Chapter-V

TREATMENT, REHABILITATION AND PREVENTIVE PROGRAMME OF DRUG ADDICTION

Treatment

Drug addiction is a complex but treatable brain disease. It is characterized by compulsive drug craving, seeking, and use that persist even in the face of severe adverse consequences. For most people, drug addiction becomes chronic, with relapses possible even after long periods of abstinence. As a chronic, recurring illness, addiction may require continued treatments to increase the intervals between relapses and diminish their intensity. Through treatment tailored to individual needs, people with drug addiction can recover and lead productive lives. The ultimate goal of drug addiction treatment is to enable an individual to achieve lasting abstinence, but the immediate goals are to reduce drug abuse, improve the patient’s ability to function, and minimize the medical and social complications of drug abuse and addiction. Like people with diabetes or heart disease, people in treatment for drug addiction will need to change behavior to adopt a more healthful lifestyle.

Treatments for drug addiction vary widely according to the types of drugs involved, amount of drugs used, duration of the drug addiction, medical complications and the social needs of the individual. Determining the best type of recovery program for an addicted person depends on a number of factors, including: personality, drug(s) of addiction, concept of spirituality or religion,
mental or physical illness, and local availability and affordability of programs.

Many different ideas circulate regarding what is considered a “successful” outcome in the recovery from addiction. It is widely accepted that abstinence from addictive substances is a successful outcome. However, abstinence is difficult to achieve in practice. Programs that emphasize controlled drinking exist for alcohol addiction. Opiate replacement therapy has been a medical standard of treatment for opioid addiction for many years.

Treatments and attitudes toward drug addiction vary widely among different countries. In the USA and developing countries, the goal of treatment for drug dependence is generally total abstinence from all drugs. While ideal, this is in practice very difficult to achieve. Other countries, particularly in Europe, argue the aims of treatment for drug dependence are more complex, with treatment aims including reduction in use to the point that drug use no longer interferes with normal activities such as work and family commitments, shifts the addict away from more dangerous routes of drug administration such as injecting to safer routes such as oral administration, reduction in crime committed by drug addicts, and treatment of other comorbid conditions such as AIDS, hepatitis and mental health disorders. These kind of outcomes can be achieved without eliminating drug use completely. Drug treatment programs in Europe often report more favourable outcomes than those in the USA because the criteria for measuring success are functional rather than abstinence based. The
supporters of programs with total abstinence from drugs as a goal stress that enabling further drug use just means prolonged drug use and risks an increase in addiction and complications from addiction.

**Residential**

Residential drug treatment can be broadly divided into two camps: 12 step programs or Therapeutic Communities. 12 step programs have the advantage of coming with an instant social support network though some find the spiritual context not to their taste. In the UK drug treatment is generally moving towards a more integrated approach with rehabs offering a variety of approaches. These other programs may use Cognitive-Behavioral Therapy an approach that looks at the relationship between thoughts feelings and behaviors, recognizing that a change in any of these areas can affect the whole. CBT sees addiction as a behavior rather than a disease and subsequently curable, or rather, unlearnable. CBT programs recognize that for some individuals controlled use is a more realistic possibility.

**12 Step Program**

One of many recovery methods is the 12 step recovery program, with prominent examples including Alcoholics Anonymous and Narcotics Anonymous. They are commonly known and used for a variety of addictions for the individual addicted and the family of the individual. Substance-abuse rehabilitation (or “rehab”) centers frequently offer a residential treatment program for the seriously addicted in order to isolate the patient from drugs and interactions with other users and dealers. Outpatient clinics usually offer a
combination of individual counseling and group counseling. Frequently a physician or psychiatrist will assist with prescriptions the side effects of the addiction (the most common side effect that the medications can help is anxiety).

In a survey of treatment providers from three separate institutions (the National Association of Alcoholism and Drug Abuse Counselors, Rational Recovery Systems and the Society of Psychologists in Addictive Behaviors) measuring the treatment provider's responses on the Spiritual Belief Scale (a scale measuring belief in the four spiritual characteristics AA identified by Ernest Kurtz); the scores were found to explain 41% of the variance in the treatment provider's responses on the Addiction Belief Scale (a scale measuring adherence to the disease model or the free-will model addiction).

**Anti-Addictive Drugs**

Other forms of treatment include replacement drugs such as methadone or buprenorphine, used as a substitute for illicit opiate drugs. Although these drugs are themselves addictive, opioid dependency is so severe that a way to stabilize opioid use is required. Once stabilized, treatment enters maintenance or tapering phases. In the United States, opiate replacement therapy is tightly regulated in methadone clinics and under the DATA 2000 legislation. In some countries, other opioid derivatives such as levomethadyl acetate, dihydrocodeine, dihydroetorphine and even heroin are used as
substitute drugs for illegal street opiates, with different drugs being used depending on the needs of the individual patient.

Substitute drugs for other forms of drug dependence have historically been less successful than opioid substitute treatment, but some limited success has been seen with drugs such as dexamphetamine to treat stimulant addiction and clomethiazole to treat alcohol addiction. Bromocriptine and desipramine have been reported to be effective for treatment of cocaine but not amphetamine addiction.

Other pharmacological treatments for alcohol addiction include drugs like naltrexone, disulfiram, acamprosate and topiramate, but rather than substituting for alcohol, these drugs are intended to reduce the desire to drink, either by directly reducing cravings as with acamprosate and topiramate, or by producing unpleasant effects when alcohol is consumed, as with disulfiram. These drugs can be effective if treatment is maintained, but compliance can be an issue as alcoholic patients often forget to take their medication, or discontinue use because of excessive side effects. Additional drugs acting on glutamate neurotransmission such as modafinil, lamotrigine, gabapentin and memantine have also been proposed for use in treating addiction to alcohol and other drugs.

Opioid antagonists such as naltrexone and nalmefene have also been used successfully in the treatment of alcohol addiction, which is often particularly challenging to treat. These drugs have also been used to a lesser extent for long-term maintenance treatment of former
opiate addicts, but cannot be started until the patient has been abstinent for an extended period, otherwise they can trigger acute opioid withdrawal symptoms.

Treatment of stimulant addiction can often be difficult, with substitute drugs often being ineffective, although newer drugs such as nocaine, vanoxerine and modafnil may have more promise in this area, as well as the GABAB agonist baclofen. Another strategy that has recently been successfully trialled used a combination of the benzodiazepine antagonist flumazenil with hydroxyzine and gabapentin for the treatment of methamphetamine addiction.

