II PHASE - II MONTH

II - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Review of weekend	Relief Drinking or Life History	A.A. Meeting
Tuesday		
General Assignments (Self-esteem Evaluation Chart)	Values violated and Displaced by.	'Feelings' (Lecture)
Wednesday		
Time Management (Lecture)	Worst Drinking episode	Assignments
Thursday		
Assignments	'Feelings'	N.A. Meetings
Friday		
Ungame	'Values'	Group

SEXUALITY AND RECOVERY

by

Barbara McFarland, Ed.D.

Hazelden

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First published November, 1984.

ISBN: 0-89486-246-4

Printed in the United States of America.

Editor's Note:
Hazelden Educational Materials offers a variety of information on chemical dependency and related areas. Our publications do not necessarily represent Hazelden or its programs, nor do they official-

Your reason and your passion are the rudder and the sails of your seafaring soul.

If either your sails or your rudder be broken, you can but toss and drift, or else be held at a standstill in mid-seas.

For reason, ruling alone, is a force confining; and passion, unattended, is a flame that burns to its own destruction.

Therefore let your soul exalt your reason to the height of passion, that it may sing;

And let it direct your passion with reason, that your passion may live through its own daily resurrection, and like the phoenix rise above its own ashes.*

Foreword

In writing this manuscript, I have primarily focused on individuals who are heterosexual. However, in my professional experience, I have found that gay couples I have treated have also fallen victim to cultural stereotypes. Despite the fact that the relationship might consist of two men or two women, there often is still a dominant, or stereotypically "masculine" partner and a more passive, stereotypically "feminine" partner. All relationships are based on certain expectations which have been greatly influenced by our beliefs about what is appropriately masculine and what is appropriately feminine in our culture. Gay individuals can still apply the principles and ideas of this pamphlet to their own recovery.

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Perhaps another issue that needs to be addressed is that often people are not in a committed relationship. However, we do relate to members of the opposite sex most of our waking day. Stereotypical attitudes can interfere in the development of positive healthy work relationships, or friendships. Therefore, learning about one's predispositions toward sexual stereotypes can influence all relationships in a positive and healthy direction.

Regardless of whether or not one is heterosexual or homosexual, in a committed relationship or not, rigidly adhering to one style of relating — dominant or passive — is detrimental to the relationship and to the personal growth of the individuals in that relationship.

Introduction

To admit that alcohol or other drugs have made life unmanageable is a beginning — one which is often a major catalyst in getting a person into treatment. Usually by the time someone enters treatment his or her life is a shambles, or close to it. After all, the disease affects every aspect of a person's life: psychological, physical, spiritual, and sexual. Yet, sexual aspects of recovery are rarely dealt with.

Sex is uncomfortable for most people to discuss unless it is in the context of a humorous anecdote or an off-color joke. Consequently, sexual issues in recovery are overlooked completely or only minimally considered as a treatment issue. Perhaps this is due to an underlying assumption that the topic should generally be limited to a discussion of sexual activity or sexual performance, which is considered a private matter best left alone.

Gender Identity

The physical aspect of sex is only one part of sexuality. The other aspect — the one that is most critical and has a direct impact on sexual performance — is what we will call "gender identity."

Gender identity is the way a person defines him- or herself as masculine or feminine. There can be a cause and effect relationship between gender identity and sexual expression. People who are more accepting of all aspects of their sexuality — their maleness and femaleness — are more able to be sexually expressive in an intimate relationship.

In order to understand gender identity more clearly, let's look at the reentry of the recovering person from treatment into normal life. For both men and women, this reorganizational process, integrating sobriety into a life previously consumed by alcohol or other drugs, is deeply affected by their ability to follow standards of sex-appropriate behaviors as defined by our culture. The underlying assumption is that such sex-typed behaviors are conducive to personal happiness and allow men and women to function in the mainstream of society. As a result of the women's movement, it has become increasingly evident that this assumption is wrong. Adhering to rigid stereotypical behaviors, attitudes, and feelings blocks personal growth and negatively affects the quality of a person's relationship with self and others.

Stereotyped Roles

Despite the strides the women's movement has made in most areas, our culture has continued to perpetuate the victimization of both men and women by encouraging people to accept stereotypical role behaviors. The recovering male is encouraged to resume his role as head of household with all the privileges and headaches inherent in that position. By virtue of his place in the labor market, he has the power and control to make major decisions in the household. However, he also assumes total responsibility for the economic security of all family members. Given this role expectation, he must be strong, aggressive, economically productive, and rational at all times. One of the obstacles the recovering man often must

overcome is the repression of his feelings.

The recovering woman, on the other hand, is encouraged to return home and resume her nurturing, caretaking, submissive/passive role of wife, mother, daughter, or employee. The privileges inherent in her role are economic security and a deep sense of emotional attachment, which are supposed to give her a sense of purpose and belonging. One of the major obstacles the recovering woman often must overcome is her repression of her own internal resources — resources which help her develop a degree of confidence in her ability to take care of herself.

The man becomes an emotional cripple dependent on her nurturance, and the woman maintains a childlike existence, dependent on his economic power and decision-making skills. Even lesbian/gay relationships often take on the dominant/submissive dynamics. This division of labor has retarded the ability of men to be nurturers and caretakers, as well as that of women to be decision-makers and bread-winners. As a result, neither gender is able to experience other aspects of their full potential as human beings.

Even with single persons who are not in a committed relationship, there can be a vague feeling of emptiness. Though a woman may be working and economically self-sufficient, she may miss the "status" and "strength" of a male. The single man, on the other hand, who has been taught to be more independent, often tends to look for nurturance in his sexual encounters with women.

New Choices

There have been changes, but old attitudes die hard. People are beginning to realize they have a choice. They can integrate many aspects of masculinity/femininity (as defined by the culture) into their personalities without feeling guilty or ashamed.

Take, for example, how unusual it was a generation ago for a man to go grocery shopping, diaper a baby, hug another man, cry in public, cook and sew, or take care of a sick child. It was quite unusual then for a woman to pursue a career, pay alimony, be sexually aggressive, choose not to have children, be athletic, make more money than her spouse, or give up her children in a divorce.

The cigarette ad that cries "You've come a long way baby" is also making a statement about men's sex roles. As things change for women, they will also change for men. This can be frightening to many people. Adhering to old sexual stereotypes seems comfortable, easier, and much safer. This is especially true for the recovering person.

Because of the failure each feels in not having lived up to cultural expectations while using alcohol or other drugs (being the good wife and mother, perfect daughter or employee, or the strong, rational husband and father, or productive employee) recovering people often try desperately to succeed with these sex-typed expectations. They may cling rigidly to what they believe will alleviate guilt. Keeping mired in guilt and trying to make up for past failures only increases the deep sense of inadequacy. Letting go of these old attitudes is a beginning of healthy recovery. What makes this letting go difficult is related to the role alcohol and other drugs played in the sexuality of the dependent person.

Sex Role Stereotypes and Chemical Dependency

Women have been divided culturally into the Good Girl type and the Bad Girl type. The Good Girl is the "ideal" woman — chaste, thoughtful, loving, selfless, kind, generous, and highly moral. She is a paragon of virtue. The Bad Girl is the opposite of this saintly creature. She is a tough, promiscuous, aggressive, selfish person who thinks and drinks "like a man." Women struggle with these bi-polar conflicts, especially in the area of sexual feelings, since our society has tended to view the expression of sexual desire as inappropriate in a female, sometimes even immoral.

In order to maintain the Good Girl image and yet be sexually responsive to a partner, many women use alcohol or other drugs to loosen up, to lower their inhibitions so they can feel sexier to please their partners more. For the chemically dependent woman, this only escalates her disease. Her drinking gets worse and her self-esteem plummets. She has become the opposite of what society says she should be. Having sex while intoxicated helps her deny her true feelings about her own sexual expression. It's a great excuse the next day to look in the mirror and say, "I was too drunk last night . . . I really got carried away . . . oh, well, if I hadn't been drinking, I wouldn't have done that." She blames the desire for sexual activity on alcohol or other drugs. That way, she can still be a "lady" in her own mind. This helps preserve the female gender identity of Good Girl, at least for a while.

Once into recovery, women are often faced with the dilemma of being "good" yet sexual, and must solve it without the use of alcohol or other drugs. This is a major recovery issue for women, one that is difficult to discuss because of the social stigma which has been attached to women who show a desire for sex. Chemically dependent women have an especially difficult time because of the additional stigma associated with the disease.

It is interesting that, for a man, the reverse occurs. Culturally, a "real" man is sexually aggressive and self-assured, not promiscuous but a "playboy" — tough, strong, and independent. This is the Marlboro Man, James Bond, Dirty Harry. Culturally, a man who is sensitive, insecure, emotional, or sexually shy is viewed with disdain. He is something of an anomaly because of his "feminine" behavior. What is acceptable for women is not for men.

In order to cope with this image, alcohol or other drugs can give the man a dose of false courage, the machismo to "stand tall" and to "bite the bullet." It lowers his inhibitions, too, for different reasons, but the result is the same.

Affects on Sexuality

Just as there are stages of the disease, there are also stages of the disease's effect on individual sexuality. Initially, chemicals are often used to help a person feel more comfortable with sex, and more sexually provocative. During the middle stages of chemical dependency, they help the person cope with conflicting feelings of gender identity and sexual expression. Of course, in the later stages of the disease, sexual prowess and conflicting feelings of gender identity become less of an issue, and the desire to drink or use other drugs becomes the individual's primary focus in life.

Alcohol and other drugs eventually affect physical performance. For males this might mean difficulty with erection or premature ejaculation. Many men dread not being good enough in bed. Because of the stereotypes, most of the responsibility for sexual initiative and creativity falls on the man. This pressure can, and often does, lead to impotence.

For a woman, frigidity, shame, or embarrassment might result from things she did while intoxicated. Because she is ashamed of and often confused by her sexual feelings, she is unable to communicate her sexual needs. Her self-hate increases, but alcohol or other drugs help her cope. These sexual self-images of failure have been embedded in the chemically dependent person's mind. Sobriety makes them all the more a reality.

For example, a sexual memory that may haunt a male might be the painful recollection that during the last several attempts at sexual intercourse he was unable to achieve an erection. The ridicule, criticism, or even silence from his partner has diminished his self-confidence as a fully functioning, competent, and desirable sexual partner. Alcohol or other drugs would numb this fear, but in sobriety he may feel trapped unless he is willing to risk again.

A woman may hold on to the memory of how sexually aggressive she was and how her moral values deteriorated during her drinking or other drug use. These sexual images deep-

ly affect her self-esteem. Alcohol or other drugs will numb her self-hate, but sobriety can keep it alive unless she is willing to forgive herself.

In recovery both sexes need to transcend the male/female stereotypes in order to shed their old rigid sexual images.

Sexual Recovery

These painful memories are difficult to shake because there is nothing to replace them. Cultural pressures and the effects of alcohol and other drugs on psychological and physical levels of functioning play havoc with the development of a healthy gender identity. In part, chemicals are used to help the person be what culture dictates. This is how they promote sexual deterioration in the chemically dependent person.

Physical, psychological, and spiritual aspects of recovery are fairly easy to determine. Physically, abstinence from mood-altering drugs and adherence to a suitable diet improves the body. A.A. meetings, therapy, and working the Twelve Steps of the A.A. program improve the psychological realm; prayer and meditation improve the spiritual realm. But what improves the sexual? What benchmarks or goals can individuals look at in order to make strides in their sexual recovery? Frequent sex is not the answer.

Recovery in the sexual sphere means the recovering person must go through a process of self-examination. Specifically, a recovering person can look toward experiencing five stages of sexual growth. These stages are not rigid and regression is not unusual.

STAGE ONE:
Awareness of Self as a Male/Female Person

This stage requires a deep self-analysis of how the person defines maleness or femaleness by cultural standards. Before beginning, one must see how detrimental it is to be either "all masculine" or "all feminine."

Being all masculine, drinking or sober, makes a man feel he has to prove something. While drinking, it can be how much booze he can tolerate. While sober, it can be how he can "beat" this problem on his own. All masculine means, "I can handle anything." Needing others is a weakness.

Being all feminine, drinking or sober, makes a woman feel she has to have someone take care of her. While drinking, the alcohol can keep her helpless and nonfunctional, pulling people in to take care of her. While sober, she may be getting sober for everyone else so they'll take care of her. All feminine means, "I can't handle anything without someone helping me."

A person can become trapped by personal boundaries of stereotypical sex-appropriate behavior. These boundaries can be a safe place to hide. For men, their softer side is denied, feelings are taboo, and after a period of time, they become emotionally crippled; their feelings are alien even to them. This makes it especially difficult to be intimate.

For women, their self-sufficiency is often squelched, and as a result, their real internal resources are yet to be tested. Being stereotypically feminine keeps a lid on the female's strength and ability to master her own fate. Using only half of one's potential and abilities causes the other half to atrophy. As men harden, they become increasingly dependent on women to nurture them, to be emotional for them; as women's strength withers, they become dependent on others to be taken care of, to be their anchor throughout life.

Breaking Out

Breaking out of these roles can create problems because the status quo is being shaken at its very roots. In a stereotypical relationship, a man reaching out for support can be met with disdain by the spouse who is fearful her "anchor" is falling apart. In her eyes, and in his eyes, too, he has to be strong to take care of her. His move out of his traditional role may be met with resistance by a spouse who does not want the balance changed. She fears it means ultimately she must change.

The same problem can occur with the recovering female who asserts herself and wants to become more financially independent by getting a job. The husband may feel threatened, fearing she won't need him as much. In his eyes, she *has* to need him for economic support; he *has* to take care of her. This alters the balance in the relationship and requires the male to see himself as more than just a paycheck and someone in charge. In creating a more balanced gender identity, the recovering person must understand that others may resist this change and want to keep him or her in what is perceived as a less threatening position.

Rewards

The rewards for struggling through this major shift in relationship dynamics are immense. With equal, interdependent, fully functioning partners there are no games or manipulations. There is no need to "win" or "lose" when there is equality. This results in a deep respect for one another's individuality. The relationship becomes a place to relax, to share, to let go, and to regroup; a place to feel a deep sense of belonging and peace.

The recovering person and spouse are used to operating in extremes. They both need to find a balance in gender identity. Every human being has feminine and masculine traits. Our culture has taught us to deny the opposite-sex trait. Healthy sexual recovery requires that people integrate the other side into their feelings, attitudes, and behaviors.

Self-Examination

In examining your sexual self-awareness, consider these questions:

How do I feel about myself as a man/woman?
How rigid am I in the expression of my gender?
How stereotypical are my attitudes, behaviors, and feelings?
How easily am I threatened by the unfamiliar?
How fearful am I of letting go?

Can I be both masculine or feminine, depending on the situation?
How do I treat members of the opposite sex?
What do I expect from members of the opposite sex?
As a man, do I view women as "sex" objects?
As a woman, do I view men as "marriage" objects?

Since this is the most critical of the stages, following are exercises which will help generate some thoughtful answers to the above questions.

Your Own Stereotypes

On a sheet of paper, write down the first name of a person of the opposite sex you admire most. List the qualities you admire (i.e. integrity, kindness, ambition, etc.) in this person. How stereotypical are the qualities you've defined? Ask a member of the opposite sex what he or she thinks of this list and your perceptions.

Divide a sheet of paper in half. At the top of one side write "masculine"; on the other side write "feminine." List all the traits that describe you. Share with someone of the opposite sex who knows you well. Then share with someone of the same sex who also knows you well. What kind of feedback have you received about your masculine/feminine self-perceptions?

STAGE TWO:
Awareness of How Others Perceive You as a Male/Female Person

This stage requires openness and willingness to see how others perceive you as a man or woman, and how consistent this is with your own perceptions.

Being able to receive feedback requires the ability to take criticism. Chemically dependent people sometimes have difficulty with this. Often perfectionistic and their own worst critics, they typically balk at negative feedback from others.

In order to get in touch with others' perceptions of your

sexuality, you must be willing to accept what may be painful to hear. This feedback will be the basis for change.

As you work on this stage of sexual recovery, it's important to move beyond the safe circles of friendships already established. It's imperative to relate to members of your own sex. A heterosexual man will not usually try to dominate or control another man. A heterosexual woman will not usually try to play helpless victim to another woman. Interacting with members of the same sex forces a person to be more honest and less manipulative.

In getting feedback about your sexual self, first ask someone of your own sex how he or she really perceives you.

Questions to consider include:

How do others see me as a man/woman?
How easy is it for members of the opposite sex to relate to me?
In what ways do I relate to members of the opposite sex, i.e., aggressive, dominating, passive, dependent?
How comfortable am I with members of my own sex?
(Women have had much greater difficulty with this because of the low status ascribed to women in our society.)

STAGE THREE:
Experimentation With Sex Roles

The last three stages are process stages which continue throughout a person's life, because, as sexual beings, we are not static.

This stage involves crossing over the boundaries of stereotypes. Once you have achieved self-awareness and awareness of others' perceptions of you, take this information and start experimenting with new behaviors, attitudes, and feelings.

For example, if you are a man, and you and others perceive you as too intellectual, rational, and emotionally inaccessible, make a concerted effort to be more open by sharing feelings. One way to begin would be to start a daily journal in which you record significant events and your reactions to them. You might also record feelings you remember from your dreams, and then see how they relate to what is happening in your life.

You can also begin to separate your feelings about what people do (actions) to you from what people say (words) to you and decide which has the greater impact. This is another step in raising awareness of your feelings. Recording these reflections can be very helpful.

If, as a woman, you and others perceive you as too self-effacing, begin to practice assertiveness. A journal of reflections can also be a powerful tool in raising awareness about self-effacing behaviors. Therapy and A.A. discussion groups are powerful springboards for this. Experimentation is painful. During this time you will have to stretch yourself, take risks, feel uncomfortable with new behaviors. But in riding these feelings out you will be approaching balanced sexuality.

The key questions to consider during this stage are

How flexible am I?
How willing am I to change?
What sexual defenses have I developed?
What are my fears about my masculine side?
What are my fears about my feminine side?

STAGE FOUR:
Differentiating Between Sexual/Physical Needs and Sexual/Intimacy Needs

Once you have become more comfortable in expanding your gender identity, in being more spontaneous and fluid in the expressions of both your masculine and feminine sides, sex will take on a new dimension. No longer will sex be merely a means by which you satisfy your physical needs. It will become a vehicle through which true human intimacy can be experienced. To someone rigidly fixated in the old sex-appropriate behaviors, this intimacy can be terribly frightening and, consequently, avoided.

The ability to give of oneself to another in the most intimate of shared experiences requires unconditional self-acceptance as a sexual being. No side of that sexuality can be repressed.

In sexual expression there is no game. No one should have to do or be anything that isn't consistent with the spontaneity of the shared experience. One reaches out and gives to the other all of oneself, not just those parts that seem to be acceptable.

The key questions to consider during this stage are

What do I expect from my partner sexually?
Do I communicate verbally what my sexual needs are?
How do I show my affection for my partner outside the bedroom?
What role does sex play in my relationship with this person?
How do I feel about initiating sex? What are the ways I do this?
How do I feel about being creative sexually? How do I share this with my partner?

STAGE FIVE:
Achieving Sexual Equilibrium

This is the stage of sexual self-actualization. It involves the ability to be comfortable with oneself as a male or female in everyday interactions and activities as well as in a sexual relationship. It requires self-acceptance and acceptance by others.

Quality recovery should include the ability to be spontaneous in the expression of the feminine and masculine sides of our personalities, and the ability to be intimate by giving of our sexual selves.

The key question to consider during this stage is this:

How willing am I to continually reevaluate myself as a sexual human being?

Quality recovery is based on achieving a balanced lifestyle. Although sexual aspects of recovery are often minimized, the recovering person must take responsibility for this part of life as a sober person. Open discussion of sexual issues, fears, and doubts is critical to the restoration of healthy sexuality.

CONCLUSION

Integrating a program of recovery for sexual growth and development only adds to the quality of sobriety for the recovering person. Reexamination of what is comfortable and familiar in terms of sexual self-definition is a painful and often unsettling task. However, ignoring the sexual side of one's self inhibits a person from achieving a true sense of balance in recovery.

Feelings are natural,
A part of us.
They are to be our friends,
Not our foes.
To be listened to as cues, signals.
To be cherished
As a part of us.

Claudia Black

Directions for THE STAMP GAME

"A Game of Feelings"

BY CLAUDIA BLACK

DIRECTIONS

Purpose: The purpose of THE STAMP GAME is to help players to better identify, clarify and discuss feelings.

Leader: THE STAMP GAME requires that one person act as a facilitator and not participate in playing the game.

Because this is an emotionally-charged game, the facilitator must be a warm, caring person, comfortable with his own feelings and the feelings of others.

Players: The game can be played with the facilitator and one to six players. Groups with up to forty participants can play by dividing players into groups of five, while the facilitator moves among the groups. Co-facilitators may assist. (See enclosed ordering instructions for additional stamps.)

Time Frame: A group of six players will take approximately 60 to 90 minutes to play the game. Allow 90 minutes if feedback (see "Extended Play") is utilized. THE STAMP GAME may be ongoing in that participants may play a portion of the game during each session. (See "Variations").

Results: Players will be able to relate more honestly to others when they have learned to express feelings. Players will begin to respond appropriately to situations when they become more aware of their feelings. As a result, players will become increasingly more effective problem solvers.

Setting: Game can be played on a large table or the floor (more fun).

TO BEGIN:

1. Players sit in a circle.
2. Facilitator places stamps in center of circle, in piles according to color and explains which colors represent what feelings.

   Red stamps — Any form of anger such as rage, frustration, irritation, disgust, etc.

   Blue stamps — Any form of sadness such as disappointment, loss, etc.

   Black stamps — Fear

   Orange stamps — Guilt

   Green stamps — Embarrassment

   Yellow stamps — Any form of happiness, such as joy, warmth, love, etc.

   Light Brown stamps — Confusion

   White stamps — Any feeling not listed above that player (Wild Card) wants to identify, e.g., lonely, helpless.

3. Ask participants to remember what it was like when they were young children and teenagers growing up in their family. Then instruct them to pick up stamps which represent the feelings they had as youngsters and adolescents.
4. Explain that the stamps represent feelings, whether or not people in their family were aware of them having these feelings. Participants should select a number of stamps representing the intensity of each feeling. Example: If a participant experienced a great deal of anger, he might take 5 to 10 red-anger stamps, compared to feeling a small amount of fear, where he might take 2 or 3 black-fear stamps.

   Let participants know that they may not immediately identify with a particular feeling and they are not required to pick up any particular stamp color(s).

   (This process usually takes approximately 5-8 minutes).
5. When all group members have selected their stamps, instruct them to arrange the stamps, in an order beginning with the feelings expressed the most as a child, to feelings shown next to the most, to those shown the least. Example: the person who knows that he hid his anger, yet found it easier to show sadness might position his blue-sadness stamp(s) before his red-anger stamp(s). The person who was afraid and showed that fear will have his black-fear stamps in front of his orange-guilt stamps if he seldom or never showed guilt.

   There is no **one** correct way to position stamps; arrangement is left up to each player.

Abbreviated Topics:

THE STAMP GAME can be used as an integral part of ongoing individual sessions or groups.

Participant may be asked:

— Pick up stamps that represent feelings you had this week.
— Pick up stamps that represent feelings you had today.
— Pick up stamps that represent feelings you had at school.
— Pick up stamps that represent feelings you had with a particular person.
— Pick up stamps that represent feelings you would like to discuss.

Or participants may be asked to associate feelings to specific situations. Pick up stamps that represent how you felt when

_____
(Give example)

Examples:

— When your mom said she was leaving,
— When your dad didn't come to see you.
— After you said 'no' to your son.

Treatment professionals may suggest that families use THE STAMP GAME (Abbreviated Topic Section) as a part of family meetings.

Facilitators are encouraged to use stamps in a variety of situations.

Extended Play:

It is suggested that if facilitator is working with a person or group over a period of time, clients may play the game more than once. Often it is played first without the feedback component. At a later time, feedback can be included.

Feedback can be a vital part of THE STAMP GAME. Let members know that feedback is optional, not required. Time and players' familiarity with each other are the key factors in whether or not this aspect of the game should be included.

1. Feedback is given after each individual has completed sharing his feelings in adulthood. To give feedback, other participants reflect on what feelings they think the participant had or presently has that he did not identify or share.

2. Feedback is given only in the form of offering stamps. To give feedback players (one at a time) take stamps from the community pile. These stamps represent what feelings they believe the sharing player has not identified. Participants place those stamps in front of the player's stamps and briefly explain to player their perceptions, e.g. "This is more anger. I feel that there is more anger with your mom, but it's too scary to share", or "this is more fear, I don't know what it's about, I just sense more fear." Instruct group members to be as specific as possible, but to **limit comments to 2 or 3 sentences.** When sharing goes beyond 2 or 3 sentences, the person giving feedback may be analyzing or intellectualizing, and should be politely asked to stop.
3. The sharing player listens without verbally responding. There is no dialogue regarding feedback. While the person receiving feedback is not responding verbally, he acknowledges (agrees and accepts) feedback by picking up new stamps and bringing them into his pile.

   Feedback cannot be rejected.

   The player receiving feedback reflects his openness (a willingness to reflect and consider feedback) by leaving stamp(s) in front of pile.

   Feedback cannot be rejected.
4. Since the purpose of the game is to assist participants in identifying and expressing feelings, it is not permissible to offer feedback which removes a feeling, i.e. removing player's stamps. Many times participants, in their desire to protect another from his or her painful feelings, inappropriately offer yellow-happiness stamps during feedback. In order to facilitate changing this pattern, discourage giving yellow stamps during feedback.
5. When feedback is completed, move to next participant.
6. Complete this extended version with a self-image or self-reflection exercise.

Reducing Vulnerability to HIV/AIDS

In Drug Abusing Populations

(The Affected, The Afflicted and Those "At Risk")

Through A Community Wide Response

Global Illicit Drug Trends: 2000

Amphetamine Type Stimulants

Drugs of the 21st century?

Following dramatic increases in ATS abuse in early 1990s, markets in Western Europe and North America are showing encouraging signs of stabilization or decline

Globally, however, illicit supply and demand are still showing upward trend

In East and Southeast Asia, illicit production, trafficking and abuse are rising. The region seems to be emerging as a prime source for both ATS end-products and their chemical precursors. The danger of spread to other parts of the world remains.

GLOBAL SCENARIO

High=High Risk=HIV

1. 134 countries have reported HIV till 1999

2. Of these, 114 countries have reported IDU with HIV

3. Almost all HIV has underlying alcohol or other drug use (UNDCP-UNAIDS document: Drug Abuse & HIV/AIDS- a devastating combination)

   Study of 10 million IDUs worldwide shows:

   - IDU is 7-22% **of all** drug use
   - **1 in 10** IDU has HIV

UNDCP RESPONSE

1. As a UNAIDS Cosponsor, UNDCP aims to reduce the vulnerability of young people by carrying out projects that promote a healthy life-style.

2. Having easy access to health services, developing life skills and being educated about the health risks that come with drug abuse are the keys to staying drug free - and free of HIV.

3. A supportive environment is crucial

The Strategy

- Target, reach and bring about behavior change in a critical mass of vulnerable population
- Aim for absolute coverage to reduce vulnerability
- Reduce vulnerability through behavior change and reduction of risk taking behavior
- Bring about behavior change through sustainable innovative community based, managed processes/ interventions
- Improve capacities of care givers to bring about behavior change & to assess coverage

The Challenges

- Create an enabling environment
- Identify, address & ensure appropriate capacity building to change behavior
- Improve, expand and network available services
- Ensure absolute coverage
- Reach all HIV-IDUs among IDUs and reach all IDUs among Drug Abusers
- Ensure that a critical mass of IDUs reached, change practices & reduce vulnerability
- Deal with the family issues & reduce vulnerability
- Target the "at risk" effectively, "Innovative IEC"

NEWS FROM THE REGION
(ASIA - PACIFIC)

- Only 3 Asian countries have HIV rates over 1% among 15-49 years old - Cambodia, Thailand and Myanmar
- However such low rates conceal huge numbers
- Sex trade and use of illicit drugs are extensive
- So is migration and mobility within and across borders.

Myanmar

Population	:	43 million
Government Figures	:	25000 HIV infected
World Bank	:	700 000 HIV infected

Growing sex trade and mounting use of intravenous drugs

Battle	:	Socio-cultural Taboo against open discussion of sexual health Social stigma attached to HIV/AIDS disease.

Yunan

- 7% sex workers inject drugs
- Amphetamines use in sex work settings is emerging rapidly in the region.
- Emerging evidence of the role of other drugs including alcohol as a co-factor determining risk.

Northeastern Region - India

7 NE states constitute < 3% India's total population but have 30% of country's total IDU population (approx: 200, 000)

Manipur

First case of IIIV detected in 1989
HIV among IDUs > 75% in 1997
Non-injecting wives of male HIV positive IDUs - 45% (late 1997).
Sentinel Surveillance ANC 1.69%, Blood donors 1.3%
Estimated Drug Users 15-20,000.
Sex Workers 1000
Total Population - 1.8 million

The Scenario is comparable to Thailand whose ANC 1998 was 1.53%

MH-26.30

(4)

ACTIVITIES OF AFTER CARE CENTER

SERVICES RENDERED

Medical Services: -

- Doctor visits twice a week
- Medications
- Psychiatric consultations
- Referrals/ testing

Therapeutic services: -

- Re-educative lectures
- Activities
  - Art therapy
  - Therapeutic Games
  - Energiser
- Group therapy
- Individual counselling
- Follow up
- Home visits
- RPP (one month)
- Crisis intervention
- Family classes
- Marital counselling
- Counselling for children with specific problems
- HIV pre/ post counselling

Extended services: -

- Yoga
- Gym
- AA / NA / Al-Anon Meetings
- Bhajans
- Sober Birthday celebrations
- Vocational rehabilitation
- Special programmes for recovering addicts
- Community awareness programme
- ACC anniversary celebrations
- Celebrations of religious festivals
- Programmes for trainees

Supportive Features: -

- Staff development programmes
- Weekly staff review meeting
- Monthly ACC review meeting
- Documentation
- Networking with other institutions
- Mobilising support groups

FOCUS OF THERAPY

COMMUNITY MEETINGS

- ✓ Every day's programme starts with the community meetings.
- ✓ Stories are used as a methodology to impart value based thoughts.

RE-EDUCATIVE LECTURES

Disease Aspect

- ✓ Disease concept
- ✓ Denial
- ✓ Dry drunk
- ✓ Relapse/warning signs
- ✓ Psycho social factors.
- ✓ Children of addicts and family violence
- ✓ Over coming grief
- ✓ Developmental task
- ✓ Powerlessness
- ✓ Human needs
- ✓ Surrender Vs compliance
- ✓ Emotional cost of dependency

Personality development

- ✓ Assertiveness
- ✓ Anger
- ✓ Negative / positive feelings
- ✓ Personality defects
- ✓ Improving quality of life
- ✓ Self esteem
- ✓ Value
- ✓ Hurt feelings

Recovery

- ✓ Problems in sobriety
- ✓ Facing challenge in life
- ✓ Building relationship

Medical issues

- ✓ Medical complications
- ✓ Smoking
- ✓ HIV /AIDS
- ✓ Sexual problems

Coping skills

- ✓ Work Ethics
- ✓ Financial Management
- ✓ Time Management
- ✓ Stress Management
- ✓ Communication

Introduction to AA

- ✓ Steps of AA
- ✓ Making amends
- ✓ Resentments
- ✓ Spirituality
- ✓ Serenity prayer
- ✓ Slogans

GROUP THERAPY ~~LECTURES~~

- ✓ Powerlessness
- ✓ Damages
- ✓ Worst Drinking/ drug taking episode
- ✓ Insane And Aggressive behaviour
- ✓ Positive/ negative qualities
- ✓ Pleasure Vs pain
- ✓ Developmental stage
- ✓ Myths and misconceptions
- ✓ Tools of recovery
- ✓ Future risk situations

ACTIVITIES

Art Therapy

- Problems in sobriety
- Group art
- Recovery tool box
- Fears
- Inside Outside
- Beauties in life

Therapeutic activities

Memory game - Ice call
- Anthakshri
- By default

Clay modeling

Finding the leader

Life skills activities

Communication
- Dumb Charades
- Guess what's the good word
- Chalk game
- Trust walk
- Pictionary
- [illegible]

Self Esteem
- Positive Strokes
- Talents time
- Tournaments
- Self Esteem Envelope
- Animals and Good points
- Personal skills

Assertiveness
- Debates

AN IDEAL ACTION

GENERATE ENERGY

1. Mind surrenders to Self
2. Intellect fixed in Self
3. Body active

AVOID DISSIPATION

1. Anxiety for results of the future
2. Worries of the past
3. Excitement over the present

CONCENTRATION

Intellect directs mind to chosen action

CONSISTENCY

Intellect directs all actions to chosen ideal

CONTROL DESIRE AND EGO

DESIRE

Is the flow of thoughts towards an object or being for fulfilling an unfulfilment felt within oneself.

MODIFICATIONS OF DESIRE

Desires fulfilled leads to greed (lobha), delusion (moha), arrogance (mada), envy (matsarya) and fear (bhaya). Desires interrupted give rise to anger (krodha).

EGO

Arises out of a feeling of :
I am supreme.
I only exist.
I am the doer.
Ego hurt gives rise to anger.

DESIRE/EGO

Causes mental agitations and inefficiency at work.

INTELLECT

To reach the goals set by you, you need to make the existing intellect available to you and also to develop it. The intellect is made available through a process called introspection. To develop the intellect further you need to study and reflect upon Vedanta. It is available in the form of a book entitled "Vedanta Treatise".

GOALS TO ACHIEVE

1. INDEPENDENCE

   Examine the life of a plant, an animal and a human being. The plant is most dependent while the human is designed to be the least dependent on the world. But man today is largely dependent upon the amenities and facilities, the environment and circumstances of the world You must shed this dependence, become wholly self-sufficient and thus regain the dignity of a human being.

2. HAPPINESS

   It is the bliss of self-realisation. It is infinite, absolute in quality and quantity. Once you enjoy the bliss of the self within, the greatest joys of the body, mind and intellect mean nothing to you. These joys are like the waters entering the ocean.

3. KNOWLEDGE

   Ignorance of Self projects this world. All the knowledges acquired in this world are in the realm of ignorance vis-a-vis the absolute knowledge of Self. The knowledge of Self is pure knowledge compared to the conditioned knowledges acquired in this world.

4. LOVE

   True love is universal, even, same to one and all. Love in the purest form is everywhere, nowhere in particular. It is regardless of caste, creed, colour, community or country. It has no fixed location. It is not concentrated in one form, it is realising oneness with the world.

5. POWER/STRENGTH

   If you are selfish and egocentric in life, your power is limited. Your actions are poor. Drop your selfishness and ego, turn selfless you command real power and strength. You become dynamic.

FUNDAMENTAL VALUES OF LIFE

1. **ACTION**
   Action is the insignia of life. Inaction is decay, death. The first lesson in personality development is therefore to be active.

2. **DIRECTION**
   What are you working for? What is the purpose of your living? What is the mission of your life? Reflect on these ideas. Fix an ideal, a goal, a cause for your living. Let your actions be directed to that ideal.

3. **OBJECTIVITY**
   Is maintaining an impersonal attitude in life. Opposite of being involved and entangled in the affairs of the world. Look at the world as you would a picture on the wall. Function in the world like an actor on the stage.

4. **SENSE-CONTROL**
   Indiscriminate indulgence in sensual pleasures results in the destruction of your personality. The senses are very powerful. They distract you from your chosen path and you lose your goal in life. Your intellect must keep your senses under perfect control. Be a master and not a slave to your senses. Besides losing your goal you ultimately lose the very pleasure of the senses if you lack control over them.

5. **DUTIES, NO RIGHTS**
   The dignity of the human race is founded upon the principle of obligatory duties, not rights. Develop the art of giving, not taking. You have no right to claim anything as yours. Your only right in the world is to give, serve the society.

6. **CONSISTENCY**
   Having fixed a goal in life let all your actions flow towards that particular goal. Keep your priorities clear and use your sense of proportion and maintain the consistency of purpose till you achieve the goal that you have set for your life.

Dear reader,

This manual has been produced as one in a set of four manuals on: Addiction Rehabilitation Programming; Community Action Against Drugs and Alcohol; Drug and Alcohol Policy Development; Design, Implementation and Management of Alcohol and Drug Programmes at the Workplace. The material is first of all designed for use by the resource centres on drugs and alcohol, under development in Southern Africa with support from the Norwegian-funded ILO project RAF/89/M05/NOR, "Establishment of resource centres for rehabilitation, workplace initiatives and community action on drugs and alcohol". However, we hope that these manuals which are of a rather universal nature will also be useful to other practitioners concerned with the reduction of drug and alcohol problems anywhere in the world.

Please note that this first version of the manuals is presented in draft form. The manuals have been designed in such a way as to allow easy additions, adaptations and modifications. We would like to invite comments and suggestions on how to improve the content as well as the presentation of these manuals. Ideas and additional elements, especially copies of case studies for inclusion, would be most welcome. It is our intention to collect such comments and feedback for a period of at least one year and then commence the revision of the manuals. A register of all those who have received copies of any of the manuals will be maintained for the purposes of periodic mailings of elements for insertion and eventual distribution of the revised version.

I take this opportunity to thank you in advance for your interest and contributions.

Geneva, April 1992.

Yours sincerely,

Jon Wigum Dahl
Project Coordinator,
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- **Facilitating growth**

The counsellor should never forget that her involvement is of prime importance in shaping the group norms. Too exacting behaviour or being too passive can both inhibit members. She needs to play her role with confidence and poise.

Basic rules that are set at the start of the group process may sometimes need further strengthening. The counsellor can draw attention to the norms through statements, observations, questions and display of appropriate non-verbal behaviour. For example, to encourage member to member communication, the following methods can be used:

- Asking for the other members' reactions
- Refusing to answer questions directly

Nodding, smiling, good attending behaviour and verbal reinforcements help shape positive behaviour. The counsellor choosing not to react to low tone conversations, late coming etc, will be noticed by members of the group. Not attending to these can even be seen as non-caring. Unhealthy practices like frequent interruptions or excessive criticism can grow on quickly and it is the counsellor's responsibility to guard against them.

The counsellor should encourage feed back. When a member is criticised or confronted, caring questions like, "How do you feel about what was just said?", helps that member respond. When many suggestions or comments have been made in response to one member's sharing, asking him, "What did you find most helpful? How did you feel to receive so much?", helps members give appropriate feed back.

The counsellor is a "model setting participant" in many ways. Displaying good attending behaviour is quickly copied by the members. By giving support and encouragement, the counsellor invites members to follow suit. The counsellor's handling of conflicts by permitting expression of negative feelings and working through them rather than suppressing them, helps members learn to do the same even in real life situations.

- **Recognising the Group's Power**

The primary therapeutic agent in a group is always the interaction between the members and not the counsellor. As an effective counsellor, she recognises that the group's power is more than her own and makes the group assume responsibility to make the interactions. If the counsellor takes the responsibility, the members would sit back and wait for the counsellor to make the interventions as if watching a movie.

The counsellor needs to resist the urge to quickly intervene with the right answers, and should wait for a discussion to follow and allow it to slowly steer to a conclusion. The group values the decisions that they arrive at and does not look for quick fix answers from the counsellor even if the solutions are just as, if not more effective.

Recording

The progress or lack of it among each member in the group and the counsellor's impressions need to be recorded. This will help the treatment professional to see and clarify the level of progress and plan further directions of progress. In case a different counsellor takes over, she will be able to

- assess the progress of each member
- set specific goals for each member
- identify and help him plan to deal with negative factors so that they don't grow stronger and interfere with the recovery process.
- use those facts to give appropriate feedback to members.

