groups of trainee peer-leaders to develop positive alternative programs for their peers.

- training of other youth by these trained youth.

PROJECT : 02 : **WORKERS EDUCATION PROJECT**

Development objective :

Alcoholism and drug abuse have penetrated all segments of society in Urban and Rural India. The purpose of the current project is to understand those segments of society which have been significantly affected by alcoholism and drug abuse and to develop mechanisms for demand reduction with a view to strengthen the human resource base of the country.

Justification of the Projects :

Among the urban workers especially men addiction cuts across highly paid professionals, middle management workers, workers in factories and workshops hotel and tourism sectors, construction, transport, dock textile - garment workers; and among the unorganized sector, low paid casual labor, petty traders, ragpickers, hotel and restaurant workers, prostitutes and victims of drug - heroin addiction especially in the large cities. A long list of categories of workers affected by brown sugar addiction in 11 cities of India has been prepared by SPARC.

Urbanization, commercialisation, faster growth of cities seem to preconditions for availability of drugs. Street corner joints, video clubs, country liquor clubs, bylanes, vacant lots etc. usually located near the work place offer easy access and exhaustion, mental

tensions and congested homes within slums; access to police is restricted and often public toilets, clubs and shops are locations where pushers and drug users meet. And barely 10 % who work in the local government departments of conservancy in hospitals - assigned to

mental tasks - sweeping, garbage collection, cleaners in hospitals - again both men women, abuse drugs/alcohol.

The scrap recycling and hotel industries absorb a majority of the youth migrants who rarely are able to graduate in their jobs or off the street. These segments are vulnerable and are often caught in the web of addiction stealing, pushing and drug addiction.

It is apparent that both unions and organizations of workers, slum dwellers, will have to use innovative techniques to understand the dimensions of drug abuse among workers, evolve education that reaches out and at the same time is rooted in collective action.

Irregular jobs, work schedules and sometimes major/minor family crises add to indifferent health, social isolation and frustration which can lead to seeking a constant 'drugged' state. Several addicts interviewed have confessed that both un-employment and sometimes the very nature of employment leads to addictive behavior.

Similarly categories of rural - urban workers and laborers affected by Opium use has been prepared on the basis of records available.

Very little effort has been made to systematically identify which are the occupations most affected. Nor has any attempt been made to understand the existing curricula for worker's education or to train the labor welfare departments in organized sector industries where they are statutory available by law with professional staff for counseling therapy etc...

Medical Practitioners approved under the E S I scheme are several thousands and require training in these aspects. Given the law on NDPS, the type of behavioral modifications brought about by heroin use, given the negative image created by media campaigns on addicts, majority of the employers would themselves need orientation and training. Early case finding, peer and union support for treatment, detoxification counseling and re-entry into the work place and after-care (slips, lapses, relapses) are issues to be addressed on a pilot basis to begin with.

Strategy of implementation :

A benchmark survey in a given city through participatory process or trained professionals sensitized to this problem and key workers in factories and workshops and through any other appropriate methodology - identification of most affected industries need to be carried out in the first place.

Through a process of negotiation one or two units of the most affected and the least affected industries should be selected to identify the extent to which and the factors responsible for the spread and non-spread of addictive behaviors will have to be determined.

Again through a process of negotiation and active participation of workers, management and a team of helping profes-sionals; education on the dimensions of drug abuse, provision of treatment for affected workers can be made, involvement of co-workers in after care and re-integration. The Welfare department of the industry, workers education boards and all the other systems concerned with labor welfare industrial safety and productivity need to be trained through properly drawn up manuals so that the existing system can be geared to deal with the problem of drug abuse in the country.

Reaching out to the unorganized sector. In the country only the large/medium industries have a provision of labor welfare and well organized unions - which cover about 18 % of all workers in the country. However as can be seen the pattern of drug abuse cuts across several worker segments - engineering workshops, transport workers, hotel workers and ragpickers. The methodology of reaching out to these segments of workers has to be carefully planned and can constitute a separate exercise through organizations and unions and unions which work among them.

Immediate Objective One:

To integrate alcoholism and drug abuse information, early prevention procedures, case identifications, treatment and reintegration of affected workers as part of the workers education curriculum.

Output	Activities
1.1 Identification of potential resource institutions and individuals for carrying out the project and to develop a working methodology for the organized sector.	Review of Literature on workers education. Personal Visits. A Workshop. A participatory Survey Data collection from
1.2 Specific agencies and industries identified.	key informants Negotiations with Unions and Management.
1.3 Development of a curriculum integrated with the manual on workers health and safety.	Identification of key trainers of trainers, with national outreach.

	Orientation of these key trainers of trainers on all aspects of drug abuse. Production of a manual and teaching aids for trainees. Pre-testing it with a group of trainers. Modification of the same in terms of vocabulary and immediate relevance/to their lives, Predominant substances of abuse.

Immediate Objective Two

To identify those segments of rural/agricultural and tribal workers and workers in the unorganized sector. Who are affected by alcoholism and drug abuse in any significant manner and to understand the socio-cultural-economic situational factors that are responsible for alcoholism and drug abuse.

Output	Activities
2.1 Specific Geographic areas identified.	Review of Gazetteers and other historical and contemporary documents to identify geographic areas/States/U.T.s/Tribal/pockets/unorganized industries. National Conference of organized national unions with outreach to unorganized sector.
2.2 A networked methodology data collection formulated.	- Sampling of areas/industries. - Identification of organizations to undertake filed data collection, Division of labor. - Procedure and tools of data collection.
2.3 Most affected rural unorganized sector labor identified.	- Data Analysis and report production.

2.4 Methodology of reaching the rural/unorganized labor identified.	A working of researchers, workers Education groups, Radio, T.V. teams NGOs of the area/close to the affected labor.
2.5 A program of drug/ alcohol education for the rural/unorganized labor developed.	Selection of three segments of the most affected rural/tribal/urban unorganized labor affected by drug abuse.
2.6 A group of Key trainers trained. A manual produced.	Train a group of key trainers in the unorganized sector on drug abuse, alcoholism. - Through such training material, develop a manual.

PILOT PROJECT NO:03 : INTERGRATED EDUCATIONAL PROGRAM :

Drug education will be a part of the regular curriculum in the educational institutes. The program would be continuous, it can be implemented through presentation on the physiological effects of drugs during lectures on various related subjects in the school.

Since the students are one of the segments of society on whom public resources are spent and much hope is placed. A large number of prevention programs do already target at students. In any case they are a captive audience so long as the heads of institutions permit drug workers to organize programs for them. However quite a few principals have expressed nervousness at the direct drug awareness programs. Their fear is that it might stimulate some of their students to experiment. Though such a position can be disputed there is no clearly thought out scientifically conceived well researched method of student education in the field of drugs.

Some of the drug workers have attempted to incorporate drug education as part of overall personality development courses in which presentations are made to parents of students on "abnormal" child/adolescent behavior and at appropriate moments they incorporate drug related information as well. Such sessions often lead to a good number of parents seeking help.

Thus any such process of student education should make provisions to include information about where and what type of services are available. In those cities, areas, neighborhoods where no such facilities are available such educational processess should not be initiated at all.

In the following paragraphs, it is proposed to incorporate drug abuse messages along with other health messages without expanding already oversized text books.

It is suggested that to begin with such an exercise should be carried out by four institutions, one each in Kerala, Calcutta, Pune and Lucknow or any other Hindi speaking city where Brown Sugar usage has spread. Thus manuals in four different languages can be produced in the next three years.

One can also think of other combination such as incorporating drug abuse and other social problems of national importance through the examination of existing text books.

Any attempt to undertake preventive measures within the educational setting should be preceded by certain steps such as;

- Orientation of the teachers, adminstrators, parents or other responsible individuals to the problem of addiction and its various dimensions.

- Facilitating and formulating a network of professionals working in the field; law enforcement officials, supportive community leaders, interested teachers, other staff and parents.

- the policy of educational institutes towards drug/s of abuse should be evolved

- the decisions on policies should be stated to the students and their support groups before admission

- the policies should consider factors such as; need for treatment, knowledge regarding various treatment approaches available and their constrains, need for professional confidentiality in order facilitate individuals to seek the service provided.It should also state whether involvement of parents in treatment is dependent on the desire of the concerned individuals.

Immediate objective:

To develop a set of graded teacher manuals to assist them to incorporate health messages in the subjects of biology, botany, chemistry, social science, civics and history for students VIth standard upwards and to introduces specifically drug related messages in the tenth standard.

Output

A set of teacher manuals

Activities

- Content analysis of text books in the following subjects, biology, botany, chemistry, social science, civics and history.

- Identifying topics which lend themselves to lead a discussion on health related messages.

- A workshop or consultation meeting between pedagogues, health educators, and community health experts to identify which messages can be built in to the curriculum by way of illustration, anecdotes, tutorials, group discussion, assignments, films, audio-visuals and other teaching aids.

- Production of the manual for one specific class and requisite teaching aids.

- Orientation of a group of selected teachers on how to use the manual.

- Field testing the manual both for its usability by teachers and effectiveness and acceptance of the students.

- Based on the above experience modifying the manual.

- Orientation of teacher training institutions on the appropriate use of the manual for future batches of teachers.

- State level seminars for key teacher trainers in the relevant subjects, who in turn would organize training program for other teachers in their respective districts or towns

PILOT PROJECT NO: 5 : MASS COMMUNICATION

It is evident from the projected and prevelant preventive measures that, professionals from the media tend to concentrate on limited aspects of addiction without placing it within right frame work. This tendency leaves out certain important dimensions of the problem.

Media professionals need to be aware of the probability of adverse effect of preventive measures due to lack of correlation between existing pattern of use/abuse within the community and projected messages. They need to consider the cultural variations when producing audio-visuals which focus on gestures and other forms of non-verbal communications to bring about change, the acknowledgement of their own limitation due to their specific background, the relationship between addiction and other social problems. The need for sensitizing media personnel is further indicated by their professional role of bringing to the notice of the general public the changing trends and other crucial aspects of addiction. They would be a good support system for the community and the marginalised population.

The curriculum would include the following :

History of abuse to mind-altering substances in India.

Steps taken at the international levels and the contribution made by the involved parties in terms of monetary contribution and in any other form.

The norms formulated by the Organizations set up by the United Nations in order to tackle the problem of addiction and drug trade in the developed and developing countries; the focus being the assumptions and the criteria selected in the formulation of norms and their implementation.

Analysis of the problem faced by the UN agencies in terms of their operatonal function and implementation of specified target goals. It will also include the difficulties they faced with their funding governments and other international agencies within and outside the UN system.

Analysis of the international laws against drug abuse, role of the Interpol, national laws, with specific reference to the years where major changes were made and the relation between these changes and cultural factors of our country, international pressure, changing trends in opium cultivation and trade trends in the global market; how they affect the drug abuse pattern in a given country.

A capsule legal and technical course on cannabis and laws pertaining to its control in the countries that cultivate and consume cannabis and those which do not cultivate but consume.

The debate on legalizing drugs and the operant variables that actually pressurize the legislators into making the kind of laws that they enact.

Money laundering techniques and strategies adopted by the international agencies in tracing and prosecuting/confiscating these properties of drug dons.

Investigative skills used by journalists in other parts of the countries in the field of drug trade and abuse reportage.

Developing accountability within the treatment community by objective reporting of their work.

Linkages of social development processes to drug abuse epidemics in different countries with specific focus on India.

Roles of media personnel in the field of drug abuse :
Prevention; mobilization of parents and the opinion leaders of the country and any given community. Lobbying support for the abusers and the treatment professionals for the creation of humane facilities and for the protection of the human rights of the abusers. Making objective appraisal of public policy and programmes funded by the government and NGOs.

Immediate Objective:

To facilitate the role of media personnel in the field of preventive education through sensitizing them to the problem.

OUTPUT	ACTIVITIES
To train the personnel involved in the field of mass communication.	- To identify interested individuals in the field. Selecting from among those who have already published or produced any communication aid in the field. - To conduct a training program for the individuals on drug addiction. - Documentation of the programme inorder to assess modifications required in terms of variables such as culture, history of opium cultivation in India, development processes and how

they interact with drug abuse.

- Evaluation of the effectiveness of the measures and the concepts selected by involving addicts as the part of the of the evaluation team.

- Production of a training manual in selected languages

ANNEXURE

TWO STATE LEVEL CASE STUDIES

A.Drug Abuse in Karnataka

SPARC-HOPE study (1988) indicates the following:

1. Drug abuse has a varied pattern in Karnataka. Alcohol, cannabis, heroin/brown sugar, cocaine, dexedrine, calmpose and petroleum were substances abuse in the different towns of the State.

2. Ganja had been seized from ten cities/towns:

   Hassan, Davangere, Manipal, Raichur, Kolar, Mysore, Chickmaglore, Karwar, Belgaum and Mandya. Ninety four persons have been arrested in this regard. However, the police have often prosecuted the offenders under the Customs Act, indicating the need to provide adequate information to the police on the NDPS Act.

3. Brown Sugar abuse has been seen in the following places:

   Mysore, Mangalore, Manipal, Davangere, Needless to point out Bangalore has brown sugar. Tumkur was also mentioned by a respondent.

   The inquiry indicated that brown sugar had not percolated to all parts of Karnataka. It appears to have two nodal points:

   Bangalore and Mangalore with the following configuration: Bangalore-Tumkur-Mysore and Mangalore-Manipal. De-addiction centres or facilities for drug addicts such as counseling services should be optimally located in Bangalore and Mangalore.

4. In Karnataka, there appears to be a link between centres of education and drug abuse. Bangalore, Mysore, Manipal are educational centres and they show brown sugar abuse. Manipal is a small town about 36 institutions educating 18,500 students annually. In the last four decades, 50,750 students have passed out (4400 engineers; 4700 doctors; 600 dental surgeons and 950 pharmacy graduates. The annual salaries of the teaching staff alone is 4.67 crores; and the assets of the institutions at current market value is over 100 crores.

Drug abuse in Kerala

Likewise, another rapid study carried out by HOPE in collaboration with SPARC in 21 towns of Kerala brought out the following pattern of drug abuse in that State.

Main Findings:

1. Brown sugar was either seized or media reports were obtained or brown sugar abusers were interviewed or were treated in the following towns: Trivandrum, Idikki, Malappuram, Quilon, Cochin, Calicut, Alleppey, Ernakulam, Tellichery, Kottayam, Palghat, Cannanore, Kovalam and Kasargod.

2. As per the Police and Customs data made available in 13 towns (for the period January 1988-May, 1989) 662 raids were conducted in which 293 persons were arrested and 2019.711 Kgs of Ganja was seized. Though brown sugar was also seized, the exact quantity was not always specified in the data provided to the present researchers. Likewise, the quantity seized in the case of opium and charas is also not specified in some of the districts and so totalling was not possible.

3. The following substances were abused in the towns studied:
Alcohol, Ganja, Charas, Pethidin, Morphine, Fortwin, Calmpose, Opium, Brown sugar and White herion.
A case of 'Snake-bite' addiction was reported in the district of Pathanamthitta.

4. Hospital data available to us did not often discriminate between alcoholics and addicts treated. Trivandrum General Hospital for instance, treated 1006 patients of substance abuse in the year 1988-89. While the Trivandrum Hospital records did not distinguish between alcoholics and drug abusers, hospitals in other towns listed below did not have breakdown of patients treated for other drugs such as ganja/charas, opium, brown sugar, morphine, and pethidine. The statistics: Alleppey - 36, Malappuram - 33, Kottayam - 56, Calicut - 99, Iddiki - 20, Cannanore - 3, Palghat - 15.

5. Eleven specialized centres/NGOs working with addicts have treated in two years a total of 855 patients.

6. The psychiatrists interviewed were asked to rank the drugs of abuse among their patients on a scale of 0-10 points. The average weightage by the respondents is given in the Table below:

Alcohol: 10.00, Ganja/Charas: 7.00, Calmpose/Valium: 4.00, Brown Sugar/heroin: 3.00, Pethidine/Fortwin: 1.75 and Opium: 1.00.

Thus according to the psychiatrists interviewed for this study, alcohol is the most abused drug in Kerala, following closely by Ganja. Interestingly, it is the introgenic form of addiction that ranks the third (including calmpose/valium/pethidine/fortwin) with a score of 3.75. The professionals need to examine their practice.

ANNEXE II

The "high-risk Population":

The media has to recognize that certain categories of youth are vulnerable to drug abuse:

a. Educated but unemployed youth.

b. Youth employed in weary jobs or those employed in polluted environs (porters, conservancy staff...).

c. Youngsters who began smoking cigarettes and beedies in childhood.

d. Youngsters with a petty criminal record.

e. Youth with low stress-management skills and low self-esteem.

f. Youth who have an alcoholic or absentee father or a father with a criminal record or youth who have lost their father in their childhood.

g. Youth who had a surfeit of pleasures, drifting through life without having to worry about money and without any meaningful pursuit in life.

The costs of addiction:

Media should highlight the economic, social and personal costs of addiction.

Economic loss:

Economic loss is very apparent when we note that:

a. The money spent on buying drugs ranges from Rs. 3/- to 500/- per day per user. The value of drugs consumed in Bombay alone would be between Rs. 179 - 300 crores if there are one lakh addicts in the city.

b. The money spent on detoxification and other medical costs for example: 50 percent of the 178 addicts interviewed in Delhi had incurred a per annum private expenditure of about Rs. 5,300/- for medical services.

c. Most addicts drop out of education leading to lowered returns in the labour markets than what they might get had they completed their courses. Most employed addicts lose their

jobs; alternatively they slide from permanent/secure jobs to temporary ones or to casual or become self employed and end up unemployed. Staying in addiction for several years makes some of them unemployable as well.

The opportunity costs lost to addiction cannot be easily calculated.

