CHAPTER I

INTRODUCTION

UNDERSTANDING DRUG USE AND ABUSE

The use of drugs in the form of herbs, roots, barks, leaves and plants to relieve pain and to control disease is as old as the human civilization. Since times immemorial, it is also a known fact that the ingestion of some drugs leads to the creation of euphoria, feeling good, serene or even powerful to an abnormal extent. These temporarily pleasurable, positive and imaginary effects of such drugs have the potential of leading to their repeated use.

Drug use for purposes other than acceptable medical direction or inappropriate prescription and unlawful use in situations where the use of certain drugs is prohibited by law is known as 'misuse' of drugs or 'drug abuse'. Put simply, drug abuse covers self-medication, self-prescription and any non-medical use of drugs. Repeated consumption of a drug may also lead to drug-dependence which is defined as a state of periodic or chronic intoxication that is detrimental to the individual and to society.

Factors leading to drug abuse

Drug abuse and drug dependence are complex phenomena. They operate on a triad comprising the drug, the individual and the environment - each one of which plays an important role individually and vis-a-vis each other. The causation of this multi-factorial problem may thus rest within an individual's personality, ignorance, inability to cope with the stress and strains of life, curiosity, experimentation, non-conducive family environment, easy availability or excess of money, easy access to drugs, involvement in criminal activities, etc.

The abuse of a drug leads to the entry and accumulation of toxins in the human body. Consequently, varied effects are produced on the physical and mental functioning of an individual, thereby affecting one's family and social relationships. The effects of drug taking depend on the type of drug ingested, quantity consumed, frequency of drug taking, body tolerance, one's previous experiences with drugs, the social environment in which it is consumed and a host of other subtle social and psychological factors.
Drugs are of different types. Some are meant for medicinal use when taken in appropriate quantity after medical prescription. Some of the drugs, even though having medicinal use, have toxic effects especially if used without prescription.

Besides, the drugs having medicinal value, there are other substances which have no medicinal use. However, their abuse is conducive to the creation of drug dependence. These substances may act as depressants, sedatives, stimulants or as producers of hallucinogenic effects and produce both psychic and physical dependence. Some of the most prominent examples of these drugs/substances are:\(^2,^3,^4\)

1. Alcohol (depressant) in any form;
2. Barbiturates (sedatives) like barbiturates methaqualone, neprobomate, benzodiazepines, etc.;
3. Amphetamines (stimulants) like amphetamine, deamphetamine, methamphetamine, methylphenidate and phenmetrazine.
4. Hallucinogens (producing hallucinations) like LSD, Mescaline, psilocybin, phencyclidine, etc.;
5. Opiates (depressant, anesthetic and hallucinogenic - depending upon the quantity administered into the human body) like opium, morphine, heroin, brown sugar, pethidine, methadone, etc.;
6. Cannabis (depressant and hallucinogenic) derivatives; and
7. Volatile inhalants (mixed and complicated effects including sedative, anaesthetic and hallucinogenic experiences) like industrial solvents, anaesthetic gases, glues, lighter fuels, etc.

Apart from the major reactions just referred to, the categories of drugs listed above usually produce marked dependence and tolerance.

Before proceeding any further, it may be useful to list these drugs in two broad categories, i.e., licit and illicit. It surprises many to learn that licit drugs include alcohol, tobacco and cannabis. The primary reason due to which these are placed in the licit category is because these enjoy social sanction. In contrast, opium, heroin and other psychoactive drugs are illicit drugs.

Drugs are consumed by different routes, i.e., through oral ingestion, inhalation, sniffing, chasing, sucking, chewing and injecting. They may be taken singly and/or in combinations, giving rise to poly-drug abuse.

Over the years, the drug scenario has broken the boundaries of abuse of traditional drugs (mainly alcohol, tobacco and cannabis) which enjoyed social sanction. Developments in the later part of the nineteenth century, both in India as elsewhere, have lent new dimensions to the problem.
Today, technological progress has led to the production of alkaloids and their derivatives from opium and cocoa leaves. Consequently, new and highly potent and dangerous drugs like heroin and crack threaten to occupy the center stage. Better communication and transportation facilities between nations has further aggravated the problem.