Another area in which drug treatment has been widely used is in the treatment of nicotine addiction. Various drugs have been used for this purpose such as bupropion, mecamylamine and the more recently developed varenicline. The cannabinooid antagonist rimonabant has also been trialled for treatment of nicotine addiction but has not been widely adopted for this purpose.

Ibogaine is a psychoactive drug that specifically interrupts the addictive response, and is currently being studied for its effects upon cocaine, heroin, nicotine, and SSRI addicts. Alternative medicine clinics offering ibogaine treatment have appeared along the U.S. border. A synthetic analogue of ibogaine, 18-methoxycoronaridine has also been developed which has similar efficacy but less side effects, however this drug is still being tested in animals and human trials have not yet been carried out.
Alternative Therapies

Alternative therapies, such as acupuncture, are used by some practitioners to alleviate the symptoms of drug addiction. In 1997, the American Medical Association (AMA) adopted as policy the following statement after a report on a number of alternative therapies including acupuncture:

There is little evidence to confirm the safety or efficacy of most alternative therapies. Much of the information currently known about these therapies makes it clear that many have not been shown to be efficacious. Well-designed, stringently controlled research should be done to evaluate the efficacy of alternative therapies.

Acupuncture has been shown to be no more effective than control treatments in the treatment of opiate dependence. Acupuncture, acupressure, laser therapy and electrostimulation have no demonstrated efficacy for smoking cessation.

Rehabilitation Facilities

The first rehabilitation programs grew out of the work that AA members did with other active alcoholics. Known as Twelfth Stepping, it involves reaching out to others in need and attempting to draw them in. This movement began in the early days of AA, when the organization's founder, Bill W., put up alcoholics trying to dry out at his house in Brooklyn, when “his home was stuffed, from cellar to attic, with alcoholics in all stages of recovery” (Al-Anon, 1970). It was a natural transition to opening up “drying out” houses in the 1940s and 1950s. Also during the 1950s, the Minnesota model, an inpatient
rehabilitation model, was developed. It combined the AA philosophy with a multidisciplinary treatment team. A treatment plan was utilized, based on individual assessment and prioritization of goals. This model, which borrows from social work practice, is still used in treatment programs. Due to the vagaries of insurance reimbursement in Minnesota, the program lasted 28 days; alcoholism programs traditionally were roughly one month long.

The 1970s and 1980s were a golden era for rehabilitation, when many costly, long-term programs nourished. Recently, and in the context of reimbursement concerns, the need for such a length of stay as an inpatient has been questioned in several studies (Holder, Longabaugh, Miller and Ruhtonis 1991). Under the pressure of managed care and new insurance guidelines, many inpatient programs have closed or been converted to a new form of treatment.

- The intensive outpatient rehabilitation program is a partial hospitalization or day program that allows the client to work or attend school, but spend from 15 to 30 hours per week at the treatment center.
- Halfway houses are residential therapeutic environments in which individuals who have completed a rehabilitation program may live while pursuing employment or while working. They should not be confused with psychiatric hallway houses and board-and-care settings.
- Long-term care facilities are residential settings for individuals who are socially and psychologically unprepared for self-
supporting life in the community. Many are religious in nature, such as the Salvation Army Adult Rehabilitation Programs.

**Detoxification Units**

Since the 1960s it has been recognized that an alcoholic needs special medical attention and social support to get through the rigors of physical withdrawal. Special facilities known as “detoxes” (detoxification units) evoked to serve this need. Some are hospital based. Others, tailed “social detoxes” or “sobering lip stations,” are free-standing, non-medical AA-related units; these units have fallen out of favor in recent years. Finally, such units can be adjuncts to full fledged rehabilitation programs. Detoxification programs, lasting from three to seven days, are misunderstood as treatment programs or modalities and are even statistically compared with rehabilitation programs and treatment facilities. Addictionologists and treatment professionals of all persuasions recognize that addiction is a syndrome that often involves relapse, and that an individual may go through treatment more than once. Detoxification is not considered anything more than the first stage of treatment by any chemical dependency professional when attempted and, by itself, will certainly fail (we are not including the heavily involved AA member who undergoes detoxification). Patients typically cycle through the program many times, often at moments of crisis, or, if homeless, during cold weather.

**Therapeutic Communities**

The other major model of treatment for chemical dependency came from a different branch of the self-help movement. Although the
term organized with patient government and other forms of “milieu therapy” in a psychiatric hospital setting, the therapeutic community (TC) is known today as a residential treatment program for drug dependency that utilizes confrontational methods and groups, hard work and a status system as rehabilitation aids.

The main goal of TCs is a complete change in lifestyle: abstinence from drugs, elimination of criminal behavior and development of employable skills, self-reliance, personal honesty and responsibility.

The philosophy behind TCs is that only ex-addicts can truly understand and deal effectively with addicts. Some TCs also employ professionals with training in vocational guidance, education, medicine and mental health who are paid or who may donate their services. Residents of the traditional TC stay at least 15 months before they return to the community. Several TCs have been experimenting with shorter resident times, ranging 2 to 9 months, based on individual client needs and progress.

The first therapeutic community for drug addicts was Synanon, which was aimed at psychiatric patients. It was founded in Santa Monica, California, in 1958. Synanon was an AA clubhouse started by Charles E. Dederich, a former alcoholic that was later expanded to include drug addicts and highly confrontational group sessions. When drug addicts came into the program, the alcoholics left because they felt associating with addicts was degrading.
Main branches of Synanon were founded based on the same philosophy for example, Daytop Village and Phoenix House. They have been used as models for a number of other programs, with modifications based on the circumstances in each community. TCs have had a major impact on drug abuse treatment.

As of 1994, there were over 400 residential therapeutic communities in the United States serving drug abusers, criminal offenders and other socially dislocated persons. These programs are quite diverse, ranging in size from 35 to 300 beds, and they serve a variety of clients.

The TC program includes encounter group therapy, educational programs, job assignments within the community, and in the later stages, conventional jobs outside the community. The primary staff are former drug addicts who have been rehabilitated in TC programs. Most TCs use self-government and group pressures, instead of relying on a professional, therapeutic personnel.

More recently, some TCs have been developed to serve criminal justice clients almost exclusively (McNeece and DiNitto 1994, 190). Drug addicts referred to TCs are placed in appropriate settings where delinquent or criminal peers and the adverse effects of crime ridden neighborhoods, and by extension communities, are physically distant, and where the temptations of peers and environment are excluded.

