CHAPTER IX

Community Based Treatment

Shanti Ranganathan

Chapter IX

COMMUNITY BASED TREATMENT

Shanti Ranganathan

Several government and international agencies have recommended that drug abuse be dealt with primarily as a community problem. Thus intervention strategies would mean assisting communities to adopt measures that would involve community leaders and lead to community empowerment. In-depth interaction with several community members from all socio-economic, age and gender groups is needed. India, Nepal and Sri Lanka have developed several projects on community based intervention, some of which are ongoing.

Most of these programmes have a lesser emphasis on the medical approach, focussing more on comprehensive psychosocial methods. The activities include prevention, education, health promotion and harm reduction as well as abstinence oriented treatment methods.

The key points are the mobilization of local resources, involvement of community leaders and de-centralization of service delivery systems. Affected individuals can in this way be rehabilitated locally with community resources, in cost-effective programmes. The present chapter is based on our extensive experience gathered from the treatment of alcoholism carried out in villages in the State of Tamil Nadu, south India. However, the basic issues covered are the core concepts involved in organizing any community based services for drug abuse. Several other authors enrich the chapter through their contributions on selected themes **(Box Items 25-29)**.

In Indian villages, several drugs including alcohol are abused. Cannabis is grown illegally in some areas and abused along with alcohol; alcohol is often fortified with psychotropics (e.g. diazepam) to enhance its potency. A community feels the need to deal with the issue of drug abuse when it faces problems like violence, premature deaths or disruption in families due to irresponsible drug-taking by its members. There is a large population of drug abusers and problem drinkers in villages and often there are no treatment centres available locally. They cannot avail of help from centres in towns since those are often both unreachable and unaffordable. Besides, the treatment process offered in cities may not be relevant to the villagers. Therefore, what are the alternatives? Building new hospitals? Deputing professionals to villages? Opening special wings in government hospitals? Organizing camps in villages?

Community Based Treatment Centre

The last alternative seems to be the most viable. In India, rural camps have been an effective way of dealing with medical problems such as immunization, eye care and dental care.
In these camps:

- treatment services are made available at the doorstep of users
- professionals are mobilized to offer their services
- the community is mobilized to accept help, and
- treatment is offered either free or at a low cost.

Treatment for alcoholism and drug abuse can also be provided through such camps, though the following factors should be considered:

- Since villagers are daily wage earners, they cannot afford to stay in treatment for long periods. The programme has to be intensive and short term.

- Many villagers are illiterate, and the treatment process should therefore be easily understandable and culture specific.

- Since drug abuse affects the family members and the community at large, involvement of the family and the community members should be an essential part of the programme.

COMMUNITY INVOLVEMENT

Drug abuse is not the problem of a single individual — if it is not dealt with, it will become the problem of the entire community. For the community to enjoy a secure and

conducive environment, the entire village needs to be involved in dealing with drug abuse.

The term 'community' means fellowship and signifies a group of people who live together, relate to each other and share a sense of belonging or obligation to their group. In Indian villages, there is a feeling of closeness — joy and pain are felt and shared among villagers. This feeling of oneness can be drawn upon in the community approach. In a closely knit community, the problems arising from drug abuse will be felt by all members and it is thus easier to make them see the need to deal with the problem. This community empowerment leads to "doing with" rather than "doing for"; responsibilities are shared and ownership rests with the community.

While working with the community, certain constraints have to be kept in mind:

- In some villages, drinking and drug-taking may be accepted as part of local life during marriages, deaths and festivals. The abuse of drugs may not be seen as an issue for concern.

- If distilling or selling alcohol and drugs is the major occupation for many villagers, they may not provide support.

- The community may not be aware of the scientific facts about drug abuse. So they may look at the abuser as a person "deserving punishment" or as "one who cannot recover".

- Some community leaders may themselves be using drugs and, therefore, may not have the necessary credibility in the eyes of the community.

- Involvement in community action requires a lot of time and energy and, above all, sustained commitment.

Preparing the community to effectively deal with these issues is the first step in organizing a treatment camp. Besides, the treatment centre cannot expect to arrive in the village and start providing services. It has to work through an already existing organization in the community, which can be called the 'host organization'.

Host organization

A few examples of host organizations are schools, voluntary agencies, rural upliftment societies, churches, etc. — mainly non-governmental agencies. The host organization should enjoy the trust and respect of the community. This organization should already be providing help in some areas — for instance, running a school, offering medical care, uplifting rural women. It should also be familiar with the members of the community and be aware of their problems.

The host organization should provide leadership and have prior experience in mobilizing community support. It should be willing to do a great deal of ground work to prepare the community — creating awareness about the impact of drug abuse and involving important leaders of the community, for example.

Prior to the camp, the host organization identifies the drug abusing population and provides infrastructure to run the camp. During the camp, it helps in organizing meals for the patients and staff and in identifying support persons for patients. It brings in patients for follow-up programmes after the camp, deals with relapses and provides support to sustain their recovery. Further details on camp detoxification are discussed in **Box Item-25** (Sri Lanka) and **Box Item-26** (India).

Community Meeting

Treatment process

Once the ground work is done, the treatment process begins. The first step is to assess and strengthen the patient's motivation. If the patient is not motivated, areas that could be motivating factors — a deep concern towards his children, a sense of worry about his job — have to be identified. To further strengthen the process, family members should be involved. In the second interview, the local physician does a medical check up and drug related medical problems should be handled at this stage.

