Indira Gandhi
National Open University
School of Social Work

BFEE-103
Alcohol, Drugs and HIV

Block

3

PREVENTION AND TREATMENT OF ALCOHOL AND DRUG DEPENDENCE

EXPERT COMMITTEE (ORIGINAL)

Prof. Abdul W. Khan
Former Vice-Chancellor
IGNOU

Prof. Thomas Kalam
Director, St. John's National
Academy of Health Sciences
Bangalore

Dr. Padam Khanna
Health Consultant
New Delhi

Dr. Glory Allexander
Chairperson
Asha Foundation
Bangalore

Ms. Enish Sareen
Sharan, New Delhi

Shri George K. Jose
Advocate, Supreme Court
New Delhi

Prof. Gracious Thomas
SOCE, IGNOU

Prof. VS. Prasad
Former Pro-Vice Chancellor
IGNOU

Ms. Bimala Kapoor
SOHS
IGNOU

Dr. Ritu Priya
Centre of Social Medicine &
Community Health, JNU
New Delhi

Dr. Rabia Mathai
International Federation of Red
Cross & Red Crescent Societies
New Delhi

Prof. Jose Puthenvedu Head,
Deptt. of Psychology
F.M.N. College, Kollam

Dr. Joseph Alencherry
Director, CANA
Kottayam

Dr. A.S. Guha
IGNOU Regional Director
Shillong

Dr. Suniti Soloman
Director, YRG Care
Chennai

Dr. A. Padmavati
Indian Social Institute
New Delhi

Fr. George Pereira
CBCI Centre
New Delhi

Dr. Anita Dighe
Direcrtor, CEE
IGNOU

Dr. V. Vasudevan
IGNOU, Regional Centre
Cochin

EXPERT COMMITTEE (FIRST REVISION)

Prof. Sanjay Bhatt
Delhi University, Delhi

Prof. Anjali Gandhi
Jamia Millia Islamia, Delhi

Dr. Rama V. Baru
JNU, Delhi

Dr. Ritu Priya
JNU, Delhi

Prof. Gracious Thomas
IGNOU, New Delhi

Prof. A.R. Khan
IGNOU, New Delhi

Prof. Santosh Panda
IGNOU, New Delhi

Dr. R.P. Singh
IGNOU, New Delhi

EXPERT COMMITTEE (SECOND REVISION)

Prof. Gracious Thomas
IGNOU, New Delhi

Prof. Jyoti Kakkar
Delhi University, Delhi

Dr. Bina Antony
Delhi University, Delhi

Dr. Suresh Pathare
CSRD, Ahmednagar

Prof. P.K.N. Ghosh
Viswa Bharti, Santi Niketan

Dr, Sanjoy Roy
Delhi University, Delhi

Dr. Habeebul Rehman
Jamia Millia Islamia, Delhi

Dr. Archana Kaushik
Delhi University, Delhi

Dr. Kaushalendra Pratap Singh
Rajiv Gandhi University
Arunachal Pradesh

COURSE PREPARATION TEAM (ORIGINAL)

Unit Writers
Prof. Jose Puthenveedu
Prof. Chocko. K.
Prof. J. Dinakarlal

Block Editor & Course Coordinator
Prof. Gracious Thomas
SOCE, IGNOU

COURSE PREPARATION TEAM (FIRST REVISION)

Contributors
Prof. Jose Puthenveedu
Prof. Chacko. Karinthayil
Prof. J. Dinakarlal

Revised by
Prof. Chacko Karinthayil

Block Editor & Programme Coordinator
Prof. Gracious Thomas
SOCE, IGNOU

COURSE PREPARATION TEAM (SECOND REVISION)

Original Contributors
Prof. Jose Puthenveedu
Prof. Chacko. Karinthayil
Prof. J. Dinakarlal

Content Editor
Dr. Rambabu Botcha
Rajiv Gandhi National Institute of Youth Development, Sriperumbudur

Programme Coordinators
Dr. Rose Nembiakkim
Prof. Gracious Thomas

Print Production

Mr. Kulwant Singh
Assistant Registrar (Publication)
SOSW, IGNOU

January, 2019 (Revised Edition)

ISBN-978-81-266-3159-9

Further information on the Indira Gandhi National Open University courses may be obtained from the University's Office at Maidan Garhi, New Delhi-110 068.

Printed and published on behalf of the Indira Gandhi National Open University by Director, School of Social Work.

Lasertypeset by Rajshree Computers, V-166A, Bhagwati Vihar, (Nr. Sec. 2, Dwarka), New Delhi-110059

INTRODUCTION TO BLOCK 3

Block 3 of the course on 'Alcohol, Drugs and HIV' is on Prevention and Treatment of Alcohol and Drug Dependence. In this block there are four units which deaf with various aspects of prevention and treatment of alcohol and drug addiction.

Unit 1 is on 'Treatment alcohol and drug dependence'. This unit will enable you to understanding the treatment stages and treatment settings, different modalities of treatment and scheme for prevention of alcoholism and substance abuse. **Unit 2** deals with 'Empowering through Education, Counselling, Referral Services and Community Responses'. It helps you to recognize the process of empowering and learn various possibilities of mobilizing community resources for drug abuse prevention. It also deals with school Based prevention programmes. **Unit 3** is on the 'Role of NGOs, and National and International Bodies on Prevention and Control of Substances Abuse. This unit sensitizes you to the need for intervention at different stages and the role different organisations have to play in the prevention and control of substance abuse. **Unit 4** is on 'Developing Skills and Competencies for Intervention Strategies'. This unit provides you good knowledge about intervention, role of counselling, motivation skills and presents to you the basic knowledge about the ABC methods of crisis intervention.

This block provides comprehensive understanding of the prevention and treatment modalities in the area of substance abuse which are essential for people working or intending to work in the area of HIV/AIDS.

UNIT 1 TREATMENT OF ALCOHOL AND DRUG DEPENDENCE

Contents

1.0 OBJECTIVES

The purpose of this unit is to describe to you what the treatment process for substance abuse is. Like any other disease, substance abuse also has an established mode of treatment. This unit will give you a clear picture of the treatment process and procedures of substance abuse.

After reading this unit, you should be able to:

- understand the concepts of treatments, detoxification and assessment;
- describe the different modalities of treatments of alcohol and drug dependence;
- explain the intervention techniques; and
- describe what is relapse prevention.

1.1 INTRODUCTION

Drugs have been used since time immemorial, mainly to get relief from the stress and strain of life and for ritual purposes. Historical evidence suggests that people have been using cannabis for 8000 years. It was used by many early civilizations as medicines for anxiety to digestive problems. About six hundreds years ago ancient Sumerian texts considered poppy plant from where opium is produced a "Joy Plant". There is mention in the ancient books of the old Hindu medicine for chronic alcoholism and even *delirium tremens*. The Aryan invaders of India used a beverage called *Somaras*. The Aryans knew the narcotic and euphoric properties of the cannabis plant thousands of years ago and there is little doubt that they made use of these substances. Buddhism in India contributed much to the habit of sobriety among the masses.

Since 2500 years the natives of South America chewed coca leaves to derive pleasure and relaxation. The Greek hero had to face the mutiny of his followers because of the 'Lotus' plant as mentioned by Tennyson in his poem "The Lotus Eaters". The Lotus is a cactus plant that contains mescaline; a hallucinogen.

In the medieval times the kings and the aristocrats took to drinking and by their example the habit spread among the masses to some extent. Allauddin Khilji, who imposed total prohibition and Aurangzeb who practised strict abstinence, were the exceptions in their times.

It is to be pointed out that for the whole of the pre-British period the masses in general remained free from the effects of drinks and drugs. The British administration attempted to derive regular revenue from the sale of drinks and drugs. The Government in the year 1790 enacted excise laws for taxation purposes and Excise departments were established in all the provinces. Their policy was maximum revenue with the minimum consumption. The first enquiry into the prevalence of drug addiction of opium and cannabis was made a hundred years ago when the Government of India appointed two Commissions in 1893, and 1895.

In 1954-55 a Prohibition Enquiry Committee was appointed and the committee recommended complete prohibition in the country to be enforced in stages. The enforcement was to proceed on two lines: educative and preventive; and legal and administrative. A Prohibition Study Team was appointed in 1963 to go into the problem and report to the Government the present position regarding alcoholic drinks and alcoholics in the country. The team recommended awareness building, modern treatment programmes, public education on alcoholism, training of NGO's, and research and prohibition. India which not so long ago was known mainly as a country for the transit of illicit drugs from 'Golden Triangle' and 'Golden Crescent' areas is now turning into a consumer country. According to the Narcotic Control Bureau figures, the annual heroin seizures in the country are about one ton.

Alcohol and drug dependence is a serious disease that affects the health and well being of millions of Indians. Treatment refers to a broad range of services, including identification, intervention, assessment, diagnosis, counselling, medical services, psychiatric services, psychological services, social services, and follow-up, for persons with alcohol and drug dependence. The components of treatment include management of withdrawal, long-term management of alcohol and drug dependence, and prevention of relapse. A number of alternative treatments are available for alcohol and drug dependence ranging from pharmocologic therapy to counselling, marital therapy and family therapy. Frequently two or more treatment modalities are combined in one therapeutic approach. This unit presents a brief overview of currently used methods and approaches in the treatment of alcohol and drug dependence. Most of the treatment modalities are of western origin, particularly for the United States of America.

1.2 TREATMENT STAGES

Drawing on the various approaches which have attempted to treat the addict, we can divide them into three major stages**,** namely ***intervention, rehabilitation, and maintenance.*** The stages incorporate the commonly used activities, and phases that have been identified by various researchers' and practitioners all over the world. All treatment modalities will have the following objectives:

- Recognition of the problem
- Understanding of the disease of addiction
- Acceptance of other inputs
- Personal responsibility for recovery as opposed to blame
- Demonstration of new behaviours and attitudes
- Developing a new healthy daily pattern of living.

James Proschaska and his team from the University of Rhode island have come up with an excellent model to explain how people change, because addiction treatment is basically a process of change.

The first stage is *Pre contemplation*. This is the denial stage, which we described earlier, where other people except the addict realizes that something is wrong. Here the emphasis that though the addict is not accepting change, he is some how on the path to change.

The second stage is called *Contemplation* stage. At this stage the addict realizes that some thing is going wrong, but he is not sure what is to be done about it.

The third is *Preparation* stage. At this stage the alcoholic takes concrete steps towards change.

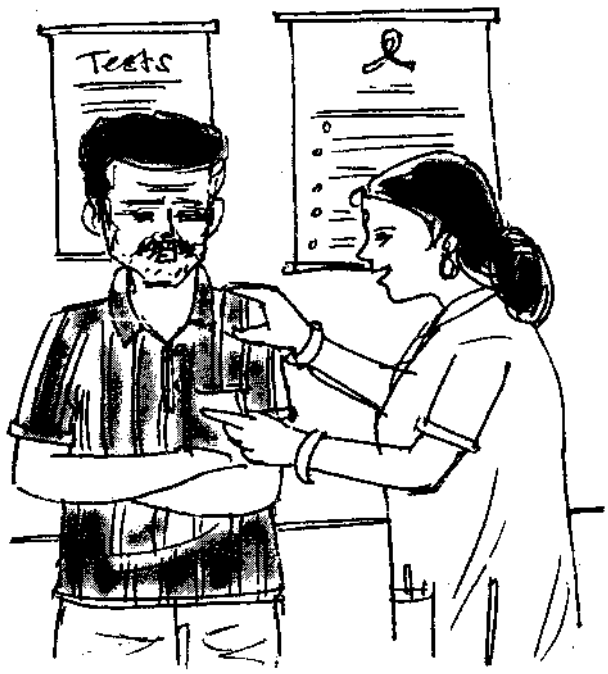
The fourth stage is called the *Action* phase. At this stage the person puts his heart into change and makes personal commitment.

The fifth stage is known as the *Maintenance* phase, which is the crucial one. In the treatment of addiction, change is not some thing that happens only once, but some thing that is ongoing.

The sixth and the final stage is the *Termination* phase, the compulsion to use lessens.

This description emphasises the fact that addiction is a process, that is ongoing. An addict has to continue to recover.

Stage I: Intervention



All the sick people in the world would long for recovery. The addict also longs for recovery, but he will not go for treatment, because he believes that other people caused his illness and they need treatment. To get a person off the drugs we need to motivate him for treatment. The first step in motivating the addict is called intervention.

The first step in intervention is the identification, by the person seeking treatment or another individual (whether a family member, supervisor, or law enforcement or

medical professional), of the existence of a problem with alcohol or drug dependence, followed by a referral for treatment. Intervention with chemically dependent individuals is an important step in the direction of treating one of the most widespread diseases in our culture.

Knowledgeable and caring persons around the abuser, who come together with a trained interventionist who will motivate the group and show them how to present their accumulated data to the alcoholic in a compassionate way, also know this as Confrontation. It is a process by which the harmful progressive and destructive effects of chemical dependency are interrupted and the chemically dependent person is helped to stop using mood-altering chemicals and to develop healthier ways of coping with his or her needs and problems. It implies that the person need not be an emotional or physical wreck (or "hit bottom"), before such help can be given.

The goal of the intervention is to break down those defenses so that reality can shine through long enough for the person to accept it. It is a way of presenting reality to a person out of touch with it in a receivable way. By 'presenting reality', we mean presenting specific facts about the person's behaviour and the things that have happened because of it. 'A receivable way': is one that the person cannot resist because it is objective, unequivocal, nonjudgmental and caring. An intervention is a confrontation, but it differs in some very important respects from the sort of confrontations with which most people are familiar and which have little *or* no positive effects.

The first step is to get a team ready for intervention. A team consisting of two or more persons who are close to the chemically dependent and have witnessed his or her behaviour while under the influence should conduct the intervention. The chemically dependent person's defence systems are far too highly developed to be breached by one person acting alone. If the person is married the wife or husband should be at the top of the list. The other persons to be included in the list are immediate supervisor, parents, children, close friends or neighbours, co-workers, a significant member of the religious community and an addiction counsellor if available.

The second step in the intervention is gathering the data. There are two types of data to be compiled in preparation for the intervention: facts about the victim's drinking or using behaviour, and information about treatment options.

The third step is the rehearsing of the intervention scene. Usually one or two 'rehearsals' prior to the actual intervention are held. Everyone who will be at the intervention, with the exception of the chemically dependent person should attend these. Each member of the intervention team should come prepared with his or her written list of facts about the chemically dependent person's behaviour.

The fourth step of intervention is to present the data to the addict in a compassionate way. For example; "you were abusive to your colleagues at the factory on 15th March and again on the 28th March. In both instances alcohol was detected in your breath." It is important for the group to remember that they have not gathered to debate the issue with the addict, but to confront the problem and persuade the person to treatment.

When the above three steps are completed you are ready for the intervention. In the intervention the victim is offered specific choices by the treatment centre, or that hospital. Usually the chemically dependent person refuses to consider either of the choices and vows to quit drinking on his own. Then the team would present the "what-if' question: "What if you start drinking again?" "What if you have just

one more drink?" The team would make an agreement with the chemically dependent that he or she would accept help. When the chemically dependent agrees to accept help, it is made available immediately. The first stage of treatment offered is called detoxification.

Detoxification

It is the management of acute alcohol or drug intoxication and withdrawal while in either independent living or in a sheltered living environment. This is the medical process of taking the affected person safely through the predictable sequence of symptoms that occur when blood alcohol/other chemical level drop during withdrawal.

