Chapter : 7

Social Welfare Programme with Drug Abuser Past and Present
SOCIAL WELFARE PROGRAMME WITH DRUG ABUSER PAST AND PRESENT

Social welfare, welfare is the state or condition of doing or being well. The term is primarily invoked when some action is considered necessary in order to enhance individual or group welfare—that is when welfare is in some way in doubt. It is, consequently, a term employed first and foremost in the arena of policy, and is intimately linked to the concept of needs, since it is by meeting needs that welfare is enhanced: welfare policies are policies designed to meet individual or group needs. The needs at issue are not merely those necessary for survival, but those necessary for a reasonable or adequate life within the society. They include not only a minimum level of income for food and clothing, but also adequate housing, education, health care, and opportunities for employment (though this is not always included). Precisely how and to what extent these needs are met clearly varies from society to society. During the twentieth century, the role of the social welfare in meeting welfare needs in advanced industrial societies has typically increased. Drug abuse and alcohol has emerged as a serious concern in India. The geographical location of the country further makes it highly vulnerable to the problem of drug abuse. In a national survey conducted in 2001-2002, it was estimated that about 73.2 million persons were user of alcohol and drugs. Of these 8.7, 2.0 and 62.5 million were users of
Cannabis, Opium and Alcohol respectively. About 26%, 22% and 17% of the users of the three types respectively were found to be dependent on/addicted to them. Article 47 of the Constitution provides that "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health." The Narcotic Drugs and Psychotropic Substances Act, 1985, was enacted, inter alia, to curb drug abuse. Within the purview of the Act, "Narcotic Drug" means "coca leaf, cannabis (hemp), opium, poppy straw and includes all manufactured goods", whereas "Psychotropic substance" means "any substance, natural or synthetic, or any natural material or any salt or preparation of such substance or material included in the list of psychotropic substances specified in the Schedule". Section 71 of the Act (Power of Government to establish centres for identification, treatment, etc of addicts and for supply of narcotic drugs and psychotropic substances) contains provisions for setting up of rehabilitation and treatment centres for addicts. India is a signatory to three United Nations Conventions, namely: (i) Convention on Narcotic Drugs, 1961; (ii) Convention on Psychotropic Substances, 1971; and (iii) Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. The erstwhile Ministry of Welfare was formed on 25th September, 1985 by transferring subjects relating to welfare of Scheduled Castes, Scheduled Tribes, Minorities and Other Backward Classes from the Ministry of Home Affairs and the welfare of the Disabled and programmes of Social Defence from the erstwhile Ministry of Social and Women's Welfare. Work relating to Wakfs was
transferred from the Ministry of Law to the Ministry of Welfare in January, 1986. The name of the Ministry of Welfare was changed to the Ministry of Social Justice & Empowerment in May, 1998. In October, 1999, the Tribal Development Division was moved out to form a separate Ministry of Tribal Affairs. In January, 2007, the Minorities Division along with Wakf Unit was moved out of the Ministry and formed as a separate Ministry of Minority Affairs, and the Child Development Division was merged with the Ministry of Women & Child Development.
As a part of the Zero-Based Budgeting exercise, it has been decided to merge the two existing Central Sector Schemes, viz. 'Scheme for the Prevention of Alcoholism & Substance (Drugs) Abuse' and 'General Grant in Aid Programme for Financial Assistance in the Field of Social Defence', with a new nomenclature, i.e. 'Scheme of Assistance for the Prevention of Alcoholism & Substance (Drugs) Abuse and for Social Defence Services' under an umbrella scheme. The Scheme for the 'Prevention of Alcoholism & Substance (Drugs) Abuse' has also been revised to incorporate changes in objectives and financial norms, keeping in view the needs of the changing scenario. The new and revised Scheme thus has two parts viz. (i) 'Assistance for the Prevention of Alcoholism & Substance (Drugs) Abuse' (Part I) and (ii) 'Financial Assistance in the Field of Social Defence' (Part II).

Psychedelic Addiction Therapy? - Old drug treatment methods were a shotgun approach. Doctors were willing to try anything to get
their patients to kick the habit, even things that would seem pretty crazy today. For example, in the 1950s and 1960s drugs like LSD were used experimentally in an attempt to treat alcoholism and other addictions. The idea of using hallucinogenic drugs to treat drug addiction was abandoned as these drugs themselves became illegal. However, addiction treatment with hallucinogens is experiencing a renaissance with the increasing popularity of ibogaine therapy. Ibogaine is derived from a root used in an African religion to "visit the ancestors." Although illegal in the US, some 20 or 30 ibogaine clinics are in operation worldwide primarily to treat heroin addiction. Ibogaine is thought to rewire the addicted brain as the patient undergoes the intense multi-day treatment. Ibogaine is very controversial for many reasons including the occurrence of fatal heart arrhythmia in some patients.

Behavioral and Cognitive Therapy - Counseling, support groups and other forms of therapy are crucial to preventing relapse. In order to stay off drugs, addicts must learn new ways of thinking and behaving. Cognitive and behavior therapy can include such things as learning to: talk openly about personal experiences, manage problems without turning to drugs identify and correct problematic behaviour identify and correct harmful patterns of thinking recognize drug cravings identify and manage high-risk situations establish motivation to change improve personal relationships develop refusal skills manage time more efficient.

The Controversy of Maintenance - The classic example of a maintenance-based drug treatment is methadone. Taken once a day, methadone suppresses heroin withdrawal for about 24 hours. Itself a narcotic, users of methadone experience a "high" and withdrawal symptoms, but both are much milder than those resulting from heroin. As a result, it is possible to maintain an addict on methadone without
severe health effects. But patients often require continuous treatment, sometimes over many years.

The Challenge of Treating Drug Addiction in Jail - Treating addicts who end up in the criminal justice system adds another layer of complexity to the issue. How should law enforcement deal with administering drug addiction treatment? Innovative approaches such as drug court may prove to be the answer. Drug courts deal with offenders charged with less-serious crimes such as possession or being under the influence of drugs. In lieu of serving a jail sentence, offenders must plead guilty to the charge, agree to take part in treatment, get regular drug tests, and report to the judge for at least one year. If they fail to complete any of the requirements they may be incarcerated. But if they complete the requirements, the charges against them are dropped and they graduate from the program.

Victorian-era treatments for alcoholism were often both ineffective and inhumane.

