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Young adult resilience for recovery to substance addiction in Assam, India:

Practitioner reflections on pathways to recovery model

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Psychosocial Interventions for Social Issues in Contemporary India (2024)

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India has more than 50% of its population below the age of 25 years. This is a huge potential human resource. However, the mental health report, National Mental Health Survey (NMHS) for the state of Assam, on which this chapter is based, highlights that in 2015-2016, nearly 5.85% of people aged 18 years and above required active interventions for one or more mental health issues including substance use disorder (SUD). This data reflects that mental wellbeing can be a hindering factor for sustainable socio-economic development and should be considered a public health priority. This chapter focuses on 'The Big Picture' project that was aimed at understanding the lived experience of young Assamese people around risk, recovery and resilience in relation to substance misuse. The bedrock of the project was the use of psychosocial visual participatory methods involving photo-led interviews which centralizes the lived experience of our participants. In total 15 young Assamese people (11 men; 4 women) aged 19-24 years provided detailed information about their journey to recover from SUD. This allowed the development of a multi-route, multidirectional pathways to recovery model comprising three phases: Recreational Use, Addiction (Relaxed, Chaotic, Strategic) and Supported Recovery. This chapter provides a summary and practitioner reflection in the context of Assam on the pathways to SUD recovery model developed in 'The Big Picture.'

Keywords: *substance use disorder, youth, positive behaviour formation, resilience, recovery, sustainable development*

Introduction

India has more than 50% of its population below the age of 25 years. This is a huge potential human resource. However, the National Mental Health Survey (NMHS), the first and largest population-based representative sample survey in India (Gautham et al, 2020), with reference to the state of Assam, the focus of this chapter, indicates that nearly 5.85% of people aged 18 years and above require active interventions for one or more mental health issues

including substance use disorder (SUD). This data (for 2015-2016) reflects that mental wellbeing concerns can be a hindering factor for sustainable socio-economic development and should be considered a public health priority.

Substance abuse especially amongst youth has been a concern throughout the world. Rapid industrialization, urbanization and changing life styles have left the youth struggling for their survival, forcing many to seek refuge in the dark world of substance abuse. India, too, is facing a similar situation that has attracted attention of policy makers and researchers (Juyal, Bansal, Kishore, Negi, Chandra, & Semwal, 2006). Before the turn of the century, the World Health Organisation estimated that globally 25-90% of children and adolescents indulge in substance abuse. (<https://www.who.int/publications/i/item/working-with-street-children-a-training-package-on-substance-use-sexual-and-reproductive-health-including-hiv-aids> 16 June 2012, Technical document) This has, at last, become of matter of priority to the government, parents, teachers, non-governmental organization and other relevant agencies (Chesang, 2013). Alcohol, cannabis (bhang) and tobacco are increasingly being abused by school going children showing a steady upward trend. Those between 16-30 years of age, a critical period in one's development, are most affected. This assumes greater relevance in developing countries like India which is already burdened with inadequate health-care facilities (Goswami, 2015). However, SUD is not confined to young people from a certain geographical area or socio-economic background. It affects both urban and rural areas and across classes, more so in the urban areas. Recent studies have shown that children of affluence, who are generally presumed to be at low risk, have problems in several domains—notably, substance use, anxiety, and depression, and the potential causes are pressures to achieve and isolation from parents. (Sunia S. Luthar 2003)

Thus, as substance abuse is increasingly becoming a public health problem, we face an almost overwhelming need to understand prevention, risk reduction and treatment of SUD.

Assam, Meghalaya, Sikkim, Tripura, Arunachal Pradesh, Manipur, Mizoram, Nagaland comprise all the eight northeastern states. The last four states share a common international border with Myanmar, the world's second largest illicit opium producing country. From the early 1970's drug use among local youth of North East India, particularly in the states closer to Myanmar, took a new turn. Alcohol is the most commonly used substance in all states except Mizoram, where Cannabis has the highest use. Children and adolescent population often experiment with drugs for fun and amusement in the company of friends, particularly in the urban areas (Goswami H. 2015). As a practitioner, similar instances have been observed where youth between the age group of 18-30 years use substances for recreational purposes and there is strong peer pressure to do so. A high stake is placed on scholastic achievement and material affluence, while structural inequalities and lack of opportunity to develop life skills contribute to college dropout, suicide and SUD. In fact, the Assam State Report of the National Mental Health Survey of India identifies adolescent SUD as an urgent public health problem. Pathak K, Deuri SP, Gogoi V, et al. 2017)

