FIRST PART

CONCEPTUAL FRAMEWORK
Chapter 1

Introduction
INTRODUCTION

Subject

The social dimensions of drug abuse powerfully influence—indeed, it might almost be said determines—at least four central aspects of the drug reality, aspects that traditionally have been presumed to grow directly out of the chemical and pharmacological properties of drugs themselves, independent of human intervention. And the most important of these things are social and contextual in nature. In the animal world, it is quite a bit easier to predict what drugs will do. But experiments with rats do not tell us very much about human behavior. This is why social dimensions are so important.

One of the social dimensions of all human experience is meaning. No object or event has meaning in the abstract, in a natural area. Rather meaning is imposed, socially fabricated—in short, symbolic. Meaning has two features: it is both internal and external. Meaning is assigned externally to objects or behavior in the process of human collaboration or interaction. But it also resides within the individual: it is arrived at as a result of a private act of choosing on the individual's part. In order for an observer to grasp that internal meaning, he must view the world from the subject's perspective, which inevitably involves empathy.

The same behavior, the same phenomenon, the same material reality, can mean completely different things to different people or to the same person in different contexts. Meaning is an ascription. It is superimposed on a phenomenon, a reality. It does not arise naturally. Anything may have multiple meanings, depending on one's point of
view. They define what drugs do, what their actions and effects on people will be. Right or wrong, each of these social definitions and descriptions will have some degree of impact on actual people in actual drug-taking situations. The positive and disinhibitory impact on sex in humans indicates the overwhelming role played by social expectations and definitions. The social, economic and technological changes present a challenge to the stability and influence of the family. The family is often viewed as the basic source of strength, providing the family have been identified. First, it may be seen as protecting and sustaining both strong and weak members, helping them to deal with stress and pathology while nurturing younger and more vulnerable members. Secondly, the family may be a source of tension, problems and pathology, influencing weaker members in harmful ways, including destructive drug or alcohol use. It may be viewed as a mechanism for family members to interact with broader social and community groups, such as peer groups, schools, work colleagues and supervisors and persons associated with religious institutions. The family may be seen as an important point of intervention - natural organizational unit for transferring and building social and community dimensions. Rapid social, economic and technological change may, under certain circumstances, weaken the sense of family and reduce the sense of belonging to other people, groups and places. Stability of relationships, environment and expectations is powerful forces in helping people manage their lives, especially important for children and young adults. In some societies, the classical problem of balancing discipline and control of children with nurturing support to encourage their exploration, understanding of self-realization may be complicated by drug abuse problems.
If the social context is significant to any understanding of problem drug use then an alternative framework to understand and respond to problem drug users is needed. One that incorporates a social understanding of a drug centred lifestyle, and acknowledges the impact of disrupted childhoods, relationship breakdowns, educational under achievement, low self esteem, unemployment, physical and sexual abuse. The social dimension to problem drug abuse and use is growing evidence that social disadvantage and social exclusion are important factors that tend to precede problematic drug abuse and use. Demonising illicit drug use It is clear then many problem drug users have experienced social exclusion and disadvantage prior to drug taking. For this group the onset of excessive drug taking in early adulthood may be a form of escape when there appears to be no legitimate way of accessing what appears to be widely available to the rest of society. In this sense social exclusion has led to problem drug abuse and use. A disproportionate number of problem drug users have been disadvantaged and socially excluded prior to taking drugs. For many the all-consuming drug-centred lifestyle is the only adult existence they have known and should be seen as an inappropriate solution, rather than the problem itself. Discourses then that emphasise the importance of physiological and psychological aspects of drug dependence are struggling to have impact because they take little account of the underlying social context of problem drug use. Directing drug users into treatment through the criminal justice system with court orders and license conditions is likely to have little long term impact unless the social inequalities are acknowledged, understood and addressed. There has been a tendency to concentrate on the drug problem, and see harm reduction and physical/psychological dependence as the means for
change, but treatment must also focus upon the person and their social context if rehabilitation and reintegration are to become realistic and achievable goals for long term problem drug abusers. Social Dimensions or drug abuser are - The social risk and protective factors of addiction; The social rehabilitation dimension of the treatment; and The social reintegration process after treatment.

Drug abuse its social dimensions of the most important elements our society. While the results are not unequivocal, research has largely demonstrated that associating with peers who use illicit substances is one of the strongest predictors of adolescent substance use. Parental influences have also been found to be significant predictors of teen alcohol, tobacco, and drug use, including the nature of parental supervision and monitoring, the quality of parental-child attachment, and the history of parental drug abuse.

Drug abuse— involving drugs, alcohol, or both—is associated with a range of destructive social conditions, including family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. Moreover, both social attitudes and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. An estimated 7.5 crore Indians are drug addicts and the number is going up significantly, spreading to semi-urban and backward areas, according to official figures. "Drug and alcohol abuse is becoming an area of concern as this is increasing while traditional moorings, social taboos, emphasis on self-restraint and pervasive control and discipline of the joint family and community are eroding", senior officials of Ministry of Social Justice and Empowerment said. As per the National Survey on Extent, Pattern and Trends of Drug abuse in India conducted
by the Centre in collaboration with United Nations Office on Drugs and Crime, the current prevalence rates within the age group of 12-18 years was Alcohol (21.4 per cent), Cannabis (three), Opiates (0.7) and any illicit drug (3.6 per cent). The survey indicated a high concentration of drug addiction in certain social segments and high-risk groups, such as, commercial sex workers, transportation workers and street children. Also the usage is higher in North Eastern states/border areas and opium growing regions of the country. Altogether, 40,697 males within the age-group of 12-60 years were interviewed and information on various aspects of drug abuse was obtained. The National Survey, the Ministry sources said, also indicates the prevalence of drug abuse among 371 women out of the sample size of 4,648 persons which is eight per cent.

It is estimated that there are about 6.25 crore alcoholics, 90 lakh Cannabis and 2.5 lakhs opiates and nearly 10 lakh illicit drug users in the country. This project had three major components viz National Household Survey, Rapid Assessment Survey and Drug Abuse Monitoring System with sub-studies on drug abuse among rural population, prison population, women, and in border areas. Concerned over wider ramifications of the spurt in drug abuse, government has put into operation a multi-pronged strategy involving motivational counselling, social-reintegration and building awareness about the ill effects of drug abuse, the officials said. The drug abuse prevalence is uneven in the country. A high level of alcohol abuse was reported from North East, high cannabis use from North East and Eastern regions and high opiate use in North East, North and Western region. While Buprenorphine, propoxyphene and heroin were commonly injected drugs, sharing of needles among IDUs is common and on an average with three partners per person, it said. However, the Ministry sources
said there is no authentic data to indicate that there is a growing menace of drug addiction in the country particularly among children and students as no timeline data for benchmarking is available. Nevertheless, they said students at the secondary/higher secondary level are vulnerable to slipping into drug abusing behaviours due to distress factors and peer influence. It was felt that educating the people on the ill effects of drug abuse through appropriate inputs in the school curricula can help reduce the element of risk of succumbing to this vice, the sources said adding that efforts were on to changing the curricula accordingly. The Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse is being implemented through 350 NGOs for running 387 De-addiction Centres and 52 Counselling Centres all over the country for providing facilities like treatment, rehabilitation Services and conducting awareness programmes of victims of substance addiction, they said. To tackle the menace, the Ministry has adopted a two-pronged strategy - supply and demand reduction. While supply reduction is under the purview of the Enforcement Agencies the demand reduction strategy is under the purview of the Ministry, sources said, drug abuse is not only a problem arising out of the availability and supply side of such intoxicating drinks and drugs but has a great deal to do with the social conditions which create the demand for or the need for consumption of such substances. "The vulnerability of modern society plays a catalytic role in promoting the consumption and abuse of narcotic and psychotropic drugs", officials said adding that findings of studies and surveys indicate the relationship of drug abuse with the socio-economic conditions or the social dynamics of the population.

Drug abuse, including the use of prescription medications and underage drinking, significantly affects the health and well-being of the
Nation's youth and young adults. Substance use affects academic performance and military preparedness and is linked to crime, motor vehicle crashes and fatalities, lost productivity, and increased health care costs. Stopping use before it begins can increase an individual's chances of living a longer, healthier, and more productive life. Put simply, drug prevention saves lives and cuts long-term costs. Recent research has shown that each dollar invested in an evidence-based prevention program can reduce costs related to substance use disorders by an average of $18.

Physicians commonly employ the term "abuse" to refer to the use of a drug outside a medical context; this is the official definition of drug abuse given by the American Medical Association. The term, however, conveys a moral rather than a scientific judgment. Since "abuse" clearly connotes something negative or bad, to employ the term is to discredit and stigmatize drug use rather than to understand or describe it. Those who use the term declare that nonmedical drug use is invariably harmful, without first investigating whether it is in fact so or what constitutes harm in the first place. "Abuse" puts forth the claim that only physicians should be permitted to administer drugs. But since the term "drug" is a social and not a medical concept, such strictly medical claims are inconsistent. One never hears of "medically unsupervised" use (and therefore "abuse") of alcohol, even though alcohol has effects similar in many ways to those substances that physicians feel they ought to control or veto. By the AMA definition, any use of marijuana, regardless of its medical consequences, constitutes abuse, since the drug is not approved for medical purposes by most, and by the most credible, physicians. Purposes such as euphoria, pleasure, relaxation, or mind transformation are considered illegitimate.
As "abuse" is used in context, however, it conveys the distinct impression that something quite measurable is being referred to, something very much like a disease, a medical pathology, a sickness in need of a cure. Thus the term simultaneously serves two functions: it claims clinical objectivity, and it discredits the phenomenon it categorizes. "Abuse" announces to the world that the nonmedical taking of drugs—actually, only certain types of drugs, since legal drugs such as alcohol are magically exempt from the definition (and thus the medical definition is a passive and curious reflection of the legal situation)—is undesirable, that the benefits obtained from illegal drugs are counterfeit, and that they are in any case outweighed by the hard rock of medical damage. But since the weighing of values is a moral and not a scientific process, we are able to see the ideological assumptions built into the term. Furthermore, the linguistic category demands verification. By labeling anything "abuse," it becomes necessary to prove that the label is valid. The term so structures our perceptions of the phenomenon that it is possible to see only "abusive" aspects in it.11

As discussed previously, while overall youth drug use did not statistically change between 2010 and 2011, past-month use of any illicit drug among 10th graders increased from 16.8 percent in 2006 to 19.2 percent in 2011.12 Marijuana typically drives the trends in estimates of any illicit drug use, and, accordingly, past-month use of marijuana among 10th graders increased from 14.2 percent in 2006 to 17.6 percent in 2011. In addition, there continues to be a decline in the perceived risk of marijuana use among teens. This is troubling, as research shows drug use trends among youth typically increase one to two years after a weakening of the perceived danger of using drugs. One possible influence on this observed trend in drug use and perception of risk is the
decreased exposure of youth to prevention messages and the presence of messages and policies that downplay the consequences of drug use. While the Administration supports ongoing research into determining what components of the marijuana plant can be used as medicine, to date, neither the FDA nor the Institute of Medicine has found the marijuana plant itself to meet the modern standard for safe or effective medicine for any condition. The Administration also recognizes that legalizing marijuana would not provide the answer to any of the health, social, youth education, criminal justice, and community quality of life challenges associated with drug use.

Latest available data indicate that there has been no significant change in the global status quo regarding the use, production and health consequences of illicit drugs, other than the return to high levels of opium production in Afghanistan after a disease of the opium poppy and subsequent crop failure in 2010. But while the troubled waters of the world’s illicit drug markets may appear to be stagnant, shifts and changes in their flows and currents can be observed below the surface. These are significant and also worrying, not because of how they currently impact on the data but because they are proof of the resilience and adaptability of illicit drug suppliers and users and because of the potential future repercussions of those shifts and changes in the world’s major drug markets.

