Indira Gandhi
National Open University
National Centre for Disability Studies

MCFTE-003
Substance Abuse Counselling and Family Therapy

Block

1

PROBLEM OF SUBSTANCE ABUSE

EXPERT COMMITTEE

Prof. V.N. Rajasekharan Pillai ***(Chairperson)***
Vice Chancellor
IGNOU, New Delhi

Prof. Girishwar Misra
Department of Psychology
University of Delhi, New Delhi

Prof. Shagufa Kapadia
Head, Department of Human Development and Family Studies
The M.S. University of Baroda
Vadodara

Dr. Rajesh Sagar
Associate Professor,
Deptt. of Psychiatry, AIIMS &
Secretary, Central Mental Health Authority of India, Delhi

Prof. Anisha Shah
Department of Mental Health and Social Psychology, NIMHANS, Bangalore

Prof. Minhotti Phukan
Head, Deptt. of HDFS
Assam Agricultural University
Assam

Dr. Jayanti Dutta
Associate Professor of HDCS,
Lady Irwin College, New Delhi

Prof. Vibha Joshi
Director, School of Education
IGNOU, New Delhi

Prof. Neerja Chadha
(Programme Coordinator)
Professor of Child Development
School of Continuing Education
IGNOU, New Delhi

Prof. Mathew Verghese
Head, Family Psychiatry Centre
NIMHANS, Bangalore

Prof. Manju Mehta
Department of Psychiatry
AIIMS, New Delhi

Prof. Rajni Dhingra
Head, Department of Human Development
Jammu University, Jammu

Prof. Sudha Chikkara
Department of Human Development and Family Studies
CCS HAU, Hisar

Mrs. Vandana Thapar
Deputy Director (Child Development), NIPCCD
New Delhi

Mrs. Reena Nath
Practising Family Therapist
New Delhi

Prof. C.R.K. Murthy
STRIDE
IGNOU, New Delhi

Prof. Reeta Sonawat
Dean & Head, Department of Human Development, SNDT Women's University, Mumbai

Prof. Ahalya Raghuram
Department of Mental Health and Social Psychology,
NIMHANS, Bangalore

Prof. T.B. Singh
Head, Department of Clinical Psychology, IHBAS, New Delhi

Prof. Aruna Broota
Department of Psychology
University of Delhi
New Delhi

Dr. Indu Kaura
Secretary, Indian Association for Family Therapy, New Delhi

Dr. Rekha Sharma Sen
Associate Professor
(Child Development), SOCE
IGNOU, New Delhi

Mr. Sangmeshwar Rao
Producer, EMPC, IGNOU
New Delhi

Dr. Amiteshwar Ratra
(Convenor & Programme Coordinator)
Research Officer, NCDS
IGNOU, New Delhi

Acknowledgement:

We acknowledge our thanks to Prof. Omprakash Mishra, Former PVC, IGNOU; Prof. C.G. Naidu, Former Director (I/c) P&DD and Head, Nodal Unit; Dr. Hemlata, Former Director (I/c) NCDS; and Dr. Arun Banik, Director, NCDS, for facilitating the development of the programme of study.

PROGRAMME COORDINATORS

Dr. Amiteshwar Ratra
Research Officer
NCDS, IGNOU, New Delhi

Prof. Neerja Chadha
Professor of Child Development
SOCE, IGNOU, New Delhi

COURSE COORDINATORS

Dr. Amiteshwar Ratra
Research Officer
NCDS, IGNOU, New Delhi

Prof. Neerja Chadha
Professor of Child Development
SOCE, IGNOU, New Delhi

COURSE WRITERS

Unit 1 Ms. Anubha Dhal, Clinical Psychologist, Delhi
&
Dr. Atul Ambekar, Associate Professor, National Drug Dependence Treatment Centre & Dept. of Psychiatry, AIIMS, New Delhi

Unit 2 Dr. Alok Agarwal, AIIMS, Delhi

Unit 3 Ms. Swati Kedia, Clinical Psychologist, Delhi

BLOCK EDITORS

Dr. Atul Ambekar
Associate Professor
National Drug Dependence Treatment Centre & Dept. of Psychiatry, AIIMS, New Delhi

Prof. Neerja Chadha*
Professor of Child Development
SOCE, IGNOU, New Delhi

Mr. Deepak Yadav
Social Worker, National Drug Dependence Treatment Centre, AIIMS, New Delhi

Dr. Amiteshwar Ratra*
Research Officer
NCDS, IGNOU, New Delhi

Course editing by the programme coordinators involved content editing, language editing, unit formatting and transformation of the units.

Acknowledgement:
We express our thanks to the course writers of Units 1, 2 & 3 for providing the art work included in their respective units.

We would like to acknowledge the various authors, books, journals and websites from which matter related to this course was researched; though they have been duly acknowledged in the relevant Units, but might have inadvertently been missed.

Concept for Cover Design : Prof. Neerja Chadha & Dr. Amiteshwar Ratra
Preparation of Cover Design : Mr. Haldar, Pink Chilli Communication, Dwarka

July, 2011

ISBN:

Further information on Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi- 110 068 or the official website of IGNOU at www.ignou.ac.in.

Printed and published on behalf of Indira Gandhi National Open University by Registrar, MPDD.

Laser Composed by: Rajshree Computers, V-166A, Bhagwati Vihar, (Near Sector-2, Dwarka), Uttam Nagar, New Delhi-110059

Printed by:

MCFTE-003 SUBSTANCE ABUSE COUNSELLING AND FAMILY THERAPY

COURSE INTRODUCTION

"Substance Abuse Counselling and Family Therapy" is one of the optional papers in the second year of the Masters' Degree Programme in Counselling and Family Therapy. It comprises both theory and supervised practicum components. The theory course (MCFTE-003) is worth 2 credits and the supervised practicum for the same (MCFTE-006) is worth 4 credits. You have to complete and clear both these components separately for successful completion of this optional paper on ''Substance Abuse Counselling and Family Therapy''. For theory course MCFTE-003, you will have continuous evaluation through an assignment, as well as term-end examination. For supervised practicum (MCFTE-006), you will have to work under the supervision of the academic counsellor alloted from the study centre you are attached with, and submit your file in the end, as per the details given in the Supervised Practicum Manual of the course (MCFTE-006).

This optional paper is designed to make learners aware of the need and potential of counselling and family therapy with specific reference to substance abuse. The theory and supervised practicum components are designed to provide the requsite knowledge, understanding, attitudes and skills to the learners, to enable them to make effective interventions with respect to substance use disorders, that are turning into a major menace in the society, running countless young lives.

The theory course (MCFTE-003) consists of two theory blocks.

THE BLOCKS

Block 1 is on ''Problem of Substance Abuse''. You have read in detail an overview of the problem of substance use disorders, in the earlier courses. This Block will acquaint you with the family issues in the context of substance abuse. The interface of substance abuse and HIV/AIDS has also been elaborated upon in the Block. To conclude, the Block focusses on the problem of substance use disorders among special population groups; particularly the women, adolescents, mental ill and prisoners.

Block 2 *viz.* 'Therapeutic Interventions'' focusses on the applied aspect. It highlights the principles that govern treatment of substance use disorders. Motivation enhancement and relapse prevention therapy have been discussed extensively in this Block. The Block elaborates on tobacco cessation. Family interventions, as well as psychosocial rehabilitation and lifestyle management in the context of substance use disorders are among the key focal areas of this Block.

Application of what you learn in these blocks at the field level, and practical exposure is the thrust of the supervised practicum course (MCFTE-006). The details are provided in the Manual for Supervised Practicum for the Course.

BLOCK 1 PROBLEM OF SUBSTANCE ABUSE

Introduction

Block 1, namely *"Problem of Substance Abuse"* will acquaint you with the fundamentals and aspects of practical significance in the field of substance use disorders. The Block consists of three Units.

Unit 1 focuses on *"Substance Abuse: Family Issues"*. It begins by recapitulating the elements of the construal of a family. The Unit highlights substance abuse as a family problem. The family issues in substance abuse, from a life span approach as well as from a biopsychosocial perspective, have been outlined in detail in the Unit.

Unit 2 in on *"Substance Abuse and HIV/AIDS"*. It discusses the interface of substance abuse and HIV in the context of sexual risk behaviours and infecting risk behaviours. Harm reduction and preventing HIV among substance users is the major focal area of this Unit.

Unit 3 focusses on *"Substance Abuse among Special Population Groups: Women, Adolescents, Mental Ill and Prisoners"*. The Unit begins with the context and pattern of substance abuse in these special population groups. The factors associated with substance use disorders in these special valuable populations groups have been discussed in detail in this Unit. The key areas of prevention, assessment and intervention are the focal areas of the Unit.

ignou
THE PEOPLE'S
UNIVERSITY

UNIT 1 SUBSTANCE ABUSE: FAMILY ISSUES

Structure

1.1 INTRODUCTION

Substance use is a growing concern for individuals, families, health professionals and the society at large. Families, in which one or more members use substances, have to grapple with a host of physical, emotional, social and legal issues. The Unit focuses on substance abuse in a familial context and the issues pertaining to it.

Objectives

After studying this Unit, you will be able to:

- Define a family and its elements and components;
- Understand substance abuse as a family problem; and
- Work on the family issues in substance use.

1.2 FAMILY

Families are ever changing in terms of context, time, cultural beliefs and interpersonal relationships amongst family members. Families can be distinguished from social groups in terms of level and duration of commitment as well as the source of connection and common goals.

1.2.1 Definition of a Family

There are numerous definitions of families in literature. Brooks & Rice (1997) defined a family as "group of people with common ties of affection and responsibility who live in proximity to one another". Families can be defined according to their structures in the following ways:

- Traditional families – These include heterosexual couples (two parents and minor children all living under the same roof), single parents, and families including blood relatives, adoptive families, foster relationships, grandparents raising grandchildren, and stepfamilies. Example: the Indian joint family setup in which grandparents, paternal uncles and their families as well as the parents and children live together in one household.

- Extended families – These include grandparents, uncles, aunts, cousins, and other relatives. Example: paternal aunt's family living with the grandparents, parents and children.

- Elected families – These are self-identified and are joined by choice and not by the usual ties of blood, marriage, and law. For some people, the elected family may be more important than the biological family. Examples include youth who choose to live among peers and other non-biologically related people who have an emotional tie (i.e., fictive kin) as well as gay and lesbian couples or groups (and minor children all living under the same roof). The couples who choose to live in without marriage would also be classified under this head.

From a therapeutic standpoint, family constitutes anyone who may be instrumental in providing support, maintaining the household, providing financial resources, and with whom there is a strong and enduring emotional bond. Further, the four characteristics of families considered vital in the context of family therapy include:

- Nonsummativity, that is the family as a whole is greater than and different from the sum of its individual members.

- The behaviour of individual members is interrelated through the process of circular causality, which suggests that if one family member changes his or her behaviour, the others will also change as a consequence. This in turn causes subsequent changes in the member who had changed initially. Further, it demonstrates that it is impossible to know what comes first: substance use or behaviours that are called "enabling" (i.e. behaviours which promote or enable substance use).

- Each family has a pattern of communication traits, which may be verbal or nonverbal, overt or subtle means of expressing emotion, conflict, affection, etc.

- Families strive to achieve homeostasis, which portrays the family systems as self-regulating with a primary need to maintain balance.

1.2.2 Family Roles

Each family member adopts one of the following roles and is required to keep the system balanced by maintaining one of these roles. These roles are usually interchangeable in a functional family but there may be less flexibility in interchanging

these roles in a dysfunctional family. The family roles can be discussed in the context of substance use as follows:

- *Enabler* – The person who allows substance abuse to continue by protecting the substance user from the consequences of his or her actions. For example, if an alcohol-dependent husband doesn't come home on time, an enabler (e.g., the wife) would make excuses to other family members for this behaviour.
- *Hero* – Is usually a sibling or another family member who begins to excel in many different areas from sports to academics or work to create the illusion of a successful family. For example, a successful brother of an adolescent with a substance use problem, who excels in academics and co-curricular activities may give an illusion that the family is well functioning.
- *Scapegoat* – May be the substance user or another family member who may display many unacceptable behaviours. This draws attention away from the substance abuse and allows the family to believe that if the scapegoat would behave appropriately; all their problems would be solved. A child who may be failing at school may take attention away from a father with a substance use problem.
- *Mascot* – The family member who uses comedy to divert attention away from the increasingly dysfunctional family system. For example, a father who is always cracking jokes may divert the attention away from his adolescent son who may be smoking excessively.
- *Lost child* – Is the family member who never causes a problem and is relatively invisible. The sibling of an adolescent using excessive alcohol may feel invisible and lost.

1.2.3 Elements of a Family as a System

To understand the dynamics of a family so as to understand the issues and plan effective intervention strategies, certain key elements of a family need to be emphasized:

- ***Complementarity*** **–** This refers to an interactional pattern in which members of the family establish roles and take on behavioural patterns that fulfill the unconscious needs and demands of the other. An implication of this element while treating substance use is that the results of one family member's recovery need to be explored in relation to the rest of the family's behaviour.
- ***Boundaries*** **–** These constitute the boundaries within the family system, which delineate one family member from another; generational boundaries within families; or boundaries between the family and other systems, that regulate the flow of information in the family and between systems outside the family. Ideally, the boundaries should be clear, flexible, and permeable which help in movement and communication. However, dysfunctional patterns may arise in boundaries ranging from extremes of enmeshment (extremely close) to disengagement (extremely aloof). When boundaries become too strong, family members may become disengaged resulting in lack of cohesion needed for the family to hold itself together. When boundaries are too weak, family members may become psychologically and emotionally too close and lose their ability to act as independent individuals. The boundaries that may be appropriate or adequate may vary from culture to culture, and the clinician

or counsellor needs to consider whether a pattern of disengagement or enmeshment is a result of culture or pathology.

- ***Subsystems –*** Within a family system, subsystems may be separated by clearly defined boundaries that fulfill particular functions. These subsystems have their own roles and rules within the family system. For example, in a family, parental subsystem may make decisions and delegate responsibilities or tasks to other members. These subsystem rules and expectations may strongly impact the client's behaviour and can be used to motivate or influence the client in a positive direction.

- ***Enduring family ties –*** Families are connected through emotional bonds more than physical proximity and daily interactions. Strong emotional ties connect family members, even when they are separated or away. Counsellors need to address issues, such as family loyalty, which may continue to shape behaviour even if clients have detached in other ways from their families of origin. With regard to treatment, it is possible to involve a client in a form of therapy even if family members are not physically present.

- ***Change and balance –*** Family rules and scripts may be changeable, but families may exhibit different degrees of adaptability when faced with the need to change patterns of behaviour. A tendency in all families, though, is homeostasis, which is a state of equilibrium that balances strong, competing forces in families as they tend to resist change so as to maintain the family's balance, which must be overcome if change is to occur. In order to function well, families need to be able to preserve order and stability without becoming too rigid to adapt. Hence a balance in maintaining flexibility is vital.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) What is a family?

.....

.....

.....

.....

.....

