CHAPTER IX

DRUG ABUSE PREVENTION

The problem of drug abuse drew the attention of the Government of India from 1986 onwards. Three pronged strategy has been adopted. This includes control of supply of drugs through strict enforcement of the Narcotics Drugs and Psychotropic Substances Act and the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act and reduction of demand for drugs through measures on the public education and awareness building, provision of facilities for the identification, treatment, rehabilitation and after care of the addicts and the training of personnel. All these efforts are in its infancy and these are still to take a momentum. The National Masterplan on Drug Abuse Control is under preparation. There are certain crucial issues that relate to various aspects of the problem and require to be given due consideration in order to add impetus to the programme. The present chapter is devoted to some of such crucial aspects. These aspects are based on the views expressed by different experts in the field and as that of the academicians. These experts belonged to the organisations such as representatives of the Ministries of Welfare, Health, Education, Youth Affairs, Narcotics Control Bureau, Police, Prison, Non-governemental Organisations actively involved in the implementation of the programme, University, World Health Organisation and United Nations Drug Control Programme. Various issues are discussed under different heads in a discussion to follow.

BUILDING UP OF DATA BASE

Problem of drug abuse has affected all sections of our society. India no more just remains a transit country but has acquired a status of consumer country. This fact is supported by large number of addicts poring into the drug prevention services extended in a form of 254 counselling, de-addiction and after care centres (upto November 1993) set up in various parts of the country under the Ministry of Welfare's sponsorship. The number of registered addicts at these centres rose from 1,627 in 1986 to 2,70,173 in 1992-93. However, this presentation of addicts is just a tip of ice berg. The actual number of addicts might be not less than five fold of those reported at these centres. This could be drawn from the experience in United Kingdom where the record of every addict who visits the drug prevention services is maintained by the Home Office but the research has revealed that the Home Office Data reflect only one fifth of those actually afflicted with the problem. In view of this notion the problem of drug addiction is much grave than but really being projected through the available data.
Exact estimates of the problem could not be worked out because of lack of national survey and building up a database. There is an utmost need to build up a machinery for developing a database and registry system in order to know the problem and its various contours. Data base will as well help in monitoring the activities under different sectors/agencies concerned with the drug abuse problem such as welfare, health, police, prison, judiciary, etc. All these sectors need to have an in-built system of monitoring of the schemes and programmes undertaken by them. In addition, an external agency may be recognised to get a feedback from each of the agencies and monitor their performance to have a consolidated view of the problem. To monitor the performance of the activities of the drug prevention agencies, the need to establish minimum standards with a view to evaluate the quantitative and qualitative aspects of services is of prime importance. Initial efforts have been made to set minimum standards with the help of the World Health Organisation. The Government of India need to take a lead role in formulating minimum standards of services that would be conducive to Indian culture and situations.

In view of the limitations of the institutional data it is imperative to conduct periodical surveys and concurrent evaluations at the national level. No single organisation exists for this purpose in the country. A full-fledged monitoring system and national surveys would enable evaluation, assessment of trends, changing pattern, epidemiological features of the problem and thereby facilitate reformulation and revision of the existing policies, strategies and programme for prevention of drug abuse in the country.

CO-ORDINATION

Drug abuse is a multifactorial problem and multifaceted and multi-disciplinary approaches are being followed in tackling this problem. Various agencies of the Government are engaged in this task and specific roles are assigned to each one of these. The Ministry of Welfare is the nodal Ministry for demand reduction and operate programmes for prevention, identification, treatment, rehabilitation, after-care and awareness building and preventive education aimed at target groups. It also conducts training programmes for the functionaries of different categories concerned with the problem.

Multi-disciplinary approaches as stated earlier is part of the drug abuse programme. Such disciplines have to have an adequate coordination for the success of the programme. The coordination mechanism to some extent operated earlier through various committees appointed from time to time. Some of these committees included Empowered Committee, Inter-Ministerial Committee, Cabinet Committee, etc. A Central Committee on Prohibition and Drug Abuse Prevention still exists and recently a High Power Committee has been set up with certain terms of references as delineated in the earlier chapter and will be submitting its report in six months. It has been realised that
practically no coordination exists for a moment. There is a need to evolve an effective coordination mechanism at the appropriate level preferably at Cabinet level in order to add impetus to the programme. The recommendation of the Task Force engaged in the preparation of the National Masterplan on Drug Abuse Control on the coordination aspect of the programme is awaited.