According to a prevalence study, 13.1% of the people involved in substance abuse in India are below 20 years of age. (*Child Protection and Child Rights. Vulnerable Children Affected by Substance Abuse. Childline 1098.* 2008). As a practitioner's observation as well as a clinic-based survey revealed that 63.6% of the substance users seeking treatment were introduced to drugs at a young age when they were 15 years or younger. (Stockings E, Hall WD et al 2016). Early initiation of drug use is often associated with poor prognosis and lifelong pattern of disturbed behaviour. The fall out of SUD is associated with a variety of psychosocial problems such as poor educational achievement, loss of employment or unemployment, depression, and disharmony in family relationships it can have long-lasting effects on the developing brain and may interfere with positive family and peer relationships and school performance (Tripathi BM, Lal R. 1999). Thus, the problem of substance abuse is multi-

dimensional and solutions entail more than the legal and health arenas. It is difficult to find statistics on adolescent SUD in Assam, particularly by gender. However, a review of the limited literature available suggests that youth 10-19 years living in a border area, use alcohol and 3.2% (only males), use drugs such as heroin and solvents while it is reported that 80% of street children in Guwahati aged 5-18 years abuse substances, 87.4% of whom abuse solvents (Madill, Duara, Goswami, Graber, & Hugh-Jones, 2023).

Community based responses to SUD in the northeastern states ranged from coercive measures against drug users by local pressure groups to various drug reduction approaches, including central and state government initiatives. Some of them being Launching of Drugs Free Assam Mobile App developed by NIC, (*Kavita Barkakoty, Assam, Dec 27, 2021* <https://informatics.nic.in/news/1389#:~:text=10%20Dec%202021%20Guwahati%20%3A%20Drugs,Director%20General%20%2D%20Narcotics%20Control%20Bureau>), Scheme of Assistance for the Prevention of Alcoholism and Substance (Drugs) Abuse for the State of Assam (<https://socialwelfare.assam.gov.in/frontimpotentdata/scheme-of-assistance-for-the-prevention-of-alcoholism-and-substance-drugs-abuse>)

The element common to all these responses has been the active participation of local non-governmental organisations and community-based organisations, the formation of which are often catalysed by addicts in recovery. One such organisation is Nirmaan Rehabilitation Facility which was central to the recruitment of participants in ‘The Big Picture’ project. Prevention is better than cure when it comes to SUD and the family and community plays an important role in both preventing SUD in young people and helping them to sustain recovery from addiction.

India has a comprehensive SUD treatment programme which includes ‘detoxification, pharmacotherapy, individual therapy, family therapy, group therapy, multifamily therapy, 12-Step programmes. (Perumbilly SA, Anderson SA. 2017). Some programmes also integrate

Indian cultural practices such as yoga, spirituality and an emphasis on social interdependence including support groups for families. (Greene D. 2021). However, more research is required to understand these programmes in the Indian context in the rehabilitation facilities, especially in the context of women addicts , who are usually underserved and disproportionately stigmatized. (Kermode M, Songput CH, Sono CZ, Jamir TN, Devine A. 2012)

The Big Picture Project

The aim of ‘The Big Picture’ project was to understand the lived experience of young Assamese people around risk, recovery and resilience with regard to substance misuse and develop a model of pathways to recovery. Its goal is to check for possible transferability of the model to a wider range of contexts, increase knowledge, enhance the voice of young people, and inform practice through impacting policy and promoting public awareness. The developed model enhances psycho-socio-cultural insights into the experience of risk and recovery, and informs prevention and treatment for youth substance misuse in Assam. This is the first model of its kind and an important public health resource. (Madill A, Duara R, Goswami S, Graber R, Hugh-Jones S. 2023).

The project took place between September 2018 and February 2022, with researchers from the University of Leeds and University of Brighton UK, supporting the main activities in Assam through the project partner organisations MIND India, Nirmaan Rehabilitation Centre, and Hope Foundation Rehabilitation Center. Both the centres are residential rehabilitation facilities that has been started with the aim of treating individuals suffering from chemical dependence such as drug addiction and alcoholism. They are run by experienced professionals in the field of substance abuse prevention and they are supported by volunteers who are recovering from addictions and have been maintaining sobriety. They focus not only on the patient but also supports the families too.

