Partnerships for Drug Demand Reduction in India

Developing Community Drug Rehabilitation and Workplace Prevention Programmes

Project AD/IND/94/808

network

community

training

workplace

Ministry of Social Justice and Empowerment

United Nations International Drug Control Programme

EUROPEAN COMMISSION

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EUROPEAN COMMISSION

PROJECT 808

Preface

The use and abuse of alcohol, cannabis, opium and other drugs has a relatively long history in India. In the last two decades, with the introduction of heroin, the problem has acquired new and alarming dimensions. Today, India is not only an acknowledged transit country but also has a significant drug consumer population. It is clear that India faces a serious problem of drug abuse, and remedial measures are urgently required.

Drug abuse ravages society in innumerable ways. It affects people in their most productive age groups. It imposes an unimaginable burden on families and often destroys them. It has a serious impact on public health. Drug abuse is a recognised risk factor in the spread of HIV/AIDS. There is a well-established relationship between drugs and crime.

Problems in the community are often reflected at the workplace. Workplaces can be seriously impacted by substance (alcohol and drug) abuse, through accidents, absenteeism, workplace violence and health related problems. Preventive measures against substance abuse and planned assistance for troubled employees not only keep such problems in check, but in the long run also improve productivity.

Responses to drug demand reduction need to take into account factors initiating and maintaining drug abuse. Problems relating to substance abuse may arise as a consequence of personal, family or social factors, or from certain work situations. As it is often a combination of these factors, multiple approaches to prevention, assistance, treatment and rehabilitation are required.

India has been cognisant of the growing problem of substance use and several agencies, both governmental and non-governmental are engaged in prevention and treatment activities. Encouraged by the sub-regional experience on community drug rehabilitation garnered between 1990 and 1992, a new project, AD/IND/94/808 **titled "Developing Community Drug Rehabilitation and Workplace Prevention Programmes"** was developed. This project was financed by the United Nations Drug Control Programme (UNDCP), with funds provided by the European Commission (EC), with the International Labour Organization (ILO) as the executing agency and the Ministry of Social Justice and Empowerment (MSJE) as the implementing agency. The project was based on the ILO Reference Model, which was used and adapted in the earlier projects.

The 808 Project titled "Developing Community Drug Rehabilitation and Workplace Prevention Programmes" focused on training and manpower development, development of community based rehabilitation programmes with a focus on Whole Person Recovery, and workplace prevention programmes. The project demonstrated the flexibility and adaptability of the ILO model of community-based rehabilitation in different regions and cultural settings within India. Human resource development formed the backbone of this project.

The project provided a good example of partnership between the non-governmental organisations (NGOs), governmental and international agencies. It also created another form of partnership, which facilitates interaction and collaboration between employers and workers, between enterprises and NGOs offering drug demand reduction services as well as between respective organisations and the community, in addressing issues related to substance abuse. The Association of Resource Managers against Alcohol and Drug Abuse (ARMADA) was a result of such a partnership, and will attempt to continue the successful collaboration built up during the project.

The project has made a significant impact both at regional and national levels. The gains achieved in this project need to be maintained and strengthened in order to achieve its long-term objective – the reduction of substance abuse and its adverse consequences through effective community and workplace initiatives in a coherent national strategy to combat substance abuse related problems in India.

This monograph presents two key experiences. The experiences of drug treatment and rehabilitation centres throughout the country in implementing community based drug rehabilitation, and that of workplace prevention programmes implemented in diverse work settings. Both these projects were based on the ILO model for community based drug rehabilitation and workplace prevention. It emphasises the need for development of integrated services for persons with addiction, a shift in focus to prevention, and for the development of effective partnerships to deal with the complex problems caused by drug and alcohol abuse in society.

Ministry of Social Justice and Empowerment
Government of India
UNDCP Regional Office for South Asia
International Labour Organization
European Commission

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Section 1

Introduction

Alcohol and drug related problems are not new in India. Over the years, however, the abuse of synthetic and semi-synthetic opiates and and psychotropic substances has replaced traditional use patterns. While alcohol is still the most widely used intoxicant in the country, heroin, cannabis, volatile solvents and pharmaceutical preparations like buprenorphine, codeine containing cough syrups and benzodiazepines are some of the other most commonly abused drugs. The South Asia Drug Demand Reduction Report (2000) represents the first major attempt to document the problem and responses to substance use (drugs and alcohol) in the region. The report acknowledges the serious resource scarcity for drug demand reduction activities and the need for Non-Governmental Organisation (NGO) involvement and external assistance for developing sustainable programmes in this area.

In India, demand reduction activities have evolved over the years. The initial interventions in the 1950's and 1960's consisted predominantly of treatment of medical complications. The 1970's and 1980's saw the development of more intensive treatment services, initially hospital based, and the emergence of the non-governmental treatment sector. In the 1990's, there emerged multiple treatment approaches to address these complex problems.

Earlier Initiatives

The Ministry of Social Justice and Empowerment (MSJE) earlier known as the Ministry of Welfare, has been sponsoring NGOs working in the area of drug rehabilitation since the mid-1980s. The focus of these MSJE funded interventions was predominantly on counselling and medical treatment of severe addictions. They focused largely on clients during their stay in the rehabilitation centres. The follow-up was poor, and focus on important aspects such as social re-integration, occupational stability, and maintenance of recovery received scant attention. Recovery was thus incomplete and relapse rates were high. The need to develop a comprehensive programme to deal more effectively with addiction related problems, the need to reach the community rather than wait for the addicts to reach the treatment centres, and to improve the quality of recovery was felt.

Intersectoral Partnerships to Tackle Drug and Alcohol Problems – Pilot Projects

The Ministry of Social Justice and Empowerment has long perceived the need for a coherent national strategy to deal with substance abuse. While several agencies (both in government and in the voluntary sector) dealing with welfare, health, education, labour have long been cognisant of the problems related to substance use, it is inter-sectoral partnerships between organisations that have led to a forward movement in the area of treatment and rehabilitation.

Two demonstration projects carried out between 1989 and 1992 involved such inter-sectoral collaboration between the International Labour Organization (ILO), the European Commission (EC), the MSJE and four Delhi based NGOs. The first project titled 'Prevention and Assistance Programmes for Workers with Drug and Alcohol Related Problems' focused on group training and the development of drug rehabilitation and reintegration services through a community-oriented approach. Emphasis was laid on recovering addicts being gainfully employed. This was done by introducing income generating activities that were supported by a revolving loan scheme. Outputs from this project included:

- Formulation of training curricula on addiction rehabilitation
- Training of NGO staff
- Production of a trainer's manual and practitioner's handbook on addiction rehabilitation
- Video presentation of the demonstration project to other NGOs
- Experience with rehabilitation of 1000 recovering addicts

The second project "Asian Regional Programmes for Community Drug Rehabilitation" addressed workers with drug and alcohol related problems in India, Philippines, Sri Lanka and Thailand. In India, this project was implemented by the Ministry of Labour in collaboration with employers' and workers' organisations and a number of enterprises. Six enterprises implemented prevention and assistance programmes. Over 8000 workers were reached and 400 staff members trained to assist in various aspects of workplace

initiatives to prevent and reduce drug problems. Information material was disseminated to these enterprises.

Project 808: Community Based Rehabilitation and Workplace Prevention Programme

The project '808' titled "Developing Community Drug Rehabilitation and Workplace Prevention Programmes" was the joint initiative of the ILO, United Nations Drug Control Programme (UNDCP), MSJE and the EC. It was conceived of in 1994 to last for three years, but was extended by a further two years, until December 1999, because of the overwhelming response to it.

The immediate objectives of the project were:

- To establish the capacity at the national level to mobilise community participation in developing drug rehabilitation services and workplace prevention and assistance programmes throughout India
- To introduce to, and train, key drug rehabilitation professionals and paraprofessionals in a wider spectrum of rehabilitation approaches and techniques
- To introduce, and train professionals (including NGO representatives) in developing prevention and assistance measures at the workplace as well as supportive action in the community.

Phase 1. Community Rehabilitation

This involved strengthening selected NGOs in various components of addiction rehabilitation under the ILO Reference Model (discussed in Section 2) with a focus on Whole Person Recovery (WPR). WPR seeks to make a person 'drug free, crime free and gainfully employed'. This phase included a rapid situation assessment of substance abuse problems in the identified community, the rehabilitation of identified substance abusers in that community, with an emphasis on vocational rehabilitation and aftercare. A major component included developing income generating activities and supported employment, as well as training of recovering drug users in developing effective work habits.

Phase 2. Workplace Prevention Programme (WPP)

Workplaces mirror the community, and the well being of the community and workplaces are inextricably linked. Therefore, it is imperative that initiatives to rehabilitate and prevent addiction be a joint venture between the community and the workplace.

The existing situation

At the time of initiating the ILO Workplace Prevention Programme, few companies had programmes to deal with alcohol and drug problems. Even those that existed were initiated mainly on a felt need, and focused almost entirely on employees with a serious problem of addiction. Relapse rates were high, leading to a pessimistic and rather negative attitude towards such programmes.

The objectives of the ILO model of Workplace Prevention used in Project 808 were to:

- Create and maintain a drug free environment at the workplace
- Generate an open atmosphere where substance users are able to come forward and seek assistance without risk of recrimination or personal consequences
- Lay down systems and procedures for identification, motivation and referral to treatment, of persons with substance use related problems.

The Results

The project successfully developed and established 18 community based drug rehabilitation programmes in nine cities/towns across India, where it replaced the 'medical' model with the 'community model'. The emphasis was on involving the family and community leaders in treatment. Focus was also on the inclusion of vocational rehabilitation and income-generating activities in rehabilitation, with the emphasis on Whole Person Recovery.

Coverage of the Community Based Drug Rehabilitation and Workplace Prevention Programmes:

- 18 community based drug rehabilitation programmes in nine cities/towns covering 25,000 drug users
- 411 participants trained over 12 training workshops
- 12 enterprises and 110,664 employees covered
- 1420 managers, supervisors, worker's representatives and NGO staff trained in local workshops

Twelve workplace prevention programmes were initiated in 8 cities through a partnership between selected NGOs and enterprises. Treatment and care was extended to employees with drug and alcohol problems. The main emphasis was on prevention of drug and alcohol problems at the workplace.

Several NGO staff and enterprise personnel were trained in both rehabilitation and prevention to create a large pool of resource persons. This was done through seminars, workshops, fellowships and study tours.

Attempt of this Monograph

There is growing work on the extent, patterns and problems associated with drug and alcohol use in India. However, the documentation of efforts to handle such problems in a comprehensive manner is completely lacking. This monograph attempts to capture the results of such interventions across the county. It is not just a report on Project 808. It is an attempt to capture the spirit of the community and workplace programmes and the need for partnerships to address the complex problems of drugs and alcohol in our society. The monograph goes beyond numbers. It provides real life examples of who benefited and how. It narrates the success stories of enterprises that initiated the workplace programme. It describes programme formulation

and the process of setting up of comprehensive community based interventions and workplace programmes. The monograph has been based largely on the reports provided by the participating organisations, project documents, evaluation reports (appendixed as source documents) and site visits by the content providers.

Several lessons learnt from the experiences gained during this project and the limitations of some of the efforts are also shared. These rich experiences provide valuable insights for treatment providers, policy makers, administrators, trainers and researchers working towards reducing drug and alcohol related problems in the community and at the workplace.

The project "Developing Community Drug Rehabilitation and Workplace Prevention Programmes" is referred to as the Project 808, CBDR (Community Based Drug Rehabilitation) project and WPP (Workplace Prevention Programme), or simply the Project in different sections of the monograph. The term "substance" refers to both drugs and alcohol. In many of the case illustrations provided, names have been changed to protect confidentiality. A list of the main abbreviations used in this monograph is provided at the end.

The International Labour Organization Reference Model

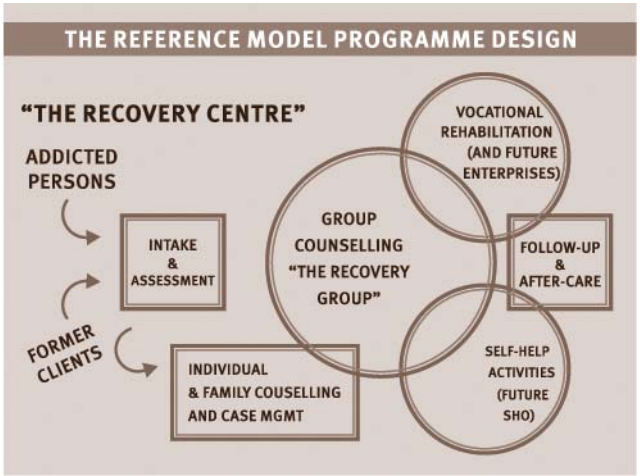
The ILO Reference Model forms the basis for both the Com munity and Workplace initiatives. Some of the key concepts of the model are discussed in this section.

Addiction Rehabilitation

The United Nations (in the resource book on *Measures to Reduce Illicit Demand for Drugs*) defines Rehabilitation as "the process of helping individuals to establish a state where they are physically, psychologically, and socially capable of coping with the situations encountered, thus enabling them to take advantage of the same opportunities that are available to other people in the same age group in the society". The crucial goal of rehabilitation is re-entry, readjustment and independent functioning of the recovered substance user into society. Rehabilitation as defined by the ILO relies on the "combined and co-ordinated use of educational, social and vocational measures for training or retraining the individual to the highest level of functional ability".

Whole Person Recovery

The aim of a comprehensive treatment programme is not just to get the addicted individual off alcohol or drugs. It focuses on making the person 'drug free, crime free and gainfully employed'. The key elements of WPR include:



- Commitment to a drug and alcohol free life
- Adaptation to work and responsibility
- Social re-integration
- Personal growth and self acceptance
- Acceptance of higher values

For people striving to WPR, four factors, popularly known as the Four Keys to Change are necessary. These are:

- Practical guidance on what needs to be done
- Caring encouragement for one's efforts - a powerful "fuel" for motivating recovery
- Successful role models who have achieved the goal
- A peer learning group working together towards that goal

Self-Help

For WPR to occur, the commitment of the addicted individual to change is crucial. The power of self-help (the idea that by helping another, we help ourselves) in recovery is well recognised. One of the best recognised self-help organisations is the Alcoholics Anonymous (AA), which was initiated in the USA in the 1930's. Several other forms of self-help groups, either led by peers (ex-users), or professionally led peer groups have served as powerful vehicles for recovery.

After-care

It has been well established that for recovery from addiction to be complete and the chances of relapse to be minimised, providing continuous care for the recovering person beyond institutional services is crucial. This includes fostering social re-integration, helping families support the recovering person, and ensuring the ex-user's adaptation to employment.

Partnerships

For effective treatment, rehabilitation and aftercare, there needs to be networking between different individuals, agencies and community organisations. Families of substance users, ex-users, non-governmental agencies, detoxification and treatment centres, hospitals, legal and enforcement personnel all play an important part in recovery.

Work and Recovery

Productive work is an essential part of recovery. Addicted individuals often need help to keep or get jobs, to adapt to work more easily, to handle the demands and responsibilities of work, to get along comfortably with fellow-workers, to be accepted as trustworthy, and to be able to accept direction and authority without resentment. This is what is called Work Conditioning.

Vocational Rehabilitation refers to training/retraining the recovering addict for suitable and viable employment, selective placement, on-the-job assistance and follow-up, sensitising key employers and workers' groups to addiction as a safety and health problem, and forging relationships with community groups that have a business and employment orientation.

Where "open employment" (conventional work for an employer) is not a viable option, alternatives such as self-employment, supported work, apprenticeship, and co-operatives may be more suitable for addicted persons in recovery.

Whatever the nature of employment, work-conditioning increases the likelihood of successful vocational rehabilitation.

Developing SMART Objectives

All organisations desire to improve programme effectiveness and achieve successful results. It is important to develop SMART objectives for this. SMART objectives are:
Specific in defining programme objectives
Measurable outcomes
Attainable goals which are
Relevant and are
Time-bound.

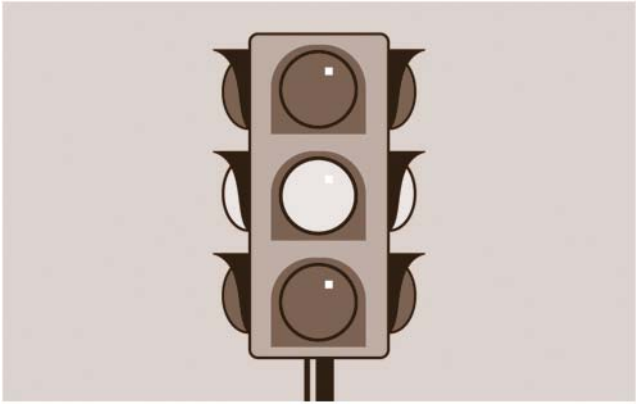
The International Labour Organization Code of Practice

The ILO Code of Practice on the management of alcohol and drug related problems at the workplace was evolved in 1995. The key points in this code of practice include the following:

- Alcohol and drug policies and programmes should promote the prevention, reduction and management of alcohol and drug related problems in the workplace
- Such problems should be considered health problems and dealt with in a non-discriminatory manner
- Assessment of the problem and evolution of a policy and programme to address issues related to alcohol and drugs needs to be a joint initiative of employers and workers
- The policy should be clear and unambiguous and apply to the entire workforce
- Job situations that contribute to alcohol and drug related problems need to be identified and appropriate preventive or remedial action taken
- Information, education and training programmes concerning alcohol and drugs should be integrated where feasible into broad-based health and safety programmes
- Principles of confidentiality and non-discrimination should be ensured to protect workers who seek assistance for such problems
- While it must be recognised that the employer has authority to discipline workers for employment-related misconduct associated with alcohol and drugs, counselling, treatment and rehabilitation should be preferred to disciplinary action

Recognising and Helping with Problems Before Addiction Sets In – The Traffic Lights Model

While addiction is a chronic and potentially relapsing condition which requires intensive treatment, it is increasingly recognised that risky (e.g. drunken driving, intravenous drug use) and regular patterns of drug and alcohol use are associated with major public health, social and workplace problems. In the context of workplace prevention of substance use, the ILO uses the traffic light analogy to categorise levels of drinking and drug use. Using this analogy, persons can be categorised under three zones: the green, amber and red.



The "traffic light" representation of the drug and alcohol problem at the workplace is simple and attractive. Persons with an addiction to substances or serious problems associated with it are categorised as being in the "red" zone, those at risk to develop problems related to use are in the "amber" zone, and those with no problems are in the "green zone". The philosophy of the ILO approach is to keep the 'greens green', shift the amber to the green and the red to green or amber. The ILO model thus shifts the focus from the red zone to green and amber zone interventions. It seeks to develop a comprehensive approach to the problem at the workplace. It speaks a language comfortable to employees and management, fosters collaborations with other agencies, focuses on policy development and guidelines as a key activity, and allows flexibility in approaches. These strengths help companies to readily accept the model.

Workplace Programmes Towards Prevention - A Paradigm Shift

Traditional workplace substance abuse programmes focused almost exclusively on providing assistance to a few workers in the red zone. A shift to a prevention programme expands the focus to the entire workforce, with an emphasis on workers in the green and amber zones. It also focuses on "life-style" changes by developing lifestyles that promote healthy living, and replace substance use with healthy alternatives.

Management Led Programmes

Substance abuse prevention programmes should be the responsibility of the management, with the focus on performance, which is a management issue. A comprehensive workplace programme on substance abuse should be integrated into management strategies, such as occupational safety and heath, to ensure long term sustainability.

Workplace Policy

For a successful programme, a written policy setting out the objectives and goals of the programme, its structure and elements, coverage, roles and responsibilities should be formulated. Guidelines must be available for training, counselling, assistance and treatment referral, testing, and consequences of policy violation.

