CHAPTER VI
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CONCLUSION AND SUGGESTIONS

“The community should restore the former addict to his proper place in society and help him avoid associations that would influence him to return to the use of drugs”

Chief of the United States Narcotics Division, Aslinger (1960:677-679)

Drug addiction has penetrated deeply in almost all segments of the society irrespective of age, sex, religion, caste, creed, community or nation. Problems of drug addiction are too many and varied in nature. These include personal misery, health problems, accidents, cost of hospital treatment, inducement to commit crime, etc. It contributes to thousands of deaths each year.

As it is a multifaceted problem, psychiatrists, psychologists, and sociologists state that it is increasing recklessly in every corner of the world. Although it is mainly prevalent in males but females too are increasingly indulging in drug abuse. Psychiatrists perceive this problem as a disease, psychologists look at the problem of drug addiction as a personality disorder, and according to sociologists drug abuse is not only a deviant act but it affects the very fibre of society. All these three dimensions i.e. bio-psycho and social are interdependent as they could affect the health, personality and social life viz. academics, occupation, relations, etc. of an addict on the one hand and his/her family on the other. Over all, the very social fabric gets disturbed.

The present study was designed to analyse the de-addiction treatment provided by CBDCs and vis-a-vis the role of community (both primary and secondary groups) in de-addicting the addict. The study investigated the participation of various groups of community in the de-addiction process.

Since the study focused on the community participation and de-addiction: theoretical base was identified for understanding the factors of drug abuse. Thus we relied upon the cause models that place primary emphasis on the factors of drug abuse such as biological theories (Genetic Theory and Metabolic Imbalance Theory), psychological theories (Self-awareness Reduction Theory, Psychodynamic Theory), and sociological theories (Anomie Theory, Differential Association Theory,
Subcultural Theory, Labelling Theory, Social Control Theory, Family Interaction Theory, and Peer Cluster Theory). All these theories begin with the causes of drug addiction.

An important dimension of this study was community based de-addiction clinics. The present study was conducted on drug addicts who visited CBDCs, irrespective of age and sex. The data was collected from 200 respondents. Apart from these 200 respondents, 14 cases have also been studied (8 from CBDCs and 6 from the CBDC of Model Jail, Chandigarh). These respondents have been presented in the case studies.

The objectives of the present study were:

1. To study the socio-economic background of addicts who visited the community based de-addiction clinics for de-addiction;
2. To study the functioning of community based de-addiction clinics in providing its services towards de-addiction;
3. To study the role of family, neighbourhood, peer group, teachers, etc. in helping the addict to get de-addicted;
4. To study the problems faced by addicts in the community based de-addiction clinics with regard to doctors, staff, and other agencies like family, neighbourhood, peer groups, police, etc. and vice-versa;
5. To suggest measures to control the problem of drug addiction and strategies to enhance community participation for more effective de-addiction programs.

Firstly, focus was given on the socio-economic background of the respondents’ visiting CBDCs and functioning of CBDCs in providing its de-addiction treatment services. Attempts were also made to find out the role of community in the form of primary (family, neighbour, and peer group) and secondary (teachers, community leaders, police officers, and NGOs) groups in helping the addict to get de-addicted. Problems faced by addicts in the community based de-addiction clinics at the hands of doctors, staff, family, peer group, neighbourhood and vice-versa were also noted. For the present study two hospitals of Chandigarh were identified viz. PGIMER - 12 and GMCH - 32 who hold community based de-addiction clinics in and around Chandigarh.

Therefore, present study was conducted in the villages and colonies in and around Chandigarh viz. Khudda Ali Sher, Palsaura, Dhanas, Bapu Dham and Kharar where CBDCs were conducted by these two hospitals. Apart from these, Model Jail,
Chandigarh was also visited as GMCH - 32 provided de-addiction treatment services there. The data was collected from the drug addict respondents visiting CBDCs for treatment. Besides this, data was also collected from the doctors, police personnel, community leaders, teachers, and NGOs.

The first question taken up for analysis was regarding the functioning of the CBDCs. While analysing the functioning of CBDCs, various components of CBDCs were studied viz. manpower, physical facilities, vehicles, medicines, medical equipments, etc. Other important areas of concern for conducting CBDCs including selection of catchment area, duration of work, registration, treatment, referrals, follow-up, maintenance of patient’s records, confidentiality, suspension, finance, etc. were studied in detail and included in Chapter II entitled “Community Based De-Addiction Clinics: An Analysis”.

