CHAPTER II

REVIEW OF LITERATURE

DRUG ABUSE SITUATION IN DIFFERENT COUNTRIES: A MACRO VIEW

A review of situation of drug problem world-wide reveals that the problem has increased over the years. The hard drugs have taken over the indigenous drugs. Drug is fast becoming the "Super State" in most Latin American countries, with Colombia as their flagship. The Pakistan is following its foot steps and may become the Colombia of Asia.1

These drugs are available through illegal cultivation within the country or come from neighbouring countries or both. Each one of the countries has introduced legislative measures to control the drug problem. Measures in the sphere of demand control have also been initiated. As reported by the International Narcotics Control Board during 1988, in the East and South-East Asia the production of opium and size of the heroin abuser population remained high. Large quantities of opiates continued to be smuggled out of Myanmar and cultivation of poppy continued. Abuse of heroin persisted and psychotropic substances were equally available.2

It was reported from the Laos People's Democratic Republic that opium and cannabis were smuggled out. In Thailand too opium was cultivated and heroin was produced and smuggled out of the country. Even cannabis cultivation had spread from north-east to other provinces and across the border in other countries. The number of heroin abusers were estimated between 2 - 3 lakhs mostly concentrating in Bangkok. Even the Amphetamine laboratories had been detected. In Hong Kong heroin remained the primary drug of abuse. The drug is being received through South-East Asia region and part of it was onwardly transmitted to Australia, Europe and North America. Cannabis came from Phillipines, Thailand and Nepal. The abuse of Cannabis and psychotropic substances specially methaqualone had increased.

Malaysia too faced a problem of opium and heroin abuse which appeared to be stabilised over the years. The drug was trafficked across the northern border and coastline of Malaysia. According to Ahmed Adnan Mohammad, Director, Field Services Treatment and Rehabilitation Division, Ministry of Home Affairs, Malaysia, the more alarming thing to be noticed was growth of drug addiction at school level as about 0.6% of drug addicts were school children. All the forbidden drugs were mostly used such as heroin, hasish and morphine.
In the South Asia region, India enacted a comprehensive legislation in 1985 (61 of 1985). The act is named as "Narcotic Drugs and Psychotropic Substances Act". This Act is a consolidation of the existing laws and provision has been made therein for control, regulation of operations relating to narcotic drugs and psychotropic substances. The Act was amended in 1988 to make it more stringent. Keeping in view the serious threat of drug abuse to health and welfare of the community and the dangers involved to the national economy, the Government of India enacted new legislation entitled "The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988 (46 of 1988). The Act provides for detention in certain cases for the purpose of illicit traffic in narcotic drugs and psychotropic substances and for matters connected therewith.

In India, large amounts of heroin and cannabis resin entered from the Near and Middle East, in addition to cannabis from Nepal. Opium had been illegally produced leading to production of domestic heroin. Methaqualone manufacture and trafficking had also been noticed. Heroin passed to the countries such as Eastern and Western Europe, Eastern part of the Arabian peninsula and Africa through India. In Bangladesh drug abuse had increased probably because of its increased vulnerability due to transit trafficking from two major illicit opium producing regions surrounding it. There had been a serious drug problem in Nepal, the number of abusers was estimated to be 20,000 and that too were mostly under 30 years of age. There was illegal cultivation of cannabis within the country.

In the Near and Middle-East region huge quantities of opium, heroin and cannabis resin were produced in the countries as gathered from the large seizures made. Heroin was increasingly trafficked to Europe. From Europe large amounts of psychotropic substances, in particular fenetylline were trafficked to the countries in this region. The heroin was easily available with a increasing demand throughout the region. Large scale production of opium and cannabis resin had been reported in Afghanistan for the last many years. The trafficking of opium and heroin to Islamic Republic of Iran from east had been reported. In Iran abuse of heroin had worsened and limited abuse of psychotropic substances continues. In Lebanon because of security problem illicit cultivation of opium and cannabis was widely spread, heroin is manufactured, heroin and cannabis resin were trafficked to Europe and North America. There were 10,000 heroin and other drug abusers in the country indicating an increase in the problem of drug abuse.