At the third meeting, medication is prescribed to reduce withdrawal symptoms and to help the patient sleep well. The basic requirement at this stage is to provide hope and confidence — an assurance that he can lead a comfortable life without taking drugs. Patients who have taken treatment earlier can also help reinforce motivation.

continued on page 162

BOX ITEM - 25

COMMUNITY BASED DETOXIFICATION CAMPS FOR HEROIN DEPENDENTS

N. Kodagoda and Y. Ratnayake

Background

Heroin made its entry into Sri Lanka around 1981. Within a few years, the estimated number of dependent persons was 40,000. Since the country was not prepared for dealing with this new situation, coping mechanisms were deficient. The most deficient area was that of treatment and rehabilitation. Whatever technical know-how that was necessary was not freely available, trained personnel were difficult to come by, and available channels through which to seek treatment were limited. A few psychiatric units offered detoxification facilities, but not further services or assistance. In this scenario, Professor N. Kodagoda, Medical Faculty of the University of Colombo, was approached by a social worker to help a particular slum community in Colombo city affected by the problem. A treatment camp was planned for that community as a result of this consultation. Later this activity was developed as a method for helping heroin dependent persons. The attributes of this method included accessibility and acceptability to the clientele, affordability, effectiveness, non-medical and non-specialist intervention, community base and participation, harnessing voluntary inputs and a 'spring board' effect for reinstatement of the client into his society.

THE MODALITY AND ITS PROGRESS

Functioning of the community based camp method for helping heroin dependents consists of five stages:

1. Preventive education in locality, combined with motivation of potential clientele to seek help

2. Preparation of clients for detoxification, family counselling and organizing community for conducting a camp

3. Detoxification

4. Development of a further treatment/rehabilitation plan by clients with the assistance of family members and community leaders

5. Follow-up.

Having started as an experimental innovation, first with a school in a slum area and then with a temple as the focus, the camp gradually gained acceptance in the government as well as in the non-governmental sector. Camps are now complementary to other institutional methods.

Objectives

In its current form, the objectives of the camp method are as follows:

- To detoxify and withdraw a selected group of heroin addicts

- To re-establish family bonds and reintegrate detoxified heroin dependents with their community

- To create awareness in the community of the existence of the heroin problem in their environment and possible individual and collective action

- To develop a sense of responsibility on the part of the public and voluntary organizations in supporting the process of treatment and rehabilitation

- To give sufficient encouragement to the clients to commence rehabilitation with confidence

- To follow-up the detoxified persons for further rehabilitation action, as and when required.

Organization of Camp

The treatment staff and volunteers of the National Dangerous Drugs Control Board (NDDCB) Project, when initiating a camp, reach vulnerable communities, visit households and assess the extent of the drug problem in the community, conduct simple awareness campaigns and identify drug dependents and their families. At the same time they meet community leaders, voluntary organizations, and government officials of the area in order to inform them about the camp and solicit their support.

Community based camps are usually held in a temple, school building, or in a community centre which has basic residential facilities for 10-15 persons. The duration of a camp is ten days. Specially in non-urban localities, food and drink for residents and volunteers is prepared at the site by family members and community members, free of charge.

On admission, each heroin dependent person undergoes a brief medical check-up performed by the Medical Officer of that area, or by another medical person designated for the purpose. The clients are then briefed on camp routine. Sufficient recreational facilities for inmates are provided in a planned manner during the camp period. In order to provide opportunities for self-discovery and self-expression, group and individual counselling, meetings, etc. are organized. Innovative activities are also provided. Religious activities, prayer, meditation, etc. help clients to re-establish their spiritual and cultural values.

Drug therapy is minimal. Methadone substitution is not offered. If substitution is used at all, it is with diminishing doses of codeine. Analgesics are used. Selected cases may get a dose of sedatives/tranquilizers. Any medical disorders that may be present in the client are looked after.

The camp is managed by a committee representing community leaders, NGOs and GOs in the area; it is often made responsible for all camp related activities such as providing food, security and other facilities.

A follow-up plan for each detoxified person is drawn up at the end of the camp through informal discussions and finally each client is assigned to designated follow-up workers for rehabilitation. If there are clients who need/request further time for recovery they are admitted to treatment centres of the NDDCB. An effort is also made, where possible, to re-instate them in their former employment, or to lead them to new avenues. Where feasible, withdrawn persons from previous camps are used in subsequent ones as camp assistants.

Prevention and Other Activities

During the ten day camp, the organizers often prepare a useful adjunct programme for the community; dental clinics, eye clinics, cultural evenings and games of sports, religious activities are some of the components. The camp clientele may be harnessed to help in these. These occasions are also utilized to impart preventive education to the community. Video and other A-V aids are made use of on these occasions, while the presence of recovering dependents helps to alter community prejudices about drug dependence.

In Retrospect

The camp method of treatment of heroin dependent persons has turned out to be a feasible, acceptable, accessible, and affordable modality, particularly in the context of developing countries. It also has the advantages of the use of community leadership, community involvement, and community resource mobilization. The method also gives an identity to community based organizations, elevates the priority of drug use related issues on NGO agendas, and brings about healthy liaison between GO and NGO sectors.

Three sub-modalities with regard to resources have emerged from past experience:

(a) all expenses borne by the government
(b) all expenses born by the concerned NGOs and the local community
(c) a mixture of (a) and (b) above where expenses towards food in particular are borne by the community.

Experience has shown the third sub-modality to be the most workable, and effective.