The findings of this chapter highlights that community based services in the form of CBDC (the treatment process) were brought closer to the alcohol/drug abusers and afflicted families, who did not want to avail these facilities due to various reasons viz. social stigma, waiting for long hours to consult doctor, standing for long hours in queue for registration, etc. The first CBDC in Chandigarh was started by the Department of Psychiatry, GMCH – 32 in Palsaura. Later, this hospital selected three more catchment areas to bring their de-addiction treatment services to the most vulnerable sections of the community. As far as manpower was concerned, it was observed that CBDCs of GMCH – 32 included Senior Resident (psychiatrist), Staff Nurse, Medical Social Worker, Attendant and a Driver. Department of Psychiatry of PGIMER - 12 initiated community based de-addiction treatment services in Kharar (Punjab). Manpower of CBDC of PGIMER - 12 included Senior Resident (psychiatrist), Medical Social Worker and a Driver. This shows that PGIMER - 12 had less manpower than GMCH - 32. It came to the fore that GMCH - 32 covered more catchment areas than PGIMER - 12. Further, no uniformity was seen in infrastructure while visiting CBDCs of different catchment areas.

It was noticed that the team members of CBDCs were not appointed on permanent basis, they used to do their duties on rotation basis which were scheduled for one year. CBDCs functioned once in a week for two and a half hours i.e. from 10:00 a.m. to 12:30 p.m. Timings were not fixed as it depended upon the number of patients in clinics and time taken by them. Regarding follow-up of patients, it was revealed that patients were regularly contacted. Supervision of CBDCs was done by
the HODs and other faculty members of Psychiatry Department of the hospital. Awareness drive was carried out by Department of Psychiatry of both the hospitals. But, majority of people were not aware of existence of CBDCs in their localities. It was also found that there were only a few women who were aware of the CBDCs. The young population was found absolutely ignorant about the awareness programs of CBDCs because they were preoccupied in studies or jobs during the campaign. It was also tried to find out the various problems faced by the CBDC team. In this regard it was found that awful conduct from low socio-economic background (especially from Bapu Dham colony), poor motivation for treatment and abstinence from drugs were the main problems faced by doctors and other staff of CBDC. Doctors felt helpless in many situations and mentioned that it was the easy availability of drugs which was making the treatment ineffective. Many a times social workers were discouraged by the local people for making contacts with addicts as it would harm the reputation of a social worker.

Besides CBDCs, community camps were also visited by the researcher. It was found that camps were more popular with the local people as compared to clinics. Camps were residential and provided recreational facilities to the inmates whereas clinics were held once in a week in a particular locality. Further, the same team of doctors and staff used to visit the other locality, the next day. Thus, lack of manpower and temporary infrastructural arrangements did not allow the hospitals to give a permanent status and a fixed place to CBDCs.

Who visited these CBDCs? was analysed in Chapter III entitled “Drug Addicts Undergoing De-Addiction: A Profile”. This chapter was divided into three parts. First part dealt with socio-economic profile of the respondents undergoing de-addiction treatment covering their age, sex, marital status, locality, education, employment, etc. Second part of the profile dealt with the respondents’ introduction to drugs, which covered their family history of drugs, their first contact with drugs, duration of taking drugs, age of initiation, etc. and the third part of the chapter covered the contact of respondents with the CBDCs, type of treatment in CBDC, cost of treatment, etc.

The total sample for the present study was 200, which included 196 men and 4 women respondents. Further, the study indicated that majority of the respondents (29%) between the age group of 30 - 39 years were taking treatment to lead a normal healthy life. More married people visited CBDCs for de-addiction treatment as compared to unmarried. They comprised of 71.5 per cent of total respondents.
Majority of the respondents coming to CBDC were Hindus. As far as education of the addict respondents was concerned, seven categories were made (i) Illiterate (ii) Primary (iii) Middle (iv) 10th/12th (v) Graduation (vi) Post-Graduation (vii) Professional Qualification. It was found that majority of the respondents visiting CBDCs for de-addiction treatment were less educated. This was also due to the fact that CBDCs were providing their services in the colonies and villages where majority of the population belonged to low socio-economic background. Majority (25.5%) of the respondents had education up to high school/secondary school level. Only 8 per cent were post graduates.