Total Staff Involvement

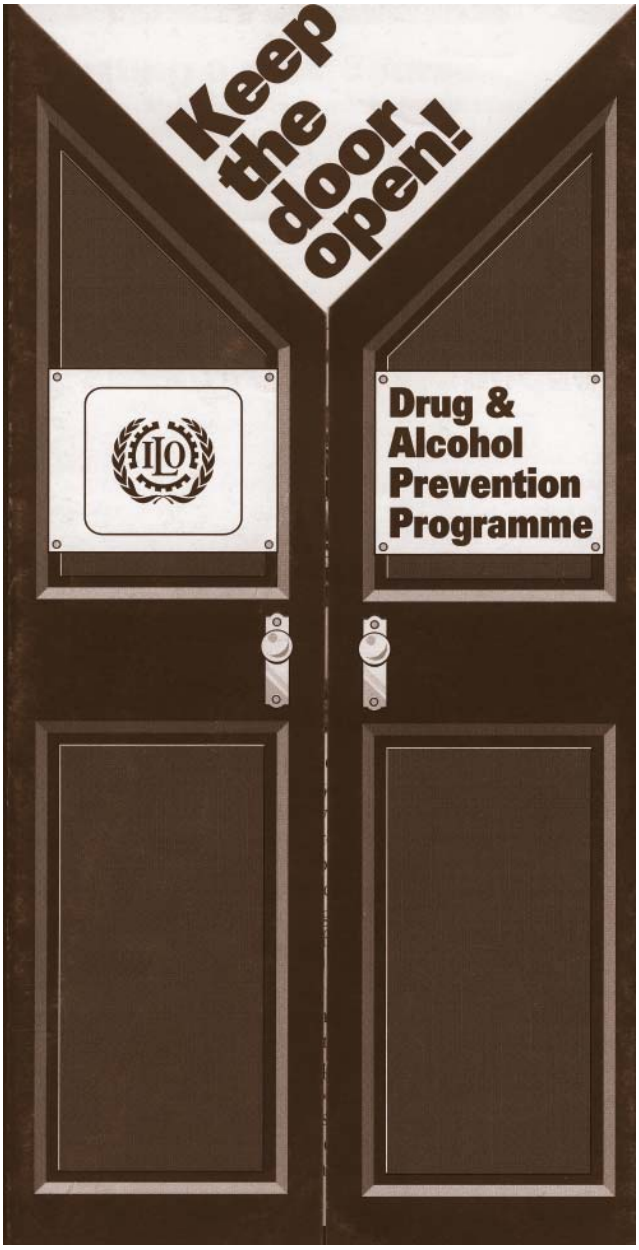
At all levels of programme planning, policy formulation and programme implementation, involvement of both management and employee representatives is vital for programme sustainability. Various levels of staff need to be sensitised and trained in the programme's objectives.

Going Beyond the Workplace

A successful workplace prevention programme ensures the involvement and well being of the worker beyond the factory gates, both at home and in the community. It also involves actively developing community and family linkages.

Ensuring Programme Sustainability

The support of the top management, availability of resources for the programme, regular programme evaluation, and integration



of the programme into ongoing programmes of health, welfare, occupational safety, security or human resources can strengthen programme sustainability. Networking with local and regional agencies for support to the programme, and networking across enterprises to share expertise and resources are other strategies to ensure sustainability.

Section 3

Community Based Drug Rehabilitation

Murugan, a weaver, was admitted for treatment to a de-addiction centre. He was unable to sleep without his nightly ration of alcohol. Despite his mounting problems, he continued to use alcohol. He became irregular at work and his wife had to take up the responsibility of weaving. Their son dropped out of school to help his mother. Murugan became steeped in debt because of his drinking. The family was virtually starving. Yet Murugan's drinking continued. He mortgaged the silk thread given to him for weaving and even sold his wife's mangalsutra (sacred marriage thread) to buy alcohol.

The story of countless such Murugans is repeated all over India.

Many such persons with drug and alcohol addiction are treated in de-addiction centres throughout the country. Of these, seventeen NGOs and one governmental institution participated in the Community Based Rehabilitation Project.

Institutional Framework

The project was a collaborative effort between the UNDCP, ILO, EC and MSJE. The Project Management Team (PMT) consisting of the Joint Secretary (Social Defence) of the MSJE, the Representative of the UNDCP Regional Office for South Asia (ROSA) and the Director of the ILO Area Office for India oversaw the project. The National Project Co-ordinator closely co-ordinated all project activities with participating NGOs, and served as the convenor of the PMT. Ongoing technical advice was provided by the ILO in Geneva. A Project Advisory Board (PAB) comprising officials of the MSJE, Ministry of Health and Family Welfare, Ministry of Human Resource Development, Ministry of Youth Affairs, Ministry of Labour and the Ministry of Information and Broadcasting, guided the project. The PAB also included representatives from the Narcotics Control Bureau, National Institute of Social Defence (NISD), UNDCP, ILO, employers' and workers' organisations and NGOs. A number of international and national consultants and resource persons also assisted the National Programme Co-ordinator.

Implementing Non Governmental Organisations – A Brief Glimpse

The NGOs were pre-selected through personal visits by the PMT. They were located in 9 cities, and covered diverse urban and rural communities throughout the country. The NGOs included:

- The CAIM Foundation, Bangalore
- Kripa Foundation, Mumbai
- National Addiction Research Centre, Mumbai
- Drive for United Victory over Addiction, Calcutta
- Vivekananda Education Society, Calcutta
- Calcutta Samaritans, Calcutta
- Galaxy Club, Imphal
- Integrated Women and Child Development (IWCDC), Imphal
- Marwar Medical Relief Society, Jodhpur
- Opium De-addiction Treatment and Research Trust, Jodhpur
- Bodhi Satwa Baba Sahib Ambedkar Samiti, Lucknow
- Social and Economic Development Institute, Lucknow
- TT Ranganathan Clinical Research Foundation, Chennai
- Sahai Trust, Chennai
- Youth Mobilisation for National Advancement, Patna
- Disha, Patna
- Muktangan Mitra, Pune

Community Based Drug Rehabilitation Activities

- Identification of participating NGOs
- Training of NGO staff in community based rehabilitation and the ILO model
- Assistance to NGOs
- Rapid Assessment Survey of substance abuse in selected communities
- Implementation of the CBDR in the selected communities
- Project Evaluation
- Linkages with Workplaces and training of selected NGOs in workplace related issues

The National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore (a governmental institution with a long tradition of working with communities in the area of mental health) also participated in this programme.

Summary of Training Activities

- 21 NGO staff trained at the TOT seminar
- 189 NGO staff trained at the city level training programmes
- 17 NGO staff given practical training through on-the-job fellowships
- 20 representatives trained through the study tour

Training of Non Governmental Organisation Staff

Various training programmes were undertaken throughout the three year project tenure and helped NGO staff transit from a predominantly 'medical' model to a 'rehabilitation model'. The training also focused on how to monitor the activities of the project, promote learning from each other, foster networking across organisations and finally, to build linkages between NGOs and enterprises. The MSJE also involved the National Institute of Social Defence (NISD) in providing training for them in CBDR.

TOT Programme

The staff of the NGOs participated in a two-week Training the Trainers (TOT) Programme in New Delhi. The training focused on WPR as advocated under the ILO Reference Model and emphasised the following areas:

- Family involvement and community participation in rehabilitation
- Appropriate intake and assessment procedures
- Case Management
- Relapse Prevention
- Crisis Management
- Vocational Rehabilitation
- Reintegration into the community
- Management by Objectives
- Research into drug problems

City Level Training Programmes

Nine city-level training workshops were conducted to extend training to number of staff from each of the participating NGOs.

On the Job Fellowships

Practical training and networking was facilitated by two week placements of NGO staff in other NGOs implementing the project.

Study Tour

On the job fellowships and a regional study tour to Bangkok and Hongkong was arranged to expose NGO staff to diverse treatment and rehabilitation settings.

Refresher 'Training the Trainers' Programme

A 4- day refresher TOT was organised towards the latter part of the project to:

- Share the experiences of working with different communities over the previous two years
- Discuss bottlenecks and problems encountered in programme implementation
- Strengthen various programming inputs, specifically case-management, follow-up, relapse prevention, vocational rehabilitation, including income-generating activities
- Develop and foster networking across participating NGOs

Assistance to Non Governmental Organisations

The project, in addition to providing training, provided each of the NGOs with resource material including publications of the ILO, UNDCP, the Government of India and local organisations. Based on their particular needs in implementing rehabilitation programmes, a package of equipment was also provided to the NGOs. No direct financial assistance was provided for the project, but for organisations funded by the MSJE, attempts were made to streamline the process of funding.

The Initial Step - Understanding Ground Realities

It is well known that drug users are a hidden population and not easily identified through traditional epidemiological studies. An alternative strategy, the **Rapid Assessment Study of Drug Abuse in Target Communities (RAS DATC)** was thus conceived to understand the extent of the problems as well as to identify potential clients for the CBDR. The RAS included:

- A survey of NGOs and community key informants
  To understand their perceptions of the extent of the drug problem in their target community and to assess the needs of the community in tackling such problems
- Interviews with substance users
  To understand the patterns and problems related to substance use.

Substance users were identified through community key informants, and by the method of 'snow-balling'- whereby one user leads the interviewer to more users, and thus increases the number identified.

Through the 18 NGOs, 513 key informants and 1271 respondents were interviewed across 9 cities in India in identified target communities, including urban slums and settlements, as well as in rural communities.

Findings of the Rapid Assessment Study

Although the findings of the RAS DATC in a specific community cannot be generalised, they nevertheless provide some insights into the extent and patterns of substance abuse. The RAS DATC also found several regional variations in the drugs being used.

Drug Types

There was a perception in all the communities, both from key informants and respondents that there had been an increase in substance use. The five most commonly used substances, in order of frequency of use included:

- Alcohol
- Heroin
- Opium (including crude opium resin, opium pod husk 'doda')
- Cannabis (as ganja, charas, hashish, bhang, marihuana)
- Other Opiates

Sedatives (including benzodiazepines, barbiturates, methaquolone, other tranquilizers) and cough syrups occupied the sixth and seventh place.

Other drugs 'ever used' according to respondents in the RAS included cocaine (0.5%), amphetamines and amphetamine type stimulants (3.3%), hallucinogens (1.5%), and inhalants (0.6%).

Heroin use was reported to have increased nation-wide in recent years. Key informants in Imphal, in the state of Manipur, which has had a serious problem with heroin, however reported a decline in heroin use, but an increase in the use of alcohol and other drugs. As a category, if all opiates are combined (heroin, opium, other opiates, cough syrups), 52% respondents reported using opiates as their primary drug in the previous year.

Regional Variations in Substance Use

In Mumbai in the western region, heroin was the preferred drug, while in Pune, alcohol use was perceived as a much bigger problem. Cannabis was a drug frequently reported by users in the communities surveyed in both these cities.

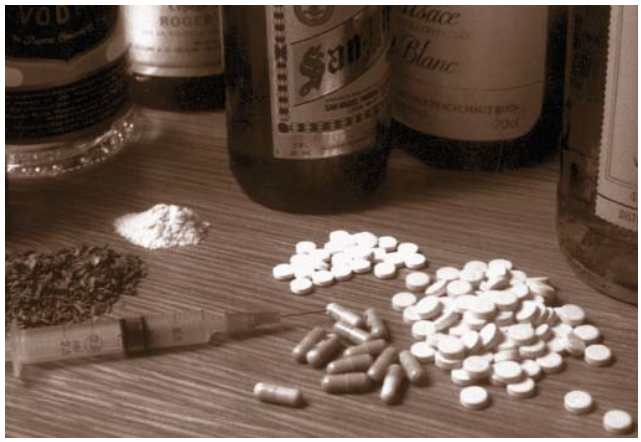
Although southern India has traditionally known alcohol and cannabis use, heroin use has been added to the list of commonly used substances.

In the North-Western state of Rajasthan, opium use is still commonly reported. Lucknow in the state of Uttar Pradesh in Central India, reported an increase in the use of cough syrups and sedatives, besides the use of heroin, alcohol and cannabis.

The problems in the North-East, represented in the RAS by Imphal are highlighted in Box 1.

Table 1: Rapid Assessment Study – Commonly Abused Drugs in the Community (N=1271)

Drug Type	Percentage reporting ever use	Percentage reporting use as primary drug during last year	Percentage reporting use as secondary drug during last year
Alcohol	74	43	22
Heroin	48	38	4
Opium	23	9	6
Other opiates	7	4	3
Cannabis	36	6	20
Sedatives	15	3	6
Cough syrup	12	1	0.1



Box 1. The Jewel Loses its Lustre

It is unfortunate that the idyllically beautiful state of Manipur is now better known for heroin addiction rather than for its pristine lakes and evergreen forests. Its capital Imphal, with bamboo and thatch houses set amidst small gardens, faces a massive problem of drug use. This border state played an important role in the transition from traditional drug use to opiates like heroin, which occurred in India during the 1980s, as it shares a 360 km-long porous border with Myanmar. This proximity to the Golden Triangle of opium and heroin production in South East Asia renders it particularly vulnerable to opiate use. Another reason for the state's vulnerability is the absence of major industrial enterprises to absorb educated youth. High levels of unemployment have resulted in immense frustration. Drug dealers have used these conditions to their advantage and to the detriment of Manipuri society. Since the 1980s, high grade heroin-locally called Number 4, has become the choice drug among addicted persons. A majority of drug users inject the drug. Needle sharing became common when the sale of needles was brought under strict regulation. An HIV epidemic followed, affecting addicts, women and entire families causing sorrow, alienation, trauma and social instability. Although key informants reported a recent decrease in heroin use, the problem remains and new drugs of abuse have emerged.

Profiles of Substance Users

98% of the respondents of the RAS (1248) were males between the ages of 12 and 65 years (mean age 21.6 years). 23% were illiterate and 26% had only a primary level of education. 60% reported a monthly family income under Rs 2000 (USD 41), possibly reflective of the communities selected for the RAS. 57% were married and 37% single. 90 % lived with their families and 62% had been stable in a single residence. Over 25% reported substance use by one or more family members. 10% of the respondents reported changing residence thrice or more in the previous three years and 8.5% reported no fixed residence.

31% percent had no fixed jobs, and 10% had changed 3 or more jobs in the preceding 3 years. Only about a third of the respondents reported having regular jobs. Persons working as taxi drivers, watchmen, autorickshaw and cycle rickshaw drivers constituted 37% of respondents.

Common reasons for initiating substance use included peer pressure (73%), curiosity (47%), family reasons (29%), 'thrill' seeking (22%), personal reasons such as relationship difficulties (24%) and loneliness (10%).

Many of the substance users (54%) obtained their drug from friends or peers. 16% reported 'other unspecified sources' of drug supply for personal use.

Reported Daily Expenditure on Drugs in Indian Rupees*

Heroin	108
Alcohol	43
Opium	34
Cannabis	19
Other opiates	67
Sedatives	31
Cough Syrup	47

*Average daily earning of respondents was Rs. 67
(1 US Dollar = approximately Rs 49)

Injecting Drug Use

289 (23%) of the RAS respondents reported injecting drug use. A very high prevalence of injecting use was reported from Imphal (in 79% of drug users interviewed). The commonest drug injected was heroin, followed by other opiates like buprenorphine (reported mainly from Chennai and Calcutta). Needle sharing was the norm among injecting users, despite availability of disposable needles and syringes. This practice carries with it the heightened risk of contracting hepatitis and HIV infection.

Problems Related to Substance Use

Most of the users (86%) felt that their functioning had been affected by their substance use, with 37% reporting serious health problems on account of such use. About one-fourth (25%) gave a history of prior arrests, of whom more than half had been arrested under drug related laws. Higher number of arrests was reported in Imphal (65%), Calcutta (40%) and Mumbai (27%).

Rapid Assessment Study Highlights

- Alcohol, heroin, cannabis, opium, sedatives, inhalants and cough syrups are the most common substances used
- Marked regional variations observed in substance use patterns
- Survey identified predominantly male users in their early 20s
- Most substance users live with their families and one in four has a substance using family member
- Only a third of respondents have regular, fixed jobs
- Peer pressure and curiosity are the most common reasons cited for initiating substance use
- Injecting drug use was commonly reported in Imphal, Calcutta and Chennai
- Unsafe injecting practices common among intravenous drug users
- One in four users had a history of past arrest
- 95% of respondents had a dependent pattern of substance use
- More than 50% had not received any treatment for their addiction
- For those with past treatment, only detoxification was carried out
- A majority felt the need for treatment

Help Seeking and Treatment Needs

95% of the users identified in the RAS met the World Health Organisation (WHO) diagnostic criteria (ICD-10) for addiction or dependence on alcohol or drugs. Less than half (44%) reported a history of past treatment for their drug habit, and where reported, it was mainly detoxification. Very few (15%) had been to a rehabilitation facility. A majority (65%) felt they needed treatment at the time of interview.

Community Based Drug Rehabiliation Initiatives – Different Organisations Adopt Target Communities

Several of the participating NGOs had been involved with the treatment of persons with addiction for many years, but their

focus had been predominantly residential based detoxification. The project brought different perceptions of the problem to each of them and a general shift in their focus to WPR and rehabilitation. Each organisation adopted a target community and was given training in comprehensive treatment, rehabilitation and 'follow-up' in the community. Here is a glimpse of some of the organisations and the backgrounds in which they work.

The Doctor Goes to the People

Substance abuse treatment has been on the agenda of the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore since its inception in 1974. In 1991, the Institute set up a separate sixty-bed de-addiction centre. Much of NIMHANS' intervention for addicted individuals was treatment centre- based. With the CBDR project tie-up, its focus shifted to the community. Emphasis now lay on motivating persons to seek help for their addiction related problems early, and on assisting them in their recovery and after care.

NIMHANS chose 2 slums in Bangalore-Old and New Bagalur for the CBDR project. Prior to this project, persons with substance abuse problems were being referred for treatment to NIMHANS through 2 NGOs working in the locality. Despite intensive in-patient treatment, outcomes were poor, and seventy patients referred over the previous three years had relapsed shortly after discharge.

These two colonies where a treatment-centre approach had failed were selected for the CBDR approach. The communities were multi-religious. Most of the potential clients were below the poverty line. The clients for the CBDR were identified both through key informants and through other clients, using a chain referral method.

Manaklao - The Rural Rajasthan Experience

Rural Rajasthan has traditionally known opium as a ceremonial drug that enjoys social sanction. People believe that it enhances sexual pleasure, physical well being and efficiency. It is also used to sedate small children to keep them quiet. It has been used in the form of a pill, a decoction made of either poppy pod husk (locally known as doda) or crude opium resin. Five to eleven percent of the population of Western Rajasthan was reported to be using opium. The younger generation is reportedly moving on to other substances, particularly alcohol, heroin and cannabis.

The Opium De-Addiction Treatment Training and Research Trust based in Manaklao, Rajasthan (popularly known as Manaklao) is credited as being the first NGO to adopt the camp method for treatment (since 1979). Over the years, the Trust built a thirty bed de-addiction centre at Manaklao and five counselling centres in different parts of the state, with centres in Jodhpur and Bhilwara serving as referral centres. A follow-up wing had been set up to rehabilitate drug users.

For the CBDR Project, the Manaklao Trust selected to work in five villages in the Osian Block in Jodhpur district.

The TTK Experience

The TT Ranganathan Foundation, renowned for its work in the area of substance abuse treatment and prevention for over thirty years, has been conducting camps for over ten years in villages and small towns around Chennai. Under the CBDR project, TTK Hospital (the centre run by the Foundation) selected the Ranganthapuram slum pocket of the Indranagar Colony in Chennai as its target community. Depite the fact that the TTK hospital provides free treatment for low income groups, there had been few takers among the two thousand odd residents of Ranganathapuram. This was attributed to ignorance and apathy, considering there were at least 100 persons with a definite addiction in that community. The men worked as masons, carpenters, plumbers, electricians, bus drivers, conductors and industrial workers. Monthly incomes ranged from Rs 1001-2000 (USD 20-42). Eighty percent of those addicted were married and lived with their families. In fifty eight percent of cases, there was another family member with an addiction. Although the primary addiction was to alcohol, the use of cannabis, heroin and other opiates, as well as sedatives was increasing. A small number injected drugs.

The Tragedy in Imphal

The problems in the north-eastern state of Manipur, have been highlighted in Box 1.

Prabha's story is a poignant illustration of the situation in Manipur. Prabha is a widow of an HIV positive addict, burdened with five children she was simply unable to support. Prabha experienced great despair because of her

situation. In her interview, she said " *I had even bought poison to commit suicide, I was so desperate*". There are many Prabhas in the northeastern state of Manipur where HIV/AIDS has assumed epidemic proportions, wreaking havoc on thousands of families.