The bedrock of The Big Picture was the use of psychosocial visual participatory methods involving photo-led interviews which centralizes the lived experience of our participants. We generated rich information through interviewing total of 30 young people. Fifteen high school students aged 15-18 years (7 males; 8 females) took part and explored with us during interview how they had successfully resisted substance use despite experiencing a high-risk environment such as friends and/or family using addictive substances (excluding tobacco) (Hugh-Jones et al., in press). A further 15 young Assamese people (11 males; 4 females) aged 19-24 years provided detailed information about their journey to recover from SUD. It is this latter group on which we focus in this chapter because their interviews allowed the development of a multiroute, multidirectional pathways to recovery model of three phases: Recreational Use, Addiction (Relaxed, Chaotic, Strategic) and Supported Recovery (Madill et al., 2023). Our participants also collaborated with us to create posters and films to convey their experiences, the latter winning many prizes at film festivals around the world (Cooke et al., 2022).

Pathways to Recovery Model: Summary and Practitioner Reflections

We describe the rigorous and systematic way in which we generated our pathways to recovery model in a previous publication (Madill et al., 2023). In short, this entailed a thematic analysis (Braun & Clarke, 2006) in which each transcript was analysed independently by two researchers who discussed and came to an agreement about their findings. These agreed upon analyses were then integrated into a model through discussion with the wider research team. The posited model was then reviewed by a mental health professional and senior rehabilitation practitioner and his team in Assam. This led to some refinements to the model including, for example, an additional pathway from ‘strategic self-management’ to ‘abstinence’. Finally, four original participants – two men and two women - were invited to test the model to see if they

could trace their own journey through its pathways. This test was successful and led to a further refinement through the suggestion by one that the path between ‘in recovery’ and ‘abstinence’ should be two-way.

We now provide a summary of our pathways to recovery model and offer reflections on it from the perspective of an experienced mental health practitioner working in the context of northeast India (i.e., the first author Dr Sangeeta Goswami). While exposition requires us to work through the phases sequentially, we try not to lose the multiroute and multidirectional nature of the model as is illustrated in Figure 1.



Figure 1: Pathways to Recovery. Non-commercial license

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Phase 1: Recreational Use

In the phase of Recreational Use, participants had the opportunity to cycle between two stages: that of ‘not using’ and of ‘casual use’ (Figure 1). Importantly, it was not apparent often

that a transition had occurred into the phase of Addiction until an individual experienced difficulty getting hold of their needed substance(s).

Substance use is one of the leading causes of death and disability adjusted life years and affects the lives of individuals, families, and society at the large. There are multifarious factors associated with initiation of substance misuse including biological, psychological, behavioural and sociocultural milieu in which the individual lives. Gururaj et al. (2016) report that SUD is prevalent in 22.4% of the Indian adult population and is 2.5 times more common in men than women. Thirteen percent of those abusing substances are children and adolescents, (Katoki, Bhagabaty, & Kalita, 2016), with only 5% of those under 20 years old seeking treatment (National Survey on Extent, Pattern and Trends of Drug Abuse in India. United Nations Office on Drugs and Crime; 2004). The most common substances abused by young people apart from tobacco, are alcohol, cannabis and opioids, with initiation typically between 13 and 15 years (Dhawan, Pattanayak, Chopra, Tikoo, & Kumar, 2016). This shows the trend towards decrease in the entry age of young people into substance misuse.

Guwahati, Assam was initially an agrarian society but with rapid change brought about by urbanization, there is a rapid change in the geo-socio-scenario. Some of the critical concerns which acts as vulnerability factors as far as youth is concerned are increasing economic disparity, regional economic unbalance, lack of equal opportunity, unemployment, influence of media, impact of violence, abuse and exploitation and easy availability of addictive substances as well as the buying capacity of young people. As a practitioner, the fall-out of these above factors observed are poor anger management, poor coping mechanism, poor communication and interpersonal skills, negative peer pressure, school and college dropout, conduct disorder, anxiety, stress, depression, suicide vulnerability and poor selection of career pathways (Practitioner's clinical observation). Similar risk factors have been cited by