Co-ordination just at the ministerial level is not adequate for the smooth and effective functioning of the programme. Effective co-ordination and linkages is required between services rendered through the agencies under health sector and the centres operated by non-governmental organisations through Ministry of Welfare's sponsorship. Linkages within the agencies in the same sectors and in other sectors of development are of great importance for programme development.

AWARENESS BUILDING AND PREVENTIVE EDUCATION

As regards awareness building and preventive education a systematic approach towards creating awareness among general population is being pursued. The Government as well voluntary organisations are engaged in carrying out various educational programmes. It is also realised that the educational approach towards creating a climate against drug addiction among the people has to be carefully planned. The Knowledge regarding dependence-producing drugs has to be disseminated carefully to avoid undue curiosity and counter productivity. It has also been widely realised that the strategy for creating awareness has to be group-specific and culture-specific. The aspects like type of drugs abused, quantity abused, company maintained, reasons for which it is abused, age of abusers, etc. are equally important and to be kept in mind while formulating the educative programmes. The educative programmes have to be an integral part of the social development process and need to be incorporated into the various welfare and developmental programmes performed in the country through different sectors like health, education, welfare, rural development, youth welfare, labour and employment and programmes for the socially disadvantaged sections of the society. It has also been realised that educative programmes have to be a part of public health education.

APPROACH TO TREATMENT BY HEALTH SECTOR

The medical treatment of addicts is the responsibility of the Ministry of Health and Family Welfare. This Ministry had been working in isolation for the last decade and with a very slow pace in opening up services for treatment of addicts. There could be number of reasons for the same. The limited contribution that this Ministry has made includes identification of beds for the treatment of addicts in the Psychiatric Departments of the major hospitals and setting up of five centres of excellence with facilities for detoxification, research, training, laboratory and examination. Of late, this Ministry realising the need to play a major role in the treatment of addicts now propose to expand its efforts through 27 medical colleges spread in various parts of the country. These colleges will not only provide services for
detoxification but also for examination, laboratory tests, research and training. It may be alright to approach through medical colleges to begin with. However, this would have limited coverage as these are located mainly in urban areas. Therefore services rendered would be beyond the reach of large segment of the population requiring these services.

In view of this the Ministry of Health and Family Welfare need to think of a via media to evolve a system that ensures wider coverage. In other words, the services should be within the reach of the people. The Ministry have under its purview a wide net work of Primary Health Centres (22059 as on 1.4.91) and Sub Centres (1,30,978 as on 1.4.91) that operate at the grassroot level. The number of Community Health Centres during the same period was 1923. This wide network could be utilised to impart services for treatment of drug addicts. This approach would be beneficial in regard to coverage, accessibility, efficacy and effectiveness in terms of cost and quality of services. Primary Health Centres have easy access to the community thereby would ensure better community participation, mobilisation of resources and motivation of addicts. In the urban areas also, the urban Health Centres network could also be made use of for treatment facilities of addicts. The other benefit of imparting treatment services through this network at the community level is that addict initially approaches such services for the treatment of physical problems that may arise due to addiction or otherwise. It is much later that he really realises that his addiction requires intervention of an outsider. Therefore, public health machinery located at the community level would be the best place for treatment of the drug addicts.

INVolVEMENT OF NON-GOVERNMENTAL ORGANISATIONS:

Non-governmental organisations have vital role to play in drug abuse control programme. Government alone cannot deal with this problem. It needs to rely heavily on self-help endeavours and community support through the non-governmental sector. Non-governmental agencies thereby need to be involved at all stages of programme development right from planning, implementation, review, execution, monitoring and evaluation. Professionals from various disciplines such as medical, paramedical, social work, psychology, Social Sciences, indigenous systems of medicines, etc. need to come together to work as a team.