Source: Learn.Genetics, Genetic Science Learning Center, The University of Utah.
In present time drug abuse research/evaluation priority areas of the ministry of social justice and empowerment. The Ministry of Social Justice & Empowerment sponsor evaluation/research study on the welfare programmes/schemes implemented by it for educational, economic and social empowerment of its target groups viz., Scheduled Castes, Other Backward Classes, Pensions with Disabilities, Senior Citizens and victims of Drugs (Substance) Abuse.3

This Ministry of Social Justice & Empowerment is under the charge of Honourable Minister Shrimati Meira Kumar since 24th May 2004. Shrimati Subbulakshmi Jagadeesan is Minister of State since 26th May 2004. Dr Veena Chotray is Secretary since 1st September 2006. Dr. Sundeep Khanna is Additional Secretary since 19th July 2004. Four Joint Secretaries and one Deputy Director-General in the rank of Joint Secretary who head the bureaus of Scheduled Castes Development, Backward Classes, Social Defence, Disabilities and PREM are assisting them. One post of Economic Advisor also in the rank of Joint Secretary remained vacant during the year. The list of subjects allocated to the Ministry is given below:

- Development of Scheduled Castes and Other Backward Classes.
- Scheduled Castes and Other Backward classes including Scholarships to students belonging to such castes and classes.
- Reports of the Commission to investigate into conditions of Backward Classes.
- Education, training, rehabilitation and welfare of the physically and mentally handicapped.
• Convention with other countries in matters relating to social defence and references from United Nations Organisation relating to prevention of crime and treatment of offenders.
• Social and Moral Hygiene Programme.
• Beggary.
• All matters relating to alcoholism and substance (drug) abuse and rehabilitation and rehabilitation of addicts/families.
• All matters relating to prohibition.
• Educational and social welfare aspects of drug addiction.
• Promotion of efforts including voluntary efforts to ensure the well being of the older persons.
• Charitable and religious endowments pertaining to subjects allocated to this Ministry.
• Research, evaluation, training, exchange of information and technical guidance on all social defence matters.

This Ministry is responsible for the implementation of the following Acts:-
• The Protection of Civil Rights Act, 1955.
• The Scheduled Castes and the Scheduled Tribes (Prevention of Atrocities) Act, 1989.
• The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (01 of 1996).
The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (44 of 1999).


CONSTITUTIONAL/STATUTORY/APEX BODIES

- National Commission for Scheduled Castes.
- National Commission for Backward Classes.
- Dr. B.R. Ambedkar Foundation.
- Rehabilitation Council of India. 4 Chief Commissioner for Persons with Disabilities.
- The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities.

The erosion of joint family structure has made a great impact on the entire support system within the community available to the needy of all ages and categories. As per the Government of India (Allocation of Business) Rules, 1961 relating to the areas of social defence the Ministry is broadly responsible for policies and programmes for rehabilitation of alcoholics and victims of drug addiction. The multi-pronged programmes and the policies of the Ministry in the area of social defence aim at equipping this group with varied services for growth and development to become active, self-reliant and productive contributors to the national economy. All the programmes are meant to prevent neglect, abuse and exploitation and to provide assistance to mainstream them. In order to rehabilitate and empower these categories, the Ministry works in close collaboration with voluntary organizations.
The interventions are meant to play the role of a catalyst and promote community action. The State Governments, autonomous bodies, NGOs, and even the corporate world are involved in formulating and implementing these policies.5

In the area of Social Defence, the Ministry mainly focuses on policies and programmes for: (i) Senior Citizens, and (ii) Victims of Substance (Drug) Abuse. The Ministry develops programmes and policies for these target groups in close collaboration with State governments, Non-Governmental Organisations and civil society. The programmes for senior citizens aim at their welfare and maintenance, especially for indigent senior citizens, by supporting old age homes, day care centres, mobile medicare units, etc. For victims of substance abuse, the programme is for drug demand reduction which is achieved through awareness campaign and treatment of addicts and their detoxification so that they may join the mainstream. These programmes are implemented through Non-Governmental Organizations with financial support from the Ministry.

Relevant Constitutional Provisions - Article 41 of the Constitution provides that the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want. Further, Article 47 provides that the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health.
Legislations - The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007, to ensure need based maintenance for parents and senior citizens and their welfare.

The Narcotic Drugs and Psychotropic Substances Act, 1985, was enacted inter alia, to curb drug abuse. Section 71 of the Act provides that, “the Government may, in its discretion, establish as many centres as it thinks fit for identification, treatment, education, after-care, rehabilitation, social reintegration of addicts and for supply, subject to such conditions and in such manner as may be prescribed, by the concerned Government of any narcotic drugs and psychotropic substances to the addicts registered with the Government and to others where such supply is a medical necessity.”

The social scenario in the country has been fast changing due to rapid urbanisation and industrialisation. The unending flow of rural population to the already crowded cities and towns in search of employment has resulted in serious problems like overcrowding, emergence of pavement/slum dwellings, breakdown of joint family system, unemployment, poverty etc. In this process, certain categories of population, who failed to cope with these rapid changes, have started lagging behind the rest of the society due to their vulnerability. They include Persons with Disabilities viz. - locomotor, visual, hearing, speech and mental; the Social Deviants, who come in conflict with law viz. - juvenile delinquents/vagrants, drug addicts, alcoholics, sex-workers, beggars etc.; and the Other Disadvantaged viz. - the elderly, the destitutes, the deserted, street children etc. All these categories need special attention of the State because of the vulnerabilities and the disabilities, they suffer from. To safeguard the interests of the
disadvantaged sections of the Society, the Constitution of India guarantees that no person will be denied 'equality' before the law (Article 14). It also promises 'right to education' and 'public assistance' in the old age and disablement (Article 41). To safeguard the interests of these groups, some important legislations were also enacted. They include - the Immoral Traffic (Prevention) Act, 1956 (as amended and retitled in 1986); the Probation of Offenders Act, 1958; Juvenile Justice Act, 1986; the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988; the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995; Prevention of Beggary Acts (State Acts) etc. Simultaneously, the Government has also undertaken many welfare-cum-developmental measures right from the First Five Year Plan with the major objective of extending preventive-cum-curative-cum-rehabilitative services to meet the special needs of these vulnerable groups. Thus, the developmental planning has been made responsive right from the beginning not only to attend to the existing problems but also to address the situations emerging from time to time.

According to the Ministry of Social Justice and Empowerment, about 3.05 lakh persons were reported to have been subjected to various addictions during 1996-97. Data on the prevailing situation of addiction to toxic substances indicate that the traditional problems of alcoholism and opium addiction continue to be very high with 42 per cent and 20.5 per cent, respectively. While the problem of traditional addictions persists with a higher magnitude, the emergence and the increasing free flow of narcotics has become a cause for concern. The drug addiction especially in the country has reached an alarming situation and continues to be unabated. Realising the ill-effects of alcoholism on the
family and other social institutions, a few States have enforced Prohibition laws. Social movements like that of the Anti-Arrack movement led by women of Andhra Pradesh, Haryana and Himachal Pradesh holds testimony to other States for action against alcoholism. No doubt, voluntary organisations have a significant role to play in this direction, as they can mobilise mass movements not only to abhor the practice of alcoholic consumption through various preventive, curative and rehabilitative services, but also by creating awareness through constant propaganda about the ill-effects of alcoholism and other addictions.

Drug and alcohol abuse is a matter of great concern in India both due to the social and economic consequences as well as due to its established linkage with HIV/AIDS. The onus of responding to the problems associated with drug use lies with the central and state governments. The constitution of India under Article 47 directs the government to prohibit use of these substances except for medical purposes. The various drug de-addiction programmes of Government of India have to be seen in this light. The activities to reduce the drug use related problems in the country could broadly be divided into two arms: supply reduction and demand reduction. The supply reduction activities which aim at reducing the availability of illicit drugs within the country come under the purview of the Ministry of Home Affairs and the Ministry of Finance with the Department of Revenue as the nodal agency and are executed by various enforcement agencies. The demand reduction activities focus upon awareness building, treatment and rehabilitation of drug using patients. These activities are run by agencies under the Ministry of Health and Family Welfare, and Ministry of Social Justice and Empowerment. The role of the Ministry of Health
Family Welfare is to address reduction of their demands through: Providing treatment services, Providing long-term care (medicines), Providing aftercare, and Providing health education. However, to provide effective and acceptable de-addiction services to a very large number of drug and alcohol users in India is a herculean task, which requires concerted efforts from several ends.