Further, the occupational status of the addict respondents was examined. For this variable eight categories were made (i) Unemployed, (ii) Self Employed, (ii) Daily Wage Labourer, (iv) Retired, (v) Student, (vi) Private Job, (vii) House Wife, (viii) Government Job. It was observed that majority of the respondents (29%) were engaged in private jobs like computer operator, medical transcriptionist, news reporter, courier boy, salesman, pantry worker, etc.

Further, 77 per cent of the drug addict respondents under treatment were from nuclear families. Besides occupation and family, the study also undertook the task of examining another important variable i.e. income. To analyse this variable seven categories were made (i) Less than Rs 3500 (ii) Rs 3501-7000 (iii) Rs 7001-10,000 (iv) Rs 10,001-15,000 (v) Rs 15,001-20,000 (vi) Rs 20,000 & above (vii) No Income. It was observed that highest number of respondents (37%) were earning less than Rs 3500 per month. Another important variable taken into account was the locality. For this three categories were made (i) Urban (ii) Rural and (iii) Outgrowth. It was noted that 67.5 per cent respondents belonged to urban locality.

In the second part of the profile of respondents, efforts were made to know the history of drug addiction in the family, age of initiation, first contact with drugs, duration of taking of drugs, type of drug addicted to, reasons of taking drugs etc. With regard to family history of drug addicts, it was found that majority (55.5%) of drug addicts visiting CBDCs had no family history of drug addiction. Most of the drug users (72%) were influenced by their friends’ circle while taking to drugs, which continued in their lives. As regards to age of initiation into drugs it was observed that adolescents were more prone to drug addiction than any other age. It was found that the highest percentage (54.5%) of the respondents started taking drugs during teen age i.e. between 13-19 years. 25.5 per cent respondents had been habitual addicts for the
last 10-14 years and the same percentage of drug abusers were habitually addicted for the last 19 years and above. The oldest addict was found to be 73 years of age. These drug addict respondents were addicted to various kinds of drugs but most (71.5%) of them were multiple drug users. Alcohol was found to be common among all of them. A large section (38.5%) of them reported that they felt relaxed after taking of drugs. Different reasons were attributed for the start of drugs. The present study revealed that majority (69%) of the respondents started taking drugs as an experiment or out of curiosity with their friends. They liked taking drugs in isolation as well as in the company of others especially company of friends was preferred by them. The highest percentage (56%) reported that they abused drugs in both situations i.e. in isolation as well as in company of friends. With regard to the reasons of taking de-addiction treatment, diverse range of reasons came to fore like they were fed up of drugs, loss of social status, health problem, accident, bitterness in family relations, feeling of shame, feeling of irresponsibility towards children, etc. Majority (38.5%) of the respondents started taking de-addiction treatment because of co-morbidity i.e. they were suffering from health problems caused by drug addiction. On the whole, it came to fore that age plays a crucial role in attracting one towards drugs. The above finding points out that in majority of the cases, respondents started drugs when they were in their teen age and friends influenced them for taking drugs.

In the third part of the profile of drug addict respondents, focus was made on treatment facilities provided by the CBDCs. Respondents got information of CBDCs through various sources which included hospital staff, colleagues, relatives (who were living in community where CBDC was conducted), priest of Gurudwara Sahib, etc. Majority (33.5%) of the respondents got information of CBDCs from their friends. It was further explored and came to fore that most of family members and neighbours came to know about the CBDCs through public announcements in community, posters pasted on the walls of Gurudwara sahib in their communities by CBDC team, and from other community members.