2) List the different elements of a family as a system.

.....

.....

.....

.....

.....

1.3 SUBSTANCE ABUSE AS A FAMILY PROBLEM

Substance use and abuse may be conceptualized as a family problem rather than an individual level problem. Certain models or frameworks have been proposed to illustrate this concept. These include:

- **Ecological Framework**

You have studied about the ecological theory in MCFT-001. The ecological framework on substance abuse conceptualizes people as nested in various systems such as families and communities. The members of the ecosystem of an individual with a substance abuse problem may include family, peers, treatment providers, non-family support sources, the workplace, and the legal system. The idea of an ecological framework within which substance abuse occurs is consistent with family therapy's focus on understanding human behaviour in terms of other systems in a person's life. Hence, it highlights the need to understand substance abuse as a dynamic process, which may be impacted by the family dynamics and may in turn affect the dynamics of the family.

- **The Family Disease Model**

This model or framework conceptualizes substance abuse as a disease that affects the entire family. Family members of the people who abuse substances may develop "codependence", which causes them to enable the person's substance abuse. Example, the wife of a person who uses alcohol, who is not educated, is a housewife and doesn't get attention from her husband may start pouring alcohol in the glass for him or serving snacks when her husband drinks alone or with friends, thereby increasing the drinking behaviour. Although, limited controlled research evidence is available to support the disease model, but it nonetheless has been found to be influential in the treatment community as well as in the general public.

- **The Structural Approach**

The structural approach to family therapy helps to understand the problem of substance use in a familial context. This model suggests that families use a limited number of self-perpetuating relational patterns and that family members divide into subsystems with boundaries that regulate family communication and behaviour. For example, an adolescent who uses excessive alcohol may have parents who do not impose any rules regarding acceptable and unacceptable drinking behaviour. This approach seeks to shift family boundaries so the boundary between parents and children becomes clear. Intervention based on this approach is aimed at having the parents work more cooperatively together and at reducing the extent to which children assume parental responsibilities within the family.

- **The Family Systems Model**

This framework is based on the idea that families become organized by their interactions around substance abuse. In adapting to the substance abuse, it is possible for the family to maintain balance, or homeostasis. For example, a man with a substance use disorder may not be able to express his feelings unless he is intoxicated. To facilitate the communication among family members, some members of the family may start accepting this form of communication as it may help them to converse with that member. Using the systems approach, a therapist or counsellor may focus on changing maladaptive patterns of interaction among family members, so that the substance abuse pattern may be altered.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

Fill in the blanks:

1) …… framework conceptualizes people as nested in various systems such as families and communities.

2) The family disease model conceptualizes substance abuse as a …… ……in the family.

3) The ……. model is based on the idea that families become organized by their interactions around substance abuse.

1.4 FAMILY ISSUES IN SUBSTANCE ABUSE

The family issues in substance use can be discussed in two ways, namely issues from a life span approach and issues from a biopsychosocial perspective. The following sections describe the various issues from these perspectives.

1.4.1 Issues from a Life-Span Approach

The life-span approach conceptualizes the crises, stressors or problematic issues such as substance abuse in accordance with each stage of life, for example, adolescence and adulthood. This highlights the change in family dynamics over the life-span, example, adolescent staying with family, adult staying alone, married couple, couple with young children etc. The issues with respect to each stage of life as per the family structure are discussed below:

- **Persons living alone or with partner**

The issues of an adult who excessively uses substances and lives alone or with a partner are likely to be centered on economic and psychological aspects.

a) The economic issues include the money that may be spent for drug use. In this situation, the partner who is not using substances may assume the role of providing the financial resources.

b) The psychological issues include denial or protection of the person with the substance abuse problem, chronic anger, stress, anxiety, hopelessness, inappropriate sexual behaviour, neglected health, shame, stigma, and isolation.

c) An important issue which encompasses both the above issues and is vital to be addressed from a therapy point of view is codependency. The characteristics of co-dependent people include exhibiting controlling behaviour because they believe that others are incapable of taking care of themselves. They usually have a low self-esteem as well as a tendency to deny their own feelings. They are excessively compliant and compromise their own values and integrity to avoid rejection or anger. They may often react in an oversensitive manner, as they are very vigilant towards any form of disruption, troubles, or disappointments. They often remain loyal to people who do nothing to deserve their loyalty. This is an important issue as this behaviour

on the part of the partner can facilitate and maintain the maladaptive substnce use pattern.

- **Persons living with spouse/partner and minor children**

Similar to victims of abuse, who believe the abuse is their fault, children of parents with substance use problems feel guilty and responsible for the parent's problem. Children whose parent(s) use illicit drugs are aware that their parents' actions are illegal and that they may have been forced to engage in illegal activity on their parents' behalf. The important issues which thus arise include the following:

a) Trust is the key development issue which impacts a child's development and it may be a constant struggle for those from a family with a parent with substance abuse problem.

b) The cognitive and psychosocial issues for children with a parent who uses substances include impaired learning capacity, a vulnerability to develop a substance use problem, adjustment problems, including increased rates of divorce, violence, and the need for control in relationships as well as emotional and self concept problems.

c) The children of women who use substances during pregnancy are at risk for the effects of foetal alcohol syndrome, low birth weight (associated with maternal addiction), and sexually transmitted diseases.

d) Latency age children (age 5 to the onset of puberty) may have school-related issues, such as truancy, while older children may be forced prematurely to accept adult responsibilities, especially of caring for younger siblings.

e) In adolescence, these children may begin drug experimentation, while the adult children of those with alcohol use disorders may exhibit issues pertaining to unsatisfactory relationships, inability to manage finances, and an increased risk of substance use disorders.

f) Substance use may lead to inappropriate family subsystems and role taking, which may rob the child of his or her childhood and may at times foster feelings of neglect in the child.

- **Persons living in a blended family**

Many people who abuse substances belong to stepfamilies, which may entail certain challenges or issues. These include the following:

a) Children, who live in two households, for example when their parents are separated or divorced, coping with different familial boundaries and ambiguous roles can be confused and develop a greater risk of social, emotional, and behavioural problems. This is particularly true when biological partners or their partners are involved in a conflict.

b) Children from stepfamilies may develop substance use problems to cope with their confusion about family rules and boundaries, which may intensify problems and become an impediment to a stepfamily's integration and stability.

c) Additional issues might include parental authority disputes, sexual or physical abuse, and self-esteem problems for children. Substance use by stepparents

may further undermine their authority, lead to difficulty in forming bonds within the family and impair the family's ability to address various problems. If the non-custodial parent uses drugs or alcohol, his or her visitation may have to be supervised, which may intensify the emotional issues for the children and parent.

d) With fewer ties to the family, there may be a probability that the adolescent will form attachments to substance-using peers. Stepparents living in a household in which an adolescent uses substances may feel they have gotten more than they bargained for and resent the time and attention the adolescent requires from the biological parent.

- **Older persons with grown children**

Older adults are likely to use alcohol and/or prescription medication as a result of retirement, lack of activity, and health problems. The issues which plague these persons include:

a) The diagnosis of problematic substance use disorder often is difficult because the symptoms of substance abuse can be similar to the symptoms of other medical and behavioural problems that are found in older adults, such as dementia, diabetes, and depression.

b) Since older adults usually live with grown up children for either financial, security or emotional reasons, their substance use problem can affect everyone in the household. For example, if the older adult's spouse is present, that person is likely to be an older adult as well and may be concerned by new and upsetting behaviours.

c) Certain economic issues may become pressing as additional family resources may need to be mobilized in the service of treating the older adult's substance use disorder.

d) Whether grown children and their parents live together or apart, the children must take on a parental, caretaking role. Adjustment to this role reversal can be stressful, painful, and embarrassing.

e) Children may cut ties with the parent because it is too painful to have to watch the parent's deterioration. This may increases the parent's isolation and may worsen his or her condition.

- **Adolescents living with their family of origin**

Substance use and abuse among adolescents may impact their cognitive and affective growth, school and work relationships, and all family members. This may bring certain psychological and social issues to the fore such as:

a) Physical issues related to excessive alcohol or drug use include violent death for teenagers, including homicide, suicide, traffic accidents, and other injuries.

b) Continued alcohol and drug use may increase certain psychosocial issues such as delinquent behaviour, impulsivity, decline in academic performance, cognitive deficits which may be irreversible, unhealthy social relationships

with peers and opposite sex, risky sexual practices, unwanted pregnancy.

c) When an adolescent uses alcohol or drugs, siblings in the family may find their needs and concerns ignored or minimized while their parents react to constant crises involving the adolescent who abuses drugs. The neglected siblings and peers may look after themselves in ways that are not age-appropriate, or they might behave as if the only way to get attention is to act out.

1.4.2 Issues from a Biopsychosocial Perspective

Substance abuse may be viewed as a problem caused by an interaction of various biological, psychological and social factors. Additionally, it may impact the family as a unit, physically, emotionally and socially. These issues are discussed below:

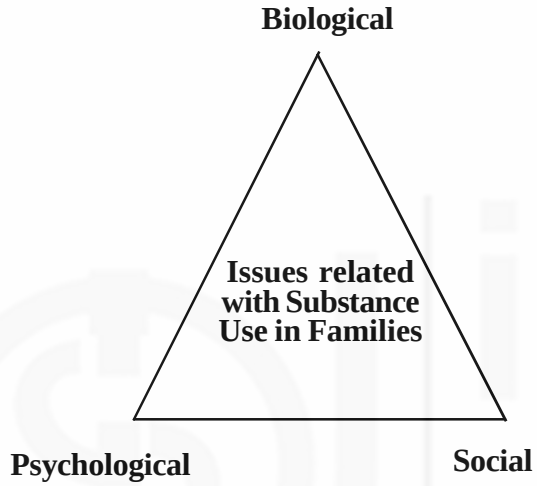

Fig. 1.2: Biopsychosocial Issues Associated with Substance Abuse in Families

Biological and Physical Issues

Substance abuse may have certain biological and physical familial issues such as:

- Physical abuse – Families with members who use substances may be at a higher risk of their children and other members being exposed to physical violence and abuse. Common forms of physical abuse include physically beating the spouse or children, which may result in injuries of various sorts ranging from minor bruises to severe injuries which may cause irreversible physical or brain damage or even death
- Biological or Genetic Vulnerability – Children of parents who indulge in substance use and misuse are at a higher risk of using substances. Substance use disorders have a strong genetic predisposition.
- Accidents and Disability – Family members who use substances are at a higher risk of accidents, particularly while driving, crossing the road or operating heavy machinery at work. These accidents due to substance use are also a leading cause for disability or handicap. Frequent and severe accidents or disability may raise other concerns such as extra costs or attending to by other family members as well as legal consequences, thereby disrupting the familial functioning and harmony.
- Diseases – Risky sexual practices as well as sharing needles in case of injecting drug use may result in sexually transmitted diseases and HIV

infections, thereby posing as a health risk for the person and his or her family. Apart from diseases, there may be a variety of health related issues such as somatic complaints which may result from withdrawals that may disrupt the family environment and add to additional economic and emotional costs.

Psychological Issues

Substance use disorders impact the emotional and psychological well being of family members in a host of ways. The psychological issues impacting the family can be discussed as follows:

- Emotional Distress – Members of a family with substance use problem may experience many types of emotional distress such as anger, irritability, anxiety and depression. Anger may be expressed verbally or through actions by the person who uses substances. Anger may also be experienced by other family members who may express it in similar ways towards the family member with a substance use problem. The person who uses drugs may express anxiety and depression through various somatic complaints.

- Impulsivity – Impulsivity comprises of engaging in certain covert or overt actions without thinking adequately about the consequences of those actions. Persons with substance use may exhibit impulsivity in making decisions or through certain behaviours. For example, the person with substance use problem may become aggressive on a minor disagreement and hit the other person. Impulsivity can lead to a host of other social and legal issues such as jail term.

- Stress – Stress is one of the leading causes for why people engage in substance use and is an important familial issue as well. The person indulging in substance use may use it as a means to cope with stressors of various kinds such as pressures at work or domestic problems. The substance dependency behaviour may in turn be stressful for the family members.

- Denial – An important issue to consider in a familial context while addressing problem of substance use is denial. This may be expressed by the person who is using substances in a manner that he or she refuses to accept that his or her substance use may be problematic. The family members may also express denial in a manner that they may choose to ignore a family member's excessive substance abuse pattern or justify it.

- Negativism – This constitutes any negative communication among family members. For example, complaints, criticism, and communicating other expressions of displeasure. The overall mood of the household is decidedly downbeat, and positive behaviour is ignored. In such families, the only way to get attention or better the situation is to create a crisis. This negativity may serve to reinforce the patterns of substance abuse.

- Parental inconsistency – This constitutes lack of consistent disciplining such as erratic and inconsistent rule enforcement and an inadequate family structure. Children are confused because they cannot figure out the boundaries of right and wrong, which may result in behaving badly in the hope of getting their parents to set clearly defined boundaries. Without known limits, children cannot predict parental responses and adjust their behaviour accordingly. These inconsistencies tend to be present regardless

of whether the person using substances is a parent or child and they create a sense of confusion.

- Unrealistic Parental Expectations – This is an important issue in understanding adolescent substance abuse patterns. In case of parental expectations being too high or too low, the child or adolescent may feel stressed or vulnerable to use maladaptive patterns of coping such as substance use.

- Family Member with Substance Use Problem – Family members with substance use problems may serve as models whose abuse patterns adolescents may imitate or copy. Also this may communicate the message that using substances in excessive amounts may be acceptable or normative.

- Neglect – Children and adolescents whose parents exhibit unhealthy substance use patterns may feel neglected. This may also hold true for partners or spouses of those who abuse substances. This may in turn increase vulnerability of children or adolescents to experiment with substances as well.

Social Issues

These issues constitute the issues that a family with a substance use problem has to face within a larger social context. This section encompasses the legal and cultural factors as well. The social issues can be elucidated as below:

- Interpersonal conflict – This may include the conflict among family members resulting from excessive substance use of a member as well as conflict between the person using substances and others, which may be a source of concern for family members. For example, the person using substances may engage in arguments or fights with others.

- Legal problems – The person who uses substances including illicit drugs may be involved in a variety of legal problems, which may affect members of the family. The legal problems may include jail sentence for possession of illegal drugs or committing violent acts, fine for drunken driving, etc. The family may incur additional costs for the same.

- Financial issues – The family members may find themselves in financial crises as a result of the person's excessive expenditure on purchasing substances or resulting from increased medical or legal costs.

- Child abuse – The children of parents with substance abuse may be vulnerable to all forms of abuse – physical, sexual or emotional. Also these children may in turn be vulnerable to develop substance use problems as adults.

- Domestic violence – This is a growing concern for spouses or partners of persons with substance abuse problems. Marital conflict and disharmony are common in families with substance use problems. Physical or sexual violence against spouses or partners of persons with substance use is a common feature.

- Stigma – Families in which one or more members use substances often have to face stigma and discrimination from the community in the vicinity.

