CHAPTER V

PROFILE OF THE COUNSELLING CENTRES

Drug addiction has afflicted various sections of society. Facilities for its identification, treatment, rehabilitation and after care being provided by Government supported voluntary organisations through a net work of counselling, deaddiction and after care centres. A community based approach has been adopted. Keeping in view the vastness and diversity of population and nature of the problem the community based approach is thought to be the best resort and most conducive to the programme development. Any programme to operate requires some nucleus point or a place wherefrom the services could be rendered to those who require. It serves as a focal point for addicts to meet the therapist and discuss their problems to find solution to the same. The team members get an opportunity to come together to dwell upon a joint plan of action and activities. It serves as a place for delivery of services to addicts and to plan and undertake activities to reach out the community.

Keeping these benefits in mind, a unit at a particular place or the so called agency is a pre-requisite of the programme. Viewing this the counselling centres have been set up to operate from a specified location preferably in the community. From this set up these are expected to provide services of identification, motivation, preventive education and awareness building, referral, treatment, follow-up and rehabilitation to the addicts, their families and the community at large.

As mentioned under methodology, the counselling Centres meant to provide 'rehabilitation cover' to the drug addicts, began functioning in the year 1986 through Ministry of Welfare's sponsorship. These were started under the Scheme of Assistance to Voluntary Organisations for Prohibition and Drug Abuse Prevention. The centres are run by the non-governmental organisations. These organisations are given assistance on the basis of certain criteria laid down in the scheme, such as, organisations should have experience in social welfare field or drug abuse prevention for atleast two years, should have facilities and resources to undertake drug abuse prevention programmes, etc.. The grants are released on recommendations of the State Governments. The performance of the organisation during the previous years is also assessed.

To begin with in 1986, the Delhi based organisations were assisted to run seven counselling centres. At the time of study i.e. during 1991 - 1992 there were 11 operational counselling centres run by five non-governmental organisations, out of which eight got selected for study purposes. Information on the
organisations running the counselling centres and on the sampled counselling centres were obtained through observations, records and interview of the Project Director/ Co-ordinators for information on various aspects through a semi-structured questionnaire. This information relate to administrative aspects, clientele profile, services rendered by these centres, performance of these centres, etc. The chapter presents a brief on the five Delhi based non-governmental organisations to which the eight selected centres belonged and gives a detailed appraisal of these centres on the basis of information received from them.

BACKGROUND INFORMATION ON THE NON-GOVERNMENTAL ORGANISATIONS

The five organisations studied are as described below. These are identified as E, A, Y, V and I.

(1) Organisation "E"

The organisation "E" is a voluntary registered body, registered in 1961. The society is running the 'Institute ' which is a constituent college of the University of Delhi. The college conducts graduate and post-graduate courses in B.Sc. (Home Science), Dietetics and Public Health, Nutrition and Textile designing. In addition, it undertakes research projects in collaboration of other institutions and also provides training to the functionaries of the Integrated Child Development Programme.

The aims and objectives of the organisation in the field of drug abuse are:

(i) to create awareness among youth and various other sections of society about the harmful effects of drug abuse and prevention of drug abuse through talks, meetings, films and slide shows, literature distribution, posters and exhibitions.

(ii) to identify drug abuse cases in the community through community surveys and interaction.

(iii) to provide counselling for drug addicts and their families.

(iv) to provide referral services to identified drug addicts.

(v) to conduct training programmes for personnel in various fields of drugs, on its abuse, prevalence and prevention.

(vi) to conduct self-help group meetings of drug addicts and their family members.

(vii) to facilitate treatment of drug addicts.

(viii) to conduct specially designed awareness building programme on drug abuse in schools and colleges.

The organisation set up a counselling centre in 1986. The centre was registered in 1989 as a society. Two counselling centres are run by the society, one started in 1986 at South Delhi, and other in 1989 at West Delhi. Activities of these centres are according to aforementioned objectives. Funding is through the Ministry of Welfare, Government of India.
(2) Organisation "A"

Organisation "A" is a registered body under the Societies Registration Act XXI of 1860. It is the Indian branch of the International Federation which enjoys a consultative status with the United Nations. The Federation, founded in England in the year 1875, aims at opposing all measures which, under the pretext of normal objectives (and specify those combating prostitution) tend to set a certain category of persons outside the common law, and by which only one of the two parties in a joint act is summoned, prosecuted and systematically debarred for the erroneously- supposed advantage of others.

The organisation was established in 1928. It is an All India character voluntary organisation having branches in 26 States/Union Territories. It aims at challenging those conditions that lead to the exploitation of women for anti-social and a social purposes. The activities in this direction involve legislative, rehabilitative, preventive and curative measures. The objectives of the organisation are:

(i) to eradicate prostitution and other evils in relation thereto.
(ii) to promote understanding and education in respect of sex relations, raise the standard of character and encourage healthy family relations.
(iii) to secure equal ethical standards of living for men and women.
(iv) to establish, maintain and assist protective Leonex, and other institutions for the shelter, training and rehabilitation of women and children in immoral traffic and moral danger.
(v) to establish, maintain and assist Family Life Institutes, Student Counselling Centres, etc. and undertake similar activities for promotion of healthy family life.
(vi) to work on multi-dimension approaches for prevention of drug abuse, and treatment of drug addicts, running counselling and de-addiction centres.
(vii) to establish, maintain and assist health clinics for diagnosis, treatment and mass education for venereal diseases centres.
(viii) to organise training programmes and conferences for the benefit of the workers in the field.
(ix) to publish journals, news letters and other literature for the promotion of aims of the association.

The organisation was running 14 counselling centres all over India. These are located in Andhra Pradesh, Goa, Gujarat, Haryana, Madhya Pradesh, Sikkim, Tripura, Uttar Pradesh and Delhi. Out of the six counselling centres of this particular organisation located in Delhi three were selected randomly and on geographical considerations, as detailed under methodology, for study purposes.

In addition to the counselling centres the organisation is running de-addiction centres.
As regards the membership to the organisation any body not below the age of 18 years may become a member, in accordance with the terms and conditions laid down by its constitution.

The source of finance of the organisation are: Central and State Governments; donations and charities; through variety of entertainment programmes, premier shows, fêtes, jumble sales, etc.; publication of souvenir and subscription fee ranging from Rs.5000 to Rs.50.

It also publishes a quarterly journal containing articles on issues concerning the association by the experts in the field and as well gives an account of the activities of the association.

(3) Organisation "Y"

Organisation "Y" was formed by Research Scholars of University with the firm belief that the main responsibility of the today's youth is to speak out effectively against existing social problems such as drug abuse and atrocities on women as also positively contribute to consumer's protection and communal harmony. The society is active in the field since 1983 and was registered in 1986. The society is running two drug counselling centres, one in Delhi and another outside Delhi.

The aims and objectives of the organisation are:

(i) to enable the rural poor to participate in social activities.
(ii) to promote the aesthetic and creative talent of alienated unemployed masses by channelling their efforts into creative art forms and social work.
(iii) to run adult education centres and anti-drug (Prevention) programmes.
(iv) to fight against societal atrocities on women and to bring them to the mainstream of the country's development.

In addition to running two counselling centres in drug abuse field, the organisation undertakes women's welfare programmes, such as, education and cooperative relations, income generating vocational training programmes, shelter and support for widows and women in distress, adult education through functional literacy, child care, nutrition and home management.

The source of finance of the organisation are Ministry of Welfare, Government of India, East India Hostels Ltd., New Delhi and donations from students.

The organisation also brings out a quarterly publication that provides information about its activities. Its members make contributions to the field by presenting papers at various national and international forums from time to time.
(4) Organisation "B"

Organisation "B" is a registered body since 1981. It constructed a 30-bedded Psychiatric hospital in 1985, detoxification facilities being provided since 1987. The hospital is, at present, functioning also as a 40-bedded De-addiction Centre. It also runs a counselling centre in South Delhi area.

The source of income of the centre is from reserve funds, contributions from International Organisations/Missions, income from Hospital fees, and Ministry of Welfare, Government of India.

(5) Organisation "I"

Organisation "I" was registered in 1985. It is a branch of the all India based organisation engaged in child welfare activities. This non-governmental organisation is working for the dissemination and promotion of social consciousness among the masses, particularly among the economically weaker and socially backward sections of society as well providing assistance and guidance to educational institutions. In the field of drug abuse prevention the council has undertaken the tasks of awareness building, community education and its effects, rendering services for the identification to referral, counselling and guidance, de-addiction treatment and rehabilitation of drug addicts. It also undertakes activities of conducting seminars and symposia, conferences, workshops and technical exchange programmes.

The organisation is engaged in the task of general social welfare, education, research and publications, drug de-addiction and rehabilitation. At present it is running three centres for deaddiction, rehabilitation, day care and after care in Delhi. It also runs two counselling centres, one each in university, and other in South Delhi. Only one counselling centre that was operational at the time of the study was included in the study sample.

COUNSELLING CENTRES

The eight counselling centres were selected on random basis. Moreover the geographical distribution of the centres was considered in order to ensure the representation of all the five organisations running counselling centres located in all the four directions of Delhi.

The counselling centres covered under the study were established at different point of time between the years 1986 to 1990. These were established in the years 1986 (2 centres), 1987 (2 centres), 1988 (1 centre), 1989 (2 centres) and January 1990 (1 centre).
OBJECTIVES AND ACTIVITIES OF THE CONSULTING CENTRES

It is very important for any programme to clearly spell out its objectives. The counselling centres were set up with certain specific objectives. Accordingly, they were required to plan out activities to achieve these objectives. The objectives mentioned by these centres included: provision of counselling services by 6 centres, provision of out-patient treatment facilities to addicts by four centres, awareness generation and prevention education by 6 centres. These were the main objectives spelled out by most of the centres.

The other objectives mentioned were identification of addicts (2 centres), referral for detoxification (2 centres), family counselling (1 centre), follow-up services (2 centres). The centres also mentioned the objectives such as motivation of addicts, provision of day care services for addicts, provision of day services for children of addicts, rehabilitation of addicts, group therapy, conducting training programmes and carrying out researches. Such responses were obtained from one centre for each category respectively.

The information received from the counselling centres reveals that the centres had no uniformity with regard to objectives of their setting-up. The objectives mainly related to the provision of counselling services and preventive education and awareness generation activities. Half of the centres included out-door treatment facilities among their objectives. The objectives relating to data collection and dissemination of information, liaison with other agencies were not mentioned as objectives by the counseling centres. Provision of group counseling and family counselling services, conduct of family visits and extension of day care facilities, etc. were not spelt out amongst the objectives by most of the centres.

In the light of the objectives, the activities/programmes performed by the counselling centres, were mainly, individual counselling mentioned by 6 centres, community based out-reach programmes including awareness programmes by all 8 centres, group counselling by 3 centres and family counselling also by 3 centres.

