Chapter – 5

SUMMARY, FINDINGS, CONCLUSIONS AND SUGGESTIONS

SUMMARY

Addiction wears many faces, Treatment works! The use of standard terminology enhances practitioners’ communication with clients, with other practitioners, and with the general public. Addiction concepts help to explain addiction. Treatment concepts clarify client variables and treatment terms. Prevention activities reflect primary, secondary, and tertiary levels of prevention. Research grounds effective prevention programs.

Addiction practitioners use theories and models of addiction to ground and guide their practice. Theories and models represent relationships between concepts and propositions. Models are broad and general, whereas theories tend to be more formal and specific. Theories and models help practitioners describe, explain, predict and control phenomena. Conventional models of addiction include the moral model, the legal model, the disease concept or medical model and the pharmacological model. Contemporary theories of addiction encompass biological, psychological, sociocultural and transcendental/spiritual theories. Comprehensive models of addiction include the biopsychosocial model and the public health agent-host-environment model. Addiction practitioners examine the origins, characteristics, adequacy and relevance of various theories and models of addiction. They identify the assumptions, knowledge bases and skills associated with different theories and models and then choose and use particular theories or models to guide their practice.
Understanding the pharmacology of drug use plus the complex dimensions and dynamics of substance abuse is essential for addiction practice. Pharmacology includes the pharmaceutics, pharmacokinetics and pharmacodynamics of drug use. Different drugs have different properties and effects. Alcohol and sedative, hypnotic and anxiolytic drugs are central nervous depressants. CNS stimulants include cocaine, amphetamines, nicotine and caffeine. Analgesics such as morphine, codeine, meperidine, oxycodone and heroin are classified as opioids, LSD, PCP, peyote and mescaline are hallucinogens. Marijuana (itself a category that includes several varieties of cannabis) is the most widely used illicit drug in the United States. Inhalants, anabolic steroids and designer drugs are also abused. Americans currently spend an estimated 70 million a year on herbal remedies. Do some individuals abuse herbs or use them to excess? Addiction practitioner must learn to recognize signs and symptoms of substance abuse, especially intoxication and withdrawal. Chronic or heavy use of alcohol and other drugs has adverse medical, psychological and social effects.

The N.D.P.S Act has brought in stringent provisions for punishment of drug offenders. Despite such provisions, objectives of the Act can be attained only by efficient implementation of the provisions of the Act. The enforcement officers have, therefore, to rise to the occasion.

There seems a little doubt, in view of the evidence that has been presented, that pharmacologic factors play a dominant role in the maintenance of smoking and that most people smoke because they are dependent on nicotine. Furthermore, nicotine dependence is not always only psychological. Many cigarette smokers fulfill the criteria for physical dependence, namely tolerance and physical
withdrawal effects. Finally, it is suggested that cigarette smokers are not simply dependent on nicotine so much as the inhalation-bolus form of intake, which makes cigarette smoking one of the most addictive of the addictive behaviours.

Substance abuse professionals are often expected to explain the effects of drugs, both to their clients and to the community. A wide variety of pharmacological, physiological, psychological and socio-cultural factors contribute in complex ways to the effects experienced by substance users.

The pharmacological variables that influence the effects of a drug include its dosage and composition, the frequency or pattern of use, the method of administration and its interaction with other drugs. Physiological factors include those processes that are involved in the absorption, distribution, metabolism and excretion of the drug. In addiction, a drug user’s sensations, emotions, cognitions and behaviours change in response to alterations in neurotransmission processes. Psychological influences include the user’s previous drug experience, expectations and mood, as well as the task the user is attempting. Finally, we must consider the influence of physical and social environments on drug effects.

Given the large number of variables and the complexity of the interactions, among them, it should be clear that can be considerable heterogeneity in the effects of drugs. However, there is also considerable consistency in users’ experiences. Recognition of the diversity as well as the commonality of drug effects is important in the assessment, treatment and aftercare of clients.