Rapid industrialization and urbanization continue to induce more and more people from a rural background to migrate city-ward in search of employment and a better life. It is a different matter that the harsh social realities of the urban milieu so often compel people to adopt dubious ways to eke out a living. The resultant weakening of social, religious and traditional control of the family and the community further enhances the erosion of social values.

Political motives also sometimes compel some countries to divert a constant flow of drugs into the enemy territory. Being used as a transit country for supplying drugs to the West, India continues to face the consequences of drug seepage in the country. The accumulation of all these factors have given rise to increased abuse of illegal drugs. In fact, a close association has been found to exist between drug trafficking and criminal activities.

**Effects of taking drugs**

Drug abuse is primarily a psycho-social problem with medical connotations linked to it. Since it affects the individual's physical and mental health, it also affects the family and the community of which the drug user is an integral part.

The individual's behaviour within the family and the community comes under a cloud primarily when he/she is under the influence of drugs. Drug dependence usually make one think of the drug throughout the day, with a hankering to get the drug by any means, consume it, satisfy the craving and, thereby, avoid the dire discomfort which follows if the drug is not available. This cycle keeps on repeating a number of times each day until some measures are taken to get out of it.

Such intensive involvement with drug abuse renders one unfit to think about others - be it he himself, members of the family or the community. In turn, it tends to strain his relations with others. His thinking being confined to drugs alone also adversely affects his capacity to work effectively, think logically and sensibly.

Quite often, drug abuse leads to neglect of one's physical health. So often, money and other resources are squandered to procure the drug. Paucity of money may also force one to take to drug trafficking or petty crimes such as stealing, pickpocketing, small thefts, etc. In a chronic state, the individual may lose his ability to use his mental faculties and may even develop psychiatric problems in some cases.
Need for an inter-disciplinary approach

As regards the complexity of the problem of drug dependence, a multi-dimensional approach needs to be followed. The addict needs to be motivated for treatment; the toxins in his body must be drained out; he is to be prepared to abstain from drugs and his mental faculties need to be built up and strengthened. Ultimately, he is to be helped to get back to the mainstream of life - a productive and constructive life, free from drugs, and socially accepted.

The problem of drug abuse primarily based on psycho-social contours need to be tackled with same perspective. The medical approach alone does not suffice. Ideally the approach comprising of services providing rehabilitation cover: such as identification, motivation, assessment, detoxification, follow-up, rehabilitation and after care and prevention and educative activities in an integrated manner be evolved. Provision of such services calls for team of experts from various disciplines to join together to plan out the course of action in each case. The team should draw experts from medical, paramedical, psychology, social work and media disciplines.

Steps in treatment of addiction

Addiction is not only a psycho-socio-medical problem but it can also be treated as a legal problem vis-a-vis the existence of Narcotic Drugs and Psychotropic Substances Act. The addicts consuming drugs for the second time is liable to punishment under this Act. The fear of law and a social stigma attached to the problem inhibit addicts to approach the treatment units for therapy. Concerted efforts to motivate addicts for treatment, therefore, be deployed including education, awareness building, counselling, community participation, etc..

Generally, as soon as the addicts approach the treatment units in India, the counselling centres, an assessment is made mainly through history taking, covering aspects such as personal history, family history, drug history and other related aspects. A total abstinence is recommended from the very first day. Detoxification is done either through indoor stay of mostly 10-15 days at detoxification centres, hospitals, or clinics or through out-patient facilities at the counselling centres or at detoxification centres.

Counselling by counsellors or social workers is the foundation for activities at all stages of treatment. It involves individual, group and family counselling. The addicts are counselled prior to the detoxification and later during detoxification and follow-up phases. The counselling centres mostly follow-up the cases when they get back to them after detoxification.
Strengths and weaknesses or positive and negative aspects of the addict's personality are assessed during the treatment process, treatment plans are worked out and long term and short term goals are set with the clients. Addicts are helped to achieve these goals one by one. They are helped in shedding off their feelings of hopelessness, worthlessness, stigma and in normalising the strained interpersonal relationships developed during the course of disease. Addicts' families are contacted and involved in the treatment process. Home visits are paid with a purpose to assess the problem and to establish family contacts.