Social and personal costs:

a. Breakdown of the family.

b. Erosion of values or the absorption of the subculture of addicted peers and onset of psychopathology.

c. Loss of self-confidence, self esteem due to public ignominy following arrests, non repayment of loans taken etc.

d. A host of respiratory and other illnesses such as Eczema, anemia, mental illness (psychosis, depression) suicidal attempts and suicides.

e. Wholesale dehumanization.

Counselling in India

A Status Paper with Outlines for Pilot Experimental Projects

National Addiction Research Centre
5 Bhardawadi Hospital
Bhardawadi Road
Andheri West
Bombay 400 058

State of the Art

The role of therapy as an intervention programme has not established its utility in isolation, for the process of social reintegration. Inspite of adhering to various schools of thought in the field of mental health, developed countries have yet to identify relevant schools in dealing with addictive behaviour, to the extent of making the individual functional for his own satisfaction. The dynamics of addiction counselling have yet to be perceived as relevant for further analysis and in-depth thinking.

Demand reduction continuum, of which therapeutic intervention is a part, would be effective only if the activities undertaken are related to cultural variations and implemented through networking with organisations involved in dealing with other aspects of the malaise of a given social milieu.

In a developing country, the number of therapists are few and only a handful of them are interested in working in the field of addiction. Professionals who enter this field come from the fields of social work and mental health. There is a group of commited people who in spite of lack of theoretical knowledge, participate in demand reduction activities for personal reasons and have developed their own methodology for dealing with addiction. Their methodology tends to be based on their personal charisma, their relationship with the target population and their philosophy of life.

Under the circumstances one has to focus on the existing pattern of intervention, its merits and drawbacks, on-going pilot projects, dynamics of addiction counselling, lacunae and future steps to be taken.

Counselling in India

General trends of the counselling processes used in India were analysed through documented case studies of psychotherapists and psychiatrists in Bombay, Pune, Goa, Vellore and Delhi and through workshops conducted by SPARC in Bombay and Madras.

The trends that came to the forefront call for further discussion in order to refine these therapeutic interventions.

In certain cases, it is apparent that the individual is brought for treatment by concerned family members who consider his addiction to be problematic behavior.Under these circumstance the rationale for setting drug-free life as the goal becomes questionable.

Counselors have not developed a methodology for dealing with the inadequate motivation of addicts to give up drugs or to become socially functional by appropriate strategies of life management. Most counsellors emphasise level of motivation and assess it based on subjective criteria, but consider it irrelevant when dealing with other health problems.

The probability of impact of any intervention based on psychological aspects tend to be handicapped in the absence of other support groups within the immediate community and society at large. The alienation of the target population due to adverse prevention would be rectified through involvement of therapists with organisations undertaking prevention or by the process of networking.

In certain parts of the country the problem has been ignored for political reasons. The lack of intervention for long period of time and the resultant spread of the problem makes counselling in isolation an important technicque satisfactory to the extent of attempting to be concerned to avoid bringing the drastic differences to the fore front. In these parts any concerned individual would facilitate and orient other relevant persons in the community to deal with the problem.

Goals of counselling

Analysis of the case studies of various counsellors in the field that were documented by SPARC raises several issues about the state of the art.

One fact that stand out is that the goal/s of counseling are always decided by the therapist or the center.

The following have emerged as the broad areas of concern in counseling drug addicts i.e. developing skills in addicts:

To be drug free
To make decisions
To handle stress (death, failures...)
To develop a positive integrated view of life, of one's own place in his social network of relationship... (raison d'etre)
To relax, to attain mental control, to assert oneself, to progressively bring the focus of control of one's living to the inner self.
To re-enter academic or employment streams.
To re-build relationships with family members, with his non-addicted former friends...
To deal with all the events(crimes,misdeeds,misdemeanors) committed at the time of addiction.
To develop a non-escapist attitude to reality, and to promote the addict to grapple with the reality of his life and his environment.
To acquire a pragmatic attitude towards money.
To learn to internalize certain minimum norms, lest he gets into more frustrating situations particularly in dealing with the law and the police.

However, Counseling of addicts occurs in different settings in India and so the specific objectives of counselors is also circumscribed by the setting and policies of the agency. For example, in day care centres, and half-way homes, the goals of counseling addicts are somewhat specific as can be seen from the following illustration:

It appears that the causes for addiction as perceived by the counselor are dependent on their own education/specialization and are not person-specific. Thus, a clinical psychologist is likely to cite malfunctioning of the ego as the cause of addiction in over 70 % of her/his patients; while another counselor with some training in T.A. is likely to cite intra-familial dynamics. Thus their approach to therapy is based on their school of thought or training. Each person is unique and so counseling cannot be done according to some pre-meditated causation and pre-packaged sets of interventions.

The causes stated by professionals are:

faulty communication pattern in the family
absent father figure
unemployment
academic failure
traumatic experiences
sexual problems and
financial crisis etc

Given the above brief account of the type generic parameters propounded in various handbooks of addiction counseling, one wonders whether even these guidelines are adequate to deal with the problem of drug abuse in India. In the following paragraphs, some of the drawbacks of the contemporary counseling practices are outlined in order to argue a case for setting up pilot experimental projects in psychotherapy for addicts.

However, it is most important to identify the roles and functions being performed by counselors in this field today and to identify those roles which can be routinized, simplified and delegated to the volunteers. (SPARC has begun a small study on the subject).

It is evident that a majority of heroin addicts have relapsed even after a year-long counseling process with frequent hospitalization and rehabilitation either at a residential center or as outpatients. Even change of environment has not prevented relapse.

Professionals also fail to distinguish between slip, lapse, relapse and readdiction and thus apply the term relapse to an individual who has slipped even once. This confussion of preception might result in a slip actually becoming relapse or readdiction.

We need to set up a concerted search among practitioners to identify those aspects of counseling heroin addicts which are specifically different from general counseling processes and to generate an indigenous body of knowledge in this specialized area of intervention.

Some counselors focus on specific areas of counseling such as spouses of addicts, some have moved from family therapy to community counseling, some of them have sharpened their practice of group therapy with addicts, rely on religion as a strong supportive element in counseling, while some focus on coping mechanisms others on environmental manipulation.

Some counselors have developed comprehensive systems of counseling processes, with their own philosophies, principles, strategies, and caveats.

Thus counseling requirements will have to be varied and will have to be segment specific and person specific.

India is a vast country with a complex matrix of drugs of abuse. It is logical to assume that users of cannabis, have to be treated differently from users of opium, or from heroin addicts.

The principles of counseling the mentally ill who have a concurrent drug problem would have to be distinct from counseling women addicted to painkillers and obesity control tablets.

Similarly, children who inhalec rubber solution or petroleum fumes need different type of assistance.

In India, we have addicts who are well placed in terms of employment and those who are sliding from good jobs into less paying, less secure and less respected jobs to utter under-employment, unemployment and unemployability. Some move from being self employed to penury.

We also have student addicts, drop outs, and addicts who have never entered the portals of an educational institution.

As can be seen from the background of the addicts, atleast sixty per cent of them cannot speak English, whereas most college education in psychology and counseling/psychotherapy is in English. Very little work has been done to develop indigenous vocabulary of the terms used in the therapy process in the Indian languages. A good number of addiction therapists cannot even speak local languages properly, so the probability of them effectively counseling addicts who come from non-english speaking categories of the population is very low. Thus there is a need to develop the recording of counseling processes recording in different settings in the country and to evaluate which aspects of the present day practice need modification.

Besides, the bulk of counselors come from the middle income or upper classes whereas atleast fifty per cent of addicts come from low income groups. The critical variables between the therapists and their clients and how they affect the therapy process has to be examined in a scientific manner.

Methodology utilised

The counselling process in India tends to fall under two major categories; individual counselling, group therapy and family therapy.

Individual Counselling:

The bulk of theoretical assumptions of the various schools of psychotherapy/counseling/social case work are based on western philosophies and are a product of the social systems where they were born. For instance, the concept of individual autonomy has much value for children in western society and the earlier the child becomes economically and emotionally is dependent of

his/her parents, the more social acceptance is indicated. Each one is encouraged to assert their personal objectives and to achieve them. Whereas in our society, a good number of us would make a decision only after taking into consideration the good of the whole family. These and other cultural variables which are characteristic of developing or developed nations will impinge on counseling practice. One counselor, for instance, points out that though the principle of acceptance is a universal requirement in all therapeutic interactions, counselors tend to take on a "Parental" role when they work with addicts. Some others indicate certain guidelines for dealing with a client who enjoys being on heroin and who has no motivation to quit except for the fact that his mother is suffering.

In India, we have never had welfare system in classical sense of the term. It has become clear that on a one-to-one basis, not more than 50-100 addicts can be helped by a single experienced counselor in one year.

Most the developed countries have a large network of social security systems and functionaries to carry out individual counseling. In a small province in Canada, the government alone employes over four thousand counselors/case workers to administer the official welfare system. Since the rise of the Reagan variety of conservative right-wing politics in the developed countries of the world, there has been a systematic campaign to undo the welfare system of the Beveridge model and a massive theoretical debate has ensued to de-legitimize the welfare system itself. Welfare state as a concept is dying and what is happening there is a search for practical methods to remove the functions of the thousands of employees who ran this mechanism for years.

The general thrust in these countries is to develop self help groups and to generally transfer the responsibility for the care of citizens onto the citizens themselves with nothing but a modicum of support services.

Since drug counseling is a nascent subject and since few of us have had the resources to conduct longitudinal research, it is somewhat premature to make any categorical statements. Only hard empirical data generated by action-research in all types of settings and with varied clients can provide a concrete background.

In India, we have not even asked the question whether counseling can bring about any change in addicts. We have assumed that one-to-one counseling services can be provided to all addicts, without even considering the costs, training and support services required.

The methodology of follow up is limited to postcards, lack of adequate staff was the reason for adapting this approach.

Group Therapy :

In the face of the large number of addicts and the paucity of counselors, another approach is group therapy, in which a group of 20 addicts can be simultaneously reached by a single therapist.

Group counseling is still not a popular form of assistance, for example, in centers in Calcutta. In Bombay, Bhatia and Cooper Hospitals used to offer group therapy but it has been discontinued due to staff turn over. KEM Hospital and the YWCA day care center in Bombay and Asha Bhavan in Goa offer group therapy.

Each group therapy session involvesnot more than twenty individuals. The sessions consist of individual sharing, dealing with specific experiences prior to addiction and vurnerable situation after addiction and written assignments.In the group situation each individual gets support from the other members, who also play a crucial role in makeing critical evaluations of the experiences and responses of the individual to attain the set goal of drug free existence.

The probbable grey areas in group therapy are : the problems of handling individuals from different walks of life at the same time; dealing with language, religious and cultural barriers; and the cost -effectiveness and utility of it to deal with behaviour adaptation acceptance of reality. At times there would be a need for individual counselling or therapy to tackle in-depth aspects of an individuals life that cannot be tackled in a group situation.

An analysis of case studies of counseling addicts drawn from counselors in different parts of the country indicates the need to clarify and systematize counseling practices with addicts. This would facilitate the analysis of counselling nuances that are culture specific and viable in terms of different dynamics of counselling determined by socio-economic and political circumstances.

Family Therapy

The methodology is based on the assumption that abuse is the result of the contribution of the family as a ssystem. The problem has to be tackled at that level and not be limited to the individual. Professionals go to the extreme of refuseing to take on individuals unless the family takes part in the therapeutic process.

This intervention would be irrelevant for street addicts who never had a family to play a role in their lives.

ONGOING PROJECTS:

Keeping the above factors in mind, the following project proposals have been made for co-funding by the UNFDAC for the Ministry of Welfare to launch and develop a coherent program which can atleast do as well as any other country's programs towards demand reduction.

In this context, what is needed in India is a set of pilot experimental projects to develop appropriate manuals for case work. Towards this end, under the UNFDAC-GOI-Ministry of Welfare projects, the consultant has prepared two projects.

Developing a counseling manual for rural heroin addicts in Uttar Pradesh. The purpose of such a project is to develop appropriate counseling vocabulary meaningful for the rural addicted youth. The bulk of counseling courses are in English since no effort has been made to develop a glossary of technical words in Hindi and their applicability to illiterate\semi literate youth in limited. This project would also help to clarify the doubts of rural youth as expressed in counseling sessions, the patterns of non-verbal communication adopted by rural youth and their meaning, their defense mechanisms with counselors, the types of transference/counter transference that occur in the helping process and their insecurity, societal rejection and the type of legal problems that arise in a rural context in the field of addiction, and also throw light on several issues on the concept and practice of counseling addicts in India.

Though the manual being produced as a result of a two year supervised counseling in Varanasi would be relevant for the Hindi belt, it would also throw light on the modalities of developing manuals in other languages.

Similarly in the ICE project in Delhi, another handbook is sought to be developed for counseling addicts drawing upon the practical experience of counselors with expert assistance/ supervision/ conceptualization. Here, the addicts who come for treatment are college -going youth as well as slum youth. There is a mixture of patients, same who are new migrants with the cultural baggage of their place of birth, and those born and broughtup in Delhi. Delhi being highly cosmopolitan with population drawn from all parts of India, the critical variables specifically hinging upon our mores and customs as they affect the counseling process can be identified.

However, in neither project have we suggested any particular school of psychotherapy to be adopted, tested, modified to suit Indian conditions. These two manuals are only expected to indicate the rural/urban differentials in counseling addicts and the cultural constraints in the choice of strategies/techniques effective in our context.

In the view of leading rigorous practitioners, general counseling practice of the pastoral type is of little practical value in assisting addicts. There are over two hundred schools in psychotherapy some of which have their own sub-schools. We recommend the practitioners to read the list of psychotherapies and examine them as to their suitability to the field of drug abuse.

SPARC has identified one such therapy which itself has over twenty variations in practice in the West.

Brief Therapy Models :

The fact that a large city like Bombay does not have more than 30 counselors goes against the possibility of offering long term psychotherapy. The options are to leave a large number of addicts to their own devices or to evolve brief intervention models.

SPARC has slated a series of training workshops on brief family therapy with drug addicts. These workshops have been conducted by experts drawn from within and outside the country. An experimental center has been set up to try out this model. Though it lacks certain equipment for recording and transcribing/viewing for supervisory purposes, it is being recorded manually and will also be rigorously evaluated by a third party for its applicability in the Indian context, specially amongst the poor.

Such experiments are far too few in the face of the enormous problem that the country faces. The Ministry of Welfare and the Ministry of Health need to entrust this task of experimentation in different parts of the country to NGOs and government centers.

Dynamics of addiction counseling :

1. Practical drug concepts
2. Social sanction and pattern of use
3. Interventions
4. Role of support groups
5. Goals of counselling
6. follow-up programme

Practical Drug Concepts

The definition and preconceptions of drugs and related addiction defines the goals and methodology of counselling. Awareness of the effects of drugs defines the perception and perspective of abuse/use.

There is no such thing as a single effect of any drug. All drugs have multiple effects and these vary from dose level to dose level, from individual to individual, from time to time, and from setting to setting in the same individual. Drug effects are a function of the interaction between the drug and the individual defined physio-logically, psychologically and socially.

When one considers the use of the term drug abuse, one should keep in mind the definition of the word drug. Also one should keep in mind effective dose, toxic dose, lethal dose, feelings, moods, perceptions, pharmacological effects, tolerance, legal versus illegal use, physical dependence and psychological dependence.

Considerable confusion exists regarding the meaning of "Drugs", "Drug Abuse" and related terms in the field of "Addiction".

Because of the confusion, any effort to communicate more effectively should avoid traditional labels and use more descriptive phrases. This is stated for two major reasons:

a) To separate scientific facts, which are the same across cultures and national boundaries, from value judgments, which are highly culture relevant and often culture-specific, and

b) To try to establish a common ground for discussion across cultures and across languages.

Such definitions will themselves be controversial for, in areas where belief, values and feelings are strong, neutral terms seem

to be almost a denial of these beliefs. Values, beliefs and feelings are important. Without them, life would be empty and meaningless, but they must be considered separate from drugs which are pharmacological agents, and from the actions of drugs. Their supposed reasons for using them determine the nature and extent of their responses more than the substances consumed.

Social Sanctions and Patern of use:

Pattern of use is related to sanctions through culture, religion, climate, economic status and social control.
Thus a familiar practice due to extensive use has to be viewed by the affected population as a problem to be dealt with, as in the case of the use of opium among the people of Rajasthan, especially the farm laborers, to increase their work potential and to deal with stress or to celebrate social events..

The accepted consumption of Bhang in different parts of the country especially on certain occassions and the use of ganja by certain segments of society such as the sanyasinys, labourers, upper class etc. are again a case in point. This behaviour when termed or viewed as anti-social tend to enchance the chances of substitution by synthetic drugs and to alienate it from social controll. This would be inevitable in the absence of other ways and means to deal with life and philosophy of existence.

In certain parts of the country opium is used for its medicinal value, especially amongst certain tribes. The decision to tackle addiction would be irrelevant as their need to it can be considered essential.

Occasional use of stimulants by students in order to stay awake to study for an examination or to finish a term paper, the abuse of tanquilizers by middle aged women which starts with prescribtions are, other areas of addiction to mind altering substances which bring to light humanity's dependence on certain substances for dealing with and continuing the life cycle.

In other cases, the problem status of a particular kind of drug use represents the emergence of particular patterns of use in new segments of the population, notably the youth (in contrast to adults) and in groups other than the lower classes and minorities.

The existent patterns of use through planned marketing strategy becomes a platform for individuals with vested interests to market synthetic forms of drugs.

The counselling aimed at a fanatic clubbing together of different drugs might become a hinderance. And the perceived graduation process tends to aggravate the chances of slips leading to relapses with regard to synthetic drugs.

In still other cases, as a result of instant communication among the nations of the world, the problem prevalent in other countries is perceived as a threat that will occur at home in the near future. For instance, cocaine is prevalent in the USA and other countries of the Northern hemisphere. A good number of demand reduction activities in India incorporate cocaine although cocaine is involved in less than one in a thousand instances of addiction.

Whatever the case, a problem is perceived and a solution is sought. Many initial responses are hasty, often emotional or irrational, imitative and seldom either wise or productive.

