CHAPTER I

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Drug abuse is not a phenomenon of recent origin. Alcohol, opium and cannabis have been used by man since time immemorial to induce a feeling of euphoria, or to find imaginary escape from the feelings of despair, dejection and anxiety.

The problem of drug abuse had not received any serious attention in the past as it was limited only to a few sections of the society. Secondly, the substances in use were not as dangerous as seen in the recent times. The advent of far more hazardous drugs like heroin, LSD, amphetamines and methaqualone on the scene, and also the growing incidence of drug abuse even amongst the school-going children and adolescents, have brought the problem to focus throughout the world. Apart from the physical and mental damage that drugs have done to millions of users, illicit trafficking in drugs has also resulted globally in the escalation of other anti-social activities such as organized crime, corruption, intimidation of public officials, illegal banking operations, and criminal violations of import and export laws.

The increased availability of drugs, expansion of communication systems, migration and urbanization, changes in the attitudes and values, are some of the major factors which have caused the spread of drug abuse since the beginning of the twentieth century. Particularly during the last two decades, there has been an unprecedented spurt
in the use of illegal drugs throughout the world, and almost every nation has been affected by this scourge.

The illicit drug business is the second largest international trade in the world at present, the first being armaments.

The abuse of drugs is spreading from urban to rural areas, from adults to the children and adolescents, and from the affluent to the poorest sections of society. No country, race, religion, caste, creed or sex appears to be immune from the deadly grip of illicit drugs. Drugs have not only affected every walk of human life in the present-day world but are also likely to endanger future generations of mankind.

Intravenous drug abuse is proving to be one of the major causes for spread of AIDS due to the shared use of unsterilized needles by the addicts.

Drug abuse has brought in its trail violence at home, neglect of children, divorces, and general disruption of smooth family life. Many addicts have been driven to the point of selling their household belongings to support their addiction, and their children have to live without food and the basic amenities of life.

Drugs have brought crimes like theft, prostitution and illicit trafficking right into the educational institutions too. The drug abuse in industry has resulted in lower productivity, absenteeism, sickness and accidents at workplace. Similarly, it has endangered safety on the public roads. Drug abuse and trafficking have accelerated
the general crime rate as illegal drugs and crime thrive on each other.

Terrorist activities and illicit arms trade; many parts of the world have been depending on drug trafficking, and pose a serious threat to the security and stability of many nations. It has also been observed by the United Nations that vast profits derived from drug trafficking are being used in many countries for bribery to prevent the enactment of important anti-drug legislation, to weaken strong drug control measures, to get the penalties for drug traffickers reduced and to undermine the community's determination to rid itself of drug traffickers.¹ In a message to mark the 'International Day Against Drug Abuse and Illicit Trafficking' on the 26th June, 1993, the United Nations Secretary-General observed: "In the post cold war era, the international community faces a number of new and difficult challenges to peace and security. None is more insidious, or more far-reaching, than illicit drug production, trafficking and consumption."²

While adopting the Declaration on the Control of Drug Trafficking and Drug Abuse on the 14th December, 1984, the General Assembly of the United Nations had described drug trafficking and abuse as an international criminal activity, and declared that the "illegal production of, illicit demand for, abuse of and illicit trafficking in drugs impede economic and social progress, constitute a grave threat to the security and development of many
countries and people, and should be combated by all moral, legal and institutional means at the national, regional and international levels." On 24th February, 1990, while expressing deep concern over the increase in drug abuse across the globe, 150 member States of the United Nations gave a firm political commitment to pool in all possible resources, financial and human, into the war against the production, use and smuggling of drugs. They also declared 1991-2000 A.D. as a decade against drug abuse, during which they plan to intensify and sustain international, regional and national efforts.

In order to understand the present-day drug dilemma, it is necessary to have a glance at the history of intoxicating substances.