The addicts are also helped in developing vocational skills, taking up a gainful employment, etc. The day care services are also extended mainly to provide alternates to drug abuse, keeping addicts away from the drug prone environment and to inculcate certain gainful skills in them.

**Prevention as most cost-effective strategy**

Provision of treatment through counselling, de-addiction, rehabilitation and aftercare centres is not the complete answer to tackle the problem. In view of multiplicity and complexity of problem requiring long term treatment and characterised by frequent relapses, preventive measures could be considered as prim and the most cost effective strategies. Though the prevention strategies are relevant to both the developed and the developing world but these are more imperative for the latter one as these countries are struggling hard to meet basic priority needs and likely to face constraints in extending services for treatment. The developing world, therefore, have to rely heavily on preventive measures.

The approaches to prevention are three fold: first, legal controls restricting the availability of drugs; secondly, educational measures providing information about drugs and influencing attitudes to drug use; thirdly, positive social measures providing alternatives of drug use for group particularly "at risk" and follow up of those who are no longer taking drugs.

The prevention programmes should take recourse of strategies of information, education, alternatives and intervention. More emphasis be laid on information and educational aspects not only towards target groups but also collateral groups like family, community and social institutions.

The programmes of information should be realistic, adequate and factual. Different modes have to be used to achieve wider coverage. Print materials, seminars and talks, and mass media campaign through T.V., films, radio, exhibitions, etc. should be encouraged. The efforts should be persuasive in nature, rather than compulsive and threatening. Pretesting of messages and assessment of their impact is essential to have desired impact and to avoid counter productivity.
Need for specially trained manpower

A cadre of manpower must be developed as the problem of addiction differs from other medical and social problems in its nature, effect, and treatment modalities, therefore, requires a team with specialized training in the field. Training through short-term and long-term courses is imperative to the programme.

Eulogizing a community based approach

Community based approach that is being tried by India and other countries is of late realized to be an answer to this widely spread psycho-socio-medical problem. Non-governmental organizations can shoulder the burden with governmental support. Agencies working at the community level engaged in welfare and related activities need be involved to contribute to the problem solving. Community leaders, influential people, youth clubs, mahila mandals, community based volunteers can also add support to the programme implementation.

Government strategy for prevention and control of drug abuse

Concerted efforts are under way both for supply reduction and demand reduction since 1980. A comprehensive law had been passed for supply control by repealing all the legislations existed on the subject. The present law is named as "Narcotics Drugs and Psychotropic Substances Act, 1985". The Act provides for an enforcement machinery. It also propagates for provision of treatment facilities to addicts.

Three pronged strategy had been adopted for demand reduction. It included awareness building and prevention education, provision of treatment facilities and training of the personnel. The Government through the Ministry of Welfare had set up 145 counselling centres, 84 deaddiction centres and 14 after care centres by March 1993. These centres were initiated in 1986. The coordinated efforts of various Ministries/Departments were channelised to undertake activities in the field of drug abuse. These involved Ministries of Welfare (nodal for demand reduction), Health and Family Welfare, Home Affairs, Finance, Information and Broadcasting and Departments of Education and Youth Affairs.

International efforts

India, being signatory to all UN Treaties and Declarations on the subject of drug abuse, is committed to these. International cooperation in India is available since the last five years through a UN body in the country naming United Nations Drug Control Programme. The assistance was extended for training of personnel; strengthening of treatment units; assistance in undertaking extensive awareness building and educative programmes; provision of guidance, advice and preparation of National Masterplan on Drug Abuse Control; etc.
Value of research, evaluation and monitoring

Research, monitoring and evaluation has to be in-built into the programme and to be considered as essential components for the programme. The extent of problem needs to be assessed. Impact of the programme to be evaluated from time to time, researches to know the dimensions, trends, nature, and other epidemiological features of the problem are required and periodic monitoring to be a part of the programme.

HISTORICAL BACKGROUND

Drug use has been universal not only in India but elsewhere in the world. More often than not, it has religious and social approval. The use of alcohol (somras) has been mentioned in the vedic literature (2000 B.C.) of the Hindus. Even in Charka's treatise on Ayurveda the harmful effects of excessive drinking have been described. India has a long tradition of consuming opium, bhang, charas, ganja especially during social functions and religious festivals.

