Given the absence of a concerted counselling strategy/methodology in the area of drug abuse in India, the paper attempts, first, to identify the areas of concern in counselling drug addicts and in helping them to develop skills. Further, the efficacy and purpose of day care centres and half-way homes, and the need for the involvement of para-professionals and volunteers in the field, are examined. The paper focuses, finally, on the role of counselling centres, and on the different types of therapies to be adopted and developed while counselling addicts.

**Theoretical Issues**

While each patient is unique and while drug counselling (as all counselling in general) is person-specific, there exist common parameters/characteristics without which counselling would remain an art restricted to a few practitioners. Building up knowledge and skills in any practice field begins with case studies which yield working hypotheses for further testing/acceptance/rejection/validation. In India, we do have a few counsellors who have developed personal insights and skills with addicts. About two hundred case studies have been documented by SPARC, based on the work of fifteen counsellors from Delhi, Bombay, Coimbatore and Pune.

A SPARC—SNDT workshop was conceived as one more step towards articulation of what is involved in counselling drug addicts. Some of the issues for discussion in this workshop were: what is certain, what is uncertain, what should not be done as part of counselling addicts and what are the requisites of counselling that can be considered minimum essentials.

It will be appreciated that the problem of heroin addiction is rather new to India and, so, there are very few practitioners in the country with practical experience in working with addicts, while, alongside, the demand for therapists has been heavy. A considerable amount of the practitioners’ time is spent on fund-raising and routine administration. In the absence of a systematized, communicable body of knowledge, the new professionals in the field have to develop on their own (often through trial and error) a method which is workable. The S.N.D.T. University (Department of Adult and Continuing Education) and SPARC facilitated the workshop in order to sharpen the focus of future discussions in the field of drug-counselling.

Since drug counselling is a nascent subject, and since few of us have had the resources to conduct longitudinal research, it is somewhat premature to make any categorical statements. Only hard empirical data, generated by action-research in all types of settings and with varied clients, can provide a concrete background. We also know little of each other’s working methodology.

Hence, the workshop was envisaged as a day of mutual sharing; as a space where practitioners, in their common concern for the affected youth, share the joys and anxieties they go through in counselling addicts. Many more such exercises are needed.
Some of the counsellors are focusing on specific areas of counselling, such as the spouses of addicts. Some of them have moved from family therapy to community counselling. Some counsellors have sharpened their practice of group therapy with addicts, some rely on religion as a strong supportive element in counselling, some of them focus on coping mechanisms, and others on environmental manipulation. One counsellor, for instance, points out that, though the principle of acceptance is a universal requirement in all therapeutic interactions, counsellors tend to take on a "parental" role when they work with addicts. Some others indicate certain guidelines for dealing with a client who enjoys being on heroin, and who has no motivation to quit it, per se, except for the fact that his mother is suffering. Some of the counsellors have developed a comprehensive system of counselling, with its own philosophy, principles, strategies and caveats.

We need to set up a concerted search among practitioners to identify those aspects of counselling heroin addicts which are specifically different from the general counselling process, and to generate an indigenous body of knowledge in this specialized area of intervention.

Objectives in Addiction Counselling

It is clear that no single school dominates addiction counselling. The following have emerged as the broad areas of concern in counselling drug addicts and in developing skills in them:

- To make decisions.
- To handle stress (e.g., death or failure).
- To develop a positive integrated view of life, of one's own place in one's social network of relationships (raison d'être).
- To relax, to attain mental control, to assert oneself, to progressively bring the locus of control of one's living to the inner self.
- To re-enter academic or employment streams.
- To re-build relationships with family members, or with non-addicted former friends.
- To deal with all the events (crimes, misdeeds, misdemeanors) committed at the time of addiction.
- To develop a non-escapist attitude to reality, and to promote in the addict the capacity to grapple with the reality of his life and his environment.
- To acquire a pragmatic attitude towards money.
- To learn to internalize certain minimum norms, lest he get into more frustrating situations, particularly in dealing with the law and the police.

It has also become clear that, except in T.T. Ranganathan Foundation, Madras, and the CMC, Vellore, no centre has any follow up system. Even in these two centres, letters are mailed to the patients and their families as a follow up. Thus, little is known of the effective, or even the ineffective, strategies in counselling.