**HISTORICAL PERSPECTIVE**

Opium was known almost 6000 years ago to the Sumerians who used to describe opium poppy as 'HULLGIL', meaning 'a plant of joy'. There is historical evidence of the eating of poppy seeds among the Lake Dwellers of Switzerland around 2500 B.C. Later, the Sumerians are said to have passed on the knowledge of opium to Babylonians and then to Persians. There is a mention of Greek usage of opium around 900 B.C. in Homer's writings. There is also a reference to the use of poppy juice in 300 B.C. in the writing of Theophratus (371-287 B.C.), a Greek naturalist and philosopher. Hippocrates is stated to have made extensive use of opium as a medical herb. The earliest reference to the use of opium in Arab countries
is in the writings of AL-Biruni (973-1051 A.D.). Arab troops and traders brought the knowledge of opium to Europe and East Asia in the 10th century. It is believed that opium found its way to China also during the same period.

The earliest historical evidence of the use of alcohol in about 3500 B.C. is found in an Egyptian papyrus which contains the description of a brewery.

Coca appears to have been in use for the last 5000 years or so, much before the establishment of Inca Empire. Coca was considered to be a plant of divine origin by the Incas, and its leaves were chewed by the ruling or affluent classes of the society at that time.

Cannabis finds its first historical mention in the herbal compendiums of the Chinese emperor Shen Nung, written in around 2737 B.C. It was prescribed for use in various ailments. Chinese physician Hoa-Gho later used cannabis mixed with wine as a surgical anesthetic. In around 1000 B.C., cannabis began to be used as a religious hallucinogen, and became a part of the Hindu Culture. It was also in abundant use throughout northern Africa at the time of prophet Mohammed. While the use of alcohol was banned, as being inimical to the spiritual life, no restriction was imposed on cannabis, and it continued to be uninterruptedly abused. Apart from the above drugs, ergot fungus found on the seeds of a plant known as "morning glory" has also been used for hundreds of years by South American Indians to achieve religious hallucinations.
Sixteenth century A.D. marks the beginning of realization that intoxicants were harmful to human beings. Even coffee and tobacco consumption was taken very seriously in some parts of the world. Religious leaders in the Muslim world started regarding coffee as analogous to alcohol and it was forbidden to any devout Muslim to such an extent that if a man requested his wife to serve him coffee, it was sufficient ground for the wife to seek divorce. In the 17th century, the prince of a small state of Waldeck in Germany prohibited coffee-drinking, and offered to pay a reward of ten thalers—a local currency—to anyone who gave information about a coffee-drinker. In the late 18th century, the Furst-Bischof Wilhelm von Paderborn in Germany forbade coffee-drinking by ordinary citizens and peasants, while permitting use of the same by the nobility and the clergy.

Tobacco consumption also became a punishable offence in Turkey, Persia, Russia and some parts of Germany in the seventeenth century. In 1650, Sultan Murad IV of the Ottoman Empire prescribed death penalty for tobacco smoking. It was considered to be a major crime in parts of Switzerland in the year 1660. In Hungary, tobacco smoking became punishable in 1689 with fine and confiscation of property. In 1691, death penalty was prescribed for it in Luneberg, Germany.

From the 16th century to the 19th century, opium and cannabis addiction started coming under adverse notice of rulers in a few countries. The Sultan of Turkey prohibited
the use of opium and cannabis in the 16th century, Emperors of China issued edicts in the 18th and 19th centuries prohibiting opium smoking, and the Egyptian ruler banned the consumption of cannabis in 1884.

Towards the end of the eighteenth century, England started selling opium, through the East India Company, to China in exchange for tea. In 1831, the East India Company supplied Indian opium worth $11 million to China, and purchased $8 million worth of tea. After the East India Company left China in 1834, trade of opium by the British merchants continued unabated. The British government encouraged opium trade between India and China due to its being a major source of revenue. As the estimated number of opium addicts in China had reached about 150,000 by the mid-nineteenth century, the Chinese Government resisted to the compulsory trade of opium insisted upon by Britain. This resistance led to the First Opium War during 1839-42, as a result of which Britain was able to force opium trade on China. In the Second Opium War with China in 1856, the British, with the help of French forces, were victorious again, and China was forced to sign treaties giving opium trading concessions to the Britishers. Migration of the Chinese to South-East Asia and other areas resulted in spread of opium addiction to these areas also.