INVoL VEMENT OF OTHER SECTORS OF DEVELOPMENT

Drug abuse problem, as currently being, should not be left to be tackled by only the specialised/specified agencies meant to deal with the problem providing counselling, de-addiction and after-care services and preventive education and training facilities. The other agencies engaged in delivering services in various fields of social welfare and development such as primary health care including maternal and child health, public and community health, education- formal and informal, women and child welfare, rural development, youth welfare, labour welfare, local-self governments need also to contribute in tackling this problem of drug abuse through their efforts for awareness building, education, prevention, identification, referral, mobilisation of the community, etc.
GRANT-IN-AID AND ASSOCIATED PROBLEMS

The efforts to combat drug abuse problem till now were limited mainly through the Government of India. The Ministry of Welfare have been supporting financially and technically the non-governemental organisations for providing services for treatment, rehabilitation, preventive education and awareness building programmes and training of personnel working in the field under the Central Sector Scheme of Assistance to Voluntary Organisations for Prohibition and Drug Abuse Prevention. Under the Scheme, 90% of the total cost of each project is met by the concerned non-governmental organisation. Each organisation is required to fulfil the eligibility conditions for grant as stipulated in the Scheme. These are: an organisation should be a registered body and should ordinarily have existed for a period of three years; its financial position should be sound; it should have facilities, resources, experience and expertise for undertaking the programme; it should not run for profit to any individual or body of individuals; it should have properly constituted managing body with its powers, duties and responsibilities clearly defined and laid down in a Constitution.

These criteria need to be followed rigrously so that only the right kind of organisations, having dedication and commitment to the programme, could avail of the financial assistance under the Scheme. Some effective mechanism to avail first hand and reliable information about the organisation requesting for financial assistance may be thought of. This could be done by formulating regional Committees consisting of the representatives of non-governmental organisations, local leaders, etc. Such Committees should carry out periodic and detailed inspections. This could also help in eliminating those organisations which may not be utilising the financial assistance properly.

The grant is released in instalments based on the audited accounts and performance of the project and also keeping in view the recommendations of the concerned State Governments/Union Territory Administrations. As per the terms and conditions stipulated in the Scheme, normally the State Governments are required to send their recommendations within a period of two months from the receipt of application from the organisation/institution.

It is very essential that the financial assistance to non-governmental organisations is released in time so that the functioning of the counselling centres is not affected adversely. A proper mechanism is required to be followed by State Governments/Union Territory Administrations, the non-governmental organisations and also the Central Government so that the bottlenecks in timely release of financial assistance could be minimised/eliminated. A well devised inspection report need to be given to the inspecting officers not only in the State Governments/Union Territory Administrations but also to the Central Government officers who happen to visit the organisations for inspection. The State Governments /Union Territory
Administrations should also be addressed from time to time to emphasise the necessity of sending timely recommendations. The non-governmental organisations will also feel their accountability once the timely release of financial assistance is ensured.

The training of personnel working in the field of drug abuse prevention is a very vital component of this programme. The National Institute of Social Defence, New Delhi has a scheme for training of functionaries. An extensive use of this scheme should be made for giving orientation to these personnel working in both governmental as well as non-government sectors. The State Governments should be fully involved in this process.

ROLE OF STATE GOVERNMENTS

The State Governments/Union Territory Administrations have to play an important role in combating the drug abuse programme. Most of the welfare and development schemes are within the purview of the State Governments. The State Governments have a wider network of social welfare, health and educational functionaries. Therefore, the involvement of the State Governments/Union Territory Administrations in the planning, implementation, monitoring and evaluation to drug abuse control programme is very essential. These could also serve as a best judge in recommending a right kind of voluntary organisations to work in this field. In fact, they could encourage good organisations to come forward. The State Governments/Union Territory Administrations should also be involved in controlling the illicit trafficking, besides controlling production, cultivation, manufacture, supply, etc. of illicit drugs. Each state should be advised to keep adequate budgetary resources in their budgets for taking various programmes to combat this problem at the State level, over and above the efforts being made by the Central Government in this direction.