Manipur has not just drug use to deal with, but also its devastating consequences, such as HIV.

It was in such adverse circumstances that the CBDR project had its greatest impact, and changed the lives of people like Prabha.

Galaxy Club of Imphal (GCI) and Integrated Women and Children Developent Centre (IWCDC) Initiative in Imphal

Two NGOs, the Galaxy Club of Imphal and the Integrated Women and Children Development Centre were already active in the field of de-addiction and counselling in Imphal.

Since 1991, the GCI has been running a de-addiction centre in Imphal called the Divine Light Centre. This thirty bed centre is located in Langthabal Kunja on the strategic National Highway 39 that links Imphal to the Myanmar border. In 1993, GCI started a counselling centre at Nameirakpam Leikai. The Divine Light Centre offers a multi-disciplinary treatment programme, as well as general awareness programmes for the community.

The IWCDC, established in 1980, was already active in the field of de-addiction at the time of entering the CBDR Project. Since 1993, it runs the Shine De-Addiction cum Rehabilitation Centre in Thangmeiband Yumnam Liekai, a semi-urban locality of Imphal.

Prior to the CBDR Project, GCI and IWCDC were concentrating predominantly on detoxification and de-addiction at their centres. The focus of both the organisations shifted to involving the larger community in both recovery and preventive campaigns during the project.

Sahai – The Helping Trust

The Sahai Trust has been combating alcoholism, drug use as well as HIV/AIDS in Chennai in Southern India, under the patronage of the Diocesan Pastoral Centre. Its work spans a range of issues like awareness generation, detoxification and rehabilitation. Following a survey carried out in Chennai, the Trust identified addicts in two communities, one in Vepery in Central Chennai and the other in Royapuram in north Chennai. Both areas reportedly had a high concentration of drug users, and easy availability of brown sugar. Most of the drug users in the community were daily wage earners, and reluctant to get away from work for treatment.

Drive for a United Victory over Addictions (DUVA)- "Cleaning Up" a Calcutta Slum

The Drive for United Victory over Addiction has been actively involved in fighting substance abuse in Calcutta for over a decade. The DUVA is a project of the Sir Syed Group of Schools (SSGS). This group of schools with a philanthropic mission, started its first night school in the Kidderpore slums in 1969.

The SSGS being a 'social welfare organisation', had already identified drug addiction as a major problem in Calcutta's slums. It had in place an education programme for preventing the use of drugs and alcohol by youth. At the time of entry into the project, DUVA had already developed a team to establish contact among people in and around some of the Calcutta slums. Given the underprivileged status of the urban poor, and the high rates of criminality, it was a challenge to address substance related problems in this group. DUVA chose Kidderpore as its target community for the CBDR Programme.

Mahabirtala and the Vivekananda Education Society (VES)

The Calcutta-based Vivekananda Education Society has been involved in substance abuse prevention since the early eighties, but had followed a primarily clinic based approach. Two municipal wards, Buroshitbala and Mahabirtala were selected by the VES to implement the CBDR Project. The problem in these areas is high, with an estimated 40% of residents being drug and alcohol users. 60% of the population is illiterate and unemployment rates are high (65%). Common drugs of abuse in the community are alcohol, brown sugar and buprenorphine.

Bihar – Non Governmental Organisations Cope with the Drug-Crime Nexus

The old quarter of Patna, capital of Bihar, is overcrowded, with half a million people jostling for survival in the most abysmal conditions. Living standards are poor, few jobs are available, and most residents do piece-meal work at low wages. Drug use and crime thrive in such an environment. The **Aniket Seva** and Youth Mobilisation for National Action (**YMNA**), two NGOs who work in this area, recognise that almost every family living here has, at least one, if not two members who use drugs.

Aniket Seva runs a De-Addiction Centre called Savera in the Bhadraghat area. This NGO observed that ganja (cannabis) and alcohol was being sold from practically every *khokha* (kiosk), and that children as young as ten and twelve were 'getting hooked'. Small children were also getting addicted to *gutka* (a mixture of tobacco and betel nut) and a host of unconventional agents such as cough syrups, anti-depressants, glues, spirits and petrol. Within a couple of years of tobacco use, they had often graduated to cannabis and 'smack' (heroin). Aniket Seva selected a 40 km slum area that

Patna – Drug Use and Peddling Go Hand in Hand

According to the Secretary of Disha, practically every second scooter or rickshaw driver in Patna uses *smack*. A scooter driver's ambition is to earn Rs 300 per day. Half the money is the rental he must pay to the owner, the other half is used to buy his packet of *smack*. These people also act as peddlers, spreading the dragnet of drugs to people living in middle and upper class areas.

stretches along the banks of the Ganga from Bataganj to Malsalami and Gandhi Maidan to Patna City.

Disha, the de-addiction centre run by YMNA, had a similar experience as that reported by Aniket Seva. Disha had received fifteen schoolboys for detoxification in the year prior to entry into the CBDR project. In many cases, when they got in touch with the boys' parents, they found that the parents themselves were addicted to substances.

In the communities chosen by these two NGOs, 99% of the substance users were male and 71% married. Over a third (36%) had monthly incomes ranging from Rs 1001-2000(USD 21-41). Over half the sample had no fixed job and only 15% reported being regularly employed. A majority found casual work as taxi, auto or rickshaw drivers, guards, hawkers, vendors or rag pickers. Nearly 10% of the respondents interviewed for the RAS had been arrested for various offences. 60% of them had not received any previous treatment.

Handling Problems in Uttar Pradesh – Social and Economic Development Initiative (SEDI) and Bodhi Satwa Baba Sahib Ambedkar Samiti (BSBS)

Two agencies in Lucknow, the SEDI and BSBS were partners for the CBDR Project.

SEDI chose the Indranagar Colony to work in and BSBS the Qaiserbag ward. In these areas, they found that the substance users were in their early thirties (mean age 32 years). 71% were married, and most had monthly incomes ranging between Rs 1001-2001. A relatively higher number (57%) had regular employment, although most respondents worked in informal sectors. SEDI and BSBS had mainly concentrated on clinic based de-addiction treatments, until their entry into the CBDR Project

Fighting Addiction in the Mumbai Slums

Mumbai is India's largest metropolis and its commercial capital. The outer ring of the city comprises slum settlements of migrants from different parts of India, mostly single adult males. Over a third (35%) of the city's population live in slums. Even many lower and middle class families live in slums because of the lack of affordable accommodation elsewhere in the city, where rentals are sky high.

Predictably, slum areas are socio-economically underdeveloped and neglected. Literacy is low, health care is inadequate, living conditions are unsanitary and the area is horribly overcrowded. Organised and unorganised crime is rampant. The net result is a population prone to drugs and alcohol. Slums are crucial to a burgeoning economy and traffic in drugs.

Two NGO's, **Kripa Foundation** and the National Addiction Research Centre (**NARC**) chose to work in Dharavi and Cheeta Camp areas respectively.

Kripa Foundation, which was started in a church compound in Bandra, Mumbai, is now a public charitable trust with a nationwide presence with facilities in Mumbai, Vasai, Vasco da Gama, Mangalore, Calcutta, Darjeeling, Imphal, Kohima, Shillong and Delhi. It tries to provide comprehensive treatment to persons with addiction, and looks at the human face of substance use problems.

The NARC has been active since the 1980's, and focuses mainly on research, documentation, training, advocacy, prevention, treatment, outreach and community work.

Both Kripa and NARC found through the RAS that substance use had reportedly increased in Mumbai in the preceding ten years. Heroin topped the list as the most common drug of abuse, followed by alcohol and cannabis. Addicts were increasingly using other opiates, cough syrups and inhalants. At least 2% reported using needles and sharing needles was common practice, increasing the user's risks for HIV and other infections. The average daily expenditure on heroin was Rs 133 (USD 3) and Rs 35 (US 71 cents) on alcohol. The substance users identified were in their early thirties (average 33 years). Those in the Mumbai slums were mostly single, in contrast from the other RAS communities. Most of them had incomes ranging between Rs. 1001-3000 (USD 21-61). A high percentage was either unemployed or casually employed. One-fourth had no fixed residence. More than a quarter (27%) reported a history of prior arrests. Several (53%) had tried treatments earlier, but predominantly detoxification. Many (56%) felt the need for treatment, but there is an acute lack of comprehensive treatment facilities in the city.

Muktangan Joins the Fight Against 'Gard'

Muktangan Mitra was started in the early eighties in Pune by a doctor couple when 'gard' (brown sugar in Marathi, the local language in Maharashtra state) became a serious problem in the community. Muktangan runs a very people- friendly community oriented treatment programme, with the active participation of family members. Muktangan also works actively in communities to prevent drug and alcohol abuse. For the CBDR Project, Muktangan worked in the Kasewadi/Harkanagar slum in Pune. This slum with an approximate population of 43,000 has experienced alcoholism as its main substance use problem. The lack of awareness about problems related to alcoholism and ignorance of treatment, combined with low literacy and poor economic conditions all contribute to the community's problems.

The Good Samaritans

The Calcutta Samaritans has a very good track record of working with substance users in the community. The Samaritans work with street children, intravenous drug users, women with substance use problems, and high risk groups such as commercial sex workers. Its drop-in centre

for youth with substance related problems has helped many persons in crisis. For the Samaritans, who had already established a range of community and treatment services, integrating the ILO concept added to the effectiveness of their work.

Mobilising the Community and Motivating Clients for Treatment

Most of the NGO's had begun to sensitise and mobilise the community they were working in during the RAS DATC itself, as this initiative requires interacting with several community key informants and decision makers. Each NGO used a variety of strategies to sensitise the community to the programme and motivate clients for treatment.

Manaklao initially faced tremendous hostility from villagers who perceived the organisation's work as an assault on their customs. Manaklao staff was on occasion even assaulted by the villagers. The staff therefore, first approached community elders and other influential people in the target village and sensitised them to the programme. Anti-drug awareness was created at *melas* (rural fairs) through public meetings, street plays, posters, exhibitions, public meetings and video shows in these villages. *Jattha* programmes were initiated, with groups of social workers touring the villages to spark off discussion on the problems associated with drug and alcohol use. The project staff spoke directly to a number of drug users to motivate them for treatment. Ex-users who resided in these villages played a vital role in convincing affected individuals to join the programme.

Other practical problems were encountered in other situations. Working in urban slums for instance had its specific problems. These included having to deal with intoxicated persons, fierce dogs, and crowds thronging around interviewers, especially during the RAS. Having a crowd around can make it very difficult to maintain confidentiality or carry out counselling.

Many of the women refused to talk to the interviewers in the absence of male family members.

Negative attitudes to drug users was a serious problem recognised by several organisations. TTK found that the attitude of many families and the community towards drug users was one of disapproval and even outright contempt. The main stumbling block for the VES was that the community members of Mahabirtala initially considered drug use as a personal, and not a social problem. The Sahai experience was a lack of interest among users to get treatment. As an official of the TTK hospital explained, "the people in the area are used to being paid ...even if something is being done for their good. We were obviously not paying them for their awareness and subsequent detoxification, so ...". In Imphal, not only the drug users, but even their wives and widows were treated with disdain by relatives and friends. The fact that many of the women had contracted HIV from their husbands compounded their problems.

Changing such attitudes was a painstaking task for every NGO. Sahai periodically organised awareness programmes for target groups such as students, unemployed youth, local community leaders, health personnel and different categories of labourers. It used photo and poster exhibitions and street plays to enhance awareness. Community leaders were identified and persuaded to become involved in the programme. VES also approached several community groups and leaders. It experimented with several methods of awareness generation. It realised that lectures did not reach out to most people. Street theatre was a more effective medium, and ex-drug users and street children were actively involved in such programmes. Posters carrying factual information about drug use in Bengali were put up. Graffiti, tableaux, street corner meetings and puppet shows were used to send home the anti-drug message in an appealing format. VES formed a committee, at the community level, with representatives of youth clubs, religious bodies, professionals, teachers, recovering persons and volunteers, and this proved a very effective channel for the dissemination of information, as well as to generate funds and other resources for prevention activities. The YMNA in Patna also made a special effort to increase awareness, publicising the problems of addiction through radio, television and films. It held special awareness generation activities for selected communities in several areas and established goodwill with

the community and local authorities. Kripa in Mumbai used similar strategies to raise community awareness prior to the launching of the community based rehabilitation project.

Treatment And Rehabilitation: Different Strokes by Different Folks

While the ILO reference model emphasises the concept of Whole Person Recovery and relies on a range of psycho-social approaches both during the initial intervention and during aftercare in the community, its strength is that it allows flexibility in approaches. The best evidence for this is the variety of interventions introduced by the participant organisations, while still adhering to the principles of addiction rehabilitation set out in the project. Hospital - based approaches, residential care approaches, camp approaches, domiciliary care approaches all integrated the elements of rehabilitation outlined by the model. While specific illustrative examples from some organisations have been drawn upon, it must be emphasised that most of the organisations followed the principles outlined in the model almost in its entirety.

I. Centre Based Treatment Extending into Community Based Aftercare

This was best exemplified by **NIMHANS**. Fifty persons with alcohol dependence identified from the Bagalur slums were motivated for treatment. A thorough physical examination and relevant laboratory tests were carried out to assess the damage caused by alcohol or other concomitantly used drugs. Most of the persons preferred admission for the initiation of treatment, because of their strong withdrawal symptoms. They were detoxified and treated for any concurrent illnesses. Following this, a multidisciplinary team engaged the persons in individual and group counselling sessions which focused on topics such as the ill effects of alcohol and drugs, skills of refusing a drink or 'joint' after discharge, alternate ways of coping with stress, and how to deal with renewed craving. A major focus of such sessions was on financial management. Clients were also counselled about high risk sexual behaviours during the health education sessions. In the group sessions, each person shared his past alcohol and drug related experiences, and the detrimental effects on himself and his family. Clients were coached in healthy ways of coping with stress, developing assertiveness and other coping skills through discussions and role play. Family members were regularly involved in family sessions addressing important issues like communication and problem solving skills, decision making, handling of negative emotions, supporting the abstinence efforts of the recovering client, and dealing with relapse. They were also encouraged to talk about their distress and difficulties and supported in their efforts to overcome the same.

On average, each person stayed in hospital for three to four weeks. At the end of the stay, if formerly addicted to alcohol, the person was offered additional help in the form of disulfiram, an aversive agent that causes an extremely unpleasant reaction if alcohol is consumed.

Vocational counselling was carried out in all cases, and for those persons who did not have a stable or satisfying work record, a Supported Employment Programme was offered.

After discharge, clients were monitored on a weekly basis, either at the Corporation Clinic situated in Bagalur or through home visits, where the counsellor also interacted with the family. Such close contact helped in early identification of relapse and immediate remedial measures.

All the clients were regularly assessed with respect to their addiction status, occupational status, financial condition, family relationships and social functioning. NIMHANS used standardised measures such as the Alcohol Severity Index, Alcohol Problem Questionnaire and Effective Measurement Units, a measure of drug free, crime free and gainfully employed status, to assess the client's progress.

The Divine Light Centre run by the GCI in Imphal offered a similar centre- based programme integrated with community after-care. At the centre, recovering clients live in a commodious dormitory and play games like volleyball and carom. A qualified yoga instructor trains them in techniques of stress reduction, relaxation and disciplining desires. The families of the substance users are also involved in the long journey to recovery. The GCI offers various kinds of vocational training.

The YMNA in Bihar detoxified and counselled persons with addiction in its fully equipped fifteen bed hospital, in batches. Medical professionals, paramedical staff, counsellors, social workers conducted the programme, which included in-depth counselling and rehabilitation. YMNA established five Self-Help groups consisting of ten persons in recovery. The groups held formal meetings twice a month, where counsellors interacted with group members to assess and address the difficulties encountered in achieving socio-economic rehabilitation. Special meetings were held once a month to

which family members of recovering persons were invited. Counsellors talked with them about problems caused by addiction and the ways and means to overcome them.

Another major component of the YMNA initiative was vocational training and economic rehabilitation of the recovering persons.

II. Camp Approach

Manaklao in Rajasthan and TTK hospital in Chennai have a long and successful experience with the camp approach for treatment of addiction. Both the organisations used this approach to help persons with addiction in this project.

In Manaklao, after sensitising the community, the next step was to persuade the key persons in the community to host a camp. Each ten -day camp is like a *mela* - with theatre, music, puppet shows, poster exhibitions and educative films on addiction. Trained psychologists and counsellors hold group meetings with village youth. This is followed by individual counselling of substance users interesting in giving up their addiction. In recent years Manaklao has begun to use ex-users to address target groups at camps with particular success.

For those identified as having an addiction problem, a health assessment was carried out, and those found medically fit were put through the rigorous de-addiction programme. Detoxification was carried out under medical supervision at the camp and medicines used to manage withdrawal symptoms. To strengthen motivation for detoxification and vocational rehabilitation, ex-users spoke to the clients at different sessions. This played an important role for those who needed encouragement. During their entire stay at the recovery camp, the clients were exposed to pictures, exhibitions, short movies and documentary films in an attempt to show them a better life following treatment. Group counselling was undertaken to keep the morale high and physical exercises and yoga were part of the treatment.

Unlike the earlier camps, under this project, Manaklao had provision to keep the recovering persons in an aftercare centre for one month. Family members were encouraged to visit weekly in order to develop a better relationship with the recovering person. One of the main functions of the counsellors became the settling of disputes and developing of cohesion within the family.

BOX 2. Middle Class Blues

In the attempt to cure addicted persons of their habits, the attitude of the user, his immediate family members and the treating agency all play vital roles. In community based rehabilitation, a humane approach and die-hard optimism are underlined. In dealing with difficult cases the keys to success are acceptance of the problem, perseverance in its elimination, commitment to good values and gainful rehabilitation. This becomes clear in the following middle class cases successfully treated by the Vivekananda Education Society (VES).

A.G. was a brown sugar and alcohol user who frequently committed crimes to support his habit. After several relapses, his family sought counselling. Thanks to regular counselling and a strict follow-up programme, he was finally sober. Because of addiction, A.G. had lost his job in a pharmaceutical company. As an important measure of rehabilitation, the company has re-employed him. This has made him stable and hopeful.

S.G., a 35-year old upper middle class substance user, had taken to theft and lying. He had been abusing alcohol, narcotics, sedatives and finally, brown sugar. He had taken to drugs as a refuge from his father's disciplinarian behaviour. S.G. was prone to hysteria. In 1996, when he began treatment, he confessed to having serious family problems. This led to family counselling and the family decided to cooperate with the efforts necessary for his recovery. The first attempt failed when he relapsed into alcohol and ganja abuse. Treatment was restarted and after detoxification he was asked to go to the TTK Hospital in Chennai for a month of rehabilitation. This time the treatment was successful and with regular follow-up he has been free of drugs. He is now married and takes active interest in his family's business of air conditioner and refrigeration repair.

The third case is that of D.M., a 35-year old middle class Bengali male, who lives with his family. He was addicted to brown sugar for seven years and came to the VES through other recovering persons. D.M. had a lot of pent up anger in him. Both he and his family were counselled and the family was prevailed upon to adopt a sympathetic attitude towards him. From the beginning D.M. displayed an exceptional will to overcome his problems with the aid of treatment and regular follow-ups. With the family's emotional and financial support and the "behaviour modification technique" D.M. was placed firmly on the road to recovery. VES also found him a job. He is married and now leads a contented and happy life.

After discharge from the aftercare centre, monthly personal visits by counsellors and social workers formed the backbone of the follow-up programme. During these visits group meetings were held to answer questions, resolve doubts and help with solving problems during the recovery process. Small groups of recovering users were set up, to function as self-help groups. Besides, every village selected for the project also had a committee of ex-users. This committee helped to keep a regular check on recovering persons and provide information about their day to day condition.

Another new component that Manaklao added under the project was vocational training, an element that had been missing in its earlier efforts. This added to the allure of the camps.

While the **TTK** has extensive experience in running camps in rural areas, the Foundation was skeptical about the response to an urban camp, in view of the social stigma, lower cohesion, and modern influences such as television, all of which pose a real threat of keeping people from the camps. Despite these concerns, the camps at Ranganathapuram proved a success.