BOX ITEM -26

DRUG DE-ADDICTION: CAMP APPROACH

D.R. Purohit

The earliest mention of opium cultivation in India placed it near the Malabar coast in 1551 (Chopra and Chopra, 1965). Its use became widespread during the Mughal period. In India, the use of opium found social sanction and much religious acceptance. Moreover, various kinds of medicinal use and the hard lifestyle of people living in villages also helped to spread its use. During our village visits for detox camps we found that about 12 per cent of the male adult population was addicted to opium (Purohit, 1985), while a study sponsored by the Indian Council of Medical Research (ICMR) reported the prevalence of opium dependence in Jodhpur city as 1.19 per cent (Mohan et.al., 1993).

There are some popular misconceptions prevailing in society regarding opium use — "Once an opium addict, always an opium addict", "If somebody gives up opium, he will either develop a serious illness or die", etc. These misconceptions prevent a large segment of opium addicts from seeking help; besides, they are frequently unaware of where to seek treatment (Purohit, 1988; Purohit and Razdan, 1988).

Basic philosophy and logistics

In rural areas the facilities for treatment of opium addiction are very inadequate. Therefore, in keeping with the popularity of eye and surgical camps, we felt the need to organize opium de-addiction camps. Initially, a pilot camp was organized in February 1979, in a small village of Jodhpur district, Rajasthan (western India). Learning from the experience of the pilot camp, various activities were streamlined. In October 1983, we moved to another area and sought community support. Our goal was to demonstrate the feasibility of treatment for opium dependence in a camp setting with active community participation.

Activities before the camp

The de-addiction camps were organized mostly by voluntary organizations. Pre-camp activities included distribution of pamphlets and posters after choosing a village. Personal messengers were sent to the adjoining villages requesting opium dependent subjects to register for the proposed detoxification camp. The registered subjects were subsequently informed by post. A suitable building was chosen and sometimes tents were erected to lodge 30-50 persons. Health authorities were contacted to depute doctors and nursing staff for the duration of the camp. The organizing agency (NGO) was involved in mobilizing support of key persons, motivating opium dependent persons, making arrangements for transport, medicines and recreational activities during the camp. Medicines were procured from the government, and in addition some drugs had to be purchased. A vehicle was arranged to carry seriously ill patients to a nearby hospital during the camp, if it became necessary. Donations were obtained from charitable trusts and local philanthropists. Grants from the government were also available.

Volunteers from the NGO and the village along with ex-addicts were involved in mobilizing community support and motivating opium users to come forward for detoxification. These camps required about four to six weeks of preparation (Purohit, 1988; Purohit and Razdan, 1988).

Activities during the camp

On the appointed day, opium addicts were admitted after screening. Any patient with serious physical or mental illnesses was excluded and referred to a nearby medical college or district hospital. Various socio-demographic and drug use related information were recorded and clinical examination was carried out. Following their admission, all the subjects were requested to deposit their valuables and personal possessions including opium, if any, with the organizers. They were searched in case of doubt.

In each camp an inaugural function was organized to educate them about the ill effects of opium addiction and prepare them for the withdrawal symptoms that could occur despite treatment. Their morale was boosted by the doctors, organizers, ex-addicts and VIPs who attended the inaugural function.

Opium was withdrawn abruptly. Patients were prescribed symptomatic pharmacotherapy like analgesics, anxiolytics, and hypnotics. Symptoms like anorexia, delirium, diarrhoea, vomiting, etc. were treated suitably.

All the patients were examined by a doctor twice daily, and in addition a doctor and one or two nursing staff were

available round the clock. Patients who developed serious illnesses were shifted to the nearest medical college or government hospital.

From the second through the tenth day patients gathered for morning and evening prayers, and recreational activities. In an informal environment, patients were provided supportive and group psychotherapy by doctors. Voluntary workers, social workers and ex-addicts attended the patients for rest of the time. They talked to them, listened to their problems, reassured them and boosted their morale. Non-professionals acted as a significant link between the patients and the doctors.

Besides these activities, dedicated and selfless services rendered by all made a deep impression on patients. Ex-addicts acted as "role-models". Non-professionals helped in general management of patients. On the tenth day a closing function was held with the following aims:

- to enable the recovered persons to take a vow to remain abstinent for rest of their lives
- to remove prevailing misconceptions about opium addiction
- to prepare them to tolerate some protracted withdrawal symptoms
- to motivate other addicts to come forward for de-addiction
- to educate and increase awareness about evils of opium addiction among general population.

It was noticed that withdrawal symptoms appeared 24 hours after cessation of opium use, peaked between 3-5 days and reduced markedly between 7-10 days. Hence the duration of the camp was 10 days.

Profile of patients and usual numbers in a camp

In most de-addiction camps the number of patients was between 30 to 50 and we found that a greater number of patients made the task difficult. Analysis of patients' profile revealed that :

- majority of the opium dependent persons were villagers (78.4 per cent)
- majority were illiterate (61.25 per cent)
- most were married (91.25 per cent)
- most were farmers (72.5 per cent)
- all reported oral opium use
- mean age of initiation to opium use was 28.5 years
- mean duration of opium use was 12.5 years
- majority had used opium once or twice daily (65 per cent)
- majority had no previous attempt at abstinence (56.2 per cent)
- mean age at the time of treatment (camp) was 43.2 years
- some had an associated physical or mental illness (18.8 per cent)

(Purohit and Sharma, 1990).

Human resources

In a camp, about 2-3 doctors, including one consultant psychiatrist, 3-4 nursing staff, and 8-10 volunteers were available. The local community provided free boarding and lodging facilities. The community also provided volunteers, emotional support to the patients and protection to staff and organizers. Involvement of the local community was the key to the success of the camp.