Alcohol withdrawal symptom ranges from the trivial to the markedly unpleasant and life threatening reactions like the delirium tremens or withdraw fits. A patient suffering from the dependence syndrome may therefore require immediate specialised medical assistance in coming out of alcohol. This may be accomplished with a General Practioner's help as an out-patient basis if social support is available but severe dependence is sometimes an indication for hospital admission so that careful observation can be provided and intensive nursing and medical care are on hand. Detoxification is not designed to address the psychological, social, and behavioural problems associated with addiction and therefore does not typically produce lasting behavioural and attitudinal change necessary for recovery.

A variety of drugs may be used to provide treatment for withdrawal, and specially skilled nursing care is needed for the delirious and agitated patient. Modern methods of care are very successful in treating this acute phase of the problem and risks to life have been much reduced. The development detoxification centres over the last few years has shown that alcohol dependents can be safely and effectively helped to overcome withdrawal symptoms. Detoxification can usually be achieved in a non medical setting provided medical service is readily available when necessary.

Stage II: Rehabilitation

This stage of treatment consists of 3 components:

1) **Evaluation and assessment**

   The development of an individualized treatment strategy aims at eliminating or reducing alcohol or drug consumption by a thorough assessment of person's physical, psychological and social status and a determination of the environmental forces that contribute to the drinking behaviour. Evaluation and assessment is done by screening which is the use of easily and inexpensively administered procedures in an attempt to establish the presence/absence or degree of severity of a condition. It currently is undertaken for many physical and psychiatric disorders.

   Diagnosis is the conformation of the nature and circumstances of a condition. It usually is accompanied by recommendations for intervention and treatment. Screening is an important preliminary step in the diagnosis of alcohol use disorders. It is needed to ensure the early identification of individuals who have begun to develop or are at risk of developing alcohol use problems. Screening tests serve to direct these individuals towards further assessment, which may include a medical and psychiatric history, physical and psychiatric examinations. Based on the assessment, a diagnosis is confirmed or refuted according to prevailing criteria. Screening methods include questionnaires and interviews for assessing psycho-social indicators of alcohol problems and

laboratory tests and other biological measures for detecting biochemical markers of excessive drinking. Screening questionnaires are often self-administered. Screening instruments typically do not provide information that is useful in selecting treatment programs and specifying treatment goals, whereas the more complex questionnaire and interviews collect richer information and permit more detailed evaluation of patient with regard to treatment planning. Many traditional screening questionnaires ask questions in 'ever' terms to determine the presence or absence of symptoms. Other screening instruments require subjects to indicate present-state habits, behaviours, and feelings. Each type has advantages and limitations.

The CAGE questionnaire is a simple method and can be easily administered. It uses a four-item instrument to detect the symptoms or problem. They are:

i) "Have you ever felt you should cut down on your drinking?"

ii) "Have people annoyed you by criticizing your drinking?"

iii) "Have you ever felt bad or guilty about your drinking?"

iv) "Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?"

One "yes" response raises suspicions of an alcohol use problem, and more than one is a strong indication that a problem exists. CAGE takes only 30 seconds to administer. When included as part of a routine health screening it may detect alcohol use problems that might be missed otherwise.

2) **Primary care**

It is the application of therapeutic activities to help the individual reduce alcohol or drug consumption and attain a higher level of physical, psychological and social functioning while in either independent living or in a sheltered living environment.

3) **Extended care (stabilisation)**

It is the consolidation of gains achieved in primary care through continued participation in treatment and supportive activities while in either independent living or in a transitional supportive, sheltered living environment.

Stage III: Maintenance

This stage consists of 3 components: i) Aftercare, ii) Relapse prevention, iii) Domiciliary care.

i) **Aftercare**

It is the continued provision of some therapeutic input to maintain the gains in functioning achieved through intensive intervention and stabilisation while in either independent living or in a transitional or long-term supportive, sheltered living environment.

ii) **Relapse prevention**

It is the continued provision of therapeutic activities to avoid the return to prior patterns of drinking and to maintain the gains in functioning achieved through brief intervention or intensive intervention and stabilisation while in either independent living or in a transitional or long-term supportive, sheltered living environment.

Relapse prevention believes that patients with more severe type of drinking and drug abuse should be offered continuing contact with a helping agency, at least for the first year or two after commencing treatment. Drinking and drug abuse problems of any severity are never resolved overnight; a patient's greater awareness of problems often evolves slowly and the wish for help may similarly evolve. Relapse is inevitable for most of the addicts. Some sort of continued availability on the part of the helper, and an assurance to the patient that someone will continue to be interested, is therefore often indicated. A regular reminder that the venture is worth while and the repeated instillation of hope at times of despair and crisis are both invaluable ingredients of effective therapy.

Relapses will most often occur within the first few months of therapy. Neither the addict nor the family should regard these as catastrophic provided they are attended to promptly and continued contact with the treatment agency is maintained. They should, however, be taken seriously and viewed as an opportunity for enhanced self-understanding and appreciation of the precipitants involved. Many relapses occur in response to deeply felt emotions and anxieties or interpersonal stress, or form an inability to withstand environmental pressures to drink. Patients who have carefully rehearsed a repertoire of techniques, for coping with these pressures have a better chance of avoiding relapse. It also helps if the likely consequences of relapse can be vividly retained in the patient's mind as this seems to offset the understandable temptation to think only of the short-term benefits which might follow a return to former habits.

For example: Shekhar recognised that relapses commonly occurred on paydays. He planned ways of avoiding this critical series of events. He would arrange to visit a friend who knew of his drinking problems on the eve of payday. If the anxiety became worse he was encouraged to phone to a friend or counsellor and talk about how he was feeling. Along with these measures he also retained a vivid mental imagery of himself lying on the road unable to get up, his dress stained with vomit. These were of course short-term psychological devices that helped him to cope in the first few months of abstinence while he effected more lasting changes in his way of life.

In recent years, relapse prevention strategies have been widely publicized, and training has been offered to practitioners. The addition of relapse prevention procedures to a treatment program is intended to reduce the probability and rapidity of relapse, although the techniques can be used for primary rehabilitation as well as relapse. The self-efficacy approach, a behavioural treatment strategy derived from Bendura's social learning theory of self-efficacy, behavioural self-control training and cue therapy are described below as examples of these techniques.

The self-efficacy treatment strategy uses careful assessment of the situations in which the person drank heavily or abused drugs during the past year to determine which contexts present a high risk or return to excessive drinking or drug abuse. The approach also involves careful assessment of the person's confidence in his or her ability to handle conflicting or stressful situations without resorting to heavy drinking or drug abuse. The key assumption underlying this strategy is that drinking or drug abuse alone does not lead to a return to chronic excessive drinking or drug dependence. We need to take into consideration the meaning of the act of drinking or drug abuse for the person, the alternative behaviours that the person has available for coping

with the stressful drinking or drug dependence situation, and the strength of the individual's belief in his or her ability to handle the situations effectively without resorting to drinking/drug abuse. Treatment consists of developing a hierarchical series of performance-based homework assignments that the person can perform successfully, thereby experiencing a sense of mastery in what were formerly seen as problematic drinking and drug abuse situations. The therapist monitors the person's feelings of self-efficacy as each assignment is completed. A variety of techniques can be used including rehearsal of the activity during the therapy session and joint performance of the task with a responsible friend or the therapist. During the treatment process, the person may also use an alcohol- sensitizing drug as additional protection.

Behavioural self-control training is another relapse prevention strategy that uses a set of self-management procedures designed to help individuals stop or reduce alcohol or drug consumption. Treatment using this modality involves self-observation of dependency behaviour through self-monitoring and the setting of specific behavioural objectives based on an analysis of the functions served by drinking or drug abuse (roughly categorized as drug abuse to cope and for pleasure). The self-monitoring of drinking behaviour through the use of structured record keeping provides information both about the function of drug abuse and situation of high risk. Self-monitoring also provides feedback about progress. For persons who use drinking or drug for coping, treatment involves the establishment of alternative cognitive and behavioural responses. For persons who use drinking or drug for pleasure, treatment involves the establishment of self-control skills to avoid intoxication and the development of alternative recreational skills.

Cue therapy consists of a series of treatment sessions in which the person is presented with the sight and smell of alcohol but consumption is strictly forbidden after the person has imagined himself in a high-risk situation for drinking. (E.g., having a fight with their spouse or attending a party.) The person and the therapist then review the feelings aroused by the alcohol and may practice response that can lead to refusing a drink. Cue therapy is based on extinction theory: the cues lose their arousal value through repeated exposure without reinforcement.

3) **Domiciliary care**

It is the provision-protected and ongoing supportive, protected living environment for those too disabled by prior alcohol/drug use to return to independent community living. This situation is warranted for those who are physically unable to lead community life due to illness or other disability.

Goals of Treatment

- Give up the dependence on drugs to handle daily problems
- Improve relationship with others
- Improved ability to handle problems
- Improved physical health
- Handle effectively employment issues
- Deal with legal issues
- Improve over all quality of life

Check Your Progress I

Note: Space is given below for your answer.

1) Describe briefly in your own words the broad range of services in the treatment of alcohol and drug dependence.

.....

.....

.....

.....

.....

.....

.....

.....

1.3 TREATMENT SETTINGS

The term, 'treatment setting' is used in different ways in the literature on the treatment of alcohol and drug dependence problems. Sometimes it is used to describe the organisational location in which treatment is provided (e.g., health care facility, mental health centre, and private practitioner's office). Sometimes it is used to describe the underlying treatment philosophy (e.g., social setting detoxification, medical setting detoxification). At still other times it is used to describe a person's living arrangement while in treatment (e.g. inpatient, outpatient; hospital, prison, residential facility, group home, nursing home, day treatment centre, halfway house). The most common use of the term in research and programme planning for the treatment of alcohol and drug dependence is to describe the environment within which treatment takes places.

Treatment can be delivered in two basic types of settings: inpatient and outpatient– although some settings represent a combination of the two. The major distinction is whether care involves overnight care in a residential facility. Inpatient care involves the provision of medical, social, and other supporting services for patients who require 24-hour supervision. Outpatient care is the provision of non-residential evaluative and alcohol and drug dependence treatment services on both a schedule and non scheduled basis.

The choice of treatment setting is related to a variety of factors, including the ability to pay, the severity of alcohol and drug abuse and attendant problems, the ability to leave the home environment to be treated in inpatient settings, and the client's orientation toward help-seeking. The varied inpatient and outpatient settings thus often serve a distinctive client population. In India most of the treatment facilities are residential.

1.4. TREATMENT MODALITIES

The content of treatment is usually referred to as the technique, method, procedure, or modality. The specific activities that are used to relieve symptoms or to induce

behaviour change are referred to as modalities. Many treatment modalities have been used to address alcohol and drug dependence problems, alone or in combination with, psychotherapy, self-help groups, aversive counter conditioning, anti-anxiety medication, self-control training, stress management, massage therapy, physical exercise, vocational counselling, marital and family therapy, hypnosis, education about the effects of alcohol, milieu management, and social skills training, Six general categories: (l) pharmacological, (2) social, (3) psychological, (4) behavioural, (5) psychodynamics, and (6) spiritual are used here below to organise its description of the variety of treatment modalities.

Pharmacological Treatment Modalities

There have been a number of attempts to classify the different drugs used in the treatment of alcohol and drug dependence. The major distinctions have been in terms of (a) drugs used to counter or antagonize the acute effects of alcohol and drug intoxication, (b) drugs used in the management of withdrawal, and (c) drugs used in long-term treatment (rehabilitation and relapse prevention). Since the purpose of this unit is only to provide the minimum required and useful information on treatment, we shall not be discussing the aspect in treatment.

Social Treatment Modalities

Alcohol and drug dependence is also a social disease. Treatment components such as marital and family therapy, women's groups, alcoholic anonymous, employee and assistance programmes are used in the treatment of chemical dependency.

i) **Marital and Family Therapy**

Many therapists now regard the participation of the patient's spouse and sometimes other family members as an essential ingredient of recovery. The spouse of the problem drinker or drug abuser often needs an opportunity to discuss the stresses that the family has experienced and to obtain information about the nature of the alcohol and drug dependence. Some therapists have endeavored to move away from a patient centered approach to alcohol problems and have come to regard the abuse as one facet of a disturbed family system. In consequence they focus attention on this system itself. Whichever approach is adopted, it is clear that the family will have to undergo significant readjustments as the problem drinker and, drug abuser finds a new style of life. There is good evidence that a spouse, who is supportive but does not collide with the drinker's or drug abuser's evasion or minimize the seriousness of the drinking problems, makes a major contribution to a favourable treatment outcome.

ii) **Women's Groups**

As increasing number of women develop alcohol-related problems, it has become evident that programmes must accommodate to their specific needs. Women commonly feel more guilty and stigmatized about having a drinking or drug abuse problem and some way find it easier to speak freely if they can have part of their treatment within a service for women only. In such a setting they find it easier to talk openly about their difficulties and particularly to discuss some of the sexual abuses many women alcoholics have experienced. In facilitating access to treatment for women, additional services such as neighbourhood-based clinics and the provision of crèches are important considerations.

iii) **Alcoholic's Anonymous, AI-Anon, and AI-Ateen**

Alcoholics Anonymous celebrated its fiftieth anniversary in 1985 and claims worldwide to have helped more than a million members. It is unwise for anyone who is significantly alcohol dependent not to have at least looked very closely at AA. This is often best achieved through initial personal introduction to a member of AA with whom the problem drinker can identify. It is too much to expect the drinker just to go to a meeting. It usually requires fifteen to twenty meeting at more than one group before any sensible opinion can be made about its value for an individual. Many people have found in AA exactly the help and understanding they require. Others may take something from AA's philosophy, but not become regular attendees. AI-Anon, an organisation for relatives and friends of alcoholics, deserves similar recognition as an extremely valuable resource. It is well worth exploring by anyone closely involved with a problem drinker, as it teaches the relative or friend to find support even when the drinking partner is unwilling to recognize or deal with the problem. Al Ateen has evolved specially for the teenage children of alcoholics.

Alcoholics Anonymous provides a fellowship which encourages frankness about alcohol problems in a group surrounded by others who can readily identify with the drinker's suffering and shame and at the same time offer support in finding a new way of life. A firmly believes that abstinence is the only route to recovery for those who regard themselves as truly alcoholic. 'Drinkwatchers' is another self-help organisation, which is concerned to help those who are consuming alcohol in a hazardous way to return to less damaging drinking habits.

iv) **Employee Assistance Programme**

Alcohol and drug dependence frequently manifest as impaired work performance. This fact can be turned to therapeutic advantage by the creation of 'Employee Assistance Programmes' whereby a company establishes a policy for dealing with employees whose work performance is impaired by alcohol misuse or other factors. The policy needs to be developed in joint consultation between union and management and applied equally to all levels within the organisation. If alcohol or drug dependence appears to be affecting an employee's work performance then he or she can choose to accept referral to an appropriate source of help with guaranteed continued employment provided they cooperate with treatment. The employee may, of course, reject such a course of action and accept ordinary disciplinary procedures. But in companies where such policies exist and are genuinely operated the extra motivation provided by the opportunity to remain employed greatly enhanced treatment outcome.

v) **Narcotic Farms**

It was a method employed by the US government in the early part of the last century. The basic idea was to provide medical model of treatment in a farm setting. The clients stayed back in the farm engaging themselves as workers for a period of time as the social workers and the doctors did the follow up on them.

vi) **Therapeutic Communities**

Charles Dederich in the USA developed the method after the Second World War. "Modern therapeutic communities immerse patients in a comprehensive

18-24 month treatment regimen built around the philosophy that the addict's primary problem is not the drug he abuses, but himself". In this approach, the primary therapist is the community itself. Drug abuse is a symptom of deeper personal disturbances.