Multiple measures towards demand reduction had been undertaken in these countries. Emphasis was placed on the training of law and drug enforcement officials in the ASEAN region.
Measures to treat and rehabilitate addicts had been introduced in Thailand. A Centre for Psychotropic Substances had been established to provide specialised information and referral services in Hong Kong. Programme to increase public awareness of the dangers of drug abuse and to treat drug abusers had been expanded. The Malaysian Government had planned an integrated approach through government agencies and community to implement intensive programmes of law enforcement, education, treatment and rehabilitation in the areas known to be affected by drug abuse and trafficking.

India had established a network of drug treatment centres throughout the country. Preventive educative measures through non-government agencies were in operation in a big way. Efforts to assess the problem were also being undertaken. In the Near and Middle East region the treatment and rehabilitation centres had been established.

As regards Russia the Report published in 1987 quoted Lt. General Vyacheslaw Pankin, Chief of the Main Directorate of Criminal Investigation Department in the USSR Ministry of Interior. The report mentioned that 15000 drug addicts were rehabilitated under the drug addiction programme of which 77% had volunteered themselves. It also mentioned that in Russia 80,000 people had been charged with drug related crimes during the past two years (report 1987). It added, the number of minors against whom criminal proceedings had been instituted had increased to 26%. The authorities expressed a fear of soldiers fighting this menace at the border some of them might have taken to addiction. The report also expressed the accepted fact that the addiction and the drug related crimes were on the increase.

In the United States of America the drug addiction was widespread. The Government had made a drug test as mandatory for the workers seeking jobs. Workers at work places found positive to drug test were immediately given options of either retiring gracefully or suffer positive eviction from service. Even the US armed forces had also made it mandatory for its servicemen to undergo drug test. There was no American workplace or campus free of drugs. The estimates showed: the United States, the world's biggest drug consuming market was spending on an average 8000 crores a year.

INTERNATIONAL TREATISE, CONVENTIONS, STRATEGIES AND APPROACHES

International cooperation in the field of drug abuse began in the beginning of the twentieth century with first attempt made in 1909 to limit the shipping of narcotic drugs. International treaties concluded between 1912 and 1972 provide the legal basis for the present drug control system. Each state party to a particular treaty is bound to adopt appropriate legislation, introduce necessary administrative and enforcement measures and cooperate not only with other countries but also with the established drug control organs.
Various international treatise, conventions and approaches are enumerated below:

1. International Opium Convention or Hague Convention, 1912.

   This was the first binding instrument of international law governing the shipment of narcotic drugs, aimed at controlling the transport of narcotic drugs deemed necessary for medical use.

2. Advisory Committee on Traffic in Opium and other Dangerous Drugs, 1920

3. Convention of 1925:

   The convention designated a Permanent Central Board. This was subsequently named as Permanent Central Narcotics Board.

4. Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, 1931.


   This called for severe punishment for illicit drug traffickers.

6. The 1946 Protocol:

   It transferred the role to United Nations that were formerly carried out by the League of Nations.

6. The 1948 Protocol:

   The Protocol brought under international control drugs outside the scope of the 1931 convention which did not include synthesised compounds with dependence producing effects.

7. The 1953 Opium Protocol: Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of International and Wholesale Trade in and use of opium.

8. The 1961 Single Convention on Narcotic Drugs:

   The Convention was adopted to consolidate the earlier international instruments.

9. The 1972 Protocol:

   This Protocol was an amendment to 1961 Convention. This was a major achievement for the control of narcotics. International Narcotics Control Board (INCB) established by reformulating the permanent and supervisory bodies.

   The new obligations dealing with the medical treatment and rehabilitation of addicts formed a part of some of provisions of the convention and they were further stressed in the Protocol.

With the adoption of this Convention the Psychotropic Substances fell under International Control. The drugs for control were mentioned under four different schedules.