Areca nut and betel leaves have been used as mild dependence producing stimulants in South East Asia and other part of the Oceania for centuries. Certain North American Indian group used hallucinogens to commune with spirit world. Wine was often served in the Middle East as an integral part of ritual meals.

Primitive people used drugs to induce states of intoxication during religious rites or in the case of hashish, to prepare warriors for battle. As far back as 2700 B.C., Marijuana was known to the Chinese Emperor and recommended for medical uses among other uses.

Use of opium and its derivatives

Opium was known to the Egyptians by 1500 B.C. This was the most important drug having medicinal value. During the Greco-Roman period, this drug was used for its sleep-inducing and pain relieving (analgesic) properties. During Christian era opium's use got spread as medicament to other parts of Europe. Besides, medicinal value, opium was also used as an agent of indulgence. This drug has a power to allay anxiety, gloom and despair, as well as to provide escape from boredom and loneliness.

The reference of opium is given in Homer's Odyssey, written in the 9th century B.C. Both as a medicine and a drug of indulgence, opium use spread throughout the world. In American communities during 18th century, doctors started prescribing this drug for various ailments. By then opium's addictive properties were not known to the medical profession. This fact is demonstrated in M.D. theses of two medical doctors of the 1790's i.e. Hast Handy and Balentine Seaman.
With the invention of opium alkaloids and also hypodermic needle the use of morphine through needle during Civil War was reported during 1856. Soldiers returned with addiction to morphine and such an addiction was termed as a "Soldier's Illness".

The spread of needle use for injecting morphine became popular even amongst general public. In Post-Civil War era several forms of opium derivatives and varied routes of administration were noticed. Opium because of its medical properties could be obtained legally. It was inexpensive and found virtually everywhere. In 1898 morphine derivative, heroin was synthesised and was used to combat morphine addiction. This drug too was later abused through hypodermic needle.

Consumption of tobacco

Tobacco was discovered by Columbus. It grew as wild herb in Cuba, Mexico and South America. It was sniffed initially in France, Spanish used it in a form of cigar, English men through pipes, red Indians smoked, sniffed as well chewed it, Americans mostly chewed tobacco. Cigarettes were introduced in the Mid-eighteenth century in Brazil and then in Spain. Russians, French and Englishmen started using it. In India tobacco was introduced in the reign of Akbar. Cigarettes took its place in later half of the nineteenth century.

In spite of forbidding of tobacco use in Muslim and Sikh religious sects, its abuse did prevail in these communities. As in Turkey the smoking of tobacco became a fashion and harsh punishment was provided to the smokers.

Emergence of new drugs and their geographical spread

Over the last century and a half new psycho-active compounds have emerged. A profusion of sedatives, synthetic opiates, stimulants and hallucinogens have been developed. Knowledge of sophisticated chemical methods of synthesis and easy access to chemicals have added to new generation of drugs. Increased international communication has facilitated the world-wide spread of these potent drugs.

Added to availability of these chemical drugs, indiscriminate and increased medical prescription and sociological factors that arise due to transition in developing countries contributed to emergence of drug abuse not only in India but abroad too. The abuse of drugs had multiplied with availability of newer drugs like LSD and Emersin during the 19th century.
WHO Expert Committee on Addiction Producing Drugs gave estimates of prevalence of drug abuse for the year, 1953, in some selected western countries, as mentioned below:

<table>
<thead>
<tr>
<th>Country</th>
<th>Prevalence per 1,00,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>4390</td>
</tr>
<tr>
<td>Canada</td>
<td>1630</td>
</tr>
<tr>
<td>England</td>
<td>1100</td>
</tr>
<tr>
<td>Italy</td>
<td>500</td>
</tr>
</tbody>
</table>

These statistics provide a clue to the enormity of the problem in those societies. The figures given by UN study in 1987 revealed that in the world 17.6 lakh people were opium addicts, 7.5 lakh people took heroin, 16 lakh on cocaine, 23 lakh addicted to amphetamines, 38 lakhs to barbiturates, sedatives and tranquillisers. These, however, were reported to be under-estimates as study only included the registered addicts.