Psychological Treatment Modalities

There are a wide variety of psychological treatments, both behavioural and psychodynamic that have been used in the treatment of alcohol and drug abuse problems. Sometimes it is difficult to determine whether a specific approach is primarily behavioural or psychodynamic. Group therapy and marital and family therapy, for example, cannot truly be classified as either psychodynamic or behavioural because practitioners from each orientation use them. In fact, the current practice is to combine different modalities and orientations to fashion multi-model treatment approaches. There are, however, certain specific modalities that, for descriptive purposes are identified with one or the other model because of the rationale for their use and effect.

Behavioural Treatment Modalities

The first clinical use of techniques derived from learning theory to reduce alcohol consumption was by the Soviet physician Kantorovich more than fifty years ago. Kantorovich used electrical aversion, but the method was shown to be ineffective, and its use as a clinical procedure discontinued. The major continuing use of behavioural methods over the intervening years was 'chemical aversion', a technique initiated at the Shadel Sanatorium in Seattle, USA. The more widespread application of behavioural methods to a range of psychopathological disorders began in the early 1960's. These initial efforts reflected a comparatively simple view of the etiology of problem drinking as an attempt to reduce conditioned anxiety. The first, uni-dimensional learning theories about the causes of excessive drinking were primarily derived from animal laboratory studies and clinical observations that alcohol eased high levels of anxiety in persons under treatment for alcohol problems. However, behavioural research with humans challenged the view that conditioned anxiety was the sole cause of excessive drinking, and suggested that cognitive elements must also be considered.

i) **Chemical Aversion** remains the best-known behavioural treatment procedure that focuses on drinking behaviour. In chemical aversion as currently practiced, a noxious stimulus is paired with a drink of the person's favourite alcoholic beverage. Vomiting is induced to condition the individual to react adversely to the sight, smell or taste of alcohol. Five aversion treatments are generally administered on alternate days during a 10 to 15 day hospitalisation. Some persons develop adequate aversion in fewer than five treatments; others require additional treatments. Because aversion is not generalised to all alcoholic beverages, the individual receives a number of different beverages at some time during the treatment.

ii) **Covert Sensitization** is "a verbal aversion therapy that uses the person's imagination to repeatedly pair unpleasant, often nausea provoking events with the anticipated acts involved in drinking. The person visualises the drinking sequence – ordering of a drink, touching the glass to the lips, and drinking itself – all in his or her usual drinking environments.

At the moment the person brings the glass to his lips and he is instructed to imagine an aversive stimulus, usually vomiting. He is asked to imagine that relief occurs when he turns away from the drink. Treatment involves repeated

sessions with the persons practicing twice a day and using the procedure whenever he or she feels the urge to drink.

iii) **Stress Management Training** has also been found to help persons with alcohol problems in staying sober, particularly when anxiety is a significant concomitant problem. Bio-feedback is one such technique. It uses an electronic apparatus to monitor physiological responses and to display them to the individual through visual or auditory feedback. The individual is trained to produce the feedback by practicing the desired response (usually the relaxation of muscle groups or meditation). The person learns to recognize the subjective states that indicate heightened muscle tension as measured in electromyography (EMG) bio-feedback or alpha waves as measured by the electroencephalograph (EEG). Subjects practice producing the desired response, using the visual or auditory feedback as cues and reinforce the desired responses. Bio-feedback training has been found to contribute to reduction in drinking but only for individuals with high levels of anxiety. Other forms of stress management training that have been used in the treatment of alcohol problems have been progressive relaxation training, meditation, systematic desensitization, and exercise.

vi) **Social Skills Training** procedures has been developed by those who believe that excessive drinking is caused by the inability to perform to one's own satisfaction in interpersonal situation. Individuals are taught in either group or social settings how to respond in typical social encounters. Sessions focus on such specific skills as how to express and receive positive and negative feeling, how to initiate contact, and how to reply to criticism. The modeling of skills role-playing and videotapes of role-playing situations are all techniques that have been used in this type of behavioural approach.

v) **Contingency Management** is another behavioural technique. It attempts to formalize through contracts the naturally occurring contingencies both positive and negative, reinforcing and punishing that result from excessive drinking or drug abuse. This approach involves identifying the target behaviour to be changed, identifying an appropriate reward or punishment to be administered for continued performance of the behaviour to be changed and dispensing rewarding of punishing events or activities contingent on a predetermined level of performance of the target behaviour. The keys to developing effective contingency management are to: (a) identify through assessment, consequences that are meaningful to the persons; (b) develop mutual agreement about the contingency; and (c) carefully and consistently carry out the contingency with all parties to the agreement performing their designated roles.

vi) **Community Reinforcement Counselling** is a contingency management approach that is designed to provide focused behavioural training to person with chronic alcohol and drug dependence. The goal of the counselling is to improve long-standing vocational interpersonal and familial problems. The reinforces used in these cases were access to family, to job and to friends, which were contingent on sobriety. Community reinforcement counselling is a broad-spectrum treatment strategy that includes the use of disulfiram; a regular reporting system to provide counsellors with feedback from friends, family, and employers on the individual's drinking behaviour or other problems; a source of continuing social support through a neighbourhood peer advisor; and ongoing group counselling.

vii) **Harm Reduction** is a set of interventions that concentrates not on ending drug dependence but on controlling the harm that drug dependence does to

the society at large. First introduced in the Netherlands in the 1980's, harm reduction policies attempt to integrate drug abusers into the larger society and to distinguish between use and abuse.

Harm reduction began when it was first discovered that HIV was often transmitted through the sharing of needles for drug injections. A needle-exchange programme whereby heroin addicts trade in their contaminated needles for clean ones was introduced as part of the harm reduction programmes. Harm reduction advocates also want to reduce the criminal activity that results from drug abuse. One proposal is to legalize drugs and dispense them to addicts under medical supervision and at nominal cost. This system was tried in Great Britain during the 1970's and 1980's. The opponents of this approach claim that it simply encourages addiction, and the apparent increase in the number of British addicts during the 1980's seemed to support this argument. It was because of this increase that the British system was abandoned. However, defenders of legislation claim that it is the only way to prevent addicts from doing as much harm to society as they do to themselves.

viii) **Controlled-drinking**: Until recently the only feasible goal for the treatment of alcohol abuse was life-long avoidance of alcohol beverages – total abstinence. Some recent advances in behaviour therapy indicate that programmes can be successfully developed specifically to promote controlled drinking.

Always, the selection of this treatment goal must be made with caution. One would never make controlled drinking a goal if it were contradicted by some physical disorder such as pancreatitis or liver dysfunction. Another important consideration is the patient's expectations about his ability to control alcohol consumption. If the patient strongly believes that under no circumstances would he be able to limit alcohol consumption, such a goal is clearly unwise.

> In 1994 Audry Kishline wrote a book: *Moderate drinking. In March 2000 she drove the wrong way on a Washington state highway and smashed her pickup on to a car killing a man and his 12 year daughter. The police found a half empty vodka bottle in her car and her blood alcohol level was .26, three time the legal limit.*
>
> *"There is not an alcoholic around who doesn't wish he could drink moderately" says Dr. Ernst Noble director of UCLAs Alcohol Research Centre. There is very little supporting documentation that moderation works. "Alcoholics in recovery have tried moderation" says Adele Smithers-Forcani; "Kishline's tragedy shows such attempts don't work."* (The Time, October 2, 2000)

At the same time, one must also gauge the potential impact of abstinence versus controlled drinking on the patient's social and professional life. For example, if the patient would be unable to maintain his employment as an announced or admitted controlled drinker, treatment aiming at other than abstinence would clearly be inappropriate. By the same token, insisting on adherence to an abstinence treatment model after repeated failure to achieve abstinence would appear to be at least as inappropriate.

Psychodynamic Treatment Modalities

A simple yet helpful definition of psychotherapy is that it is "an interpersonal process designed to bring about modifications of feelings, attitudes, and behaviours which

have proven trouble to the person seeking help from a trained professional". Contemporary psychotherapy is characterized by a variety of theoretical orientations. Very often the psychotherapy offered to a person with alcohol or drug abuse problems reflects the orientation and training of the therapists; there have been no real comparisons of the effectiveness of the different theoretical varieties of psychotherapy in treating persons with alcohol or drug abuse problems. What has emerged, however, is a set of principles or techniques that are recommended for use with persons experiencing alcohol or drug dependence. As with the other modalities described current practice is to include psychotherapy as a component in a multimodality approach. Psychotherapy principles are often embodied in the overall design of these multi-component programmes.

Psychotherapy also varies in the format through which it is delivered; it can be offered in individual sessions, in-groups of unrelated persons and in-groups of family members. In addition types of psychotherapy vary in duration – the number of sessions and the period of time over which those sessions are spaced. Duration has ranged from short-term to long-term. There does not appear to be substantial evidence, supporting the greater effectiveness of longer periods of time in the few studies that have considered this variable. The various formats are discussed in the following:

i) **Individual Psychotherapy**

In recent years 'individual psychotherapy' has not been seen as a major contributor to the treatment of persons with alcohol and drug dependence. The lack of support for use of this approach comes from a history of failure in the use of psychoanalytically oriented methods, which viewed alcohol and drug dependence as symptom of underlying pathology and sought to resolve the underlying conflict through the use of interpretations and development of insight. There are those, however, who feel that individual psychotherapy or counselling continues to play an important role in the treatment of alcohol and drug dependence. Most psychotherapists and counsellors focus on contemporary life problems and the drinking and drug abuse behaviour rather than on historical and developmental issues. Supportive rather than uncovering therapy is the primary mode.

Specific variations of the approach have been developed based on clinical experience in which the therapist is made a more active role to be both supportive and confrontative, and to be aware of the characteristic defence structure and ego disturbances of persons with alcohol and drug dependence. Individual psychotherapy generally is recommended only as part of a more comprehensive rehabilitation effort that can include alcohol and drug education, referral to Alcoholics Anonymous, family intervention with referral to AI-Anon and AI-Ateen, the prescription of disulfiram, and specific efforts to remove life problems that contribute to continued drug abuse and problem drinking.

ii) **Group Psychotherapy**

Unlike individual psychotherapy, group psychotherapy is among the most commonly used psychotherapeutic techniques for the treatment of alcohol and drug dependence. Group therapy is used in most primary and extended rehabilitation programmes. Group therapy as a distinct singular treatment is rare. As with individual psychotherapy, group therapy is offered in concert with alcohol and drug education, referral to Alcoholics Anonymous, and additional supportive activities. Similarly to individual psychotherapy, groups

tend to vary according to the orientation and training of the therapists or the ideology of the overall program of which they are a component. Consequently, variety is a prominent feature of group therapy for alcohol problems, and there is no standardisation as to the length of participation in the group, frequency of group meetings, length of group session, number of therapists, and style of group interaction.

The advantages that are often cited for the use of group psychotherapy focus on the technique in which persons with alcohol problems share experiences surrounding alcohol use with others that have had similar experiences. In this approach, group members provide both support for the difficulties to be encountered in staying sober while confronting the behaviours that are assumed to be characteristics of such persons; denial, manipulativeness, and grandiosity.

As a primary rehabilitation modality is either an inpatient or outpatient setting. Group psychotherapy generally involves a daily 1 to 1/2 hour session led by a staff member. When group therapy is used an extended care of aftercare modality, the group may meet as frequently as three times a week and as infrequently as once a month. The optimal size for groups is generally considered to be 8 to 12 persons, although in practice groups vary from 4 to more than 20 persons. As with other kind of group psychotherapy, the use of male and female co-therapists is seen as optimal for facilitating the group process.

iii) **Group Dynamics**

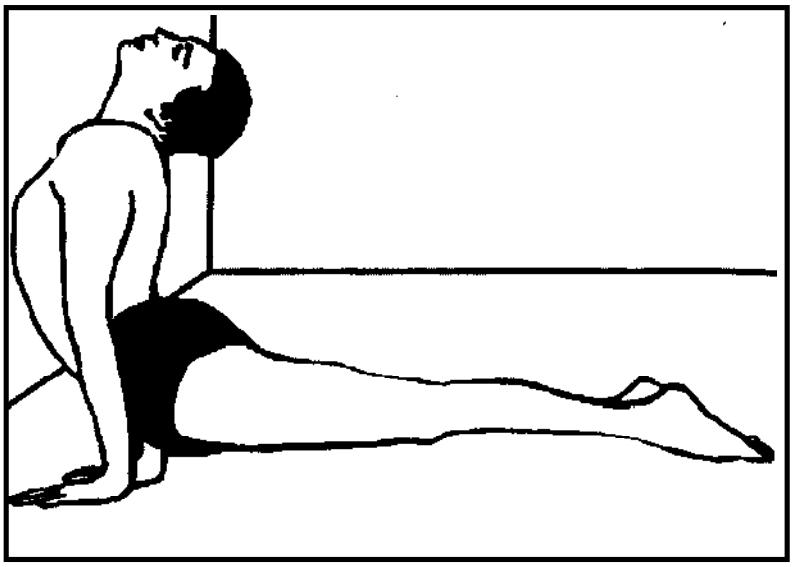
In addition to group psychotherapy, organised programs often use the principles of group dynamics in conducting other components for the overall treatment programs. These components may include educational groups that present factual material about the physiological action of alcohol. Educational groups vary in size and style. The most common format is large group presentation of material through lectures, films and videotapes, followed by a discussion period in which the goal is both to clarify and amplify the factual material and to correct misconceptions and emotional reactions.

iv) **Activity Groups**

Activity groups are another type of group psychotherapy organised around a specific recreational event and used widely in organised programs. The objectives of activity group participation are to relearn social skills by interacting with other people in sober contexts, to learn and practice alternative recreational activities that will eventually replace drinking, and to become familiar with community resources. Many organised programmes also use community meetings or ward management meetings as group therapy vehicles.

Spiritual Treatment Modalities

Alcohol and drug dependence can be treated through spiritual intervenation. The person addicted to alcohol and drugs gives primary importance to drinking and using drugs. A sense of the higher power is necessary to fight against the compulsion to drink and use the drugs. Prayer and meditation is universally accepted as one of the methods of recovery from alcohol and drug dependence. In meditation, the individual learns to concentrate on a thought, a sensation, a word, an object, or some mental state. Some techniques are very active and require that the person make a strenuous effort to focus on a specific thing.



Certain yoga techniques, for example, require that the practitioner maintain specific postures and deliberately controls his or her breathing or other bodily functions. Other meditation techniques, such as transcendental meditation, are passive approaches. Practitioners simply remain in a quiet atmosphere and make relaxed attempt to achieve a state of inner peace. The individual concentrates on a mantra and tries, but does not strain, to exclude all other thoughts. Most passive techniques are practised for 20-minute periods each day, typically once in the morning and again before dinner.

Relaxation often helps people who are tense and generally anxious. In one approach emphasis is placed on learning to contract muscular tension with muscular relaxation. In another, meditation procedures are employed. Relaxation therapies appear to be helpful for recovery and rehabilitation of alcohol and drug dependents.