Follow-up

De-addicted patients were supplied one week's medicine and were requested to come for follow-up either to the nearest government hospital, or by contacting the organizers. By and large, aftercare services were provided by the government hospitals.

Due to lack of resources in terms of man power and budgetary provisions, systematic and regular follow-up was done only at a few places. From our experience and through a few follow-up studies we found that about 60-70 per cent of patients remained abstinent following their treatment in the camps at the end of two years (Purohit and Vyas, 1982). Outcome depended on the proportion of treated subjects from a village, contact with other abstinent ex-patients, frequent contact with an aftercare agency, and social variables in the addict's own community (Westermeyer, 1978).

Conclusion

Initially, our goal was to demonstrate the feasibility of camp detoxification. Public awareness, education and removal of misconceptions regarding opium use and treatment were subsequent and additional activities. Opium de-addiction in a community camp was a novel experiment. It has been replicated at various places in Rajasthan, Gujarat and Himachal Pradesh by different psychiatrists, physicians and general doctors. It conforms to the concept of community health care where services to the community are provided at its doorstep and according to its needs. Moreover, it is accessible, acceptable, affordable, cost-effective, more conducive for group interaction, health education and awareness. It appears to be a better approach for the rural population of India.

References:

1. Chopra, R.N. and I.C. Chopra (1965). *Drug Addiction with Special Reference to India.* Centre for Scientific and Industrial Research, New Delhi.

2. Mohan, D., D.R. Purohit, P. Sitholey, B.M. Tripathy, R. Ray, N.G. Desai, H.K. Sharma, D.K. Sharma, A.B. Sethi

and S.E. Tewari (1993). 'Collaborative Study on Narcotic Drugs and Psychotropic Substances'. Report submitted to ICMR (Indian Council of Medical Research).

3. Purohit, D.R. (1985). 'Drug Addiction Survey of Hariyada and Joliyali Villages of Jodhpur'. (Unpublished)

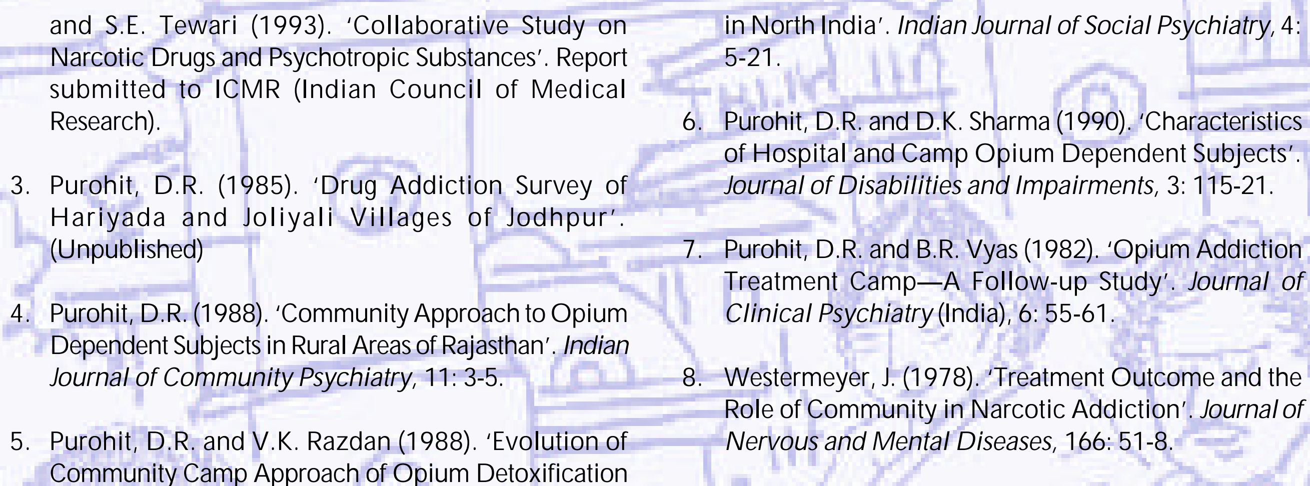
4. Purohit, D.R. (1988). 'Community Approach to Opium Dependent Subjects in Rural Areas of Rajasthan'. *Indian Journal of Community Psychiatry*, 11: 3-5.

5. Purohit, D.R. and V.K. Razdan (1988). 'Evolution of Community Camp Approach of Opium Detoxification in North India'. *Indian Journal of Social Psychiatry*, 4: 5-21.

6. Purohit, D.R. and D.K. Sharma (1990). 'Characteristics of Hospital and Camp Opium Dependent Subjects'. *Journal of Disabilities and Impairments*, 3: 115-21.

7. Purohit, D.R. and B.R. Vyas (1982). 'Opium Addiction Treatment Camp—A Follow-up Study'. *Journal of Clinical Psychiatry* (India), 6: 55-61.

8. Westermeyer, J. (1978). 'Treatment Outcome and the Role of Community in Narcotic Addiction'. *Journal of Nervous and Mental Diseases*, 166: 51-8.



Community Mobilization

The open sharing of experiences of previous camp patients will provide optimism and realistic hope to the patients.

Treatment camps are conducted for a period of 15 days in the village of the patients. This is a residential programme and has medical as well as psychological components. Follow-up support is provided for a period of 12 months.

Treatment focusses on helping the individual give up drugs totally for life, and making improvements in every area of his life — work, family, interpersonal relationships, etc. The treatment programme is specifically designed for camps in rural areas and includes:

- Treating physical problems associated with drug abuse (medical support)
- Strengthening belief in a higher power (prayer)
- Providing basic information about drug use and abuse (informative lectures)
- Helping them to share the damage caused (group therapy)
- Guiding them to develop short term and long term goals (counselling)
- Strengthening motivation by providing tips to stay sober (sharing by recovering patients)
- Inculcating values through narration of stories (story telling).

