CHAPTER X

SUMMARY AND RECOMMENDATIONS

This chapter provides an overview of the study's findings and the recommendations on the basis of the findings.

The study was conducted to study the functioning of eight counselling centres from five non-governmental organisations in Delhi, providing services to drug abusers. The data, collected about the working of these centres, cover their physical aspects and the services provided by them. An attempt has also been made to assess the effectiveness of these centres and to suggest measures for improvement.

Data were collected about the addicts in two distinct categories. One category includes all the addicts registered with these centres between 1990-92. Detailed information was also collected, through personal interviews, from a sample of 125 addicts who utilized the services of these centres. The information elicited from the respondents related to their socio-economic background, the type of drugs abused and the consequences which they and their families faced due to drug abuse. The type of facilities extended by the centres to them and their assessment of the same. This helped not only to get an overview of the addicts in general but also to get in-depth information about the selected respondents.

SUMMARY OF THE FINDINGS

PROFILE OF ADDICTS

Geographic Distribution

Due to the very nature of the sampling design, the addicts were found to be residents of various parts of Delhi, i.e., East, West, North, South and rural Delhi (depending mainly on the location of the centres). Except 14%, who were from Delhi's rural belt, the rest were from various urban pockets. Nearly half (46%) resided in private colonies followed by those inhabiting slums/resettlement colonies/unauthorised huts adjoining such areas (17%). An almost similar proportion was found to be living in DDA flats (16%).
Migration

More than half (55%) of the addicts' families were reported to have migrated to Delhi in the past from the very States whose border areas have been known to serve as transit points for the influx of drugs, i.e., U.P., Punjab and Rajasthan. The other States included Haryana and Tamil Nadu. The sample also included one family which had migrated to India from Myanmar.

Age

Nearly half of the addicts were in the prime of their life, i.e., between the ages of 21-30 years. Those between 31-45 years comprised about one fifth of the sample. It is worth noting that about 7% of the addicts were found to be below 20 years of age.

Sex

With the exception of two females, the remaining respondents were males. Even in case of the addicts registered with the centres during 1990-91 and 1991-92, female addicts were found to have reported only at half of the centres and not more than three female addicts at any one of the centres came for treatment. The data indicate that the problem of addiction was much more prevalent among males than females. At the same time, it is very likely that the social stigma attached to the problem may have prohibited the female addicts to report for treatment. This, however, is an area that requires further exploration.

Educational status

A majority of the addicts (63%), who availed of the services of the counselling centres, had low educational attainment (up to the middle level or below). Of these, about one fifth were illiterate.

In contrast, about 20% of the addicts, who received treatment at the counselling centres during 1991-92, were graduates/technical graduates and above, as against 8% in 1990-91 (the percentage for this category was 9% in case of the respondents who were interviewed by the researcher).

Even amongst the adult family members of the addicts' families, the level of literacy, in most cases, was low. About one third of the members of the addicts' families (30%) were illiterate, another one third (32%) included literate (without schooling or education just up to the primary level). Those with higher education (up to graduation or above) were just 7%.

Marital status

The data, both from the counselling centres as well as the sampled addicts, revealed that married addicts (55%) out-numbered the unmarried ones (upto 40%). One of the reasons for this was that a substantial proportion (over two-fifths) of the respondents reported to have got married when they were only 20 years of age or even lesser.
Among the addicts, the proportion of the separated, widowed and the divorced respondents was found to be more than their representation in the general population distribution. The percentages of these categories were to the extent of 7% and 2%-3% respectively for the sampled addicts and for those registered with the centres during 1990-92. In fact, in about 37.5% of the separated addicts, drug addiction was reported to be the cause for separation.

Occupation

Nearly one sixth of the registered addicts (15.8%) and 11% of the sampled addicts were found to be unemployed. The main occupations of the gainfully employed addicts were found to be petty business, transport work, scooter driving, rickshaw pulling, manual labour and government service. The percentage of addicts who were self-employed or were engaged in some petty business, shop keeping, property dealing, etc. was 38% in case of respondents and nearly 20% in case of those listed in the centres' records. The labourers and those engaged in low paid jobs such as peons/fourth class employees constituted as many as 18%. The percentage of scooter drivers, rickshaw pullers, and transport workers was up to 17%. About one tenth of the addicts registered at the centres were found to be working in government service as attendants, clerks, assistants, etc. The data showed that drug addiction cut across various occupations, enveloping people from all walks of life and sparing no one.

Nearly half of the members of the addicts' families were found to be either housewives or students. The earning members in the addicts' families were mostly engaged in the occupations pursued by the addicts themselves. Some of the other occupations followed by the other working members in the families were petty business, cloth selling, junk dealing, and self-employment (42%). Some of the members were also engaged in rickshaw pulling/scooter driving and transport work (11%) with another 10% working as labourers. Only 2% were found to be working as professionals.

Income

Over three fifth of the respondents had monthly incomes of up to Rs. 2000/- per month (57.6%) while those with incomes up to Rs. 3000 and above were less than one fifth (16%) of the sample. In contrast, more than 90% of the addicts registered with the counselling centres during 1990-92 had monthly income up to Rs.3000/-. The data are indicative of the fact that addicts even from relatively higher income brackets also availed the services of the counselling centres. According to the data, nearly one tenth (14%) of the respondents and one fourth of the registered addicts also reported having no income.

Considerable variation was observed in the data relating to the monthly incomes of the addicts' families. In fact, in terms of the monthly incomes, the respondents' families could be grouped into three more or less equal groups. Thus, one third of
the families had incomes of up to Rs. 2,000 per month (In this category, there were 8% wherein the family income was found to be up to Rs. 1,000 per month). A slightly higher proportion of the respondents (37.6%) reported their families' incomes to be between Rs. 2,000 to Rs. 5,000 per month. In contrast, the families' incomes in case of the rest (31%) were reported to be higher than Rs. 5,001 per month, with some families earning as much as Rs. 20,000 or above.

Religion and caste

Information pertaining to religion and caste could be obtained only from the respondents. The data showed that a majority of them (63.2%) were Hindus, followed by Sikhs (20.8%), Muslims (12%) and Christians (4%). Compared to the religion-wise distribution of Delhi's population, the data showed that the proportion of Sikhs in the sample was higher. However, this can possibly be due to the fact that some of the centres in the sample catered to areas predominantly inhabited by the Sikhs. The data also show that 27.8% of the Hindu respondents belonged to the scheduled castes.

Type of Family

Over one half of the respondents (54%) belonged to nuclear families while 44% belonged to joint families. The addicts' families were moderate in size with an average of 5 members.

NATURE AND EXTENT OF DRUG ABUSE

Information was collected from the sampled addicts on various aspects of drug addiction. The data provided by the counselling centres also reflected the type of drugs abused by the addicts. The information so received from these two sources is presented below.

Drugs abused

The data indicate that more than half of the respondents (56%) consumed more than one drug during the total span of their addiction. About one fifth were found to be abusing more than two drugs at the time this study was conducted. In contrast, the proportion of the addicts registered with the counselling centres during 1990-92 showed that only about one tenth (11%) of abusers used more than one drug. A possible reason for this can be the addicts' hesitation in providing a bluntly truthful picture to the centres of the quantity and type/s of drug/s taken by them. In contrast, they possibly found it easier to relate to the researcher and, therefore, projected a truer picture concerning drug abuse by them, notwithstanding the fact that it was a grimmer one.

Brown sugar/smack was reported to be mainly consumed by the respondents. The data show that, irrespective of the fact whether they abused a single drug or more than one drug, three-fourths of the respondents (75%) were addicted to this drug. For
the addicts registered with the counselling centres', the corresponding figures were reported to be 65% and 47% respectively during 1990-91 and 1991-92. The counselling centres' data also showed up to 20% to be addicted to alcohol (alcoholics were not included in the scope of the study).