The extent of global illicit drug use remained stable in the five years up to and including 2010, at between 3.4 and 6.6 per cent of the adult population (persons aged 15-64). However, some 10-13 per cent of drug users continue to be problem users with drug dependence and/or drug-use disorders, the prevalence of HIV (estimated at approximately 20 per cent), hepatitis C (46.7 per cent) and hepatitis B (14.6 per cent)
among injecting drug users continues to add to the global burden of disease, and, last but not least, approximately 1 in every 100 deaths among adults is attributed to illicit drug use. Opioids continue to be the dominant drug type accounting for treatment demand in Asia and Europe and also contribute considerably to treatment demand in Africa, North America and Oceania. Treatment for cocaine use is mainly associated with the Americas, while cannabis is the main drug causing treatment demand in Africa. Demand for treatment relating to the use of amphetamine-type stimulants (ATS) is most common in Asia. Globally, the two most widely used illicit drugs remain cannabis (global annual prevalence ranging from 2.6 to 5.0 per cent) and ATS, excluding "ecstasy", (0.3-1.2 per cent) but data relating to their production are scarce. Total production and cultivation of coca is known to be stable, while the production of opium has returned to levels comparable to 2009. Global annual prevalence of both cocaine and opiates (opium and heroin) has remained stable; with ranges from 0.3-0.4 per cent and 0.3-0.5 per cent, respectively, of the adult population aged 15-64.¹⁴

**Annual prevalence and number of illicit drug users at the global level, 2010**

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<td>Ecstasy</td>
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Research Problem

India too is caught in this vicious circle of drug abuse, and the numbers of drug addicts are increasing day by day. According to a UN report, One million heroin addicts are registered in India, and unofficially there are as many as five million. What started off as casual use among a minuscule population of high-income group youth in the metro has permeated to all sections of society. Inhalation of heroin alone has given way to intravenous drug use, that too in combination with other sedatives and painkillers. This has increased the intensity of the effect, hastened the process of addiction and complicated the process of recovery. Cannabis, heroin, and Indian-produced pharmaceutical drugs are the most frequently abused drugs in India. Cannabis products, often called charas, bhang, or ganja, are abused throughout the country because it has attained some amount of religious sanctity because of its association with some Hindu deities.

The International Narcotics Control Board in its 2002 report released in Vienna pointed out that in India persons addicted to opiates are shifting their drug of choice from opium to heroin. The pharmaceutical products containing narcotic drugs are also increasingly being abused. The intravenous injections of analgesics like dextropropoxphene etc are also reported from many states, as it is easily available at 1/10th the cost of heroin. The codeine-based cough syrups continue to be diverted from the domestic market for abuse Drug abuse is a complex phenomenon, which has various social, cultural, biological, geographical, historical and economic aspects. The disintegration of the old joint family system, absence of parental love and care in modern families where both parents are working, decline of old religious and
moral values etc lead to a rise in the number of drug addicts who take drugs to escape hard realities of life. Drug use, misuse or abuse is also primarily due to the nature of the drug abused, the personality of the individual and the addict's immediate environment. The processes of industrialization, urbanization and migration have led to loosening of the traditional methods of social control rendering an individual vulnerable to the stresses and strains of modern life. The fast changing social milieu, among other factors, is mainly contributing to the proliferation of drug abuse, both of traditional and of new psychoactive substances.

Several psychological theories of drug abuse and use rely on the notion of a psychological pathology, defect, or inadequacy: There is something wrong in the emotional or psychic life of certain individuals that makes drugs attractive to them. They use drugs as an escape from reality, as a means of avoiding life's problems and retreating into euphoric bliss and drugged-out indifference. Psychological factors fall into two basic varieties: those emphasizing the mechanism of reinforcement, and those stressing that the personalities of the drug user, abuser, and especially addict are different from those of the abstainer, and are causally related to use and abuse. The mechanism of reinforcement is fairly straightforward: People tend to maximize reward and minimize punishment; they continue to do certain things because they have a past history of being rewarded for doing them. Drug users are individuals who have been rewarded for use, and hence they continue to use. While reinforcement theories underplay personality factors, personality theories, as you might expect, emphasize their important role in causing drug use and abuse. The precise personality configuration that is said to determine drug use and abuse varies with
the theorist; a range of personality factors is invoked here. The key factor that binds these psychodynamic theories together, however, is that they postulate that certain individuals have a type of personality that impels them to drug abuse and use.

Sociological Theories - Biological and psychological theories tend to emphasize individualistic factors, although the researchers who propose them usually indicate that broader factors are at work. For instance, two psychologists associated with the problem behavior-proneness line of thinking (Jessor and Jessor, 1980, p. 105) incorporate the environment or, to be more specific, the “perceived environmental system”—especially parents and friends—into their model. However, their focus is on the characteristics of the individual. In contrast, sociologists tend to make broader, structural factors the focus of their theories. For most sociologists, the crucial factor to be examined is not the characteristics of the individual, but the situations, social relations, or social structures in which the individual is, or has been, located. More specifically, it is the individual located within specific structures. The field of sociology proposes seven partially overlapping sociological theories to help explain drug use: (1) anomie, (2) social control, (3) self-control, (4) social learning and subcultural, (5) selective interaction/socialization, (6) social disorganization, and (7) conflict. (I’ll mention an eighth theory, routine activities theory, only in passing.) The overlap among these theories is sufficiently great that some of the theorists who endorse one of them also support one or all of the others. One of the key impacts of illicit drug use on society is the negative health consequences experienced by its members. Drug use also puts a heavy financial burden on society. Expressed in monetary terms, some US$ 200 billion-250 billion (0.3-0.4 per cent of global GDP) would be
needed to cover all costs related to drug treatment worldwide. In reality, the actual amounts spent on treatment for drug abuse are far lower — and less than one in five persons who needs such treatment actually receives it. The impact of illicit drug use on a society’s productivity — in monetary terms — seems to be even larger. A study in the United States suggested that productivity losses were equivalent to 0.9 per cent of GDP, and studies in several other countries showed losses equivalent to 0.3-0.4 per cent of GDP. The costs associated with drug-related crime are also substantial. In the United Kingdom of Great Britain and Northern Ireland, a study suggested that the costs associated with drug-related crime (fraud, burglary, robbery and shoplifting) in England and Wales were equivalent to 1.6 per cent of GDP, or 90 per cent of all the economic and social costs related to drug abuse.16

In the area of drug abuse and use is any chemical that, upon consumption, leads to changes in the functioning of human mind and more specifically leads to a state of intoxication. A wide variety of drugs are available and are abused. Alcohol is one of the oldest and most popular psychotropic substances known. It is a brain depressant and its effects on the user depend on the level of alcohol in the blood. Alcoholic drinks available in India can be divided into Indian Made Foreign Liquor (IMFL), Indian made country liquor (IMCL), and home brewed country liquor (HBCL). Opioids are either derivates of the Opium plant or they have a similar action on the body like Opium. Heroin, popularly called — smack or — brown sugar □ is one of the very common forms used. Cannabis is available in various forms viz: Bhang, Ganja and Charas.. Nicotine the main active chemical in Tobacco is yet another legal and popular substance.
Types of drugs - A drug, broadly speaking, is any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function. In the area of Substance Use Disorders a drug or a substance is any chemical that, upon consumption, leads to changes in the functioning of human mind and more specifically leads to a state of intoxication. Some of these substances, like Alcoholic beverages and Nicotine (Tobacco), are legally allowed for trade and consumption in India (albeit with some regulations). These are called Licit (or Legal) substances. The trade and consumption of many other substances are strictly prohibited and are therefore called Illicit (or Illegal) substances. The World Health Organization (WHO) lists substance use disorders for the following classes of substances.17 Substances listed by WHO – Alcohol, Opioids, Cannabis, Sedative Hypnotics, Cocaine, Other stimulants, including caffeine Hallucinogens, Tobacco, Volatile solvents A brief description of common drugs of use is as follows.

Alcohol - Alcohol is the most available drug on the market and is not illegal to use or to be possessed. Alcohol abuse is "one of the most difficult problems to treat because the use is accepted at any social function and abusers deny that they are addicted. Alcohol is a depressant and sedative and becomes addictive when ingested in large amounts and at regular intervals. It slows down the activities of the nervous system that controls bodily functions, causes drowsiness, lack of concentration, slowness in thinking, impaired interpersonal relationships and leads to economic dysfunction and poverty" (Hodge et al. 2001:6).18 These authors (2001:6) point out that the dangers of too much alcohol consumption include: mental deterioration, lack of alertness, thus people under the influence of alcohol are prone to accidents, damage of organs like liver, kidney and others; also permanent damage to the foetus if the
abuser is pregnant, blackouts, convulsions, severe psychological dependence, death (from over dosage).

Alcohol affects the body as follows (Rehn, Jenkins and Cristal 2001:107-108)\textsuperscript{19}:

- It makes the individual carefree and sociable.
- It causes slurred speech. At this point it has begun to work. At this level in some countries, such as the USA and the RSA, once the individual has passed the legal intoxication level, the person is not supposed to drive a motor vehicle.
- It impairs motor skills that mean that the individual cannot coordinate well enough to drive a car. Not only the driving of a vehicle, any of a large number of other intricate procedures concerning machine, etc.
- It causes confusion. At this stage, the individual cannot recognize things around him well.
- It causes the individual to go into a stupor that means that the individual is too drunk to know anything.
- It can cause the individual to go into a coma.
- Finally, it causes respiratory paralysis that is connected with the gag reflex.

This means that when the individual vomits, he cannot get rid of the vomit because of the comatose state and death occurs. Dakota and Forks (2003:120)\textsuperscript{20} define an alcohol-related problem as "drinking that causes problems with parents, teachers, friends or the law". In their study on teen drug abuse, Dakota and Forks (2003:128)\textsuperscript{21} found that "25% of Americans die as a result of substance abuse. The average 18 year old has seen 100,000 television commercials encouraging him or her to drink. That is why 90% of high school seniors have tried alcohol,
53% get drunk at least once a month, 43% smoke marijuana and about 1/3 are smoking cigarettes; 95% of untreated addicts die of their addiction, 50% of traffic deaths are alcohol related, 40% assaults are alcohol related, 97% of addicts never see treatment."

Du Pond (2001:65)²² points out that an estimated 10% of children (more than 7 million) have at least one parent who is dependent on alcohol or illicit drugs and 6% have at least one parent who is in need of treatment for illicit drug use. Some parents suggest that millions of children are currently being reared in environments characterized by mothers that are addicted. Children of substance-abusing parents are widely considered at high risk for a range of biological, developmental and behavioural problems and "shockingly high numbers of children in the RSA" have mothers who are addicted to alcohol (Green, Ball and Ottoson 1999:4)²³.

**Opioids** - Opium is the prototype opioid which is derived from the poppy plant. An opioid is any drug that acts like opium in the human body (described below). They may be - Naturally occurring substances, such as morphine; semi-synthetics such as heroin, oxycodone that are produced by modifying natural substances and pure synthetics such as methadone that are not produced from opium but act just like opium on the human brain. When given to a subject who has not previously experienced the effects of the drug, opioids produce an unpleasant feeling.

However on continued use, injecting heroin or morphine produces a short lived (less than a minute) intense experience -"rush". It is described as a state of profound happiness. There is also pain relief due to inability to feel any pain (opioids are used as medications for pain-relief for this property) and a dreamlike state characterized by decreased
responsiveness to the environment. Heroin, popularly called—smack—or—brown sugar—is one of the very common forms to be used. Heroin may be smoked, chased (inhaled) or injected (intramuscular or intravenous).—Chasing—(inhaling the vapors emanating from a heated metallic foil) is the commonest mode of heroin use in India. Several other opioids that are used as medications (for pain relief) are also abused. Common among these are codeine cough syrups, morphine and pentazocine injections, dextropropoxyphene capsules and buprenorphine tablets / injections.

Cannabis - Cannabis is derived from the plant cannabis sativa, which grows wild all around the world including India. At low dose, cannabis causes a state of well being (high) and a dreamy, state of enjoyment. This is generally followed by a period of drowsiness. Even relatively modest amounts of cannabis can impair coordination and make the operation of heavy machinery hazardous. Perceptual and sensory distortions also occur. Subjective sense of time seems to be much slower than it actually is. At higher doses confusion and mental / behavioral problems may occur. Cannabis is available in various forms: Bhang- paste of leaves of the plant or dried leaves, Ganja—dried flowering stem of the plant and Charas or hashish—extracted from the resin covering the plant. It can be smoked in cigarettes, or in clay pipes (most common method in religious settings and rural areas) or in water pipes like the traditional hookah. Bhang, which is used in various religious festivals, is legal in India. Charas and Ganja which are also obtained from the same cannabis plant are illegal.

Marijuana - Marijuana is an addictive hallucinogenic drug, which is smoked by the abuser. It causes "an unnatural thirst or hunger, uncontrolled mood swings, talkativeness, impaired perception, disturbed
judgment, mind disorders, a feeling of well being and euphoria (pleasant feeling of excitement and of escaping reality) and it alleviates anxiety" (Rehn, Jenkins and Cristal 2001:112). These authors (2001:108) state that the dangers of the use of marijuana include:

- Excessive aggression when combined with alcohol
- Accidents due to distorted perception
- Physical damage in the form of bronchial irritation, risk of lung cancer, chromosome damage, ultimately brain damage.
- It is usually the first step of addiction before abusers move to hard drugs.