The other activities mentioned by these centres included home visits (2 centres), out-patient detoxification (2 centres), follow-up services (2 centres). Training of workers, provision of day care services, economic rehabilitation of addicts, referral of addicts, identification and examination of patients, performing awareness programmes in schools, encouraging addicts to formulate AA/NA groups were the activities mentioned by a single centre in each case.
The above information reveals that the counselling centres mainly focused attention on preventive education and awareness building and on individual counselling. The educational activities were performed at the centres and in the community through out-reach programmes. All the centres did not give importance to family counselling and group therapy. The important activities, such as, motivation and identification of clients, family visits, provision of day care facilities, collection of information and its dissemination and liaison with other agencies were not at all realised as an activity by most of the centres.

**PHYSICAL FACILITIES AT THE COUNSELLING CENTRES**

The success of any programme or agency is assessed mainly through the quality of services it provides. The quality care depends on number of factors relating to the agency's set-up, facilities available at the agency, quality of staff, etc. What most matters is the skills and techniques deployed in dealing with addicts. The physical facilities at the same time do impinge upon the quality care. It is so, specially in case of drug abuse problem as the agencies meant for drug abusers are likely to face problem in getting proper accommodation at an hygienic and safe place because of public resistance. Some minimum provisions with regard to physical facilities is a must for the smooth and effective functioning of the programme. The counselling centres, therefore, would be required to be located at places that is within the reach of people. These need to provide adequate place to carry out all its activities in a congenial environment. Keeping these needs in view the counselling centres were studied with regard to physical facilities.

**Location of the centres**

All these centres were located in the urban areas of Delhi except one in Kishan Garh village which was located near the DDA locality in semi-rural area.

Out of the centres located in the urban areas, two were in private locality, two in a congested commercial area, one near resettlement colony, another one near LIG, DDA flats as well jhuggies and village and the remaining one was in the college premises.

Four of the eight centres were functioning from the present location since its inception. One of the centres got shifted within the college premises from one of the department to administration block. The three centres, which were shifted from the previous locations, were housed in a rented accommodation. Completion of lease (contract) or selling of the premises were the reasons for a shift. This shift was to the location near to the previous ones and it took place only after 1 1/2 to 2 years of functioning of these centres at the previous location. This reflects that for the counselling centres to find a rental accommodation for a longer duration was difficult. Change of location of centres within a short duration might have affected the functioning of the centres.
Two centres were located in a free accommodation provided at college campus and Government of National Capital Territory of Delhi, Dispensary, respectively. Another six centres were in rental accommodation and paying a rent varying from Rs. 500 to Rs. 5000 (Rs. 500(1), Rs. 2000(2), Rs. 5000(1)) per month. This wide variation with regard to rental payment by the counselling centres depended on the location of these centres and the space occupied by them.

Accommodation

Assessment of the physical facilities available at the centres was made by considering the aspects of accommodation, rooms, waiting place, furniture, equipment, electricity, water and laboratory facilities. Observation as a method was used. However, Project Coordinator was asked to point out any deficiencies existed in regard to physical facilities that had bearing on the functioning of the centre and the measures undertaken to remove these inadequacies.

So far the adequacy of the space is concerned the counselling centres should have adequate place to carry out different functions in a congenial atmosphere. It should provide a comfortable place for reception of addicts, rooms with enough privacy to perform counselling sessions, room for a psychiatrist to examine the client and provide a therapy, adequate space for group therapy sessions and day care activities, etc. The centres lacking such provisions may not be termed as adequately spaced.

On observation it was assessed that the total plinth area of these centres ranged from as low as 32 sq. ft. to 200 sq. ft. Four centres were with inadequate space, having just a small single room for all activities or with two small rooms with or without any waiting place or place for registration. The centres which had adequate place, had provided separate rooms for counselling, doctor's examination, waiting place and place for registration. One of the centres was found to be just satisfactory in regard to accommodation to perform all activities by making adjustments.

So far a waiting place for the addicts goes, only three centres had adequate waiting place. Another three had some waiting place which could be taken as satisfactory and rest of the two centres had no waiting place or inadequate place for the clients to wait for their turn.

Furniture and equipment

Certain minimum furniture would be expected to be available at the counselling centres for the staff to perform activities such as examination, individual counselling, group and family counselling sessions, day care activities, etc. It would also be required for the preservation of the records. The minimum furniture required at the centres would thereby depends on the staff deployed at these centres and their activities.
On observation it was found that the furniture items at the centres included tables, chairs, almirah, cabinet, etc. The office tables available at the centres varied in number. One centre with just a single table may be taken as inadequate, two centres having 2-5 tables seems to be satisfactory, the another four centres had 3-5 tables which may be adequate for the functioning of the centre. The remaining one centre had occupied eight tables that were beyond requirement of the counselling centre. The counselling centres were with adequate number of chairs between 9-30 chairs.

In addition to tables and chairs, the other items of furniture that were available at the counselling centres were, file cabinet (2 centres), almirah (2 centres) and examination table (2 centres). A patient bed was also available at one of the centres.

As regards equipment, two of the centres did not have any equipment. The other centres were equipped with Blood Pressure apparatus (6 centres), weighing apparatus (3 centres), stethoscope (6 centres), Intravenous stand, screen and room-cooler (one centre), microscope (1 centre), Blood test apparatus (1 centre). Telephone facility was available only at one of these centres.

Water supply was adequate at three centres, satisfactory at another three and the remaining two centres had inadequate supply. Three of the centres had not installed water cooler, one centre had provided with thermos water jug but the remaining two had installed water cooler.

All the centres, except one had an adequate supply of electricity. They all provided adequate fans as well. The centre without an electric facility had applied for the same.

**Laboratory facilities**

Laboratory facilities were available only at one of the centres to carry out blood, urine and stool tests. These tests were done by the pathologist appointed by the organisation. The laboratory was equipped with microscope, haemoglobinometre, test tubes, slides and chemicals to carry out the tests.

The counselling centres got the tests done by referring addicts to the de-addiction centre of the same organisation (3 centres), de-addiction centre of the organisation or a private doctor (1 centre), X-Ray from private clinic (1 centre). Two of the centres neither got laboratory facilities nor they referred clients to other agencies for tests. Referral was done only for detoxification.
Assessment of physical facilities

The responses varied on the physical inadequacies existed in view of the activities of the counselling centres. These were mainly inadequate space, lack of privacy for the addicts, lack of day care facilities. The responses in each category were given at least by two centres. The other responses included inadequate waiting place, lack of detoxification facilities, lack of water supply and toilet facilities. One of the centres responded that no inadequacies existed at their centre.

To come over the inadequacies two of the centres expressed their inability to do anything as to get an adequate accommodation at proper place on rental basis was found to be difficult by them. However, another centre was trying to get a bigger accommodation. Other measures adopted were referral to private doctors for tests and to hospital for detoxification. To solve the water problem, one of the centre had taken up a matter with the college authorities. It may also be mentioned that one centre had taken no action to remove the inadequacies.

WORKING PATTERN OF THE COUNSELLING CENTRES

Five counselling centres functioned on four days in a week with Saturday mostly half day and rarely full day depending on the activities to be performed on that day. The two other centres worked on all six days of the week and the remaining one was functioning from Monday to Friday.

These centres either operated for eight hours (9 A.M. to 5.30 P.M.) as responded by half of the centres (4 centres), the remaining half functioned for six hours from 9 A.M. to 3 P.M. or 10 A.M. to 4 P.M.

Most of the centres (5 centres) neither had prepared nor followed any fix schedule for performing various activities. However, two centres mentioned that they had developed monthly plans giving number of cases to be treated, talks/community programmes to be held, follow ups to be carried out and home visits to be performed. One centre mentioned that they devoted 4-5 hours daily for the services at the counselling centre and 3-4 hours in the community for follow-ups/home visits, family counselling, outreach programmes, etc.

STAFFING

The counselling centres under the Ministry of Welfare's scheme could engage a staff including Psychiatrist/Medical Officer 1 (part time), Counsellors 2 (full time), Social Workers 2 (full time), Project Coordinator (1 full time). These are technical staff members, the other supporting staff include Clerk-cum-Accountant (1), Sweeper (1), Peon (1) and a driver in case a vehicle is provided to the centre or centre owns a vehicle. The requirement of the staff for each one of centre is approved by the Ministry and accordingly, grants are released. The qualification and duties are also specified for these staff.
members in the guidelines published by the National Institute of Social Defence in 1991 and these are Annexure X.

All the eight centres were studied in regard to staff in-
position at the centre, their qualifications and work experience, 
main functions performed by each category and additional responsibilities shouldered, if any. The details are discussed category-wise as follows:

(1) Project Coordinator

Out of eight centres studied, five centres had appointed one project coordinator (in case of one of the centres the project coordinator mostly operated from the main organisation located at a different place). Two of the centres belonged to the same organisation had a common project coordinator who usually remained at the main organisation. The tasks of the project coordinator at the other centre were performed by a staff designated as centre incharge/social worker/welfare officer. The project coordinators were mostly females (5 out of 7) and drew a monthly salary of Rs.2000 at 5 centres and Rs.1550 at other two centres. Three project coordinators were in their young age between 20-25 years, the other three between 40-45 years and one project coordinator was as old as 56 years. Four project coordinators were post graduate [MA Psy.(1), MSW(3)- Personnel Management, Medical and Psychiatry and Generic Social Work]. The two graduates were with Pass Course and Commerce background.

None of the project coordinators was with a working experience of less than one year. Three had experience of 1-3 years; other two 5-6 years and the remaining two with of 12 years and upto 25 years in the social welfare field. However, the experience in the field of drug abuse prevention was less than the total work experience, it ranged from a year to seven years with 1-2 years in case of two coordinators, 4-5 years for other three coordinators and more than six years for remaining one.

One of the seven project coordinators had undergone a one week's orientation course on alcoholism and drug abuse at Madras as a part of pre-job training. The other coordinator too had an orientation course in Management of Organisation for a week at Vishwa Yuva Kendra, New Delhi.

The duties performed by the project coordinators mainly included 'coordination and administration of all activities of the counselling centres as mentioned by three centres; organisation and conduct of awareness programmes, meetings/talks, etc. mentioned also by three coordinators, maintenance of records and reports by two coordinators. The other tasks mentioned by a single centre in each case respectively were counselling, follow-up visits, identification of cases, liaison with government and other organisations, organisation of the training programmes, office maintenance and organisation of camps. The additional responsibilities included for one project coordinator were taking teaching sessions and administration work.
It can be inferred from the above that most of the counselling centres had appointed project coordinators. They were mostly graduates with work experience of not less than a year in the field of drug abuse. Those who were graduates had longer work experience and were also older in age than the others. The project coordinators mostly had not undergone any pre-job or inservice training in the field of drug abuse. As regards duties the centres widely varied. They were either not very clear about the duties/functions of the project coordinator or the project coordinator performed the limited jobs at the centres.

(2) Counsellors

Counsellors were appointed by only three centres, at one centre clinical Psychologist was occupying the post of the counsellor. They were mostly females (3) and one male. All the three counsellors were working since the inception of the centre and the clinical Psychologist had joined in 1990. Three counsellors were between 24-28 years and the remaining one as old as 50 years. The salary drawn by the staff amounted to Rs. 2000 per month in three cases and Rs. 2500 per month in one case.