Addiction to other narcotics like opium was reported by about one tenth of the respondents (11%), the corresponding proportion for the registered addicts being only 5.4%. While the proportion of the respondents, addicted to morphine, pethidine, heroin and codeine, was only 3%, the figure for the addicts (reportedly abusing these drugs) registered with the centres was between 5%-7% during 1990-92.

Only 6-7% of the addicts in both the categories (respondents as well as the registered addicts) were found to be addicted to cannabis. This drug was mainly abused in the form of ganja or charas. In case of abusers of more than one drug, it was usually consumed in combination with smack or alcohol. Addiction to drugs like cocaine, barbiturates, and tranquillisers was reported to be in rather minuscule proportion, i.e., less than 1%.

Analysis of the data on abusers of more than one drug among the respondents showed that two-thirds of them took two to three drugs. Most of these addicts (around 90%) abused drugs in combination with smack/brown sugar. More than half (57%) even abused cannabis. Nearly one-fourth of the addicts were also found to have abused raw opium/synthetic opiates such as TDZ, prolixon, morphine, nitravit, etc. and tranquillisers (calmose and phenargan).

It is clear from the data that abuse of narcotics, especially smack/brown sugar was prevalent in Delhi. Cannabis abuse also existed to a great extent but might not have been a major cause of addiction to it since it was not used as a common drug of abuse. The other drugs such as raw opium, synthetic narcotics, tranquilizers and barbiturates were also abused to a significant extent (reported in about one-fourth of the cases), mostly in combination and usually not regularly but as a common drug of abuse.

Drugs abused for the first time

It was interesting to observe that, the general notion among the people that addicts begin with the abuse of some socially accepted drugs, has been undergoing a slight change during recent years. The data in this context revealed that two-fifths (40%) of the addicts had started by abusing smack/brown sugar. The consumption of socially accepted drugs as a first drug of abuse was reported by another 42% of addicts who started abusing alcohol or cannabis whereas little over one tenth (11%) had started by abusing raw opium.
Age at first experience with drug

It is noteworthy that an overwhelming majority of the respondents (88%) was found to have consumed some drug by the time they were 25 years of age. Among them, nearly two-fifths (43%) were between the ages of 16-20 years. One fifth (20%) were found to have started abusing drugs even as children - a matter of grave concern.

Duration of drug abuse

More than three third of the respondents (71.2%) were found to have been consuming the drug for more than 5 years. Respondents who reported abusing drugs for as long as seven years or more were more than half (52.8%). The data is indicative of the fact that the addicts approached the counselling centres only after prolonged addiction.

Frequency of drug abuse and quantity abused

All the respondents were found to be indulging in drug abuse practically every day. Whereas one half took drugs thrice a day, nearly one third consumed drugs twice daily. Nearly one fifth (18%) took drugs even four times or for an unspecified frequency each day.

Nearly one third of the addicts consumed 3/4 gm to 1 gm of smack/brown sugar daily in 2-3 doses. More than 20% abused one and three-quarter grams to four grams of drugs daily. Those who consumed the drug for unspecified frequency could not specify the quantity of the drugs consumed. The daily quantity in case of raw opium ranged from 250 gms to 750 gms. Cannabis was reported to be consumed from 5 gms to 70 gms daily. While synthetic opiates, injected in the form of TDZ, proxivon or morphine, was used to the extent of up to eight ampules daily, tranquillizers, in the form of pills, were consumed on an average from six pills to even forty pills daily.

Drug addiction among family members

More than one-third of the addicts' families had a history of drug abuse. The drugs abused included both traditional as well as illegal lethal ones like brown sugar/smack, alcohol and raw opium. Father and male siblings were found to be the victims of drugs in the family. History of abuse among near relatives, i.e., cousin, father-in-law and brother-in-law was also reported. The husbands of both the female respondents were also reported to be abusing drugs. The abuse of drugs by family members or relatives apparently created a situation which made the family members more prone to drug addiction.

One half of the afflicted family members sought medical treatment of which one-third sought medical help primarily for the problem of drug addiction. That addiction can lead to medical complications and can even be fatal was found in six cases out of 43 (14%) of the addicted family members.
DRUG ABUSE AND ECONOMIC CONSEQUENCES

Expenditure on drugs

In order to support their addiction, most of the respondents found themselves under a heavy recurring financial burden. According to the data, more than half of the addicts (54%) spent up to Rs. 500 per week on drugs on an average. Another one fifth (20%) reported spending between Rs. 901 to Rs. 2000 weekly on drugs. A small percentage reported spending even higher than Rs. 2001 (as much as Rs. 7000) per week. Some of these respondents were compelled to raise resources by even indulging in antisocial activities. A small percentage which was not required to spend any money on drugs was engaged in drug trafficking and peddling.

Taking into consideration the duration of drug abuse and the amount of recurring expenses on drugs, the total estimates of expenses work out to be exorbitantly high. Viewed thus, nearly half (46%) of the respondents spent between Rupees one lakh to five lakhs on drugs, depending on the drug abused and duration of abuse. A smaller proportion had spent even more than Rs. 5 lakh.

The addicts utilised various ways to get money to support their drug habit. Analysis of the multiple responses provided by them indicated that over than three-fourths (78%) used their own earnings. Whereas nearly one-third (29%) got money from their family, 16% reported using even their savings. As shall be detailed a while later, it was found that some of the addicts sold their own and/or their families' household articles as well. A few of them were also compelled to procure money by indulging in antisocial activities.

Impact of addiction on employment

The respondents were divided into three categories as per their employment status. These were self employed, employed in various concerns and students. The data in this context indicated that drug addiction had a definite impact on their work performance. Nearly three fourths (74%) of them, whether employed or self-employed, reported being unable to attend to their work due to drug addiction. The students, similarly, could not pay attention to their studies.

A substantial proportion (60%) of the employed respondents stated that they could not work regularly. More than half (57%) of them frequently absented themselves from their jobs while two-fifths (40%) did so occasionally. Over two-fifths (46%) of these had absented themselves for less than three months and nearly one third for more than six months. The duration of absence from work was more among the self-employed respondents as 58% of those, who could not work, had absented themselves for more than a year (even up to three years) from work and another 32% for less than a year.
The self-employed addicts reported being absent more frequently than the employed ones largely because of the nature of employment, more discipline and accountability being imposed on the latter category. In case of the students, one completely stopped going to school and was debarred. The other one absented himself from most of the classes.

Drug addiction was the basic reason for change of job in case of nearly half of the addicts. The change in job(s) was the outcome of factors like their inability to cope up due to drug dependence, threat of suspension or termination of their services or the wish to avoid drug-inducing environment at the work place.

Those addicts who were not able to work due to addiction obviously encountered financial loss. This loss was more among the self-employed addicts than the employed ones. The estimated amount of money lost by the addicts, whether employed or self employed showed that the loss ranged from a minimum of Rs. 10,000 up to as much as five lakhs, depending on the duration of absence and the duration and type of addiction.

Nearly two-thirds (63%) of the self-employed respondents, who were unable to work, had no one else to look after the work performed by them. In other cases, members of their families and partners/employees managed the job.

In case of about half of the employed addicts, the employers could know about the former's problem of addiction. Around three-fifths (58%) of these employers expressed an attitude of sympathy and advised them to give up drug taking. In some cases (11%), however, the services of the addicted employees were terminated. It was ironical to find a small proportion of employers (8%) who were reportedly pleased with the respondents' addiction habit as it initially resulted in increased work output.