The international body noticed an increase in the problem of drug abuse in late 1970s and felt a need to adopt a strategy. The strategy called for international cooperation to combat drug abuse and trafficking with the following objectives: (1) improvement of drug control systems; (2) maintenance of a balance between legitimate drug supply and demand; (3) eradication of illicit drug supply; (4) reduction of illicit traffic; (5) reduction of illicit demand and prevention of inappropriate use of licit drugs and (6) treatment, rehabilitation and social-reintegration of drug abusers.

The action plan adopted spelt out control and demand measures. It emphasis on preparation of Masterplan by each organ of UN and for setting up the Task Force.

12. Declaration on the Control of Drug Trafficking and Drug Abuse, 1984:

It was adopted in view of a realisation came in that drug trafficking and abuse as an international criminal activity demanding urgent attention and maximum priority.


The Comprehensive Multidisciplinary Outline (CMO) in four parts covers aspects on prevention and reduction of illicit demand, advocates the reinforcement and extention of measures for control of supply of drugs instituted by the international drug control treatise, deals with suppression of illicit traffic and finally urges for efforts to treat and rehabilitate drug addicts.


The convention in addition to providing for the criminalisation of the drug trafficking offenses bars all havens to drug traffickers.
In India, drug abuse has acquired the status of a social problem to be reckoned with, more in urban areas than in the rural areas. This problem is complex and has to be studied appropriately with an epidemiological approach. Three factors are involved: Agent (Drug abused), Host (Person affected) and Environment (Society/culture). Interactions between these factors have to be probed into to evolve realistic plans for coping with the problem. Such studies are relatively of recent origin even in Western countries. In India they are rare. However, the studies sponsored relate mainly to prevalence.

These studies constitute the base for the following review.

In 1972 a study on drug abuse was conducted by Dube among the adult population of Agra region (16,725 individuals). The prevalence was estimated at 2.27%, using mostly alcohol followed by bhang, ganja, opium and more than one drug.

It was more in semi-rural areas. The incidence of mental illness was significantly higher among drug users than among non-drug users.

In contrast, the Delhi University campus presented a different picture. Five per cent of the students used habit-forming drugs. Fifty per cent of the male students had drug experience at some time or the other. Besides cannabis, heroin, alcohol and LSD were reported.

El Nagar, et. al. during 1971 studied addiction to alcohol in West Bengal and found 13/1000 were addicted to alcohol and drugs. In the city of Lucknow during 1973 Thackore, et. al. reported addiction to alcohol to be 18.6/1000. In Tamil Nadu Verghese, et. al. in 1972 reported 2/1000 addicted to alcohol. Gurmeet Singh and Brij Lal during 1977 reported on the basis of study of Sangrur district of Punjab that 299.8/1000 persons above the age of 10 years had abused tobacco, alcohol, opium, cannabis, etc.

Dev and Jindal found prevalence rate for alcohol to be 741/1000 among the adult male through their study of villages in Ludhiana, Punjab. Dev in 1977 studied that amongst the general population of Punjab 54.3% of urban sample and 40.4% of rural sample have abused synthetic drugs such as LSD, etc.

In a study of the attitudes and motivation of chronic heavy users of cannabis (Mendhiratta, et. al., 1978), over two thirds of the addicts (68.33%) were found to have started drug use before they were 20 years of age. The duration of drug use in most of the cases was as high as 12 years of age (4-30 years range). Over three-fourths (76.6%) were taking twice or more every day. The study showed that, in a majority of cases (63.33%), drug use started because of the company of friends or religious groups (21.66%). Two-thirds in the group were found to continue to take drugs in group situations. While curiosity and peer influence were the main reasons to start drug use, enjoyment...
and relief from tension were the reasons for continuing drug abuse. An important finding of the study was that over three-fourth of the drug abusers (77.6%) wanted to discontinue drug use for reasons of adverse health, poverty and social stigma.

During 1977-78 another study was conducted by Verma et al. in the rural and urban areas of Union Territory of Chandigarh and two villages near Jullunder City to assess the population attitude towards alcohol use. The sample was 1031 individuals. The survey revealed that current users of alcohol constituted a sizeable 24% of population. The attitude of this group felt a few drinks once/twice a week was permissible without bad effect. Non-users (60%) had a restrictive attitudes while the current users had liberal attitudes. Most of the sample consisting of Hindus had an ambivalent attitude towards alcohol. Consequently the author concluded India consisting mostly of Hindus is vulnerable to serious alcohol related problems.