Day care centres provide individual counselling to prepare the addicts to go in for detoxification and rehabilitation. They also act as a half-way home for persons who come out of the rehabilitation centre after six months of staying away from normal social life. In this context, counselling has certain specific objectives, such as:
— helping the addict to strengthen his motivation to enter detoxification and treatment
— helping him to make concrete plans of how he will deal with his former addicted colleagues
— how to deal with associational memories, and situational factors that might be conducive to relapse
— how to deal with nagging and continuous reminders of the fact that he had been on drugs, with the lingering suspicion on his rectitude in handling money and hesitancy in giving him responsibilities. Family members often do not realise that their gestures and attitudes may not be helpful to recovery. The addict has to develop skills to deal with these situations and not lose his equilibrium and equanimity.
— the etiology of drug abuse often has inter-sibling status discrepancy and family-pathology. If the family pathology has not been handled by the therapist through family therapy, then the addict has to be prepared to gain an insight into the family dynamics and learn not to take a self destructive stance while dealing with his pathological family setting.
— Addicts often tend to develop depression/suicidal tendencies in the period of recovery. They also tend to become anxious and disturbed at rather innocuous comments, gestures and actions of people close to them. Helping addicts at such moments entails being available to them, reassuring them, clarifying issues that are immediate problems and where suicidal tendencies are perceived, to induct professional help.

The purpose of these half-way homes and follow up programmes are to help the addicts with a gradual re-entry into the open society. These day care centres provide a drug-free atmosphere during the day time, and have prayer, group discussions, and T.A. sessions, in the company of recovering or former addicts. They also have games, reading material and referral services. One such centre in Calcutta (Antara Drug Centre) included occupational therapy such as candle-making and carpentry. Half-way homes help the addicts in their transition from a totally sheltered atmosphere of the rehabilitation centres to a completely vulnerable life in the open community. Arunodhay Midway Home performs such a function together with rehabilitation.

It has become very clear that, on a one-to-one basis, not more than 50 to 100 addicts can be helped by a single experienced counsellor in a year.

Para-professionals and Volunteers for Counselling Addicts

Looking at the low number of professionally qualified counsellors in the country, and since helping drug addicts is an intense process of at least a year's duration, it does not seem possible to rely exclusively on trained social workers, psychiatrists, psychotherapists or psychoanalysts to help the large number of addicts in the country. Besides, those in service already have a large number of mentally ill patients to attend to.

In this context, developing a cadre of para-professional counsellors or volunteers to work in collaboration with, or under the guidance of, professionals is indicated. It must also be remembered that not all existing professionals are interested in, or have the aptitude for, working with drug addicts. Parents of drug addicts and persons who have
expressed interest in the work, can be trained initially and can work under supervision, on an ongoing basis, with psychiatrists and counsellors.

This appears to be the principle on which four counselling centres in Delhi have been structured. They prepare the addicts for detoxification camps and continue individual therapy sessions as a follow up.

A group of professionals in the U.S.A. have picked up working class youth and trained them in basic counselling, and in methods of intervention in the field of drug abuse. In Thailand and in the FFDA programme at Hong Kong, the communities have mobilized themselves to evolve their own strategies to fight narcotics and assist their addicted youngsters through the communities’ own counselling efforts. In India, as elsewhere, drug abuse is a problem that affects all classes. Thus, it should be possible to find volunteers who need not look upon this work as their sole occupation. The questions then would be:

— How to help them to understand the realities of the addicts among the urban poor?
— How to assist them to declass themselves and to mingle with all economic classes, to speak their idiom, and to grasp the import of their language and non-verbal communication patterns?
— How to support ex-addicts interested in working in the field since most of them would need to begin their adult life with family responsibilities?

SPARC is attempting network therapy with a group of working class women to deal with the problem of drugs as a model in community based therapy. Only time and evaluation can tell whether it will work.

**Brief Therapy Models**

The fact that a large city like Bombay does not have more than 30 counsellors goes against the possibility of offering long term psychotherapy. The options are to leave a large number of addicts to their own devices or to evolve brief intervention models.

SPARC had a training workshop on brief family therapy with drug addicts, which was led by an expert from Cyprus Institute, U.S.A., who is also an author of a book on the subject. Two experimental centres have been set up to try out this model. It will also be rigorously documented and evaluated for its applicability in the Indian context, especially amongst the poor.

Such experiments are far too few in the face of the enormous problem that the country faces. The Ministry of Welfare and the Ministry of Health need to entrust this task of experimentation in different parts of the country to NGOs and government centres.