Recording is thus extremely useful and clearly necessary. But for the "time-pressed" counsellor, if recording needs a lot of time, it can become stressful and poor compliance will result. To prevent this, recording should be structured, and carefully structured recording will not take more than 10 minutes.

If 5 sessions are held in a week, a weekly recording will suffice. If the session is once a week, recording can be done immediately. Group therapy initiated changes may continue in-between these sessions also. Recording helps the counsellor keep tabs on the issues discussed and maintain continuity between sessions.

The ultimate goal of group therapy is to aid self understanding and initiate change to the maximum level possible in each and every member of the group. Three factors contribute to this outcome.

1. The skill of the counsellor.
2. The openness of the members who constitute the group
3. The (genuine) interaction between the members.

Therefore, the skill of the counsellor needs to be sharpened periodically through frequent self-assessment, clinical reviews with peers, openness to new techniques and readiness to explore in directions suggested by group therapy research studies. The counsellor has some control over the second factor also in the sense that through a display of supportive care and concern, she can facilitate the group to become open and honest in their sharing. This will lead to genuine "feeling level" interaction and conflict resolution. To put it plainly, the counsellor even though a catalyst, is the key player and her skill is of prime importance.

Time spent at home [illegible]	[illegible]	21.12/13.5days
Type of sig. influence		
Adult	30.8%	65.3%
Peer group only	69.2%	34.7%
Jobs		
Supervised	19.3%	51.2%
Unsupervised	72.1%	31.0%
No information	8.6%	17.8%

Coping strategies and skills

To deal with a wide range of stressors likely to be encountered in everyday life, the individual requires to acquire a wide range of coping and social skills. They may be cognitive or behavioural

Cognitive skills - self assurance, cognitive restructuring, cognitive distraction, self control etc.
Behavioral skills - problem solving, action through negotiation / compromise, withdrawal through leaving/ avoiding the situation, communication skills, assertiveness, social networking, engaging in alternate activities, relaxation

Practical performance skills and Survival skills (which may be considered "aberrant" in the wider community) –e.g. fighting, running fast, reacting quickly, weathering physical harm etc. may be very important for the street child.
However , a child who has not had the opportunity to learn adequate coping and survival skills may use drugs as a coping strategy. The majority of the drug using children studied had very poor adaptive coping skills.

Coping strategies and skills	Maladaptive/ Antisocial (%)	Adaptive/ Pro-social (%)
General Coping strategies employed	68.7	31.3
Dealing with sadness	64.1	35.9
Dealing with anger	65.5	34.5
Dealing with frustration	59.8	40.2

High Risk Behaviour

One of the major realizations from the study was that drug use / abuse could not be viewed in isolation. Drug use in children formed just one of the many elements which contributed to their High Risk Lifestyle.

Delinquency and Criminal behaviour

78% of the children interviewed had self reported Delinquent behaviour. This included stealing, fighting, rape and self directed aggression. The delinquent behaviour predominantly occurred in the context of the peer gang (70.3%) but a significant proportion of the deviant behaviour was solitary.

Age inappropriate sexual behavior

About half (51%) of the children who were specifically assessed reported being sexually active. Almost all of these predominantly male children reported one or more incident where they had either been forced into, or paid for, or offered drugs in exchange for sex. Although a small number reported indulging in sex for comfort with peers, a significantly large number of children regularly visited commercial sex workers.

There was a nexus between street children and local commercial sex workers, many of whom abused alcohol and drugs. Children frequently acted as pimps or go – betweens in exchange for money, drugs, shelter or sexual favours.

Attitudes and practices inimical to safe sex

The sexually active children, by and large, reported having sex in intoxicated states and not using barrier contraception, despite knowledge of condom use and the potential for HIV and other infection. Intoxication made them careless or daring. The other attributions for not taking precautions were that they couldn't care less, or that they did not think it could happen to them.

What is striking is the *significant positive relationship between the use of "solution" and the state of being sexually active [Pearson's correlation coefficient 11.002, df=1, p= 0.000911] and delinquency [Pearson's correlation coefficient 33.46, df=1, p= 0.00000]*

Children with high risk behaviour in comparison with those without

1. Had more drug use (71% vs 34%; χ^2=22.98, df=2; p=0.00001)
2. were older (19[14] vs 20[14] ; t=0.46, p=0.003)
3. Had more drug using peers (10[6] vs 7[2], t=3.8; p=0.009)
4. Had lower education (1[3] vs 3[3]; t=3.81, p=0.
5. Started alcohol earlier (13[3] vs 15[3], t=2.1, p=0.042)
6. Earned more (Rs 42[20] vs Rs 33[31], t=2.2; p=0.029)

7. Worked in unsupervised jobs (78% vs 39%; D2=13.3 df=2; p=0.0013)

General Health

The children also reported a wide variety of general health problems. Some of the common complaints (incidence in the last month) were 1. cough, breathing problems and chest pain (58%); 2. Headache (41%); 3. Stomach problems (29%); 4. Fever and bodyache (28%); 5. Toothache (27%); 6. Skin problems (26%); 7. Burning sensation while passing urine / sores on genitalia (19%); 8. Tingling and numbness of hands & feet (10%) and 9. Accidental injuries to body and limbs (10%).

The use of solution was significantly related to occurrence of Tingling and numbness (possible peripheral neuritis) [Fisher's Exact Test- p= 0.003] , possible S.T.D.s (Burning sensation while passing urine / sores on genitalia) [Pearson's – 8.4, df=1, p= 0.0002], stomach problems [Pearson's – 14.6, df=1, p= 0.0001] and headache [Pearson's – 4.5, df=1, p= 0.03].

Emotional problems were frequently reported with as many as 33% complaining of chronic lack of interest in their day to day existence and sadness with crying spells in 16.3%.

Deliberate self-harm and self-mutilation

Self mutilation , specifically scarification and slashing themselves with sharp objects, especially when intoxicated with "solution" was a peculiar phenomenon found universally amongst boys and girls.

Some of the children attributed this to self directed anger and states of sadness enhanced by the drug. Others said they slashed themselves in groups as part of a bonding ritual and that the drug had an anaesthetic effect.

Some children reported incidents when other children killed themselves by flinging themselves under a passing vehicle or deliberately standing in front of an oncoming train while intoxicated. Almost all the children recounted having known at least one child who had died suddenly while inhaling solvents, although these claims could never be substantiated.

Gender and Drug Abuse

The data regarding girl children is much more sketchy. This is partly because most of the participating organisations in the study had a greater street presence among the boys. Also boys outnumber girls on the street. This is not to detract from the fact that a significantly large number of girl children land up on the streets. From key informants we learnt that the girls stay in their own gangs (which often include one or two small boys), some of the girls enter into informal "marriages"

with some of the older boys, while others are given shelter by various adults. Almost invariably these girl children are subject to physical and sexual abuse. A large proportion are engaged in commercial sex work, whether willingly or unwillingly. The use of alcohol and inhalant drugs is very high among the girls. Use of chewing tobacco and betel nut is almost universal.

Compared to the boys, the girls have a far worse outcome. The boys at least have a chance of opting out of street existence, taking up stable jobs or establishing marriages and families, and some of the older boys do. The girls recorded have no such choice. Sickness, ill health (physical and emotional) are high. Some girls die as a consequence of illegal abortions, most others due to a combination of poor nutrition and excessive drug use.

Existing Resources

Access to resources affects a child's ability to learn skills, change attitudes and perceptions, decrease some of the stresses.

The children studied had very little access to health care, education , age appropriate leisure activity. Additionally they were naturally suspicious of the very structures that the State has erected to take care of these children. Most of the children preferred to stay on the streets or even get admitted to a "mental hospital" rather than having to go to the Juvenile Home.

Almost all the children (more than 90%) had been been abused, violated and exploited by policemen at some time in their short lives and understandably wanted to have nothing to do with the Police.

With respect to Health Services it was quite clear that the children:

1. Underutilized the existing state instituted health services, could not afford private medical care and only went to the hospital or to the local doctor under extreme circumstances. And even then most children ran away from hospital or discontinued treatment prematurely.

Most of the caring services, having been developed by adults for adults, rarely recognized issues of children nor did they accommodate the valid needs of the children. Health and welfare agencies (esp. Governmental) have fixed rules and admission criteria which exclude unaccompanied minors from their services. Children involved in "aberant" activities are poorly understood by mainstream services, and receive low priority, are often 'criminalized' or stigmatized.

Children mistrust Establishment maintained services. Adolescent children tend to reject adult values and align themselves more with their peers, so that it is difficult for them to submit themselves to a health care system controlled by adults.

2. The children on their part rarely identified health as a major concern. They often regarded themselves as invulnerable, focused on the here and now and not on long term consequences. Their marginalization from the rest of society reinforces the belief that no one cares - the present is all they have to look forward to!

The reluctance to seek help may also stem from the fear that admitting to illness might make them different from peers or cause employers to look for healthier employees.
72.2% of the children assessed wanted to stop their drug use but 51.5% wanted nothing to do with establishment structures.

3. Children also lack information about existing resources and often pick up misleading or erroneous information. This is a function of what information they trust and who they trust as information providers. For example 65% of the children assessed in the Bangalore study had picked up their knowledge about illicit drugs solely from their peers. This is reflected in their help seeking choices. Around 70 % of the children who wanted to stop their drug use, said they had never tried to do so as they were not aware of any place or person who could help them.

Advice and treatment related to Drug Abuse

Availability

In most parts of the country there are provisions for advice and treatment related to Drug Abuse. There are a large number of Drug De Addiction Centres [see Reference], both Governmental (funded by the Ministry of Health and Family Welfare) and those run by Non – Governmental Organizations (funded in large measure by the Ministry of Social Welfare).

Accessibility

Most of these organizations do not admit , nor provide care to children. On the other hand , most of the organizations dealing with children and especially street children are acutely aware of the seriousness and urgency to deal with the issue of drug abuse but are unaware of how to do it or who to approach.

Specificity

Furthermore, most of the drug de-addiction centres deal specifically with the treatment of drug abuse and some are only centres for detoxification. And going by currently available information, none of the de-addiction centres have treatment and rehabilitation programmes tailored to the requirements of adolescent children. Children requiring a broader spectrum of intervention, find themselves in inappropriate surroundings faced with interventions incongruous to their needs. Not surprisingly they lose interest pretty soon and concentrate their efforts in getting back onto the streets, where they relapse quickly.

Treatment mixed

Children admitted in surroundings dominated by adults with histories of drug abuse and recidivism, almost invariably, find themselves in positions of exploitation. Also there is a real risk of the children acquiring more maladaptive skills than they originally came in with.

Referral through the Governmental Systems (Juvenile Justice Act)

At least in Karnataka and specifically in the city of Bangalore , drug using children are hardly ever referred under the provisions of the Juvenile Justice Act to De-addiction centres for treatment. While data from Juvenile Homes was not available at the time of writing, it is the experience of colleagues who work in collaboration with the Juvenile Justice system that drug abusing children manage to evade that net. Children who are able to earn and maintain an independent existence on the streets effectively manage to stay outside the ambit of the Governmental Juvenile care systems. And it is these children who are at greatest risk for drug abuse delinquency and sexual high risk behaviour. Paradoxically, it is this group of children who are in greatest need of intervention that the organs of the Juvenile Justice Act manage to overlook.

Referral through the Non Governmental Systems

It is then left to the N.G.O. network of children's agencies which maintain contact with the affected children and get some of them to care facilities.

Though the problem of street children is not really new, they have by and large been ignored by policy makers and were for a long time subsumed under the rubric of "working children". Street children are working children no doubt, but their peculiar problems warrant a sub categorization, so that they merit separate attention. It was only in 1991 that the Ministry of Welfare, Government of India recognized street children as a special group of deprived children who need welfare and in 1993 introduced a grant-in-aid scheme for N.G.O's working with street children. While most of these N.G.O's have an effective street presence they are usually overwhelmed by drug related problems as most of their personnel are not trained to deliver advice and treatment related to Drug Abuse.

Also, most of the organizations prefer to work in isolation and have inadequate access and referral procedures to the de-addiction services in the region.

Network & Outreach

An effective way of bypassing these difficulties is to form broad networks of organizations offering different services. Drug abuse is a complex heterogenous problem and is the concern of not only the specialist in addiction medicine but also impinges on the concerns of a variety of professionals working in other areas. Those working in the areas of broad community developmental work as well as those working with women and children are likely to come up against drug abuse related problems as impediments in the smooth running of their programmes. Networks provide the potential for a broader range of intervention at lower cost, a broader coverage of clients and a multiplier effect of the specific intervention.

Why prevention is important

In addition to long-standing concerns over the deleterious health, legal, and pharmacological effects of substance abuse, new urgency now exists for the development of effective intervention strategies because of the role played by intravenous drug use in the transmission of acquired immunodeficiency syndrome (AIDS) as well as the significant correlation of sexually high-risk behavior with substance abuse. Unfortunately, the treatment of substance abuse problems has proven to be both difficult and expensive. Even the most effective treatment modalities typically produce only modest results, and treatment gains are often lost due to high rates of relapse.

Prevention offers a logical alternative to treating individuals after they have developed such an insidious disorder. However, the development of effective prevention strategies has proved to be far more difficult than was initially imagined.

Prevention Strategies: Possible Interventions

In view of the adverse health, social, and legal consequences of substance abuse and the difficulty of achieving sustained abstinence once addictive patterns of use have developed, it is readily apparent that the most economical approach to the problem of substance abuse is prevention. Prevention efforts have taken place on several different levels and have taken many forms. Prevention has been conceptualized in terms of supply and demand reduction models and as primary, secondary, and tertiary prevention. Each encompasses a different aspect of prevention, and has substantially different operational implication.

Supply And Demand Reduction

Supply reduction efforts are based on the fundamental assumption that substance use can be controlled by simply controlling the supply. This has been the driving force behind the activities of law enforcement agencies, particularly with respect to the interdiction of drugs by governmental agencies and local police departments. Demand reduction efforts, on the other hand, are conceptualized as those that attempt to dissuade, discourage, or deter individuals from either using drugs or desiring to use drugs. Demand reduction includes prevention, education and treatment programs.

Supply Reduction

The NDPS Act which regulates Drug Policy in India has a number of defects. To start with it directs its attention to the lesser of the harms. All over the world, as in India, there are significantly more deaths associated with the use of alcohol and tobacco than there are illegal drug users. Yet the NDPS Act focuses exclusively on the illegal drugs.

The law intends to restrict, by means of criminal penalties, the use, distribution and manufacture of selected drugs. The primary aim is eradication, i.e. to make all illegal drugs, especially illicit narcotics,

totally unavailable. Failing that to contain drug use by increasing the social, economic and opportunity costs of using, buying and selling illicit drugs. In effect, this ensures limited availability at severely inflated prices.

Legal controls used to suppress the use of selected drugs produce unanticipated (or ignored) consequences:

1. A black market is created with higher prices, illegal practices and low quality / toxic goods and the additional costs of policing this subterranean economy falls on the tax payer.
2. Legal markets in analogous substances (legal drugs) are protected.
3. A corrupt and violent enforcement structure is made more likely.
4. Users are stigmatized and barred from legitimate work and opportunities and may be denied legal and procedural protections.
5. Mutually competitive and destructive intervention paradigms -- treatment and education versus punishment -- are established.
6. Courts are clogged with minor offenders and costs of processing and prosecution are escalated.

In spirit, the NDPS Act and the current national drug policy approaches the currently legal drugs in one way, the currently illegal drugs in another way, and the currently illegal only when -- used -- without a prescription not at all. There is no logical or scientific basis for such a legal / illegal classification. Recreational mood -- altering drugs need to be rationally classified according to their addictive potential and long term health risks. In such a classification, cigarettes are the most harmful on the basis of their addictive potential and their ability to cause long term harm not only to the user but also those in the user's vicinity. Yet, present policy is constructed on such a bimodal distribution of legal and illegal drugs. This division is based solely on history, politics, prejudice and not science. Such a policy does nothing to solve the drug problem but only intensifies it. This artificially creates two groups of recreational -- mood altering drugs, those which are "OK to use" and those which are "not OK".

The present policy conflates the illegal drug problem with the illegal - drug - related crime problem. There is much crime directly related to drug use. Crimes such as murder, theft, rape, vehicular accidents are all commonly found in association with drug abusers. However the most dangerous drug in this regard is not an illegal drug but the legal one, alcohol.

For currently illegal drugs, the majority of crimes associated with their manufacture, distribution, sale and use is a result, solely due to the fact that they are illegal. Trafficking and use are in itself, thus criminal. The whole class of drug related crime is created not by the action of the drug on a user but by the law itself. Now, prices of certain drugs are artificially high because of their illegality and some users commit crimes against persons and property to support their habits, crimes which they

otherwise would perhaps not commit.

However it is erroneous to to propose simple legalization or decriminalization as a solution to the substance abuse problem. Simple legalization of the currently illegal drugs, if properly implemented would solve much of the drug - traffic - related crime problem but would do nothing to solve the substance abuse problem, especially that major part of it which is caused by tobacco and alcohol.

The recent experiments with Prohibition of alcoholic beverages in certain states in India, served as a short, sharp reminder that criminal law enforcement as a means for reduction in drug use / abuse is largely ineffective in the short term and often irrelevant in the long term.

The drug problem is not caused simply by the presence of a drug, if it were, neither alcohol nor tobacco use would be declining in the United States, which they are. A limited national anti- smoking campaign in the United States has led to a decline of almost 30% over a 25 year period. This was accomplished with an educational program of modest proportions and some restrictions on smoking in public places. In Great Britain, since World War II, significant reductions in alcohol related liver cirrhosis deaths have been achieved by modestly limiting availability and controlling price to favour beer and wine over spirits.

The drug problem is caused primarily by demand for drugs and those factors which create demand.

Demand Reduction

Substance abuse prevention efforts can be divided into five general strategies:

1. Information dissemination approaches, which may also include the use of fear or moral appeals.
2. Affective education approaches.
3. Alternative approaches.
4. Social resistance skills approaches.
5. Broader competency enhancement approaches, which emphasize personal and social skills training.

Information Dissemination

The easiest and most frequently used approach is the use of programs that rely on provision of factual information concerning pharmacology and adverse consequences of use. Information dissemination approaches to substance abuse prevention are based on a rational model of human behavior. Substance abuse is seen as being the result of insufficient knowledge of the adverse consequences of using psychoactive drugs. The prescription for preventing substance abuse, according to this model, is to educate adolescents about the dangers of smoking, drinking or using drugs. It is assumed that, once they are armed with this knowledge, they will act in a rational and logical way and simply choose not to become substance users. It has also been assumed that exposure to factual information about the dangers of using drugs will effect changes in attitudes which

to him will lead to non - substance use behavior. Within the context of the information dissemination dissemination approach, individuals are seen as being essentially passive recipients of factual information.

Information dissemination programs take the form of public information campaigns and school based lectures, such as in drug education. Public information campaigns involve the use of pamphlets, leaflets, posters, and public service announcements to increase public awareness of the problem of tobacco, alcohol, or drug abuse and alter societal norms concerning use. School programs involve classroom curricula, assembly programs featuring guest speakers (frequently policemen or health professionals), and videotaped films.

Many information approaches have been designed to deter substance use by emphasizing and even dramatizing the risks associated with substance use. The underlying assumption of fear arousal approaches is that evoking fear is more effective than a simple exposition of the facts. These approaches go beyond a dispassionate presentation of information by providing a clear and unambiguous message that substance use is dangerous. In addition, many traditional prevention programs have focused on the immorality of substance use. Program providers not only teach the objective facts but "preach" to students about the evils of smoking, drinking, or using drugs and exhort them not to engage in these behaviors.

The empirical evidence concerning the effectiveness of the different approaches to tobacco, alcohol and drug abuse prevention described above indicates quite clearly that these approaches are not effective. Studies testing information dissemination approaches to prevention have consistently found that they can increase knowledge and change attitudes toward substance use but do not reduce or prevent tobacco, alcohol or drug use. It seems that increased knowledge has virtually no impact on adolescents' desire or intention to engage in tobacco, alcohol or drug use in the near future. Some studies have even suggested that this approach may lead to increased usage, probably because it may serve to stimulate adolescents' curiosity.

Information dissemination approaches are inadequate because they are too narrow in their focus and are based on an incomplete understanding of the factors promoting substance use and abuse. Although knowledge about the negative consequences of substance use is important, it is only one of many factors considered to play a role in the initiation of substance use among adolescents.

Affective Education

Affective education place more emphasis on students' personal and social development. Affective education approaches focus on increasing self-understanding and acceptance through activities such as values clarifications and responsible decision making, improving interpersonal relations by fostering effective communication, peer counseling, and assertiveness, and increasing social institutions. A common component of many affective education programs is the inclusion of

norm-setting messages concerning responsible substance use.

The results of affective education approaches have been as discouraging as evaluations of informational approaches. Although affective education approaches have, in some instances, been able to demonstrate an impact on one or more of the correlates of substance use, they have not been able to impact on substance use behaviour.

Alternatives

One method of preventing substance abuse which has been a part of both community and school based interventions has been to restructure the adolescents' environment to provide them with alternatives to substance use and activities associated with substance use. However, while some alternatives do reduce substance use, some may even increase it.

The approach typically involves the establishment of youth centers providing a particular activity or set of activities in the community. It is assumed that if adolescents can be provided with real life experiences, and as good children and adolescents in healthy communities frequently participate in prosocial activities, self-gratification, and self-esteem, then these activities will actually take the place of involvement with substance use.

A type of alternatives approach is targeted more to specific individual needs. For example, the need for relaxation or more energy might be satisfied by exercise, participating in sports, or hiking; the desire for sensory stimulation might be satisfied through activities that enhance sensory awareness such as learning to appreciate the sensory aspects of music, art, and nature; and the need for peer acceptance might be satisfied through participation in sensitivity training or encounter groups.

While some activities have been associated with non-substance use, intriguingly enough, others have consistently been found to be associated with substance abuse. For example, entertainment activities, participation in vocational activities, and participation in social activities have been found to be associated with more substance use. On the other hand, academic activities, involvement in religious activities, and participation in sports have generally been associated with less substance use. Consequently, it is important in the selection of alternatives, programs could be counterproductive if the wrong type of activities were selected. At the same time, activities that may be the most appropriate alternatives are likely to be those which would have the least interest for individuals at high risk for using drugs.

Psychological Inoculation

Briefly, how-to-say-no techniques generally teach students how to recognize situations in which they will have a high likelihood of experiencing peer pressure to smoke, drink, or use drugs so that these high-risk situations can be avoided. In addition, students are taught how to handle situations in which they might experience peer pressure to engage in substance use. Typically, this includes

teaching students not only what to say (i.e., the specific content of a refusal message), but also how to deliver it in the most effective way possible.

If adolescents are likely to be teased by peers for refusing to try cigarettes, they can be forewarned of the likelihood of encountering that kind of pressure and provided with the necessary skills for countering it. For example, they can be trained to reply: "If I smoke to prove to you that I'm not afraid, all I'll really be showing is that I'm afraid not to do what you want me to do. I don't want to smoke, therefore I'm not going to". If adolescents are likely to see older youth posturing and acting "tough" by smoking, they can be taught to think to themselves: "If they were really tough, they wouldn't have to smoke to prove it."

Another distinctive feature of these programs is the use of peer leaders as program providers. The peer leaders used in these interventions are typically older students. Peer leaders could also be the same age as the participants and may even be from the same class. The rationale for using peer leaders is that peers generally have higher credibility with adolescents than do adults. Finally, students are generally provided with the opportunity to observe other students using these skills, as well as to practice these skills through the use of role playing in class.

Personal and Social Skills Training

Substance abuse is conceptualized as a socially learned and functional behavior, resulting from the interplay of social and personal factors. Substance use behavior is learned through modeling and reinforcement and is influenced by cognitions, attitudes, and beliefs. Personal and social skills training prevention approaches typically teach two or more of the following:

1. General problem-solving and decision-making skills
2. General cognitive skills for resisting interpersonal or media influences.
3. Skills for increasing self-control and self-esteem
4. Adaptive coping strategies for relieving stress and anxiety through the use of cognitive coping skills or behavioral relaxation techniques
5. General social skills
6. General assertive skills

These skills are taught using a combination of instruction, demonstration, feedback, reinforcement, behavioral rehearsal, and extended practice through behavioral homework assignments.

The intent of these programs is to teach the kind of generic skills for coping with life that will have a relatively broad application. This is in contrast to the resistance skills training approaches which are designed to teach skills with a problem specific focus. Personal and social skills to situation directly related to substance use and abuse (e.g., the application of general assertive skills to situations involving peer pressure to smoke, drink, or use drugs). These same skills can be used for dealing with many of the challenges confronting adolescents in their everyday lives, including but not limited to

smoking, drinking, or drug abuse.

Mass Media

It has long been recognized that the media is a powerful source of influence in shaping attitudes, beliefs, norms, and behaviors. Social commentators have criticized the media for a variety of [illegible] promoting tobacco, alcohol, and drug use.

Magazines and cable television channels bombard children with cigarette and alcohol advertisements, as well as the ever-expanding array of advertisements for proprietary drugs. By contrast, the net effect of public service announcements designed to prevent substance use, which typically run during times of low viewership, can only be characterized as infinitesimal compared with advertisements promoting tobacco, alcohol, and drug products.

Most mass media campaigns of public service announcements have relied on information dissemination, fear-arousal strategies, or both. Most media campaigns have not been adequately evaluated, and when evaluated, these campaigns have produced inconsistent effect. Some campaigns have increased knowledge and changed attitudes in the desired direction, other have had no effect, still other have produced negative effect (i.e., have increased substance use). An overwhelming majority of mass media drug abuse prevention programs have failed to change behavior. This is not surprising when one recognizes that most public service announcement campaigns fail to reach the intended audience.

Public service announcements must be aired during "prime time" or other high viewership periods. Furthermore, media campaigns must de-emphasize the use of information dissemination and fear-arousal [illegible] designed to combat the powerful [illegible] to smoke, drink, or use drugs.

Description of an Innovative Intervention

The Action Programme described above, initiated by the Forum for Street and Working Children in connection with the De-addiction Unit and the Child and Adolescent Psychiatry Unit of the National Institute of Mental Health was implemented in 4 phases.

1. Initial assessment of the problem of Drug Abuse in the Street Children of Bangalore through key informant interviews.
2. Detailed assessment using questionnaires constructed for the study
3. An experimental brief intervention aimed at sensitizing groups of selected children and teaching them Life skills.
4. Follow up assessments.

The experimental brief intervention consisted of a single viewing of an animated video film ("Cold-

tooth" made by the Street Kids International) and two or three workbook sessions. Using projective techniques, groups of children were encouraged to interpret an open - ended series of images, in the light of their own experiences. This allowed the children to review their maladaptive responses to day to day stressors and their drug use. Further sessions were utilised to generate, from the peer group, alternative adaptive strategies that the children could use for the same situations. The focus was on attempting to teach children general problem solving techniques which would not only aid them in handling situations promoting drug use but also help them devise healthier strategies to deal with ongoing life problems. While the dangerous effects of drug use was a subject for discussion, no attempt was made to project abstinence from or stopping of drug use as the central theme of the training package.

The film show and the workbook sessions were conducted by the street educators, who by virtue of their [illegible] of the children. The educators the package had been tested [illegible] through a series of two workshops.

[illegible] technique which [illegible] not affect [illegible]. The group handling and teaching techniques are relatively simple and can be easily imparted to the trainers with minimal training.

The intervention yielded gratifying results in the short term. A follow up assessment was conducted within three months after the intervention.

Despite the fact that the drug abuse cessation message was not the central theme of the package, a surprisingly large number of the children (75%) had stopped or reduced use of solvent drugs.

Change in Solvent use	Frequency	Percentage
Stopped use	28	34.6
Decreased use	28	34.6
Stopped for some time and restarted	[illegible]	[illegible]
Thought of stopping but not [illegible]		
No change	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	81	100

This effect had to a lesser, but still significant, extent, generalised itself to tobacco use. Nearly 60% of the children had stopped or decreased their tobacco intake.

Change in tobacco use	Frequency	Percentage
[illegible]	[illegible]	[illegible]
Decreased use	[illegible]	[illegible]
Stopped for some time and restarted	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
No change	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Chapter in Textbook: Curriculum for IAS Staff College

Children with a Substance Abuse Problem

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De... addiction Unit, N... ...stitute of Mental Health... ...Bangalore

[illegible] contribute to illnesses like mood disorders and increase risk of [illegible] health. For

[illegible] and juvenile crime.

[illegible] of the adolescent drug abuser are the longer-range

[illegible] continues to abuse alcohol and drugs into adult life.

[illegible] Immunodeficiency Syndrome (AIDS), violent crimes,

unemployment. Those problems carry costs in lost productivity, [illegible] destruction of families and a

weakening of the bonds that hold society together. A recent study of the social cost due to alcohol abuse in

Karnataka conservatively estimated the cost due to reduced industrial productivity caused by alcohol related

sickness, absenteeism and unemployment to be approximately Rs. 691 crores per year (Benegal, 1988).

The [illegible] associated with drug abuse treatment is that while many effective strategies exist

[illegible] and abstinence, long term maintenance of abstinence or avoiding relapse is a greater overall

challenge.

Adolescence - A Critical Period of Transition

Adolescence is a developmental stage where the major focus is on developing self-identity, a phase which is marked by dramatic changes and re-adjustments. This results in new stresses and anxieties, which characteristically increases vulnerability to peer pressure. This is also a stage for practicing new roles. From early childhood, youngsters practice adult roles, through pretend play. During adolescence this shifts to actual behaviour. After 10 years of age the pre-adolescent begins experimenting with a range of new "adult" behaviours, and for many children, regardless of culture and throughout the world, cigarettes, alcohol and other drugs have become a normal part of coming of age.

The social task of adolescence is increasing autonomy from parents and a corresponding increase in reliance on peers for validation and direction. Conformity to the peer group increases rapidly during pre and early adolescence when it peaks and then gradually declines. Adolescents typically assess themselves and their behaviours through the reactions of their peers; acceptance by peers is critically important and more than at any other age, rejection can be devastating.

This is also the final stage of intellectual development. There is a shift from concrete operational thinking to formal operational or abstract thinking, which is much more flexible. While on the one hand this sophisticated reasoning capability allows the adolescent to think hypothetically and deal with proposition and theory, this also invariably results in tensions and confrontations with authority figures and institutions. Adolescents are able to begin questioning rules that had previously been taken for granted and this is also a period when alternative life styles are considered or experienced.

Risk taking increases during adolescence. Exploring any new behaviour, naturally involves risk taking, but adolescents also appear to engage in risk taking just for the exhilaration of the dare. Adolescents also want to impress their peers but are not yet adept at assessing risks. They frequently assume that if they engage in any behaviour several times without negative consequences the perceived risk goes down.

There is also the tendency to exaggerate based on immediate experience, which allows risks to be minimized. Adolescents have a sense of 'invulnerability' - an attitude that "it won't happen to me". Since adolescent thought is more anchored in the here and now than is adult thought, they are less concerned with the far off future. Given their immediate time orientation, the immediate gratification of need, for example the satisfying and pleasurable short term effects of smoking, may outweigh the potential longer-term negative health consequences.

Also some risks may seem more immediate than others. The risk of losing status with peers, being rejected or ridiculed or thought immature or inexperienced may seem more dangerous or aversive than the possible risks of taking a drink or accepting the offer to take some other drug.

Adolescent Drug Abuse :

Is defined as the frequent use of alcohol or other drugs during the teenage years or the use of alcohol or other drugs in a manner that is associated with problems or dysfunction. This definition reflects the recognition that a relatively large number of teenagers try alcohol and other drugs without becoming involved in the frequent use of those substances or developing drug related problems.

Because of the rapid changes they are experiencing, adolescents are at risk for developing substance abuse more quickly than are adults. The initiation of substance use and early stages of abuse have their root in adolescence although the patterns that are characteristic of adult substance abusers are relatively rare in adolescents. The precise point along the use/abuse continuum at which use becomes abuse is arbitrary.

Criteria for substance abuse involve a) a pathological pattern of use, b) impairment of functioning in work and social relationships, c) physical and emotional deficits.

To wait to intervene until this point with the adolescent would be irresponsible. There is no widely accepted

consensus as to when substance becomes abuse, and for children and adolescents - especially young adolescents - any degree of substance use is frequently viewed as abuse.

The substance use progression

Drug use follows a rather predictable developmental progression, beginning with experimentation and recreational use of alcohol and cigarettes. Subsequently the individual may then progress to use of marijuana and other illicit substances like opiates.

During experimentation and recreational use, substances are associated with euphoria and pleasure and are not perceived to cause bad things to happen. With more regular use, tolerance and need for the substance develops, and the individual becomes preoccupied with substances and may begin using them every day. Often at this stage multiple substances are used. Functioning begins to decline and the reason for using the substance shifts; instead of using the substance for pleasure, the individual now uses the substance to prevent negative feelings. Thus, a major element in substance use is the prevention of the negative experiences of the withdrawal symptoms, either physiological or conditioned, as the individual associates relief of improvement with use. Both psychological and physical dependence may follow the stage of regular use. Attempts to discontinue use at this point results in symptoms of an abstinence syndrome.

The fact that there is this sequence does not necessarily mean that there is a causal relationship, however, and use of substances at one stage does not mean an individual will necessarily progress beyond that state. In fact, most people use alcohol and other substances without ever developing compulsive habits and loss of control. Experimentation with substances has become so prevalent and normative that one recent study suggests that adolescents who experiment with substances may actually be psychologically healthier compared with either individuals who have never experimented or individuals who abuse substances! They may be more curious and more prone to exploration and adventure.

World wide, the risk for substance use (legal and illicit) peaks between 18 and 22 years of age, with the exception of cocaine use, and risk for use of substances, excluding cocaine and prescription psychoactive substances, appears to decline after age 25 years. The reasons for this decline in young adulthood may be that conventional adult roles in marriage, family, and career are being assumed during this stage, and these roles are incompatible with deviant behaviour. The greatest risk that an individual will develop long-lasting or lifelong patterns of abuse occurs for those individuals who begin using substances before the age of 15 years.

Risk Factors for Adolescent Drug Abuse

It is difficult to ascertain, which risk factors or combination of risk factors are most virulent, which are modifiable, and which are specific to drug abuse rather than generic contributors to adolescent problem behavior. Current knowledge about the risk factors for drug abuse does not provide a formula for prevention

but it does point to potential targets for prevention intervention.

These risk factors can be roughly divided into two categories. First are broad societal and cultural factors, which provide the legal and normative expectations for behaviour. The second group includes factors that lie within individuals' and their interpersonal environments. The principal interpersonal environments in children's lives are families, school, classrooms, and peer groups.

Contextual Factors

Individuals and groups exist within a social context: the values and structure of their society. For example, shifts in cultural norms, in the legal definitions of certain behaviours, and in economic factors have been shown to be associated with changes in drug-using behaviours and in the prevalence of drug abuse.

1. *Laws and norms favorable toward behavior*. Research on the effects of laws on alcohol consumption has focused on the three interventions by law: (a) taxation, (b) laws stating to whom alcohol may be sold, and (c) laws regarding how alcohol is to be sold.
Alcohol consumption is affected by price, specifically the amount of tax placed on alcohol at purchase. Increase in taxes on alcohol lead to immediate and sharp decreases in liquor consumption and cirrhosis mortality. Studies examining the relationship of minimum drinking age and adolescent drinking and driving have generally shown that lowering the drinking age increases teen drinking and driving and teen traffic fatalities; and raising it decreases teen driving while intoxicated (DWI's) and deaths.

Studies of restriction on how alcohol is sold have shown that allowing patrons to purchase distilled spirits by the drink increased the consumption of distilled spirits and the frequency of alcohol-related car accidents.

Legal restrictions on the purchase of alcohol and norms unfavorable toward alcohol use clearly are associated with a lower prevalence of alcohol abuse. Conversely, laws and norms that express greater tolerance for the use of alcohol are associated with a greater prevalence of alcohol abuse. Similar relationships exist between norms regarding legal drugs and the prevalence of illegal drug abuse.

2. *Availability*. The availability of drugs is dependent in part on the laws and norms of society. Nevertheless, availability is a separable factor. Whether or not particular substances are legal, their availability may vary and is associated with use. When alcohol is more available, the prevalence of drinking, the amount of alcohol consumed, and the heavy use of alcohol all increase . With regard to illegal drugs, measures of drug availability were significantly related to the use of cigarettes, alcohol, marijuana, and other illegal drugs, even after controlling for the amount of money available to the subjects. Availability of drugs affected substance

use indirectly among junior high school youths.

3. *Extreme economic deprivation.* Indicators of socioeconomic disadvantage, such as poverty, overcrowding, and poor housing, have been shown to be associated with an increased risk of childhood conduct problems and delinquency. However, research on social class and drug use has not always confirmed popular stereotypes. A slight positive correlation between parental education and high school seniors' marijuana use has been reported. Parental occupational prestige and education were positively related to teenage drinking. Whereas there appears to be a negative relationship between socioeconomic status and delinquency, a similar relationship has not been found for the use of drugs by adolescents. Only when poverty is extreme and occurs in conjunction with childhood behavior problems has it been shown to increase risk for later alcoholism and drug problems.

4. *Neighborhood disorganization.* Neighborhoods with high population density lack of natural surveillance of public place, high residential mobility, physical deterioration, low levels of attachment to neighborhood and high rates of adult crime also have high rates of juvenile crime, and illegal drug trafficking. Community economic level and community disorder-criminal subculture was significantly related to officially recorded delinquency.

When neighborhoods undergo rapid population changes criminalization rates increase. Neighborhood disorganization has been hypothesized to contribute to deterioration in the ability of families to transmit prosocial values to children.

Individual and Interpersonal Factors

Certain characteristics of individuals and of their personal environments are associated with a greater risk of adolescent drug abuse.

1. *Physiological factors.* Physiologically mediated temperamental traits like Sensation seeking and low harm avoidance predicts early-onset alcoholism. Poor impulse control in childhood predicts frequent marijuana use at an early age .

Researchers have sought to assess the independent contribution of genetic factors to the development of alcoholism through twin and adoption studies. Among males, similar twins are more than twice as likely as dissimilar twins to be concordant for alcoholism.

Early-onset alcoholism that is associated with impulsivity and aggression apparently has a partial foundation in individual physiological characteristics.

Genetic vulnerability may influence Early onset drug and alcohol abuse.

2. *Family attitudes*. Families affect children's drug use behavior in a number of ways. Beyond the genetic transmission of a propensity to alcoholism in males, family modeling of drug using behavior and parental attitudes toward children's drug use are family influences related specifically to the risk of alcohol and other drug abuse. Poor parenting practices, high levels of conflict in the family and a low degree of bonding between children and parents appear to increase risk for adolescent problem behavior generally including the abuse of alcohol and other drugs.

Parental and sibling alcoholism and illegal drug use increase the risk of alcoholism and drug abuse in children. Parental drug use is associated with early initiation of use in adolescents, and with frequency of marijuana use. Similar findings have reported for adolescent drinking habits.

Children who are highly prosocial and assertive generally come from authoritative families. Parental nondirectiveness or permissiveness seems to contribute to higher levels of drug use. Common characteristics of families with adolescent drug abusers include negative communication patterns (criticism, blaming, lack of praise), inconsistent and unclear behavioral limits, and unrealistic parental expectations of children.

The evidence suggests an independent contribution of family interactions to adolescent drug use, separate from the effects of parental drug use. Studies have found that parental drug use in a rewarding family structure only slightly promoted frequent marijuana use but in an unrewarding context, there was a clear association between levels of drug use by parents and their children.