The families of drug abusers should also be encouraged to attend the programme on a non-residential basis. The goals of family therapy are to enable the family to express the feelings of shame, anger and hurt that they may have suppressed for years and to help them develop a caring attitude towards the addict.

It is pertinent to note that rural women display tremendous forebearance and are often willing to let go of the past and support their husbands in their recovery. Since it is their first exposure to treatment of this kind, they very quickly develop trust in the treatment staff and hope in the process of treatment.

A programme is needed during such community based activities for the support persons of those who have received treatment in the camp. Support persons are those who have a keen interest in the welfare of the addict. They may be a family member (uncle, sister, brother, father-in-law), a friend, neighbour, any other recovered addict living in the same village, or the person who has brought him for treatment. The ideal support person does not use drugs, meets the patient frequently and is respected and held in high regard by the patient.

The support person can offer assistance if the patient is in need of a job or if a reconciliation has to be brought about between him and his family. He makes sure that the patient attends follow-up meetings. In case of relapse, the support person can intervene and provide necessary help. The support person can provide information about the recovery of patients to the treatment agency.

Follow-up is as important as the primary treatment programme. The goals of follow-up are to consolidate the changes made by the patient during treatment, strengthen his motivation to lead a drug free life and help him make improvements in his quality of life. A counsellor should visit these sites periodically. The treatment team usually comprises a doctor, a nurse and a counsellor.

Community resources

A local general physician or a licensed medical practitioner (LMP) from the village should be involved in such community based activities. Since he is likely to be familiar with the people belonging to that village, he will be able to help in identifying the persons needing help. He should be able to provide medical assistance to patients prior to, during, and after the camp.

The members of the host organization are vital resources in organizing camps.

An Awareness Campaign - Dhaka

Anti-Drug Campaign in Colombo

Recovered addicts from earlier activities including camps can assist the treatment team in bringing new and relapsed patients to the project team. Treatment is a joint venture of the treatment team, the host organization and the community. The counsellor suggests appropriate steps for their immediate future and reaffirms their goals; caring encouragement is given by the host organization. The recovering subjects in the community are successful role models and peers, and co-patients provide mutual support to one another (Ch'ien and Zackon, 1994).

Involvement with Other Parallel Programmes

Awareness programmes for villagers on allied fields should also be carried out periodically. For example, we at the TTK Hospital make use of our audio-video van (donated by UNDCP) to project short films followed by lectures and discussions. So far, we have created awareness in this manner on alcohol abuse, *ganja* use and HIV/AIDS.

Community based treatment services are also needed in urban areas. Dr. Sell **(Box Item-27)** discusses an innovative project—the open community approach—where rehabilitation can commence before and without detoxification. Another very successful project on drug de-addiction among slum dwellers in Delhi is discussed in **Box Item-28**. Finally, **Box Item-29** discusses the collaborative effort of ILO, UNDCP and Ministry of Welfare, Government of India, on a community drug rehabilitation and workplace prevention programme. This is a joint venture between the community and the workplace.

OUR EXPERIENCE

TTK Hospital has conducted more than 45 camps in several villages. From our experience, we find that with minimal infrastructure, quality care can be provided in villages at low cost. Disulfiram can be used responsibly and acts as a powerful support.

We have used tablet disulfiram very successfully for subjects with alcohol dependence to promote abstinence. Local doctors are briefed adequately regarding disulfiram-alcohol reactions.

A year or two after treatment, qualitative lifestyle changes can be seen in patients. Typically, they pay back debts, get their daughters married, their sons rejoin school, festivals are celebrated and household articles are bought.

Community education and involvement lead to occasional drug users giving up drugs, abstainers continuing as non-users and problem users willingly accepting help.

A well implemented treatment programme results in a positive outcome, which in turn spreads to other communities, who can take them as role models and follow suit.

RESOURCES DOCUMENTS

1. Ch'ien, James and Fred Zackon (1994): *Addiction Rehabilitation — Principles of Effective Programming for Developing Nations.* International Labour Office, Geneva.

2. Ranganathan, S (1996): *The Empowered Community — A Paradigm Shift in the Treatment of Alcoholism.* TT Ranganathan Clinical Research Foundation, Chennai.

BOX ITEM - 27

THE OPEN COMMUNITY APPROACH TO DRUG ABUSE CONTROL

H. Sell

The open community approach to drug abuse control was developed in the South East Asia region of WHO in a learning and experimenting process based on ethnographic research, over a period of about 15 years.

The realization that drugs of addiction tend to have strongly unpleasant effects in the uninitiated led us to the assumption that strong socialization processes must be at work in the plunge into regular, and perhaps dependent drug use. The strength of such socialization or learning processes is equally exemplified by the dependence on aspirin in some areas of North Eastern Thailand, and by the high prevalence of 'pseudoheroinism' in Asia and in the USA — (psychological) dependence with a daily intake of heroin which cannot possibly be (physically) addictive. Other observations confirmed that social or learning processes can also influence withdrawal symptoms. For example, opiate-like withdrawal symptoms have been reported in aspirin dependent persons in Thailand, and the insistence on staying awake during the first night of detoxification has reportedly led to sound sleep without tranquilizers in a detoxification centre in Colombo.