Sometimes, it is described as 'epidemic of drug abuse'. The newly emerging drugs, crack and designer drugs all the more pose a challenge. The designer drugs is a class of highly potent synthetic substances which mimic some of the properties of known drugs but which may also display new and very dangerous side effects. Their clandestine manufacture is easily accomplished and likely to pose difficult problems of control. These drugs are prevalently abused in North America and other parts of the world are likely to face a threat of its spread.

Influence of drugs on youth

Late 50's and early 60's gave emergence to 'Beat' Generation and Flower Children in America, 'Teddy Boys" in England and 'Sun Toribers' in Japan. These were the youngsters influenced by drugs. Similarly, affluent sections of Indian youth got influenced and took to drugs during 70's because of familial, social reasons or Westren influence as well availability of drugs.

Drug abuse in Britain

As in other societies, abuse of drugs in United Kingdom is an old phenomenon. The legal drugs, such as, alcohol and tobacco are being extensively abused but enjoy social sanctions. These drugs too pose a problem so far addiction is concerned. Statistics reveal that about 1,00,000 people were convicted each year in the United Kingdom for public drunkeness and around 15,000 patients were admitted each year to Psychiatric hospitals in Britain for alcohol dependence and psychosis. Alcohol abuse also lead to deaths mainly due to liver diseases and cirrhosis of liver. Data also revealed that every year at least 1,00,000 people died prematurely in U.K. due to the effects of smoking. Cigarette smoking was a prime cause for respiratory problems.
Abuse of illegal drugs including cannabis, heroin, cocaine, amphetamines, LSD, solvents had been noticed to varied intensity from time to time and had become a matter of concern. The abuse of these drugs had increased over the years both among males and females. The number of narcotic addicts notified to Home Office(U.K.) rose substantially from 3605 (1977) to 19,179 (1988).

Strikingly, more females and adolescents started abuse of the drugs. The females constituted 28.57 per cent as per 1988 Home Office index. Home Office index also reflected that since 1983 nearly 50 per cent of newly reported addicts were below 25 years of age and same pattern continued even in 1988. Abuse of drugs like methadon, cocaine had also shown an increase over 1977 figures in 1988. Abuse of solvents was also on an increase amongst youngsters. Crack and designer drugs too posed a problem. The researchers assessed the problem to be a five fold than the Home Office index which was considered to be an underestimate.

Looking back to the historical prespective in U.K., it is conceived that until 1912 opium and cocaine were freely available but thereafter controls were imposed. In 1920 and 1923 "Dangerous Drugs Act" was passed which necessitated the doctor's prescription for obtaining opium, its derivatives and cocaine. Later, Rolleston Committee brought out its report in 1926. It perceived addicts as patients and recommended even for the prescription of heroin to those addicts who did not benefit from the treatment.

In spite of all these efforts, the problem of addiction continued to increase may be due to indiscriminate prescription by some of the medical professionals. Brain Committee was then constituted and met twice in 1958-59 and 1964. Based on the recommendations of this Committee the "Dangerous Drugs Act" of 1967 was passed. The Act included aspects such as: (i) Compulsory notification of addicts to Home Office. (ii) Right to prescription of heroin was limited to the doctors holding special license from the Home Office and (iii) Setting up of special clinics to treat the addicts.

With the enactment of the law a large number of addicts pored into the newly set up clinics due to non-availability of drug in the market. In addition to heroin addiction the abuse of poly drugs was also noticed to prevalent increase in varied combinations in order to hasten the effect of the drug. Even the injection of barbiturate in combination to opium all the more complicated the situation. Influx of variety of complications related to drug problem was also noticed. AIDS is one of the fatal complications to which addicts, who inject drugs in an unsafe manner, were more vulnerable.
To cope up the existing problem a complete and comprehensive legislation entitled "Misuse of Drugs Act" 1971 was passed which replaced the existed legislations. The Act dealt with almost all drugs with abuse and/or dependence liability and laid down specific requirements for their prescription, safe custody, etc. The regulations made under the Act, inter alia, covered aspects pertaining to doctors, like obligation to notify, prescription of controlled drugs to addicts, prescription of heroin, cocaine and dipipanone to addicts.

Advisory Council on Misuse of Drugs (ACMD) set-up under the Act, representing various disciplines was responsible for reviewing the situation in regard to misuse of drugs and advised Government about appropriate measures to educate public about dangers of drug abuse, best way of treating and rehabilitating the drug abusers and about promoting research into drug abuse. Various reports it had brought out, of which latest in two volumes were "Drug Misuse & AIDS".