The counsellors belonged to the disciplines of B.Sc (Home Science) with Post Graduate Diploma in Dietetics, M.A. Psychology, M.Phil Psychology and M.A. Social Work. The working experience was mostly 1-1/2 to 3 years in case of three counsellors and remaining one had 25 years of experience. Working experience in a drug abuse field was mostly 1 to 1-1/2 year in 3 cases and one had 3 years of drug experience. Only two out of four counsellors had some exposure to the field through inservice training. One of them had undergone a two months counsellor's course at Madhurai and the other one had twice attended an ILO workshop on Drug Abuse at Work Places.

The duties narrated of the counsellors were mainly conducting counselling sessions by all the four centres. The other duties mentioned included participation in awareness programmes (2 centres), paying home visits (2 centres), referral (1 centre), group counselling (1 centre), recording and reporting (1 centre). Among the additional responsibilities, recording and reporting was mentioned by one centre and participation in the activities of the main organisation by another centre.

The above details indicate that not even half of the counselling centres had appointed counsellors. They were mostly young and varied in terms of monthly salary. They were qualified in different disciplines of social sciences such as Psychology, Social Work, Sociology and Home Science. All were at least with a work experience of one year. None of them had undergone pre-job training but half had inservice training in drug abuse field. The main functions performed by the counsellors were conducting counselling sessions. The centres differed with regard to responses on duties performed in addition to counselling sessions.
(3) Social Workers

All the centres had appointed social workers, however, their number varied. Three centres without counsellors had appointed 2, 3, 4 social workers, respectively and the fourth one had appointed four social workers -cum- counsellors. One centre was having two social workers and no counsellor. One post was lying vacant. The four centres with counsellors had 2 social workers in case of two centres and only one in case of other two centres. It is important to note that the number of social workers working at the 7 out of 8 centres was less than the number suggested by the government (2 social workers and 2 counsellors per centre).

The above information reveals that the centres were under staffed. The social workers at one of the centres were designated as Welfare Officers. It may also be mentioned that in case of two centres three social workers appointed were just new encumbrants joined three to eight months back.

Out of the 20 Social workers/ Welfare Officers/ Social Worker-cum-Counsellor in 8 counselling centres, 8 were in the age group of 20-25 years and remaining 12 between 26-30 years. The salary drawn by the social workers was Rs. 2000 by 11 social workers, Rs. 1800 by another 6 and Rs. 1900, Rs. 1500 and Rs. 1600 respectively by remaining three social workers. Twelve social workers were Masters in Social Work, one Bachelor in Social Work, two B.Sc. Home Science and B.Ed. and two Masters in Sociology and the remaining one with Masters in Psychology. The social workers were specialised in Home Science (2), Family Welfare (4), Industrial Relations and Personnel Management (5), Sociology (1), Social Work generic (5), Community Development and Youth Welfare (2) and one in Abnormal Psychology.

The work experience in the field of drug abuse and in social welfare matched in most of the cases. It may be mentioned that this experience was as low as 2 months with maximum upto 7 years. The distribution of social workers as per work experience in drug abuse field shows that out of 20 social workers one was with 7 years of experience, 7 had 2-3 years of work experience, 7 with one to less than 2 years of experience and remaining three were with work experience of 6-8 months and 2 with 2-1 months.

None of the social workers had undergone pre-job training in the field of drug abuse. However, 7 social workers had in-service training by attending a two months counsellor's course at Madurai/Baroda/Hyderabad.

The duties that the social workers performed were mainly individual counselling (6 centres), field work/home visits (6 centres), organising awareness programmes (5 centres), follow-up activities (3 centres), family counselling (3 centres). The duties like history taking, identification of cases, community meetings and talks, recording and reporting were mentioned by two centres in each case. In addition, responses such as referral to hospitals, accompanying clients to hospitals, group counselling were received from a single centre in each case. Amongst the
additional responsibilities recording/reporting was mentioned by 2 centres and correspondence and administrative work by another three centres.

As detailed above the counselling centres had not appointed the required number of Social Workers. The workers were mostly in their young age between 20-30 years and were qualified in Social Work or in other Social Science subjects. The centres varied with regard to salary of social workers. All the staff members were not with the work experience of at least one year in the field of social welfare or drug abuse. They were all without the pre-job training but less than the half of them had undergone in-service training. The Social Workers mainly performed the activities such as individual counselling, awareness building and preventive education and field visits. The centres varied with regard to duties other than these carried out by them.

(4) Psychiatrist/Medical Officer

The psychiatric and medical problems may be pre-existing conditions to drug addiction or it may be a concomitance of the same. These conditions need to be treated along with problem of addiction for which services of doctor/psychiatrist at the counselling centres would be necessary.

The Psychiatrist was appointed by four centres on part time basis, one had a full time Psychiatrist and other a full time Medical Officer. Two centres did not have any Psychiatrist/Medical Doctor on their rolls. Barring one centre in which the psychiatrist had joined in 1990, however, in all other centres Psychiatrist/doctor was working since the inception of the centre. The Psychiatrists were either M.D. in Psychiatry (1 centre), MBBS and DPM (4 centres), and MBBS (1 centre). The medical person was with experience of not less than three years in drug abuse field with a range up to 6 years (5-6 years (4 doctors) and 3-4 years (2 doctors) ). All the doctors were males. They drew a salary of Rs.100 per visit (about Rs.2000 per month) in case of part time employment and Rs. 2500 and Rs. 3750 per month by full time two doctors, respectively.

The Psychiatrist/Doctor was responsible to make assessment of the case by carrying out psychiatric examination and prescription of medicines were mentioned by all the six centres. The psychiatrist/doctor also performed the duties such as counselling, mentioned by two centres and detoxification by one centre.

The supporting staff included Accountant-cum-Clerk at 7 centres, peon one each at 6 centres and 2 peons at another centre. Two centres had appointed part time sweeper, whereas, others had full time sweeper. Driver was available at two centres.
PROFILE OF ADDICTS

Information on drug addicts visited the counselling centres for treatment during the years 1990-91 and 1991-92 were obtained from the records available at the counselling centres. This information pertained to number of cases registered at the centre during these two years, type of drugs abused and the age, sex, marital status, educational level, occupation, monthly income of the addicts. Source of referral to the centres was also included in the profile. The inferences drawn from the data received on these components are discussed in details to follow.

Registration

Table 5.1 gives the number of addicts registered at the eight sampled counselling centres during 1990-91 and 1991-92. It can be inferred from the Table that the average number of drug addicts obtained services at these centres ranged between 7 per month to more than 90 per month during these two years. However, in case of five of the centres addicts numbering from 8-16 were registered per centre per month. The average number of addicts got registered at these 8 centres was only 26 addicts per month per centre.

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<td></td>
<td>336</td>
<td>28.00</td>
<td>172</td>
<td>14.30</td>
</tr>
<tr>
<td>IV</td>
<td></td>
<td>109</td>
<td>9.08</td>
<td>131</td>
<td>10.92</td>
</tr>
<tr>
<td>V</td>
<td></td>
<td>88</td>
<td>7.30</td>
<td>89</td>
<td>7.42</td>
</tr>
<tr>
<td>VI</td>
<td></td>
<td>186</td>
<td>15.50</td>
<td>200</td>
<td>16.67</td>
</tr>
<tr>
<td>VII</td>
<td></td>
<td>969</td>
<td>80.75</td>
<td>443</td>
<td>36.92</td>
</tr>
<tr>
<td>VIII</td>
<td></td>
<td>665</td>
<td>55.42</td>
<td>1109</td>
<td>92.42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>2578</td>
<td>26.85</td>
<td>2393</td>
<td>24.93</td>
</tr>
</tbody>
</table>

The reasons for a small number of registration of new cases at these centres could be many, it may be a lack of awareness of the centre and need for treatment among public, stigma attached to the problem, lack of identification and motivation of the addicts on the part of the centre or lack of credibility of the centre or counselling services in general amongst the people, etc.
Drugs abused

Table 5.2 presents the type of drugs abused by the addicts treated at the counselling centres during 1990-91 and 1991-92. Most of the addicts abused only one drug, however, around 11% either abused two drugs (7.9%) or more. These drugs were abused mainly in combination to smack/brown sugar or alcohol or both and at times even barbiturates were abused.

The addicts treated at the counselling centres represented with addiction to brown sugar/smack in most of the cases during 1990-91 and 1991-92. The percentages were 65.32% and 46.72%, respectively, during these two years. The cases of alcohol addiction were 11% during 1990-91 and comparatively higher (19.35%) during 1991-92. The representation of cannabis addicts at these centres were small in number (2.8%) during 1990-91 and it rose to 7.2% during 1991-92. The cannabis derivatives in descending order of extent of abuse were charas (more than 1%), Ganja and Bhang.

Addiction to opium was also presented by nearly 5.4%. Cases of Morphine, Pethidine, heroin and codeine addiction increased from mere 2.4% in 1990-91 to 6.5% during 1991-92.

The data reflects that the addiction to drugs like LSD, cocaine, barbiturates, amphetamines, etc. was not at all substantial and presented only at 1 or 2 centres.

To sum up, it is learned that the addiction to smack/brown sugar was prevalent amongst the addicts presented at the counselling centres. Alcohol addiction too was found to be amongst significant numbers. Synthetic derivatives of opium like Morphine, Pethidine, codeine and heroin were on an increase leading to addiction through injection. The number of cannabis addicts increased at the counselling centres during 1991-92 over 1990-91 may be for the simple reason of improved realisation about the harmful effects of this traditionally abused drug. This might have taken place due to the efforts made by the counselling centres to educate people about the ill-effects of drugs through their out-reach programmes. Addiction to other drugs like cocaine, barbiturates, LSD and amphetamines was presented by a small number of addicts. (Figure 5A)
<table>
<thead>
<tr>
<th>YEAR</th>
<th>BROWN SUGAR S.</th>
<th>OPIUM</th>
<th>OTHER OPIATES</th>
<th>ALCOHOL</th>
<th>CANNABIS</th>
<th>LSD</th>
<th>AMPHET.</th>
<th>COCAINE</th>
<th>TWO DRUGS</th>
<th>MULTIPLE ABUSERS</th>
<th>OTHERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-91</td>
<td>1634</td>
<td>121</td>
<td>65</td>
<td>285</td>
<td>72</td>
<td>0</td>
<td>1</td>
<td>34</td>
<td>234</td>
<td>66</td>
<td>16</td>
<td>2578</td>
</tr>
<tr>
<td>%</td>
<td>65.32</td>
<td>4.69</td>
<td>2.42</td>
<td>11.05</td>
<td>2.5</td>
<td>0</td>
<td>0.04</td>
<td>1.32</td>
<td>9.08</td>
<td>2.56</td>
<td>0.62</td>
<td>100</td>
</tr>
<tr>
<td>1991-92</td>
<td>1118</td>
<td>147</td>
<td>157</td>
<td>463</td>
<td>165</td>
<td>43</td>
<td>0</td>
<td>6</td>
<td>157</td>
<td>93</td>
<td>29</td>
<td>2039</td>
</tr>
<tr>
<td>%</td>
<td>46.72</td>
<td>6.14</td>
<td>6.55</td>
<td>19.35</td>
<td>7.63</td>
<td>1.3</td>
<td>0</td>
<td>2.33</td>
<td>6.56</td>
<td>3.89</td>
<td>1.63</td>
<td>100</td>
</tr>
</tbody>
</table>

* Includes heroin, morphine, pethidine and codeine
DRUGS ABUSED BY ADDICTS AT COUNSELLING CENTRE DURING 1991-92

(Figure 5A)

---

[Bar chart showing the number of addicts in thousands for different drugs and years]
Age distribution

Drug addicts mostly belonged to young age group of 24-40 years as nearly 40% addicts were in this age group. As shown in the Table 5.3 more than 65% addicts belonged to the age group 18-40 years. However, quite a substantial number, up to 35% were above 30 years.

