CHAPTER IV
COMBATTING DRUG ABUSE

Abuse of drugs in any society is embedded in its civilisation. However, no society has ever approved drug abuse. Even though some of the traditional drugs have been given social sanction, the society do frown upon when it gets to addiction. Realising the harmfulness of taking drugs, the Governments in any country have been taking steps to fight out this menace.

DEMOGRAPHIC FEATURES OF DELHI

Since the study pertains to the National Capital Territory of Delhi it would be relevant to recount some of its features before looking at the efforts towards dealing with the problem in India and elsewhere.

The territory is spread over 1483 sq. km. lying in the northern part of the country and surrounded by Haryana on all sides except east where U.P. touches. As per 1981 census there were 30 census towns in Delhi and the inhabited villages numbered 314.

According to 1991 census the Delhi had a population of 93.7 lakhs with a exponential growth rate for 1990-91 of 4.15. Rural population constituted only 10.07% of the total as per 1991 census. The density of population was 1352/sq. km. and the sex ratio (no. of females per 1000 males) stood at 827, much lower than the all India ratio of 927. The Scheduled Caste population in Delhi was 19.05% as against 16.48% for India as per 1991 census.

The population of Delhi is highly literate in comparison to most of other states. The effective literacy rate, according to 1991 census, was 75.29 (males 82.01, female 66.99). Age distribution of population during 1981 reveals that 35.55% of the total population was in age group of 0-14 yrs and 45.25% in 15-39 yrs. As regards marital status of population in Delhi, never married constituted 54.55%; married 43.82%; widowed, divorced and seperated together were 1.61%.

Delhi is the largest commercial centre in northern India as well the largest centre of small industries. As per 1991 figures 8550 industrial units were functioning in Delhi providing employment to 7.65 lakh persons. Total workers or work participation rate was 31.64% (males 51.92% and females 7.36%) for 1991. During 1981 the percentages were 31.93% (males 52.47% and females 6.52%). The cultivators were 0.56%, agriculture
labourers 0.26%, house hold industry 0.54% and other workers 30.57%. The percentage of non-workers for 1981 was 67.81% and that of marginal workers 0.26%.

Delhi's population as per 1931 census included 83.60% Hindus, Muslims 7.75% ranked second, Sikhs were 6.33%, Jains 1.19%, Christians 0.99% and Buddhist 0.11%.

THE INITIAL STEPS: TOWARDS ACHIEVING PROHIBITION

The background

In India efforts towards achieving prohibition were taken even since pre-independence period as alcohol was abundently abused and its harmful effects were realised. In 1920, prohibition was adopted as an essential part of the constructive programme under the leadership of Mahatma Gandhi. It was introduced as a part of social uplift programme. Later, the comprehensive prohibition laws enacted in some of the States in 1937, were annuled after the resignation of popular Ministries in 1939.

Constitutional provisions

The Constitution of India enshrined prohibition as a means of raising the standard of living of the people and improving public health as a part of Directive Principles of State Policy. Article-47 of the constitution of India enjoins: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health".

Prohibition is a State subject and the responsibility for fulfilling the Constitutional obligations in regard to it rests largely with the State governments concerned. Production, manufacture, possession, transport, purchase and sale of intoxicating liquors as also levies of duties of excise on manufacture/production of alcoholic liquor for human consumption and opium, Indian hemp and other narcotic drugs and narcotics comes under the State List. The Government of India seeks, however, to serve as a catalyst in pursuading the State Governments to take meaningfull and effective steps in the direction of fulfilling the Constitutional obligations. Schedule-VII of the Constitution defines the distribution of responsibility between the Central and State Governments.

Prohibition and the Government of India

The Government of India, besides pursuading the State Governments to take meaningfull and effective steps in fullfilling the Constitutional obligations regarding transport and purchase and sale of intoxicating drugs, it has been
financially supporting a large number of voluntary organisations to undertake various preventive, therapeutic and rehabilitative programmes in the field. Under the Scheme of Assistance to Voluntary Organisations for Education Work for Prohibition and Prevention of Atrocities on Women which later renamed in 1986 as Scheme of Assistance to Voluntary Organisations for Prohibition and Drug Abuse Prevention, was operated by the government, the then ministry of Social and Women's Welfare, for mobilising public opinion against drinking and drug abuse. Grant-in-aid is given to all India and other major voluntary organisations for carrying out educative publicity by means of conferences, meetings, seminars, camps, puppetary, posters, pamphlets, essays, debate competitions and T.V. plays, etc., educative publicity through mass media, T.V. and radio.

The government in 1975 announced 12-point minimum programme for prohibition to be implemented by the State Governments. (Annexure III). In addition, it issued specific guidelines for implementation by the State Governments in 1978 (Annexure IV) to ensure a speedy progress towards implementation of the minimum programme. These inter alia included, discontinuence of advertisements and public inducements, banning the location of liquor shops near industrial, irrigation and other development projects; reducing the percentage of alcoholic content in the beer; putting control on production and consumption of liquor; restriction on drivers of vehicles; tightening the legislation; and organising wide spread publicity and propaganda on the evils of drinking.

With regard to tribal areas a differential approach was adopted in view of their culture and traditions as also to safeguard their interest in the implementation of excise policy. The specific guidelines applicable to tribal areas are at Annexure V.

In order to achieve a total prohibition in four years by the period ending 31 March 1978 the Government suggested some immediate and long term measures. (Annexure VI)

However, the objective of achieving total prohibition within four years remained unfulfilled mainly due to loss in revenue by the State Governments. It was not even possible for the Central Government to compensate it fully. Public opinion rather favoured temperance than total prohibition. The total policy was reviewed in 1980 and the earlier guidelines of controlling availability of intoxicating drinks and restricting their use in the public interest, with compensation offered in the loss of revenue, continued to be adhered to. A high priority was placed on awareness building, voluntary action and community participation in this field.
EMERGENCE OF NEW DRUGS

Until 1980's, the traffic of heroin and other drugs through India from "Golden Crescent" (comprising of Iran, Afghanistan and Pakistan) and "Golden Triangle" (comprising of Myanmar, Thailand and Laos) did not pose any serious problem. Consumption of alcoholic beverages was the only problem. However, the vulnerability of Indian Territory to the transit traffic in recent years has caused unprecedented enforcement problems. The spill over from such transit traffic has given rise to problem of addiction to illicit drugs in the country. The demand for such drugs was met not only by see page from the transit traffic, but also coupled with leakage of opium from licit cultivation and clandestine manufacture of crude heroin and morphine.

Trafficking of drugs through India

The drugs in the country got through South East Asian and South West Asian regions and Nepal from the border States. From S.E.A. region heroin was smuggled from Myanmar to North Eastren Border States mainly Mizoram, Manipur and Nagaland. The major part of such drugs was utilised locally and only little was smuggled to Bangladesh. The Indian and Myanmar nationals were mainly involved in drug trafficking from the S.E.A. region.

The heroin originated in the S.W.A. region was smuggled mainly through Rajasthan border. The other border States involved are Punjab and Jammu and Kashmir. In addition to heroin entering into Rajasthan from S.W.A. region, it is being locally manufactured and even smuggled to other countries such as Bangladesh. Heroin was smuggled through metropolitan cities, Bombay, Delhi, Madras and Calcutta in varying quantity. The Indians, Pakistanis, Afgans and Nigerians were engaged in drug trafficking in India. The S.W.A. region also smuggled hashish through Bombay, Rajasthan and sea coast in Gujarat.