These issues are important as they may help to plan effective intervention strategies

for an individual, within a familial context. Understanding these issues helps to sensitize us to see substance use as a familial problem rather than just an individual problem. The approaches or frameworks are helpful in understanding the problem of substance use in a familial arena and conducting family therapy sessions. These may be additionally helpful in conducting future researches on family variables in substance use disorders as well as planning social and health policies for families with substance use problems.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answers with that provided at the end of this Unit.

1) Match the following:

i)	Biological issues	a)	Stigma
ii)	Social issues	b)	Genetic vulnerability
iii)	Psychological issues	c)	Emotional distress

1.5 LET US SUM UP

The key points can be summarized as follows:

- Family constitutes anyone who may be instrumental in providing support, maintaining the household, providing financial resources, and with whom there is a strong and enduring emotional bond.
- Types of families according to structure include traditional, extended and elected families.
- Characteristics of family include non-summativity, causality, communication traits and homeostasis.
- The roles in a family include enabler, hero, scapegoat, mascot, and the lost child.
- The elements of family as a structure include complimentarity, boundaries, subsystems, enduring family ties, change and balance.
- The frameworks that conceptualize substance use as a family problem include ecological approach, structural approach, system framework and family disease model.

1.6 GLOSSARY

Boundaries : These constitute the boundaries within the family system, which delineate one family member from another; generational boundaries within families; or boundaries between the family and other systems, that regulate the flow of information in the family

and between systems outside the family.

Circular causality : The characteristic that if one family member changes his or her behaviour, the others will also change as a consequence.

Complementarity : This refers to an interactional pattern in which members of the family establish roles and take on behavioural patterns that fulfill the unconscious needs and demands of the other.

Enabler : The person who allows substance abuse to continue by protecting the abuser from the consequences of his or her actions.

Family : A group of people with common ties of affection and responsibility who live in proximity to one another.

Hero : This is usually a sibling or another family member who begins to excel in many different areas from sports to academics or work to create the illusion of a successful family.

Homeostasis : The characteristic which portrays the family systems as self-regulating with a primary need to maintain balance.

Lost child : It is the family member who never causes a problem and is relatively invisible.

Mascot : The family member who uses comedy to divert attention away from the increasingly dysfunctional family system.

Nonsummativity : The characteristic that the family as a whole is greater than and different from the sum of its individual members.

Scapegoat : This may be the substance user or another family member who may display many unacceptable behaviours.

1.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1) A family is a group of people with common ties of affection and responsibility who live in proximity to one another. It may be traditional, extended or elected.

2) The elements of a family as a system include complementarity, boundaries, subsystems, enduring family ties, change and balance.

Check Your Progress Exercise 2

1) Ecological

2) disease

3) family systems

Check Your Progress Exercise 3

1) i) b

ii) a

iii) c

1.8 UNIT END QUESTIONS

1) Analyse substance abuse as a family problem.

2) With the help of examples, discuss family issues in substance abuse from a biopsychosocial perspective.

UNIT 2 SUBSTANCE ABUSE AND HIV/AIDS

Structure

2.1 INTRODUCTION

Over the past few years the world community has started looking at the problem of substance use in an entirely new light. Till a few decades back substance use was seen as just a social / legal / moral problem or at the most as a medical problem at the fringes of mental health. With the advent of epidemic of HIV/ AIDS, and its clear association with substance use however, the perception about substance use problems has undergone a sea change. Now there is increasing evidence that people who use drugs remain vulnerable to acquire and transmit HIV infection on account of various 'high risk' behaviours. These risk behaviours include sexual risk behaviours as well as behaviours consisting of lending and borrowing used injection equipments – so common among injecting drug users. In this unit we discuss how and why substance users are at risk through both these types of behaviours. We also discuss various ways in which such a risk can be miniminsed and how HIV among substance users can be prevented.

Objectives

After studying this Unit, you will be able to:

- Understand the relationship between substance use and HIV/AIDS;
- Analyse the concept of harm reduction and various strategies for preventing HIV among drug users; and
- Impart correct safer practices messages to people in need.

2.2 SUBSTANCE ABUSE AND HIV: SEXUAL RISK BEHAVIOURS

In the context of HIV, it is important to understand two key concepts: ''Risk'' and ''Vulnerability''. *Risk* is the "probability that a person may acquire HIV infection", while *vulnerability* is the result of "societal factors that affect adversely one's ability to exert control over one's health" (UNAIDS, 1998).

Thus, any behaviour which increases the likelihood of transmission of infection from one person to another are considered high risk behaviours. Those individuals or groups of individuals who exhibit certain identified 'high risk behaviours' more commonly than others are identified as 'High Risk groups' (HRGs) or 'Most-at-Risk Populations' (MARPS).

The following factors may increase the vulnerability of a person / group to HIV or other harmful situations:

1. Personal factors such as sexual history, personal knowledge, and membership of specific social networks may increase vulnerability.
2. Factors such as quality of services offered to individuals in need, geographical access, and cost will also increase or decrease vulnerability.
2. Finally, there are societal factors such as cultural norms which influence a person's behaviour. Poverty and gender norms are other societal factors that increase vulnerability.

It is now a well documented fact that substance users are at an increased risk of HIV because of their vulnerability of high risk sexual behaviours. Lets us first understand, what various high risk sexual behaviours are.

2.2.1 High Risk Sexual Behaviour

All those sexual activities which enhance the risk of exchange of body fluids between two partners having sex, are loosely termed high risk sexual behaviours. These include:

- **Sex with multiple partners:** Having sex with multiple partners increases the likelihood of spread of sexually transmitted infections from one partner to another.
- **Sex with a partner who has multiple partners**: Even if you are having sex with just one partner, but that partner in question has multiple partners, the risk of exposure to sexually transmitted infections gets enhanced. Sex with sex workers (sometimes also known as commercial sex workers) would fall under this category.

- **Sex in the presence of other sexually transmitted diseases**: Certain sexually transmitted diseases result in ulcers, discharge or breach in the surface of genitals. Having sexual intercourse in the presence of such diseases provide increased opportunity for the body fluids from one person to gain entry into another body, thereby enhancing the risk of transmission of HIV.

- **Type of sexual practices**: Not all kinds of sexual practices have the same risk of transmission of HIV and other infections. The risk is lowest in *oral sex* (where one person's genitals come in contact with the mouth of another) followed by *peno-vaginal* intercourse (in which the male genital organ is inserted into the female genital organ). The highest risk of infection is during the *anal sex* (in which a male genital – penis – is inserted in the anus of a female or a male partner). The risk is highest in this form of intercourse because the anal passage is much smaller in size than the vagina and is also not as well lubricated, which increases the risk of damage to the surface, bleeding and thereby enhanced opportunity for exchange of body fluids.

- **Forced or coercive sex**: If sexual acts are performed forcibly when one of the partners (usually female) is unwilling, it enhances the risk of injuries to genitals, thereby increasing the risk of transmission of body fluids.

- **Unprotected sex**: The risk of transmission of HIV and other sexually transmitted infections can be minimized if people use condoms correctly and consistently every time they have sex. Condoms act as barriers, not allowing body fluids to come in contact with each other thereby providing protection against not only sexually transmitted infections and HIV but also against unwanted pregnancy.

2.2.2 Substance Use and Sexual Behaviour

Having discussed the various sexual behaviours which could be termed as 'high-risk', the question arises, what is the relationship of substance use with the high risk sexual behaviours? Indeed, many studies have demonstrated direct and indirect linkage between alcohol/substance use and sexual behaviours. An observed association between drug use and high risk sexual activity could imply (a) that these two behaviours are part of a larger risk taking tendency, or (b) drug use itself influences sexual risk taking or (c) both. There are various ways in which substance use can influence the vulnerability of an individual to engage in high risk sexual behaviours.

- **Effect of substance**: There is often a misperception that drug users have low libido or that drug use affects a person's capacity or desire to have sex, and hence drug users have low risk of indulging in sexual activities. In fact the truth is just the opposite. The intoxicating effects of drugs increase the risk of indulgence in risky behaviours. Alcohol, Cocaine and almost all intoxicants can cloud the judgement of a person, diminishing the user's capacity to take correct decisions. Thus, under the influence of substance, a person may experience enhanced sexual desire, reduced inhibitions and poor decision-making and executing capacity. Condom use is low under the influence of alcohol. Alcohol use and sexual experimentation during adolescence and youth are risk factors for acquiring sexually transmitted diseases. In a study from India, among 200 students, sexual behaviour was found to be strongly associated with alcohol use. In yet another study among adolescents in Mumbai, alcohol use was associated with the

perception that "consumption of alcohol before sex heightens sexual pleasure and makes it long lasting".

Let us take these examples. A young man after taking heroin may plan a visit to a sex worker, or a young woman, under the effects of a few beers, may provide consent to her boyfriend to have sex. Both these individuals may not have taken these decisions had they been fully sober. Additionally, the same intoxicating effect of these substances may also influence the likelihood of use of condoms. The same young man visiting the sex worker may forget to use condoms under the influence of heroin. The same young woman may find it difficult to assert use of condoms by her boyfriend after she has consumed a few beers. Even if these people do remember to use condoms, under the effects of drugs they may not use condoms correctly (they may forget to check the expiry date or they may make mistakes in putting on or removing the condoms etc.). Thus, the drugs in these instances have directly influenced the capacities of users to make rational decisions and to act upon them.

- **Socio-Cultural Factors**: Using drugs and having sex have both been seen by society as 'fun' activities. Indeed use of intoxicating substances and sexual activities very often go hand in hand in the same settings. Alcohol and other drugs are often available at brothels (or other sex work settings). Joining a peer group which favours both substance use and indulging in high risk sex influences the behaviour of group members. Commonly held misconceptions and myths about property of psychoactive drugs to enhance sexual potency/ power also influence both – drug use and risky sexual behaviours.
- **Economic factors**: They are often poorly understood, but a host of economic factors also enhance people's vulnerability to drug use and risky sex. The rates of drug use – including injecting drug use, yet another risk for HIV infection – among female sex workers are much higher than women in the general population. Many female sex workers have to resort to / continue working in the sex trade in order to support their drug use habit. Often, female sex workers also report taking drugs to relieve the mental stress associated with working in the sex trade and thus, the vicious cycle of drug use – sex work continues. Similarly, economic factors often force young men to migrate away from their place of origin in search of employment. Such migrant workers – on account of stressful, lonely living conditions – are also at risk of both, drug use and engaging in risky sex (like visiting sex workers).

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Which among the following is NOT an example of a high risk sexual behaviour?

   a) A 24 year old man having sex with a female sex worker

   b) A 38 year old man having anal sex with another man

   c) A 32 year old woman having oral sex with her husband

   d) A 19 year old man with an ulcer on penis having unprotected sex with his girlfriend

2) Which of the following statements is incorrect?

a) Drinking alcohol may enhance the sexual desire and reduce the inhibitions

b) Drug users are not generally sexually active

c) Some people believe that using drugs may increase the pleasure associated with sex

d) Poverty may increase the vulnerablility to drug use and risky sexual behaviour

2.3 SUBSTANCE ABUSE AND HIV: INJECTING RISK BEHAVIOURS

2.3.1 Injecting Drug Use in India

Looking at the vast history of substance use patterns in India, Injecting Drug Use (IDU) is a relatively recent phenomenon. While historically, the use of certain intoxicating substances has been prevalent in India for many centuries now (particularly plant-based substances like various cannabis derivatives, opium and locally brewed alcohol), in the 1980s, with the introduction of heroin in India, the situation changed to a great degree. Many users of a traditional, plant-based (and relatively less potent) drug like opium shifted to modern, synthetic (and more potent) drugs like heroin and pharmaceutical products.

In the 1990s, many heroin users switched to injecting modes of taking opioid drugs. The phenomenon was first noted in the north-eastern states of Manipur and Nagaland. Gradually, however, the phenomenon spread first to bigger cities in other parts of the country and then to many other states like Punjab, Haryana, West Bengal, etc.

Use of injecting drugs is observed not just in India but in several other countries. According to recent estimates, there are about 16 million injecting drug users globally (Mathers et al, 2008). Similarly the HIV among IDUs is also progressing in India at an alarming rate. At the national level IDUs have been identified as one of the groups (among other vulnerable groups such as Female Sex Workers and Men-Who-Have-Sex-with-Men) most vulnerable to HIV.

2.3.2 Why do People Inject Drugs?

Route of consumption of a substance may depend on a number of factors. Most frequently, it is a function of the type of substance itself, for example some substances have only one route of consumption (alcohol is consumed only orally), while others may have multiple routes (tobacco may be chewed, smoked, inhaled or snuffed depending on the preparation). Similarly, some substances are injectable while others are not. Substances which may be injected include

- Opioids (e.g. heroin or brown sugar),
- Stimulants (e.g. cocaine),
- Sedatives
- Anaesthetics (ketamine)

Some of these substances have other routes of consumption as well; for example heroin (smoked, chased or injected), cocaine (smoked, snuffed or injected). A person who is habituated to any of these substances or substances may prefer a particular route of drug consumption over the other. For a substance which can be taken from other routes, a drug user may prefer the injecting route due to the following reasons:

- Perceived faster onset of action of the drug and the resultant euphoria
- More economical route of consumption as the entire drug consumed enters the blood stream and is available to produce high (maximum use of the available "stuff"). In contrast, the use of same drug orally or by smoking is associated with wastage of a proportion of the available drug.
- Peer group influence (everybody else is also injecting the drug in a group)
- Habit (person has always used the substance through the injecting route)
- Cheaper (some drugs are cheaper than others producing similar effects but can only be injected; for example pharmaceutical opioids and heroin)
- Personal preference (''I like it through the injecting route only'')

A drug user may choose the injecting route despite understanding some or most of the harmful consequences of the same. Others may be indulging in these practices due to lack of awareness regarding these risks. Table 2.1 describes the common routes of drug use and their characteristics.

Table 2.1: Common Routes of Drug Use and their Characteristics

Route of drug use	***Characteristics***
Oral	• Easiest route to take drugs though not all drugs can be taken through this route • One of the least efficient route of drug intake as significant proportion of drug is destroyed before it reaches the brain • Delayed 'rush' as it takes longer for the drug to reach the brain and exert its effects • In general, least harmful route for taking drugs
Smoking/inhalation/ chasing	• Drug reaches the blood circulation through lungs and then onwards to the brain • More rapid onset and less wastage as compared to oral route • Vary harmful as it damages the linings of the lungs and can give rise to various respiratory diseases
Injecting	• The most efficient route of drug intake • Drug reaches brain fairly quickly and gives effects rapidly • Requires much less amount of drug (hence cheaper) • Most damaging or harmful route of taking drugs

2.3.3 How Many People Inject Drugs in India?

Estimating the number of Injecting Drug Users in India has proved to be very challenging due to variety of factors. Some of them are: large population and land-mass of the country, huge variations in the occurrence of the phenomenon across different regions, small frequency of the phenomenon in comparison to the population of the country, etc. However, a number of attempts have been made to estimate the number as accurately as possible. At present the National AIDS Control Organisation (NACO) estimates that there are about 1.9 lakh IDUs in India (NACO expert group, 2005). Interestingly, India figures among the developing and transitional countries with the "largest populations of IDUs" as per the global experts.