Hypothesizing that such socialization processes leading to dependence can best be reversed by socialization processes out of dependence (irrespective of physical addiction, i.e. by working with dependent persons as groups rather than individuals), the concept of village-wise detoxification was introduced for rural opium users in Myitkyina, Myanmar and in Manaklao, Rajasthan, in the early 1980s. In this approach, outreach workers (often ex-user volunteers) spend time in a village identifying opium users, working with them and their families in efforts to create optimism and to overcome helplessness and hopelessness. They mobilize the community and finally take as many of them as possible (ideally, of course, all of them) to an institution for detoxification together, as a festive event and common achievement.

It was soon realized that there was no need for an institution, but that this mass detoxification could be even more effectively be done in the communities concerned, under trees, in tents, or in whatever accommodation the community could provide. Thus, following the outreach workers' and volunteers' community mobilization efforts, a team with some medical support moved into a community for mass detoxification, with full community support. We called this the camp approach. It was successfully adapted to rural alcohol problems in Tamil Nadu, and to urban heroin problems in many parts of India and Sri Lanka.

However, it became clear that this approach still did not seem to sufficiently address the second main component of dependence or 'junkyization' (in addition to perceived hopelessness and helplessness), a chaotic or meaningless social life. Ethnographic research taught us that dependent persons tend to have a severely limited 'social menu', their social contacts being mainly limited to partners in the drug sub-culture, and even these contacts being erratic and superficial. Community based drug demand and harm reduction projects should, therefore, have a stronger component of re-building meaningful social lives for the dependent person (irrespective of his/her state of addiction).

There was then, increasing focus on group work with dependents and their families, formation of self-help groups of (ex-)users and their families; cognitive therapy, in a way that would re-build meaningful social lives. The goal was an enrichment of the 'social menu' for drug dependent persons. Such enrichment requires intensive work to increase community participation, which depends on the degree to which communities appreciate the contribution of any project to their quality of life. We realized that the needs perceived by communities and by project staff converged: re-building a meaningful social life for drug dependents and efforts to assure communities that this will help to increase the quality of community life in general. In order to be able to quantify the perception of the quality of community life, indicators for the quality of community life (QOCL) were developed. Thus, the camp approach was extended to what we came to call the **community approach to drug abuse control**.

When working with drug dependent persons we realized that the changes in lifestyle, the un-learning of a social role and the process of socializing into a new one, was at times intolerably upsetting, perhaps frightening, too ambitious a goal to be achieved in a short period of time. The dependent person may at times slip back into his/her

familiar lifestyle of drug use. We recognized the need to accept this 'in-and-out flexibility' between new and old lifestyles by adding the word 'open' to the concept of community approach, and abandoning the concept of 'relapse'. In the **open community approach**, we recognize that for many drug dependent persons, the main problem is not the 'medical' condition of addiction, but the 'psycho-social' issue of a dependence related lifestyle and the often drastic changes required to change into a new social role and lifestyle.

It became obvious very early on that the time after detoxification is particularly unsuitable for meaningful rehabilitative work with dependent persons, since their mental agenda is dominated by drugs and little besides. We firmly believe that the process must be inverted; detoxification can be useful if it follows successful rehabilitation, i.e. after confidence in coping has been restored and a meaningful social life been rebuilt. In fact, in many instances, detoxification is not even necessary after successful rehabilitation. One can leave it to the person to detoxify him/herself: **rehabilitation before/without detoxification**.

The open community approach is, in the case of opioid dependents, facilitated by oral opioid maintenance. This facilitates the rehabilitative work with dependents in addition to its recognized effect of harm reduction. We use sublingual buprenorphine where available and feasible. We prefer buprenorphine over methadone for several reasons: withdrawal from buprenorphine is relatively easy; there is no risk of overdose deaths—an up to four days dose can be given at once in the case of transportation problems; and its antagonist effect prevents, from a certain dosage upwards, "topping off" with heroin.

Comparative studies of the effectiveness of methadone vs. buprenorphine as published in international literature are inconclusive although in general slightly more favourable towards buprenorphine, especially in dependents with a low opiate habit size. These studies, however, do not seem very relevant in the context of the open community approach because they follow the traditional research paradigms of clinical trials like double blind and random assignment schemes which are inappropriate to evaluate the contribution of a drug to the facilitation of social processes.

Wherever an evaluation of the open community approach to drug abuse control has been attempted, it has been found to be remarkably successful, whether facilitated by oral maintenance or not. Rates of total abstinence in alcohol and opium dependents of between 60-80 per cent have been reported, with similar success rates in urban heroin dependents, if some controlled use is also considered a success. Perhaps the most significant outcome is the enthusiasm and sense of well being and confidence in doing something useful in outreach workers. Some people argue that the approach is soft on drugs, but it is certainly hard on human dignity and the quality of life of marginalized people.

BOX ITEM - 28

FIVEYEARS AT NIZAMUDDIN

Jimmy Dorabjee

In the mid-1980s Nizamuddin in New Delhi was an area populated by refugees from Bangladesh and Bihar. Living in abject poverty in ramshackle and patchwork *jhuggis* (single slum dwelling units) among the graves that dot the landscape, the residents were mainly daily wage *kabadi* (scrap) workers. Piles of *kabadi* lay stacked inside and outside their homes, awaiting sorting for sale to various dealers. Drug use was common here, with *ganja* (cannabis) and brown sugar (heroin) being popular.

I remember walking down the narrow slum lanes, garbage piled near the entrances of huts made of plastic, sheets, mud and wood. When it rained I had to wear my muddy sports shoes as the narrow pathways of the slum were slushy and wet. Flies were everywhere, millions of them, and they sometimes got into your mouth when you took a breath or tried to speak. There were lots of kids playing around the slum — dirty, small and underfed children — a result of the slum dwellers' disregard for family planning measures.