Hashish was being smuggled from Nepal in the country through Indo-Nepal border in Bihar. It was smuggled out to United States and European countries. Nepal also had been a source for cannabis herbal/ganja. This was also produced in southern and northern States of India such as Tamil Nadu, Kerala, Andhra Pradesh and Almora in U.P. Opium is now rarely smuggled from other countries. It had been trafficked from Myanmar for further transmission to Srilanka.

There was also a licit poppy cultivation in the country for medicinal and scientific purposes. As a result of strict vigil by the narcotic machinery, the illicit cultivation was detected in hilly terrain of U.P. and Arunachal Pradesh in Uttarkashi and Tirap Districts. Methaqualone was mainly manufactured in Bombay based laboratories and trafficked to African countries.
EXTENT OF DRUG PROBLEM

There was no hard data or definite estimates available to assess the extent of abuse of drugs in the country. However, data available through research studies, at hospitals, clinics, treatment units for addicts, police records, media reporting, etc. had indicated an increase in the problem of addiction in the country.

The Government of India took cognizance of the problem and showed concern towards the changing scenario of the drug problem in the country. It commissioned research studies on drug abuse amongst student groups in 1975-76 and repeat studies in 1985-86. The studies covered four metropolitan cities and five other cities, Varanasi, Jabalpur, Jaipur, Hyderabad and Bombay with coordinating centre as All India Institute of Medical Sciences. Studies on the industrial workers and rural population were also sponsored by the Government.

In addition, in 1989, a wider study was undertaken in 33 towns, cities and border areas of the country to assess the extent of the problem. A report entitled 'Drug Abuse' including summaries of these 33 studies had been published by the National Institute of Social Defence. Studies on the law enforcement and functioning of treatment units was underway with Ministry of Welfare's sponsorship. The Government had been committed to assess the extent of the problem and evaluate the functioning of the treatment facilities set up for addicts from time to time. Researches were financed under the Scheme of 'Grant-in-aid for Research and Publications' operated by the Ministry of Welfare.

The research studies show that the problem of drug abuse is not confined to any particular strata, however, cultural and regional variations do persist. The problem has become a matter of serious public concern in the country. The newly arrived psychotropic substances at the drug scene pose the highest threat to the quality of life of the people. The changing trend of drug abuse marked with influx of illegal drugs is closely associated, among other factors, with socio-economic changes, characterised with industrialisation, urbanisation, rural urban drift, loosening of informal means of social controls and increased stress and strains of the modern life. The traditional values of moral hygiene, morality and social responsiveness have eroded and given way to materialism, consumerism and individualism. Both abundance and deprivation of opportunities seem to make the individual vulnerable to social deviation, such as, drug abuse.

In Delhi assessment of the problem of drug addiction had been taken up with concern since 1975 with initiation of studies by the Government amongst school and college students. Studies on hospital patients in Psychiatry Departments and as part of all India studies were also carried out in Delhi. The important findings of some of these studies are highlighted over here to give an overview of situation of drug abuse in Delhi. The mention of these studies has also been made under chapter on review of literature.
A study of English medium high school students in Delhi from three senior classes (225 individuals) in the age group of 14-16 years was conducted in 1976 by Mohan and others. According to it about one-third (34.2%) of the students were drug users. A slight decrease in the prevalence of drug abuse vis-a-vis the seniority of class level was also observed (35.06% to 32.87%). The prevalence of drug use in descending order was, tobacco (31.1%), alcohol (26.1%), cannabis (12%), tranquillizers (5.8%), sedatives (4.9%) and opium (1.3%).

Another study by Mohan, et. al. (1978) on Delhi University students (502 individuals) reported the prevalence of drug abuse to be 32.2%. Alcohol (23.5%) and tobacco (22.1%) were the most commonly abused drugs. Cannabis abuse was reported to be 15.2% in case of males whereas 7.9% females abused painkillers. Amphetamines and cocaine were reported to be 15.2% in case of males whereas 7.9% females abused painkillers. Amphetamines and cocaine were reportedly tried on an experimental basis by males.

The study revealed that male abusers started drug abuse from early age of 16 years (81.8%) and reached the peak by the time they were 18 years. Thereafter, the pattern shows a decline. Those who showed a higher prevalence were male hostlers or those residing in private lodges, children of professionals or business community and boy with liberal behaviour such as dating.

Seva Singh and Neelam Chopra found among 60 drug users and non-users of Delhi Law Faculty in 1979 that drug users in general possessed a low degree of ego-strength, a higher level of anxiety with a tendency between neuroticism and extraversion dimensions of personality in comparison to non-drug users.

As reported in a study of Delhi College and university students (4415 students of nine colleges) by Khan and Ummithan, drug users most commonly used analgesics (15.2%), followed by tobacco (10.9%), alcohol (9.2%), bhang (6.3%) and ganja (1.6%). A negligible percentage also used cocaine, heroin and LSD. The other characteristics of drug users were that females used more of analgesics whereas males were more prone to use alcohol. Giving up drugs through personal decision was supported by family and peer group.

A number of clinical studies were undertaken on patients at various drug de-addiction clinics or in Psychiatric Departments. A study of 1722 cases at a deaddiction clinic in a hospital in Delhi (Jiloha and Munjal, 1980-84) revealed that, in 1980, heroin addicts were nil as against 81% in 1984. The group was mainly in the age group 10-18 years, employed in restaurants, travel agency or school drop-outs without any job. The number of persons visited the clinic in 1984 also showed an increase of 63% over the figures for 1980.
In 1984 (span period 1980-84), study of 105 heroin addicts who attended the deaddiction clinic of a hospital in Delhi by Adityanjee, et. al.21 and Mohan et. al.22 showed a sudden rise of heroin dependence amongst young educated males from nil in 1980 to 37.8% in 1984. This increase was attributed to the easy availability of this drug in the recent years and the marked decrease in its cost.

The salient characteristics of these abusers were that they were in the final year of school or dropped out of college (80%), unmarried, unemployed or in jobs connected with tourism and hotel trade. Most of them consumed multiple drugs. An overwhelming majority (85%) had some mental disorders and nearly half (47.6%) discontinued treatment after the initial assessment.

A major study on 4000 industrial workers in Delhi was conducted by Gangrade and Kusum in 1978 and reported the prevalence of drug abuse to be 10.4%.23 Alcohol was reportedly used by 10%, followed by cannabis (35%) and opium (0.02%). The frequency of drug abuse was once to several times a week (85%) and the drugs were consumed mainly for relaxation and pleasure. More than half of the abusers (55.4%) were between the ages of 21-35 years and they began drug abuse after taking up employment in some industry. The prevalence rate amongst divorced, separated and widowers was reported to be double (20%) to that reported in case of married and unmarried respondents.

A study highlighted the fact that drug users had a negative attitude towards their job, low self-esteem and unhappy childhood. They were anxious and hostile towards life and unsatisfied with their family life and job.

Another study was conducted in Delhi as a part of 23 research studies sponsored by the Government of India in the Ministry of Welfare during 1989 in order to ascertain the magnitude and direction of drug abuse/addiction in the country.24 The information was collected through records, from sampled addicts and knowledgeable persons. It was reported that the addicts belonged to age group 15-25 years. One third of addicts had monthly income of Rs. 1000/-. Addicts were mostly unmarried (60%). Most of them with educational status up to class XI or below.