**Glue, paint, paint thinners, aerosols and polish removers** - As it is illegal to possess marijuana in RSA, it can be expensive to obtain. Abusers therefore tend to abuse substances that are more readily available and not illegal to buy, such as glue and paint. The homeless and poor often abuse these substances. These substances have a depressant effect on the abuser when they are inhaled. They cause slurred speech, inability to focus, stupor and seizures. The individual tends to move slowly as if lethargic and has a "drugged appearance". The individual sometimes tends to become hostile and aggressive (Lopez, 2001:12). Polish remover slows down the activities of the nervous system that control the body functions (WHO, 2002:13). According to Seigal (2003:4), inhalants are an assortment of chemicals and toxins that when inhaled are poisonous to the brain. They include common household items such as spray paints, air fresheners, glues, correction fluids and hair spray. Inhalants can cause disorientation, hallucination, memory loss and lack of coordination. Seigal (2003:8) states further that these inhalants "literally seal out the transfer of oxygen to the blood stream. The body can simply suffocate from lack of
oxygen. The inhalants contain a wide variety of toxins, which target different body parts for example the brain, the skin, liver and kidneys." Addiction to Benzene and gasoline (petrol) causes serious injury to bone marrow and to the immune system. It is toxic to the reproductive organs, causes hearing and vision loss and said to be linked to an increased risk of leukaemia (Seigal, 2003:14)\textsuperscript{29}.

Seigal (2003:4)\textsuperscript{30} highlights the following signs of inhalant use:
- breath and clothing that smell like chemicals
- spots or sores around the mouth
- paint or stains on body or clothing dazed or glassy-eyed look
- nausea or loss of appetite
- slurred speech red and running nose.

**Nicotine** - Nicotine the main active chemical in Tobacco is yet another legal and popular substance the world over. Nicotine generally causes heightened alertness and improved functioning in continuous repetitive tasks. Users also report relaxation and decrease in fatigue with smoking and irritability, restlessness, anger and frustration with difficulty in concentration and sleep while trying to leave. Tobacco, the commonest substance of use in India, is legally and socially sanctioned and used in a wide variety of ways including smoking, chewing, applying to gums, sucking and gargling.

**Cigarettes** - Cigarettes regularly serve as the starter drug-delivering agent. Cigarettes provide the drug nicotine. Children become hooked on cigarettes at any age. Nicotine has demonstrated dose-related euphoric effects similar to those of cocaine and morphine (Henning, Miyasato & Jasinski, 2004:16)\textsuperscript{31}. Cigarettes cause the worst of all drug habits found in the smoking of tobacco. The first step towards addiction may be as innocent as a boy's puff on a playground. Tobacco holds a
special status as a gateway to the development of other drug dependencies not only because tobacco use usually precedes use of illicit drugs, but because tobacco use is more likely to escalate to dependent patterns of use of other more dependence producing drugs (Ronald & Davis, 2004:5)\textsuperscript{32}.

Wood (2004:14)\textsuperscript{33} adds that cigarettes' toxic chemicals impair impulses and ethical controls, that is, cause addiction, brain damage, aboulia (impaired reasoning, ethical controls, and will power). Children may have conduct disorders and difficult temperaments resulting from the manner they were brought up. For instance, if the parents and other family members engage in substance abuse, children are likely to develop a range of affective, behavioural, cognitive and social problems. Many of these children present poor school readiness and performance, low bonding and attachment to school (Barber, Bolitho & BeHand, 2003:14)\textsuperscript{34}.

Mansell and Liu (2003:50) \textsuperscript{35} state that cigarettes use among adolescents is mostly prevalent among adolescents whose parents face many challenges that limit their ability to provide for the physical and/or emotional needs. These challenges include drug addiction, scarce financial resources, unstable housing, familial history of substance abuse and lack of social support from family and friends.

Mansell and Liu (2003:50)\textsuperscript{36} go on to say that, on average, children affected by maternal addiction are susceptible to a high level of risk. From the time of their conception and continuing through childhood, their environment has been characterised by an accumulation of factors known to place children at increased vulnerability for physical, academic and socio-emotional problems.
The majority of these children experienced pre-natal exposure to cigarettes and other drugs. More factors that may lead to adolescent drug abuse include rigidity in parenting attitudes, single parenthood, stressful life events and large family size (Van Leeuven, Hopfer, White & Peterson, 2004:27-29)\textsuperscript{37}. According to Erikson and Mackay (2002:20-30)\textsuperscript{38}, more than 5,500 billion cigarettes are manufactured annually, and there are 1,2 billion smokers in the world. This number is expected to increase to two billion by 2030. Green, Ball and Ottoson (1999:4)\textsuperscript{39} add that in spite of the real or apparent benefits of the psychoactive drug, the drug carries with it the potential harm, whether in the short or the long term.

**Sedative/ Hypnotics** - These are medications that are prescribed by doctors to reduce anxiety and produce sleep. They are also abusable because of their easy availability and cheap price. Though detail discussion is outside the scope of this chapter, certain medications like Diazepam, Nitrazepam and Pheniramine are widely used. These may be used either in tablet preparation, as injections or as cough syrups.

**Cocaine and other Stimulants** - Cocaine is an extremely addictive drug and is illegal to possess or deal in. The effects of cocaine appear almost immediately after only a single dose and disappear within minutes. It makes the user feel euphoric, energetic, talkative and mentally alert, especially to the sensations of sight, sound, and touch. It can also temporarily decrease the need for food and sleep. The short-term physiological effects of cocaine include constricted blood vessels, dilated pupils, increased body temperature, increased heart rate, and an increase in the blood pressure. Large amounts of cocaine may lead to bizarre (strange in appearance), erratic (unreliable) and violent
The signs of cocaine dependence include:
- small constricted pupils
- injection marks
- bruises on the arms, thighs, groins, ankles and neck
- unnatural calmness
- drowsiness
- personality changes
- decreased appetite
- sexual drive
- tremors, vertigo, and muscle twitch (World Bank, 1999:60)

Some cocaine users feel restless, irritable and anxious, energetic, and competent (Mustonen, 2002:4). Cocaine, a common substance in Americas and Europe, is extracted from the leaves of a plant that grows widely in Latin American countries. As of now, it is not widely available in India. It is generally snorted. Its use cause a short lived sensation (7 to 10 minutes) of "rush" which is felt intensely pleasurable to the user. Therefore it is not generally taken continuously but in "binges" or "runs" where it is taken every thirty minutes to few hours. There are some other stimulants called **Amphetamine Type Stimulants (ATS)** - These cause activation of the brain thereby increasing alertness, producing euphoria, improving performance and decreasing fatigue.

**Hallucinogens:** These are also called **Psychedelics.** These are a group of various drugs that have the common property to alter how a person sees or hears things (i.e. produce hallucinations).

**Inhalants** - These are substances that give vapors without heating. They are mostly petroleum products: glue, thinners, cleaners, solvents etc. The vapors are “huffed”, sniffed or “Bagged” (re-breathing from a
Their use also produces a rush and sense of wellbeing and an urge to reuse after only five to six minutes. On regular use however they are associated with brain damage and multiple liver and lung problems. Their use is growing especially among children and adolescents.

**Common substances used in India** are Tobacco, alcohol, cannabis, opium and heroin are the major drugs of abuse in the country. The following table gives the estimate of various substance users in the country.

<table>
<thead>
<tr>
<th>Substance used</th>
<th>Percentage of males who are ‘Current Users’ i.e. used the substance in the last month (in %)</th>
<th>Estimates of Number of Users in the country (in Lakhs)</th>
<th>Dependent users in the country (requiring urgent treatment, in Lakhs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco:</td>
<td>55.8</td>
<td>1628</td>
<td>--</td>
</tr>
<tr>
<td>Alcohol:</td>
<td>21</td>
<td>620</td>
<td>105</td>
</tr>
<tr>
<td>Cannabis:</td>
<td>3</td>
<td>87</td>
<td>23</td>
</tr>
<tr>
<td>Opiates:</td>
<td>0.7</td>
<td>20</td>
<td>5</td>
</tr>
</tbody>
</table>

Drug and alcohol use can change depending on factors such as the availability of drugs, introduction of new drugs in drug markets, new modes of administration, and rapid social changes. Some factors play a more direct role in the causation of the drug abuse problems amongst adolescents such as certain psychological factors, for example lack of behavioural control, depression and lack of support due to chaotic home environments where there is no family stability (William & Covington, 1998:6). Family instability may be caused by many factors such as
unrest, quarrels among family members; for example, father and mother, or parents and children (Taylor & Carry, 1998:11). Using alcohol and tobacco at a younger age increases the risk of using other drugs later. Some teens experiment and stop, or continue to use the drug occasionally without significant problems (WHO, 2004:2). Lawson (2002:10) emphasises that adolescent smoking may seem an innocent activity yet it is a marker for potential drug abuse and depression. Adolescents with emotional problems are "more likely to use drugs and to contemplate suicide. Another possibility is that the use of drugs aggravates pre-existing depression or other emotional problems. Drugs and alcohol may also impair the judgment of teens considering suicide and making suicidal attempts more likely" (Gordon, 2004:6). For adolescents there is a strong relationship between the use of drugs and violence. Those who engage in violent behaviour are extremely likely to report using alcohol and other drugs. Leningson (2002:10) found that 94% of violent adolescents reported using alcohol, 85% reported using marijuana, and 55% reported using several illegal drugs.

What This Means For Prevention - This suggests several potential points of intervention for either preventing drug abuse or reducing drug abuse risk. Interventions can and should be developed to target individual, family, and community determinants of drug abuse. However, most prevention research has focused on testing the effectiveness of school-based interventions targeting individual-level risk factors. A school-based intervention is likely to effectively prevent drug abuse if it impacts on drug-related expectancies (knowledge, attitudes, and norms), drug-related resistance skills, and general competence (personal self-management skills and social skills).
Increasing prevention-related drug knowledge and resistance skills can provide adolescents with the information and skills needed to develop anti-drug attitudes and norms, as well as to resist peer and media pressure to use drugs. Teaching effective self-management skills and social skills (improving personal and social competence) offers the potential of producing an impact on a set of psychological factors associated with decreased drug abuse risk (by reducing internal motivations to use drugs and by reducing vulnerability to pro-drug social influences).

**Social Welfare with Drug Abuser** - Welfare scheme drug addicts. This scheme are being implemented through State Governments, Union Territory Administrations and Non-Governmental Organizations. The objectives of implementation of these programmes are to ultimately provide the benefits to the targeted groups. Delivery of benefits in terms of financial and physical achievements to these groups by implementing agencies are known by way of assessment by the concerned divisions while releasing central assistance to these implementing agencies. It is necessary that the impact of the schemes and programmes need to be assessed and evaluated from time to time by independent evaluation agencies. Research/evaluation studies are sponsored to Universities/research institutions/professional bodies to get the feedback about effectiveness of the schemes. These agencies collect information from actual beneficiaries and become a primary source of assessing success of the programmes/schemes. Reports of these agencies serve as feedback about the real situation of status of programme implementation. Finally, the feedback from these reports acts as catalytic change in revision of the approach, norm, coverage etc. Also, the schemes can be appropriately modified to make them more
effective for implementation, otherwise, phased out if their utility is not found. Besides, it is also necessary to identify emerging issues those require policy interventions.49

Drug and Alcohol abuse has emerged as a serious concern, adversely affecting the socio-economic health of the country. The stress and strain of the modern day life has rendered the individual more vulnerable to the problem of substance abuse. Addiction to drugs not only affects the individual involved but also affects the family and society at large. In a national survey conducted in 2001-2002 by United Nations Office on Drugs and Crime (UNODC) and Ministry of Social Justice and Empowerment, it was estimated that about 732 lakh persons were user of alcohol and drugs. Of these 87, 20 and 625 lakhs were users of Cannabis, Opiates and Alcohol respectively. About 26%, 22% and 17% of the users of the three types respectively were found to be dependent on/addicted to them. As the sample size was small (40,697 males only) looking to the country’s population, the estimates can at best be taken as indicative only. The survey also indicated that other drugs such as Sedatives/Hypnotics, volatile substances, Hallucinogens, Stimulants and pharmaceutical preparations were also abused. After this survey, no other survey has been under taken on the extent, trends and pattern of alcohol and drug abuse in the country. In view of the above, National Sample Survey Organization (NSSO) has been requested to undertake a National Survey on the extent, pattern and trends for drug abuse in the country. Accordingly, during 2008 a Committee was constituted to suggest an appropriate survey methodology for undertaking a pilot survey on drug abuse. The report of the Committee was received in May, 2009.
Now a pilot survey in the States of Punjab and Manipur and the Metro of Mumbai has been initiated by the NSSO. The Ministry of Social Justice and Empowerment, as the nodal ministry for drug demand reduction, coordinates and monitors all aspects of drug abuse prevention which include assessment of the extent of the problem, preventive action, treatment and rehabilitation of addicts, dissemination of information and public education. The Ministry provides community-based services for the identification, treatment and rehabilitation of addicts through voluntary organizations.