Effective problem solving requires careful definition of the problem (in descriptive rather than conclusive terms), evaluation of the methods utilized, fields and strategies relevant to the problem stated, and constant evaluation of progress, identification of errors, and willingness to opt for new approaches when old ones fail. Drug problems have been so ill-defined, in such global and value-laden terms, that it is little wonder that disagreements and controversy prevail. The problem must be defined in objective, descriptive terms: who is using what substances with what frequency and for what reasons?

There are three basic elements in the use of any drug, licit or illicit, medical or non-medical use:

a) the substance, b) the individual who uses it, and
c) the social and cultural context in which the use occurs.

Any approach to deal with the problem must take into account all three factors. An action based exclusively on one will probably fail.

Each element is complex; the relative degree of complexity with which each is perceived usually depends on experience, background, training and personal or professional interests of the viewer.

Interventions perceived and undertaken:

The analysis of various case studies of counsellors bring forth the tendency for selective perception of caustory factors and uniform utilisation of the same methodollogy or strategy of intervention.

The result being a co-dependent therapist, stagnated approaches and clubbing together of the target population.

The intervention required during pre and post treatment is varied and its mergence leads to the emmergence of further confusion and inappropriate preparation of the individual to deal with society.

Any training process for counselors in the field of addiction should also incorporate information on the legal implications of drug use and abuse. This important factor tends to be neglected by counsellors, due to ignorance, lack of emphasis and selective perception.

Role of Support Groups:

We need to develop training packages to orient trainers in the State/Central Health Education Bureau; the NSS State level coordinators; the Military & Police training centers, the Workers Education Boards; trade unions ,the personnel departments in all industries, community workers and immediate support groups.

Day Care centre

In Bombay, the YWCA day care center provides individual counseling to prepare the addicts to go in for detoxification and rehabilitation. They also act as a half way home for persons who come out of the rehabilitation center after six months of staying away from normal social life. In this context counseling has certain specific objectives, such as :

- helping the addict to strengthen his motivation to enter detoxification and treatment.

- helping him to make concrete plans of how he will deal with his former addicted colleagues.

- how to deal with associational memories, and situational factors that might be conducive to relapse.

- how to deal with nagging and continuous reminders of the fact that he had been on drugs. Lingering suspicion by other his rectitude in handling money and their hesitancy in giving him responsibilities. Family members often do not realize that their gestures and attitudes may not be helpful to recovery. The addict has to develop skills to deal with these situations and not lose his equilibrium and equanimity.

- the etiology of drug abuse often has inter-sibling status discrepancy and family-pathology. If the family pathology has not been handled by the therapist through family therapy, then the addict has to be prepared to gain an insight into the family dynamics and learn not to take a self destructive stance while dealing with his pathological family setting.

- addicts often tend to develop depression/suicidal tendencies in the period of recovery. They also tend to become anxious and disturbed at rather innocuous comments and gestures and actions of people close to them. Helping addicts at such moments entails being available to them, reassuring them, clarifying issues that are immediate problems and, where suicidal tendencies are perceived, inducting professional help.

Half-way Home

The purpose of these half way homes and follow up programs are to help the addicts to a gradual re-entry into society. These day care centers provide a drug free atmosphere during the day and have prayer, group discussions T.A. sessions in the company of recovering or ex-addicts. They also have games, reading material and referral services. One such center in Calcutta (Antara Drug Center) includeds occupational therapy-candle making, carpentry etc. Half way Homes help the addicts in their transition from the totally sheltered atmosphere of the rehabilitation centers to a vulnerable life in the open community. Arunoday Midway Home performs such a function together with rehabilitation.

Counseling Centers :

Here again one finds professionals offering psychotherapy, psycho-analysis, family therapy and group therapy both in the non-profit and commercial setting as well as in the Public Sector.

The Ministry of Welfare has funded 86 counseling centres. Practically none of these has a community base; nor do they have an outreach program.

Hospital administrators are yet to issue circulars to social workers and clinical psychologists and psychotherapists stating that house-calls to the homes of addicts to meet their parents and for the collection of detailed background information requisite for treatment is a permitted expenditure. In the absence of such support, follow up and involvement of the relatives, friends and neighbours for the recovery of the addict is not possible.

The concept of preventive counselling would be relevant as a demand reduction activity for youth. The establishment of counselling centres within educational institutes or their envirans areas would increase their utility.

In two workshops conducted by SPARC, participants stressed certain issues in setting up addiction counseling centers for students in colleges. They felt that a cluster of colleges in a given area should pool money to set up a common center for career guidance, counseling and crisis intervention for their students. They also felt that the counselors and the records should be out of bounds for principals and the teaching faculty.

Other dimensions of setting up these centres and precautions required were high lighted through prior attempts.

The experiment of setting up a separate center for women addicts in Goa has a lesson for administrators. Not more than two women addicts sought admission in this center at any given time and so the center was converted into a center for male addicts.

It appears that due to the overwhelming stigma attached to female-addiction, it is not advisable to set up centers with such obvious names. It would be better to start centers for "women in crisis", network with other organizations working with women and train/orient the staff of women's organizations to the phenomenon of addiction among women. Women's crisis centers should have specialized facilities for female addicts while they would also attend to other problems.

The centre was converted to cater to male addicts. Subsequently, realizing the need to give occupational training to recovering addicts, this center was converted into a work center where addicts coming out of another center were admitted for occupational training.

Follow-up Programme

In the field of addiction any intervention undertaken has to involve follow-up programmes for identification of lacunae, modification required and documentation for assessment of

utility.

At present in India the follow-up programmes are limited to post cards, involvement in self-help groups and regular visits to the centre.

There is a need for systematic documentation of the follow-up programmes undertaken. This concept can be facilitated through the establishment of a group of objective and committed individuals who besides assessing the lacunae of the present interventions will undertake the responsilbilty of implementing follow-up programmes.

Lacunae

Interventions made:

The guesstimates of journalists and professionals regarding the number of abusers tend to be exagerated for obtaining funds and supporting organisations catering to their vested interests. But the existent methodology of approach would be inappropriate for tackling 1/4 of the guesstimated population. Hence there is a need for identifying the requirements of tackling addiction besides counselling.

1. The need for drop-in centres that can provide a drug milleu after detoxification.

2. The need for drop-in centres that can facilitate the probability of interupting the stereotyped behaviour pattern of addicts.

3. The need for night-shelter to cater to the individuals from the lower strata, to identify critical cases of the poor/ street addicts for providing immediate medical attention and to identify new cases inorder to provide treatment before further complications.

4. The need for community based counselling centres which can tackle the drawbacks of centres situated in areas away from the affected population, the lack of support groups for facilitating the rehabilitation process and creating a probability for emergence of para professionals through the involvement of community workers and other interested indiyiduals.

5. Trained persons in different schools of therapy after they it have been evaluated through pilot projects under the consultancy of international therapists.

6. Facilitating the creation of courses within accademic institutes that are practice oriented.

7. The need for systematic follow-up programmes inorder to assess and modify the therapeutic interventions made.

Future Needs

Training :

While each patient is unique and while counseling is person specific, common parameters/characteristics exist without which counseling would remain an art restricted a few practitioners. Building up knowledge and skills in any field begins with case studies which yield working hypotheses for further testing/ acceptance/rejection/ validation. In India, we do have a few counselors who have developed personal insights and skills with addicts. About two hundred case studies have been documented by SPARC, based on the work of fifteen counselors drawn from Delhi, Bombay, Coimbatore and Pune.

In the field there also exist individuals who over the years have developed their own methodology of work, but might be hampered due to lack of futher information on various other therapeutic technique that can enhance their approach and also realise the merits of critical evaluation of their methodology for refinement. Training programs for these individuals would be crucial for developing the state of the art in our country.

Identification of relevant schools from the existeing number of innovative psychotherapies would take us a step further in dealing with the problem. This would involve the training of consellors in specific schools that would be useful and their subsequent evaluation in terms of their utility for various target populations and cost-effectiveness. Subsequent training of others in the field with emphasis on to modifying the techniques to suit the cultural requirement for its effectiveness as a tool.

The need for creating practice - oriented training courses in therapy that can be intergrated with relevant accademic fields or provided as seperate courses for interested individuals exists.

The SPARC - SNDT workshop was organized to articulate what is involved in counseling drug addicts. The UGC in collaboration with the Association of Schools of Social Work organized a series of workshops through Jamia Millia Islamia college of social work and Madurai School of social work to develop a curriculum for training counselors in the field of drug abuse. The Ministry of Welfare invited the Christian Counseling Center which has no exposure or experience in the field of drugs, being situated in a remote village in Tamilnadu, to evolve a curriculum for training addiction counselors.

The problem of heroin addiction is rather new to India and so there are very few practitioners in the country with practical experience in working with addicts,while the demand on the therapists has been heavy. A considerable amount of the time of practitioners is spent on fund-raising and routine administration. In the absence of a systematized, communicable body of knowledge, the new professionals in the field have to develop their own, a method which is workable to the Indian conditions often through trial and error.

What is needed is a network plan to develop a cadre of counselors b re-training interested professionals and training volunteers selecte from both middle and working classes and ex-addicts.

Little effort has been made to identify the process of counseling specific to addicts. There are well over two hundred schools of psychotherapy. In India, only two or three organizations use any systematized model. Most practitioners claim to use eclectic model drawing from different schools.

However, no one has tested which aspects of the amorphous eclectic system works with drug addicts and which dimensions do not work.

PROPOSED PILOT EXPERIMENTAL PROJECTS IN COUNSELING ADDICTS

PROJECT NO: 01 : BRIEF STRATEGIC FAMILY THERAPY

Brief Therapy (BT) had its origins in the work of Erickson who was a pioneer in using the clients resistances in a positive and effective manner. Jay Haley, a master in the use of paradoxical techniques in strategic family therapy, widened the scope of Brief Therapy.

Brief Strategic Family Therapy (BSFT) focuses on solving the clients presenting problem within the framework of the family. This is in keeping with the two basic assumptions about the nature of families in the BSFT model, which are:

i) the family and its members are a system, and

ii) the family interaction occur in typical patterns called.

Structures:

A family presents one member as the "problem" or the "sick" one. This person is referred to as the Identified Patient (IP). The family's expectations of therapy is that the IP needs to be changed. The BSFT therapist however, recognizes that, although one of the members manifests some symptom (drug abuse, psychotic behavior etc.) these symptoms are maintained because the entire family participates in mal-adaptive patterns of interaction. Therefore, the treatment targets the family as a whole, rather than focusing on individual behavior in isolation.

A family tends to repeat typical interactions among its members, forming typical behavior patterns. These typical or habitual patterns of interaction define a family's structural organization. A dysfunction results when the family attempts to resolve a problem applying a mal-adaptive pattern of interaction. That is, when a problem arises, the family responds with a particular set of interactions, not because it will be effective in resolving the problem, but because that particular type of interaction has become habitual. The purpose of therapy is to facilitate new patterns of interaction which resolve problems effectively; i.e. to change the family structure.

BSFT is strategic i.e. problem focused and pragmatic. A "problem" is defined as " a type of behavior that is part of acts between several people". (Haley) The first task of the therapist is to redefine the presenting problem in such a way that it can be solved. Successful redefining or reframing, as it is called,

lifts the problem out of the "symptom" frame and into another frame, that does not carry the implication of immutability. While reframing, the therapist doesn't just pin on any other frame, but takes into account the conceptual framework of those whose problems are to be changed, i.e. he reframes the problem in their language.

Most often, during the therapist's attempts to create this new problem and solve it, changes occur in the interaction, that subsequently lead to the solution of the problem originally presented by the family.

It is possible to accomplish BSFT goals (i.e. reduction of drug abuse or symptoms, and improved functioning of the whole family) while working primarily with one person in therapy. This is called One Person Family Therapy (OPFT). This can be accomplished, based on the assumption that if the behavior of one person in a family changes, then the other family members also have to change their behavior. They will have to change because " if a system is to maintain itself and its typical patterns of behavior, the behavior of each member must co-ordinate with, be maintained by, and be contingent on the behavior of each and every one of the family member."

BSFT is present and future oriented. The goal is not the exploration of the past, but rather the manipulation of the present, as a tool for change (Minuchin).

BSFT is time limited, with approximately 12 to 15 weekly sessions. This is made possible by the therapeutic strategies employed which are:

i) The use of Joining, for entering the family system in a manner designed to avoid systemic resistance to change. Once the therapist has successfully joined the family system, he quickly establishes a leadership position to bring about change.

ii) He then diagnoses the family structures based on interactions that occur in his presence. After this assessment is done, he plans a series of interventions that are strategically designed to restructure dysfunctional patterns of interaction.

This planning focuses the therapeutic process thereby shortening it.

Immediate Objective :

To develop alternative forms of psychotherapies to tackle the problem of addiction.

Output	Activities
Professional trained in various innovative forms of psycho-therapies.	- Analysis of the existing psycho-therapies and their drawbacks. - Analysis of culture of the community earlier forms of help therapies that existed.

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PROJECT : 05 :DEVELOPMENT OF TREATMENT ZONES

Immediate Objective:
To facilitate the emergence of treatment zones in areas which are highly affected.

Output	Activities
Treatment Zones	- Identification of highly affected areas in the given city/community. - interviewing addicts in their dens and establishing a rapport. - identifying their needs for treatment, recreation, environmental change. - Providing detoxification facilities in their dens - Providing recreational facilities - Providing opportunities for alternate life styles for those who want. - involvement in community projects. - maintenance of their area localities. - setting up a library - setting up a night shelter - alternate occupation - Assessing after a period the extent of involvement in treatment and activities chosen by the target population. - Providing an opportunity for individuals to learn skills required to exist in the society. - Doing a follow up study to assess the no. of individuals who have given up addiction, who have slipped, relapsed and those whose life-styles have not changed. - further analysis, through interviews of individuals who have remained aloof. - Collecting their views, reasons. - Modification of the methodology of intervention made. - facilitating the affected population to handle the operational details of the zones.

- Providing information on treatment to the affected population or friend of affected population.

- Lobbying for more treatment facilities at low cost.

- Lobbying for facilities for re-integration of addicts.

- Tackling the stigma attached to addiction.

- Facilitating reintegration of addicts.

- Analyze the hazards faced during the process of providing preventive measures.

- Documentation of whole process.

- Training of other women s organizations by the trained persons.

Immediate Objective :

To facilitate the process of re-integration of the addicts into the community to their advantage.

OUTPUT	ACTIVITIES
Development of a manual of guidelines for establishing a drop-in center.	- Analysis of the existing facilities for recreation, personal development and vocational or non-academic training. - Conducting a follow-up of the affected after detoxification in various treatment centers, camps or rehabilitation centers for assessment of the following: - reason for relapse - duration between slip, relapse and addiction. - the attempts made or options selected to deal with these stages. - the modification required as per the affected population. Analyse the problems faced by individuals or organisations already involved in various stages of dealing with the problem. - Identifying capable and interested persons from the affected population and those individuals who were addicted but have totally left the field after being drug free. - Involving the target population in establishing a drop-in center. - formulating the rules as per the views of the target population and individuals interested in the field. - Assessing the utility of the centre after a period of six, twelve and eighteen months. - Modifying the activities and methodology of intervention.

- creating a co-operative run by the affected population.

- members of the population will take over handling of treatment zone along with an NGO.

- Training of others to set up separate treatment zones.

PILOT PROJECT :06 **DROP IN CENTERS:**

It is recommended here that some of the counseling centers be converted into drop in centers with counseling services and other facilities for addicts.These centres will be located in different geographical areas. Informal centers with facilities for counseling and other activities can facilitate individuals to become involved in activities outside their drug-using milieu.

These drop-in centres should be run by individuals who are flexible by temperament and innovative and would utilize this opportunity to rehabilitate addicts by involving them in developing a methodology of conceptualizing a drop in center suitable to them and their colleagues.

A typical drop in center would perhaps include the following:

- Basic facilities for toilet/bathing.
- Facilities for addicts to involve themselves in physical, intellectual or recreational activities.
- Counseling and career guidance facility

The focus is to provide opportunity for individuals who have completed detoxification/rehabilitation programs to be involved in activities besides drug consumption, to provide opportunities for high risk population to be involved in activities and seek counseling services as a preventive measure. A casual atmosphere might facilitate individuals who use or abuse drugs to drop-in at first due to the facility for involvement in interesting activities and at later stages seek treatment for themselves or for their colleagues.

The participation of the community is vital because the funds required for the implementation of the program and to facilitate the support groups to take part in the functioning of the center specifically to facilitate the evolution of a democratic house committee to take care of the center. The initial preparation of the center and subsequent maintenance of the center can be done by the target population.

PILOT PROJECT NO: 08 **NIGHT SHELTERS:**

PROJECT JUSTIFICATION

As in the case of drop in centers, some counseling centers need to be converted into night shelters.

Certain segments of the affected population might be street addicts who in critical conditions would require a shelter specifically in the present conditions where even the ten beds supposed to be set aside for addicts are not available in cities like Bombay.

These night shelters would consist of facilities for medical attention and/or atleast an ambulance which would take the addicts who require immediate medical attention from the streets. Each night this ambulance/van should make rounds to known drug users hang-outs and identify such addicts who need help. In this manner, one can also identify young addicts and new addicts early enough to provide meaningful service toward their recovery.

There should be facilities for extra-curricular activities which would provide an opportunity to offer a structure in the life of the addict who has been conditioned to a stereo typed behaviour revolving around addiction.

The various aspects that might hinder the probability of demand reduction activities being effctive are the following:

- over-emphasis on counselling
- counselling being a western concept might be too alien for the lower strata of the society and the street addicts
- an abuser being oversensitive to the stigma attached to addiction might find it difficult to travel in overcrowded buses and trains
- the centers when located in posh areas will not be point where abusers might seek professional guidance
- the fact that government hospitals do not want to deal with addiction and set aside beds for addicts only on paper.
- the lack of trained counsellors who are interested in the field.