India is a Welfare State, committed to ensure the 'Well-Being' and 'Quality of Life' of its people in general and of vulnerable sections in particular. The Preamble, Directive Principles of State Policy and Fundamental Rights in the Constitution of India stand testimony to the commitment of the State to its people. These provisions envisage a very positive role for the State in bringing about groups of society. It reflects its special concern for the welfare and development of the Disabled through special provisions to safeguard their rights. According to Entry 9 in the List II of Schedule 7 of the Constitution, the subject of 'Relief to the Disabled and Unemployable' is the responsibility of the State Governments. Article 14 of the Constitution states that the State shall not deny to any person equality before the law or equal protection of the laws within the territory of India. While Article 15 of the Constitution prohibits discrimination against any citizen on the grounds of religion, race, caste, sex etc. Article 15(A) (e) directs the State to renounce the practices derogatory to the dignity of women. Article 16 provides for equality of opportunities in matter of public appointments beings and forced labour; Article 24 prohibits employment of children below 14 years of age in any factory of mine or other hazardous occupations. Article 38 directs the State to strive for minimizing the inequalities in income, status, facilities and opportunities amongst groups of people, towards securing proper distribution of ownership and control of
material resources so as to subserve the common good. Article 41 states that the State shall, within the limits of its economic capacity and development make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want. While Article 45 provides for free and compulsory the children up to the age of 14 years, Articles 46 lays down that the State shall promote with special care the educational and economic interests of the weaker sections of the people. Article 47 states about the duty of the State to raise the level of nutrition and the standard of living and to improve public health. The problem of drug abuse received special attention during Eighties in respect of its control and extending welfare cum rehabilitative services. The Narcotic Drug and Psychotropic Substances Act of 1985 was amended in 1988 to make the law stringent for effective control over narcotic drugs and psychotropic substances. Subsequently, the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act (1988) was passed, which provides for preventive detention of persons trafficking in drugs. The enforcement machinery was also strengthened.9

The socio-economic situation in the country has been fast changing since the mideighties, especially as a result of the New Economic Policy. The concept of liberalization is reflected in the new trends in the economy of the urban areas. In the rural and tribal areas however, though the impact of market-friendly economy has made some inroads, the rural poor who are assetless and unskilled have not been able to benefit from the radical changes that have taken place in the economy. There is an increasing recognition that economic growth, although essential for dealing with many social problems, often is
accompanied by acute social problems in the absence of deliberate social planning. A strategy of overall development should, therefore, include as an essential component, those social welfare activities that help to ensure that national plans and policies are fully responsive to the needs and aspiration of the people. While remedial measures still remain essential, high priority would be accorded to the developmental and preventive functions of social welfare. The Government of India had resorted to planned development as early as 1951 for minimizing inequality in income, status and opportunities of its people. Reduction in the incidence of poverty, drug abuse, and improvement in the quality of life by bringing about opportunities of self-development and employment continue to be the basic approach. The objective of a sustained and equitable development is being pursued not only by ensuring rapid economic growth and redistribution of income and provision of basic social services for the deprived but also generating the participation of such people in improving their own life. Many policymakers and the general public have long believed that at least a good portion of welfare recipients were not working and remained unemployed for long periods of time because of alcohol and other drug (AOD) use. Actual data about the incidence of such use have often been conflicting and incomplete. As the easier-to-place welfare recipients move out to work, the remaining pool is more likely to comprise those with the most recalcitrant impediments to steady employment. Alcohol and other drug dependency is widely considered to be one such barrier. Having been given broad authority under to test and sanction welfare recipients for use of controlled substances, a few states have integrated responses to substance abuse into their welfare-to-work programs and are showing promising results.
Program on Poverty and Social Welfare Policy:
- Low schooling.
- Little work experience.
- Lack of the job skills and credentials employers value.
- Lack of "work readiness."
- Worries about employer discrimination.
- Mental health problems.
- Alcohol and drug dependence.
- Physical health problems and family stresses.
- Experiences of domestic violence.

Various lists of this type have been developed, some longer, some shorter. The greater the number of obstacles, the less likely a recipient is to find and keep work. None of the lists cite substance abuse as the barrier faced by the greatest number of recipients. It is, however, recognized as one of the most daunting. Research on the ability of such barriers to derail employment success indicates that, if substance dependence (as opposed to substance use) is combined with any one or two of the other employment obstacles, a welfare recipient has a less than 60 percent probability of working.

Concomitant with social work value base, this research highlights that practitioners must not make assumptions or generalise about the impact of parental problem drug use on the child. Parental problem drug use should not be addressed in isolation but should be viewed as part of the whole picture to ensure that the implications for the child are properly assessed. For example research shows that many families with parental problem drug use will experience financial difficulties or significant poverty and research has shown a link between poverty in childhood and poorer employment prospects in adulthood (Feinstein and
Drug abuse, now more than at any point since welfare reform, is also the least obvious explanation for why some families require public assistance.

The First Five Year Plan (1951-56) recognized the importance of promoting social services for maintaining and consolidating the gains of economic development, attaining adequate living standards and social justice. Accordingly, a comprehensive Social Welfare Programme that was developed during the First Five Year Plan included welfare of Women and Children, Family Welfare, Welfare of the Physically and Mentally Disabled. The Central Social Welfare Board was set up with the object especially of assisting voluntary agencies in organizing welfare programmes for Women and Children and the Disabled Groups. In September 1955, the Ministry of Education constituted a National Advisory Council for the education of the physically disabled. The functions of this Council were to advise Central Government on problems concerning the education, training and employment and the provision of social and cultural amenities for the physically and mentally disabled to formulate new schemes and to provide liaison with voluntary organizations working in the field. In the Ninth Five Year Plan, the approach to the Social Welfare was distinct from earlier Plan approaches, because it sought to adopt a three fold strategy specific to each individual group namely, i) Empowering the Persons with Disabilities; ii) Reforming the Social Deviants; and iii) Caring the Other Disadvantaged, through various preventive, curative, rehabilitative and developmental policies and programmes. The major strategies adopted in the Ninth Plan for Reforming the Social Deviants are – I) tackling the increasing problem of Juvenile maladjustment through - i) close collaboration with Governmental and Non-Governmental organizations
for effective enforcement of the Juvenile Justice (JJ) Act, 1986; ii) ensuring minimum standards of service in various mandatory institutions set up all over the country under J.J. Act, 1986; iii) encouraging more and more voluntary organizations to take up the responsibilities of extending welfare-cum-rehabilitative service for Reforming the Juvenile Delinquents/Juvenile Vagrants and other children who come into conflict with law; II) To control/reduce the ever-increasing emerging problems of alcoholism, drug addiction, HIV/AIDS through - i) strict enforcement of legislation to prohibit/restrict the production of alcoholic drinks with necessary punitive measures; ii) expanding the services of preventive, curative and rehabilitative services for problems of alcoholism, drug addiction, HIV/AIDS through counselling and running of de-addiction camps and centers; iii) developing an integrated strategy involving all concerned to curb the ever-increasing inter-related problems of drug addiction and HIV/AIDS; and iv) launching of awareness generation programmes/campaigns to educate/sensitize and make people, especially the younger generation, conscious of the ill-effects of these problems.11