A baseline survey by Sharan (Delhi based NGO) in 1989-90 established that heroin use among males was very high. Access to treatment was difficult and in many instances, services were denied since the admission criteria of various institutions put treatment out of reach. Besides, drug users from slum communities were unable to spend long stretches of time in detoxification or rehabilitation centres as they were often the sole earning members in their families. We realized that the available treatment was not geared to their needs. After persistent requests for assistance, a decision was made to provide treatment services. Sharan already had credibility in the community as we had been providing health and nutrition services to the community since 1989.

From 1990, Sharan began to hold periodic detoxification camps, under tents in the open field, involving the community in the detoxification process. However, relapse rates were high and most drug users relapsed soon after discharge from the camps. There were other changes — by 1992, we discovered that many users were injecting drugs and that our responses did not adequately address various aspects of high risk behaviour like injecting drug use and the high level of needle sharing. Also, due to the frequent relapses, a sense of hopelessness had started to affect all of us.

In March 1993, after a literature review, we began a sub-lingual buprenorphine substitution programme in an attempt to reduce the frequency of injecting. The objectives of the programme were to de-criminalize drug use, provide economic benefits to drug users (medications were free) and to reduce both infections and drug use. The staff consisted of a Medical Officer, two health workers and counsellors. A few months later, we started a mobile buprenorphine dispensing unit that operated on every day of the week; drug users do not stop taking drugs on holidays. A few volunteers joined us briefly, but could not handle the all-pervasive poverty and hopelessness and soon dropped out.

Our activities included going to drug users' houses, sharing tea and talking to them, providing information on HIV/AIDS and the risks associated with injecting, and distributing daily medications. We often arrived at the health clinic early in the morning to find a dozen clients waiting for us for medication. The clientele grew from 15 to 35 to 53, until with funds for the programme that became available from the European Union in 1995, the total rose to more than 1600.

The project office moved from a small room deep inside the slum where the health and nutrition programme clinic functioned to its present site.

We made detailed inquiries about the major drugs being abused, the mode of administration, the reasons for relapse and the users' expectations. Through focus group discussions with family and community members and ethnographic observation, we came to understand a great deal more about the situation of drug abuse.

We have always tried to convey to the clients that once on the maintenance/substitution programme, if they feel the need to use drugs, it is our fault; that we have not assessed their dosage needs accurately. In our experience, this approach helped to establish honesty. From there, we could either look at increasing the dosage or look at other ways to help the client. Our services were non-judgemental and drug users felt free to talk about their drug use pattern.

And we soon began to notice changes. After a couple of months, clients came in looking cleaner, faces bright from

washing or bathing, they shaved more often, their clothes were cleaner than before. Often, clients brought family members into the centre, and they began attending peer education sessions on safer drug use and safer sex. The general mood and atmosphere among clients became more positive.

In our experience we have found between 2 mg to 4 mg buprenorphine is the ideal dose for 90 per cent of our clients with the remaining 10 per cent needing upto 6 mg, along with a few other medications. Out of the 1600 plus clients we have had so far, only a handful have needed more than 4 mg to be maintained comfortably.

Other Services

Besides buprenorphine maintenance, we also carried out several awareness programmes, frequent home/family visits and provided support and assistance to drug users and their families. To date, about 80 subjects were detoxified in camps and an additional 50 subjects went through home detoxification. About 400 subjects have been referred for specialist medical treatment. Ninety subjects were referred to our detoxification centre and an additional 120 subjects availed of our long term rehabilitation programme.

Results

Out of our 1611 clients, 25 were women. The majority (69 per cent) were heroin users and 449 (28 per cent) were IDUs. The majority (51 per cent) came from an area outside a 5 km radius from our centre. It was seen that 645 (58 per cent) heroin dependent subjects and 110 (24 per cent) IDUs had reduced their drug consumption considerably following treatment. There was improvement in health (reduction in abscesses) and in social and occupational functioning. Needle sharing also went down. Overall, the quality of life had improved and about 74 per cent were employed. The abuse of buprenorphine tablets dispensed was rare. Only three subjects had crushed the pills and injected them.

Lessons learnt

- Staff attitude needs constant monitoring. Abstinence orientation of treatment providers works adversely on treatment.
- Training and re-orientation of staff must be ongoing.
- Divided doses (two-three times a day) are more suitable than single daily dose. Take-home doses are also needed for those travelling long distances.
- Once the maintenance dosages are established, most clients respond well in terms of psychosocial functioning.
- Besides medication, additional services like indoor games, counselling facilities, educative sessions on safer injecting and safer sex, medical check-ups, referrals, home based detoxification and outreach are also needed as part of a comprehensive treatment strategy. These are possible through a drop-in centre.
- The concept of controlled drug use is unfamiliar but achievable by many.
- We should expect that many will abuse the system if abstinence is the goal.
- Clients sometimes gather pills to be used for a "rainy day" as well as to sell. It is important to shell the tablets rather than hand them out in the foil wrappers.
- Positive behaviour change occurs only after intensive contact.
- Peer educators are great as motivators. By giving small jobs to clients who do well, we can attract a large number of patients.
- Though community acceptance is initially difficult, it is possible when religious or community leaders are taken into confidence and the benefits of the programme are explained to them.
- Multi-drug users need a different dosing regimen and are generally not satisfied with buprenorphine tablets alone.