APPROACHES TO TREATMENT OF ADDICTION

Addiction is a disease. Unlike other diseases in the medical field there is no definite organism and definite medical intervention/treatment that could give relief from this problem. It is a psycho-socio-medical problem that needs to be tackled in all its facets. Pure medical intervention is not an answer to the problem and it fails in producing the desired results. It has been viewed by the experts that the bio-psycho-social model in appropriate combination depending on the need of the case would work well in treating an addict. The addicts should be treated out of the psychiatric set up has also been concensused by the experts. The existing clinics operated by the health sector lay more emphasis on treating the physical symptoms mainly and psychological aspects are touched upon only to some extent. However, the social aspects are more or less ignored. In the welfare sector though the psychological and social aspects are given prime importance over the medical aspects but it is not true in case of all the centres who too continue to rely on
medicines and concentrate on treating withdrawal symptoms by providing symptomatic treatment. Counselling services and social support extended by these centres likely to vary from centre to centre in the absence of any guidelines. What is being practised largely is extending guidance and advice than counselling. The centres need to have a knowledge of the subject so that they could identify the needs of the patient and plan out activities jointly in a team by involving patient into it. The credibility of the social model need to be established so that realisation of its usefulness over the pure medical model be realised.

There are around 28 different approaches in the treatment of drug addiction that are being practiced in different parts of the world. These include individual psychotherapy, group psychotherapy, family therapy, acupuncture, abstinence, aversion therapy, maintenance therapy, pharmacotherapy, peer counselling, hypnosis, self-help group treatment, after care, etc. There is no scientific evidence to establish that which of the approaches is better than the other. What may work for one individual may not work for another individual. What may work the best in one culture may not prove that effective in the other culture. Therefore, approaches used in the treatment of addiction need to be individual, group and culture specific. In view of this as mentioned earlier the schemes of the government should keep a room for innovation by not being too rigid.

In India it is mainly abstinence that is being practised. An addict is given symptomatic treatment during the withdrawal phase. In number of cases addict finds it difficult to stay without drugs. In such cases advice to maintain abstinence does not really help. With such addicts harm reduction strategies may be experimented that might work better. However, such strategies of harm reduction lead to dichotomy and need to be practised with caution and only on selective basis with certain addicts and culture where abstinence may lead to greater sufferings. These strategies may include putting patient on low dose of the same drug, gradual reduction in the dose of the drug, provision of a substitute to the drug of abuse, advice on a use of safe and clean needle and syringe and its disposal, etc.

It has been observed that all kinds of conditionalities are imposed in admitting addict for treatment. It is usually perceived by the people and the professionals that the problem is voluntarily caused and till the addict becomes totally helpless he is not easily accepted for treatment. Such an attitude requires a change and treatment should be extended to the addicts as a matter of right.

An addict needs to be treated in totality of his life situation. Drug addiction is usually not only a culmination of individual factors but also factors imbedded in his family and culture. It is widely accepted concept that the life style of an individual makes all the more difference. The World Health
Organisation made efforts in 1983 by convening a meeting of the experts who arrived at the unusual concensus/unconventional concenses statement. This concensus related to the factors conducive to good outcome in treatment and poor outcome in treatment. According to the inventory produced, it was highlighted that treatment services in terms of psychotherapy, detoxification and length of in-patient stay provided to drug users made little or no difference and it was the environment that made a difference. Later in 1991 'Kathmandu Declaration' was arrived at by the concensus of 35 participants representing 18 non-governmental organisations from the subcontinent representing Pakistan, Srilanka, Nepal and India. The concensus mentioned that messages of optimism and empathy works well with drug users. Interventions in the field of drug abuse are rather meaningless as long as these are addressed to individual or a substance as drug use is much more a life style. Any meaningful intervention would have to address basically to issues of life style/living together/social issues and not individual issues alone. Medical approach alone is not an answer to the problem.

Experiences have proved that there is no correlation between cost of treatment and its effectiveness especially in the field of drug abuse prevention. The camp approach in Srilanka is one of such example which is most cost-effective model of treatment for drug addicts. In view of the vastness of country's population, gravity of problem and striking priorities of meeting the basic needs, the drug abuse control programme will face resource crunch. Drug addiction is a difficult and complex problem. It has high relapse rate and an addict may even require an intervention of as long as five years. Keeping these aspects in view, the need for evolving cost-effective models and strategies is imperative. Deployment of trained personnel is another requisite of the programme.