A significant geographical variation has been noticed in the prevalence of IDU across different regions of the country. The North-Eastern states particularly Manipur, Mizoram and Nagaland alone house approximately one third of the IDU population of the country. The metros (Delhi, Mumbai, Chennai, Bangalore and Kolkata) and some North-Western states like Punjab, Haryana and Rajasthan contribute another one third. The remaining third of the IDU population is spread across rest of the country in small pockets.

2.3.4 The Usual Drug Use Career

It has been seen in India, that it is uncommon for drug users to start their drug-use careers with injecting. Typically, most IDUs start as users of other substances which typically include the licit substances like tobacco and alcohol (usually in adolescence). Thereafter, some of them graduate to illicit drugs like cannabis (*ganja* or *charas*) which is often followed a period of opioid use through non-injecting route; mostly smack / brown sugar through chasing. After this, some of the opioid users may shift to use of opioids through the injecting route due to the various reasons mentioned above. However, there are always exceptions to this usual outline. Some drug users start taking opioid injections directly, without an intervening period of brown sugar chasing. Additionally, sometimes people are given prescriptions of opioid injections for health reasons (such as pain) by doctors as pain-killer medications, but gradually develop dependence on it.

2.3.5 Profile of a Usual IDU

While drug use and injecting is not limited to any particular demographic group, most vulnerable are those who belong to the underprivileged sections of the society. Since IDU represents a rather severe form of drug use, which is associated with many socio-occupational consequences, it is likely that the IDUs which require services are those who belong to poorest section of the society. Consequently, the typical IDU who would come into contact with services, would be a man, in his productive years, but not likely to be regularly and gainfully employed. He may be married, but likely to have poor social support. Years of drug dependence would have led to severe dysfunction in almost all aspects of his life. It is not uncommon for an IDU to be homeless, with limited means to sustain themselves, to maintain their hygiene, or even to have two square means a day. Involvement with criminal justice system is also common. However, there are always exceptions and one may come across those IDUs who do not fit this description – women IDUs, IDUs belonging to middle or upper socio-economic strata, IDUs holding white collar jobs and staying with their families etc.

2.3.6 Injecting Drug Use: HIV Risks and Vulnerabilities

Injecting drug users are more at risk of HIV as compared to the general population because of factors such as exposure to high risk situations as a result of their drug taking behaviour as well as are highly vulnerable to HIV infection due to discriminatory laws against them/their practices, decreased access to health services and increased stigma and marginalization by society.

☞ Injecting Drug Use: HIV Risks

As discussed above, amongst IDUs the risk of acquiring HIV infection may be related to their injecting or sexual practices. The sexual risks of drug users in general have been discussed earlier in this unit.

As discussed earlier drugs can be taken in a variety of ways including drinking, smoking, snorting and rubbing, but in the context of HIV, it is the injection of drugs that creates the biggest risk of HIV transmission. Sharing of a needle contaminated with HIV-infected blood is one of the most efficient vehicles for HIV transmission. The risk with a single act of sharing used needle is 5 times that of the risk associated with heterosexual intercourse. This efficiency of transmission is one of the reasons for such high prevalence of HIV infection amongst IDUs in India (discussed later in this unit). It has also been realized that due to this high efficiency of transmission, HIV spreads very rapidly amongst a network of IDUs and then to their sex partners.

Injecting is very often a group activity. It is not unusual for a group of IDUs to have lesser number of injecting equipments than required. Consequently IDUs sometimes share their injecting equipments. The sharing may involve:

- Sharing needles
- Sharing syringes
- Sharing injecting paraphernalia (i.e. the cookers or pots in which drug has been prepared for injecting).

Reasons behind sharing injection equipments

- ***Economic reasons:*** Unavailability of injecting equipments — the drug may be procured from a drug-peddler, but the injecting equipment may be available only at a pharmacy, which may be reluctant to sell needles-syringes or may choose to sell them at a premium.
- ***Psychological reasons:*** Sometimes IDUs may choose to share their injecting equipments, just because they feel their bonding with each other will be strengthened by this act.
- ***Poor awareness:*** Lack of awareness of consequences of sharing or of safe injecting practices also contributes to risky practices.

The box above lists some of the reasons why IDUs share their injecting equipments. All of these sharing practices are associated with risk of transmission of various blood-borne infections. The important among these are HIV, Hepatitis-B and Hepatitis-C.

The re-use and sharing of contaminated needles and syringes is common amongst IDUs in India. In a National Survey of behaviours of IDUs, a relatively high proportion of respondents reported injecting drugs with a used needle or syringe. These behaviour patterns of IDUs are harmful to their health, as injecting drug use through unclean syringes fuels the rapid spread of injection-related diseases such as HIV and Hepatitis.

Besides actual needle sharing, indirect sharing such as the use of common spoons, solutions, and cotton swabs as well as dipping the needles into the ampoules could also be another, important factor in the spread of HIV among IDUs (Kumar, 1998).

Moreover, use of illicit drugs even by addicted individuals is punishable under law. As a result, drug users end up injecting in circumstances which are extremely unhealthy and promote risky injecting behaviours. The IDUs inject drugs in places called 'shooting galleries': locations where the needles and syringes provided by a dealer are used in rapid succession, without adequate (if any) sterilization between use, by a number of different users. For a fee, professional injectors administer to 'clients' the drugs which they have purchased, and in so doing, provide a potential hazard for transmitting HIV and other blood-borne viruses. Other possible reasons for reuse of the injecting equipment could be poverty, socio-psychological and cultural factors such as a sense of camaraderie, connection and of solidarity.

☞ Injecting Drug Use: Vulnerability to HIV

As explained earlier, vulnerability factors are those which may not increase the risk of HIV directly, but increase the likelihood of occurrence of sexual or injecting-related risky behaviours amongst IDUs. A number of such factors have been identified:

- ***Vulnerability due to myths and misconceptions:*** Some IDUs use drugs because they believe that drugs will increase their pleasure during sex (Des Jarlais, 2002). When women who use drugs are also involved in sex work, the risk of acquiring HIV infection through unprotected sex compounds the existing risk of transmission through the reuse of needles and syringes.

- ***Gender-related factors:*** Women face more risk of HIV infection than men, both due to biological factors (greater surface area exposed to infection, concentration of HIV in semen more than in vaginal secretions) and socio-economic factors (subordinate status in society, lack of say in sexual relationship, dependence upon males, forced sex, etc.).

- ***Vulnerability due to socio-economic conditions:*** Many IDUs belong to the underprivileged sections of the society and hence often do not have enough income to support their drug habit. To pay for the drugs they may also indulge in commercial sex or illegal activities like thefts which in turn increases their vulnerability to HIV transmission. An IDU with limited resources to sustain the drug habit is more likely to utilize them on purchasing drugs than on buying new needles and syringes for each injecting act.

- ***Vulnerability due to early age of initiation:*** Often drug abuse starts in youth. Young IDUs are at higher risk of HIV infection than older IDUs because they:

  — are less likely to be aware of HIV risks;

  — are more likely to engage in risky drug-using behaviour;

  — are less likely to seek out and use drug treatment and other health services.

- ***Vulnerability due to marginalisation, stigma and discrimination:*** People with drug dependence problems are marginalized as drug use is highly stigmatized both within the general community and among health care workers. Stigma can be described as 'attitudes and thoughts', and discrimination as 'the behaviour based on stigmatizing attitudes and thoughts'. Since Injecting Drug Use is seen as a deviant behaviour, it creates barriers to accessing adequate treatment and prevention services making IDUs more vulnerable to HIV and its effects.

- ***Vulnerability due to criminalization of IDUs:*** As injecting drug use is an illegal and covert activity, it adds to the marginalization of IDUs by increasing their risk of imprisonment. This, in turn, makes it more difficult for them to access HIV prevention and treatment services. Additionally, drug laws in some areas make it an offence to distribute or possess syringes for non-medical purposes. IDUs fear that, while carrying needles and syringes, they will be stopped by police who will use possession of drug paraphernalia as evidence of a drug-related crime. Hence they may have to resort to sharing.

- ***Stigma and discrimination:*** Another factor that is common to drug users is the stigma and discrimination that they face which acts as a factor increasing their vulnerability to HIV.

☞ **HIV in India: Role of IDU**

India is often described as having not one but many epidemics of HIV. Since the beginning of the HIV epidemic in India, largely the epidemic has been concentrated among certain population sub-groups. These include: Females Sex Workers (FSW), Men-having-sex-with-men (MSM) and Injecting Drug Users (IDUs). It has been seen that in various parts of the country, the epidemic begins usually in one of these 'High Risk Groups' and then subsequently reaches the general population. However, among these population groups, IDUs are known to be the population most vulnerable and at-risk since the spread of HIV epidemic in this population tends to be 'explosive' or rapid in nature.

As per the surveys carried out in 2008-09, at the national level, nearly 1 in every 10 IDUs is living with HIV infection. This is highest among any population sub-groups which are surveyed regularly for HIV positivity rates (FSW and MSM). Additionally, in certain parts of the country HIV positivity rates among IDUs is much higher than the national average: Maharashtra (24%), Manipur (18%), Tamil Nadu (17%), Punjab (14%), Delhi (10%). In some parts of Punjab about one-third to half of IDUs surveyed have been found to be HIV positive.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answers with that provided at the end of this Unit.

1) Which among the following statements is NOT correct?

a) Injecting route is one of the most efficient ways of Drug Use

b) Injecting Drug Users are among the population groups which are at highest risk of HIV

c) Some people prefer injecting route because it results in a slow onset of effects of drugs and the effects last longer

d) Opioid group of drugs are the most commonly injected in India

2.4 PREVENTING HIV AMONG SUBSTANCE USERS: HARM REDUCTION

As discussed in the earlier units, three overlapping strategies have been described to manage and control substance use. These are:

- *Supply reduction*; which deals with reducing the availability ('supply') of drugs by having laws and regulations in place.
- *Demand reduction*; which deals with reducing the need ('demand') of these drugs by either preventing the onset of substance use among non-users or providing treatment to drug-users
- *Harm reduction*; which involves those programmes and policies that reduce the harms associated with drug use without reducing drug use per se.

This section would focus on the third strategy viz. harm reduction.

2.4.1 Harm Reduction: The Concept and Definition

The advent of the AIDS epidemic has forced the public health field to respond to this global threat in pragmatic ways. While the concept of harm reduction has been used in the context of a variety of risky behaviours, primarily it has been seen as an HIV prevention strategy for drug users. One of the most accepted definitions of harm reduction is "policies and programs that are aimed at reducing the harms from drugs, but not drug use per se (Ritter and Cameron 2005)".

The phrase in the definition "..not drug use per se" often makes purists and authorities uncomfortable, since sometimes this phrase is misinterpreted as an excuse to encourage or condone drug use. Nothing could be farther from truth. Harm reduction does not condone or encourage drug use, nor does it reject abstinence. Harm reduction is a flexible approach that stresses understanding of the needs of the drug user, and responding to these needs in a way as realistic as permissible. This is an approach, which is transparent, less ideological and based on facts rather than beliefs.

2.4.2 Harm Reduction: Strategies and Interventions

The concept of harm reduction recognizes that strategies that help one individual may not suit another individual and that there is no single strategy, which can adequately address the full range of potential drug-related harms. Therefore, a range of possible interventions and strategies have been developed. Important 'harm reduction' strategies for prevention of HIV among Injecting Drug Users (IDUs) are as follows:

- **Needle and Syringe Programmes (NSPs)**

These are one of the most basic harm reduction approaches for preventing HIV among IDUs. At its most basic level, this strategy involves supplying new, clean needles and syringes to IDUs, in exchange of old used, needles and syringes. The philosophy behind this exchange is that people who inject drug will have better access to clean and uninfected injecting equipments, free-of-cost, to protect themselves and their injecting partners from transmission of HIV. The 'exchange' component has multiple benefits. First, it ensures that all the used injecting equipments have been collected from the IDUs and destroyed under supervision, minimising the risk of reuse and accidental exposure. Secondly, it provides an opportunity for frequent contact with IDUs, during which not just needles and syringes but education and other services can be delivered. However over a period of time, the programmes scope of NSPs has gone beyond just needle and syringe provision to also include provision of other important services such as, outreach, risk-reduction education, condom distribution and referrals to substance abuse treatment and other health and social services.

A number of studies have evaluated the effectiveness of NSPs and found them effective in reducing risky behaviour among IDUs as well reducing the risk of acquiring HIV infection. Overall, there is a strong body of evidence for the positive impact of NSPs on HIV risk behaviours and HIV infection.

- **Opioid Substitution Therapies**

As discussed in the earlier units as well, substance use disorders are best conceptualized as chronic relapsing disorders. They are more akin to chronic health conditions like diabetes, depression or hypertension as opposed to acute conditions like malaria or viral fevers. Thus, only a short-term course of treatment will eventually result in relapse to drug use by a large majority of drug users. Obviously, then like other chronic diseases, drug dependence also requires a long-term treatment. This is where the Opioid Substitution Therapy comes into the picture.

These treatment approaches are also known by a variety of names such as "agonist maintenance programme" or "Oral Substitution Treatment (OST)". They work on the philosophy of substituting an illicit drug of unknown purity and potency (such as heroin), procured in an illegal manner and used through a potentially harmful route (e.g. injecting), by a safe, legal medication which has a known purity and potency, and is used through a safer route (orally). This reduces the need to take the illicit, dangerous drug.

Such a treatment has pharmacological rationale. If an individual who is using one type of opioid drug (e.g. heroin) is given another medication with similar action (e.g. buprenorphine); the medication will occupy most of the receptors. If now the

user takes heroin it may not exert its effects since the receptors are already occupied by buprenorphine. This phenomenon is called 'cross tolerance'.

Various research studies conducted throughout the world including India have conclusively established that OST is effective in reducing use of illicit drugs, reducing the risk of injecting and consequently HIV, reducing the risk of overdose, and improving the socio-occupational functioning. This treatment has been found to promote the transition to a fulfilling and healthy lifestyle. The research also suggests that the provision of substitution treatment is cost-beneficial because of the substantial reductions in crime and drug use. In case of IDUs who are HIV positive, OST has been recognised as a very effective strategy to improve compliance and adherence to ART medicines (Anti Retroviral Treatment, the treatment given to people who are HIV positive), and improvement in overall functioning and quality of life of the IDUs. Thus, in case of HIV positive IDUS, if possible, stabilization of substance use with substitution treatment is recommended prior to the commencement of ART.

Only a few medications have been developed which could be used for a substitution treatment approach. At the moment, this approach is available only for opioid group of drugs. Since, many IDUs in large parts of the world and almost all IDUs in India use opioid drugs, this treatment is of particular relevance for our country.