By the eighteenth century, opium addiction had become quite rampant in Europe. In middle of the nineteenth century, cannabis use became fashionable among bohemian
artistic and literary circles. A club named "Le Club des Hachichins" was established in Paris where eminent writers like Baudelaire and Gautier consumed large quantities of cannabis-based sweets under the belief that it promoted creativity. Later, in the United States also, writers like Bayard Taylor and Fitzhugh Ludlow glorified the use of cannabis through their writings about ecstatic experience with this drug.

In the nineteenth century, morphine, cocaine and heroin were discovered. Morphine, the main alkaloid of opium, was discovered in 1804 and has been considered to be a valuable medicine for the relief of pain. It did not take long for morphine to become a drug of abuse. The primary reason for this was that after the invention of the hypodermic syringe in America in 1856, morphine was liberally used for ameliorating the agony of soldiers wounded in the Civil War, apart from its administration to soldiers suffering from dysentery. These soldiers became addicted to morphine to such an extent that even after coming back from the war, they continued to use it by injecting themselves with the drug. The number of soldiers so addicted during the Civil War was reported to be around 4,00,000. Morphine addiction later came to be known as "the Army Disease.”

Cocaine was discovered in 1859, and was initially considered to be a harmless stimulant. It was advocated by Sigmund Freud for the treatment of morphine addiction, depression and chronic fatigue. Freud himself was an enthusiastic user of cocaine, and considered it to be a
'magical drug'. However, it was later realized by him and others that the use of cocaine had inherent dangers, and that it was a failure as a cure for morphine addiction. By then, a large number of people had already become addicted to cocaine. During the last part of the nineteenth century, even advertisements appeared in the press for sale of coca leaves and cocaine. Coca leaves, considered a dangerous narcotic at present, were used in the manufacture of the famous international drink 'Coca-Cola' till 1903, when the manufacturers were forced to switch over to decocainized coca leaves for flavouring.

Heroin, an alkaloid of opium, was discovered in 1898 and was sold freely as a sedative for cough in USA. Other opium derivatives were also sold in that country through public advertisements at that time as 'expectorants' and 'soothing syrups'.

At the end of the nineteenth century, efforts to control the production and consumption of opium in U.K. were made whereby the Pharmacy Act, 1868 was passed to control the supply and sale of drugs including opium.

The early twentieth century witnessed the enactment of the Harrison Act, 1914 by the United States Congress, and of the Dangerous Drugs Act, 1920 in U.K. Both these Acts were aimed at controlling drug abuse. On the other hand, new drugs of addiction were also being discovered at the same time. Veronal was discovered in 1903, Procaine in 1905 and Phenobarbital or Luminal in 1912. Amphetamine...
was synthesized in 1927, and was used by the Allied as well as the German soldiers during the Second World War to ward off sleep and fatigue, and also "to give Dutch courage before an assault". LSD was discovered in 1938, and Meperidine in 1939. Methadone, another synthetic narcotic, was developed by the Germans during the Second World War as natural narcotics were not available with them.

Drug abuse has been gradually increasing since the beginning of the 20th century. The international community too has been making efforts to control this menace since that time. These efforts as well as the current global scenario are discussed later in this Chapter.

MEANING OF THE TERM 'DRUG'

The term 'drug' has four sets of definitions: scientific, medical, sociological and legal. According to the basic scientific definition, this term refers to a substance, which by its chemical nature, affects the structure or functions of a living organism. Medical definition explains the drug as "any chemical agent which affects live protoplasm". Viewed in the light of scientific or medical definitions, substances like medicines, alcoholic beverages, narcotics, cigarettes, food and even water may fall within the scope of the term 'drug'.