Interestingly, respondents’ duration of treatment in the CBDCs varied. Maximum time taken by a drug addicted respondent to recover was four years. According to Dr. S. K. Mattoo (Head of the Psychiatry Department, Drug De-addiction Centre, PGIMER - 12) “The success rate for de-addiction is only 20 per cent in one year which showed a very high rate (80%) of relapse.” The reason behind this low rate of success was “lack of motivation” among patients and persistent desire.
“to gain euphoria” which one feels after taking these drugs. Majority (66%) of the respondents received all the medicines free of cost in CBDCs. The respondents, who did not get medicines from CBDCs due to the non-availability of medicines in the CBDCs, had to buy the medicines from the market. 9 per cent of respondents had to spend approximately Rs 500 per month on medicines. It was also noticed that time spent on each visit varied. Majority (69%) of the respondents had to spend around half an hour per visit including time taken in registration. Maximum number of respondents under study were first time visitors and majority (94.5%) of the respondents reported that they never took treatment from any other hospital or rehabilitation centres before coming to CBDC. An attempt was made to find out the problems patients faced at the hands of doctors. 26 per cent respondents complained that they did not get all the medicines from the CBDCs, and had to purchase from the market. Another 8 per cent did not get any of the medicines from the CBDC. 15 per cent respondents did not receive any counselling in the CBDCs. Sometimes it became inconvenient for patients, especially when CBDCs remained closed on gazetted holidays, 3.5 per cent respondents faced this problem and had to return home without a follow-up treatment. There was no way to inform the patients about the closure of CBDC on certain days. 2 per cent respondents were not satisfied with the behaviour of the doctors. They complained that doctors did not attend them humbly and sympathetically. 2.5 per cent drug addict respondents faced communication problem. It was observed that doctors who visited these Punjabi speaking areas hailed from other than Punjab. Thus at times patients felt uncomfortable to communicate with the psychiatrists. Remaining 43 per cent respondents reported that they did not face any problem in CBDCs with regard to doctors and other staff members.

The next objective was to find out the participation of various agents of community in drug de-addiction. To fulfil this purpose various social groups viz. primary (family, neighbour, and peer group) and secondary (teachers, community leaders, police officers, and NGOs) groups in helping the addict to recover were taken up vide Chapter IV and Chapter V entitled “Community and Drug De-Addiction: An Interface-I” and “Community and Drug De-Addiction: An Interface-II” respectively.

In Chapter IV, the role of family, neighbours, and peer groups were dealt with. Relevant questions were asked to probe the role of family in de-addiction treatment of its members. The role of family support in de-addiction was investigated and it was found that majority of the respondents (91%) received ample support from their
family members to shun drugs in the form of love, care, encouragement, motivation, mental, emotional and moral prop up. Further, findings revealed that majority of the respondents (65.5%) felt close to one or the other family member which played an important role in their treatment. Majority of the respondents (51%) preferred to visit the CBDC alone, took their own responsibility and were highly motivated to take the treatment. All the rest of the respondents visited the CBDC with one of their family members or other than family member. As far as taking addict family member to the social function or gatherings was concerned, it was found that only 2 per cent respondents informed that their family members felt ashamed while taking them along to social gatherings. Besides this, feeling of shame among the family members was noticed, most of the respondents (63.5%) shared that their families felt ashamed of the fact that they were related to drug addicts. Out of them, large number were children of the addicts. They had to face ridicule of their friends and peers because of their parents’ addiction. One of the pertinent questions in the participation of family in de-addiction was to know the involvement of the family members in giving medicines to the respondents. Findings of the present study revealed that majority of the respondents (89%) followed a regular and proper schedule of intake of medicines, themselves. The study also revealed that 79 per cent of the respondents were taking or participating in family decisions and abuse of drugs made a little impact on this facet of their life. In the capacity of the head of the family, men enjoyed the power of decision making and the women were left with an insignificant role to play in the decision making. The frequency of disputes entered into by the addicts with their family members was explored and it was found that 43.5 per cent of the respondents usually entered into a dispute with other family members, especially with their spouse. Further, the findings revealed that only 6 per cent of the respondents’ families borrowed money for their treatment. Mostly, the families found the treatment affordable at the CBDCs and did not have to borrow money.

Besides the support given to the addict by his/her family, an effort was also made to find out the various problems faced by the addicts from their families and vice versa. In this regard it was found that 63.5 per cent respondents’ families felt disgraced and ashamed of them. 9.5 per cent families considered them irresponsible and disbelieved them. 16.5 per cent families became abusive towards them and 3.5 per cent did not support them and left them to fend for themselves. With regard to the problems faced by the families from their addict kins it was found that they also
passed through the diverse crisis. Anti social behaviour, extramarital relationships, complacency, etc. led to disharmony within the family.