Ministry of Health & Family Welfare - In the field of health a number of ongoing programmes have a direct bearing on the prevention and reduction of The Leprosy Eradication Programme is sought to be tackled through various measures such as extension of Multi-Drug Therapy in uncovered areas, health education and training activities and corrective surgery. is not only confined to the traditional abuse of alcohol, opium and cannabis but a new dimension is emerging through induction of synthetic drugs, Injecting drug use and pharmaceutical substance abuse. Research studies, the Country Profile (UNDCP) and the Progress Reports received from NGOs working among alcohol and
drug addicts not only indicate an increasing trend of addiction but also point out its prevalence among various sections of the society. To control the supply and demand of drugs and alcohol, a two pronged strategy has been adopted. While control of drug supply is taken care of by the Narcotics Control Bureau, the Ministry of Social Justice and Empowerment is the nodal Ministry for drug and alcohol demand reduction. The main objectives of the alcohol and drug demand reduction programme are i) building awareness and educating people about ill effects of drugs; ii) dealing with addicts through a well rounded programme of motivation, counselling treatment, follow-up and social re-integration of the addicts; iii) capacity building through imparting drug abuse prevention and rehabilitation training to service providers. Since drug abuse and alcoholism is a psycho-sociomedical problem, the Ministry of Social Justice and Empowerment has provided a whole range of services including awareness generation, identification, treatment and rehabilitation of addicts through voluntary organizations.

New Initiatives - The National Centre for Drug Abuse Prevention (NCDAP) was set up in 1998, with assistance from United Nations International Drug Control Programme (UNDCP). This is in lieu of the already existing Bureau of Drug Abuse Prevention in the National Institute of Social Defence. The main activities of the Center include i) providing training to various levels of functionaries working in the field of drug demand reduction; ii) upgradation of information and establishment of appropriate database and web-site and; iii) development of linkages and networking in the field of drug demand reduction and local, national and international levels. To increase its outreach, NCDAP is setting up 5 Regional Resource Training Centres with the help of NGOs having technical capability and expertise. The
Centre has also developed training manuals in 13 specific areas of - i) symptomatic behaviour and addictive personality; ii) Counseling Issues and Process, iii) Rehabilitation and Relapse Prevention; iv) Prevention and Management of Drug Abuse and HIV/AIDS; v) Organisation of Self-Help Groups; vi) Preventive Interventions for High Risk Groups; vii) Patient Profiling, Recording and Documentation; viii) Research, RAS, Monitoring of Trends of Drug Abuse; ix) Programme Management for Families and Co-dependency of Addicts; x) Treatment and Rehabilitation of Drug Addicts in Prisons/Correctional Setting; xi) Drug Abuse Prevention Programme for Medical/Para Medical Functionaries; xii) Training for Youth Coordinators of National Level Networks; xiii) Work Place Prevention. Special initiatives are being taken in the North East in view of the enormity of the problem and the close nexus between injecting drug use and HIV/AIDS. A three pronged strategy was adopted for the North East which includes training and enhancing the capabilities of the NGOs in the area, extending the outreach of drug abuse prevention scheme by opening of new centers and awareness and education programmes. Five training programmes for Trainers, and 15 training courses for Service Providers in the North East as well as attachment training of Service Providers in reputed centers have also been implemented. In order to provide for better training and qualified personnel amongst service providers, the Ministry of Social Justice and Empowerment had taken up in collaboration with UNDCP and International Labour Organisation (ILO), a number of projects which include ‘Community Drug Rehabilitation and Work Place Prevention Programme’. Under this programme, 20 NGOs have been identified all over the country with the objective of training at least 4000 service providers in rehabilitation of drug/alcohol addicts. Two
other major projects being implemented are ‘Community Wide Drug Demand Reduction in India’ and ‘Community Wide Drug Demand Reduction in the North East States’. The major objective of these projects is to develop the capacity of the Drug Demand Reduction Programme and institutions adequately to address the increasing incidence of alcoholism and drug abuse in the country and for the North East in particular. In another collaboration with UNDCP, UNICEF, WHO, NACO and ODA, a Project on Reducing Risks Behaviours and HIV/AIDS/STD Drug Abuse among Street Children was taken up. City level plans have been prepared for the cities of Mumbai, Hyderabad, Calcutta and Delhi. A National Action Plan has been formulated to strengthen the intervention of drug demand reduction programme for the street children. To assess the magnitude, nature and pattern of drug abuse in the country, the Ministry of Social Justice and Empowerment, in collaboration with UNDCP, is conducting a National Survey. The Survey will provide authentic information on the actual dimension of the problem and facilitate appropriate need-based interventions to address the problem of alcoholism and drug abuse in the country.

The critical and persisting issues in this programme is that in spite of the revision of the Scheme, it has not been possible to take the scheme to the needy groups especially in the rural areas. In fact, the State Governments have not developed ownership of this programme even through the spread of drug addiction and its lethal combination with HIV/AIDS have serious implications for them. The Scheme would receive best coverage if the local NGOs, the PRIs and the local bodies network in setting up facilities in the community. Another problem area is the tardy rehabilitation achievement. Though, the ultimate goal of the treatment for alcohol and substance abuse is complete rehabilitation of
the addict or “Whole Person Recovery” (WPR), yet the relapse rate of addicts treated in the Government assisted voluntary agencies is as high as 80-85%. This is because the ongoing programme does not provide for in-depth rehabilitation services. Nor is there standardization of facilities of services. There is very little interventions and facilities designed for certain high-risk groups such as street children, sex workers, etc.

Though, the North-Eastern region has been acknowledged as a high drug and IDU induced HIV/AIDS area, yet except for Manipur which has 20 NGOs working in the State, other States like Meghalaya, Mizoram, and Nagaland have just about 2-7 Centers. In the case of alcohol consumption, though the National Endeavor is to reduce the production of liquor, and introduce prohibition, yet State Governments have not taken any measures in this direction for fear of losing excise revenue on alcohol.

National Institute of Social Defence (NISD) - The NISD is the only Institute of its kind at the national level for relevant interventions in the area of Social Defence. The objective of the Institute is to strengthen and provide technical inputs to the Social Defence Programmes of the Government and to train manpower resources for this purpose. The main areas of activities covered by the Institute include documentation, research and conducting training programmes pertaining to Juvenile Justice administration, child adoption, systems involved in child protection, drug abuse prevention and care of senior citizens. It also undertakes review of policies and programmes in the field of social defence, anticipate and diagnose social defence problems and develop preventive, rehabilitative and curative policies.