It is under these circumstances that the project for night shelter can be justified.

Immediate Objective:

To establish a night shelter for the lower strata of the society.

MEFRAME	OUTPUT	ACTIVITIES
	1. A night shelter	- Analysis of the pattern

	established	of use if required in specific areas
2.	A manual on out reach programme published	- Identification of the organisation involved in dealing with addiction among the poor and the street addicts - Identification of volunteers involved or interested in the field from the same areas or otherwise - Orientation of these persons on various aspects of addiction and the role of support groups - Purchase of a van - taking night rounds to identify critical cases who need immediate medical attention - Identifying those cases who have just started taking drugs - Creating facilites for activities to break stereotyped patterns of addiction - contacting other agencies who are involved in (re)habilitation or social integration of drug abusers - Contacting day care center or drop-in centers for those who have started taking drugs - Involving the target group if possible in the operation of the centre - documentation of the whole process and the hurdles involved in evolving the programme - Analysis of the utility of the programme

- Making a draft on the process

- Utilising the view points of the target population in order to modify the programme

- Production of a manual on establishment of a night shelter

Detoxification of Substance Abuses

A Status Paper with Outlines for Pilot Experimental Projects

National Addiction Research Centre
5 Bhardawadi Hospital
Bhardawadi Road
Andheri West
Bombay 400 058

DETOXIFICATION OF SUBSTANCE ABUSERS
(HEROIN TYPE)

Dr.Dayal Mirchandani
MD. DPM. FPS.

Drug Abuse is a major problem and is here to stay. It had been estimated that there are over 700,000 Brown Sugar addicts in India, with one lakh in Bombay city alone. Drug abuse is rapidly spreading to the smaller towns and villages of India. The abuse of brown sugar has cut across all social strata from doctors to coolies. Today a large proportion of drug abusers are likely to be from the poorer sections of society.

The economic costs of drug abuse are high in terms of man-days lost at work, the health hazards posed to the user and the cost of treatment. It also leads to the diversion of a lot of money and to the consequent corruption of law enforcement agencies. Additionally, many addicts take to crime in order to be able to support the habit. Some steal while others get involved in the drug trade.

More important than the economic costs is the "human cost" in terms of misery, self-destruction and suffering not only of the addict, but also of those close to him, such as his family, friends and co-workers. The tremendous suffering caused by drug abuse cannot be quantified but it far outweighs the economic damage.

Research shows that current treatment techniques used with heroin abusers are not very effective and even with years of treatment, relapse rates as high as 90 % are common. Studies have shown that over a period of years a number of heroin addicts "mature" and stop the habit themselves. It has been observed that they stop a number of times, either in treatment or by themselves, before finally giving up the drug altogether.

Therefore, from a "public health" point of view, given the large number of addicts and the paucity of treatment facilities-let alone effective therapy, -providing effective 'detoxification' is in by itself a useful strategy. Detoxification is the first step in the rehabilitation of the addict during which period the addict is helped to abstain from the drug so that his body can adjust to a drug-free state.

Often, addicts use detoxification to keep the cost of their habit down. Most of them know that once they have developed a tolerance to heroin, following detoxification, they would require a smaller amount of heroin to obtain the same effect. So even if the addict's motivation is not to give up the drug or to enter into long treatment, one should not deny him detoxification, as it helps him to keep his expenditure on the drug down. Often this helps keep the addict from having to resort to criminal activity in order to support the habit. It also helps to reduce the total quantity of the drug ingested and in turn reduces the health hazards attendant to the use of the drug which are dose dependent.

Many addicts resort to self-detoxification, haphazardly using medication or using other unscientific methods which, by themselves pose a danger to the health and life of the addict. It is therefore important to provide a cheap, painless, and easily accessible technique of detoxification which would be acceptable to the addict. A frequent criticism of this approach has been that if painless detoxification were made easily available to an addict, there would be little motivation for him to stay off the drug once detoxified, because he knows that an addict should be allowed to suffer the withdrawal symptoms, as this would act as a deterrent to his resuming the habit. However, since 80 % or more addicts relapse after detoxification, the thought of undergoing painful and expensive detoxification process frequently makes them keep on postponing repeat detoxification. This prevents them from seeking treatment. Also, as a doctor it is not ethical, on humanitarian grounds, to make a patient suffer, especially when there is no scientific evidence to show that it helps.

BROWN SUGAR

This is a crude form of heroin and has became a major drug of abuse. It is a powder, brownish in colour, containing a small percentage of heroin and opium alkaloids. The percentage of heroin contained varies with the purity of the drug.

When the drug is originally smuggled in, it has a higher heroin content than when it reaches the street. As it changes hands from smuggler to wholesaler to retailer, it is diluted at each stage to increase bulk and value. Various substances such as talcum, starch, glucose, aspirin and other chemicals are used as dilutants. These by themselves constitute a major health hazard since they make up the bulk of the drug that the abuser buys from the retailer, while the heroin content may be merely 10 to 15 %. Purer forms of heroin known as white sugar are also available at much higher costs.

Brown sugar is mixed with tobacco and smoked in cigarettes. Another mode of ingestion is heating the drug on aluminium foil and inhaling the fumes - a method known as "chasing". A few addicts make a solution of the drug and inject it intravenously or intramuscularly: this method is not popular in India.

THE PHARMACOLOGY OF OPIATES

Opium is the extract from the seed capsule of the poppy plant (Papaver Somniferum). Natural opium contains alkaliods such as Morphine and Codeine. The most widely abused narcotic is Heroin a simple derivative of Morphine(di-acetly morphine). A number of synthetic compounds with similar effects to that of the natural opiates are also available. These too, have a high abuse potential, eg. Methadone, Pentazochine (Fortwin), Pethidine, Dextropropoxyphene and Diphenoxylate (Lomotil). This group of drugs stimulates the 'opiate receptors' in the brain to trigger off their effects.

CLINICAL EFFECTS

When used for the first time, heroin and morphine may cause nausea, vomiting and dysphoria (an unpleasant mental state). These drugs are powerful pain relievers. For the narcotic addict the ingestion of the drug usually produces a very pleasant state of euphoric and an alleviation of psychic pain such as depression and anxiety. The patient may appear slightly drowsy. Flushing and itching of skin may be observed in some cases. Pupillary constriction, decreased respiratory rate and constipation are also observed.

TOLERANCE

With use, a tolerance to these drugs develops, so that the same dose of the drug no longer produces the earlier effects. The addict has to increase his intake of the drug to achieve the same effects. Addicts who have developed a tolerance can take surprisingly large amounts of the drug, which would often be sufficient to cause death in someone who has not developed tolerance.

ACUTE INTOXICATION

This is caused by an overdose of the drug. The patient may be stuperose with slowed respiration, pin-point pupils, Bradycardia, hypotension and hypothermia. Opiate overdose should be treated in the same way as morphine or opium poisoning.

CHRONIC INTOXICATION

With use the patient develops tolerance to the physical and psychological effects of the drug. He has to keep increasing the amount of the drug he uses to achieve the euphoria and relief of anxiety and depression. Once the person has become addicted to the drug and physical dependency has occurred, the only reason he may continue to use the drug is to prevent the withdrawal symptoms, since unless he increases his intake he no longer experiences the "high".

WITHDRAWAL SYMPTOMS

A physically addicted person develops unpleasant withdrawal symptoms on discontinuing the use of the drug. The first signs usually appear 10 to 14 hours after the last dose, reach a peak on the second or third day and gradually subside over the next week.

The symptoms initially consist of yawning, rhinorrhea (discharge from the nose), lacrimation (tears), pupillary dilation, sweating and restlessness. Later, muscular aches and pains, abdominal cramps, diarrheoa, vomiting, agitation, profuse sweating, insomnia and dehydration may be observed. The patient may complain of mild aches and pains, as well as insomnia for a few months afterwards. With proper treatment the addict should experience no discomfort and withdrawal symptoms when being "detoxifed".

CAUTION: One use of Buprenorphine (Norphine) with Substance Abusers:

Our experience and anecdotal evidence leads us to believe that there is a dangerous adverse drug interaction between Buprenorphine and Diazepam with severe respiratory depression and even apnoea. This interaction has apparently only been noticed in India.

In view of the above we would caution you not to use Buprenorphine with Substance Abusers as in our experience the majority of addicts abuse/use Diazepam and other Benzodiazepenes in addition to the drug they are addicted to. Diazepam has a very long half life and remains in the body for a number of days after discontinuation. Caution is also needed in prescribing Diazepam to anyone using Buprenorphine.

CLONIDINE DETOXIFICATION: This is a centrally acting adrenergic stimulating agent which finds use in the treatment of arterial hypertension. It has been found to be highly effective in alleviating the signs and symptoms of opiate withdrawal syndrome (Gold et al 1978, Gangadhar et al 1982). Washton et al in an outpatient trial found it to be a safe and effective treatment for opiate detoxification. Some of the advantages mentioned by Gold et al (1980) are 1) Rapidity action 2) It is a non-opiate 3) Non-euphoria producing 4) High success in inpatient and outpatient detoxification 5) Enhances the role of the doctor-patient relationship. Ginsberg et al (1983) have reported very few adverse effects and no deaths reported in the literature. The common side effects noticed were hypotension, sedation, and rarely the unmasking of other psychiatric disorders. We find that the sedation and hupentation are an advantage in that it helps the addict confined to the house.

ADVANTAGES OF OUTPATIENT DETOXIFICATION: It keeps down the cost of treatment. In Bombay, this can range from a thousand rupees to sixty thousand rupees in some private nursing homes. We find that patients are more willing to be detoxified at home. They are more cooperative and find it easier to deal with the boredom of being restricted indoors. Experience has shown that ward boys and other addicts can be bribed to supply the addict with drugs even when they are hospitalised. At home it is easier to keep a close watch on the addict and to restrict undesirable visitors. The cost of medication can be kept down to as low as Rs. 20 to 30. The only other cost is the doctor's fees. As treatment can be administered by the family physician this can be kept down. Hospitalisation costs are saved.

Another advantage we find is that by involving the family actively in the treatment of the patient, they are likely to have a higher involvement in the rehabilitation and future therapy of the patient. It builds a strong relationship between the doctor and the patient/family. The family also gets used to the idea that they have a crucial role in the therapy of the addict rather than leaving the patient to the "expert" to cure by magic.

PROCEDURE: A detailed medical examination and history, history of drug use, and a complete medical examination including pathological and Radiological investigations if necessary. The chemically dependent person may be dependent on more than one substance, hence this should be enquired about. They may also abuse tranquillizers, hypnotics, methaquelone and even alcohol.It is also useful to elicit a history of previous attempts to stop, severity of the abstinence syndrome and behaviour of the patient during this period. Past history of psychiatric illness i.e. psychosis, depression should be obtained. The question of suicide should be openly discussed with the patient's relatives and the patients. If there is any risk, however small, a psychiatrist should be involved in treatment.

Following this the patient can be assigned to either Outpatient Inpatient treatment. He is a person who is ill and suffering and uses the drug to relieve his psychological pain and suffering. The addict is psychologically and interpersonally very skillful in manipulating people and may appear compliant or aggressive to get his own way. Dealing with the addict is like playing chess with a chess master who appears to be mentally retarded, but is full of surprises.

CRITERIA FOR INPATIENT TREATMENT:

1) Physical illness such as pulmonary tuberclosis, cardiac disease, hepatic disease, gross debilitation and any other medical illness that is likely to require close supervision- these patients should be detoxified under the supervision of a physician in a hospital. Pregnant women should not be detoxified with Clondine as this medication does not cross the placental barrier, and this is likely to lead to an abstinence syndrome in the foetus with disastrous consequences. Such patients should be detoxified by a specialist. Neonates born to mothers who are narcotic addicts may also develop an abstinence syndrome after birth and should be treated by an expert.

2) Psychological Disorders Severe depression with suicidal intent (patient has made suicidal threats or says he is considering suicide); past history of severe psychiatric illness (psychosis/severe depressive illness); history of suicidal attempts in the past-such patients should be detoxified under the care of a psychiatrist, as should be any patients addicted to more than one drug.

3) Social and Other Reasons Patients without anyone responsible to look after them while they are being detoxified; patients whose relatives feel that they cannot control and keep the patient at home while he is being detoxified; past history of the patient being uncontrollable and troublesome while being detoxified - such patients may be detoxified under the supervision of a General Practitioner in a "Detoxification Camp" or hospital/nursing home. Adequate nursing staff and ward boys should be available to keep watch on the patient. Any of the scientific techniques described can be used in the inpatient setting.

OUTPATIENT DETOXIFICATION

The majority of patients can be detoxified on an Outpatient basis (except for those previously described as requiring Inpatient treatment).

If the patient is chosen for Outpatient treatment the procedure should be explained to the patient and least one or two responsible relatives. A contract should be made with the relatives that that they will not allow the patient out of the house, failing which treatment will be stopped immediately. Do not underestimate the time required for this process or promise to try and cut down the time required as a means to motivating the patient to enter into treatment. Ten days to two weeks should be allowed for, although close supervision may only be required for the first week or so. If the relatives feel that they cannot 'control' the addict or enforce the agreement he has made, then friends, neighbours or even hired guards may have to be involved. Alternatively, inpatient treatment can be suggested. A history of difficulties encountered in the past is useful at this time.

CLONIDINE DETOXIFICATION

Clonidine should be started 8 to 10 hours after the last dose of the narcotic, when the addict starts experiencing mild withdrawal symptoms such as yawning, piloerection (gooseflesh), rhinorrhea. Relief is usually rapid with a total abolition of all withdrawal symptoms within an hour or two.

We usually start with two tablets of 100 mcg(microgrammes) three times a day. If withdrawal symptoms are well controlled this dose is continued for two more days. From the fourth day onwards start reducing the Clonidine gradually tapering down at the rate of one tablet per day. In some cases which give a history of only using small quantitites of heroin for a short period, one tablet three times may suffice on the first day. In other cases, 6 tablets per day may not suffice, in which case the dose can be increased to one mg.per day (ie. 10 tablets of 100 microgrammes each) in three or four divided doses. (The maximum dose recommended is 20 mcg/kg/day). With these patients it is useful to give a slightly higher dose at bed time. Once the withdrawal symptoms have been controlled the dose can then be reduced after a day or two at the rate of one tablet per day. While tapering off Clonidine, it is helpful to reduce the afternoon dose first, then stop the morning dose and finally stop the night dose. With experience it is possible to individualise the patient's medication on the basis of body weight, amount and duration of the narcotic abuse and previous history of severity of withdrawal symptoms.

PRECAUTIONS

On the first day it is necessary to record the patient's blood pressure two hours after the first, or preferably, the second dose. Should the standing blood pressure fall below 90/60 mm Hg, the next dose can be postponed. The patient is restricted to bed and the next day's dose reduced to half. If the blood pressure still remains below 90/60 mm some other technique of detoxification should be used. Standing blood pressure should be

recorded daily. If it is below 90/60 mm then reduce the dose and confine the patient to bed. Hypersensitivity to the antihypertensive effect of Clonidine is rare and we have not had to discontinue treatment because of this. Some patients complain of giddiness and unsteadiness on standing up. This is due to postual hypotension. Therefore all patients should be warned not to stand up suddenly but to sit down for sometime and then stand up with support. Bathroom and other doors should not be locked in case the patient slips and falls. Abrupt discontinution of Clonidine may cause rebound hypertension. Hence the drug should tapered off gradually. This effect is usually only noticed after Clonidine has been used for 30 days and therefore should not be a problem.

SIDE EFFECTS

1) Hypotension 2) Postural Hypotension 3) Sedation - this could be an advantage even though patients may complain about this. This sedative gradually lessens each day.

DRUG INTERACTION

Tricyclic antidepressants interfere with the effect of Clonidine and should not be used until the patient has withdrawn from Clonidine. Antipsychotic medication like Chloropromazine potentiate the hypotensive effect of Clonidine and may also cause a confusional state when used with Clonidine. Hence they should not be used.

ADJUVANT MEDICATION

Most patients become quite anxious and require additional tranquilisers. Diazepam 5 mg.TDS or Lorazepam 1 mg.TDS usually suffices, the dose can be safely doubled if required. Insomnia is usually a problem and Diphenhydramine 50mg., HS or Phenargan 50mg. at bedtime usually suffice. If required 10mg. of Nitrazepam can be given as required. The anti-anxiety medication can be gradually tapered off after the fourth day. Drug abusers are liable to become addicted to Nitrazepam and tranquilisers. Diphenhydramine (Benadryl) or Phenargan (Promethazine) may be continued for sometime to help induce sleep.

ALTERNATIVE METHODS OF DETOXIFICATION

1. Acupunture :- This has been found useful in controlling withdrawal symptoms during the detoxification phase. It can also help in reducing discomfort during the post detoxification phase. Unfortunately, frequent sessions are required (every few hours during the detoxification phase), making treatment expensive. Though it has often been touted as a "cure" for drug addiction, there is no evidence that acupunture influences the long term outcome of drug addiction.

2. Electrical Methods :- Various techniques such as Neuro-Electro Therapy (N.E.T.) and Electrosleep exist where a small electrical current is passed across the brain. This controls the withdrawal symptoms effectively. Such mediums can be constructed for a few hundred rupees but are often sold for

large sums. One should be careful in using such machines unless the safety for human use is certified by the required Government agency.

3. Herbal Remedies :- Herbal remedies have been tired, many of them containing opium. There is little scientific documentation about the efficacy of such remedies. High doses of Vitamin C have also been tried, with some success.

SPECIAL PRECAUTIONS WITH MEDICATION

All medication should be locked up and given to the addict only as and when prescribed, by a responsible person. (Some patients may take an overdose, by manipulating the family or with suicidal intent or because sometimes the patient is confused and may forget that he has already taken his medication).

It is advisable to dispense medication. When medication is dispensed and the patient and relatives do not know the name of the medication, the doctor can withdraw treatment at any time if required, especially if the addict or family do not follow instructions properly. It also prevents unsupervised use by the patient in the future if he relapses. Addicts commonly advise other addicts about medication they have received so that they can detoxify themselves.