In this chapter we have covered the important topics of comprehend-size assessment and diagnosis. We began by discussing individual assessment and the concept of initial evaluations and went on to examine systematic behavioural assessment and the assessment devices that the substance abuse counselor is likely
to find most helpful. We then presented an overview of a scientific form of evaluation known as the a prior method of case assessment or formulation: next, we surveyed standardized scales that counselors can in evaluating their substance abusing clients. To clients finally, we presented a thorough discussion of diagnosis.

Competent and professional assessment and diagnosis require careful administration of interviews and objective measures. Counselors who fail to build their diagnoses and treatment plans on comprehensive techniques are failing their clients and violating professional standards of practice.

It is important that counselors not become frustrated as they begin this process. Assessment and diagnosis are difficult, but counselors will become much more confident with continued education and practice. Be patient, for the fruits of complete assessment and correct diagnosis are improved treatment outcomes. When our clients succeed, so do we.

In this chapter we addressed the issue of how to counsel individual substance abusers. We discussed the development of treatment plans, the necessity of pre-treatment preparation, general counseling techniques, specific behavioral techniques, the ongoing support offered by Alcoholics Anonymous and Narcotics Anonymous and controlled drinking.

Clearly, a board range of counseling techniques are available to the substance abuse practitioner. The ethical and professional responsibility to be competent and well trained requires a continuous investment of study and self-criticism and an openness to competent supervision. Clients are limited only by counselors’ abilities and counselors abilities are limited only by their willingness to learn.
Individual counseling of substance abusers can be a most rewarding activity. It is never boring or unfulfilling so long as the counselor creatively applies a number of techniques. Counselors who choose to rely on one or a small number of techniques run the real risk of “burning out” and generally depriving their client population. If, on the other hand, counselors choose to remain open and inquisitive, they will enjoy long and exciting careers from which both they and their clients will get benefit greatly.

Relapse prevention is an important part of a comprehensive treatment program. The relapse-prevention model covered in this chapter requires coping skills that enable all recovering clients to handle the high-risk situations they encounter. If they can cope, they do. If they cannot cope, the likelihood of relapse is great. It is the therapist’s responsibility to educate clients about relapse and to give them a wide-ranging treatment that is focused on relapse prevention. Every skill that enables the client to resist relapse is a coping skill. It is no small task to help clients develop the skills they need, but it is easily accomplished. Take a head-on perspective to this problem and it begins to be resolved—neglect it grows larger.

The new cognitive-behavioral model we have examined in this chapter hinges on the development and maintenance of coping skills in the substance-abusing client. These skills, learned in counseling, are applicable to the broad range of unique experiences that each client encounters. We discussed of addiction (moral, medical and social), determinants of relapse, convert antecedents of relapse, relapse prevention, specific intervention strategies for relapse prevention and global intervention strategies for relapse prevention. Relapse prevention should be ongoing throughout the counseling process. It is important that the counselor be sensitive to
individual differences and create relapse-prevention strategies that closely match the needs and experiences of individual clients.

Social response to substance abuse problems traditionally has focused on treatment or legal approaches. However, the high cost and questionable effectiveness of these approaches have stimulated a growing interest in prevention, which is now viewed as an essential component of the substance abuse services network.

A review of contemporary prevention programs indicates that a number of issues must be addressed if prevention initiatives are to be effective. These issues include the following:

1. disagreement over the definition and measurement of substance abuse problems
2. community and professional resistance to prevention programming
3. controversy over the goals of prevention programs
4. failure to develop adequate causal models of substance abuse
5. failure to utilize socio-behavioural research in designing programs to modify risk factors
6. lack of adequate resources to fully implement programs
7. inadequate time for expected changes to occur
8. insufficient intensity to establish and strengthen behavioral changes
9. failure to define the target population adequately and to match the prevention program to population characteristics
10. use of stringent evaluation models.
Several steps can be taken to develop more effective prevention programs. The first step is to utilize empirically validated planning processes that combine information from social, behavioral, educational and health research. The second and third steps are to ensure that the program is comprehensive and intensive, so it can both reach the intended target population and promote changes in behavior. Fourth, the internal and external consistency of the program must be monitored, in order to avoid mixed messages and to provide a message that can be assimilated by the target population. Fifth, prevention providers must be carefully selected and trained, to achieve audience acceptance of them as credible sources of information. Sixth, in order to survive, prevention programs must be community owned; that is, they must become a part of the community. Finally, continual public evaluations of prevention programs are essential if we are to prove and adapt our programs to changing community needs.