Outpatient Treatment

The term “outpatient treatment” denotes a non-residential setting where treatment takes place. It can involve any number of
individual, group or family sessions, in which the client is present one or more times per week, up to about ten hours per week. Treatment may use any of a number of approaches, including Twelve Step-style groups, interactive group therapy, confrontational groups, support and relapse prevention, occupational counseling and so on. Outpatient treatment in which the client is present 10-30 hours per week is usually called “intensive outpatient treatment”, “day treatment” or “partial hospitalization”.

If only because it is the least expensive option, most addictions treatment takes place on an outpatient basis. In fact, attendance at an outpatient program can be undertaken for the following purposes:

- For initial assessment and referral into inpatient care
- As a followup to inpatient or intensive outpatient rehabilitation, called “continuing care”
- The entire course of treatment, where addiction is not overly severe

**Addiction Treatment versus Psychotherapy**

Based on our examination of addiction, some differences between addictions treatment and standard psychotherapy should be clear. The first stage – no easy task is to get the addict into treatment by hook or by crook; until then, you’re “just talking to a chemical”. Then, it is necessary to break through the system of denial, rationalization and minimization. While facilitating a process of recovery, treatment must ensure that the addict does not “fall through the cracks” between detox and rehab, or rehab and halfway house, and develop strategies for the client to avoid relapsing. In
accomplishing these tasks, addictions therapy must draw upon skills and interventions from psychotherapy and counseling models, especially in developing communications skills that establish rapport with the client. Treatment that approximates true psychotherapy can only come in a later state of treatment, when stable-sobriety is achieved, and painful or threatening issues can be examined without overwhelming the client and triggering a relapse.

**Commonalties in Treatment**

"Pure" therapeutic communities, Minnesota model rehabs or other traditional models are becoming a distinct minority. Therapeutic communities, which once focused on graduating "ex-dope fiends," increasingly recognize the need for aftercare, and involve their residents in Narcotics Anonymous. AA-based rehabilitation centers recognize needs of "dual diagnosis" (mentally ill chemical abusing) clients who require medication, previously considered heretical, federal and state requirements for agency licensure and certification training of counselors, have also made it possible to describe features that any treatment setting is likely to include.

1. Clients are screened for eligibility and appropriateness for the treatment setting and agency, based on a psychosocial summary, records provided by a referring agency, and standardized tests such as the Michigan Alcoholism Screening Test or the Addiction Severity Index.
2. Clients go through an intake procedure, where they are informed of confidentiality regulations that ensure their privacy. An orientation to the agency and to the treatment process takes place.

3. Based on an assessment of the client's strengths, weaknesses and special needs, a treatment plan is drawn up that identifies long- and short-term goals, and prioritizes them in importance. Assessments are continually updated and adjustments are made to the plan, where necessary.

The following treatment components are usually in place:

4. Individual counseling sessions focus on goals and objectives of a treatment plan and strategies for relapse prevention. A generic counseling approach is usually employed (Corey and Corey 1993; Ivey 1994) and elements of eclectic models such as cognitive behavioral or rational-emotive therapy are frequently borrowed (Ellis et al., 1988) to help clients identify and explore the interaction of their behavior patterns, attitudes and thought processes and emotions.

5. Group counseling sessions facilitate the ability of the client to observe and model the communication of emotions and needs in an open, honest and direct manner. Groups reduce isolation, provide support, hope and positive role models, identify with other addicts in the recovery process. Because of their many benefits and cost-effectiveness, most treatment takes place in group settings (Vanicelli, 1992).
6. Family counseling slopes the “enabling” of addiction by kin – the “help” that hurts – and allow the emergence of honest communication patterns within the family system. It also educates the family on the dynamics of addiction (Kaufman, 1985).

7. Client education focuses on the nature of addiction, the effects of drugs and triggers for relapse.

8. Toward the end of the client’s stay in this setting, careful planning takes place for the transition to the next stage of treatment, or for the termination of treatment. Vocational and educational goals are stressed for reentry into society. Ongoing participation in recovery support is crucial.

**Current Trends in Providing Treatment Services**

In the past decade, addictions treatment has moved beyond simplistic implementation of self-help models. It has recognized the unique needs of a variety of populations and subsequently incorporated the concept of “cultural competency”. One of the major contributions to cultural competency and ethnic sensitivity has come from the family therapy field (McGoldrick, Pearce and Giordano, 1982). The special needs of addicted women, pregnant women and women with children, and elderly addicts have been addressed with special focus programs.

**Certifying Qualified Counselors**

The separate treatment models that evolved for drug addicts and alcoholics led to separate governmental and certification entities. Over the past decade, most of these bodies have been merged into
single chemical dependency or addictions authorities and certification boards, although New York State accomplished this step only in 1995-1996. Most recently, the recognition of the terrible health costs of tobacco consumption has led to the addition of nicotine to the realm of responsibility of addictions authorities and to the knowledge areas required of counselors.

While qualifications for becoming addictions counselors once included merely being a recovering addict and having the enthusiasm, energy and empathy to work with other addicts, the credentialing requirements became more rigorous in the 1970s. From the mid-1970s on, a credentialing system evolved that demanded increased levels of competency. Today, most states operate certification boards, which are linked in a national consortium and certification, is also provided by the national addiction counselors' association (see Appendix C, page 199).

Certification requirements include educational preparation, passing a written exam, and service experience. The certification consortium requires an oral and written case presentation as well. Although minor variations in the credentialing systems exist, counselors must be able to perform the following tasks:

- Screen candidates for eligibility and appropriateness
- Follow intake procedures
- Handle patient orientation and education
- Practice case management
- Assess patient strengths and weaknesses
- Develop and implement a treatment plan in collaboration with the client
- Handle cases involving addiction-specific individual, group and family counseling
- Understand the pharmacology of addictive substances and dynamics of addiction.
- Maintain ethical practices and patient confidentiality.
- Understand the role of the addictions counselor and how it differs from that of other professional roles.

One of the most important advances in the field has been the development of a subfield for addicts with concurrent psychiatric disabilities (mentally ill chemical abusers, also referred to as MICA) (Kelly and Romando, 1993). This field is particularly complex as many symptoms of mental illness share similarities with chemically induced organic brain syndromes (early in the days of crack cocaine, many patients were over-diagnosed with “paranoid schizophrenia” in public hospitals in New York City – especially by newly arrived, out-of-town physicians).