In summary, the risk of drug abuse appears to be increased by family management practices characterized by unclear expectations for behavior, poor monitoring of behavior, few and inconsistent rewards for positive behavior, and excessively severe and inconsistent punishment for unwanted behavior.

3. *Family conflict*. Although children from homes broken by marital discord are at higher risk of delinquency and drug use, there does not appear to be a direct independent contribution of "broken homes" to delinquent behavior. conflict among family members appears more important in the prediction of delinquency than does family structure per se. Parental conflict is associated with antisocial behavior in children even when the home is unbroken and that even in samples in which all homes are broken, the extent of family conflict is associated with the likelihood of antisocial behavior in the children. Use of heroin and other illegal drugs has been strongly associated with parental marital discord.

In summary, children raised in families high in conflict appear at risk for both delinquency and illegal drug use.

4. *Low bonding to family*. Parent-child interactions characterized by lack of closeness and lack of maternal involvement in activities with children appear to be related to initiation of drug use. Conversely, positive family relationships-involvement and attachment-appear to discourage youths' initiation into drug use. Adolescents' reports of parental trust, warmth, and involvement explained small portions of the variance in the extent of

tobacco, alcohol and marijuana use.

Bonding to family may inhibit drug involvement during adolescence in a manner similar to the way in which family bonding inhibits delinquency.

5. *Early and persistent problem behaviors.* The greater the variety, frequency, and seriousness of childhood antisocial behavior, the more likely antisocial behavior is to persist into adulthood.

Children characterized by withdrawal responses to new stimuli, biological irregularity, slow adaptability to change, frequent negative mood expressions, and high intensity of positive and negative expressions of affect more often become regular users of alcohol, tobacco, and marijuana in adulthood than "easy" children, who evidence greater adaptability and positive affect early in life.

6. *Academic failure.* Failure in school has been identified as a predictor of adolescent drug abuse. Poor school performance has been found to predict frequency and levels of use of illegal drugs. In contrast outstanding performance in school reduced the likelihood frequent, drug use.

The available evidence suggests that social adjustment is more important than academic performance in the early school in predicting later drug abuse. *Early antisocial behavior in school may predict both academic failure in later classes, and later drug abuse. Academic failure in late elementary grade may exacerbate the effects of early antisocial behavior or contribute independently to drug abuse.*

7. *Low degree of commitment to school.* The use of hallucinogens, cocaine, heroin, stimulants, sedative, or non-medically prescribed tranquilizers is significantly lower among students who expect to attend college than among those who do not plan to go on to college.

Factors such as how much students like school , time spent on homework and perception of the relevance of course work are also related to levels of drug use. *There appears to be a negative relationship between commitment to education and frequent drug use among junior and senior high school students.*

8. *Peer rejection in elementary classes.* Low acceptance by peers seems to put an adolescent at risk for school problems and criminality, which are also risk fact factors for substance abuse.

Traits of the child that have been associated with peer rejection aggressiveness, shyness and withdrawal have been examined for their relationship to drug use. Found that children who had been shy in first grade reported low levels of involvement in drug use, whereas those who had been aggressive or had shown a combination of aggressiveness with shyness in first grade had the highest levels of use. Childhood traits relevant to peer rejection-social inhibition, isolation from peers, and aggression against peer-were not significantly associated with adolescent drug use stage. However, aggression against peers during adolescence was associated with stage of use, and teenagers who were less socially inhibited and less isolated from peer were likely to be at a more advanced stage of use.

The link between peer rejection and subsequent drug use may not be a simple one. Shyness, to isolating a child from his or her peers, may protect the child against drug use by eliminating one source of influence to use, drug-using peers. Aggressiveness, on the other hand, though resulting for some children in exclusion from groups of conventional peers, may be associated with acceptance by other aggressive and perhaps delinquent peers who could foster drug use.

9. *Association with drug-using peers. Peer use of substances has consistently been found to be among the strongest predictors of substance use among youth.* Youths who did not drink alcohol reported fewer school friends who drank than did those who drank, friends' use of alcohol and marijuana was related to a youth's own use of both.

10. *Alienation and rebelliousness. Alienation from the dominant values of society, low religiosity, and rebelliousness, have been shown to be positively related to drug use and delinquent behavior.* Interpersonal alienation measured at age 7 predicted frequent marijuana use at age 18. High tolerance of deviance, a strong need for independence, have all been linked with drug use. All these qualities would appear to characterize youths who are not bonded to society.

11. *Attitudes favorable to drug use.* Research also has shown a relationship between drug use initiation and specific attitudes and beliefs regarding drugs. *Initiation into use of any substance is preceded by values favorable to it use.*

12. *Early onset of drug use.* Early onset of drug use predicts subsequent misuse of drugs. Misusers of alcohol appear to begin drinking at an earlier age than do users. *The earlier the onset of any drug use, the greater the involvement in other drug use and the greater the frequency of use.* Earlier initiation into drug use also increases the probability of extensive and persistent involvement in the use of more dangerous drugs and the involvement in deviant activities such as crime and selling drugs. Conversely, a later age of onset of drug use has been shown to predict lower drug involvement and a greater probability of discontinuation of use.

Drugs of Abuse

1. Cigarette Smoking

Although many people smoke because they believe cigarettes calm their nerves, smoking releases epinephrine, a hormone which creates physiological stress in the smoker, rather than relaxation. The use of tobacco is addictive. Most users develop tolerance for nicotine and need greater amounts to produce a desired effect. Smokers become physically and psychologically dependent and will suffer withdrawal symptoms including changes in body temperature, heart rate, digestion, muscle tone, and appetite.

Psychological symptoms include irritability, anxiety, sleep disturbances, nervousness, headaches, fatigue,

[illegible] years, or an entire lifetime.

[illegible] frequent

[illegible] physeme; heart disease; stroke; cancer of the mouth, larynx,

[illegible] bladder.

[illegible] but devastating preventable cause of disease and premature death.

[illegible] produced their bodies are still developing and changing and the

[illegible] easily

[illegible] highly addictive. One-third of [illegible] who are first "experimenting" and [illegible] addicted by the time they are 20.

2. Oral Tobacco and Betel Nut

3. Alcohol

Ethyl Alcohol [illegible] and psychological dependance. It is used by oral ingestion and the duration [illegible] hours. It is the liquid (distilled product of fermented fruits, grains and [illegible] antiseptics and for its sedative action.

[illegible] are potential for abuse. The possible effects it can have are Intoxication, Sensory alteration, Anxiety reduction

The Sy[illegible] triggering, Odor of alcohol on breath, Loss of coordination, Slurred speech, Dilated pupils

Chronic use may lead to Ulcers and liver damage. Withdrawal from the drug in a chronic user often leads to a typical Withdrawal Syndrome characterized by Sweating, Tremors, Altered perception, Psychosis, fear, auditory hallucinations, Confusion, disorientation, loss of motor nerve control, Convulsions, shock, Respiratory depression and possible death are other effects of misuse.

Alcohol is abused due to its potential to aid relaxation, enhance sociability and give a relatively cheap 'high'. But alcohol is a depressant that decreases the responses of the central nervous system. As little as two beers or drinks can impair coordination and thinking.

In addition Alcohol is often used by substance abusers to enhance the effects of other drugs. Alcohol continues to be the most frequently abused substance among young people.

On younger drinkers, the developmental process may be slowed, resulting in physical and mental growth problems. Alcohol users tend to display impulsiveness, immaturity, pleasure - seeking behaviors. In some cases, the user may have experience memory loss, liver damage, cardiovascular problems, and death.

4. Inhalants

Inhalants refer to substances that are sniffed or huffed to give the user an immediate head rush or high.

They include a diverse group of chemicals that are found in consumer products such as aerosols and cleaning solvents. Inhalants are chiefly abused as they give a cheap and quick High .Inhalant use can cause a number of physical and emotional problems, and even one-time use can result in death.

Using inhalants even one time can put a child at risk for sudden death, suffocation, visual hallucinations and severe mood swings or numbness and tingling of the hands and feet.

Prolonged use can result in headache, muscle weakness, abdominal pain, decrease or loss of sense of smell, nausea and nosebleeds, hepatitis, violent behaviors, irregular heartbeat, liver, lung, and kidney impairment, irreversible brain damage, nervous system damage, dangerous chemical imbalances in the body, and involuntary passing of urine and feces

Short-term effects of inhalants include: heart palpitations, breathing difficulty, dizziness, headaches.

Death can occur in at least five ways:

1. asphyxia—solvent gases can significantly limit available oxygen in the air, causing breathing to stop;
2. suffocation—typically seen with inhalant users who use bags;
3. choking on vomit;
4. careless behaviors in potentially dangerous settings, and
5. sudden sniffing death syndrome, presumably from cardiac arrest.

Every year, young people all over the world die of inhalant abuse. Hundreds suffer severe consequences, including permanent brain damage, loss of muscle control, and destruction of the heart, blood, kidney, liver, and bone marrow.

More than 1,000 different products are commonly abused. Many youngsters start because they feel these substances can't hurt them; because of peer pressure, or because of low self-esteem. Once hooked, these victims find it a tough habit to break.

These effects can last 15 to 45 minutes after sniffing.

The products usually abused are ordinary household products. The problem is that substances which can be safely used for legitimate purposes, can be problematic in the hands of an inhalant abuser. Glues/adhesives, nail polish remover, marking pens, paint thinner, spray paint, butane lighter fluid, gasoline, propane gas, *typewriter correction fluid* [Erazex] household cleaners, cooking sprays, deodorants, have all been reported as having been abused.

If someone is an inhalant abuser, some or all these symptoms may be evident:

Unusual breath odor or chemical odor on clothing, slurred or disoriented speech, drunk, dazed, or dizzy appearance, signs of paint or other products where they wouldn't normally be, such as on the face or fingers, red or runny eyes or nose, spots and/or sores around the mouth, nausea and /or loss of appetite. Chronic inhalant abusers may exhibit such symptoms as anxiety, excitability, irritability, or restlessness.

Inhalant abusers also may be seen constantly smelling clothing, sleeves or rags, or sitting with a pen or marker near their nose.

5. Marijuana or Cannabis

Marijuana is a widely used illicit drug and tends to be the first illegal drug teens use.

The physical effects of marijuana use, particularly on developing adolescents, can be acute as Marijuana may cause impaired short-term memory, a shortened attention span and delayed reflexes and the repeated use of marijuana may cause breathing problems.

Short-term effects of using marijuana include sleepiness, difficulty keeping track of time, impaired or reduced short-term memory, reduced ability to perform tasks requiring concentration and coordination, increased heart rate, potential cardiac dangers for those with preexisting heart disease

Bloodshot eyes dry mouth and throat, decreased social inhibitions, and rarely paranoia, hallucinations

The Long-term effects of using marijuana are an enhanced cancer risk, decrease in testosterone levels for men; also lower sperm counts and difficulty having children; increase in testosterone levels for women, also increased risk of infertility; diminished or extinguished sexual pleasure

psychological dependence requiring more of the drug to get the same effect

Marijuana blocks the messages going to the brain and alters perceptions and emotions, vision, hearing, and coordination.

The potential for Physical Dependence is unknown but it is known to cause moderate psychological dependence. It is usually smoked or ingested orally. Its effects last around 2-4

Cannabis or Marijuana comprises the dried up leaves and flowering tops of the hemp plant while Hashish consists of resinous secretions of the cannabis plant

5. Narcotics

Narcotics are drugs which have been traditionally used medicinally to relieve pain. Most of them have a high potential for abuse. They are usually favoured by users because they cause relaxation with an immediate "rush". Use results in euphoria, drowsiness, respiratory depression, constricted (pin point) pupils. Overdosage can cause slow, shallow breathing, clammy skin and can potentially result in convulsions, coma, and possible death

A characteristic withdrawal Syndrome is manifest in watery eyes, runny nose, yawning, cramps, loss of appetite, irritability, nausea, tremors, panic, chills, sweating.

The outward indications of possible misuse consist of scars (tracks) caused by injections, constricted (pin-point) pupils, loss of appetite, watery eyes and nose, cough, nausea, lethargy and drowsiness. The paraphernalia required for administration like silver foil, syringes, bent spoons, needles, etc. may be found.

The types of narcotics which are commonly in use are synthetic, semi synthetic derivatives of opium

Morphine or Pethidene (used as analgesics) which have a high potential for dependence and are usually found in ampoules for injection. Heroin a white crystalline powder and a derivative of morphine and its cheaper, diluted version called "Brown Sugar" is usually inhaled after heating over foil. But Heroin is also injected by advanced users. Since these preparations are costly, and relatively more difficult to access as they are subject to strict vigilance most users have switched to drinking Cough mixtures containing Codeine

(a semi synthetic analogue of Opium) or injecting Buprenorphine ["Tidigesic"] which is a synthetic opioid.

6. Depressants

Other drugs which are frequently used are the over - the counter drugs used traditionally to relieve anxiety, irritability, tension like Diazepam ["Calmpose"], Nitrazepam ["Nitrosun"] and very rarely medicines like Methaqualone ["Proderm"].

These have a high potential for abuse and the development of tolerance. They produce state of intoxication similar to that of alcohol. Combined with alcohol, they increase the effects and multiply the risks.

The possible effects are sensory alteration, a body reduction and intoxication. Small amounts cause calmness and relaxed muscles. Large amounts cause slurred speech, impaired judgment, loss of motor coordination. Very large doses may cause respiratory depression, coma, death. Newborn babies of abusers may show dependence and withdrawal symptoms, behavioral problems, birth defects.

Symptoms of Overdose include : Shallow respiration, clammy skin, dilated pupils; Weak and rapid pulse, coma, death.

There is a characteristic withdrawal syndrome comprising : Anxiety, insomnia, muscle tremors, loss of appetite.

Abrupt cessation of the drugs or reduced doses may cause convulsions, delirium and death.

Indications of Possible Misuse: Behavior similar to alcohol intoxication (without odor of alcohol on breath); Staggering, stumbling, lack of coordination, slurred speech; Falling asleep while at work, difficulty concentrating; Dilated pupils.

Stimulants like Cocaine, Ecstasy (MDMA) are rarely used in India as of the present moment.

Drug Abuse amongst Street Children in Bangalore

Magnitude of the problem

Street children constitute a marginalized population in most urban centres of the world. There are major difficulties in trying to estimate the number of street children and the magnitude of difficulties they experience. In their marginalised state they constitute a truly "hidden" population who are not covered by nor find place in the national census, educational or health data. This problem is further compounded by the fact that they are also a highly mobile population.

A very rough estimate would place the number of street children in the city of Bangalore at around 60,000. About 50 children land up at the Bus Station alone, every day, having run away from home. Some children live with their parents in urban slums.

An Action Research Programme run by the Bangalore Forum for Street and Working Children and the National Institute of Mental Health and Neurosciences (1997-98) looked at the status of drug abuse amongst

the Street Children of Bangalore and the impact of a brief intervention . Some of the data gathered from a study of 321 children are discussed below.

Homeless youth and the phenomenon of street children is not the exclusive preserve of the developing world nor is it particularly recent. Historically, the streets of large urban areas have been the 'theatre and the battleground' for the children of the poor. They have invariably been exploited and marginalized: used as cheap and expendable labour, for sex and for criminal acts. Most are male, their peer relationships, group life and survival strategies are much the same all over the world, although they are usually younger in developing than in developed countries. More recent economic situations (recession), political changes, civil unrest, increasing family disintegration and natural disasters have led to larger numbers of children heading from rural areas and smaller towns to larger cities and their streets. Some come from families which can no longer support them due to poverty and overcrowding, some come to the streets after being orphaned due to parental death or family disintegration and some are members of whole families who live on the streets while some are born on the streets to older street children.

A number of distinct groups of young people have been subsumed under the definition of "Street Children".

1] Children living on the streets, whose immediate concerns are survival and shelter.

2] Children who are detached from their families and live in temporary shelters such as abandoned houses and other buildings, hostels, shelters etc. or moving about between friends.

3] Children who remain in contact with their families but because of poverty, overcrowding or sexual and physical abuse within the family, spend some nights and most of their days on the streets.

4] Children in institutional care who have come from a situation of homelessness and are at risk of returning to a homeless existence.

The NIMHANS – Forum Study similarly found a wide variety of street living styles. Only around 35 % of all the children interviewed stayed exclusively on the streets.

Living status (n=321)	Frequency	%
At home	131	40.8
Street alone	095	29.6
Street / in a gang	080	25.8
Other	047	14.6
Street with parents	036	11.1
Not known	001	00.4

Most of the children surveyed had left their homes because of economic hardship and had migrated to the

city in search of jobs. A smaller but significant number had been rendered homeless because of the breakdown of their families due to death or desertion of parents, or because of significant abuse related to drug use in one or both parents.

Reasons for living on the street		%
Economic Problems	65	34.4
Family Problems	51	19.2
Drug Related Family	18	07.1
By Choice	23	08.6
Drug Use by Self	09	03.4
Multiple	30	11.3
Force to Study	01	00.4
No Choice	09	03.4
No information	59	22.0

Most of the children were employed in the unorganized sector as Rappidhers, Vendors, Coolies, some had odd jobs in Vehicle repair shops and eating houses. The girl children were often employed in "beedi" factories but a large proportion had been pressed into commercial sex work as soon as they landed up on to the streets.

Sociodemographic Profile		
Age 14.5 - 5.41 years (+-SD)	Sex: 91.9% Males	Education 2.4 (±.9) Years
Working days 5.2 (±.4) day/week		Daily Income Rs.35.00(±26)

Of the 291 children assessed for Drug Use, 197 were Drug users and 94 were Non users.

Street children who use drugs are even more marginalized and are neglected in relation to provision of services. In general, adolescence is a time of experimentation, exploration, and a search for identity. And such a process by its very nature involves risk taking. In some countries, by the time they reach adolescence, many young people have been out of home for some time; working, begging, abandoned or sick. By adolescence they have also been exposed to many drugs, especially those easily available or associated with work - industrial glues, petrol, cannabis, tobacco and alcohol, in a milieu where social and peer influence are critical and drugs are easily available, drug use becomes one aspect of the child's developmental process and even a part of life. In this context, much of the drug use is not mindless nor necessarily pathological. Relief of boredom or hunger or depression and frustration, wanting to feel good, to keep awake or get to sleep or to dream may be some of the functions served by drug use.

A way of conceptualizing the risk of drug use in this population is the Modified Social Stress Model

(Programme on Substance Abuse, WHO, 1992). The model proposes that increased risk for drug use is a function of the level of perceived personal (dis)stress, the image that drugs have in that particular community and subculture and the perceived effects on the individual of particular drugs. The risk is decreased by positive attachments that the child may have, the possession of adequate coping strategies and skills, and access to necessary resources.

Risk for Drug Use = (Dis)stress + Normalization of Drug Use+ Drug Effect
Attachments+ Coping Strategies+ Resources

Stress. There were many levels of stress that the children faced.

1] Major Life Events had occured in the children's lives without them having any control over the situation. Such shock requires variable periods of adjustment. Drug use is often an attempt to cope with the pain and to assist in the period of adjustment.

In the Bangalore children, Family disruption due to Parental death, Abandonment and conflicts with stepparents were commonly seen.

Intactness of Family	Number (Valid %)
Family Intact	105 (44.9%)
Broken Family	126 (55.1%)
Not Known	247

Migration from rural areas to cities. Physical and sexual assault and exploitation were also particularly common.

2] Everyday problems and Enduring life strains

Young people, like adults face daily "hassles". For most disagreements with parents, school and household chores are as serious as it gets. For children on the streets the everyday problems encountered are far more grave, persist over time and cannot be easily resolved as they relate in most part to their deprived socioeconomic environment.

Finding accommodation / somewhere to sleep enough to eat / clothes to wear, families demanding money, unhealthy living environments, avoiding violence and sexual abuse or coping with exploitation by police and peers and lack of access to employment and recreation.

Survival becomes the all consuming daily task. Drug use was often reported by the children as a way to attempt to escape from this chronic conflict.

3] Life transitions

Street children need to be continually adapting to new situations - moving between communities/ cities with

disruption in peer relationships and the need to adjust with a new group of peers. Drugs are used to facilitate acceptance among the new peers and deal with the discomfort associated with the transition.

4] Developmental changes of adolescence

For many street children there is little time to gradually complete the developmental tasks of adolescence. The factors which have propelled them on to the streets have forced them to adapt to adult roles while still in the process of growth and development. Use of drugs as an attempt to cope with their stressful lives can further impede their development and this is most dramatically seen in their inability to engage in formal operational thinking or progress beyond the concrete thinking of younger children.

Normalization of drug use

The term normalization refers to the extent to which a particular drug using behaviour may be considered "normal" in a society or subculture and how that society reinforces that belief. They include

1] Price: Where incomes are low, the cheapest drugs tend to be consumed. Amongst street children therefore inhalants , such as typewriter correction fluid ("Solution"), petrol, glues which are cheap and easily available are widely used. In Bangalore, against a background of widespread adult use of alcohol, street children too tend to use alcohol. Because alcohol is relatively higher priced and perhaps more difficult for children to access, its use is limited among the very young. Cannabis again is used by older adolescents and opioid drugs like heroin ("brown sugar") or Buprenorphine are rarely encountered. This is a peculiar pattern as these drugs are relatively popular in the other Indian cities and is probably due to the fact that opioid drug abuse even among adults in the region is low. A reason for this could be that Bangalore is not on the usual shipment route.

2] Availability

Availability is to a large extent culturally determined . Of the licit drugs (alcohol, tobacco) the community decides which should be controlled and how. But when it comes to illicit drugs availability is determined by the supply of that drug and the level of vigilance of drug enforcement agencies. The attractive profits associated with the supply of illicit substances ensures their continuing supply. The trade is so vast that any increase in vigilance of law enforcement agencies to increase the probability for detection and punishment for illicit production, importation, trafficking, dealing or using is likely to result in only a small impact. The level of vigilance adopted by the authorities varies over time and is very sensitive to both local and international politics. Such vigilance and the very fact of the illicit nature of certain drugs contributes to the problems experienced by the drug user. The illicit nature of these drugs makes the user a criminal, marginalises him within the society and requires the user to use more drastic means to acquire the drug. This is often the major source of the criminality and violence associated with drug use. The illicit nature of the drug also increases the possibility of corruption on the part of those responsible for vigilance.

Then again there are those drugs for which there are no formal controls on their availability in different

communities such as caffeine and traditional drugs such as betel nut. To these can now be added the unusual substances (at least in the Indian context) which are used for intoxicant purposes like the freely available solvents and glues.

c) Societal attitudes and reference group norms

Drug use has been an integral part of most societies. Each society has its own attitudes, beliefs and rules or prescriptions for drug use. Many sub-cultures appear to condone drug use which in the wider community would be considered deviant. Use of certain drugs seem to be a normative pattern among groups of street children.

Drug using children were significantly more likely to perceive drug taking as beneficial, less likely to consider drug use as dangerous and had a significantly larger drug using peer group. Surprisingly, although drug use (especially alcohol) was high in families of the children this factor did not significantly predict drug use in the children, which was determined more by peer influences.

Attitudes	Drug users	Non users
Perceived positive benefit of drug use	68.8%	36.6%
Drug use perceived as dangerous	61.5%	98.3%
Personal disapproval of drug taking	33.4%	93%
Friends disapproval drug taking	20.5%	60%
No. of friends using drugs	9.1 [5.2]	4[3.5]
Drugs used by friends		
Inhalants, alcohol, cannabis etc.	79.7%	26.6%
Tobacco only	18.2%	17.9%
Nil	--	33.3%
Not known	5.1%	20.2%
Drug use in family		
Father		
Nil	10.2%	14%
Alcohol etc	71.1%	64.3%
Tobacco only	8.8%	13.0%
Not known	10.2%	8.8%
Mother		
Nil	38.0%	37.1%
Tobacco only	31.6%	35.5%
Alcohol etc	22.8%	27.4%
Siblings		
Nil	64.9%	72.5%
Tobacco only	12.3%	6.5%
Inhalants Alcohol Cannabis etc	27.4%	21.9%

Drug experience

Drugs vary in their physiological actions. A particular drug is more likely to be used if the subjective experience of using that drug (a complex interplay of the drug's pharmacology on the individual in a certain environment with certain expectations) is an experience which was desired.

In the Bangalore study, almost all the 281 children assessed for positive drug expectancies revealed beneficial experiences following inhalant use.

Beneficial effects of taking "Solution"	Percentage
Feel happy, decreased pain	28.2
Boost energy	20.8
Decreases Hunger	8.5
Stimulant	7.2
Numb	7.2
Alerting	00.6
Increases Confidence	00.6
Combination	46.6
Not mentioned	7.6

The data also revealed an interesting gateway phenomenon of progression of drug use. Most of the smaller children (around 10 – 11 years) start off with tobacco use and when they are a little older they graduate to use of inhalants. By the time they are 13 years old the use of inhalants tapers off and alcohol supercedes inhalants as the drug of choice. This is around the same time that the child is also confronted with the illicit drugs like cannabis and heroin sugar etc.

Drug use	Frequency (%)
Smoking tobacco	76%
Chewing tobacco	45.9%
Inhalants ["Solution"]	48%
Alcohol	42.1%
Cannabis	15.7%
Opioids	2%

Age at onset of use	Mean age [SD]
Age at onset of tobacco use (smoking)	10.76[2.4]years
Age at onset of tobacco use(chewing)	10.79[2.5]years
Age at onset of Inhalant use	11.59[2.5]years
Age at onset of Cannabis use	12.79[2.5]years
Age at onset of Alcohol use	13.15[2.6]years
Age at onset of Opioid use	13.45[2.8]years

Type of inhalant used	Frequency (%)
Shoe polish (Cobbler's)	11.2%
Adhesives	2.0%
Paints and thinners	1.5%
Petrol	9.1%
Money spent on drugs per day	Rs 18.80[16.6]

Attachments (to family, work and peer group)

Determined by a] exposure to opportunities and influences within the group

b] skillfulness of performance in the group

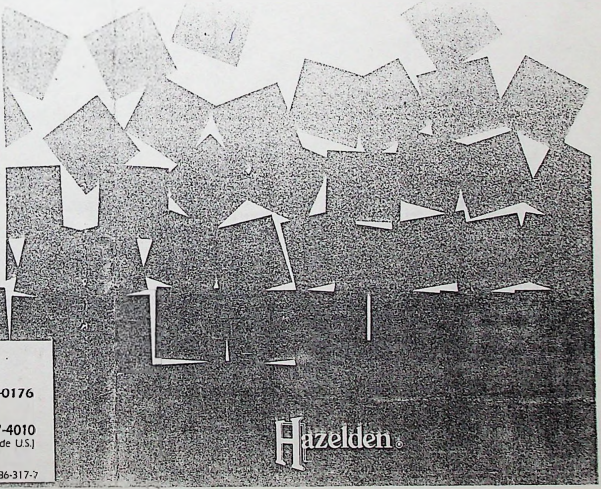
c] rewards received from the group

Strong attachments to a group are likely to occur if a young person has high exposure to that group is seen to perform well in that group through learning the necessary skills (e.g. pick-pocketing) Young people who develop strong attachments to family and schoolwork are less likely to develop attachments to a drug using peer group who expect and reward socially unaccepted behaviors. Young people detached from their families are at greatest risk, since their exposure is often limited to peers in similar positions as theirs. Even those of the children who remain in contact with their families often find that the rewards that they receive from their families are less attractive and consistent than those from their peers. In these circumstances, when their peers are using drugs or hold pro drug attitudes, they themselves are more than likely to take up similar drug using behaviours. Drug users spent less time at home, and had significantly less adult attachments than non-using children. Another factor which significantly predicted drug use was the nature of the childs job. Children who worked in unsupervised jobs (e.g rag picking) were more likely to be using drugs than children working under the direct supervision of an adult.

Attachments	Drug Users [n=197]	Non-users [n=84]
Attachment to family		
None	20.2%	24.3%
Some	79.8%	75.7%

CODEPENDENCY, A SECOND HAND LIFE

Stephanie Abbott



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As you make these outward and inward changes in things you *do* have power over, you will feel much more comfortable about surrender to lack of power over someone else, even if that person is greatly loved by you, and is getting very sick.

In spite of all your good intentions and insight, you may still find yourself devoting time each day to circular thinking, or yet one more attempt to control the uncontrollable. Pay attention to the pain it gives you because its message is, you need more help. Many have found a spiritual counselor is a helpful guide. Health professionals who understand alcoholism have helped many. You deserve as many allies as you can find to help you on your journey.

About the pamphlet:

Codependency is a normal reaction to alcoholism. This pamphlet is written for those who are in a relationship with an alcoholic, and whose behavior is geared toward controlling or changing the alcoholic's behavior.

About the author:

Stephanie Abbott is director of Family Counseling at Brighton Hospital, Brighton, MI, and president of the National Foundation for Alcoholism Communications. She writes a regular column for *Alcoholism/the national magazine.*

may have to repeat it several times. Next, follow with whatever aids you in switching these thoughts. It may be strenuous exercise, an Al-Anon meeting, or talking it out with a friend. Other helpful devices include reading Al-Anon or other literature written for family members. It may help to immerse yourself in mental work, something challenging that absorbs all your attention. Others do better with physical chores. Remember to be gentle with yourself, and that all growth and change means a certain amount of temporary dislocation.

These are immediate first aid tactics for obsessive thoughts and actions, or feelings of anxiety and helplessness. They all work by breaking the cyclical patterns and giving you a sense of control.

A woman with many alcoholic relatives looks at her recovery program like this: "I decided to look at it like a project. I was so overwhelmed with problems, most of them belonging to other people, that for me the easiest way was to deliberately be my own helper. I slowly improved my life by asking myself every day what a caring friend would recommend. Today I enjoy most days and accomplish a lot because I think about what *I* need for the first time. I can allow myself to get help from other people."

For the longer view, think about how you would live your life if you were not involved with an addicted person. What would you be thinking about if you were not thinking about this person and the problem? There lies the clue for what you could be doing with your life, and it deserves careful thought.

Al-Anon suggests we "act as if," and to live our way into healthy thinking. While you are at work on attitudes, examine what ideas are upsetting, such as the belief that anyone can control someone else's drinking. You can behave as though you did *not* secretly believe you had enormous power over others. The new behavior — putting challenge, pleasure, and accomplishment into your life — will make it more rewarding to continue the efforts with your emotional growth.

CODEPENDENCY, A SECOND HAND LIFE

STEPHANIE ABBOTT

Hazelden®

First published August, 1985.

ISBN: 0-89486-317-7

Printed in the United States of America.

Editor's Note:
Hazelden Educational Materials offers a variety of information on chemical dependency and related areas. Our publications do not necessarily represent Hazelden or its programs, nor do they officially speak for any Twelve Step organization.

This sounds like a very large job, and it is. But it is to be done slowly, in small steps, and at your own pace. There are many people who have gone ahead of you, and they can be there for you as a sponsor, a counselor, or in their writing. Use all those resources when you need them.

You will discover change brings anxiety and that is normal. The fear will diminish as you get used to new patterns in your life. It's important to be gentle and nonblaming with yourself. Remember, your goal was good and reasonable — to help someone else and to feel better yourself. The problem was that it didn't work. You are now beginning a process that *will* work and it will be accomplished in small steps, a day at a time.

You begin with the basic philosophy of allowing the alcoholic the right to be wrong, the right to hurt, and the right to get well or not. You will begin today to concentrate on your own thinking, behavior, and needs.

Remember, when you begin to become obsessed about anything, your thoughts circling around and around, it is simply a process you've used to solve a problem, but *it doesn't work*. Whether you are scheming about methods to control someone else, rehearsing what you will say next time, or going over painful events from your past, you are wasting valuable time. You could be productive instead, by doing something that feels better, or organizing your own day. Be aware also, that though it may feel to you that the alcoholic is the source of your feelings, actually you generate them yourself by your own thoughts and actions. When you notice your feelings come from you and are not put in you by another person, you begin to take charge of yourself. This will do a great deal to lessen your feelings of helplessness. Then you can begin to change nonproductive bad moods.

For example, when feelings of panic take hold, it helps to remember that every mood passes. This one will too. Switch these thoughts by a firm message to yourself to stop it. You

stronger than the pain of the current situation. On the emotional level, you may even believe you can't survive without the alcoholic in your life.

What You Can Do

The Truth Shall Make Ye Free — but first it shall make ye miserable. — proverb

It's hard to let go. We hang onto habits, relationships, and defenses long after they stop being good for us. It's natural to ignore what we know, hoping that if we don't notice it, we won't lose what we thought we had. But as Freud commented, "Much is won if we succeed in transforming hysterical misery into common unhappiness." It is very sad to face the reality of our powerlessness over someone else and the uselessness of obsessive behavior, but it will release us from hysterical misery!

The First Step, as Al-Anon states, is to admit the situation to yourself: you are powerless over alcohol and your life is unmanageable. Your thinking and feelings have become obsessive. The alcoholism is not the problem you can solve; your anxiety and fear are. Your misery and what to do about it is the problem that lies before you. The chemically dependent person needs help, but so do you.

To admit powerlessness is to surrender to a new way of looking at your life. Many people equate surrender with defeat and humiliation. They are like the alcoholic who chooses death over admitting the self-destructiveness of his or her life-style.

Yet those who have made the choice to let go of a drug or another person have found that surrender was liberation. You can't stand guard over someone else without losing your own freedom.

You can make a decision for acceptance, and live through that pain until it is finished, rather than staying in pain for a lifetime. Today you can decide to learn how to feel better, by changing your own thinking and actions.

IN OTHER WORDS

In an effort to avoid awkward repetition I have used the words *chemically dependent, alcoholic,* and *addict* interchangeably. What I have to say applies to anyone in a relationship with someone who uses mood-altering chemicals in a harmful way. For that matter, it extends to people involved with someone who uses food, gambling, sex, or work to avoid feelings and relationships.

POWERLESSNESS AND OBSESSIVE THINKING

If you are in a relationship with an alcoholic, this pamphlet was written for you. If you have had a normal reaction to living with alcoholism, then you are familiar with the feelings of helplessness and confusion, and you have spent time obsessively trying to solve the problem. Perhaps by now you are exhausted and depressed, wondering what's wrong with you that you can't make things better. Or perhaps you now understand that addiction to chemicals is a disease, and the alcoholic needs special help you can't give, yet you can't seem to stop the "helping" behavior you know is useless.

You know it is useless because you have tried everything you can think of to change that person's behavior and nothing works for very long. You may know it is useless because your Al-Anon group tells you it is, or your counselor has pointed out that nothing you do changes anything.

A wife tells of her efforts: "I hid his bottles, and looked for the ones he had hidden. I spent hours putting water in the vodka, and marking levels of alcohol on the bottles. Looking back, I can see how pointless it all was, but it seemed important at the time. I used to pace the floor crying, my mind so blank I couldn't think. I rehearsed what I would say to him, and imagined what he would answer. I was sure if I could plan the right words, I could reach him."

The reason nothing you do works is because chemical dependency is powerful. Addiction to mood-changing drugs, including alcohol, makes people self-centered, and the only thing that gets their attention for very long is a threat to their well-being. People go into treatment and get well only when they begin to feel threatened by what will happen to them if they continue drinking or using. That is why it is so important that you do not solve the problems or prevent the crises that drinking causes others.

problem solving. If you were freed from the fears that lead to obsession, you would have the serenity in which you could identify choices and options. What, for example, would you be thinking about if you were not thinking about the alcoholic in your life? What would you be feeling if you were not using activity to block your emotions?

If you did not have a compulsion to play counselor to the alcoholic, if you stopped helping and watching, what would you be doing with your life?

A grown daughter looks back on her adult years with her alcoholic mother: "My sisters got as far away as they could but I got stuck. I still spend too much of my time checking on her, thinking about her, and helping her solve her problems. It's kept me from ever having much of a life of my own. In a way, I guess I'm living hers."

Obsessive thinking and behavior serve to block out anxiety, which may feel overwhelming. This may be a fear of abandonment, of being alone and unsupported. These fears may have a traumatic origin. Perhaps you had an alcoholic parent. If you were raised in an alcoholic home it's very likely neither parent gave you focused attention. Your chemically dependent parent was unable to be emotionally close, or to put your needs first. Your other parent was usually too absorbed in the problems created by the chemical dependency to have energies for you, either. You may have felt emotionally abandoned. Now, in your adulthood, these fears of still another abandonment can be so intense you will do anything to avoid that terrible feeling, even to living in a toxic, chaotic environment. This is a very normal and natural reaction, but you stay in pain to avoid pain. To survive you will do whatever "works," even if it means walling off your feelings by compulsively focusing on something outside yourself.

Other people may think it is remarkable that you will cling to a painful, abusive relationship. That is because they can't understand your terror of being alone and abandoned is far

You may question yourself, analyzing your behavior, past and present, as to how it might affect the alcoholic. Living this way can be a form of addiction. Addiction has been described as an experience that blocks our awareness, fills time and occupies attention, and has an overwhelmingly compulsive quality. It also is a relationship to an activity that harms the person and affects self-respect. You may decide this thinking and behavior, revolving around another person, is indeed addictive.

There are other kinds of obsessive preoccupation. A spouse may become overly involved with work and begin to use it as the only source of good feelings. Or the spouse's energies may switch to the children, so there will be the kind of emotional involvement more appropriate to a marriage, plus an engulfing kind of control.

A teenager may obsess about collections or sports to block out negative feelings, or use compulsive achievement as the connection with life. If you can't get good feelings from relationships, you may work all the harder to feel good about accomplishments.

Why Obsession?

Obsession does serve a purpose. It gives an illusion of power and control over life. Some people even experience worry as an accomplishment of a task, and have a worry quota, whether the problems are large or small. Obsession gives a sense of movement, though there is no change, so that it is an "action" that fills the day, whether it is scheming, actively rescuing the chemically dependent person, or blocking out awareness by endless, pointless tasks.

From the fear of loss of control and the feeling of omnipotence comes compulsive behavior, which helps you feel you are doing *something,* and covers the feelings of helplessness.

Obsessive thinking may allow you to blame all your problems on The Problem, which releases you from the effort to solve them. In this way, it blocks out solutions and creative

Powerlessness

If you are the parent, child, or spouse of an addict, you may find it extremely difficult to admit complete powerlessness over the behavior of that person. You have spent a great deal of energy trying to deny that feeling. You may have covered debts, lied and covered up for the alcoholic, or spent many hours counseling that person. This behavior helps you feel better temporarily. It's normal to tidy up the alcoholic, to pretend to outsiders that nothing is wrong, or to cover up to the employer.

It just doesn't work. As long as you deny your powerlessness you will continue to rescue the alcoholic from crises. As long as you rescue the alcoholic from consequences of drinking, that person will drink. It's as simple as that.

If we look at what it means to be powerless, we understand it means to be completely unable to change or control. In Alcoholics Anonymous, the First Step is to admit powerlessness over alcohol. In Al-Anon, the First Step is the same — you have no power over the alcohol within someone else.

It is very natural when you are under stress to try to control what is happening. It has been shown in lab animals that a feeling of control over the environment reduces stress. Those animals with choice and some power have less pathology, and fewer negative chemical changes. If the researcher induces stress but gives the animal no opportunity for control, and no way to predict events, eventually it will have problems with eating and sleeping, which are symptoms of depression and anxiety.

High stress, lack of predictability, and powerlessness are all part of the environment for the family living with a chemically dependent person. To avoid depression and anxiety, the family tries to deny reality with efforts to control the drinking and behavior of the alcoholic. To admit the truth, that the traumatic events can't be controlled or completely avoided, is to admit powerlessness and feel the depression.

For example, you may find you spend hours counseling the alcoholic; you explore the behavior, you lecture and explain. You may begin to feel like a cassette player forever set to "play." Somehow none of these conversations do any good, but you feel better temporarily because you have avoided that feeling of powerlessnness.