Drug Addiction and socially unaccepted activities

A large proportion (57%) of the respondents were found to have sold their own and/or their family members' belongings, household articles, etc. to support their drug habit. The items sold for this purpose included ornaments, watches, utensils, furniture, means of transport, motor parts, etc.

Nearly one-fifth (18%) of the respondents reported using anti-social activities to satisfy their craving for drugs. These included stealing of money/belongings (44%), supplying drugs to others, snatching of drugs, pickpocketing and even committing a murder.

Two fifth (40%) of the respondents reported having a brush with the law. In fact, more than one-fourth (28%) of them were apprehended for possessing drugs, another 18% while they were actually consuming drugs and a similar number while receiving it from others. The other acts and events which brought them into
conflict with law were supplying drugs, accidents, stabbing and murder, gambling and pickpocketing, fighting, etc. These data clearly point out to a nexus between drug addiction and anti-social/criminal activities.

Reasons for drug abuse

A large majority of the respondents (70%) started with drug abuse mainly because of peer group pressure and friends' company. Some of the other common factors in this regard included curiosity, experimentation and enjoyment in case of nearly one fifth (18%) and a sense of adventure (reported by 20%) of the addicts. Psychological factors giving rise to stress and strains, medical reasons, excess of money, improvement in work efficiency, etc., were reported to be the other causes leading to drug abuse.

Drug dependence was found to be the main reason for continuing drug abuse in case of two thirds of the respondents (66%). Peer group pressure and friends' company were the other reasons for continuing drug abuse as reported by nearly one fourth (22%) of the addicts.

It is clear that peer group pressure plays a very important role in introducing the individual to drug abuse. It was mainly in the company of friend(s), neighbour(s)/locality boys and colleagues at work that some drug was consumed for the first time by a very large majority of the respondents (80%). Subsequently, half of the addicts (50%) were found to continue to consume drugs, mainly in the company of friends, while the other half started taking the drugs alone.

Medical implications of drug addiction

Over two-fifths (42%) of the respondents were found to have developed medical or psychiatric problems while on drugs. The physical problems comprised mostly respiratory problems, including tuberculosis, in about one third (31%) of those afflicted with medical problems. The other physical problems were mainly those related to the digestive system (reported by 21%), skin and muscular problems (stated by 23%) and feelings of general weakness and loss of weight (19%) of addicts.

A small proportion (6%) of the addicts were also found to have developed psychiatric problems due to addiction. A comparison of the data about the incidence of psychiatric problems in the respondents with that of the general population indicated that drug addicts were comparatively more prone to develop psychiatric problems than the general population, the rate of prevalence of psychiatric problems in the latter being estimated to be between 1%-2%.

Family, friends and drug behaviour

The addicts encountered mixed reactions of their family members and friends, depending on the latter's understanding of the problem and social values and stigma attached to the problem of addiction.
A sizeable majority (58%) of the family members felt bad and reflected their worries on learning about drug abuse by one of their family members. In contrast, nearly two-fifths (39%) of the families expressed their annoyance and anger in different forms. Quite a few (22%) advised the addicts to give up drugs. However, negative and non-supportive attitude such as hopelessness, being ashamed of the addicts' act, indifference and desertion by the spouse were expressed by a smaller percentage of family members.

On the basis of their reaction to the addicts, the friends could be grouped into three categories. The largest category comprised those who showed a positive sense of concern (42%) about the addicts, advised them to leave the drug or even took them for treatment. The second largest category comprised those who broke the friendship (39%). The third category included those who did not show any particular reaction or they themselves were addicted to drugs (26%).

In case three fifth of the addicts, family members helped them in solving their problem. Help from friends was reported in a much smaller percentage (9%). In contrast, 17% of the addicts did not receive help from any quarter.

Nearly two-thirds of the respondents (63%) who received help, reported being escorted to treatment centre, hospital or detoxification centre by the family members and/or friends. About one-fifth (17%) were only informed about the availability of some treatment facilities at the treatment centres, while another 17% were merely advised to give up drug taking.

COUNSELLING CENTRES

Organizations running counselling centres

The five non-governmental Organizations, running the eight counselling centres included in the sample, were found to be engaged in conducting a variety of social welfare activities in the field of women welfare and development, youth welfare, public health and nutrition, child welfare, education and adult education, indoor facilities for the psychiatric patients and prevention and control of drug abuse. Training of personnel and home science students, research and documentation were some of the other activities performed by these centres.

All the five Organisations were registered bodies and had existed for more than five years in the field of social welfare. Except two organisations which had branches in other States, the rest were confined to Delhi. All were receiving funds from the Ministry of Welfare to undertake programmes for drug abuse prevention. They also raised funds through fees, donations, cultural programmes and international bodies and missions.
Objectives of the counselling centres

The centres were mainly geared to provide counselling services, out-patient treatment facilities, awareness generation and preventive education. Some of the other objectives (mentioned only by one or two centres) were identification of clients, referral for detoxification, family counselling, follow-up services, motivation of clients, provision of day care services, rehabilitation of addicts, group therapy, and organization of training programmes and research.

The responses received from the centres appeared to indicate that they were not clear about the basic objectives for which they had been set-up. Only counselling, awareness building, preventive education and provision of treatment facilities were the objectives which could be said to be broadly attempted to be realized by most of the centres. The other important objectives were not realized by most of these centres.

Activities of the counselling centres

Two functions were mainly reported to be performed by most of the centres. These comprised implementing out-reach programmes (all the centres) and conducting counselling sessions (6 out of 8 centres). Three of the centres reported undertaking group and family counselling sessions. Paying home visits, extending follow up services, training of workers, providing day care services, identifying and examining the addicts, providing referral services, extending support in the formulation of self-help groups and performing awareness building programmes in schools were the functions reported to have been undertaken only by a couple of centres.

Location and set up of the counselling centres

The counselling centres selected for the study were set up between the years 1986-91. By 1992, all of them had been functioning for at least one year or more. Five of the centres had been operating since or before 1988.

Except one centre functioning in a semi-rural area, the rest were located in different areas of urban Delhi. The services of these centres were mostly concentrated within a radius of 3 - 5 kms. Some of these centres even extended services to a distance up to 10 - 20 kms.

Situationwise, the centres were located in private colonies, congested commercial area, near resettlement colonies, jhuggies and village and in a college campus. Half of the centres, functioning in rented accommodation, had been shifted to new accommodation within two years of their operation. The rent ranged from Rs.500/- to Rs.5000/- per month. Two of the centres were provided with free accommodation by the university and the civic authorities.
Infra-structural features of the counselling centres

The centres differed in terms of the accommodation available with each. The plinth area covered by each centre ranged from as little as 32 sq. ft. to 200 sq. ft. Half of the centres had grossly inadequate accommodation, having just one or two rooms with or without any waiting place. With the exception of one centre with satisfactory space, the rest could, at best, be called as having barely adequate space.

Except one centre, all the centres had adequate number of chairs and tables. However, other items of furniture, so essential for the functioning of a counselling centre like a file cabinet, almirah, examination table/bed for patient, etc., were available at only two centres.

The equipment, apparatus to check blood pressure and stethoscope were available at 6 out of 8 centres. Apparatus for weighing were also available at three centres. Only one centre had telephone facility. Except one, all the centres had electricity. It was surprising to find that two centres did not even have adequate water supply.

Only one centre had laboratory facilities. Two of the centres did not refer their clients for laboratory tests. Another four centres got these tests done at a de-addiction clinic run by the same organization to which they belonged to or through private clinics.

Little over one fourth of the respondents (29%) felt that the centres had inadequate space. Lack of care facilities during day-time and recreation facilities were also mentioned.