**Patient Placement Criteria Today**

Treatment professionals use patient placement criteria to match the severity of the addiction to the level of care needed, ranging from medical inpatient care, non-medical inpatient care and intensive outpatient care, to outpatient care (CSAT 1993; 5-8). Unfortunately, the new managed care guidelines established by many health insurance carriers simply do not allow for treatment beyond
outpatient care or brief inpatient detoxification. Moreover, matching
the client’s profile to a treatment modality is more likely to achieve
lasting success. A person with severe attention-deficit hyperactivity
disorder, for example, tends to be disorganized and forgetful, and is
unsuited for the strict behavioral expectations of therapeutic
community. Likewise, an emotionally fragile individual is unsuited to
confrontational groups.

Special Focus Programs

Programs have been created that are similar to AA and NA, but
without the spiritual emphasis, which some potential members find
difficult to accept. These programs include Rational Recovery, which
evolved from Albert Ellis’s Rational-Emotive Therapy (Ellis et al. 1988),
and similar programs named Smart Recovery and Secular
Organizations for Sobriety (Christopher, 1989). One of the principles
behind these programs is early intervention. In contrast to past
practices, where the early addict was scooped up off the street (fitting
the ideology of the addict “hitting rock bottom”), treatment begins at
an earlier phase of addiction.

There has also been a recent shift to mandated or involuntary
involvement with treatment. Two components of this practice include
the following:

• Originally called “industrial alcoholism programs,” have existed for
some time. Their goal is to identify and refer addicted employees to
treatment programs. This model has been adapted for use in school
settings (student assistance programs or SAPs) and in
organizational settings such as labor unions or consortia of unions (member assistance programs). Some states now fund SAPs and certify SAP professionals.

- The therapeutic community has always counted many court mandated clients, but the trend accelerated tremendously in the 1990s, with demonstration programs established in Colorado, Texas and New Mexico for collaborative planning of criminal justice and addictions treatment systems. Many treatment programs have retooled to accommodate convicts paroled or serving out their sentences, and treatment programs have been instituted in prisons (see "Fighting the Drug War" below).

**Maintenance Program**

Maintenance programs (which offer support to those addicted to morphine, methadone and heroin) are based on the principle that, if past treatment programs have not been successful, "incurable" addicts should be able to register and receive drugs, such as narcotics, under supervision. Proponents of these programs contend that many addicts are forced into a life of crime to support their habits but would become law abiding and useful citizens if they received narcotics (usually a less euphoric type, such as methadone) legally. Moreover, it's argued, the illicit narcotics trade would be eliminated due to the loss of these customers. Opponents of maintenance programs say that sufficient treatment programs exist to cure many addicts and that providing addicts with substitute narcotics does not solve the basic problem causing drug dependence.
The concept of maintenance on a noneuphoric opiate is now widely accepted in the United States as one way to help treat drug abusers.

Methadone Maintenance. Vincent Dole and Marie Nyswander were the first doctors to use the synthetic narcotic methadone in a rehabilitation program with heroin addicts in the mid-1960s.

Methadone maintenance (MMT) involves replacing street heroin with methadone, a synthetic opiate that allows clients to stabilize themselves physiologically so that they can explore alternative ways of functioning. This type of treatment model is usually provided on an outpatient basis.

There are now 1,15,000 addicts on methadone maintenance in the United States. Forty thousand of them are in New York state and about half that many are in California. Methadone is widely employed throughout the world, and is the most effective known treatment for heroin addiction. (Nadelman 1996)

Methadone maintenance is used to reduce illegal heroin use. Although it can be used to detoxify heroin addicts, most such individuals return to heroin. Methadone is most effective when used as an adjunct to reduce or, in a minority of cases, eliminate heroin use by stabilizing addicts as long as it takes to reassemble their lives and avoid returning to previous patterns of drug use. Further, even after 20 to 30 years of methadone use, research shows that “... almost no negative health consequences are experienced” (Nadelman 1996).
How successful is methadone treatment? A recent California study found that one dollar spent on treatment saves taxpayers seven dollars. The savings occur as a result of reductions in crime and the need for medical care (Swan 1995). Another study showed that “over a six-month period, the costs to society for an untreated heroin abuser costs $21,500, $20,000 for an imprisoned drug abuser and $1,750 for someone undergoing methadone maintenance treatment” (Swan 1994).

Once stabilized on methadone, the addict faces a crucial period of adjustment. After being devoted to maintaining a heroin habit 24 hours a day, 365 days a year, the addict must be transformed into a self-supporting, socially acceptable person. Methadone maintenance establishes the potential for such a change, but it is the person’s motivation and capabilities that determine the success of the rehabilitation effort. A range of medical, psychiatric, social and vocational services are usually available during this phase of treatment.

One supervisor of a methadone clinic associated with a Brooklyn, New York hospital explains the process it employs:

First of all, we test for alcohol, benzodiazepines [Valium like substances] and other drugs. Clients with positive tox [who test positive for drugs] are administratively discharged. They come in at 6:30 for their dose, and then the vast majority go off to work! Methadone, job counseling, and GED classes allow them to get their lives together. Our goal is to taper them off to zero.
While many criticisms have been levied against the use of methadone, other research findings contradict this skepticism. Recent research findings show that, since the 1980s, 65% to 85% of methadone-treated patients not only remain in treatment for a year or more, but they also dramatically cease or strongly curtail their criminal behavior and have strong records of gainful employment while receiving the drug (Swan 1994). In addition, methadone is reported to reduce the risk of AIDS infection. This benefit alone is believed to lower the costs to society, especially those associated with providing health care to AIDS patients.

The new long-acting methadone analog, levoalpha-acetylmethadol (LAAM), need only be taken three times a week and is being used experimentally in some programs. Initially, addicts participate in intensive daily counseling. Later in the program, they come in for the maintenance drug and follow-up treatment less frequently. Addicts may be treated with daily methadone first to increase the probability that they will at least attend counseling sessions and then be switched to LAAM when they reach an appropriate point in the program. Currently, LAAM is an investigational drug and has not been approved by the U.S. Food and Drug Administration (FDA) for general clinical use.

**Opiate Antagonists**

An antagonist is a compound that suppresses the actions of a drug. Narcotic antagonists have properties that make them important tools in the clinical treatment of narcotic drug dependence. For
instance, they counteract the central nervous system depressant effects in opioid drug overdoses.

Opiate antagonists are occasionally used as adjuncts to inpatient treatment; they are more typically associated with the emergency treatment of opiate poisoning (overdose), however. Some physicians claim to perform instant detoxification with the use of an opiate antagonist during sedation.