The first treatment camp was held for ten days. Nineteen patients were selected after assessing their motivation for treatment. The goals of treatment were to help clients give up alcohol/drugs completely and to effect positive change in their lives, leading to Whole Person Recovery. Treatment was free and included follow-up services, medicine and food.

Before starting of the camp, sixteen of the nineteen persons with addiction required medications for treatment of withdrawal. By the time the camp was initiated, a majority had already been abstinent for a few days. The camp began with a thorough medical examination by the doctor. The first day was spent orienting the participants to the ten-day therapy programme. The rules of recovery and the objectives of WPR were explained. After two days those with alcohol addiction were given disulfiram that would effectively act as a fence around them. The camp schedule included games, music, songs and video films. Group therapy, re-education lectures, counselling and sharing sessions were conducted by ex-users.

Follow-up services included home visits by project staff, the initiation of self-help groups and arranging regular get-togethers for clients. The goal was celebration of one year of sobriety.

A second camp was conducted a few months later. This time the treatment period was extended to thirteen days, to provide a longer period for effective counselling. Altogether forty six persons were treated in the two camps.

III. Delivering Services Closer Home - Community Approaches

Muktangan Mitra in Pune and **Sahai Trust** in Chennai both worked in large slums. Muktangan worked intensively in the community through home visits by its staff and volunteer ex users to motivate addicted persons to come forward for treatment. While a few chronic cases were referred to the centre, many cases were managed at the counselling centre. Individual and family counselling was carried out. Regular group counselling was held. Sharing by ex-users, motivating persons to attend AA/NA (Narcotics Anonymous) meetings, helped in maintaining sobriety. Muktangan built a strong rapport with various Ganesh mandals and youth forums to celebrate various functions and festivals throughout the year.

Sahai Trust developed a peer educator's programme and network intervention as an effective strategy. Some of the ex-users had joined the programme as peer educators. An outpatient clinic was run in Vepery and a Community Outreach Centre at Perambudur. De-addiction services were made available at these sites. On an average, twentyfive to thirty five addicted persons visited the clinic daily. High risk sexual behaviours as well as drug use behaviours were assessed. For those requiring long term residential care, they were referred to the centre's rehabilitation centre, situated in a scenic resort.

As co-dependency (behaviours of significant others that maintains the drug habit in the user) is an important aspect of substance use, the process of recovery necessarily calls for active and intensive involvement of the family. The staff and counsellors attached to the Sahai Trust constantly liaised with families, holding formal meetings with them twice a week, and periodically visiting them at home. These families were also motivated to form self help groups.

DUVA staff began to pay greater attention to home visits, follow up, self-help programmes and day care. Local schools and police stations were also involved to widen the reach of the programme. Workshops, street corner meetings, rallies, leaflets and posters were utilised extensively for propaganda purposes. For a comprehensive recovery, medicines, yoga, individual therapy, group counselling, marital and family counselling and behaviour therapy were all included in the rehabilitation/ prevention process.

In both Lucknow and Patna all four NGOs included a number of new components in their ongoing activities. They have now

ventured into the larger community and are concentrating on preventive education as much as on recovery. Their follow up procedures have also undergone a major change with group meetings and ex-users being actively involved. Group meetings in which life histories are shared have emerged as key interactive sessions. Centres such as Disha now keep daily progress report charts.

NARC was able to achieve successful rehabilitation by taking the community into confidence. This was possible because key informants wanted to tackle the drug problem and many addicted persons themselves sought treatment. In the process NARC learnt that most addicted slum dwellers suffered from additional health problems like tuberculosis. This finding underlines the need for establishing medical facilities in these areas in future, to assist in the struggle against addictions. The chances of an HIV/AIDS epidemic breaking out are also high, given the unsafe sexual practices in slums and the prevailing sexual myths. These findings underline the need for establishing medical facilities and counselling in these areas. Throughout the Project, NARC concentrated on preventive measures, treatment and after-care.

An important lesson learnt by NARC during the Project was that while a large number of youth in Cheeta Camp were not addicted to anything, they were still at risk. Hence "to sustain this group there is a need for channeling their energies constructively for retaining (their) drug free status. The concept of prevention should include those who are not addicted in the first place".

Work as an Essential Part of Recovery

Being gainfully employed is one of the most crucial components of recovery under the ILO model. Encouraging and supporting clients to return to work or develop vocational skills is an important area of intervention, and as evident from the narratives that follows, was done in a variety of ways for the CBDR project.

Employment Is The Answer

DUVA from Calcutta learnt during the project that instead of drugs and alcohol, people needed alternative ways of enjoying themselves, as well as employment to keep them occupied, productive and debt free.

In several cases, unemployment, low self-esteem and rejection were found the main causes of addiction as well as relapse. Hence, finding some gainful employment during rehabilitation was considered important. Part of the resources for vocational rehabilitation came from the Project and the rest was contributed by DUVA.

The programme of re-employment and income generation includes training of clients in printing, bookbinding and stationery making. Motivated clients undergoing this training received a monthly stipend of Rs.500 (USD 10). DUVA introduced 'social marketing' of the commodities produced in the rehabilitation centres. Local clubs, police stations, resource persons (including professionals like doctors) and schools were persuaded to purchase their stationery from these centres. This was yet another way of involving the community in rehabilitation and reinforcing the message of recovery from addiction.

GCI began to offer vocational courses in carpentry, flower pot making, weaving and embroidery (especially for women). It helped some clients start small businesses like marketing automobile lubricants or running paan shops, tea shops and fast food joints.

Tangible Work

NARC started freelance electrical repair work services, a scrap shop, a screen printing unit, jewelry box making and zari work programmes. These provided gainful employment to some recovering persons. Their programme of after care was based on the acceptance of the reality that human beings are different and require varied types of intervention for bringing about change, as also for its sustenance.

Box 3. Teaching Livelihood Skills

Savera used a group of professionals to provide basic skills to recovering persons. One such professional, Kusum, teaches candle making and tailoring. She points out that "*these may seem like simple activities, but for someone living in this area, it makes the difference between starvation and earning a livelihood*".

Twenty-four year old Mukul Kumar, working as a tailor from his tiny house in the Meena Bazaar, has done Kusum proud. She taught him cutting and stitching and Kumar has been tailoring for the last three years.

"I now earn Rs 2000 per month and the number of orders I receive has steadily increased," says Kumar, pointing proudly to the sewing machine that he has purchased by taking a loan from Savera. He is repaying the loan in monthly instalments.

Santosh Mishra used to inject himself daily with pethidine. The social worker with Savera recalls with a shudder the morning when Mishra's mother brought him to the clinic. *"Santosh was in such a pathetic condition that there was almost no flesh on his left arm. We feared that it would have to be amputated. Santosh managed to survive, though he did suffer two relapses. He too was taught tailoring and is working in a tailor's shop. He is married and is the proud father of two children".*

Vocational Training

To add to the allure of its camps, Manaklao added vocational training, an element that had been missing in its earlier efforts. Before initiating vocational training every patient had to undergo a test for an assessment of their interest and aptitude. Based on the results, Manaklao selected four trades for vocational training, namely carpentry, welding, tailoring and handicraft making. Each client's family status, economic status and family profession were considered before allocation of the trade.

Training for skill development, lasting for a minimum of two months followed the allocation of the trade. Subsequently, an advanced vocational training for a period of six months was provided at the Manaklao Centre. Raw materials for the training were resourced through helping agencies involved in the Project. All articles and materials manufactured in the workshop were sold in the open market. Money received through sales was used for buying new raw materials and to run the vocational rehabilitation centre - thus constituting a revolving fund for this programme.

Meanwhile, through networking efforts in the city of Jodhpur, several industrialists were involved in this project. A number of clients were rehabilitated among the different industries that had links with the Manaklao trust. Members of the committee of ex-users were also able to help persons in recovery find employment.

Alternatives to Conventional Employment

YMNA discovered another problem. Even after addicted persons recover, they find few employment opportunities available to them. This often triggers off a feeling of frustration, which makes them return to substance use.

To overcome this problem, Disha, the centre run by YMNA, employed recovering persons in a variety of jobs. The maximum number has been employed in running a mess for the centre.

The presence of the ex users provides a major psychological boost to persons undergoing rehabilitation. *"When they realise we've got out of the habit, they believe they too can do it. It's amazing how much good our presence does to them,"* says twenty five year old Rakesh who started taking *smack* and *ganja* at fifteen, when he dropped out of school to help his father run his contractor's business. He has been managing the mess for the last two years. *"We charge two hundred rupees per month from clients undergoing rehabilitation, and ensure they get good, healthy meals,"* says Rakesh.

The project director at Disha, the centre run by YMNA launched Operation Green to supply potted plants to nurseries and individual buyers. The scheme was launched with fifteen recovering persons receiving training in basic gardening and marketing skills from nurseries located close to this centre. Once they had learned the basics, they were encouraged to grow and market a variety of potted plants.

'Operation Green' was a great success. Clients in recovery learnt to become responsible by taking care of plants on a day-to-day basis. They also learnt the basics of marketing.

Not only do these centres help provide persons in recovery with jobs, they also provide the means to start petty businesses. For instance, they provided a cart and an iron to a recovered client who wanted to iron clothes for a living, a cart and weighing scales to another who wanted to sell vegetables.

As a result of all these efforts, the majority of the recovering persons have been rehabilitated economically as well as socially. Many have been placed in jobs in commercial establishments. YMNA also started networking with other institutions engaged in community based rehabilitation programmes. It took the initiative to coordinate the activities of a large number of NGOs operating in north Bihar and held a joint mass awareness campaign against drug abuse for the rural masses.

The SEDI in Lucknow, provided clients undergoing rehabilitation with the requisite tools and a small amount of working capital. Clients are expected to repay the worth of these goods on a monthly instalment basis. Those who earn a decent income display obvious pride and a sense of purpose. This makes the NGOs' work worthwhile.

Micro Credit to the Rescue

More often than not the problems associated with poverty arise because the poor do not have control over the means of production in market driven societies. They cannot employ themselves gainfully and thereby assume some control over their lives. In the absence of capital, the poor feel powerless and their sense of alienation increases. This may be a primary cause of drug addiction in many cases.

One possible way out of this lies in large-scale recourse to micro credit. Micro credit means small capital loans at affordable rates of interest to the poor as a means of income generation. This credit can come from concerned individuals, cooperatives, cooperative banks, commercial banks, ministries, welfare funds, NGOs and other public institutions. Except the usurious moneylender, almost anyone can help the poor through micro credit.

Micro credit is safe credit. As experience in Bangladesh shows, the recovery rate of such loans is ninety five percent. This is quite unlike the large amounts of credit taken from banks. The success of schemes like Grameen Bank and Grameen Phone in Bangladesh proves this point. Thousands of poor families, obvious targets of drug peddlers in different circumstances, have reaped the benefits of micro credit in poor Bangladesh. Small loans for cycle rickshaws, rickshaw and cycle repair

shops, an electrician's tools of trade, a small-scale fast food joint, a screen printing unit or tools necessary for plying other trades – these are typical examples of micro credit use.

The experiences with micro credit are highlighted in Box 4. In summary, micro credit plays a heightened role in improving the lives of poor recovering substance users in an era of dwindling employment opportunities. It is central to the notion of Whole Person Recovery, community based rehabilitation and helps to re-integrate formerly addicted persons back into

Box 4. Micro Credit in the CBDR Project

Micro credit was included as a concept integral to WPR in the ILO project and several agencies participating in the project have used it effectively.

The Calcutta Samaritans, a group active against substance abuse for the past twenty eight years, included vocational rehabilitation under ILO guidelines in the menu of services it offered to interested clients. It started a micro credit programme with a revolving fund of Rs. 1,68,000 (approx. USD 3429) set up for poor street level substance users.

This money has been effectively utilised to train recovering clients in screen printing, motor vehicle driving, knitting, mushroom farming, pig raising (for interested tribal clients) and tailoring (for the wives of users). All profits from these programmes go to the revolving fund. So far 200 clients have been productively trained.

The NGO Muktangan Mitra is active in the Kasewadi slum of Pune, working among dalits. Many of them are sweepers and coolies employed on daily wages and lead an economically precarious existence.

Their micro credit programme began with seed money of Rs. 1,68,000. Project officials had suggested a loan ceiling of Rs.5000 (USD 102) per person, to widen the net of this scheme. However, it was later felt that due to inflation and devaluation of the rupee, sticking to this limit was impractical. Rs.15, 000 (USD 306) was given to one recovering person to open a shop. The loan is being regularly returned. Another bought a plastic moulding machine. A computer operator obtained Rs.5000 to buy a printer – he is reportedly doing well.

Other organisations also have interesting things to report about micro credit. The YMNA from Patna managed to help many recovering clients by arranging small loans from commercial banks and financial institutions. Many such persons now own "flourishing" businesses. They are repaying their loans regularly and leading happier lives free of drugs. Arranging micro credit with the help of government, semi-government and non-government agencies to ensure complete rehabilitation and self-employment is also on the priority of organisations like the BSBS in Lucknow.

In Manipur in the North East, small loans have helped widows and children of addicted men affected with AIDS to survive. The organisation Horizon of Prosperity and Education (HOPE), has mobilised widows into a self help group and given them loans to buy looms or start small eateries. The Galaxy Club of Imphal has loaned recovering clients money to start mushroom farming, open fast food joints or do tailoring businesses.

Box 5. A Future for Sameer

Thirty five year old Sameer, formerly a drug user, runs Shine's singularly successful mushroom unit. The unit is housed in Shine's premises and is being expanded, with more room and racks. It produces excellent mushrooms.

All materials necessary for the crop are locally procured. Sameer says that he and his helpers try to prepare the raw materials needed for production themselves. This keeps costs low and makes repayment of the loan from the revolving fund an easier option.

Sameer is a matriculate who comes from Moirang in West Imphal. His parents separated when he was young and he has never seen his father. His blind mother is a singer and teaches music in the Government Ideal Blind School in Takyal.

At the tender age of eleven, Sameer started his journey into the world of drugs by experimenting with alcohol. This, he says, is quite common in Manipuri society. Gradually he added mandrax and other sedatives to his drug diet. Curiosity and high school peers drew him to morphine in 1981. When it was banned two years later, he moved on to heroin, which was widely available in Imphal. But the habit was not cheap and he began to steal money from his mother and relatives and even peddled drugs to support his habit.

In 1984, fed up with his life, he approached a psychiatrist for treatment. There were no proper de-addiction centres in Manipur at that time. Sameer went through seven or eight de-toxification procedures, with steady relapses. In 1990, he underwent treatment at a rehabilitation centre but soon relapsed. Four years later he went to another centre and remained clean for seven months before a relapse followed. In 1995, he tried yet another detoxification centre for a year before relapsing again. In 1998, he went to the KRIPA centre for three months before relapsing. Finally, in 1999, he arrived at Shine and since then he has managed to remain clean.

The mushroom unit was started after Sameer was trained in mushroom growing with a loan of Rs. 6,300 (USD 129) from the revolving fund. Now he trains other clients and pays them a stipend from his income. The income from the sale of mushrooms goes solely to him. Expansion of the unit is being financed by the sale of mushrooms.

Sameer lives in the centre, helps out with other chores and visits his mother once in a while. His face lights up at the suggestion of marriage. Yes, he does want to marry a girl of his choice *"if she says yes after she gets to know all about me"*. For Sameer, like many of his peers in Manipur, is HIV positive.

society. It gives the recovering persons gainful employment, income, greater control over their lives and future, and much needed self esteem and hope. Thus, it counteracts the fundamental causes of drug addiction amongst the poor and exploited sections of society.

Supported Employment

Lack of work conditioning (regularity at work, consistent performance and good peer relations at work) is identified as one of the major problems with chronic drug users, and can be one of the factors that lead to job loss and relapse. The Supported Employment Programme (SEP) focuses on development of good work habits.

The NIMHANS Experience

Attempts made by the NIMHANS team to identify potential sources of employment through a private employment agency were unsuccessful. Depending on their work experience, interest and available opportunities, clients were referred to the Department of Psychiatric and Neurological Rehabilitation in NIMHANS for vocational training in printing, carpentry, tailoring or weaving.

After discharge, they continued to come to the Rehabilitation Centre for training. They were given an advance for local travel, which was deducted from their first salary. They were paid minimum wages as per government rules.

Group therapy was conducted twice a week with emphasis on enhancing self-esteem, anger control techniques, relapse prevention and drink and drug refusal. Financial management, work ethics and discipline, problems at work leading to relapse, communication and problem solving skills as well as assertiveness training were part of the agenda in therapy.

SEP played a major role in the recovery of substance abusers, especially those that had had frequent relapses after return to the community. Improvement in self-esteem and confidence, along with significant reduction in drinking and other drug use were direct results of the supported employment.

Rehabilitation Efforts that did not Work in Some Communities

Sahai offered vocational rehabilitation services as part of its treatment and facilitated job placements for recovering or recovered patients. The income generation opportunities offered under the project added to its attractiveness. Like all communities compelled to live in slums, unemployment is a major problem in Vepery. Whatever little employment is available is also off-limits for drug users and ex-users, as employers consider them 'shirkers' and are not willing to trust them with any responsibility.

Vepery has a large leather industry and market. Sahai Trust's attempts at setting up a leather unit has failed so far because of scarcity of raw material and finances. Another drawback is that the addict population is a floating population, making it difficult to sustain work. The Trust is now engaged in other income-generating activities with community support.

Attempts were made by the NIMHANS team to identify potential sources of employment through a private employment agency. After de-toxification, clients were trained to make applications, visit an employment agency accompanied by a counsellor and shortlist probable jobs. Thereafter, they were encouraged to go and meet the prospective employer. The counsellors found it quite a chore to persuade the clients, who were mostly illiterate, and had never filled out any forms in their lives, let alone job applications, to do so.

The clients were also reluctant to take up the jobs offered and complained about the distance, the remuneration and the work environment. In short, the attempt was a failure. The programme at NIMHANS therefore shifted to adopting a supported employment programme in its fully fledged Rehabilitation Centre.

Extending Economic Support to Families

Some of the NGOs extended the vocational rehabilitation services not just to the addicted clients, but to their family members as well. The TTK hospital involves many spouses and family members of addicted clients in its rehabilitation centre, where tailoring is the main activity.

To help female relatives of clients, Shine has established a self-sustaining weaving unit. The social marketing of cloth produced in this unit is being successfully pursued. Shine also interacts with women's groups, youth clubs and other NGOs to build a social consensus against drugs in Manipur.

GCI sparked off HOPE, a women's self help group in Namei Rakpam Leikai. Under the banner of HOPE, village women have come together to share their problems and work towards a brighter future. Although widows of addicts started the group, wives of current users and clients have joined it in large numbers. As a consequence of their husbands' drug addiction and personal neglect, these women earlier suffered

Box 6. Prabha and Her Friends

Prabha's poignant story was mentioned earlier in this section. There are thousands of Prabhas all over Manipur, who had become the victims not only of their drug using family members, but also the victims of ostracisation and ridicule of society.

HOPE changed their lives forever.

In the rural area of Namei Rakpam Leikai, full of rice fields and bamboo groves, where ducks and geese paddle in small ponds and every house grows its own cabbages and peas, addiction had shattered many lives.

The stories of women like Prabha and Rani demonstrate what a little support and love can do to change despair into strength. Prabha got a loan of Rs 18,000 (USD 367) from HOPE. The money came from the one-time grant of Rs 1,68000 (USD 3429) that the GCI had been given under the Project to provide micro credit to recovering clients and/ or their family members.

Prabha bought a loom and yarn with the loan. In her spare time she doubles as a cook in a nearby hostel. While she is away, her younger sister keeps the loom going. Prabha has managed to send three of her five children to a residential-educational lodge or school meant for poor children. The other two live with her and attend school. As Prabha serves you tea and biscuits, the radiance of her smile reflects the beauty of her proudly tended kitchen garden. When you leave, the *thak-thak* of her loom follows you for quite a distance, reinforcing the hope and will that has made all this possible.

Rani, another AIDS widow, now runs a flourishing tea-shop known for its *pakodas* and has started sending her two children to a private school. She is an active member of HOPE and is busy adding more seating space to her tea-shop.