The smack, cocaine and cannabis were the drugs most commonly abused by the addicts. More than 50% of the addicts used more than one drug in addition to smack, thereby indicating use of multiple drugs. About half of the addicts started the drug habit between 18 to 24 years. It was mainly friends who introduced addicts to drugs. Relief from tension and anxiety was one of the major cause for taking drugs. Dependence on drugs was one of the major reason for continuing using drugs.

The occupational group most affected by drugs was reported to be transport workers, daily-wage workers, pickpockets, ragpickers, etc.
Main sources of supply of drugs were perceived to be Sansi Tribe, peddlers, and pushers in various resettlement and crowded colonies in Delhi; pan and cigarette shops and Dhabas in certain areas like Raghubir Nagar, Regarpura, Jama Masjid, Peharganj, Old Delhi, Walled City, Delhi Main Railway Station, all the resettlement colonies and Jhuggi Jhopri Colonies.

As regards type of treatment taken by addicts, it was medicine and exercise in most cases, and counselling, Psychotherapy, yoga, etc. in less than 5% cases. One third of addicts did not find the treatment at the clinics helpful because of lack of motivation, ineffective medicines and force by friends to use the drug.

The study reported the prevalence of drug addiction in Delhi to be 2 to 5 per cent as perceived by the informed persons.

A review of research studies showed that the drug addiction was realised to be a problem only after 1980 as researches during 1980-84 on patients revealed the influx of newly emerging drugs such as brown sugar and heroin in Delhi too.

EXPERT GROUPS SET UP BY THE GOVERNMENT

The Government of India has been concerned about the problem. It engaged number of experts from time to time in order understand about the drug scenario that prevailed in the country and to take timely action for tackling the problem. Details of various Expert Groups formulated at different point of time is presented below.

National Committee on Drug Addiction

The Ministry of Health and Family Welfare responsible for treatment of addicts had set up a National Committee on Drug Addiction on 2 June 1976 under the chairmanship of Shri C. Gopalan, the then Director General, Indian Council of Medical Research, New Delhi. The committee reviewed the prevalence of drug abuse in the country and reported that the problem was more amongst students, male and men, tobacco and alcohol were drugs of common abuse, students too used psychotropics more in comparison to general population. It expressed that there were signs to believe that drug abuse in the country was on an increase.

The Committee recommended for setting up of a National Advisory Board of Drug Control to initiate action for immediate implementation of programmes. It suggested for undertaking (i) legal and penal measures (ii) educational measures and (iii) social action.

Amongst legal and penal measures it recommended for creation of National Advisory Board of Drug Control, enactment of comprehensive and stringent act, evolution of national policy on alcohol, establishing a registration service for drug addicts and supply of needed drugs to those registered, strengthening the implementing machinery and securing better coordination.
Educational measures suggested included creation of continued awareness among all social groups and drug education as a part of health education at all levels of society. Carefully designed, factually correct and scientifically evaluated programmes for this purpose need to be developed by the Department of Social Welfare, Education and Mass Communication in consultation with the Department of Health was also emphasised upon.

As regards 'social action' the Committee suggested measures to create a rational and educated public opinion on the drug problem. It believed that a better upbringing of children and youth, strengthening of the family and peer group, involving youth in challenging programmes and a social transformation will reduce the need for using drugs or will provide alternates and these are more lasting solutions to the problem.

The Committee further suggested that measures for treatment of drug addicts should be adopted as a part of general health services. Initially 4-6 centres may be set up with Central Government's assistance in institutions where facilities were available and later extended to one centre in each one of the States. However, rehabilitation of addicts were felt to be the family's responsibility. Voluntary agencies should be involved in the programmes and State can play a useful and supplementary role was also expressed by the Group.

**Expert Group on Alcohol, Human Health and Nutrition**

Expert Group on 'Alcohol, Human Health and Nutrition' was constituted by Government of India in the then Ministry of Social Welfare in 1979 under the chairmanship of Prof. V. Ramalingaswami, Director, All India Institute of Medical Sciences. It was set up with a purpose of developing a paper for the Cabinet on the effects of human consumption of alcohol in different forms on health and nutrition.

The Group reviewed the existing state of knowledge of the problem and presented situation obtaining in India against the background of socio-cultural patterns and ways of life. The group concluded that the consumption of alcohol in some of the States in the country had been increasing, prevalence of alcohol abuse and addiction was assessed to be 1-2% in general population, frequency of consumption more in poorer strata of society ranging between 2-4% of poor population, infrequent drinking and light drinking did not pose any serious health hazard, heavy drinking might affect both physical and mental health significantly, the effects of heavy drinking more marked in poorer sections and in those with nutritional deficiencies, consumption of large amount of alcohol predispose to nutritional imbalances because improper absorption of certain essential nutrients, problem of alcohol consumption mixed with various denaturants and adultrants was of serious concern.
The Group supported the recommendations made by the Study Team on prohibition in 1964 (Tek Chand Committee) i.e gradually reducing the available alcohol to the public in a phased manner. It recommended for a further research in (a) the drinking patterns amongst various communities in India in various parts of the country by using uniform terminology and standardised proforma. (b) study of alcohol-nutrition interactions more intensively to identify hazards in under-nourished populations and (c) investigation into the consumption of the adulterated and denatured alcohol.

The recommendations made by the Expert Committee were further gone into by the Working Group set up under the Chairmanship of Joint Secretary, Department of Social Welfare Government of India with members from other concerned Ministries and Departments. The group suggested lines along which further action could be taken in the light of the recommendations made. It considered recommendations under three heads: firstly measures designed to educate the public, through better publicity and otherwise, regarding the effects of alcohol consumption on public health. Secondly, suggested measures which could be appropriately taken to lessen the ill-effects of alcohol on human system so as to safeguard the health of the public. Lastly, the sponsoring research studies in the areas where lack of precise data persist.

As regards educational and social measures the steps were suggested to dispel the misconceptions of therapeutic and stimulating effect of alcohol on the basis of irrefutable and medically proven facts and to forewarn the public in regard to true effects of alcohol consumption on human system. Concrete steps include; incorporation of education in school, undergraduate colleges curriculum, using mass media and other educative media like radio, T.V., print media, extensive efforts in colonies with poorer sections of population. It suggested that the measures to lessen the ill-effects of alcohol on human system should focus on weaning away the addicts, lessening of ill-effects of alcohol on human system, through controls over alcoholic strength, production, sale, etc. Research areas as suggested by Expert Group were reiterated by the Working Group.

Working Group on Drug Abuse

In the 11th meeting in December 1982 of the Central Prohibition Committee it recommended for setting up of Working Group with leading experts and representatives of research organisations to study the ill-effects of drinking and drug abuse.

Consequently, the Working Group to review and monitor the situation regarding drug abuse and advise on the measures/strategies on drinking and drug abuse was constituted on 20 April 1983 under the chairmanship of Secretary, earwhile Ministry of Social and Women's Welfare. The central Ministries of Health and Family Welfare, Education, Home, Information and Broadcasting represented on the Group.27
Expert Committee On Drug Dependence

An Expert Committee on Drug Dependence Services was set up by the Government of India in January 1986 to draw up a plan for implementation of Health Services in the area of Drug Dependence keeping in view the provisions of NDPS Act. The Committee submitted its report in July 1986 and suggested for an establishment of National Centre to deal with all aspects of research, treatment, manpower development, health services and drug abuse monitoring and prevention in country with similar centres at State level. It further suggested for setting up of thirty bedded deaddiction units all over the country to act as designated centres under the new Act. For immediate purposes, the Committee recommended for the utilisation of existing resources by re-allocating beds in the general health care facilities.