Table 5.3: AGE OF DRUG ADDICTS PRESENTED AT THE COUNSELLING CENTRES DURING 1990-91 AND 1991-92

<table>
<thead>
<tr>
<th>YEAR</th>
<th>12-17</th>
<th>18-23</th>
<th>24-30</th>
<th>31-45</th>
<th>46-60</th>
<th>61+</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-91</td>
<td>85</td>
<td>739</td>
<td>1030</td>
<td>542</td>
<td>164</td>
<td>18</td>
<td>2574</td>
</tr>
<tr>
<td>(%)</td>
<td>3.30</td>
<td>28.67</td>
<td>39.95</td>
<td>21.02</td>
<td>6.36</td>
<td>0.70</td>
<td>100.00</td>
</tr>
<tr>
<td>1991-92</td>
<td>45</td>
<td>562</td>
<td>932</td>
<td>699</td>
<td>148</td>
<td>7</td>
<td>2393</td>
</tr>
<tr>
<td>(%)</td>
<td>1.88</td>
<td>23.49</td>
<td>38.95</td>
<td>29.21</td>
<td>6.18</td>
<td>0.29</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Addiction at early age is another trend depicted in the figure. Two to Three per cent of addicts were between 12-17 years of age. The reason for addicts visiting the counselling centres after the age of 30 years or above could be explained as addicts might have approached the centres after their addiction had fully set in and there was no escape than treatment. It may also be possible that some of the addicts might have began drug abuse at later age of 30 plus. The data clearly show that the youngsters were most given to addiction and they belonged to the age group 18-30 years. The research studies mentioned under review also supports the same view.
Sex distribution

The data of the counselling centres showed that the male addicts predominately approached the counselling centres for treatment. It was only half of the sampled counselling centres reported about the registration of female addicts by them during 1990-92. The number of such female addicts did not exceed three at any one of the centres during these years.

The female addicts, therefore, were comparatively much lesser than the male addicts because of gender related and social factors. The negligible number of female addicts approaching the counselling centres is no indication of addiction problem amongst females as the social stigma attached to the problem restricts female addicts from coming to these centres for treatment.

Marital status

Married as well as unmarried were given to drug addiction. Table 5.4 shows married (55%) out numbered the unmarried (40%). It leads to think that more of married addicts visit the counselling centres than the unmarried. This distribution differs from the representation of married and never married population to the total population in Delhi. The possible reasons for such a variation may be marriages were performed at an early age, addicts might had started with drug abuse when they were not married but by the time they reported at the counselling centres their marital status might have changed, the married addicts might be taking drugs as a defence to the responsibilities of the married life.

TABLE 5.4: MARITAL STATUS OF ADDICTS VISITED COUNSELLING CENTRES DURING 1990-91 & 1991-92

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MARRIED</th>
<th>UNMARRIED</th>
<th>WIDOWER/ER</th>
<th>DIVORCEE/SEPARATED</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-91</td>
<td>1415</td>
<td>1040</td>
<td>40 *</td>
<td>83</td>
<td>257</td>
</tr>
<tr>
<td>%</td>
<td>54.89</td>
<td>40.34</td>
<td>1.55</td>
<td>3.22</td>
<td>100.0</td>
</tr>
<tr>
<td>1991-92</td>
<td>1338</td>
<td>840</td>
<td>82 *</td>
<td>133</td>
<td>239</td>
</tr>
<tr>
<td>%</td>
<td>55.91</td>
<td>35.10</td>
<td>3.43</td>
<td>5.56</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* THERE WAS ONLY ONE WIDOW.

It is also important to notice that around 2-3% of the addicts had marital status as separated/divorced/widow/widower. This percentage is higher than the percentage of population in this category to the total population of Delhi (1.61%). The loneliness in life or stress and strain caused by breaking of family ties may be possible reasons to take to drug addiction. It may be addicts' status of being separated of divorced is a consequence of drug addiction.
Educational status

The addicts who visited counselling centres were mostly with low educational status. More than 65% of the addicts were educated up to intermediate or below. The illiterate constituted nearly 14% during 1990-91 and 1991-92 (Table 5.5).

**TABLE 5.5: EDUCATIONAL STATUS OF DRUG ADDICTS PRESENTED AT COUNSELLING CENTRES DURING 1990-91 AND 1991-92**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ILLITR</th>
<th>LITRATE</th>
<th>PRIMRY</th>
<th>MIDDLE</th>
<th>SECDY.</th>
<th>HR. SECY</th>
<th>GRAD.</th>
<th>POST-GRAD OTHE. I &amp; ABOVE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-91</td>
<td>388</td>
<td>183</td>
<td>645</td>
<td>266</td>
<td>248</td>
<td>638</td>
<td>161</td>
<td>46</td>
</tr>
<tr>
<td>1991-92</td>
<td>333</td>
<td>167</td>
<td>305</td>
<td>335</td>
<td>245</td>
<td>555</td>
<td>257</td>
<td>196</td>
</tr>
</tbody>
</table>

* THE CATEGORY POST-GRADUATE & ABOVE ALSO INCLUDES THOSE WITH PROFESSIONAL & TECHNICAL QUALIFICATIONS, SUCH AS LLB, CA, MBBS, B.E, ETC.

The addicts with education up to primary level or no education were between 47% and 33.6% respectively, for 1990-91 and 1991-92. As could be seen from the Table, during 1990-91 comparatively less number of addicts with higher education visited the counselling centres than during 1991-92. The number of graduate addicts or with other higher qualifications were nearly 19% during 1991-92 and it was only 8% for the year 1990-91. Such a trend leads to think that with the lag of time the credibility of the counselling centres amongst people might have improved and more number of addicts got motivated for treatment because of better awareness of its ill-effects either through the efforts of the counselling centres or through mass media activities or both.

The educational distribution of addicts is in consonance with that of literacy level amongst males in Delhi. It means that both literate and illiterates are given to drug addiction. They do avail services of the counselling centres. The percentage of those with higher education was comparatively lesser than those with low educational level.

Occupation

Table 5.6 gives a distribution of addicts by occupation during the years 1990-91 and 1991-92. The Table shows that 15.4% of the addicts were unemployed during these years. The addicts were mainly engaged in occupations such as business, transport work, scooter driving, rickshaw pulling, labourer and government service, etc. It can be inferred from the Table that during 1990-91 the scooter drivers, rickshaw pullers, transport workers, and
<table>
<thead>
<tr>
<th>YEAR</th>
<th>UNEMPLOYED</th>
<th>GOVT. BUSINESS</th>
<th>AGRI. SERVICE</th>
<th>AGRI. LABOUR</th>
<th>LABOURTRANSPORT</th>
<th>PICKHAM</th>
<th>SCOOTER</th>
<th>PROP.</th>
<th>OTHERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-91</td>
<td>367</td>
<td>273</td>
<td>532</td>
<td>21</td>
<td>52</td>
<td>376</td>
<td>108</td>
<td>197</td>
<td>352</td>
<td>20</td>
</tr>
<tr>
<td>%</td>
<td>14.40</td>
<td>10.59</td>
<td>20.61</td>
<td>0.93</td>
<td>2.02</td>
<td>14.16</td>
<td>4.19</td>
<td>7.64</td>
<td>15.21</td>
<td>0.79</td>
</tr>
<tr>
<td>1991-92</td>
<td>389</td>
<td>293</td>
<td>461</td>
<td>30</td>
<td>31</td>
<td>562</td>
<td>45</td>
<td>93</td>
<td>238</td>
<td>179</td>
</tr>
<tr>
<td>%</td>
<td>14.26</td>
<td>12.49</td>
<td>19.26</td>
<td>1.23</td>
<td>1.29</td>
<td>10.35</td>
<td>2.01</td>
<td>3.89</td>
<td>9.95</td>
<td>15.17</td>
</tr>
</tbody>
</table>
labourers together constituted 43.4%, however, the corresponding percentage during 1991-92 was 28%. The percentage of scooter drivers were up to 15% and of labourers up to 16% shows that this class is more given to drug addiction. Businessmen engaged in various kind of self- employment, such as, shopkeeping, merchant work, property dealing, etc. constituted a substantial percentage of nearly 20% during both the years. The percentage of addicts in government service mainly occupying jobs of attendants, clerks, assistants, etc. was 11.5% during these two years.

It is important to note from the Table that during 1991-92, 15% of the addicts approached the counselling centres were engaged in professions such as law, medicine, engineering, etc. However, percentage of professional addicts for 1990-91 was negligible. The reason for such a shift could be thought to be better awareness of ill-effects of addiction and motivation through the centres' activities. It may be recalled that the similar shift in trend was noticed for the educational background during these two years.

Income Distribution

More than half to about three fourth of the addicts either earned nil or up to Rs.1000/- per month during 1990-92 as shown in Table 5.6. The addicts without any income constituted about one fifth and one fourth during these two years, respectively. The percentage of those with an income of more than Rs. 1000-3000 was comparatively higher during 1991-92 (nearly two fifth) than 1990-91 (nearly one fourth). The Table reflects that addicts visited the counselling centres mostly belonged to the low or middle income groups as more than 90% had monthly income up to Rs.3000. The addicts from the higher income groups rarely visited these centres.