Both talk warmly of their friendship with Bimla, who is recently widowed. Bimla's husband, Nabadip, addicted to heroin, had recovered at the GCI and obtained a loan of Rs.4,000 (USD 82) in 1998 to start a fast food joint. He served soyabean soup, finger chips and *tharoi,* a popular snail curry. Bimla assisted her HIV positive husband in their growing enterprise. People who had earlier ostracised Nabadip became his customers as he recovered his self-esteem and began earning a livelihood by the sweat of his brow. People in the neighbourhood, earlier victims of Nabadip's thefts, began patronising his small restaurant and still remember his culinary skills. Nabadip passed away a few months ago, comprehensively rehabilitated and clean. His dream of a happier life is being realised by his wife, who has inherited a flourishing business and has almost repaid the loan to GCI.

alone, in silence. The condition of HIV positive women is particularly grave. Health disorders like TB, fevers, aches, skin problems, loss of appetite, insomnia and depression are common. Since attention is focused on the ailing husband, the children suffer the consequences of neglect and growing frustration. This aggravates depression and guilt among the women. However, gradually, through group discussions involving the families, and employment programmes for the women, the feeling of despair turned to hope. The women began by articulating their feelings in group meetings but soon learnt that it was not enough to just have a shoulder to cry on. They had to band together to demand better care at the primary health centres, and more information from doctors. With help from GCI, they educated themselves on ways of improving the health and nutrition of their families. The group is like an extended family. Whenever a family

Box 7. Women with Addiction

Many drug users take *smack* because they believe it will enhance their sexual pleasure. Some husbands initiate their wives into this habit to make them less inhibited.

"The trickle of women addicts is fast becoming a stream," says the president of the BSBS. He cites the example of 50-year old Nasreen Begum from Gole Ganj in Lucknow. Her husband Tehsin Khan got her into the habit of taking drugs. The president says, *"we have managed to detoxify her and she is presently in the care of our social workers, who are visiting her at home once a week."*

The founder-director of the Patna based YMNA, has opened a centre for women with addiction called Phulwari. This women's only centre helps ensure women are treated privately, which is important because women with addiction are highly stigmatised in society.

Simran Kaur, a schoolteacher, is one of the few women to have come to Aniket Seva, a Patna based NGO, for treatment. Her alcoholic husband encouraged her to take a few pegs of whiskey with him in the evenings. This soon increased to half-a-bottle and then to drinking two bottles a day.

"I would have drunk myself to death were it not for the intervention of my parents. They realised that if I didn't get medical assistance, my son and daughter would also end up as alcoholics," admits Kaur who is back to teaching English and Maths to class eleven children in a private school.

Social workers believe that women with addiction have to face many more obstacles than their male counterparts before they can come for treatment. For one, most centres are not equipped to admit women. Women require separate facilities and female nurses. Says an NGO counsellor, *"Male attendants can hardly be expected to look after women especially during the crucial period when they are having withdrawal symptoms."*

member is sick, all the women visit with the customary helpings of rice and fish – the local prayer for quick recovery. Expenses like funeral costs are shared. Skills like weaving, knitting, embroidery, food processing and pickle making are learnt from each other in this co-operative enterprise.

The loan carries no interest but HOPE charges its members a nominal three percent interest. This amount is retained as a "group fund" and disbursed as micro loans to other members. HOPE is now a registered organisation and its members are keen on developing accounting and communicating skills. However, they plan to keep their loans small and repayable.

The Impact of Community Based Drug Rehabilitation (CBDR)

The many case examples cited earlier bear testimony to the effectiveness of the CBDR project. It is clear that this effort changed many lives for the better. In addition to individual case stories, some of the organisations also carried out evaluations to assess the overall impact of their programme.

At the TTK hospital, 46 patients were treated in the two camps. While two of them died subsequently, 51% remained drug free at the end of the year (this includes cases of temporary relapse), and 26% continue to drink. 19% suffered severe relapses.

Shine has treated and trained 43 patients of the 50 chosen for the CBDR Project. Of these 23 are reported clean (53.5%) and 14 have relapsed (32%). Of the treated clients, 26 are gainfully employed. Loans granted from Project funds have played a crucial role in keeping several former clients employed and clean.

In Muktangan Mitra, there were 117 alcohol addicted persons when the project began. 72% of them have abstained from alcohol, when followed-up two years later. Mitra's effort has been home and community based since these poor workers cannot afford hospitalisation. Micro credit has been helpful in these conditions.

The impact of the VES in Calcutta had the maximum visibility. The Calcutta Police declared Mahabirtala a drug-free zone after one year's work.

Lessons Learnt from the CBDR

The CBDR project clearly demonstrated the usefulness and translatability of several of the key concepts of substance abuse rehabilitation, as outlined by the ILO model. It held many lessons for the participating organisations, the monitoring agencies and individuals involved at various phases of the project.

Outcome of CBDR – An Evaluation Study

NIMHANS, an organisation known for its expertise in setting up and evaluating models of care, carried out a study to compare outcomes between clients who had after-care and those that did not. The 50 patients hailing from the Bagalur community were compared with 49 others who were also admitted for in-patient treatment at NIMHANS. While the in-patient treatment was identical for both groups, the Bagalur group received weekly aftercare in the community. They were also offered supported employment, which has been described earlier. The control group of 49 did not receive any after care, but were advised routine monthly follow-up at the hospital. Both the groups were evaluated at baseline and on follow-up at 3 month, 6 month, 9 month, and one year.

Advantage of a Comprehensive Approach

As is evident in Figure 1, both the study group and control groups showed a significant reduction in the average number of drinking days per month at 3 months following treatment. But the group receiving aftercare (study group) maintained this improvement even at 6, 9 and 12 months, while the control group did not sustain this improvement.

Similarly, in terms of problems with their family, both groups showed a reduction in such problems 3 months after treatment, but only the group receiving rehabilitation and aftercare managed to maintain and improve relationships at 6, 9 and 12 months. In a condition where longer term recovery rates, in the best conventional circumstances are under 30% and relapse is the rule, the community approach clearly demonstrated the lasting benefits in terms of client

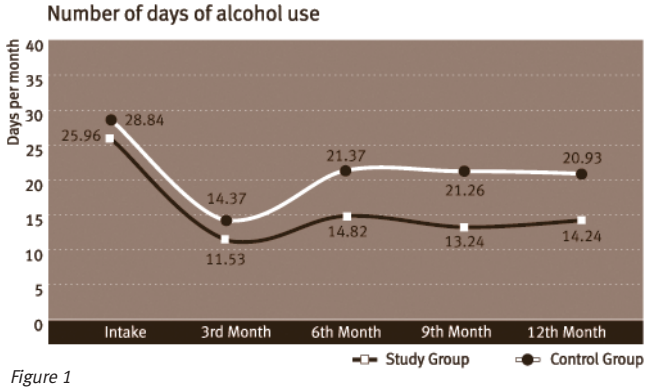


Figure 1

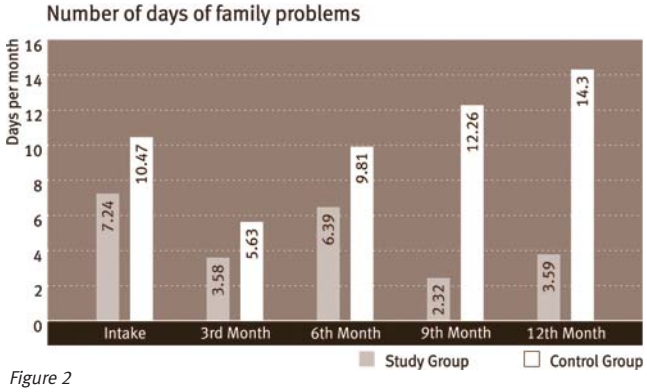


Figure 2

recovery, family satisfaction and improvement in financial status.

Work Conditioning and Vocational Rehabilitation

The realisation of the importance of gainful employment, work conditioning and vocational rehabilitation and their contribution to WPR was a very significant aspect of the Project. The relief that it brought to families in abject poverty and despair and the positive changes it brought for individual people is remarkable.

Role of Aftercare

The importance of aftercare was very convincingly shown by the NIMHANS study, which underlines that proper monitoring and aftercare can help to minimise relapse and maintain the gains that clients make at treatment programmes.

Power of Self-help Groups

Self help groups, for both recovering addicts and their families have a positive and supportive role in recovery. Substantial experience with traditional groups such as the AA as well as professionally led groups was gathered during the project.

Involvement of Ex-users

Persons who have successfully quit and have achieved whole person recovery are indeed the most convincing role models for addicted persons, and are very effective volunteers for community programmes. The CBDR project demonstrated the pivotal role of ex-users in mobilising the community, motivating addicted persons to obtain treatment, running self-help groups and in aftercare.

Importance of Dedicated Staff

One of the primary reasons for the success of the CBDR across all organisations was the presence of sensitive, dedicated and well trained staff. Much of the success in treatment and rehabilitation of addicted persons hinges on empathic staff that can establish a good working relationship with the client and work with the client for his or her recovery.

Any successful programme needs a competent captain at the helm. The National Project Co-ordinator provided effective leadership and support to all the partners in both the CBDR and Workplace Prevention Programmes. His determination and direction was a driving force for the entire project.

Commitment of Agencies

The CBDR was an example of how crucial the support and networking of agencies at local, national and international levels is for successful programme implementation. The NGOs established networks in the local communities, and with each other. They also involved state government agencies concerned with drug rehabilitation. Many government agencies at the central level, as well as international organisations worked in partnership during the programme.

Extending the Expertise into the Workplace

With the NGOs having been trained in all aspects of drug treatment and rehabilitation, and having developed expertise in mobilising the community and in principles of prevention, the stage was set to link the trained NGOs to enterprises to develop a programme of workplace intervention. Some of the NGOs, notably TTK Hospital, Calcutta Samaritans, Mutangan Mitra had already initiated programmes with workplaces, but this had not been a systematic and planned activity. A training workshop held in New Delhi brought together representatives of NGOs and workplaces to discuss approaches to prevention at the workplace of alcohol and drug use.

Section 4

Workplace Prevention Programmes

Substance Use and Workplace: What do Organisations Traditionally do?

The traditional approach of organisations towards substance abuse among its employees has been one or more of the following:

- Deny that it is a problem
- Regard substance use as a purely personal decision which does not involve the company in any way
- 'Tolerate' the workers with substance use problems and compensate for their lack of efficiency
- Take disciplinary action including termination when addiction sets in, i.e. when the person has no control over his/her substance use.

Advantages of Workplace Substance Use Initiatives

- The workplace mirrors the community. Handling workplace problems can reduce the burden on the community
- Workplace programmes reach the entire workforce
- The workplace offers a target group for prevention campaigns
- It is an effective location for early intervention, treatment and re-integration into work

The Rationale for Workplace Interventions

Companies are increasingly becoming aware that the workplace mirrors the community and that community problems will indeed be workplace problems. Waiting until serious problems set in for the substance user and then terminating him will prove costly to the company (loss of worker's skill and cost of retraining another worker).

The impact of drug and alcohol use in the workplace is being increasingly recognised. Substance use negatively impacts upon the enterprise through accidents, absenteeism, lost productivity and health costs. It also affects the workers and their families by affecting physical well being, destroying relationships, reducing job performance and causing health, family, legal and financial problems.

Many of the problems caused by substance use at the workplace are due to intoxication and post-use impact (hangover effect), in addition to the other effects of addiction. The Exxon Valdez accident is an example of how human error, often compounded by behaviours such as drinking at work can cause devastating accidents and financial losses in billions to companies.

It is estimated that:

- Upto 40% of accidents at work involve or are related to alcohol use.

Was the Captain Drunk? The Exxon Valdez Disaster

The Exxon Valdez, a 986-foot vessel, was used to haul oil across the Atlantic. On 24 March 1989 at 12.04 am, the vessel ran aground in the Blight Reef causing an oil spill of 11 million gallons (the amount spilled was equivalent to 125 olympic size swimming pools). The oil spill impacted on 1300 miles of shoreline. The economic impact of the accident, including its effect on fishing, tourism and loss to fauna was estimated at a staggering 2.8 billion dollars.

Among the causes for grounding as concluded by the National Transport Safety Board, were fatigue, excess workload, and the failure of the captain to provide a proper navigational watch, possibly due to the effect of alcohol.

During the enquiry, it emerged that the captain, who had been seen earlier in a local bar, admitted to having some alcoholic drinks and a blood test showed alcohol in his blood even several hours after the accident. The captain had always insisted that he was not impaired by alcohol. The State charged him with operating a vessel under the influence of alcohol. A jury however, found him 'not guilty' of the charge.

The incident aroused major concern about workplace safety, and the need for provisions and policies to prevent drinking at the workplace.

- Absenteeism is 2 to 3 times higher among habitual substance users.
- Of all accidents at work, 20-25% involve intoxicated workers injuring themselves or colleagues.
- Job fatalities linked to drug and alcohol account for as many as 15-30% of accidents.

Employees with drug and alcohol dependence claim three times as much sickness benefit and file five times as many workers' compensation claims.

Substance using employees create higher safety risks from intoxication, negligence and impaired judgment. Problems with co-workers through increased work-load on the non substance user, disputes, grievances, intimidation and violence are common problems associated with substance use at the workplace.

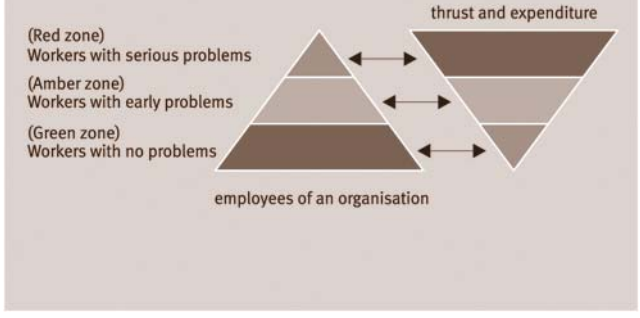
The International Labour Organization Reference Model at the Workplace

The simple analogy of the traffic lights to categorise workers into green, amber and red zones based on their substance use status was described earlier in Section 2.

Most employees in any organisation are in the green zone and the challenge is to keep them there. Red zone strategies (treatment and rehabilitation) are intensive, expensive, are available only for a few and are often associated with relapses. Green zone strategies are relatively inexpensive, look at ways of preventing substance use, and thus reach a large population before problems begin. These strategies include developing healthy lifestyles. Amber zone strategies assist persons in identifying early and potential problems associated with substance use and encourage self-monitoring, change, and early intervention, which has better results. The objectives of workplace programmes is thus to address employees in all the three zones, with a thrust on the green zone with strategies preventing problem use of alcohol or drugs.

Substance Use Zones and Costs of Intervention

Figure 3



Courtesy: MICO

Indian Workplaces – Focusing on the Alcohol and Drug Problem

This is a true incident from a transport company, one of the enterprise partners in the WPP programme and highlights the serious problem associated with alcohol use at the workplace.

On a bus trip from Bangalore to Goa which entails a travel of sixteen hours, Mr. K. and another colleague took turns at driving. On the return from Goa, the colleague started drinking till he was intoxicated. When he took the wheel the passengers protested. Mr. K. therefore offered to drive through the night instead of his colleague. The next morning the colleague took over from Mr. K., and within the next 10 Kms collided with a tree. Mr. K. who was sitting next to the driver was killed and two others were seriously injured. ***An innocent employee had died because of his colleague's drinking!!!***

Workplace Prevention Programmes (WPP) – Building Partnerships

In 1997, the 808 Project initiated a workplace drug and alcohol abuse prevention programme with seven private companies and five public sector enterprises who volunteered to participate. These organisations recognised the seriousness of the problem at their workplace, and the need to seek solutions. Motivation to address the issue stemmed both from humanitarian grounds as well as from concerns about productivity and safety. Prior to the programme, some attempts had been made to check substance abuse among employees, but these were unsatisfactory. Efforts ranged from spreading awareness to disciplinary action, but were usually sporadic and piecemeal. In contrast, the WPP Project recommended a coherent strategy and plan that defined the problem and laid down procedures and systems to deal with it.

The CBDR project had already trained NGO staff in treatment and rehabilitation and sensitised them to the merits and strategies of prevention. The workplace prevention programme was initiated with a joint orientation of workplace representatives and NGO staff. Each organisation was partnered by an NGO to

Participating Organisations and Partner NGOs

Organisations

- Brecco Lawrie Ltd., Calcutta
- Calcutta State Transport Corporation, Calcutta
- Tata Iron and Steel Company, Jamshedpur
- Mahindra & Mahindra, Mumbai
- Karnataka State Road Transport Corporation (KSRTC), Bangalore
- Motor Industries Co. Ltd., Bangalore
- Hindustan Motors Limited, Tiruvallur
- The Hindu, Chennai
- Goa Shipyard Ltd., Vasco da Gama in Goa
- Cummins India Ltd., Pune
- Modi Rubber Ltd., Modipuram
- Karnataka Power Corporation Ltd., Bangalore

Partner NGOs

- Caim Foundation
- Kripa Foundation
- Vivekananda Educational Society
- Drive for United Victory over Addiction
- Calcutta Samaritans
- T.T. Ranganathan Clinical Research Foundation
- Muktangan Mitra
- Indian Council of Education
- NIMHANS

sensitise the organisations, initiate awareness programmes, provide treatment and rehabilitation to employees in the red-zone, in the preliminary phase. The NGO was also expected to train key employees in identification and counselling of employees with alcohol and drug problems, and refer them for treatment when necessary. Employee representatives from all levels-supervisors, managers, and trade-union representatives were all involved in the sensitisation.

9 NGOs assisted the 12 enterprises in nine cities in India.

Understanding The Problem

The case example illustrated at the start of this section is not unique to one organisation. Different organisations feel the impact of drugs and alcohol at the workplace in different ways.

Box 1. The 12 Enterprise Survey

The survey covered 12 industries – both public and private – located across the country and involved in diverse activities like publishing, manufacturing automobiles, ship building and heavy-duty machinery manufacturing enterprises. There was variability in staff strengths across organisations, ranging from just over 1,000 to 75,000 in one organisation. The total staff strength of the organisations was 1,10,664.

The survey aimed at:

- Understanding the extent and nature of alcohol and drug problems in the organisations
- Gathering secondary data with regard to accidents, absenteeism, work tardiness, sick leave and unexplained behaviour
- Making possible links between workplace problems and alcohol and drug abuse

The survey used the key informant method- where persons knowledgeable about the workplace were administered a questionnaire regarding their perceptions of drug and alcohol use among workers and the resulting consequences, both occupational and personal. Informants from departments like security or the canteen who had information about employees not normally known through conventional sources, were specifically interviewed. Records of the employees containing information related to work, health, social backgrounds, legal and administrative problems were scrutinised.

Eight hundred and seventy one employees from 12 industries participated in the study. They belonged to different categories within the organisations. Categories included supervisors (25%), managers (23%), shop stewards (10%), occupational and health workers (4 %) and others (38 %).

Some Key Findings

- Drug use uniformly low, alcohol related problems a major concern
- 2/3 of the informants believed alcohol use was a problem (ranging from 23% in a private limited company producing tyres to 97 % in a government owned public transport system in Karnataka)
- More than 50% were aware of workers coming intoxicated to work (ranging from 12 % in a company producing electrical goods in eastern India to 84 % in a company producing motor parts in South India)
- Nearly 50% maintained that sick leave taken by workers was often related to alcohol use
- 50% felt that habitual alcohol users were facing significant personal problems
- Perception that alcohol and drug use adversely affected colleagues was variable (only 8 % in the company producing electrical goods in East India while 82 % in the company producing motor parts in South India said drugs and alcohol were adversely affecting colleagues)
- 93 % in a public sector undertaking involved in ship-building and repair and 88 % in a motor vehicle building organisation in western India were aware of preventive programmes.
- Only 27 % of respondents were satisfied with existing preventive programmes in their organisation (ranged from 1% in an organisation producing motor parts to 61 % in the public sector ship building)

Commonly Noticed Tell-tale Signs of Alcohol Related Problems Among Employees

- Taking off from work the day following salary day
- Reporting sick or coming late during the first week of the month
- Strained interpersonal relationships
- Irritable and uncooperative attitudes
- Deteriorating health –frequent complaints of stomach upset, ulcer, abdominal pain, sleep disturbances and psychological problems like anxiety and depression
- Impaired productivity and efficiency

One important preliminary step to planning any programme of intervention is a comprehensive understanding of the extent of this problem and possible responses to it. The organisations sensitised in the orientation programme were initially encouraged to make an assessment of the extent of drug and alcohol problem in their workplace. The methodology and highlights of this survey are highlighted in Box 1.