The sociological definition relates the term 'drug' to a narcotic drug. Few people would prefer to use this term to refer to common medicines like aspirin, analgin or cough syrup. Similarly, the people habitually using alcohol, tobacco or analgesics are hardly considered to be 'drug abusers' in the sociological context.
There is no standard legal definition of the term 'drug'. It varies from statute to statute. In India, for example, mosquito repellents and the chemicals used for destruction of insects causing disease in human-beings, too fall within the definition of 'drug' under the Drugs and Cosmetics Act, 1940. For purposes of the Drugs (Control) Act, 1950, a 'drug' is only that drug to which the Act has been declared to be applicable by the Central Government. 'Drug' has a still different definition under the Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954.

The meaning of the term 'drug' as given in most of the English dictionaries generally encompasses all the four sets of definitions mentioned above. However, the meaning assigned to this term by different people i.e. physicians, pharmacists, mediamen, policemen, public health officials and lawyers, depends on their own profession or activities.

The international conventions and agreements on narcotics too do not specifically define 'drug'.

In a nutshell, the definition of 'drug' is determined by the context in which it is used. For the sake of clarity and precision, it may be mentioned that the term 'drug' as appearing in this work refers, unless the context requires otherwise, only to a 'narcotic drug' or 'psychotropic substance', as defined in the Narcotic Drugs and Psychotropic Substances Act, 1985 in India.
'Drug abuse' has been defined by the World Health Organization as 'persistent or sporadic excessive drug use, inconsistent or unrelated to acceptable medical practice.'

On the basis of the above definition, drug abusers may be put into three categories:

(a) Persons who use totally banned narcotic drugs or psychotropic substances which have no legitimate medical use e.g. heroin, cocaine, methaqualone, LSD and charas etc.

(b) Persons who use narcotic drugs or psychotropic substances, restricted legally to medical purposes only e.g. morphine, codeine, tranquillizers and sedatives etc., for non-medical purposes i.e. without being medically prescribed or contrary to the medical prescription.

(c) Persons who habitually use prescription drugs not falling within the scope of 'narcotic drug' or 'psychotropic substance', e.g. analgins, antibiotics, and steroids etc. without being medically advised to do so.

For obvious reasons, it is not intended to bring drug abusers falling in category (c) above, within the ambit of this study.

Even amongst drug abusers of the first two categories above, there are further three classes:

(a) Persons consuming the drug on one or more occasions just to satisfy their curiosity but
not falling prey to it;
(b) Persons occasionally consuming the drug for recreation without becoming habituated to it;
(c) Persons who have already become addicts or drug-dependent.

All the above three classes of persons violate the drug laws. However, society concerns itself primarily with the persons who have developed drug dependence, and are commonly referred to as the 'addicts'.

'Drug Dependence' is a term introduced by the World Health Organization in 1964 for describing the process of abuse of drugs. It was intended to replace the terms 'drug addiction' and 'drug habituation', used earlier by WHO, as the use of these terms, in its opinion, had resulted in the ongoing confusion. However, the terms 'addict' and 'drug dependent' are still used interchangeably in the current literature on the subject.

'Drug Dependence' has been defined by the World Health Organization as follows:

"A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid discomforts of its absence".
The three main components of the above definition are:

(a) Taking of a drug;
(b) Interaction between drug and the human body;
(c) Psychic or psychological and sometimes also physical dependence resulting from the above interaction, and characterised by a compulsive desire to repeatedly consume the same drug:
   (i) either for experiencing the pleasurable effect again or,
   (ii) for warding off the withdrawal symptoms caused by the abstinence from the periodic use of that drug.

Taking of a drug

Generally speaking, a person takes a drug for the first time to satisfy his or her curiosity, or to have fun and heighten pleasure, or to relieve tension or anxiety, or just to identify himself with a certain group or a drug-oriented society. However, the second and subsequent drug use is not axiomatically for the same reasons. Glatt stresses that "the factors which are responsible for initiating drug abuse or the onset of dependence are not necessarily the same as those involved in maintaining the state of dependence." The factors which influence the drug-taking behaviour are discussed elaborately, particularly in the Indian context, in Chapter II of this work.