SUPERVISON

Daily home visits by the treating physician are necessary in the first few days. Vital signs and standing blood pressure should be recorded. Some time spent talking to the patient and the family enhances rapport and helps them follow up and carry out instructions. Doctors should review the intake/output chart maintained by the relatives and also the medication chart. It is advisable not to call the patient to the Doctor's Clinic after the first few days when the patient has stabilised, as it then becomes difficult to restrain and keep him at home, the patient assuming, then, that he can now go out.

Regime II: Diphenoxylate (Lomotil)

This has been used in the detoxification of opiate addicts quite successfully (Gurmeet Singh et al, 1984).
In this technique addicts can be stabilised on between 30 to 60 mg. of Diphenoxylate per day in three to four divided doses for a few days when the the medication is gradually tapered off. Adjuvant Medication or Minor tranquilisers, e.g. Diazepam, Lorazepam are used to control anxiety and Diphenhydramine or Promethazine and Nitrazepam are given at night to induce sleep. With experience, these can be used for Inpatient or Outpatient detoxification.

Note: Lomotil Tablets contain 2.5 mg of Diphenoxylate and 0.05 mg of Atropine to prevent abuse. Our experience has been that Atropine does not interfere with treatment or cause excessive side effects. At the close level suggested patient receives 0.75-1.5 mg of Atropine per day.

Many addicts and families have the mistaken notion that detoxification is a "cure" for narcotic addiction. It should be repeatedly emphasised that this is not so and that psyhotherapeutic help should be resorted to as soon as possible for specialised treatment and rehabilitation.

The family should be educated about their role in the treatment of the addict and in preventing the addict from relapsing, by keeping a close watch on him and holding him responsible for his actions. When available, the family can be directed to Families Anonymous - a group of the families of drug abusers, which will give them support and which can teach them the techniques other families have used with their chemically-dependent members. They may also be guided to Alcoholics Anonymous, a group for alcoholics, for they can learn a lot about drug abuse in these groups as well. Siblings may attend Al-Teen groups.

Personally, I have strong reservations about Narcotics Anonymous as it socialises the addict with other addicts, and some of the other addicts who have relapsed may initiate the patient to start using the drug again. Alcoholic Anonymous may be a better option, if at all.

If psychiatric facilities are not available the treating doctor may be tempted to treat the addict with psychotropic medication for relief of symptoms such as anxiety and depression. Minor tranquilisers such as Diazepam, Lorazepam and hypnotics such as Nitrazepam should be avoided as the substance-abuser may become chemically-dependent on them. Vigorous exercise and relaxation training, yoga and religion are useful ways of dealing with minor psychological difficulties. The clinically-depressed addict may benefit from adequate doses of trycylic Antidepressant medication much as Amitryphyline, Imipramine, Doxopin - these have a low abuse potential.

The psychosocial rehabilitation of the addict is a complex task best left to the professional. The referring doctor should be careful about who he refers his patients to as there are a number of practitioners with dubious qualifications in the field. In our experience Family Therapy has been the most effective form of therapy with addicts. Results of therapy all over the world are poor and placing the addict in a rehabilitation centre for years has not been found to be very useful.

PILOT PROJECT NO: 01: COMPARATTVE ANALYSIS OF OUT-PATIENT VERSUS IN-PATIENT DETOXIFICATION OF ADDICTS

PROJECT JUSTIFICATION :

In our country, the number of professionals interested in dealing with addicts is very limited, which has led others working in the field to charge exorbitant fees. This tendency finds support in the general view held by professionals that only motivated individuals should be treated and their tool for assessment is subjective perception and inability of the addicts to assert themselves regarding their right for treatment just as any other patient and not be blamed totally for lack of result through practitioners who refuse to document their work and create accountability.

Out-patient treatment would facilitate the family to get involved in the treatment, to reduce the expenditure incurred, to facilitate the individual to deal with reality and not be forced to adjust after being detoxified in a conducive environment.

The Project period should be three years, inclusive of two years follow up and report-writing.

IMMEDIATE OBJECTIVE :

To analyse the cost and effectiveness of outpatient or inpatient treatment and the target groups who would benefit by each modality.

OUTPUT	ACTIVITIES
A manual for detoxification.	Select a particular hospital or centre offering in-patient or out-patient treatment or two hospitals/centres in the same locality offering either in-patient or out-patient treatment. Formulating the methodology for data collection; inclusion and assessment follow-up criteria. Selection of a study sample. Follow-up of the study sample at intervals of two years or for a period not exceeding two years. Areas covered during follow-up should not be restricted to successful cases only but also involve cases of relapse, lapses and slips,DAMA, etc.

Identification of problems and modification in terms of operational details suggested by the patients:
delay in receiving OPD services, extent of influence of external factors or inter-personal relationships that interfere with out-patient treatment procedure and promotes DAMA self-medication opted for by the patients.

The evaluation of the cost and effectiveness of the treatment; if benefiting target population; and the psycho-social factors that facilitated the outcome.

Production of report based on the findings.

Production of a manual on guidelines for low cost detoxification.

PILOT PROJECT NO: 02: TRADITIONAL SYSTEMS OF MEDICINE

PROJECT JUSTIFICATION

Indian civilization has coursed through several millenia with the the assistance of traditional systems of medicine. Ayurveda and Yoga, Siddha and Unani medical systems together with folk medicine and Homeopathy have developed effective treatment regimens of a sustainable nature suited to our conditions- To date, just 15 % of the population is serviced by the allopathic network of practioners and health centres.

Opium, Ganja, Bhang and other mind-altering substances have been in widespread use and their abuse must have been not uncommon. Thus there must be methods of treatment for overdose of poisons. We need to unearth traditional practices and strengthen their applicability to contemporary problems such as heroin abuse.

IMMEDIATE OBJECTIVE :

To assess the cost and effectiveness of various traditional systems of medicine in comparison with other allopathic modalities.

OUTPUT	ACTIVITIES
Production of a manual on the effectiveness of application of various approaches.	Selection of traditional systems of medicine to be used for detoxifying addicts.
	Selection of particular centres who have been using traditional methods.
	Methodology of data collection .
	Decoding the study sample.
	Review of literature/documentation on oral traditions from senior practitioners.
	Documentation of the process.
	The following medical systems are suggested here: Acupuncture, Homeopathy, Ayurveda, Siddha, Unami.
	In the evolution of TSM in India, one of the efforts has been to develop an integrated medical system and for a while degrees were also given under the integrated curricula though purists have opposed such exercises. (For an account of the development of TSMs in India, of K.N. Udupa, 1958, G.A.A. Britto, 1985).

There exist in the field of drug abuse, some centres use acupunture - WHO has promoted it in Asian countries. In India, BPT and a few private centres use acupuncture.

A few doctors have started using Homeopathy (Delhi Police Correctional Foundation, Dr. Jerajani). Kashi Club through a contract to Dr. Udupa, would test the regimen for Ayurveda under the UNFDAC - Government of India funded Project at Varanasi.

Some projects should be set up to develop a regimen for treating addicts in each of the traditional systems and also to test out the feasibility of an integrated regimen.

Selection of sample undergoing other forms of treatment such as allopathic medicine for comparative study.

Evaluation of the approaches.

Follow-up at intervals for both the samples.

Production of report based on the study.

Training of other professionals in the modalities found useful.

PILOT PROJECT NO: 03: SELF MEDICATION

PROJECT JUSTIFICATION

It is evident from studies that a certain section of addicts are able to deal with their addiction through self medication, but no further attempt has been made to understand the phenomenon or its utility.

In a devoloping country where there is a lack trained professionals to deal with addiction, where the cost of detoxification is currently high, where soft forms of drugs like cannabis have been used for centuries, where social control along with rather than stigmatization played a major role and where at present stigmatization has received social and legal sanction, one needs to look at the possibility of devoloping modalities for self medication and have the probable adverse effects, due to ignorance, could be avoided.

Whether anyone likes it or not, addicts the world over resort to self-medication and it is important to provide technically sound advice and guidelines to addicts and their peers.

OUTPUT	ACTIVITIES
To produce a manual on steps for self-medication.	Selection of different areas where drugs are prevalent or where hard drugs are replacing soft forms of drugs (conducting a study on the pattern of use, if needed). Collection of data on methods adopted by addicts to deal with health problems arising out of their addiction. Analysis of various forms of self medication utilized and the complications faced. Analysis of the positive aspects of the method and its cost-effectiveness. Production of report on the study. Circulation of the report to professionals for their suggestions and to ex-addicts. Production of a manual on guidelines for self medication.

Pilot Project 04: Maintenance on Opium

Coming to the methods of medication, one of the options available to us purely the political economy of opium cultivation in the country is to use opium tincture for maintenance and detoxification or substitution of drugs. The world's demand for raw opium from India for medicinal purposes has shrunk by over 40 per cent in the last decade resulting in unsold stocks of mountains of opium being guarded by a couple of hundred of armed security personnel leading to a hike in the cost of production of opium, which in turn makes our opium uncompetitive in the world market. If we can develop a proper regimen for the use of opium (raw and tincture) in the treatment of heroin addicts and aggressively market the same in the place of methodone and other synthetic compounds being used in the West for maintenance and Substitution /treatment, then, not only would our Revenue Ministry be happy to earn precious foreign exchange/ contribute to reduction of the imbalance in the hard currency trade, but it would reduce the anxiety of some of us working in the field of demand reduction of the possibility of the emergence of an Indian source of heroin. So far the world has not devised a methodology of convincing the opium growing community to give up opium cultivation and switching over to orchids/pisciculture or other means of earning/ enhancing their incomes. In India, we have not even looked at the problem in any systemic manner but have assumed that issuing administrative fiats to the farmers to reduce cultivation of opium by 10 percent of the acreage each year would bring about the reduction of the amounts of opium produced in the country. Alternatively, we have assumed that by reducing the commission of Lambardars who collect opium from farmers and deliver it to the government's purchasing agencies would automatically impel the peasants to produce less on a fewer number of acres. The third strategy being followed is the reduction of the per kilogram purchase price of opium from farmers. It is likely that the farmers who continue to produce opium on the same number of hectares, hoard the quantity they do not manage to sell or do not need to sell in order to continue to remain in farming, looking for customers to buy their opium at higher rates.

OUTPUT	ACTIVITIES	PARTY RESPONSIBLE	TIME FRAME (MONTHS)
Development of a set of guidelines for the appropriate use of Yoga, Ayurveda and homeopathic medical systems in the treatment of drug abusers.	Determination of and application of criteria for inclusion of patients for treatment under traditional systems of medicine (TSM).	To be Contracted out (sub contract B)	3-18
	Recording of Clinical and laboratory data of patients as per allopathic procedures.	Medical team	
	Development of prelimnary treatment regimen according to TSM.	The Contracted team of TSM experts.	
	Development and utilization of a set of formats for recording data of patients as per the TSM requirements.	The Contracted team of TSM experts.	
	Follow up of patients upto a minimum of six months after SM treatment.		
	Recording of data as per medical team allopathic system: post treatment and after six months.	Medical team	
	Development of final regimen for the use of TSM for the treatment of addicts.	The Contracted team of TSM experts.	21-24

Re(habilitation) of Addicts

A Status Paper with Outlines for Pilot Experimental Projects

National Addiction Research Centre
5 Bhardawadi Hospital
Bhardawadi Road
Andheri West
Bombay 400 058

(RE)HABILITATION OF ADDICTS

INTRODUCTION

The management of drug abuse in India is as new a concept as large scale heroin abuse in urban India is. In order to create a debate among professionals and policy makers on the most cost-effective and efficient methodologies and services, the following papers have been produced by a team of researchers at SPARC:

-Prevention of Drug Abuse
-Counseling Addicts
-Medical Management of Drug Abuse
-Habilitation of Addicts

The structure of the above named papers deals largely with the following :

1. Theoretical considerations of the particular aspect of management of drug abuse.

2. Description of the current practice in India in different organizations.

3. A critique of the prevalent practice in the light of the magnitude of the problem and other criteria

4. Outlines for a set of pilot experimental projects in order to sharpen the technology of intervention in the field of drug abuse management in the Indian context.

In this paper the authors dwell at length on long-term residential rehabilitation centres.

DEFINITION OF TERMS

(Re)habilitation can be defined as a process that attempts to aid addicts to physically, psychologically and socially cope with situations likely to be encountered after detoxification and thus utilize the opportunities that are available to others of the same age group in society.

Detoxification, After care, Social- and Vocational-integration are parts of a continuum, which aim at assisting people in their transition to a meaningful way of life. The starting point of this continuum is when a drug-dependent person seeks to overcome his habit. Detoxification is an important adjunct to the longer efforts needed to integrate him into society. Thus, After-care, Vocational- and Social-integration go well beyond the scope of detoxification. After-care services meet the medical requirements of detoxified patients.

Social reintegration is functionally a part of the (re)-habilitative process, used in its broadest sense. It is probable that for certain individuals in the affected population, the term "social reintegration" will refer to their first "integration" into society (as in the case of delinquents, street children, etc).

Two general objectives that apply to all efforts at (re)-habilitation are :

1. To modify the attitudes, values, behavior and skills of former drug-dependent persons so as to encourage their transition to, and maintenance of, a drug-free way of life.

2. To provide social supports needed to establish or re-instate these individuals in the community in roles they find more satisfying than in their former life pattern, where they could function with greater self-assurance.

SOME GENERAL CONSIDERATIONS:

While setting up rehabilitation programs, we need to consider the following :

a) Since Drug dependence is often a recurring pattern of behavior, it is vital that rehabilitation personnel set realistic goals for the program lest their morale decline/ they get burnt out/they give up their jobs or the program itself collapses.

b) Long-term residential programs (spanning anywhere between six months to a year) could cater to the needs of certain categories of addicts; they are not at all necessary for ALL addicts, as they are certainly not the sole modality of rehabilitation in any proven sense whatsoever. It is not even clear what types of heroin addicts could or could not best benefit from such residential long-term rehabilitation programs. The major goal of any approach needs to be the reintegration of the individual to society. Retaining the addict in institutions for long stretches of time may further enfeeble his weak moorings in the family, neighborhood and his work place/educational settings; thus eroding norms and alienating him further.

c) It is evident that rehabilitation programs do not require large, elaborate physical structures to carry out their activities. Therefore existing buildings should be utilized. They should be located in affected areas or at least be within the reach of the targeted population.

d) Considerable persuasion might be required to motivate individuals to enroll for rehabilitation programs. The probability of individuals dropping out of the program should be borne in mind.

e) Networking with other organizations is crucial for facilitating individuals to enter the program after detoxification.

f) Assessment of the individual's treatment history, personal and social factors, his vocational history and health is important while planning a program of rehabilitation and social reintegration.

g) Programs of social reintegration should incorporate a follow-up phase to ensure that the client does not encounter unforeseen difficulties in the community.

h) A successful community program of rehabilitation will depend on positive attitudes of that community towards drug-dependent persons.

i) The success of any community rehabilitation is dependent on successful job placement.

j) Drug craving, developing a new social network, adjusting to drug-free activities and deriving satisfaction from them, dealing with stress and pain, maintaining relationships, and dealing with slips and lapses are some of the important aspects of recovery.

Social reintegration will be difficult for individuals who had deviated from the set path of life, specifically those who, besides depending on drugs, had also neglected their academic life, training or social skills.

The effectiveness of rehabilitation programs would have to be determined through a set of outcome criteria which take into account the ways in which the individuals develop roles for themselves in the community both socially and occupationally, and not be limited to their behaviour regarding drugs.

The areas in an individual's life that need to be verified are:

1. Subsequent use of drugs
2. Employment records/attendance at academic or training courses
3. Involvement in criminal activities
4. Relationship with family and community at large
5. Attitudinal changes
6. General state of the client's health.

At present, the focus of various rehabilitation centres has been limited to individuals who had accepted the set process of change in order to arrive at a drug-free state. There are others who have quit drugs without ever entering into any treatment program or without recourse to professional help. They have either utilized self-medication or found alternatives to their activities which reinforced their stereotyped behaviour; or have left the addiction circle and merged with the general public in a new city or under a new name.

The maintenance of a drug-free status is related to :

- An opportunity to partake in interesting activities. This in turn breaks the stereotyped pattern of behaviour associated with addiction.

- Self-help groups are able to sustain their role in the deaddiction process as they are devoid of stigma. This is important, as the stigma attached to addiction hinders the individual from re-integrating himself into society.

- Therapy sessions often tend to focus on intra-psychic problems and ignore social issues that facilitate or hinder the person's reintegration into society.

- Research studies show that at times individuals who have opted out of drug addiction, tend to cultivate other addictive behavioral patterns such as gambling, overeating etc.

- Rehabilitation institutes utilize religious faith and group pressure to motivate the addict to remain drug-free. It is the priority of rehabilitation centres that their patients continue to remain drug-free in order to sustain their program or professional career. Several addicts might not want to reach a totally drug-free status but to become socially and vocationally functional, if needed, with the assistance of soft drugs such as Cannabis, for instance.

In the Indian context, the facilities currently available for addicts to seek professional help are limited.

The methodology currently adopted by these centres cater to just a small segment of the universe of addicts.

In order to justify the large investment in terms of professional time, money and space, and also to increase their chances of a higher rate of success, they screen out and accept only - highly motivated individuals.

To illustrate, a residential rehabilitation centre catering to 20 addicts for six months, would require a spacious building, recreational area, staff, cooking arrangements... Thus, almost all of these centres charge a high fee when not fully subsidized by the government.

To raise a question, how many rehabilitation centres would Bombay need, keeping in mind that the lowest estimate puts the number of heroin addicts at around 40,000? We would require 1000 rehabilitation centres! This country cannot afford such methodology except by way of a token symbolic political gesture.