Since 1980 the problem of addiction had further increased in UK. Multi-dimensional measures are underway to deal with the various aspects of the problem including prevention, treatment, rehabilitation/after care, research and training.

**Historical perspective of drug abuse in India**

In India a long tradition has existed of consuming opium, bhang, charas, ganja etc. These drugs were mostly consumed during social functions and religious festivals. The reference to cannabis appears in "Artharva Veda" a religious text dating 2000-1400 B.C. Hindu saints took cannabis for better concentration during meditation. The use of opium was probably introduced in India by muslim traders during the 9th century. Habitual use of opium appeared in Moghul period i.e Sixteen Century.

In India scenario from the western world is different. It was only during 1930's that the number of opium eaters started increasing even since the British started commercial farming of opium to solve their balance of payment problem with China which arose due to large scale import in Chinese tea into England. Consumption of opium and cannabis, hitherto, increased and became socialised in places with extreme weather conditions such as the hot zones including Rajasthan desert and also in Himalayan Hill areas.

The drugs were used to socialise and also for its medical properties, etc. In some parts of the country the elder offered liquor and ganja to honoured guests. The agricultural labourers and other in hard manual occupation in some places used ganja, charas, opium as self medication sedatives or were introduced to these drugs by their employer. These workers, many of them, later lost the productivity as well developed psychosis and presented in a society as withdrawn people. The society neither considered such addicts as sick people nor criminals. In some parts the infants were given even opium to put them to sleep.
Legislation in India regarding opium and users of opium

Opium as a drug has been Central Government monopoly since 1857. Historically, the statutory control over opium and other narcotic drugs (except cannabis) was exercised through three Central enactments, i.e. the Opium Act, 1857, the Opium Act, 1878 and the Dangerous Drugs Act, 1930. The main purpose of opium control legislation were two fold: (i) to centralise cultivation and (ii) to increase revenue from its export as well its sale for domestic consumption.

In the post independence period total prohibition on open sale of opium was imposed. The quantity of excise opium issued for consumption to officially registered users was reduced to nearly one-nineteenth, in 1960-61, of the amount issued in 1947-48. The total number of registered addicts in 1975 was 80809. Opium dens now have practically vanished due to police and excise action. The controls on opium cultivation have been fairly successful may be because of its long history of consumption/cultivation and gradual imposition of these controls.

As per the records of State Excise Department in Delhi there were 125 registered opium addicts in 1989. These addicts were left out of 300 initially enrolled. These addicts purchased between 6 gms. and 50 gms. opium every month divided into weekly quota. The number of such registered addicts was 27,000 in West Bengal of these 7000 were women addicts and 15,000 in Orissa state.

History of alcohol and advent of its abuse in India

Though there is mention of 'Somras' historically(2000 B.C.) but the society at large disapproved the consumption of alcohol during various periods and through religions such as in Buddhist era, Moghul period, etc. Alcoholic drinks are prohibited among Muslims, certain caste Hindus and Jains.

Alcohol use existed before the Britishers came to India but their entry led to adopting their way of life, style and norms especially by the armed forces personnel who were in close contact with them.

Alcohol production and revenue generated from it

The alcohol consumption further increased by the substitution, for revenue purposes, of pot- still distillation by regular commercial production. Production of alcohol had increased from 260 million litres in 1971-72 to 796 million litres in 1987-88 indicates the excessive consumption of alcohol in the country. More liquor shops had been opened over the years. In addition, there is illicit production of liquor too. It was estimated that there were more than 10 crore liquor consumers Rs. 12,000 crores annually on liquor of which Rs. 3000 crores were collected by State Governments as excise duty and rest had gone as profit into the hands of traders. The excise duty of States rose from Rs. 50 crores to Rs. 3000 crores since independence.
Cocaine abuse: history and present status in India

Problem of cocaine abuse practically disappeared now. But historically, it was estimated that there were half a million cocaine eaters in India during the period between the World Wars. No cultivation was done in India, and the drug was smuggled into the country usually from East Asian Countries. It was mostly used by the poorer classes along with betel leaves. After 1960's cocaine abuse was not existed as a problem and now there seems to be no illicit trafficking of the drug in the country. The reason for such a change could only be guessed to be diversion of illicit traffic away from India towards more profitable markets and may be a result of controls imposed.