Check Your Progress II

Note: Space is given below for your answer.

1) Briefly describe social treatment modalities.

.....

.....

.....

.....

2) Briefly describe behavioural treatment modalities.

.....

.....

.....

.....

3) Briefly describe spiritual treatment modalities.

.....

.....

.....

.....

1.5 SCHEME FOR PREVENTION OF ALCOHOLISM AND SUBSTANCE ABUSE

Substance Abuse and alcoholism is recognized as a psycho-sociomedical problem and the Ministry of 'Social Justice and Empowerment, Government of India, provides grants-in-aid to NGOs to provide whole range of services including awareness generation, identification, treatment and rehabilitation of addicts.

The various schemes financially assisted by the Ministry are the following:

1) Awareness and Preventive Education
2) Drug Awareness and Counselling Centres
3) Treatment-cum-Rehabilitation Centres
4) Workplace Prevention Programme
5) De-addiction Camps
6) NGO Forum for Drug Abuse Prevention
7) Innovative Interventions to Strengthen Community Based Rehabilitation
8) Technical Exchange and Man Power Development Programmes, and
9) Surveys, Studies, Evaluation and Research on the subjects covered under the scheme.

Awareness and Preventive Education

Under this scheme four areas are covered:

1) Production and dissemination of educative and publicity material:
    a) posters/flash cards/flannel charts/flip charts
    b) pamphlets/brochures/leaflets
    c) hoardings/panels/banners
    d) booklets/periodicals etc.
2) Community participation programmes:
    a) corner meetings/workshops/conferences
    b) essay/debates/slogans/dramas/one act play competitions,
    c) Street plays/folk media etc.
3) Training Camps for Voluntary Workers
4) Any other activity for awareness building programme against drugs/alcoholism

Drug Awareness and Counselling Centres

These Centres will provide following services to the community:

a) Awareness Building
b) Motivational Counselling
c) Screening of Abusers Addicts.
e) Follow-up Services

Treatment-cum-Rehabilitation Centres

Treatment-cum-Rehabilitation Centres will provide following service to the community:

i) Preventive education and awareness generation
ii) Identification of addicts
iii) Motivational counselling
iv) Detoxification
v) Vocational rehabilitation
vi) After care and reintegration into the social mainstream.

Workplace Prevention Programme

It is recognised that the primary responsibility in this regard rests with the management and trade unions. In order to encourage these activities, financial assistance upto 25 per cent of the expenditure for the setting up of a 15-bedded or 30-bedded treatment-cum-rehabilitation centre shall be provided to the industry/ enterprise. The balance of the expenditure according to the norms shall be borne by the industry/enterprise. Such centres will be located in an industrial establishment or a group of industrial establishments having strength of at least *500* workers or more in a particular area which will then be eligible for assistance.

De-addiction Camps

An organisation running a treatment-cum-rehabilitation centre may organize de-addiction camps in areas prone to drug abuse especially in rural areas with the objective of mobilising the community, promote awareness and collective initiative towards the prevention of alcoholism and substance abuse. They would utilise their staff and community resources for this purpose. However, certain additional inputs shall be necessary, for which an additional grant may be sanctioned under this scheme.

NGO Forum for Drug Abuse Prevention

The main function of NGO forum will be to bring about an effective coordination among voluntary organisation engaged in this field to establish linkages among the programmes being offered by them, and to ensure convergence of service in the area of their operation. All the organisations being supported under this scheme should be represented on the Forum, with one of their representatives being nominated as the chairperson on a rotating basis. The office of the forum may be located in the organisation being represented by the chairperson. All State Regional forums will be affiliated to the National federation.

Innovative Interventions to Strengthen Community Based Rehabilitation

Those treatment-cum-rehabilitation centres, which would have the capacity to do so, would be encouraged to develop innovative interventions to strengthen the community based approach towards rehabilitation of recovering addicts, like half-way homes, drop-in, centres etc. For this purpose an additional amount of 5 percent of the total approved expenditure for the centre would be admissible to the organisation.

Technical Exchange and Man Power Development Programmes

A de-addiction-cum-rehabilitation centre will be entitled to receive financial assistance under this scheme to meet expenditure on deputation's of its regular members of staff to other reputed centre identified by the Ministry of Social Justice and Empowerment.

Surveys, Studies, Evaluation and Research on the Subjects Covered under the Scheme

Financial assistance shall be admissible to eligible organisations based on the merit of the proposal to be decided by the Ministry of Social Justice and Empowerment.

Check Your Progress III

Note: Space is given below for your answer.

1) Briefly highlight the various schemes of the Ministry of Social Justice and Empowerment for prevention of alcoholism and substance abuse.

.....

.....

.....

.....

1.6 LET US SUM UP

In this unit we have made an attempt to understand the treatment options available for alcohol and drug dependence. In this process, we have examined the treatment stages, treatment setting and treatment modalities. The discussion on treatment modalities covered pharmacological treatment, social treatment, psychological treatment, behavioural treatment, psychodynamic treatment and spiritual treatment. Apart from this, we also briefly touched upon the efforts being made by the Ministry of Social Justice and Empowerment in providing grants-in-aid to NGOs for a whole range of services including awareness generation, identification, treatment and rehabilitation of addicts. haps best known.

1.7 SUGGESTED READINGS

Irwin G. Sarason & Barbara R. Sarason (1996), *8'h Edition: Abnormal Psychology*, Prentice-Hall of India Ltd., New Delhi.

Jellinek, E.M. (1960), *The Disease Concept of Alcoholism*, New Haven: Hilhouse Press.

Chopra R.N. & Chopra f.c. (1965), *Drug Addiction with Special Reference to India*, Council of Scientific and Industrial Research, New Delhi.

Vernon E. Johnson, *D.O.* (1986), *Intervention. Johnson Institute Book*s, Minneapolis.

UNIT 2 EMPOWERING THROUGH EDUCATION, COUNSELLING, REFERRAL SERVICES AND COMMUNITY RESPONSES

Contents

2.0 OBJECTIVES

The purpose of this unit is to outline what action can be taken by various groups in the community to facilitate the prevention and treatment of drug abuse. Preventive education, counselling education for the parents and community leaders, motivating the family and addict for treatment and identifying the treatment programmes are means of empowering the community.

At the end of this unit you will be able to:

- recognize the process of empowering;
- identify substance abuse prevention education programmes;
- familiarize yourselves with various means of identifying the addict; and
- learn the various possibilities of mobilizing community resources for drug abuse prevention.

2.1 INTRODUCTION

The previous unit has outlined different treatment programmes. Substance abuse is a treatable but not a curable disease. So prevention of substance abuse is of maximum importance. This unit describes how to empower the communities to prevent substance abuse as well as how to motivate the addict and the family for

treatment. In many ways substance abuse is induced by the society, so, the society is to be made aware of the role it plays in promoting addiction and empower it to prevent recurrence.

Society has many organs. To organise an effective prevention and treatment strategy, the involvement of all these organs are essential. We shall be discussing how this balance can be achieved. There are certain areas of prevention and treatment, which may not be understood by the individual, family and the community. Due to ignorance, the prevention and treatment programmes may be met with resistance. A section on dealing with resistance is included in this unit to serve this purpose.

2.2 THE EMPOWERING PROCESS

"No matter how ignorant the person is, there is one thing he knows better than anyone else, that is where the shoe pinches in his own feet, and because it is the individual that knows his own trouble, even if he is not literate or sophisticated in other aspects. Every individual must be consulted in such a way, actively, not passively, that he himself becomes a part of the process of authority, of the process of social control that his needs and wants have chance to be registered in a way where they count in determining the social policy".

These are the words of the famous social thinker and educationist John Dewey. If a change or modification in the attitude and functioning of the society is expected, the members of the society must feel it to be their need and make the necessary modifications in their social structures and interactions. The lasting social changes are those which people themselves create. People support what they build up.

Drug abuse prevention and treatment methods were considered to be the fields of doctors and psychiatrists. To some extent this is true. On the other hand, addiction is a socially induced disease. Addiction is a coping mechanism as far as the addict is concerned, though a negative and destructive one. The addict, by the use of the chemical, is trying to balance his own personality vis-a-vis the expectations and demands of the society. The more diseased the society, the greater its potential to produce addicts.

Empowering is a participatory process. Participatory action is for human development rather than physical targets. It is training personnel for continuing effort rather than for technical knowledge. Participatory development allows the people to shape their own development. The people themselves identify the problems, address the problems and provide feasible solutions. It is a democratic and cooperative method.

Empowerment and Participation

Empowerment is achieved through participatory action. Participatory action is made possible through conscientisation. It is the process by which an individual or a group is made aware of the true nature of the problem that affects the concerned individual or the group. Conscientization increases the understanding of the people about the problem and its possible solutions. This process gives them a sense of control. Integrity, culture, personal values and self-identity are the foundations of empowerment. The aim of empowerment is to tap collective power. For power to be most effective, it should be collective. The whole community should become empowered with self-reliant individuals, who are ready to challenge the present situation, and look for other solutions.

Check Your Progress I

Note: Space is given below for your answer.

1) What is your understanding of empowering communities?

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

2.3 PREVENTIVE EDUCATION

"A stitch in time saves nine". This is more than true about drug abuse, because drug abuse can only be prevented and not cured. Experience has taught us that prevention is a crucial element in the long-range goal of eliminating drug abuse. There is a section of the world population that is unrealistic to think that there can be a drug free world. But experience has taught us that it is not possible to make the world drug free. However, with concerted effort, we can minimise its misuse to some extent.

Drug abuse is a world phenomenon. Drug abuse prevention should be therefore a world-wide activity reaching every nation, society, school, family and business. It must bring awareness to everyone and motivate all to participate in the fight against illegal drugs and their use. Prevention includes education both to halt drug use and to convince those who use drugs to quit using it.

Educational programmes play a vital role in the overall fight against drug abuse. For those who have started to use drugs, proper education provides a pathway to successful intervention and treatment by increasing the users awareness of the dangers connected with drug abuse and by helping them make the choice to stop. Education is also critical in helping parents and educators understand the nature of the problem and consider the best way to respond to a particular situation.

Prevention programmes provide a basis for teaching young people to develop healthy behavioural patterns which do not include drug taking, and for instilling in them a sense of responsibility. Drug abuse education should be fully integrated into public and private, religious or secular, school curricula, with emphasis on the destructive effects of drugs use, the encouragement of excellence in teaching, health and overall personal well-being.

Preventive education programme should have the following main objectives:

- To value and maintain sound personal health,
- To respect laws and rules prohibiting drug use,
- To resist peer pressures to abuse drugs,
- To promote student activities that are drug free and offer healthy avenues for student interests, and
- To promote religious and cultural values which strengthen drug free life-styles.

2.4 PREVENTION STRATEGIES

All are aware of the need of preventing substance abuse. It is important to know how one should go about this important activity. There are various factors that induce drug addiction. Prevention should effectively tackle and produce positive results on those areas helping the individual to live a healthy life. Thus we can identify the following strategies:

- Strategies focused on the individual,
- Strategies to educate the family,
- Prevention through school based programmes,
- Prevention through mass media, and
- Prevention by strengthening law enforcement.

Strategies Focused on the Individual

This is the most often used method. It is aimed at imparting the correct attitudes, knowledge and moral standards to the individual. Correct knowledge, accurate information about the drugs and their effect on the individual will lessen the possibility of drug abuse. This strategy should have the following elements: It should provide factual information about alcohol and other drugs. It should provide the means to meet the emotional, social and psychological needs of the young people. It should also help them to understand that addiction can happen to anyone. The programme should have elements that teach coping skills and address the antisocial behaviour of the individual.

Strategies to Educate the Family

Family includes the parents, siblings, and close relations. We have explained earlier that addiction is a family disease. Family is an important agent in building up a drug free society.

The strategy should have the following elements to make it effective in combating drug abuse:

- Parents should be given accurate information about drugs like alcohol, cigarettes etc.
- Parents should be helped do develop skills in building up healthy family relations.

- Parents should be helped to implement drug prevention strategies at home by being role models, helping the child to have creative activities, and resist peer pressure.
- Clear family norms should be established for the use of alcohol or tobacco by the elders in the family.

Prevention Through School Based Programmes

The school is the second home of the child. Broadly the school-based programmes should be with the involvement of the parents. Some of the important points for a school-based progrmme are:

- Having clear policies regarding use of alcohol, tobacco and other drugs. It should be clear to the students that violation will invite certain sanctions.
- Develop a curriculum to impart drug prevention education. They should be clear and easy to understand. They should be appropriate for the target group's needs and interests.
- The school can establish a *Students Assistance Programme*. This is to identify and assist students who are already having problems and helping them out.
- Helping the teachers to develop skills and knowledge to handle the education for drug resistance as well as for helping out those students who 'have already become addicts.'
- Assisting the teachers to identify their attitudes and beliefs about alcohol and drug use.

Prevention Through Mass Media

Mass media includes printed materials like newspapers, radio, television, Internet, films and folk arts. These have decisive influence on young person. They can be positive and negative.

Media approach includes radio, television, billboards, booklets, posters, public events etc. To be effective the programme should:

- have person who are credible to impart the message. The message should be appealing and appropriate for the target group.
- involve the public both in the planning and execution.
- be culturally acceptable for the target group.

Prevention by Strengthening Law Enforcement

All the countries and governments will have laws related to drug abuse. Due to the indifference of the public, or because of the inefficiency of the law enforcing mechanism itself, drug abuse will continue to increase some of the possible actions in this regard are mentioned below:

- increase of sales tax on alcohol,
- enforcement of minimum drinking age,
- discouragement of setting up of liquor shops,
- prohibition of alcohol and tobacco advertising,
- elimination of sponsorship of sport and social events by the alcohol industry.

2.5 COMMUNITY RESPONSE TO ADDICTION

Drug abuse is a social problem as well. Communities respond to it in different ways. The response of the community to the prevention effort will depend on the attitude to the problem of drug abuse. Prevention strategies should take into consideration the attitude of the community to the existing problem in the community.

To make the anti drug policy and implement the programmes, it is essential to reach out to the community for support and assistance. Any prevention effort needs to get the community behind its effort by taking action to:

— increase community understanding of the problem through meetings, media coverage, and education programmes,

— build public support for the policy and develop agreement on the goals of prevention and enforcement,

— educate the community about the effects and extent of the drug problem,

— call on the local professionals such as doctors to share their experience, and

— mobilize the resources of community groups and local business to support the programme.

Community Involvement in Prevention and Treatment

Addiction looks like the problem of one individual initially. Gradually it spreads and becomes the problem of the whole community. Addiction leads to violence and insecurity in the community. It encourages petty thefts, crime and at times even dacoity. Since the community wants to enjoy peace and security it will get involved in dealing with the problem of addiction as a group. All segments of the

community must be motivated to promote drug free environment in the community. These include the doctors, primary health workers, teachers, police, religious heads and Panchayat leaders.

Involving the community members will have certain definite advantages:

— Both the common man and the professionals will come together to share their experiences.

— Community leaders will become more acquainted with the problem of addiction.

— Belongingness in the community will increase.

— Community members will be able to support the recovering addicts' actively in their recovery.

— It will rebuild the social contacts and social life of the recovering addict.