- The expressed goal of professionals in the field of rehabilitation tends to be social reintegration while their activities do not facilitate the process nor can they support it. Certain rehabilitation centres which are also involved in preventive activities utilize the Fear Approach but the shortcoming of this approach is that it does not eliminate the stigma attached to addiction.

- The tendency to perceive prevention, detoxification and rehabilitation in isolation tends to hinder the social reintegration process.

- The lack of systematic documentation in the field of rehabilitation could lead to exaggerated statistics as to rate of success of their methodology. This lack of documentation and its monitoring does not help in adapting Western models to suit the local conditions in the Indian cultural context. Further, there is little accountability and much self-delusion regarding the best methods of working with addicts.

The staff have invested heavily towards establishing rehabilitation centres. Being keen on maintaining the program, they are apt to succumb to the pressure to increase the rate of success of the program and so ignore or fail to meet the challenges of recovery. They may not consider social or vocational reintegration as a component of the theory and practice of rehabilitation.

Conceptually, readdiction is a process that has several stages: slip, lapse, relapse, readdiction. If counselors misinterpret slips as readdiction, difficulties could arise which would cause the counselor to either underrespond by ignoring or denying the signs of a slip, or overrespond by trying to rush the person for preliminary treatment focusing only on drug-use.

When rehabilitation services are being planned, the following measures should be undertaken :

A. Resource Inventory:

An assessment of existing resources in the community or those which can be made available through national, State, or Municipal programs must precede or be a part of the preparation for setting up rehabilitation programs. Such a survey would avoid delay in developing the program as also in curbing unnecessary expenditure.

The resource inventory should include information on:

Local labour market
Vocational training opportunity
Education up-gradation programs
Job placement services
Facilities for post-treatment observation
Counseling and half-way homes or drop-in centres.

B. Human Resource:

A resource inventory would identify persons or groups in the community who can assist in the process of rehabilitation and social reintegration. They may be professionals skilled in the relevant disciplines; executive personnel with management skills; persons with special skills within the community; or instructors in trades that are appropriate to the needs of the client; or community leaders and local authorities who are interested and knowledgeable. The involvement of the community in the design of the program would motivate them to an sustain optimal level of performance.

The Measures for rehabilitation and social reintegration are:

1) improving educational qualifications and skills,

2) expanding job opportunities and

3) social support

These are naturally interdependent and hence tend to overlap each other.

PROGRAMS FOR IMPROVING EDUCATIONAL QUALIFICATIONS AND SKILLS

Educational Upgrading and Vocational Training is imparted to the client to pave the way for his entry or return to the educational stream and to cultivate skills or improve ones qualification. This would prove beneficial to young clients who have dropped out of formal education but who have the requisite motivation to enhance their educational level. The operational cost of the program may increase as educational needs and career goals are variables. To provide training in skills relevant to the local economy or to the informal sector, the design of the program should be congruent with the local labour market as also with the economy of the community. It should be tapered realistically to industrial and commercial parameters. An attempt should be made to inculcate attitudes which will improve the clients social functioning and career; and to deal with societal attitudes towards addiction and to develop self-confidence.

A survey should be undertaken to determine the needs of the local labour market; an assessment of the training courses available; their strengths and criteria for admission; the development of required non-existent courses through recruitment of relevant competent instructors, provision of equipments and other training requirements.

Finally, a working committee consisting of representatives from the labour force, industry, the educational system and the affected population should work in liaison with the community and assist in co-ordination.

THE INDIAN CONTEXT

In India, under the Ministries of Education and Labour, we have several ITIs and 46 Shramik Vidyapeeths to offer training for post-Matriculation courses as also for high-school dropouts. In addition, innumerable apprenticeship and self-employment programs operate both under Government and private commercial or industrial auspices. A large number of Non-Governmental Organizations (NGOs) have also specialized in offering vocational training courses.

Thus it is not at all necessary for new NGOs in the field of drug abuse to set up new technical training institutes exclusively for addicts. It would not only be a duplication of efforts but they would be fraught with failure when undertaken by nascent NGOs in the field of drug abuse. Educational planning is an extremely complex exercise best left to experts in that discipline.

However, educational planning in the country has been lopsided and has been made to suit certain vocal segments of the country. It does not cater to the requirements of this vast country's teeming millions. Hence, a group of NGOs in the field of drug abuse may commission studies or act as a pressure group for a national/regional/city appraisal of educational and job-oriented training opportunities for the current number of youth who need them and projected for the future needs of youth in their areas of concern. The Ministry of Welfare and the proposed Association of recovered addicts* may impress upon development planners, policy makers (commencing with the Planning Commission, and leaders of various political parties to name a few) to look into the basic question as to how our youth may participate in our

politico-economic and economic structures.

PLACEMENT SERVICES

Change agents have on many an ocassion, used their personal contacts with influential people to secure jobs for addicts, but these efforts have often failed to achieve their purpose largely due to inadequate preparation of both addicts and employers.

The effectiveness of job placement will depend on the following concurrent requirements: local labour conditions, attitude of the community to employ the treated addicts and adequacy of training.

Job placement and counseling services would help the target group to find employment and to deal with related problems. An evaluation of the effectiveness of the program could be undertaken by following up on a client's performance.

The criteria for job placement should pivot on the interest of the client. Concurrently, the services of counselors need to be employed so as to deal with problems of the client or would-be employer. Given the long list of registered unemployed youth at employment exchanges, it appears that little relief would come to addicts from that quarter.

Whereas a large number of addicts are either unemployable or unemployed and probably became addicts due to the enormity of pain that they have had to undergo in their struggle for survival, there is a segment among addicts who are basically social rebels. They need to be identified and assisted to become social change agents.

INCOME-GENERATING PROJECTS FOR ADDICTS

A few NGOs have attempted without any previous experience to set up production-cum-training units for addicts. Far from reality is it that all addicts can be made into tailors or leather-goods craftsmen or candlemakers!

Other organizations venturing into income-generating activities have faced the following problems:

a) Difficulty in maintaining Quality Control.

b) Designing skills are woefully inadequate-understanding buyer-preferences is a specialized skill and discipline.

c) Cash-flow problems are perennial since wholesale buyers delay payments for as long as possible. Charity oriented organizations and social work professionals do not possess the acumen to make a business viable.

d) Developing markets, securing orders, ability to supply quality goods on time, are all failure-prone areas.

e) Product-diversification is necessary to sustain continuous production to adapt to market fluctuations. Skills necessary for new products may not be available with the target group for whose benefit the production-unit has been set up in the first place.

(see Appendix for Pilot Project for developing a placement service)

f) The overhead costs of administering the production-cum-training units become so high that without a large subsidy available each year, the artisans employed would receive a mere pittance for their efforts.

g) There is also an economy of scale to be considered. The critical volume needed for viable production varies from product to product.

h) Whether an export market is available makes a difference to the viability of income-generating products. The supporting agency would need to be familiar with licensing for the export goods.

i) Accounting, audit and placing of an appropriate quantum of raw material are areas where trainees flounder and disrupt business.

For the above and other reasons not listed here, NGOs in the field of drug abuse would do well to avoid income-generating projects until they have:

- Adequate risk- or venture-capital
- The expertise needed for such projects
- An outright grant of a recurring nature for every year from the government or any other charities towards underwriting the annual losses as social costs.

COMMUNITY WORK PROJECTS

ILO consultant Hans Galver has developed the concept and practice of Work Teams through pilot experimental projects in several countries. These pilot projects are funded by the ILO.

The overall purpose of community work teams is to provide income-generating activities for recovering addicts, to enhance their participation in society and to create a more receptive attitude in the community towards them.

This program is tailored to the needs of a specific community and will be useful to that segment of the younger population who cannot fit into the conventional labour or educational stream. The work chosen has to be in line with the interest of the targeted population.

The program can be implemented through a group of representatives of the clients, or voluntary organizations involved with the support of the local government.

Methodology:

Addicts are first identified in a given slum/locality.
Background information on them is gathered.
They are facilitated to enter detoxification/therapy process.
In the post-detox period, homogeneous groups of treated addicts are formed.
Through a process of community organization, tasks useful to the community are identified.
Matching of groups with the tasks is undertaken.
Resources to carry out the task are identified within and

outside the local community.
Group processes and group norms are developed. Responsibility for the group is entrusted to two or three levels of leadership.
Training or orientation is imparted to the group.
On going after-care for medical needs if treated addicts.
Counseling is continued.
Differential quota of work is allotted to addicts depending on their health status.
Should anyone does not turn up for work on a given day, the co-addict-workers look him up and find out the reason for absence.
Wages are kept somewhat below the market rate in order to encourage recovering addicts to become independent of work teams and as each work-team sheds some members, other are taken in.
The Community which sees their youth, who have wasted some years are now doing productive work, gradually begins to contribute to the maintenance of such work teams.
If some of the work teams consolidate, then, they are given training in maintaining accounts, handling cash, effecting public relations... and assisted to form their own firm/ company to carry on business.
In some countries, such work teams have grown into full-fledged transport corporations.

It is with this understanding that a pilot project (see Appendix) is proposed for NGOs working in the field of drug abuse in India.

A. SUPPORTIVE SOCIAL APPROACHES:

Family programs: The objective of family programs is to assist the habitué develop a sense of belonging and ties with people whom he can depend on for advice, understanding and support. Placement in foster families can be a means to deal with adverse effects of disturbed family background during the period of rehabilitation, thus helping them to form social links at an early stage.

The steps for implementing this program are:

Identification of fostering families, matching of a particular client to a particular family, acquainting the family with the needs and potentials of the client, establishing an on-going relationship with the staff member, the foster family and the client.

Complications can arise due to lack of adequate number of families and insufficient information available to foster families regarding problems likely to be encountered. The fostering families would need to be adequately prepared.

In India, we have not yet attempted to develop foster parents' programs even for children in any systematic manner or on a large scale. There are some NGOs who have several years of experience in developing foster parents for children. A dialogue between these agencies and NGOs in the field of drug abuse on the nuances of setting up foster parents' program could pave the way for pilot experimental projects in this regard.

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B. HALF-WAY HOMES

The purpose of Half-way Homes is to assist habitués to gradually sever ties with residential rehabilitation centres and to face the challenges and demands of society in a graded manner.

The immediate objective is to identify employment opportunities in society, to assess the skills and capacities of clients, and to cement contacts between clients and employers.

Half-way Homes should provide living accommodation for eight to twelve persons in the neighbourhood away from the drug-using population. The residents would be collectively responsible for the operation and maintenance of the Half-way House, with a staff in charge of the overall management. The location needs to be close to academic institutions, training centres and places of work.

The utility of the program would be determined by the length of stay, the efforts made to provide an opportunity for the client for a phased reintegration into the society and preventing dependence on Half-way Houses.

C. DROP-IN CENTRES

Drop-in centres are akin to Half-way Homes except that drop-in centres do not offer an eight-hour structured program nor do they compel recovering addicts to spend the whole day in nor insist on regularity of attendance. It is a place which is run in such a manner as to make addicts feel they are welcome there anytime as also to attract them whenever they feel the urge to return to drugs.

The objective of drop-in centres is to help the client to maintain a drug-free life outside institutional settings and to support their reintegration in society.

An informal social environment and counseling services could be a point of reference for the client with relatively few acquaintances in a drug-free milieu. The centre should preferably be located in a central area and have recreational facilities for counseling sessions.

Operational costs depend on assistance from the community and maintenance of the centre should largely be the responsibility of the clients. For effective functioning a democratic committee should establish rules for the use of the centre and decide on their enforcement.

These day-care centres could be places where, in the post-detoxification phase, occupational therapy project could be implemented. The objectives of occupational therapy projects are limited to assisting the addicts to structure their time, develop concentration, learn to deal with authority and the other routines which are essential parts of work life. A sketch of a pilot project for this purpose is outlined in the Appendix. The staff requirement for such a project are : an Occupational therapist, a career guidance person and an assistant to take care of clerical duties.

D. RESIDENTIAL PROGRAMS

In this context, it is vital to distinguish therapeutic communities from other approaches to rehabilitate and re-integrate addicts. In the therapeutic community program, the aim is to keep the former drug user in a drug-free state, without necessarily returning him to the larger society.

Therapeutic communities

This approach views recovery as the total responsibility of the individual and the centre provides a conducive environment for it. The individual is viewed as an immature person who requires help. The period of stay to achieve this varies from centre to centre.

The close contact with professionals, ex-addicts and mature people sensitive to the problem is supposed to be part of the process. The methodology of behavioural modification involves confrontation, loss of privileges or status, group pressures, acceptance, praise, advancement in social structure; the response of the group depends on manifested behaviour of the recovering addict.

The program intends to create abstinence from mind-altering substances, develop a new life style which is non-violent, positive, spiritual and socially acceptable.

The program's time frame is laid down depending on the processes to re-structure behavior patterns or to deal with immediate psychological or social problems, to facilitate their re-entry to the main stream. The therapeutic community is usually run by persons with previous addiction history or by professional staff or by both.

The individual passes through three phases: self-examination and confession; development of appropriate attitudes, values and self-image; and reinforcement of these changes. Encounter therapy for self-examination and shifts of one's belief system is achieved and maintained through group praise.

The criteria for admission and removal is based on the level of motivation. At times, to test motivation, admission is made difficult.

Communities which attempt to create group cohesiveness between the staff and target population through shared decision-making are less harsh.

The facilities and equipment at the centre are relatively simple and these centres are either financed by the government or by private sources.

Institutional Rehabilitation in India

The objective of residential programs is to improve the quality of inter-personal relations, develop responsibility, and maintain a drug-free life.

The program is designed to avoid relapse by providing a sheltered

environment and restricted contact with the outside world. There should be facilities for counseling and detoxification. The operation and maintenance of the centre are the responsibility of the affected population with support from change agents.

This approach is expensive in comparison to other approaches. It may prove useful to persons with long-standing addiction who have been recently detoxified and specifically to those who have not had the experience of living compatibly with others.

In India, the term rehabilitation denotes an approach to tackle the problem of addiction by providing a conducive environment for the affected population, in an institutional setting, for a period of one to six months.

At present in India, there are five Government funded After-Care centres in the country. Non-governmental organizations like Kripa, Bombay; Good Samaritans, Calcutta function as rehabilitation centres. The methodology followed by these centres is not identical. ("A case study of a rehabilitation centre" (SPARC 1986), which is a documentation of Asha Bhavan does bring to light the method selected by the centre to deal with addiction. (Requests for copies should be addressed to SPARC Documentation centre on Addiction).

MINNESOTA MODEL

This model refers to a treatment program for alcoholics and drug habitués with a specific ideology related to the Twelve Steps of Alcoholic Anonymous and Narcotic Anonymous. It includes a comprehensive and multi-professional approach but the emphasis is on self-help therapeutic community, utilizing lay therapists who are themselves recovering from chemical dependence.

The model does focus on the value of 'multiprofessional' approach in the management of addictive behavior. In particular, the value of the ex-alcoholic or ex-habitué is upheld in this approach. The model actively involves the individuals in their own treatment within the parameters set by the program. This approach utilizes 'group therapy', stress on the sharing of life histories, written assignments, encounters and peer evaluation.

This model attempts to provide a spiritual, psychological, social and physiological rationale comprehensible to the patient. To maintain the newly acquired life style and belief system, it draws on AA and NA services.
The Minnesota Model receives support from studies, which claim success for two-thirds of the treated population over a period of one year's follow-up. But these follow-up studies have been criticized on their:

1) methodological criticisms call for further research incorporating inclusion criteria
2) lack of control groups
3) duration of follow up
4) assessment-procedures and diagnostic outcome criteria.

To recapitulate the foregoing, the components comprising the Minnesota Model are :

the time of discharge and follow-up. No control group or comparison group was included. The behavioral areas examined by Rossi, Stach and Bradley appear to be highly subjective. Further operational definitions of these areas were not provided.

At Hazelden, during the years between 1973 and 1975, Laudergan conducted a study - another study was carried out by Gilmore during the period 1978-83. The methodology followed by both these researchers was to collect data through questionnaires from all patients who gave consent and stayed in treatment for a minimum of five days. The questionnaires were sent to them at the end of the Fourth, Eighth and Twelfth months after their discharge from the treatment program. Those individuals who did not respond to questionnaires were contacted by telephone wherever possible. The study period included all patients discharged during the period June 1, 1973 to December 31, 1975.

The total number of patients admitted for treatment was 3638, including those in the study, which was 1652. The `study population' was selected on the following criteria:

1) Those who had successfully completed the program and were discharged with a medallion.

2) Those who returned the questionnaire after the Fourth, Eighth and Twelfth months.

(Note: Patients who returned to Hazelden for treatment or went to any of its extended care units were excluded from the study).

Other methodological defects of the above study were that:

1) Classification regarding problems with either alcohol or alcohol and drugs at the time of treatment was determined solely by the self-report of the respondent to the questionnaire.

2) Details of the number of patients who could not be traced as also those who withheld consent are not given by the authors.

If we exclude the number of persons who came `shopping', and also those who went through part of a treatment program and then sought Discharge Against Medical Advice for one or the other reason, then the computation of the rate of success is illusory. There is every reason to suspect that at least 80 per cent of those who withheld consent had relapsed. Excluding them, too, from the purview of the total number of persons treated makes the rate of success an exercise at generating false statistics particularly when the reasons for withholding consent are not taken into consideration.

THE UTILITY OF INSTITUTIONAL REHABILITATION:

There is a slim chance of a particular modality, catering to an aspect of addiction, being adequate to tackle the problem. The approaches selected need to be culture-specific and related to other social problems.

Institutional rehabilitation might be a useful model for a small

Alcoholic Anonymous/Narcotics Anonymous
Disease concept of addiction
Group therapy
Ex-addicts/alcoholics as counselors
Family therapy

There have been extravagant claims of success rate of the Minnesota Model of rehabilitation without it being substantiated through systematic, serious follow up studies. Among the centres adopting it, the Hazelden Foundation has attempted to evaluate its own program. The need for further systematic research will be evident from the following brief account of their lacunae:

During the period 1955-56, Willmar State Hospital conducted a follow-up study of all patients living in rural areas by the following methodology:

A counselor interviewed the patients and other informants such as probate judges, Sheriffs, County Attorneys, police departments, welfare agencies and AA groups.