Causes of influx of new drugs in India

During 1960's the scenario started changing radically with the influx of tourist hippies and major political turmoils. A rush of hippie tourist in Goa brought with them LSD, cocaine and such synthetic derivatives. It was not readily available, therefore, only some of the affluent youth took to abuse of these drugs. From the year 1979 the addiction scenario changed dramatically because of significant political turmoils such as (i) in 1978 Russia took over Afghanistan and occurrence of Iran-Iraq war; (ii) blockade of drug trafficking from Thailand because of strengthening of enforcement machinery in the country; (iii) rise in Tamil Militancy in Sri Lanka; (iv) deterioration of the political/economic condition and revival of insurgency in the North Eastern border areas in India. These resulted in induction of cocaine and LSD into the country.

The golden crescent (Pakistan, Afghanistan and Iran) began to operate vigorously and the golden triangle (Burma, Thailand and Laos) got extended into the North-East of India. Sections of militants of Srilankan Tamils, Punjab and North Eastern region took to drug trade to finance their activities. The traders net work dealing in charas, ganja supply has shifted to new drug trade of crude heroin. Crude form of heroin (brown sugar) was made available at cheap rates. It is from 1979 drug addiction had started escalating in India, covering the middle and lower middle class in its fold. A conservative estimate could place the figure of drug addiction at 2.5 million.

India a transit country for drug trafficking

The geographical location of India between the two chief sources of opiates in the world - the Golden Crescent and Golden Triangle has made it a transit country for supply of drugs to western world. This transit state emerged because of conditions in regard to smuggling of silver, gold and other contraband goods prevailed in the world market. The bunker Hunt brothers of the United States engaged in International business in silver collapsed financially, therefore, there was a crash in price of silver in the international markets and out-smuggling of silver stopped, and one main source of inward smuggling of gold and other contraband goods was no longer available.
Around 1980, the laws in India were antiquated. Opium Act of 1878 (amended by Opium Act of 1957) and the Dangerous Drugs Act of 1930 were applicable. Under these acts no stringent punishment was available. It ranged from six months to three years and the offences were bailable. At the same time, in Pakistan in spite of ban on the illicit cultivation of opium the illegal cultivation in certain areas of the North-West Frontier Province, particularly areas contiguous to Afghanistan continued. In all Golden Crescent produced approximately a 1000 metric tonnes of opium (200 metric tonnes in Pakistan, and 400 metric tonnes each in Afghanistan and Iran) and bulk of it was converted into heroin in refineries situated in the region. In Afghanistan alone, opium poppy was illegally cultivated in 27, provinces.

Earlier with legal cultivation of opium in Pakistan the addiction was not a problem and at that time drug used to be smuggled to Sicily and France, for conversion into heroin to cater to the needs of illicit market in the western world. The ban imposed on opium cultivation led to increased illegal activities, number of refineries started in Chagai regions of Bluchistan, Peshawar and Krachi leading to increased production of heroin and problem of addiction in Pakistan. At the same time developments in the world had further added to India becoming transit country. The price of 1 kg. of heroin was as low as Rs.10000/- in Pakistan in comparison to Delhi and Bombay (Rs.1 lakh to Rs. 2 lakh) and us $ 1,00,000 in procurers market of us $1,000,000 in streets of New York. Because of enourmous profit in the western world the heroin was smuggled from Pakistan to these countries. However, the law enforcement agencies kept strict vigil on the passengers, baggages and cargo originating from Pakistan which led to a shift from direct smuggling by the organised drug trafficking syndicates to westen world through India as a transit country.

As mentioned earlier, the laws in India were not stringent and were bailable. Therefore India emerged as a major transit country. The baggages originated from Pakistan were checked thoroughly but there was no suspician in the baggages cargo originated from India. Many smugglers, who were engaged in smuggling of gold, contraband goods and silver earlier, took to drug smuggling. Gold which is smuggled from Dubai to India, was also being smuggled to Kranchi, from where it would move to Lahore, and then to Amritsar. At Lahore, drugs, particularly heroin, would also be picked up and smuggled into India along with the gold, through the Punjab sector. While the gold remained in India most of the drugs got smuggled out of the country.