Although community involvement is essential and helpful in prevention and treatment of drug abuse, it has certain hurdles to be overcome:

- In some communities drinking and use of some kind of drugs may be a socially acceptable custom at the time of marriages and festivals. Thus drug use may not be considered as a problem.
- Production of alcoholic drinks and some drugs like ganja may be a livelihood for many in the village. Such people may refuse to cooperate or may even actively oppose the move.
- Some communities, due to their ignorance, may consider addicts to be criminals who do not deserve any help.
- If the organisers of prevention or treatment programme themselves are drug users, the movement will have no credibility.
- Organising community involvement calls for long-term planning and sustained commitment.

Check Your Progress II

Note: Space is given below for your answer.

1) Why are prevention strategies important?

.....

.....

.....

.....

.....

.....

.....

2.6 MOTIVATING THE ADDICT AND THE FAMILY FOR TREATMENT

Motivating means influencing a person to change his functional behaviour and in treatment it means changing his dysfunctional behaviour. Motivation plays an important part in treatment of addicts. Unlike other diseases, the addict and his family often will not seek treatment due to the denial syndrome. Refusal for treatment can also be due to the lack of sufficient knowledge about addiction. Motivating the addict would include:

— encouraging him to give up drugs,

— awakening the desire to make changes in ones life-style,

— creating the realization that it is essential to take an active part in the treatment programme, and

— thereby willingness to make adjustments in order to recover.

An addict usually does not come for treatment, unless forced by circumstances. The force can be from relations or due to factors like life-threatening illness, loss of job, a police case or even a threat of divorce or divorce itself. Even under such conditions, the addict comes to a counsellor only for getting temporary relief. The person will not admit that his problem is the drug. He would talk about his illness, the court case, or hide the fact that his wife has left him.

The focus of motivation is to make the person realize that his real problem is the drug, and other problems are the results of his drug use. The addict will have very low motivation for treatment.

He will also be having fear about withdrawal and anxiety about the nature of the treatment.

To motivate a client successfully, the following points will be useful:

— Accept the addict as a person, and not as an addict or a drunkard. This will strengthen his self-esteem and trust in the counsellor.

— Feel with the person, compassion and understanding. Instead of reasoning and argument; build up trust in the treatment process. Do not preach or admonish.

— Be non-judgmental. Do not label the person or his actions as good or bad.

— Build up a relationship and keep the relationship even when the client does not cooperate.

— Maintain confidentiality about the client's affairs. This helps to strengthen the trust between the client and the counsellor.

Even though the addict may be brought for treatment, the family members will not be ready to take active part in the treatment. As we have discussed earlier, the addict's family needs treatment as much as the addict himself. Families often want the addict to change and they refuse to accept their share in the family disease. Motivating the family members for treatment would require the counsellor to:

— help them to breakthrough the wall of delusion,

— build up their inner strength to accept the family disease, and

— identify and recognize the feelings of the family members.

The family of the addict lives in a make believe world of their own, which we have described in Block 2, Unit 3. The family members suffer from denial syndrome. They will also have built up many defense systems to cope with the problem of addiction in the family. The belief that everything is alright except the addict's behaviour in the family prevents them from actively getting involved in the treatment process.

Accepting the family disease calls for admitting vulnerability on the part of the family members. The family members will have to be encouraged to identify their share in helping the addict to give up his addictive habit.

Addiction of one member of the family will have hurt the feelings of all other members of the family. Mostly these feelings remain unexpressed. In case they are expressed, that is done in an aggressive and unhealthy manner. Admitting the exact nature of feelings and the expression of it by the family members prepares the ground for the addict to reveal his feelings to the family members.

Dealing with Resistance

Treatment and recovery is a process of change. It is natural to expect resistance to change. Change means facing the unknown. Healthy persons find it easy to face change. Addicts and co-addicts find change threatening. Due to addiction the self worth of the family is damaged. Treatment and recovery requires honesty in admitting ones feelings and sharing them with others. The rule of the addictive, thinking is 'do not feel', 'do not trust' and 'do not talk'. The recovery process requires that the individual breakthrough this destructive programming. Certain guidelines can be helpful in dealing with the resistance to change. These include:

- helping the family to develop realistic expectations about the addict and of their own effort establishing rapport with each family member, so as to support them in the recovery process.
- bringing up to the surface the hidden interactions of the family which enables the addict to continue his addiction by manipulating others.
- identifying and reducing over activity by certain members in the family by educating them about addiction.
- co-opt in to the team family, the members who have gone through similar crisis, who can act as role models.

Check Your Progress III

Note: Space is given below for your answer.

1) What are the important aspects of motivating the client, and the family of the addict for treatment?

.....

.....

.....

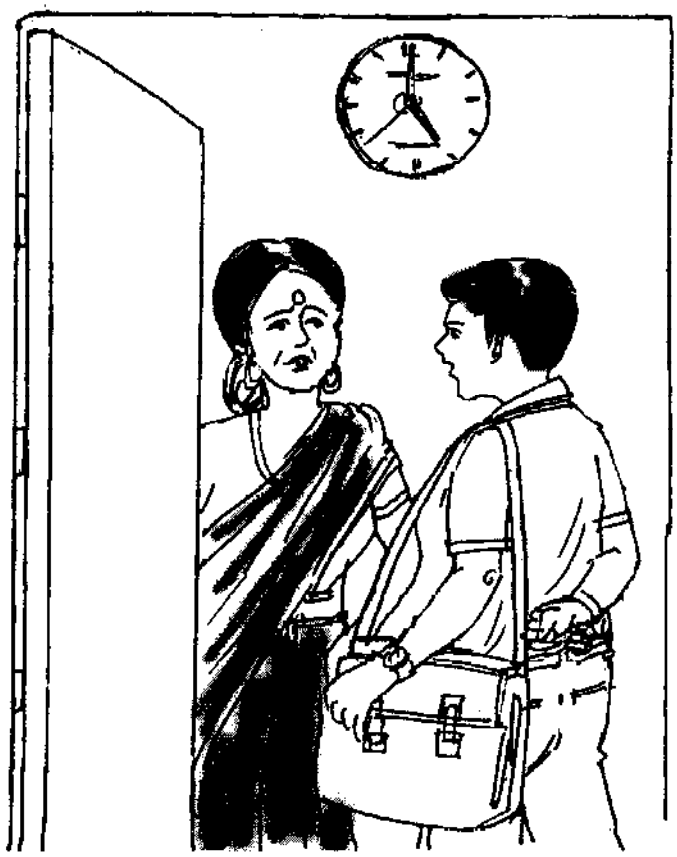
.....

.....

2.7 IDENTIFICATION OF AN ADDICT

It is easy to identify an 'addict'. It is not easy to identify addiction in its early stages. When it is alcoholism, it is even more difficult. The addict is capable of concealing his habit from the family members easily. There are certain external signs noticeable in his behaviour and appearances. Most of these are applicable to students or adolescents:

At Home



- The addict comes home late.
- He will have new friends.
- He will be unwilling to tell who the friends are.
- The old friends who are not using drugs or alcohol discard him.
- He often misses family meals.
- He is often found closed up in the room and remains aloof, not talking to any member of the family.
- He goes to bed late and gets up late.
- The addict spends a long time in the bathroom, if he is an injecting drug user.
- Syringes, and other paraphernalia related to drug abuse may be found in his room.
- Demand for money increases.

- Valuables from home like tape recorders, watches, fans, jewellery of other family members and dresses will start disappearing (theft),
- Refuses to go for religious services, social functions etc.

At School

- Poor attendance in the school.
- Sudden decline in the academic performance.
- Asks for leave during schools hours.
- Picks up quarrels in the school.
- Refuses to go to school or finds fault with school authorities or teachers.

Physical Changes: Addiction changes the personality of the addict. It is primarily noticed in the physical appearances of the addict. Neglect of personal appearance, cleanliness, stained fingertips, cigarette burns, skin rash, needle marks on the forearm, slurred speech, sweating, loss of appetite, fatigue, restlessness, drowsiness, drooping eyelids, blank facial expressions with dark circles under the eyes (clearly noticeable in case of alcoholics), redness of eyes, use of dark glasses to cover the redness of the eyes, unsteady gait, sudden weight loss, uses long sleeved shirt to cover the pock marks on the arm, withdrawal syndromes may be noticed like vomiting, diarrhoea, muscle crams, sleeplessness etc. are some of the changes easily noticeable if one is an addict.

2.8 SCHOOL BASED PREVENTION PROGRAMMES

School plays a very important part in the formation of an individual's personality. Drug abuse prevention should start early in life. This normally happens in the family set up. The second step of preventive education takes place in the schools.

An effective drug prevention programme in the school covers a broad set of education objectives. The programme consists of four objectives:

Objective 1: To value and maintain sound personal health

To understand how drugs affect health. An effective drug prevention education program instills respect for a healthy body and mind and imparts knowledge of how the body functions, how personal habits contribute to good health and how drugs affect the body.

At the primary level, children learn how to care for their bodies. Knowledge about habits, medicine and poisons lays the foundation for learning about drugs. Older children begin to learn about the drug problem and study those drugs to which they are most likely to be exposed. Children are present-oriented and are likely to feel invulnerable to long-term effects of drugs. For this reason, they should be taught about the short-term effects of drug use, such as impact on appearance, alertness, and coordination.

Objective 2: To respect laws and rules prohibiting drug use

The second objective teaches children to respect rules and laws as the embodiment of social values and as tools for protecting individuals and society. It provides

specific instructions about laws concerning drugs. While students in the early grades learn to identify rules and to understand their importance, the older students learn about the school drug code and laws regulating drugs. This can include topics like what rules are, and what will happen if there are no rules in society, legal and social consequences of drug use, penalties for driving under the influence of alcohol or drugs, relationship between drugs and other crimes, etc.

Objective 3: To recognize and resist the pressure to use drugs

Social inf1uences play a key role in encouraging children to try drugs. Pressures to use drugs come from internal sources, such as a child's desire to feel included in a group or to demonstrate independence, and external inf1uences, such as the opinions and example of friends, older children, and adults and media messages.

Students must learn to identify these pressures. They must then learn how to counteract messages to use drugs and practice saying 'NO'. The education program emphasises influences on behaviour, responsible decision making, and techniques for resisting pressures to use drugs.

Sample topics for these objectives are: influence of popular culture, peers, pressure on the students, ways to make responsible decisions, ways to resist peer pressure, and other situations in which students may be pressured into using drugs.

Objective 4: To promote activities that reinforces the positive, drug-free elements of student life

School activities may aim to provide students opportunities to have fun without drugs and to contribute to the school community — build momentum for peer pressure not to use drugs. These school activities also nurture positive examples by giving older students opportunities for leadership related to drug prevention.

Some of the activities suggested to help attain the above objectives are: Provide leadership opportunities to students, provide leadership training to be peer leaders, encourage literary activities promoting drug free life, like painting, writing plays etc, encourage role models who are not connected with drug use, form study groups in the school about drug abuse, drug trafficking, crime etc, provide sports facility in the school and encourage the Scout Movement, and the NCC.

Referral Services

Referral services means guiding an individual to an expert or specialist for advice, (especially directing of the patient to a psychiatrist medical specialist). Most people are able to identify the problem of addiction in their own lives or in the family. Some will have enough skills and knowledge to motivate the addict for treatment. When one's ability to handle the problem effectively is limited, it is better to refer the person to a more competent person or organisation.

Referrals can be of three kinds: (i) Self-referral; (ii) Referral by parents, friends or other voluntary organisations; and (iii) Compulsory referral.

Self Referral: The main source of self referral may include information received from a recovering addict, a friend, or seek voluntary agencies. This induces the addict to come for treatment or other help voluntarily. The person may have a high degree of motivation.

Referral by Parents, Friends or Other Voluntary Organizations: This referral is also of voluntary nature. Someone refers the client for treatment to anyone of

the several known options. For example, the person making the referral may tell the counsellor about a suspected case of alcohol or drug abuse. He may provide the name of the user and chooses to remain anonymous, thus leaving the counsellor to get in touch with the person. The person making the referral many be the parent, spouse or any other concerned individual. The person may permit his or her name to be used.

Compulsory Referral: (Also known as mandatory referral). In this case the referring party actually introduces the addict to the counsellor, or to the treatment facility. This can happen in an educational institution where a student is identified as being under the influence of alcohol, or other drugs and the principal or any other authorized person orders the student to go for treatment or to meet the counsellor, if there is one in the school/college. A person arrested for intoxication may be compulsorily referred for treatment by a judge.

Networking with Other Agencies: Creating a drug free world is not left to one individual, one agency, or one nation. It has to be a collaborative effort. An individual effort can have only limited outcome. It has limitation in terms of resources and experiences.

A net is different from the bars of a window. Though the bars are stronger they are connected only at two points. The net is connected to other threads, at a number of points though they are not so strong as the bars. What gives strength to the net is its close connectedness. Networking is possible with different groups.

The strategies to be adopted can include:

1) Involve local law enforcement agencies in all aspects of prevention. Police and courts would have well established and mutually supportive relationship with other agencies working for prevention of drug abuse.

2) Involve student organisations in prevention of drug abuse. They will have enthusiasm and manpower. What is required to put that into action will be the expertise from other agencies.

3) Engage cultural organisations in prevention activities. Culture is a powerful binding and educational tool.

4) Get the support of religious organisations to work for a drug free society. All religions condemn abuse of alcohol and other drugs. Besides, religion is a powerful agent for self-discipline. Most recovery programmes are based on the intervention strategies.

Check Your Progress III

Note: Space is given below for your answer.

1) What are some of the ways of identifying an addict?

.....

.....

.....

.....

.....

2.9 LET US SUM UP

Drug addiction cannot be cured, so it is best to prevent it. Education is the chief tool for preventing drug abuse. Education for avoiding drugs should start from home at an early age and continue through school and college.

The community is an effective agent in the prevention and treatment of drug abuse. Communities need to be empowered to do it. Involving communities in prevention and treatment of abuse has multiple benefits. There will be more learning, more participation and more responsibility on the part of the community members in making the community drug-free.

Treatment is possible only if the addict and his family find it useful and necessary. Motivating the family and the individual is of prime importance. An addict can be identified by observing him at home, in the school and by his physical appearance.

Drug education and treatment is a collaborative effort. Therefore various social and governmental agencies should work together to obtain optimum results.

2.11 SUGGESTED READINGS

U.S. Department of *Health and Human Services*, New York, (1984). Preventing Alcohol Problems through Students Assistance Program.

WHO/ TISS Workshop (1996), *Involvement of Youth in Health Promotion*, Tata Institute of Social Work, Mumbai.

B.K. Mahajan & M.C. Gupta (1991), T*extbook of Preventive and Social Medicine*, J. P Brothers, New Delhi.

UNIT 3 ROLE OF NGOs, NATIONAL AND INTERNATIONAL BODIES ON PREVENTION AND CONTROL OF SUBSTANCE ABUSE

Contents

3.0 OBJECTIVES

We have been discussing substance abuse from different angles in the previous units. This unit aims at introducing to you the need for intervention in the fight against addiction. The unit also aims at showing to you the different stages in which the intervention is possible – prevention control, treatment and rehabilitation. It will also show in the unit that substance abuse is a global, national, social, family and individual problem and hence intervention by international organisation, national bodies and NGOs is essential to put up an effective fight against this evil. An opportunity is given to you to have a look at some organisations though not in detail. It is hoped that after you go through this unit you will be sensitized to the need for intervention at different stages and the role different organisations have to play.