In 1957, a sample of 20% of patients was chosen for a follow-up on the same lines as the '55-'56 study. Based on these studies, it has been concluded that at best, the effectiveness of the program was then limited to 45 per cent of the patients.

In the year 1963, Rossi, Stach and Bradley published their findings after conducting a further detailed study over a period of five years. The authors stated that there was no appreciable change in their program in the given period. A sample of 12% of all admissions was selected. Thus, 208 male alcoholics were traced who, at the time of research, had completed 21.3 months after treatment. Interviews were conducted with the patients by the research team or by specially trained County social workers. A Five-point rating scale of drinking behavior was utilized but the validity of the rating scale was not established. Out of the sample of 208, 83% were traced. It was found that 11 patients were institutionalized and 13 had died. Out of 149 patients located in the community 49 patients(24% of the original sample) had abstained from alcohol for six months or more and 35 of them (17% of the original sample) had improved on their previous longest record of abstinence for six months or more. One year of further follow-up was done for those found to be drinking with mild effects. It became evident that out of 45 patients, only one continued drinking with "mild effects" and only three had stopped drinking, whereas the remaining 41 were by that time suffering serious effects as a result of their continued drinking.
The study also considered "behavioral areas" such as self questioning attitude, belief problems within self, sibling relations, budgeting, employment, harmony at work, and income. Patients who continued to be abstinent after discharge showed improvement in 16 out of 20 areas, while those drinking with "mild effects" improved in only 11 areas. Patients drinking with "serious" effects showed even poorer outcome, but a certain improvement had occurred in all groups.

These studies might show valuable impressive results but are methodologically deficient. The results cannot be causatively related to the treatment provided by the treatment centres. No account was taken of other forms of treatment received between

Past histories of unpatterned social behaviour is a common factor among heroin habitués and delinquents. Several studies which compared delinquents and habitués with control groups of non-delinquents and non-habitués matched for relevant variables (such as social class, place of residence, intelligence and ethnic background) showed that young urban habitués cannot be distinguished from young urban delinquents (Glueck and Glueck, 1950, Chen et al., 1964, Vaillant, 1966a and c).

Alcoholics had a significant incidence of parental addiction. Lack of patterned behaviour noted on admission was often secondary to unemployment and marital instability which in turn were themselves consequences and not contributory factors to alcohol abuse. Only five percent of alcoholics evinced delinquent behaviour prior to abuse. The alcoholic is rendered susceptible to relapse because alcohol dependence destabilizes patterned activities.

The habitué begins his drug-seeking behaviour more due to lack of opportunity in other forms of competing independent activities than due to morphine or heroin per se being a powerful reinforcer or temptation.

A study noted that New York habitués had spent only 20% of their adult life actively addicted and 80% of their life was spent being unemployed by the time they reached the age of 40 (Vaillant, 1966 b).

For an individual who does not have employment, addiction does provide a patterned form of behaviour, though stereo-typed. Having been a misfit both in school and during adolescent periods, the habitué finally achieves social reinforcement, addiction becomimg an absorbing occupation.

Among alcoholics, dependence can be defined by the degree to which alcohol seeking and consumption becomes the individual's most salient and preoccupying source of gratification(Hodgson and co-workers, 1978).

It is probable that addiction might be reinforced through the fear of discomfort during withdrawals, imagined or real, and through non-pharmacological factors. It is a fact that the chronic use of narcotics provides little or no conscious gratification and early in the alcoholic's drinking career, alcohol ceases to become an effective tranquilizer. The non-pharmacological reinforcements might be friends, syringes, pubs, rituals of drinking or injection etc.

Withdrawal symptoms might also be related to past experience and not be dependent totally on the drugs. Physiological response to withdrawal of the chemical has been noted in research wards when an individual who has been abstinent for months experiences withdrawal while watching another habitué go through it. This phenomenon has been noted in different detoxification centres and camps in India and has been called conditional withdrawal.

It is also probable that an individual who believed himself to be a hard core habitué and expected to go through heavy withdrawals actually suffers severe withdrawals although his peddler had been selling him milk sugar in the few months prior to the detoxification.

percentage of the addicts-particularly those who took to drugs due to inadequate/inappropriate ego development in spite of coming from economically and socially sound families with adequate educational and career opportunities.

Such residential centres may be useful for another set of addicts who have a hopeless family situation.

For some addicts, such a program could be counter-productive.For example, if we took a rag-picker and put him away in such centres for six months or a year, then, on being put back on the streets, his survival skills would have been blunted and his network of social contacts for surviving there would have withered away, even to the extent of his body not being able to withstand the occupational health hazards of rag-picking, leaving him susceptible to illness.

However, these are only our hunches and there is no research study to indicate what types of addicts need long-term residential rehabilitation programs, nor who may benefit the most from such programs.

As per the study it was found that only 3% abstinence for a year resulted in 100 cases with 770 detoxifications via voluntary hospitalization or short term imprisonment. (George E. Vaillant - 1966)

Studies and literature reviews show that the effectiveness of in-patient treatment in comparison to out-patient treatment or brief detoxification is not significant (Edwards and Gutherie 1966, Edwards and Grant 1980) among alcoholics. A comparison of in-patient treatment to out-patient treatment for alcoholics showed no variation in effectiveness after a period of two years. (Vaillant 1980).

Denial of detoxification because of uncertainty regarding its long-term effectiveness would be as inhumane as denying treatment to diabetics. Detoxification does reduce the person's suffering and mortality and no justification can be given for exclusion from medical coverage, from treatment centres or from shelters for the homeless.

Research in the USA has indicated that the number who gave up heroin had increased over several years. The number of habitués with a marginal adjustment, however, remained more or less constant. They either continued substance-abuse intermittently or were institutionalized for illness or crime related to abuse. The data collected from the follow-up of alcoholics also showed a similar trend. The habitués, as per the study, did recover slowly but it could not identify reasons for the change.

NON-PHARMACOLOGICAL FACTORS IN RELAPSE

It is probable that focus on non-pharmacological variables would enable us to answer some pertinent questions: Why does addiction begin? **Why does relapse occur ? Why does relapse not occur?** These questions might help us to understand the possible interventions required.

Parole and AA do not expect an individual to give up his addictive behaviour without providing him with an alternate set of behaviour patterns. The AA methodology which facilitates the preventive process are: busy schedule of social and service activities with supportive former drinkers, especially at times of high risk like holidays. AA encourages its members to return again and again to group meetings and to sponsors, who provide an external conscience.

Among both alcoholics and addicts formation of a new relationship with a non-blood relative was associated with abstinence.

But couples therapy was not particularly useful in facilitating abstinence among alcoholics. An old dyadic relationship with a long history of suffering would re-awaken old guilts and old angers which can be conditioned reinforcers to alcohol abuse. (Orford and Edward, 1974).

The study among heroin habitués showed that mothers often gained gratification through their child's addictive behavior.

The formation of new relationships associated with abstinence often involved another person's total dependence on the recovering addict or a person who trusts him to be independent and does not nag him on his erstwhile dependence on drugs. This could be compared with the twelfth step in AA.

Group membership could facilitate abstinence due to the conversion process which occurred through `strangely trivial' significant incidents that often triggered remission (Knupfer 1972). Group membership also provided the `new non-stigmatized identity which was cited as important by Stall and Biernacki in 1986. This could not be compared with the study of heroin habitués at Lexington as they belonged to an historical cohort (1950-1960) which preceded the popularity of self-help groups and Narcotics Anonymous in America. In the case of alcoholics among the 28 abstinent for three years or more, 14 had attended 300 or more AA meetings. Adherence to treatment regimen is at times the result and not cause of abstinence. It has been documented that when pre-morbid characteristics of alcoholics are controlled, then the apparent superiority of various treatment interventions disappear.

Addiction viewed as a constellation of conditioned, unconscious behaviour could explain the reason for success of parole, maintenance and AA over conventional forms of therapy. Community intervention can serve to impose a structure in the life of the habitués. Voluntary hospitalization has not been as effective as a year of parole. The probable reason for lack of effectiveness through voluntary hospitalization many be because it occurs in the presence of many conditioned reinforcers (other habitués, peddlers, community stress, etc.).

If the treatment we offer does not seem to be more effective than natural healing processes, then there is a need to understand the natural healing process better.

Since Alcoholics Anonymous and Narcotics Anonymous are helpful to alcoholics and addicts in the Judes-Christian countries their applicability to Indian context cannot be automatically assumed. Hence we recommend a pilot experimental project. (See Appendix).

The fact that relapse can be brought about through conditioning to non-pharmacological factors brings to light the possibility of returning to drugs even after abstaining from it for a long duration.

It is evident that poorly-patterned social behaviour may contribute to use or abuse of drugs and that behavioural patterns that are adopted during the period of addiction could be associated with relapse. Factors that had restructured the habitués life in the community such as parole, methadone maintenance and AA were able to sustain abstinence. There is a need to realize that relapse and not dependence is the major hurdle.

The severity of prior-addiction does not predict relapse. Individuals who manage to remain drug-free are those who attained a structured form of behaviour developed alternate competing source of gratification established new relationships.

Among alcoholics and addicts two or more of the following factors aid abstinence:

-compulsory supervision
-experiencing a consistent aversion towards drinking (e.g. use of disulfiram or a painful ulcer);
-finding a substitute dependence to compete with addictive behavior(e.g. meditation, compulsive gambling, overeating);
-obtaining new social supports(e.g. satisfactory employment, new relationship)
-inspirational group membership that provide sustained source of hope, motivation and self-esteem (self-help groups and religion).

In the USA, a year of parole was found to be effective in the case of heroin habitués. In fact, individuals who were awarded parole were severe offenders and their past histories did not contain favorable prognostic factors (Vaillant, 1966). These successful cases had previously relapsed after other forms of treatment.

Parole was not useful as an intervention strategy because it offered a form of punishment but due to its ability to alter and reinforce habitué's schedule of daily routine. The change may have been due to:

- the requirement of proof on weekly employment,
- alterations in the friendship network,
- external source of vigilance against relapse.

Work provides an opportunity for structured behaviour which in turn interferes with addiction.

It was found that a structured laboratory setting could moderate drinking in alcoholics who, in a community setting tended to binge uncontrollably.

Interventions like AA and parole provide a substitute for drugs. In the absence of competing dependency, disulfiram alone could not prevent relapse.

APPENDIX

Immediate Objective:

To establish an All-India Association for addicts.

OUTPUT	ACTIVITIES
Formation of All India Association for addicts.	- Identification of NGOs capable of functioning in a democratic manner. - Identification of recovering addicts or ex-addicts interested in bringing about societal change. - Orientation workshop on global trends of addiction, global issues - demand reduction activities, legal restriction story of drug abuse, and other allied social and political problems. - Selection of any particular field of action by the participants - Detailed study in the area of interest under guidance of thinkers in that area such as: - legal problems, drawbacks and merits of detoxification methods, preventive measures, rehabilitation processes etc. - Formulation of an action plan in that particular field. - Establishing contact with Government officials and other concerned persons to bring about change. - Analysis of the utility of involvement in these activities. - Documentation of various activities undertaken in different fields. - Modification of the training methodology if required. - production of pamphlets on their experiences - Trained individuals who subsequently sensitize other interested individuals - Production of a manual on the process the NGOs who were involved.

PILOT PROJECT : FORMATION OF AN ALL-INDIA ASSOCIATION OF RECOVERING ADDICTS

PROJECT JUSTIFICATION :

In India, the management of drug abuse is somewhat new and while some projects are good, some are extremely well run on professional lines and some are marked by deep commitment. One also finds some projects are commercial ventures. There is little public accountability. There is a need for a watchdog body of committed and informed people drawn from various walks of life. There is a likelihood of medico-legal problems and ethical battles emerging between treatment centres and enforcement machinery. Often human rights of addicts are violated blatantly. The entire ire of society arising out of the addiction problem is sought to be privatized and the addicts are penalized for the failures of society to develop a caring community where the youth feel they belong. Inequalities and regional imbalance characterize our country where a few lobbies manage to corner the maximum fruits of all developmental investments.

In either case, the basic reason for supporting recovered addicts is that they understand the implication of addiction, how society responds to addicts and how addicts are exploited at different levels by different groups (from the peddler to policemen and sometimes even helping professionals).

But it does not automatically follow that recovered addicts automatically that they are familiar with various approaches to the management of drug abuse in the world today nor would be all be capable of assessing the applicability of some of the Western models or even experiments done in developing countries in this field as to their applicability to the Indian context. Some of them would need training in management of non-government organizations (fund raising, accounting, office maintenance, writing skills, team building ...).

It is in this context that we invite NGOs to innovate in this regard: One, to set up a national association of recovered addicts and another pilot project, to set up a fellowship for a group of carefully chosen recovered addicts which would induct them to work in the field of drug abuse.

PILOT PROJECT : ADVENTURE GROUPS

PROJECT JUSTIFICATION

An analysis of research studies done by NIDA, in the field of follow-up and after-care brings to the forefront the fact that addiction could be best tackled through the provision of competing occupations which could:

- sustain the interest of addicts,
- increase hope,
- eliminate stigmatization of addicts and
- aid their re-integration.

At present preventive measures undertaken do not consider the various kinds of needs of the target group which is not homogenous. A section of addicts consists of individuals who have rebelled against society and may have accepted addiction as a means to cope with the stress that arises from an attempt to assert one's individuality.

The aim of this pilot project is to assess the utility of alternate activities as a measure of habilitation of addicts. There exists such a group begun by some highly talented and educated youth `recovered habitués' in South India.

In Thailand, where ex-addicts have been attached and subsequently certified by Universities to take up government-funded programs as counselors, the methodologies adopted by them are those of the classical casework and other institutional welfare management procedures.

There are those who leave drugs on their own and who, by their own creative methods quit the drug scene altogether. Due to this the repertoire of skills and methods available for the management of drug abuse remains restricted.

Case-history analysis of ex-addict/ex-alcoholic counselors have revealed that many of them get burnt out. The Burnt-out Syndrome might express itself in ways other than relapse to drugs (Freudenberger,1986).

In India and often elsewhere too, the options available to a recovering habitue is restricted to becoming an ex-addict counselor which offers limited scope to bring to fruition his own innate potentials in different fields. Even while he choses to work in the field of addiction, the job of the counselor limits his options. Self-help groups condition the addicts to modify their attitudes to suit the group-ideology through peer evaluation, the recounting of experiences which create guilt and by offering group support conditional to behavior modification. Poverty of ideas in the management of drug abuse can be traced to such socialization of recovering addicts who enter the field as change agents.

In those rare cases in India, where ex-addicts have set up agencies to cater to addicts, it has been made possible when large institutions and powerful contacts have provided sustained support to the former over a period of five or more years (such as Churches, industrial houses, etc.). Even here, one notices the tendency of these ex-addicts to set up institutions on Western

Models and they become professional managers of established institutions.

It is in this context that adventure groups are recommended, four cities to be chosen for the experiment. In each city, a organization may set up such an adventure group. Membership to this group should be restricted by precisely laid down criteria. All NGOs working in the field of drug abuse may select the most talented social rebels out of their patients and refer them to the agency running the adventure group(Organizing Agency). Naturally, the O. A. should aggregate compatible individuals into the group to foster cohesion and other group processes.

The functions of the Organizing Agency are :

a) To form groups among the selected members of the adventure group.

b) To organize group discussions among the members regarding various group activities, and to analyze the pros and cons of each option, and to recognise the implications of each for all the members and for the organizing agency in terms of resources to be identified and committed.

c) To ensure democratic functioning of the group, lest its own staff take it over wholly or control the group in a rigid fashion, holding the whole venture to ridicule by its members.

d) To progressively reduce its own role in the functioning of the adventure group.

e) Over a period of time, to assist the adventure group to register itself into a Society with norms developed by senior members and to continue the activity independent of the organizing agency.

The fact that this project is aimed at a particular section of addicts (who might not be willing to be conditioned totally by the society), it is vital that the organization selected to help the group, should consist of individuals receptive to and interested in alter-native non-conventional activities. The members will have the right to put forth their views and modify the methodology of implementation.

CAVEAT:
At each stage of the process described below, the members of the action group may drop out or may have to request those who have lost interest to quit the program, failing which the group itself may evict those members.

Immediate Objective:

To evolve adventure groups for individuals who have rebelled against the system as a specific preventive measure.

OUTPUT	ACTIVITIES
Formation of Adventure groups.	- Identification of recovering addicts interested in alternate forms of activities in the habilitation period. - Survival training - involving trekking, hiking, martial arts etc. (NCC or defense personnel may support this activity). Others may be interested in studying philosophy, astronomy, occult, permaculture, socio-economic cultural variations in the country, anthropology, etc. - Organizing for this adventure group, an orientation to the problem of addiction, the methods of intervention and their drawbacks. Existing forms prevention and their possible alternatives. - Activities in which the adventure groups can be involved are: - Documentation of organizations working in the field. - Training the adventure group in societal analysis. - Interviewing abusers or ex-addicts, eliciting their views of society, its institutions catering to maintain the system and alternatives perceived. - Analysis of the existing system, its methodology by which it is sustained, adapted, how it integrates innovations/ change and how the society pursues some goals, who sets these goals (Basically the attempt is to facilitate the members to take up structural analysis of our society). - Conducting an exercise on "The India of My Dreams" wherein each of the members of the adventure group: Those who show interest specific social issues will be assisted to undertake a detailed study of that social problem and to become an expert critic.

PILOT PROJECT: A PROGRAM OF SUPPORT TO EX-ADDICTS WORKING IN THE FIELD OF DRUG ABUSE

PROJECT JUSTIFICATION:

It is well known that recovered addicts have been effective agents of change in the field of drug abuse in various countries. In India too, a few ex-addicts have been assisted by NGOs, Churches and individual philanthrophists to set up registered organizations to run services for demand reduction. These ex-addicts have often employed other recovering addicts to run their centres.