Regarding support of neighbours in the recovery of drug addict, it was found that 77 per cent of the respondents had cordial relations with their neighbours and they were helped by them in difficult times. Further, concerning financial assistance from neighbourhood, it was observed that 58.5 per cent of the respondents were getting financial help provided to them by their neighbours without any rider. Exploring the assistance provided by the neighbours in resolving family disputes, it was observed that 58.5 per cent of the respondents got cooperation of their neighbours in settling the disputes rose on the issue of drug addiction. 69.5 per cent did not like that the neighbours should have any say in the decision making process of the family. It was later transpired that the whole locality was in the grip of drug abuse as a large number of persons residing there were consuming one or the other drug. 59 per cent respondents’ neighbours were aware about the problem of drug addiction among respondents. Only 7 per cent respondents reported that their neighbours came forward for help and accompanied them to the CBDCs. One woman reported that she alone brought five addicts from her neighbourhood to CBDC. Further, it was found that 41.5 per cent of the neighbours encouraged respondents to shun drugs and lead a healthy life. They convinced them to take treatment. They exhorted them to give up drugs totally. 44.5 per cent addict respondents did not like to spend time with their neighbours whereas 38.5 per cent of them liked to spend time in the company of their neighbours. On the issue of drug addiction in the neighbourhood it was found that 47.5 per cent addict respondents had neighbours already indulging into substance abuse. Interestingly, 41.5 per cent of respondents’ neighbours were motivating the drug addicts to leave drugs whereas 47.5 per cent of respondents’ neighbours were themselves taking drugs. In this situation, who would be exercising more influence on the drug addicts? The data points out the risks of indulging in drug taking behaviour is more than recovering from the already existing addiction.

It was also tried to find out the ill treatment, addicts have to bear at the hands of their neighbours. It was found that 28.5 per cent respondents felt that their neighbours unnecessarily interfered in their personal matters. 10.5 per cent respondents felt that their neighbours had changed their behaviour towards them and started ignoring them. 29 per cent of the neighbours were non-supportive towards them and 32 per cent neighbours had no problem from their neighbours. On the other
hand, neighbours too suffered a great cost from nearby addicts. Neighbours were seen worrying about their kins. Conflicts with the neighbours, lack of interaction were some of the problems that aroused out of drug abuse commonly cited by the neighbours. During interaction with the neighbours, it came to the fore that open fights, creating late night ruckus on the streets disturbed the overall environment of locality.

In case of the drug abuse among the friends of addict respondents, it was found that all the friends of the 46 per cent respondents were abusing different types of drugs. Friends’ support in treatment was also examined during the present study in which 30.5 per cent respondents received guidance to cope up with craving for drugs. 2 per cent addicts told that their friends took them to doctors for consultation in the event of relapse. It was found that 45.5 per cent of them got financial support from their friends when it was required. Majority of the respondents (59.5%) liked to spend time with their peer group. As loneliness was concerned, 66 per cent of the respondents secured company of their friends when they felt lonely and dejected. 6.5 per cent of the respondents’ friends were oblivious of their drug de-addiction treatment.

With regard to problems faced by the addicts, it was found that majority of addicts faced various kinds of problems from their friends. 21 per cent of drug addict respondents received drugs from their friends in spite of their treatment, 3 per cent friends denied of providing financial help. And when emotional support was probed, it was found that 18.5 per cent of the drug addicted respondents never got emotional support from their friends. Apart from these problems other problems which came into fore were friends’ unsupportive behaviour in solving problem and unsympathetic attitude. On the other hand, problems faced by the friends from their addict friends, it came to fore that they suffered from their irritated and frustrated nature. Peers found it difficult to help them in settling quarrels. Further, it was also revealed that addicts coerced their friends to take drugs.

The role of teachers, community leaders, police, and NGOs was explored in Chapter V entitled “Community and Drug De-Addiction: An Interface-II”.

Firstly, we examined the role of teachers and it was observed that a few schools were taking interest in eradicating the problem of drug addiction from the schools. Teachers made efforts at their own level in drug eradication from the schools.
through various means like imparting moral values to their children, chart or poster making, writing competitions on the subject of drug addiction, etc. Regarding the awareness of CBDCs, it was revealed that except teachers from Khudda Ali Sher none of the other school was aware of CBDC in their locality. In addition to this, no future action plan for combating drug abuse among the school children was found. Further, it was noticed that there were a few children who were abusing tobacco in the schools. Tobacco is considered as a gateway drug and if one is addicted to tobacco it is easy for an addict to consume other dreadful drugs like cocaine, marijuana, heroin, etc. The prevention of drug abuse at this stage is of utmost importance and schools played insignificant role in this regard.