The Narcotic Drugs and Psychotropic Substances Act, 1985, was enacted, inter alia, to curb drug abuse. Section 71 of the Act (Power of Government to establish centres for identification, treatment, etc of addicts and for supply of narcotic drugs and psychotropic substances) provides that “The Government may, in its discretion, establish as many centers as it thinks fit for identification, treatment, education, after-care, rehabilitation, social reintegration of addicts and for supply, subject to such conditions and in such manner as may be prescribed, by the concerned Government of any narcotic drugs and psychotropic substances to the addicts registered with the Government and to others where such supply is a medical necessity.” Accordingly the Ministry has been supporting Integrated Rehabilitation Centre for Addicts (IRCAs) under the Scheme of Prevention of Alcoholism and Substance (Drugs) Abuse being run by voluntary organizations.

India is a signatory to three United Nations Conventions, namely:

(i) Convention on Narcotic Drugs, 1961;
(ii) Convention on Psychotropic Substances, 1971; and
(iii) Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.
Thus India also has an international obligation to, inter alia, curb drug abuse. The United Nations General Assembly, in its 20th Special Session in 1998, has accepted demand reduction as an indispensable pillar of drug control strategies. The demand reduction strategy consists of education, treatment, rehabilitation and social integration of drug addicts for prevention of drug abuse.

Drug Abuse Prevention Strategy including successful experience of some selected States The Ministry of Social Justice and Empowerment recognizes drug abuse as a psychosocio-medical problem, which can be best handled by adoption of a family/community-based approach by active involvement of NGOs/Community Based Organisations (CBOs). The strategy for demand reduction is three pronged: 50a) Awareness building and educating people about ill effects of drug abuse, b) Community based intervention for motivational counselling, identification, treatment and rehabilitation of drug addicts, and c) Training of volunteers/service providers and other stakeholders with a view to build up a committed and skilled cadre. Awareness building and educating people about the ill effects of alcohol and drugs is one of the key components of the strategy. In this respect one of the success stories regarding stopping of consumption of liquor in public places from the State of Haryana is noteworthy. Smt. Roshani Devi, sarpanch of Kothal Khurd village of Mahendragarh district along with a group of like minded women with the support of Sakshar Mahila Samooh built a momentum in the village against the consumption of liquor in public places. As a result of efforts of the above women consumption of liquor in public places totally stopped in the village. In recognition of the commendable work done by Smt. Roshani Devi and the group of women, Her Excellency the
President of India, felicitated the women in a function at Rashtrapati Bhawan on 11.07.09.

The Ministry launches a national level awareness campaign each year on the occasion of 26th June. This year also all the State Governments, related central Ministries, all the RRTCs and Delhi base NGOs were requested to organize appropriate awareness generation programmes. Slogans in form of tickers were also broadcast on a number of TV channels in the month of June. A programme for observance of the International Day Against Drug Abuse and Illicit Trafficking was organized in the Mavalankar Auditorium on the 26th June this year. Sh. Mukul Wasnik, Hon’ble Minister, SJ&E, Sh.D.Napoleon, Hon’ble MOS,SJ&E attended the function. Sh. Ghulam Nabi Azad, Hon’ble Minister of Health and Family Welfare was also present on the occasion as Chief Guest.

A National Consultative Committee on De-addiction and Rehabilitation Services (NCCDR) under the chairpersonship of Minister for Social Justice & Empowerment has been constituted in July, 2008. The Committee has representation of various stakeholders including agencies dealing with supply and demand reduction. The Committee advises the Government on issues connected with drug demand reduction, education/awareness building, de-addiction and rehabilitation of drug-addicts. The first meeting of the Committee was held on 10.12.08. Two major recommendations which emerged in the meeting were - (i) To bring about further necessary changes in the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse and (ii) To formulate a national policy for Prevention of Alcoholism and Substance Abuse and rehabilitation of its victims. A sub committee of the NCCDR
has been constituted to take necessary steps in regard to both the above recommendations.

Two Central Sector Schemes, viz. ‘Scheme for the Prevention of Alcoholism & Substance (Drugs) Abuse’ and ‘General Grant in Aid Programme for Financial Assistance in the Field of Social Defence’, have been merged and renamed as ‘Scheme of Assistance for the Prevention of Alcoholism & Substance (Drugs) Abuse and for Social Defence Services’. The new and revised Scheme has two parts viz. (i) ‘Assistance for the Prevention of Alcoholism & Substance (Drugs) Abuse’ (Part I) and (ii) ‘Financial Assistance in the Field of Social Defence’ (Part II). The revised scheme has come into effect from 1.10.2008. Assistance to Voluntary Organizations for Prevention of Alcoholism and Drug Abuse The Scheme of Assistance for the Prevention of Alcoholism and Substance (Drugs) Abuse is being implemented for identification, counseling, treatment and rehabilitation of addicts through voluntary and other eligible organizations. Under this scheme, financial assistance up to 90% of the approved expenditure is given to the voluntary organizations and other eligible agencies for setting up/running Integrated Rehabilitation Centre for Addicts (IRCAs), Regional Resource and Training Centres(RRTCs), for holding Awarenesscum- deaddiction camps (ACDC) and Workplace Prevention Programmes,etc. In case of North-Eastern States, Sikkim and Jammu & Kashmir, the quantum of assistance is 95% of the total admissible expenditure. The balance has to be borne by the implementing agency.

The Scheme has since been revised w.e.f. 1.10.2008. Some of the important features of the revised scheme are (i) the honorarium rates for service providers of the Integrated Rehabilitation Centres for Addicts (IRCA) projects have been enhanced, (ii) provision for food for inmates
who are below poverty line (BPL) has been introduced at the rate of Rs. 900/- per month per inmate, (iii) Panchayati Raj Institutions/Urban Local Bodies have been included under the organizations/institutions eligible for receiving assistance under the scheme and (iv) the 15 and 30 bed IRCAs can be upgraded to 20 and 40 beds respectively, in the urban areas and the North-East.

Regional Resource and Training Centres - Training is an important component for capacity building and skill development for the service providers. It is important to have exposure to the new trends regarding the kind of drugs abused, medical and psychiatric problems, new medicines/methodologies available for the treatment of addiction through participation in training programmes and conferences. Updating and training through refresher courses needs to be provided to existing staff.

A National Centre for Drug Abuse Prevention (NCDAP) has been established 1998, in the National Institute of Social Defence (NISD) at New Delhi to serve as an apex body for training, research and documentation in the field of alcoholism and drug demand reduction.

Eight Non-Governmental Organizations (NGOs), with long years of experience and expertise in treatment, rehabilitation, training and research have been designated as Regional Resource and Training Centres (RRTCs) for different regions of the country. These serve as as field training units of National Centre for Drug Abuse Prevention (NCDAP) on various aspects of demand reduction. RRTCs provide the following services to the NGOs working the field of Drug Abuse Prevention: Documentation of all activities of the NGOs including preparation of Information Education Communication (IEC) material; Undertaking Advocacy, Research and Monitoring of drug abuse
programmes; Technical support to the NGOs, Community Based Organisations and Enterprises. A list of eight RRTCs, with the details of States/UTs attached to each.

Drug Abuse Monitoring System - Drug Abuse Monitoring System (DAMS) is an online database, wherein data on the types of drugs, method of consumption, and clinical and general profile of treatment seekers at De-addiction centres is collected on a quarterly basis for understanding the trends of drug abuse in the country. This system is to further strengthen the existing interventions and would be useful for developing appropriate preventive strategies in changing drug consumption behavior. Under the Scheme the Ministry assisted 107 NGOs which were running 118 IRCAs (Treatment Centers). An amount of Rs.10.15 crore was released as grant-in-aid to NGOs during 2009-10 up to 31.12.09.

Financial Assistance in the Field of Social Defence - The Scheme of ‘General Grant-in-Aid Programme for Financial Assistance in the Field of Social Defence’ aims to: i. Meet urgent needs falling within the mandate of the Ministry which cannot be met under its regular schemes and ii. Support such initiatives of an innovative/pilot nature in the area of welfare and empowerment of the Ministry’s target groups, as cannot be supported under its regular schemes. Financial assistance is given up to 90% of the approved expenditure to the voluntary and other eligible organizations. In case of an organization working in a relatively new areas where both voluntary and Government effort is very limited but the need for the service is very great the Government may bear up to 100% of the cost. This scheme has been merged with the central sector scheme for ‘Prevention of Alcoholism and Substance (Drugs) Abuse’ w.e.f 1.10.2008, and now constitutes part II of the ‘Scheme of
Assistance for the Prevention of Alcoholism and Substance (Drugs) Abuse and for Social Defense Services.’ The major funding under the scheme has been to the Jammu & Kashmir Rehabilitation Council for Rehabilitation of Widows, Orphans, Handicapped and Older Persons. During 2009-10, an amount of Rs.300 lakhs was released to the Council.

The Ministry of Social Justice & Empowerment had supported the project IND/G86: Empowering Communities for Prevention of Drugs and HIV in India, implemented by UNODC, in April 2005. The project was implemented during Aug. 2005 to September 2009 with a budget estimate of US $ 4.77 m. The project aimed to (i) prevent and reduce the abuse of drugs and the spread of drug related HIV in India and (ii) to strengthen the capacity of government and civil society organisations to prevent drug abuse and scale up interventions, which reduce the harmful consequences of drug use. Based on the findings of the National Survey on Extent, Patterns and Trends of Drug Abuse, published in 2004, and the related recommended programme interventions, the following four components were proposed in the project (i) develop a drug awareness programmes for schools; (ii) develop a national drug awareness programme; (iii) establish self help groups for young women affected and afflicted by drug use and related HIV; and (iv) document good practices.

Some of the major achievements under the various components are as follows: Programme of Drug Abuse Prevention in Schools: (a) National curricular framework recommended inclusion of awareness related materials on drugs and HIV by NCERT and State level text books. (b) Developed a set up of 11 modules on substance abuse and HIV (c) Trained a pool of 35 Master Trainers (MTs) (d) 2 Nodal teachers from 200 schools each trained (e) Providing knowledge and life
skills for children out of school. Develop a National Drug Awareness Programme: (a) The “I Decide” national awareness programme on drug abuse was launched on the 26th June, 2006 (b) Interactive Information, Education and Communication (IEC) material like Flip Charts, Pocket Calendars, Posters, Badges, Wrist bands, Brochures, etc. have been developed. These IEC materials have been adapted and replicated in several local languages such as Hindi, Bengali, Angami, Mizo etc. (c) More than 1900 Peer Trainers (PTs) and about 6000 Community Volunteers trained, who take the message of substances abuse prevention at the grassroot level. The volunteers also reach out to the key community influencer like church leaders and women’s groups. (d) About 125 NGOs reach out to more than 600 schools for spreading awareness on substance abuse and HIV through organizing art competitions, slogan writing, road shows, seminars, street plays etc. Programme for Young Women’s Self Help Groups (a) About 90 SHGs consisting of female partners of substance users and female substance users, have been formed across 12 states in the country. (b) 86 peer educators are attached with the SHGs. (c) 20 Drop-in-Centres are in operation (d) SHGs have been given access to micro credit and vocational training to empower and assist them to contribute to family income. Some of them have been begun to produce spices, handicrafts, etc. and started to sell their products in the local markets.

Social cohesion and disruption (separation of families and communities) Social ills: alcoholism, drugs, prostitution, crime, HIV/AIDS Socioeconomic impacts of cash injection into local economy Social or cultural disruption due to population influx Changing relationships between groups (gender, age, socioeconomic status, ethnicity) Disturbance impacts (e.g., noise, dust, pollution, traffic). The
sociologist who uses social construction theory is interested in how we know about a particular social phenomenon. Shemay also be interested in alternative ways of knowing something. For this reason, social construction theory is the basis of the sociology of knowledge. For centuries, opium has been cultivated in the northeastern states of India for medical use by both people and livestock. It is also used in festivals and celebrations in these areas as well as Rajasthan. Most areas have now curtailed this practice, but it remains prevalent in remote areas, such as in the east of Arunachal Pradesh. Illicit cultivation of opium poppy still occurs in India. It has been argued that illicit cultivation of opium poppy in the north east became commercial when the tribal population came into contact with timber merchants from the plains in the late 1980s. There is very little economic activity in these districts, and agricultural practices are essentially still subsistence-based. Opium is often the only marketable commodity produced, and it has the added advantage of being collected at the farm gate by traders or wholesalers – an option not normally available for other agricultural products.