In pursuance of the recommendations of the Committee the Ministry of Health and Family Welfare have set up five centres of excellence in Delhi and other States. Beds have been provided in the general hospitals. The Ministry proposes to extend the treatment services through medical colleges.

GOVERNMENT OF INDIA'S EFFORTS TO TACKLE THE PROBLEM

In order to tackle the problem of drug abuse strategies to reduce both supply and demand have been adopted. A stringent legal action has been initiated against traffickers, peddlers, pushers, etc. by enactment of 'Narcotic Drugs and Psychotropic Substances Act, 1985'. To reduce the demand the multidimensional approach has been adopted. The aspects covered are identification, referral, treatment, rehabilitation, education and public awareness.

The Coordinated Approach

Different Ministries/ Departments of the Government concerned with the problem is illustrated in a chart.

Department of Revenue, the Ministry of Finance is responsible for the enforcement of the law. The Ministry of Health and Family Welfare is concerned with medical treatment of drug addicts. Publicity through government media is the responsibility of the Ministry of Information and Broadcasting. The Departments of Education and Youth Affairs and Sports are also engaged in tackling this problem. The Ministry of Welfare has been entrusted with the nodal responsibility of activities relating to educational and social welfare aspects of drug abuse.
DRUG ABUSE PREVENTION AND CONTROL

CENTRAL COMMITTEE ON
PROHIBITION & DRUG
ABUSE PREVENTION
Representatives: 1, 2, 6
K/O Industry, Tourism & NGOs)

HIGH POWER COMMITTEE ON
DRUG ABUSE CONTROL
Chairman: Finance Minister
Representatives: All Ministries 1-6 & NGOs)

NATIONAL INSTITUTE OF
SOCIAL DEFENCE
Research, Training &
Technical Assistance

1. MINISTRY OF WELFARE
   Moral Ministry

2. MINISTRY OF HEALTH AND
   FAMILY WELFARE
   (Medical treatment)

3. MINISTRY OF FINANCE
   Enforcement of Law

4. MINISTRY OF HOME AFFAIRS
   Treatment of drug addicts
   in penal institutions

5. MINISTRY OF INFORMATION AND
   BROADCASTING
   Education through mass media

6. MINISTRY OF HUMAN RESOURCE
   DEVELOPMENT
   a. Department of Education:
      Preventive measures in
      schools & colleges
   b. Department of Youth &
      Sports: Prevention through
      youth bodies

NON-GOVERNMENTAL
ORGANISATIONS
- Counselling Centres
- Deaddiction Centres
- Aftercare Centres
- Preventive Education
  & Awareness Building
The coordination of the efforts of various agencies and provision of technical advice is done by the various standing committees such as Central Committee on Prohibition and Drug Abuse Control, Empowered Committee, Interministerial Committee and Cabinet Sub-committee. An Empowered Committee was constituted with a view to evolve strategies for drug abuse control on 15 January 1987 under the chairmanship of the Secretary, Ministry of Welfare including senior officers of the concerned Ministries/Departments as members. In accordance with the high priority accorded to the problem, a Cabinet Sub-committee was constituted to oversee and coordinate the programme. Presently these two committees do not exist.

The Central Committee on Prohibition and Drug Abuse (reconstituted from the earstwhile Central Committee on Prohibition) under the Chairmanship of Minister for Welfare, with representative of the concerned Ministries, voluntary organisations and individual experts has been constituted. The Committee's functions mainly relate to undertaking periodical reviews for prohibition policy, recommending measures to counteract difficulties, suggesting measures to intensify publicity, promoting scientific research and studies and implications of prohibition and alcoholism, review the situations on drug abuse in the country and assessment of effectiveness of these measures to develop comprehensive system of information and evaluation and also to strengthen social and educational institutions to undertake activities at community level on awareness building and education. Review of media publicity and suggesting ways and means of involving voluntary organisations, families and community in the drug abuse control programme. The functions of the Central Committee on Prohibition and Drug Abuse are at Annexure VII.

Recently the Government of India constituted a High Level Committee on 10 August, 1993 under Narcotics Control Bureau, Ministry of Finance under the chairmanship of Minister of State for Finance. The other members include Members of Parliament, Officials from concerned Ministries- Health, Home Affairs, Welfare, Revenue, Narcotics Control Bureau and representatives of the Non-governmental Organisations. The Committee was to undertake a comprehensive review of the present arrangements for dealing with the various aspect of the problem of drug abuse including regulations and control of licit use, enforcement of prohibition of illicit use and detoxification, welfare and rehabilitation of addicts. It is expected to submit its report within a period of six months.

**Efforts to control supply of drugs**

In order to control the illicit trafficking in drugs the Government of India have taken a number of legislative, administrative and preventive measures. Till 1985 there were number of legislations dealing with different aspects. Enactment of 'Narcotic Drugs and Psychotrophic Substances Act,' was a major development in unfolding of the strategy of control. The act came into force with effect from 14.11.85.
This act is a consolidation of the existing laws and provision has been made therein for control, regulations of operations relating to narcotic drugs and psychotropic substances. Under the act no person can produce or manufacture, possess, sell, purchase, export and import interstate narcotic drugs and psychotropic substances except for scientific and medicinal purposes. Stringent penal provisions are provided for in case of violation. Under the law not only possession of drug in small quantities but even abetment for consumption are punishable. The minimum punishment for most drug trafficking offences under the said Act is 10 years and a fine of Rs. one lakh extendable to Rs. 2 lakhs. For repeat offences the minimum punishment is 15 years rigorous imprisonment extendable to 30 years and a fine of Rs. 1.5 lakhs extendable to 3 lakhs. The courts have also been given the discretion to impose higher amount of fine.

The law also provides for treatment of drug dependents. An appex enforcement agency known as Narcotics Control Bureau was also constituted in March 1986. It provides for maintenance of effective operational coordination both with the local and foreign enforcement agencies in the country.

The NDPS Act was further amended in December 1988 and provided for stringent punishment for financing illicit traffic and harbouring offenders and death penalty for repeat offences. It also provide for forfeiture of property derived from or used in illicit traffic. Annexure VIII gives a source-wise quantity of drug seized and number of seizures from 1989 to 1993.

Keeping in view the serious threat of drug abuse to health and welfare of the community and the dangers posed to the national economy, the Government of India enacted new legislation naming 'The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988 (No.46 of 1988). The Act provides for detention in certain cases for the purpose of illicit traffic in narcotic drugs and psychotropic substances and matters connected therewith. The Act inter alia spells out the persons to make detention orders, conditions of detention and recommends for setting of Advisory Boards, if necessary.

AGENCIES ENGAGED IN CONTROL OF DRUG SUPPLY IN DELHI

Several agencies have been conferred with legal powers for enforcement of drug laws. These agencies have varied role to play as regards their involvement and contribution is concerned. These agencies are Central Bureau of Investigation, Central Excise, Narcotics, Customs, Revenue Intelligence, Border Security Force.

In Delhi powers have been invested by the Government of National Capital Territory on Officers in Revenue department. Inspector in Drug Control Department and Sub-Inspector in Excise Department of Administration within the metropolitan area under the NDPS and PIT Acts.
Narcotics Control Bureau is the apex enforcement and co-ordinating authority. C.B.I. has a special cell for narcotics based at Delhi. It mainly deals with cases under NDPS Act relating to inter-state and international gangs of drug traffickers.