Unfortunately, these efforts at control on your part do accomplish something. They give the addict the idea that there is no need to change anything, because the family member will take the responsibility for the lecture, the forgiveness, and whatever is necessary to avoid disaster.

When the family is still struggling for control of the situation, the alcoholic is firmly in control of the family. As long as you are trying to get good feelings from the relationship, which is actually impossible as long as the person is using chemicals, you will walk on eggs to minimize problems. For example, you may agree to anything to avoid a fight, or take on all the chores rather than see them undone. This gives all the power in the relationship to the alcoholic. When you stop trying to control, and let the natural consequences of the disease occur, you can no longer be manipulated.

A father commented, "We couldn't bear to face the truth about our daughter's addiction. She kept the house in an uproar but we kept trying. We bribed her not to drink, we let her break rules we wouldn't tolerate the other children breaking. Finally, we had to admit to ourselves that nothing we could think of would work. We gave her the choice of treatment or leaving home. It was very hard to do. But in admitting powerlessness over her condition we gained the strength to do it."

As the spouse or parent, you may feel the drinking or drug-taking is rebellion, as though the person were "getting drunk at you." You may feel loss of self-respect because you believe somehow you should be able to control that person's defiance. As long as you believe this, you will feel as though you have lost a contest every time the addiction manifests itself.

If you grew up with an alcoholic parent and now have an addicted spouse or child, you respond with behavior you learned in the past, behavior you used for survival. You may feel a drive to change others, to control and fix for the "good" of other people. If you had an alcoholic parent and now find yourself married to an alcoholic, you may have unconsciously repeated the original family conflict in order to give it a happier ending this time. There may be despair and depression when you discover that your goal of changing the past by doing it differently in the present can't work.

If you are a fairly typical adult child of an alcoholic, you will deny your powerlessness and try to solve all the problems by yourself. It has been said that children of alcoholics are seen in all the best self-help bookstores.

Again, power lies in accepting powerlessness. When you stop exhausting yourself with useless attempts to change someone else, when you stop blaming yourself for not achieving what no one could achieve, you are free to look at other options. As Al-Anon literature states, living with alcoholism is too much for most of us.

Obsessive Thinking

You may find you spend hours each day, or lie awake at night, worrying about your situation. This may take the form of fantasies in which drinking becomes physically impossible for the alcoholic, or you may scheme about techniques to avoid drinking situations. Or you may rehearse your lecture to the addict. You may torture yourself worrying where that person is, and with whom. You are afraid the addict will get killed on the highway and yet you are afraid he or she won't. You may go over and over the past, reminding yourself of the pain. Or you may project horrors into the future, as if you could solve problems before they happen. You may be quite aware this sort of thinking does you no good and wish you could stop it.

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MANUAL ON COMMUNITY ACTION

AGAINST DRUGS AND ALCOHOL

(First Version)

by Samioullah Lauthan

in collaboration with the
Vocational Rehabilitation Branch
International Labour Office
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PART II. THE ROLE OF GOVERNMENT AGENCIES, NONGOVERNMENTAL ORGANISATIONS AND OTHER COMMUNITY GROUPS

PREFACE

This set of manuals is a response to the need to introduce measures against drug and alcohol abuse in developing countries. In those countries a large number of programmes must be started quickly with limited resources. Lacking well-established programming practices of their own, their planners and service providers must study the work and ideas of others; they must analyse what that work means for their own cultures and adapt it to their needs. These publications are designed to help them in their task.

The four manuals are described briefly below.

"Manual on addiction rehabilitation programming" by Fred Zackon.

This volume is intended for the staff of addiction rehabilitation programmes. It is designed to be used by all service staff, although it is mainly a tool for programme leaders. The text provides a guide for the development of model programmes based on the author's Reference Design. It describes the key issues and actions for building such programmes. Most of the approaches described have already gained wide acceptance in the field of addiction rehabilitation. Some attention is given to administrative issues, but the primary focus is on client services. The context is integrated and all the elements derive from a unified perspective, which means that staff must operate as a team with a common understanding and purpose.

"Manual on community action against drugs and alcohol" by Sam Lauthan.

Those who live in communities where drug and alcohol abuse occurs must feel concerned at the situation and be aware of the dangers of allowing it to deteriorate further. Community action to combat substance abuse means that individuals and groups must work together to find social responses to the problem and to provide healthy alternatives to alcohol and drugs. All segments of the community must be motivated to develop a total commitment to the task of protecting vulnerable groups and individuals from the dangers of substance abuse.

The manual provides guidelines on forming local associations of the widest possible variety of expertise and good will as the best way to develop the multidisciplinary approach which is necessary to tackle this complex problem. It describes a step-by-step methodology to be followed in planning and implementing a community-based demand reduction

programme. It also gives a brief introduction to the role of government agencies and nongovernmental organisations in the fight against drug abuse. The manual includes some basic information about substance abuse generally, as people involved in community action need to be well informed about the realities of the situation in order to tackle their work with confidence and competence.

"Manual on drug and alcohol policy development" by Ragnar Waahlberg.

The social effects of substance abuse are well known and clearly documented. For example, there is no doubt that a high level of alcohol consumption in a country correlates with a high level of social and health problems, with violence and criminality.

This manual is designed to help decision makers formulate a national policy on alcohol and drugs and to develop a preventive strategy. The aim of a national policy on alcohol should be to restrict the damage caused by excessive consumption, and the aim of a drug policy should be a drug-free society. The manual includes chapters on reducing the supply of alcohol with the objective of preventing excessive drinking, and on preventing people from ever beginning to use illicit drugs. The focus is on prevention, rather than cure, as the foundation of a national strategy. It offers a step-by-step guide to drawing up a policy and creating the instruments needed for implementation.

"Manual on the design, implementation and management of alcohol and drug programmes at the workplace" by Sverre Fauske.

The aim of this volume is to help managers, union leaders, occupational health professionals and social workers to design and implement programmes on the prevention of drug and alcohol abuse at the workplace. It is also intended for local resource personnel to help them in their collaboration with government, management, union representatives and consultants on alcohol-and drug-related problems at the workplace.

Concern for the welfare of people at work is central to the activities of the International Labour Organisation. This concern includes taking measures to combat substance abuse. ILO involvement in this field is based on the agreement of governments, employers and workers that workplace initiatives are an effective means of preventing and reducing alcohol and drug abuse. The scale of the problem should not be underestimated, as drug-related issues affecting workers have become a serious concern in many countries. The costs to industry and the community have been estimated in billion dollar terms; they

involve lower productivity, absenteeism, accidents and staff replacements as well as sickness and accident insurance claims. In human terms the costs to individual workers and their families are also great if they lose their jobs as a result of drug and alcohol abuse.

The focus of this manual is on prevention rather than cure. It distinguishes between primary prevention (awareness), secondary prevention (assistance) and tertiary prevention (rehabilitation), and provides guidelines and suggestions for those responsible for introducing workplace programmes.

The title page of all four volumes indicates that the publication is the first version of the manual. The manuals are designed in such a way that they can easily be adapted in the light of experience with their use and the second edition will incorporate new developments in the field. The ILO encourages and welcomes the ideas of all those who use this material. Readers are invited to submit their comments and suggestions for the second edition to The Vocational Rehabilitation Branch, International Labour Office, CH-1211 Geneva 22, Switzerland.

INTRODUCTION

Substance abuse is an extremely complex problem which affects every part of the world today. In the search for solutions it is necessary to take account of the medical, psychological, social and legal dimensions of the question as well as the economic aspects. Abuse of drugs and alcohol occurs on a large scale in the industrialised countries and has become a real threat to developing nations in recent decades. Most of the countries of Southern Africa have serious problems with alcohol, cannabis and methaqualone (mandrax), and some of these countries have begun to experience cases of heroin and cocaine trafficking.

Those who live in communities where drug and alcohol abuse occurs must feel concerned at the situation and aware of the dangers of allowing it to deteriorate further. The quality of life of all members of the community is threatened when substance abuse is rife and every individual suffers the consequences of inaction. Communities in many countries are already facing natural disasters such as drought, which are compounded by economic disasters such as inflation and unemployment; such communities cannot afford to ignore the issue of drug abuse and cannot allow their precarious economic situation to be eroded further by the social disasters of drug addiction and alcoholism.

Community action to combat substance abuse means that individuals and groups must work together to find social responses to the problem and to provide healthy alternatives to alcohol and drugs. Young people in particular need facilities for physical exercise and recreation, stimulation for their creative talents and mental abilities, and an environment which provides aesthetic satisfaction. Their spiritual needs also must not be overlooked in the effort to provide a positive outlet for the energy and enthusiasm typical of the young. Young people and workers are statistically most at risk of falling into dependency, but there is no social group which is free of the threat of substance abuse.

All segments of the community must be motivated to develop a total commitment to the task

of protecting vulnerable groups and individuals from the dangers of alcohol and drug abuse. A large number of people can give assistance in this effort . They include psychiatrists, doctors, primary health care workers, psychologists, anthropologists, sociologists, school administrators, teachers, the business community, labour leaders, trade unionists, police and customs officers, youth club leaders, religious leaders, social workers and parents. Professional groups and private individuals can all participate in community action if they can spare a few hours every week or every month to work on an advisory board or as resource persons on a Community Action Committee. Forming an association of the widest possible variety of talent, expertise and good will is the best way to develop the integrated, multidisciplinary approach which is necessary to tackle such a complex problem.

The Community Action Committee

Prevention activities at grassroots level are the responsibility of local Community Action Committees.

In order to set up a Committee the project takes the initiative by making a simple survey of existing resources in the local community, concentrating on potential human resources. A list is then drawn up of the local organisations whose members could make a valuable contribution to prevention activities. The list is long: it includes professional bodies and associations such as the police and customs authorities, the educational system, primary health care services, the media and the local business community, as well as voluntary clubs and organisations such as amateur sports clubs, youth groups and parent-teacher associations. Nongovernmental organisations involved in charity work and religious bodies can also play a vital role in preventing substance abuse in the community.

The social worker attached to the national drug prevention project contacts all the local associations identified by the survey and invites them to a seminar or a public meeting in order to discuss the situation and the possibilities for action. The objective of this preliminary meeting or meetings is to establish a consensus on the need for action, before any specific steps are taken to initiate activities. Once such a consensus is clearly established the social worker invites the associations which have demonstrated their interest and concern to nominate one of their members to serve on the Community Action Committee. When the Committee is formed it should elect a Chairman and hold regular meetings every month or so. The project coordinator should be appointed Secretary of the

Committee.

From this point on the active involvement of the national project is gradually phased out: the project remains in the background, concerned only to maintain the motivation of Committee members and advise them as requested. The basic structure of the community action component of a national drug and alcohol prevention project is illustrated in the organigram in Annex I.

The function of the Community Action Committee is partly to give advice to the local population on drug-related matters, partly to serve as an information channel between the local community and the national centre, and partly to mobilise funds and other resources for prevention activities. Committee members themselves are often actively involved in lecturing to school-children and youth groups on the dangers of drugs and alcohol, or in fund-raising for campaign work. The Committee acts independently because activities undertaken at local level are not usually funded by the national resource centre. This arrangement gives committee members both responsibility and authority, as they are not merely carrying out proposals made at national level. The element of independence is motivating for committee members, who give their time voluntarily.

The basis of community action is networking through informal social contacts. Committee members can intervene on behalf of recovering addicts by helping them find employment and assistance when needed. They can also give professional advice on practical matters, such as handling money and finding a home, or personal matters such as health problems and mental stress. These activities are more concerned with secondary prevention than primary prevention, which is aimed at the whole population rather than particular individuals. This point indicates the importance of the work of the committee members, who are aware of local needs of all kinds and who are in a position to respond to them.

Community action work must have a target. The target may be quantifiable and relatively easy to measure (e.g. a reduction in the number of drug- or alcohol-related accidents during the year), or it may be qualitative, relying largely on people's impressions and informed opinions for assessment (e.g. an improvement in the quality of life in the locality). The ultimate target of community action is to involve the local population at all levels in raising awareness of the dangers of drugs and alcohol and thus to strengthen the general level of resistance to the attraction and temptation of dependency-creating substances.

Understanding the high-risk groups

During the past twenty years an enormous amount of literature has been published on the question of substance abuse and the reasons why people fall into dependency and addiction. However, researchers have not yet reached a comprehensive understanding of the phenomenon in spite of advances in biophysiology and pharmacology.

In a country where drug abuse is common any young person or adult may be considered at risk, but some are at greater risk than others because drug problems are not distributed uniformly over social groups. Adolescents are at high risk, even if they live in so-called "safe" areas, because of the stresses caused by the personal development which takes place during adolescence. During this period the healthy young person will learn to:

develop self-confidence;
take the initiative;
explore, experiment and take risks;
discover personal aptitudes and come to terms with weaknesses;
develop an independent identity;
work towards emotional and social maturity;
assume some economic independence;
become physically mature.

During this difficult phase young people lose the protection afforded by childhood before they gain the experience and maturity of adulthood. In addition to this it must not be forgotten that adolescents have to respond to the stresses of their environment at the same time as they are working towards their own personal development. The environmental stresses include:

increasingly complex relations with other people;
problems related to sexuality;
the disappearance of the extended family;
finding a job or starting a training course;
negative peer pressure;
new technology;
the population explosion.

In addition to the above, those adolescents and young adults who live in high-risk areas often have to cope with a particularly difficult situation in the family and community. They probably experience economic hardship and may have psychological problems. They also lack facilities for leisure-time occupations.

There are only two possible responses to the many types of stress listed above; fight or flight. It is a tragedy that so many adolescents and young adults have chosen the latter course, through drug taking and heavy drinking. However, not ALL young people in high-risk areas use drugs, and not ALL young people in low-risk areas refuse drugs. We must therefore be very cautious when using expressions such as "high risk" and "low risk". Programmes and activities designed to combat substance abuse in all areas must develop different approaches aimed at non-users, experimenters, occasional users, regular users and addicts.

Non-users must be encouraged to continue to refuse drugs and helped to resist peer pressure to experiment. Experimenters must be informed that although drug users may appear to function normally they run the risk of becoming addicted, taking an overdose or being arrested. Occasional users are the most difficult group to convince because they derive pleasure from drugs but do not suffer from withdrawal symptoms and are not yet dependent. For the same reason regular users are difficult to reach, although they may realise that they are already developing tolerance and increasing their intake of the drug. Alcoholics, drug addicts and poly-drug abusers need to be motivated to seek treatment, even if they have made previous unsuccessful attempts to stop drinking or taking drugs. Treatment must be followed by after-care and rehabilitation services, preferably at community level.

The expression "high-risk" group does not refer only to adolescents living in an environment where drug-taking and drinking are common. Other high-risk groups are retired people who drink to help themselves to cope with loneliness and boredom, and business and professional people in stressful jobs. The adult children of alcoholics are also considered to be at risk because they grew up in an environment where alcohol was always present. Also at high risk are people who live in urban slums because very often the production and sale of home-made alcohol is their main source of income. This group should be the target of special programmes designed to tackle the multiple problems of slum dwellers; such programmes should include field workers and peer leaders with whom the slum dwellers can identify. Youth clubs and other youth movements should be involved

in the planning and implementation of these programmes, which need to help young people develop the necessary coping skills to grow up and lead a drug-free life in a high-risk environment.

Working in high-risk areas or with high-risk groups is a tough job requiring sustained effort and almost unlimited patience. Field workers and programme initiators must bear in mind that modifying the immediate environment of adolescents and young adults will take years, and that readjusting social trends and lifestyles will take decades. Such long-term goals are realisable if field workers and members of community action groups are genuinely motivated and are determined to start NOW.

The present manual is designed to help all those interested in community action to plan and implement their activities. It is intended for government officials, policy makers, programme planners, primary health care personnel, educators, voluntary social workers, religious groups and youth club leaders; in fact it can be useful to any individual or group wishing to contribute to the fight against drug and alcohol abuse.

The manual consists of two parts.

Part I describes a step-by-step methodology to be followed in planning and implementing a community-based demand reduction programme. It deals systematically with the different steps involved in mobilising the community and in designing, implementing and evaluating the programme.

Part II gives a brief introduction to the role of government agencies and nongovernmental organisations (NGOs) in the fight against drug abuse. It then lists a number of activities that can be undertaken by the main community organisations and institutions, including primary health care services, parents' groups and womens' organisations, schools, religious groups, the police and customs services, the media, the business community and service clubs. The organisations mentioned and activities listed are not exhaustive. Programme planners are expected to add to the suggestions and to try out new ideas. Besides adapting the proposed activities to the local situation, programme planners and policy makers must have the courage to initiate and innovate.

The manual also includes some basic information about important aspects of the problem

of substance abuse. People involved in community action need to be well informed about the realities of the situation in order to tackle their work with confidence and competence. In-depth knowledge about intervention skills can only be provided through intensive training courses and workshops, which should be organised with the help of local and foreign experts. It may be possible to organise some technical cooperation activities in this field with the assistance of international agencies interested in combating substance abuse. The international community is continuously calling for global, international, regional and national cooperation to reduce both the supply and demand for dependency-forming substances. In this context it goes without saying that cooperation must first become a reality at the local community level.

PART I

PLANNING AND IMPLEMENTING A COMMUNITY-BASED PROGRAMME

Taking the initiative

During the last few years governments in developing countries have begun to show real concern about the problems and dimensions of substance abuse. There is now a clear understanding of the need to revise legislation, to strengthen and update agencies and to improve services. New measures and appropriate strategies also have to be developed. Until very recently most resources have been directed towards supply reduction through suppressing the production, distribution and sale of illicit drugs. However, worldwide experience and research shows that demand reduction strategies are equally important in the fight against substance abuse and that there is a need for the further development of demand reduction strategies through a wider variety of prevention, treatment and rehabilitation approaches.

Factors to consider

Before designing programmes and setting objectives it is important to consider the factors which influence the policy and organisation of demand reduction programmes:

- the political structures in place and the political processes involved;
- the dynamics of decision making by government agencies:
- the traditional methods of problem solving and decision making;
- the interactions between leadership and power groups within the community;
- the availability of financial and human resources at community level;
- the feasibility of international assistance in terms of finance and training.

In spite of the urgent need for action and the pressure to respond quickly, it is necessary to take the time to plan a step-by-step approach and to avoid hasty decisions and mistakes. Decision makers and service providers have a duty to plan carefully and to pay attention to all the elements involved in a community-based programme. There are eight essential steps in the planning process:

- needs assessment;
- community mobilisation;

- training and manpower development;
- development of material resources;
- setting goals and objectives;
- defining activities to meet the objectives;
- implementing and monitoring activities;
- evaluating the process and results.

Needs assessment

In order to tackle even a simple problem effectively it is necessary to have a clear understanding of its causes and consequences. When the issue is as complex as the problem of substance abuse it is clear that a thorough assessment of the situation is essential. There are three main reasons why needs assessment must be carried out adequately:

- to enable policy makers and programme planners to make a rational and effective use of assets, particularly in developing countries where financial resources are very limited;
- to provide clear facts in order to convince government officials, policy makers, community leaders and funding agents of the urgent need for community action:
- to establish priorities for the action plan.

A scientific survey is the most reliable way of collecting data, but it is also the most expensive method. However, there are a number of alternative approaches, and a lack of resources and expertise should not prevent programme planners in developing nations from making an assessment of the nature and extent of substance abuse in their country. Information available from three main sources can be helpful until the necessary funds and expertise are available for large-scale surveys; the information sources are substance abuse indicators, social anthropology and the informed opinions of community leaders.

Substance abuse indicators

These are quantitative and verifiable data which can be obtained from police records and the health services. They provide information on the following important aspects of the problem:

- the drugs which are used in the community;
- the demographic characteristics of the drug users;
- the number of known drug smugglers, dealers and users;
- the number of seizures including illicit alcohol and prescription drugs;
- the purity of the illegal drugs seized, which indicates the closeness of the offender to the producer or smuggler of the drugs;
- variations in the market price of drugs, which indicates the availability of drugs
- on the streets;
- the number of drug-related deaths by overdose, suicide, homicide, work accidents and traffic accidents;
- the number of alcohol- and drug-related crimes of violence and theft, compared with the number of cases not related to substance abuse;
- the percentage of admissions to hospitals, treatment centres and prisons which are related to substance abuse;
- the number of known traffickers.

These data, collected over a number of years, indicate trends in drug trafficking and some of its consequences. However, it must be noted that experience in the industrialised countries seems to indicate that the "known" addicts probably represent only about ten per cent of the real number of addicts in a given community at a given time. In developing countries the known cases may represent a still lower proportion of the total number of addicts in view of the stronger social stigma attached to drug addiction in many parts of the world.

In order to ensure that police and health service records are as accurate as possible it is advisable to update and standardise the files on a regular basis. This work could be undertaken by social scientists or social workers with experience in the field of substance abuse who should collaborate closely with the data collection and record keeping sections of the police and prison departments and health services. Data recorders may need to follow a basic in-service course on principles of case work and counselling to develop their awareness of the delicate and sensitive psychosocial factors involved in the data collection process, particularly in regard to substance abuse.

Social anthropology

Substance abuse is not only a question of figures and statistics. One of the most important aspects for programme planners is the need for information on the beliefs, traditions, values and practices of socio-cultural and ethnic groups within the community.

Social anthropology provides policy makers with a good insight into the sub-culture of drug abuse. Through detailed case histories a wealth of information can be gathered about the knowledge, beliefs and values, attitudes and behaviour patterns that characterise drug abusers in their specific socio-cultural context. Social anthropology is a simple method of collecting information by involving the human resources which already exist in the community to be studied. According to Walters (1980) the types of information that can be obtained by "street anthropologists" are the following:

- types of drugs used;
- age and circumstance of first drug taking;
- routes of administration;
- economics of drug use;
- drug effects;
- relationship of setting to perceived effects;
- physical and social benefits and risks;
- adverse reactions and treatment histories;
- criminal justice cases.

Informed opinions

In every community there are individuals whose professional or social role puts them in a position to provide an informed opinion on the nature and extent of substance abuse. These natural information-providers include:

- local doctors;
- mental health specialists;
- primary health care workers;
- school teachers;
- youth leaders;
- police officers;

- lawyers;
- family counsellors;
- probation officers;
- bankers;
- shop keepers;
- taxi drivers;
- café and bar owners;
- community elders.

Data may be collected by interview. Generally, a questionnaire is used to cover the basic information required but this should be complemented by an unstructured interview in which the respondent talks spontaneously about the problem. Aspects of the drug scene which were previously unsuspected by prevention workers may come to light in this way.

Epidemiological survey

An epidemiological survey is the best method for measuring the nature and extent of substance abuse in a given locality, but it is also the most expensive of the methods discussed here. Programme promoters will need the collaboration of the local university survey team and / or experts from the private sector and outside consultants. Considerable expertise is required to choose a good sampling method and to design a questionnaire which will be appropriate for the educational level of the population and the socio-cultural context. If the necessary funds are available the epidemiological survey should be repeated at regular intervals to show trends in the prevalence and incidence of substance abuse in the locality.

Alternative data collection methods include self-administered mail questionnaires, group-administered questionnaires and telephone interviews, although the latter are not appropriate for the rural areas of developing countries.

Assessing existing programmes and services

After collecting all the available data on the nature and extent of substance abuse in the community, programme planners need to assess the existing programmes and services and the human and material resources available for community action.

The following factors should be taken into consideration:

- the number of government agencies and nongovernmental organisations offering prevention and treatment services;
- the types of activity arranged and the approaches adopted towards prevention, treatment and rehabilitation;
- the socio-demographic characteristics of the various target groups being reached;
- the communication network and collaboration between the agencies and organisations working in the field;
- the facilities and equipment available, including teaching materials and transport.

Interpreting assessment data

The findings of the data-collecting effort must be interpreted with caution. It is important to complement the indicators of drug abuse obtained from addiction registers, health service records and seizure statistics with reliable data from other sources. Assessment studies sometimes produce conflicting results, which again emphasises the need for alternative interpretations. The methodology and findings of the assessment should be formally reported in a document to be circulated for comment and specialists in social measurement techniques should be asked to assist in interpreting the data collected.

In summary, needs assessment is a complex undertaking. In order to achieve the best possible result the national substance abuse resource centre will need the help and support of experts to design, initiate and evaluate programmes and to undertake research studies on issues specific to local conditions.

Community mobilisation - the need for linkages

Substance abuse is a community concern that requires a community response. The problem must be faced in the home, in night clubs and tourist resorts, in public parks and playgrounds, in schools and youth clubs, at social gatherings and at work.

Substance abusers and the families of substance abusers need the support of government services. At the same time nongovernmental organisations must be encouraged to work in

the field of prevention, treatment and rehabilitation. The various organisations engaged in combating drugs and alcohol should, however, avoid a duplication of services. Nongovernmental organisations should aim to supplement government assistance by filling gaps in the services offered. They can often respond to local needs more effectively than public services owing to certain special characteristics:

- they can act quickly because of their informal structure and independent status;
- their voluntary nature means that they are less restricted by financial constraints than either the public or the private sector;
- they are close to the community and can reach specific target groups:
- their members are genuine field workers and the local population can identify
- with them;
- their leaders usually have influence and prestige , and can successfully press for action or solicit support.

There are three major preparatory steps for involving the community in action to combat substance abuse. The first step is to reach a consensus on the need for action by approaching the various community groups individually and contacting leaders in order to discuss the situation and to share ideas for action programmes. The second step is to enlist potential volunteers to serve on the Community Action Committee. It should be stressed that expert knowledge is NOT a requirement for this work; a genuine commitment to winning the fight against substance abuse is the most important quality that an individual needs to make a difference to the drug scene in the local community. The third essential step is to make sure that the aims and objectives of the resource centre are clearly understood by all the individuals and groups participating in the work.

Constraints in community mobilisation

Several factors might make it difficult at first to interest the general public in drug- and alcohol-prevention activities, the first problem being that drug-taking is not always seen as an issue of concern. Certain drugs and alcohol have traditionally been a part of the local way of life in the majority of communities and although addiction is clearly unhealthy it is frequently seen as a personal problem rather than a social problem. The resource centre may have to counter this view by making the general public aware of the dimensions of the problem and the real costs of addiction, both in terms of economic loss and in terms of damage to the quality of life.

A second difficulty which is frequently encountered is that access to women, adolescents and social drop-outs may be difficult for religious or political reasons. The personality of those who voice community needs and organise programme activities may be decisive in reaching certain target groups. Community action workers need to have credibility and to be accepted by social groups who are marginalised from the mainstream of community life.

Political and financial interests in the profits to be made from dependency-creating substances are extremely powerful. Activities related to combating drug and alcohol abuse may have to face lobbies or other pressures from those who sanction the abuse of these substances.

Other difficulties faced in mobilising community resources have to do with the personality of the individuals involved in the work. Programme promoters, educators and trainers who themselves use substances which create dependency will not have the necessary credibility in the eyes of the community.

Involvement in community action requires a lot of time and energy, and above all it requires sustained commitment and enthusiasm. Promoters must therefore guard against the danger of "burn-out" by delegating responsibility. A second-line community action group will need to be developed as activities progress.

There is often a tendency to fight against other people instead of fighting against the problem and conflicts will inevitably arise between individuals serving in community action programmes, and possibly also between nongovernmental organisations and service providers. In all circumstances the interests of alcoholics and drug addicts and their families must be given priority over self-interest and petty jealousies. Individuals and groups must have the humility to accept the fact that they will not go far alone and that they need a strong coalition of well-intentioned partners. Above all they must be ready to share experience, expertise and resources and be willing to learn from their own mistakes and those of others.

Training and manpower development

Community educators and field workers are the agents of change whose work is indispensable in a community-based prevention programme. We have already stressed in

this manual that it is not necessary to be a specialist or expert to start such a programme and that people who are genuinely motivated can make a real difference to the situation in their community if they have some basic knowledge about substance abuse. Information on the following subjects is necessary for field workers and other potential resource persons working in primary prevention programmes: prevention approaches; basic definitions of the terminology of substance abuse; signs and symptoms of drug use and abuse; the nature of denial; the nature of negative peer pressure; and decision-making skills to resist negative peer pressure. In addition, field workers should have some knowledge of the types of drugs used in the community, the modes of use, their effects and withdrawal symptoms. Some basic facts on drugs are provided in Annex II to this manual. The following sections present general information on the other six topics listed above.

Prevention approaches

There is now increasing awareness among drug control agencies that too little emphasis has been placed on strategies to reduce the demand for drugs. Until very recently the effort to control substance abuse focused largely on reducing supply by suppressing the production and distribution of illicit substances, but it is now accepted that supply reduction must be balanced by demand reduction, which means preventing people from starting to use dependency-creating substances, or preventing them from continuing to use these substances indefinitely.

Preventive measures can be applied at three levels. The first is primary prevention, which aims at controlling or reducing the incidence of substance abuse by preventing experimentation or delaying the age at which young people begin to drink alcohol. Secondary prevention attempts to reduce the prevalence of substance abuse by early diagnosis and by providing counselling and treatment for drug users to encourage them to return to a drug-free lifestyle. Tertiary prevention aims to prevent recovering addicts from relapsing through the provision of rehabilitation and social reintegration programmes.

The four main approaches to primary prevention are through drug education and information, alternative activities, values clarification, and social skills.

Drug education and information campaigns are widely used in many countries. The main strategies are the provision of objective information and the use of scare tactics. Factual information is provided about the different types of drugs of abuse, the modes of

administration, the effects on health, and the economic and social consequences of abuse. This type of campaign has often been criticised because it may arouse the curiosity of non-users if too much stress is laid upon the euphoric effects of the drugs. On the other hand the objective and scientific information provided can demolish myths and misconceptions about alcohol and drug abuse. For example, there is new scientific evidence that cannabis, which is usually believed to be harmless, can damage the brain, the respiratory organs and the reproductive system. Scientific information can also help to raise awareness of the real dangers of needle-sharing and casual sex in the spread of AIDS. Information campaigns should not be limited to giving facts about drugs but should also lay stress on the benefits of a drug-free lifestyle.

The scare approach is very commonly used by parents. It may discourage youngsters who have never experimented with drugs but it does not work with adolescents who have experienced euphoria induced by a drug. Young people who are at particularly high risk very often do not care about the long-term consequences of drug abuse and are only concerned with immediate gratification. They may be using drugs themselves or have friends who are regular users but who suffer no apparent consequences. It is pointless to tell such adolescents that their first experiment with drugs or alcohol will make them ill, as their experience has already shown them that this is not the case. The young people will then not be interested in hearing what these teachers have to say about drug-taking because they will believe that they know nothing about the subject.

Young people need to explore their environment, experiment with life and test their limits. Therefore they should have creative and meaningful experiences which fulfil these needs and provide an outlet for their energy. Recreational centres must provide activities that serve some of the functions of drinking or drug-taking; excitement, challenge, relaxation, and relief from frustration, alienation, discrimination, pain, sickness and boredom. Such activities are more important when children are left to themselves outside school hours because both parents are working; it is particularly important to provide occupation for children during the school holidays. The activities which satisfy the needs of adolescents include; physical exercise such as swimming, running and climbing; organised sport which fosters the discipline of obeying rules; games which develop the team spirit and sportsmanship in accepting defeat and frustration without resort to alcohol or drugs; hiking in aesthetically satisfying surroundings; camping and sharing tasks and responsibilities; undertaking voluntary social work; learning to appreciate art; learning to relax in a healthy way; acquiring the discipline of good eating habits and diet; and learning about counselling

techniques.

The values clarification approach is based on the assumption that choices are influenced by values and that people who abuse drugs have not developed a clear set of moral or spiritual values. This approach relies heavily on inculcating good behavioural norms and moral values in young children. It is assumed that children who have been taught not to lie to their parents and teachers will be able to express their feelings freely irrespective of peer pressure. They are also expected to be able to resist the pressures of advertising for alcohol. The values clarification approach is an effective prevention tool for young children and adolescents who have not yet experimented with drugs. It is less effective for occasional or regular users, who are enjoying the "pleasure phase" of drug taking. In addition, the approach is not effective with people who are already dependent on drugs because the whole world of the addict revolves around the drug, which has priority over everything else in life.

The social skills approach is based on the assumption that most new drug users are encouraged to experiment by an actual user. Experience has also shown that hard-core addicts who have experienced severe withdrawal symptoms rarely induce non-users to try. The main culprits in spreading drug use are casual and occasional users who seem to be enjoying life. Therefore the social skills (or interpersonal) approach aims to provide non-users with coping skills to resist external pressure to use drugs. The following skills form the basis of this approach:

- interpersonal communication;
- increasing feelings of self-worth and self-esteem;
- resisting peer pressure;
- problem solving and decision making;
- analysing and resisting advertising for alcohol;
- assertiveness and stress management;
- controlling anger and frustration;
- distinguishing between positive and negative persuasion.

Substance abuse is a complex problem and no single approach used in isolation will be successful in preventing it. Community educators should determine which combination of approaches would best suit the needs of the individual or group in question.

Basic definitions

The following terms are very frequently used in discussions on substance abuse.

Drug: any natural or synthetic substance which, when taken into a living organism, may modify its functions.

Use: use of a substance implies that the individual is in control, not compromising physical health or damaging family life, social activities or work abilities.

Misuse: misuse refers to a non-medical or inappropriate use of psychoactive drugs.

Abuse: abuse of a substance refers to a pathological pattern of use causing impairment in social or occupational functioning. The duration of abuse is at least one month.

Tolerance: tolerance is a state in which markedly increased amounts of the substance are required to achieve the desired effect.

Dependence: abuse leads to dependence, which is characterised by a compulsion to take the drug on a continuous or regular basis in order to experience its mental effects or to avoid the discomfort resulting from its absence. There are two types of dependence: *physical dependence*, which is a state triggered by the abrupt cessation of a drug which has produced an adaptive physiological state, and *psychological dependence*, which is characterised by an emotional drive to continue taking a drug whose effects are felt to be necessary to maintain a sense of well-being.

Withdrawal syndrome: withdrawal or abstinence syndrome is characterised by the stressful symptoms resulting from sudden deprivation of a drug that is habitually used. Symptoms may be mild and not always clinically evident (cocaine, cannabis), or very marked (opiates), or even life threatening (barbiturates).

Signs and symptoms of drug use and abuse

Field workers and educators engaged in a public awareness campaign are constantly asked to describe the signs and symptoms of drug use. Great caution is required in answering this question and people must be constantly warned about the danger of jumping to hasty conclusions at the first possible signs demonstrated by their children, students, friends and relatives. It must be stressed that the symptoms which are listed below are NOT proof of drug taking; they are no more than indications that a person MAY be using drugs. Even if several of the symptoms appear at the same time it may mean no more than that the individual in question is passing through a period of emotional or psychological stress.

With all the reservations mentioned above, the following are some of the signs and symptoms that may be associated with drug use and abuse:

- sudden mood changes;
- unexplained irritability or aggression;
- loss of interest in hobbies, sports or studies;
- frequent lies and subterfuges;
- bouts of drowsiness or sleepiness;
- loss of interest in physical appearance;
- unpunctuality and absenteeism;
- borrowing money;
- "losing" money or valuables;
- lack of respect for authority;
- unusual smells on the body or clothes;
- stains or marks on the skin or clothes;
- approval of the drug culture.

The nature of denial

Programme initiators and field workers must be prepared to face a barrier which is very often a stronger deterrent that any threat that traffickers can make. This is DENIAL. Denial must be faced at the level of users , families, the community and the state.

USERS deny having a drug problem even after they realise that they have started to develop tolerance or have already become dependent. FAMILIES deny that one of their members has a drug problem because the honour and good reputation of the family is at stake. Unfortunately, many families give higher priority to protecting their reputation than to protecting the lives of their members. The COMMUNITY denies that there are abusers and traffickers in its midst, or will only admit that there is a problem in the big cities and the slums. The STATE denies that the problem is serious in spite of an increasing number of arrests and cases of overdose. If the problem is acknowledged the authorities fear that hey will be held responsible for causing it or for allowing the situation to deteriorate.

Users, families, the community and the state, by denying the reality of the problem, tend to put the blame on the product, the media, neighbouring countries, etc., thus reinforcing the belief that the only possible strategy in the fight against drug abuse is supply reduction. In the meantime all the victims of substance abuse continue to suffer physically, morally and economically.

When substance abuse reaches epidemic proportions the responses are inadequate and inappropriate because they have not been prepared realistically. Hasty solutions are sought and very often only a single aspect of this complex problem is addressed. It frequently happens that foreign models and approaches are "imported" and adopted without proper consideration of the economic and socio-cultural context in which they are to be applied.

The nature of negative peer pressure

The negative influence of peers is very often associated with drug abuse, particularly among adolescents. Parents of young delinquents or drug abusers are well aware of a terrible force against which they feel helpless but which they are unable to understand.

When the issue of substance abuse occurs, the attitude of uninformed parents is first to deny the existence of the problem, then to moralise, plead, threaten, scold and evoke the family honour and reputation. They then try to arrange for treatment, but frequently end by

cutting themselves off from their child when nothing works. In response to the same situation the peer group provides approval, a sense of intimacy, and prestige when the inexperienced drug taker moves from legal to illegal hard drugs. In cases where parents might tend to over-protect their children and take all their decisions for them, the peer group encourages young drug users to decide for themselves about their lifestyle. The peer group also provides a strong sense of belonging. All members of the group have similar values and behaviour patterns; they have their own symbols, ways of dress, music and dance, which together amount to a sub-culture within the larger community.

For all the reasons above peer pressure, which may appear irrational to parents, exerts a strong influence on young drug users or abusers. The same applies to adults who fall into drug use, because it must not be forgotten that peer pressure is relevant to all age groups. It fulfils, although negatively, some of the basic psychological and social needs of the individual.

Under such real pressure from their peers it is not hard to understand why drug users disobey or desert their families to move into the drug culture. While they are still in the euphoric stage they do this in order to gain more pleasure, and when they have started to experience withdrawal symptoms they do not hear the pleas of their family or see their distress because they have reached the point where the next dose has priority over everything else.

Decision-making skills to resist negative peer pressure

Decision making is quite a difficult process. Certain skills are required for a person to be able to make the right decision in a difficult situation. Some decisions require a long period of reflection and deliberation. They might include choosing a career or starting a family. Other situations demand a quick decision. For example, a person driving a car has to decide in a flash of a second what action to take in an emergency, and at the same time be as sure as possible that the decision is correct.

Resolving to resist negative peer pressure to use drugs is very difficult, because, apart from

the physical and psychological attraction of drugs, the peer group uses rejection strategies against someone who tries to refuse drugs. For example, they might be called a coward or a baby. In a slightly different situation the peer group might exert pressure on reluctant members by providing assurance against the dangers and consequences of risk-taking behaviour.

Without denying that it is quite difficult to resist negative peer pressure, it is still possible to avoid problems by adopting the procedure below:

1. Identify and define the activity that is being proposed by thinking about the following questions:

   - is this proposed activity legal?
   - if it is legal, is it moral? (e.g. truancy)
   - is it dangerous to the self or others?
   - will adults be present where this activity is to take place?
   - would parents approve if they knew of this activity?
   - does it correspond to the family's cultural values?

2. Devise a plan of action based on the answers to the questions above.

3. Evaluate the possible outcomes of the plan. Try to anticipate the likely consequences of the chosen course of action and assess their advantages and disadvantages. Re-examine values and emotions which might have become distorted by the impact of advertising and other media images. Emotional reactions interfere with the decision-making process and can prevent a person from making an objective and rational choice. Balance the short-term pleasure against the real risk factors associated with drug use.

4. When the evaluation exercise is finished the next step is to act upon the strategy which has been consciously and deliberately chosen. This means finding strong arguments to resist negative peer pressure or to counteract any other type of difficulty.

5. Whether the final outcome of the decision was positive or negative, it is possible to learn a lesson for the future. When a similar situation arises again it will be much

easier to deal with.