Two opiate antagonists, naltrexone and cyclazocine, block heroin from having an effect on the heroin addict. Further, naloxone (Narcan) is often used as an antidote for opioid overdose (commonly known as narcotic poisoning). Narcotic antagonists are generally best suited for opioid-dependent patients who want to leave therapeutic communities and methadone-maintenance treatment programs.

Antagonists were developed as a by-product of research in analgesics. Scientists were interested in dissociating the dependence producing properties and necessary pain-relieving properties of substances that could replace morphine. This research led to the development of nalorphine, the first specific opiate antagonist. Although its short duration of action and frequent unpleasant side effects limited its clinical usefulness, its properties stimulated further research on this class of drugs (Archer 1981; Palfai and Jankiewicz 1991).

As we will discuss in more detail later, clonidine (Catapres) is useful in treating opiate-dependent people timing the difficult withdrawal stages (Ginzburg 1986). Studies thus far show the value of
this drug for withdrawal from heroin, morphine, codeine and methadone. Clonidine is not addictive and does not cause euphoria, but it does block cravings for drugs. It also makes the person feel better compared with the depression experienced by addicts using other methods of withdrawal.

Antabuse, which goes by the trade name Disulfiram is a drug used for treating alcoholics. This drug is perceived as a deterrent drug – it makes people violently ill if alcohol is used. “Antabuse interferes with the normal metabolism of alcohol, resulting in serious physical reaction if even a small amount of alcohol is ingested” (McNeece and DiNitto 1994, 113). The greatest asset in using this drug is its ability to deter impulsive drinking (McNeece and DiNitto, 1994).

Steps to Curb: Suggestion – Studies

Dr. Vimla Veeraraghavan of the Jawahar Lal Nehru University stated that drug consumption can be seen first as anti-social behaviour calling for suppressive measures against the abuser a personal maladjustment calling for medical or psychological treatment and end product of the social and cultural factors that produce conflicts in individuals. To combat this problem the strategy needs legal, medical, psychological social measures.

Psychiatrists feel that the Western model of investing money and time has failed- to harvest desired results and at the same time, it is not suitable for India (Indian conditions) and instead they suggest of reinforcing of cultural and religious strength.
If the illegal trafficking is controlled or stopped millions of addicts might turn into a law and order problem – as deprived of drug, they turn violent – is what worries the social worker?

Following measures have been suggested against drug:

(a) **Social defence**

Social scientists and Y. Study Groups have repeatedly stressed the importance of family and society in fighting off the drug menace.

(b) **International co-operation**

SAARC countries recently met to devise joint measures to counter the growing menace of drugs. They decided to co-operate in the war against drugs and Non-Governmental Organizations (NGOs) fighting the drug menace met in Delhi and came out with the following suggestion –

(i) The best solution lies in effective international co-operation.

(ii) The big mafia leaders be caught and hanged. They mostly sit far away from drug-peddling channels, therefore, it is difficult to get access upto them.

(iii) Deterrent punishment to addicts and traffickers is required.

**Cure from Addiction**

Addiction is difficult to break. It is almost always necessary for the patient to be removed from home and from associations with which the addiction started. The treatment must, therefore, be carried out in an institution taking care that the addict does not take secret supplies from anywhere. Immediate and sudden stoppage of the drug is followed by alarming withdrawal symptoms, including delirium and
hallucination. A gradual reduction of the drug is also difficult to achieve on account of the constant and possibly uncontrollable craving for the pleasant effect of the drug. Therefore, at home where adequate supervision is not possible drug control is doomed to failure and relapses are common even in institutional management.

Cheerful company, plenty of exercise in the open air, good appetizing food, attention to bowels and certain drug like benzentrine and hyosicne and phenobarbiturate to break the addiction are the cardinal features in treatment. Psychotherapy has a valuable place in the management of an addict.

Amsterdam has been aptly described as a city “rich in history, outstanding in art and colourful in appearance”. But like any other metropolis it has its problems of pollution, traffic congestion and housing shortage. Yet another problem which the Dutch are trying to tackle in their characteristic way is drug addiction. The policy which the city of Amsterdam has adopted towards drug addiction is one of the discouragement and pragmatism. Since the deterrence is one of the planks of its drug policy, a large element of it consists of law enforcement, to which the police and the legal authorities devote much of their time and effort. In a total population of 700,000 there are around 5,000 heroin users and 3,500 regular cocaine users, most of whom are also addicted to heroin.

The pragmatic policy is directed at the actual drug addicts. The policy is in response to the inescapable reality that these people are too involved with drugs to be extricated from addiction. It aims at
reducing the risks run by the addicts by establishing and maintaining contacts with as many of them as possible in order that they may receive help on the day they ask for it. This approach has taken the form of an extensive methadone maintenance programme.

There are a considerable number of foreign addicts in Amsterdam. With a view to solving this problem, Amsterdam has worked out a number of possibilities for voluntary return in consultation with neighbouring countries. If addicts do not opt for this form of return and are detained by the police for a criminal offence, they are deported. The city of Amsterdam claims that their policy of discouragement and pragmatism has paid rich dividends; that the number of addicts has shown a perceptible decline over the years. That is why they strongly recommend this policy to others with similar problems, adapting it, of course, to local conditions.

The illicit traffic in narcotic drugs has assumed alarming proportions and the worldwide concern over the power and influence some of the drug kingpins wield has resulted in the US and Colombia declaring an all out war against drug peddlars. And the medallion cartel in Colombia, already notorious for bumping off scores of judges and police officers has started retaliating again in a big way. The cartel's "silver-or-lead" method (silver denoting heavy bribes to law enforcement officials and influential politicians, failing which they are threatened with "lead" that is bullets) proved very effective all these years in giving to officers the shivers down their spine.
Indian narcotic operators too have the same modus operandi sandwiched as it is between the Golden Triangle (Burma, Nepal, Thailand and Laos) and Golden Crescent (Afghanistan and Pakistan), India has for long been made a lucrative transit point by drug operators to smuggle narcotics like hashish (charas) and heroin to Europe and America. And since the eighties the illicit drug menace has only worsened in the country causing problems of abuse and addiction.