During the same year 1978, another study was conducted among students in different colleges of Bombay on drug and alcohol dependence by Muttagi from the Tata Institute of Social Sciences. This study reported that hard drugs acquired a footing among college students in Bombay. This group (19-24 years of age) were mostly drawn from affluent families with parents having moderate attitudes. Factors motivating were personal (curiosity or thirst for adventure) and peer group influence and easy availability. Abusers were favourably disposed towards the socially acceptable drugs (tobacco and alcohol).

From a similar study of drug prone areas of Bombay in 1984 by the same author, the findings revealed that mostly abused drugs were tobacco and alcohol. The normal sequence was to start with smoking to marijuana to alcohol to opium to brown sugar. The author was of the opinion that drug abuse had been on an increase, true of socially acceptable or hard drugs. LSD lost popularity.

There are number of studies related to mental illness and drug abuse. In one of the study Chopra and Smith found in 1974 that 11% of the patients admitted with psychotic symptoms were cannabis users. Sethi and Gupta (1972) studied 2000 patients. It was revealed that 1 per cent of private cases and 0.6% of hospital cases of the total sample showed drug dependence and almost all of them were dependent on alcohol. Goyal and D'Netto found that 14.4% of patients admitted to the Forward Military Psychiatric Centre in the Northern sector had ever taken cannabis and of these, only three took it frequently and three regularly.

A study (1980-84) by Jiloha and Munjal on persons attending Deaddiction Clinic in a hospital in Delhi revealed that in 1980 heroin addicts were nil as against 81% in 1984. Of this group school drop-outs were 41%. The author recommended an epidemiological study on drug use in schools and other institutions.
Adityanjee, et. al. in a survey of heroin dependence in New Delhi during 1984 showed a sudden rise of heroin dependence amongst the young educated males which was attributed to easy availability of these drugs in the recent years and the marked decrease in their cost.22

A study by Rao and others in 1978, covering hospital psychiatric patients at Madurai during 1970-74, revealed that only 1.7% of the patients at psychiatric department were drug dependent, i.e., drug addiction was not a menacing problem at that time. However, between 1970-74, the incidence of drug dependence was found to have risen from 1.1% to 2.4%.23

As per the expert report during 1982-88, 40 women addicts were treated at the deaddiction clinic of the G.B. Pant hospital of Delhi. Most of them were married and began addiction because of protest to husband's habit. Of these 10% were pathedine or fortwin addicts. The addiction developed after medical prescription to relieve pain after accident. It was also reported that 30% of these addicts were drug pushers and kept around 10 gms of heroin with them to support their addiction by selling it.24

Yet another study on prevalence of drug abuse among male students in a high school in Delhi in the English medium was conducted in 1977 by Mohan, Thomas, et al.25 The findings were revealing, 34% of the sample population were drug users, mostly using tobacco (31%), alcohol (26%) and cocaine was used by 13%, on experimental basis. Half of of this group were addicts of tobacco and 5% for opiate drugs.

In 1984 another study was conducted by Sundaram, Mohan, et. al. in Ajmer district of Rajasthan among the rural population above 15 years of age.26 Alcohol dependence was reported in 3% of the drug abusers. The abuse was mostly among married and illiterate Hindus, probably due to increasing permissiveness of the society.

There were certain other studies. Mohan reported in 1980 overall prevalence in males in three border districts of Punjab to be 33% for alcohol, 14.4% for tobacco, 0.8% for opium, painkillers and 1% cannabis.27 Sethi and Trivedi reported in 1979 in their study of eight villages of U.P. the current prevalence rate of 24% for drug use and 83% for alcohol users.28

No national survey has so far been done to assess the problem of drug abuse and alcoholism in the country. To initiate meaningful intervention programmes the Government of India in the Ministry of Welfare sponsored eleven research studies in 1975-76, mostly conducted in the University centres of Bombay, Delhi, Hyderabad, Jabalpur, Jaipur, Madras and Varanasi.29 The remaining four studies were conducted in the rural areas of Punjab, Ajmer, among industrial workers in Delhi and amongst a selected communities of Varanasi.30-33 The findings of these studies can be summarised as follows:
Drug abuse is more common among boys than among girls. 