Community leaders are the most prominent members of their respective communities who could curb the drug addiction from their communities. It was found that Sarpanches participated in de-addiction or drug prevention program. These community leaders organized tournaments for youth, opened gym and stadium for youngsters. Sarpanches visited door to door in their villages and convinced people for the de-addiction treatment. After looking into the role of community leaders participation of another secondary group was studied i.e. police. Police is regarded as a protective arm of the state. Police personnel were interviewed both in the Police Stations as well as at the Police Posts to know about their participation. It came to fore that raid, patrolling, CLG (Community Liaison Group) and Dehati Dora (village tour) methods were employed by them to curb drug problem. They raided suspicious places of supply or possession of illegal drugs. Patrolling also helped in preventing the problem. CLG (Community Liaison Group) in its recent meeting decided to collaborate with residential members and psychiatrists from PGIMER – 12 to provide drug de-addiction treatment. It was noticed that most of the patients were police personnel at Bapu Dham Police Hospital for taking drug de-addiction treatment. As far as NGOs were concerned, they had multifarious activities to perform and were facing financial crunch and could not handle full-fledged drug de-addiction centres, nor was there any NGO, exclusively working for drug de-addiction.

The ongoing discussion concludes with a few observations. Firstly, researcher did not notice any collaborative effort of the groups (family, police, doctors, etc) under study. Neither NGOs were aware of the CBDCs nor did the doctors know about the existence of NGOs in the locality. Secondly, Police and local leaders never made any joint efforts to recover the drug addicts. Thirdly, CBDCs were functioning
without the participation of all the members of the community. In the present study, it was noticed that CBDCs, family, peers, NGOs, Police, local leaders, doctors were seen working from different platforms and absolutely unaware of existence of each others’ roles, objectives and strategies. Lastly, jail inmates could not be treated effectively as there was no follow-up strategy after their release from the correctional institution.

**Remedial Suggestions**

There are number of studies on drug addiction and de-addiction treatment. Few of them concluded that eradication of substance abuse needs community participation. But there is hardly any study which is being conducted on community participation in drug de-addiction treatment. Thus, in the present study, an effort was made to see the community participation of both primary and secondary groups. In primary groups; family, neighbours, and peer groups were included. In secondary group; teachers, community leaders, police and NGOs along with the CBDCs were included. The role of each group in curbing and eradicating the evil of addiction was investigated and lacunas were found at different levels of treatment. Thus, after looking at the role of various groups, a few suggestions have been penned down so that effectiveness and efficiency is achieved in the treatment process.

Following are the suggestions:

1. **CBDCs**: PGIMER - 12 was running only one CBDC i.e. in Kharar. There is a need to open more CBDCs in different areas of Kharar and villages located in its vicinity, as Kharar itself is a vast place requiring this service. It is further suggested that PGIMER - 12 must also provide free medicines to the patients, so that patients are able to take treatment properly.
   - Hospitals (PGIMER -12 and GMCH-32) need to advertise about their CBDCs regularly through newspapers and by distributing pamphlets in the community so that people know about the de-addiction programs offered by these hospitals.
   - Team of each CBDC is require to motivate addicted patients for regular follow-up.
   - CBDCs must also hold meetings at least once in a month with the community leaders, teachers and police to come out with strategies and encourage people to take treatment.
• There is a need to give permanent location to CBDCs. Regular appointment of staff members of CBDCs, improvement in infrastructural facilities like drinking water, proper sitting arrangement, etc. are important to run the CBDCs effectively.

• Trained Clinical Psychologist is a pre requisite for providing counselling services. None of the CBDCs was having councillor on rolls to do counselling. It is suggested to appoint councillor on regular basis in all the CBDCs.

• At last, there is an urgent need to add residential characteristic to CBDC. It has been noticed that Camps are more successful as compared to CBDCs, because of their residential and recreational facility.

Neighbours: It was noticed that role of neighbours in the present situation was almost nil. In modern times, neighbours are no more considered as extended arms of the families. They are not coming forward to help the afflicted family to cope up with the problem. Neighbours can also play a positive role in making the addicted person understand about addiction and its consequences on the family, health, etc. It is suggested that regular counselling sessions and public lectures be organised for them.