REFORMING THE SOCIAL DEVIANTS: Drug(s) abuse - Social deviance, as a form of human behavior that fails to conform to
the accepted social norms, has its genesis in the intricate relationship between the individual and the environment with which he/she constantly interacts. It is, therefore, imperative that the objective should be to tackle the problems of social deviance by considering the recent development in Social Sciences and providing a deeper understanding of phenomenon of crime. Among various forms of social deviance, drug abuse poses a serious threat to the well-being and welfare of people in the country. There is ample evidence to establish that our country is no more a transit country alone for lethal drugs originating from 'golden triangle' or 'golden crescent'. Apart from schools, a wide range of narcotic drugs and psychotropic substances are reported to be consumed among various population groups. The interrelationships between drug abuse and HIV infection on one side and between drug trafficking and terrorism on the other has compounded the problem. Though India has enacted a comprehensive legislation to curb trafficking in and abuse of drugs and taken many a initiative to reduce the demand, there is no indication of the trend being reversed. Besides strengthening the implementation of the law, the need for expanding and consolidating the network of awareness generation and the identification, treatment, counselling and rehabilitation of addicts is being strongly articulated in knowledgeable circles. There is also an urgent need for strengthening an effective mechanism to coordinate efforts on the part of governmental and non-governmental agencies concerned with drug abuse and related issues. While formulating the Tenth Five Year Plan, focus should be given for consolidation and expansion of existing programmes and also to give a definite thrust for developing appropriate / suitable services for various categories of Social Deviants. the Steering Group suggests the following recommendations:
The problem of drug abuse should be tackled both by controlling the supplies and by reducing its demands. India is a transit and consuming country of drugs. For demand reduction far more definite and concrete action is called for.

- Once, the results of the National Survey are available, a National Policy on Alcohol and Drug Demand Reduction should be adopted. The Policy may include strategy/approach – supply and demand control measures, awareness generation, counseling, treatment, rehabilitation, international cooperation and manpower development, etc. While the existing De-addiction-cum Rehabilitation Centres may be consolidated on the basis of certain minimum standards, priority should be given for preparing a map of affected areas for setting up of new Centres.

- Success of prohibitory measures taken against alcoholic abuse depends heavily on people’s participation which should be generated through concerned action. In order to coordinate all aspects of alcohol and drug demand reduction and to review the situation and advice the nodal Ministry for appropriate measures, a Core Committee on Drug Abuse Prevention should be set up by the Ministry of Social Justice and Empowerment

- To deal with the problem of drug abuse prevention, training programmes must be provided for service providers, family, community and others. The training content of drug abuse control in the medical profession, social work, nursing profession, prison officials, police should be geared up to deal with the newly emerging variations in the problem of drug abuse prevention such as IDU induced HIV/AIDS.

- The focus of the existing Counseling Centres for prevention of drug abuse which are being presently supported for identification of the addicts and motivating them for treatment should be shifted to identify
vulnerable and potential high risk groups in the society and ensuring that they do not fall prey to drug addicts. Special facilities need to be created for treatment of groups like street children, women, sex workers etc. There should be increase in number of camps in rural areas for prevention and treatment of addiction.

- Rehabilitation of addicts, or Whole Person Recovery (WPR) should be the objective of treatment of the addicts. To ensure effective implementation, maintenance of minimum standard and uniformity in the basic services for Rehabilitation and De-addiction Centers, in-built monitoring and evaluation should be incorporated in all the schemes relating to drug abuse prevention.

- The nexus between HIV infection and injecting drugs through shared needles, particularly in the North-Eastern parts of the country should be dealt with on a priority basis with education and awareness on the dangers of sharing the needles. Also awareness generation and preventive education should be carried out amongst the school children, sex workers, street children, occupational groups, etc.

- The present system of treatment relies to heavily on allopathy systems. The problem of alcohol and drug addiction being more psychosomatic in nature, alternative systems of medicine which are more holistic in nature such as Ayurveda, Homoeopathy and Yoga need to be more extensively used.

Genesis of the Drug De-addiction Programmes in India - The Ministry of Health and Family Welfare (MOHFW), Government of India, in 1976, appointed a high powered committee to examine the problem of Drug De addiction and suggest future guidelines. The report of this high-powered committee was submitted in 1977 and was laid on the floor of the Parliament. The recommendations of the report
emphasized the need to evolve appropriate strategies and to bring about better coordination among different Ministries and Departments working in this area. The Planning Commission and the Central Council of Health Ministers reviewed and accepted the report in 1979. In the late seventies and early eighties, the country was presented with new challenges in the field of drug de-addiction as refined products such as heroin entered into the Indian illicit drug market for the first time. The issue was also complicated by the increasing reports of Injecting drug use (IDU) especially from the North-eastern region of the country and with the emergence of HIV infection in the country. It was in this context that the Govt. of India adopted a three-pronged strategy for demand reduction consisting of: Building awareness and educating people about ill effects of drug abuse. Dealing with the drug dependent patients through programme of motivational counselling, treatment, follow-up and social-reintegration of recovered patients. To impart drug abuse prevention/rehabilitation training to volunteers with a view to build up an educated cadre of service providers. The objective of the entire strategy is to empower the society and the community to deal with the problem of drug abuse. Rehabilitation of addicts as well as their counselling comes under the domain of the Ministry of Social Justice & Empowerment (MSJE) in Government of India, while demand reduction by way of treatment and after care is the concern of Ministry of Health & Family Welfare. However, the activities of both the government agencies overlap considerably in several ways. The approved budget for the de-addiction programme in the 10th Five Year Plan was Rs.33.00 crores which has increased in the 11th plan considering the need for comprehensive de-addiction services in the country.
Role of Ministry of Health and Family Welfare - The Drug De addiction Programme in the Ministry of Health & Family Welfare was started in the year 1987-88 which was later modified in 1992-93. The programme was initiated as a scheme with funding from the central government and implementation through the states. Under the scheme, a onetime grant in aid of Rs.8.00 lakhs was given to states for construction of each Drug De addiction Centre and a recurring grant of Rs.2.00 lakhs was given to Drug De addiction Centres established in North Eastern Regions to meet the expenses on medications and other requirements. At present 122 such Centres have been established across the country including centres in Central Government hospitals and institutions of which 43 centres have been established in the North Eastern Region. Under this programme, a national nodal centre, the “National Drug Dependence Treatment Centre”, has been established under the All India Institute of Medical Sciences (AIIMS), New Delhi which is located in Ghaziabad while two centre i.e. NIMHANS, Bangalore and PGI, Chandigarh have also been upgraded by this Ministry. The purpose of these centres was to provide de-addiction and rehabilitation services to the patients and to conduct research and provide training to medical and para-medical staff in the area of drug de addiction.13

The National Drug Dependence Treatment Centre, AIIMS - The De-addiction Centre, AIIMS was established during the year 1987-88 and functioned from the premises of the Deen Dayal Upadhyay Hospital, Hari Nagar, New Delhi till 2003. The centre was subsequently shifted to its own building constructed at CGO complex, Kamla Nehru Nagar, Ghaziabad and was designated as the National Drug Dependence treatment Centre. It started both, outdoor and indoor treatment facilities
in the year 2003. The centre also established a Community Clinic at Trilokpuri, New Delhi that started functioning from August 2003. The centre has also started a unique Mobile De-addiction Clinic at Sunder Nagari, New Delhi from 2007 as part of its endeavour to widen its services. Apart from rendering patient care services, the centre has been engaged in a number of other activities to fulfill its role as the nodal centre in the field of drug de addiction. These activities included conducting research, training programmes for general duty medical officers, nurses, paramedical professionals, development of resource material for professionals, patient awareness booklets, organization of national workshops, etc.

