CHAPTER III

METHODOLOGY

It is worthwhile to mention that the counselling centres have been functioning since 1986. It is also important to note that the number of these centres grew to 145 without a single evaluation. The intention at the time of setting up of 7 centres, was initially to expand only after an evaluation of their functioning. It was thus natural for a researcher, exposed to the Government programmes, to conceive an idea to undertake a study of these centres. Hence, the study entitled "Appraisal of the Rehabilitation Services Provided to Drug Abusers through the Counselling Centres" has been undertaken.

This evaluative study has been undertaken with the specific objective referred to in the previous chapter, to assess the functioning of these centres in the light of the aims with which these were set up.

NATURE, SCOPE AND BENEFITS OF THE STUDY

An evaluative approach has been used in this study. The National Capital Territory of Delhi has been chosen due to two reasons: 1) these were the first counselling centres in India and 2) all of them were located in Delhi which incidently was also convenient for the researcher. The Counselling centres run by the non-governmental organisations with the sponsorship of the Ministry of Welfare under the "scheme of assistance to voluntary organisations for drug abuse prevention" have been included in the study and a sample of addicts availed services at these centres were studied to assess the effectiveness of the centres.

As the study is confined to the counselling centres located in Delhi, the results of the study may not apply to the other parts of the country.

The study has given an opportunity to the researcher to understand in depth the various aspects of problem of drug abuse and also to critically appreciate these. It focuses its attention primarily to study the functioning of counselling centres in a scientific manner. The study aims forward to bring out the existing gaps in the functioning of counselling centres and to make suggestions for the use of policy planners and the programme formulators and implementators.
Since the present study has planned as an in-depth study on the evaluation of the drug abuse programme in India, it will certainly add to the available information that can be useful for academicians, research scholars, and students. It is anticipated that it will benefit the providers of service at these centres in refining their approaches towards prevention, care and rehabilitation of drug abusers. The methodology followed in the study can also serve as a model for replication in other parts of the country to get a holistic view of the functioning of the counselling centres in India.

**SAMPLING DESIGN**

The sampling design followed two types, one is selection of the counselling centres and the other is selection of the sample of clients/addicts treated at these centres.

All the twelve counselling centres, run by five non-governmental organisations, under the Government of India's sponsorship in the National Capital Territory of Delhi by the year 1991 constituted the universe for the study. One of the organisations for which grant-in-aid was discontinued did not fall within the purview of the study.

From this universe at least one counselling centre with not less than one year of standing (the time period that usually taken by the centre to become operational) has been selected for the study. For the organisations having more than one centre in operational state, two to three centres (representing up to half of the total centres run by the organisation) had been selected randomly. While making the selection, the geographical distribution of these centres had also been considered in order to cover various zones of Delhi. Thus, a total of eight counselling centres representing all five organisations were selected for the study.

To draw the sample of addicts a two-stage stratified sampling design was adopted. The organisation (five) running the centre had been treated as strata. From the eight centres selected during the first phase of the study, one centre from each one of the organisations had been chosen at the first stage randomly. The criteria of the geographical distribution of these centres had also been kept in mind while making a selection.

At the second stage, 25 cases were chosen randomly representing five per cent or more of the average total new cases of addicts registered annually at the counselling centres during three years (1987-1990) or since its inception. These cases were distributed into the strata of clients under treatment, recovered addicts/recovering addicts, relapsed/drop-outs/combined, others, practically proportionately. The grouping of the addicts have been adopted to ensure a representation from the point of view of appraisal of the centres and not with the purpose of driving a comparative picture of addicts fell in these categories. By this procedure the size of clients/addicts selected for the study constituted 125 in number.
Table below summarises the sampling frame.

### SAMPLING FRAME

<table>
<thead>
<tr>
<th>Organisations Running Centres</th>
<th>No. of Operational Centres</th>
<th>Selected Centres</th>
<th>Sample of Addicts/Centres</th>
<th>No. of Centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>2</td>
<td>2</td>
<td>25(1)</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>6</td>
<td>3</td>
<td>25(1)</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>1</td>
<td>1</td>
<td>25(1)</td>
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<tr>
<td>IV</td>
<td>1</td>
<td>1</td>
<td>25(1)</td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>1*</td>
<td>1</td>
<td>25(1)</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>11</strong></td>
<td><strong>8</strong></td>
<td><strong>125(5)</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Only one centre out of the two was operational as other centre had shifted to a new location.

Figures in parentheses indicate number of counselling centres.