TABLE 5.7: INCOME DISTRIBUTION OF ADDICTS PRESENTED AT COUNSELLING CENTRES DURING 1990-91 AND 1991-92

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NO-INCOME</th>
<th>100-500</th>
<th>501-1000</th>
<th>1001-300</th>
<th>3001-500</th>
<th>5001+</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-91</td>
<td>599</td>
<td>408</td>
<td>795</td>
<td>608</td>
<td>145</td>
<td>23</td>
<td>2578</td>
</tr>
<tr>
<td></td>
<td>23.24</td>
<td>15.83</td>
<td>30.84</td>
<td>23.58</td>
<td>5.62</td>
<td>0.89</td>
<td>100</td>
</tr>
<tr>
<td>1991-92</td>
<td>432</td>
<td>141</td>
<td>658</td>
<td>971</td>
<td>152</td>
<td>49</td>
<td>2393</td>
</tr>
<tr>
<td></td>
<td>18.05</td>
<td>5.89</td>
<td>27.50</td>
<td>40.58</td>
<td>6.35</td>
<td>1.63</td>
<td>100</td>
</tr>
</tbody>
</table>
Source of referral to the counselling centres

Table 5.8 presents the source of referral of addicts to the counselling centres for treatment. It may be noted that one fifth of addicts came themselves for treatment to the counselling centres during 1990-91 and 1991-92. Family and friends had played a very important role by bringing addicts to the centres. The family was the major unit who performed this task by representing nearly 40% during 1990-91. More number of friends were helpful during 1991-92 (more than one fifth) than 1990-91. The social workers seem to be actively working at these centres and engaged inter alia in the task of identification of addicts as well in creating awareness and motivating addicts for treatment. The Table shows upto one fifth, 22% of the addicts were referred to the centres by the social workers. Ex-addicts surprisingly did not figure at all in the list during 1990-91, probably, the centres might have merged them in the category of others. However, during 1991-92 a small number (3%) of ex-addicts served as a source of referral. The responses among others included newspapers, relatives, posters/hoardings, other persons than family and friends, etc.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>SELF</th>
<th>FAMILY</th>
<th>FRIENDS</th>
<th>PRIVATE</th>
<th>HOSPITAL</th>
<th>SOCIAL WORKER</th>
<th>EX. ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-91</td>
<td>674</td>
<td>1016</td>
<td>359</td>
<td>16</td>
<td>3</td>
<td>388</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td>26.14</td>
<td>39.41</td>
<td>13.93</td>
<td>0.62</td>
<td>0.12</td>
<td>15.95</td>
<td>4.73</td>
</tr>
<tr>
<td>1991-92</td>
<td>541</td>
<td>561</td>
<td>547</td>
<td>40</td>
<td>77</td>
<td>530</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>22.61</td>
<td>23.44</td>
<td>22.86</td>
<td>1.67</td>
<td>3.22</td>
<td>22.15</td>
<td>1.17</td>
</tr>
</tbody>
</table>

Areas of operation

Four of the centres located in North, East and South Delhi mostly concentrated their activities within 1-5 kms. range. The areas covered by these centres were, Bara Hindu Rao, Krishan Ganj, Nanak Pura, Sadar Bazar, Nabi Krim and Pahar Ganj in North Delhi by one of the centre; the other centre covered Turkman Gate, Sitaram Bazar, Jama Masjid, Minto Bridge, Chabri Bazar, New Delhi Railway Station, Kala Mahal, Pahari Imbli, Motia Mahal, Chudhi Bala (areas in the north and walled city); Dakshin Furi, Madan Gir, Sangam Vihar, Tigri, J.J. colony, Khanpur Depot, Harijan Basti Khanpur, Deoli village in South Delhi were covered by different centre. Okhla, Bharat Nagar, Nai Basti, Sunlight colony, Sukhdev Nagar, Khizrabad were the areas in south Delhi catered by other centre.
Two of the centres even covered areas up to 10 kms in West and North Delhi. These areas included Tilak Vihar, Shahpura, Gurunanak Nagar, Chakhandi, Krishna Park, Vikas Puri, Mahavir Nagar, Sultan Puri, Tilak Nagar and Rohini in West Delhi and Kotla, Seva Nagar, Katwaria Sarai, South Extension, Jal Vihar, Kalkaji, Ber Sarai, Madan Giri, Lodhi Road, Gautam Nagar in South Delhi. The remaining one centre had even extended activities upto 20 kms. of range covering areas such as Mehrauli, Kishan Gard, Masood Pur, Mahipal Pur, Lado Sarai, Malviya Nagar, Batti Mines, Fatehpur Beri, Balveer Nagar, Krishna Nagar, Arjun Nagar, Sardarpur Enclave, Shahpur Jat.

To sum up, the counselling centres mostly tried to concentrate their activities in a radius of 3-5 kms but some did extend them to 10-20 kms range. Since the counselling centres covered number of areas widely spread in the north, south, east and west parts of Delhi, could be taken as representative of the Delhi's population of addicts visit the counselling centres.

SERVICES PROVIDED BY THE CENTRES

The counselling centres aim to provide rehabilitation cover through services for identification, motivation, referrals for detoxification, follow-up and rehabilitation. In order to fulfill this aim they provided different kind of services.

In order to assess the services provided by the counselling centres the information on the aspects like medication, detoxification, psychological intervention, type of services, mode of identification, laboratory tests were obtained in addition to individual counselling sessions, group counselling sessions, family counselling and other services.

Identification of cases

Identification is the first step to therapy. It is very essential to adopt and deploy various methods for identification of cases of drug addiction within the community. Special and extensive methods are required to be utilised in order to know of addiction cases as drug problem carries associated stigma with it, legal connotations and ignorance.

The counselling centres utilised multiple methods to identify the addicts. The responses received from the centres were awareness-building and preventive education programmes as used by 6 centres, contacts and meetings with local leaders/heads/panchayats was mentioned by 4 centres, community visits/field visits by 3 centres. The methods such as convening public meetings, through contacts with ex-addicts/addicts under treatment, local organisations/clubs were mentioned by two centres in each case. Four of the centres also mentioned that the clients do visit on their own.
It can be inferred from the above mentioned details that awareness building and preventive education were the methods used by most of the counselling centres for the identification of drug addicts. Community involvement and participation were other means of identification, frequently deployed by these centres.

**Type of services**

At seven centres out-door services were available and the remaining one centre provided out-door services at the counselling centre and in-door at the detoxification centre which is located in the same premises. The indoor facilities were with 10 beds and sponsored by the Ministry of Welfare and provided detoxification with a stay of client for 10-15 days on an average. Out of the seven centres with only out-door facilities four centres had facilities for detoxification at the detoxification centre run by the same organisation to whom the centre belonged.

**Detoxification**

The abuse of drugs leads to entry and accumulation of harmful substances in a body. In a process of treating the addicts the first thing is to drain out these toxins and to further stop its entry into the body. Detoxification is a process through which the addicts' body become toxin free and also free of symptoms that arise due to withdrawal of drugs. Depending on the stage of addiction the addict had approached the counselling centres, most of the addicts had to undergo the detoxification before proceeding further with a treatment plan. The counselling centres were studied with regard to detoxification facilities extended by them to the addicts.

Addicts detoxified through the counselling centres during 1990-91 and 1991-92 are presented in Table 5.9. It is inferred that out of 2578 addicts registered during 1990-91 (Table 5.1), 2240 (75.8%) required detoxification. The percentage for 1991-92 works out to be 86%. During 1990-91 57.6% of the addicts were referred for indoor detoxification, whereas, only one fourth were detoxified through indoor facilities during 1991-92. They were mostly put on out-patient detoxification at the counselling centres or through referral to any other detoxification facilities, during 1991-92.

**TABLE 5.9: ADDICTS DETOXIFIED THROUGH CONSELLING CENTRES DURING 1990-91 AND 1991-92**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>OUTDOOR</th>
<th>INDOOR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-'91</td>
<td>790</td>
<td>1165</td>
<td>1955</td>
</tr>
<tr>
<td>2</td>
<td>40.41</td>
<td>59.59</td>
<td>100</td>
</tr>
<tr>
<td>1991-'92*</td>
<td>1437</td>
<td>469</td>
<td>1906</td>
</tr>
<tr>
<td>75.39</td>
<td>24.60</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

* FOR ONE CENTRE DATA WERE NOT AVAILABLE
The possible reasons for provision of detoxification services mainly through out-patient care than through indoor facilities could be availability of limited number of such facilities in Delhi. The other reason that could be thought of is that the out-door detoxification is as effective as of indoor detoxification. However, this hypothesis need to be further researched.

On an answer to the question whether each case of addiction requires detoxification, 50% (4 centres) of the centres endorsed this view. The other 50% felt that every case does not require detoxification. One centre responded that only 1% of the addicts do not require detoxification, the other centre mentioned 5% do not require as they are determined to leave the drug, the response given by other centre that 60% addicts who had recently started drug taking and are young students do not require detoxification. One of the centre responded that 100% smack addicts do not require detoxification and in case of cannabis and alcohol addiction, 40% require detoxification. It was also mentioned by this particular centre that the detoxification is mostly required in case of chronic addicts. The above reflects that the counselling centres expressed differential view as regards need for detoxification. It seems that they were not clear about the concept of detoxification. It may be because of lack of training or non-availability of any common glossary defining such terminologies to which all of them could refer to.

The centres got the addicts detoxified mostly through referral to the detoxification centre of the same organisation to which the centre belonged was mentioned by five centres. Three centres referred cases to detoxification units set up in the hospital or at other organisation or at times to the private clinics. The detoxification units, whose services were utilised, located at Vidya Sagar Kaushalaya Devi Memmorial Trust (Nehru Nagar), Ashiana (Shivaji stadium), Ilajgarh (Filmistan), Jeevan Jyoti (pankha Road), AIIMS, Drug Deaddiction Unit at Deen Dayal Upadhaya Hospital, Holy Family Hospital, etc.

**Laboratory tests**

Drug addiction affects both body and mind of addicts. The physical disorders may exist prior to addiction or it may be a concomitance of it. However, these conditions need to be diagnosed and treated alongwith treatment of addiction. The laboratory tests to assess the physical condition would be required to be performed for the addicts. The counselling centres had expressed their views on the need for the laboratory tests and also informed about the type of laboratory tests they usually recommended for the addicts approached them.

It was felt by one of the centres that no laboratory tests are necessary for addicts. The other centre, however, mentioned that blood test (6 centres), X Ray chest (5 centres), urine test (4 centres), HIV test (1 centre) are required for the addicts. Three centres got these tests done privately, two from the de-addiction clinic of the same organisation, other from the clinic of the centre (1 centre), one from hospital and the other centre at the detoxification centre.
Medication

Most of the counselling centres used medicines in the treatment of addicts as 6 out of 8 centres prescribed medicines to the addicts. These medicines were mainly sedatives, hypnotics, tranquillisers, analgesics and vitamins, such as, librium, nitavite, lomotil, phenargan, equibum, disprin, amitrine, diazepam, hypnotex, brufen, seripax, multi vitamins, etc. These drugs were mainly used as symptomatic treatment to lessen the effect of withdrawal symptoms and to improve the general health of addicts.

Psychiatrists' Intervention

The researches carried out in India as well in the West have given to understand that more of the drug abusers are likely to develop psychiatric problems in comparison to those who do not abuse drugs. It, therefore, becomes imperative to screen the addicts for such ailments as they approach the treatment facilities with a purpose to rule out its existance or to treat it along with drug problem in case it persists. Psychological tests would help in assessing the state of mind of addicts.