Drug De-addiction Centre, PGI, Chandigarh - This centre was established during 1988-89. The centre has facilities for both outdoor and inpatient care. The centre has been upgraded with an inpatient capacity of 30. The centre conducts drug de addiction awareness programme, treatment camps, counselling and provides free medication to all patients in Chandigarh and neighbouring states.

Drug De-addiction centre at NIMHANS, Bangalore - Drug De addiction centre at NIMHANS, Bangalore was established during the year 1991. The centre is functioning as a Regional Centre. A separate building has been constructed with a cost of Rs.5.10 crores and currently houses 30 inpatient beds. The centre conducts therapeutic group session for both inpatients and outpatients. The centre caters to more that 50% of the patients seeking treatment for substance abuse problems in the city of Bangalore. The Centre also treats patients from different parts of Karnataka, Andhra Pradesh, Tamil Nadu and Kerala. Referrals are also received from other states of the country. There have been several
referrals from countries in the SAARC region and other countries as well.

Most recently the Ministry of Health have put considerable emphasis on community based treatment and has embarked on demonstration projects involving the district administration and district health administration. Currently, such a project is ongoing at a district each in three states, namely, Uttar Pradesh, Madhya Pradesh and Assam. It has been proposed that as a part of this programme, paramedical staff like ASHA workers, basic health workers and other health staff would be involved besides medical doctors and nurses. As a result training programmes have been held and several resource materials had been developed or are being developed. Currently, the following resource material are available: Manual for physicians, Case book on Substance Use Disorder, Manual for Nurses, Manual on brief therapy, Manual on Psycho-social Intervention, Manual for Long-term Pharmacotherapy

The following two would be available soon: Manual for Paramedical staff (this document), Guidelines for minimum standards of care for Government De-Addiction centres.

Demand Reduction Approach: Initiatives of Ministry of Social Justice and Empowerment - The Ministry of Social Justice & Empowerment has been implementing the Scheme for Prohibition and Drug Abuse Prevention since the year 1985-86. Unlike the MOH&FW, the MSJE follows a State-Community partnership approach as the mechanism for service delivery. Accordingly, under the Scheme, while major portion of the cost of services is borne by the Government, the Non Governmental Organisations (NGOs) provide actual services through the Counselling and Awareness Centres; De-addiction cum Rehabilitation Centres, De-addiction Camps, and Awareness
Programmes. Under this Scheme, the Ministry is assisting more than 400 voluntary organisations (NGOs). All these centres have experts from various fields including doctors, counsellors, community workers, social workers etc. Thus, it is a multi-disciplinary approach being applied according to the needs of individual cases. They work in coordination with the community resources as well infrastructure and services available under other related agencies. Apart from this, this ministry has established a National Centre for Drug Abuse Prevention (NCDAP) under the aegis of the National Institute of Social Defence, New Delhi, to serve as the apex body in the country in the field of training, research and documentation in the field of drug abuse prevention. The centre has been conducting three months certificate course on de addiction Counselling and Rehabilitation of Drug Abusers. Eight NGOs have been developed as Regional Resource and Training Centres (RRTCs) to provide training and information at the regional levels.

Convergence - The de-addiction programmes in India developed by the two Ministries appear to run in parallel with little cooperation between the two agencies. The overcome this problem, several meetings have been held to establish effective linkage between the activities carried by the NGOs and the treatment centres supported by the Ministry of Health.

Monitoring and Evaluation - The MOH&FW periodically evaluates the Drug De-addiction Centres established under the Drug De-addiction Programme. With the financial assistance from WHO, the NDDTC, AIIMS has been conducting these evaluations of status of functioning of Government De addiction centres on the following parameters: 1. Patient load, 2. Treatment being provided, 3. Availability
and utilization of equipment, 4. Staffing in terms of posts available and filled, 5. On-site interviews, and 6. Review of records. The evaluation findings have served as a valuable input into the reformulation of the National Drug De-addiction Programme.

Health and Family Welfare - National Health Programmes, DRUG DE-ADDICTION PROGRAMME (DDAP) - The basic role of the Ministry of Health and Family Welfare in the area of drug de-addiction is demand reduction by way of providing treatment services including preventive health and after care. The Drug De-addiction Programme of the Ministry was started in 1987-88 with the establishment of 6 De-addiction Centres in Central Institutions viz. AIIMS, New Delhi, Dr. RML Hospital, New Delhi, Lady Hardinge Medical College & Smt. S.K. Hospital, New Delhi, JIPMER, Pondicherry, PGI, Chandigarh and NIMHANS, Bangalore.

A scheme under central sector assistance to states during 1992-93 was introduced for providing an assistance of Rs.8.00 lakhs (as a one time grant) to States/UT Governments towards construction of building for establishing Drug Deaddiction Centres in identified Medical Colleges and District Level Hospitals. One of the essential requirements of the Scheme is that the State Government shall provide necessary land and also meet the recurring expenses towards staff, medical care, diet, maintenance etc. The scheme, in addition to above mentioned grant, also provides grant of Rs.2.00 lakhs (recurring grant) per annum to the Centres in North-Eastern States to meet the cost of medicines, linen, diet etc. 122 Centres have been established so far including 6 centres established in Central Hospitals/Institution.s and 43 Centres in North Eastern States.
National Drug Dependence Treatment Centre, AIIMS - National Drug Dependence Treatment Centre, AIIMS which was established during the year 1987-88 and was functioning at Deen Dayal Upadhyay Hospital, Hari Nagar has now shifted in its own building constructed at CGO Complex, Kamala Nehru Nagar, Ghaziabad started indoor facilities w.e.f. 2.12.03. Community Clinic of this centre at Trilokpuri has been functioning from 1.8.2003. Apart from rendering patient-care services, the centre is engaged in a number of research projects and CME activities. Professor and Chief heads the Centre. Other members during this period were Additional Professor(No.3), Associate Professor(No.2) and Assistant Professor(No.2). The Centre has carried out Under Graduate and Post-graduate teaching for MD(Psychiatry) and PhD students. In addition the Faculty presented their own research work through weekly seminar once every week besides CCR & CGR in every semester. Now NDDTC have become one of the 20 global resource Centres for training and capacity building for doctors to treat substance use disorder. The network of these centres covers all the region of the world. Dr. Rick Rawson and Dr. Walter Ling, UCLA, USA are coordinating this project and the activities are being supported by the UNDOC(HQ, Vienna).

Drug De-Addiction Centre, JIPMER, Pondicherry - Drug De-Addiction Centre, JIPMER, Pondicherry was established during 1987-88. during the year centre conducted a study of temperamental characteristics in children of unipolar and bipolar patients. The study report has been accepted for publication. The centre has also conducted a study of predictors of suicidal ideation in patients with major depressive disorders. In 131 cases of substance abuse/dependence were evaluated during the period under review. Majority were dependent on
alcohol. The other category includes 8 cases of multiple substance abuse. In addition to that various sensitization and awareness programmes were organized.