Drugs most commonly abused were alcohol (9.15%), tobacco (15.8%) and painkillers (20.1%). 

Drug abuse was more prevalent among students with urban background, high income group families and residents of college hostels. 

Consumption of drugs like LSD, cannabis, opium, cocaine, etc. was indeed small. 

Causes for drug abuse were mainly psychological such as satisfying curiosity, relieving tension, etc. 

The repeat study done in 1985 only strengthened the findings of the earlier studies and was confined to student groups.

The earlier research studies served mainly the purpose of delineating the broad contours of the problem among the target groups. In order to have a composite picture, the Government of India in the Ministry of Welfare sponsored 23 projects in 13 selected cities/towns and border areas. An expert group appointed for the purpose gave a common research design with uniform guidelines. Information was collected from official records of police, jails, hospitals, welfare agencies. Informed persons and drug addicts were also interviewed. 

The study brought out that the prevalence of drug abuse varied in different parts of the country. Thus, in Amritsar, Indore, Bhopal and border area of Jammu, the prevalence was minimal (less than 1%). In contrast, Delhi, Srinagar, Jammu, Bombay, Cochin, Hyderabad, Madras and Trivandrum showed prevalence rates between 1-5%. Prevalence of more than 5-10% was noted in Dimapur, Ajmer, Dhanbad, Jodhpur, Kanpur, Patna, Ahmedabad, Goa, Nasik and Vishakhapatnam. The cities with a prevalence rate higher than 10% were mainly in the north-eastern region and southern region, i.e., Guwahati, Imphal, Shillong, Puri, Bhurbaneshwar, Bangalore and Manglore. 

The other salient findings of these studies are given below:

1. Drug abuse is not religion/caste specific. 
2. The worst group affected in the age of 16-35 years. 
3. Lower income groups are more susceptible. 
4. The source of supply was through peddlers operating through shopkeepers and panwalas. 
5. Drugs most commonly abused were cannabis and heroin. 
6. A large proportion of addicts was either unemployed, labourers, transport workers or students. 
7. Most of the studies reflect that on an average not less than 2% of the population is given to drug abuse. 
8. Awareness about the ill-effects of drugs existed in these cities but it still has to reach to the lower strata of the society.

Information received from the informers substantiated the findings given above. Law effectiveness had been rated as low and prevention, legal and educational activities had been emphasised as the felt need.
The Centre for Youth and Social Development, Bhubaneshwar (Orissa) conducted a case study in Bhubaneshwar and Cuttack cities in April, 88 to assess the national situation of drug abuse.\textsuperscript{36} This was mainly exploratory with the objectives of identifying drug addicts. A type of drug users and the circumstances in which they were compelled to use. The study revealed that non-student addicts (72%) out-numbered student addicts (23%). Addiction was more prevalent among literate groups (college students out-numbering the school students) rather than illiterate groups.

The Government of India in the Ministry of Welfare in 1989 commissioned study through Jamia Millia Islamia to assess the impact of media programmes on the audience.\textsuperscript{37} The study was titled as 'Projection of Drug Addiction by the Media'. It was reflected that televised programmes were most effective and best conceived in comparison to other channels of communication such as radio, news paper, magazines, etc.