Four centres sought Psychiatrists opinion in every case in order to treat the physical and mental symptoms associated with addiction, to prescribe medicines and to rule out mental illness, if associated. One of the centres felt, only complicated cases needed Psychiatrist's intervention. The other centre opined that all addicts do not suffer with psychiatric problems, therefore, all cases did not require Psychiatrist's intervention.

It may be mentioned that none of the centres were using any psychological tests for diagnosis and treatment of addicts.

Counselling Services

Counselling is a base in dealing with the drug abuse problem which is neither a pure physical problem and nor just a mental problem, it is a psycho-socio-medical problem and need to be dealt within the totality of addict's life situation. Counselling is the best resort to take care of the psychological, social, economic, familial aspects of the problem.

(a) Individual Counselling

Individual counselling is a process of a person with problem being helped by another with good will and expertise for overcoming the problem. The problem with drug addicts is complex, variegated and different from the usual run of the problems. The addict with all his desire to help himself feels helplessness and can not stand the compulsiveness of drug and sense of guilt, self-pity and loneliness overwhelm him and reduce the person to zero. This is exactly the situation where individual counselling
is imperative. Any other alternative method is inept, irrelevant and inappropriate. The functioning of counselling centres without counselling services for drug addicts is meaningless. The centres were studied in regard to different aspects of individual counselling.

Number and duration

Table 5.10 presents number of individual counselling sessions conducted by the centres by number of addicts. It can be seen from the Table that on an average 6-10 counselling sessions were performed by each centre per day. The average number of sessions performed for an addict was only 2-3 sessions, with a range of 1 to 20 counselling sessions. It is surprising to note that in case of one centre the average number of sessions per addict fell from 20 in 1990-91 to just 1.61 in 1991-92.

TABLE 5.10: INDIVIDUAL COUNSELLING SESSIONS HELD AT COUNSELLING CENTRES BY NUMBER OF ADDICTS DURING 1990-91 AND 1991-92

<table>
<thead>
<tr>
<th>CENTRE</th>
<th>1990-91</th>
<th>1991-92</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO. OF SESSIONS</td>
<td>NO. OF ADDICTS</td>
<td>NO. OF SESSIONS</td>
</tr>
<tr>
<td>J</td>
<td>1435</td>
<td>1063</td>
</tr>
<tr>
<td>II</td>
<td>1005</td>
<td>348</td>
</tr>
<tr>
<td>III</td>
<td>2740</td>
<td>1120</td>
</tr>
<tr>
<td>IV</td>
<td>1183</td>
<td>805</td>
</tr>
<tr>
<td>V</td>
<td>1699</td>
<td>389</td>
</tr>
<tr>
<td>VI</td>
<td>5443</td>
<td>451</td>
</tr>
<tr>
<td>VII</td>
<td>7665</td>
<td>185</td>
</tr>
<tr>
<td>VIII</td>
<td>4873</td>
<td>3487</td>
</tr>
<tr>
<td>TOTAL</td>
<td>24143</td>
<td>7848</td>
</tr>
</tbody>
</table>

The responses received from the Project Coordinators as regards individual counselling sessions are as mentioned below:

<table>
<thead>
<tr>
<th>No. of sessions</th>
<th>No. of counselling centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10</td>
<td>3</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
</tr>
<tr>
<td>16-25</td>
<td>2</td>
</tr>
<tr>
<td>50-55</td>
<td>1</td>
</tr>
<tr>
<td>56</td>
<td>1</td>
</tr>
</tbody>
</table>

The above shows that most of the centres felt that minimum 5 sessions be carried out for addicts which mostly ranged upto 25 sessions.
The average duration for which the individual counselling sessions lasted as mentioned by the project coordinators was 30-45 minutes by 50% (4 centres) of the centres. Three centres mentioned 15-30 minutes. However, one centre conducted counselling sessions only for 15 minutes.

As regards adequacy of space to carry out counselling sessions, five centres felt they had adequate space and the other three expressed the inadequacy of space.

Contents

While answering to the question on the content of counselling sessions, the centres had outlined various aspects on which these sessions were based. The multiple responses received were, assessment of the addict's problems and reasons for him to get into drugs was mentioned by 5 centres, understanding of social and family background of an addict was mentioned by two centres. Four centres mentioned that through the counselling sessions the addict is made to understand the facts and concepts associated with drug behaviour. During these sessions addict is motivated to leave the drug and his motivation level is also assessed, was indicated by two centres. The another important aspects that is dealt with through counselling were building up confidence in addict, helping him in improving his self image and strengthening of and surfacing out the positive aspects in addicts personality were mentioned by four centres. Counselling services also helped addicts to make decisions for themselves by enabling them to pick and choose a suggestion out of the number of alternate suggestions offered to them during the counselling sessions, was pointed out by two centres.

The counselling sessions gave due importance to the role of family members. They were meant to assess the interpersonal relationships within the family, family's beliefs and views of the problem, efforts to improve the relationships and also to seek family's support and cooperation was mentioned by four centres.

The aspects like economic rehabilitation and building rapport, attending to drug related problems such as job, sexual problems, etc. were also taken care of during the counselling sessions in case of two centres.

Problems encountered

As regards the problems encountered by the staff in counselling addicts, two centres did not face any problem. However, the problems mentioned by other centres were mainly irregularity in attendance of addicts to the counselling sessions as faced by three centres, and lack of family support was mentioned by two centres. The other problems mentioned by a single centre in each case respectively included language problem, unwillingness towards bringing family to the centre, lack of privacy leading to difficulty in discussing the issues, ignorance, non-realisation of importance of counselling by addicts and having more faith on medical therapy or medicines.
Usefulness of the sessions

The individual counselling sessions were responded to be perceived as useful by 7 out of 8 centres as it provided an opportunity to the addicts to express themselves and the addicts were usually perceived to be satisfied after the sessions. In case of one centre it was mostly perceived to be useful.

(b) Group Counselling

Group counselling is a technique of treating patients in groups with similar problems. This technique emphasises the fact that the patient's problems are not unique. It makes available the acumen and experience of addicts' peers, who do sometimes spot denial and confront the addicts.

Group counselling helps the addicts to discuss/share their experiences with one another, and through this process they learn skills of coping, decision making and problem solving. The group may consist of patients with problems with any addiction producing drugs; patients with alcoholism, group of relapse cases, group of new entries, etc.

Group counselling sessions were used by all the eight counselling centres for addicts with any drug problem. However, one of the centre was conducting separate group sessions for alcoholics. Centres also conduct group sessions for a group of addicts, family members and friends and for family members and addicts together as mentioned by two of the centres. It was also mentioned that counselling in groups was done for family and community groups by one centre in each case.

All except one centre had adequate space to conduct group sessions and the one without adequate space tried to adjust within the available space or utilised premises of the de-addiction centre.

The size of group for which sessions were organised ranged between 4-10 with an average size of 6 members. In these groups the interaction between the group members was encouraged. They were encouraged to talk, discuss their problems and share their experiences with others was mentioned by six centres. However, out of the remaining two centres, one mentioned that Eclectic Approach is used by them and the other emphasised on 12 point Alcoholics Anonymous (A.A) philosophy.

In case of open groups, consisting of addicts with abuse to varied drugs, members were encouraged to share their experiences with each other. However, in a close group with specific and common problems even the solutions to the problems were discussed and learned through others experiences. One of the centres mentioned that with the group of illiterate addicts one can not be too professional in conducting the group therapy sessions. The other centre as well pointed out that for the selection of a group criteria of area, age, marital status, commonality of problems were followed.
The responses to the problems faced by the social workers and counsellors in conducting the group sessions varied. One of the centres was of the opinion that there were no problems in conducting the sessions. The major problems faced by four centres were lack of cooperation, irregularity in attendance, indifferent attitude. It was mentioned by one centre that the group members deviated from the point of discussion or purpose quite often, and arguments usually started and they criticised or blamed each other. The other one centre expressed that initially the addicts failed in understanding the concept of group counselling and A.A. philosophy. The inadequacy of space to conduct sessions was also mentioned by one of the centres.

<table>
<thead>
<tr>
<th>CENTRE</th>
<th>NO. OF SESSIONS</th>
<th>NO. OF ADDICTS</th>
<th>AVERAGE SESSION PER ADDICT PER GROUP OF SIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>238</td>
<td>466</td>
<td>3.06</td>
</tr>
<tr>
<td>II</td>
<td>312</td>
<td>416</td>
<td>4.50</td>
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<tr>
<td>III</td>
<td>36</td>
<td>326</td>
<td>0.66</td>
</tr>
<tr>
<td>IV</td>
<td>71</td>
<td>363</td>
<td>1.17</td>
</tr>
<tr>
<td>V</td>
<td>13</td>
<td>47</td>
<td>1.66</td>
</tr>
<tr>
<td>VI</td>
<td>296</td>
<td>287</td>
<td>6.19</td>
</tr>
<tr>
<td>VII</td>
<td>2</td>
<td>7</td>
<td>1.71</td>
</tr>
<tr>
<td>V</td>
<td>36</td>
<td>1876</td>
<td>1.17</td>
</tr>
<tr>
<td>Total</td>
<td>1334</td>
<td>3788</td>
<td>2.11</td>
</tr>
</tbody>
</table>

Table 5.11 gives the number of group sessions with number of addicts registered during 1991-92. In all 1334 group sessions were held at 8 counselling centres during the year. The average number of sessions organised by a centre during a month amount to 14 sessions and the average number of sessions per addict range between 1 to 6 sessions (average 2 sessions per addict) with an average group size of six members.

(C) Family Counselling

Drug addiction is not only a problem of an individual who takes drugs. It is as well a problem of family members. Family members get victimised because of addiction of one of their family members. The family express number of emotional responses such as guilt, anger, shame, hurt, fear, loneliness, etc. The behavioural responses include, denial to disease by family members, they may act as protector, controller and likely to put blame on the client, on others, etc. In a family there may be lack of communication, unsatisfactory sexual relationship, mismanagement of finances, or difficulty in maintaining discipline. At times the interpersonal relationships within family gets strained.
The family members of drug addicts are called co-dependents. Co-dependency means being a partner in dependency. The co-dependency is the term used to describe a person whose life is affected, as a result of her involvement with the drug dependent person. The co-dependent normally develops unhealthy pattern of coping with life. The co-dependent even wants the addict to leave the drug unconsciously takes up defensive and destructive roles which strengthens his drug dependency. Co-dependents react to the situation in a divergent ways instead of acting in a healthy manner. Therefore, these along with a addicts need a therapy.

Table 5.12 presents number of family counselling sessions held during 1991-92 and number of addict's families extended these services at the counselling centres. In all 4773 sessions were held for 2731 families indicating on an average 1-2 sessions performed in each case. However, the average sessions per family range between 1-7 sessions. In case of two centres the number of sessions were less than the number of families covered, may be for the reason that the families were counselled in groups. The average number of family counselling sessions per centre per day falls at 2.5.