Though it is extremely difficult to estimate the extent of illicit cultivation, according to a UNODC-sponsored study in 2001 which received logistical support from the Central Bureau of Narcotics (CBN), some production of opium was reported in Arunachal Pradesh (in the Upper Siang, Lohit, Changlang districts and Khonsa circle of Tirap district), Uttarakhand (Uttarkashi and Dheradun districts) and in Himachal Pradesh (Kulu, Mandi and Kalpa districts). Certain quantities are reportedly also produced in Jammu & Kashmir, Bihar and West Bengal (NCB 2002). Reports in 2004 cited experimental cultivation in Karnataka. The market dynamics of illicit opium cultivation have been studied in some depth in Arunachal Pradesh. In order to determine the
extent of illicit cultivation of opium poppy, a survey was carried out with logistical support from the CBN in three districts of Arunachal Pradesh. The survey covered 86 villages out of 506 on the three districts Upper Siang, Tirap and Changlang. Out of 86 villages 52 were observed to be growing opium. The main findings of the survey are as follows: (a) the majority of the cultivators had only started opium growing in 1999; (b) the size of the plots varied between 50sq.m and 12ha.; and (c) the average yield is approximately 5-8kg/ha. On this basis, it was estimated that cultivation in Arunachal Pradesh could reach 1,000ha, and that about half of this amount was accounted for in Lohit district. CBN destroyed 248, 153 and 218 hectares of illicit poppy during 1999, 2000 and 2002 respectively in Upper Siang, Lohit, Tirap and Changlang districts of Arunachal Pradesh. It also destroyed 9 hectares of illicit opium in Kullu during 2001 in association with Himachal Pradesh police.

The extent of such cultivation is very limited in comparison with the quantity of licit opium cultivation in India. Nonetheless, in line with its obligations under the international drug control treaties, India has stepped up its efforts to destroy illicit opium. Cannabis is also illicitly cultivated in the states of Jammu & Kashmir, Himachal Pradesh, Uttar Pradesh, Andhra Pradesh, Tamil Nadu, Kerala and Manipur. Every year, 80 to 100 tonnes of ganja (cannabis herb), both indigenous and smuggled is seized by the enforcement agencies (NCB 2002). Judged on the basis of seizures, most of the cannabis cultivation in India occurs in the north east (NCB 2004). India is the only country currently producing licit opium gum for medical and scientific purposes for domestic needs and for export under the terms of the 1961 Single Convention.5
Opium poppy is cultivated in three states of India – Madhya Pradesh, Rajasthan and Uttar Pradesh – in the following 22 districts: Madhya Pradesh: Mandsaur, Neemuch, Ratlam, Ujjain, Jhabua, Shajapur, and Rajgarh. Rajasthan: Kota, Baran, Jhalawar, Chittorgarh, Udaipur and Bhilwara. Uttar Pradesh: Barabanki, Faizabad, Ghazipur, Mau, Lucknow, Raibareilly, Bareilly, Shahjahanpur and Budaun. The Central Bureau of Narcotics, based in Gwalior, implements a stringent licensing system in India. The crop is generally sown in November and harvested in March-April. Opium is used to extract alkaloids such as morphine, thebaine and codeine. After the extraction of the opium, the pods are crushed and the poppy seeds are extracted and can be used as condiments in Indian cooking.

Issues of specific concern - Organized Crime - Organized crime in India is present in large cities and especially in Mumbai which is generally considered the commercial capital and where it is believed that organized criminal groups began to establish themselves from the early 1960s onwards. Its organised criminal gangs are involved in the following kinds of business. While most gangs indulge in many of these activities, they do specialize in certain areas:

a) Settlement of business disputes and recovery of dues - In any business culture where there is a propensity to evade taxes a significant part of all business transactions are usually done in cash. Debtors in such transactions who do not pay their dues cannot be taken to court for obvious reasons. Such disputes tend to be settled and dues recovered by organized criminal gangs through threats backed by credible display of force. Once debt recovery is effected, the criminal gang takes a certain agreed upon percentage of the recovered sum. Even where the business transactions are accounted for and legal, the recovery of dues through
the normal judicial process is often slow. In such cases, some businessmen prefer to settle disputes through the use of organized criminal gangs.

b) Contract killings - Contract killings are another important aspect of the business of organized criminal gangs. Colloquially, hiring someone as a contract killer is referred to giving him ‘supari’. The value of the ‘supari’ depends on the importance of the person to be killed and the difficulty involved in killing. Killing a person who has private guards, for instance, would command a higher amount of ‘supari’ than one without and similarly, the richer the man, the higher the amount of supari. However, the average cost of a contract killing is too high for the common man on the street to be threatened. Hence, Mumbai is considered quite safe for the ordinary citizens despite the existence of a large network of organized criminal gangs.

c) Smuggling - Smuggling has been a very profitable venture in the underworld thanks to the high rates of customs duties in India. With a view to saving the scarce foreign exchange for essential needs, the Government of India banned import of gold for many years resulting in a significant difference in the national and international prices of this commodity. Gold smuggling, therefore, has become an attractive business. The Government of India permitted the import of gold and reduced import tariffs on most commodities. Further, the government has also been encouraging multinational companies to establish their manufacturing facilities in India with the result that electronic goods and other consumer durables are now available in the local market. Smuggling has thus been rendered less and less profitable in recent years and hence organized criminal gangs are gradually shifting to smuggling of drugs both into the country and out of it.
d) Extortion - Extortion from businessmen and industrialists is another regular source of income for organized criminal gangs. Since the entire business community can be terrorized into submission, few will oppose making the regular payment or ‘hafta’ to the gangs. In return for the hafta, the organized criminal gang provides ‘protection’ from other criminal gangs. The city of Mumbai is thus divided into territories among different organized criminal gangs. Gang warfare among these groups is common.

e) Drug trafficking - India is one of the few countries of the world where drugs are manufactured, smuggled into and out of the country, sold in the large domestic market and precursors are manufactured and diverted both for use within the illicit drug industry within the country as well as for smuggling out of the country. These patterns provide considerable business opportunities for the underworld. According to information available to UNODC, most gangs have a specialised department dealing with drug manufacture and trafficking.

f) Human trafficking and prostitution - Human trafficking including running brothels is another important business for organized criminal gangs. This subject is dealt with in detail below.

g) Hawala and money-laundering - As explained above, Hawala is an informal method of transfer of money both within the country and to other countries. Hawala operators also convert the money into other forms of currency and move the money through different countries and banks to conceal traces of the money. Ill-gotten money earned through bribes, smuggling, drug trafficking and other crimes is transferred through hawala. Additionally, a significant percentage of legitimate business activities are unaccounted for mainly to evade tax. In some businesses, unaccounted for cash transactions have become the market
norm. Money in such cases cannot obviously be transferred through banks and hence it is transferred through hawala operators. Hawala is thus a thriving profitable business.

h) Financing of Bollywood movies - Until recently, Bollywood movie producers did not have access to credit from banks due to certain regulations. Organised criminal gangs find an excellent opportunity to invest their money in these projects and, although no statistics are available on the matter, it is reported that the Bollywood movie industry is financed to a significant extent by money from the underworld. The government is currently considering regulatory changes which would give film producers access to bank credit thus reducing their dependence on the underworld.

i) Financing of real estate - The cost of registering the real estate (commonly called “stamp duty”) is approximately 15% of the transaction value of the property in most states in India. Individuals thus tend to declare a much lower value on the property in the documents than the authentic transaction value. The result is that the average documented price of property in specific given areas is much lower than the market value. The remaining amount is transacted in cash. Thus, persons with illegal money can invest their money by buying real estate. Organised criminal gangs invest in real estate as it is not only an excellent place to deposit funds but also to earn money through businesses. Often properties are purchased in *benami* (pseudonymous) deeds to circumvent the regulations of land ceiling.

Types of Drug Abuse - 1. Stimulants: These are substances that directly act and stimulate the central nervous system. Users at the initial stage experience pleasant effects such as energy increase. The major source of these comes from caffeine substance.
2. Hallucinogens: These are drugs that alter the sensory processing unit in the brain. Thus, producing distorted perception, feeling of anxiety and euphoria, sadness and inner joy, they normally come from marijuana, LSD etc.

3. Narcotics: These drugs relive pains, induce sleeping and they are addictive. They are found in heroin, codeine, opium etc.

4. Sedatives: These drugs are among the most widely used and abused. This is largely due to the belief that they relieve stress and anxiety, and some of them induce sleep, ease tension, cause relaxation or help users to forget their problems. They are sourced from valium, alcohol, promotazine, chloroform.

5. Miscellaneous: This is a group of volatile solvents or inhalants that provide euphoria, emotional disinhibition and perpetual distortion of thought to the user. The main sources are glues, spot removers, tube repair, perfumes, chemicals etc.

6. Tranquilizers: They are believed to produce calmness without bringing drowsiness, they are chiefly derived from Librium, Valium etc.

Victims of Substance (Drug) Abuse - The strategies for victims of substance (drug) abuse are given as under: Thrust will be given to the prevention of drug abuse by ensuring effective involvement of parents, community, schools and colleges; Efforts will also be made to involve the corporate sector, civil society and other institutions like religious and elected bodies, to prevent drug abuse; There is a need to have a National Policy on Drug Abuse Prevention and Rehabilitation; The ongoing programmes of the National Institute of Social Defence (NISD) such as collection of statistics, documentation, research and programmes for training pertaining to prevention of drug abuse and care of older persons to continue. The training programme should be
organized both in-house as well as in collaboration with other organizations working in related areas.\textsuperscript{51}

The Ministry's Annual Plan, 2010-11 budget estimates and revised estimates for Scheme for Prevention of Alcoholism & Substance (Drug) Abuse Budget Estimates 41.00 and Revised Estimates 31.00 Rs. Crore.\textsuperscript{52}

\textbf{Review of Literature}

\textbf{International Narcotics control strategy Report (2004)}\textsuperscript{53} found that opiates abuse accounted for 43% of Indian drug abuse. Drug users are largely young and predominately male. National Survey (2004)\textsuperscript{54} on the extent, pattern and trends of drug abuse in India found that opiates are primary drug abused and 49% of respondent's families had history of drug abuse. Studies on drug addiction indicated that easy availability of drugs (Hans 1986)\textsuperscript{55} and irrational exaggeration of effects of drugs Phadke (1989)\textsuperscript{56} has resulted in abrupt risen drug abuse. Jolly (1976)\textsuperscript{57} argued that as society cannot fulfill all aspiration of man thus it results in frustration and drug abuse among youth. Randhawa (1991)\textsuperscript{58} reported that deviant behaviour including drug abuse is learned within primary groups particularly peer group and family.

Ahmad Nadeem, Bano Rubeena, Agarwal V.K., Kalakoti Piyush (2009)\textsuperscript{59}. The epidemic of substance abuse in young generation has assumed alarming dimensions in India. Changing cultural values, increasing economic stress and dwindling supportive bonds are leading to initiation into substance use. Cannabis, heroin, and Indian-produced pharmaceutical drugs are the most frequently abused drugs in India. Drug use, misuse or abuse is also primarily due to the nature of the drug abused, the personality of the individual and the addict's immediate
environment. The processes of industrialization, urbanization and migration have led to loosening of the traditional methods of social control rendering an individual vulnerable to the stresses and strains of modern life.

**Johanna D. Birckmayer et.al. (2004)**. The problems associated with the use of alcohol, tobacco, and other drugs (ATOD) extract a significant health, social, and economic toll on American society. While the field of substance abuse prevention has made great strides during the past decade, two major challenges remain. First, the field has been disorganized and fragmented with respect to its research and prevention practices; that is, there are often separate ATOD prevention “specialists.” Second, both the prevention researchers who test the efficacy of specific prevention strategies and the practitioners who implement prevention efforts often lack an overall perspective to guide strategy selection. To address these limitations, we present an ATOD causal model that seeks to identify those variables (Domains) that are theoretically salient and empirically connected across alcohol, tobacco, and illicit drugs. For the researcher, the model demonstrates important commonalities, as well as gaps, in the literature. For the practitioner, the model is a means to recognize both the complexity of the community system that produces ATOD problems and the multiple intervention points that are possible within this system. Researchers and practitioners are thus challenged to work synergistically to find effective and cost-effective approaches to change or reduce ATOD use and associated problems.