Concerned with the problem, the Indian Government enacted a comprehensive law, called 'The Narcotic Drug and Psychotropic Substances Act, 1985', which came into force on 14th November, 1985. It was soon discovered that even this legislation did not provide fool-proof deterrence as drug offenders were being released on bail by courts on some technical or flimsy grounds. The notorious case of Virmani and his co-conspirators, in which they were nabbed only to be released on bail despite the serious nature of the prosecution charges is still fresh in people's mind. Strangely enough though the offences under the 1985 Act, were made non-bailable, the lower courts granted bails on technical grounds. To offset this and many other lacunae, the Cabinet Committee in 1988 made a number of recommendations to put teeth into the existing law. Accordingly a new deterrent law called 'The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988', was enacted. The NDPS Amendment Act came into force from 29th May, 1989. The amendment provides that the drug related offences shall be cognisable.
and non-bailable, and provides for forfeiture of property and a detailed procedure relating to such forfeiture. The amended law applies to all properties and assets of traffickers acquired within a period of six years immediately preceding the date on which the trafficker is charged with an offence under the Act. There are many other provisions, which the law enforcement agencies hope, will prevent confirmed drug traffickers from taking protection on legal and technical grounds.

**Controlling the Drug Abuse**

The addicts and the ex-addicts put together suggested following measures in order of priority to control the problem of drug abuse:

- strictness of police and the administration,
- severe punishment to the culprits,
- educating the drug addicts about harmful effects of drugs,
- by creating social awareness about dysfunctional consequences of drugs,
- by solving the problem of unemployment,
- by banning the production and distribution of drugs and by destroying the drugs,
- clinical hospital services,
- proper rehabilitation services,
- family control, and
- proper leisure and recreational facilities.
Measures suggested by the informed persons to control the problem of drug abuse in order of priority were as under:

- generation of awareness among people,
- effective check on easy supply or availability of drugs,
- strict implementation of the NDPS Act,
- de-addiction camps and proper medical attention and facilities,
- proper rehabilitation of addicts,
- prohibition of alcohol as also of other drugs,
- creation of special agencies to deal with the problem of drugs and the drug users,
- strengthening of the family role, and
- generation of self control among the addicts.

Various other suggestions were also made by the informed persons to control the problem of drug abuse. These included:

- sealing of borders to stop the supply of drugs,
- reduction in unemployment,
- lowering the prices of country liquor,
- banning the sale of drugs by chemists without prescription,
- creation of special agencies by the government to identify the drug sellers,
- putting the alcoholics behind bars,
- suspension and termination of services of the corrupt officers of the concerned agencies,
- removal of addicts from the hostels and, if need be, closure of hostels,
- banning of outsiders entry into colleges, and
- creation of proper leisure and recreational facilities for the people.

Certain other suggestions pertaining to the socio-cultural, moral and spiritual aspects of life were as under:
- search of religious and spiritual solutions of the problem,
- correct religious teachings by religious leaders,
- by providing creative activities to the people,
- removal of alienation of the people,
- reduction of frustration among the youth, and
- inculcation of socio-cultural values, etc.

The suggestions to eliminate the problem of drug abuse were almost the same as in case of controlling drug abuse. However, emphasis on various suggested measures changed with the reduced support for each one of the major suggestions. Few of the important suggestions to eliminate the problem of drug abuse, in order of priority were:
- effective check on drugs,
- generation of awareness among the people,
- strict implementation of the NDPS Act, and
- de-addiction camps and medical facilities.

As against 2.2 per cent informed persons who thought it is not possible to control the problem of drug abuse, nearly one-fourth
(22.6%) informed persons thought elimination of drug abuse is not possible. These people believed that things are not going to change drastically and are likely to continue as they are. However, they are also optimistic and hopeful about the situation not being beyond redemption, and can be corrected satisfactorily with sincere effort and honesty.

Lack of legal awareness among people is a major hindrance in the prevention of drug abuse. What to talk of the common man even the informed persons exhibit lack of legal awareness. While one-third of the informed persons did not know about drug prevention law(s), another one-third did not know about the name and the nature of these law(s). Except the NDPS Act the knowledge about other drug prevention laws was confined to only a handful people including the informed persons.

Opinions were equally divided with regard to the effectiveness or otherwise of the drug prevention laws.

The major reasons for the effectiveness of the drug prevention laws, particularly the NDPS Act, in the opinion of informed persons were: fear of punishment (10 years of sentence and a fine of Rs. 1 lakh), effective implementation of the law by the police and strict court decisions. A small minority also gave credit to heavy publicity of the law in the media.

The major reasons for the ineffectiveness of the laws in order of priority were: lack of proper implementation or enforcement of the laws, failure of administration in checking the supply of drugs,
corruption and involvement of drug prevention agencies in smuggling, lack of awareness about the laws and legal jargons, legal loopholes, illegal cultivation of drug substances, policy of prohibition, pronounced influence of smugglers, etc.

Having summarized the major findings of the study it would be in the fitness of things to highlight the major limitations of such a study. A study of this nature encounters limitations both at the epistemological as well as ontological level. At the epistemological level limitations pertain to theory building. Limitations both of the size and authenticity of the data put a question mark on the validity and reliability of an attempted generalization. Absence of generalization further complicates the task of theory construction and as such interpretation of the data only at the descriptive level or at best at the analytical level sufficiently indicates theoretical limitations of the study. On the ontological level any study on a theme pertaining to drug addicts faces the problem of their very existence. Do they exist? and where do they exist? and how to transcend this distance? always remains shrouded in mystery. Unlocking of this mystery consumes a great part of the resources and requires great skill. Application of leisurological approach can resolve the problem to a great extent. And this is what the investigating team did to construct the phenomenon of drug addiction which in the ultimate analysis proved to be an enriching-experience both at the academic level as well as at the level of praxis whereby it could become possible to offer suggestions to overcome the problem of drug abuse.
One month training on Drug Demand Reduction was organized by NISD in collaboration with the Calcutta Samaritans, the Regional Resources and Training Centre (RRTC), East Zone II in Kolkata from 23rd August to 21st September, 2006. 21 participants drawn from the eastern region were present in the training. Most of the participants were working as social workers or counselors.

One month training has an overall objective of enhancing the skill of NGO functionaries to improve the quality of intervention and ensure effective service delivery. With this view in mind, participants were given a comprehensive overview and intensive exposure to a number of crucial issues relating to Drug Demand Reduction.

The training started with introducing the basic issues like, Drug use and abuse, dependence, addiction, tolerance, withdrawal, types of abusers, trafficking scenario, signs and symptoms, addictive behaviour and personality traits, stages of addiction, co-dependency and approaches to DDR. The training moved into more specific issues like awareness creation, aspects of whole person recovery, setting goals of treatment, counseling, legal provisions, etc. considering that addiction first ten days were devoted to underline the above topics.