Mackinzie M Bachand in “Familial, social, and individual factors contributing to risk for adolescent substance use” (Whitesell M, Bachand A et al., 2013)

Traditionally, locally prepared liquors are prevalent in the social life of the tribal peoples of Assam (e.g., rice beer like Ruhi and Haria) as well as consumption of opium and marijuana because it is freely available in nature and cultivated in the villages. Gradually, substance such as cocaine and heroin made an appearance as geographical boundaries expanded the ‘golden triangle’ of illicit drug production was formed, including parts of Burma, China, Laos, and Thailand. Most recently, initiation into substance use is commonly via ‘sniffing glue’ or other solvents in school children as young as 9 years old followed by smoking from the age of about 14 years when substance use unfortunately can increase often due to peer pressure. In fact, in Guwahati, the largest urban area in Assam, peer influence, ‘fun,’ and curiosity are key reasons reported for substance use, with highest rates among middle-school children (Goswami, 2015).

The overall economic growth in Assam and other northeast states like Mizoram, Nagaland, Arunachal Pradesh, Meghalaya, Manipur have changed the social scenario too. The influence and impact of urbanisation and easy flow of money have led to a change in the lifestyle of people. The peer pressure of upkeeping a certain lifestyle is not only seen with the children but also with the parents as parenting style has shifted from authoritative or democratic towards permissive and laissez-faire. This led to more spending power and buying capacity in the hands of young people. On the other hand, late adolescence and early adulthood can bring academic pressure, competition in employment, and increased family responsibilities and associated family disharmony, feelings of financial, emotional, and life opportunity deprivation which, alongside negative peer pressure can lead some young people to substance misuse. And those most vulnerable to addiction include children with a family history of substance use and/or those with emotional and behavioural problems (Mahanta, Mohapatra, Phukan, &

Mahanta, 2016). Some, however, demonstrate resilience even when at high risk of SUD, and conversation with some young people in the clinic setting, revealed that they did not want to experiment with substances because they had seen their siblings, other family members, and peers suffering from withdrawal symptoms and struggling to recover. Some were even reticent to try cigarettes due to childhood memories of being hugged by their father smelling of cigarette smoke and making them feel suffocated.

Phase 2: Addiction (Relaxed, Chaotic, Strategic)

The second phase, Addiction, can be conceptualised as a kind of negative event horizon from which there is no return to the phase of Recreational Use per se. Addiction consists of three possible sub-phases: Relaxed Addiction, Chaotic Addiction, and Strategic Addiction.

Relaxed Addiction. At first, there may be no motivation to quit because the substance(s) of addiction are available and the positives of using substances are perceived generally to outweigh the negatives. Here the young person is reasonably happy to live in the stage ‘in addiction’ because it does not cause them a problem and may indeed bring perceived benefits such as peer acceptance.

Various forms of addictive substances such as cannabis, opium, opiates and cough syrups are abused in northeast India, with tobacco and alcohol abuse very high in some states (Mahanta, Mohapatra, Phukan, & Mahanta, 2016). Most often, it has been observed that there is no motivation to quit because the substance(s) of addiction are available and the positives of using substances are perceived generally to outweigh the negatives. This is seen particularly during the formative period of life, when boys and girls start to use substances to fit in with peers, by dint of general inquisitiveness, and growing-up with the norm of substance use in their family and wider community. With regard to the latter, for example, in rural areas, homemade alcoholic drinks are used by parents and elders in social functions without inhibition and in which contexts many young people to try alcoholic drinks. They continue in tolerable

doses, some graduating to commercially available alcoholic drinks, and gradually becoming habitual drinkers.

Children of parents with SUD are at increased risk for abuse or neglect, physical problems, poor behavioural or impulse control, poor emotional regulation, conduct or oppositional disorders, poorer academic performance, psychiatric problems such as depression or anxiety, and substance abuse (Daley, 2013). The risk of substance abuse is relatively higher among those who had never been to school and more common in those from a joint family when compared to others. Though not found to be statistically significant, substance use is more common in case of deaths of both parents. This may be again due to lack of family support and to be ‘forced’ into adulthood before they are ready (Duara, Hugh-Jones & Madill, 2021). Most importantly, easy access to substances and available pocket money apart from other factors make youth and adolescent boys and girls vulnerable to slip into relaxed addiction.