The Central Excise and Customs have a very limited involvement in NDPS Act cases in Delhi, mostly at Air-port and occasionally at foreign port office, for illegal imports/exports. Department of Revenue Intelligence mainly focuses attention on cases of illegal imports and exports etc. of precious metals with only minimal involvement in NDPS Act cases in Delhi after setting up of NCB.

Delhi Police is the main agency responsible for street level enforcement. Detections, recoveries and arrests under NDPS Act are carried out by the Police Stations staff and by the Crime Branch.

The Crime Branch has a small Narcotic Cell which deals with cases under NDPS Act along with those under Excise and SIT Act. A Special Narcotic Cell has been set-up from their own resources under the Deputy Commissioner of Police with the staff of one Assistant Commissioner of Police, three Inspectors, seven SIs/ASIs and six other ranks. This cell has taken over the responsibilities of the earthwhile cell in the Crime Branch and is now specifically responsible for enforcement of NDPS Act and coordination.

The Crime Branch of Delhi Police has conducted some studies into the socio-economic profile of the persons arrested under NDPS Act and also identified the main endemic areas in Delhi affected by drug abuse. It works out programmes of education and treatment by coordination of efforts of voluntary organisations. It also undertook preventative educative activities in the phased manner through area based approach by concentrating efforts in more vulnerable areas. It organised one month intensive programme in the Walled City of Delhi and further plans to extend its efforts in other areas.

Excise Department of the National Capital Territory of Delhi also plays a role in drug abuse prevention. As per notification issued under NDPS Act, the Officers of this department are empowered to searches, seizures and arrests etc. There is a small Excise Intelligence Bureau working under the Department with a staff deputed from Delhi Police consisting of one ACP and three SIs. The work of the department relating to enforcement is, however, limited and involves collection of information/intelligence and organisation of raids in coordination and association with the Delhi Police, registration of cases and all further follow up on prosecution etc. being done by the Delhi Police.

The Prohibition Publicity Directorate under the Excise Commissioner has been involved in substantial work relating to public education and publicity against drug abuse since 1987.
The peculiarity of the Indian efforts towards tackling the problem of drug abuse is that unlike, in most other countries, the nodal responsibility of demand reduction lies with the Welfare Ministry. Main responsibility for medical treatment is that of Ministry of Health and Family Welfare. It initially provided treatment services in a few Psychiatric Departments, but the treatment did not get any impetus in the health sector. Thereby, in India the need for medical treatment of addicts was also met through the community based approaches adopted by the welfare sector with the involvement of non-governmental organisations. The Ministry of Health and Family Welfare now has been giving a fresh look to this aspect and this too is under consideration of the Task Force set up to prepare national masterplan on drug abuse control.

The Ministry of Health and Family Welfare, in addition to five centres of excellence, proposes to provide treatment facilities through 27 medical colleges to begin with along with facilities for training, examination, laboratory tests, research and evaluation.

India has adopted a community based approach that was picked up by many of the western countries after the realisation that hospital based model, heavily medicalised did not work effectively until unless psycho-social aspects of the problem are looked into as well.

As mentioned earlier the Ministry of Welfare shoulders the nodal responsibility for drug abuse prevention. It has formulated three pronged strategy covering components:

(a) awareness building and public education for drug abuse prevention;
(b) community based action for the identification, treatment and rehabilitation of drug addicts; and
(c) training of Governmental and Non-Governmental functionaries engaged in drug prevention.

Awareness building and public education

Awareness building and preventive education programmes aimed at teaching the potential target groups who are likely to get afflicted is of much greater consequence in the long-term perspective. A systematic approach towards awareness building among general population is being pursued. It is, however, realised that the educational approach towards creating a climate against drug addiction among people has to be carefully planned. The knowledge regarding dependence producing drugs has to be so transmitted as to avoid undue curiosity or counter productivity. Both governmental and non-governmental organisations are engaged in such activities. Publicity on drug abuse prevention has been mounted up in collaboration with the Ministry of Information and Broadcasting, Government of India.
Special quickies/slogans/spots were prepared and telecast at suitable intervals not only in the national programmes but also from the regional broadcasting stations in local languages. Serials are also given on television and radio highlighting the problem of drug abuse, mainly among youth. Video quickies on drug abuse prevention through doordarshan telecast and Directorate of Electronics for dissemination in villages through non-governmental organisations. The oldest weekly ten minutes radio programme 'Aao Haath Badhayan' is broadcast over 79 commercial channels of AIR to create awareness about the various social welfare programmes, including drug abuse prevention.

The other methods of publicity are also being tried. These include print publicity in a form of literature, folder, comics, cards, hand-bills, brochures, slogans on letter cards and other postal stationery, computerised railway tickets, press advertisements on programmes and activities, publicity through banners, bus back panels, hoardings, cinema slides, PVC stickers, etc. Traditional media is also used by involving Song and Drama Division in developing songs, dramas, street plays and puppet shows.

Nation wide campaign was also launched including dance drama by Anand Shankar troupe on the theme, seminars, exhibitions, rallies, etc. The Directorate of Field Publicity, having a network of 257 field units and 22 regional offices spread all over the country also undertake awareness campaigns against drug addiction in collaboration with the governmental and non-Governmental organisations.

The publicity efforts of the official mass media are closely reviewed by a Nucleus Group constituted by the Ministry of Information and Broadcasting. It carefully plans the media campaign so as to avoid counter productive effect that may result through indiscriminate publicity. The State Governments/Union Territory Administrations have been advised to impress upon State Universities to mount a special vigil against drinking and drug abuse in educational institutions and also to report on the information on abuse of drugs to the enforcement agencies in their State. The State Governments/Union Territory Administrations have been requested to undertake informational, educational and motivational programmes on drug abuse to refrain people from drugs.

A concerted effort is being made to develop and strengththen the community support system to generate support from private, non-governmental, religious and other institutions but also help the people in organising themselves against drug abuse. The Ministry of Welfare has, therefore, been providing financial assistance to a number of non-governmental agencies to undertake awareness building programmes which include poster/slogans competitions, street plays, mime shows, puppetary, pantomime, rallies, production of educative material, etc.

Currently much greater focus is given on awareness programmes for specific target groups. Efforts are on to prepare suitable messages and educational material in keeping with the diverse
needs of the various segments of the society. Strengthening voluntary organisations in undertaking educative publicity is also undertaken. United Nations Fund For Drug Control (UNFDC) has extended funds in this direction. They have even provided publicity vans to voluntary organisations.

**Services**

As a part of demand reduction the infrastructural facilities have been built up since 1985-86 primarily through the Ministry of Welfare. These facilities cater to the needs of identification, referral, detoxification and medical care, follow-up and rehabilitation and after care. This holistic approach is required to deal with this psycho-socio-medical problem.