Community Leaders can also create awareness in his/her community about drug de-addiction, consequences of drug addiction and treatment facilities in and outside the area (in case patient wants to get treatment outside his/her community). Community leaders need to organize drug awareness talks every month or arrange workshops in community biannually/annually. For this, they may contact teachers, psychiatrist, MSWs or other experts who can make people understand the subject. They can encourage youth of their respective communities towards sports and education and other activities and also honour those who excel in their field. With this, youth will get encouragement and motivation and their energies can be channelized in the right direction. Community leaders must take initiative to open stadium/gyms/sport clubs in community and encourage the youth to take advantages of these facilities. Interaction of the community leader with other community leaders of different areas is required to see how they work on drug awareness programmes and what implementations they are pursuing, so that an identical programme in their community can be started. Community leaders can take bold steps to appeal to the government to bar liquor shops in their areas.
Educational Institutions: A comprehensive prevention program comprising of school curricula and classroom management techniques as well as other school environment activities may be developed. Family-based activities may be encouraged to enhance positive parent-child interaction. Media campaigns discouraging tobacco, alcohol may be launched. The real test of a teacher is to leave his impact beyond the classroom. The teacher can involve family as well as the community in prevention efforts. Teacher can implement the best strategy at hand and incorporate concepts and skills in various subjects and school settings. He/She can also extend these activities to home and the community. Teachers are not well trained in dealing with the drug addicted students. Teachers are not well equipped to respond to the questions raised by the students so that they feel comfortable in discussion about drug use and employ demonstration techniques to show that most young people do not approve of drug use.

In order to create a general school environment in support of drug prevention ideas or skills, charts, posters, artwork can be displayed on prominent places in the school to remind students about the bad effects of the drug abuse. Teachers must encourage their students to perform skits or presentations during assemblies to communicate the important messages against the use of drugs.

The teacher can promote preventive measures and help to build a strong relationship between parents and children. It becomes effective only when talks, workshops for the parents can be organized on drug abuse prevention programs. Representatives of community, health professionals, police officers may be invited to speak to the students about issues related to the drugs. Home work assignments, talks by students, telecast of telefilms related to drugs, monitoring students on symptoms of drug addiction e.g. furtive glances, watery eyes, drowsiness, marked restlessness, frequent yawning, etc. may be helpful. Counsellor be appointed in every school to counsel the students.

Police Personnel: A few suggestions for functioning of the police personnel can be made such as, in case police arrests any addict, they must refer him to a psychiatrist to CBDC or any other drug de-addiction hospital. Addicted persons in jail be provided with proper drug de-addiction treatment. It is not possible to refer all the drug addict inmates to hospital so it would be better if detoxification facility is provided in the jail. Appointment of psychiatrists and other needed staff like MSW and psychologist, staff nurse in jail will be helpful in the treatment process. Police must establish rapport with the local community leaders and other educated youth and encourage
them to give information regarding any incident of selling and purchasing of drugs in their community. Police can play an active role while patrolling. Chemist shops be regularly raided to check the sale of illegal drugs.

**Proposed Strategies**

In addition to the above suggestions, following strategies are proposed which may prove more beneficial in curbing the menace of drug.

1. It has been observed that adolescents are easily accessing the gateway drugs from their nearest areas. These gateway drugs later introduce them to more dreadful drugs. News papers are full of news of seizing of drugs, peddling of drugs, drug addiction among youth, drug addiction among men, drug addiction among women, etc. The reason of increase in drug addiction is its easy availability to a common man. These drugs could be banned in and across the border with the strict policies. Government should make more strict laws to control the demand and supply of drugs. Government must put ban on all the gateway drugs (tobacco in all forms and alcohol) and strict vigilance is required on illegal supply of drugs. Thus, government is the only source to control the supply of drugs.

2. *Cannabis Sativa* has been noticed everywhere across the roads as an unwanted weed. Drug addict person are easily getting it without any expense and consuming it in the form of *Ghanja, Charas, and Bhang*. Therefore, it is essential to cut down this unnecessary weed to end three dreadful derivates (*Ghanja, Charas, and Bhang*). Here, it is proposed that government and local community should cease the growth of this unwanted weed.