India has adopted a community based model for the treatment of addicts by setting up counselling, de-addiction and after-care centres. The community based model has its own advantages over the institutional model as it is more within the reach of the people and enjoys better credibility. It has a potential of mobilising addicts, their families and community into the various activities. The institutionalised model may not attract many clients. Distant location of such institutions limits the accessibility of the clients to the centres. Drug addiction carries a social stigma with it and thus institutional model with sophistication of urban set up hinders a common person in approaching and availing services at these centres.

The community based centres require infrastructure from which these could operate. At this central place, which is located within the community or in the near surroundings, the staff deliver the services. At the same time services are extended within the community and the family. Community participation is sought in the best possible manner through various educative and other techniques. Family is involved in the treatment of the addicts. Community resources are mobilised. Linkages are established with other agencies delivering services in the field of drug abuse and also with agencies active in the
community by way of providing services in welfare and development fields. These could be the youth leaders, teachers, functionaries engaged in women and child welfare and development, mahila mandal workers, community health workers, traditional birth attendants, police, etc..

The existing number of 254 centres is too inadequate in view of the gravity of the problem. In India, under the five years plans, the Welfare and Development sectors are treated as residual sectors and often face resource constraint when compared with high priority sectors. Then arises a question of how many and how fast the number of such centres could be replicated? Here we would have limitations. Are we confident that these centres are producing good results, is the another question likely to be posed and to which we have no answer for a moment and might have to take steps in near future in this direction. The best answer in a present situation to all these problems would be to think of utilising existing net work of agencies available in a form of Primary Health Centres and Sub Centres.

It is difficult especially in case of urban areas to locate a suitable, safe and hygienic accomodation for these centres at the community level with the available finances. People are not prepared to rent their premises for activities involving drug addicts. They find addict to be a nuisance and lack sympathy towards them as they frequently exhibit unsocial behaviour. The attitude of the people required to be changed through education. The State Governments need to come forward by making provision for free accomodation or at subsidised rates at a place within the community which is safe and hygienic.

TREATMENT OF ADDICTS UNDER THE LAW

Status of addict under the law and treatment of addict under law are debatable issues. The Narcotic Drugs and Psychotropic Substances Act, 1985 prohibits possession in small quantity of illegal drugs or substance which is liable to punishment. Therefore, every addict under the law is an offender. In case the law is strictly implemented, it would definitely lead to lower attendance at the treatment agencies providing services to the addicts. This requires a fresh look into the provisions of the law. The act also requires the Government to establish as many centres as it may think fit for identification, treatment, education, aftercare, rehabilitation and reintegration of addicts. By implication, these provisions call for an appropriate handling and compulsory treatment of addicts. However, compulsory or forced treatment under law has failed to produce desired results in several countries and led to frequent relapses.

The law is, therefore, required to notify centres for treatment. Only two centres have been notified under the law for treatment. It is further worth mentioning that no addict has been treated under law for a offence of mere consumption of a drug. On one hand their is a concensus that drug addiction is a disease and on the other hand mere consumption of a drug under the law is treated as an offence. Such a dilema need to be resolved. The
sections of the law that could not be implemented in its true sense may be repealed. It may also be added that a treatment centre even run by the police authorities as a non-governmental organisation treat addicts on voluntary basis and not as an offender. It is, therefore, increasingly emphasised that the drug addict be taken as a sick person rather than a person liable to punishment.

**TRAINING**

Mere financial assistance to organisations to set up drug prevention services is not enough. There is a need to evolve certain guidelines for the organisations to understand the basic concepts of the drug problem, the functions and activities these are expected to perform, the type of staff they require and what are their specific roles, etc. This would certainly help especially the new organisations to know what these are expected to do and this would also establish uniformity in approaches in drug abuse field. This would also help in evolving an effective monitoring system. At present, very little has been done in this direction. What is available is the guidelines for the counselling centre prepared by the National Institute of Social Defence. There is need to develop guidelines on the other aspects of care. It needs to be ensured that the guidelines so prepared get disseminated to those for whom these are meant.