To help memorise the different steps of the decision-making process described above, they can be described as the IDEAL method.

I dentify the nature of the activity, situation or problem.
D evise a plan.
E valuate the possible outcomes of the plan.
A ct upon the chosen strategy.
L earn from past mistakes to avoid future problems.

The previous sections presented some very basic and general information for people working in community-based prevention of substance abuse. For further knowledge and training in specific intervention skills intensive training courses need to be organised with the help of local and international experts. Priority should be given to developing skills in the principles of social work, case work (individual counselling), family counselling, group counselling, rehabilitation and aftercare (relapse prevention), assessment of drug dependents, short-term and long-term management of drug-dependent persons, and treatment approaches.

Development of material resources

Members of the Community Action Committee will need to make an assessment of the material resources available for a public awareness campaign. They have to know what teaching aids and audio-visual equipment can be reserved for their use, and then they have to develop or buy any other material which is found to be necessary. Materials developed in other countries, such as documentaries, posters or TV spots, will need to be adapted for the local community. Even after they have been adapted they will have to be pre-tested on the target audience before they are put into general use. Pre-testing consists of assessing the reactions of a target audience to a particular approach, message or material, which will then be modified accordingly.

A pre-test can also be used to determine the background knowledge, attitudes and perceptions of participants at the beginning of a training course or seminar. A post-test questionnaire is then administered after the course to measure the impact it has made.

Setting goals and objectives

Having gathered all the necessary information on the nature and extent of substance abuse and the existing programmes and services, the next step for the members of the Community Action Committee is to develop complementary programmes. These new programmes should have specific objectives designed to attain the major goal of community action against substance abuse. The major goal is to reduce the demand for alcohol and other drugs and to provide help to those already affected by alcoholism and drug abuse. The smaller and more specific objectives are usually determined by the gaps that have been discovered between the existing programmes and services, the material resources available in the community and the real needs which have been identified.

Specific objectives must respect the following criteria. They must be:

limited in time (they must state when various aspects of the programme are to be accomplished);
qualifiable (they must be clear and precise, not vague and ambiguous);
measurable (they must help determine the success or failure of the programme);
realistic (they must not be utopic or unreasonable).

An example of a specific objective might be as follows:

To reduce by March 1993 (time) the number of arrests of young people between 15 - 24 (quality) for possession of illicit drugs in the community of . . . . . by 25 per cent (measurable and realistic).

Defining activities to meet the objectives

This is usually done by reversing the observations made during assessment. For example;

Observation	Activity proposed
No parent groups	Set up ten parent groups by organising talks and film shows to sensitise parents.

Lack of resource persons	Increase number of resource persons by organising short training courses and seminars for primary health care staff, social workers, teachers, police officers.
Deficient mass media coverage	Improve contacts with the media through meetings, submitting articles to the press and by using a multi-media approach (magazines, posters, TV, radio, theatre).

Having defined the activities which will meet the specific objectives the Committee will have to calculate the human and material resources required to organise these activities. It may be necessary to raise funds by holding a campaign on an appropriate occasion such as the local carnival.

Implementing and monitoring activities

The resource centre may start to implement its prevention, treatment and rehabilitation programmes as soon as it has a full-time staff including a national project coordinator, a centre manager, a job placement officer, one or two trained counsellors and a secretary.

The full-time staff will, of course, need the support of a pool of professionals and voluntary social workers at two important levels of the structure of the centre, i.e. the Advisory Board and the Community Action Committee. Another vital aspect is the link with the network of government ministries and agencies and nongovernmental organisations. The responsibilities of each agency and organisation must be clearly defined and rationally delegated in order to facilitate the monitoring of the activities.

Monitoring is a day-to-day evaluation of activities during the implementation of a programme or project. It depends on the establishment of a communications network which functions horizontally between government agencies and nongovernmental organisations and vertically between the local population and the policy makers and programme planners.

In order to monitor tasks each member of the Committee should be responsible for

monitoring the implementation of the activities specific to each group or organisation involved. Regular meetings of the Community Action Committee should be held every month or every three months so that each organisation may report on its past activities, the problems it has encountered and the progress achieved in present activities, and its plans for future activities. At these meetings the responsibilities to be assigned to each nongovernmental agency or service can be discussed and agreed.

Members of the Committee, who are usually very busy people, should make a point of being present at every meeting and of studying the agenda carefully in advance.

If possible, a full-time coordinator should be appointed for the proper monitoring of activities which are intra- or inter-nongovernmental organisation.

Detailed record keeping is not only important for good management and service delivery, but can also help projects and programmes to learn from their mistakes. It is even more important if it has been decided to replicate a particular model which was developed by a different programme, perhaps in a different country, or conversely, if another programme displays interest in replicating this model. Such detailed day-to-day record keeping can probably best be organised in the form of a diary.

In order to benefit from the close monitoring of activities members of the team and managers of specific programmes must remain open to feedback and feel able to contemplate different approaches.

Efforts must be constantly sustained to foster, develop and strengthen the community network. A multidisciplinary and integrated approach can be encouraged by including a cross-section of the community in the implementation of every programme.

Evaluating the process and results

A major difficulty in organising the fight against drug abuse is that no objective evaluation has ever been carried out on hundreds of programmes all over the world. The result is that many nongovernmental organisations or government services continue to offer activities which are popular and successful but have neglected to improve their less successful approaches. A large number of organisations have ceased their activities in the prevention of alcohol and drug dependence, simply because they have not evaluated the programmes

they started in order to detect and correct their weaknesses. Evaluation does not mean only deriving satisfaction from the successful parts of a programme; it also means discovering shortcomings in planning and implementation. Substance abuse programmes need to be evaluated and revised constantly because of the changing pattern of drug use and the occasional appearance of new drugs on the market.

A proper evaluation exercise provides the following benefits for programme planners:

- factual data which permit the formulation of more realistic objectives and strategies:
- better identification of the needs of target audiences and high risk groups;
- better understanding of conditions in the field and the needs of field workers on the part of policy makers and funding agents.

Precise information adds to the credibility of a programme and justifies further funding and expansion of activities. It also ensures that maximum use is made of existing services and resources. Further, the testing of strategies, approaches and audio-visual materials results in a more rational use of human and financial resources.

The two most important aspects of evaluation are process evaluation (efficiency) and outcome evaluation (effectiveness).

Process evaluation is usually an assessment of the efficiency of the methodology and procedures used during a campaign. It helps to identify barriers and obstacles that block service delivery and also brings to light factors that may have been overlooked or unknown to the initiators of the project at the planning stage.

The factors to be assessed in a process evaluation are as follows:

- punctuality and assiduity of programme operators and field workers;
- number of operators actually participating in the activity compared with the number planned;
- experience and training required of personnel;
- time actually spent on specific activities compared with the time estimated;
- money spent compared with budget provision;
- reasons why funds voted were not utilised;

- approaches which proved to be appropriate for the target audience;
- number of posters, stickers, pamphlets and handouts distributed;
- number of talks, film shows and exhibitions organised;
- dynamics of successful collaboration between nongovernmental organisations and other agencies.

Outcome evaluation aims to measure the effectiveness of the programme and the impact it has made on the target audience. It indicates whether the programme has reached its objectives and the extent to which the different community groups have changed their beliefs, attitudes and behaviour.

An outcome evaluation should not be made immediately after a programme has finished because the desired results may not be observable for some time. However, too long a delay may mean that the impact the programme has made is beginning to be forgotten. It is for programme planners to decide on the best moment to carry out the evaluation in their own particular context.

The factors to be assessed in an outcome evaluation are as follows:

- the extent to which target groups developed an understanding of their role in prevention;
- the way in which the activity or programme was received by the community;
- the number of persons it reached;
- the number of people who have requested the services offered by the programme;
- the number of enquiries made about the programme;
- the extent to which young people can demonstrate the skills they have learned in problem solving, decision making and drug resistance;
- the extent to which high risk groups have developed self-esteem and assertiveness;
- the advantages derived by members of the community in terms of school, family, social rehabilitation, health recovery and economic progress.

Factors to be assessed after a certain lapse of time include:

- the number of arrests connected with alcohol and drugs;

- the number of hospital admissions and accidents connected with substance abuse;
- increases in personal income as a result of improved attendance at work;
- money saved by firms operating an Employee Assistance Programme by a reduction in the number of working hours lost through absenteeism and poor time keeping.

Individual programmes should be evaluated in the light of their specific objectives. It is useful for planners to know which were the most popular and least popular activities in the programme so that the least popular functions can be re-examined. A successful activity should also be re-evaluated periodically because the situation in the field changes constantly. Findings from programme evaluation coupled with any new epidemiological findings should help planners decide whether to re-invest in a programme, adjust it or discontinue it in favour of some other prevention initiative.

PART II

THE ROLE OF GOVERNMENT AGENCIES

NONGOVERNMENTAL ORGANISATIONS

AND OTHER COMMUNITY GROUPS

Primary health care services

Primary health care staff are responsible for bringing health services to the community, particularly in rural areas. Medical personnel and social workers, together with traditional healers, represent a very important network through which prevention, treatment and rehabilitation programmes can be channelled. Their presence is fully accepted by the community, which gives them a major advantage in drug- and alcohol prevention activities. In the routine of their daily work they deal with patients suffering illness or accidents as a result of substance abuse; they treat the victims of traffic accidents, those injured at work, people involved in fights and other forms of violence, attempted suicides and overdose cases. Health personnel are thus very familiar with the consequences of substance abuse and are usually willing to take part in prevention work.

As a matter of routine, then, primary health care personnel intervene in crisis situations and provide short-term treatment for alcohol- and drug-abusers. On the basis of their knowledge and experience they can become first-choice educators for primary prevention programmes. They simply need some additional training in intervention techniques and the possibility of improving and updating their knowledge of new drugs coming onto the market and new modes of use and abuse. It should be noted in this connection that methaqualone (mandrax) smuggling is fast becoming a real threat in many African countries, and doctors need to be very aware of the risks of over-prescribing for their patients. Pharmacists and health educators should work to raise public consciousness of the real dangers of using prescription drugs for non-medical purposes.

Primary health care workers are also ideally placed to start or pursue the collection of epidemiological data for research purposes and to help policy makers and programme planners design accurate and relevant campaigns based upon local realities. Finally, primary health care professionals need to participate in the development of a pool of trainers and resource persons to support the programmes. Once prevention activities have gained the necessary momentum specific courses for the training of trainers will have to be developed with expert help.

Parents' groups

Members of all kinds of organisation, both formal and informal, have one thing in common - parenthood. Parents have the most significant role to play in any programme for the

prevention of substance abuse and the treatment and rehabilitation of addicts.

It is not easy for parents of adolescents today to help their children cope with even the normal stresses of growing up, not to mention possible drug problems. Adolescents are living in a world of high technology and sophisticated mass communication, where rapid change undermines the security of familiar things. Parents who have not kept pace may complain about the behaviour and lifestyle of their children and point out that they were adolescents too, and that they did not react as their children are reacting. It is certainly a fact that today's parents were adolescents before their children, but not like them. They did not grow up in the same psycho-social environment. The adolescents of the 1950s and 60s were not exposed to the millions of images that are penetrating our homes today, often glamourising the drug-subculture of western countries. Pop music, videos, pornographic magazines and other cheap publications have saturated the market and invaded our public places. It is hardly possible to ignore their presence.

Today's parents have a duty to assume the new roles they are called upon to play. They must not rely entirely on the schools for their children's psycho-social development, and they must make sure that they have the information they need to protect their children from the use and abuse of drugs.

When people rely too heavily on the educational system to guide their children they forget that the mother and father are the child's first two teachers in any society. In many developing countries, where the extended family is still common, children can benefit from the presence of more than just two "teachers" in their infancy. However, this important cultural advantage is fast disappearing and even the nuclear family is threatened as fathers move to big cities to find work and children are left alone with their mother for long periods. Sometimes whole families move to slums on the outskirts of big cities, where the children are exposed to a high-risk environment.

Parents today can no longer be contented with feeding and clothing their children and leaving them to grow up without supervision or guidance. It is their duty to give protection from the negative influences that surround their children on all sides, notably peer pressure and advertising. Parents must understand that prevention of substance abuse is not a question of supply reduction alone. While police and customs officers are doing their best to suppress production, smuggling, distribution and consumption of illicit drugs, parents need to set up or join existing community groups to form a strong coalition to reduce the

demand for drugs and alcohol. Instead of always relying entirely on the government and waiting for things to happen, parents must come out of the shadows and make things happen by acting NOW.

Sometimes people who desire to serve their community take no action to set up a parents' group because they have no meeting place. This is not really a problem at all, as many national nongovernmental organisations all over the world started with regular meetings of a small group of 15 - 20 people in the homes of interested neighbours, on a rotation basis. Such groups can also make good use of under-utilised classrooms after school hours if they can make appropriate arrangements with the local education authority.

Parents' groups can work to protect young people from substance abuse by:

- seeing that a responsible adult is always present during youth activities;
- offering only soft drinks to their children and their children's friends;
- setting clear standards of behaviour for their children and insisting that they be home at a reasonable time in the evening;
- avoiding the use of tranquillisers and pain killers when their children are sick;
- teaching healthy eating habits from the very beginning. Children who understand that abuse of food, notably sugar, salt and fat can be harmful to health are likely to refuse illicit drugs when they are told of the harm they cause, even in small amounts;
- helping children to develop self-discipline, self-esteem and decision-making skills;
- encouraging children to learn to defend themselves and solve their own problems, by not being over-protective;
- developing an attitude which is not threatening or blaming when talking to children;
- getting to know the families of their children's friends.

In order to promote the growth of parents' organisations the members of the original group might undertake to bring along one more parent to the next meeting. Parents' groups should contact any women's organisations in their area because women as wives, mothers and sisters are transmitters of positive lifestyles and cultural values. Sometimes they are also the victims of an alcoholic father, husband, brother or son. Parents' groups and women's organisations can make a formidable team when they work together and all the possibilities for collaboration should be explored.

Parents who are anxious to protect their children from substance abuse need to know the

signs and symptoms to watch for so that they can take immediate action to prevent further drug taking if their child begins to experiment with illicit substances. The commonest signs and symptoms of drug taking have already been presented in Part I of this manual.

Parents' groups and women's organisations can help adolescents become aware of the dangers that surround them so that they are better able to protect themselves. For example, they might organise a lecture or discussion on guarding against the persuasive effect of alcohol advertisements. The main advertising technique is to associate the product with the kind of users that adolescents would like to be. They show alcohol being consumed by rich people, successful people, attractive and healthy people. Advertisements show people having fun and enjoying themselves while drinking; they do not show the misery and despair caused by alcohol.

Other activities which might be organised by parents' groups and women's organisations could concentrate on the dangers of substance abuse and teenage pregnancy. Films, lectures and discussions should stress that the body of a young teenage girl is often not fully grown and not reproductively mature, and that a high proportion of teenage pregnancies end in miscarriage or still birth. They should emphasise the dangers of abortion and the risks of trying to conceal a pregnancy. The effects of alcohol and drugs on the unborn child can be devastating and no dependency-creating substances at all should be used during pregnancy. There is a particularly serious risk of damage to the foetus during the early weeks of pregnancy among girls and women who continue to drink or take drugs , not knowing yet that they are pregnant.

Parents' groups and women's organisations can organise talks, film shows and exhibitions on the role of all the members of the family of a substance abuser during treatment, and even more particularly during rehabilitation and social reintegration. They should lay stress on the dangers of relapse after treatment and work to promote relapse prevention strategies. Finally, in order to gain the best publicity for their cause these groups might seek the active support of the First Lady, either at local level or at national level.

School programmes

Debate on whether schools should provide drug education for their pupils has continued

for decades. School administrators, teachers and parents have shown considerable reluctance to introduce discussion of substance abuse into the school timetable, arguing that there are no drug users among school students. This is an example of the denial response which was discussed in Part I of the manual. In many countries the educational community still refuses to accept that at least a few of their students may have started to experiment with drugs.

Educators and parents must realise that alcohol is available everywhere and that children are bound to come into contact with heavy drinkers. If other drugs, such as cannabis, amphetamines, opiates and cocaine are fairly easily available in the community, then sooner or later young people will come into contact with them as well, and possibly with drug abusers who will induce them to experiment. It is therefore essential that young people learn about drugs from people who really care for them, not from addicts. Parents can give guidance in the home, teachers can give drug education at school and religious leaders can discuss the topic at their meeting place. This is infinitely better than for such education to take place in the streets and bars where the "teachers" are drug-abusing peers, dealers and pushers.

A drug education programme given in a school in no way compromises the reputation of that school. Quite the reverse is true, because it adds to the credibility of the school and demonstrates that the administrators and teaching staff have a real sense of civic responsibility as well as having the best interests of their pupils at heart.

Even if there are known cases of students using or abusing drugs, this does not necessarily mean that they have experimented with drugs on school premises. They interact with many youths who are not at school, and they may well be using drugs outside class hours and away from the school setting.

School children and students are a captive audience for anti-drug and alcohol campaigns; programme planners can take advantage of the fact that they do not have to attract young people to attend meetings and discussions because they are already on the spot. Schools may choose to offer drug education as an extra-curricula activity or to integrate it into the regular timetable. In countries which have arranged drug education on an extra-curricula basis the results have not been very encouraging. This seems to be because the initiative was not supported by teachers who argued that their duties did not include such subjects or by parents and students because there were no examination credits attached to the

classes. Other countries have therefore chosen to integrate drug education in the existing school curricula. Below we give an example of an integrated approach to prevention education through the school curriculum.

General science	Nutrition (abuse of sugar, salt and fats) Medicines - need to read instructions carefully and avoid improper use Stress and stress management - physical exercise, aerobics and relaxation Effects of drugs on the development of adolescents
Language and communication skills	Role playing of peer pressure situations, focusing both on negative pressure and the decision-making skills needed to resist it Essay writing on personal experience of peer pressure Vocabulary work on the terminology of drug abuse Oral expression work on advertising and pro-drug messages, poems and songs Study of local newspapers for reports on arrests, seizures and overdose cases
Mathematics	Calculating the alcohol content of drinks Statistical surveys and data collection Ratios, percentages, bar charts, pie charts
Art	Art for persuasion Posters for cigarettes and alcohol Designing posters for a healthy lifestyle Art competitions for anti-drug posters and slogans Sponsoring by local firms for mass reproduction of the winning posters.

Teacher training courses should begin to include modules on drug education in order to help the teachers of the future with this aspect of their work in schools. In the meantime the education authorities should organise in-service courses, seminars and workshops with the support of health care personnel, police officers and social workers. These professionals

may also be invited to the schools as guest speakers to complement the work of the teachers on specific topics related to substance abuse and to make the curriculum more effective.

Tasks to be undertaken by schools

- Draw up and circulate a clear policy prohibiting illicit drugs, alcohol and the improper use of prescription drugs on school premises, at school-sponsored functions and while students are representing the school. All students, parents and staff should receive a copy of the policy document, which must specify the penalties following any violation of the rules.
- Establish a solid school - family partnership.
- Introduce drug education classes into the existing curriculum.
- Invite professionals working in the field of drug abuse as guest speakers.
- Invite voluntary workers and interested parents as guest speakers and discussion leaders.
- Emphasise the role of physical education and sport in developing a healthy lifestyle.
- Make a file of newspaper cuttings on the national and local drug problem; discuss the content of these articles with students in class.
- Hold discussions, film shows and seminars for students and parents.
- Organise fund-raising activities to support anti-drug programmes (a fun run, sales of stickers or T-shirts).
- Refer high risk students to counselling services.
- Organise health-promotion activities such as athletics meetings and hikes.
- Set up anti-drug clubs using student leaders as positive role models.
- Establish a correspondence network with other anti-drug clubs, nationally or locally.
- Organise recreational activities and healthy occupations during school holidays.
- Strengthen the parent - teacher association and motivate the members to act as a bridge between the family and the school.
- Set up a school advisory board with representatives from the school administration, the parent - teacher association, the student council, the police, the media, local nongovernmental organisations, the medical profession, youth organisations and religious bodies.

Religious groups

It is well known that the three fundamental elements governing drug abuse are the agent (the drug), the host (the user or abuser) and the context (the socio-cultural environment). The religious beliefs and traditions of a society, its cultural and moral values determine the ways in which that society reacts to drugs, the importance it attaches to substance abuse and the attitudes it displays towards users and abusers. The heads of religious bodies and the leaders of socio-cultural organisations play a very significant role in demand reduction by reinforcing the teachings and principles of religion.

Like the school community, the religious community can benefit from the presence of a captive audience. Religious leaders can address their regular congregation without the need to invest a great deal of time and energy in persuading the public to attend the meeting. It may be said that members of a church congregation are unlikely to be abusing drugs or alcohol, but they could well be unaware that their own children are experimenting with drugs if they do not know the signs and symptoms of drug abuse.

Another very important mission of religious leaders is to stress the distinction between the sinner and the sin. Non-users of alcohol and drugs sometimes tend to condemn the individuals who fall into addiction rather than attack the cause of their distress. Medicine aims to destroy the disease and save the patient, and prevention strategies aim to destroy the drug culture and save the victims.

Tasks to be undertaken by religious bodies and socio-cultural organisations

- Promote and strengthen traditional customs and beliefs.
- Publicise and support anti- drug and alcohol activities.
- Make drug education publications available on the bookshelves.
- Include subjects related to drug and alcohol abuse in the training of religious leaders. They should have some knowledge of tolerance and dependence, signs and symptoms of abuse, withdrawal syndrome, the causes and consequences of abuse, prevention, treatment and rehabilitation approaches, causes of relapse and prevention of relapse, individual, group and family counselling.
- Refer substance abusers to treatment and counselling services.
- Remind members of the congregation of the importance of spiritual values.

- Invite members of the congregation to take part in an outreach programme attached to the place of worship. There is an urgent need to contact the ever-increasing numbers of young people who are leaving their families and drifting into the big cities where they no longer have the support of their parents and the extended family. With some training volunteers can develop a caring attitude towards abusers and relapsed addicts who no longer attend religious meetings and refer them for professional care.

The police and customs services

Law enforcement officers have a vital role in preventing substance abuse. The four main objectives of penal laws have been identified as the defence of public security, the punishment of the offender, the deterrent effect of making an example to discourage others, and the subsequent rehabilitation of the offender. The fourth objective is quite frequently forgotten even though failure to rehabilitate an offender is the main cause of recidivism and the perpetuation of the wrong. Further, many offenders cannot logically be rehabilitated or reintegrated into society because they were never integrated into the mainstream of community life.

There are three main groups of offenders in the world of drug abuse. They are:

- drug dealers who are selling drugs for profit and who do not use drugs themselves;
- drug dealers who are themselves addicted and who are dealing mainly in order to ensure their own supplies; they are arrested frequently;
- drug addicts who have resorted to crime in order to pay for their drugs; they are usually arrested while committing a crime or while purchasing drugs.

There is a consensus on the need to imprison the non-addicted, profit-seeking dealers or smugglers and to seize their assets. However, it can be very difficult to make a moral distinction between addicted dealers, who are often exploited by the big dealer, and addicted consumers who get involved in theft, violence and prostitution in order to buy drugs. It is not easy to decide how far they are responsible for their actions in the light of the various contributing factors that lead to experimentation, tolerance and dependence.

The legislation of Washington DC defines an addict as " a person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety or welfare,

or who is so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction".

Canadian legislation describes an addict as "a person suffering from a disorder or disability of mind as evidenced by his being so given over to the use of alcohol or drugs that he is unable to control himself or is incapable of managing his affairs or endangers himself or others".

These definitions imply a recognition that counselling and rehabilitation services need to be introduced in prisons. Outside prison, for high-risk groups and the community at large police officers, customs officials and prison wardens can act as educators, social workers, allies and friends who care for the welfare of the community.

Tasks to be undertaken by law enforcement officers

- Give talks on the importance of rules, discipline, law and authority.
- Disseminate information on the law regarding the production, processing, trafficking, possession and consumption of illicit drugs.
- Seek information from the community about the following questions:
  the extent to which existing legal provisions are applied in practice;
  the reasons why the law is not applied;
  the need for new legal provisions to counteract new techniques and strategies adopted by drug dealers.
- Develop more positive attitudes towards prisoners and ex-prisoners.
- Set up a pre-release scheme to prepare prisoners for social insertion or reinsertion; the staff of the resource centre should collaborate in this scheme, which would have the major objectives of preparing prisoners to face life without resorting to drugs and alcohol, and of preparing prisoners' families to adopt a caring and supportive attitude towards the released prisoner in order to prevent relapse.
- Introduce drug education into the training curriculum for law enforcement officers.
- Update and extend data collection to include etiological and epidemiological factors of substance abuse.
- Make prisoners aware of the dangers and modes of HIV transmission and the risks of promiscuity in prisons.
- Encourage police officers to specialise in drug prevention activities.

The media

Radio, television and the press are basic tools for spreading a message quickly, although the mass media are generally conditioned by whether an event is "newsworthy". Heroin, cocaine, and crack are considered newsworthy and so are overdose cases involving young people, but alcohol, tobacco and psychotropic pills have no news value, nor do recovering addicts and their problems during rehabilitation.

However, it must not be forgotten that the media have helped to raise public awareness of a drug problem in many countries where its existence was denied or was not accorded any importance. Once the population is conscious of the problem and the need for action the role of the media is to support and supplement the efforts of government agencies and nongovernmental organisations to reduce the demand for drugs through prevention, treatment and rehabilitation programmes.

Although media messages are considered to be impersonal and receive little feedback from the target audience, they can still be used to support and reinforce community activities by announcing functions and events in advance and by reporting them as they happen. Good media coverage is important for several reasons. It can:

- build public support for the goals of the resource centre or a prevention programme;
- inject enthusiasm into field workers;
- create a snowball effect if the event is newsworthy;
- strengthen the legitimacy of the resource centre or the work of the Community Action Committee in the public view;
- put the spotlight on the resource centre so that the opinions of the staff will be known in the area.

A press release is a cheap means of providing reporters with basic information on any event organised by the resource centre or a nongovernmental organisation. A press release usually answers questions beginning with WH:

WHO is organising the event or function? WHAT is being organised? WHERE is it taking place? WHEN is it scheduled? WHY is it being organised?

General strategies in the development of media contacts

- Establish personal contacts with editors of newspapers and directors of TV and radio stations.
- Make sure that each member of the Community Action Committee is in touch with at least one journalist and keeps this journalist informed of prevention activities.
- Be impartial and do not neglect "minor" media.
- Involve journalists in workshops and training courses on substance abuse. This will improve their understanding of the complexity of the problem and may encourage them to adopt a less sensational and more positive approach in their reporting.
- Choose knowledgeable people to give interviews in order to build up the programme's credibility.
- Involve well-known and respected public figures in the publicity in order to attract attention.
- Avoid glamourising the drug culture.
- Avoid mentioning the euphoric effects of drugs in short press articles or TV spots which do not allow for a clear explanation of the dangers of repeated use.
- Include people with first-hand knowledge of the drug culture in coverage of prevention work.
- Prepare and distribute media kits with background information on the strategies being implemented and the responsible agencies.
- Prepare material for the publishing or broadcasting in the form which the media request.
- See that the messages to be publicised are accurate and well presented.
- Avoid copying the style of communication used in other countries and make sure that the message is intelligible to the local population.
- Respect deadlines.
- Send unsolicited material to local newspapers, radio and TV stations.
- Include the name and phone number of a contact person working in prevention who will give further information to the media.
- Send a word of thanks to producers, editors and reporters.

In working with the press it is useful to negotiate with editors who run regular editorials on specific issues, or a letters-to-the-editor feature, or a special weekly column to raise public awareness of important questions. The articles that are submitted to the press should be very carefully written by experienced people so that they are accurate and credible. This is

a means of avoiding mis-reporting. Newspapers and journals are, of course, primarily a source of information and should be used as such by prevention programmes. A collection should be systematically built up of articles and data on alcohol- or drug-related crimes and accidents, cases of suicide and overdose, and violent incidents connected with substance abuse.

In working with radio and TV stations it is important that messages should be positive and that they should emphasise the solution rather than the problem. It is wise to take advantage of the live quality of these media by organising talk shows and encouraging direct phone calls from listeners and viewers. Invite addicts and recovered addicts to appear on the show with their families and friends to give first-hand accounts of the experience of addiction. Social workers, health staff and law enforcement officers should also be invited to talk about their work in the prevention of substance abuse. After a talk or documentary film it is interesting to arrange a discussion session and a panel of experts might be invited from time to time to take part in this. When the prevention project itself prepares short radio or TV spots for submission they must be in conformity with the standard time slots allotted by the media.

Multi-media activities can also make an impact on public awareness and sympathy. Exhibitions, puppet shows and the theatre can attract a lot of attention. Involve popular singers in anti-drug concerts and invite well known athletes and sports personalities to drug- and alcohol-free discos, carnivals, sports meetings and fund-raising activities.

Finally, as an annual event a prevention project could organise a Drug Awareness Week using a multi-media approach and culminating in a major event on June 26, which is the International Day against Drug Abuse and Illicit Trafficking.

The business community

In countries where human expertise is limited and financial resources are scarce, the business community has a major role to play in supporting prevention, treatment and rehabilitation programmes. Both in the industrialised parts of the world and in the developing countries private sector firms and agencies working against substance abuse are moving towards mutual support and assistance. All over the world business firms and

companies sponsor drug prevention campaigns and promote healthy activities.

Substance abuse does not affect the abusers and their families alone; it also affects their employers, the community and the whole nation. This is why Employee Assistance Programmes and other workplace initiatives are an important component of prevention strategies. The Community Task Force needs to draw the attention of employers to the consequences of substance abuse among the workforce, and to make them aware that it can occur at all levels of the hierarchy from top managers to handymen. The following consequences are a direct result of substance abuse at the workplace:

- sickness causes increased medical costs;
- absenteeism and bad timekeeping reduce output;
- accidents result in injury, disability or death;
- accidents also damage machines and equipment;
- there are supervision problems because discipline is not maintained;
- bad labour relations cause disputes;
- crimes such as pilfering and embezzlement increase because addicts need money to buy their drugs;
- addicts start pushing drugs at the workplace in order to maintain their own supplies;
- deadlines are missed and business is lost because of impaired judgment;
- trainees fail to benefit from courses because they cannot learn;
- time is wasted during working hours because dependents cannot concentrate.

As a result of all the above factors, the quality of service declines, production is sub-standard, resources are wasted and public confidence is lost.

Apart from the negative effects of substance abuse which are obvious in the workplace there can also be consequences for the physical and social environment. Public health may be endangered and criminality is likely to rise when there is a problem of substance abuse among workers. For example, poor quality products may cause illness or injury to consumers. Drug abusing workers in the transport sector could cause fatal accidents to innocent members of the public, and workers responsible for essential services could cause a serious decline in the quality of life of the community if these services broke down.

Tasks to be undertaken by private firms

- Support public awareness campaigns by providing transport, refreshments, etc. during seminars and training courses.
- Provide training and employment opportunities to youths who are at risk of substance abuse and to recovering addicts.
- Sponsor pamphlets, stickers, posters, T-shirts, etc. which can be marked with a logo to identify the donating firm.
- Sponsor large-scale coverage of drug-free concerts, sports and recreational activities.
- Invite prevention workers to talk to employees about problems of substance abuse.
- Send managers and supervisors on training courses for the prevention of substance abuse at the workplace.
- Refer employees who are abusing drugs or alcohol for treatment and grant them paid leave until they are able to resume work.
- Pay for time on radio and TV for anti-drug spots and programmes.

Note: See the companion manual on workplace programmes for more information on the role of the business community in the prevention of drug and alcohol problems.

Service clubs

Clubs such as the Rotary Club, the Lions Club and Round Table can undertake or sponsor the same type of activities as the business community. Members of these clubs are usually people who are well known locally and have many contacts in the community. Such clubs can put the expertise of their members at the disposal of the Community Task Force to stimulate the multi-disciplinary approach which is necessary for combating the drug problem. They can also sponsor study tours to help field workers improve their knowledge and skills, and last but not least, they can undertake fund-raising on a large scale to finance programmes for prevention, treatment and rehabilitation.

The Community Action Committee and the high-risk groups

The introduction to this manual includes a section on understanding the high-risk groups, notably young people. Members of the Community Action Committee need to be aware of

the various risk factors which might predispose certain individuals or groups towards substance abuse. The three types of factors involved are individual risk factors, psychological risk factors and environmental risk factors. It may be difficult to make a clear distinction between them and in any case they tend to operate together so that a person might be influenced by all three types at the same time. Nevertheless, it is useful to think about them in isolation and the lists below may be helpful in this.

Individual risk factors

Genetics:	Increasing evidence is emerging that certain individuals may be genetically predisposed to develop addiction.
Age:	Certain drugs are abused more by young people than older people and vice versa.
Sex:	Generally, men use alcohol and drugs more than women do.
Personality:	The "non-conformist" type might be at higher risk than the conventional type. Poor communication and problem-solving skills are common among addicts. Lack of religious belief is also associated with substance abuse.

Psychological risk factors

- Lack of interest in achievement
- Rebellion, alienation and early anti-social behaviour
- Lack of empathy with others
- Sensation-seeking behaviour
- Need for immediate gratification
- Risk-taking behaviour
- Lack of self-confidence and self-esteem
- Psychological stress
- Affectional deprivation
- Feelings of unworthiness

Environmental risk factors

- Easy availability of drugs
- Alcoholism or drug addiction among family members
- Social expectation of drug use

- Perceptions of the drug culture
- Unemployment
- Discrimination
- Lack of parental control
- Broken home
- Low educational level
- Occupations which involve contact with alcohol (e.g.catering industry)
- Negative peer pressure
- Extreme poverty in the midst of affluence
- Influence of the media and advertising
- Lack of enforcement of drinking laws.

Primary prevention is aimed at the whole population but the Community Action Committee can still organise activities with the high-risk groups particularly in mind. Below are some examples of such activities.

- Work closely with leaders of youth clubs and train volunteers as peer counsellors.
- Organise recreational activities and social events which will interest young people.
- Launch awareness campaigns to inform the at-risk groups about the services which are available in the community.
- Organise drug free / alcohol free parties.
- Organise recreational activities for the lonely, the sick and the old.
- Run sustained information campaigns aimed at reducing casual sex, to combat the increasing threat of AIDS.
- Help young people to improve their coping skills (communication, problem solving, stress management).
- Provide accurate information about the so-called "soft" drugs.
- See that the social and psychological needs of young people are met in the local community.

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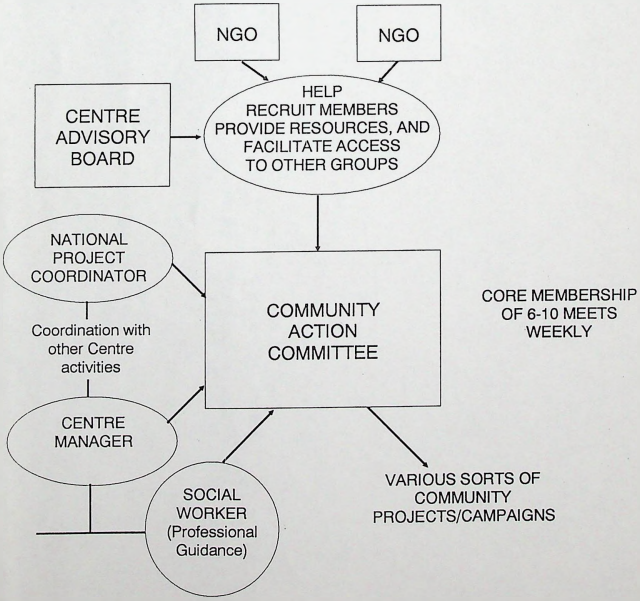
ANNEX I

Basic structure of Community Action



Some basic facts about drugs

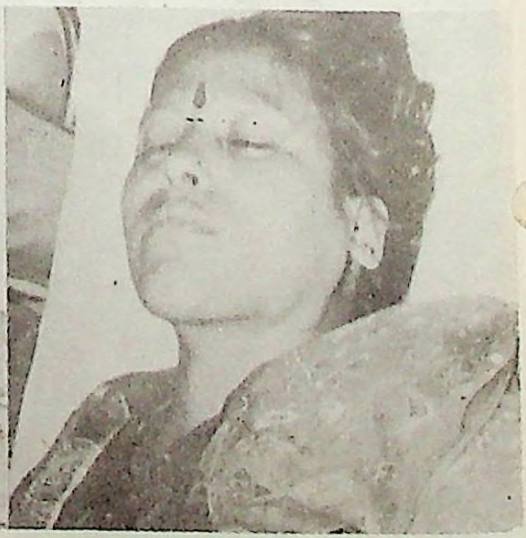
DRUG	MEDICAL USE	MODE OF USE	EFFECTS	WITHDRAWAL SYMPTOMS
I. OPIATES • Opium • Morphine • Heroin • Pethidine • Codeine • Methadone	Analgesic	– Smoking – Oral/IM/IV – IM/IV – Oral – Oral/IV	Depressant Analgesic Antitussive Euphoria Sedation Nausea Vomiting Constipation Respiratory depression	Common Cold-like symptoms: – Rhinorrhoea – Goose flesh – Feeling hot and cold – Abdominal cramps – Diarrhoea – Restlessness Pains yawning - Bone Muscle Joint
II. ALCOHOL (Ethanol)	Solvent/ disinfectant	Oral	Depressant Sedative/anxiety relief in small dose Depression ataxia in larger dose	Tremors of hands, tongue and body. Anxiety, Insomnia Most severe, Delirium Tremens
III. SEDATIVE/ HYPNOTICS • Benzodiazepine • Barbiturate	"Sleeping pills"	Oral	Sedatives: calm, anxiety and restlessness. Hypnotics: Induce drowsiness and sleep	Insomnia Anxiety Statu epilepticus Tremors Anorexia Abdominal cramp Irritability
IV. CANNABIS • Marijuana • Hashish • Gandia (active agent: 9 - tetrahydro-cannabinoid - THC)	Treatment of glaucoma in a few countries (e.g. Jamaica)	Smoking	Depressant in low dose. Hallucinogen in high dose. Apathy. Psychosis	Amotivational Syndrome
V. HALLUCINO-GENS • LSD (Lysergic Acid Zethyamide) • Mescaline • PCP (Phencyclidine)	–	– Oral – Smoking – IM/IV	States of altered perceptions as illusions, hallucinations and delusions	

DRUG	MEDICAL USE	MODE OF USE	EFFECTS	WITHDRAWAL SYMPTOMS
I. Amphetamines Dexedrine Benzedrine Methylampheta-mine (Ice) Ephederine	Appetite suppressant	Oral	Euphoria, increased alertness, wakefulness, appetite suppression, decreased fatigue. Schizophenia - like psychosis	
II. Cocaine (an alkaloid extracted from the leaves of the coca plant) Crack	–	– Smoking – Snorting – I/V	Euphoria, increased alertness	Insomnia, lethargy fatigue; Aches and pains; Nausea and vomiting, loss of weight Paranoid psychosis
III. Khat The khat leaves from the schrub catha edulus. Active principle: cathirone	–	Chewing	Euphoria, increased alertness, decreased fatigue, appetite suppressant	Fatigue, lethargy, decreased alertness
IV. Cola Nuts	–	Chewing	Euphoria, decreased fatigue	
V. Nicotine	–	Smoking	Decreased fatigue	
VI. Caffeine		Oral	Increased alertness. Decreased fatigue	
VII. Solvents	–	Inhaling	Skin problems around mouth and nostrils Respiratory infections	

Anti-Liquor Movements In India

When thousands of men give up liquor under the inspiring influence of women social activists

Bharat Dogra



Pictures on this page and cover depict
the Pather anti-liquor movement.