3.1 INTRODUCTION

Substance abuse is a growing global problem. No country or society can claim immunity. The world has realized that unless we put up a well-planned fight and device effective intervention strategies, this evil is going to engulf the world. Many of us have realized this and at times at least some of us have thought that something concrete should be done and that we should not allow things to go on like this. But many of us lack the initiatives, convictions, drive, know how or the will a global problem with varied ramifications, an individual cannot put up any fight alone. International Organisations have a very important part to play as international drug trafficking has its links with terrorist and subversive activities that have marred

the peace of the world. Further addiction leads to untold health problems especially in a world threatened by HIV and Hepatitis B/C.

The national bodies also have their role to play not only in demand reduction but also in supply reduction. Within the country there should be efficient machinery to check illicit brewing/distilling and drug trafficking. The Government cannot do it all, especially in a vast country like India. It is the bounden duty of the NGOs to come to the help of the Government in its attempt to eradicate the drug menace.

3.2 SUBSTANCE ABUSE: THE NEED FOR INTERVENTION

People are using different kinds of substances. Even school going children and street children have access to different varieties of drugs. A lot of money is wasted on alcohol and other drugs worldwide. The individual is affected in many ways. The addict's physical and mental health are affected. His finances get drained. His family life is jeopardized. Addiction causes industrial and road accidents as it impair judgment. It affects one's efficiency and hence results in the loss of manpower. In short, it kills one's personality. An addict becomes undependable, and is never trustworthy. Indulging in stealing, pawning, gambling and telling lies are just a part of an addict's life. He is the wrong role model to the younger generation.

Addiction causes untold damage to the society also. Addiction is at the centre of several crimes and it disturbs social tranquility, as it is the cause for many antisocial activities. Addiction is responsible for various social disturbances – from street fights to gang wars. How can one expect tranquility in a society infested with hard core drug addicts, illicit distillers and liquor barons? International and cross border drug trafficking, drug syndicates and drug mafia have brought about untold miseries to nations. Smuggling, terrorism and subversive activities all have links with drug trafficking.

In developing countries, addiction acts as a stumbling block to development and productivity. Derek Rutherford, Director of Eurocare in his book *A Lot of Bottle* quotes a letter from a rural Zambian man to the Zambian mail? : "We have no water, no light, no schools, no washing facilities but the municipality says that they will build a beer hall for us. If we drink beer, the municipality can earn money so that one-day we will have a water pipe. How much beer do I have to drink before my children can have water to drink?" In countries, which already face poverty, addiction plays further havoc. Derek Rutherford says: "In developing countries nearly 800 million people do not get enough food and about 500 million are chronically malnourished. A poor man's drinking money comes from cuts in the family budget. Consequently drinking is a frequent cause of malnutrition which compounds the problem of alcohol abuse". This is very true of a country like India. Do you remember a part of the speech of Professor Shekhar Saxena of AIIMS that we quoted in an earlier unit? "Not every poor person drinks, but if he drinks, the money comes from cuts made in food and education for children. Drinking by men is a frequent cause of malnourishment and school drop-out among children and a vicious circle of poverty, violence and disease in the family."

The Indian drug scene is not as simple as this as far as its impact on the family is concerned. Professor Saxena's address in the WHO conference quoted above is only a pointer to the greater calamities Indian society experiences. Addiction serves

as a major cause of domestic violence and wife battering. Just imagine the trauma of the wife and children of an alcoholic! In an even otherwise male dominated Indian society, addiction leads to further oppression of women. Derek Rutherford, after a visit to India in the early 1990's writes: "Use of alcohol is now common among 1 in 4 adult males in various parts of the country and is spreading among educated urban women of middle and upper economic social groups. People start to drink at an earlier age – even among the school population. Over the last ten years excessive drinking and alcohol dependence has increased. Not less than one third of hospital beds are now occupied by persons with an alcohol related illness including road and industrial accidents" (The Globe, No.2, 1991).

We have had a glimpse of the multifarious problems chemical dependence creates for society, especially in a developing country like India. With no resources to handle this as a medical - psychiatric problem and with limited know-how to handle it as a burning social issue, very often instead of facing the problem, we quite comfortably turn the other way round or sweep it under the carpet, and pretend as though in the midst of many social problems to be tackled, substance abuse is negligible. Hence it enjoys only a low priority in our social service agenda. But as responsible citizens of India and as a person with social responsibility by now you would have realized the need for intervention – intervention at various stages.

What do we mean by intervention? Intervention refers to our own effort to curb the abuse of a substance either at the demand point or at the supply point. Our intervention strategy may aim at either preventing people from experimenting with substances, or effectively controlling the supply or sale or treating or rehabilitating an addict who otherwise it may become a social liability. In the sections below we will be discussing in detail the intervention strategies and also the role-played by different agencies including the Government. The question one may raise is, why should there be an intervention? This question is very natural because many believe that this is an avoidable bad habit and one becomes an addict out of his choice. We have to seriously think of intervention strategies because anyone may become a chemical dependant any time. Many become substance abusers by chance – out of ignorance and due to circumstances. Moreover, addiction being a social problem, an individual cannot be isolated and blamed. Having realized that addiction causes damage to an individual, family, society, nations and the whole world. Is it not our duty to plan strategies of intervention with a view to curb this social menace? As you read this unit you will realize that unless there is a concerted effort to fight addiction, substance abuse is sure to grow into a grave problem.

3.3 THE INTERVENTION STAGES

We were, in the earlier section, discussing the need for intervention to curb substance abuse. There are many people who have not yet experimented with drugs; quite a few who have experimented and some who have become confirmed addicts. We cannot apply the same intervention strategy to all these people. But at the same time all these people are in need of intervention. The intervention should be with a view to prevent, control, treat and rehabilitate. In the sections below we will be discussing in detail the intervention strategies to be adopted for different stages and the role played by the organisations to achieve this. Any intervention activity done with the aim of preventing people from experimenting with substances

is done with the youth and the general public as the target group. As you are aware, anyone is likely to be a substance abuser. When we get involved in demand and supply reduction activities we do it with the aim of controlling. When a person becomes a confirmed addict he needs the support of medical and psychiatric treatment and also counselling and guidance. But when one submits for treatment and gets help, he is in need of rehabilitation. He needs the support to make his life meaningful and requires the courage to face the challenges of life. So, as you go through this unit you will realize that only if we are geared to intervene at all these stages we can put up a concerted and effective fight against substance abuse.

Prevention

Do you remember the proverb we discussed in an earlier unit? 'Prevention is better than cure". Once a person experiments with substances and starts taking them habitually or becomes an addict, it is very difficult to redeem the person. So the ideal stage of intervention is before the person has his first experimentation with substances. In order to have an ideal preventive strategy it is good to tell people about the evils of substance abuse even when they are very young. Do you know the saying "Catch them young"? We should reach young people even when they are in their early teens with messages against addiction. It must be noted that many young children, be it school going kids or street children, get introduced to drugs. In a country like India youngsters in schools and colleges very easily get exposed to drugs. (Refer to the section 5.4 'The Rationale Behind Demand Reduction' in Block 2.) While talking about demand reduction we said that the first step in our fight against substance abuse is keeping the youth away from substances. Do you remember what was said in 5.5 of the same unit? We affirmed that our youth should be taught the way to say 'No' to drugs.

Conducting awareness programmes is a prerequisite for any successful prevention work: For school or college students, seminars, symposia and such exercises will be very effective. Including lessons on addiction in the syllabi will also have its effect. But many Indian children don't go to school or college. They are child labourers working in hotels, shops, and factories or as construction labourers, assistants to mechanics, or assisting in cottage or handicrafts industries. Many of them are street children, rag pickers and even beggars. How can we reach these young boys, most of whom are illiterate, through seminars? Maybe we can take the message through street drama or folk arts. It is here that our mass media can play a major role. Many of these boys will be going to films or watching television programmes on public television sets. We can have a detailed discussion on the prevention strategy when we discuss the role of the Government and the NGOs.

Control

There is a Chinese proverb, which says "First man takes a drink, then the drink takes a drink, then drink takes the man". What the proverb suggests is that once a man starts drinking, no force can have control on him. Hence the best policy is never to start drinking. Can a person who has started drinking keep his habit under control? In the West many who have realized that it is not possible to put an end to man's drinking habit have started talking of 'sensible drinking'. What they mean is, man may drink but it should be within limits. But one wonders whether any such control is possible and whether 'sensible' can be used as an adjective of

drinking at all! Many ask the question as to how sensible 'sensible drinking' is. It is an exercise in futility if we try to spend our time teaching people how to have control over their drinking. What is a 'sensible' quantity to one may be totally insensible for another. There will be a lot of difficulty in having 'control' in this sense.

'Control' may be used in another sense also. Do you remember discussing the concept of keeping drugs away from our youth? As mentioned in an earlier unit, availability is the reason for many people taking substances. Having control over the availability or imposing restrictions on the supply of drugs may be of some relevance. When we use the term 'control' in this sense, the responsibility of the Government becomes great especially in a country like India. In our country, it is not possible to start a distillery or brewery without a license from the government. The Government itself serves as the wholesaler in many states. The Government auctions retail outlets and their functioning is subject to the conditions prescribed by the Government. The Government, if it wants, can introduce a licensing system. Of course this applies only to the legal drugs: But how can 'control' be applied when it comes to illegal drugs? Stringent laws that curb the illegal trafficking and illicit distilling alone can bring about an effective control on drugs. This can be discussed in detail when we talk about the responsibility of the Government.

Treatment

Alcoholism or addiction is variously understood as a bad habit, sin, or as a disease. A close look at an addict will reveal to us the fact that it is nothing but a disease. It is a progressive disease. It is a terminal disease. Why is it considered a disease? Just as a patient having a health problem, say heart disease or cancer is in need of medical treatment, an addict is also in need of treatment. Like any other disease addiction too can be medically managed. It is said that 'Once an addict, always an addict' because some of the physical and mental damages caused by addiction are irreversible. Hence many consider addiction as a treatable disease and not as a curable disease. Anyhow it is evident that addiction is a problem that needs medical intervention. It is a disease that needs the service of physicians and psychiatrists. We are not discussing the treatment process in this unit as it comes under the scope of Block 3, Unit 1. All that we have to bear in mind is that just as we take a patient to a physician for treatment, if we take an addict (patient) to a doctor who is specially trained to handle an addict, that will be a good intervention strategy. But unless an addict (patient) wants to come out of his substance abuse and unless he is convinced of the effect of the treatment, the efforts others take may be totally in vain. Moreover, an addict should not be treated in isolation. A proper follow up, especially monitored by a trained counsellor, is necessary for making the treatment effective. This therapy should not be aimed at the addict patient alone but also at the members of the family. Family therapy is essential to make the family members cope with and accept the treated addict. In spite of all the attempts by the physician, psychiatrist, counsellor and the family members, the addict patient may drift back to his old habits or there may be occurrences of what we call relapse. So, very often treatment does not serve in an effective intervention. Many who spend their time in treating addicts get disappointed and dejected on account of this. But still, without equipping ourselves for intervention medically, any fight against addiction may not be effective.

Rehabilitation

Rehabilitation is also an important aspect of intervention. There are many substance abusers who want to quit their habit. But many questions come up in their mind preventing them from opting for treatment or quitting the habit on their own. One of the most pertinent questions is "Will society accept me once I stop substance abuse? This is a genuine question as the addict will have feelings of guilt and shame which make him believe that the society around would never be able to forget all that he had done while being an addict. Another question he might ask is "What will I do once I quit my habit?" This is all the more true of a developing country like India where, due to the poverty in the society, an addict who has come out of his habits will find it very difficult to get a suitable living.

Rehabilitation is the art of teaching the ex-substance abuser to cope with the demands of real life situation which includes the demands of the society. Rehabilitation is the art of making the society accept an ex-addict. Rehabilitation is the way shown to an ex-addict to start the life afresh. Rehabilitation is the courage given to a former substance abuser in leading a life successfully without ever turning to the substance. Hence it is obligatory that we evolve the right rehabilitation strategy that suits the individual and the society. You would have by now understood that intervention at post-treatment stage is also very vital.

Check Your Progress I

Note: Space is given below for your answer.

1) What do you mean by rehabilitating an addict?

.....

.....

.....

.....

.....

.....

3.4 ROLE OF INTERNATIONAL BODIES

As we said earlier, substance abuse is a global problem. It has invaded underdeveloped and developed countries alike. There is no difference except in intensity. International drug trafficking, with its links with smuggling, illegal arms trade and terrorism has created many problems for international relationships. The world knows about the assassinations, and subversive activities with which drug mafias and syndicates have links. Hence any war against addiction is likely to be lost unless waged globally. Many international organisations have given serious thought to this growing menace and vowed to fight it. These organisations have thought about interventions at various stages and have devised their own strategies that are as varied as advocacy, treatment, organising ex-addicts, rehabilitation, regional cooperation for fighting drug trafficking, planning demand and supply reduction etc.

In this section, it is not possible to make an exhaustive study of all the international organisations involved in the fight against substance abuse. However, attempts are made to inform you of the concerns of WHO and some other international bodies. As you read this section you should realize that international organisations like WHO and regional organisations of nations like SAARC have started giving serious thought to this problem and work for supply and demand reduction. The world and world organisations also should earnestly work against substance abuse as it plays havoc in society. While many reel under poverty, a lot of money is wasted on substances. Mr. Derek Rutherford of Eurocare observes: "The global wealth of the alcohol industry could adequately feed, water, educate house and provide medical care for everyone in the world ten times over".

The United Nations Organisation is aware of the growing drug menace globally and the harm it does to global peace. Since drug trafficking is in the midst of many international disturbances and as addiction stands on the way of development, substance abuse finds an important place in UN agenda. A few observations made in the World Drug Report of United Nation's International Drug Control Programme (UNDCP) will reveal to us the seriousness with which UN has looked into substance abuse. The World Drug Report presents a factual picture of global trends in illicit drug production, trafficking and use. The report contains useful definitions of terminology and a brief, but lucid explanation of the chemical make up of various drugs and their effects, both physical and psychological on the user. The report points out that the production of coca leaf has more than doubled and that of opium poppy more than tripled since 1985 according to statistics produced by the UNDCP. The report also says that the huge increase in the volume of raw material production has inevitably led to a dramatic increase in the worldwide land area under cultivation which had reached 280,000 hectares by 1996. This report is to be taken very seriously by India.

Do you remember our telling you in an earlier unit that India is transit point in international drug trafficking as it lies between the Golden Crescent and Golden Triangle countries. This report says that the vast majority (90 per cent) of illicit opiates is produced in the Golden Triangle and Golden Crescent countries. The UN has also revealed to the world that there is an average of 16 per cent annual increase in the abuse of synthetic drugs since 1980. Besides making some startling revelations on the links between health and substance abuse, the report discusses

in detail the links between crime and substance abuse. In its bid to curb illicit drug trafficking the UN in this report has said that it is harmful to the economy of any country including the producer-country: "The relatively small portion of profits from illegal drugs which are brought into the country can itself be distortional to the national economy". Since its establishment in 1946, the United Nations has exercised drug control functions and responsibilities. The report sees the role of the UN as one of developing and reconciling different trends in world drug policy: "The complexity and number of the legal agreements on drugs created the need for unification and simplification. Efforts in this direction, culminating in three different drug control conventions, represent a continuing quest to reconcile the differing medical, scientific, political, social and economic interests of an increasing number of participating countries as the number of substances continues to proliferate".