The Ministry of Welfare should also develop some basic literature by organisations with expertise in the field. In view of this, there is a need to identify some institution/organisation with expertise to produce guidelines and training materials and ensures its dissemination and utilisation by the organisations. The material so produced may be translated into regional languages. Better linkages between the grant sanctioning organisation and the organisation responsible for production of material and its dissemination be developed. Same holds true for production of educative material through specialised agency and be disseminated properly. These efforts should continue in a systematic manner.

Staff employed at the drug abuse prevention centres need to be well trained and dedicated to work they are assigned with. Dealing with the drug addicts has its inherent problems because of the nature of the disease. It may take long for an addict to come out of addiction and to fully reintegrate into the mainstream of life. Frequent relapses may also occur. The staff need to have patience, be empathetic to the addict and understand his problem and reaction of the family and the community towards addicts. The staff, therefore, need to develop skills in dealing with addicts. They should be versed in conducting effective counselling sessions, identification of addict's needs, involving an addict into his treatment process, seeking family's and community's cooperation, carrying out group counselling and family counselling sessions, consulting other team members and an addict to jointly work out a plan of action that suits an addict within his milieu and culture, engaging addict in day care and recreational activities and planning out after care approaches.
towards treatment of an addict. The staff should have ability in establishing better linkages with other agencies for the purposes of referral, dissemination of knowledge, training of personnel and to carry out joint programmes. It should also have an ability to mobilise community resources and plan out various awareness building and preventive education programmes within the community.

The organisations do encounter difficulties in getting qualified and experienced staff at their centres. They also face difficulty in sustaining the available staff at their centres. The problem could be dealt with by imparting in-service training of varied duration to the staff. National Institute of Social Defence conducts such courses in collaboration of different organisations and institutions of a duration of three days, seven days and fifteen days and train about 1200 functionaries in a year. The efforts of NISD alone is not sufficient to train a large number of functionaries employed in the field. In order to fill in the back log of training, the organisations/institutions located in different regions and having expertise and facilities for training may be identified to meet training requirements of their region. On the job training may also be provided by the senior staff to the junior ones. In addition pre-job training facilities may be strengthened by the incorporation of drug abuse content appropriately in the curriculum of medical and paramedical professionals and students of social work, psychology and other social sciences disciplines. The curriculum of school and college students may also include adequate knowledge on the subject at appropriate levels. More of the youth leaders are required to be trained in view of wider network of National Social Service volunteers and volunteers under the Nehru Yuva Kendras scheme available in the country. Youth leaders certainly could be more responsible and effective as the problem of drug addiction strikes this group to a great extent.

REHABILITATION

Rehabilitative approach through compulsory treatment in institutions set up under the law is neither feasible nor practicable in Indian context. Keeping in view the culture specific nature of the problem it is considered more appropriate that the responsibility for rehabilitation of the drug abusers continues to be discharged by his family and the social group to which he belongs, with such support from the State as is found necessary on an individual basis. Community based agencies including education, religious, health and social welfare organisations have a vital role to play in regard to the identification, referral and mobilisation of rehabilitative resources.

In practice detoxification is given importance being a shorter and quicker process. However, rehabilitation and aftercare, though continuous and longer process but an essential way to recovery of addicts, is usually neglected.
The objective is not merely to achieve abstinence from drugs. The aim should be to minimise repeated relapses. Therefore, problem needs to be tackled with understanding, concern, dedication, love, tolerance, etc. The rehabilitation process may encounter problems such as lack of necessary desire to be drug free on the part of the addict, inadequate facilities for detoxification, lack of community and family support and inconducive atmosphere at home and in the surrounding environment, lack of trained and experienced manpower, unsuitability of location, set up and inadequate facilities provided by welfare institutions for addicts, economic set backs and problems in getting re-employed, etc.

A well planned rehabilitation process is required in each case. Concerted efforts of various organisations/institutions within the community should be channelised to meet the needs of addicts and fulfilling the desired goals.