Training moved on to relapse prevention techniques, SDT / HIV / AIDS, sexual behaviour and practices psychological management, addiction counseling alternative therapies, out reach and crisis management, etc. The issues of social re-integration, rehabilitation and minimum standards of treatment. Therapeutic community treatment, workplace prevention were taken up in detail. The
participants were taken up on a field visit to PASAC ITI project run by Calcutta Samaritans rehabilitation unit of Emmanuel Ministries Calcutta – Role of international agencies and role of community and developing a referral network were also taken up. As the training drew close to completion the participants were given exposure to preparing therapy manual, DAMS practice and Advocacy issues.

Preactive programmes gain effectiveness and sustainability when implemented in the context of a string public health system and linkages to other programmes. Abstinence has historically been seen as the best treatment for drugs, which is also the most effective way of preventing HIVs transmission among injecting drug users. Programmes based on abstinence range from detoxification to rehabilitation and from primary care to after care. These are residential programmes and require round the clock professional inputs. The ministry of social welfare and justice and empowerment provides grants to 400 addiction centres all over India, providing one to two months of treatments. Detoxification is only the initiation into treatment and not a complete treatment for addiction. Relapse after detoxification is common and relapse rates often reach upto 90% in the Asian region, and linked with rehabilitation approaches. For this National Institute of Social Defence conducts long term and short term courses for care givers. Some of the courses conducted include 3 months certificate course and one month basic course. Other short term courses are in the nature of Thematic Skills Building Programmes such as counseling issues – Drug Abuse and HIV/AIDS
rehabilitation and relapse prevention, co-dependency and family therapy, management of centres.

In terms of strategic consultations in Drug Abuse Prevention, the institute organized National Consultative meet for convergence of drugs and HIV/AIDS. National steering committee meeting and strategic consultations on project H.13, consultation with Treat-Net and Annual meet of RRTCs. The efforts have been strongly supplemented by the initiatives of the civil society which is the most crucial factor for any such attempt to succeed. Above all trying to develop appropriate strategic and pragmatic long term approaches to reduce HIV/AIDS transmission among drug addicts populations and sexual darkeners.

On the occasion of International Day against drug addiction and illicit trafficking Athencottasan Muthamizh Kazgham (AMK) a voluntary organization active in Naduvoorakai in Kanyakumari district of Tamilnadu, undertook a series of programmes to create awareness among the masses. AMK also runs a deaddiction centre supported by Ministry of Social Justice and Empowerment, Government of India. To sensitize and create awareness among the adolescents and youth, the age group affected most by the menace of drugs AMK organized a district level elocution competition on the topic “views of students on anti-drug” overall 58 students from 38 colleges participated in this three days programme between 20th-22nd of June 2007. To elicit specific response to understand better the opinion of a specific age
group. There were derived into three categories, high school, college and higher education students.

On 26th June 2007, the International Day against Drug Abuse and Illicit Trafficking AMK undertook an anti drug sticker campaign. The campaign further taken up by pasting the stickers on major places of the town. Pamphlets were also distributed in mass, t-shirts and badges of UNODC (social initiative, July 2007)

National sensitization workshop on Drug Abuse Prevention was organized by NISD in collaboration with the institute of Criminology and Forensic Science (LNJN NICFS) on 12th to 14th August 2007 in New Delhi. This workshop comprised of 37 senior officers of police, prosecution, judiciary, prison services along with 12 representatives of the prominent NGOs working in the field of Drug Abuse Prevention. They hailed from 22 states and union territories of India. The objectives of the training were to dovetail services of the enforcement agencies, service providers and welfare departments of states. It also aimed to providing a platform for sharing of issues of supply and demand reduction and identify areas of synergy. Concluded by saying that Drug addicts should not be treated as criminals. Citing Sec. 27 of Clause 64A of NDPS act, granting exemption from punishment for carrying certain amount of drug for personal consumption, these should be sent for rehabilitation to get fresh change to lead clean life. Thus the spirit of the law is to encourage decriminalization of addicts (social initiative, July, 2007, Vol. 1)
Drug Abuse Prevention

Drug Abuse Prevention is one of the core concerns of the Institute. In view of the growing threat of drug abuse and a comprehensible impediment that it brings to the nation's progress it was decided to give the-then Bureau of Drug Abuse Prevention at the Institute a broadened role with expanded mandate by setting up a National Centre for Drug Abuse Prevention (NC-DAP) in its place in September 1998. The mandate of this unit of the Institute is to give technical support to the Govt. on Policies relating to Drug Abuse Prevention and facilitate a wider and improved coverage of services throughout the country for drug demand reduction. Through NC-DAP, the Institute has been able to expand the reach of its activities and has worked out strategies to streamline the issue of drug abuse and bring about qualitative improvement in the nature of service delivery. NC-DAP has evolved a strategy for the capacity building of the service providers through a series of training and orientation courses., especially for the service providers involved in the field of Drug Demand Reduction. To formulate effective intervention modules and programmes, impetus has been provided to research and documentation activities to develop deeper insight into the problem and trends information and pattern of drug abuse through adequate documentation and feedback mechanism from the field.

Aims and Objectives

NC-DAP was set up with a view to augmenting the ongoing efforts of the Govt. of India to curb the menace of drug and alcohol
abuse in the country and endeavors towards creation of a drug free society. The Center endeavors to achieve the set objectives by:

- Raising the competency standards of the functionaries/personnel working in the field of drug demand reduction and related sectors.
- Standardization of care under Drug Abuse Prevention Programme.
- Updating information and creating a database on extent and pattern of Drug Abuse and interventions developed at local, regional and national levels.
- Promoting advocacy and networking arrangements in the field of drug abuse prevention.

**Target Groups**

The Centre caters primarily to the training requirements of those functionaries/service providers working in the treatment and rehabilitation centers supported by the Ministry of Social Justice and Empowerment including Project Officers, Counsellors, Social Workers, Out-reach Workers, Community Workers, Nurses and Ward Boys/Caretakers. The Centre also organizes need based training programmes for the representatives of concerned government departments including health, youth affairs, prisons and correctional institutions, and functionaries of NGOs working in the related sectors like HIV/AIDS.

**Activities**

The activities of the Centre inter-alia include

- Capacity building of various levels of functionaries working in the field of Drug Demand Reduction.

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• Up-gradation of information and establishment of appropriate database and monitoring systems.

• Development of linkages, facilitating advocacy, and promoting networking arrangements in the field of Drug Demand Reduction at local, regional, national and international levels.

• Developing programmes for preventive education to control the incidence and spread of drug and alcohol abuse.