There are several other recovered addicts who for want of minimum survival support, are unable to put all their skills in the service of drug abusers. Hence the present project proposal of training and fellowship.

However, due to lack of exposure and adequate training the predominant model that has emerged in India through ex-addicts is the residential, high cost, long term, rehabilitation centres.

<u>Suggested Areas for Training Recovered Addicts.</u>

Assessment of the pattern of use of drugs in places where the study has not already been done.

Analysis of the treatment history including self-medication, attempts made in order to tackle addiction through involvement in various activities or drug substitution.

Identification of facilities already available in the field and organizations involved in other social problems who can be facilitated to take on drug abuse related work in different capacities.

Documentation of various action groups in the field of addiction and other social fields. In order to facilitate the following:

Facilitating and supporting action groups who are already involved in the field. The action groups would also be facilitated to take on preventive work focusing on target groups such as parents youth and peers.

Introduction to law and analysis of the jurisprudence of the Law.

Assessment of various vocational training facilities and academic courses available in the city/area. Identification of alternatives possible and expressed needs of affected population.

Identification of the requirements of the high risk population and to formulate viable and cost-effective preventive measures.

Identification of various youth groups and analysis of their activities in order to identify the modifications required and the roles they could play in the field of demand reduction.

Assisting the trainees in the skills required for networking with other organizations in order to facilitate them to take up various demand reduction activities such as prevention,

Some of the areas for foremost National concern are:

a. Communalism - National integration
b. Development of tribal population
c. Environment
d. Women's development
e. Mass Movements
f. Political economy of drug abuse and alcoholism
g. Educational system

Each group will be provided clues on resource persons/institutions and supported with necessary assistance for collating, editing, publishing etc. They would also be given training in various methodologies of bringing about social change. Some of them will be made apprentices with leading persons working in their areas of interest.

- Dialogue with policy makers and administrators and giving talks, writing articles in news papers based on their experience.

- Follow up study to assess the extent of changes in the individual in terms of assertiveness, optimism, experimental to use with drugs, use or addiction the same substitution of drugs, extent of impact of addiction on their activities.

- Subsequent training and facilitation of other individuals to form adventure groups by the trained individuals, the individual or group will take on specific activities they are interested in and establish their own groups.

detoxification, counseling, (re)habilitation. Setting up new organizations or groups to meet the needs or correct the lacunae that exist.

Facilitate organizations to evolve action plans for their city through discussions with other groups such as; NGOs working in the field, concerned government officials, law enforcement officials, legal advisors, media personnel, community support groups, interested individuals from the affected population, action groups and educational institutes interested in the field.

The implementation of the action plan would be discussed with the Government by the NGO representing the group and individuals from the affected population. Involvement of these individuals would empower them to aquire skills required to establish a platform for direct dialogue with government officials.

Training them in the methods of evaluation of preventive measures.

Creating awareness among various target groups such as parents, friends, community workers, industrial sectors, labour unions, religious heads, educational institutes, policy makers,government officials, organizations working in related fields, professionals working in related fields, media, law enforcement officials, politicians, funding organizations, officials of correctional institutes, administrators of hospitals, action groups, documentation centres, Judiciary, agricultural labourers where opium is cultivated.

Identification of instructors or training institutes that could disseminate information on prevention and treatment.

Conducting training programs for the instructors of future instructors.

Assisting them to evolve different approaches/modalities of psychotherapies (from among the 200 or more schools of counseling in vogue worldwide today).

Orienting them to different data sources and methods of documentation and generating primary data on drug related areas.

Immediate Objective One:

To train a select number of ex-addicts in all aspects of demand reduction.

OUTPUT	ACTIVITIES
1.1 A number of recovered addicts committed to work in the field identified.	- Through the NGOs working in the field, recovered addicts are identified. - Selection is made out of them.
1.2 Their current level of knowledge, skills and exposure assessed. And an appropriate training plan made.	- To test their administrative and organizational skills to run an NGO - To upraise their understanding of prevention, treatment and recovery process. - To develop a training program.
1.3 A number of fellowship established.	- To place the trained addicts in positions of responsibility in selected organizations. - To provide monthly fellowships. - In the meantime to assist them to register their own societies. - To assist them in project formulation. - To assist them in times of organizational crisis. - To act as resource persons and to periodically evaluate their evaluate their programs. - The subsequent training of others by the trained persons.

PILOT PROJECT : ESTABLISHMENT OF OCCUPATIONAL THERAPY PROGRAMS

OUTPUT	ACTIVITIES
Occupational therapy program established.	- Analysis of the work history and possible job opportunities for each of the patients. - Case by case identification of the types of basic skills required for each one. - Development of an individualized plan for enhancing the skills identified for each. - Acquisition of relevant equipment - Assessment of each ones post-detox skills in each of the requisite area relevant to his career (such as a truck driver truck driver would be assessed for his motor co-ordination skills, a copy writer for his ability to keep to deadlines/punctuality etc.) - Development of a daily routine for all addicts to assist them for time- structuring, concentration etc. - Development of appropriate mechanisms for follow up. - Assessment of the impact of the program through the analysis of the incidence of slips, lapses relapses, readdiction and drug-free cases.

PILOT PROJECT : DEVELOPING PLACEMENT SERVICE

Immediate Objective:

To develop a placement service for addicts.

OUTPUT	ACTIVITIES
Placement service	- Analysis of the facilities existing form of vocational training technical education, career opportunities. - Analysis of their utility for the target population, to facilitate social re-integration and the extent to which the addicts or ex-addicts utilize them/can utilize them. - Providing career guidance and job placement after taking due care to match the patient and the job, - Identification of addicts with potential to become social change agents - Placing them with social change agents such as Sundarlal Bahuguna, Baba Amte, Narayan Singh Manaklao, Dr. Arole and other charismatic leaders in various social settings.

PILOT PROJECT : WORK TEAM

Immediate Objective:

To facilitate the process of rehabilitation through involvement in community projects.

OUTPUT	ACTIVITIES
Work team.	- selection of CBOs or action groups in project areas. - An orientation workshop for these groups on various aspects of addiction, specifically on rehabilitation process. - Identification of individuals who require vocational rehabilitation. - Selecting a group of individuals who have been detoxified but lack skills and qualification which can aid their rehabilitation. - Forming the identified treated addicts into a work team. - Work team develops norms taking up contracts, roles for each member towards after care needs of co-members, norms for division of profits, wages, attendance, dismissal of members from the group, admission of new members to the group... passing out of work group. - Identification of community projects, which are considered important by the community. - Involvement of the group in the community projects. - Follow up of these individuals after their involvement in the community project for an year. - Assessment of the intervention made through systematic documentation and by members of the work team. - Production of a manual based on the process of intervention.

APPENDIX II

PILOT PROJECT : INDIGENOUS FORMS OF SELF-HELP GROUP

PROJECT JUSTIFICATION:

Self-help groups do not expect an individual to give up his addictive behaviour without providing him with an alternate set of behaviour patterns. The AA methodology which facilitates the preventive process are: busy schedule of social and service activities with supportive former drinkers, especially at times of high risk like holidays. AA encourages its members to return again and again to group meetings and to sponsors who provide an external conscience.

The cultural hurdles faced when attempting to imitate the West are the lack of attempt to analyze the adverse impact of alien language, the need for integrating the cultural variation and philosophy, utilizing premises other than church settings for conducting the meeting, the need for understanding the perception of the drug abusers about the group meetings. The tendency of Narcotics Anonymous to insist on a total drug-free state, may clash with the views held by the target population of various cultural backgrounds.

Immediate Objective:

To evolve indigenous forms of self-help groups.

OUTPUT	ACTIVITIES
Indigenous forms of self-help group.	- Identification of 2 self-help groups. - Keeping one group as a control group on the classical AA/N.A. model. - groups analysis of the experimental group. - studying the culture of target population, the symbols used, language idioms, philosophy of life, life style. - Analysis of philosophy, symbols, life style emphasized by the groups. (Observers with expertise in Vipassana, Indian philosophy, Islam, and Hinduism.) - Interview addicts who are participating in the group and those who have left the groups who discontinued. - Formulating guidelines for the formation of a self help group that is culture specific. - Integrating this variation in the experimental group. - Interviewing the target population to assess the appropriateness of the modifications to be made and documenting their views on further change. - Follow up documentation of both the groups for a year after the changes are made in the experimental group. - Comparing the utility value of modified groups with earlier existent groups. - Training others to develop groups relevant to the culture. - Documenting NA meetings in 2 groups for a year.

N.B. The turn over in N.A. groups is very high and principles of Anonymity have to be maintained.

ASHA BHAVAN

Treatment at this centre is for a minimum period of six months, during which period drug abusers live in a secluded and conducive environment aimed at facilitating them to modify unacceptable behavioral patterns adopted in addiction.

The staff of this centre are selected on the basis of their interest in working with the drug abusing population. As most of them are individuals who have had a previous history of addiction, their experience is use-worthy. The staff and the affected population are involved in daily chores and extra curricular activities to promote group-feeling.

The centre stipulates that motivation is the ground rule for admission. Verification of the client's level of motivation is the first step of the program. It does not provide detoxification facilities-medical management of the affected population is carried out in hospitals. The program covers spiritual, emotional and psychological aspects. Modification of one's belief system is sought to be achieved through group pressure, loss of privileges or status within the group, praise, acceptance or advancement in the authority structure within the centre.

Life at the centre may be divided into three stages. In the first stage, the movement of addicts outside the centre is restricted. Second, they are not permitted to handle money or maintain outside contact. The third stage includes rewards in terms of permission to handle money, to leave the centre for a short duration, the patients, however, are prohibited from seeking employment or entering the academic stream. Involvement in outside activities is discouraged to maintain their concentration on themselves.

The follow-up program is dependent on the individual's desire to maintain contact while evaluation of the program is limited to the expressed opinion of the target groups during house meetings.

CALCUTTA SAMARITANS:

The Arunoday centre in Calcutta is based on the Minnesota Model and hinges on the role of love and affection within the parameters of discipline set by the centre in order to facilitate the abuser to re-discover his identity. Treatment consists of detoxification for a period of upto thirty days and subsequent stay at the centre for rehabilitation, for six months.

The process consists of individual counseling, group therapy, behavior therapy, psycho-drama weekly sessions on rehabilitation readjustment and motivation, occupational therapy and spiritual therapy.

The individual is urged to take care of personal hygiene, make his own bed, wash his own linen and to maintain the dormitory.

The printing press attached to the centre, the vegetable garden,

a small-scale fishery project painting, clay molding and other handicrafts provide different avenues for occupational therapy. Spiritual therapy includes meditation, devotional group activity and group singing.

Group therapy aims at facilitating individuals to explore their experiences and associated feelings so as to gain a better insight about themselves. These exercises assist them to analyze a particular attitude or impression that surfaces in a given day.

Behavior therapy and psychodrama are used to inculcate responsible behavior patterns which exclude the portrayal of dependence on chemical substances.

The centre feels that a relapse to drugs (specifically to heroin) can be prevented through abstaining from nicotine and all other forms of drugs.

In order to facilitate integration with 'society', the recovered habitués are encouraged, in the latter part of the rehabilitation to assist in a school for under-privileged children, or in a home for abandoned boys and to take to recreational activities and games.

DELHI POLICE FOUNDATION:

The Delhi Police Foundation for Correction, De-addiction and Rehabilitation (DPFCDR), established Navjyoti clinics at police stations to detoxify habitués in order to decriminalize them. These centres cater to youth in Delhi and the suburbs.

Their process consists of detoxification, rehabilitation and re-integration of the individual in society. The individual is facilitated to establish positive and constructive relationship with his family and restablish his career.

The centre utilizes Allopathic and Homeopathic medicine, Yoga and recreational activities.

The follow-up process is carried out by Special Police Officers (i.e. members of the public who volunteer to assist Navjyoti in its after-care work) through home visits. If the habitué does not report to the centre, Navjyoti sends out a post card asking him to report regarding his well-being either personally or by mail. Coming from a police related centre, the rate of compliance is rather high.

KRIPA FOUNDATION

Kripa has adopted the Minnesota model (Hazelden) for the purpose of treatment. Two of its centres use this methodology.

Admission to the program is scheduled for a specific month of the year. The entire treatment process continues for a minimum period of 12 months. The in-patient program and preliminary care lasts for a period of three months each with extended care being provided for six months.

The program is based on spirituality, discipline, group cohesive-

ness, sharing of individual experiences and restricted contacts with family members. The influence of external stimuli are controlled through limited reading material(handbooks and related literature on AA and the NA magazine "Grapevine"). The individual is "taught" to be satisfied with his or her life. The program also involves 'Rational Emotive Therapy' and spiritual disciplines like 'Yoga' and 'Zen'. The Kripa Foundation collaborates with an employment assistance scheme.

The program intends to instill a feeling of self-worthiness and to facilitate the process of social reintegration. Counseling sessions are aimed at identification of personal problems and modifying behavior patterns. Family service is conducted once a week, as chemical dependence of even one person affects the entire family. After completion of the year-long treatment, the individual is expected to continue his or her participation in NA meetings for life.

Kripa has not yet undertaken any long term evaluation. The follow-up activity is dependent wholly on the ex-inmates' own subsequent involvement in NA and AA meetings.

MANAKLAO TRUST:

Opium deaddiction Treatment, Training and Research Trust (The Manaklao Trust) emphasizes a community-based therapeutic approach with detoxification.

The individual is viewed as a product of the cultural socio-psycho-economic environment. Elimination of addiction is undertaken in this framework. Addiction is viewed as conditioned behavior which is sustained through the behavior of the individual and his interaction with the society.
They feel the major causes for addiction in certain segments of the affected population are : lack of faith in humanity, rebellion against the hypocritical, self-centreed, competitive and mechanical life style of the present society. The important factors that might have contributed to the spread of addiction in Rajasthan are: the social sanction for consumption of opium during rituals like birth, death, festivals and soon the belief that it is impossible to give up addiction, utilization of opium to increase the number of hours of work of agricultural labourers by rich farmers and public works contractors; paucity of remunerative occupation for a large number of agricultural labourers in the desert conditions that mark the Western Rajasthan Thar region, the habit of mothers to ingest or feed opium to the infants when they go to work in order to put them to sleep.

Apart from the treatment centre at Manaklao, mobile camps are organized in order to treat patients in their own area and to organize support groups. Community surveys have been undertake done to assess the availability of volunteers compatible with varied ethnic and religious community groups of habitués in order to enhance the effectiveness of change agents.

Candidates for the camps are selected on the basis of their willingness to discuss their addiction and associated problems.

Physicians, psychiatrists, nurses, social workers, community workers, ex-habitués, parents and friends participate on a voluntary basis during the camp. A trained nurse provides medical care at night.

During the detoxification camps the organizers provide emotional support which they perceive as one of the major factors for preventing relapse. Besides detoxification which consists of giving tranquilizers to deal with symptoms of withdrawal, they utilize 'hug therapy' to create an emotionally conducive environment of acceptance and love.

After the withdrawal symptoms subside, music therapy (consisting of folk and devotional songs) and recreational activities are utilized to maintain the drug free state.

At the end of the ten-day camp, the individuals are obliged to take a vow to abstain from drugs and the local support groups give them encouragement and facilitate their re-integration into society. The support group continues to provide positive peer pressure even after discontinuation of the treatment, by warning ex-habitués not to participate in opium-offering ceremonies.

The first of the approach of the Manaklao Trust is principally dependent upon the charismatic, affable and dynamic personality of the Director, Padmashree Narayan Singh.

However, in the post-detoxification phase, the Manaklao system of habilitation tackles structural issues in the villages and hinges on the priests and leaders of caste associations to de-legitimize opium drinking and to ban the public serving of opium during religious ceremonies and social events in their respective villages.

Under the UNFDAC - GOI scheme to support NGO projects in demand reduction, an integrated comprehensive, district-wide community project is being set up which would not uproot the addict from his social milieu at all, but would have activities covering the entire spectrum of demand reduction activities.
(For further details contact: Opium De-addiction and Counseling centre, Rajdadi-ji-ka-nohara, Inside Sojati Gate, Jodhpur, Rajasthan.)

Under the same UNFDAC - GOI scheme, in the urban context, the Dr. Vidyasagar Kaushalyadevi Memorial Health centre in Delhi is developing work teams for vocational rehabilitation of addicts as part of community - based integrated demand reduction project.
(For further details contact: Dr. Vidyasagar Kaushalya Devi Memorial Trust, Nehru Nagar, New Delhi - 110 065.)

T.T. RANGANATHAN PROGRAM:

TTR Hospital has adopted a residential multi-disciplinary therapeutic program to tackle the problem of addiction.

Addiction is viewed as being a chronic and progressive disease that leads to physical, emotional and social problems.

The program is tailored to achieve the goals set by the centre namely, to attain total abstinence from alcohol and drugs for life and to instill positive changes in the behavior and the attitudes of the patients.

The treatment program which lasts from four to six weeks provides medical help for physical addiction and associated problems. A therapeutic program for psychological problems consists of individual counseling, lectures, group therapy, relaxation techniques, recreational activities and educative films. Individualized care and attention are provided.

A follow-up program is maintained for a period of five years through participation in after-care programs held every week at the hospital, visits to their doctors or counselors within a period of fifteen days in the initial stages and monthly follow-up visits after three months.

The social support program of the centre aims at exploring the possible support the recovering patients could receive from the society in their process of recovery. The contact with support people, family members (other than the spouse) with co-workers or with friends facilitates in establishing recovery and ensuring regular follow-up.

The hospital also has a two-week program for the family, based on the concept that addiction is a "family illness" that affects members of the family apart from the concerned individual. The program provides necessary information to the parents while the therapists provide them with emotional support to cope with stress when dealing with addicted individuals. The program consists of lecture sessions, group discussions, assignments, relaxation techniques and AL-Anon.