Staffing

Under the scheme of the Ministry of Welfare, besides other inputs, the counselling centres were provided with service and supportive staff. The service staff included a project coordinator, counsellors, social workers and psychiatrist/medical officer. The supportive staff consisted of clerk-cum-accountant, peon, driver and sweeper.

Considered in-charge of the counselling centre, the project coordinator was available at all the eight counselling centres. One of the organisations with two centres had one project coordinator for both of its centres. Thus, seven project coordinators in all looked after the eight centres covered under the study.

Under the Ministry's scheme, each counselling centre was required to have two counsellors and two social workers. Against this staff allocation, in place of having 32 appointees in eight centres, there were only twenty four. Specifically, counsellors
were appointed by only four centres. Social workers (20 in number) were given different designations like welfare officers/social workers-cum-counsellors/ social workers, etc.

Data regarding the educational qualifications of the project coordinators, counsellors and social workers show that four-fifths (80%) of them had post graduate degrees and the remaining were graduates. Almost two-thirds (65%) had a degree in social work while the others had degrees in sociology, psychology, clinical psychology, home science, commerce, etc. The fields of special interest (in case of those with degrees in social work) were industrial relations, personnel management, medical and psychiatric social work, family welfare, community development and youth welfare. Clinical/abnormal psychology, home science and commerce were some of the other areas of specialisation.

In terms of work experience, the range varied from those with just two months' experience to those with 25 years of experience. Nearly two-thirds (65%) of the staff had experience of one to three years in the field of drug abuse. One-fourth of the social workers had work experience of less than eight months.

None of the staff members had undergone pre-employment training. Nearly one-third had undergone in-service training mainly by attending a two months' course in counselling of alcoholics and drug abusers or by participation in seminars/workshops.

In terms of emoluments, counsellors and social workers drew salaries between Rs. 1500-2000 per month. The salary range of counsellors was a little higher, being between Rs. 2000-2500 per month.

Considerable variance was observed in regard to the duties of the staff in these centres. In some cases, the researcher found it difficult to elicit information about the specific duties of each category of the functionaries. To illustrate, the duties of the project coordinator mainly included coordination and administration of all the activities of the centres; organisation and conduct of awareness programmes, meetings/talks, etc., and maintenance of records and reports (responses available from 2-3 centres in each case).

The counsellors' responsibilities were mainly to conduct the counselling sessions, participate in implementing awareness programmes and pay home visits (responses from only 2-3 centres). The social workers mostly performed duties like conducting individual counselling sessions, carrying out field work and paying home visits and organising awareness programmes. Performing follow-up activities and family counselling, history taking, identification of cases, community meetings and talks, recording and reporting were some of the other duties said to be performed by them.
The other service staff deployed by the counselling centres comprised psychiatrists/medical officers. The data showed that six centres availed the services of a psychiatrist/medical officer mostly on a part time basis (in two cases, as full time staff). These personnel were qualified doctors (with or without a specialisation in psychiatry) and had experience of at least more than a year.

While the part time doctors drew a salary of about Rs. 2000 per month, those working full time received between Rs. 2500-3750 per month. The main responsibility of the medical staff was to make an assessment of the case by carrying out psychiatric examination and prescribing medicines. In two centres, the doctor even carried out the function of counselling the clients.

Registration of addicts at the counselling centres

During 1990-91 and 1991-92, the registration of addicts (new cases) varied from 7 per month per counselling centre to more than 90. The frequency of registration in case of a majority of the centres (five centres) was between 8-16 addicts per month per centre. The average monthly registration at these centres was reported to be 26 addicts. Considering the prevailing rate of drug abuse to be between 1%-2%, the number of addicts requiring counselling services was likely to be far more than the number of addicts actually served at the centres.

Source of referral to the centres

The data revealed that the family was the main source of referral in about two-fifths of the cases. Friends and social workers were referred to as the source of referral by 15% of the cases in each category. One fourth of the addicts also came to the centres on their own. Publicity through news papers, posters/hoardings, etc., was reported to be responsible for referral in very few cases.

Nearly one-third (31%) got to know the centres through ex-addicts or friends who were themselves drug addicts. Friends (other than addicts) also played a helpful role in 17% of the cases. Awareness building, preventive education programmes and community visits by the staff of the counselling centres were stated to be responsible for creating awareness amongst 30% of addicts. In contrast, family members, colleagues or relatives were reported to have acted as informants only in a small number of cases.

TREATMENT OF ADDICTION

Drug addicts may or may not visit the treatment facilities in order to be free from the clutches of addiction since it depends on their understanding of the problem, its severity and various factors associated with their personality and environment. They may visit a single agency or might avail services from a number of agencies. The visits to these agencies
may or may not be regular (as required for effective treatment). All these aspects were studied for the sampled addicts who received treatment from the counselling centres.

Realisation of the need for treatment

An overwhelming majority (90%) of the respondents realized that their addiction warranted treatment. Whereas nearly one-half (48%) visited drug prevention agencies, little over one tenth visited de-addiction units attached to hospitals. Nearly one-fourth (27%) were willing to undergo treatment or got themselves treated. Only a small percentage contacted private practitioners, friends or imposed self-control on themselves.

Agencies approached by addicts for treatment

Over 60% of the addicts were found to have approached a single agency for treatment, i.e., some counselling centre. One-fifth visited two organisations while 17% visited more than two such organizations.

From amongst those who approached a single agency for treatment, only one fourth were exclusively treated at the counselling centres. In case of a sizeable majority (61%), treatment at the counselling centres was made available along with referral to other agencies for detoxification. The remaining respondents received services at the counselling-cum-detoxification facilities offered by the organization to which the counselling centre belonged. Three-fourths of the respondents required facilities for detoxification along with services of the counselling centres.

Multiple responses were obtained from the respondents who approached more than one organization for treatment. A significant proportion (61%) of them visited counselling centre as well as a detoxification centre. Nearly one-fifth in each case were found to have approached private practitioners, private clinics/nursing homes, hospitals and/or dispensaries. Services of the Nav Jyoti Clinics, managed by the police, were utilised by 13% of the addicts. The other service units which a small number of the addicts approached included detoxification camps, yoga ashram and counselling centres.

Most of the addicts received services from a of single agency. However, a large number of addicts were reported to have shifted from one treatment agency to another. The likely reasons could be lack of faith in treatment, non-availability of services at one place, fear of law, nature of disease as compounded with frequent relapses, etc.

Duration of treatment

Taking into consideration the duration of treatment at other agencies and the counselling centres, nearly half (48%) of the addicts received treatment for upto three months. Only one fourth of the addicts had treatment ranging from one and a half years to as long as nine years.
Over one third (34%) of the respondents received treatment from the counselling centres for a duration of one month or less. Most (42%) of the addicts received treatment for up to three months. A small number was also found to have been treated (16%) for more than one and a half years.

The duration of treatment at other agencies was less than three months in nearly four-fifths of the cases (76%). The treatment extended by the counselling centres was mostly for a short duration. It was, however, for a longer duration in comparison to treatment given by the other agencies. Two-fifths (40%) of the addicts were treated for more than six months.

Frequency of visits to the counselling centres

Around 60% of the addicts visited the counselling centres 1-2 times a week for a period of up to six months. Only one-fifth of the addicts visited the centres daily for treatment. With increase in the duration of treatment, the percentage of those who visited daily came down to just 7%. On the contrary, the number of those who visited on a fortnightly, monthly or occasional basis increased with increase in the duration of treatment.

Three-fourths of the addicts were reported to be regular for treatment as prescribed by the counselling centres. A very large majority (85%) of those, who were irregular in treatment, reported that they had been contacted by the staff of the counselling centres.