<table>
<thead>
<tr>
<th>CENTRE</th>
<th>NO. OF SESSIONS</th>
<th>NO. OF FAMILIES</th>
<th>AVERAGE SESSIONS PER FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>576</td>
<td>309</td>
<td>1.86</td>
</tr>
<tr>
<td>II</td>
<td>900</td>
<td>291</td>
<td>1.99</td>
</tr>
<tr>
<td>III</td>
<td>63</td>
<td>312</td>
<td>0.20</td>
</tr>
<tr>
<td>IV</td>
<td>84</td>
<td>84</td>
<td>1.00</td>
</tr>
<tr>
<td>V</td>
<td>102</td>
<td>85</td>
<td>1.20</td>
</tr>
<tr>
<td>VI</td>
<td>1986</td>
<td>297</td>
<td>6.69</td>
</tr>
<tr>
<td>VII</td>
<td>690</td>
<td>481</td>
<td>1.43</td>
</tr>
<tr>
<td>VIII</td>
<td>372</td>
<td>872</td>
<td>0.43</td>
</tr>
<tr>
<td>Total</td>
<td>4773</td>
<td>2731</td>
<td>1.75</td>
</tr>
</tbody>
</table>

The staff of most of the counselling centres (6 out of 8 centres) opined that on an average 2-10 counselling sessions are required for the addict’s families. However, the remaining two centres mentioned as high as 20-25 sessions as a requirement of each case.

It was expressed by all the centres that family counselling does play an important role in the rehabilitation process of an addict. All the centres organised family counselling sessions. Spouse and parents were usually involved by the counselling centres as mentioned by 4 centres, the other 2 centres mainly dealt with spouse and mother, one centre talked of involving parents in case of unmarried addicts and spouse of a married addict, remaining one centre could not specify and responded that they dealt with anyone from the family depending on the case and availability of the member.
As regards the problems encountered by the counselling centres in dealing with the family members, the two centres did not encounter any problem. The other 4 centres mainly faced lack of cooperation of the family members as they had lost faith because of frequent relapses. It was also expressed that they found it difficult to seek father's cooperation. The family members at times did not turn up on the specified days and time mentioned by one of the centres. The other limitation added by the centre was timings of the centres which may not suit family members. It was also expressed by one centre that family members particularly mothers were very emotional and sensitive and addict could play tricks with her.

The counselling centres also delineated the important aspects they followed while counselling the family members. These were making family realise the problem-explaining that it is a disease, etc., was mentioned by 3 centres. The family members were also made aware of the kind of support they could render in the recovery of the client, mentioned by 2 centres. Two centres pointed out that the family was advised to have flexible and sympathetic attitude towards the addict and as well keep a watch on him, assessment of the interpersonal relationship within the family and needs and problems of the family members were also made during these sessions.

The family counselling sessions opined to be perceived by family members as very useful responded by 2 centres, 4 centres felt that mostly it was perceived to be useful or helpful and the remaining 2 centres responded it to be alright or satisfactory.

FAMILY VISITS AND FOLLOW UP

Involvement of addicts' Families in treatment is important. As mentioned earlier it is not only treating the addicts but also their families who too require help ultimately for the benefit of the addicts. Family plays an important role in the treatment of the addicts as the life of the addicts is knitted around these. The family visits are performed with varied purposes.

All the counselling centres performed family visits with a purpose mainly to understand and assess the social background, status and place addicts enjoyed in the their families, reaction and behaviour of family members to client's problem, client's behaviour in relation to family members and to confirm the truthfulness of the details given by an addict were mentioned by 6 out of 8 centres. The other purposes mentioned out of these 6 centres were to understand the interpersonal relationships within family members (3 centres), to know the reaction of neighbour (1 centre), to advise family on the importance of their involvement in the treatment process (1 centre). The remaining 2 centres performed family visits to counsel the family members (1 centre) and to pursue or motivate the family for detoxification (1 centre).
The complex problem of drug addiction unlike other diseases requires sustained and continuous follow-up for a longer duration in order to help the addicts to be drug free and able to reintegrate in the main stream of life. Follow up is, therefore, an essential component of treatment specially in case of such a complex problem with multiple dimensions and causation. The long term and continuous treatment would help in taking care of psycho-social aspects of the problem. The detoxification lasts only for 10-15 days or more. After this if the addict is not followed up, he is likely to give up treatment or simply may not turn up because of varied reasons, it may be personal, social, familial, physical, etc.

In case the client did not turn up for treatment as desired or instructed by the counselling centres the centres try to contact them through different measures. These included home visits and correspondence through letters mentioned by 4 centres, 2 other centres performed only home visits, one centre used varied methods such as telephonic contacts, writing letters and home visits, the remaining one centre paid home visits and pursued through awareness campaign and home visits.

**OTHER SERVICES PROVIDED BY THE CENTRES**

Day care services, self-help group approach, vocational guidance, economic rehabilitation, contact with employer, etc. have their own importance in the rehabilitation process. The counselling centres need to deploy these measures in order to help the addict to get back to the main stream of his life situation.

**Day Care Services**

Out of eight centres selected for the study only two centres had provided day care services to their clients. These services helped in keeping the client occupied and away from the drug prone environment as well helped in their education. The activities performed included playing carum, drawing, painting, making greeting cards, envelops and doing office work, etc. During the day the clients were also educated through film shows or video shows. On an average 50 addicts were provided day care services during the year was mentioned by one of the 2 centres and the other had not maintained record of such an activity. However, on an average day care services were provided from 2-3 months by one centre and the other centre did not follow any specific duration or limit.

**Self- help Groups**

Self-help group is the concept that helps the client to learn from others experiences and thereby refrain from taking drugs. In this group setting the addict is able to share his experiences, listen to others presented similar problems. It gives an environment for self expression, decision making, taking care of psychological weaknesses emerged due to drug taking,
helps in building up confidence, sense of belongingness and a determination to lead a drug free life. Such self-help groups work on 12 principles of A.A. philosophy. The counselling centres in order to rehabilitate the addicts must encourage their clients to formulate such groups or to become members of the groups already existed.

Three out of eight centres had helped the clients in formulating self help groups and it was expressed that such groups had proved to be useful as it helped the addicts to share their views and develop better rapport mentioned by one centre, two centres mentioned that it motivated them to stay drug free, helped in building confidence (2 centres), solving problems amongst themselves (1 centre).

In addition to self-help groups, one of the eight centres had formulated community clubs to help the addicts to have alternate means of recreation than drugs.

ECONOMIC REHABILITATION

The drug addiction usually put an addict into financial crises. Lot of money gets drained out while an addict is on drugs. The addict may not be able to work as efficiently as before and produce the same goods while he was drug free. Addiction creates lot of problems for addict as well for others at work place and for an employer. Addict may lose job in this process. The attitude of employer and colleagues changes and they may not continue to have faith in them. Ultimately the whole process not only effects the economy of a family and particular community but the nation's economy gets drained. In such a situation economic rehabilitation becomes a necessity in dealing with addicts to preserve the productivity of mostly this younger segment of the society.

Only four out of 8 counselling centres did undertake measures to economically rehabilitate the addicts. The help extended by these centres included admissions to vocational training institute like Shramik Vidya Peeth and others (1 centre), meeting with employers to secure previous employment to the addict (2 centres), recommending addicts for jobs to various agencies (2 centres) and providing jobs at the counselling centres to some of the addicts/ex-addicts (1 centre). It was only a small number of addicts were helped by these centres to rehabilitate them economically. These efforts are just a tip of iceberg.

COMMUNITY INVOLVEMENT

The community based approach adopted through the counselling centres to provide rehabilitation cover to drug addicts by the Ministry of Welfare thought to be best recourse to deal with such a wide spread and complex problem of drug dependence. Community participation and involvement has become essential to get the desired results. It is definitely a people's
programme and the community need to take action to combat this menace and help in reintegration of an addict into the main stream of life through participation at each step of the treatment. The community can participate in number of ways.

All the eight counselling centres tried to involve community workers in the rehabilitation of the addicts. The community leaders/local leaders, pradhans, teachers, businessmen/industrialists, other influential community people, etc. were frequently involved. Their participation was sought to organise training programmes, help in identification of addicts, organisation of community level meetings, participation in motivation of addicts for treatment, help in economic rehabilitation of addicts, organising community level education programmes such as talks, meetings, film shows, rallies, etc.

LIAISON BY COUNSELLING CENTRES

For the smooth and effective functioning of the counselling centres to provide quality care to the addicts and attack the problem in its totality the services of other agencies dealing in supply control and demand reduction need to be channelised by the centres. It would lead to strengthening of the activities of the counselling centres and making their approach more comprehensive.

Only 4 out of 8 centres mentioned that they liaison with other counselling centres by availing facilities for detoxification, exchange of knowledge and information on the addict and at times to undertake a joint programme. As regards liaison with the enforcement agencies, 3 centres mentioned that they coordinate with the Narcotics Control Bureau, participate in the training programmes organised for functionaries responsible for supply reduction, provide a report to court authorities in an event of court case registered against addict.

PERFORMANCE OF THE CENTRES

The quantitative indicators to judge the performance of the centres, inter alia, cases recovered, cases relapsed and cases dropped out. These three components are complex and there is no clear cut definition of these terminologies. However, attempt to define these has been made under operational definitions. The data on these aspects were not maintained at all the centres. Tables 5.13, 5.14 and 5.15 respectively, give information on these three components centre-wise.
FIGURE 5c

Addicts recovered, dropped out and relapsed by those registered at the counselling centres during 1991–92.
From the Table 5.13 on the cases recovered, it could be inferred that only a small number of cases were reported to be recovered during 1990-91 and 1991-92. If the information is looked at against the number of cases registered during the same period the percentage of recovered addicts to registered addicts range between 8% to 38% with average of 28.46% for 1990-91. The corresponding percentage for 1991-92 is between 5% to 50% with an average of 41.8%. The data show that nearly 10%-40% of the registered cases got recovered.

**Table 5.13 : Addicts Recovered After Treatment at the Counselling Centre During 1990-91 and 1991-92**

<table>
<thead>
<tr>
<th>CENTRE</th>
<th>NO. RECOV</th>
<th>NO. REGIS</th>
<th>% (2 TO 3)</th>
<th>NO. RECOV</th>
<th>NO. REGIS</th>
<th>% (4 TO 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>19</td>
<td>81</td>
<td>23.46</td>
<td>32</td>
<td>117</td>
<td>27.35</td>
</tr>
<tr>
<td>II</td>
<td>*</td>
<td>37</td>
<td>16.37</td>
<td>60</td>
<td>172</td>
<td>34.88</td>
</tr>
<tr>
<td>III</td>
<td>55</td>
<td>336</td>
<td>16.37</td>
<td>60</td>
<td>172</td>
<td>34.88</td>
</tr>
<tr>
<td>IV</td>
<td>9</td>
<td>109</td>
<td>8.46</td>
<td>6</td>
<td>131</td>
<td>4.58</td>
</tr>
<tr>
<td>V</td>
<td>30</td>
<td>88</td>
<td>34.09</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VIII</td>
<td>251</td>
<td>665</td>
<td>37.74</td>
<td>560</td>
<td>1109</td>
<td>50.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>364</td>
<td>1279</td>
<td>28.46</td>
<td>695</td>
<td>1661</td>
<td>41.84</td>
</tr>
</tbody>
</table>

*Information on recovered addicts was not maintained at centres VI and VII for both the years and at centres II and V for 1990-91 and 1991-92 respectively.*

Information on the relapsed cases were not available for the three centres. Table 5.14 gives data on this component. In all during 1991-92, 734 addicts were relapsed. The number of registered addicts at the five corresponding centres during the same year was 1945. The percentage of addicts relapsed to the number registered during the year was 37.74% ranging between 14.6% to 43%.