### TOOLS AND TECHNIQUES

The counselling centres were studied in relation to specific objectives of assessing the physical set-up, staffing, administrative and financial aspects. The study also provided a profile of addicts served during 1990-1991 and 1991-1992, the scope and content of services provided such as out-patient/in-patient, identification, detoxification, referral, counselling services- individual, group, family, follow-up services, day care services; preventive and educative measures; family and community involvement; therapeutic measures available and utilised; measures to rehabilitate the client; suggestions to improve the functioning; etc.

The tools used to study the centres include semi-structured interview schedule, on the spot observations, case records of the clients and registers, reports and records. The schedule was pre-tested before its introduction. It was filled in by interviewing the project director/ coordinator /social worker/ counsellor for the specific information concerning the various specific duties performed by them. (Annexure I).
An interview schedule had been devised (Annexure II) to elicit information from the addicts. After pre-testing the schedule was administered to the sample of addicts. The addicts were at different stages of treatment, i.e., addicts under going treatment, recovered addicts, drop-outs and those relapsed and others who had changed their addiction pattern from illegal drugs to legal drugs, etc. The addicts were contacted mostly at their residence or at the counselling centre depending on their availability.

The interview schedule for addicts was meant to elicit information on demographic aspects and family history of addicts, clients' drug history, services availed by them from the counselling centres and their effectiveness.

The specific questions posed to the addicts related to the services received by them from the centres, their perception of the centres, medical, psychiatric and other problems faced due to drug habit, current problems, if any, reasons for drop out, suggestions for improvement in the services at the centres and also to combat the problem of drug abuse. Information was also collected on the reaction of the family, friends and employers; problems in the family, history of drug addiction in the family, financial loss incurred by the family and/or addict on account of addiction and the means adopted to cope up with these problems. Details were obtained on drug(s) abused by addicts, duration, quantity, frequency, type of drug users associated with, factors responsible for drug abuse, associated problems, perception of the problem and measures adopted for treatment, the average money spent on treatment.

The data from the counselling centres and from the sample of the addicts were collected during April 1991 to May 1992.

DATA ANALYSIS AND REPORT WRITING

The information collected from the counselling centres had been compiled manually. The data obtained by interviewing addicts being quite substantial, were codified and computer processed. To do this, the researcher herself learnt to use the relevant software packages. The data have been subject to careful analyses to bring out the salient features of the functioning of the centres in relation to:

(i) Adequacy and suitability of staff.
(ii) Financial inputs given.
(iii) Variations among the centres and the reasons therefor.
(iv) The perception of the clientele of the services.
(v) Reasons for drop-out/ relapse.
(vi) Percentage distribution of clients by demographic characteristics - age, sex, marital status, occupations, economic status, educational level, etc.

(vi-a) Living condition, family size, type of problem, duration, quantity, etc.

(vii) Percentage distribution of clients by type of drug abused.

(viii) Income loss to the family/clients.

(ix) Amount of money usually spent by family on treatment of addicts.

(x) Utility and effectiveness of counselling, group therapy services, family counselling, etc.

(xi) Type of suggestions for improvement in services.

(xii) Type of suggestions by clients to combat drug problem in the country.

Data so collected and compiled have been tabulated and statistical inferences are drawn from the same. Finally, the findings have been documented in a report running into ten chapters. The report has been prepared by incorporating field impressions, experience in the field of drug abuse, primary and secondary data, their analyses and interpretation and related readings on the subject.

The Introductory chapter provides a brief on the problem of drug abuse and discusses a historical perspective of the problem. Chapter Two is devoted to review of literature presenting a macro view of problem in other countries, micro view in respect of India and the rational of the study. The third Chapter presents the methodology states its design, sampling, scope, tools and techniques, pre-conceived notions, problems encountered and operational definition of terminologies relevant to the study. Chapter Four, entitled Combatting Drug Abuse, describes the approach of the Government of India and of Western countries and the role of International bodies. In Chapter Five, a profile of Counselling Centres is described on the basis of data received from the counselling centres. Chapter Six brings out Socio-Demographic aspects of drug abusers. Chapter Seven is devoted to Drug Addiction: Social and Legal Aspects discussing type of drugs abused, its financial, medical, psychological and social consequences. In Chapter Eight on Drug Addiction and Treatment, the details of various treatment components and its assessment by the respondents are covered. Chapter Nine on Drug Abuse Prevention is based on impressions drawn from the views expressed by eminent experts in different forums and meetings. The last Chapter, provides a Summary and Recommendations. It is followed by a detailed Bibliography on the subject.
PRECONCEIVED NOTIONS

Before undertaking this study, the researcher had some pre-conceived notions about various aspects of drug abuse. These notions emerged during her work in the field of social welfare, particularly at the Bureau of Drug Abuse Prevention and after participating in a Specialised Training Course in Addiction Behaviour at the University of London, United Kingdom.