SERVICES OFFERED BY THE COUNSELLING CENTRES

The data revealed that a substantial number of the addicts were treated only through out-door facilities. This could either be due to a limited number of detoxification services or due to a notion whereby outdoor services were perceived to as effective as indoor services - an aspect which needs further investigation.

Seven centres out of eight provided out-door services. While three of the seven centres had provisions for in-door facilities at the detoxification centres run by the same organization, one centre had an attached de-addiction unit located in the same premises.

Over half (54%) of the respondents were provided with out-door facilities at the counselling centres along with in-door detoxification at other places. Another sizeable segment (36%) was treated only through out-door services, either at the counselling centres or both at the counselling and detoxification centres.

Type of treatment provided by the counselling centres

The respondents were reported to have received both medical and psychological treatment at the counselling centres. Medical treatment predominated at all the centres as nearly all the
addicts received medicines at these centres. A very large majority (84%) of the addicts were reported to be detoxified or were referred to other agencies for detoxification. Individual counselling sessions were reportedly undertaken in case of almost all the addicts. Group sessions were reported to have been conducted for comparatively lesser numbers (59%)

The role of families in the treatment process was obviously not well recognised as only 6% of the addicts' families were advised or counselled. It was found that nearly one fifth of the addicts were attempted to be educated through video film shows. Other measures in this regard included the provision of educational inputs through meetings/seminars, recreation and day care activities and organisation of Narcotics Anonymous (NA) meetings.

Medical treatment

As mentioned earlier, almost all the addicts received medicines. The information received from the counselling centres shows that 6 out of 8 centres provided medicines. The addicts in contact with two of these centres (did not supply medicines) received medicines from the de-addiction centres while undergoing detoxification. The medicines most commonly used by the centres were sedatives, hypnotics, tranquilizers, analgesics and vitamins. The drugs were used as a form of symptomatic treatment to take care of withdrawal symptoms and to improve the addicts' general health.

The response received from the centres varied about the need for psychiatrist's opinion in the treatment of drug addicts. According to one half of the responses, the psychiatrist's opinion was useful whereas the rest did not feel it to be necessary. Consequently, the services of part time psychiatrist were felt to be sufficient at a counselling centre.

Detoxification

The response from six centres projected the view that almost all the addicts required detoxification. The opinion in case of the rest was that a majority of the addicts (60%), who started abusing drugs in the recent past, did not require detoxification. In their view, only chronic cases, that too of alcohol and cannabis addiction, required detoxification. According to the response from one of the centres, the smack addicts did not require detoxification.

With rare exceptions, the respondents were reported to be detoxified while under treatment at the counselling centres. Five centres out of eight had facilities for detoxification. The others referred the cases to different organisations/hospitals for this purpose. During 1990-91, most of the addicts were detoxified through out-patient detoxification at the counselling centres or through referral to the detoxification centres. The reason was limited availability of beds for detoxification or because out-door detoxification was presumed to be equally effective, an area which needs further investigation.
Medical tests

Information provided by as many as six centres indicated that some laboratory tests were necessary in order to take proper care of the addicts' physical problems. The main tests indicated for this purpose were Blood test, Chest X-ray and Urine test. Mention was made in only one centre about the need for the HIV test. It was somewhat surprising to find that, in case of one centre, the view prevailed that there was no need to conduct any such tests.

According to two-thirds of the respondents, blood test, urine test and chest X-ray had been carried out on them, the proportion varying between around 50% to 66% for different tests, while they were under treatment at the counselling centres. A small number also indicated that sputum test, stool test and test for AIDS were also carried out.

The tests were carried out in about half of the cases at the de-addiction clinics of the hospital and for about 45% at the de-addiction centre/clinic of the organization which managed the counselling centre. Only 6% of the respondents were found to have got these tests conducted at some private clinics.

COUNSELLING SERVICES

Individual counselling sessions

Most of the addicts (95%) were reported to have participated in individual counselling sessions while under treatment at the centres. As per the counselling centres' data, these centres performed 6-10 counselling sessions per day. However, the average number of sessions performed per addict worked out to be only two to three sessions. Information provided by the project coordinators showed that, on an average, five individual counselling sessions were provided in each case with the range extending to as many as 25 sessions, depending on the need of the case.

Over two-thirds of the respondents (68%) mentioned participating in more than five individual counselling sessions. While one-third of the addicts had as many as 15 counselling sessions, the frequency of such sessions was reported to higher still in case of nearly one-fifth. (The range of sittings was found to as varying from 26 to as many as 100).

As per information provided by half of the centres, the duration of these sessions was mostly 30-45 minutes. Counselling sessions in case of three centres were reported to last from 15-30 minutes and in one case for just 15 minutes. In case of three centres, it was opined that there was inadequate space to perform counselling sessions.

According to information provided by five of the centres, efforts were made in the counselling sessions to understand the
reasons for drug abuse and problems associated with addiction. Building self-image and self-confidence in the addicts and enabling them to bring out their positive qualities were the aspects discussed in these sessions. The sessions were also used to understand and improve inter-personal relations with family members. Some of the other aspects covered in the counselling sessions (responses from three centres) included understanding of social and family background of addicts, motivating addicts to leave addiction and helping them in decision making, etc.

A majority of the respondents (61%) recalled being informed about the ill-effects of drug abuse during these sessions. Nearly half of them mentioned that they were told about how to say no to drugs. According to one-third, their drug problem was discussed in detail during these sessions. Only upto one-fifth stated that aspects like building of self-confidence and implications of drug abuse on family, health and employment, etc. were discussed. They were also advised to keep themselves occupied and also on need for utilising day care services, maintenance of good health by consuming proper diet and regular exercises.

With few exceptions, the addicts found the counselling sessions to be useful. The reasons for viewing them as useful included the provision of factual information, creation of awareness about the ill-effects of drugs and motivation to leave the drug. According to the data from seven centres, the counselling sessions seemed to be perceived as useful by their clients since they provided opportunities to the addicts to express themselves freely.

In the context of counselling, it was learnt from the centres that the main problems comprised the irregularity of addicts in attending the sessions and the lack of support from the family (reported by three centres). Some of the other problems reported by the centres were lack of privacy, unwillingness on the addicts' part to bring their families, non-realization of the importance of counselling sessions and expressing more faith on the medical treatment than on the psycho-social approach.

Group counselling

Nearly three-fifths (59%) of the sampled addicts had been exposed to group counselling sessions while under treatment at the counselling centres. In this regard, the counselling centres' data revealed that, on an average, each centre had conducted 14 group counselling sessions in a month during 1991-92. The average number of such sessions per addict ranged between 1-6 'for a group of six members. It was also learnt from two of the centres that group sessions had been conducted for a group comprising both addicts and family members.

Two types of groups were utilised for conducting group sessions. One comprised an open group, consisting of drug abusers of different drugs with the members encouraged to share their
experiences with one another. The second type was a close group with specific and common problems. Herein, the members discussed their specific problems with concern and even offered solutions. In either case, the members learnt from each other's experiences through these groups.

On an average, the group consisted of six members (ranging from four to ten) as per information obtained from the counselling centres. One of the centres reported using an eclectic approach in the group sessions and another followed the 12 point A.A. philosophy. The foregoing also appears to indicate that, compared to individual counselling, group counselling was accorded lesser importance by the counselling centres.

**FAMILY AND TREATMENT**

According to the respondents, their families had played an important role in their treatment. Out of 70% of the addicts who sought help, while on drugs, nearly three-fourths were helped by family members. The latter accompanied the respondents to the counselling centres for treatment (reported by about one-half) during the first visit. Among the family members, the mother and spouse played a major role. In case of follow-up visits, about one-fourth were accompanied by their family members.