While substance abuse prevention efforts have met with a number of problems, epidemiological studies indicate that most members of our society do not experience acute or chronic substance abuse problem. Informal prevention activities are already in place that can and do work. The challenge is to formalize and systematize these activities to increase their effectiveness. Each prevention effort has helped enhance our knowledge of what is needed and contributed to more successful prevention programming.

The epidemic of drug use and associated adverse health consequences pose a formidable public health problem. It is widely acknowledged that drug abuse is a community problem and that it is multi-dimensional. Thus, a combined and coordinated strategy involving different sectors of the community is needed in order
to effectively address drug prevention and intervention. Based on the findings from the study, an action plan that incorporates multiple intervention strategies (community based drug prevention, community out research, peer intervention, drug treatment) targeting multiple behaviours (poly drug use, pharmaceutical drug use, injection related risk behavior, sexual risk behavior overdose) at multiple levels (street level, family, community, schools, workplace, institutions, non-formal institutions) involving multiple sectors (policy, law, enforcement, treatment professionals, drug users) have been proposed. The process of rapid assessment has laid the foundation for community based action through initial consultations with stakeholders and affected communities. These findings have to be used to advocate necessary policy changes.

Tobacco has been used in many forms throughout history, but in modern America cigarette smoking has been the most important form of tobacco use. A decreasing percentage of the American population is now smoking, and the cigarettes they do smoke have decreased in tar and nicotine content. Two areas of concern have been increased smoking among young women and the more recent use of smokeless tobacco by young men.

Smoking shortness and individual’s life expectancy considerably and cigarettes are associated with over 3,50,000 premature deaths each year in the United States. In addition, there are risks to the developing fetus if the mother smokes during pregnancy.

The reason people find it so difficult to stop smoking is a dependence on nicotine, which appears to have both relaxing and alerting properties. Nicotine gum is one approach that has been used to assist people who want to stop smoking.
FINDINGS

1. There are more drug addicts coming from urban areas than the other two areas.

2. The mean age among the urban drug addicts is 37.29% and among rural lies and semi urban lies is 36.21 and 36.07 respondents.

3. There are more respondents (59.70%) among urban followed by 19.5% in rural region.

4. There are 23.6 percent of urban respondents in 10 to 20 thousands income group followed by 22.5 per cent urban respondents in 5 to 10 thousand income group.

5. The data show that there are very less number of respondents living in joint families.

6. More number of forward caste people are more prone to drug addiction than the other caste people.

7. The Hindu urbanization more prime to drug addiction than the other community people.

8. There are more number of respondents from Chittoor district especially from urban areas become the de-addiction centre from where the data collected is located in Tirupati city of Chittoor District which is an urban centre.

9. Majority of the respondents (26.30%) are drinking from 5 to 10 years followed by 25.80 per cent of respondents drinking from less than 5 years. But 6.30 per cent of respondents are drinking alcohol since more than 25 years.
10. About ¾th (73.80%) of the respondents are consuming alcohol regularly every day followed by 15.70 per cent taking alcohol weekly once.

11. The study shows that more number of drug addicts (78.00%) comes from urban areas than the (22.00%) rural areas.

12. Most of the respondents (79.00%) are living in Nuclear families, joint families (10.30%) and broken families (10.70%).

13. Reasons for drug addiction are mainly because they procure more money out-of-way and wanted to spend on drugs to get happiness out of it 70.50 per cent of respondents get addicted because of their association with peer group and friendship circle.