Drug De-addiction Centre, National Institute of Mental Health and Neuro Sciences, Bangalore - Drug De-addiction Centre at NIMHANS, Bangalore was established during the year 1991. This Centre is functioning as a Regional Centre. A separate building has been constructed with the cost of Rs. 5.10 crore and currently houses 30 inpatient beds and also has rooms for inpatient and outpatient therapeutic groups. The De-addiction Centre caters to more than 50% of the patients seeking treatment for substance abuse problems in the city of Bangalore. The Centre also treats patients from different parts of Karnataka, Andhra Pradesh, Tamil Nadu and Kerala. Referrals are also received from other states of the country including the North - Eastern states and recently there have been several referrals from countries in the SAARC region and other countries as well. During the year One week training Programme for 20 Medical Officers on “Substance Abuse Management” from 20-25 June was conducted. Three Medical Officers from Iraq under the WHO fellowship Programme were trained for 20 days. The de-addiction team of the centre have been entrusted with the work of monitoring the Southern De-addiction centres and the same has been initiated.

Drug-De-addiction Centre, PGI, Chandigarh - Drug De-Addiction Centre, PGI, Chandigarh was established during 1988-89. The centre conducted an one day Camp on De-addiction in the catchment area of Kharar Civil Hospital and conducted one lecture service for workers in a factory. During the year 517 patients evaluated, 98 patients were
admitted in the Drug-De-addiction ward and 155 patients attended the Yoga service.

New Initiatives - The linkage between the centres managed by NGOs funded by Ministry of Social Justice and the centres supported by the Ministry of Health to achieve synergy in treatment and rehabilitation services is under implementation. A project on buprenorphine maintenance Programme has been launched by NDDTC, AIIMS with the support of United Nation Office on Drug and crime(UNDOC). The issue of alleged misuse of Proxyvon or similar drug formulation has been taken up with all the State Drug Controllers of North East States in order to ensure strict enforcement under the provision of drugs and Cosmetic Rules, as the drug is under schedule ‘H’ (Prescription Drug) of the Drug & Cosmetics Act.14

The growth of social services is necessarily a slow process. Its principal limitations relate to the financial resources available and resources which can be spared for social services, lack of trained personnel and of organisations devoted to social welfare and lack of reliable data pertaining to social problems. These factors tend to limit the immediate objects of social welfare services to groups which are in a vulnerable position or need special assistance. The aims of social welfare are, however, wider in scope. Social Welfare is concerned with the well-being of the entire community, not only of particular sections of the population which may be handicapped in one way or another. Problems which have already come to the fore must no doubt claim attention; equally, it is necessary to take steps to prevent the occurrence of new problems.
Social Welfare Support Organisations in Ballia Districts

Government Agencies

1. **District Magistrate Office**  
   Address: Collectorate, Ballia  
   Tel No.: 05498-220857(O) 220311(R)  
   Fax No.: 05498-22064

2. **Senior Superintendent Of Police Office**  
   Address: Ballia  
   Tel No.: 05498-220373(O), 229312(R)

3. **Women Assistance Cell**  
   Address: S.S.P. Office, Ballia  
   Tel No.: 05498-22373  
   Services: Counseling For Marital Dispute Cases

4. **Social Welfare Office**  
   Address: Vikas Bhawan, Ballia  
   Tel No.: 5498-220190Fax No.: 05489-221899

5. **District Probation Office**  
   Address: Nazarat, Near Koshagar, Ballia  
   Services: Widow Pension Widow Remarriage, Legal Advice.

Non-Government Organisations

6. **Naval Training and Research Sansthan**  
   Address: Middhi, Ballia  
   Tel No.: 05498-221324  

7. **Subhash Memorial Manav and Seva Sansthan**  
   Address: Maniyar, Near Central Bank, Ballia  
   Tel No.: 05494-264117(Pp), 267479(R)  

8. **Purvanchal Gramin Chetna Samiti**  
   Address: Po Athilapura, Radhopur, Ballia  
   Tel No.: 05491-226140, 238271  
   Email: Dovsws@Sify.Com  
   Services: Community Based

Address: Village Shahpur, Ballia Tel No.: 05498-282607

10. Nav Bhartiya Nari Vikas Samiti
Address: Po Bahedi, Ballia Tel No.: 05498-225010 Fax No.: 05498-223522
Email: Nbnvs@Rediffmail.Com
Services: Vocational Training for Women, Health Awareness Programme

11. Shivam Seva Sansthan
Add: Mahila Hospital Road, Jagdishpur, Ballia – 277001, Uttar Pradesh Tel: 91-5498-225346 Email: Shivamsevasansthan@Yahoo.Com
Contact Person: Dr. Manoj Kumar Singh
Purpose: Social Work

In this study information was gathered from respondents about social welfare programme with drug abuser past and present. The information obtained has been presented herewith in the form of various tables.
Table: 7.1

Frequency and Percentage Distribution of Respondents according to the Reasons of Relapse

<table>
<thead>
<tr>
<th>What are the Reasons of Relapse?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Problems</td>
<td>6</td>
<td>11.54</td>
</tr>
<tr>
<td>Treatment was inadequate</td>
<td>11</td>
<td>21.15</td>
</tr>
<tr>
<td>Bad Company</td>
<td>21</td>
<td>40.38</td>
</tr>
<tr>
<td>Sexual Problems</td>
<td>4</td>
<td>7.69</td>
</tr>
<tr>
<td>Stress</td>
<td>10</td>
<td>19.24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The above table shows an overall percentage distribution of respondents according to reason of relapse: 11.54 percent reported family problems one of the reason of relapse; 21.15 percent reported treatment was insufficient; 40.38 percent reported bad company; 7.69 percent said sexual problems; and 19.24 percent reported stress is the reason of relapse.

The majority of respondents reason of relapse reported bad company.
Table: 7.2

Frequency and Percentage Distribution of Respondents according to Rehabilitation Training

<table>
<thead>
<tr>
<th>Are You Receiving any Specific Training for Rehabilitation?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>65</td>
<td>26.00</td>
</tr>
<tr>
<td>No</td>
<td>185</td>
<td>74.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Graph 41

Respondents according to Rehabilitation Training

The above table shows an overall percentage distribution of respondents according to rehabilitation training: 26.00 percent received any specific training for rehabilitation; and 74.00 percent did not receive any specific training for rehabilitation.

The majority of respondents did not get any specific trainee for rehabilitation.
Table 7.2(a)

Age wise distribution of the respondents according to their status of received any specific training for rehabilitation

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Received any specific training for rehabilitation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Below 18 years of age</td>
<td><img src="image" alt="Table" /></td>
<td></td>
</tr>
<tr>
<td>18 years and above</td>
<td><img src="image" alt="Table" /></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td><img src="image" alt="Table" /></td>
<td></td>
</tr>
</tbody>
</table>

Figure in parenthesis shows the percentage.

Chi-square $x^2 = 0.21$; d.f. = 1; $p = 0.65 >0.05$ not significant

Graph 42

Age wise respondents according to their status of received any specific training for rehabilitation
The above table shows that 71.00 percent respondents are below 18 years age group and 75.00 percent respondents are 18 years and above age group no status of received any specific training for rehabilitation. Chi-square $x^2 = 0.01$; d.f. =1; $p = 0.92$, $>0.05$ not significant.