Members of the families not only accompanied the addicts for treatment but majority of them (92%) also extended cooperation in many other ways. According to more than one-fourth of the respondents, the family members took them to the detoxification centres as well and provided care and support during treatment. One-fifth of the addicts also reported that members of their families had extended economic support to them. A few (10%) expressed that emotional support was available to them through their families.

Family counselling

The importance of family counselling in the rehabilitation process was endorsed by all the centres. The sessions were used to make an assessment of the inter-personal relationships within a family and the needs of the addicts and their families.

According to the data from three fourth (6 centres) of the centres, family counselling sessions were perceived to be useful or helpful by most of the families. The response from the families, as indicated by the rest of the centres, was that these sessions were perceived as satisfactory.

In practice, however, only three centres reported having organised family counselling. Further, a very small proportion of the respondents' families (6%) had been involved in these sessions organised at these centres. According to the data made available by the counselling centres, the average number of family counselling sessions, conducted during 1991-92, worked out to just 1-2 sessions per family with a range between 1-7 sessions. The average number of family counselling sessions per centre per day worked out to be less than 3. In case of two
centres, the number of family counselling sessions was less than the number of addicts, reflecting that all the families were not counselled.

Information from the centres showed that the spouse and parents were mainly involved in family counselling sessions. Amongst the parents, the mothers of the addicts were mostly reported to have participated in these sessions since it was found more difficult to secure cooperation from the father in this regard. Some of the other problems, encountered in conducting these sessions, were the problem of non-cooperation on the part of the families (reported by half of the centres). This non-cooperation might had resulted from frequent relapses and loss of faith by family members in the addict. Whereas the timings of the centres did not suit many of the family members in some cases, in some other instances, the emotional attitude of the mothers towards the addicts proved counter-productive.

FAMILY VISITS AND FOLLOW UP

Home visits were stated to be undertaken by all the centres. Five centres reported to follow-up addicts through letters. One of the centres utilised the telephonic facility for this purpose.

Nearly 88% of the respondents informed that their families had been contacted by the counselling centres. Home visits were reported to have been made by the social workers and/or the counsellors in case of three-fourths of the families. Whereas home visits by the social worker and the counsellor were reported by nearly 40%, a somewhat lesser proportion of the respondents (34.4%) mentioned about home visits having been made by the social workers alone. Home visits by the counsellors alone were reported by just 15% of the respondents. A still smaller proportion of the respondents informed that they had been contacted only at the centres.

According to the views obtained from six counselling centres, the purposes of paying home visits were mainly to assess the social background of the addicts, their status in the family and to verify the information given by the addicts. The other purpose was to understand the inter-personal relationships in the family. These visits were also utilised to conduct family counselling sessions and to pursue the families on their role in treating the addicts.

As mentioned by the addicts, during the home visits, their families were advised to have a sympathetic, loving and supportive attitude towards them, pursue them to continue with the treatment and to keep a close watch on them so that they did not restart drug abuse.

The data indicate that home visits were utilized to assess, counsel, educate, motivate, seek the families' cooperation in the treatment process and follow-up. Both counsellors and social workers performed this duty.
DAY CARE SERVICES

Only two centres had provision for day care facilities for the addicts. According to information provided by these centres, day care facilities were helpful in keeping the addicts occupied and away from the drug-prone environment. The services included the provision of some indoor games like carrom and facilities for drawing, painting, making of greeting cards/envelops, showing video films and engaging in some office work.

Only 7% of the respondents were found to have utilized day care facilities while under treatment at the counselling centres. It was found at one of the centres (it had maintained a record of day care services) that only 50 addicts in a year were extended day care facilities at the centre for about 2-3 months per addict.

SELF-HELP APPROACH

According to information provided by the staff of three counselling centres, the addicts were helped in forming self-help groups. These groups provided opportunities to the addicts in sharing their views with one another in decision making, in boosting motivation to keep off drugs and in building self-confidence. Friends and ex-addicts were also reported to be instrumental in case of nearly one-fifth of such addicts in forming such groups which were felt to be useful. In this context, it may be noted that only 14% of the respondents were members of the Narcotics/Alcoholics Anonymous (NA/AA) group.

DROP OUTS

The data available at the counselling centres for the years 1990-91 and 1991-92 showed that a small proportion (10% to 14% respectively) of the registered addicts discontinued treatment during these years. In contrast, the information received from the respondents pertained to their total span of treatment, irrespective of the agency they were treated at. In their case, about one-third (34%) were reported to have discontinued treatment during the period of their addiction.

A very large majority (86%) of these had dropped out for the first time, indicating that they had discontinued treatment while being treated at the counselling centre. It is worth noting that 9% of the drop outs had discontinued treatment for as many as nine times.

The most common reason for dropping out of treatment (stated by 44% of the addicts who had discontinued treatment), was a strong urge to take drugs. Inability to visit the centre because of its unsuitable timings or the type of jobs performed by the addicts were the reasons for dropping out in case of 14%. Absence of relief, influence of friends and mis-conceptions were the reasons for drop out in case of another 12% of the addicts.
The causes for discontinuing treatment, in case of about one tenth (9%) of the addicts related to the functioning of the counselling centres. The responses included location of the centres at a long distance, lack of medicines and unfavourable attitude of the staff at the counselling centres.

**Drug Addiction and Relapse**

Information about relapse was available at only five centres for the year 1991-92. According to it, nearly two-fifths of the registered addicts (37.7%), on an average, relapsed at any of the five centres during the year with a wide range of 14%-43%. Two-thirds of the respondents (66.2%) also revealed that, irrespective of the agency they were treated at, they had relapsed during their treatment. A significant proportion of the relapsed addicts (58%) re-started drug abuse within three months of discontinuation of treatment. Only 9% were found to have relapsed after a year of treatment.

Education concerning relapse prevention was imparted to three-fourths of the addicts. The aspects covered were limited. The addicts were mainly suggested (in about 70% of the cases) to avoid the company of those who abused drugs. The other suggestions including imposing self-control and having a strong will-power in order to refrain from drugs (reported by more than one-fifth of the addicts).

**Cost of Treatment**

The counselling centres provided treatment free of cost. Therefore, two-thirds (67%) of the respondents did not have to spend any money on treatment. Nearly one-tenth of the addicts who were treated at the counselling centres and had availed the benefit of detoxification facilities, reported spent up to Rs.500/- mainly on food and other facilities which were not covered in the scheme of the Ministry of Welfare. In contrast, those who had availed the services of private agencies (13%) were found to have spent from Rs. 10000-50000. It is obvious that the expensive treatment, offered by private agencies, was beyond the reach of the common persons.

**Economic Rehabilitation**

Only half of the centres were found to be taking steps to promote the economic rehabilitation of the addicts. The measures taken included helping the addicts in securing their previous jobs, referral to different agencies for job placement and employing some of them at the counselling centres. The addicts were also helped in receiving vocational training at the Shramik Vidyapeeth, Ministry of Human Resource Development. As revealed by the information received from the addicts, these activities had been extended only to a few addicts and were not intensively pursued.
The addicts' responses show that nearly one-third (30%) of them faced economic crises. A very large majority of these (84%) were not helped at all (or they themselves did not ask for help in this regard). Clearly, the counseling centers did not attach much importance to the addicts' economic rehabilitation.

OUTCOME OF TREATMENT

Besides individual counseling, the services rendered by the counseling centers helped one-fourth of the addicts to finally give up drug abuse. These services also enabled about one-fourth of the addicts to understand that it was not only they who suffered because of drug abuse but other individuals who take drugs also suffer. They were also motivated to undergo treatment.

Only 17% of the addicts treated by the counseling centers were reported to have fully recovered by being drug free for a period of one year or more. Nearly one half (44%) of the respondents either found it difficult to leave the drug (33%) or did not follow the treatment regularly or dropped it (11%). One-fifth were out of withdrawal symptoms but did not complete the treatment. Nearly one-tenth of the addicts did not perceive the services to be useful.