**Amanpreet Singh (2010)**. A partially exploratory and partially descriptive study was conducted to find out the strategies adopted by wives of addicts to grapple with the problem of addiction among their
spouses. For this study, 100 wives of addicts were interviewed on pre-tested interview schedule. This study was conducted in a village of District Sangrur (State Punjab, India). The present study was conducted to facilitate better understanding of lives of wives of addicts. 89% of wives of addicts were actively attempting to deaddict their husband. 57% took their addict husbands to de-addiction center. 59% of wives of addicts reported to village panchayat while 15% reported to police about problems associated with addiction of their husbands. 37% reported to pressurize their husbands through their father or brother(s) by using coercion. 10% of wives of addicts employed psychological pressure like stop talking/communicating with their addict spouses. Only 4% resorted to divorce or live separated from their husbands permanently. A total of 100 wives of substance abusers were included in the present study. Out of these majority (74%) were of age group 20 - 40. However majority of their husbands (68%) were of age group 30 - 50 years. Following is the description of socio-economic variables of respondents and their spouses. Majority of respondents (92%) had present marital status married and were living with their spouses. 4% wives were widows and 4% were separated/divorced. Majority of wives (96%) had arranged mode of marriage while 4% had love / love-cum-arrange marriage. In the present study majority of wives were found to employ various coping mechanisms to counter addiction or problems associated with addiction of their addict spouse. Reporting to village panchayat, reporting to police and taking refuge in their parental house were mechanisms used by wives of addicts to counter problems associated with addiction of their husbands. It was also found that wives of addicts attempted to deaddict their husbands by taking them to de-addiction centers and/or by taking support of superstition. Parental family of
wives of addicts also coerces their husbands to abandon drugs. It was found that socio-economic status of wives of addicts impacts on their coping strategies. Those who had higher educational qualification showed more propensities to report to police, take refuge at parental home and use psychological pressure on their addict husband. Those wives of addicts who were doing jobs and had less number of children commonly resort to take refuge at their parental home. Respondents belonging to nuclear families in comparison to joint families were more likely to approach village panchayat for redressal of problem associated with addiction of their husband. The tendency to take support of fake God men or superstition was found to be more in childless and less educated women.

World Drug Report (2012)\textsuperscript{62}, about 230 million people, or 5 per cent of the world’s adult population, are estimated to have used an illicit drug at least once in 2010. Problem drug users number about 27 million, which is 0.6 per cent of the world adult population. Throughout the world, illicit drug use appears to be generally stable, though it continues to be rising in several developing countries. Heroin, cocaine and other drugs kill around 0.2 million people each year, shattering families and bringing misery to thousands of other people. Illicit drugs undermine economic and social development and contribute to crime, instability, insecurity and the spread of HIV. Global opium production amounted to 7,000 tons in 2011. That is more than a fifth less than the peak of 2007 but an increase from the low level of 2010, the year in which a plant disease destroyed almost half of the opium harvest in Afghanistan, which continues to be the world’s biggest producer. The total area under coca bush cultivation in the world fell by 18 per cent between 2007 and 2010 and by 33 per cent since 2000. Efforts to reduce cultivation and
production of the main plant-based problem drugs have, however, been offset by rising levels of synthetic drug production, including significant increases in the production and consumption of psychoactive substances that are not under international control.

Amanpreet Singh (2009)\textsuperscript{63}, Drug Abuse among Rural Youth: A Sociological Study of Punjab, study was partially descriptive and partially explorative in nature and centered around males of age group 20-25 years. 50 drug abusers from six villages were interviewed. Snowballing sampling technique and information from village elders were used to identify drug abusers. Present study revealed that drug abuse among rural youth is a multifaceted problem. Peer pressure or influence, addiction in family history and exposure to drugs were found to be main instigators for youth to indulge in drug abuse. Factors responsible for continuation of drug abuse were mainly withdrawal symptoms and social labeling of addicts. The main consequences of addiction among youth were found to be negative impact on health, loss of social reputation and broken families. It was found that drug abuse among rural youth is a multifaceted problem. Influence of peer group or peer pressure acted as the major instigator factor for youth. Among familial factors, history of addiction in father, siblings or other relatives living with them acted as instigation for drug abuse among youth. There was a tendency among youth to ape the habit of addiction of their elders. Factors like frustration, curiosity towards drugs also instigate youth towards drugs. The three aspects of addiction of village youth i.e. instigator factor, continuation factors and effect of drugs on addicts were explored. From results it is evident that problem of drug abuse need immediate attention. There is a dearth of literature on the evil of drug abuse among rural youth. Absence of adequate health care system in
villages could exacerbate the problem of drug abuse. Moreover, unrestricted working of quacks in villages is worsening the whole state of affairs pertaining to drug abuse among youth. The counselling of youth and their awareness regarding ill-effects of drugs is need of the hour. The lack of social support or positive community response results in non-recovery of drug abusers even in cases where drug abuser is motivated to leave drugs. The bursting of social stigma and de-labeling of addicts will help save youth from clutches of addiction. Study also suggests that along with appropriate medical de-addiction and followup of addicts will help contain the problem of addiction. Present study further proposes that the problem of addiction is multi-dimensional and solution to the problem not only fall entirely within legal or health arenas. This problem should be tackled on family front, medical front, legal front, and community front. Several agencies are required to work collectively for eradicating problem of drug abuse from youth. This study also points towards the in-depth study on role of family, community and government in collaboration with each other to combat the menace of addiction among rural youth.

Mohammad Sourizaei, Javad Khalatbari, Mohammad Mojtaba Keikhayfarzaneh and Ramnaz Raisifard (2011). Drug use is one of the most dangerous problems of human societies in the modern era, which, in addition to numerous health problems, put also the cultural-social foundations at risk, and unfortunately, the youth are the most vulnerable age group for drug abuse. Nowadays, the emphasis is to cooperatively and coordinately prevent drug addiction and because this principle is superior to drug abuse treatment, there have been numerous training methods for preventing drug abuse for different age periods.
The present study is aimed to review these methods and also the causes of drug abuse and the researches done in this field.

**Ramachandran V. (1991)**65 Cannabis, heroin, and Indian-produced pharmaceutical drugs are the most frequently abused drugs in India. Cannabis products, often called charas, bhang, or ganja, are abused throughout the country because it has attained some amount of religious sanctity because of its association with some Hindu deities.

**Bushmueller and Zuvekas (1998)**66 perform an interesting study that determines that income positively affects moderate drug use but negatively affects daily use. One important aspect of Bushmueller and Zuvekas' work is that they differentiate between young adults and what they defined as “prime age” adults (30-45 year olds). When controlling for age, the relationship between drug use and income is not monotonic for younger people. They find that income positively affects drug use for young workers. But income negatively affects heavy drug use and those with lower incomes use drugs more often than those with higher income levels. Also when controlling for age, prime age men display a negative relationship to problematic drug use and employment but younger men do not. It might be argued against Bushmueller and Zuvekas that drug use affects income attainment. In another comparable study, Gill and Michaels (1990) conclude that drug use actually increases wages a little for all ages of people, and thus people earning an income demand more illicit substances.

**Van Ours (2006)**67 investigates employment and productivity effects of the use of cocaine and cannabis. He finds that the job attainment rate decreases with cannabis use. In fact, as soon as someone starts using illicit drugs their likelihood of finding a job goes down. Much of this decrease can be attributed to required on-the-job drug
testing. When an individual finally holds a full time job, three different outcomes are possible for the individual according to Van Ours. First there can be past cannabis use and no current cannabis use, second there can be past and current cannabis use, and finally there can be no past cannabis use and no current cannabis use. The unemployment rate increases as past demand increases for cannabis, while the unemployment rate decreases as past cocaine use increases.

Chatterji (2006)\(^{68}\) also estimates a model to determine the association between illicit drug use during high school and the number of years of high school completed. He finds that marijuana and cocaine demand while in high school reduces the number of years of high school actually completed.

Wallace and Bachman (2003)\(^{69}\) determine differences in high school seniors’ drug use dependent on family background and lifestyle behaviors and experiences. Drinking has been found to be more prevalent among white Americans than among people of other races. Research indicates that drug use is generally lower than average among black and Asian youth. For Native Americans, drug use is generally higher. In another study, alcohol and drug consumption results indicate that black males and females have higher abstention rates than white counterparts. Black and white females have similar rates of heavy drinking, but black males have a higher rate of heavy drinking compared with white males.

Arora, Monika et al. (2008)\(^{70}\). The tobacco industry undertakes various activities to increase the sale of tobacco products. The present study investigated the receptivity to tobacco marketing and exposure to tobacco advertisements with tobacco use among urban youth in 2 cities of India. The project covered 32 schools in Delhi (16 schools) and
Chennai (16 schools). A self-administered questionnaire survey was conducted covering 11,748 students who represented 94% of the sample at baseline: 5,889 (50.6%) students were from Delhi, 7,153 (61.4%) belong to government schools, 6,386 (54.9%) were males, and 6,165 (52.9%) were in Grade 6. In this study 24.8% of sixth grade and 9.3% of eighth grade students had ever used tobacco, and 6.7% and 2.9% respectively were current users. Of the 493 students who responded that they had a favourite tobacco advertisement, 238 recollected specific brand names. A total of 52 brands were listed including smoking and chewing forms of tobacco products. Of the students reporting brand names, the average number of brands reported was about one per student. Although a few students (n=3) reported up to 5 brands, most reported just one (n=186), and others reported about 2 to 4 brands (n=49). There were more favourite advertisements reported for chewing tobacco (n=236) than smoking tobacco (n=83). Among smoking forms, Wills, a cigarette brand name of Indian Tobacco Company, was the most reported tobacco brand followed by Gold Flakes of ITC, and Red and White of Godfrey Phillips India Ltd. Among advertisements of chewing tobacco product brands, Pan Parag was the most reported brand. Of the 11,642 students, 11,568 (99.3%) responded to questions of receptivity to tobacco advertising; of these 5.8% (n=665) were categorized as moderately receptive, and 64.5% (n=7465) were categorized as not at all receptive. Of the 11,642 students, 10,877 (93.4%) responded to the questions related to exposure to tobacco advertising. About 37% students reported having seen tobacco advertisements at more than 4 places, about 50% reported to have seen tobacco advertisements at 1-4 places, and 13.2% reported not having seen any tobacco advertisement on any of the 7 places listed in the
survey. The index of exposure to tobacco advertising was significantly associated with current use of any tobacco Drug Abuse/ Alcohol/ Tobacco product among these students. The relationship between exposure to advertising and tobacco use did vary by grade for both ever-tobacco use (p<0.06) and current tobacco use (p<0.05). The dose response relationship was present for sixth graders, but not for eighth graders. The relationship between exposure to advertising and ever tobacco use also varied by gender (p<0.05). The prevalence of ever tobacco use increased with exposure levels among girls (p=0.2), but not among boys (p=0.66). The relationship does not vary by gender, however, the prevalence of current tobacco use increased with increased exposure to tobacco advertising for both boys and girls. All the psychological factors studied showed a significant positive association with the exposure index, except for intentions to chew tobacco. Students who reported greater exposure scored higher on all psychological risk factors, indicating that they were at greater risk for tobacco use as compared to students who reported having not seen any tobacco advertisement. Among various psychological risk factors, exposure to advertising had the strongest relationship with perceived prevalence of chewing tobacco and smoking tobacco. It was recommended that a comprehensive ban should be imposed on tobacco advertising in order to effectively lower tobacco prevalence rates. Current legislation in India needs to be effectively enforced, and loopholes in the legislation need to be tightened to avoid advertising and promotion of tobacco products through surrogate means such as brand stretching.