14. Most of the respondents are taking depressants (93.17%), stimulants (80.17%) such as Alcohol, Sedative Hypnotics, Cocaine, Tobacco, Amphetamine, as they are easily available to the respondents in the market.

15. The study shows that there are more number of forward caste people (48.00%). Who are addicted to drug than other category of caste people.

16. Most of the respondents (95.33%) had aggressive behaviour to other normal people.

17. There are 74.33 per cent of respondents who drink alcohol in the company of his friends.

18. Majority of respondents (49.83%) were advised by the recovery addicts to visit the De-addiction Centers and only 21.83 per cent of friends/neighbours/family members advised to visit the above centre.
19. It shows that majority (85.17%) of respondents could not perform duty well due to their drunken state.

20. It is shown that on an average an amount of Rs.4 to 6 thousand is spent by 20.70 per cent of respondents followed by 16.30 per cent of respondents who spent Rs.8 to 10 thousand per month on alcohol/drug. It shows that on an average, each respondent is spending an amount of 9,428.60 per month, which is very high.

21. It is found that, there are more number of literatures (91.20%) drug addicts than illiterates (18.80%).

22. There are more number of drug addicts (62.60%) from Chittoor District followed by 25.10 per cent from Kadapa District. Only 10.20 per cent and 2.0 per cent respondents come from Kurnool and Ananthapur Districts respectively.
CONCLUSION

Messages of prevention

- Drug abuse is **preventable**
- Drug dependence is **Treatable**
- Those not abusing drugs must protect themselves from pressure to use (eg. Peer pressure)

Prevention Activities

Certain principles are useful remember when deciding on the techniques and methods of planned prevention. Some important principles are:

- Avoid mass awareness campaigns. Targeted interventions are more useful in drug abuse prevention.
- Focus on the positive aspects of not using drugs. This includes messages on saying ‘NO’ to drugs and resisting peer pressure.
- Provide factual information on drugs. Scare tactics (showing skulls and bones) usually do not work.
- Focus on healthy ways of having fun. This may include group activities like games, cultural programs or activity workshops.
- Education, including academic education, vocational training and value-based education, are useful techniques of prevention.
- Job placements are pre-job training are especially useful for high-risk youth.
- Harm minimization may be the first step to help youth at risk (eg. Providing information on clean injecting practices to youth not yet willing to give up injecting drug use).
It is not possible to treat alcohol and drug problems without addressing relapse issues. The counselor plays a key role in helping clients to recover from relapse and re-establish their sobriety. The early period of sobriety can be difficult and the counselor needs to appreciate every progress made and support him/her through difficult times with messages of hope and optimism. In a way the counselor walks with the client as a guide, identifying pitfalls some evident and some hidden and teaching him/her much needed coping skills to overcome or sidestep each of them.

The counselor: The Catalyst in recovery

The strength of the counseling relationship greatly influences the recovery process. The counselors’ professional ability to identify problem areas and work with the client, is based on a good grasp of the issues involved in addiction recovery, along with an attitude that is helpful and optimistic.

Recovery can be conceived of as a journey that the client undertakes. The unfamiliar terrain, the unexpected twists and turns, the need to respond differently to each, the effort it demands – all this can make it challenging and satisfying at the same time. The counselor works as the client’s allay, prodding him/her on when progress is poor and urging them to slow down when they go too far and too soon. The appreciation and encouragement, along with caution and guidance, of the counselor can help the client go smoothly through their journey to achieve qualitative recovery.

After the Crisis

Once the crisis has blown over, or the recovering addict has been able to adapt to the new situation, you can reduce the time spent with the client, and
encourage self-reliance. It is also useful to go over the episode in a review, and help the client strengthen his/her useful responses and change unhelpful responses to a crises. This will make the client stronger and help them face any future crises more successfully.