BOX ITEM - 29

COMMUNITY DRUG REHABILITATION AND WORKPLACE PREVENTION PROGRAMME

Mukhtiar Singh

In India, drug and alcohol issues have largely been perceived as a medical problem and services have been limited to detoxification and care for one to two weeks. However, the results of such efforts are not satisfying and the relapse rate is high. There is a need to develop a comprehensive programme to deal with this complex problem.

Work is vital for recovery. Studies have shown that about 30-40 per cent of addicts are unemployed. Those who are employed have to retain their jobs. This is not possible unless vocational rehabilitation is a part of the programme, and this component was missing from the Indian programmes.

Against this background, the ILO is executing the project **Developing Community Drug Rehabilitation and Workplace Prevention Programme in collaboration with UNDCP and Ministry of Welfare, Government of India**, in ten cities — Bangalore, Calcutta, Chennai, Delhi, Imphal, Jodhpur, Lucknow, Mumbai, Patna and Pune.

The **ILO-Reference Model** has several distinct features. The participating NGOs identify the catchment area in the community as the project site. In order to assess the needs of the community, a survey on the drug and alcohol use problem and available community resources is carried out. A time bound **Action Plan** is developed. Vocational rehabilitation is an integral part of the project and the emphasis is on imparting and upgrading the occupational skills of the recovering addicts. Assistance is provided to them to get a job or start their own income generating activities.

In India, despite modern developments and the influence of western civilization, community plays a vital role in life. Family, the primary unit of the community, is still very strong. These two social institutions were not adequately involved in earlier programmes. In this present project we have fully involved the families and the community. This helps in easy social reintegration of the recovering addicts. The well being of the community and the workplace are inextricably linked. This means that the initiatives to control drug and alcohol related problems need to be a joint venture between the community and the workplace. This is precisely the focus of the project.

There are several partners in the programme, since it is not possible for one agency to provide all services to its target group. City and state level NGO forums have been formed on the initiative of the project. Networking between government agencies and NGOs and among NGOs themselves has developed.

Whole Person Recovery is the main objective of the ILO model. As per this model mere cessation of use of drugs and alcohol is not enough. The whole addictive personality has to change and the person must change his lifestyle. He has to fulfill the following conditions to signify substantial and mature recovery:

- Commitment to a drug free life
- Acceptance of higher values
- Adaptation to work and responsibility
- Social reintegration — in family and community
- De-addiction
- Personal growth and self-acceptance.

When a recovering addict stays sober (drug free), not involved in criminal activities (crime free), earning his livelihood and discharging his social obligations (gainfully employed) it can then be interpreted that he has achieved **Whole Person Recovery** (WPR).

For people striving to achieve WPR four factors, popularly known as the four keys to change, are necessary. These are:

1. Practical guidance from respected person(s) for what needs to be done.
2. Caring encouragement for one's efforts — this is a powerful "fuel" for motivating recovering addicts and moving them forward.
3. Successful role models who have achieved the goal.
4. A peer learning group working together towards that goal.

As per the project design participating NGOs will continue to get support and they, in turn, will be extending their technical expertise to the individual enterprises in establishing the workplace prevention programme. They will also provide assistance and treatment services for subjects referred by the enterprises. However, the main

activities of the programme in the workplace will be carried out by the enterprises themselves through their trained personnel, focussing on awareness creation, health promotion, integrating with other programmes of occupational safety and health, improving working conditions, human resource development and productivity enhancement. Efforts will also be made to link up with other programmes in the workplace and the community to ensure its sustainability. Such links are sure to improve the programme content, leading to better working environment and improved quality of life of the workers.

After several rounds of discussions with employers' and employees' organizations, and governmental and non-governmental agencies, a strategy was worked out on initiating steps for the workplace prevention programme. A series of two-day orientation seminars were held at Bangalore, Mumbai, Calcutta, Delhi, Chennai and Pune in April and May last year. The industries have welcomed these initiatives. At the Mumbai workshop, the Secretary General of the Employers' Federation of India said: "The ILO has taken a very bold step by undertaking such a project and the government, employers and workers should get involved in the project".

The standard reaction of managers who either refuse to admit that this problem exists in their company or employ the "hire and fire" approach is being replaced by frank discussion and open admission of the existence of the problem. There is a growing realization of the adverse consequences of drugs and alcohol at the workplace in terms of absenteeism, loss of production, accidents, increased medical and compensation claims, and the need to take preventive measures. This was aptly voiced by the President of the Federation of the Indian Chamber of Commerce and Industry (FICCI) at the Delhi workshop: "Drugs not only affect productivity of each individual, but also have a negative impact on fellow workers and can affect the discipline of the workplace. The neglect of such problems would only result in continued and growing loss to the nation as a whole."

For the first time in India, 11 well known industrial enterprises have taken up the workplace prevention programme in collaboration with the government, international agencies and NGOs. The five-day workshop in Delhi for representatives of the participating enterprises and NGOs helped the participants to go over various concepts and issues of the programme and develop enterprise-specific draft policies and action plans. The commitment of the top management and the support of the employers' and employees' organizations has provided a sound base for the prevention programme. As we go along, the involvement of managers, supervisors, trade unions and workers and their families will further strengthen it.

By the end of the project, there would be 18 community based rehabilitation and 11 workplace prevention programmes in place as "model" programmes. In addition, there would be a cadre of trained manpower in the field of drug demand reduction. These efforts are bound to give a new direction to the programme to reduce abuse of drugs and alcohol and minimize their adverse consequences on social and economic development, thereby ensuring improvement in quality of life.