The perception of most key informants was that drug problems are low, but there are significant alcohol related problems among many workers. While this perception is probably accurate, it must be recognised that drug use often goes underdetected, as drug use most often leaves no telltale signs, in contrast from alcohol use.

Many of the respondents were aware of persons coming intoxicated to work. The implications of being under the influence of drugs and alcohol in the workplace are serious and need to be tackled. For instance, accidents on shop floors of industries manufacturing heavy machinery or spare parts can lead to physical injury, and, in extreme cases, result in death.

Excessive drinking was also found to lead to late arrivals, tardiness when in office and absenteeism.

The study also found that employees were hiding the drinking problems of co-employees because of the stigma attached to drinking. In some organisations, identifying the alcohol user may mean taking administrative action, which both the co-employees and administrative departments want to avoid. This attitude of colleagues only aggravates the individual's problem. In the absence of a policy towards drug and alcohol problems, no preventive or remedial action could be taken.

Surprisingly, awareness about preventive programmes was very high. In a heavy-duty machinery manufacturing organisation in southern India – all the persons interviewed were aware of preventive programmes for alcohol and drug abuse. While awareness was high, satisfaction with preventive programmes was low.

The survey finds that most problem drinkers and drug users in the workplace continue to function fairly adequately, unless the problem becomes extreme. However, coming to work intoxicated is a serious safety concern for the organisation, and absence, tardiness and reduced efficiency all mean lowered productivity and result in financial losses for the company.

A Prevention Programme – Making Sense to Organisations

From the productivity point of view, it makes good business sense for companies to adopt a prevention programme against alcohol and drug abuse at the workplace. A series of recommendations emerged for such a programme from the survey. They included:

- Educate key informants on the assessment, early identification, and possible referral of those facing problems of substance use.
- Train key personnel within the organisation to develop skills to help affected workers.
- Encourage peer driven activities at the workplace. Recognise the role of abstinent drug or alcohol users in providing a good role model and in motivating co-workers to change.
- Focus on identifying problems based on deteriorating work performance.
- Start counselling services wherever possible.
- Integrate alcohol and drug prevention and treatment services with existing health and safety programmes within the organisation.

Training and Sensitisation

1. Two – day sensitisation workshops were held in six major cities and involved government officials, employer's representatives, worker's organisations and NGO staff. The local Chambers of Commerce hosted these workshops.

2. Participants were taken on a study tour to Malaysia for the Third International Private Sector Conference on Drugs in the Workplace and Community in October 1997. This helped to orient the NGO staff and the enterprise representatives to the programme for workplace prevention.

3. A national workshop on workplace prevention programme was held in Delhi for representatives of participating

enterprises and NGOs. The aim of the workshop was to sensitise the participants on the nature and effects of drug and alcohol problems in the workplace, to explain concepts and issues in workplace prevention, identify the role of various staff in the workplace and NGOs in the programme, to work out enterprise specific draft policy statements and action plans, and to understand how to set up and run a workplace prevention programme.

4. Two day workshops were held in all the twelve enterprises to establish the programme within the workplace. These workshops brought together trade unions, and management, including managers, supervisors as well as facilitator co-workers. Doubts about company policies were cleared and action plans with a time frame for adoption and implementation developed.

Policy Development

The Project advocated a comprehensive Alcohol and Other Drugs (AOD) prevention and assistance policy that set out the aims of the programme, assigned responsibilities for execution, and established a steering committee to oversee implementation.

In most of the companies, the programme was integrated with ongoing activities like technical training programmes. Management and workers' unions sat together and worked out an AOD policy for the company before launching the programme.

The programme had two basic aims:

- To create a drug-free environment and to generate an atmosphere where substance users are able to come forward to seek assistance, without risk of recrimination and professional consequences.

- To lay down systems and procedures for assisting potential cases of addiction, including guidelines for identifying users, initiating a dialogue with them, organising treatment at an appropriate facility under specified terms, and setting conditions for resumption of duty.

All the companies adopted a policy on alcohol and drugs use at the workplace.

Companies and individuals initially expressed several doubts about adopting such a policy, especially fears of stigmatisation and recrimination. This had to be repeatedly clarified at different fora, including meetings held with various representatives by the National Project Co-ordinator. Some companies instituted a stand alone Alcohol and Other Drugs (AOD) policy. Others incorporated the AOD component in a safety or occupational health policy.

All the policies recognise AOD problems as health problems requiring assistance. The conditions for assistance have also been enunciated. They vary across companies in terms of duration of leave, financial assistance for treatment and the number of times a person would be entitled to assistance. The policies highlight that seeking assistance would not jeopardise the person's career. The consequences of continuing non-

BOX 2. A Model Policy

The policies of the twelve organisations that participated in the WPP Project adhere to some general principles, but vary in the details. For instance, some AOD policies cover alcohol, other drugs and tobacco, while one restricts itself only to alcohol. Similarly, some policies offer reinstatement after dismissal so long as the employee is declared medically fit within a stipulated period of time, while others do not. A few policies extend medical benefits such as covering the complete cost of treatment to employees seeking assistance; others offer a fixed amount towards such expenses. The AOD policy is tailored to suit each organisation. The participatory process of policy making enables each organisation to select its own modus operandi for dealing with the issue.

Here are the main points any AOD policy needs to consider and cover:

- Coverage: specific substances covered by the policy
- General approach: prevention and assistance (aims and objectives, such as a drug-free environment, non-discriminatory stance)
- Scope within the organisation: the categories of employees and management for whom the policy is applicable
- Steering committee: a body with employers' and employees' representatives to oversee policy implementation
- Assigning responsibility: clearly spelling out the roles and responsibilities of all concerned including management, employees, company unions, personnel department, medical and welfare departments (if any), so that systems for AOD policies are put in place and run effectively
- Facilities: provision of facilities for medical examinations and monitoring, through medical or welfare officers, and collaborations with specialised treatment agencies such as NGOs and hospitals
- Rules regarding use of substances defined above: for example, prohibition of consumption on premises and of reporting for duty under the influence
- Rules and procedures governing AOD tests: the conditions under which an employee may be asked to undergo a test, for instance, to determine cause of an accident/error, or on the basis of a supervisor's assessment
- Prevention strategies: information dissemination, recreational activities, random checking, etc.
- Rules to respect confidentiality of employees' medical history and records

Assistance Strategies:

1. Procedures for identifying addicted employees (behavioural and other indicators).
2. Ways of initiating a dialogue with substance using employees to discuss the problem and offer help.
3. Guidelines for a series of offers of assistance, followed by warnings and conditions for disciplinary action where the user is unresponsive.
4. Measures to provide counselling (to the individual and/or family).
5. Procedures for referring addicted employees to a rehabilitation facility.
6. Rules concerning costs of treatment and leave in case of hospitalisation.
7. Processes to assess treated cases and determine fitness for resumption of duty after treatment.
8. Regulations regarding relapses.
9. Rules for dismissal on grounds of AOD use.

performance despite intervention are spelt out in most of the policies. The policies have been translated into local languages and disseminated among employees.

Policy Safeguards Worker's Right to Non Discriminatory Treatment

In order to ensure that substance users do not suffer discrimination, companies adopted policies that protect the rights of those seeking treatment. A history of substance addiction must not affect prospects for increments, promotions, and job security, subject to terms specified in the policy. This assurance is vital to creating an open atmosphere where an addicted employee does not fear the possibility of dismissal by admitting that he/she has a problem with substance use.

Each of the policies specifies a system to identify employees with addiction and rehabilitate them. This includes an offer of treatment, counselling, and assessment for resumption of duty. Policies also spell out the kinds of financial aid the company would provide, and rules regarding leave from work, applicable in case of hospitalisation for treatment. While the specifics of each policy differ, the basic approach to assistance focuses on offering medical help and counselling, rather than immediate disciplinary action such as suspension or dismissal.

Nearly all the AOD policies require that a user be provided a series of opportunities to accept help, failing which disciplinary action is warranted. Most companies set out a timeline, such as: informal chat, confirmation of addiction, first offer of help, first warning, second offer of aid, second warning, etc. Discharging the employee is the last resort. In addition, some companies offer to reinstate the worker after such dismissal if he/she is successfully rehabilitated within a certain period. Thus these policies reveal a more complete understanding of the problem of substance use and addiction.

Programme Implementation

Prevention and Assistance – A Two - Pronged Approach

Green Zone strategies

The programmes set out to prevent addiction by generating awareness of the risks and consequences of substance use. All participating enterprises conducted awareness programmes using a variety of methods - messages on pay slips, logo and slogan competitions open even to family members of employees, awareness campaigns (articles in in-house magazines, leaflets, street plays, puppet shows, poster/painting/essay competitions) and meetings. Some of the enterprises used experts in their city to sensitise employees not just to alcohol and drug problems, but also to prevention strategies including life skills training, health promotion, and prevention of HIV, among others. Many of the enterprises included AOD training in the training programme for new recruits as well as for in-service training. Some of the organisations organised health camps and drew attention to the issue through special days like 'No Tobacco Day'.

As part of their Alcohol and Other Drugs (AOD) policies, all twelve companies prohibited the consumption of alcohol and drugs on their premises (some also banned tobacco, including cigarettes and *gutka*). Many firms decided not to serve alcohol at official gatherings, while some resolved not to associate themselves with companies producing alcohol or cigarettes. A power production company disallowed the consumption of alcohol in public spaces in its residential colonies, and had the licenses of liquor vendors in the area cancelled.

Some of the enterprises, e.g. the transport industry undertook regular breathalyser tests of its staff, with follow-up action for those who tested positive for alcohol use while working.

Most companies actively involved the family members in their awareness programmes. One organisation conducted summer camps for employees and their children, and nearly all encouraged social and recreational activities for the extended community.

Amber Zone Strategies

Medical officers were trained in early detection and counselling for substance related problems, to include alcohol and other drug assessment and in counselling persons with substance use related health problems. Health camps were conducted as part of the strategy of early detection. Some of the enterprises encouraged employees to self–administer screening instruments for identifying problems.

Red Zone Strategies

The need to provide assistance and rehabilitation to workers addicted to alcohol or drugs was clearly spelt out in the AOD policy document itself.

Assistance programmes were set in place in all the enterprises

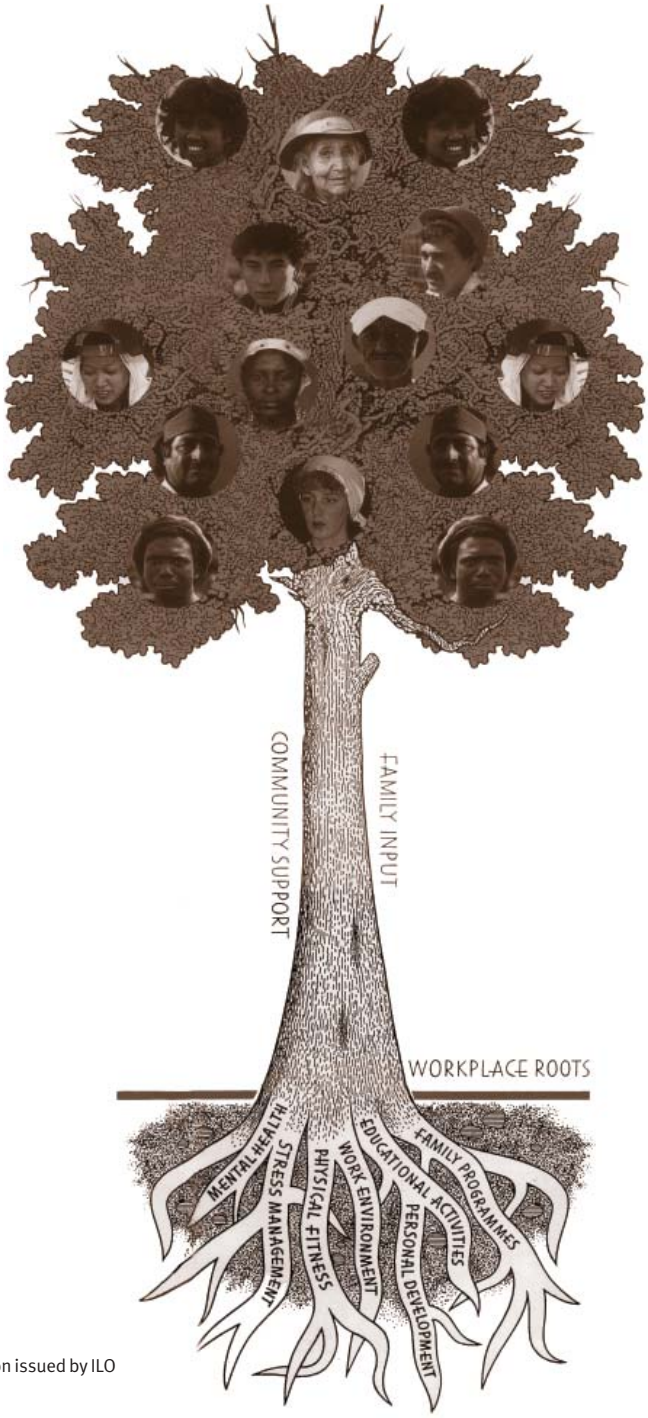
through designated NGOs While some of the enterprises worked solely with designated NGOs, others began to identify larger networks for care and prevention, in addition to NGOs. In some enterprises, social welfare officers carried out counselling. In others, NGO staff provided this service. Referral of cases was made either to the designated NGOs or other treatment centres. Ex-users served as role models to encourage others to seek treatment.

Developing Regional Networks

The expertise to carry out awareness programmes to promote healthy lifestyles and to prevent alcohol and drug problems may not always exist in-house. In addition to support from designated NGOs, each organisation identified a network of support professionals, ranging from medical doctors to safety experts to provide both awareness and assistance to its employees.

Participatory Approach

From the beginning, the WPP Project urged participating organisations to bring all concerned parties to the table. Owners/managers and employers grew to learn the value of involving workers in this process. In every case, the policy was drafted, discussed and finalised by employers and employees' representatives. This participatory approach ensured that the final AOD policy was acceptable to and binding on all members of the organisation. It also ensured that the concerns of both parties were addressed.



Public Interest Information issued by ILO

Section 5

The WPP Experience - Impact and Sustainability

The individual experiences of different organisations have been outlined as box items. Each tells a success story. Overall, the results of the WPP have been most encouraging. With comprehensive policies in place, the companies have been able to address the problems of shop-floor accidents and unproductive work behaviour; some have reported significantly lower losses and improved worker morale.

The impact of the programme is evident through several telling signs. Employers perceived fewer problems at the workplace. Supervisors, who monitored treated employees, were extremely satisfied at the positive changes in the employee's work behaviour including improved attendance,

Coverage of the WPP:

- Included 12 enterprises and 110,664 employees
- 9 NGOs strengthened in WPP
- Total of 1420 managers, supervisors, worker's representatives and NGO staff trained in local workshops

Box 1. Employee's Reactions

Mr. D, a thirty-eight year old from Bangalore started consuming alcohol at the age of eighteen. He had progressed to addiction without ever realising its consequences. In the last few years, he had made some attempts to stop, but restarted drinking because of severe withdrawal symptoms. He used to spend as much as Rs eight hundred to nine hundred a day on drinking with his friends. He once pledged his daughter's silver anklets to support his drinking habit.

Following treatment, which was supported by his organisation, his health has improved significantly. His family is extremely supportive in his recovery. His financial status has improved. He has decided to spend his evenings reading or supervising his children's studies rather than be with his drinking peer group. "*The organisation has made me a human being again. I will be eternally grateful*" is his response to the programme.

BOX 2. Perfect Partnerships: TISCO and Calcutta Samaritans

India's leading private producer of steel, the Tata Iron and Steel Company (TISCO), has an enviable record in employee welfare. TISCO's Jamshedpur plant has a hospital that included a 15-bed de-addiction centre (DAC), run by its Community Development and Social Welfare [CD&SW] Department.

However, as the absence of expert help became noticeable the company invited the Calcutta Samaritans to take over the DAC in April 1998. At this point, an alcohol and drug use prevention policy was already in place.

The Samaritans began by assigning a full-time Administrator to the DAC, to work with volunteers and officials of the CD&SW department. The CD &SW department meanwhile focused on awareness programmes through producing leaflets, posters, pamphlets, and arranging discussions at inter-departmental councils.

The DAC undertakes several tasks like spreading awareness, conducting rescue operations, hospitalisation, detoxification or treatment, rehabilitation, day care programmes including meditation, physical exercises, group therapy programmes, games and prayers. As an integral part of its treatment, the DAC provides intensive counselling to family, friends, peers and work associates of clients. The DAC is now a 30-bed facility and is partly funded by TISCO.

TISCO's policy in case of substance use by employees is very clear: the company pays for the first round of treatment, including hospitalisation. Complete confidentiality is maintained and colleagues of the hospitalised employee are not told (though the personnel department is informed for administrative reasons). In case of relapse, all treatment costs are deducted from the employee's salary in monthly instalments. If there is a second relapse, the employee is dismissed.

The success of TISCO's programme can be measured by the fact that not a single employee has had to be dismissed for substance use related problems so far.

increased productivity and a decrease in substance related workplace problems.

The WPP created a forum of partnership between the employers and workers. Many of the activities were financed by the enterprises themselves, with only technical input from the Project. However for sustainability, the programme needs greater ownership by the companies with support from other agencies in the community, including NGOs.

A large body of employee and worker representatives has been trained under the WPP. Networking with NGOs and local organisations has helped in making organisations more confident about preventing and effectively assisting troubled employees.

Employees too have gained. They now have a system that provides help and contributes to their welfare. All companies have reported cases of full and complete recovery and rehabilitation. Undoubtedly the greatest benefit of AOD policies is the removal or reduction of the stigma attached to addiction, by recognising substance abuse as a health problem and dealing with it in an open and empathetic manner. Another significant indicator of programme impact was the feedback from family members for whom the intervention brought the maximum relief.

Box 3. None for the Road

Transport Company Curbs Accidents

During the state elections, a Karnataka State Road Transport Corporation (KSRTC) bus was carrying a police party on election duty. The party stopped at a *dhaba* where the driver joined the police in a drinking binge. The bus was later involved in a collision with a mini-bus. Twelve including the driver died and thirty five were injured.

Alcoholism in bus drivers takes on a menacing edge as it jeopardises a large number of lives not only of the driver but also of passengers, as well as bystanders and pedestrians, in the event of an accident. The large number of fatal accidents had earned the KSRTC the sobriquet of "killer buses".

Besides accidents, alcoholism had lead to a high degree of absenteeism and problems in maintaining discipline in the organisation. Drivers and conductors habitually thronged the bar across the road from the headquarters of the KSRTC during their free time and often just before reporting for duty. There were numerous instances of employees coming intoxicated to work and indulging in violent behaviour. In fact, an employee with a chronic drinking history killed a deputy work superintendent. The story at headquarters was repeated in all the other depots as well.

The KSRTC Servants (Conduct and Discipline) Regulations of 1971 prohibit drinking eight hours prior to and while on duty. These rules were violated with impunity. The usual response of the management was to turn a blind eye and not get involved, perceiving alcoholism as a self-inflicted problem. At times, such employees were charge sheeted or dismissed. Usually, the immediate supervisor, in the absence of a supportive structure, was frightened of reporting an employee with alcohol related work problems.

Even in cases where disciplinary proceedings were initiated, the time lag between finding an intoxicated employee and producing him for medical examination ensured that there were few cases with medical evidence. In any case, dismissing an employee after two or more decades of service would lead to loss of valuable personnel. Training another person to the same level of expertise was timeconsuming and expensive. Dismissal

was neither in the Corporation's nor the employee's interest.

The Price Of Addiction

KSRTC continued to be in the red for a whole decade and had accumulated losses of more than Rs.4000 (USD 81.6) million. In 1996, a new set of officials stepped into the administration and began systematically stocktaking of the problems plaguing the Corporation.