By the end of March 1993, 143 counselling centres, 84 de-addiction centres and 14 after care centres have been established. The counselling centres are located in all the major states (23) and 2 Union territories. While the de-addiction centres are located in 18 major states and the National Capital Territory of Delhi. The after care centres are located in Goa, Maharashtra, Manipur, Mizoram, Nagaland, Punjab, Rajasthan, Tamil Nadu and Delhi. These centres are run by voluntary organisations aided for the purpose by the Ministry of Welfare, Government of India under the Scheme of Assistance to Voluntary Organisations for Education Work for Prohibition and Drug Abuse Prevention. The grants provided for the purpose since 1987-88 are as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th>Amount (Rs. in lakhs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seventh Plan (1985-90)</td>
<td>89.10</td>
</tr>
<tr>
<td>1987-88</td>
<td>5.67</td>
</tr>
<tr>
<td>1988-89</td>
<td>35.00</td>
</tr>
<tr>
<td>1989-90</td>
<td>44.50</td>
</tr>
<tr>
<td>1990-91</td>
<td>44.50</td>
</tr>
<tr>
<td>1991-92</td>
<td>69.20</td>
</tr>
<tr>
<td>1992-93</td>
<td>78.70</td>
</tr>
<tr>
<td>1993-94</td>
<td>138.60</td>
</tr>
</tbody>
</table>

Each one of the counselling, de-addiction and after care centres are appropriately staffed with counsellors, social workers and medical personnel. Periodic monitoring of the centres is done by the Government of India in the Ministry of Welfare.

The total number of beds of 84 de-addiction centres financed by the Ministry of Welfare and run by voluntary organisations are about 1260. Besides, as part of the hospitals in States and Union Territories the beds are provided for the purpose. The total comes to less than 1500 beds through out the country. Such centres are also functioning as adjuncts of the police stations and as specific wing in Tihar Jail and other jails.
The Table below gives the number of addicts registered and detoxified since inception of the scheme in 1986-87 at the counselling, de-addiction and after care centres.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Registrations</td>
<td>1627</td>
<td>12155</td>
<td>38837</td>
<td>131360</td>
<td>226935</td>
<td>253212</td>
<td>9695</td>
</tr>
<tr>
<td>(Sept. '92)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35114</td>
</tr>
<tr>
<td>Detoxified</td>
<td>367</td>
<td>3983</td>
<td>11679</td>
<td>3903</td>
<td>56649</td>
<td>71225</td>
<td></td>
</tr>
</tbody>
</table>

On comparison of the figures for the registration for 1986-87 to 1991-92 wherein number of centres rose from mere 7 to 252 the average number of case registration increased from 23 patients per centre per month to 84 patients per centre per month, showing nearly four times increase.

Based on a sample of monthly statements from 15 bedded de-addiction centres the general pattern of patients treated per month as reported by the Ministry of Welfare is as follows: (period upto 22/6/90).

(1) Number of drug addicts registered:
   (a) New cases 13,048
   (b) Old cases 29,041
   Total 42,089

(2) No. of addicts de-toxified through:
   (a) O.P.D. 6,149
   (b) Indoor 7,958
   Total 14,107

The average per centre works out to 25 cases per month per centre. A bed is utilised for detoxifying 2 individuals every month on an average. The utilisation is nearly optimum since on an average detoxification is carried out for 10-15 days of indoor therapy. The treatment is only voluntary. The data derived from institutions cannot be generalised for the community and no prevalence rates can be calculated therefrom.

The spacial distribution of these centres indicate that there are many areas which are yet to be covered. Emphasis of the new strategy formulated is not only on consolidation of the existing services but also to prepare programme for the North-Eastern region, border areas and traditional areas of drug consumption, such as, Rajasthan, parts of Uttar Pradesh, etc. Special target groups which are susceptible, such as, transport operators, industrial workers and youth in slums will be given more attention.
Addiction is a multifactorial problem and needs to be tackled with multifaceted efforts. Detoxification is usually done through indoor care of addicts for a period of 10-15 days through community based de-addiction centres and beds in hospitals. During this period the efforts are made to take care of the physical condition, withdrawal symptoms and craving for drugs, provision of initial psychological support and get back the addicts on the road to recovery. The effort should not end with this. Psychological counselling, sympathy, understanding and constant encouragement, cooperation and support by the family members - all these play a crucial role in rehabilitating the addicts so as to leave no room for relapse.

Concerted efforts on the part of the counsellors, family members, friends and community are called for to make them feel like a productive member of the society to help them make a gradual entry into the main stream of normal life and wipe out addiction psychology. The counselling centres set up through non-governmental organisations provide a rehabilitation cover to the addicts by carrying out activities covering all aspects right from identification, referral for detoxification, follow-up and rehabilitation.

A longer and continuous care for those who could not be treated by being in their own environment which may not be conducive to their recovery, is provided through their stay in after care centres. This stay may extend from a month to three months depending on needs of the case.

Another concept being propagated is that of therapeutic community which is a form of treatment in a residential setting. The group interaction process enables the residents to recognise their own weaknesses and to inculcate values and scales to cope with their problems. The concept of self-help group is also propagated and an example of such a programme is that of Alcoholic Anonymous groups in Bangalore, Panaji (Goa), Madras, Sikandarabad, Delhi, Cochin, Pune, Manglore, etc. Some religious agencies are also extending facilities for drug addicts to organise themselves and to help each other in their rehabilitation problems. In addition, Narcotic Anonymous groups also exist in the country.

**Agencies operating in Delhi**

It is important to note that the health and other developmental services in Delhi are provided by a multiplicity of agencies like Government of National Territory Delhi, Central Government, Local Bodies namely Municipal Corporation of Delhi (MCD), New Delhi Municipal Committee (NDMC) and Delhi Cantonment that operate in their own jurisdiction. All these agencies work independently with little coordination. The services in the field of drug abuse are provided through hospitals, specialised drug deaddiction clinics, voluntary organisations running counselling, deaddiction and after care centres under Government of India's sponsorship, private organisations, police run clinics, etc. In the control of drug supply the bodies, such as, Narcotics Control Bureau, Delhi Police, Customs, Central Excise
Department, etc. have specific and important role to play.

The Ministry of Welfare, Government of India, a nodal Ministry for demand reduction, to begin with, started seven counselling centres in Delhi in 1986. Thereafter their number increased over the years and on 31 March 1993 there were 12 counselling centres, 6 de-addiction centres and 2 aftercare centres run through six voluntary organisations. The organisations are assisted under the Scheme for Assistance to Voluntary Organisations for Prohibition and Drug Abuse Prevention. List of these centres is at Annexure IX. Assistance is extended to organisations of All-India level (having branches/activities in 2 or more States/UTs/or major ones). In addition, the centres are also run by police and other organisations not be relying on Government assistance.

The Government run counselling centres are located in the community and provide services of awareness building and education, identification, counselling, support, guidance, rehabilitation and follow-up. They are staffed with project coordinators, social workers, counsellors, part time Psychiatrist and secretarial/support staff- clerk, peon, chowkidar, driver, etc. The de-addiction centres are units that provide indoor as well outdoor services in order to detoxify the addicts. They are 15-30 bedded. The withdrawal symptoms are taken care of during the stay of a patient and follow-up services are extended. The staff consists of medical and paramedical personnel, such as, psychiatrist, doctors, nurses, pharmacist; social workers counsellors and supporting staff. Services rendered include detoxification, counselling, education, follow-up, etc. Aftercare centres are meant to reintegrate an addict in the society through provision of in-house facilities. As mentioned earlier there were only two such centres with medical staff, social workers and counsellors. These provide counselling services, vocational training, guidance, etc.