- **Outreach Services**

Many drug users, particularly the IDUs, are not accessible through the conventional hospital-based or centre-based services. They remain 'hidden' due to a number of factors such as inaccessibility of services, unattractiveness of facilities, distance, poor awareness of need and availability of treatment, stigma, etc. 'Outreach' was conceived to overcome these barriers and to reach out to people within their own communities or local milieu, outside of the usual service settings. Community based outreach involves: finding drug users, observing them, establishing contact and rapport with them in their natural environments; providing information about unsafe as well as risk behaviours; promoting and supporting safe behaviours and referring them to the required services etc. Indeed, in technical terms outreach is more of a *mode of service delivery* apart from being a service in itself.

Outreach-based interventions typically offer information about safer drug use and safer sex, provide a link between people who use drugs and social and/or medical services, distribute needles and condoms, and prove indispensable in collecting information about recent developments in the drug scene. Many outreach based interventions involve current and former drug users in the capacities of street outreach workers, programme staff, leaders of peer counselling groups etc. The outreach workers are preferably selected from within the community and often themselves are recovering drug users ('peer educators').

Outreach services have been proved to be effective for reaching hard-to-reach, hidden populations of drug users and provide the means for enabling IDUs to reduce their risk behaviours.

- **Health Education and "Behaviour Change Communication"**

With a rights-based harm reduction approach, the drug users possess the full right to the information about how and why they should prevent harm, and where to find the means to do so. Education and communication with a harm reduction approach, focuses on providing non-judgmental information about different drugs,

their properties and effects, about the law and legal rights, about how to reduce risks, and where to get help if needed. Research shows that drug users can and do adopt safer behaviours in response to information about safer modes of drug-use, and that this change is greater if the information and education is coupled with skills-training as well as the means to ensure safety.

An important aspect of education and communication for behaviour change is the medium of these messages. These strategies are likely to be most successful when they are delivered through other drug users i.e. 'peers'. Often, peers (recovering drug users or even current drug users who have adopted safer behaviours) are able to communicate more effectively since they are more acceptable to the drug use community and the recipients can easily identify with them.

Besides the medium it is also important to look at the content of these messages. Messages for adopting safer behaviours should not inadvertently be seen as promoting or encouraging drug use. Thus, often a hierarchical approach is employed whereby it is stressed that the ideal form of behaviour change would be to "stop taking drugs completely". However since this may not be feasible for many drug users, the next best option for them would be to at least "stop injecting drugs". Those who would find even this difficult may be advised to "inject, but safely, by always using a new needle and syringe". Figure 2.1 presents a hierarchy of messages for safer practices intended for IDUs.

Fig. 2.1: Hierarchy of safer practices messages for IDUs

- **Promotion of Safer Sexual Practices**

As discussed earlier in this unit, drug users are at risk of transmission of HIV not only because of injection related behaviours but also because of various high risk sexual behaviours. While there is a huge evidence-base of effective approaches to prevent transmission of HIV through sexual routes in general population, such evidence is limited with respect to specific population of drug users.

There are certain kinds of sexual behaviours which are associated with higher risk of transmission of HIV and in general any intervention which is aimed to minimise these behaviours would be effective in preventing HIV. The most important of

these interventions is "condom promotion". Use of condoms should be promoted as not only just a contraceptive device but also as a barrier for protection against various sexually transmitted infections including HIV. It must be remembered that just promoting condoms is not enough, but peoples' access to condoms should also be improved simultaneously. Thus, many agencies working with drug users also distribute condoms to drug users. Additionally, just providing condoms does not guarantee their correct usage. Consequently many at risk populations are provided with skills to use condoms properly. In addition specific at-risk populations like drug users must be made to understand the influence of substance use on sexual behaviour. Sex workers are also often trained on improving their condom negotiation skills with their clients. A relatively recent development is arrival of 'female condoms' (to be used by females, by inserting them into the vaginal cavity prior to the sexual intercourse), but they have not been very popular.

2.4.3 Harm Reduction: Controversies

Despite being an approach grounded within public health and human rights, and despite the presence of a considerable evidence base, there are controversies about the concept of harm reduction. There remain people with reservations about its effectiveness, effects and intentions. Many people mistakenly believe that adopting the harm reduction approach would result in encouragement to and in fact proliferation of drug use in the society. Many strategies described under harm reduction are also sometimes seen as contraventions of the laws and regulations (for instance many people believe that distributing needles and syringes would tantamount to facilitate drug use by people – an illegal activity). The fact however remains that not only all of the harm reduction strategies described here are fully legal as per the Indian and international laws but they are proving to be actually life saving measures for millions of people who remain at risk of drug use related HIV.

As a strategy for reaching out to the IDUs, Government of India has endorsed 'harm reduction' in the National AIDS Prevention and Control Policy, of 2002. It is a framework in which effective HIV prevention can be carried out among IDUs and their sex partners.

2.4.4 Preventing HIV among IDUs: India's Approach under the National AIDS Control Programme

National AIDS Control Organization (NACO), is the Government agency mandated to deal with HIV related issues in the country. Under the National AIDS Control Programme, the 'harm reduction' interventions are provided to the target population of IDUs through NGO run projects. Typically these interventions go by the name of "Targeted Interventions", i.e. providing services which are targeted towards a particular population group (in this case, IDUs). These targeted interventions provide the following package of services to the IDUs:

- Counselling on risk reduction and behaviour change (Behaviour change communication, BCC)
- Risk reduction materials: Needles, syringes, abscess prevention materials (spirit swabs, distilled water, etc.), and condoms
- Detection and treatment of Sexually Transmitted Infections (STIs)
- Treatment for health related aspects – general medical conditions, abscess management, etc.

- Opioid Substitution Treatment (OST)
- Referral to appropriate agencies for other services
  - — HIV related services: ICTC, ART, etc.
  - — Drug relates services: Detoxification, rehabilitation, OST
  - — Others: night shelters, vocational training, etc.
- Facilitating formation of support groups as well as some self help groups
- Advocacy for ensuring smooth implementation of the programmes (with the general community, local political or religious leaders, medical community, law enforcement authorities)

All the above mentioned services are provided to IDUs through either the "Outreach" based services (i.e. mobile services) or the "Drop-in-Centres — DIC" (i.e. static services). The outreach team consists of an outreach worker and his/her team of peer educators. While an outreach worker may or may not be from the IDU community, the peer educators are either current or former injecting drug users. On the other hand, a DIC is a small, secure facility where IDUs can visit, can have rest, can avail recreation facilities, other services and hold meetings. The DIC generally consists of 3 – 4 rooms: a room for counselling, a room for rest and recreation, an abscess dressing room for nurse, and a doctor's room for medical examination. A nurse/ANM, counsellor and a part time doctor (visiting the DIC 2 – 3 times a week) are stationed at the DIC along with some of the outreach staff.

Check Your Progress Exercise 3

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Which of the following is NOT an example of a Harm Reduction approach for reducing risk of HIV among drug users?

   a) Distributing needles and syringes free of cost to Injecting Drug Users

   b) Distributing condoms to alcohol users who visit a brothel

   c) Organising a mass awareness campaign in which school children pledge not to take drugs

   d) Teaching injecting drug users to inject drugs safely

2) Describe briefly "behaviour change communication" for preventing HIV among drug users.

   .....

   .....

   .....

   .....

2.5 LET US SUM UP

- Substance users should be seen as a population group, specially at-risk of acquiring and transmitting HIV infection.
- Since some drug users use drugs through injection route, they remain more at-risk because, sharing injecting equipments is a very efficient mode of transmission of HIV.
- Drug users also engage in high-risk sexual behaviours and hence can acquire and transmit HIV infection through the sexual routes as well.
- The approach called 'harm reduction' is the most pragmatic and effective approach to prevent HIV among drug users (and consequently prevent HIV among the entire community).
- Harm reduction comprises of various strategies: Needle Syringe Exchange programmes, outreach, health education and behaviour change communication, opioid substitution therapies etc.
- The concept of harm reduction has been endorsed by the national policy in India. Under the National AIDS Control Programme, various 'harm reduction' strategies have been employed to prevent HIV among IDUs in India.

2.6 GLOSSARY

AIDS : Acquired Immune Deficiency Syndrome. A disease (syndrome) characterized by reduction of body's immunity making the body vulnerable to other infections / diseases. This follows the HIV infection. (see HIV)

Harm Reduction : Those policies or programmes which are aimed at reducing the harms associated with drug use, but not necessarily reducing the drug use per se.

HIV : Human Immune Deficiency Virus. A virus (microorganism) which spreads through body fluids (like blood, semen, vaginal fluids) from an infected person to another. The infection often results in the condition called AIDS. (see AIDS)

IDU : Injecting Drug Use. A pattern of drug use, in which people use drugs by injecting in the blood vessels (veins) or in the muscles. Usually a more potent, efficient and severe form of drug use.

Needle Syringe programmes : Programmes which involve supplying new needles and syringes to people who use drugs. Usually such programmes deliver various other services as well.

Opioid Substitution Therapies : A type of treatment approach where a person who is dependent on a harmful drug is provided a similar ('substitute') but much safer and legal medication under medical supervision and often coupled with various other services.

Outreach : Reaching out to. A strategy which involves actively going out and seeking / helping the beneficiaries.

Sexually transmitted infection / diseases : A group of infectious conditions which spread by sexual route. Usually affect the genitals but may also sometimes affect other parts of body.

2.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1) c

2) b

Check Your Progress Exercise 2

1) c

Check Your Progress Exercise 3

1) c

2) It focuses on providing non-judgmental information about different drugs, their properties and effects, about the law and legal rights, about how to reduce risks, and where to get help if needed. These strategies are likely to be most successful when they are delivered through other drug users i.e. 'peers'. A hierarchical approach is employed whereby it is stressed that the ideal form of behaviour change would be to "stop taking drugs completely". However since this may not be feasible for many drug users, the next best option for them would be to at least "stop injecting drugs". Those who would find even this difficult may be advised to "inject, but safely, by always using a new needle and syringe".

2.8 UNIT END QUESTIONS

1) What is the basic difference between risks and vulnerabilities?

2) Why are drug users more vulnerable and at-risk for HIV?

3) Write a brief note on "harm reduction".

2.9 FURTHER READINGS AND REFERENCES

Atul Ambekar, Alok Agrawal, B. M. Tripathi, "Harm Reduction: An Overview", in Ambekar A, Tripathi BM, (Eds), *Drug Abuse: News-N-Views*, March 2008 (Harm Reduction: Prevention of HIV among Drug Users), National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi

Atul Ambekar, Meera Vaswani, "Drug Abuse-related HIV/AIDS Epidemic in India: Situation and Responses", in Browne-Miller A. (Ed) *The Praeger International Collection on Addictions*, Vol II, 2009: Praeger Publishers: Westport, CT

Atul Ambekar, Ravindra Rao, Debashis Mukherjee, Swati Kedia (2010), *Counseling in Targeted Interventions for Injecting Drug Users*, United Nations Office on Drugs and Crime, Regional Office for South Asia AND Tata Institute of Social Sciences, Mumbai.

UNIT 3 SUBSTANCE ABUSE AMONG SPECIAL POPULATION GROUPS: WOMEN, ADOLESCENTS, MENTALLY ILL, AND PRISONERS

Structure

3.1 INTRODUCTION

Psychoactive substance use, until lately, has largely been perceived as a male problem and research has, as a result, been insensitive to the gender implications of drug use. Around the mid 1970s, western institutes like the National Council on Alcoholism and Drug Dependence (NCADD) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) started to focus scientific and public attention on this subject (Blume, 2005).

Increasing evidence for substance use in women now show important gender differences in biology, epidemiology, socio-cultural factors and psychological comorbidity. With women being more sensitive to the physiological effects of some substances, it remains a major source of morbidity, mortality and also sexually transmitted diseases. Also, women of child-bearing age are at risk for reproductive-health complications and for bearing off-springs with foetal alcohol and/or drug effects.

In many developing countries, substance use no longer remains a predominantly male activity, yet there is a dearth of literature on substance abuse among women from these places, including India.

In addition to women, the other special population group that the Unit would focus on is the adolescents. Most of the substance users tend to start use in adolescence usually with use of licit substances such as tobacco and alcohol. Some adolescents may give up these substances subsequently; however, many may go on to develop abuse/dependence. Substance use during adolescence is also associated with high-risk behaviour, increased risk of HIV/STDs, interpersonal problems, decline in academic performance and failure to complete education. Co-morbid psychiatric disorders are also more common in adolescents who have substance use disorder as compared to their non-substance using counterparts.

Case Vignette

Master Sunil (fictional name), a 15 year old boy has been forcibly asked by his parents to talk to the counsellor. They complain that he has been sniffing ink-erase fluids (an inhalant) for the past few months and is not ready to leave it. The interviewer requests the parents to wait outside, while she can talk to Sunil. The father agrees reluctantly but only after scolding Sunil. Finally, showing empathic concern the counsellor does manage to build a rapport with Sunil. Sunil is scared of being 'locked up in a treatment center', though he also wants to give up his drug habit. The interviewer takes time to alley this fear and assures him that nothing would be done without his consent. That calms him down and he starts telling the interviewer about how he started using drugs and what makes him continue taking them and how sniffing the fluid is affecting his studies.

The above case illustrates the complexities involved in the assessment and intervention for adolescents with substance abuse disorders, as well as the importance of understanding their perspectives on their difficulties and motivations for changing their substance use behaviour.

Further, the mentally ill and prisoners constitute two special population groups in the context of substance abuse, to which attention needs to be paid.

Objectives

After studying this Unit, you will be able to:

- Know the extent and pattern of substance use in women and adolescents;
- Conceptualize the need for studying substance use in these population groups;
- Carry out assessment;
- Know the importance of prevention;
- Be able to understand treatment principles; and
- Evaluate the problem of substance abuse in the context of the mentally ill and prisoners.

3.2 EPIDEMIOLOGY

3.2.1 Extent and Pattern of Substance Abuse in Women

India is known to be a 'dry' culture country, with generally low consumption of alcohol and drugs as compared to the West. Indian women are traditionally believed to be immune to drug use by "social inoculation" through customs and mores. Earliest national studies of the late 1970s, 1986 and 1989 reported negligible drug use rates among women (Mohan, 1981; Mohan and Sundaram, 1987 and Ministry of Welfare, 1992) with alcohol use in 3.2 percent, and barbiturates, cannabis, heroin, pethidine, morphine use in as low as 0. 1 - 0.3 percent (Mohan, 1981).

The 'National Survey on Extent, Pattern and Trends of Drug Abuse in India' of 2001, in addition to finding the community prevalence of substance abuse in men carried out focused surveys on the specific problems of women and drug abuse. The "Rapid Assessment Survey (RAS)" component collected information on drug use by non-random sampling from 14 cities of India and found that around 8% of drug users surveyed, were women. Heroin, alcohol, cannabis and painkillers were the dominant substances of abuse, and Injecting Drug Use (IDU) among women varied from 3 to 73% across sites. Another component of the national survey, the "Focused thematic study on drug abuse among women (Women's study)" involved interviews with 75 women substance users enrolled with a snowball sampling technique from Mumbai, Delhi and Aizawl.