Specifically, these notions were:

(i) Heroin/smack/brown sugar is the drug of addiction with which addicts mostly report at the counselling centres in urban areas, especially metropolitan cities.
(ii) Addiction is more of a problem of young age, 20-30 years.
(iii) Males are more given to addiction than females.
(iv) Addiction has an effect on work efficiency and productivity of the addicts.
(v) Addiction leads to indulgence in immoral/illegal activities such as stealing, pickpocketing, lying, selling of household goods, drug trafficking, etc.
(vi) Family cooperation is mostly available in dealing with addiction.
(vii) Curiosity, experimentation and peer pressure are the most common causes of addiction.
(viii) Addiction may give rise to medical problems.
(ix) Addiction leads to financial lose.

As elaborated later, these positions are fully supported by study findings.

PROBLEMS FACED

Some problems encountered by the researcher in conducting the study are detailed below:

(i) Old records at the counselling centres were not kept in order and in an organised fashion thereby selection of sample took a long time.

(ii) Some of the organisations were reluctant to cooperate initially. It was only after repeated persistence that they relented and provided the data.

(iii) Some of the addicts/clients had supplied wrong addresses. This led to considerably wastage of time. Besides, more addicts had to be added to complete the sample.

(iv) Interviewing the clients took a long time because of the personal and sensitive nature of the problem, stigma attached to it as well its legal connotations.
OPERATIONAL DEFINITIONS

An attempt has been made to provide a set of definitions and descriptions of the words and terms that are relevant to the study. Different texts were consulted in order to arrive at these definitions. The terminologies in the drug field are so complex that it often became very difficult to arrive at a clear/complete understanding of these various terms.

**Drug dependence**

A drug is a substance that when taken into the living organism, may modify one or more of its functions.

The main drugs are opiates (narcotics), cannabis, cocaine, hallucinogens, amphetamines, barbiturates and analgesics, depressants and tobacco. All licit and illicit drugs, except alcohol and tobacco fall under the scope of the study. These licit drugs are deliberately kept out of the study's purview as they enjoy social sanction and are prevalently abused.

The term narcotics has two definitions. Medically defined, a narcotic is any drug that produces sleep or stupor and also relieves pain. Legally defined, the term means any drug regulated under the narcotic laws. Some of these regulated drugs are pharmacologically non-narcotic (cocaine). Hypnotics are the agents that induce sleep. Depressants are any of the several drugs which calm or sedate by acting on the central nervous system. Medical uses include the treatment of anxiety, tension and high blood pressure. Stimulants are any of several drugs which act on the central nervous system, producing excitation, alertness and wakefulness.

**Psychoactive drug** is one that is capable of altering mental functioning.

Any substance in excessive amounts can act as a poison or toxin with drugs, the margin between the dosage that produces beneficial effects and dosage that produces toxic or poisonous effects varies greatly. However, this margin will vary with the person taking the drug. Such effects are termed as toxic effect (poisoning) of drugs.

Besides using drugs for medical purposes or for widely accepted purposes, these drugs may be misused or abused. Drug misuse is any intake of a drug which harms or threatens to harm the physical or mental health or social well-being of an individual, of other individual, of other individuals, or of society at large, or which is illegal.

A drug may be considered to be misused if its use is unlawful, if it is a licit pharmaceutical substance used other than for acceptable medical direction, or inappropriately prescribed.
The term drug abuse according to the United Nations Social Defence Research Institute refers to all drug use which is not indicated on generally accepted medical grounds (1976).

**Habituation** is a condition resulting from the repeated consumption of a drug which includes these characteristics:

(a) A desire (but not a compulsion) to continue taking the drug for the sense of improved well-being that it engenders;
(b) Little or no tendency to increase the dose;
(c) Some degree of psychic dependence on the effect of the drug but absence of physical dependence and, hence no abstinence syndrome;
(d) A detrimental effect, if any, primarily on the individual.

**Drug Addiction** is a state of periodic or chronic intoxication produced by the repeated consumption of a drug. Its characteristics include:

i) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;
ii) a tendency to increase the dose;
iii) a psychic (psychological) and generally a physical dependence on the effects of the drug;
iv) an effect detrimental to the individual and to society.

Drug addiction implies a strong psychological and physical dependence, resulting in a withdrawal syndrome when the use is stopped. The primary stress is on psychological factors like loss of control and craving.

The terms habituation and drug addiction have been replaced by a wider term like Drug Dependence which is characterised by a group of symptoms. Drug Dependence is "A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid discomfort of its absence. Tolerance may not be present. A person may be dependent on more than one drug."