Mr. Javier Perez de Cueller, the then Secretary General of UN in his address to the UN International Conference on Drug Abuse and Illicit Trafficking held in Vienna in June 1987 observed: "In fact just as drug addicts lose their health and freedom, so many states are marred by corruption, and may even find their independence threatened. International security itself is at stake, for drug trafficking is frequently tied to illegal arms deals, subversion and terrorism. In short we are confronted by an evil which is not only destroying the human being but also undermining the foundations of society through corruption and violence". The UN has since then worked for bringing together nations to fight drug trafficking and curb crimes associated with drugs. In 1988 the UN held convention against Illicit Trafficking in Narcotic Drugs and Psychotropic enacted substances. The convention aims at facilitating law enforcement cooperation, extraditing criminals involved in drug-related crimes and seizing and forfeiting assets deriving from drug profits.

The WHO has done tremendous and commendable work in the field of substance abuse. It has played a vital role in the international arena by creating public opinion against alcohol and drugs. It was in the year 1951 that WHO took up the alcohol question for the first time. It appointed an Expert Group with the task of certain investigative and informative activity assigned to it. In 1975 the Board of WHO and its General Assembly took up the alcohol question again. The Director General of the organisation was instructed to highlight this field with the aid of statistics, so as to aim at the reduction of the consumption of alcohol. In 1977 the member states of WHO approved and adopted the target "Health for All by the Year 2000". In 1979 WHO decided on an action programme where among other things the following issues were taken up:

- A decrease in the consumption of alcohol especial1y among the youth and pregnant women
- Action to be taken against production and selling of alcohol
- Offer of medical care and rehabilitation to addicts
- Compilation of the statistics of consumption and alcohol related problems
- Improve cooperation among countries to tackle the issue of addiction.

In 1980 the World Health Organisation's European Region worked out concrete goals and strategies where they recommended a significant reduction of consumption

upto the year 1995 and a 25 per cent decrease upto the year 2000. In 1983 the WHO implored the countries to formulate a national alcohol policy with precautionary efforts. Today the WHO is putting up a relentless fight against substance abuse. The WHO is making attempts to handle the issue from different angles especially as it is concerned about the link substance abuse has with HIV and Hepatitis. It has brought out some publications too. The WHO is involved in this fight through Programme on Substance Abuse under their Division of Mental Health and Prevention of Substance Abuse. The world can hope that WHO will continue to play a very vital role and guide the world in its fight against substance abuse.

Any discussion on International organisations working against addiction will be incomplete without mentioning Alcoholics Anonymous, popularly known as AA. AA is a nonsectarian ally formed to help problem drinkers. It all started as a small fellowship in Akron, Ohio in 1935 under the initiative of Bill W. and Dr. Bob, two persons with long histories of irresponsible drinking. Today the movement has about 5 lakh members spread in about 100 countries, "Alcoholic Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership… AA is not affiliated with any sect, denomination, politics, organisation or institution, does not wish to engage in any controversy, neither endorses nor opposes any causes. The members primary purpose is to stay sober and help other alcoholics to achieve sobriety." AA continues to be a very effective fellowship with the programme of twelve suggested steps for recovery from alcoholism.

Drugs are playing havoc in the public and private lives of Europeans. So the European countries give serious thought to alcohol and drug problem and to the ways of curbing trafficking in drugs. In December 1995, forty six European Governments gathered in Paris and signed the European Charter on Alcohol. Realizing the growing menace of alcohol, initiatives were taken to establish an alliance of voluntary and non-governmental organisations within the European Union and Eurocare was formed.

Mention also must be made of the recent initiatives of SAARC. The member countries in the South Asian regions have vowed to fight the menace of trafficking in drugs.

The awakening of different international organisations to the evils of substance abuse and trafficking in substances can be seen as ray of hope. Substance abuses, being a global problem, one should not discriminate between the developed and underdeveloped countries. Besides creating problems for individuals and societies, it does endanger world peace because of its links with anti-social activities including terrorism. Drug trafficking has become an international activity. Jonas Hartelius in his booklet *The World A Drug Scene* has said "A drug syndicate can operate over two or three continents creating problems for police and customs in many countries. Drugs may be produced in one country, refined in another, smuggled in a third, sold in a fourth and the profits laundered in the fifth. This has created enormous problems for law enforcement agencies. Concerted efforts to combat this international crime are made by the International Criminal Police Organisation (ICPO, Interpol) and the Customs Co/operation Council (CCC)".

3.5 ROLE OF NATIONAL BODIES

In this section we will be discussing various national bodies that are involved in prevention, control, treatment and rehabilitation of the problem of abuse and addiction. By now you would have realized that fighting addiction is no easy job. Substance abuse and drug trafficking are not that easy to be eradicated. Many national bodies are involved in intervention and curbing demand and supply. After you read this section you will realize that a concerted and sincere effort is necessary if any meaningful work is to be done. To understand the role of national bodies it is necessary to have a look at the drug problem in India from different angles, the types of drugs available – gateway, legal and illegal, how legal drugs especially alcohol are manufactured and marketed, and how illegal drug trafficking and international drug trade are checked.

In India the use of nut based gateway drugs, popularly known as 'ghutkas' and tobacco based drugs known as 'thampaks' are becoming very common, especially among the young. There is no restriction whatsoever on the sale of these 'ghutkas' and 'thampaks' which are available in small attractive sachets. In the same way cigarettes are accessible to anyone. All that the Government wants is a mandatory warning 'Cigarette smoking is injurious to health' printed on every cigarette packet. It is obvious that there is no national body that wields any meaningful control over the sale of these gateway drugs. As a consequence, they are sold anywhere, even near schools and colleges, and still worse even in college and university canteens.

Though our Constitution says that "the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and drugs which are injurious to health". Alcohol is a legal drug in most of the States. In our federal set up, the Central Government does not have much say in lifting prohibition. It is an irony that in India it is the state government, which very often serves as the distributor of alcohol. The Government in many cases has its own distillery, godowns, wholesale depots and even retail outlets. Don't you think that it is a paradox that in a country which has Gandhi who fought against addiction as the Father of the Nation, the Government is involved in liquor trade inspite of what is mentioned in the Constitution? Though there are some regulations controlling the retail outlets like sale timing. places where there shouldn't be any liquor shops, advertisements etc. these regulations are respected more in their breach than observance. Very often the State government is a mute, helpless spectator when the distribution system does not respect the law.

It must be admitted that the Indian Government and the state governments are putting up a relentless fight against illegal drugs. We have a Customs Department, which is very vigilant in airports and seaports and tries its best to prevent international drug trafficking. Being a transit point for international drug trafficking, the Customs Department conscientiously works towards preventing smuggling in and smuggling out hardcore drugs. Our Excise Department, which is responsible for licensing liquor industry, is also vigilant in preventing illicit brewing or distilling. Very often we read of confiscation of spurious liquor. Many state governments have special action forces to tackle drug related issues. State governments shall take very severe action against those who cultivate cannabis and poppy and the Police Department and Forest Department are involved in it. India has a very long international border and a very extensive seacoast. Hence international drug trafficking is not done through airports and seaports alone. Much of the international drug trafficking is done through our coasts, and Indo-Pak and Indo-Bangladesh

borders. Many of our Government organs are involved in checking the trafficking. The services rendered by our Military, Border Security force, Navy and Coast Guard are commendable.

As far as treatment is concerned most of our Government hospitals do not have any facility for treating an addict or undertaking any follow up. Before the law of the nation an addict is treated on par with any other criminal thereby depriving him of the possibility of kicking of the habit. NIMHANS, Bangalore is doing excellent work in the field of treating, counselling and rehabilitating addicts. The India Government's Ministry of Health and Ministry of Youth Welfare are also doing some work but without any remarkable thrust or tangible result. It is a fact that several medical colleges and hospitals have de-addiction centres where several patients are receiving treatment.

3.6 ROLE OF NGOs

After reading the previous section, probably you would have formed the opinion that our Government is not doing what it should in its fight against substance abuse. It is not so. We have to understand that in a vast country, like India with over 100 crore population and with poverty as the biggest problem, the Government cannot put up a fight against substance abuse alone. It is at this juncture that the role of Non-Governmental organisations becomes vital. The main role of any NGO is to lend a helping hand to the Government in its fight against any social evil and in its endeavour to work for social upliftment. Certain important functions of NGOs in the fight against addiction are given below.

In the past the NOGs in India have done yeoman service in the implementation of family planning and in the eradication of illiteracy. In the same way the NGOs should realize the enormity of the problem of chemical dependence and should come forward to help the Government to fight addiction. Women's Organisations too have a vital role to play as it is the woman in the male-dominated Indian society who becomes an easy victim of substance abuse in the society. Addiction becomes an additional cause for her exploitation and suffering. The NGOs can conduct awareness programmes even in remote villages. Many of the NOGs spread the message through street drama and folk arts. Mention must be made of Kerala Sastra Sahitya Parishad in this context. The NGOs can also spot the problem abusers, counsel them and direct them for treatment and help in rehabilitation. The private agencies and non-profitable or charitable organisations can run hospitals exclusively for treating addicts and this will be a good step in the fight against substance abuse. The services rendered by TTR foundation in Chennai is worth mentioning. It is also heartening to note that some hospitals have separate department to handle issues of substance abuse related cases. The services of St. John's Hospital, Bangalore in this regard are laudable. Do you know that Women's Organisations were responsible for creating awareness about drinking in Andhra Pradesh? When a woman is oppressed on account of man's addiction, women's organisations should come to the rescue of the woman and also to the society at large. In the Western countries many NGOs have their advocacy programmes, counselling and, treatment centres, half-way homes, day care centres and rehabilitation centres. Instead of blaming substance abuse on the West, we have many lessons to learn from the NGOs in the West in our fight against substance abuse. Service Organisations like Rotary Club and Lions Club have their programmes on addiction. The Government, NGOs and Service Organisations

together should put an efficient, effective and successful fight against substance abuse.

Don't you think it will be good to know about some of the NGOs, which have done some good work in the field of substance abuse. It is not possible to give an exhaustive list but it is only in the fitness of things that we mention representative list:

TRADA (Kottayam) Kerala.

CAIM Foundation (Bangalore) Karnataka

TT Ranganathan Clinical Research Foundation, (Chennai) Tamil Nadu

Shanti Seva Sadan, (Bangalore) Karnataka

Helping Hands, (Bangalore) Karnataka

Turning Point (Chennai) Tamil Nadu

Shakti (Pune) Maharashtra

Sahara House, New Delhi

Kripa Foundations (Bombay) Maharashtra

ADIC (Thiruvananthapuram) Kerala

Check Your Progress II

Note: Space is given below for your answer.

1) What are some of the issues taken up by World Organisation with regard to prevention and control of substance abuse in 1979?

.....

.....

.....

.....

.....

.....

3.7 LET US SUM UP

We discussed in this unit the need for intervention in substance abuse. Substance abuse is a global problem, it is a national problem, it is a social problem, it is a family problem and it is a problem of individuals. Hence it is essential that there should be intervention with a view to achieve demand and supply reduction. We also discussed the several stages in which effective intervention can be done. We can work for prevention, control, treatment, and rehabilitation. It being a global problem that affects international peace and tranquility and of humanity at large, we realize that international bodies have a very important task in curbing drug

menace. We talked about the WHO and AA, the world scenario and the role of the international bodies, and our own country. This made us think of the alcohol industry in India and the role the Government plays as far as the supply of liquor is concerned. We also discussed the role played by several Government bodies — the Customs Department, Ministry of Health, Ministry of Welfare, Military, Navy, Border Security Force, Coast Guard etc. This made us realize that the NGOs in India have an inevitable role to play in the fight against substance abuse. We looked at some of the programmes that can be undertaken and also at some of the NGOs.

3.8 SUGGESTED READINGS

Anil Agarwal (1995), *Narcotic Drugs, National Book Trust*, New Delhi.

Thomas, Gracious (1997), *Prevention of AIDS: In Search of Answers*, Shipra Publications, New Delhi.

Larry Siegel (ed: 1987), *AIDS and Substance Abuse*, Harrington Park, New York.

UNDCP (1999), *Drug Demand Reduction Report*, UNDCP Regional Office, New Delhi.

UNIT 4 DEVELOPING SKILLS AND COMPETENCIES FOR INTERVENTION STRATEGIES

Contents

4.0 OBJECTIVES

Addiction is treatable. Addiction is a compulsive obsessive disorder. The addict will not seek treatment unless motivated, or even forced. This unit is to familiarize you with the process of motivating the addict for treatment. One of the ways to motivate the addict is through intervention counselling.

When you complete this unit you will be able to:

- discuss a good knowledge about intervention counselling;
- distinguish between other forms of counselling and intervention counselling; and
- practice the motivation skills in counselling. Present basic knowledge of crisis intervention.

4.1 INTRODUCTION

We all know that usually sick people want to get treatment. Though an addict wants to get rid of his habit, he will not accept treatment. This is because he is afraid of the pain of the withdrawal syndrome, as well as due to the fact that addiction solves his problems. Only few people accept treatment without force from other people.

From experience we have learned that people can be motivated to take treatment before addiction progresses to the last stage. This process is called ‘intervention’. Intervention is a specialized approach. It calls for knowledge and skills. This lesson will provide you with sufficient information and give you suggestions as to how to acquire the necessary skills. Skills ofcourse are to be practised.

A brief unit like this cannot discuss all the types of counselling skills. Moreover, you have already been introduced to the art of counselling in the previous blocks. This unit will focus on the use and effectiveness of using these skills to motivate the addict to accept treatment before the addiction deteriorates further. For more details on counselling, its techniques etc. you may read the course on Communication and Counselling (block 2 and block 3).

4.2 WHAT IS INTERVENTION?

Intervention is a process by which the harmful, progressive and destructive effects of drug dependency are interrupted and the person receives some kind constructive help, to terminate her/his use of drugs. Intervention implies that a person need not hit rock bottom before such help can be implemented. Intervention is a method by which the reality of his illness can be presented in an acceptable way to the person who suffers. It means getting together and discussing in a loving and caring way the concerns of one's family about the person's harmful use of drugs and alcohol.

If not treated, addiction leads to death. Addiction is allowed to progress to the final stage of death due to several reasons:

i) Ignorance

ii) Refusal of the client to accept treatment

iii) Lack of skill

Many are not aware that addiction is a disease like any other disease and it can be treated. There is also the notion that if treated an addict should be permanently freed of addiction. Addiction is a treatable disease, but not a curable disease. As many of the treated addicts relapse, others refuse treatment, or are discouraged from getting treated. This leads addiction to grow and reach the final stage of disability or death. It is possible to stop the progress of addiction, if ignorance about the nature of addiction is removed.

In a very few cases an addict may seek help when he hits the rock bottom. It is an expression which means that the addict has no where to go but to take treatment. It is similar to a drowning person who hits the bottom of the well and comes to the surface before he goes down again. Such cases are rare. Most of the addicts die of addiction before they accept treatment willingly. The addict refuses treatment for various reasons. As we have noted in the previous lessons, for the addict, addiction is not a problem but the solution to his problem. He will continue to blame his addiction on someone or something. To the addict the reality of addiction is frightening. When the addict accepts the consequences of addiction, he will accept treatment.

Motivating is a skilled job. Addicts are often forced, and not motivated. When the use of force is needed to motivate, it has to be used skillfully. The family members and others who are concerned about the addicts should acquire certain basic skills before they can take care of the addict.