In addition to Punjab, Rajasthan and Gujarat also became vulnerable. While drugs smuggled through Punjab sector, and through Sriganga Nagar and Bikaner sectors of Rajasthan, would move to Delhi, drugs smuggled through Jaisalmer and Barmer sectors of Rajasthan and Gujarat moved to Bombay. Thereby Delhi and Bombay emerged as major exit points. The transit traffic has resulted into a spill over problem causing drug addiction in a country and particularly in Bombay and Delhi it took roots.
Nepal as a source for cannabis

Nepal situated at Northern border of the country, is a major source of cannabis herbal and to some extent cannabis resin in the country. The Indo-Nepal border which is 1,568 kilometers long, has been an area for smuggling and trafficking since long. It has wild growths of cannabis on the foot-hills close to border. It is also cultivated in the Terrai region of Nepal. Major trafficking of Ganja from Nepal to India is carried through the four centres viz. Siktal, Raxaul, Jainagar and Bhimnagar in the state of Bihar. In 1984, HMG of Nepal took drastic action against the drug traffickers and their abettors. It resulted in marginal reduction in the flow of cannabis.

Drug cultivation in golden triangle and routes to India

Golden triangle is a major source to the increased heroin addiction in the country. It makes North-Eastern states of Arunachal Pradesh, Nagaland, Manipur and Mizoram vulnerable through which the long Indo-Burma border (1000 kms. long) runs. Reports indicate that atleast 80,000 to 1 lakh hectares of land in Burma is under illicit cultivation which is in control of a Burmese communist party and has potential to produce 1000 to 2000 metric tonnes of opium. Out of the 22 refineries operating in the Golden triangle the major portion (17) operates in Burma. Five refineries operate in Laos near Thai border and some in Thailand itself. In addition 60 mobile laboratories operates in Burma and these are under the control of Shaw United Army. The heroin from Myanmar is smuggled into India, especially from routes Tamu-Moreh-Imphal; Mandalay-Tiddim-Singhat-Churachandpur-Imphal; and Mandalay-Tiddim-Champai-Aizawal.

Cultivation and production of drugs in India

It is not only that India is threatened due to influx of drugs from other countries, the illicit cultivation of poppy in India too creates a problem. It is cultivated in a small pocket in Chakarata hills of Dehra Dun District, and large scale illicit cultivation of cannabis in the Idukki district of Kerala, ganja cultivation had been noticed in J. & K., in Ukhral district of Manipur State. The minor cases of attempts to convert opium into morphine base have also been noticed. Mathaqualone is a sedative-hypnotic drug and its manufacture was banned in January 1984 but illicit manufacture does persist through factories.

Emergence of Service Facilities

The developing countries were of the opinion till 1970 that drug addiction was problem of the western world and their populations were safe. This view could not be held for a long. However, in 1975 itself realisation came that the developing countries would not be escaped from the drug menace. In view of this realisation even in India efforts to know the extent of the problem started by the Government of India. It sponsored multicentred research studies on school and college students as they were thought to be the most vulnerable to the problem of drug abuse. The individual researchers also conducted studies.
Hospital records of the Psychiatry Departments too reported cases of addiction of smack after 1980. These were the indications of induction of drug abuse problem in the country that required a vigil and concerted efforts.

A trend in drug abuse noticed a change by more youngsters at early age taking to drug abuse. Since India served as a transit country for trafficking of drugs, the seepage of drugs resulted into more people taking to drug addiction in the country. This changed scenario had led the Government to undertake measures for prevention and control of drug abuse.

To begin with, the Government of India in Ministry of Welfare in 1986 set up seven counselling centres in Delhi on an experimental basis in order to provide a rehabilitation cover to the addicts. These centres provided services of identification, referral for detoxification, follow-up and rehabilitation. Beside these, the centres were also entrusted with the responsibility of awareness building and preventive education, documentation and coordination. The centres were managed by professionals mainly in social work and Psychology. The medical profession contributed through part time services. A number of such centres were replicated through out the country without any evaluation.

REFERENCES

2. Ibid.

10. Ibid.


14. Ibid.