The survey found that the predominant substances of abuse in drug using women were:

Type of Drug	*Prevalence in the Sample*
Heroin	91%
Propoxyphene	35%
Alcohol	33%
Minor tranquillizers	23%
Cannabis	2%
Cough Syrup	15%
Injecting Drug Use (IDU)	40%

Source: Ray et. al., 2004

A more recent assessment of 1865 substance using women from all over the country shows similar result of 75% being current regular user of heroin and

around 50% using alcohol and sleeping pills regularly. Previously unreported substances like solvents (toluene) were reported by around 33% of the substance using women. Additionally, mean age of initiation for solvent use (16.5 yrs) now precedes the initiation of tobacco (18.4 yrs) thereby becoming the gateway drug in many cases. Injecting drug use was reported in 41% of these women (Murthy, 2008). Though the results of these surveys cannot be generalised to the country because of the non-random sampling, they do give us a glimpse into the severity and magnitude of drug use problem in the hidden women population. At present, national level population prevalence data is available only for tobacco through the NHFS III (2005 - 06) and shows that around 10.8% of Indian women use tobacco, mostly in chewable form (8.4%). Only a minority of Indian women smoke cigarettes or bidi (1.4%).

3.2.2 Extent and Pattern of Substance Abuse in Adolescents

Very few studies are available which have specifically looked into substance abuse in the adolescent age group. Some earlier studies in 1970s, found alcohol to be the most commonly used substance (10-15%) across gender, followed by tobacco (8-15%) and tranquilizers (1-2.5%). At that time, the study did not report any opiate/stimulant use (Mohan et al., 1976-77). The survey after 10 years found similar figures with an addition of heroin abuse by a small minority of adolescents (0.02-0.04%).

A National Sample Survey (1995-1996) gave figures based on more representative sample and they reported that in the age of 10-20 year olds, current regular use of tobacco was by 8% males and 2% females; alcohol use by 1.3% males and 0.5% females. They also reported a higher prevalence in rural areas. The National Household Survey (NHS) was the first survey in the country carried out specifically to provide figures of prevalence for drug use in the country using a representative sample. In this study, 21% of the respondents were 12 -18 years old and 19% were students. It reported that 21% of current users of alcohol, 3% of current users of cannabis and 0.1% current users of opiates were below 18 years of age and 10% opiate users and 2.5% of current alcohol and cannabis users were students (UNODC, 2004).

The Drug Abuse Monitoring System (DAMS), which provided data from treatment seekers from 203 de-addiction centres reported that 0.4% of treatment seekers in de-addiction centres in various states were less than 15 years of age and 3.6% of the substance users were between 16-20 years of age. Also, among heroin, cannabis and propoxyphene users, 0.5 to 0.8% were in the age group below 15 years. The proportion of opium and alcohol users in this age group was comparatively low. The Rapid Assessment Survey (RAS) found that about 13% of substance users from the sample were below 20 years of age (Ray et al., 2004).

It must however be noted that though in most surveys, very few adolescents are found using drugs; a large majority of the adult drug users report that they started using drugs while they were in the adolescent age group.

3.3 FACTORS ASSOCIATED WITH SUBSTANCE ABUSE IN WOMEN

3.3.1 Genetic Factors

Though genetic factors have been implicated as the cause of alcoholism in men, the same has not found such a strong association in case of women. In females,

there is evidence that genetic factors are strongly modulated by environment. In a study of female twin pairs, the risk of genetic factors responsible for drinking fell from 60% to 40% following marriage or shifting out of the family. One of the most important factors emerging in almost all studies was the drinking behaviour of the spouse (Murthy, 2005). In women, *initiation* of drugs, particularly cannabis and cocaine use is shaped more by environmental factors, whereas genetic factors have been found to have a greater impact in the *progression* to abuse or dependence (Kendler, 1998).

3.3.2 Biological Factors

Gender differences in the physiological effects have been most studied for alcohol and lesser for other drugs. A given amount of alcohol leads to higher blood concentration in women and therefore, women tend to become intoxicated after drinking smaller quantities of alcohol than do men. This could be due to less body water in comparison to size because of which women achieve higher blood concentrations after drinking an equivalent amount of alcohol.

Additionally, higher proportion of fat and lower levels of alcohol dehydrogenase enzymes in the stomach would result in a higher amount of alcohol in the systemic circulation. Moreover, estrogen plays an additive role in alcohol-related liver damage. It has been reported that women who meet diagnostic criteria for premenstrual syndrome drink more heavily than controls (Tobin, 1994) and have a high rate of alcohol abuse and dependence. Conversely, increased drinking in both female social drinkers and alcoholics during the premenstrual phase is associated with higher premenstrual symptomatology (Allen, 1996).

Women's greater sensitivity to alcohol may explain, at least in part, why alcohol dependence and the physical damage caused by alcohol progresses more rapidly in women ("telescoping" of the disease). The same story has also been reported for other drugs thus indicating a need for early intervention.

3.3.3 Psychological Factors

Only a few studies have examined the psychological predictors of alcohol use in women and they all tend to emphasize the strong association of co-morbid psychological factors in this group as compared to men (Merikangas, 1998). Low self esteem, history of childhood sexual abuse (Kendler et al., 2002) and impaired ability to cope are found to be strong predisposing factors for future problem drinking as well as substance use in females.

Data from the large-scale nationwide studies in the USA have demonstrated a higher lifetime prevalence of psychiatric co-morbidity in women than in men with alcohol/drug abuse (Kessler et al., 1994; Anthony and Helzer, 1991). Women with anxiety and depression are found to be more vulnerable to heavy drinking as compared to men (Wang & Patter, 2001). The other psychiatric disorders found commonly in women with alcohol abuse are, Bulimia (Schuckit et al., 1996), and Post Traumatic Stress Disorder - PTSD (Dansky et al., 2000). In a 27 year old follow-up study, it was reported that the best predictors of later drinking problems were: 'drinking to relieve shyness', 'to feel high' and 'to get along better on dates' (Fillmore et al., 1979). Studies from India also report association of depression and anxiety in the women using substances (Murthy, 2003).

3.3.4 Socio-Cultural Factors

The traditional expectation that women will drink less than men and will drink only on special occasions acted as a protective factor. However, women's' roles have

been changing in the society and these changes have been associated with increasing alcohol and drug-related problems in this group. Cross-cultural analysis has shown that, unlike men, women with higher education tend to consume more alcohol than less educated men (Ahlstrom et al., 2001).

Although social norms act as protective factors, they can also pose as a hindrance in treatment-seeking. The social stigma attached to heavy drinking and drug use in women (substance using women are often mistakenly perceived as sexually promiscuous) brands such women as "fallen individuals". This stigma leads to denial in both the affected women and her family, which may lead to either a delay in treatment seeking or not seeking treatment at all. This social stereotyping also encourages sexual and physical abuse of these women (Blume, 1991).

Evidence shows that women may be more affected, as compared to men, by family history of alcoholism and violence (Chermack et al, 2000). Women are more likely to have substance using "role-models" in the family in form of father/ spouses. Other factors like young age, unemployment, early marriage and lack of social support increase the vulnerability of substance use in women. It has been found that more female substance users are likely to get separated or divorced. Though criminal activity is less in substance using females as compared to males, existing data indicate that dependency on drugs and increased vulnerability makes women more prone to participate in drug related crime (Shankardass, 1998) like, peddling activities, sex work, pick-pocketing and theft. Women drug users also engage in unsafe practices such as early initiation into sex and forced or coercive sex to support their drug use habit. Such sex work put them at conflict with law resulting in harassment by both hardened criminals as well as police. These issues from the Indian studies reflect a global truth of more victimisation of female drug users.

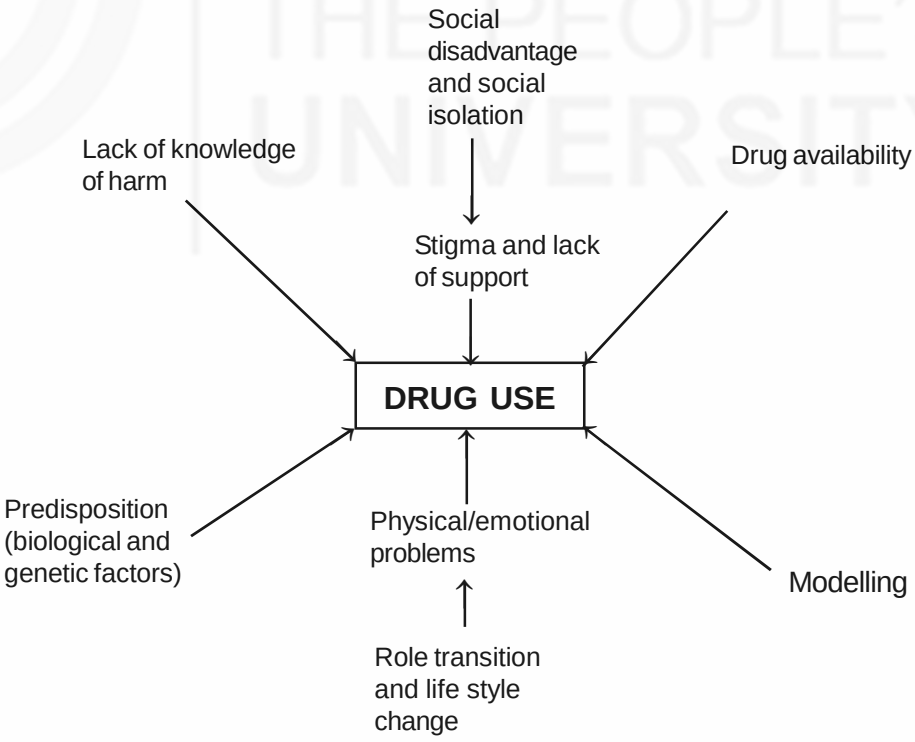

Fig. 3.1: Interacting Factors Leading to Substance Abuse among Women

Adapted from : Murthy P. (2002). Women and drug abuse: The problem in India.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Mark the following statements as True or False:

Statement	*True*	*False*
i) In women, genetic factors play as important a role as the environment in development of substance use disorders.		
ii) There are significant physiological differences between men and women which makes the latter vulnerable to development of dependence on alcohol/substance.		
iii) Women who have been sexually abused always end up becoming dependent on alcohol/substance.		
iv) Social factors always play a protective role towards women with respect to substance use.		
v) Women who have undergone tremendous stress or trauma are more vulnerable to substance use.		

3.4 INITIATION AND COURSE OF ILLNESS IN WOMEN

3.4.1 Initiation

Usually initiation of any substance begins during adolescence (in both males and females) and some of the reasons commonly cited for the same are: depression, adjustment issues, hanging out with older male friends, peer pressure, feeling of a sense of glamour and power, reduced stereotypes about feminity, need for independence and autonomy. However, some of the gender specific risk-factors could be:

- Puberty tends to increase incidence of depression in women which may trigger alcohol/substance use
- A study found that more women as compared to men reported drinking as a mean of escaping stress or dealing with frustration
- Women are found to be more vulnerable to peer pressure or pressure by their boy-friends, which may lead to initiation of alcohol/substance use
- Significant transitions, like moving from one neighborhood to another, or from school to college
- Sexual/physical abuse, which are faced more often by females are strongly related to initiation of substance use

In an Indian study, positive expectancy regarding benefits of drinking was cited as common reason for initiating alcohol use. And it differed amongst males and females as shown in the following table (Table 3.1) (Murthy et al, 1995; Chandrasekhar, 1994).

Table 3.1: Positive Expectancies from Alcohol

Females	*Males*
• Elevates mood	• Improves sleep
• Provides strength after childbirth	• Relieves tiredness
• Improves health and relieves tiredness	• Increases joys
	• Cements friendships
	• Improves sexual performance

3.4.2 Course

The course of substance use disorders, particularly alcohol, seems to be different for women than for men. The interval between the age of first drinking and treatment seeking seems to be shorter for women than for men. As mentioned previously, studies suggest that women experience greater medical, physiological and psychological impairment earlier in their drinking career. In addition, women seem to progress between landmarks associated with the developmental course of alcoholism (e.g. regular drinking or loss of control) sooner than men. In other words though fewer women than men start drinking, women, after the initiation of drinking, tend to start drinking regularly sooner than men and tend to start developing dependence sooner than men. This accelerated progression of alcoholism in women is commonly referred to as "telescoping."

Telescoping like rapid progression has also been reported in opioids and in cocaine. Only for cannabis, no gender differences in patterns of use were found in a large Australian survey of adolescents (Rey 2002).

Many women use substances to improve mood, increase confidence, reduce tension, cope with stress, decrease inhibition, enhance weight or lose weight. These emotional and relational reasons can lead to continued and increased use of substances.

3.5 ISSUES SPECIFIC TO WOMEN

3.5.1 Pregnancy and Lactation

Foetal alcohol syndrome (presence of craniofacial anomalies, central nervous system dysfunction, and major organ malformation) and foetal alcohol effects have been recognized as leading causes of mental retardation all over the world. Prenatal exposure to alcohol and other substances have also been found to be related to persistent deficits in attention, reaction-time, orientation, motor coordination. These children are also found to have lower mean birth weights, and growth retardation. Moreover, the risk of adolescent pregnancy and its complications are also associated with substance abuse.

3.5.2 Sexual Functioning and Behaviour

Traditionally, alcohol is believed to increase sexual power and enjoyment; however, various studies have shown that it is the "positive expectancy", which is responsible

for increased sexual enjoyment. In fact, heavy drinking actually tends to inhibits sexual enjoyment. Women who drink heavily have been shown to be more likely to have sexual experiences at an early age, to have a greater number of sexual partners, and to have unprotected sex, which exposes them to unwanted pregnancies and sexually transmitted infections. It also makes them more vulnerable to physical as well as sexual abuse and rape. Additionally, some women, after developing dependence are forced to resort to sex work in order to earn money to support their drug habits. This further increases their vulnerability to sexually transmitted infections.

The role of addictive disorders in the spread of sexually transmitted diseases has been highlighted by the Human Immunodeficiency Virus (HIV) epidemic. The vast majority of HIV positive women are between the ages of 13 and 39 years (Campbell, 1990). Half are injection drug users, often also heavy drinkers, while an additional 15% are non drug-using partners of male users (Cohen, 1989). Furthermore, alcohol consumption in heterosexual women is associated with less condom use (Trocki, 1991), with female heavier drinkers being more likely to engage in risky sexual behaviour, posing additional risk of getting infected.

Indian studies have reported the same. Women are found to be more susceptible to hepatitis and HIV infection and to the adverse effects of AIDS because legal and social status is not shared equally between men and women (Kumar, 2008).

3.5.3 Health Consequences

Women develop alcohol liver disease with comparatively shorter and less intense drinking than men and more women die from cirrhosis than men. Heavy alcohol consumption may also be associated with increased risk of menstrual disturbances, infertility and breast cancer. Alcohol intake is also directly related to the risk for hypertension and to overall cardiovascular mortality in women (Hanna, 1992). Prolonged heavy drinking is also known to be an etiologic factor in many diseases of the gastrointestinal, neuromuscular, cardiovascular, and other body systems (Ashley, 1977). There is growing evidence that women may develop many of these pathologic effects of alcohol more rapidly than men.