The Government of India in the Ministry of Welfare in 1988 sponsored multicentric study in all four metropolitan cities and Jaipur for an objective and critical appraisal and evaluation of various aspects of administration of drug laws, including legal, administrative and procedural, and analyse the nature and extent of public participation and the role of non-governmental organisations in the field. The Delhi report in detail presented the existing structure and gave detailed recommendations inter alia achieving better coordination between various enforcement agencies, training of personel, provision of services, etc.\textsuperscript{38}

Strong relationship has been reestablished between addiction and crimes because addicts, after exhausting all the money to procure drugs shift to peddling and other street crimes. In a survey done by Delhi Police recently it was found that at least 50% of the drug addicts admitted to various deaddiction clinics had a criminal past.\textsuperscript{39} These excluded those who did not report to the police. The study reported that drug addicts did involve in chain snatching, motor vehicle thefts, car stereo thefts and petty burglaries.

A study carried out in the north east police district in Delhi in July 1988 revealed that about 82 criminal cases involving drug addicts were registered in the district between January 1 to July 25, 1988.\textsuperscript{40} Out of these 24 were that of pick-pocketing, 14 of small thefts, 3 of motor vehicle thefts etc. The study clearly established nexus between drug addiction and crime specially pick-pocketing.

The reports have led to believe that there is a link between Drug Trafficking and Terrorism and other organised criminal activities. At the 954th meeting on 13 February 1985, the Commission on Narcotic Drugs based on evidences concluded that clear links existed in many parts of the world between drug trafficking and terrorism and organised criminal activities. A study published by the Executive Intelligence Review, a private US organisation, mentioned that "where there is terrorism there is usually a drug connection. Drug peddling is the quickest way
to raise funds for gun running and other activities the study added".

In India too drug peddling has been linked with terrorism and smuggling as often reported by the press. The Government made a statement (May 1985) in Parliament that it had come across some instances in the border areas where terrorist activity and drug trafficking had some connection.

Acquired Immuno Deficiency Syndrome (AIDS) is another associated problem for drug users, who inject drugs into their veins by sharing a needle infected with AIDS virus. It is not a small proportion but 1/4 of AIDS cases carry infection through contaminated blood left in the needle, syringe or other drug related implements. Six AIDS cases were discovered in India in 1986 and thereafter the government started surveillance and took measures to prevent its occurrence.

In the North-Eastern region, especially in Manipur, where drug abuse through needles is rampant it was reported that 50% of such cases were found to be HIV positive. A survey conducted in 1988 by the Indian Medical Association, Manipur Branch had supported that intravenous drug abuse was limited to 10,000 addicts. The survey also found that 1,30,000 persons were addicted to alcohol, 13,000 to ganja, 45,000 to phensidyl (a cough syrup), 16502 to tablets such as camphose, mandrax and other mood alleviators, 600 to opium and 150 to morphine. The addicts need to be educated about this fatal disease.

In the West where AIDS had widely spread the measures such as needle-exchange programme operated through voluntary as well statutory organisations. Under this programmes needles free of cost were made available to those who injected drugs and these were to be returned after use for safer disposal. This strategy was, however, adopted to reduce the harm.

Epidemiological features

The studies made so far analysed the social setting also, along with prevalence, in which drug abuse was assessed. Mohan in 1978 reported significant correlation of drug abuse with variables like per capita income, nuclear family, parents and friends smoking and consuming alcohol. Khan in his study concluded that married were found to be more on drugs than unmarried students. Bhat reported that drug abuse was correlated with urban background, history of smoking, residing in hostels and having friendship with drug abusers. Gangrade and Gupta gave associated factors for drug use. Drug users had negative attitude towards job, low self-esteem and were anxious and unsocial by nature. Gurmeet Singh during 1979 while studying medical students found that number of social and developmental factors were closely linked to drug abuse and that one could predict the academic performance of students, their characteristic lying, cheating and sexuality by merely knowing their drug taking (alcohol drinking) status.
Ponnudurai, et. al. in their study to assess factors pertaining to alcohol and drug abuse among internees with the help of youth survey questionnaire devised by W.H.O., found that 22.67% of males indulged in alcohol abuse at least once a month. Cannabis was most commonly abused drug by 9.33% of male internees. The commonest causes for consuming these drugs were to be sociable or enjoyment, curiosity, relief from psychological stress, etc. The drugs like marijuana and amphetamines could be easily obtained and the peer pressure was the main source of introduction to drugs.