Check Your Progress I

Note: Space is given below for your answer.

1) What do you understand by intervention?

.....

.....

.....

.....

.....

.....

4.3 ROLE OF COUNSELLING

Counselling has many purposes. It is a tool for effecting changes in humans. The goal of treatment of addiction is to effect changes in the life-style of the addict. Therefore, the main role of counselling in substance abuse is to give the addict insight into his problem of addiction. Sigmund Freud, the father of the Psychoanalytic School of Psychology said 'insight is cure'. An addict has an unrealistic worldview. Changing the perception of the addict about his own life and its problems will enable him to see it from a more realistic angle.

This new insight is given to the addict through information, communication, restructuring of life-styles, recapturing his own identity and enabling integration. Addiction has devastating effect on the self-image, interpersonal relationships and moral and religious principles and practices. Terrible fear, helplessness and fatalism overcome the addict. This continues to inflict severe psychic pain on him.

All his effort will be to escape this psychic pain. Addiction from its very beginning is a choice and decision. The primary motivations are to feel normal and get immediate relief of pain and feel euphoric. Unfortunately, this addiction progresses through increased reinforcement leading to isolation and alienation. So to rekindle life in the addict, confrontation is needed rather than other forms of therapy. Confrontation is a method of evaluating human behaviour in the context of interpersonal interactions.

Principles in Addiction Counselling

Irrespective of training, all have some abilities to counsel. Addiction is a very complex phenomenon. Therefore to counsel an addict certain basic principles should be followed strictly:

1) Understanding the chemically dependent person. The chemically dependent person is different from others because s/he suffers from a compulsive obsessive disorder. A clear understanding of chemical dependency, its symptoms, and implications are essential for helping a dependent person.

2) Chemical dependency is a family disease. Effective treatment of chemical dependency is possible only by involving all the members of the family of the addict. The chemical dependency of the addict has usually negatively influenced the family members and their living patterns.

3) Remember that the main problem of the addict is the chemical. The addict will project the real problem as smoking rather than abuse of the chemical. The person should be directly confronted with the problem of his dependence on the chemical. The counsellor should feel comfortable and confident to talk to the person about his drug use.

4) Having empathy and compassion for the drug dependant person. Terms like drunk or even addict should be avoided, if the person is not familiar with them. A drug dependant person does not go by logic in his actions. He is guided by emotion, which in turn is motivated by the need to avoid pain. So logic and arguments do not appeal to the dependent person.

5) The values and the perception of the dependent person is different from the others. The counsellor should be able to understand and accept this as part of the disease of addiction. These may be strange or unreal as far as the counsellor is concerned. Yet that is how the dependent person views life. To change the view of the dependent person it is essential that the counsellor understands how the client feels.

6) Understand and accept that relapse is a part the recovery process. Addiction is not a curable disease. The counsellor needs to support unconditionally the addict in his recovery, which means that he should be supported also at his relapse.

7) Establish short-term goals for recovery.

What the Counsellor Should Do?

1) Gather all possible informations related to the extent and consequences of chemical dependency. Collect all relevant informations related to the social

circumstances such as occupation, family, finances of the addict, etc. Explain to the client and to the family members or relatives the role of the chemical in the life of the client and how it affects the life of the client. The assessment of the counsellor should be shared with the other members of the addict's family.

2) Discuss with the addict the meaning of chemical dependency as a disease. Help him to understand and handle denial, and make realistic plans, motivating him to maintain sobriety.

3) Help the addict to resolve interpersonal and intra-personal problems, in accordance with the assessment initially made.

4) Help the addict to make sobriety plans. They include the short-term as well as long-term sobriety plans. Short-term plans are meant for handling the immediate environment that influences his maintenance of sobriety and to formulate steps for relapse prevention. Long-term goals will be to help the client make efforts to attain a change in his life-style, personality, characteristics and values and plan aftercare measures and long-term follow up.

Check Your Progress II

Note: Space is given below for your answer.

1) Explain any three important points of intervention counselling.

.....

.....

.....

.....

.....

4.4 MOTIVATIONAL SKILLS

The purpose of counselling is to enable the client to change and cope more effectively with life. Motivation is one of the key elements in counselling. In fact, it is the first phase of any therapeutic treatment. Motivation can be defined as the desire to change one's own dysfunctional behaviour. In the context of counselling the addict, it will include the following:

- Giving up drugs
- Desire to make changes in one's life-style
- Realization that it is essential to take an active part in the treatment programme, and
- Willingness to make adjustments in order to recover.

How to know if the addict is motivated?

If the addict is motivated:

— He will accept that there is a problem with the chemicals

— He will ask for help to handle the problem

— He would come for treatment willingly

— He will cooperate with the treatment programme by following the regulations of the treatment centre; and

— He will have a desire to get better for his own sake.

The addict does not usually come in for treatment for addiction. His main concern could be:

— Health

— Financial problems

— Problems at workplace

— Police/legal issues, and

— Divorce threat etc.

The counsellor can effectively use these issues as a starting point. At this stage he may not be able to face the problem of addiction squarely. The counsellor's concern would be to highlight the issue the client sees and use it as a tool to focus on the problem of addiction.

Strengthening the motivable area is another tool at the disposal of the counsellor.

Every individual will have some persons who have great influence in his/her life. This may be due to affection towards them, or due to some other relationship. The counsellor should identify such persons and use their influence to motivate the client. Building up positive relationship with the client by acceptance, non-judgmental and empathetic attitude of utmost importance in motivating the client for treatment and recovery. The person of the client is important in counselling. Some of the tested methods to enhance the motivation of the client follow.

Verbalization and Feedback

The counsellor can repeat to the client his own experience of the damages caused by addiction. When the client hears what had happened to him from another person, it will have a deeper influence in his life.

Group Therapy

The experience of other recovering addicts who have kept off from chemicals can be effectively used to reinforce motivation. It will give him the assurance that it is possible to stay sober, and assure him he is not alone in his struggle. This is best done in a group session where these persons are given the opportunity to share these experiences.

Crisis Counselling

Crisis involves a threat and an opportunity. Crisis is also a turning point. Crisis intervention is a *short-term counselling aimed at reducing the impact of the crisis situation that the individual faces and helping the individual to take the necessary steps in making the best use of the crisis.*

In this kind of counselling the counsellor has a supportive role. The main goal of this counselling is to help the client to identify the unhealthy coping mechanisms and replace them with more healthy ones.

Giving proper insight, helping the person to make use of all his physical, psychological and spiritual potentials are important aspects of crisis counselling. The individual in a crisis condition is often out of touch with reality. His thinking is unrealistic and irrational. The concern of the crisis intervention counsel is to help the client to overcome his irrational thinking and accept reality and its consequences.

Crisis is a turning point. A person in crisis is like a stranger at a junction, unable to make a decision as to which way he should turn. The counsellor can effectively support him to see where he wants to go and how he can go there.

Substance Abuse as a Crisis

In the initial stages of substance abuse, the dependent and the family members deny the problem. After some time the crisis begins to develop. Usually a close family member will be the one to admit the nature of the crisis. It is often this person who will seek assistance on behalf of the addict.

The counsellor should be aware that before the present crisis situation developed, the addict would have faced other crisis situations in his life. The addict managed to postpone the full impact of the previous crisis due to his own psychological makeup and took to abuse of chemical as a coping mechanism.

A crisis can develop from either inside the person or from outside. A crisis is a normal aspect of human life. Crisis builds up stress. Emotionally healthy persons have the ability to handle crisis situations reasonably well. Persons with addictive traits in them often lack these coping mechanisms and skills.

Crisis builds up stress in the person. Stress is good and is needed for the individual to grow to his full potential. Stress is a process that enables the body to resist the stress or, in the best possible way, by enhancing the functioning of the organ system to be able to respond to it. The stress that helps the person to grow is *Eustress* and the stress that damages the personal growth or an over load of stress is called *Distress. This is a case where the stress increases and performance decreases.*

In human beings there are certain healthy coping mechanisms known as defence mechanisms to cope with stress situation. If healthy coping mechanisms are not learnt, the person may try to avoid the problem by some other means. Addiction is one such unhealthy coping mechanisms. When stress reaches a point where even this means is not effective, he exhibits other mentally disturbed states. To change this style of functioning, a person has to be helped by someone one from outside. To diffuse a crisis situation four factors are needed:

i) The exact perception of reality by the person in crisis;

ii) Adequate network of people;

iii) Adequate time to perceive the situation; and

iv) Learning sufficient healthy coping mechanisms.

4.5 THE A.B.C METHOD OF CRISIS COUNSELLING

All crisis counselling has the same goal. It is to help the persons in crisis to regain their previous level of functioning. When the client attains this level of functioning the person is further helped to grow to higher level of functioning. Before beginning the helping process, the counsellor has to find out whether there is a real crisis situation. This can be done in the following way. The counsellor should ask:

i) Is there some thing that troubles the client recently that affect his feeling or behaviour?

ii) Is this feeling or behaviour becoming progressively worse? How can the time of the onset be linked to some external event?

If the answers are positive, there is a crisis. The ABC model of crisis counselling is designed by Waren L. Jones.

A, B and C stand for:

A : Achieve contact with the person,

B : Boil down the problems to the essentials, and

C : Cope actively with the problem.

Achieving contact: The counsellor establishes rapport and maintains contact with the person in crisis by making use of the basic counselling skills like attending and empathy. The client in crisis needs unconditional acceptance and support from the helper. The person in crisis should be given ample opportunities to speak out his problems and express his feelings freely.

Boiling down the problems to the essentials: The counsellor helps the person in crisis by responding the verbal and non-verbal clues from the client. The goal of responding is to get the client to focus on the problem confronting the client. Focusing is done through *identification and clarification.* This is done by leading the client to focus his attention and energies on :

a) the precipitating factor,

b) the threat to the social role of the client,

c) the individual's coping methods, and

d) the new factors which might prevent the person from coping.

Coping actively with the problem: As we mentioned earlier, the goal of crisis counselling is to strengthen the coping skills of the client. This is done by evaluating the crisis situation and mobilizing the resources available to cope with the situation. There are five steps to this process:

1) Establishing of goals. It is important to begin with short-term achievable goals, which help the client to see that he is capable of altering the crisis situation. Once the short-term goals are achieved, he can be helped to move on to long term goals.

2) Identifying resources. This is done by taking stock of the internal and external resources available to the client to deal with the crisis.

3) Formulating alternatives. A crisis situation develops for the person when he finds no alternative mode of dealing except the one available to him right now. Alternatives are found by brain-storming, as well looking at both the negative and positive alternatives.

4) Implementation of alternatives. Helping the client try out alternatives which are not familiar to the client. At this stage the client may develop resistance to the new alternatives because they are not familiar to him.

5) Review and redefine. Periodic review of the goals and the implementation is essential for better implementation. When certain methods are not effective, they need to be modified for more effective functioning.

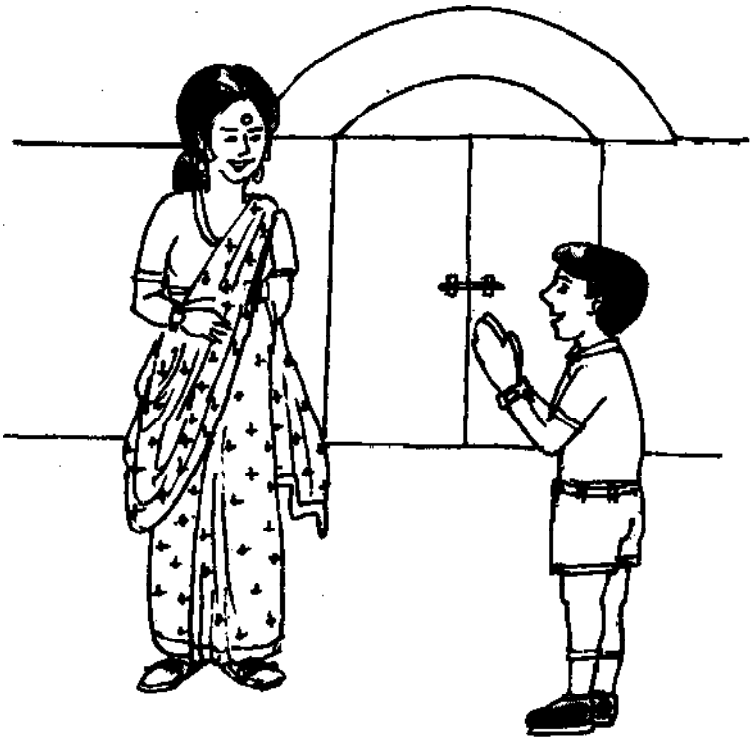
Techniques in Crisis Counselling

Benjamin Rush developed some useful methods of helping crisis counselling. These are:

1) The counsellor taking up the role of the 'parent figure' to gratify the dependency level of the client. Although crisis is not necessarily a psychological problem, it occurs to persons who are unable to cope with their environment. Most of them are more dependent in nature. So when a crisis develops, they will look for some parent figures to resolve their problem. The counsellor can use this as a stepping stone to help the client to build up the client's coping skills.

2) The emotional catharsis is allowed in an understanding relationship. The counsellor becomes an agent in the identification and expression of the emotional block the client is experiencing.

3) Objective review of a stress situation in an atmosphere of supportive relationship. Due to the crisis situation the client is unable to perceive the situation objectively. The counsellor can effectively help the client to view the situation objectively.



4) Building up self-esteem by strengthening the personality of the client. Persons with low self-esteem are likely to develop crisis situation more often. Helping to build up a strong personality is a means of helping the client to deal with the crisis more successfully.

5) Changing the environment and life situation of the client. Some of the crises are the result of the environment. The client may sometimes feel helpless in the present environment. The counsellor can help the client to make appropriate modification in the environment.

6) Action therapy. Some crises make the individual emotionally immobile. Leading the client to some kind of positive action can instill in the client the belief that change is possible.

7) Using religious resources. Humans are religious by nature. Almost all humans have faith in some power greater than they are. The counsellor can build on the positive side of the religious life of the client to resolve his crisis by encouraging proper religious activities.

Follow up for a short period of time. If the client is left to himself, he may find himself going no where. The counsellor must make a definite follow up programme to evaluate and review the progress of the action plan formulated by the client with the help of the counsellor.

Check Your Progess III

Note: Space is given below for your answer.

1) Briefly explain crisis counselling.

.....

.....

.....

.....

.....

.....

4.6 LET US SUM UP

Intervention is a process by which the harmful, progressive and destructive patterns of behaviour can be interrupted and a person is helped to achieve a healthy behaviour pattern before the effect of his present behavioural pattern totally destroys him. The addict does 'not ask for help'. Therefore, someone from the family is motivated first. The counsellor has to identify the areas which the addict can be motivated.

Crisis counselling is an effective tool of intervention. Crisis counselling is a short-term counselling meant for reducing a crisis situation and helping the person to overcome the crisis. Establishing a helpful relationship with the person in crisis, by helping the person to boil the problem down to its essentials and helping the person to cope actively with the problem, reduces the problem.

4.7 SUGGESTED READINGS

Howard, Clinebell (1982), *Understanding and Counselling the Alcoholic*, Abington Press, Nashville, Tennessee,

Abraham, J.Twerski, M.D. (1990), *Addictive Thinking*, Hazelden Foundation, Pleasant Valley, MN, USA.

Sharon, Weschider Cruse (1989), *Another Chance. Science and Behaviour Books*, California.