In addition to the efforts of the Central Government the other voluntary body is Navjyoti clinic-Delhi Police Foundation for De-addiction, correction and rehabilitation. The Foundation started functioning in June 1987, particularly with the objective of providing early intervention through treatment, counselling and social rehabilitation with a view to prevent drug addicts from taking to crime. It was running four indoor clinics providing four weeks residential treatment free of cost, a day-care centre and one workshop for patients. These all are run from Police Stations/Police Post premises. All these clinics are consolidated into one organisation at Sarai Rohilla. The treatment modality basically comprises of homoeopathic systems of medicines, yoga, psychotherapy and counselling.

Navjyoti also runs vocational training and adult education centres for rehabilitation of addicts. The funds are raised with the community support. It also undertakes research activities and involves families in a process of reintegration of addicts. It has developed linkages as well with banks, such as, State Bank of India and Indian Bank in order to economically rehabilitate the addicts.
Sanjivini is another voluntary organisation that organises counselling sessions. The centre refers cases after identification to de-toxification clinics of the hospitals and thereafter those, who require longer aftercare, are referred to aftercare homes. The organisation works through counsellors and social workers.

Sahara House is another body that provides residential facilities. It helps addicts by providing solution to psycho-social problems through community living and interpersonal demand-reduction programme.

It is not only the voluntary sector that renders services to the drug abusers, hospitals running de-addiction clinics as part of psychiatric department or independently also exist in Delhi. In Delhi Deen Dayal Upadhaya Hospital runs a 30 bedded de-addiction centre. Psychiatric department of All-India Institute of Medical Sciences, G.B. Pant Hospital and Lady Harding hospital also provide services by having special units for de-toxification of addicts.

The Delhi Medical Association has recently formulated an Anti Drug Abuse Committee. This professional body of physicians and specialists in government and private practice is active in educating medical professionals through training programmes, production of educational material for display at medical and chemist units, etc. It also produces news letter and bulletin. The University/Colleges specially in social work field also contribute by organising academic forums and undertaking research studies in the field.

PROFESSIONAL EDUCATION AND TRAINING

Manpower development is a pre-requisite of any programme. In order to build a cadre of voluntary workers, who are competent to handle the problem of drug abuse and alcoholism and to develop their knowledge of the emerging problem and its dimensions, Ministry of Welfare has initiated a comprehensive training programmes through its apex institute, the National Institute of Social Defence, New Delhi.

The training programmes cater to both governmental and non-governmental functionaries. Priority attention is given to the training of enforcement machinery and social welfare agencies. A large number of social workers, counsellors, youth leaders, police personnel and other functionaries were oriented to serve as instructors of preventive actions. The course content include drug abuse and alcoholism, its extent, prohibition policy and programmes, legislative measures, causative factors, social implications, role of voluntary organisations, etc. During the year 1992 (Jan-Dec) 32 training courses were organised, training 800 functionaries with a duration of 3 days, 7 days and 15 days. It has trained about 4000 functionaries up to November, 1993.
The Ministry of Welfare during 1989-91 even introduced a two months duration course on counselling techniques for counsellors and social workers through Schools of Social Work. These training programmes are supplemented by workshops, conferences and technical meetings.

Training programmes are organised by voluntary bodies and universities in collaboration with the above mentioned National Institute of Social Defence. During 1992, 13 courses were organised in Delhi in the field, training youth leaders, representatives of voluntary organisations, D.T.C. workers, social workers, Anganwadi workers, etc.

**MONITORING AND EVALUATION**

Concurrent monitoring and evaluation is important to make the assessment of the problem. The Ministry of Welfare undertakes the work of monitoring by receiving monthly reports from counselling, de-addiction and after care centres. From time to time supervision and inspection of the centres is carried out in order to assess the functioning of these centres. The Indian Council of Medical Research has been given the responsibility of monitoring the drug abuse treatment programmes of the Ministry of Health and Family Welfare.

Since treatment is voluntary, the data available will not enable quantitative assessment of the problem. In view of the limitations of institutional data there is need to conduct periodical surveys at the national level. No single organisation exists for the purpose. Such national surveys enable evaluation, assessment of trends, changing patterns, epidemiological features of the problem. Efforts may also be made to take a cognizance of all Ministries/agencies/organisations engaged in drug prevention activities. The information from these bodies need to be collected/collated, interpreted and assessed periodically.

Various sources from which information could be obtained on different aspects of the problem may comprise medical, social and legal agencies.

**EFFORTS IN THE WEST**

So far the discussion confined to the efforts made in India in dealing with the problem of addiction. In the West too the problem of addiction has aggravated since 1980s. Multidimensional measures are underway to deal with the various aspects of the problem including prevention, treatment, rehabilitation/aftercare, research and training.

The strategy adopted for prevention is three fold: (i) reduction in the availability of drugs of abuse; (ii) reduction in the demand for drugs of abuse; (iii) harm reduction.
Supply of illicit drugs is being controlled through the enforcement of law. The prescribed drugs are controlled through better education of doctors in regard to prescription of non-addictive drugs. Efforts are also underway to produce less addictive drugs for prescription. In regard to illicit drugs lack of political will prevails as these drugs are readily and abundantly available publically in pubs, off-licence shops and otherwise.

Reduction in demand for drugs includes public education. This area has not been given much attention. Media activities intensely advocate the use of alcohol and tobacco. This all the more induces youngsters to experiment with these substances at an early age. Preventive education includes production of educative material, sessions in schools, use of electronic media for education, etc. The impact of such programmes has not really been evaluated.

Recently more emphasis is laid on harm reduction. This approach basically aims at minimising the harmful consequences of drug abuse as its total eradication is viewed as near impossible. Under the strategy of harm reduction even a prescription of drug of abuse is permissible for those addicts who cannot manage without it. Such an approach prevents addicts from using adulterated drugs from the black market which lead to associated complications and AIDS in those addicts who share infected equipments. It propagates the supply of injection equipments to addicts, condoms for safer sex and relevant preventive education and behaviour modification.

The harm reduction approach creates dichotomy as it may lead to building a misconception that giving up drugs is a difficult or impossible task and only resort is to continue with it. It might come in the way to motivate the patients and at the same time even the drug workers find it difficult to advise on safer use of injection equipment. The availability of free injection equipment might lead to excessive abuse through injection. Therefore, approaches under harm reduction strategy need to be applied with lot of caution and discretion in order to take care of existing dichotomy.

In order to treat the addicts with growing problem of heroin and cocaine addiction in U.K., Drug Dependence Treatment Units (D.D.T.U.s) were set up in 1967 on recommendation of the Brain's Committee. These clinics are mostly attached to the general hospitals. These units are headed by psychiatrist consultants and other staff include senior and junior doctors, nurses, social workers, psychiatrists and administrative staff. Each unit member has got specific role to play. First assessment point is a nurse, social worker takes care of social aspects that may relate to housing, accommodation, social adjustment, employment, family and child problem, probation, arranging and preparing for rehabilitation, etc. Psychologist helps in treatment process by dealing with various psychological aspects through specialised technique. Patients are referred to these clinics by their general practitioner, social workers, probation officers, other social welfare agencies or it may be at times self referral.
To begin with these clinics mostly dealt with the abuse of drugs like heroin/cocaine but gradually the coverage was even extended to cases with other drugs of abuse. In-patient services are also provided by some of the DDTUs. Experience has shown that these units do not attract many patients. The addicts are mainly admitted for purposes like assessment, stabilisation of the drug dose, detoxification, treatment of complications, etc. Stay of patients in such clinics vary from month to six months.