**Table 5.14 : No. of Addicts Relapsed After Receiving Treatment at the Counselling Centres During 1991-92**

<table>
<thead>
<tr>
<th>CENTRE</th>
<th>Addicts Relapsed</th>
<th>Total Relapsed</th>
<th>No. Regd</th>
<th>% of Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within 3 Months</td>
<td>3 to 6 Months</td>
<td>6 to 12 Months</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>19</td>
<td>18</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>II</td>
<td>12</td>
<td>15</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>V</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>VII</td>
<td>70</td>
<td>65</td>
<td>35</td>
<td>170</td>
</tr>
<tr>
<td>VIII</td>
<td>186</td>
<td>155</td>
<td>137</td>
<td>478</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>253</td>
<td>194</td>
<td>734</td>
</tr>
</tbody>
</table>
Information on drop-out of treatment by addicts was available for 7 centres and presented in Table 5.15. The percentage of addicts dropped treatment during 1990-91 and 1991-92 to the addicts registered at the centre during the same years was 13.91% and 10.12%, respectively.

**Table 5.15: Addicts Dropped Out Treatment at the Counselling Centres during 1990-91 and 1991-92**

<table>
<thead>
<tr>
<th>CENTRE</th>
<th>NO. DROPPED</th>
<th>NO. REGD.</th>
<th>% OF (2)to(3)</th>
<th>NO. DROPPED</th>
<th>NO. REGD.</th>
<th>% OF (5)to(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>18</td>
<td>81</td>
<td>22.22</td>
<td>5</td>
<td>117</td>
<td>4.27</td>
</tr>
<tr>
<td>(II)</td>
<td>19</td>
<td>144</td>
<td>13.19</td>
<td>13</td>
<td>132</td>
<td>9.85</td>
</tr>
<tr>
<td>(III)</td>
<td>21</td>
<td>336</td>
<td>6.25</td>
<td>29</td>
<td>172</td>
<td>16.86</td>
</tr>
<tr>
<td>(IV)</td>
<td>58</td>
<td>109</td>
<td>53.21</td>
<td>72</td>
<td>131</td>
<td>54.96</td>
</tr>
<tr>
<td>(V)</td>
<td>27</td>
<td>88</td>
<td>30.68</td>
<td>38</td>
<td>89</td>
<td>42.70</td>
</tr>
<tr>
<td>(VI)</td>
<td>170</td>
<td>1028</td>
<td>16.54</td>
<td>60</td>
<td>443</td>
<td>13.54</td>
</tr>
<tr>
<td>(VII)</td>
<td>46</td>
<td>665</td>
<td>6.92</td>
<td>5</td>
<td>1109</td>
<td>0.45</td>
</tr>
<tr>
<td>Total</td>
<td>341</td>
<td>2451</td>
<td>13.91</td>
<td>222</td>
<td>2192</td>
<td>10.12</td>
</tr>
</tbody>
</table>

Note: Information on drop outs at Centre VI was not available.

From the three Tables on recovery, relapses and drop-outs, it can be broadly summarised that 30-40% of addicts recovered, 40% relapsed, and 10-13% dropped-out the treatment of the total number of addicts registered during the year.

**Preventive Education and Training Programmes**

The counselling centres have to expand its activities in order to educate people about the ill-effects of drug abuse and for preventive education. Prevention is the most cost-effective technique especially for tackling the complex problem of drug abuse which involves long-term treatment for the reintegration of the addicts. This disease also does not present an encouraging prognosis as frequent relapses are being encountered by the therapists. In view of this preventive activities need to be given a prime place in the programme strategy.

All the counselling centres carried out outreach activities. The activities performed were mainly talks/lectures (7 centres), video film shows (7 centres), distribution of handbills giving information on the counselling centre (7 centres), organizing rallies (4 centres), poster exhibitions (4 centres), plays and skits through the Dance and Drama Division of the
Ministry of Information and Broadcasting (3 centres) and conducting public/group meetings (6 centres). The other activities included contacting influential people such as local leaders, doctors, teachers, etc. (1 centre), announcements through loud speaker (1 centre) and magic show performances (1 centre).

The talks/lectures were regularly done by performing mostly 2-3 activities per month per centre on an average by five centres. The remaining three centres even carried out more than 15 activities in a month ranging up to 35. Video shows on drug abuse prevention were arranged by 7 centres with a frequency of 1-2 shows by 4 centres and 3-4 shows by the another three centres.

Through these out-reach activities the awareness was created amongst general public as reported by 6 centres, school students were covered by 7 centres, college students by three centres, family members and parents by 5 centres. The other groups covered were youth leaders (3 centres), women groups (2 centres) and community leaders (1 centre).

As regards the production of material on creating awareness and for preventive education, only two centres had produced five types of brochure-leaflet in Hindi and English for teachers, parents and on the counselling centres and also one in Punjabi language. The one other centre had developed pamphlets for parents on information about the counselling centre. The other centre distributed material containing information on the counselling centre produced by its organisation. No separate brochure giving information on the centre was developed in case of five counselling centres.

Training of functionaries, community leaders and others who could contribute to fight drug menace is imperative. This community based network of counselling centres come in contact with various groups of community workers. The centres through its activities could identify the functionaries for training and organise the training programmes as per the needs of various groups.

During 1991-92 two of the five organisations to which eight centres belonged had organised seminars for three days in collaboration with the National Institute of Social Defence, New Delhi mainly to train youth leaders and D.T.C. workers. The number of such seminars conducted were upto three by each of the organisation.

The contribution of the counselling centres was limited and all the centres did not take initiative to undertake training programmes.
RECORDING, REPORTING AND RESEARCH

For scientific treatment of any problem, information thereon should be discriminately and judiciously recorded on its different aspects. Records thus come to play a vital role not only in drug abuse aspects but in every conceivable human endeavour. However, these essentially should not lead to proliferation and duplication. Records should be devised in such a way with a view to maximum utilisation and minimalism. Storage and retrieval aspects are to be given due importance in record systems and they need to be analysed from time to time.

The counselling centres required to maintain detailed records on the addict, his treatment process and the functioning of the centre itself. The centre need to maintain basic records such as case history sheet, drug abusers record card, register for registration of new cases, register for registration of old cases, follow up register, register for home visits, case counselling, group counselling and case file consisting of complete details of the case and follow ups.

While studying the records at the counselling centres it was observed that no uniformity existed in the records maintained at all the eight counselling centres. The guidelines for counselling centres in Drug Abuse prevention was published by the National Institute of Social Defence, Ministry of Welfare only in 1991 and prior to it no standard guidelines were made available to the counselling centres by the sponsoring agency to ensure uniformity in the maintenance of records.

All the eight centres had devised their own record system, some similarity did exist in the type of records maintained but broadly the method of recording varied in most of the centres.

It was learned that centres had a varied History Forms covering different aspects like identification data, family history, drug history, personal history, treatment availed, etc. Except one out of eight centres, all the centres had devised their own case history form but 2 centres did not use it for all the cases. The detailed case history files were only maintained by three counselling centres.

Register for the registration of new cases or OPD register was maintained by all the centres. Separate follow up register was available at 5 centres. Registers for individual counselling (3 centres); group counselling (3 centres); family counselling and home visits (6 centres) were devised. Area survey and publicity register were used by (3 centres) and outreach programmes, meetings, talks registers were maintained at two centres.
The other working records maintained at the centres were
name/address register (2 centres), referral register (1 centre),
register of daily activities (1 centre), movement register (1
centre), medicine consumption register (2 centres) and stationery
register (1 centre). It may also be mentioned that the records at
one of the centres varied completely and the project coordinator
was reluctant to show the records maintained, it was however,
reported that OPD registration register, follow-up register,
counsellor register, social worker register and project
coordinator register were devised by the centre.

As regards reporting is concerned all the eight centres
were sending monthly report to the Ministry of Welfare in the
proforma supplied by the Ministry, the sponsoring agency. In
addition, the counselling centres prepared annual report and
auditor's statement of accounts on the utilisation of funds and
supplied the same to the Ministry.

Only 4 centres (50%) used the records maintained at their
centre for research work or for the assessment of drug problem.
The records were utilised to know the type of addiction by 2
centres, for an assessment of case by one centre, assessment of
the problem and bringing out research papers by another centre,
one more centre mentioned that records were utilised by them to
assess the level of awareness on drugs in the community.

FINANCE

As mentioned earlier all the counselling centres were
functioning under the Union Ministry of Welfare's sponsorship.
The Ministry provided 90% of the approved grant and 10% was
required to be contributed by the organisation running the centre
as per the scheme of the Government of India.

Review of the expenditure incurred by the counselling
centres during 1990-91 and 1991-92 revealed that most of the
centres spent between Rs. one and a half lakhs to two lakhs per
year. The two centres even reported an expenditure of Rs. two and
a half lakhs to three lakhs. The counselling centres, therefore,
varied with regard to the expenditure on provision of services.
The average expenditure per centre was around Rs. 1.88 lakhs and
Rs. 2.16 lakhs respectively, during 1990-91 and 1991-92. Taking
into consideration the number of addicts registered during these
two years, the average expenditure per addict was between Rs. 75
to Rs. 100 respectively, during these years. It reflects that the
services provided by the counselling centres are cost effective.
SUGGESTIONS OF THE COUNSELLING CENTRES

Many suggestions were given by the project coordinators for better functioning of the counselling centres. These could be classified into administration related suggestions and service or programme related suggestions.

As regards service/programme related suggestions the centres should produce more of new aids/educative material from time to time and also they should be provided with aids and equipments to carry out such activities, was suggested by two of the counselling centres. Two centres felt that the detoxification facilities should be available at the counselling centres or counselling centres should function as a part of detoxification centre. Provision of day care facilities at the centre was suggested by two centres. It was also mentioned by one of the centres that more measures to rehabilitate the addicts should be taken and the other one centre suggested that the quality care was required to be provided than emphasis on the quantity or numbers catered to.

The suggestions relating to administrative aspects have bearing on the functioning of the centres, included, ensuring job security or continuity in services of the staff of the counselling centres was mentioned by three centres. It was expressed by two centres that more number of social workers/counsellors should be provided at the counselling centres to carry out activities in an effective manner. One of the centres mentioned that Psychiatrist's services are essential at the counselling centres. One of the centres even felt that grants from the Ministry must be received on time and adequate working space must be provided, was mentioned by another centre.