The client who successfully graduates from an after care service will have made substantial who person recovery to lead a normal life. Yet, the road to recovery is a continuous journey. Though the risks of relapse decrease with the passage of time relapse can still occur. The aftercare experience enhances the client’s capacity to cope with this risk and make progress on a drug free life.

At every stage of treatments help is needed at the individual level. Client profiling helps in identifying each individuals unique strengths and addressing his specific problems.
SUGGESTIONS

The data from the various components and studies of this thesis point towards several key issues. It was noted that.

- Depressants and stimulants are early available to the respondents in the market.

- Drug abuse should be planned:
  - Presentation of drug abuse – primary prevention as well as arrest of progression
  - Treatment
  - After care and rehabilitation

- UNODC describes the three ‘pillars’ of demand reduction as epidemiology, prevention and treatment.

- Petraitis et al (1998) in a review article on the correlation of adolescent substance abuse report that home environment, media depiction, political climate and social alienation had no direct effect on drug abuse. The group suggested that factors like peer approval, drug availability, unemployment, assertiveness and substance specific intentions, smoking by peers, academic stress, extraversion and thrill seeking usually promoted drug use. Emotional stability and higher self-efficacy acted as deterrents.

The term ‘treatment’ refers to a variety of activities and process which aim at helping individuals with drug related problems (UNODCCP 2000). Marlatt et al (1997) reported that there are various components to the help-seeking process. These include
- Self recognition of substance related problems.
- Occurrence of events (negative) proceeding treatment entry
- Coercion
- Barriers to help seeking

The study by Marlatt et al (1997) proposed that psychosocial problems, which are related to substance use, many promote help seeking. There can be several external factors e.g. family, problems at work place, etc., that influence the decision to seek help. However, mere recognition of the problem may not lead to treatment. Informal advice and suggestions from social network may also influence treatment seeking. Outreach programmes may facilitate referral to a treatment centre.

Harwood and Fergusson (1998) in their study reported the three common reasons for not seeking help were: ‘did not need help because I could handle problem by self’, ‘did not think to seek help’ and ‘thought the problem would get better by itself’. The reasons were different in the Indian study quoted earlier (Pal et al, 2003).

The factors that may help early initiation of treatment are outreach programmes, reduced waiting time, case management and motivational interaction (Marlatt et al, 1997). The authors recommended less stigmatizing of users, less intensive interventions, involvement of health care professionals in primary care settings and a public health approach would facilitate treatment seeking and retention in a treatment centre. The authors further stated that expanding community involvement and low threshold programmes were important.
The plan could be further modified based on the opinion of drug users and KIs. (Key issues) following completion of the study, Kumar (2002) suggested broadly further kinds of information. These include.

1. **Prevention of Drug Abuse**
   - Target young people
   - Focus on cannabis and alcohol abuse
   - Prevent shift to IDU
   - Delay first sexual act

2. **Treatment**
   - Enhance treatment capacity
   - Facilitate entry into treatment
   - Treatment for health damage
   - Training of peer educators
   - Upgrade emergency services to treat overdose.

3. **Harm Minimisation**
   - Drug substitution
   - Needle syringe exchange programme
   - Safe sex practices
   - Voluntary counseling and testing of HIV
4. Programme evaluations - issues

- Organizational structure

- Background and training of service providers

- Assessment impact and effectiveness

- Coverage of target population

- Attitude and response of local communities

Finally, the thesis demonstrated that multiple indicators, multiple methods and information obtained from multiple sites provide a holistic picture of extent, pattern and trends of drug abuse in the country.

It is to suggest that drug addiction is more in urban areas particularly much more in District Head Quarters like Chittoor. But especially in Tirupati which is a great pilgrimage centre. The necessary steps are to be taken in regard to the eradication of drug addiction at urban level more.

Counseling on food style bringing awareness more and more by the Health Department and NGO’s.

A special attention is to be taken in conducting Yoga, Spiritual, Individual counselling, Family counseling, Group therapy and Group activities and with regular follow up by the De-Addiction Rehabilitation Centres.