The in-patient units provide therapeutic environment to the patients. It carries out number of activities to benefit the patients and these include counselling/individual therapy, group therapy sessions, relaxation, recreation, physiotherapy, occupational therapy, day services, etc. The environment provided and activities carried out help the patients to enter into a different life style which is not centred around drugs. A close check is enforced in in-patient unit in order to keep them drug free. Patients are usually escorted to various places and even the diet is supplied from the ward itself. Detoxification is done either by using opiate drugs, such as, methadone lictus, non-opiate drugs, sedative drugs, acupuncture, neuro-electric treatment, alternative medicine. Steps in detoxification process varies depending on a case. It includes stabilisation, reduction, abstinence, substitution and maintenance, etc.

Each drug of abuse has specific treatment measures in addition to general measures. The problem of alcoholism is dealt with separately. The in-patient and out-patient services are provided. Limited services are available to deal with this equally harmful drug menace and drug problem needs to be dealt in its totality.

The ultimate role of the treatment process is to help the drug abusers to integrate into the society at large and lead a healthy and productive drug free life. Some of the cases showing inability to cope up without drugs are given maintenance therapy.

In U.K. National Health Scheme (N.H.S.) is responsible for treatment and however rehabilitation is the responsibility of social services department. Such a dichotomy has led to the separation of two essential components of treatment process which should occur concurrently. In practice it is mostly detoxification given importance as shorter and quicker process.

Rehabilitation is mainly performed through religious or charitable organisations. The activities of all such bodies are co-ordinated through the statutory voluntary body naming Standing Conference on Drug Abuse (SCODA). These voluntary organisations were started in haphazard manner depending on local needs, interests, skills and fundings. These organisations provide day-care centres, walk in functioning services, telephone advisory services, self-help groups and residential facilities.
The services include vocational rehabilitation, rehabilitation through provision of therapeutic communities, environment, hostels, etc. Self-help groups, such as, Narcotics Anonymous, Alcoholic Anonymous, Families Anonymous, Parents Anonymous and other supportive groups are also rehabilitation units. Minnesota method is also used in taking care of the addicts. Its philosophy is based on Narcotics Anonymous principle.

**Voluntary sector**

Voluntary sector has shouldered enormous responsibility in dealing with drug problem the World over. In the west there are statutory or non-statutory bodies which extend services of information, guidance, counselling, referral, day care, needle exchange and also rehabilitation/aftercare services. These agencies are known as street agencies in U.K. and non-governmental organisations in India. These are mostly located within the community.

Residential services are provided in hostels or within therapeutic communities' set up. These organisations are generally staffed with nurses, social workers/social scientists, psychologists, or persons with field experience or at times some agencies even engaged ex-addicts.

There is mushroom of such organisations in London. These started in a haphazard manner. No uniformity in terms of physical set up, staff, work etc. exists within these organisations. Their activities are, however, coordinated by a voluntary organisation named SCODA. The drug dependency units of hospitals keep close contact with these organisations and refer patients for rehabilitation and aftercare. Even these organisations refer cases to general practitioners or to NDTUs for detoxification.

All the organisations located in London providing residential services follow a criteria of abstinence from drugs for admission except in case of single organisation namely Rehabilitation of Metropolitan Addicts (ROMA) that provides services to those on drug substitution, stabilisation/maintenance therapy. Most of the organisations either provide services to drug users or to alcoholics.

In addition to providing services, the other yeoman task performed by these voluntary organisations is production, collection, dissemination of latest documents in drug prevention field. The Institute for the Study of Drug Dependence (ISDD), is one of such organisations. Alcohol Concern has also maintained upto date library on alcohol related material. Such organisations serve as useful informative centres for researchers, policy makers, planners and for those who are responsible for delivering the goods.

The process of receivin, finances for voluntary organisations is complex and a multi-window process which requires contact with various Divisions, such as, Departments of Health, Housing, Home Office, Regional and Local bodies, or
Charitable Organisations to get funds for different purposes. Such a procedure discourages good organisations to compete and make a dent. This kind of system needs to be simplified and streamlined.

Unlike India, voluntary organisations generally maintain an effective coordination and co-operation with the departments and organisations in the field.

Public awareness exist to a greater extent than in India mainly due to the extensive efforts put in by these voluntary organisations in providing information and services.

As mentioned earlier, in India the drug abuse prevention programme is primarily implemented through non-governmental organisations performing multiple activities involving various components of programme. However, their involvement and co-ordination of efforts made by them in ensuring a quality of services is an important aspect which needs priority attention.

**ROLE OF UNITED NATIONS IN INDIA**

A team of U.N. experts headed by Assistant Secretary General and Executive Director of the UN Fund for Drug Abuse Control (UNFDAC) visited India in October 1986 to explore the possibilities of increasing co-operation between UNFDAC and Government of India and provision of U.N. support to programmes of drug abuse prevention. 34 of projects were proposed and funded by UN.

The project on Drug Control Programme was initiated for five years which ended in December 1993. Under this project UNDCP supported activities in the field by assisting voluntary agencies to operate projects for awareness building and preventive education, provision of equipments to treatment centres, development of necessary manpower through consultations, conferences and training programmes both within and outside the country. UNDCP's assistance has been found valuable as it also provided forum for the sharing of knowledge and experience with other countries on drug abuse prevention.

The UN assistance could be availed of during 'International Decade Against Drug Abuse' (1990-2000) as per the Global Plan of Action unanimously adopted in February 1990 by the General Assembly of the United Nations provided the Central and State Governments in India prepare a comprehensive plan of action covering all the aspects of control of supply as well demand reduction.

Consequently, the Government of India set up in June, 1993 for four months (whose term was extended upto March, 1994) in collaboration with UNDCP, a National Task Force to develop a National Drug Control Masterplan. The team is headed by Shri C. Chakravorty, Retd. Director General, Narcotics Control Bureau and represented by members from Ministries of Finance, Welfare and
Health and Family Welfare. In addition, it has also appointed consultants. This Task Force is expected to prepare a comprehensive document covering all essential components relating to policy, strategy, priority and specific programmes of action to be undertaken during the period from January 1994 to December 2000. This will serve as a single document outlining all national concerns in drug abuse control programme.

**WHAT ARE WE LOOKING FORWARD TO?**

The measures adopted in India so far for drug abuse prevention, are in their infant stage. There is lot more to be done to strengthen the preventive and educational measures for general public and specific target groups and areas. Treatment facilities certainly have to be community based with greater emphasis on psycho-social approach than mere detoxification for a shorter duration. Counselling has to be an essential component of the programme at all stages. Family, friends, community leaders need to be involved.

The quality of services must be ensured by encouraging good voluntary organisations, setting of the standards and through periodic monitoring.

Strong data base has to be built up. Extent of the problem must be assessed periodically. Concurrent and periodic evaluations should be performed and preferably should be in-built into the programme.

An integrated model of services comprising of counselling, deaddiction and rehabilitation aspects must be evolved. It is worth mentioning that the Government of India on the basis of the experience gained during the seventh five year plan have taken steps to re-formulate the existing Scheme of Assistance to Voluntary Organisations for Prohibition and Drug Abuse Prevention in order to provide integrated services.

Law needs to be implemented in its true spirit. The short comings in the laws must be removed. With effective checks on supply of drugs and by reducing demand for drugs of abuse, we look forward for a healthy society with minimal drug abuse.
REFERENCES


4. Ibid.


7. Ibid.


23. Ibid.


31. Ibid.

32. Ibid.