The information received from the counseling centers on the number of addicts recovered during 1990-91 and 1991-92 showed that, on an average, nearly 30% to 40% of the registered addicts recovered during these years. However, a significant variation (from 5% to 50%) was noticed in this regard among the centers.

The average percentage of registered addicts who relapsed and dropped out of treatment was reported to be 38%. As far the drop-out addicts are concerned, 10-13% of the addicts were, respectively reported in this category for the years 1990-91 and 1991-92. The information obtained from the counseling centers and from the addicts more or less matched in regard to drop-out cases and relapsed addicts.

ADDICTS' PLANS FOR THE FUTURE

It was heartening to note that nearly 80% of the respondents were hopeful of becoming drug-free. In about half (46%) of the cases, their plans for future were mainly related to employment. They were either looking for new jobs or trying to secure their previous jobs, taking up employment with better prospects or trying to further expand their existing business. Around one tenth of the addicts desired to settle down in life. Only about one-fifth of the addicts were found to have no specific plans for the future.

AWARENESS BUILDING AND PREVENTIVE EDUCATION

All the counseling centers reported that they conducted outreach activities. These activities were used to create awareness and impart education within the community. The activities performed by around four-fifth of the centers mainly included delivering talks/lectures, organizing public and group
meetings, arranging educational video shows (only one-fifth of the respondents mentioned about exposure to these shows) and distributing handbills containing information about the centres' activities. Half of the centres reported that they had organised rallies and exhibitions. Three of the centres utilised the services of the Song and Drama Division of the Ministry of Information and Broadcasting to conduct programmes for educating the community.

The frequency of organising educational programmes was assessed on the basis of the data available at the centres. Thus, five centres reported organising 2-3 talks/lectures on an average in a month. The rest reported organising as many as 16 to 35 talks/lectures in a month. On an average, the frequency of video shows, in case of half of the centres, was stated to be 1-2 shows every month. Three centres reported arranging 3-4 such shows per month on an average.

According to the views obtained from five centres, the awareness programmes were carried out to sensitise the general public about the need of avoiding drug abuse. Whereas seven centres focussed on creating awareness among school students through these activities, five centres covered attempted to cover the family and parents of the addicts. Youth leaders, women groups and community leaders were barely covered by these programmes.

Only three counselling centres had produced some material for awareness building and preventive education. Material for educating parents and teachers had also been developed by these centres. It was mostly produced in Hindi and English. In case of one centre, such material had also been got prepared in Punjabi to suit the needs of the community in which it was located.

**TRAINING PROGRAMMES**

None of the centres on their own organised any training programme in the field of alcoholism and drug abuse prevention. However, two of the five organisations were reported to have conducted such courses during 1991-92. The courses were organised in collaboration with the National Institute of Social Defence, Government of India. The youth leaders and D.T.C. workers were trained by these organisations.

**COMMUNITY INVOLVEMENT AND LIAISON**

It was reported by all the centres that they had been involving community workers in rehabilitation of the addicts. The influential persons mostly involved included community leaders and local leaders, pradhans, teachers, businessmen/industrialists, etc.

It was found that only half of the centres had established liaison with other counselling centres. Such liaison was limited to availing of detoxification facilities available at the other centres and/or organisations, exchanging of information on the
client and working out a joint programme. One third of the centres were also found to have established a liaison with the enforcement agencies. They shared information about the addicts with the authorities (in case of their legal involvement).

RECORDING, REPORTING AND RESEARCH

All the counselling centres followed their own recording system. While some similarities were found with regard to the type of records maintained at these centres, a considerable amount of differences existed vis-a-vis the method of recording. The type of records mostly maintained at these centres were:

(i) Register for registration of new cases (maintained by all centres).
(ii) History Form (7 centres)
(iii) Home Visit Register (6 centres)
(iv) Follow-up Register (5 centres)
(v) Registers for Individual Counselling (3 centres), Group Counselling (3 centres).
(vi) Rea Survey and Publicity Register (3 centres).
(vii) Daily Medicine Consumption Register (3 centres).

The history taking form differed at all the centres. Two centres did not use it for all the cases. Detailed case history files were maintained by only one third of the centres.

The reporting was done mainly on monthly and quarterly basis through supply of information in a prescribed proforma to the Ministry of Welfare.

Only half of the centres utilised the records for purposes of research and assessment of the drug abuse problem.

SUGGESTIONS FOR IMPROVEMENT IN THE SERVICES

Suggestions were offered by the staff of the counselling centres to bring about improvement in the functioning of these centres. These relate mainly to the service components of the programme and administrative aspects having a direct bearing on the functioning of these centres. The main suggestions given by the staff of two of the centres are given below.

Service-related suggestions

- The counselling centres should prepare/produce and make use of new educational material and aids from time to time. All possible educational material and equipments should be provided at the centres.

- Single window system should be evolved for detoxification by interlinking both the de-addiction as well as the counselling centres.

- Provision for Day Care facilities should be made at the counselling centres.
More emphasis should be laid on quality care than the number of addicts covered.

Suggestions related to administration

- Mechanism should be evolved to ensure job security and continuity in service to keep up the morale of the staff employed at the counselling centres.

- More social workers and counsellors should be appointed to ensure more effective services to the addicts.

The other suggestions related to making provision for the services of the Psychiatrist and making available adequate space at the counselling centres. Timely release of funds by the Ministry of Welfare was also emphasized.

SUGGESTIONS BY THE ADDICTS

Over three-fourths of the addicts felt that the problem of drug abuse was increasing in the country. Based on their experience and understanding, the addicts gave some suggestions to combat this problem. The suggestions presented below are based on the responses received from about one-fifth of the addicts:

Suggestions on control of supply of drugs

- Supply of illicit drugs in various areas and localities be effectively checked.

- Police should organise raids and arrest the drug suppliers and traffickers.

- A through revamping of the police machinery was demanded (Police was blamed for encouraging drug abuse in the country by not taking any action against the traffickers/pushers).

Suggestions about the control of demand for drugs

- Activities for preventive education on drug abuse should be carried out on a massive scale.

- There was a need to expand treatment and rehabilitation facilities by setting up more of counselling and de-addiction centres so as to cover larger number of addicts.

ISSUES EMERGING OUT OF THE FINDINGS

The key issues that have emerged from the study are delineated as follows:

1. Wide variations were found to exist with regard to functioning and administrative aspects of the counselling centres. These aspects include the agencies' physical set-up, location,
accommodation, spacing; staffing, objectives and functions; services such as individual and group counselling, family visits and family counselling; patient intake, detoxification, day care services; rehabilitation, awareness building and preventive education, community involvement; recording, reporting, data collection and dissemination, research activities, liaison with other agencies and training.

2. The activities of the counselling centres were limited with regard to awareness building/preventive education as also in the availability and use of various effective educational aids and techniques for carrying out these activities. The centres need to plan effective and frequent out-reach programmes.

3. The centres varied with regard to conducting the counselling sessions, their number, need, coverage, content, steps, assessment, etc. The group counselling service was given much lesser importance while family counselling was ignored in most cases.

4. The families of the addicts were generally prepared to extend cooperation by involving themselves at different stages of treatment process. The extent of cooperation by the families depended on their understanding of the problem.

5. The present number of the counselling centres was inadequate to meet the increasing demand for treatment. The centres lacked in extending facilities for detoxification and laboratory tests. Thereby, the addicts were referred to other agencies for detoxification and examinations. However, the treatment in the private sector was so expensive that, by and large, it was beyond the reach of most of the addicts.