Benegal, Vivek, Veleayudhan, Ajay and Jain, Sanjeev. (2000). India is traditionally perceived to be a ‘dry’ culture, but alcohol use in some form has always existed in the country. The present
study was done to estimate the cost of alcohol dependence to the individual patient, and the cost borne by the state in treating a patient with alcohol dependence syndrome. A total of 113 patients were selected as the sample and data was collected from secondary sources. The mean age of the sample was 38.37 years. Around 12.3% were white collar workers, 32.7% were blue collar workers, and 46.9% were manual labourers. Among these 84.4% were married, 8.3% were unmarried and 7.3% were separated or divorced. It was found that the respondents consumed 223.74 ml of absolute alcohol equivalents per day, had been dependent on alcohol for 7.71 years, and had Drug Abuse/Alcohol/Tobacco first used alcohol at 23.5 years. The alcoholic beverages preferred were spirits (mainly whisky and brandy) 69%, arrack (locally brewed and distilled alcohol) 27%, and beer 0.9%. With a mean monthly earning of Rs.1660.95 [1703.78], they spent Rs.1938.40 [1649.82] on buying alcohol, contributing Rs.601.84 [1072.88] to family expenses, i.e. 33% of the individual’s salary. About 40% of the group did not contribute any money at all to the family expenses. They had also incurred loans worth Rs.8388.29 [Rs.21447.11]. Only 6.3% of the patients were admitted to deaddiction centres for the first time. The mean number of admissions was 2.06 [1.71] over the last two years. Only 25% of the subjects paid for their treatment, the rest received treatment free of cost. The responsibility for financial support of the family had been taken over by the spouse or other relatives in 88.6% cases. Around 7.3% marriages had broken down, and 15% of all the alcoholics had lost their jobs. About 9.7% families had to send one or more children below 15 years to work to supplement the family finances. Private cost of alcoholism amounted to Rs.11086.88, external cost amounted to Rs.18,798.82, and the total social cost of alcohol
dependence was Rs.29,885.80 per patient per month. In Karnataka it was estimated that there were 5 lakh alcohol dependent individuals (3.97% is the prevalence rate in the state). The cost per person per day for detoxification and counselling in NIMHANS was calculated to be Rs.600/-. Each patient was admitted for 38.42 days per admission, and with a mean of 2.06 admissions over 2 years, the cost of health care in a year, assuming all alcohol dependent individuals undergo at least one admission in a year, was estimated to be Rs.1129.39 crores. Cost of medical treatment (data is available for head injury only) amounted to Rs.0.15 crores. Loss of productivity due to sickness, absenteeism and unemployment amounted to Rs.691.18 crores. The Total Health and Family Welfare budget of Karnataka for 1995-96 was Rs.469.58 crores. Therefore, alcoholism caused substantial economic loss to the individual and state. Knowledge needs to be disseminated on the public health aspects of alcohol related problems among the community to reduce health problems, and its cost to the individual and the nation. The costs are heavy and place a severe burden on society’s scarce resources, more so in a developing economy.

Family Health International, New Delhi. (2007)72. HIV infection related to injecting drug use (IDU) is becoming a public health problem in states like Assam and Mizoram. A need was felt to assess the problem in this region. The study was carried out in five north-eastern states of India, viz Manipur, Nagaland, Mizoram, Meghalaya and Assam with funding support from USAID. Rapid Field Assessment (RFA) was done in Assam at Guwahati (14), Tezpur (1), Jorhat (1), Dibrugarh (1) and Tinsukia (1) centre(s). Heroin, brown sugar, cannabis, opium, SP, synthetic and psychotropic drugs were the most commonly used drugs in Assam. The size of IDU population as reported by SACS and NGOs
was estimated to be around 300 in Assam. However, Drug De-addiction Centres (DDC) reported the number of IDUs to be between 250 and 300, and PLHA reported that there were 400 IDUs in Guwahati alone. Drug use in the state was showing an upward trend, and as a result, so was HIV among IDUs. According to one DDC about 70% of IDUs were HIV positive. IDUs preferred to inject in isolated and deserted places. In Manipur, 30 interviews were conducted. Out of 9 districts, the most drug prone areas were East and West Imphal, Thoubal and Bishenpur. Key Informants (KIs) generally agreed that most IDUs were young males. However, there is an increase in the abuse of adhesives and dendrite by young school children. Some KIs believe that 6000 – 17,000 IDUs are HIV infected. In Meghalaya, 20 in-depth interviews were conducted, and discussions with stakeholders from SACs, DDCs and NGOs were held. The total IDU population of Meghalaya was estimated to be 1462. In Assam and Meghalaya, either private or government HCPs (Health Care Providers) were present in the vicinity of almost all the sites. In Manipur, no HCPs were available in the vicinity of 424 (31.7%) sites. In Nagaland, there were about 173 sites, but no HCPs were available. However, NGOs were present in most areas in Manipur and Nagaland. About 5-6 NGOs associated with drugs and HIV / AIDS looked into the needs of the target groups in Meghalaya. In half of Manipur’s IDU sites, the users were both youngsters and old people. Nearly 33% of the IDUs comprised adults and 20% were young (18-25 years). Male IDUs were also many more than females. IDU population appeared to be relatively small in some states, however the problem is spreading in all districts of these states. Due to the associated health risk of injecting drugs to the individual and the community, the public health response needs to be strengthened to tackle the drug use issue in Drug
Abuse/ Alcohol/ Tobacco north – east India. Inadequacy of the current program interventions to reach out to the target population was reflected in the study. High rate of risk taking behaviours like sharing injection equipment was positively correlated with availability of risk reduction activities like Needle and Syringe Exchange Programme (NSEP) in the area. It is necessary to expand and strengthen the already existing activities in all the states to deal with the IDU and HIV / AIDS issue in north–east India.

Reddy, Srinath K. and Gupta, Prakash C. (2004)\textsuperscript{73}. Tobacco is used in a wide variety of ways: smoking, chewing, applying, sucking, gargling, etc. National Household Survey of Drug and Alcohol Abuse in India (NHSDAA), conducted in 2004, reveals that there were 1,860 tobacco users in the 12-18 years category, 7026 in the 19-30 years category, 5,186 in the 31-40 years category, 4,193 in the 41-50 years category, and 3,638 people were in the 51-60 years category. NFHS-2 (1999) reported that tobacco use among men was 46.5% and 13.8% among women aged 15 years and above. The prevalence of smoking among men was reported to be lower than the NSS (1996) (29.3% vs 35.3%) where most respondents were males, and the prevalence of smokeless tobacco use among women was higher (12% vs 8.6%). NHSDDA (2003) found the prevalence of tobacco use to be highest in South Bihar (94.7%), followed by Uttar Pradesh (87.3%), and the lowest rate was found in Kerala (20.6%). The Global Youth Tobacco Survey (GYTS-2000-04) supported by WHO and CDC revealed that 17.5% school students in the age group of 13-17 years were current users of tobacco. Among students aged 13-15 years, 14.6% were current smokeless tobacco users. Users ranged from 2% in Himachal Pradesh to 55.6% in Bihar. Current smoking in India was reported by 8.3%
students. It ranged from 2.2% in Himachal Pradesh to 34.5% in Mizoram. The GYTS India results show that non-cigarette tobacco use (13.6%) was three times more common than current cigarette smoking (4.2%). Over one-third of students (36.4%) were exposed to second-hand smoke inside their homes and nearly half (48.7%) outside their homes. The exposure to second-hand smoke inside the home ranged from 9.9% in Punjab to 79.0% in Meghalaya; and outside the home it ranged from 23.5% in Punjab to 84.4% in Meghalaya. The study reveals that the toxic effects of tobacco include Mutagenicity, Carcinogenicity and Genetic damage in humans. Nearly 3000 chemical constituents have been identified in smokeless tobacco, while close to 4,000 are present in tobacco smoke, and many of them are harmful. Tobacco contains tobacco-specific nitrosamines (TSNs), formed during fermentation and Drug Abuse/ Alcohol/ Tobacco curing of tobacco, which are carcinogenic. The Nicotine content of different tobacco products is Pandharpuri 54.77 mg/ g, Zarda 26.20 mg/ g, Masheri Br.1 6.02 mg/ g, Masheri Br.23.08 mg/ g, Rawa Tobacco 116.91 mg/g, Rawa Masheri 4.99 mg/ g, Beedifilter 42.05 mg/ g, Cigarette tobacco 14.19 mg/ g, and Beedi tobacco 35.15 mg/ g. According to US General’s Report (2004), tobacco is responsible for the death of 1 in 10 adults, with 2.41 (1.80 – 3.15) million deaths reported in developing countries, and 2.43 (2.13 – 2.78) million deaths reported in developed countries. Among these, 3.84 million deaths were in men. The leading causes were Cardiovascular diseases (1.69 million deaths), Chronic Obstructive Pulmonary disease (0.97 million deaths), and Lung Cancer (0.85 million). 50% of the unnecessary deaths due to tobacco occur in middle age (35-69 years), robbing around 22 years of normal life expectancy. To control tobacco consumption several initiatives have been taken. Under Ministry of
Health and Family Welfare (MOHFW) the Government of India has set up Central Health Education Bureau (CHEB) and its state branches called the State Health Education Bureaus. Every year, the CHEB conducts activities on 31 May, which is designated as No Tobacco Day. Directorate of Advertising and Visual Publicity (DAVP) creates awareness among the masses about various public and social health issues. WHO – SEARO (South East Asia Regional Office) initiated an year long campaign in January 2000 to curb tobacco consumption in South East Asia. National Tobacco Control Cell (NTCC) developed 13 anti-tobacco television advertisements targeting the entire spectrum of tobacco products used in India. Kalyani programme was launched by Ministry of Health in collaboration with Prasar Bharati in 2002 to telecast a weekly health show on Doordarshan. It discusses issues related to six diseases including those related to tobacco use. The different varieties of unmanufactured tobacco and its value in Rs. in million in 2003 was Fluecured Virginia (Rs. 4857.94 million), Burley (Rs. 746.58 million), Sun Cured natu (Rs. 127.96 million), Top leaf/jutty (Rs. 74.13 million), Lal chopadia (Rs. 143.04 million), Judi (Rs. 32.82 million), and others (Rs. 108.62 million). It was suggested that a National Coordination Body (such as a National Commission for Tobacco Control) should be created through an initiative of the Union Ministry of Health and Family Welfare. This body should have representatives of key stakeholder groups. It should help to catalyze policy, create partnerships, facilitate implementation at multiple levels, monitor performance of NPTC related activities, and provide advice to central and state Governments on the methods and means by which programme implementation can be strengthened. Such a body should ideally have the status of a statutory body but should remain fully
autonomous. Mechanisms should be evolved to obtain more precise estimates of morbidity and mortality attributable to tobacco use in India. Health facilities should be completely tobacco free, over and beyond what is required by the law.

Singamma Sreenivasan Foundation, Bangalore. (2008)\textsuperscript{74}. Alcohol has habit-forming and potentially addictive properties besides being hazardous to health. It also has detrimental effects on family and children. "Arrack" is diluted rectified spirit, readily used in place of alcohol in Karnataka. This study was undertaken before the ban on the sale of arrack in Karnataka. It is important to know that State excise on liquor contributed around 15% the State’s tax revenue. More than 50% of the revenue from liquor came from arrack sales. It contributed around Rs. 1565.40 crore out of Rs. 3414.94 crore in year 2005-06. However, the sale of arrack faced major protests by women and Stree Shakti self help groups. Therefore, the major objectives of the study were to study the impact on liquor consumption with respect to its geographical proximity, and to study the impact on the nutritional status of children (< 6 years) where liquor is consumed. A total of 1200 households were selected as sample from 120 villages, from 3 districts of Karnataka namely Chamarajanagar, Bijapur and Bellary. From each district 40 villages and from each village 10 households were selected. Out of 1194 households, 402 reported liquor consumption sometimes, whereas 230 households reported liquor consumption on daily basis. 84% village households had access to liquor vending in close proximity. The correlation matrix suggested that people from SC, ST communities were frequent consumers of arrack. This was directly corrected to their lower socio-economic status and negatively correlated with the level of education. This was proven by the fact that Bellary’s Hadgali taluk had
maximum illiterates 66%, and 60% households consumed liquor, which was the highest in all 3 districts and taluks. To check the impact on nutritional status of children coming from Arrack consuming households their height, weight and Mid Upper Arm Circumference (MUAC) were noted. Out of 108 male children studied, 57 were from Arrack consuming households and 51 were from Non Arrack consuming households. Children from Non-Arrack consuming households were found to be nutritionally better off. Also Non Arrack consuming households had more female children, 53 out of 99, as compared to Arrack consuming households. The problem of arrack consumption has subsided after its ban. Stree Shakti self help groups have helped the Government in implementing the ban. The recommendations given were to impose a total ban on sale of arrack, or alternatively to limit its access. After the ban, the Government provided Indian made liquor (IML) as an alternative, with limited access, to curb the crunch of Rs. 2000 crore in revenue.