3.6 ASSESSMENT AND TREATMENT

While the details of assessment have been covered elsewhere there are certain issues specific to assessment of women, which have been highlighted here. Assessment of the client is usually necessary to diagnose and treat the client, but in drug dependence management, the utility of assessment goes beyond diagnosis and treatment. Assessment serves some very important purposes (see box below).

Purpose of Assessment

- Building rapport with the women drug user – the time spent in assessment provides an opportunity for us to build a relationship of trust and harmony with her
- Measuring the extent of problems faced by the women drug user
- Planning referrals
- Planning appropriate management of the client
- Motivating the client for seeking help

Assessment is not a one-time task. Often, one may not be able to complete all the aspects of assessment in one session. More than one session may have to be conducted to complete the required assessment. Assessment can be carried out by eliciting information from the female client, conducting a physical examination, applying standardized tools and also by laboratory investigations. In case, a family member is available, information can also be acquired from them.

3.6.1 Areas for Assessment

The following areas need to be explored to understand the extent of problems faced by the client. Exploring all of these areas would provide a comprehensive understanding as well as help in planning further management of the client.

Areas to be Covered in Assessment

- Basic socio-demographic profile
- Drug use details
- Complications
- High risk behaviours
- Medical/psychiatric history
- Level of motivation

- ***Basic socio-demographic profile:*** Includes information regarding client's age, sex, marital status, educational status, place of residence. Gathering this information would help in getting a rough sketch of the client.
- ***Details of drug use:*** Includes the following information:
  - Alcohol/substances commonly used
  - Frequency and amount consumed
  - Mode of consumption — alcohol is consumed orally, other substances like heroin may be consumed either orally (e.g. opium, liquid prepared from poppy straw), through inhalational route (e.g. smoking/chasing heroin), or through injecting route (e.g. injecting heroin or pharmaceuticals)
  - Last instance of use (to get an idea whether the client is currently intoxicated or in withdrawals)
- ***Complications with drug use:*** Complications resulting from alcohol/ substance use can occur in multiple spheres of life, which should be actively enquired.
  - *Physical damage:* Weight loss, menstrual abnormalities, blackouts etc.
  - *Psychological:* Guilt and shame due to drug use, anxiety, depression, etc.
  - *Occupational-financial:* Inability to work productively, loss of job (unemployment), frequent change of jobs etc.
  - *Marital / familial / social:* Fights with family/spouse due to drug use, neglect of household responsibility, physical violence towards family

members, outcast from family, separation/divorce, homelessness, stigmatisation due to drug use in the society, etc.

- *Legal:* Involvement in illegal activities to obtain drugs (e.g. thefts, pick pocketing), arrests/detains by the local police, charged under NDPS Act, driving under intoxication of drugs, physical fights under intoxication of drugs.

- ***High risk behaviours:*** As discussed earlier, female drug users are at risk of sexual abuse/rape. Many of them also indulge in sex trade to procure substances. Surveys have also indicated presence of needle sharing in female injecting drug users. Thus, the assessment of high risk sexual as well as injection-related behaviours becomes an important area to be assessed. However, this is a very sensitive area and should be assessed after establishing adequate rapport and assuring the client of confidentiality of information provided.

- ***History of medical and psychiatric illness:*** Since a female drug user is prone to either develop or already has a history of myriad of medical and psychiatric co-morbidities, assessment should include enquiries about the same. Especially important in case of women are the reproductive and sexual health history (menarche, pregnancy, menstrual cycles etc.)

- ***Family history and current living arrangement:*** In case of women this is very important as many women have substance users in the family, particularly the spouse. Additionally the available social support should be enquired into.

- ***Motivation level:*** The motivation level of the client to reduce the high risk behaviours including drug use should be assessed.

3.6.2 Synthesis of Assessment

Synthesis of findings obtained during assessment is an important step as it will help the counsellor/therapist in formulating a plan for helping the client further. The synthesis should typically include the salient features of the client's history with focus on immediate issues or priority issues at hand. Thus, for example, if the assessment shows that the client is pregnant, then the appropriate referral should be made rather than on starting counselling to reduce drug use. A typical synthesis would mention the background of the client in terms of socio-demography, current drug use status and dependency status, involvement in high risk behaviour (both injecting and sex related), motivational level, referral status and current level of social support.

Tips for successful assessment

Some clinicians or counsellors are able to perform better assessment than others. There are a number of factors that govern a successful or better assessment.

- *Establishment of rapport:* If the assessor is able to form a good rapport with the client, the chances of client co-operating with the assessor and answering truthfully increases manifold.

- *Non-judgmental attitude:* The counsellor should not judge the client on the basis of her drug use behaviour, HIV status, physical condition, relapse or other factors such as religion, sex, etc.

- *Effective communication:* The counsellor should be able to articulate his/her thoughts clearly and be able to answer the client's queries as truthfully as possible.
- *Active listening:* The counsellor should listen to the client actively and patiently about her problems.
- *Confidentiality of the responses:* The counsellor should ensure that confidentiality is maintained with regard to some of the information provided by the client. At places, where the information has to be shared with other staff members, the counsellor should take prior permission from the client before doing so.
- *Drug using status of the client:* If the client is under intoxication or is suffering from withdrawals, then the counsellor will not be able to assess the client effectively. In such cases, the client should be asked to return back when she is feeling better for assessment.
- *Outcome of assessment:* The client should be informed about the benefits of carrying out the assessment (e.g. referrals, better health status, etc.). Otherwise, the client would feel that the assessment is being carried out to fulfill some of the obligations of the counsellor (e.g. maintain records).

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Which of the following questions will NOT be asked during the assessment of a women with drug use problem:

a) Why do you take drugs?

b) What are the drugs that you are currently using and in how much quantity?

c) How could you as a woman get into the habit of drugs?

d) What made you decide to quit now?

e) Do you feel guilty for using drugs?

f) Have you had sexual relationship with anyone?

3.6.3 Treatment

Once the assessment has been completed and synthesized, the counsellor can chart out the treatment plan with the first step being psycho-education. It is important to educate the client about the substances that she is using and its ill-effect. The next important step in management is, linking the medical problem (if any) with the substance use and subsequently recommending reduction of substance use or complete abstinence. Sometimes, though in-patient treatment may be the best choice, but it has to take into considerations social issues; such as small,

unattended children at home. There is an increasing recognition of the need for separate services for women with substance use to address their special social and emotional needs. Once detoxification (i.e. the initial phase of treatment which is focused on treatment of withdrawal symptoms) is completed, the ***role of the counsellor*** is to:

- Ensure compliance with treatment
- Help the client recognize high risk situations (in which alcohol/substance use may occur) and developing strategies to deal with them. For example, if a women always uses alcohol after a fight with her husband, she can be taught effective anger management and conflict-resolution skills.
- Involve family members in long-term treatment planning and rehabilitation
- Enhancing social support for these women

To summarize, ***treatment approaches to substance dependence*** in women include:

- Establishing confidentiality and rapport, and most importantly, being non-judgmental
- Assessment of severity of the problem
- Taking into account the presence of co-morbid disorders
- Providing psycho-education to both patient and her family
- Providing feedback of the damage due to substance
- Helping in reduction of substance use or abstinence and in handling high risk situations
- Increasing the self esteem
- Referring to specialists if required (such as a women who has a co-morbid psychiatric problem)

3.6.4 Barriers to Treatment-Seeking

Women substance users often face certain barriers and obstacles that prevent them from either seeking treatment on time or seeking treatment at all. Some of such barriers are:

- Family responsibilities, such as looking after the house or children
- Lack of appropriate social support
- Lack of women friendly treatment services as most treatment services do not always address the unique needs and issues of women
- Lack of knowledge about long-term consequences of alcohol/substance use
- Stigma and discrimination surrounding female drug use

3.7 RISK AND PROTECTIVE FACTORS IN CASE OF ADOLESCENTS

Addiction always develops as a result of the complex interplay between the individual, the agent (alcohol/substance) and the environment. The individual and the environment has their own protective and risk component. The factors pertaining to the individual that may act as risk for development of substance use disorders are:

- **Individual Factors:** It has been found that presence of behavioural disorders like conduct disorder, oppositional defiant disorder and attention-deficit hyperactivity disorder are high predictors of development of initiation of substance use and progress into dependence (McMohan et al., 1994). However, studies have suggested that if the children were diagnosed at an early age and provided apropriate treatment, they were less likely to initiate substance use later in life (Biederman et al., 1998).

  Presence of psychiatric disorders, like depression, anxiety and post-traumatic disorders also appear to be predictive of development of substance use disorders (Substance Abuse and Mental Health Service Administrations, 1999). Elevated rates of substance abuse have also been reported among adolescents with eating disorders, particularly bulimia (Friedman et al., 1987). Epidemiological studies have also found a strong correlation between affective disturbances and substance abuse (Substance Abuse and Mental Health Service Administrations, 1999). Presence of these psychiatric disturbances coupled with substance use also makes these adolescents more vulnerable to suicides (Harrison and Luxenberg, 1995).

  Difficult temperamental traits like moodiness, negativity, poor compliance and provocativeness, aggression, high novelty-seeking and low harm-avoidance have also been found to lead to development of substance use (McMohan et al., 1994; Robin & Jonson, 1996). Other factors pertaining to the individual include low self-esteem and positive expectancy regarding the effect of alcohol and substances, such as increased social/physical pleasure, improved sexual performance, reduced stress and tension and improved ability to cope with negative feelings (Brown et al., 1985).

- **Peer Factors:** Peers may play a pivotal role in initiation and maintenance of alcohol and substance use. At the same time, they can also play an important role in abstaining from drug using behaviours. The peer influence is very strong at the time of adolescence, which may encourage either pro-active or delinquent behaviour. If an individual is rejected by non-drug using social group or he/she does not feel a part of that group, they may turn to deviant peer group in search for social acceptance. A pull towards such a deviant group may also be a result of family conflict, school failure, and lack of bonding with religious beliefs (Buckhalt et al., 1992).

- **Genetic Factors:** Though research has not been able to identify a single "addiction gene", there is evidence to indicate that alcohol/substance use runs in the family. It has been reported that biological children of alcohol-dependent parents have a two to nine-fold increased risk of developing the same (Bohman et al., 1987). Sibling and twin-studies have also reported genetic predisposition for use of both alcohol and other substances (Cornings, 1997). A genetic predisposition may be direct, that is, presence of a gene

that contributes to positive response to alcohol/other substances or indirect, that is, by determining certain personality characteristics that may increase the probability of exposure to alcohol/substance abuse.

- **Family Factors:** Poor parent-child relationship, turbulent marital relationship, and family disharmony have consistently been associated with delinquent behaviours, including substance use (Webb & Baer, 1995). Childhood abuse, especially in case of women is found to be a significant predictor of initiation and maintenance of substance use (Wilsnack et al., 1997). Other forms of maltreatment, like psychological unavailability and neglect, lack of warmth and affection, rejection, harsh/inconsistent discipline were strongly correlated with substance use. Further, presence of parental substance use disorders and parental affective disorders were found to be associated with development of adolescent substance use disorder (Su et al., 1997).
- **Gender:** Illicit drug use is twice as prevalent in men as compared to women and alcohol use is thrice as common (National Institute of Drug Abuse, 1999). Studies have found that risk factors differed by sex. In females, absence of resiliency and lack of self-control in early childhood was found to predict substance use, whereas in males it was lack of self-control. Other studies have reported higher incidence of internalizing disorders in females, and presence of externalizing disorders in males in relation to substance use disorders (Luthar et al., 1996).
- **Community Factors:** Easy drug availability, social norms facilitating drug use, and relaxed laws and regulatory policies are some of the community factors responsible for substance use in adolescents.

In relation to adolescent substance use, there are some **protective factors** within the individual, family and environment that boosts one's ability to resist adverse outcomes. Some of these protective factors can be — growing up in a nurturing home, protective and supportive school environment, positive self-esteem, self-control, social competence and academic achievement, sense of morality and resiliency.

It must be noted that these risk and protective factors play a role in not only substance use by adolescents but inflence a host of other consequences such as sexual risk behaviours, teen pregnancy, school drop-out, and involvement in violent crimes.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

Which of the following is NOT a risk factor for development of substance use disorders in adolescents?

A. Assertiveness

B. Non-conforming attitude

C. Alcohol dependence in father

D. Lack of prosocial peer group

3.8 PREVENTION INTERVENTION

"A stitch in time is better than nine."

This saying adequately reflects the need for prevention. Adolescence is a developmental period with major changes in all spheres and thus it is important to prevent the initiation and development of substance use disorders. In the period prior to 1970s, the prevention effort was based on "information-deficit" approach with the belief that children lacked adequate knowledge regarding the effects of drug-use; and thus primarily the approach was dissemination of information. During the 1970s and 1980s, prevention approaches were based on the theoretical assumption that adolescents experimented with alcohol/substances because they had not yet fully developed their own internal value system to resist external pressure. Thus, the prevention efforts focused on social and interpersonal influences. During the 1990s, the prevention programmes became more comprehensive, evidence-based and culturally-relevant.

An effective prevention programme should be able to:

- Enhance protective factors and reverse risk factors
- Address all forms of drug abuse, i.e.
  - Under-age use of licit drugs (e.g. alcohol, tobacco)
  - Use of illicit drugs (e.g. heroin, marijuana)
  - Inappropriate use of legally obtained substance
- Be tailored to address risk specific to population, e.g. age, gender
- Target at multiple settings
- Incorporate evidence-based aspects for planning structure, content and mode of delivery
- Be long-term with booster sessions to reinforce original prevention goals
- Include appropriate training of personnel.
- Employ interactive techniques (peer discussions, parental role-plays) as they are found to be most effective.

Prevention programmes have developed a new nomenclature to address the target audience and the focus. Thus, the three types of prevention programmes are:

- *Universal:* Designed to address a general population, such as community or school
- *Selective*: Target an at-risk population group, for example, those children whose parents have alcohol/substance dependence

- *Indicated*: Target individuals who already demonstrate problem behaviour or have other high-risk behaviours.

3.9 ASSESSMENT AND INTERVENTIONS IN CASE OF ADOLESCENTS

3.9.1 Assessment

A detailed and comprehensive assessment of adolescents is required including type, frequency and mode of substance use, complications arising out of the same, medical/psychiatric history, educational/occupational history, sexual history.

It should also include a detailed assessment of the family functioning and adolescent's relationship with peers. It is also important to assess the motivation level and attitude/knowledge regarding drug use.

Assessment includes interview with adolescent as well as with other family members or significant care-takers. However, it is imperative that each should be interviewed separately and preference should be given to interview with the adolescent first.

