



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 (IWDCD), 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, methaqualone, 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.

4

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

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



number of arrests was reported in Imphal (65%), Calcutta (40%) and Mumbai (27%).

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 Rehabilitation 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. Despite 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 Ranganthapuram. 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 Development 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.

6

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 Bhadrachhat 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.

12

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.

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

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.

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

Box 4. Micro Credit in the CBRD 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 Mukhtangan 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.

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 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.

15

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 1,68,000 (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.

16

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.

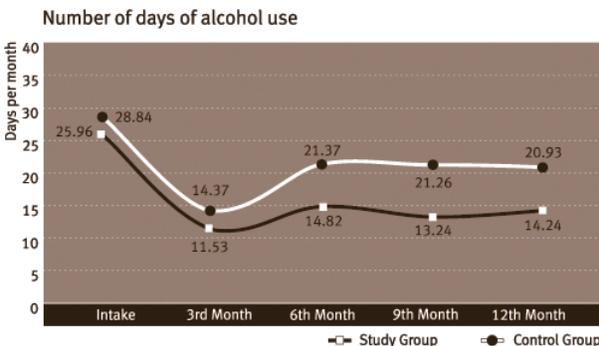


Figure 1

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

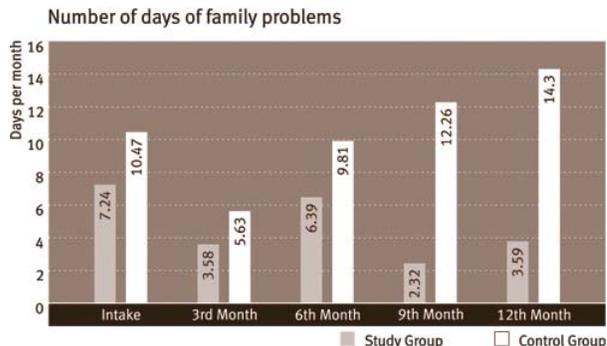


Figure 2

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.