Singh, Manmeet and Singh Sarabjeet. (2001)\textsuperscript{75}. The objectives of the study were to examine the alcohol consumption habits among 100 teenagers of five schools of Ludhiana city, Punjab to know the reasons related to alcohol consumption and effect of media. Information was collected through questionnaires and interviews. The study found that 68% teenagers consumed alcohol while they were studying in Class 10 or at the age of 15-16 years. Around 15% had their first drink when they were in Class 6 and 7. The first exposure to alcohol of 38.23% teenagers was at marriage parties while 23.52% had their first drink at home; 55.83% respondent reported that they consumed alcohol for the first time in the company of friends. Data revealed that beer was the hot favourite with 50% respondents, followed by whisky (35%). About
55.88% teenagers mentioned that their families consumed alcohol, so they also were in the habit of taking alcohol; while 44.12% said that they consumed alcohol but not their family members. About 64.70% respondents claimed that they did not experience any effect of liquor after their first drink. 79.41% respondents consumed alcohol every now and then. 64% respondents felt that media had a powerful role to play in encouraging a person to drink. It was suggested that parents should help the teenagers to understand the difference between messages in advertising and truth about the dangers of drinking. About 91% respondents were of the opinion that the practice of selling liquor to underage persons should be strictly prohibited, and 81% felt that Government must reduce the number of vendors drastically. A blanket ban should be imposed on drinking at marriage parties (56%) and in markets/public places (63%). The Government can play a significant role in arresting this menace through effective policies. Media can play a vital role in overcoming the menace of alcoholism, especially when presented through dialogues.

Ghulam Muhammad (2003)\textsuperscript{76}. Drug abuse, and particularly heroin addiction, has been spreading in Pakistan at a fast rate since the late Seventies. It has now become a serious social problem, which is probably going to stay. There is no pushbutton solution for its control and eradication. Over simplification of the problem is not likely to solve the complex issue of heroin addiction. It requires concerted and continuous struggle on the part of all concerned: governmental and non-governmental organizations, politicians, and religious leaders. The drug addicts resort to crime for generating income for the purchase of narcotics. The situation is becoming serious due to the number of heroin addicts in the country. An alarming rate of increase of 100,000 addicts
per year is highly dangerous to society. The drug addicts are affecting nearly 20 million dependents and family members with psychological, social, and economic repercussions. The present study reveals different clues as to how the situation may be approached in finding possible solutions to this grave problem. In addition to the 'Introduction', the main discussion has been organized in four chapters. Of these, Chapter 2 has been devoted to presenting a theoretical framework and review of the related studies. In chapter 3, research methodology has been elaborated. A structured interview schedule was employed for the collection of data from 204 drug heroin addicts through interviews. Snowball sampling technique was employed for the selection of respondents. They were in age group 15-40 years. 66 Univariate and 06 Bivariate Tables were formed for a systematic presentation of data. For the analysis of data, procedures like frequency and percentage distribution, chi-square of independent test (X2), and contingency coefficient test were used. Generalizations were based on these tests. Six hypotheses were tested. Chapter 4 was devoted to discussion of tables, In chapter 5 the conclusions were drawn and suggestions made. The data accumulated through interviews formed the bases of conclusion

Narendra Pal Singh and Dr. Shekhar Rajpoot(2012). Drug abuse is a complex phenomenon, which has various social, cultural, biological, geographical, historical and economic aspects. The disintegration of the old joint family system, absence of parental love and care in modern families where both parents are working, decline of old religious and moral values etc lead to a rise in the number of drug addicts who take drugs to escape hard realities of life. Drug use, misuse or abuse is also primarily due to the nature of the drug abused, the personality of the individual and the addict's immediate environment.
The processes of industrialization, urbanization and migration have led to loosening of the traditional methods of social control rendering an individual vulnerable to the stresses and strains of modern life. The fast changing social milieu, among other factors, is mainly contributing to the proliferation of drug abuse, both of traditional and of new psychoactive substances. The present study is a descriptive and partially explorative in nature and centered around males of age group 20-35 years. 100 drug abusers from six villages of Agra district (U.P.) were interviewed. Snowballing sampling technique and information from village elders were used to identify drug abusers. Present study revealed that drug abuse among rural youth is a multifaceted problem. Peer pressure or influence, addiction in family history and exposure to drugs were found to be main instigators for youth to indulge in drug abuse. Factors responsible for continuation of drug abuse were mainly withdrawal symptoms and social labeling of addicts. The main consequences of addiction among youth were found to be negative impact on physical and mental health, loss of social reputation and broken families. All inhabitants were males. Majority 96% of inhabitant were Hindu and mostly belongs to scheduled caste while 4% Muslims. The percentage was higher because the study was conducted in dominated areas. Regarding education qualification inhabitant were having educational qualification up to 12th while 40% were illiterate 28 addicts were 8th pass. Only 8% of inhabitants had graduate / post graduate degree holder. Thus the sample has inhabitant having lower educational qualification. Majority of inhabitant of agriculture based occupation i.e. 41% were small farmers and 31% were agriculture laborers. 9% were unemployed while 8% were student. 7% were doing job and 4% were having their own small business. Majority of addicts
71% had total family monthly income from Rs. 7000 to 11000 while 9% had above 11000 total family incomes. Thus majority of inhabitant were of lower socio economic status. Majority (72%) of inhabitants belonged to joint families while 28% belonged to nuclear families. In context of number of family members majority (78%) inhabitant had more than 6 members in their families while 22% had 1 to 5 family’s members. It is evident from the data on socio-economic status that majority of inhabitant hailed from lower strata of society having lower economic and occupational status.

Ravneet Kaur & Jatinder K. Gulati (2007). Substance abuse is the use of a drug or other substance for a non-medical use, with the aim of producing some type of 'mind-altering' effect in the user. This includes both the use of illegally produced substances, and the abuse of legal drugs, in a use for which the substance was not intended. Often this involves use of the substance in excessive quantities to produce pleasure, to alleviate stress, or to alter or avoid reality (or all three). Addiction is a state of physical or psychological dependence on a substance. Physical addiction includes the development of tolerance (needing more and more of the drug to achieve the same effect) and withdrawal symptoms that appear when the user stops taking the drug, and disappear when more of the drug is taken. Addiction to any drug may include these general characteristics: • Feeling that one needs the drug on a regular basis to have fun, relax or deal with your problems • Giving up familiar activities such as sports, homework, or hobbies • Sudden changes in work or school attendance and quality of work or grades • Doing things one normally wouldn’t do to obtain drugs, such as frequently borrowing money or stealing items from employer, home or school • Taking uncharacteristic risks, such as driving under the
influence or sexually risky behaviour • Anger outbursts, acting irresponsibly and overall attitude change • Deterioration of physical appearance and grooming. • Wearing sunglasses and/or long sleeve shirts frequently or at inappropriate times • No longer spending time with friends who don't use drugs and/or associating with known users • Engaging in secretive or suspicious behaviors such as frequent trips to storage rooms, restroom, basement, etc. • Needing to use more of the drug of choice to achieve the same effects • Talking about drugs all the time and pressuring others to use with you • Feeling exhausted, depressed, hopeless, or suicidal • There are certain signs and symptoms of being addicted to specific drugs. Certain factors predispose teenagers to drug abuse. These include • Family history of substance abuse, • History of depression and low self-esteem, • Feelings of not fitting in, and dropping out of the mainstream. • A smoking habit has likewise been correlated with substance abuse. Teens who smoke are eight times more likely to use marijuana, and twenty-two times more likely to use cocaine.

P. Singh (2006)\textsuperscript{79} a study by the Chandigarh-based Institute of Development and Communications revealed that the percentage of households affected by drug abuse was 61 in Majha, 64 in Malwa and 68 in Doaba. In Rajasthan, Madhya Pradesh and Uttar Pradesh, opium and bhukki are sold at authorized shops. Realizing that Punjab has a flourishing market; many Rajasthani vendors have opened their shops close to the Punjab border. “Though we put up nakas to prevent people from bringing the contraband from Rajasthan or Haryana, many manage to conceal it in their undergarments,” says a police officer who had a stint in Abohar and Fazilka. “Addicts do not miss any opportunity. They make frequent trips to the shop in case there is some laxity or the
absence of checking at the border because of the deployment of forces elsewhere. If one brings in say 5 kg of bhukki, he or she ends up saving Rs 1,000 besides getting his or her supply of the drug for a week. Though the rate in Rajasthan varies between Rs. 180 and Rs. 220 a kg, it is between Rs. 450 and Rs. 500 a kg in Punjab. Another common addiction for farm laborers is gutka, which has come with migrant laborers. It is also cheap,” he adds. The problem of addiction among farm laborers is equally severe in the Doaba and Majha regions also. Speaking on condition of anonymity, this police officer reveals that people belonging to the lower middle class are usually addicted to opium, charas and ganja. In the case of institution areas, say colleges, the chemical substances in demand by students in the state are smack and psychotropic drugs besides cough syrups. Girls are no exception. Bhukki becomes the most-sought-after “contraband” when elections, be these to the gram panchayat, the block samiti, the zila parishad, the Vidhan Sabha or the Lok Sabha, are to be held. In the Vidhan Sabha elections of Punjab in February, 2007, alcohol was sold on mobile shops at prices getting lower day by day while the prices of vegetables were shooting up day by day. Though bhukki continues to grip rural Punjab, alcohol, smack, heroin and various pharmaceuticals have displaced traditional drugs in the more affluent urban areas. Injectable pharmaceuticals are wreaking havoc in the rural areas. Of the 65 AIDS deaths reported from Patti tehsil in Amritsar during the past few years, at least 50 per cent of the victims were suspected to be drug addicts. It was the frequent use of the same needle for injecting drugs that led to the spread of the fatal disease. Singh (2006) concludes that a multifold increase in the prices of liquor, including beer, may further encourage the consumption of cheaper drugs like bhukki, charas and ganja besides
psychotropic and sedative drugs by urban youth. Affordability and availability remain major factors.

The present thesis 'Drug Abuse: Its Social Dimensions' is undertaken to explore the current status of drug abuse with respect to different variables, which creates social dimensions of drug abuse.

**Importance of Research**

In the last four decades sociologists have studied various kind of prevalent behaviours, but the aspects related to the behaviour of drug abusers has remain completely neglected. Some psychiatrists and medical scientists have expressed some views on the problem of drug abuse and addiction, sociologist have tried to highlight the conceptions inherent in drug abuse, and have not attempted to expound any principle based on these conceptions that will not only help in finding the cause of drug abuse also help in analyzing the process of addiction.

The drug abuser is today confused, which is terrifying situation in terms of his future. Therefore, in such situation the current research work in the field of sociology has an importance all its own.

**Aims of Research**

The aim of the thesis to be performed can be laid down as –

1. To identify the cases of drug abuse in municipal area of Ballia (Tehsil)
2. To find out the nature and extent of drug abuser in aforesaid area.
3. To identify major socio-economic factors contributing to drug abuse.
4. To examine different population groups afflicted or susceptible to drug abuse.
5. To examine Employed, Unemployed drug abusers.
6. To locate sources of supply, availability and accessibility of drug of abuse.

7. To identify and analyze social factors responsible for initiation and introduction in drug abuse.

8. To explore the efforts to withdraw and suggest measures for effective control and prevention of drug of abuse.

**Hypotheses of the Study**

Hypothesis is a formal affirmative statement predicting a single research outcome, a tentative explanation of the relationship between two or more variables. When the problem has been identified, certain answers or solutions in the form of hypothesis, educated guess or speculation may be based upon past experience, informal observation or information gained from others. This approach clearly establishes the nature of the problem and the logic understanding of the investigation. The hypotheses of the present study are in the form of null hypothesis.

Following hypothesis of the study:

1. There is not any relative found indulge in using drug(s) with drug(s) addict,

2. There is no down fall in level of physical health by using drug(s).

3. There is no any effect found on family relation of drug(s) addict.

4. There is no contribution of increasing consumerism and western culture towards usage of drug(s)

5. There is no drug addict found how initiated treatment for the drug addiction.

6. There is no effect of any special training of drug addict for their rehabilitation.
Limitation

1. The present research was limited to only small sample consisted 250 respondents, from selected area of Ballia Tehsil, District Ballia.

2. Area of Ballia Tehsil is very broad for this reason other Tehsils are not included in this study.

3. The limitations of the present study was that topic of the present research was very sensitive and researcher had to probe in the personal and private family matter of the drug addicts, usually they do not like to share their personal and private and familial mutte to a strange person.

4. Inspite of these hurdles, the researcher with the help of community leaders, social workers, working at the field of drug addiction, tried his best to collect the data as possible establishing after the best report with the respondents.
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