Pather - A Village Which Defeated the Liquor Contractor

Pather village of Saharanpur district has emerged as a major symbol of the anti-liquor movement in India. For nearly three months the people of this village, assisted by Disha, a voluntary organisation carried out a grim struggle for the removal of the liquor vend from this village. Nearly fifty persons of this and surrounding villages, including particularly the women activists of Disha, were injured in the police repression unleashed on the movement. Such was the moral force behind the movement that despite this repression the movement continued till the government finally agreed to remove the liquor vend from this village.

The determination of the people in the face of severe repression won widespread admiration in neighbouring villages and Disha started getting requests to help other villages to get rid of their liquor shops.

The liquor vend at Pather had at one time become the number one problem of the people of this village. The location of the vend was such that it attracted truck-drivers and tipplers from several surrounding villages as well. Soon it become a meeting place of several anti-social elements. Drunk people at all times of the day and night created havoc in the marketplace and even ventured into some of the nearby homes. They frequently entered into violent brawls with villagers. On one occasion a communal riot was barely averted when they even entered a religious place.

Within the village the easy availability of liquor led to a big increase in the consumption of liquor. Even several children who tried to imitate elders got addicted to liquor and went to

the extent of stealing grains and utensils from their own houses to buy liquor. Women were the worst affected. It was difficult for them to walk near the liquor vend but they had to come to the market and the bus stand located quite close to the liquor vend. There were several cases of harassment and attempted molestation. Domestic violence increased greatly in the village. One drunk person from a neighbouring village threw acid on a woman.

Disha had been working in this village for several years particularly to mobilise women and it had set up a Mahila Jagriti Sangh or women's awakening committee in the village. As the liquor vend increasingly became the number one problem for villagers, this question was invariably discussed at Disha's meetings in the village. Initially Disha was unsure how far it can get involved in an anti-liquor movement which could affect some of its other work, but once the villagers, particularly women - expressed their determination to oppose the liquor vend, Disha felt it was its duty to support the village women and this involvement went on increasing as the liquor mafia proved very difficult to dislodge.

Initially when the villagers had met the DM and other officials, they appeared sympathetic and said that this liquor contract will be renewed. But these proved to be false assurance and the administration appeared increasingly to take the side of the liquor contractor. Therefore the village decided to sit on an indefinite dharna in front of the liquor vend.

Seeing a big crowd approaching the liquor shop on March 31, 1993 the contractor fled, but the real battle was to get the contract cancelled officially and so the dharna (sit-in) continued.

Days passed into weeks and the weeks into months, but the administration chose to turn a blind eye to the mounting resentment in the village. Many villagers, particular women, were beginning to endure a lot of hardships at the dharna and had to forego their livelihood work. Frequently they were harassed by goons of the liquor mafia, who even threatened to kidnap women activists and their children.

Finally the people decided to march to Saharanpur city to meet the authorities. It was here that the police unleashed a brutal lathi charge on the protest march of the anti-liquor movement.

Mahfooz, a physically handicapped participant in the movement was beaten so badly that it took three months for him to recover from his serious injuries. Several women activists had to the hospitalised for several days.

However the news of this repression spread far and wide and the administration and political leaders came under pressure to withdraw the liquor vend. As soon as the news of the cancellation of the liquor contract reached the village, people hugged each other and women cried with happiness. A halwai (sweet seller) distributed all the sweets stocked in his shop. People rushed to temples and mosques to offer thanksgiving prayers.

In the course of this agitation such a moral force was created that many habitual drinkers took a pledge to give up liquor. What is more many of those gains have been sustained. During a recent visit to this village, this writer met several people who gratefully recalled the movement which rid the village of its biggest problem. Several villagers testified that the consumption of liquor is now only about 10% to 20% of what is was before the movement. As a result of this saving, several kutcha houses and shops have been

converted into pucca structures; the village and in particular the market wears a new prosperous look.

Mahfooz, who was injured so badly in the movement, says, "If the contractor dares to come again I'll again participate in the movement to oust the liquor vend."

Anti-Liquor Movements in India

According to World Health Report 1997 (brought out by the WHO), the use of alcohol, illicit drugs and other psycho-active substances causes at least 1,23,000 deaths annually. Alcohol is also implicated in a range of social problems including crime, violence (particularly against women and children), marital breakdown and major losses in industrial productivity. Both acute and chronic effects of alcohol on blood pressure have been noted. The cost of alcohol related harm is estimated to account for 2 to 3% of GNP in many European countries. About 120 million people are dependent on alcohol.

In addition the functioning of several distilleries is associated with high pollution risks.

Keeping in view the enormous social and health costs of alcohol addiction, de-addiction can obviously make an important contribution to human welfare. However, mostly this issue is considered at an individual level - and it generally takes an individual a lot of effort with medical help and family support to overcome the addiction.

However in India several social movements against alcoholism have led to the surprising result that thousands of persons have given up the consumption of liquor under the strong motivation of movements of social reform and change.

In some parts of Mahasamund district of Madhya Pradesh, during the last 15 years an inspiring effort has been made for the release of bonded labourers and their rehabilitation by providing satisfactory livelihood opportunities to them.

Social activists who played a leading role in this campaign stressed from the outset that unless simultaneous efforts to fight the menace of alcoholism are made, the economic gains of released bonded labourers (RBLs) will be lost very soon.

Shashi Sail, a leading woman activist of this region says, "In the villages women were very willing to participate in this movement against liquor as they are frequently the worst victims of alcohol abuse. We encouraged women to form special squads who drove liquor contractors and traders from villages."

Mukti Niketan (MN), the leading voluntary organisation in the release and rehabilitation effort, successfully combined this with an anti-liquor movement. As the released bonded labourers were highly motivated for starting a new life, they were also more responsive to receiving the message against liquor. As MN had been clearly working at several levels to rescue them from exploitation and create new livelihood opportunities, its moral authority to speak against alcohol abuse was accepted by the RBLs in large numbers and they agreed to give up the consumption of liquor.

Rajam Tanti a grassroot social activist of MN who has been involved in several struggles against liquor, says, "Both aspects of the effort were equally important - the fact that people were receptive to the message against liquor and the fact that a sustained effort was continued to keep away the liquor sellers from villages."

As a result several hundred habitual drinkers have been able to give up the consumption of liquor in this region. Earlier de-addiction of liquor addicts as a result of a social movement had taken place on an even larger scale among the iron ore miners of Dalli Rajhara. Infact the trade union of iron-ore miners and released bonded labourers both are closely related to each other.

The iron-ore miners under the leadership of a legendary trade unionist and social reformer Shankar Guha Niyogi had won significant economic gains around 1977-78. Initially this appeared to cause an increase in liquor consumption but Niyogi soon mobilised the trade union to check this disturbing trend. He sat on a protest fast against the sale and consumption of liquor which had a high moral impact on workers.

Niyogi did not treat the anti-alcoholism as a relatively insignificant activity of the union. In the initial stage it became a major concern of leading CMSS activists. Through repeated assertions a climate was created in which the tribal members felt that the consumption of liquor was a betrayal of the union that fought for them. Once this feeling was generated, the task of weaning the tribals away from alcohol was not difficult since traditionally they attached a great deal of importance to honouring trust and loyalty.

It was realised that some constructive work had to be found to occupy their leisure hours or else the idle mind would inevitably be driven back to the liquor shop. Hence various workers were assigned specific tasks such as keeping a watch on the workers who were more prone to the various vices. Others were asked to supervise the construction of schools and a hospital and the numerous other activities of the union.

The punishment given to offenders was quite unique. Initially an offender would be asked to pay a fine ranging from Rs 50 to Rs 100. However, behind his back, the money was returned to his wife. Soon this secret leaked out and the offenders became smug and careless. The union then reverted to imposing genuine fines.

Another interesting aspect of this experiment was that the addict's own family members were effectively used to rid him of his deadly habit. They were persuaded to report all violations of the union's regulation by the addict and continuously protest against the consumption of liquor by him. Helped by the changed climate in the labour colonies the wives and even grown-up children could now wage their own individual battles against an alcoholic husband or father.

The overall result of this sustained campaign against liquor has been that a large number of miners have given up drinking altogether while the few who continue to drink have significantly reduced their intake. It is difficult to cite precise statistics as no studies have been made of this unique experiment, but in her own simplistic way Sonaribai, a tribal woman said, "If previously we consumed one rupee's worth of liquor now we consume four annas worth."

Rajendra Sail, Director of Mukti Niketan who saw the movement at Dalli Rajhara and later helped to replicate it in parts of Mahasamund district says, "The anti-liquor movement had been a very important part of our struggle. The poor and oppressed people have understood how liquor is used to keep them in a state of helplessness. As this awareness has grown, so have their feelings against liquor."

Published By : Bharat Dogra,
C-27, Raksha Kunj, Paschim Vihar, New Delhi-110063 Tel.: 5575303

Composed At : Sharma Computers, 4/5 Moti Nagar, New Delhi-110015

Printed By : Kulshreshtha Printers, 11 Tyagi Vihar, Nangloi, Delhi

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PROGRESSIVE SYMPTOMS OF ALCOHOLISM

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An act of drunken brutality

Inspector K Manjunath Rai and right: Chandrakeshavalu

Alcoholism and dependence on his wife for money brought out the worst in Chandrakeshavalu. He beat his wife to death with an iron rod in front of his children and fled, but was caught within hours

Law 'n' outlaw

But for the swift action of the police, a murderer would have got away with his crime forever. What makes the cold-blooded murder all the more tragic is that it took place before the innocent eyes of the couple's 12-year-old son and seven-year-old daughter at 4.30 am, on October 17, 2001.

Chandrakeshavalu (42), who worked as a waiter in the Air Force Officers' Mess in Kammagondanahalli, Jalahalli West, terrorised, brutalised and bashed his wife for money for his alcohol. His wife Balnagamma (34), bought sarees from cities and sold them in rural areas, for a living. Steeped in alcohol Chandrakeshavalu stopped going to work and became dependent on his wife and harassed her whenever she refused to pay for his drinks.

The two went to bed after a quarrel on that fateful night. But Chandrakeshavalu woke up and took her to task, around 4.30 am, much to the helplessness of Mahesh and Laxmi, their two children. All it took for Chandrakeshavalu to put an end to his wife's resistance, was an iron rod. He hit her so hard on the head that she was silenced forever. The sight of the blood-stained face of a dead Balnagamma spoke volumes of her husband's act of brutality.

All this happened with much screaming. Enough to alert the neighbours that something serious had occurred. Chandrakeshavalu he fled with a few clothes and the iron rod and ran. Shankar, a neighbour, lodged a complaint with Gangamma Gudi police station around 6.15 am.

Gangamma Gudi Police Station Inspector K Manjunath Rai and his men took up the case. "Our immediate challenge was to prevent him from leaving the State. If that had happened, he could have escaped forever," says Rai. The fact that it was not easy to get any transport in a forest area, during the wee hours, dawned on Rai.

Investigation was launched and questioning of people began. In the process, the police stumbled on the key informer (whose identity the police refused to divulge), who told them that Chandrakeshavalu had already reached the railway station and was about to board a train for Kurnool district, Andhra Pradesh. He was apprehended on the platform within 24 hours of the incident. Not only did he confess to the crime but also told the investigating officers that he had hid the iron rod and the blood-stained clothes in an old shed in the Air Force forest area while escaping. Police later recovered both items from the spot.

The 8th Additional Chief Metropolitan Magistrate's (ACMM) Court transferred the case to City Sessions Court which in turn transferred it to Bangalore City Fast Track Court No 1. The Court after taking the account of the witnesses, including the two children of the deceased, pronounced life sentence (14 years imprisonment) to Chandrakeshavalu on December, 24, 2002. The verdict was given by Judge Gopalkrishna and Y R Jagadish was the public prosecutor.

The children are being looked after by their grandparents (Balnagamma's parents), while Chandrakeshavalu is serving his life sentence in Parrappan Agrahar jail. His period of appealing to a higher court is over. The case file was closed within 14 months.

Gaihlot Mohammed Javed

Deccan Herald 13/3/03.

Help Your Child Develop Strong Values

A strong value system can give your child the courage to say "No" rather than listen to friends.

Be A Good Role Model or Example

Your habits and attitudes may strongly influence your child's ideas about alcohol, tobacco, and other drugs.

Help Your Child Deal With Peer Pressure

A child who has been taught to be gentle and loving may need your "permission" to say "No" to negative peer pressure.

Make Family Rules

It's helpful when you make specific family rules about your child not using alcohol or other drugs or smoking cigarettes. And it's helpful to tell your child the punishment for using them.

10 LIFE SKILLS

The World Health Organization has identified ten life skills essential for every individual to develop – These skills are even more important for adolescents to develop to promote optimum health. They provide a guideline to enable Friendly Advisors to integrate within the curricula.

1. Problem Solving

Every individual faces problems. The facilitation of solving problems is important. This can be even undertaken during the games period through games, puzzles apart from academic mathematics!

2. Decision Making

It is important to delegate some of the routine classroom responsibilities to the students. Forming them into groups enables the group to take responsibilities for the task/ project being assigned.

3. Critical thinking

Every change brings in positive and negative consequences. Discuss non-threatening, impersonal situations first in terms of pros and cons. {Ground Rule: there is no "wrong or Right answer. Permit students to voice their opinions.} Debates help with critical thinking.

4. Creative thinking

Opportunities for story writing, art and the SUPW period are also avenues to develop creative thinking

5. Communication Skills

Using verbal and non-verbal communication, practicing of assertive skills is important for adolescents. Education on the changes an adolescent is going through helps them introspect on the effective communication processes they need to develop.

6. Interpersonal Relations

Begin with peer relationship building through teams. Introduce teacher guides or Friendly advisors for every team. Work on projects together. Being a liaison between parents and children may be needed.

7. Empathy

Can be done through fun. E.g.: draw a funny picture depicting another person in your class. After students have drawn it ,ask them to rub off that person's names and instead write their own. Then discuss how they felt when drawing some-body else and how they felt when they found out it was they!

8. Self Awareness

Read more about Maslows Hierarchy of Needs and Johari's Window. A teacher once asked students to write something good about a student on each day of the class. This was displayed for the named student of the day to read. Several students learnt to value themselves more after an exercise like this. A Friendly Advisor is very influencial in helping students to get to know themselves.

9. Management of Stress

Stress is part of life and its management within the school enables students to cope with stress in a healthy manner. Yoga, games, counseling, dramatics, music and peer support helps address stress. {Tip: Stresses need to be address; they just don't disappear}

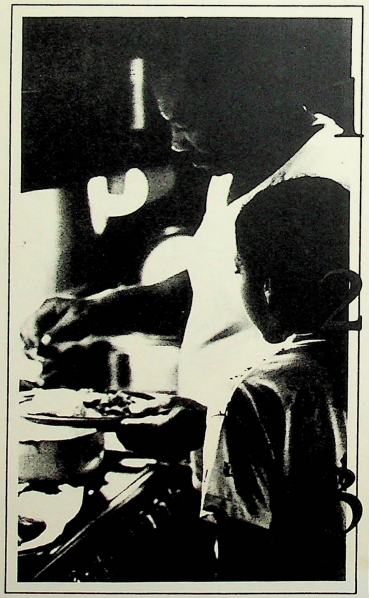
10. Management of Emotions

Awareness of the influence of hormones {"chemicals"} on mood swings enables adolescents to cope with their emotions. Further, talking about how to address "anger" constructively {e.g.: move away from whatever is making you angry; or beat up a cushion instead; or control speaking when you are aware that you are angry} helps. Anger is a normal emotion that needs constructive ways of expression.

Prepared by INSA/India, May 2001

INSA

quick list:



Talk **With Your Child About Alcohol and Other Drugs**

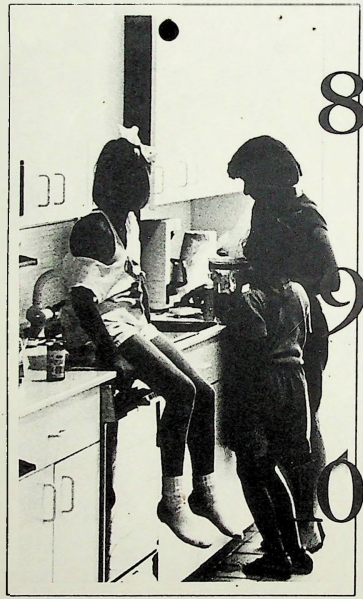
You can help change ideas your child may have that "everybody drinks, smokes, or uses other drugs."

Learn **To Really Listen to Your Child**

Your child is more likely to talk with you when you give verbal and nonverbal cues that show you are listening.

Help **Your Child Feel Good About Himself or Herself**

Your child will feel good when you praise efforts, as well as accomplishments, and when you correct by criticizing the action rather than the child.



Encourage

Healthy, Creative Activities

Hobbies, school events, and other activities may prevent your child from using alcohol, tobacco, or other drugs out of boredom.

Team Up

With Other Parents

You can join other parents in support groups that will reinforce the guidance you provide at home.

Know

What To Do If You Suspect a Problem

You can learn to recognize the telltale signs of alcohol, tobacco, and other drug use and get help.

OSAP

10 Steps to help your child say "NO"

MINISTRY OF SOCIAL JUSTICE AND EMPOWERMENT
GOVERNMENT OF INDIA

MANUAL
ON
MINIMUM STANDARDS OF SERVICES FOR THE PROGRAMMES UNDER THE SCHEME FOR PREVENTION OF ALCOHOLISM AND SUBSTANCE (DRUGS) ABUSE

Prepared by

T T Ranganathan Clinical Research Foundation

IV Main Road, Indira Nagar, Chennai 600 020

ACKNOWLEDGEMENT

I owe many people a great deal of gratitude for their support in making this project of setting quality standards in the field of addiction a reality.

I owe many people a great deal of gratitude for their support in making this project of setting quality standards in the field of addiction a reality.

My first thanks goes to Ms. Asha Das, Secretary, Ministry of Social Justice & Empowerment, Government of India, New Delhi for initiating the process of developing a Manual on Minimum Standards of Services in the field of alcohol and drug abuse prevention and entrusting our organisation with the assignment. I am also grateful to Mr. Dharmendra Deo, Joint Secretary in the Ministry for his continuous support and guidance to the project.

I am thankful to my team at the TTK Hospital comprising Ms. Lakshmi Sankaran, Dr. Raymol R Cherian, Ms. V. Thirumagal and Dr. Anita Rao for interacting with me, providing me support and helping me in the preparation of the Manual.

I am appreciative of the efforts and the guidance of the entire team of Resource Persons (Dr. Rajesh Kumar, Fr. Joe Perreira, Mr. C.G. Chandra, Dr. Pratima Murthy, Mr. Vijayan Pavamani, Mr. N.S. Manaklao, Dr. A. Jayanta Kumar, Mr. Kanitkar, Dr. Dewakar and others) present at New Delhi to discuss every component of the draft Manual and advise on the feasibility for implementation.

I am grateful to Mr. Anand Bordia, National Project Manager, UNDCP and Mr. Mukhtiar Singh, National Project Co-ordinator, ILO for their appreciation and support for the initiative.

I am grateful to the members of FINGODAP for providing constructive criticism during the conference to improve the document and also for their wholehearted acceptance to implement the Minimum Standards of Services.

I am obliged to Mr. A. Goswami, Desk Officer, Ministry of Social Justice & Empowerment, Government of India, New Delhi for his ongoing interaction with me regarding the scheme, continually motivating me to improve, refine and extend my thinking.

Shanthi Ranganathan
Honorary Secretary
T T Ranganathan Clinical Research Foundation
TTK Hospital
Chennai

FOREWORD

With the mandate for coordinating alcohol/drug demand reduction strategy of the Government of India, the Ministry of Social Justice & Empowerment, for the last 15 years, has been implementing wide range of community based programmes, through the voluntary sector, for prevention of alcoholism/drug abuse and treatment/rehabilitation of addicts. From a modest beginning of 7 centres in 1985-86, we have now 480 centres, spread all over the country, under the programme "**Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse**". The budgetary allocation has multiplied manifold to reach Rs. 22.00 crores.

The community based organisations associated with the programmes have been engaged in a wide variety of innovative, need based, localized interventions, adapted to the felt needs of the community in general and the target groups in particular. The experience gained over these years through counselling, awareness programmes, treatment through institutionalised as well as camp-based programmes and rehabilitation of addicts etc. have made available to us a vast repertoire of knowledge, expertise and success stories on all aspects of demand reduction. Training programmes meant for the service providers on the principles and practices of care and protection in substance abuse rehabilitation have, over the years, set certain minimum standards of services amongst the rehabilitation professionals.

However, considering the size of the country, the wide variety of socio-cultural settings, varying degrees of capacities amongst the implementing agencies, there has been a long felt need to identify the best practices in delivery of services and codify them into a set of guidelines which could be uniformly applied to all the implementing agencies as minimum standards.

T.T.Ranganathan Clinical Research Foundation [TTK Hospital], Chennai, with their pioneering work and vast experience in the field was entrusted with the responsibility to tabulate and assess best practices and evolve common minimum

guidelines which can be used as minimum standards and practices. They were requested to prepare a Manual in consultation with the Ministry, the Voluntary Sector and the experts with experience and knowledge in the field.

This Manual on Minimum Standards of Services for the programmes under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse is a result of this effort. With "Whole Person Recovery" as the avowed objective, the Manual defines the essential components involved in alcohol and drug demand reduction programmes under the Scheme, the minimum infrastructural requirements for each component, the nature and quality of services, the activities involved in delivery of different services, the inputs and the anticipated outputs for each of the activity, the mandatory records to be maintained etc. It has also laid down the framework of networking and linkages between the services and institutions to ensure holistic interventions and optimum utilisation of resources. Besides standardising the experiences into practices, it would also ensure an objective performance based evaluation of the programmes.

The Manual has defined a code of ethics for the service providers along with rights and duties of the clients. This is intended to ensure a positive, empathetic and caring environment within the institutions.

This Manual, if implemented sincerely by the partners, the Government and NGOs, is expected to usher in a new era of quality-based services through voluntary organisations in the social sector. It would also pave the way for continuous review and refinement in standards through new experiences and increasing maturity in implementation of programmes.

Asha Das
Secretary
Ministry of Social Justice & Empowerment
August 6, 2001

CONTENTS

CHAPTER 1

INTRODUCTION

'Quality is never an accident. It is always the result of careful planning, teamwork and a commitment to excellence'.

When drug addiction surfaced as a problem in India in the 1980s, many voluntary organisations initiated programmes to deal with addiction. In the absence of documented literature on the nature of services to be offered, each centre developed its own programme based on its understanding and the resources available. Gradually others also followed suit. While there were only 36 centres in the year 1987, 480 Centres are functioning today. The beneficiaries have also increased from 12000 patients in 1987 to about three lakhs in the recent years.

This tremendous growth in the availability of services has been made possible with the active support and financial assistance from the Ministry of Social Justice & Empowerment, Government of India under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse.

While the availability of services has increased, in the absence of specific criteria to implement services or maintain quality, programmes are still being developed and implemented in an unplanned, haphazard manner. It is now time to look beyond just the number of programmes conducted or clients served, and focus on the quality of service delivery. Work in this field cannot be justified on the basis that we are responding to a felt need but we also need to ensure that we respond in a manner that is efficient and effective.

It has become imperative to design a framework, which will help organisations to develop their programmes and ensure that these programmes maintain an acceptable standard in service delivery. This manual on `Minimum Standards of Services' provides such a framework.

The Ministry substantially funds the following services: –

- Drug awareness and counselling centres
- Treatment-cum-rehabilitation centres
- De-addiction camps
- Workplace drug prevention programmes

This manual presents specific criteria and defines the minimum standards of care that should be maintained. The manual addresses issues relating to four major areas:

- The facilities or resources that are essential
- The variety of programmes and frequency with which these will be offered
- The specific roles and responsibilities of the staff
- The clients' rights and the code of ethics for the staff

Information related to minimum standards needed for each of these has been presented in simple language with easy to follow instructions. The formats of records that need to be maintained have also been provided in the Annexure to facilitate necessary documentation.

Implementing the `Minimum Standards of Services' strategy shall bring with it many benefits.

- The expectations of the Ministry are clearly perceived without ambiguity, facilitating adequate level of service delivery.
- Assessment and evaluation of programmes to ensure financial assistance is based on objective criteria rather than on subjective issues.
- NGOs can structure their programmes to ensure effective service delivery.
- NGOs can review their services and make appropriate changes.
- It helps staff to work in a focused manner and improve teamwork.
- Ensures optimum utilisation of resources through networking and convergence.
- Efforts in this direction can also provide valuable information to support research studies, assess adequacy of services provided, and plan appropriate staff training programmes where necessary.

Implementing the minimum standards of service benefits the funding agencies, the NGOs and the clientele they serve. It helps them to work in a coordinated manner and use the limited resources available in the most effective way.

****

CHAPTER 2

ABOUT THE SCHEME

The government believes in addressing the problem of substance abuse in its totality. This includes creating awareness, early identification, treatment and rehabilitation and sustained follow-up care. Further, the Government is of the considered view that substance abuse is a psycho social medical problem which can be best addressed through community based interventions. Hence, special emphasis has been given for involving and mobilising the community.

Under the **Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse**, the non-governmental organisations have been entrusted with the responsibility for delivery of services and the Ministry bears substantial financial responsibility (90% of the prescribed grant amount).

The Aims And Objectives of the Scheme for Prevention of Alcoholism and Substance Abuse are:

- To support activities of non-governmental organisations, working in the areas of prevention of addiction and rehabilitation of addicts.
- To create awareness and educating the people about the ill effects of alcoholism and substance abuse on the individual, the family and society at large.
- To develop culture-specific models for the prevention of addiction and treatment and rehabilitation of addicts.
- To evolve and provide a whole range of community based services for the identification, motivation, detoxification, counselling, after care and rehabilitation of addicts.
- To promote community participation and public cooperation in the reduction of demand for dependence-producing substances.
- To promote collective initiatives and self-help endeavours among individuals and groups vulnerable to addiction and considered at risk.
- To establish appropriate linkages between voluntary agencies working in the field of addiction and government organisations.

The following legal entities are eligible for assistance under the Scheme:

1. A society registered under the Societies' Registration Act, 1860 (XXI of 1860) or any relevant Act of the State Governments / Union Territory or under any State law relating to registration of charitable societies.
2. A registered public Trust
3. A Company established under Section 25 of the Companies Act, 1956
4. An organisation / institution fully funded or managed by Government or a local body

5. An organisation or institution which has been approved by the Ministry of Social Justice and Empowerment.

The eligible organisations as defined above should also:

a) Have a properly constituted managing body with its powers, duties and responsibilities clearly defined and laid down in writing.
b) Have resources, facilities and experience for undertaking the programme.
c) Not be run for the financial profit of any individual or a body of individuals.
d) Have existed at least for a period of three years.
e) Be of a sound financial position.

For financial assistance under the Scheme, an Organisation / Institution, should apply in the prescribed proformae as revised from time to time, along with the relevant documents, to the Ministry of Social Justice and Empowerment, Government of India, New Delhi, along with the recommendation of the State Government / UT Administration.

Grant is generally released in two **instalments** representing two halves of the financial year.

The **quantum of assistance** is not more than 90% of the grant amount. In case of the seven North Eastern States, Sikkim and J & K, the quantum of assistance will be 95% of the total admissible expenditure. The balance of the approved expenditure shall have to be borne by the implementing agency out of its own resources. The Universities, Schools of Social Work and such other institutions of higher learning will be eligible for 100% reimbursement of approved expenditure.

The Scheme has the following components for financial support:

1) Awareness and Preventive Education
2) Drug Awareness and Counselling Centres
3) Treatment-cum-Rehabilitation Centres
4) Workplace Prevention Programmes
5) Deaddiction Camps
6) NGO Forum for Drug Abuse Prevention
7) Innovative Interventions to Strengthen Community Based Rehabilitation
8) Technical Exchange & Manpower Development
9) Surveys, Studies, Evaluation and Research
10) Any other activity considered suitable to meet the objectives of the Scheme.

The Manual has laid down the standards for the major programmes funded by the Scheme. In addition, the Manual prescribes a "Code of Ethics for Staff" simultaneous with the "Rights and Duties of the Clients". A chapter has also been included on the role of volunteers in drug prevention programmes.

******

CHAPTER 3

DRUG AWARENESS AND COUNSELLING CENTRES

Drug awareness and counselling centres function as **outpatient units** and offer the following services:

- Awareness building in the community
- Assessing and motivating clients to take help
- Referral services
- Follow-up services

The centres are staffed by counsellors / social workers / psychologists / sociologists / recovering addicts (with two years of sobriety).

- **Activities for awareness building in the community**

  - Awareness programmes should address specific target groups (vulnerable and at risk groups) in the neighbourhood, in educational institutions, industries, slums and social welfare organisations with the purpose of sensitising the community about the impact of addiction and the need to take professional help to treat addiction.

  - Most importantly, the awareness programmes should start at school level addressing adolescent group and continue with college students. Parents / teachers should undergo training to develop skills to understand the psychology of the youth and to help them keep away from substances. Specifically the high-risk groups like children of alcoholics, street children, and school dropouts should be addressed.

  - The awareness programmes should be appropriate to the local culture and in local language. Utilization of audio visual aids like OHPs, slides and films and employing innovative methods like street plays, puppet shows, seminars, group discussions are to be included.

  - The key persons in the community, like panchayat leaders, school/college principals/teachers/lecturers, men holding position of respect and credibility should be involved in the programmes.

Minimum activities	Records to be maintained
Two awareness programmes a month based on the needs of the community / target group with the active involvement of key persons from the community.	**Awareness programme register (Annexure 1)** to be maintained by the project-in-charge containing the following. • Details of programmes conducted with feedback from 5 people (who participated in the programme) for each programme.

One article relating to prevention, treatment and rehabilitation services on alcoholism /drug abuse to appear in daily newspaper, magazine or mass media (television, radio) once in six months.	• Copy of the article published / details of the programme telecast / broadcast.
External evaluation of the awareness programme by a professional in the field of addiction once a year with assistance from FINGODAP members.	• Evaluation report

- **Activities for assessment and motivation**

- Assessment of addiction through personal interviews (with clients and family members) and through use of standardized tests
- Providing counselling services to motivate the addict to enter treatment
- Delivering services according to a schedule / timetable to offer individual counselling, group therapy and family counselling for the patients and their families on a regular basis.

Minimum activities	Records to be maintained
Intake form to be completed on the very first day of meeting the client.	**Intake Form (Annexure 2)**, which has demographic details, addiction history and prior medical history to be filled by counsellor.
Providing counselling every time he visits the centre until he is motivated to take help from a government hospital or a nearby treatment - cum – rehabilitation centre. Case history to be completed within a week / four sessions with the client. Meeting family members / support persons within 4 sessions.	**Case history form (Annexure 3),** which covers family, marital, occupational and financial history with counselling notes to be maintained by the counsellor.
Objectives and content of each of the services provided (counselling, group therapy, family counselling, follow-up) to be described.	**Therapy Manual (Annexure 4)** to be prepared by the project-in-charge.

- **Activities related to referral services and follow-up**

- Identification of both government and non-governmental agencies, working in the field of addiction and networking with them on a regular basis.

- Referring clients after motivation to other centres for detoxification / treatment.

- If referred to the government hospitals, maintaining regular contact with the client during detoxification and providing follow-up services on completion of detoxification to facilitate rehabilitation.

Minimum activities	Records to be maintained
Networking with government and non-governmental organisations working in the field of addiction and allied sectors for referral purposes.	**Network Directory (Annexure 5)** containing all relevant information to be maintained by project- in-charge.
If a client is referred to a government organisation, one visit to be made by the counsellor every week until discharge (if the Government organisation is located in the same district as the NGO) and in other cases, contact to be maintained in the manner considered feasible e.g. by letter, by telephone and / or fortnightly visits.	**Case history form (Annexure 3)** to include visits to government hospitals to be recorded by the counsellor.
Organise a minimum of two group meetings every week for clients who have undergone detoxification (mainly for clients who are living in the same geographical area as the NGO).	**Group therapy record form (Annexure 6)** to be maintained by the counsellor.
On completion of detoxification, follow-up is to be maintained as under: <u>For clients who are living in the same geographical area as the NGO</u> o One counselling session every week during the first three months o One session every month from the third month till he completes one year. o One session every two months for one more year till he achieves two years of sobriety. o Initiating the client to self-help groups wherever available. If not available, encouragement to be given to form self-help groups.	**Follow-up card (Annexure 7),** which has details of counselling notes, home visits and letters written to be maintained by the counsellor.

For clients who do not live in the same geographical area as the NGO o one counselling session with individual / family (if possible) every one / two months for the first one year. o one counselling session with individual / family (if possible) every three months for the second year of sobriety. The sessions can be held either at the community or at the premises of the NGO. Failure to report for follow-up visits for two months to be followed up with two letters and one home visit for the patient and one letter to the family / significant person.	
Drinking / drug taking history and improvements made to be recorded. Whole person recovery to be assessed twice a year and recorded.	**Follow –up- card (Annexure 7)** with details of whole person recovery to be maintained by the counsellor.
Maintaining letter of endorsement from clients for receiving free counselling services o at the time of referral or at the time of follow-up on completion of 3 months from clients referred to government organizations	**Endorsement letter (Annexure 8)** from each patient to be maintained by the project-in-charge.
Explaining to the client and his family members about the treatment and the medicines provided and its consequences and getting a declaration-cum-Indemnity before treatment.	**Declaration - Cum – Indemnity Bond (Annexure 9)** to be maintained by the Project-in-charge.
Half-yearly report with details of patients to be maintained	To be maintained by Project-in-charge in format prescribed from time to time for reporting to the funding agency.

- **The physical aspects of the centre**

- The centre should be preferably located in a reasonably quiet locality with adequate space.
- Name of the centre (with complete address) and sponsoring agency to be displayed prominently.
- Rights of the clients shall be prominently displayed in the premises of the Centre for information of the clients, the family members and the visitors.
- The Centre should be properly ventilated, well lit and maintained in a clean manner.
- It should have toilet facilities, drinking water facilities and telephone facility.
- The centre should be easily accessible through public conveyance.
- The following facilities should be available:

- ✓ reception, enquiry / registration counter / waiting space with seating arrangements for a minimum 5 persons
- ✓ cubicles / rooms for providing individual counselling, group therapy and family counselling.
- ✓ space to store records of patients to ensure confidentiality and a system of easy retrieval

- Addiction related educational material such as posters to be prominently displayed at strategic points.
- Information pamphlets, handouts and other educational materials in the vernacular to be made freely available to the public. It is desirable if the Ministry provides the materials.
- Overhead projector to be available for creating awareness. It is desirable if the Ministry provides it.

□ **Job description of staff**

1. **Project in charge-cum-senior counsellor**

Responsibilities as a Project In charge

- Coordinating and managing the counselling centre
- Taking care of administrative responsibilities of the centre – attendance, allocation of job and maintenance of discipline.
- Preparing Half yearly / Annual report and application forms for grant purposes.
- Liaisoning with government and non-governmental organisations working in the field of addiction.
- Checking whether the records are maintained properly.
- Supervising and providing guidance to counsellors
- Organising case discussions
- Organising training programmes for counsellors

Responsibilities as a senior counsellor

- Assessing problem areas of clients
- Collecting case history both from the client and significant persons
- Visiting governmental and non-governmental agencies to support the client in treatment.
- Conducting group therapy for clients
- Providing counselling for clients and their family members
- Providing follow-up counselling
- Maintaining individual case records of patients seen
- Conducting awareness programmes

2. **Counsellors / Social workers / Community workers**

- Motivating the client to take help
- Assessing problem areas of clients

- Collecting case history both from the client and significant persons
- Visiting governmental and non-governmental agencies to support the client in treatment and escorting him for admission to other organisations.
- Conducting group therapy for clients
- Providing counselling for clients and their family members
- Providing follow-up counselling
- Conducting awareness programmes
- Maintaining records

□ **Training requirements of project in charge / counselling staff**

- Orientation of one-month duration to be provided to new staff on counselling, conducting group and family therapy and on maintenance of patients' records.
- Updating and training through refresher courses to be provided to existing staff at least twice a year – to attend one training conducted by Regional Resource Training Centre by each staff.
- Professionals from other counselling centres to be encouraged to visit the centre once a year and share their experiences. Similarly, staff to visit other counselling centres once a year and learn from their experiences.
- Case discussions to be conducted once a week to ensure quality of service delivery.
- Project in charge to be provided orientation of maintenance of accounts and other records.

3. **Accountant-cum-clerk**

As an Accountant

- Writing main account / petty cash account and preparing monthly expenditure statement
- Disbursement of cash for salaries and incidental expenditure.
- Assisting the Chartered Accountants in preparing Balance Sheet and liaisoning with project coordinator regarding funds
- Maintaining asset register

As a clerk

- Receiving phone calls and playing the role of a receptionist
- Maintaining attendance, leave letters
- Maintaining records for telephone calls, stationery and electricity.
- Getting stationery and cleaning items for the centre
- Attending to the work of the centre at post office, bank and also purchases of various items.

CHAPTER 4

TREATMENT–CUM- REHABILITATION CENTRES

The **Treatment–cum- Rehabilitation centres** are mandated to provide the following services:

- Preventive Education and Awareness building
- Assessing and motivating the clients to take help
- Detoxification and medical care
- Psychological therapy
- Vocational rehabilitation
- After-care / follow-up

The Treatment-cum-Rehabilitation Centres aim to enable the addicts to achieve total abstinence and improve the quality of their lives by helping them to :

- identify areas of necessary change and taking action.
- become aware of risk factors for relapse and develop positive coping skills
- strengthen inter-personal relationships
- develop healthy work ethics
- sustain their recovery through follow-up services

As prescribed by the grant-in-aid scheme, both medical and psychological services are provided on an **in-patient basis**. The after care / follow-up services are provided on an **out-patient basis**. Medical care is provided by physician / psychiatrist and nurses. Psychological care is provided by social worker, psychologist, sociologist or a recovering person with a minimum of two years of sobriety.

- **Activities for Awareness Building and Assessment and Motivation of clients**

As described in Chapter 3 for similar activities.

- **Activities related to detoxification and medical care**

- Detoxification services are to be provided to make the withdrawal period safe and comfortable.

- Treatment is to be provided for other related medical and psychiatric disorders (diabetes / hypertension / depression, suicidal thoughts etc.). Services of other specialists, hospitals and testing laboratories should be utilized, where necessary, to ensure appropriate care.

- Medical care is to be provided during the follow-up as well.

Minimum activities	Records to be maintained
Prescribing medicines to minimize withdrawal symptoms and to deal with related medical and psychiatric problems.	**Medical manual**, which describes protocols (based on research or in keeping with accepted practice) for prescribing medicines to be maintained by the Medical Officer.
Medical history to be obtained on the day of admission. Providing essential medicines for detoxification and withdrawal related emergencies free of cost. Medical complaints of patients, prescription of medicines / reasons for change of medicines to be recorded by the medical officer. In case of any untoward incident like fits, delirium or accident, the patient to be monitored on an half hourly basis till he gets back to normalcy.	**Medical case sheet (Annexure 10)** to be filled by medical officer / nurse.
For hypertensive patients, blood pressure to be checked everyday till discharge	**Blood pressure chart (Annexure 10)** to be maintained by the nurse.
Temperature to be recorded for patients running temperature, until normal temperature is recorded for a minimum of two days.	**Temperature chart (Annexure 10)** to be maintained by the nurse.
Medicines essential for detoxification and withdrawal related emergencies to be made available at all times and to be checked for quantity and availability once a month.	**Stock Register (Annexure 11)** to be maintained and checked by the nurse once a month.
In case of any medical/ psychiatric problem beyond the scope of the detoxification centre referral should be made within 2 days. Violent patients need to be assessed and transferred if necessary to department of psychiatry.	**Medical case sheet (Annexure 10) –** the need for referral and medical / psychiatric problems exhibited by the client to be recorded by the physician.