6. Some important aspects of the treatment process like provision of day care facilities, education to prevent relapses, efforts to retain addicts for longer treatment, economic and vocational rehabilitation for their re-integration in the society and treatment of associated physical and mental illnesses were not given due consideration by the counselling centres.

7. The centres had inadequate accommodation at a proper place with insufficient space to perform their activities. Further, they lacked equipment and facilities for conducting laboratory tests. The centres also differed with regard to their understanding of different concepts and terminologies.

8. The populations vulnerable to drug addiction were children and teenagers; low income groups, those engaged in petty business, transport workers, rickshaw pullers, manual labourers; those living in backward areas/slum dwellers and those belonging to the scheduled caste families; persons who were separated, divorced or widowed and those from families with a history of addiction. The centres provided limited coverage of addicts belonging to these categories.

9. The staff of the counselling centres was inadequate in number and lacked experience and training in the drug abuse field.
10. The counselling centres generally lacked in establishing effective coordination with other agencies as also with the enforcement machinery.

11. A vast scope exists to mobilise the community resources and seek community participation by the counselling centres for development of their programmes.

12. The counselling centres had practically no uniformity with regard to recording and reporting. These records were not utilised to improve the modalities of treatment. They were not even maintained in an organized manner.

RECOMMENDATIONS

The following recommendations emerge from the findings and analysis of the study:-

1. Uniformity in regard to the set up and functioning of the counselling centres needs to be achieved by introducing set guidelines. The guidelines so evolved should clearly define different concepts and components of the programme like the aims, objectives and functions; minimum standards regarding physical facilities and staffing; survey and identification of addicts; counselling, de-toxification and various therapies including family therapy; family visits, follow-up, day care services; vocational training and rehabilitation; information collection, recording and reporting; dissemination of information, awareness building and preventive education; liaison with other agencies; and training, research and publication. The existing guidelines may be modified and brought in tune with the emerging socio-economic realities. It must be ensured that the centres strictly follow the guidelines. To this end, a monitoring system is also needed to be evolved to ensure that the minimum standards are met by the centres. Periodic and concurrent evaluation of the programme be planned out. An effective machinery, inspection teams, committees be identified to undertake this task.

To bring about uniformity in the understanding by the centres of the different concepts and terminologies used in the field of drug abuse, a glossary may be brought out.

2. The number and variety of awareness building and preventive educational activities should be planned by the counselling centres. All possible means of communication, including folk media, should be used to make an impact on the community, especially the more vulnerable groups therein. The centres should strive hard to evolve effective and inexpensive educational aids. An agency which can specially design, produce and disseminate the educational material should be created and entrusted with such responsibility.

3. Individual counselling should be provided by the centres to all the addicts. Group counselling sessions should be more extensively utilized. The need also exists to evolve more
cohesive groups for this purpose. Building up of self-help groups should be encouraged. While the number of sessions should certainly be as many as needed by each case, a certain minimum number of sittings in such sessions should also be worked out.

Since the quality and content of these sessions make a lot of difference, the staff should be skilled in conducting counselling sessions. To attain this objective, training of staff in counselling techniques is an imperative. Guidelines for the counselling centres should specify all these aspects in detail.

4. Counselling centres should avidly seek the support and cooperation of the family members in treatment of the addict. Family visits must be paid by the staff of the counselling centres and the family of the addict should be counselled as required.

5. Since most of the addicts require detoxification, provision for the same should be made by having more of counselling-cum-de-addiction centres. By the same logic, much closer linkages need to be established between the existing counselling centres and de-addiction facilities. The staff of the counselling centres should also be trained to effectively provide out-door detoxification services. The possibility of extending domiciliary detoxification also needs careful consideration in order to cater to larger numbers of addicts. The Government of India should promote more of such centres under the aegis of non-governmental organizations. The services provided by these agencies should be, to the extent possible, free of cost.

6. The counselling centres should treat each addict with the objective of helping him/her to be re-integrated into the mainstream of his/her life situations. To achieve this goal, the centre should treat an addict, bearing in mind the totality of his/her life situation. Provision should be made for day care facilities at the centres. Greater efforts need to be made to sustain the addicts for availing the services for a longer duration in order to help them to be fully re-integrated and rehabilitated in the society. The counselling centres must also educate the addicts about relapse-prevention techniques.

The economic and vocational rehabilitation of addicts, being ignored at present, be given due consideration. All possible measures in this regard should be worked out right at the initial stage when the addicts approach the centres. The associated physical and mental problems should also be treated simultaneously at the counselling centre and/or by channelizing the services of health agencies and others as per the need of the case.

7. The counselling centres must have a certain uniform minimal but adequate physical facilities. These should include the provision of adequate space for reception, counselling of the addicts under privacy, place to conduct group sessions and space where a doctor can properly examine the addicts. The provision for other facilities, essential for the smooth functioning of the centres is also a must.
8. Each centre should carefully take stock of the areas of its activities and identify the extent of the problem and the groups vulnerable to addiction. Such an exercise should specially cover the youth; the unemployed; persons with low educational background; those engaged in petty business, transport operation, rickshaw pulling, manual labour, etc. Special attention should be paid to the backward areas and slums with large population of the scheduled castes and other groups living in depressed conditions. Attention also needs to be focussed on those who are separated, widowed and divorced.

In view of the limited coverage of the addicts by the counselling centres, the centres should make use of various means to identify and motivate them for treatment at an early stage. The community-based activities of the centres need to be expanded with emphasis on the involvement of various community level groups which can serve as a source of referral.

9. Under staffing of the centres certainly and adversely affects their performance. The centres should, therefore, appoint sufficient staff as specified by the sponsoring authority. In appointing staff at the centres, preference should be given to staff with work experience in the field of drug abuse and/or social work in related fields. The staff at the counselling centres should be skilled. The counselling centres must get their existing staff trained in coping with drug abuse and other related aspects. They should be given on the job training besides exposure to specialized courses.

The guidelines should clearly spell out the duties of various categories of the staff at the counselling centres. In view of the fact that counselling centres mostly engaged social workers than counsellors, there is no need for having a distinction between the roles of these two categories of functionaries. These workers can be utilised interchangeably for undertaking activities at the centres as well as for outreach programmes.

The scheme of the Ministry of Welfare for assistance to voluntary organizations should be so modified and implemented as to ensure a timely release of assistance. The staff of the centres be given some incentive on the basis of the years of service they put in at the counselling centres. This is likely to be helpful in retaining an experienced staff at the centres for a longer duration.

10. The counselling centres must coordinate with other centres and agencies and establish liaison with the enforcement machinery for proper development of the programme. The services of various agencies may also be channelized through such coordination. Information on different aspects can be shared by convening monthly or bi-monthly meetings in rotation. Joint programmes can also be planned out.
11. Community participation should be encouraged by adopting various means. Agencies which can participate in the programme in a particular community should be identified and involved in carrying out different activities. The staff at various centres need to extend their efforts within the community by having frequent contacts in the areas served by their centres.

12. Minimal, uniform and essential records must be maintained by all the counselling centres. Similarly, a uniform system of reporting should be evolved. The centres should be provided with a feedback in order to develop an insight into their functioning so that they can be enabled to bring about the necessary modifications. In order to have a national database, the importance of instituting a standardized and concise reporting system needs no iteration.

The recommendations given above are based on the study's findings and the researcher's experience of working in the field of drug abuse. They have been earnestly put forth for the consideration of those concerned with the problem at different levels of policy making, programme formulation and its implementation. Underlying these suggestions is the researcher's fond hope that their implementation may help to improve the functioning of the counselling centres and the programme of drug abuse prevention. Implementing and experimenting with these suggestions may also lead to the creation of a service delivery package in this field which may be worth replicating for the country as a whole.