**Training and Capacity Building**

NISD runs a number of programmes and training courses, tailored for specific target groups. Training and capacity building efforts takes a three pronged programme approach. These are:

(i) **Certificate Courses**

- 3-Months Certificate Course on “De-addiction Counselling and Rehabilitation” is run for functionaries working in Treatment cum Rehabilitation Centres.

- 1-Month Basic Course on “Drug Abuse Prevention” has been designed to build the knowledge base of service providers of Treatment Centres by giving them basic knowledge in Drug Abuse Prevention.

(ii) **Thematic Skill Building Programmes**

Under this category the following two to five days programmes are generally undertaken by the Institute:

**Drug Addiction Identification, Initial Motivation and Early Intervention** to orient service providers on symptomatic behaviour,
early identification and early warning signs so as to equip them with requisite techniques on early intervention.

**Counselling for Addiction - Individual Family and Group** to train counselors working in drug demand reduction so as to expand their knowledge base, sharpen their clinical skills to counsel the individual addicts separately and in groups to give up drugs/alcohol and take treatment that works and also to their families on efficacy of their support in the process of recovery.

**Preventive Interventions for High Risk Groups** with the aim to sensitize the service providers working with high risk groups on issues pertaining to behavioral changes that need to be worked on the high risk settings like truckers, commercial sex workers, etc.

**Research, Rapid Assessment & Monitoring of Drug Abuse** on the relevance, scope and contents of research, rapid assessment and monitoring of drugs of abuse to obtain evidence for planning strategic intervention.

**Management of Co-dependency and Family Issue** to enable Counsellors/Social Workers to deal effectively with significant others including family and co-dependents of addicts.

**Rehabilitation and Relapse Prevention - Issues & Modalities** for service providers to development and implementation of rehabilitation and relapse prevention programmes.

**Prevention and Management of Drug Abuse and HIV/AIDS** to orient and expose the service providers in the field of HIV/AIDS prevention among drug users.
Alcohol and Drug Abuse Prevention at Workplace to sensitize Labour and welfare Officers of corporate houses and project officers / senior counselors of Treatment and Rehabilitation Centres working with the necessary tools and techniques required to initiate action for starting workplace prevention programmes in new enterprises.

A Learning Pack for Youth Coordinators designed for youth coordinators of National Service Scheme and Nehru Yuvak Kendra on drug (substance) and alcohol abuse prevention.

Treatment and Rehabilitation of Drug Addicts in Prisons / Correctional Settings to sensitize and empower middle level functionaries working in prisons / correctional setting on drug and alcohol abuse prevention issues.

Documentation for Addiction Management-Assessment, Client Profiling, Recording and Documentation to ensure proper recording and documentation of programme activities.

Management Development Programme (MDP) to provide basic skills and understanding of the programme to chief functionaries and project managers on need to ensure delivery of quality service at the respective centers.

Orientation Course based on TNA (Training Needs Assessment) on selected thematic issues relating to treatment on needs assessment at their operational areas.
**Strategic Consultations**

In addition to Certificate Courses and thematic skill building programmes, NCDAP in NISD also organizes strategic consultations with various stakeholders to evolve strategies for convergent action and bring synergy in ongoing programmes of different partners. These are:

- **Annual Consultative Meet of Regional Resource and Training Centres (RRTCs),** eight in number located in different parts of the country to serve as regional extension centers of NCDAP, NISD. This consultative meet is organized annually to plan out the activities of NC-DAP, NISD as well as RRTCs strategizing the key issues of concerns based on emerging trends, latest evidence and experience gained at the operational level. The meet also aims at evolving strategy for eliciting greater participation of NGO's functionaries and other stakeholders in NC-DAP, NISD programmes, ensuring their active participation with projects / programmes undertaken by the Ministry of Social Justice and Empowerment and NISD in collaboration with UNODC, NACO, Ministry of Health and Family Welfare, Sports and Youth Affairs, Human Resource Development, Information & Broadcasting, etc.

- **Regional Meets on Sensitizing NGOs on IT Initiative** were organized by six Regional Resource Training Centres at New Delhi, Kolkatta, Pune, Chennai and Imphal. These Meets aimed at providing inputs to NGOs on the use of Software for Electronic Management of Half Yearly Reports in respect of the programmes implemented by them.
under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse and DAMS.


**Programmes Conducted this Year:**

The Centre through its long and short-term programmes organized 36 training courses covering nearly 1067 persons during the current financial year. The detailed list of training programmes organized during the financial year by NCDAP is at Annexure-IV. A graphic representation of the programme organized subject wise with number of functionary covered is as under

**Media and Publicity Background**

Media and Publicity activities of NISD broadly fall in Preventive, Protective and Promotive category. It aims at developing software for preventive education to control the incidence of drug and alcohol abuse, protective attitude of stakeholders to safeguard child rights and promotive campaign to strengthen the concept of intergenerational living and the care of elderly.

The role of the Media and Publicity Unit is to develop requisite IEC material for print and audio-visual media in order to create awareness on the issues of Drug Abuse Prevention.

**Video Spots**

In the year 2004 -2005 the Media Unit produced eight video spots with the help of the Directorate of Advertising and Visual
Publicity (DAVP) which convey the message of how to be sensitive to the needs of the aged, child rights and exploitation and message on drug abuse prevention for telecast through television channels and also for dissemination of messages during exhibitions etc.

**Exhibition and Events**

To create awareness among the target audiences / general mass exhibitions / health mela are being organized in different parts of the Country from time to time. Some of them are celebration of specific days on issues of concern by the Institute / Ministry while others are organized by some other Ministries / agencies.

The Institute participates in these public events to promote preventive education and create greater awareness about issues of concerns.

**National Youth Festival, 2005**

The Institute had also participated in the National Yuva Kriti Exhibition held at Hyderabad between 21-25 Feb 2005. The Media Unit developed exhibition panels on Drug Abuse Prevention for this purpose. These panels were displayed in the NISD stall in the exhibition. The main focus was to give information to the youth on drugs and how to keep away from them. On the same topic a presentation through multimedia was done to have a better impact on the visitors. Literature bookmarks and caps with relevant messages on drug abuse were also distributed. A questionnaire on Knowledge Aptitude and Practice survey (KAP survey) was distributed amongst visitors to assess the knowledge and sensitivity towards drug abuse.
In addition to visitors from all over the country, eminent dignitaries including the then Cabinet Minister of Youth Affairs and Sports Shri Sunil Dutt and the First Lady of Andhra Pradesh also visited the NISD stall.