- Availability of essential equipment like ECG machine, Oxygen cylinder, suction apparatus, BP apparatus, weighing machine and urine sugar testing material is desirable.

- Availability of an ambulance with a driver is desirable to admit patient to the hospital in case of emergencies.

□ **Activities for psychological services**

- Assessing the problems related to addiction and motivating the addict to participate actively in the treatment.

- Providing psychosocial treatment for the total recovery of the addict through individual counselling, group therapy, re-education and yoga. Treatment plan to include exposure to self – help / support groups and introduction to other recovering addicts.

- Providing psychological care to families and support persons of the addict.

Standards on programme structure

Minimum activities	Records to be maintained
A schedule / timetable to be developed and followed. Rules that need to be adhered to by the clients to be prepared – e.g. waking time, recreation time. Issues that warrant disciplinary actions - e.g. missing sessions, trying to abuse drugs inside the centre and the disciplinary measures that can be taken to be laid down.	Therapy manual (Annexure 4) to be prepared and maintained by the senior counsellor.
Patients to complete treatment within the prescribed period. Drop out or extension of treatment beyond the one month period to be recorded with reasons.	Case History Form (Annexure 3) to be maintained by the nurse / counsellor.

Standards on counselling

Minimum activities	Records to be maintained
Record of patient's attendance to psychological therapy sessions.	**Attendance Register (Annexure 12)** to be maintained by the counsellor.
Case history to be completed within two weeks through counselling sessions with client and family members. During the one-month programme, a minimum of 8 counselling sessions to be provided. Each session to last for at least half-an-hour to forty-five minutes and main issues recorded in brief. Issues such as HIV positive status, extra marital affairs, legal problems, marital separation, gambling or traumatic childhood experiences to be handled with extra effort and care.	**Case history form (Annexure 3)** to be completed by the counsellor.
Treatment plans to be specifically recorded keeping in mind the whole person recovery.	**Case history form (Annexure 3)** to be completed by the counsellor.

Standards on re-educative lectures

Minimum activities	Records to be maintained
Three educative sessions to be conducted each week. The contents of the re-education lectures to be documented and standardized and followed to ensure uniformity. Basic issues such as disease concept, addiction related damage, relapse, overcoming personality defects, methods to stay sober, self-help / support groups principles and HIV-AIDS to be covered. Assertiveness, decision making and problem solving skills to enable them to withstand pressure to be taught.	**Therapy Manual (Annexure 4)** to be maintained by the senior counsellor

Standards on group therapy

Minimum activities	Records to be maintained
5 sessions per week and each session to be conducted for at least one hour. Each group to have a maximum of 15 and a minimum of 5 clients. Groups to be divided based on languages the patient speaks comfortably Issues related to damage due to addiction, symptoms of addiction, powerlessness and unmanageability, breakdown of values and character defects to be discussed.	**Therapy Manual (Annexure 4)** to be maintained by the senior counsellor.
Observation of individual patient during the group therapy sessions to be recorded once a week.	**Group therapy record (Annexure 6)** to be maintained by the counsellor conducting the group therapy session.

Standards for the family programme

The addiction treatment centre should have programmes for the family members including significant persons. The goals of the programme are to help them understand addiction as a disease and in turn develop a caring attitude towards the addict. Another goal is to help them deal with their negative emotions and improve their quality of lives.

Minimum activities	Records to be maintained
Four counselling sessions for family members to be provided (either individual or combined sessions) whenever possible. Through the sessions, to help the family members to achieve personal recovery by becoming aware of their enabling behaviour, negative traits and develop methods to deal with their feelings of shame, guilt, anger and resentment.	**Case history form (Annexure 3)** to be maintained by the counsellor.
One educative session to be conducted each week. The contents of the re-education lectures to be recorded and followed to ensure uniformity.	**Therapy Manual (Annexure 4)** to be maintained by the senior counsellor.

Basic issues such as the objectives of the treatment programme, medications given, the disease process, relapse, recovery, impact of addiction on the family to be provided. **In the absence of family members / support persons, this service need not be insisted upon.**	

Other Issues related to psychological services

Minimum activities	Records to be maintained
Identity card with registration number to be given to the patient at the time of discharge. Discharge to be made by the counsellor in consultation with the doctor / project director.	**Identity card (Annexure 13)** to be issued by the counsellor.
A letter of endorsement from the patient that he received free treatment	**Letter of Endorsement** signed **(Annexure 8) by** the patient maintained by the counsellor.
Explaining to the client and his family members about the treatment and the medicines provided and their consequences and getting a declaration-cum-indemnity.	**Declaration - Cum-Indemnity (Annexure 9)**

A manual which provides information about the vision of the organisation, members of the society, facilities and functions of the centre to be available and updated every year. Organisation chart to be included.	**Administrative manual (Annexure 14)** to be prepared by the project-in-charge.
Half-yearly report with details of patients to be maintained	To be maintained by Project-in-charge in the format prescribed from time to time for reporting to the funding agency.

- **Activities related to Vocational Rehabilitation**

- Recovering addict to be given a vision for resettling in the society. A list of vocational options to be provided to the patient.

- Culturally relevant vocational training to be considered utilising local resources and the marketability of the products wherever possible - e.g. candle making, tailoring, carpentry and mat weaving.

- Identification and networking with government recognised vocational centres to refer recovering clients for training.

- An employee who has been dismissed due to addiction can be helped to get back to his prior employment by liaison with the employer.

Minimum activities	Records to be maintained
Education, skills and prior work experience of patient to be assessed before initiating him into vocational training.	**Assessment Form (Annexure 15)** to be maintained by the vocational instructor.
Maintenance of a directory and networking with specialised services – vocational training, job placement	**Networking directory for specialised services (Annexure 16)** to be maintained by the project-in-charge.

- **After - care / follow-up and rehabilitation services**

After- care and rehabilitation are essential components of addiction treatment. The outcome of therapy depends largely on the effectiveness of the follow-up efforts towards the patient's re-integration into the community to attain whole person recovery. Rehabilitation through vocational training to facilitate income generation can be part of the services by the Addiction Treatment Centre. After care / follow-up services are provided on an outpatient basis.

- **Activities for aftercare and rehabilitation of the patients and family**

- A clearly defined after care programme (counselling, relapse prevention programme, self-help programme, reaching out to patients through home visits) to be made available with focus on the whole person recovery of the individual.

- Procedures to be clearly laid out to address relapse issues (in both detoxification and counselling services)

- After- care plans of alternative methods for patients who have not recovered have to be explored and support to their family members to be ensured.

Minimum activities	Records to be maintained
Patient to be prepared for discharge with focus on short-term and long-term goals - e.g. developing work ethics, improving inter-personal relationships and financial management.	**Case History (Annexure 3)** – recovery plans to be recorded by the counsellor.
Regular follow-up services to be provided on completion of treatment for clients who are living in the same geographical area as the NGO. The sessions can be held either at the community or at the premises of the NGO. - One counselling session every fifteen days during the first three months - One session every month from the third month till he completes one year. - One session every two months for one more year till he achieves two years of sobriety. Failure to report for visits for two months to be followed up with two letters and one home visit for the patient and one letter to the family / significant person.	**Follow-up card (Annexure 7)** which has details of counselling notes, home visits and letters written to be maintained by the counsellor.
Drinking / drug taking history and improvements made to be recorded in every visit. Whole person recovery to be assessed twice a year and recorded.	**Follow up card (Annexure 7)** to be updated by the counsellor.
Patients completing one or more years of sobriety to be encouraged by sending a congratulatory letter.	**Congratulatory letter (Annexure 17)** signed by the counsellor / project-in-charge.
Relapse has to be handled with specific input to increase the understanding and coping mechanism of the addict – four counselling sessions.	**Therapy Manual (Annexure 4).**
Maintenance of a directory and networking with specialised services – vocational training, job placement, referral to half way home / after-care centre.	**Networking Directory for specialised services (Annexure 16)** to be maintained by the project-in-charge.

The physical aspects of the Treatment–cum-Rehabilitation Centre

- The centre should be located in a reasonably quiet locality with adequate space.
- Name of the centre with complete address and sponsoring agency to be displayed prominently.
- Rights of the clients shall be prominently displayed in the premises of the Centre for information of the clients, the family members and the visitors.
- The centre should be properly ventilated, well lit and maintained in a clean manner. Water to be made available.
- Following facilities should be available:
  - ✓ Waiting space with seating arrangements for a minimum 5 persons
  - ✓ Reception / enquiry and registration counters
  - ✓ Cubicles / rooms for consultation for physical examination
  - ✓ Nursing Station with facilities to store drugs, linen, and records of patients
  - ✓ Facilities with privacy for providing individual counselling, conducting group therapy, re-educative lectures, family classes. They should be airy with comfortable seating on floor mats/ chairs. Blackboard, chalk and other material to be provided.
  - ✓ Recreational facilities such as books for reading, indoor (carrom, chess) / outdoor games, radio and television.
- Mattresses and pillows should be provided for each patient. Bed linen to be changed at least once a week
- Each patient to be provided with a locker / storage space to store personal belongings.
- There should be one bathroom for ten patients and one toilet for five patients. Open toilets to be discouraged.
- Space should be provided to store records of patients to ensure confidentiality and a system of easy retrieval. Computerisation of case histories to be considered and implemented.
- Addiction related educational material such as posters to be prominently displayed at strategic points.
- Information pamphlets, handouts and other educational materials in the vernacular to be made freely available to the public.

Job responsibilities of staff

1. **Project Director**

Responsibilities as a Project In charge

- Coordinating and managing the treatment and rehabilitation centre.
- Taking care of administrative responsibilities of the centre – appointment of staff, attendance, allocation of job and disciplinary action.

- Preparing Half yearly / Annual report and application forms for grant purposes.
- Checking whether the records are maintained properly.
- Liaison with governmental and non-governmental organisations working in the field of addiction.

Responsibilities as a senior counsellor

- Supervising and providing guidance to counsellors
- Organising case discussion
- Organising training programmes for counsellors
- Assessing,problem areas of clients
- Collecting case history both from the client and significant persons
- Conducting group therapy for clients
- Providing counselling for clients and their family members
- Providing follow-up counselling
- Maintaining individual case records of patients seen
- Conducting awareness programmes

2. **Medical Officer / Psychiatrist**

- Assessing clients with regard to their physical / mental condition and providing treatment for their medical and psychiatric problems.
- Prescribing medication during detoxification, follow up and relapses and handling all medical emergencies e.g. DT, fits and acute psychotic episodes
- Liaison with specialists in psychiatry, internal medicine, neurology, pathology and biochemistry for referral in case of further treatment.
- Maintaining all records of detoxification, emergencies and follow up of patients
- Participating in the case discussion with the counsellors to plan the treatment and recovery of individual patients.
- Contributing to awareness building and preventive education programmes.

Training requirement for general physician / psychiatrist

- Exposure to new trends regarding kinds of drugs abused, medical and psychiatric problems, new medicines / methodologies available for the treatment of addiction through participation in training programmes and conferences once a year.

3. Nurses

- Minimal history taking on admission
- Dealing with emergencies and assisting the Medical Officer
- Giving medication and injections;
- Maintaining all registers and records of patients in detoxification (e.g. blood pressure and urine sugar)
- Supervising the functioning of ward boys, sweepers

Training requirement of Nurses

- A mock emergency drill to be carried out once every three months to deal with issues like breathlessness, acute psychotic episode, convulsions and cardiac arrest. The medical officer will guide the drill.
- New nurses will be given training for a period of one week with information on drug addiction, about psychiatric problems, effects of psychiatric medicines and day-to-day management of the centre.

4. **Ward boys**

- Assisting the nurses in the detoxification unit
- Attending to the personal hygiene of bed- ridden patients
- Escorting the patients to labs or other specialists
- Monitoring the visitors and checking patients for possession of drugs
- Conducting physical exercises for the patients
- Cleaning of the detoxification centre including toilets

5. **Counsellors / Social workers / Psychologists / Recovering addicts**

- Functioning in a team to coordinate activities and receive feedback from other members of the team.
- Counselling to include assessment, motivation, building rapport, counselling families and significant others and planning treatment strategies from admission to follow-up.
- Conducting re-educative classes, family therapy and group therapy.
- Recording and documentation of the patient's treatment processes.
- Conducting awareness programmes in the community.
- Net working with government and non-governmental agencies.

Training requirements of counselling staff

- Orientation of one-month duration to be provided to new staff on counselling, conducting group and family therapy.
- Updating and training through refresher courses to be provided to existing staff at least twice a year – to attend one training conducted by Regional Resource Training Centre by each staff.
- Professionals from other addiction treatment centres to be encouraged to visit the centre once a year and share their experiences. Similarly, staff to visit other treatment centres once a year and learn from their experiences.
- Case discussions to be conducted once a week to ensure quality of service delivery.

6. **Yoga/ other therapists**

- Conducting physical exercises / yoga for the patients
- Conducting meditation and classes on spirituality

7. **Accountant-cum-clerk**

As an Accountant

- Writing main account / petty cash account and preparing monthly expenditure statement
- Disbursement of cash for salaries and incidental expenditure.
- Assisting the Chartered Accountants in preparing Balance Sheet and liaison with project coordinator regarding funds
- Maintaining asset register

As a clerk

- Receiving phone calls and playing the role of a receptionist
- Maintaining attendance, leave letters
- Maintaining records for telephone calls, stationery and electricity.
- Getting stationery and cleaning items for the centre
- Visiting post office, bank and shops as and when needed
- Keeping receipts, bills and disbursing cash.

8. **Sweeper / Peon**

- Cleaning the entire centre including bathrooms
- Visiting post office, shops, paying electricity, telephone bills as and when needed

CHAPTER 5

DE-ADDICTION CAMPS

An organisation running a Treatment–cum-rehabilitation Centre may organise De-addiction camps in areas prone to drug abuse especially in rural / semi urban areas where institutional services are either not available or not feasible due to socio-economic reasons.

- **The camp approach has many benefits:**
  - Treatment is cost effective because existing facilities available in the community are made use of.
  - Involvement of family / support persons become feasible.
  - The local community is involved in organising the camp, hence, they provide support to the addict in recovery and they also get sensitised to the impact of addiction.
  - Sustained involvement of the community promotes collective initiative towards prevention of addiction.

- **Activities for conducting de-addiction camps**

- Creating awareness in the community about the problems associated with drinking and drug addiction and the need for appropriate treatment.

- Prior to conducting the camp, a local host organisation has to be identified from the community. The host organisation could be any local organisation (government / non-government / panchayat), providing health care / education / rural upliftment / micro credit system. The host organisation should have credibility and be trusted by the community. The host organisation should be involved in providing / facilitating infrastructure such as accommodation for conducting the camp, organising meals for the patients and treatment staff, and mobilising local support persons.

- Involving the community in identification, intervention and providing support during recovery. Identification of addicts to be done through multiple contacts – formal / informal leaders, local physicians, community workers, teachers etc.

- Treatment to include detoxification and psychological therapy for the patients and therapy for family members for a period of 15 days by conducting a camp at the community itself.

- On completion of camp, to provide follow-up care for a minimum period of one year.

- To sustain the momentum built at the time of the camp, meaningful follow-up activities to be conducted on an ongoing basis.

Minimum activities	Records to be maintained
To involve the community, identification of a host organisation and sensitizing them about the impact of addiction and the need for treatment. Two programmes to be organised prior to the camp at the community.	**Profile of Host organisation (Annexure 18)** to be maintained by the counsellor.
Identification of patients through community network – formal / informal leaders, panchayat leaders, families of addicts, Youth Associations, teachers, Mahila Mandal workers, Religious leaders and health workers / recovering addicts. Through personal contact or by distribution of pamphlets, making people aware of the camp programme.	List of identified addicts to be maintained by the counsellor. List of resource persons with addresses to be maintained by the counsellor.
The selection criteria to be clearly defined and followed-up.	**Camp Manual** to be developed and maintained by the counsellor.
Providing detoxification and dealing with addiction related medical complications.	**Medical case sheet (Annexure 10)** to be maintained by the medical officer.
Identification and creating linkages for medical services to handle emergencies during detoxification, during follow up and relapses through local resources such as physicians, hospitals and primary health centres.	**Network directory (Annexure 5)** to be maintained by the project-in-charge.
Developing a structured programme for duration of 15 days with the focus on medical care as well as providing support to improve the quality of life. Providing a minimum of 8 re-educative sessions for patients, 8 group therapy sessions and 4 individual counselling sessions.	**Therapy Manual (Annexure 4)** to be maintained by the project-in-charge. **Case History Form** to be maintained by the counsellor **(Annexure 3)**
To provide support to the family, conducting five sessions for families with components of re-educative sessions, group therapy, and counselling.	**Camp Manual** to be maintained by the project-in-charge.
To sustain the recovery, conducting one follow-up meeting at the camp site once in two months for a period of two years.	**Follow-up card** to be maintained by the counsellor **(Annexure 7)**.

- **Activities for creating awareness in the community**

- Formal and informal methods that include community participation such as dramas, competitions, pantomime shows, street plays and folk media to be organised depending on the target audience.

- Messages to be sensitively designed so as not to arouse any undue scare, curiosity or experimentation with alcohol and drugs

- The language, content and style of message to be culture-specific according to the target groups to be addressed

- Education against alcohol and drug abuse to incorporate contents of socially healthy alternative life styles

Refer Chapter 3 for minimum activities and records to be maintained.

- **Staff required for conducting a camp**

- A minimum of three counsellors, one nurse and a ward boy are required for 25 patients.

- Physician and other support persons from the campsite to be utilised.

- **Training requirements of staff**

  - The treatment staff to be exposed to work in a treatment centre that already conducts de-addiction camps to observe and understand the camp approach.

  - Training to include methods to mobilise and work with the community.

  - Specific training on pantomime shows, street plays and folk media to be included.

CHAPTER 6

WORKPLACE ALCOHOL / DRUG PREVENTION PROGRAMME

Addiction, especially addiction to alcohol is a major problem in industries and other places of work. According to some of the studies conducted, 7-10% of the work force may have problems related to alcohol / drug use. It creates problems for the employer, managers, union office bearers and supervisors. Some of the problems faced are unpredictable absenteeism upsetting production plans, accidents leaving an unpleasant impact, constant worry over product quality and deteriorating discipline in the department.

A comprehensive strategy against the spread of alcohol and drug abuse includes building awareness, training supervisors / managers on the impact of addiction and offering treatment services. The scheme by the government of India encourages and gives grants to non-governmental organisations to undertake work place alcohol / drug prevention programmes in urban areas. The programme is focussed towards **promoting health, maintaining safety and improving work performance.**

The Scheme has listed two types of interventions

1. A 15 or 30 bedded treatment cum rehabilitation centre to be established by the industry / enterprise. Financial assistance upto 25% of the expenditure for setting up such a Centre shall be provided by the Ministry. Only an industry with a minimum strength of 500 workers or a cluster of units wherein 500 people work will be eligible for assistance. For this component, the services shall be the same as that of 15 / 30 bedded Treatment-cum-Rehabilitation Centre (Chapter 4).

2. A Treatment cum Rehabilitation Centre (15 / 30 bedded) run by an NGO taking up work place alcohol / drug prevention programmes as part of its activities. Additional funding of 25% of that admissible to a 15 bedded centre to be provided to employ additional staff such as counsellors / community workers / part time medical officer.

□ **Activities related to workplace alcohol / drug prevention programme**

- To create awareness among the employees about the impact of use and abuse of alcohol / drugs in relation to the quality of work.

- To create awareness among the families of employees about the impact of use and abuse of alcohol / drugs in relation to health, finances and general well being.

- To educate and change the attitude towards use of alcohol and drugs and promote healthy leisure time activities and coping skills.

- To conduct awareness programmes for the management as well as union office bearers regarding the impact of addiction and the need to develop a policy.
- To conduct training programmes for supervisors / managers to identify early phase addicts through poor job performance, absenteeism etc.
- To collect data regarding absenteeism, accidents, poor job performance among the employees and relating them to use and abuse of alcohol.
- To identify, refer and facilitate treatment of workers with problems of addiction.

Minimum activities	Records to be maintained
To conduct one programme a month on creating awareness about the impact of addiction and related issues – lecture, film shows / street plays and puppet show at the workplace / residential areas of employees. To conduct one programme every six months for families of employees on the impact of addiction and related issues. To conduct one programme every three months for supervisors / managers / worker representatives on early identification / motivation of problem employees and related issues. To conduct one programme every six months for management / union office bearers on the need to have a policy to deal with addiction and to develop a plan of action. To create and organise a meeting of steering committee in the institution to deal with addiction once in three months	**Awareness programme register** to be maintained by Project-in-charge - **(Annexure 1).**
To help the industries to collect data regarding absenteeism, accidents and poor quality of work due to the use and abuse of alcohol / drugs.	Questionnaire to be developed based on the requirement of the industry (Model as prescribed by the ILO).
To treat patients referred by industries as and when needed.	**Register for patients referred by industries** to be maintained by the counsellor **(Annexure 19)**

- **Training requirement of staff**

The counsellors or community workers should have undergone at least one week training in an organisation that conducts such workplace alcohol / drug prevention programmes.

CHAPTER 7

CODE OF ETHICS FOR STAFF

The primary obligation of all staff is to ensure quality of services to the clients. The relationship between the staff and the client is a special one and it is essential that the staff have the maturity as well as the ability to handle the responsibilities entrusted to them.

Every staff member on joining the organisation shall undertake to abide by the following **code of ethics: -**

1. Conduct oneself as a mature individual and a positive role model by not using alcohol / tobacco / other drugs on the premises.

2. Respect client by treating him with dignity.

3. No sexual relationship of any kind with clients or their relatives.

4. No physical restraint or corporal punishment of any kind to be used to detain or restrain patients who are in normal physical and mental condition even for acts of misbehaviour. **Only in extreme cases where the client is violent or delirious or not in a position to take care of himself, physically restraining him is allowed to ensure protection to the patient from inflicting harm to himself or others.** This should be resorted to with the prior permission of the project in charge.

5. No denial of food to any client as a means of punishment or otherwise.

6. Not to make use of / exploit the client for the benefit of self/staff/organisation.

7. Recognize the best interest of the client and refer him if necessary to another agency or a professional for further help.

8. No photographic, audio, video or other similar identifiable recording is made of patients without their prior informed consent. If done for research / training, the purpose has to be explained and consent obtained preferably in writing.

9. Maintain all client information in the strictest confidence. Information about the patient or his progress in treatment not to be divulged to any individual or authority without the patient's consent.

10. No discrimination to be made against a HIV–AIDS patient regarding admission or in providing any other services.

CHAPTER 8

RIGHTS AND DUTIES OF THE CLIENTS

Rights of the clients

1. Services shall be available irrespective of religion, caste, and political belief of all clients.

2. Services shall be available irrespective of the particular drug (s) abused (e.g. alcohol, ganja, brown sugar) or routes of administration (e.g. intravenous).

3. Services shall be available irrespective of the history of prior treatment.

4. Services shall be provided with dignity, respect and safety in a supportive drug-free environment.

5. Exclusion criteria for admission shall be clearly stated e.g. medical complications / psychiatric problems.

6. Expulsion criteria from services shall be clearly defined – e.g. being violent and abusing drugs / alcohol on the premises.

7. Clients and their relatives shall be informed of the nature and content of the treatment as well as the risks and benefits to be expected of treatment. They would be made aware of conditions and restrictions prescribed in the centre before admission.

8. Clients can wear their own clothes in keeping with local customs and traditions.

9. Clients can have contact with, and visits from, family or support persons while in treatment with the prior approval of the treatment staff.

10. The Centre shall maintain confidentiality of information regarding participation in the programme and of all treatment records except in the case of inspection, monitoring / evaluation by the funding agency.

11. Access shall be made available to the project-in-charge or management to air grievances / register complaints about the treatment or the staff.

12. Rights of the clients shall be prominently displayed in the premises of the centre for information of the clients and their family members.

Duties & Responsibilities of the Clients and Family members/ Support persons

There can be no absolute rights. Enjoyment of rights and privileges enjoins upon an individual to fulfil certain duties and responsibilities. Patients and their family members / support persons shall have to abide by the following guidelines which will help in the smooth running of the centre and in ensuring them to avail of their rights:

1. The use and / or possession of alcohol and / or drugs shall be prohibited. Anyone found to be in possession or use of alcohol / drug shall face disciplinary action as prescribed by the organisation. Similarly smoking shall be strictly prohibited in the prescribed areas.

2. The centre shall have the right to check the belongings of the patient for possession of alcohol / drugs at the time of admission and at any time during his stay at the centre.

3. Violence or using foul language shall be strictly prohibited.

4. Sexual relationship of any kind with other patients / their family members shall be strictly forbidden

5. Gambling in any form and playing cards shall be prohibited.

6. Borrowing from or lending to (money or any valuables) other patients / family members shall not be allowed.

7. Adhering to the rules set by the treatment centre regarding waking up time, bedtime, meals, therapy programme, for issue of medicines, etc. shall be mandatory.

8. Keeping the rooms, kitchen, dining room etc. clean; making beds for oneself, changing linen; watering the plants etc. shall be other duties of the inmates.

9. Lights, fans and geysers should be switched off when not in use.

10. Wastage of water shall be strictly prohibited.

11. Radio/tape recorder to be used in low volume not inconveniencing other patients.

12. Family members / support persons shall follow the rules prescribed by the centre with regard to out-passes and visiting hours.

CHAPTER 9

SERVICES OF VOLUNTEERS IN DRUG ABUSE PREVENTION PROGRAMMES

Utility of Volunteers and their Applicability

The problem of addiction is increasing with time and the available resources are becoming increasingly insufficient to meet the needs. People showing care and concern are a rich human resource. There is a need to develop committed individuals who are prepared to provide voluntary services. Mobilising them in Drug Abuse Prevention Programmes is one of the best ways to enhance the quality of services provided. Besides, there is no additional cost incurred by the organisation.

People who can be Volunteers:

- ✓ recovering addicts and their family members
- ✓ retired persons from the local area
- ✓ youth, students and lecturers from colleges
- ✓ women with some spare time who are committed

Selection and development of Volunteers

Some precepts for developing and managing the services of volunteers call for a systematic effort. These have been outlined below:

- Volunteers must be **selected** carefully. Selecting good role models showing commitment with personal qualities that addicts or family members can look up to is important. They should be preferably be non-smokers and teetotallers. If the volunteers are recovering addicts, they should be sober for a minimum period of one year.

- Volunteers need **orientation through proper training inputs**. Programmes or procedures instituted to train volunteers could be in consultation with the professional staff. The qualification, experience and personal qualities of volunteers should be assessed before assigning them tasks. Some of the areas which could be included in training are as follows:

  - ❖ The disease concept of addiction and its impact on the different areas of the individual's life

  - ❖ Some theoretical inputs on human relations and basic communication skills

  - ❖ The various services offered by the organisation e.g. some information about the characteristics of the community being served, the types of problems encountered by patients and the role of the volunteer in relation to the programme, the patients and the community.

  - ❖ A clear delineation of the volunteer's role emphasizing particular functions and activities she/he is expected to perform as well as those of the professional staff.

- ❖ Instructions regarding the necessity for maintaining confidentiality.

- Volunteers need **supervision** once they assume their position as part of the programme's workforce. They should be assigned a capable staff supervisor who can help, guide, be supportive and evaluate their work. By providing regular supervision, the staff could also indicate that the volunteers' efforts are taken seriously.

- Volunteers who are recovering patients should work along with a senior staff member. It is important that no ex-patient is to be treated as a specimen on display by either the public or the staff.

- Volunteer's **spirit of service and 'voluntarism' need to be nurtured** through genuine teamwork with the professional staff. It is important that she/he feels supported and appreciated by the professional staff as a partner deserving respect. Sharing credit with them is a key means of rewarding volunteers. Ceremonies held in the community at which volunteers are honoured are ideal for sustaining their commitment and for stimulating the spirit of service in other community members.

Role of Volunteers

While it is for the concerned organisation to work out the various roles of a volunteer depending upon the requirement, the following areas are suggested for the possible involvement of them.

In the service delivery:

- Organising / conducting awareness programmes – educating community members, preparing posters, display materials, etc.

- Networking with government / non-governmental organisations working in the field of addiction in the same locality

- Making visits to the government hospital to meet the patients admitted for detoxification.

- Making home visits

- Initiating the patients to join self-help groups and conducting self-help groups (for recovering addicts / family members / support persons)

- Providing social and emotional support to patients

- Conducting re-educative lectures for patients and family members/ support persons

- Writing letters on behalf of counsellors

- Networking with other agencies in getting employment for patients, medical assistance for related illnesses, legal aid etc.

- Maintaining records such as awareness programme register, network directory etc.
- Conducting recreational programmes at the centre
- Organising special programmes during festival times at the centre/ community
- Helping the Project Director in preparing the various manuals viz. therapy manual, administrative manual and other documentation work.

In Administration:

- Maintaining cleanliness of the premises
- Receptionist activities viz. receiving phone calls, giving information and guiding patients
- General secretarial and clerical activities
- Fund-raising activities

****

ANNEXURE 1

AWARENESS PROGRAMME REGISTER

Lectures / street play / puppet show / film

1. Date and month of awareness programme
2. Locality where the programme was held
3. Target group and number of participants
4. Topics handled
5. Methodology used to impart information
6. Feedback from a minimum of 5 people including key persons

Articles published / broadcast / telecast

1. Date and month of publication/broadcast/telecast
2. Name of publication / TV channel / Radio Station
3. Title of the article/message/programme
4. Feedback received, if any.

Yearly evaluation report

1. Name of the evaluator
2. Background information about the evaluator
   (education, work experience, expertise in the areas of evaluation / addiction)
3. Feedback given by the evaluator

ANNEXURE 2

INTAKE FORM

(Assessment, diagnosis, referral, admission and discharge)

Socio-Demographic Information

Name of the patient :
Address & :
Telephone No :

Registration No :
Date of entry :

Sex :
Religion :

Age :
Caste :

Educational Qualification:

Illiterate
Primary education
Middle
High /Higher Secondary (equiv.)
Graduate
Post graduate
Training (Diploma etc.)

Occupation:

Never employed
Currently unemployed
Part-time employment
Full time employment
Self-employment
Student
House wife
Pensioner
Others

Income :

Marital Status :

Never married
Married
Widow / widower
Divorced
Separated
Separated / divorced due to drug use

Living arrangements:

With family
With friends or distant relatives
Living alone
On the street

Referral by :

Self
Friends
Family
Social worker
Physician
Recovered addicts / their family members
Government hospital
Treatment-cum rehabilitation centre(NGO
Through awareness programme
Any other

Name of family member / Support person accompanied the patient:

Address :

Telephone No :

Drinking / Drug History

Record all details about alcohol / drugs abused:

Drugs	Age of first use	Years of use	Years of excessive use	Specific type of drugs	Route of admini-stration	Frequency of use in the last 6 months	Quantity used in the last 6 months	F u ii a
Depressants Alcohol, Tranquilizers, Sedatives / Hypnotics								
Narcotic analgesics Opium, Heroin / brown sugar, Morphine, Codeine, Pentazocine , Buprenorphine								
Cannabis Ganja, Charas, Bhang								
Stimulants Amphetamine, Cocaine								
Hallucinogens LSD, PCP								
Inhalants Petrol, Glue								
Substance not classified Cough syrup, Anti histamine / Anti depressant / Anti psychotic / Anti cholinegic								

If the client is an IV user, frequency of sharing practices: (indicate Never-N, Rarely-R, Occasionally-O, Frequently-F)

Sharing practices	Frequency
Needle	
Needle and syringe	
Paraphernalia	
Drugs	

Date of last drink / drugs taken: ..... days ago

Diagnosis:

Drug dependence
Alcohol dependence
Alcohol and drug dependence

Prior treatment for addiction:

Year	Place of treatment	Days / months of sobriety

Other associated psychiatric complications in the past / present:

Depression
Suicidal ideation / attempts
Confusion
Aggressive outbursts
Hallucinations
Paranoia

Physical problems (record specifically):

Impression of counsellor (for counselling centres):

Denial : Mild / Moderate / Severe

Motivating factor for present treatment efforts:

Willingness for treatment: Unwilling / ambivalent / willing

Action taken: Yes / No Describe details:

If referred, name of organisation:

Government De-addiction Centre
NGO Treatment-cum-rehabilitation Centre
Treatment for TB
Treatment for HIV-AIDS
Psychiatric treatment centre
Treatment for any other infections
Any other

Details of treatment received:

Hospital visits of counsellors

Date	Details of visits

Name & Signature of Counsellor (with date):

ANNEXURE 2

CASE HISTORY FORM
(to be used prior to detoxification / after treatment)

Medical history and drug taking history are available in Intake / Medical form.

I. Family History

1. Details regarding parents and siblings (provide relevant information)

II. Childhood and adolescent history

2. How would you describe your childhood / teenage years?

3. Did you experience the following before the age of 15 years?

Situations	Present	Absent
Poverty / severe debts Early parental loss Extra marital affairs of parents Broken home / single parenting Violence Any other		

4. Childhood / adolescence (before the age of 15 years)

Behaviour problems Identified	Childhood & Adolescence	
	Present	Absent
Running away from home Frequent physical fights and violence Destruction of others' property Stealing Scholastic backwardness Experimenting with drugs / alcohol Gambling Any other		

III. Marital History

5. Details regarding spouse:

Name :
Age :
Religion / Community :
Education :
Occupation :
Income per month :

Other details about spouse (history of addiction in her family, her addiction history if any, any other significant event in her life and attitude towards addiction)

6. Number of years of marriage :

7. Details regarding previous or subsequent marriages, if any Yes No

8. Have you been separated from your spouse due to your addiction? Yes No
If yes, period of longest separation

9. Is patient suspicious of spouse? Under the Influence of alcohol/drugs: Yes / No; While abstinent: Yes / No

10. Any instance of violence in the family? Yes No
If yes, give details

- Physical violence directed towards family members

- Violent incidents with neighbours and outsiders
- Breaking articles at home
- Verbally abusive

11. Details regarding children

No. of children Male Female

12. Health status of family

Has there been anyone in your family who has suffered from any of these problems?

Problems	Parents & Siblings				Spouse / Children			
	Yes	Relation -ship	No	Don't know	Yes	Relation -ship	No	Don't know
Major depression								
Suicide / attempted suicide								
Psychiatric illnesses								
Alcohol dependence								
Drug dependence								
Any other								

13. Family damage as seen by the counsellor Mild / Moderate / Severe

IV. Sexual history

14. Record extra marital experiences (If unmarried, pre marital) Present Absent N.A

If present,

- Age of partner:
- Is it a sustained relationship?
- For how many years have you known each other ?
- What is the living arrangement?
- Any children Yes No Details

15. Have you been involved in any high-risk sexual activities?

Sex with commercial sex workers Yes No

If yes, did you use condoms Always Sometimes Never

16. Sex with casual acquaintances Yes No

If yes, did you use condoms Always Sometimes Never

17. Have you been tested for HIV?

If yes,
Positive/ Negative
Not willing to reveal
Not collected reports
Not applicable

18. At present do you have any sexual problems? Yes No

Reduced libido
Impotency
Excessive sexual urge
Complete abstinence
Any other

V. Occupational History

19. At what age did you start working?

20. How long have you been working?

21. Have you received any special award, recognition, merit certificates or promotions in the past?

22 Did you change your job frequently due to addiction? Yes No

23. Did you have any periods of unemployment? Yes No
If yes, for how long and for what reasons?

24. Occupational damage

	Yes	No		Yes	No
Absenteeism			Loss of pay		
Warning / memos			Accidents on the job		
Suspension order			Attend work under the		
Dismissal order			influence of alcohol /		
Transfer order			drugs		

25. Specify nature of current work:

26. Occupational damage as perceived by the counsellor — Mild / Moderate / Severe

VI. Financial History

27. Details of debts to be cleared: — Amount

Money borrowed from family and friends
Loans from banks
Loans from place of work
Money borrowed from money lenders
Money for redeeming articles from pawn shops
Outstanding debts at various shops
None

28. Financial damage as perceived by counsellor — Mild / Moderate / Severe

VII. Legal history

29. Have you driven a vehicle under the influence of alcohol / drugs? — Yes / No

If so, — No. of times
Stopped by police
Arrested / fined
Had an accident (major or minor)

30. Have you got into trouble with law for the following? — Yes / No

Assault
Possession of drugs
Pushing drugs / sale and production of alcohol
Any other crime

VIII. Religious beliefs

31. Are you a

Believer
Non believer
Indifferent

32. Do you

	Always	Sometimes	Never
Pray at home			
Visit temple regularly			
Go on pilgrimages			
Celebrate festivals			

33. Counselling notes (with clients and family / significant members):

Session No. with date	Issues dealt with

34. Record treatment / recovery plans related to the following areas

- alcohol / drug free life
- physical well being
- healthy relationship with family members
- crime free
- occupational and financial improvements

35. Case Summary

(To include demographic details, family of origin, alcohol / drug use history, medical history, occupational history, financial situation, marital history, short and long-term goals).

Discharge details (for de-addiction-cum-rehabilitation centres)

Date of discharge :
If extended, reasons for extension :
Period of extension :
In case of drop out Date :

Reasons for drop out :

- Poverty, hence not able to stay
- Lack of family support
- Legal problem
- Inadequate facilities
- Personal / Any other reasons
- (lack of motivation)

ANNEXURE 4

THERAPY MANUAL
(for drug awareness and counselling centres)

I. Guidelines to prepare therapy manual

- Schedule / timetable for patients
- Rules that need to be adhered to by the patients at the counselling centre
- List of re-educative topics – relapse prevention, whole person recovery, coping skills, improving relationships with family etc. to be included.
- Content of re-educative topics for patients
- Issues to be dealt with in counselling sessions for patients
- Group therapy rules, topics for group therapy and role of therapists
- List of re-educative topics for family members
- Content of re-educative topics for family members
- Issues to be dealt with in counselling sessions for family members
- Statement of quality parameters

THERAPY MANUAL
(Treatment-cum-rehabilitation centres)

II. In addition to the above

- Rules to be adhered to by the patients
- Issues that warrant disciplinary action
- Disciplinary measures prescribed by the management
- Strategies to deal with relapses – re-educative sessions and their content, issues to be handled in counselling sessions.

ANNEXURE 5

NETWORK DIRECTORY
(for various referral services)

Name of the organisation :
Address :
Phone No :
Contact person :
Government / Non-government: :
Services available :
Admission procedures :
Time and day of admission :
Duration of treatment :
Kind of treatment provided :
Discharge policy :

ANNEXURE 6

GROUP THERAPY RECORD FORM – WEEKLY

Date	Attendance					Level and focus of Sharing	Participation / response to others' sharing	Observation and Signature of Counsellor
	1	2	3	4	5			

ANNEXURE 7

FOLLOW-UP CARD

Name of the patient : Reg.No.
Address :
Referral to :

Date /month	Issues dealt in counselling	Other forms of communication – letter, telephone calls etc.	Status of whole person recovery

Status of whole person recovery – Half yearly assessment

Areas of improvement	Half yearly	Half yearly	Half yearly	Half yearly
Alcohol / drug free life				
Physical well being				
Healthy relationship with family members				
Crime free				
Occupational and financial improvements				
Regularity in follow-up and attendance to self-help groups				

Home visits

Date and month	Date of patient's last visit to the centre	Reasons for making home visits	Issues dealt during the visits	Response to the home visits

ANNEXURE 8

LETTER OF ENDORSEMENT FOR FREE TREATMENT SERVICES

Name of patient : Reg. No.