Drug use takes place by all accounts in a social setting with certain attributes of permissiveness of families with high income and high educational status. Drugs were taken due to the influence of peer groups and campus friends. Physicians also played a major role in initiation to tranquillisers and pain-killers. Common reasons for taking drugs were to relieve tension, to have pleasurable sensation, heighten sexual pleasures and to challenge social values.

Critical analysis of the studies

An overview of the studies conducted during 1972 to 1990 indicate that these were oriented towards assessment of prevalence of drug use. Notwithstanding these are limited in coverage and scope. These are too limited that they do not permit generalisation even to the level of a State, let alone the country as a whole. At best these were prevalence studies without any attempt to determine incidence. At times the sizes of the study population were too small to get at reliable estimates of prevalence.

Correlative studies are conspicuously non-existent. The phenomenon of drug abuse is complex interacting with variables psychological/sociological and enviormental. There is place for in depth studies to establish validity of the intervening variables.

The studies have measured extent of use of socially acceptable drugs like tobacco and alcohol. These are bound to be leading since there is no intervention programme for tobacco and the prohibition has been lifted because of revenue considerations. What would be desirable for future evaluative studies is to get at firm estimates of the prevalence of hard drugs like heroin, cocaine, LSD, etc. and establish a baseline.

Another important aspect to be noted is that the studies were mostly age-specific confined to school/college students in urban areas. General population surveys were only small in number. Such surveys would have been more appropriate with adequate samples. These may be drug specific or cover all drugs.
There is no evaluative research on the intervention programmes run either by the government in collaboration with voluntary organisations or by other agencies. Counselling, deaddiction and rehabilitation centres are on the increase. These are vital components of war against drug abuse. Training of functionaries is yet another vital component of the programme. Evaluation of the working of these centres and clinics and of the training aspects is the need of the hour.

RATIONALE OF THE STUDY

The counselling centres have been established to cater to the needs of identification, follow-up and rehabilitation of addicts prior to and after detoxification. Detoxification is carried out either at the centre or through referral to hospitals/ detoxification centres/ clinics/ camps, etc. These centres are set up with the following aims:

1. Provision of rehabilitation cover;
2. Supply of information of sources of treatment;
3. Coordination with other rehabilitation centres;
4. Data collection and storage;
5. Dissemination of data;
6. Support with individual and group therapy; and
7. Liaison with enforcement agencies.

Keeping in view the aims of the centres, it was thought to be appropriate to conduct an evaluative study of the functioning of these centres and the services offered with a view to take corrective measures in time. Consequently, the researcher took up the evaluative study on the counselling centres in Delhi. The study is entitled "Appraisal of the Rehabilitation Services Provided to Drug Abusers through the Counselling Centres". The objectives of the study are as follow:

OBJECTIVES OF THE STUDY

Broadly speaking, the objectives of this study are as follows:

1. To analyse the functioning of the counselling centres vis-a-vis their avowed aims;
2. To assess the effectiveness of the services provided by the counselling centres;
3. To develop an understanding about the consequences of drug abuse on the lives of drug addicts and their families.

The, specific objectives of the study are:

a. To learn about the physical set-up, staffing pattern, administrative and financial aspects of the centres' functioning;
b. To study drug abuse preventive activities like awareness building and educative activities undertaken by the centres;
c. To assess the steps taken by the agencies, e.g. individual counselling, group therapy and recreational activities 'available' and 'utilised' for rehabilitation of the client;

d. To study the scope and content of rehabilitation cover provided in terms of identification, coverage, type of treatment measures used, the number of clients rehabilitated and the frequency of drop-outs and relapses;

e. To study the involvement of the family and the community in rehabilitating the clients;

f. To study the follow up services;

g. To assess the effectiveness of services provided, through a sample of rehabilitated addicts/drop outs/relapses/under treatment and others at varying stages including those who change the drug(s) being abused or who relapse and re-continue de-addiction, etc.

h. To study the grave consequences of drug abuse on addicts and their families.

i. To offer some suggestions for bringing out possible improvements in the existing programme of drug abuse prevention.

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