Chaotic Addiction. There is the possibility that an individual shows Chaotic Addiction, cycling between the stages of ‘in addiction’ and ‘abstinence’ because the needed substances or not available and/or because there is an attempt to quit on one’s own (Figure 1).

As part of the Indian socio-economic and cultural context, parents are entrusted with supporting their children at least until they are financially independent (Sinha, 1995). In turn, children have responsibility to respect their parents’ position and expectations (Hofstede, 2011; Sinha, 1995). This can be a double-edged sword. Young people feel responsible for meeting social expectations to look after elderly parents and helping them financially, since they raised them and paid for their education and this may come be in conflict with the young person pursuing their own personal goals.

For example, a young Nepalese man of 32 years from Mizoram was brought to the clinic by a relative because he had started abusing marijuana and alcohol. From a humble background, his father had died while he was in the final year of college, and he had to take up

a job immediately and support his mother. The pressure of work and lack of contact with friends led him to feel exhausted and frustrated and he had turned to substances. At the same time, he did not neglect work but was aware that his efficiency was declining and that, to meet his responsibilities, he needed to improve. However, he found it impossible to quit on his own and got stuck in Chaotic Addiction cycling between the stages of being ‘in addiction’ and mere ‘abstinence’ that never reached true recovery. Hence, he sought help from his family who then reached out to mental health professionals.

In Chaotic Addiction, the tendency is to think that they do not need external help. This may be due to lack of knowledge about the effects of withdrawal and feeling that seeking help is a sign of weakness and poor will power. Attempts at recovery, but which results in episodes of mere ‘abstinence’ include removing substances from their home and vicinity, looking for a steady job, avoiding drug taking peers, and avoiding personal triggers.

Strategic Addiction. There is also a possibility that an individual shows Strategic Addiction and this can be very hard to spot and it takes its toll on well-meaning family and friends. In Strategic Addiction, there is another kind cycling: that is, between the stages of ‘in addiction’ and ‘strategic self-management’ (Figure 1). What can be so difficult about this sub-phase is that, although it looks like a real effort to quit, the person addicted has no intention of doing so and, instead, engages with interventions – particularly medical substitution therapy - in order to sustain their habits and to mollify other people.

There is a thin line between Chaotic Addiction and Strategic Addiction and both sub-phases bear heavily on family and friends. Many studies and reports document adverse effects of SUD on individual family members and on the family system (Daley, 2013). This includes high relationship distress, tension and conflict related to the SUD. While in the stage ‘in addiction’, the young person may express many negative emotions such as anger, frustration, anxiety, fear, worry, depression and may act out through violence towards family members.

Other destructive behaviours include selling household items and stealing, or borrowing money with no real intention of return, to buy the required substances. This can create fear, despair and shame throughout the family.

SUD impacts the social functioning of the individual and becomes a burden for society as well. Social problems associated with SUD include unemployment, inability to maintain a job, criminal behaviours, vulnerability to exploitation and crime, incarceration, HIV transmission due to drug injecting and high-risk sexual behaviours – all of which create dependency on the family. The focus of rehabilitation is usually for men suffering from SUD and there is little residential support for women in addiction. This may be due to the greater social taboo and social expectation attached to how women should act. For example, a few young women aged between 20-30 years who came to the clinic, mentioned that, although like their brothers, they smoked weed and consumed alcohol they kept this knowledge from their parents because, as women, they would receive a more negative response. This anticipation of strong judgement stops women from seeking help and getting the support they need from family and society as a whole.

It has been observed that families of drug users are often characterized by parental substance abuse, parental disharmony, parental aggression, and poor attachment between parent and child leading to poor interpersonal relationships and less emotional support available for many young people with SUD. Thus, the family system itself can become a hindrance against recovery. Further complicating the issue of substance abuse, psychiatric disorders are prevalent in people with SUD. For example, it has been found that antisocial personality disorder and borderline personality disorder are especially comorbid with SUD (Mirin et al., 1991). Though this holds true, it is to be noted that young people with SUD and with no personality disorder, can demonstrate destructive manipulation to secure family resources to support their addiction while in the sub-phase Strategic Addiction. Specifically,

mostly unknown to their family, they cycle between the stages of ‘in addiction’ and ‘strategic self-management’ to support their habit. Strategic self-management imitates real intention to quit but is used by the young person to sustain themselves when, for example, they do not have the money to purchase substances or when their substance of choice is unavailable. A major strategy widely available in northeast India is to leverage family hope that they will recover by engaging with the medical intervention of Oral Substitution Therapy (OST). The young person with SUD may undergo OST scores of times unsuccessfully before their family is able to understand that they are being manipulated into supporting the addiction and misdirecting their resources.