For counselling services

I, Mr / Ms.....of age .....residing at (address).....
.... have received free of cost counselling / treatment services from (date) .... to..... ..... for alcohol / drug addiction. I shall also avail of the follow-up services to be provided free of charge by the centre.

For treatment-cum-rehabilitation services

I, Mr / Ms.....of age .....residing at (address).....
..... have received free treatment from (date) .... to.....
..... for alcohol / drug addiction.

I received free treatment which included medical care, essential medicines and counselling services at the treatment centre. I shall also avail of the follow-up services to be provided free of charge by the centre.

Signature of the patient

Date : Signature of support person

To

Project in charge
Name of the Organisation

ANNEXURE 9

DECLARATION-CUM-INDEMNITY
Counselling centres and de-addiction-cum-rehabilitation centres
(to be signed by the patient)

I_____aged_____years, presently residing at_____

do hereby solemnly declare and state as under:

1. I have voluntarily and of my own accord admitted myself to the counselling centres/ de-addiction-cum-rehabilitation facility run by .....

2. I state that I have been informed about the entire treatment and medication in detail and that I also fully understood and am aware of the implications and consequences thereof.

3. I am aware of the provisions of the various rules, regulations, bye-laws and guidelines in respect of any act governing such treatment and medication as also all laws, rules regulations and guidelines, relating to the same including the narcotic Drugs and psychotropic Substances Act, 1985, and the Drugs and Cosmetics Act, 1940, and the rules, regulations and bye-laws framed thereunder as also all guidelines and notifications pertaining to the same.

4. I declare and confirm that I have taken upon myself the entire responsibility, liability, risk and consequences as may arise during or after the said treatment and medication and that I shall not in any manner and at any time hereafter hold the said treatment facility, the said ..... and the said Trustees / members, as also the staff and representatives liable and or responsible in any manner whatsoever.

5. I agree and undertake that I shall from time to time and at all times hereafter render harmless, indemnify and keep indemnified the said counselling centres/ de-addiction-cum-rehabilitation facility, and the Trustees / members as also the staff and representatives and all such other persons lawfully claiming under them, or any of them or their estates and effects against all suits, actions, proceedings, claims and demands that may be made taken or adopted against the said counselling centres/ de-addiction-cum-rehabilitation facility, their Trustees / members, as also the employees, representatives and others claiming under them by virtue of them having commenced, carried out and treated and given medication to me and also from and against any claim or demand made, taken or adopted by any public body or authority or by person or persons whatsoever for any act, deed, matter or

thing done, committed, omitted, caused, contemplated, purported or sought to be done by me or by anyone whatsoever under my instructions, direction during the course of and after the completion of treatment and medications or otherwise however and shall also indemnify and keeping for me / indemnified the said counselling centres / de-addiction-cum-rehabilitation facility, and their Trustees / members, as also the staff, representatives and all persons legally claiming by and from under howsoever and shall also indemnify from and against all costs, charges, expenses, damages, penalties or payments that they or any of them may have to suffer or insure or be put to by virtue of them or any of them having commenced, carried out, completed / terminated o· stopped the said treatment and said medication on me.

6. I further agree and undertake that this indemnity shall ensure for the benefit of the said counselling centres/ de-addiction-cum-rehabilitation facility, their Trustees / members, the said employees, representatives or any of them and all persons and parties claiming under them or any of them.

7. I state that I am aware of all the statements and declarations made by me in the Declaration-cum-indemnity executed by me on _____day of _____ 200 and I hereby confirm and ratify the same. I further state that I am aware of all the statements, declarations and forms executed/filled in by me and I hereby confirm and ratify the same.

8. I further agree and undertake that the statements, undertakings and indemnities herein contained shall remain in full force and effect for all times to come for the benefit of the said counselling centres/ de-addiction-cum-rehabilitation facility, their trustees / members, the said staff, representatives and such other persons claiming under them or any of them for all times hereafter.

9. I am making this declaration solemnly and sincerely without any force, coercion or undue influence and the full force and effect should be given to all the statements and declarations made by me herein above.

Solemnly declared at _____
this_____day of _____
200___

_____
Signature

In the presence of:

1)_____and _____
Signature

2)_____

_____
Signature

To

Project in charge
Name of the Organisation

DECLARATION-CUM-INDEMNITY
Counselling centres and de-addiction-cum-rehabilitation centres
(to be signed by parents / spouse)

We, (1) _____aged _____ years and

2) _____aged _____years both presently residing at _____

do hereby solemnly declare and state as under:

1. We are the parents / spouses / guardians of Shri / Smt_____ aged _____ years of _____ presently residing at _____

2. Our son / daughter / spouse has voluntarily and of his/her own accord admitted himself/herself to the Counselling Centres / De-Addiction-cum-Rehabilitation Centre run by the ..... and we are aware of the same and have granted our consent/approval in that behalf.

3. We state that we have been informed about the entire treatment and medication in detail and that we are aware of the same and have granted our consent/approval in that behalf.

4. We also confirm that the entire details of the said treatment and medication have been given in full detail to our son/daughter/ward and that he/she has fully understood the implications and consequences thereof.

5. We along with our son / daughter / ward are aware of the provisions of the various rules, regulations, bye-laws and guidelines in respect of and governing such treatment and medication as also all laws, rules, regulations and guidelines touching, relating to the same including the Narcotic Drugs and Psychotropic Substances Act, 1985 and the Drugs and Cosmetics Act, 1940 and the rules, regulations and bye-laws framed thereunder as also all guidelines and notifications pertaining to the same.

6. We declare and confirm that we have taken upon ourselves the entire responsibility, liability, risk and consequences as may arise during or after the said treatment and medication and that we shall not in any manner and at any time hereafter hold the said Counselling Centres / De-Addiction- cum-Rehabilitation Centre and the said Trustees / members, as also the Doctors,

employees, staff, servants representatives liable and/or responsible in any manner whatsoever.

7. We agree and undertake that we shall from time to time and at all times hereafter save harmless, indemnify and keep indemnified the said Counselling Centres / De-Addiction- cum- Rehabilitation Centre and the Trustee / members as also the Doctors, employees, staff, agents, representatives, servants and all such other persons lawfully claiming under them or any of them or their estates and affects against all suits, actions, proceedings, claims and demands that may be made taken or adopted against the said Counselling Centres / De-Addiction- cum- Rehabilitation Centre, the said Trustees / members, as also the Doctors, employees, staff, agents, representatives, servants and others claiming under them by virtue of them having commenced, carried out and treated and given medication to our son/daughter/ward and also from and against any claim or demand made, taken or adopted by any Public body or authority or by any person or persons whomsoever for any act, deed matter or thing done, committed, omitted, caused, contemplated, purported or sought to be done by us or by anyone whomsoever under our instructions, directions during the course of and after the completion of treatment and medications or otherwise howsoever and shall also indemnify and keep informed/indemnified the said Counselling Centres / De-Addiction- cum-Rehabilitation Centre, and the Trustees / members, as also the Doctors, employees, staff, servants, agents, representative and all persons legally claiming by and from under or in trust for them or any of them may have to suffer or insure or be put to by virtue of them or any of them having commenced, carried out, completed/terminated or stopped the said treatment and said medication or our son/daughter/ward.

8. We further agree and undertake that this indemnity shall ensure for the benefit of the said Counselling Centres / De-Addiction-cum-Rehabilitation Centre, the said Trustees / members, the said employees, staff, agents, representatives and servants or any of them and all persons and parties claiming under them or any of them.

9. We state that we are aware of all the statements and declarations made by our son/daughter/spouse in the Declaration-cum-Indemnity executed by our said son / daughter / spouse on _____ day or _____200_____and we hereby confirm and ratify the same. We further state that we are aware of all the statements, declarations and forms executed/filled in by our son/daughter/ward and ourselves, and we hereby confirm and ratify the same.

10. We further agree and undertake that the statements, undertakings and indemnities herein contained shall remain in full force and effect for all times to come for the benefit of the said Counselling Centres / De-Addiction- cum-Rehabilitation Centre, the said Trustees / members, the said employees, staff, agents, representatives and such other persons claiming under them or any of them for all times hereafter.

11. We are making this declaration solemnly and sincerely without any force, coercion or undue influence and the full force and effect should be given to all the statements and declarations made by us herein above.

Solemnly declared at _____
this _____day of _____
200___

1) _____and _____
Signature

2) _____

_____
Signature

In the presence of:

1) _____and _____
Signature

2)_____

_____
Signature

Acknowledgement

- The Declaration-cum-Indemnity Bond has been provided by **Kripa Foundation**.

ANNEXURE 10

MEDICAL CASE SHEET

Regn. No.

Name : Age : Date of Registration :

Drinking / Drug History (refer Annexure 2)

Previous history

Withdrawal symptoms experienced when the patient stopped

	Alcohol	Drugs
☐	Tremors	Tremors
☐	Insomnia	Insomnia
☐	Fits	Diarrhea
☐	Nausea	Severe pain
☐	Aches / Pains	Restlessness

Other psychiatric complications

- ☐ Depression
- ☐ Suicidal ideation / attempts
- ☐ Confusion
- ☐ Aggressive outbursts
- ☐ Hallucinations
- ☐ Paranoid ideas

History of other medical problems in the past

- ☐ Haematemesis
- ☐ Jaundice
- ☐ Abscesses
- ☐ Bleeding piles
- ☐ Skin problems
- ☐ Any other

Chronic health problems

- ☐ Diabetes
- ☐ Liver disorders
- ☐ Epilepsy
- ☐ Respiratory problems – Pulmonary TB / Chronic Bronchitis / Bronchial asthma
- ☐ Cardiac problems – HBP / IHD / RHD
- ☐ Infections
- ☐ Others

History of previous head injuries, if any

Other information

Use of Tobacco products – Smoking / Pan chewing / Others :
Knowledge of allergy to specific drugs :
Family history of alcoholism / drug abuse / psychiatric illness :

Physical condition at the time of admission

Physical examination on the day of admission

Pulse rate Blood pressure
Urine sugar Weight

* Tremors	* Jaundice	* Malnutrition
* Lymph nodes	* Loss of body hair	* Clubbing of nails
* Glossitis	* Wasting of muscles	* Spider naevi
* Flushed face / excessive sweating	* Abscess	* Anemia
* Palmar erythema		* Gynaecomastia
* Pedal Edema		* Injection marks

Record abnormalities, if any, on examination of the following :

Respiratory system	Yes / No
Cardio vascular system	Yes / No
Gastro intestinal system	Yes / No
Nervous system	Yes / No

Medication provided during treatment

Date / month	Complaints	Medication	Reasons for continuing / change of medication	Signed by physician

Any untoward incident occurred during treatment Yes No

If yes, describe the incident

Action taken:

Referral to other organisations

Date of referral:
Need for referral: Medical Psychiatric problems
Name of the institution where referral was made

B.P. CHART

Name : Age :
Reg. No:

Date	Time	B.P.	Pulse	Medication

TEMPERATURE CHART

Name ..... Age .....
Month ..... Year .....
Diagnosis.....

Date											
Hours	7	13	19	7	13	19	7	13	19	7	13	19
F												
107												
106												
105												
104												
103												
102												
101												
100												
99												
98												
97												
Pulse : B.P.												

ANNEXURE 11

STOCK REGISTER OF MEDICINES
(pertaining to detoxification and emergency medical conditions)

Date	Items	Available stock in No.	Nurse's signature

ANNEXURE 12

ATTENDANCE REGISTER

For patients

Name of patient	Date / Present / absent 1 2 3 4 5 6 7 8 9 10

For family / support person

Name of family member / support person	Date / Present / absent 1 2 3 4 5 6 7 8 9 10

ANNEXURE 13

IDENTITY CARD
Name of the Organisation and Address

Name of the Patient :

Address :

Year of Admission :

Registration No :

ANNEXURE 14

Administrative Manual - A Manual on the functioning of the organisation

- Vision of the organisation
- Milestones in the growth of the organisation
- Organisation chart
- Functions of the organisation
- Registrar of Societies – formalities to be adhered to
- Grant application and other relevant material
- Contract for renting the premises
- Staff details
- Staff welfare measures – leave rules, list of holidays
- Information about issues like electricity, water, telephone etc.
- Code of ethics

ANNEXURE 15

Vocational rehabilitation unit- Assessment form of trainees

Name & Address: Reg. No. Name of counsellor:

Age:

Education:

Marital status:

Kind of drugs abused	Years of abuse	Year of treatment	Period of sobriety

Follow-up

Regularity of follow-up
Regularity for NA / AA

Work experience

Details of any skill training undergone:
Details of past employment if any:
Counsellor's remarks, if any
Reasons for initiation to vocational training:

ANNEXURE 16

NETWORKING DIRECTORY - SPECIALISED SERVICES

- Vocational Training Centres
- Job placement services
- Half way homes / After Care Centres
- HIV Rehabilitation Centres
- Day Care Centres

Name of the Organisation :
Address :
Phone No. :
Contact person :
Services provided :
Admission procedure :
Charges levied :
Any other remarks :

ANNEXURE 17

CONGRATULATORY LETTER

Dear.....,

Congratulations! You have successfully completed one year without alcohol and drugs. In addition, you have also made many positive changes in your life after treatment. All of us here are delighted and send our best wishes for many more years of sobriety.

Your efforts through follow-up have made it possible for you to stay sober. Your family members have also extended their support for your recovery. We hope you will continue these efforts to safeguard your sobriety in the future too.

We would like you to come to the centre and share with the patients who are currently undergoing treatment. Your experience will provide hope for them and increase their motivation to recover. This will be a gratifying experience for you. Do let us know in advance your convenient date so that we can make arrangements.

Wishing you many more years of sobriety.

With best wishes

Yours sincerely,

COUNSELLOR

ANNEXURE 18

PROFILE OF THE HOST ORGANISATION

Name of the organisation	:
Address	:
Telephone No	:
Contact person	:
Year of establishment:	
Services provided	:
Community's perception regarding the services provided by the organisation (interview five persons who have made use of their services)	:

ANNEXURE 19

REGISTER FOR PROVIDING TREATMENT TO PATIENTS REFERRED BY INDUSTRIES

Name of the patient	:
Name of the industry	:
Department where the patient works	:
Department / individual who referred the patient	:
Problems due to addiction in the area of work	:
Date of admission	:
Date of discharge	:
Type of intervention / treatment provided	:
Remarks by the counsellor	:
Date & signature of counsellor	:

MH-8.

Mental Health Situation In India

BASIC NEEDS INDIA.

"Since eleven years he is suffering from mental illness but in these years he never got any other physical illness. It is really surprising ... not even fever for that matter ... Why does he live.. ? Why doesn't he die soon due to some other dreadful illness .. ? This is how we often feel about him" – **father of a person with mental illness**

Abstract. Mental disorders have profound implications on the health and well being of not only individuals but also of families and entire communities. The magnitude of the problem is increasing day by day with the rapid changes in the life style of the present demanding society. In the process of understanding this paper, we are presenting the mental health scenario in three levels. Firstly, we are trying to give you the ground realties behind mental illness. Secondly, we are trying to give you an idea about available infrastructure and their current situation in terms of human resource, existing government hospitals and private facilities. Lastly, to acquaint you with the government initiatives and legislations regarding mental health.

Mental, behavioral and social health problems are an increasing part of health problems in the world and in India too. Though the burden of illness resulting from psychiatric and behavioral disorders is enormous; it is grossly under represented by conventional public health statistics, which lead to focus on mortality rather than morbidity and dysfunctional. The number of people with mental illness will increase substantially in the coming decades for following reasons. First the number of people living in the age groups of risk for certain illness is increasing because of the changes in the demographic features. Thus there has been increase in the number of person with mental illness in the age group of 15- 45 years. Secondly, there has been substantial increase in the geriatric population having mental health problems, as the life expectancy is increasing. Thirdly, overall increase in the rate of depression seen in all age groups as an effect of changing socio- cultural-economic and political situation.

Mental and behavioral disorders account for 12% of the global burden of disease. It is estimated that nearly 450 million people suffer from a mental or behavioral disorders in the world. Nearly 10 % of disability adjusted life years (DALYs) across all age groups are due to depressive disorders, suicides and alcohol related problems. Depression ranks third among men and second among women, yet mental health budgets of most of the countries is less than 1% of the total health expenditure.

The current situation with regard to mental health care is characterized by (i) very limited mental health care facilities;(ii) grossly inadequate professionals to provide mental health care; (iii) less than 10% of those needing urgent care are getting any modern medical care; (iv) families are the current care providers but with limited support and skills for care; (v) no support schemes for voluntary organisation; (vi) lack of a regular mechanism for public mental health education; (vii) limited administrative structure for monitoring the mental health programme and (viii) limited budget for mental health care as part of the total budget.

569
7/10/06

for info BP | SJC | NT | RNTN
send back to filing

BPD | SJC

1) one copy to the clinical team member
2) Send a copy to Library resource file immediately
3) ⇒ circulate the original to all the members

Ground realities

1. Demographic characteristics

India is a country with an approximate area of 3287 thousand square kilometer (UNO, 2001). Its population is 1.081 billion and the sex ratio (men per hundred women) is 106 (UNO 2004). The literacy rate us 68.4 % for men and 45.4% for women. The proportion of population under the age of 15 years is 32 % and the proportion of population above the age of 60 years is 8%. The life expectancy at birth is 60.1 years for males and 62 years for females. The healthy life expectancy at birth is 53 years for males and 54 years for females

2. Prevalence:

A majority of the classical psychiatric epidemiological studies in the last four decades have been population based, focusing on general psychiatric morbidity in a small to medium population. A conclusion arrived at from these house-to-house surveys:

- It is estimated that 1 percent of the population suffers from severe mental disorders
- Ten percent of the population is reported to have common mental disorders.
- The reports also reveals that 15 – 20 % (in some studies it is 40 %) of the people approaching primary health care centers, general hospitals or private clinics for general health problems requires psychiatric assessment and evaluation. But most of them are not aware of it. They think and believe that they have some physical illness, and take various methods of treatment for relief, often in vain.

If we project this figure in our country, there would be little more than 10 million population suffering from severe mental illness, and the figures for common mental disorders will be 10 times to that of severe mental illness.

3. Treatment

Mental health care has always been influenced and determined by contemporary beliefs, and India is no different. Traditionally, mentally ill people were often cared in temples and religious institutions, based on the principles that mental illness is a form of spiritual affliction and could thus be cured by religion. Superstition with inadequate mental health services in the community makes people with mental illness to subject to various harmful treatments, they are subjected to black-magicians, village quacks and witches and physical abuse in the name of treatment. They are kept outside the margin of the community meaning chained, locked in the rooms, wandering in the streets, staying for ever in closed wards of asylums, hospitals, etc.

4. Stigma and discrimination:

A large section of people with mental illness are still inside their houses without any treatment, because their family members don't recognize the illness

or they find it embarrassing to be recognized as family member of mentally ill who are commonly called as 'mad'. There is a fear that they would be victims of disgrace and indignity and thereby they loose the status or acceptance they enjoy in the community. The stigma is so tremendous, people feel ashamed and deny the illness. Therefore, the first and foremost element that shrouds the realm of mental illness is stigma attached to it. The very thought of some one in the family getting mental illness is a big shock and they do not want to believe it.

Due to stigma attached to the families, people with mental illness become the victims of discrimination and human rights abuse. The discrimination is seen from the family members and goes right up to the policy makers and state authorities. The attitude of the public is that, who care what we do for people with mental illness. People with mental illness have been treated as second-class citizen with no adequate facilities given either the state or the central government. As a result they face chronic ill health, and are an economic & social burden to the community leading to social destitution. Soon families loose hope and are left to the mercy of others.

5. Legal discrimination:

As per the law, a person with mental illness cannot sign any documents of sale, purchase, lease or any contract The act is silent on these issues during the lucid moments/stabilized stage. Family members, mostly brothers, take undue advantage of this clause to deny the property rights to the person with mental illness; end up with ensuring the chronic mental illness, so that the so-called sane siblings enjoy the property.

Marriage and Divorce Act also permits legal separation of life partners if one of them is found to be mentally ill (certified by a psychiatrist). Generally in rural communities men are permitted to marry for the second time if his first wife is suffering from any disease like mental illness, epilepsy and etc. On the other hand if a married man becomes mentally ill, community insists wife to be caregiver and undergo all the problems. If a family has person with mental illness, eligible boys and girls getting life partner is almost next to impossible because of the stigma and is seen as a family illness. There are occasions where they hide the information and after marriage, problems erupt. It is also common a close relative getting pressurized to marry such a person.

6. Poverty and mental illness

Poor people with mental illness are not only vulnerable due to their condition, but also the vulnerability brought about by poverty, which is a consequence and to some extent cause of their condition. One of the main reasons that people find it hard to accept people with mental illness as equal members of their communities is that they do not see them as capable of contributing to the household or the community. For decades, researchers have known that poverty and mental illness are correlated; the lower a person's socioeconomic status, the greater his or her chances are of having some sort of mental disorder. Yet determining if one comes first - if being poor renders a

person more susceptible to mental illness, or if mental illness pulls a person into poverty - is decidedly difficult and the relationship between poverty and mental health has long been assumed to be interactive.

Available infrastructure and their status

The major changes in mental health scenario began with the tragedy at Erwadi, the asylum fire in the Ramanathapuram district of Tamilnadu, it was a disaster which opened the eyes of policy makers and the general public to attend to the needs and voices of people with mental illness. During the last 50 years, the place of mental health as part of the general health has changed to some extent. From a situation of no organized mental health care at the time of independence, currently mental health issues are seen as part of the public agenda in few places all the credit goes to judiciary intervention.

A. Regional disparity

The state run health care system in India is striving hard to overcome the regional disparity between rural and urban. The adequate health services and the normal health standards in rural areas seem to be much below the average. Cities and big towns are growing with private health care facilities catering to the needs of middle class and rich communities. The costs for diagnosis and treatment are so exorbitant that some get into debt traps. In rural areas hardly any facilities exist and the attitude of the government health professionals is not at all patient friendly. When people are losing faith in the government health care system, we can imagine what will be the fate of mental health care in India. The budgetary allocation for mental health is very meager, most of it goes to maintenance of hospitals and a very little portion for treatment.

In paper mental health has been stated as part of primary health care system. But in reality, primary health centers are not equipped to treat people with mental illness in their centers. Only few primary health centers (DMHP programme has been implemented) are providing mental health care and treatment in the community.

B. Mental health professionals:

We have limited facilities to train human resource in mental health. The irony is that all this centers have become centers to export trained people abroad. Many mental health professionals are immigrating to other developed countries, where jobs are more lucrative. For instance in 2003 itself, more than 82 psychiatrist sought short term and long term employment in the United Kingdom in response t the latter's international recruitment drive.

Undergraduate training in psychiatry is not changing in spite of many efforts and this continues to be a major barrier to create medical doctors adequately trained in psychiatry after their basic training.

Some of the government and private medical colleges do not have the departments of psychiatry in its full strengths to train the young medical graduates in psychiatry.

The inadequacy of mental health human resource is a major barrier in caring for people with mental illness in the community. Even most of districts don't have public sector psychiatrists. Comparatively mental health professionals are more in the states of Kerala and Tamilnadu. Very few mental health professionals are based in rural areas, most states allow public sector psychiatrist to have private clinics.

Availability of mental health professionals for entire country:

Number of psychiatrist per 100, 000 population	0.2
Number of psychiatric nurses per 100,000 population	0.05
Number of psychologist per 100,000 population	0.03

C. Infrastructures available

Most of the district hospitals are not fully equipped and supplied with psychiatric medicines to treat people with mental illness; most often they are referred to multi specialty centers in the capitals/big towns. The medical professionals view mental health as an alien subject and do not give importance to either learn or practice in their day to day practice.

There are 42 mental hospitals in the country with the bed availability of 20,893 in the government sector and another 5096 in the private sector hospital settings to take care of an estimated 1,02,70,165 of people with severe mental illness and 5,12,51,625 of people with common mental disorders needing immediate attention.

The psychiatric medicines have been supplied only in few primary health centers, community centers and the district hospitals. amitriptyline, lithium, chlorpromazine (CPZ), phenobarbital, phenytoin sodium, haloperidol, carbamazepine, imipramine and resperidone is made available in few district hospital. The rates of resperidone (better drug than CPZ in terms of side effects) is cheaper then CPZ. Drugs like CPZ have been purchased in surplus, which has lesser utility (eg- in Karnataka). Adequate laboratories facilities are lacking in the district hospitals to find out the serum level for lithium administration. None of these drugs are routinely distributed by government to the primary health centers except in some districts, where DMHP is operational.

Child guidance and rehabilitative services are available only in mental hospitals and in big cities, it is not felt important to cascade down so that the services are decentralised.

One third of the mental health beds are in the state of Maharastra and several states do not have mental hospitals. Some mental hospitals have more

than 1000 beds and several still have a large proportion of long stay patients. During the past two decades, many hospitals have been reformed through the intervention of the voluntary organizations, media, national human rights commission and judiciary.

Availability psychiatric beds

Total psychiatric beds per 10,000 population	0.25
Psychiatric beds in mental hospitals per 10,000 population	0.2
Psychiatric beds in general hospitals per 10,000 population	0.05
Psychiatric beds in other settings per 10,000 population	0.01

The survey of 37 mental hospitals conducted between November 2001 and January 2002 revealed a dismal picture, apart from poor infrastructure, the most glorious deficencies are in the area of qualified staff. Some mental hospitals do not have even a single psychiatrist on their permanent roster.

Sl No	Facilities	Adequate		Inadequate	
		Number	%	Number	%
1	Infrastructure	12	32.4	25	67.6
2	Staff	10	27	27	73
3	Clinical services including investigations	16	43.2	21	56.8
4	Availability of medicines and treatment modalities	28	75.7	9	24.3
5	Quality of food	23	62.2	14	37.8
6	Availability of clothing and linen	15	40.5	22	59.5
7	Recreational facilities	18	48.6	19	51.4
8	Vocational rehabilitation facilities	14	37.8	23	62.2

D. General hospital psychiatry:

It is speculated that the birth of general hospital psychiatry in India was due to lack of sufficient funds to open more mental hospitals. These new units needed mobilization of very few resources like a little space in an already functioning hospitals and few mental health professionals to manage the people with mental illness. What started, probably as an economic necessity, has now become a major force in the delivery of health care. A provision for establishment of inpatients wards for people with mental illness requiring admission has been provided in the mental health act. It has to be noted that the psychiatric units in the general hospitals are not well established, and able to take care of psychiatric problems associated with other illnesses.

E. Private psychiatry:

it is interesting to note that very large numbers of private psychiatrist have located themselves in cities which are district headquarters but are not the state capitals. The reason could be that most state capitals have medical college departments of psychiatry or some other governmental psychiatric facility and a private psychiatric facility would be more welcoming in other cities of state where no such facility exists. It seems that distribution of private psychiatrist in India is

some what related to the position of the states in socioeconomic hierarchy. Thus a relatively prosperous and educated states of west and south India (Kerala, Tamilnadu) has highest number of psychiatrist. North zone has proportionately less number with exception from Punjab and Delhi. States of central and east zone have the least number of psychiatrists in private practice.

F. Mental health financing:

The country spends 2.05% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurance and social insurance. Government fund for health services are provided both by the states and the center. In the 10th five-year plan estimates; mental health constitutes 2.05% of the total plan outlay for health. The country has disability act, which has included mental illness as 7th disability, in reality people with mental illness are not availing any benefits under disability schemes.

G. Non governmental organization:

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. NGOs are involved in counseling, suicide prevention, training of lay counselors, and provision of rehabilitation programmes through day care, sheltered workshops, halfway homes, hostels for recovering patients and long term facilities. There are also self help groups of parents and people with mental illness which has been recently established. It has to be noted that most of the NGOs have their setups and outlets in the urban areas catering to the needs of middleclass and upper economic groups.

Policy and legislation

A. National Mental Health Programme (NMHP) 1982

The National Mental Health Program is the outcome of the developments in providing mental health care through different methods as well as the overall goals of the health care in general. The first concerted efforts to formulate a national program were held in July 1981. On August 2 1982, a small group of experts met to consider the revised document and finalize the same. This document was presented to the central council of health and family welfare and the committee recommended the NMHP for implementations.

The **objectives** of the program are:

- To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged of the population
- To encourage application of mental health knowledge in general health care and social development.
- To promote community participation in mental health services development and to stimulate effort towards self –help in the community.

The specific approaches suggested for the implementation of the NMHP are

- Diffusion of mental health skills to the periphery of the health service system
- Appropriate appointment of tasks in mental health care.
- Equitable and balanced territorial distribution of resources
- Integration of basic mental health care with general health services
- Linkage to community

Progress of the NMHP:

From the time of the formulation of the NMHP in August 1982, in the last two decades the following initiatives and activities have been taken up in districts where the district mental health programme been implemented:

- Sensitization and involvement of state level programme officers
- Workshops for voluntary agencies
- Workshops for mental health professionals namely psychologists, psychiatric social workers, psychiatric nurses
- Training programmes in public mental health for programme managers –
- State level workshops for the health directorate personnel, development of models of integration of mental health into primary health into primary health care up to the level of district
- Preparation of support materials in the form of manuals, health records for different types of health personnel and health education materials
- Training program for teachers of undergraduate psychiatry
- Initiation of district mental health programme in 28 districts of 22 states
- Expansion of district mental health programme for 100 districts with the budgetary allocation of 190 corers in the 10th five year plan.

B. The District Mental Health Programme (DMHP)

The DMHP, which operates as part of the National Mental Health Programme was launched in 1996-97 in four districts. By 2000 the DMHP was extended to 22 districts in 20 States and Union Territories and by 2002 the DMHP further extended to 27 districts in 22 States and Union Territories, providing for services to over 40 million of the population. In the current 10th plan period (2003 – 2007) the government has announced the programmes extension to 100 districts across the states, with a total budget outlay of 200 Core rupees

Barriers to reach the goals set out in the in the 1982 document have been many. The goals were too ambitious to begin with and sufficient attention was not paid to all aspects of implementation of NMHP. The first and foremost barrier has been the lack of funding. Though NMHP came up in 1982 the subsequent three five years plans did not make adequate funding allocation. Further even the funds allotted were not fully utilized. It was only in the 9th Five-year plan that a substantial amount of Rs 28 cores was made available and it is projected in the 10th Five-year plan to be Rs 190 cores.

The critical review of District Mental health programme reveals that

a. Lack of administrative clarity to utilize the allocated funds. The programme looked good on paper, but was extremely unrealistic in its targets, especially considering the available resources of manpower and funds for its implementation.
b. The approach was top down and did not take into consideration the ground realities. The poor functioning of the primary health care in India in general as well as the poor morale of the health workers not taken into account. A structure that was attending to given tasks so inadequately would certainly be unable to absorb new targets of integration.
c. The DMHP continues to be the extension of professionals rather than integration of mental health with primary care.

Central Government has sanctioned DMHP in 100 districts in year 2004, the districts are yet to implement the programme and appoint required mental health professionals for the programmes. It has to be noted that few districts do not have psychiatrist and the facilities in the district hospital to support the mobile team of district mental health programme.

C. National Health Policy- 2002

The 2002 health policy refers twice to mental health. In its assessment of the current scenario Section 2.13 states that:

'Mental health disorders are actually much more prevalent than is apparent on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Sometimes, based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance is placed on faith cure. Serious conditions of mental disorder require hospitalisation and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower. NHP 2002 will address itself to these deficiencies in the public health sector'.

Section 4.13 states the policy prescription towards mental health:

'NHP 2002 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff.

The proposed National Mental Health Policy outlines the prioritized agenda for extending within a pragmatic time frame basic mental health care facilities to all sections of the populations across the country by the year 2020.

D. Legislations related to mental health:

The Mental Health Act of 1987 and the Persons with Disabilities Act 1995 are the two legislations that are directly applicable to people with mental illness.

The Mental Health Act (MHA) 1987:

Mental Health Act is "an act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their properly and affairs and for matters connected therewith or incidental thereto". In the Mental Health Act, 1987, a modest attempt has also been made to bring mental illnesses on par with physical illnesses, thus reducing the stigma attached to mental illnesses

It is not simply a. cosmetic improvement over the out dated Indian Lunacy Act 1912, but represents the conclusion of lengthy presentation by the Indian psychiatric society to the Government of India. This Act came into force in April 1993, as per the Government of India order, even though it is still in hibernation in some states. The establishment of mental health authorities, both at the center and state is a welcome step. These authorities are expected to act as friend, philosopher and guide to the mental health services. Provisions have been made for establishing separate hospitals for children under the age of 16 years; for people abusing alcohol and other drugs and for other special groups. Emphasis on outpatient care has been made to safeguard the human rights of the mentally ill person. Stringent punishment has also been lead for those who subject the mentally ill to physical and mental indignity within hospitals.

The notion of care in the community has not been addressed in the current legislation. No effort has been made to provide after care services for the discharged patients. There is no thinking over the alternative to hospital care. Authorities are using the clause of the act leading to many medico-legal problems, and difficulties for the private nursing homes.

The ground realities of its implementation:

The mental health act has not been implemented in Arunchalpradesh, Chattisgarah, Utaranchal, Bihar, and Orrisa

State Mental health Authority has not been constituted in Arunchal pradesh, Chattisgarah, Uttaranchal, Bihar and Orrisa.

Mental health rules have been framed only in Goa, Manipur, Sikkim, Assam, Chandigarah, Delhi, Gujarath, Madyapradesh, Mizoram, and Tamilnadu,

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995:

PWD act came into force on February 7, 1996. This law is an important landmark and is a significant step in the direction of ensuring equal opportunities for people with disabilities and their full participation in the nation building. The Act provides for both preventive and promotional aspects of rehabilitation like education, employment and vocational training, job reservation, research and manpower development, creation of barrier-free environment, rehabilitation of

persons with disability, unemployment allowance for the disabled, special insurance scheme for the disabled employees and establishment of homes for persons with severe disability etc. There are also statutory bodies for implementing the Act at central and state levels.

Even though it is welcoming, that people with mental illness have been considered as disabled in the act, the later chapters of the act does not talk about any provisions to be given or set aside for people with mental illness. The act does not assure right to treatment and make financial provision for the purchase of the psychiatric medicines.

While there is much talk about the implementation or lack of implementation of the Act, there is little understanding about the indicators to measure the level of implementation. At present, conducting a session on the Act or putting up posters on the Act, are referred to as 'advocacy'. A clearly defined set of indicators for the implementation needs to be worked out. There is also a great need to come up with strategies to decentralize the implementation of the Act at the District/ Taluk and village level.

The rate of mental illness is increasing cutting across rich/poor, urban/rural. Though it seems like the states are taking notice of the gravity of the issue and attempts to address the needs of people with mental illness, let us be clear that, this lukewarm response is because of the pressure from the judiciary. Health including mental health is a fundamental right. Millions in India perhaps, don't know that it is their right to avail treatment. People with mental illness are crying **"my name is today"** Do we hear his/her voice?.

M. Sundararaju
T.M.S.S.S
Trichy.

NATIONAL CENTRE FOR DRUG ABUSE PREVENTION (NC-DAP)

INTRODUCTION

- The NC-DAP was set up in NISD in September 1998, in lieu of the existing Bureau of Drug Abuse Prevention to strengthen and provide Technical inputs to the Government of India's Programmes on Drug Abuse Prevention.

VISION STATEMENT

- Empowering Communities for Drug Abuse Prevention

AIMS AND OBJECTIVE

- Raising the competency standards of the functionaries / Raising the competency standards of the functionaries / personnel working in de-addiction centres and other related sectors.
- Invigorating efforts for preventing or minimizing any anticipated or consequent harm related to drug abuse in clients and in the community.
- Standardization of care in drug abuse prevention.
- Updating information and creating a database on extent and pattern of drug abuse and its various interventions at local, regional and international levels.
- Developing standards of monitoring systems of various interventions.

ACTIVITIES

- Capacity building of various levels of functionaries working in the field of Drug Demand Reduction.
- Up-gradation of information and establishment of appropriate database and monitoring systems.
- Development of linkages and networking arrangements in the field of Drug Demand Reduction at local, regional, national and international levels.

TRAINING INITIATIVES BY NC-DAP

- Instituted three month certificate course on De-addiction Counselling & Rehabilitation and 5 day short-term training courses.
- Developed 12 short-term training manuals in collaboration with expert NGOs.
- Established 3 Regional Resource Training Centres in Collaboration with UNDCP.

SHORT-TERM TRAINING MANUALS

- Symptomatic Behaviour & Addictive Personality
- Counselling issues and process
- Rehabilitation & Relapse Prevention – Issues and Modalities
- Prevention and Management of Drug Abuse and HIV / AIDS
- Organisation of Self-help Groups
- Preventive Interventions for High Risk Groups
- Patient profiling, recording and documentation
- Research, RAS & Monitoring of Trends of Drug Abuse
- Programme Management for Families and Codependency of Addicts
- Treatment and Rehabilitation of drug addicts in Prisons / correctional settings
- Training for Youth Coordination of NYK / NSS
- Workplace prevention

ACHIEVEMENTS

- Three month certificate courses on De-addiction Counselling & Rehabilitation
- 21 short-term training courses based on the developed training manuals

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FUTURE ACTION PLAN FOR YEAR 2001

The centre intends to organise the following training courses:

1. 6 Three month certificate courses at national and regional level
2. 50 short-term training courses based on the 12 training manuals
3. courses for Training of Trainers
4. management Development Programmes for the Management / executive members of NGOs
5. orientation on DAMS and subsequent implementation of the activity

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WHAT CAN YOU DO?

- Respond promptly in deputing participants for the courses
- Ensure the eligibility criteria of NC-DAP for the participants, are maintained
- Give regular feedback / suggestions
- Suggest specific subject / issues to be included in training initiatives
- Cooperate in follow-up activities

ELIGIBILITY CRITERIA

- Minimum one to two years experience in the field of Drug Abuse Prevention and Rehabilitation
- Should not have attended any training course organised by this institute
- Should be working as Project Director / Officer, Senior Counsellor, Medical Officer / Doctor and Social Worker having basic knowledge of addiction rehabilitation.
- Participant should be highly motivated towards the cause and likely to stay in the organisation for a minimum period of one to two years.
- Should have good communication skills and able to write, read, speak and understand English.
- Participant should be prepared to stay continuously for full three months without any absenteeism.
- The nominee should be below 50 years of age.

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TEAROFF

Thirteen Principles of Effective Drug Addiction Treatment

More than two decades of scientific research have yielded a set of fundamental principles that characterize effective drug abuse treatment. These 13 principles, which are detailed in NIDA's new research-based guide, *Principles of Drug Addiction Treatment: A Research-based Guide*, are:

1. No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each patient's problems and needs is critical.

2. Treatment needs to be readily available. Treatment applicants can be lost if treatment is not immediately available or readily accessible.

3. Effective treatment attends to multiple needs of the individual, not just his or her drug use. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.

4. Treatment needs to be flexible and to provide ongoing assessments of patient needs, which may change during the course of treatment.

5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.

6. Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.

7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. Methadone and levo-alpha-acetylmethadol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine.

8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.

9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.

10. Treatment does not need to be voluntary to be effective. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.

11. Possible drug use during treatment must be monitored continuously. Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.

12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection. Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.

13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

Principles of Drug Addiction Treatment: A Research-based Guide (NCADI publication BKD347) has been mailed to *NIDA NOTES* subscribers in the U.S. Copies of the booklet can be obtained from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686. The guide also can be downloaded from NIDA's home page at www.drugabuse.gov. NN

NIDA NOTES covers drug abuse research in the areas of treatment and prevention, epidemiology, neuroscience, behavioral science, health services, and AIDS. The publication reports on research; identifies resources; and promotes communication among clinicians, researchers, administrators, policymakers, and the public. Readers are encouraged to identify subject areas they would like to see highlighted.

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NIH Publication No. 99-3478
Printed December 1999