3. Initiate steps to appoint psychiatrists and include homeopathy physicians for the treatment of drug addiction is needed. According to Dr. Rajeshwar S. Rana, Assistant Director (Homoeo) cum Office Incharge Ayush Nodal Officer (Ayush) (NRHM) Chandigarh Administration, Homoeopathy can play a great role in drug de-addiction. People with addiction of alcohol, cigarette and *afeem* can be treated with homeopathy. Its treatment doesn’t take long time. Dr. Kiran Bedi also invited homoeopathy physicians in Tihar Jail (largest jail in the world) to treat drug addicted patients. Homoeopathy doctors visit on a daily basis, to provide exclusive attention to the substance-afflicted inmates in each prison. These doctors perform their duties exemplarily, much to the satisfaction of their patients. The medicinal doses dispensed by them seem to work wonders for
those under their care. These medicines proved effective in controlling, to a large extent, the painful symptoms caused by withdrawals, such as running nose, trembling or quivering of the body, watering of eyes, sleeplessness, and other related manifestations. The treatment pattern is basically holistic in keeping with the tradition of homeopathy. On the other part, the doctors had to ensure that the patients actually take the medicines in their presence. In this holistic system of medicine, medicines like diazepam, its variants, pain killers and sleep inducing medicine have no role to play. The homoeopathic therapy provides considerable respite to the habitual drug users. Such therapy brings about other advantages as well. For instance, the homoeopathic medicines are non-addictive. Their usage reduces the pressure on other already overburdened allopathic doctors to a great extent (Bedi; 2002). In the present study it has been observed that doctors are giving sleep inducing pills rather they should learn from the other’s experiences and homeopathy should be included in the treatment.

4. Presently, the grants provided to drug treatment centres are very meagre and remuneration for the services of professionals is paltry. To retain the staff with them, hospitals need to revise their salaries. Another way to keep them working sincerely and committedly towards this cause is to give them regular incentives for specific jobs like, doing follow ups, bringing drug addicts to CBDCs, etc.

5. Studies have shown that twelve step and Alcoholic Anonymous are important ideas and are working successfully in recovering the drug addict. In these programs, the recovered individuals need to separate himself/ herself from other places, people and objects previously associated with the addiction. Here also, it is proposed to start these programs so that recovered addicts do not fall prey to drugs again.

6. Recovered drug addicts need to be involved as mentors in the de-addiction process.

7. Women are suffering innumerable health problems like mouth ulcers, neck and ear cancers, etc. because of the intake of multiple drugs. Due to social and cultural factors, it is very difficult to bring women to CBDCs for treatment. Lack of preparation before implementing any scheme results in the failure of the scheme. To catch this vulnerable section of society, strong mechanism is required so that effective implementation of the programs becomes reality.
8. As it has been discussed earlier that family is the most fundamental unit of socialization. Parents persistently shape the behaviour of their child knowingly and unknowingly. Thus, they must control their own self while providing limitless financial help to their children. In other words, it is vital duty of parents to watch where the child is spending money. Apart from this, checking of their school bags, meeting their teachers, enquiry of peers, etc. are few another strategies parents can adopt. Parents can be informed via media, teachers, local leaders, councillors, etc.

9. Lastly, joint action by all the groups of community is proposed. This is possible only when programs and policies are designed in such a way that instead of elaborate institutional arrangements, the focus shifts to mandatory consultations and periodical assessment of each other.

Theoretical Implications

Studies have shown that recovered drug addicts returning to the same community after recovery do not succeed in their rehabilitation. These studies have been done on those drug addicts who are away from their original communities for some time and join therapeutic communities. In the present study, the drug addicted remained in the community during the treatment and his/her own community members including family, peers, neighbours etc. provided support in the treatment. Support by various members of the community and treatment offered by Community based de-addiction clinics had lacunas which is why the treatment was not very popular and successful. Our findings highlight the role played by one’s own community lacks from various standpoints. In the present context our findings are very close to Sutherland’s Differential Association.

Edwin Sutherland’s Differential Association highlights that the deviant behaviour is a learnt behaviour and is learnt in interaction with others. One of Sutherland’s propositions that a person becomes addict if definitions favourable to violation of law exceeds over definitions which are unfavourable to law. Excess in such definitions is a product of frequency, duration, priority and intensity of socialization to others. In the present context, we have seen drug addicts are getting an environment which push them towards drugs. That environment is of intimate small group of family, friends and neighbourhood. Undoubtedly, de-addiction treatment is to be conducted in small intimate social groups wherein members can share among themselves the accepted social norms. When a person is visiting CBDC, once in week
or once in month, he/she is away from the treatment process and environment for a long time and spends more time within the same community from where he/she has learnt abusing drugs. In the community, there is no one who can act as mentor or role model to help the drug addict in changing his/her life style. Addiction and De-addiction are two different behaviours. If drug addiction is a learnt behaviour, de-addiction too is a learnt behaviour. It is learnt through communication with intimate others that enables both prosocial and anti social behaviour. In the present context, agencies both formal and informal, responsible for de-addiction are working unfocusedly without any planned and well researched strategies, making the whole effort fruitless.