Therefore this study suggests that there is no association of age groups and status of received any specific training for rehabilitation.
Table 7.2(b)
Monthly Income wise distribution of the respondents according to their status of received any specific training for rehabilitation

<table>
<thead>
<tr>
<th>Monthly Income (in Rs.)</th>
<th>Received any specific training for rehabilitation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>≥ 3000</td>
<td>8 (36.40)</td>
<td>14 (63.6)</td>
</tr>
<tr>
<td>3001 to 6000</td>
<td>22 (38.00)</td>
<td>36 (62.00)</td>
</tr>
<tr>
<td>6001 to 8000</td>
<td>11 (16.70)</td>
<td>45 (80.30)</td>
</tr>
<tr>
<td>8001 to 10000</td>
<td>18 (22.00)</td>
<td>64 (78.00)</td>
</tr>
<tr>
<td>≥ 10000</td>
<td>6 (18.75)</td>
<td>26 (81.25)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65 (26.00)</strong></td>
<td><strong>185 (74.00)</strong></td>
</tr>
</tbody>
</table>

Figure in parenthesis shows the percentage.

Chi-square $\chi^2 = 8.27$; d.f. = 4; $p = 0.08$, $>0.05$ not significant

Graph 43
Monthly Income wise respondents according to their status of received any specific training for rehabilitation
The above table shows that 63.60 percent respondents had monthly income of less than Rs. 3000, 62.00 percent respondents in Rs. 3001 to 6000 income group, 80.30 percent respondents in Rs. 6001 to 8000 income group, 78.25 percent respondents in Rs. 8001 to 10000 income group and 81.25 percent respondents in above Rs. 10001 income group in status of not received any specific training for rehabilitation. Chi-square $x^2 = 8.27$; d.f. = 4; p = 0.08, >0.05 not significant.

Therefore this study suggests that there is no association of income groups and status of received any specific training for rehabilitation.
Table: 7.3

Frequency and Percentage Distribution of Respondents according to Counselling Facility in Rehabilitation Process

<table>
<thead>
<tr>
<th>Are You Receiving Counselling Facility in Rehabilitation Process?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>78</td>
<td>31.20</td>
</tr>
<tr>
<td>No</td>
<td>172</td>
<td>68.80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The above table shows an overall percentage distribution of respondents according to receiving counselling facility in rehabilitation process: 31.20 percent received counselling facility in rehabilitation process; and 68.80 percent did not receive facility in rehabilitation process.

The majority of respondents did not receive counselling facility in rehabilitation process.
Table: 7.4

Frequency and Percentage Distribution of Respondents according to Family Support before Induction to Drug(s) Addiction

<table>
<thead>
<tr>
<th>Did You Get Any Family Support before Drug(s) Addiction?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>188</td>
<td>75.20</td>
</tr>
<tr>
<td>No</td>
<td>62</td>
<td>24.80</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The above table shows an overall percentage distribution of respondents according to the family support before drug(s) addiction: 75.20 percent of respondents got family support before drug(s) addiction; while 24.80 percent did not get any family support before drug(s) addiction.

The majority of respondents had family support before drug(s) addiction.
Table: 7.5

Frequency and Percentage Distribution of Respondents according to Family Support in Rehabilitation Process

<table>
<thead>
<tr>
<th>Did You Get Any Family Support in Rehabilitation Process?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>92</td>
<td>36.80</td>
</tr>
<tr>
<td>No</td>
<td>158</td>
<td>63.20</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The above table shows an overall percentage distribution of respondents according to the family support in rehabilitation process: 36.80 percent of respondents get family support in rehabilitation process; while 63.20 percent of respondents did not get any family support in rehabilitation process.

The majority of respondents had family support in the rehabilitation process.
Table: 7.6

Frequency and Percentage Distribution of Respondents according to Who Can Play a Role in Reduction of Drug(s) Addiction

<table>
<thead>
<tr>
<th>Who Can Play Important Role in Reduction of Drug(s) Addiction?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>118</td>
<td>47.20</td>
</tr>
<tr>
<td>Community</td>
<td>12</td>
<td>4.80</td>
</tr>
<tr>
<td>Peer Group</td>
<td>28</td>
<td>11.20</td>
</tr>
<tr>
<td>Non-Government Organization</td>
<td>42</td>
<td>16.80</td>
</tr>
<tr>
<td>Government Organization</td>
<td>38</td>
<td>15.20</td>
</tr>
<tr>
<td>Any Other</td>
<td>12</td>
<td>4.80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The above table shows an overall percentage distribution of respondents according to who can play role in drug(s) reduction: 47.20 percent reported that family play important role in reduction of drug(s) addiction; 4.80 percent answer is community; 11.20 percent answer is peer group; 16.80 percent answer in non-government organization; some 15.20 percent answer is government organizations; and 4.80 percent answer was any other.

The majority of respondents family play important role in reduction of drug(s) addiction.
Table: 7.7

Frequency and Percentage Distribution of Respondents according to Suggestions for the Prevention, Welfare Treatment and Rehabilitation of Drug(s) Addicts

<table>
<thead>
<tr>
<th>Suggestions for the Prevention Welfare Treatment, and Rehabilitation of Drug(s) Addicts</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>To set a rehabilitation center for drug(s) addicts</td>
<td>10</td>
<td>4.00</td>
</tr>
<tr>
<td>To stop the poppy cultivation</td>
<td>32</td>
<td>12.80</td>
</tr>
<tr>
<td>To give death sentence to drug(s) trader/seller</td>
<td>12</td>
<td>4.80</td>
</tr>
<tr>
<td>To Ban Illicit Drug(s)</td>
<td>54</td>
<td>21.60</td>
</tr>
<tr>
<td>To create awareness among the youth about negative effects of Drug(s)</td>
<td>142</td>
<td>56.80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The above table shows an overall percentage distribution of respondents according to their suggestions for the prevention, welfare treatment and rehabilitation of drug(s) addicts: 4.0 percent suggested that to set a rehabilitation center for drug(s) addicts; 12.80 percent suggested to stop the poppy cultivation; 4.80 percent suggested that to give death sentence to drug(s) trader/seller; 21.60 percent suggested that illicit drug(s) should be ban; 56.80 percent suggested to create awareness among the youth about negative effects.

The majority of respondents suggested creating awareness among the youth about negative effects.
Summary

From the study of the social welfare programme with drug abuser past and present one concludes that - The majority of respondents (40.38%) reason of relapse reported bad company. The majority of respondents (74.00%) did not get any specific trainee for rehabilitation. Therefore this study suggests that there is no association of age groups and status of received any specific training for rehabilitation. 71.00 percent respondents are below 18 years age group and 75.00 percent respondents are 18 years and above age group no status of received any specific training for rehabilitation. Chi-square $x^2 = 0.01$; d.f. = 1; $p = 0.92$, $>0.05$ not significant. Therefore this study suggests that there is no association of income groups and status of received any specific training for rehabilitation. 63.60 percent respondents had monthly income of less than Rs. 3000, 62.00 percent respondents in Rs. 3001 to 6000 income group, 80.30 percent respondents in Rs. 6001 to 8000 income group, 78.25 percent respondents in Rs. 8001 to 10000 income group and 81.25 percent respondents in above Rs. 10001 income group in status of not received any specific training for rehabilitation. Chi-square $x^2 = 8.27$; d.f. = 4; $p = 0.08$, $>0.05$ not significant. The majority of respondents (68.80%) did not receive counselling facility in rehabilitation process. The majority of respondents (75.20%) had family support before drug(s) addiction. The majority of respondents (63.20%) had family support in the rehabilitation process. The majority of respondents (47.20%) family play important role in reduction of drug(s) addiction. The majority of respondents (56.80%) suggested creating awareness among the youth about negative effects.
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