The Director, Security and Vigilance was struck by the relationship between alcohol and the various problems encountered by the company. He initiated a series of evaluations to gauge the extent of alcohol use among employees. An initial assessment identified about 2,100 employees who were addicted to alcohol. The number of accidents during 1995-96 alone was 2626. In the same year, shortage of staff due to absenteeism had led to cancellation of 52.5 million kms of trips and 17,488 disciplinary cases were also pending.

When the staff spent the night out and had the day's earning with them, those with alcohol addiction were likely to use the earnings to support their habit. The loss to the corporation from this practice was calculated at Rs 62 million (USD 1.26 million). Delayed departures and breakdowns led to annual revenue loss of Rs 10.3 million (USD 0.2 million) and Rs 36.2 million (USD 0.7 million) respectively. At this stage, KSRTC sought the help of the National Institute of Mental Health and Neuro Sciences (NIMHANS) which had expertise in the area of substance abuse.

In January 1997, KSRTC introduced a programme on general health, as it was felt that the employees might view a

programme dealing solely with addiction problems with suspicion. In May 1997, KSRTC conducted a systematic assessment and formulated a comprehensive programme to deal with addiction related problems at the workplace. About 150 employees were identified as key Informants and their assistance was sought to gauge the extent of the problem.

High Accident Rate

Although the accident rate in the enterprise had registered a fall, 502 people died and 4327 people had been injured in 1997. A pilot study found that two percent of the employees were coming intoxicated to work. About seven percent of deaths of employees were directly attributed to alcohol. Many deaths categorised as due to "ill-health" or "natural" appeared to be connected to addiction related complications. High levels of substance abuse and high-risk sexual behaviour were observed in drivers and conductors on long distance duties away from home. The associated risk of HIV infection was found to be significant.

To reduce the costs of substance abuse to the organisation and to the individual, KSRTC formulated a comprehensive AOD policy. Their programme was officially christened as *WAPPA* (Workplace Alcohol Prevention Programme and Activities) which locally means inviting a person to join the initiative. Implementation committees were set up both at the depot level to deal with the day- to- day working of the programme, as well as at the Corporation level to plan strategy and oversee the entire programme.

Assistance and Prevention

The WAPPA applied the traffic light model to categorise the workforce into three groups. This model, being familiar to the workers, had an immediate impact on them.

A depot level assessment revealed that there were 5248 employees, including 2358 drivers, 932 conductors, 767 mechanics and 191 others, in the 'red zone' (much higher than the initial assessment). Medical treatment and assistance for those in the red zone was an immediate necessity. However, the number of employees in the red zone was so large that even all the treatment centres put together could not accommodate them. In 1997, with a budget of Rs.1.5 million (USD 0.03 million), the KSRTC started a 30-bed de-addiction centre at its hospital in Bangalore.

The Red Zone

Employees in the red zone were sanctioned medical advances of five thousand rupees and thirty to forty days of leave, and sent to various treatment centres, including CAIM and KSRTC's de-addiction centre. The de-addiction centre, managed by trained counsellors and social workers, conducts a comprehensive six week programme. This begins with a detailed physical evaluation and treatment includes structured daily activity, nutritious diet, physical exercise and yoga, individual, group and family counselling and work skill upgradation.

Families, overwhelmed with financial stress, and verbal and physical abuse from the addicted individual were encouraged to come to the de-addiction centre. Counselling, support and suggestions for follow-up, problem solving, better communication and financial management were given to family members. The Centre also carried out depot level follow-up and undertook home visits when employees failed to report for follow–up meetings.

Recovered employees were asked to maintain diaries to record their progress. The diary was meant to act as a constant reminder to the concerned employee of his commitment to the programme. The depot supervisor ensured that the diary was faithfully maintained and used by the employees. Recovered employees were commended for the efforts and improvements they had made in recovery. Success stories were shared to create a positive attitude towards the process of change. Recovered employees were encouraged to function as group leaders and motivate others for treatment.

Weekly review meetings were conducted at various depots to monitor the progress made by treated employees. Incentives and rewards for positive behaviour, help in re-integration into the workplace, flexibility in changing shift timings, transfer to a depot near the place of residence of the employee and harnessing support from the family were some of the strategies used for the treated employee to support his recovery. In case of a relapse, the employees were again referred for treatment, but at their own cost and with leave due to their credit. After a second relapse, disciplinary action was initiated against employees.

The Amber Zone

About 14,000 employees were estimated to be in the amber zone. Early identification, facilitating self change, training staff in communication and assistance skills, improving awareness of early signs of non-performance and working with families and medical personnel to identify early social and medical problems were the strategies followed for the amber zone. Workshops were conducted for the employees to inculcate awareness about problem recognition with respect to alcohol and drugs use. Self-evaluation and monitoring with regard to drinking, a realistic idea of possible future problems and preventive action were stressed in the training sessions.

Heavy responsibility, unrealistic performance targets, overwork, underwork, fear of retrenchment, low job security, poor promotional avenues and harassment were identified as high risk factors for alcohol related problems at the workplace. A training module for supervisors, focussing on good communication, interpersonal skills, early identification and handling of work related problems, was evolved as part of the strategy for the amber zone.

The successful moving of many employees from the red to the green zone, with the attendant improvement in health, work, family environment and finances motivated many persons in the amber zone to seek treatment.

The Green Zone

For employees in the green zone, the thrust was on awareness programmes focussing on the hazards of alcohol and drug use. Myths and misconceptions about intoxicants were dispelled. The employees were made aware that initial,

apparently innocuous use could progress to problem use and addiction. The concerns of the Corporation and and consequences of alcoholism on the workplace were shared.

The Corporation acquired 113 breath analysers for various depots for routine and surprise checks, to act as a deterrent against employees coming intoxicated to work. De-addiction awareness has been incorporated into the orientation/ induction training programmes organised by the KSRTC training institutes.

WAPPA started off as an exercise in improving productivity and cutting costs. However, it gradually evolved into a programme for the humane handling of addiction, benefiting both KSRTC and the employees. Previously, many addicted employees could not stop or reduce their drinking due to their fear of severe withdrawal symptoms. Apprehension of strict disciplinary action and stigmatisation were other factors that led employees to continue drinking. The programme legitimised the need for treatment of the addicted individuals. By emphasising work performance, it reduced the moral and stigmatising attitudes towards alcohol consumption. The incentives for recovery and maintenance of sobriety in the programme also played a constructive role in recovery.

Awareness and assistance strategies brought home the realisation to many employees that they had a problem. Family members, who had borne the brunt of the addiction, played an active role in treatment, aftercare and follow-up and rediscovered the humane side of the recovered person. Improvement in attendance, fewer crew shortages and lesser disciplinary problems were the positive effects at the supervisory level.

Reduced Accidents and Losses

The Corporation benefitted when the accident rates fell, substance use at work plummeted to negligible levels and there were fewer incidents of indiscipline. There had been 63 assaults on colleagues and supervisors in 1996. After one year of WAPPA, this figure came down to 16 in 1997. The attendance of post-treatment employees improved dramatically, with a 71% increase in the case of those who had been working for less than 10 days a month. The increase in revenue due to improved attendance, reduction in cancellation of trips from 20% to 6.7%, reduced pilferage, fewer accidents and compensation claims, and decrease in disciplinary cases has been computed by KSRTC.

The cost-benefit analysis of WAPPA shows that the programme can potentially reduce losses to the Corporation by a staggering Rs 171.20 million (USD 3.49 million). The Association of State Transport Undertakings, an apex body of state run transport undertakings, has directed all its 64 members to visit KSRTC to study and adopt the programme.

Perhaps the non-condemnatory, non-moralising attitudinal component of the WAPPA has played a crucial role in transforming persons with alcohol problems. From being social nuisances, they are now people realising their potential as humane, nurturing and productive individuals.

BOX 4. Drinking and Driving Don't Mix

Nobody knows better than drivers do that drinking and driving make for a deadly cocktail. Yet the transport sector is riddled with an acute problem related to alcohol use.

Long hours of driving in the night is highly stressful. Most drivers in the Calcutta State Transport Corporation attributed their drinking to stress.

The Calcutta State Transport Corporation, in collaboration with the VES, introduced a Workplace Prevention Programme in its Thakurpur, Tarantala and Lake depots with the aim of reducing accidents, absenteeism, medical and compensation claims as well as grievances and disciplinary action.

The CSTC's Alcohol and Other Drugs or AOD policy is akin to that of the Karnataka State Road Transport Corporation. However, the CSTC has shown less tolerance to relapse. Even the first relapse invites disciplinary action.

After conducting a rapid assessment survey, the CSTC began implementing its addiction control policy in earnest. Steering committees at the corporate, middle management and depot levels were put in place to oversee implementation of this policy.

In addition to providing treatment to the addicted employees, CSTC conducted 84 orientation, awareness, counselling and inter-personal programmes as well as training workshops and seminars. The data speaks for itself. At the Thakurpur depot, out of 44 workers identified as chronic alcoholics, 30 went for counselling and treatment and all have reduced their intake of alcohol. At Tarantala Depot, out of 12 chronic alcoholics, 10 went for treatment, 4 became alcohol free and 6 reduced their level of intake. At Lake Depot, 63 workers were identified as alcoholic and 53 went for treatment and counselling. Awareness among all the workers increased.

Setting up self-help groups, extending the programme to all the depots and forming a steering committee to monitor the progress of the project are part of the CSTC 's future agenda.

Box 5. The Face Off with Feni

Goa Shipyard Makes A Breakthrough

"I drank Directors Special when I wanted to feel like a director of my company, Officers Special when I wanted to act like a big time officer and Eight p.m. when I felt like a naval officer...what I wanted to feel like dictated what I drank that day!!"

- A Recovered Employee, GSL

Courtesy: ILO

With every second shop either a bar or liquor store, drinking is a tradition in Goa. The tropical paradise state of Goa has over 7000 licensed bars and pubs and an equal number of illegal establishments catering to the large tourist population. Goa is also one of the biggest problem states with respect to alcohol and drug use. Alcohol is promoted through hoardings and advertisements as aggressively as tourism. Many Goans also brew their own spirits. The most common of these is *feni*, a traditional spirit made of distilled coconut or cashew nut.

A study conducted in Goa on the impact of alcohol consumption on industrial workers revealed a high prevalence of alcohol use among them, with rates varying from 40% to 60%. Twenty five percent of employees in the shipping industry reported hazardous drinking.

It is against this extremely challenging backdrop that Goa Shipping Limited (GSL) began efforts in 1995 to assess, prevent and control the abuse of alcohol and drugs amongst its workers. The Chairman and Managing Director was strongly convinced of the need for an Employees' Assistance Programme to equip employees to help themselves. GSL and the Kripa Foundation collaborated with the Project in November 1997, to formulate guidelines for the alcohol and drug abuse prevention programme at the workplace.

GSL Profile

A public sector undertaking, GSL is a high security company manufacturing sophisticated hi-tech vessels for defence purposes. Centrally located in south Goa's industrial belt, Vasco de Gama, GSL employs about 1900 regular workers, 500 contract labourers and 200 managerial and administrative staff. In 1995, at the beginning of the programme, about 200 workers were identified as *'troubled'* employees, the majority of them prey to alcoholism.

The easy availability of alcohol and a permissive social climate contribute to alcoholism. There are 8 bars right outside the gates of GSL. The red light area is at an easy distance of just 2 kms.

Kripa Steps In

To formulate and implement a drugs and alcohol policy at GSL was no small task. The four strong unions operating within GSL initially refused to accept that substance abuse was a significant problem amongst the workers. *"We didn't want the workers to be labelled as 'bebdos' (drunkards). We were afraid that management may take disciplinary action against these workers,"* says a union leader.

The workers needed much convincing that an Employees' Assistance Programme (EAP) was in the interest of the workers, but once they understood this, they actively supported the programme.

With assistance from the Kripa Foundation and the Project, GSL has been actively involved in the prevention, diagnosis and treatment of substance abuse amongst its employees. The management and the unions discussed and agreed on a GSL Alcohol and Other Drugs Policy (GSL AOD Policy) and formed a steering committee to oversee its implementation.

The steering committee has representatives from the management and from the employees and it meets at regular intervals - at least once in a quarter. It takes initiatives to make the AOD prevention policy effective and reviews its implementation. In brief, this group plans, initiates, directs, monitors and evaluates GSL's AOD abuse and prevention policy.

The GSL AOD Policy

The GSL AOD policy is intolerant towards the consumption of alcohol or drugs during working hours or on company premises. The company can remove a person from any position of risk when work performance is affected by the state of intoxication of a worker. The individual may not be allowed to work until deemed fit to perform the job safely and productively. The company provides transport to the person's residence but they are not paid for the lost time.

Officers and supervisors can play a crucial role in identifying workers with problems and gently steering them to resources that can put them on the path of recovery. At the beginning of the programme in 1996, 10 volunteers from the officer and supervisor level attended a basic training workshop on EAP guidelines (held in collaboration with Kripa Foundation, Mumbai) to equip them to take on the role of facilitators.

The workshop taught officers and supervisors to spot habitual and occasional substance abusers. They were trained to remain alert to inconsistent or poor quality work, increased absenteeism, drastic change in behaviour and indebtedness amongst the workers.

It is the responsibility of the facilitators to intervene while ensuring that their intervention is focused on performance problems. The second step for the facilitator is to urge a

potential problem worker to seek counselling and take preventive measures. The facilitator refers the worker to the EAP coordinator whose responsibility it is to ensure that the worker avails of the counselling and treatment facilities at the Employees' Welfare Centre.

If the employee's condition is serious, a one-to-one interview is arranged to advise them of the problem and offer help. If the problem continues, a second interview is held to caution the individual, offer help and warn of disciplinary action.

In case of a third relapse, the employee is given the option of obtaining help (in-house or from outside) or facing the consequences of disciplinary action and even dismissal.

Appropriate disciplinary procedures can be initiated if an employee is found to be involved in the trafficking of drugs, in possession or use of drugs other than those prescribed by a medical practitioner, or convicted in any court of law for any drug abuse related offence. So far no employee at GSL has been discharged due to consumption of drugs or alcohol.

The GSL AOD policy agrees that "addiction to alcohol or drugs is a disease and an addicted employee needs support and encouragement of the family, colleagues and employers to help take the path to recovery. The company also acknowledges the need for medical guidance as addiction is a permanent and progressive illness and should be treated as such."

Setting Up The EAP Centre

Guided by Kripa, the chief medical officer of GSL started the EAP centre in a barrack within GSL premises. The centre now occupies the entire floor of a building. It is now known as the Employees Welfare Centre, to avoid being labelled the *bebdo* or drunkards' department. The EWC provides counselling, evaluations and assessments. The GSL medical centre refers workers to the EWC if they test positive for alcohol or drugs.

The in-house facilities available at the EWC, with assistance from Kripa's Goa centre, include individual and family counselling, group therapy, mental health consultation, self-help group meetings (Alcoholics Anonymous) and counselling for HIV/AIDS patients. A part time social worker acts as the coordinator. Two counsellors from Kripa are available throughout the week. An HIV/AIDS counsellor from Positive People visits once a week. Competent medical officers and a psychiatrist are available at the medical centre. For employees requiring intensive rehabilitation, the Kripa rehabilitation centre is available at Anjuna.

Testing for alcohol or drug use and abuse is done at various stages at GSL. At the pre-employment stage, all selected candidates are required to go through a medical examination. A positive test result is deemed sufficient for the candidate's rejection. Tests are conducted on any employee charged with having caused an accident or injury, disregarded a safety rule or otherwise acted in an unsafe manner.

AOD testing is also conducted if an employee is violent, behaves abnormally or erratically, has suspicious physical symptoms and is habitually absent. Random or unannounced testing is also carried out. This is applicable to all employees and at least twenty five percent of the employees are tested at random every year.

Testing for Substance Abuse

The list of persons to be tested is kept confidential and the persons are notified only on the morning of the test date. The employee's right to confidentiality and privacy is recognised and maintained. The company bears the cost of the tests and any employee who tests positive is referred to the EAP where alcohol and/or drug evaluation and assessment are provided.

In 1995, with the help of the trained facilitators, 200 troubled employees or 'hazardous drinkers' were identified in GSL. Since January 1996, when the EAP commenced, 157 employees have registered with it and 132 have availed of its in-house facilities. Of these 95 have recovered, 24 are not well and 13 are dead. Of the 25 workers that were referred to either the Kripa rehabilitation centre or the Institute of Psychiatry and Human Behaviour (IPHB), 17 recovered, 4 are unwell and 4 have died.

Returning to Work

A 50 to 60% recovery rate has been averaged at GSL. In the case of relapse of a treated employee, one or two opportunities are given but the employee has to bear the cost of treatment. Most of the troubled workers that opted for rehabilitation have remained sober for over two years since the beginning of the EAP.

There have been some relapses, but as many employees will testify, the EAP has helped many troubled souls at GSL turn their lives around. Further, as per the GSL AOD policy, the management and the unions are committed to bringing about an attitudinal change among supervisors, officers and co-workers towards the rehabilitated employee.

The company also recognises the need to address the concerns and issues of the non-addicted majority. It seeks to create awareness of healthy lifestyles through dissemination of information, education, training and promoting positive lifestyles amongst the employees. Workshops are held periodically in collaboration with Kripa to disseminate information on alcohol and other drug use, and other preventive strategies.

Focus on Healthy Lifestyles

The scope of the EAP has widened beyond alcoholism, drugs and HIV/AIDS to encouraging generally healthy lifestyles. A number of health awareness programmes have been initiated at GSL. Activities such as exhibitions on various lifestyle problems, film shows, lectures, street plays, observance of safety week, basic yoga courses and self development programmes for children of GSL employees are held regularly. The company sponsors no event associated with alcohol.

GSL frequently organises health camps. Workshops on low backache, heart disease and smoking have been held. Medical check-ups of employees over 40 (approximately 1000 employees) are done annually.

The GSL management has had to face the reality of numerous bars and pubs right outside its gates and the fact that sixty percent of its workforce exits the gates at lunchtime. Last year the management tried to introduce breath analysers to check employees coming to work intoxicated. There was strong opposition from the unions and some of the officers. According to a union leader, *"We felt that the management was labelling us as bebdos. But later we realised we had misunderstood their intentions. Now if they introduce breath analysers, I don't think anyone will object."*

The signs of success of GSL's programme are clearly visible: the rate of absenteeism has dropped, and the employees in the green zone have remained there. A new GSL AOD policy has been formulated and a budget for the EAP has been allocated. Many other industries in Goa are beginning to show a keen interest in starting similar programmes.

Goayard Samachar, the in-house GSL magazine best sums up the achievement. *"The EAP seeks to bring home to every individual that he is a potential winner. It has succeeded beyond expectations, as the troubled employees who have availed of its facilities and come out triumphant will testify…this incredible success rate has encouraged the EAP to continue their efforts in the rehabilitation of problem employees. When the company plants the seed of prevention, the employer, the workers and the community reap the benefits."*

Box 6. The Mahindra Story

Alcoholism and drug use among employees are serious problems faced by many companies. Such problems cause absenteeism, losses, inefficiency and increased risks on the factory floor. They inflict untold misery on the workers' families. The struggle against these problems in the Mahindra & Mahindra Automotive Company in Mumbai that has 10,500 employees is exemplary. It is noteworthy that in M & M's campaign against the scourge of alcoholism the management received full cooperation from the employees' union. Without this, the assistance rendered by the Project and Kripa to M & M would not have been so productive.

To fight alcoholism and other ills affecting its employees, a Welfare Centre was opened at M & M in 1971 (the company was established in 1945). M&M officers had noticed that many employees seemed to have financial problems. They not only availed of all the loans and advances available under company rules but also borrowed from moneylenders and were in serious debt.

A door to door survey revealed a fair number of addicted employees. Initially the Welfare Centre's focus was on counselling addicts from a moral point of view. The limitations of this old fashioned approach were evident in due course, as employees did not give up drinking or taking drugs. Something new had to be done to complete the denial-acceptance-treatment-prevention process.

A more holistic method was adopted in 1982. The managers talked to their counterparts in other companies who were also tackling similar problems, pored over new literature on the subject of addiction and got in touch with NGOs active in campaigns against substance abuse. The problem was now identified as a disease. The realisation that this disease required special treatment and rehabilitation dawned upon the earnest crusaders of M & M.

Nishant Alcoholics Anonymous

To stop substance abuse a self-help group called Nishant Alcoholics Anonymous (AA) Mahindra Group was set up in 1982. Nishant means the "end of the night". A recovered branch

manager led the group. In the same year employees began to be admitted for specialised treatment at the Kripa Centre.