Some interview schedules and instruments commonly used with children are mentioned in the table below:

Table 3.2: List of Interview Schedules and Rating Scales

Interview Schedules	• Diagnostic Interview Schedule for Children and Adolescents • Kiddies Schedule for Affective Disorders and Schizophrenia • Achenbach's Behaviour Checklist • Developmental Psychopathology Schedule
Rating Scales	• Teen Addiction Severity Rating Scale Index • Adolescent Drug and Alcohol Diagnostic Assessment • Adolescent Problem Severity Scale

3.9.2 Treatment

Once the assessment is over, the counsellor can chalk out the treatment plan depending upon the requirement of the client and the need of the hour. Some of the treatment approaches commonly used are:

- **Psycho-education:** The most important part of the treatment process is educating the adolescent as well as family members about the harmful effect of each of the substances that the adolescent is using. Also, it includes informing the adolescent about the treatment process, and reinforcing that all information provided by the adolescent would be kept confidential and no coercive measures would be used.
- **Motivational Interviewing**: It is used if the adolescent has been forced into the treatment and assessment reveals poor motivation. It is a patient-centered interview style and the primary goal is resolving conflicts regarding the pros and cons of change (using/not using substance), enhancing motivation and

encouraging positive change. The style of the interviewer is characterized by empathy and acceptance and avoidance of direct confrontation. Statements associated with positive behaviour change are encouraged so as to support self-efficacy and a commitment to take action (Miller & Rollinck, 2002).

- **Contingency Management**: It has been shown that contingency management helps adolescents remain abstinent and also improves problems in other areas such as depression (National Institute on Drug Abuse, 1999). It follows two simple principles:
  - — Rewarding behaviours/ activities incompatible with drug use (for example, not meeting drug-using peers) and
  - — Withholding rewards/applying sanctions when drug use or other targeted behaviours occur.
- **Cognitive Behaviour Therapy:** It has been found useful in treating adolescents with substance use disorders (Drug Strategies, 2002; Wagner et al., 1999; Azrin et al., 1994). To conduct a cognitive- behaviour therapy, the counsellor must do further assessment which would involve identifying triggers or situations that make the adolescent take alcohol and drugs and then teaching the adolescent appropriate skills for dealing with the same.

Case Vignette

Master Vishal, 15 year old presented with a history of smoking ganja for the last 3 months. During the "risk assessment", it was revealed that he was able to abstain from ganja for as long as 5 days, but whenever he met some of his ganja-using friends, he was unable to say "NO" to them. His friends would convince him to smoke ganja "just this one time." The counsellor addressed the issue by teaching assertiveness to the boy and also helped him strengthen the skill by practising in the session and also by giving homework assignments.

- **Social Skill Training:** Research indicates that early initiation of substance use leads to interruptions of normal developmental acquisition of social skills and deterioration of previously learnt skills. Thus, goal of social skill training include enhancing adolescent's capacity for the following (Monti, 2003) :
  - — Effective and meaningful communication
  - — Listening reflectively
  - — Forming empathic relationships
  - — Monitoring and modifying one's own non-verbal behaviours
  - — Adapting to circumstances to maintain relationships
  - — Assertiveness
- **Relapse Prevention:** It is a part of the cognitive-behaviour therapy along with additional emphasis on life-style modification and life-style balance. More details of the same would be covered in Block 2.
- **Family Therapy:** As emphasized above, family plays a pivotal role in

adolescent's life — both as a protective and a risk factor. Thus, it is important to work with the family in order to decrease the negativity, resolve issues which may trigger a relapse and enhancing the positive factors of the family. A thorough family assessment should be conducted before intervention is planned. Primarily, the intervention includes psycho-educating the family, developing positive communication, conflict-resolution skills, and providing positive feedback to the adolescent. More details about the same would be covered in Block 2.

- Treatment must involve the adolescent client's family because of its possible role in the origins of the problem and its importance as an agent of change in the adolescent's environment.

- Substance use problems often get worse during a life crisis, such as divorce, the death of a loved one, or children leaving home.

3.10 SPECIAL POPULATION GROUP: MENTALLY ILL

At times, individuals with substance use disorders may also present with co-morbid signs and symptoms of other psychiatric disorders. Earlier, it was believed that the psychiatric symptoms were solely due to use or withdrawal from alcohol or other psychoactive substances and hence the treatment was given accordingly, that is, abstinence. With the advent of research, the cause-and-effect relationship between substance use disorders and other psychiatric disorders became a matter of debate. Did Mr. A consumed alcohol because he was depressed or he became depressed after chronic consumption of alcohol? Did Mr. X's manic symptoms came after *ganja* use or whether *ganja* was consumed excessively due to underlying psychopathology? The issue still remains unresolved and at times, difficult to answer.

Individuals presenting with both psychiatric symptoms and substance use disorder have been termed as "dual diagnosis" cases by the Substance Abuse and Mental Health Service Administration (SAMHSA). It is also becoming clearer that this sub-group of patients do not respond adequately to standard and traditional methods of addiction treatment and needs a more tailor-made approach (Sciacca, 1996).

Presence of comorbidity is found to be associated with worse prognosis overall (Havassy & Arns, 1998), including homelessness (Sullivan, 2000), being both victims and perpetrator of violent crimes (Wenzel, 2000; Modestin & Ammann, 1995) and increased risk of both suicidal/homicidal deaths (Rasanen et al., 1998).

Some of the principles underlying treatment of clients with dual-diagnosis are as follows:

Flexibility of approach

Continuity of treatment

Repetitive practice of skills (e.g. relaxation exercises, thought stopping)

Medications where necessary (e.g. anti-psychotics, anti-depressants)

Though various models have been proposed for treating clients presenting

with substance use disorders and co-morbid other psychiatric disorders. However, the following approaches are more popularly used:

Sequential: As the name suggests, the model proposes treating one condition at a time followed by the treatment of the other one. However, the difficulty faced by the clinician is determining which condition to treat first. Also, at times, the mental health practitioner may be ill-equipped to deal with substance use problem and the specialist dealing with addiction may not be adequately equipped to deal with mental illness.

Parallel: Both the problems are dealt with simultaneously. This approach can work well if both the conditions are being dealt with by the same person. However, if they need different program and staff, then the problem of poor communication, conflict regarding treatment approach can substantially increase the risk for the patient.

3.11 SPECIAL POPULATION GROUP: PRISONERS

The prison population can be considered as a high risk group with respect to drug use and as compared with the general population, drug use is over-represented or wide-spread in the prison (Ray et al., 2004). Being incarcerated does not mean that drug use would cease. Though, most individuals reduce to stop their drug use after imprisonment due to low availability of illicit drugs, some continue to use even to a greater extent and some may even initiate drug use after being incarcerated.

Health consequences:- Drug abusers in prison setting face greater number of health hazards. Due to low availability of illicit drugs, many injecting drug users (IDUs) tend to share their needles/syringes or other paraphernalia. In a study carried out in Luxembourg, it was reported that syringes were cleaned with water in 70% of the cases and in 22% of the cases, they were not cleaned at all (NR, 2001). A multi-centre study was carried out in some prisons in Belgium, Germany, Spain, France, Italy, Portugal and Sweden (WIAD-ORS, 2001), which reported higher level of risky sexual behavior in incarcerated IDUs.

Legal consequences:- Prison inmates caught in the possession of illicit drugs are punished under prison regulation. The incident might be reported in the individual's file. The common sanctions applied may be- restriction of rights, deprivation of prison leaves, or punishment in isolated cells.

▪ Drug Access and Supply in Prison

There can be many ways of accessing drugs in the prison. Any contact with the outside world could be an opportunity for smuggling drugs into prisons- for example, during visits (a visitor may carry drugs in their clothes, body cavities or inside food), transfers to courts for trial, small leave, through mails/parcels, drugs being thrown inside over the prison walls. They may also be smuggled in by the prison staff. The continuity of supply as well as the quality of drugs may vary considerably. And the prices of drugs are atleast two to four times higher than what one gets outside the prisons. Payment may be in the form of goods, exchange of services (which may even include prostitution) and/or participation in drug distribution.

Several methods are being used to prevent smuggling either periodically or randomly – searching cells of the inmates, body checks after prison leave, checking all parcels, supervision of visits and placing nets over walls of prisons.

▪ Treatment

Drug using offenders are a particularly complex group and thus are more challenging to treat, rehabilitate and integrate into the society. Studies have also shown that the severity of drug use and vulnerability to outcome of drug abuse among inmates increases considerably if these issues are not addressed.

For treatment, it is important to distinguish between different groups of drug offenders as different levels of interventions may be applicable for them. Roughly, four broad groups are recognized:

Recreational Drug User: who uses drugs but is not dependent on them and their use is not related to their offense

Problem Recreational User: whose use of drugs may be getting out of control and may have led to minor offenses , particularly, in relation to alcohol

Early Stage Dependent User: who are in early stages of dependency and are beginning to commit acquisitive crime to fund their drug use

Severely Problematic Drug User: who have an established drug dependency and a history of extensive acquisitive offending to fund their habits

Based on the level of drug use, it is important to provide appropriate level of care for these individuals to reduce their drug use as well as crimes.

3.12 LET US SUM UP

- Substance use problems often get worse during a life crisis, such as divorce, the death of a loved one, or children leaving home.
- Women who drink alcohol or take drugs during pregnancy risk harming their unborn child.
- Women with substance use problems often have a history of physical or sexual abuse, or are currently in an abusive relationship.
- Some women suffering with depression will use alcohol or other drugs in ways not prescribed in an attempt to feel better, but this can worsen the depression.
- Women entering treatment for a substance use problem are more likely to have attempted suicide than men.
- Women with a substance use problem may also experience eating disorders, agoraphobia, and other panic disorders.
- Women's dependence on alcohol often develops earlier in life than men, and they may experience more health problems as a result of their drinking.
- The same amount of alcohol affects a women more than a man.
- Over time, too much alcohol can cause serious health problems such as

damage to the liver, heart, stomach, and brain.

- Heavy drinking may also increase the risk of menstrual problems or some forms of cancer.
- Women who want help for a substance use problem often face barriers that make it difficult for them to get to treatment services or to successfully complete treatment.
- Treatment must involve the adolescent client's family because of its possible role in the origins of the problem and its importance as an agent of change in the adolescent's environment.
- Adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and unique environmental considerations (e.g., strong peer influences).
- Not all adolescents who use substances are, or will become, dependent. Programmes and counsellors must be careful not to prematurely diagnose or label adolescents. This may do more harm than good in the long run.
- Counsellors should be take into account the different developmental needs based on the age of the adolescent.
- In addition to age, treatment for adolescents must also take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Many adolescents have explicitly or implicitly been coerced into attending treatment. However, coercive pressure to seek treatment is not readily conducive to the behaviour change process. Consequently, treatment providers must be sensitive to motivational barriers to change at the outset of intervention.

To summarize, women, adolescents, mentally ill and prison population are treated under the heading of "special population" as all these groups come with their own specific needs and issues, which must be handled in a sensitive way. Though, the assessment and intervention principles primarily remain the same as those used with adult, male, treatment-seeking substance users, but they need to be adapted to meet the needs of this population.

3.13 GLOSSARY

Epidemiology : A branch of medicine that deals with the incidence, distribution, and control of diseases.

Foetal Alcohol Syndrome : A congenital syndrome caused by excessive consumption of alcohol by the mother during pregnancy, characterized by retardation of both mental and physical development in the child.

Gateway Drug : A habit-forming drug that is not addictive but its use may lead to the use of other addictive drugs. For example, tobacco.

Incarcerated : To be put into jail

Predisposing factors : To render vulnerable, susceptible, or liable. For example, genetic factors can make a person vulnerable to depression, thus acting as predisposing factors

Positive Expectancy : A tendency to expect positive outcome after a particular act

Psychoactive Substance : Any drug that can produce mood changes and distorted perceptions. For example, heroin, marijuana

Resilience : The positive capacity of people to cope with stress and adversity.

Telescoping effect : In substance use research, tendency for women to get addicted faster than men due to their biological and genetic make-up

3.14 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

(i) True, (ii) True, (iii) False, (iv) False, (v) True

Check Your Progress Exercise 2

a, b and e

Check Your Progress Exercise 3

1- Assertiveness

3.15 UNIT END QUESTIONS

1) What is the need for studying substance use disorders separately in women and adolescents?

2) What are the various health hazards faced by women who abuse alcohol/ substances?

3) Describe how social factors can play the role of both risk as well as protective factors with respect to substance use in women?

4) What are the special issues to be kept in mind before and during the assessment of a female substance user?

5) What are the common substances used by adolescents and which are usually termed as the “gateway drugs”?

6) Write a short note on importance of prevention in the context of substance use disorders in women and adolescents.

7) Ms Sujata (fictional name), a 24 year old women has come to the attention of a counsellor with complaint of smoking cigarattes for last 6 months and

smoking *ganja* for last 4 months. She also complains of mood swings, difficulty in adjusting with friends in college and inability to say NO. She started using *ganja* because her boyfriend offered this to her and she didn't want him to think that she was "un-cool". She realizes that drug use is not a good habit but is unable to leave it. She belongs to a middle socio-economic status family and her father takes about 3 drinks of alcohol everyday after which there usually is a fight between the parents.

Chalk out the areas of assessment and an intervention plan for Sujata.

8) Describe the various risk behaviors present in the prison population and the reasons for carrying out these risk behaviors.

3.16 FURTHER READINGS AND REFERENCES

Benegal V. Treatment Of Women Drug Users: Special Issues. In Drug Abuse: News-n-Views (eds) Tripathi BM, Ambekar A, Agarwal A. 2007. Available at: http://www.aiims.edu/aiims/departments/spcenter/nddtc/nddtc_publi.htm.

http://www.emcdda.europa.eu/html.cfm/index34919EN.html

http://www.ukdpc.org.uk/resources/RDURR_Full_Report.pdf

Lal, R (2005) "Substance Use Disorder: Manual For Physicians". National Drug Dependence Treatment Centre, New Delhi

Leslie K (2008). "Youth Substance Use and Abuse: Challenges and Strategies for Identification and Intervention." Canadian Medical Association Journal; 178 (2): 145-148

Modestin, J & Ammann, R (1995). Mental Disorders and Criminal Behavior. British Journal of Psychiatry; 166 (5): 667-675

Murthy P (Principal author and Scientific Editor). Women and Drug use in India: substance, women and high-risk assessment study. Ministry of Social Justice and Empowerment and United Nations Office on Drugs and Crime, 2008

Sciacca, K (1996). On Co-occurring Addictive and Mental Disorders: A Brief History of the Origins of Dual Diagnosis Treatment and Program Development (An Invited Response). American Journal of Orthopsychiatry; 66: 3

Toumbourou, JW et al. (2007). "Interventions to reduce harm associated with adolescent substance use" The Lancet, Vol. 369: 1391-1401

UNODC (2004). The Extent, Pattern and Trends of Drug Abuse in India: National Survey - Ray, R (Principal author and Scientific Editor). Ministry of Social Justice and Empowerment and United Nations Office on Drugs and Crime.

NOTES

OPTIONAL PAPER 3: SUBSTANCE ABUSE COUNSELLING AND FAMILY THERAPY (MCFTE-003)