In summary, there are three possible sub-phases of Addiction: Relaxed Addiction, Chaotic Addiction, and Strategic Addiction. It is essential to understanding the sub-phase in which a young person is at any moment because that provides insight into the young person’s motivation with regard to substances and viable, and non-viable, approaches to intervention. Families can benefit from mutual support organisations such as Al-Anon or Nar-Anon which provide opportunities to learn from others affected by SUD. These services have started in Guwahati a decade ago, who also extends their services to the families too. However, these services few and far between in Assam and needs to be are not expanded. These support groups are helpful to reduce the emotional burden on the family, allowing members to focus on their own lives and the wellbeing of each other while their family member with SUD is undergoing treatment.

Phase 3: Supported Recovery

Real change can occur when an individual moves in the phase of Supported Recovery. This involves engaging meaningfully with the stage ‘supported treatment’ and subsequently, if fortunate, progressing to the stage ‘in recovery’ (Figure 1). A central feature of this transition is acceptance of the support needed to quit. However, despite engaging with meaningful

treatment, there is the possibility of relapsing to ‘in addiction’ before being ‘in recovery’ or after a period of being ‘in recovery’, directly or via ‘abstinence’ defined merely as an interlude of not using the substance of addiction (Figure 1).

Even though phase 3 involves the idea of *supported* recovery, most substance users do not engage with this willingly, at least at first. Many will have tried to quit on their own unsuccessfully through, what we have identified above as Chaotic Addiction, and been disheartened. Many will also have utilised the pretence of engaging in recovery through Strategic Addiction and be cynical and nihilistic towards recovery opportunities. However, for the fortunate, the time will come when the young person is ready to grapple sincerely with what is required to begin the true journey to recovery, understanding that they cannot do this alone.

Entering Supported Recovery usually requires persistence from family and in the direction of professional services that are realistic in not promising a quick fix. This most likely means a quality residential facility with staff who understand the life-long effort required. As well as dealing with physical withdrawal, Support Recovery helps the young person with SUD create a new approach to life that mitigates the need for substances and distance from drug using context. Hence, rehabilitation facilities in Assam involve medical and psychiatric interventions but, importantly, alongside a structured routine of activities including yoga, meditation, and group discussion. There is a need to develop effective group psychological interventions for young people with SUD in the context of northeast India. One such intervention in recent times (2023) is MiCBT: an evidence-based therapy approach using core principles of Cognitive Behavioural Therapy through mindfulness-based exposure practices that directly challenge schematic beliefs. This has been piloted at MIND India, Guwahati by Ms Sandamita Choudhury, Consultant of MIND India and Founder of Spreeha Wellness Centre) with promising results. Further exploration will provide evidence based data, which will help to establish MiCBT as an alternative group therapy in the rehabilitation centres

Supported Recovery is difficult to sustain and there is always a risk of relapsing back into the stage ‘in addiction’ before reaching the stage ‘in recovery’ and, sadly, even after some of years after. For example, in the clinic, some addicts in recovery mention that they find it difficult to keep on track when they return home from residential rehabilitation because they re-enter a social context which includes still using peers. This highlights the importance of integrating fully with a recovery community focused on the goal of staying clean and providing alternative, meaningful activities. Quality rehabilitation facilities enable integration with appropriate community support, but there is a need for better medical and professional psychosocial follow up after a residential rehabilitation period.

The importance of community approaches to rehabilitation of young people with SUD has been recognised for some time given their resource efficiencies and the inclusion in the healing process of family and neighbourhood, often severely impacted by the drug misuse of members (Tripathi, 1999). However, although understandably, many people are suspicious of people known to be in recovery from substance addiction and, for example, are unwilling to offer them employment. Hence, as part of their recovery journey, some addicts in recovery support themselves to reintegrate into society by demonstrating their sincerity and reliability through volunteering and, for some, eventually gaining employment in the rehabilitation sector. For many, this is a path that provides them new meaning and purpose in life and a way of giving value to the community as they stabilise a lifestyle of sobriety. Although rehabilitation work is extremely valuable, wider training is required in employability skills, vocational skills, and general life skills to enable addicts in recovering to reintegrate into society. Such training increases ‘psychological capital’ comprising the positive psychological resources of hope, self-efficacy, resilience, and optimism. “Research shows that psychological capital can be a predictor of substance abuse with a significant negative relationship between psychological capital and relapse tendency (e.g., Krasikova et al., 2015; Zeng & Wei, 2023).