Gradually the encouraging message that abstinence was possible began to spread among the addicted employees, as well as the other employees. The number of Nishant members increased as recovered employees started helping others. The most impressive part of this effort was the cooperation offered by the employees' union and by workers themselves. With the help of the union, giving assistance to employees with a drinking problem became a routine activity at M & M. Other developments followed.

Due to the intervention of the Project it became easier for the management of M & M to recognise addiction as a health problem on par with other diseases. Organisations like Kripa and Sevadhan played a crucial role in convincing senior personnel to adopt the new approach being taken towards drug and alcohol abuse. Consequently, in 1992 M & M started treating the absence of alcoholic employees under treatment as medical leave. Later, as part of the Project, the focus of the de-addiction programme shifted to prevention.

M & M's drive towards an "addiction free world" has included organising regular worker education programmes about substance abuse, yoga, counselling for stress and work-pride programmes. Assistance to workers undergoing treatment for addiction includes: full reimbursement of medical and rehabilitation treatment expenses by the company, formation of support groups for families of alcoholics and the maintenance of proper treatment records to facilitate follow-up after treatment.

Box 7. Hitting the Jackpot at Hindustan Motors

"My name is Venugopal. I am a multiple addict identified and sent for treatment and rehabilitation at TTK Hospital by Hindustan Motors (HM) and at the cost of HM...I thank our management for providing me such a wonderful opportunity to win the lifetime Jackpot called sobriety and Ms Shanti Ranganathan for being a great inspiration and motivating factor. As far as I am concerned no amount of money or fame can compensate my sobriety that I am enjoying now... By the grace of God and the wonderful fellowship of AA I never had my first fatal drink today," wrote an employee of Hindustan Motors in a letter to the Project coordinator.

For Hindustan Motors, a company that produces earth-moving equipment at its Tiruvallur plant in Tamil Nadu, safety on the shop-floor is of paramount importance. With ten percent of the workforce given to abusing alcohol or drugs, safety was being jeopardised and accidents were frequent. Staff and workers came late to work and did not like being reprimanded for it. Rudeness and violent behaviour were common at the factory. Workers and staff regularly took sick leave because of addictions. This company reported the highest number of employees coming to work under the influence of alcohol or drugs (eighty four percent) among the twelve workplaces surveyed. It also had very high levels of absenteeism.

The problem was obviously crying for attention. Before the Project the company had a programme for referring addicted employees to the TTK Hospital for recovery. Twenty four employees had been sent to the TTK Hospital. The focus of the programme however remained on the heavily addicted employees falling in the red zone.

Under the Project the philosophy of HM underwent a paradigm shift. The focus started shifting from the red zone to the green zone. The management put together an awareness generation package and held workshops. A draft policy on drug and alcohol abuse was prepared with employee participation.

At the initial stage the management faced many hurdles. Non-user employees resented the fact that they had to undergo training under the Project. Coincidentally, the company had just obtained a prestigious global tender and had embarked on an all-time high production and sales effort. Employees did not want to put in extra hours for training and the department heads would not release them during work hours to attend the workshops. Department heads had to be persuaded to allow the employees to participate in campaign activities. This perseverance paid off, with unions and management coming to a mutually satisfactory agreement.

A contest was held in English and Tamil, asking for attractive slogans and logos for the year-long campaign. The slogan "Addiction leads to destruction" was adopted and inscribed on pens and salary slips and used on posters displayed in the canteen, union, office and other conspicuous places in the plant. An article on the programme was carried in the house magazine "Tracks". Employees also wrote, composed and sang a song against addiction that was later recorded and audio cassettes given out free.

Keeping the alcohol and drug use profiles of staff and workers fully confidential, the management sent some more employees to TTK Hospital for recovery and rehabilitation. It paid for the treatment, deducting the amount from the medical expenses allowed to workers. Workers' families were closely associated with the Project. Self-help groups for recovering employees and their families and friends were started. The company set up a green committee to oversee implementation of its prevention campaign.

Half way through the Project HM began tasting the sweet fruit of its employee friendly policies. One year later HM reported substantial reduction in absenteeism. In 1997-98 before the Project was implemented nearly 12.5% of staff and nearly 10.3% of workers had absented themselves from work. One year later the figures had gone down to 9.4% and 8.9% respectively.

The best encomium came from a supervisor. *"The campaign affected me so much that I have given up smoking too,"* said this supervisor who refused to be identified.

Box 8. AOD Policy Helps Modi Rubbers

Modi Rubbers is a large tyre producing industry in the small town of Modipuram near New Delhi. The industry reported some use of alcohol on the factory premises but its bigger problem was the large number of employees coming to work under the influence of drugs or alcohol.

As in the case of other industries this one too had to deal with absenteeism, shop-floor fights and lack of punctuality. What really worried the management was the increasing incidence of employees drinking during lunch breaks. This occasionally led to disruption of work.

Under the Project, Modi Rubbers, in consultation with workers' unions, hammered out an AOD policy. The policy stipulated that the management would grant sick leave to addicted employees who opt for treatment and would also pay for hospitalisation. After discharge these employees would be allowed to opt for lighter duties for a while to give them time to cope with the stress of abstinence. This choice, the employees were assured, would not affect their chances of promotion and other career opportunities.

The company has noticed a distinct improvement in the work environment and health of its employees since the implementation of the alcohol and other drug abuse policy.

Box 9. The Hindu Promotes Total Health

THE HINDU

The newspaper industry is probably one of the worst affected by the adverse consequences of alcohol and drug abuse. Drinking is a fashion in the media and press clubs take pride in their bars.

Few media organisations address the problem upfront, though almost all have problems with drunk journalists sauntering in late for work or drinking at the workplace, especially during night shifts.

A prestigious media group from the south that publishes a daily newspaper, the Hindu, decided to confront the problem head on. In comparison to other enterprises this organisation reported one of the highest levels of work related complications because of alcohol and drug abuse. Late arrivals, tardiness at work and abuse of substances at the workplace, leading to frequent quarrels, were some of the problems that the management experienced.

The organisation had a prevention policy in place before the Project and used to refer addicted employees to de-addiction centres. The Project provided it with a new perspective by involving employees in all categories (workers in the press, journalists, and advertisement and management personnel) in the prevention campaign. The enterprise came up with a package called "Towards Total Health", which included prevention of substance use as an integral part of health.

Lunch packets prepared in the office canteen were emblazoned with messages against substance abuse and calendars carried short messages on healthy living. The calendar for 1999, when the Project was being implemented, carried this message along side a picture of a girl sitting outside a temple: *"The world today is a very different place than it was yesterday. This is more visible at the workplace than anywhere else. While work becomes more and more interesting and challenging, with it comes the need for good health care. As we cannot change the world, we must at least take charge of our lives by learning to cope, and recognise the things that make for a healthy life. This calendar makes an effort to provide you with simple tips on diet, modifications of lifestyle, early detection of disease and its prevention, fitness and exercise, and stress management. Take care of your health for it is the essence of life."*

The Hindu observed occupational health day, designated smoking zones declaring most of the workplace a no-smoking area, and held several talks on issues such as the right to health, the adverse effects of alcohol on health and the hazards that alcohol poses to society.

At the end of the Project there was marked improvement in the working atmosphere of the publishing house. Encouraged, it continues with the campaign.

Box 10. Cummins and Muktangan Mitra Partnership

Cummins Inc, Pune, the world's largest designer and manufacturer of diesel engines, had a major problem of alcoholism. The Project changed Cummins' perspective on the issue of alcoholism by shifting the focus from the addicted employee to the entire workforce. The management realised that reinforcing the message of abstinence among non-users is far more cost effective than letting things slide and then arranging for de- addiction of addicted individuals.

The Project involved the company's top management in the effort to prevent and curb alcohol and drug abuse at the workplace. Cummins provided a room to Muktangan Mitra, its partner NGO, in the factory premises to organise and run its activities. It provided facilities to families of addicted workers to congregate and discuss the issue. It included anti-addiction messages in its technical and safety training programmes and published information on the adverse consequences of substance abuse in its house magazine 'Pratima'.

Cummins set up a committee with MM representatives on it

and implemented many anti-addiction programmes. Poster exhibitions and sports competitions on festive occasions were part of the campaign. The factory also organised a competition to climb the Sinhgarh fort atop a hillock nearby. This is a famous fort that Shivaji had captured.

By the end of the Project the change in employees was visible. The number of fights among employees were reduced. The interventions helped to bring families closer. Husbands actually began to discuss workplace problems with their wives.

Cummins was so enthused by the Project results that it invited 20 other enterprises to a conference, to tell them about its experiment with prevention at the workplace as an integral part of the work atmosphere.

Box 11. MICO Keeps the Greens Green

MICO, the Motor Industries Company Limited, has been a major producer of spark plugs and diesel injection systems. It set up a new factory in Naganathapura, on the outskirts of Bangalore to manufacture auto electricals.

MICO has had a long tradition of carrying out various awareness and assistance programmes for its employees. In the past, a collaborative programme had been set up by MICO with NIMHANS to provide assistance to employees with addiction at its Bangalore plant.

The Naganathapura factory did not have any serious problems with alcohol or drug addiction. Yet, it has many characteristics that may make it potentially prone to this problem. The work force is young, with many employees in their early twenties. Many of them live alone. Those coming from deprived circumstances suddenly find themselves with a lot of money from their earnings, and little to do in their free time. All these provide a fertile ground for development of substance related problems.

MICO Naganathapura thus decided to adopt a pro-active preventive approach. The worker's union actively supported the programme. Employees regularly attended awareness programmes on the early problems associated with alcohol and drug use. In addition to this, ways of spending their leisure time, financial managment, consequences of substance use on safety, health and productivity are topics discussed during the orientation training of new employees. Life skills education and awareness on a range of health issues are also provided.

Keeping the Greens Green is the Naganathapura mantra.

Moving Forward from the Workplace Prevention Programme – Formation Of The ARMADA

In the next phase of the WPP, more enterprises have been recruited. There is an effort to replicate the programme on a nation-wide basis. The ARMADA has been formed.

The Association of Resource Managers against Alcohol and Drug Abuse (ARMADA) is a forum committed to arming workplaces and workforces against alcohol and drug abuse.

The first National ARMADA Workshop was held in New Delhi in December 1999, and the preliminary steps for the formation of ARMADA India were concretised in July 2001.

The primary objectives of the ARMADA are to:

- Develop a network for sharing information and experiences relating to WPP
- Promote the concept of workplace substance abuse prevention programmes
- Assist organisations in developing policies and programmes based on the rich experiences of the WPP
- Develop a pool of human resources and resource material that will be useful in awareness building and training

ARMADA India intends to mobilise support from various enterprise, employee federation and national and international bodies and to establish linkages between the workplace and community, as well as with other programmes addressing this issue.

ARMADA strongly reinforces the concept of peer communication and learning. It promotes company responsibility. Although ARMADA India is employer based, the scope of membership has been extended not just to managers from enterprises but to various organisations and individuals keen on promoting a healthy workplace through the prevention of alcohol and drug abuse.

Section 7

Developing Community Drug Rehabilitation and Beyond

The long term objective of the Community Based Drug Rehabilitation and Workplace Prevention Project envisages reduction of substance abuse and its adverse consequences on social and economic development, through the introduction of effective drug rehabilitation and social reintegration programmes as well as workplace initiatives in a coherent national strategy to combat drug and alcohol related problems in India.

The project on Community Based Drug Rehabilitation and Workplace Prevention helped in shifting emphasis to a more community and business oriented approach, and strengthened bridges between NGOs and enterprises, to their mutual benefit. It demonstrated a successful collaborative partnership between the Government, international agencies and employers' and worker's organisations on the one hand, and improved the communication and dialogue between the Government and the NGOs, on the other.

The project adopted the ILO reference model for community based drug rehabilitation and workplace prevention. Its flexibility allowed it to be adapted and improvised, to meet different needs in different environments, crucial in a large and diverse country like India.

The project also brought focus on several key issues required for successful implementation and for sustaining community and workplace prevention and intervention activities in different areas. These include:

- Strengthening of NGOs and Systems of Care
  - Strengthening of NGOs and continuing support to them to provide good quality rehabilitation services and prevention programmes
  - Development of minimum standards for treatment and rehabilitation
  - Training of NGO personnel in HIV/AIDS prevention and management
- Training and Resource Development
  - Training to focus not only on skills for substance abuse treatment and prevention, but also on administrative mechanisms including record keeping and documentation
  - Intensification of training programmes to increase the trained pool in this area.
  - Development of regional programmes for staff training and monitoring
  - Production and dissemination of resource and training material, especially in regional languages for use by NGOs
  - Setting up of a National Centre for Drug Abuse Prevention, for dissemination of resource material on training, service delivery and research relevant to policy makers, programme planners and service providers.
- Expanding the Programme
  - Replication of the models established in this project to other NGOs and to other workplaces
  - Expanding the programme to cover vulnerable groups such as street children, sex workers, tribal populations and other work sectors
  - Active collaboration with the media for effective advocacy campaigns

Expanding the programme will involve the initiatives of government, non-governmental agencies, ARMADA, enterprises, communities and concerned individuals. It also needs to bring into focus other commonly associated problems such as smoking, high risk sexual behaviour and violence. An ideal programme would also move towards developing a healthy lifestyle and minimising stress among employees.

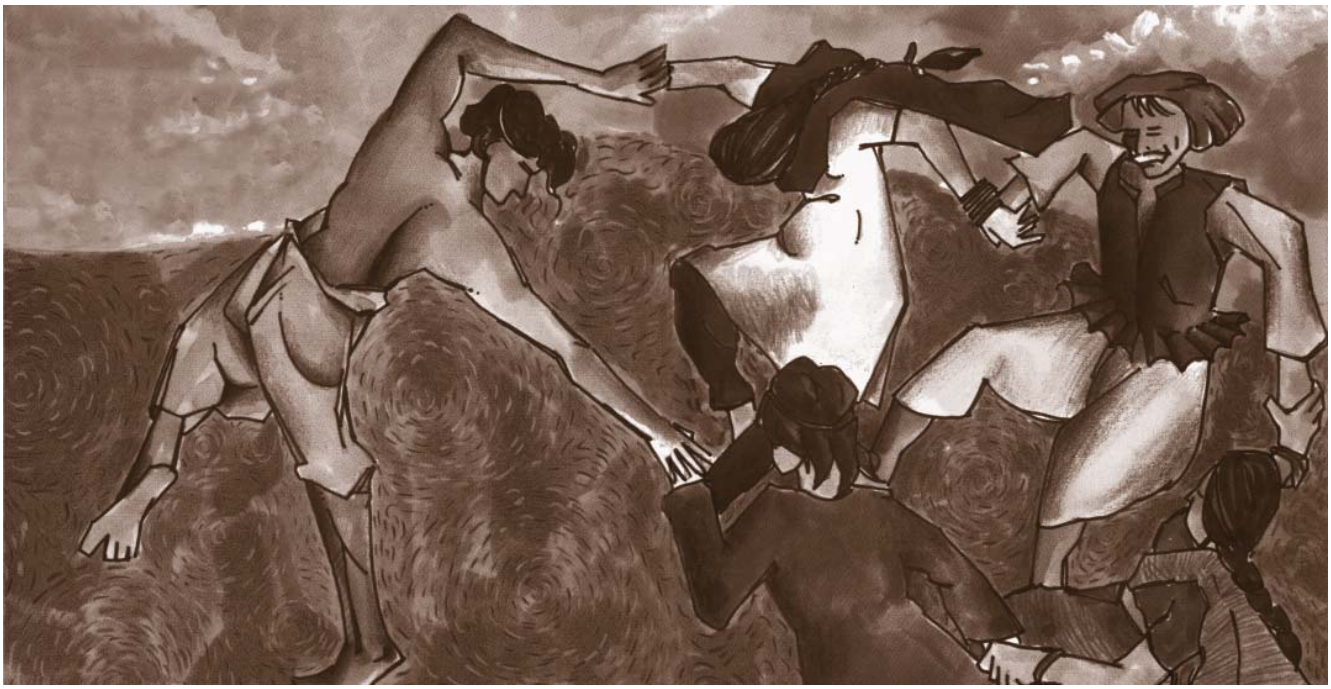
Increasing the Impact of the WPP

Measures to increase the impact and coverage of the programme include:

- Development of regional programmes for workplace staff training and technical monitoring, utilising the services of NGOs and other organisations in the region
- Training of medical and paramedical staff in early detection, treatment and rehabilitation of workers with drug and alcohol problems

- Extending the programme to more enterprises and to their subsidiaries
- Involving more worker's bodies, actively involve Chambers of Commerce and federations of employers
- Integration of community prevention and aftercare components into the workplace programme
- Possible extension of the programme to the communities of enterprises (e.g. townships and residential colonies)

The vision of the 808 project is aptly summarised in the Final Evaluation Report of the Project. "Utilising a combination of activities aimed at institution building, training, community mobilisation and networking, this project is designed to establish a lasting partnership on drug demand reduction in India"



Section 8

Source Documents and Selected References

Source documents for the monograph include the project reports prepared by the non-governmental organisations and enterprises, project documents and evaluation reports listed below, as well as from site visit reports by content providers.

Source Documents

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25 Report of The Rapid Assessment Study Of Drug Abuse in Target Communities in India by Mittal S and Chien J.
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List of Main Abbreviations

AA:	Alcoholics Anonymous
AIDS:	Acquired Immune Deficiency Syndrome
ARMADA:	Association of Resource Managers against Alcohol and Drug Abuse
AOD:	Alcohol and Other Drugs
BSBS:	Bodhi Satva Baba Saheb Dr Ambedkar Smarak Samiti
CBDR:	Community Based Drug Rehabilitation
CD&SW:	Community Development and Social Welfare
CKI:	Community Key Informants
CSTC:	Calcutta State Transport Corporation
DCRWPP:	Developing Community Rehabilitation and Workplace Prevention Programme
DAC:	De-addiction Centre
DUVA:	Drive for United Victory over Addiction
EAP:	Employees Assistance Programme
EWC:	Employees Welfare Centre
GCI:	Galaxy Club of Imphal
GSL:	Goa Shipyard Limited
HIV:	Human Immunodeficiency Virus
HOPE:	Horizon of Prosperity and Education
HM:	Hindustan Motors
ILO:	International Labour Organization
IWCDC:	Integrated Women and Children Development Centre
IPHB:	Institute of Psychiatry and Human Behaviour
KSRTC:	Karnataka State Road Transport Corporation
MM:	Muktangan Mitra
MSJE:	Ministry of Social Justice and Empowerment
M&M:	Mahindra and Mahindra Company
NARC:	National Addiction Research Centre
NGO:	Non Governmental Organisation
NIMHANS:	National Institute of Mental Health and Neuro Sciences
ONPC:	Office of the National Project Coordinator
OPD:	Out Patient Department
PAB:	Project Advisory Board
PMT:	Project Management Team
RAS:	Rapid Assessment Study
RAS DATC:	Rapid Assessment Study of Drug Abuse in Target Communities
SEDI:	Social and Economic Development Institution
STDs:	Sexually Transmitted Diseases
TISCO:	Tata Iron and Steel Company
TOT:	Training Of Trainers
TTK:	T T Krishnamachari Hospital
TTR:	T T Ranganathan Clinical Research Foundation
UNDCP:	United Nations Drug Control Programme
VES:	Vivekanand Education Society
WAPPA:	Workplace Alcohol Prevention Programme Activities
WPR:	Whole Person Recovery
YMNA:	Youth Mobilisation for National Advancement

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While there has been accumulating knowledge of the problems associated with substance (drug and alcohol) use in India, there has been little documentation on effective responses for preventing and dealing with these problems.

This monograph captures the experiences of a collaborative project on Developing Community Drug Rehabilitation and Workplace Prevention Programmes in India. The project highlights the importance of an integrated approach to substance use problems. It portrays the experiences of non-governmental organisations and enterprises in evolving comprehensive strategies to deal with substance related problems. It highlights the impact of effective community based and workplace prevention programmes.

The project represents a unique partnership between civil society, the private sector, government and international agencies to address substance abuse issues, which affect the lives of millions around the country.

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United Nations International Drug Control Programme

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