**Group Therapy**

In the face of the large number of addicts and the paucity of counsellors, another approach is group therapy, wherein a group of 20 addicts can be simultaneously
reached by a single therapist. Group counselling is still not a popular form of assistance for example, in centres in Calcutta. In Bombay, Bhatia and Cooper Hospitals used to offer group therapy which has now been discontinued due to shortage of staff. KEM Hospital, the YWCA day care centre in Bombay, and Asha Bhavan in Goa offer group therapy.

**Narcotics Anonymous**

Yet another option available in some cities is the Narcotics Anonymous. The Narcotics Anonymous is a near zero-budget operation, and does not promote or advertise any individual into prominence. Their silent work is based on solidarity with co-addicts, and in helping them to lead a drug free, spiritual way of life. Narcotics Anonymous has become a global movement along the lines of Alcoholics Anonymous. These sessions not only provide the necessary acceptance of the addict, but are built on fellowship, mutual concern, and love for the co-addict. A good number of addicts have turned over a new leaf, and some of them are actively working against addiction. Several therapists adopt Narcotics Anonymous sessions as one of the components of their therapy.

A similar group process for parents of drug addicts has also been launched in some cities in India under the name of Family Anonymous. We need to facilitate the already ongoing process of indigenization of this movement in terms of symbols/idioms.

The Mental Hospital at Kilpauk, Madras, the Professional Social Workers Forum, T. T. Ranganathan Foundation, Madras, the Tata Institute of Social Science, Bombay, the College of Social Work at Nirmala Niketan, Bombay, S.N.D.T. University, Bombay, SPARC, Delhi and Bombay, CYSD, Bhubaneshwar, Christian Counselling Centre, Vellore, and Indian Institute of Youth Welfare, Nagpur, are already involved in training personnel at various levels for helping addicts. The SNDT University, in collaboration with SPARC, has set up a certificate course in counselling addicts. SPARC and T.I.S.S. have started a "training of trainers" programme for social work educators in 18 schools of social work in Maharashtra. This is being funded by the Ministry of Welfare.

What is needed is a network plan to develop a cadre of counsellors by re-training interested professionals, and training volunteers selected from both middle and working classes and the ex-addicts.

We can also envisage the evolution of the co-counsellor system wherein existing experienced, expert counsellors take on helpers and train them through a planned in-service programme. However, it is most important to identify the roles and functions being performed by counsellors in this field today and to identify those roles which can be routinized, simplified and delegated to the volunteers. SPARC has begun a small study on the subjects.

We need to develop training packages to orient trainers in the State/Central Health Education Bureau, the NSS State level coordinators, the Military and Police training centres, the Workers’ Education Boards, trade unions and the personnel departments in all industries, law, teacher-training, nursing, medicine and all allied professions and channels of communication/training.
Counselling Centres

Here, again, one finds professionals offering psychotherapy, psychoanalysis, family therapy and group therapy, in both the non-profit and commercial settings, as well as in the Public Sector.

Hospital administrators are yet to issue circulars to the social workers, clinical psychologists and psychotherapists that house-calls to the homes of addicts, to meet their parents and for collection of detailed background information for treatment, is a permitted expenditure. In the absence of such support, follow up and involvement of the relatives, friends and neighbours, the recovery of the addict is not possible.

The phenomenon of rehabilitation centres, or counselling services run by ex-addicts, is of considerable theoretical interest. What were the factors that facilitated the emergence of such a group of ex-addicts in some cities and not in others? This is a question that needs further exploration.

In two workshops conducted by SPARC, some participants had pointed out the difficulties of setting up addiction counselling centres for students in colleges. Where a college cannot afford the salary to a full-time professor, it was felt that a cluster of colleges in a given area should pool money to set up a common centre for five or six colleges for career guidance, counselling and crisis intervention for their students. They also felt that the information available with the counsellors and their records should be confidential and not available to even the principals and to the teaching faculty.

The experiment of setting up a separate centre for women addicts in Goa offers a lesson to administrators. Not more than two women addicts sought admission in this centre at any given time and so the centre was converted into a centre for male addicts. Subsequently, realising the need to give occupational training to recovering addicts, this centre was converted into a work centre where addicts coming out of another centre were admitted for occupational training.

It appears that, due to the overwhelming stigma attached to female-addiction, it is not advisable to set up centres with such obvious names. It would be better to start centres for "women in crisis", to create networks with other organisations working with women, and to train/orient the staff of women's organisations to the phenomenon of addiction among women. Women's crisis centres should have specialized facilities for female addicts while they would also attend to other problems faced by women.