Characteristics will vary with the agent involved and, accordingly, it is designated with particular type of drug dependence in each specific case - for example drug dependence of the morphine type; of the cocaine type; of cannabis type; of barbiturate type, etc.

Drug dependence is a phenomenon characterised by cluster of symptoms of compulsion to use the drug (inspite of desire to stop continued drug use) establishment of stereotype drug behaviour, occurrence of tolerance and withdrawal and reinstalation of drug behaviour.
(a) Psychological Dependence

An attachment to drug use which arises from a drug's ability to satisfy some emotional or personality need of an individual. This attachment does not require a physical dependence, although physical dependence may seem to reinforce psychological dependence.

(b) Physical Dependence

Physiological adaptation of the body to the presence of a drug. In effect, the body develops a continuing need for the drug. Once such dependence has been established, the body reacts with predictable symptoms if the drug is abruptly withdrawn. The nature and severity of withdrawal symptoms depend on the drug being used and the daily dosage level attained.

A drug having the capacity to interact with a living organism to produce a state of psychic or physical dependence or both is termed as Dependence Producing Drug.

Drug Dependents are those drug users who indicate their inability to stay without using one or more substances of a specific category of a drug and express a craving for it.

Craving is a term applied to both physiological and psychological dependence, the user's desire or need to continue using a drug.

A decrease in response to a drug dose that occurs with continued use is termed as Tolerance. The degree of tolerance and the rate at which it is acquired depend on the specific drug, the person using it, and the frequency and magnitude of its use. Dosage of drugs that produce tolerance, e.g., alcohol, barbiturates, and heroin - tend to be increased by persons using them as their tolerance to a particular drug increases.

When an addict goes without drug for a period longer than he/she, can tolerate he/she displays a cluster of symptoms known as Withdrawal Syndrome. These are:

(i) restlessness, twitching, excessive yawning, sweating, watering of eyes and running of nose.
(ii) severe abdominal cramps, diarrhoea and vomiting and
(iii) dilation of pupils.

Abstinence is the total avoidance of a behaviour or substance state of being drug-free.

Relapse

Relapse is a state where an addict encounters reversion to old habit of drug taking behaviour following a seemingly satisfactory social adjustment.
For study purpose, it may not be possible to strictly demarcate the clients into two categories, viz., drop-out and relapse. These categories may be presented by a single client at different stages of addiction. At times, inability to do without drugs leads to relapse and thereby dropping of treatment. Clients who sought treatment at more than one agency or more than one time at the same agency might have relapsed at one time or dropped treatment at another instance.

Counselling

Counselling is a scientific process of assistance extended by an expert, in an individual or group situation to a person with problem(s) in order to enable him to learn and pursue a more realistic and satisfactory solution to his problems.

Drug counselling is primarily an advisory service. It deals with the realities of the client's present situation. Counselling entails assessing the specific needs of individual clients and then providing, or directing the client towards the service that meet these needs.

A whole range of problems are dealt within the counselling sessions when appropriate specific treatment options can be discussed, such as in-patient or out-patient detoxification, maintenance treatment, drug-free therapeutic communities, etc. The necessary arrangement for their implementation can also be initiated therein.

Counselling Centre is an agency providing rehabilitation cover to the drug abusers.

Rehabilitation Cover is a gamut of services expected to be provided by the counselling centres. It consists of survey, identification, awareness building/ preventive education, referral; detoxification, follow-up, rehabilitation, etc.

A minimum average time period taken by the counselling centre for drug abuse prevention to become functional or to undertake all the activities continuously and smoothly is notionally taken as one year. This period is termed as the operational period. After completion of one year since its inception, the centre may be taken as a counselling centre in an operational state.

Detoxification

Detoxification is a process which aims at withdrawing the person safely from physiological drug dependence.

Rehabilitation

It is a process of reintegrating the drug abuser into society so that he/she can cope without drugs and can be restored to the best possible level of functioning.
The addict who had completed the rehabilitation process is known to be a rehabilitated addict.

The period from treatment to rehabilitation may vary from case to case. However, for the study purposes, the addicts who could remain free of drugs for a year or more have been categorised as rehabilitated addicts. The addicts who could stay off drugs for at least six months and continuing with a treatment have been categorised as rehabilitating addicts.

**Vocational rehabilitation**

Vocational rehabilitation is a treatment modality aimed at helping clients to acquire job-related skills.

**Drop-out**

Addict who had left the treatment on his own against the instructions of the counselling centre/ treatment unit is considered to be a drop-out.

**Client Under Treatment**

Addict seeking treatment at the counselling centre / treatment units at any point of time is termed as a client under treatment.

**REFERENCES**


3. Ibid.