What next?

The Ministry of Social Justice and Empowerment, Government of India, introduced the Minimum Standards Of Care in the field of Addiction Treatment / Prevention since 1987. This includes prevention efforts, creating awareness, early identification, treatment and rehabilitation, sustained follow-up care, and also involving and mobilising the community. The scheme provides financial assistance to support NGOs to offer treatment of addiction and provide composite or integrated services for the rehabilitation of substance dependent people. It aims for ‘whole person recovery’ and has guidelines for the structure and functioning of these centres.

Regular assessment of these centres is important to check that guidelines are being implemented effectively and that the objectives of the centre are being met (Tripathi & Ambekar, 2009). Based on these prescribed standards, in September 2022 the Ministry of Social Justice and Empowerment, Government of Assam, compiled guidelines to regulate rehabilitation and de-addiction centres and, subsequently, to monitor their functioning (Government of Assam, 2022). Following this action, an appropriate Standard Operating Procedure has been developed for the rehabilitation centres which is however, yet to be finalised.

The Big Picture project, some of the outcomes of which have been described above, has therefore been timely in providing evidence-based information to support state policy in the region. We outline the following major policy-related implications of our work on psychosocial interventions for substance abuse.

First, *investment in family and community education and peer-to-peer support* is likely an economical and effective strategy for preventing youth SUD and enabling rehabilitation. Positive support systems are one of the foremost requirements for recovery from addiction and there is a significant positive association between perceived friendship quality and resilience.

Specific actions include government investment in: (i) community education on substance abuse prevention and rehabilitation pathways; (ii) family support programmes to address the impact of SUD on the family system; and, (iii) peer advisors within school and colleges who can educate and support other young people to avoid, or to see help in relation to, addictive substances.

Second, *financial support is needed from the government for setting-up high-quality rehabilitation centres*. Interventions are best geared towards encouraging a young person to accept support to quit. Effective interventions, including medical treatment, require also long-term psychosocial support to have the best chance of sustaining sobriety. Although providing a valuable service, many personnel in private rehabilitation facilities and providing long term support are volunteer addicts in recovery without adequate training. Specific actions include: (i) working with medical professionals to integrate long-term psychosocial support in a package of care and to avoid reliance on short-term, medical-only treatment; (ii) building on current policy for alcohol and substance use rehabilitation centres so that there is a high standard of service delivery and accountability; and, (iii) ensuring the monitoring of compliance with standards of care, including the training of rehabilitation personnel and their continuing professional development.

Third, *investment in women's rehabilitation* is needed due to the immense stigma women experience, even when in recovery, and will have the additional potential benefit of contributing to the well-being of their current and future children. Specific actions include: (i) acknowledging the need for women-only rehabilitation facilities and encouraging these through preferential start-up grants; and, (ii) implementing recommendations of the Assam State Report of the National Mental Health Survey (Pathak et al., 2017) to work closely with addiction rehabilitation services to decreasing stigma and encourage help-seeking through better public awareness.

Conclusion

In Assam, people with SUD and associated mental health challenges are often stigmatized and assumed to be criminals. As an educational tool, the pathways to recovery model, described and reflected on here, has the potential to challenge myths about SUD, enhance the effectiveness of SUD management, and act as a prevention measure by increasing awareness of the pitfalls amongst youth. With government investment, sustained recovery from SUD can be envisioned for young people with appropriate support from their family, rehabilitation facilities, medical professionals, voluntary sector, and community. We suggest that key policy developments to enhance recovery from SUD to the benefit of all should include: (i) investment in family and community education and peer-to-peer support; (ii) financial support for setting-up high-quality rehabilitation centres; and, (iii) investment in women's rehabilitation. Future research may include a trial of the effectiveness of our pathways to recovery education package and extending our understanding of the pathways to long term recovery from SUD in Assam.

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