Interaction between drug and the human body

After taking the drug, a person does experience the feeling of euphoria or heightened pleasure or relief from
tension and anxiety. However, according to the scientific evidence, this effect is only the result of benumbing of the central nervous system which is not able to effectively transmit signals of tension or pain or anxiety to the brain. This effect will depend on the quantity of the drug taken, frequency of its taking, the route of its administration, personality of the person consuming, and also the social setting in which the drug is consumed.

Drugs bring about temporary alterations in the cerebral circulation and brain metabolism. The nervous system consists of specialized cells known as 'nerve cells' or the 'neurons'. Each cell consists of a number of impulse-receiving branches called 'dendrites', and of one impulse sending branch known as the 'axon'. Each cell also receives 'excitatory' or 'inhibitory' impulses from other nerve cells through the medium of 'axons'. However, the nerve cells do not come directly in physical contact with each other but are separated by microscopic spaces known as 'synapses'. The 'synapse' thus regulates the flow of impulses between the nerve cells. Stimulant drugs may change the biochemical condition at the synapse, which results in the emission of extra nerve impulses. On the other hand, the depressant drugs will retard or switch off the regular propagation of the nerve impulses. Thus, drugs cause synaptic changes of chemical nature and whether such event will result in stimulation or depression of the nervous system will depend on the type of drug used.

According to another view, each drug attacks a specific
receptor in the brain, and it explains why different drugs have dissimilar effects on the nervous system i.e. depressant, stimulating or hallucinogenic.

Physical dependence and the psychological dependence

Physical dependence is a phenomenon resulting from the pharmacological effect of the constant use of drugs on the body. It manifests itself in the form of withdrawal symptoms or an abstinence syndrome, if the drug is withheld from a drug-dependent person. The usual withdrawal symptoms are restlessness, diarrhoea, vomiting, sleeplessness and loss of appetite.

The reason for the appearance of withdrawal symptoms is that the periodic use of a drug brings about constant alterations in the neurotransmission system and if the drug is not consumed again after the effects of the earlier dose start wearing off, the neurotransmission system begins to return to normal, causing discomfort thereby. In other words, the constant use of a drug affects the metabolism and the central nervous system, and the body gets so attuned to that drug that abstinence from its use immediately results in withdrawal symptoms or abstinence syndrome. The extent of physical dependence and intensity of withdrawal symptoms will vary from drug to drug, and will also bear a close relationship to the total daily dose and the interval between doses, duration of drug dependence, and the health and personality of the person concerned. Some drugs, however, do not cause any physical dependence, and their repeated abuse is solely due to psychological dependence of the person concerned on such drugs.
An important feature of physical dependence is the development of tolerance. 'Tolerance factor', as it is called, may be defined as the ability of an organism to become used to increasing amounts of a substance upon repeated exposure to it. The reason for this phenomenon is not exactly known. However, Richard Barrymore speculates that it may be "partly because the body learns to destroy the drug more quickly and partly because the brain cells become more accustomed to the drug concerned." According to Mark S. Gold, one reason for development of 'tolerance' is that the individual cells of the body become less sensitive to the concentrations of the drug in the blood. As a result, the initial doses of the drug develop tolerance in the concerned individual, and subsequently, he has to take higher doses of the drug to have the same effect the original doses gave him. The progressively increasing doses also become necessary to relieve the suffering which arises when the effect of previous dose starts wearing off gradually. Interviews with a few heroin-dependent persons in the course of this investigation revealed that some of them had started with a daily dose of 50mg. but graduated to 2 gms. daily i.e., 40 times of the initial dose, within 2 to 3 years.

Psychological dependence is not, in sharp contrast to physical dependence, caused primarily by the drug itself, but is relatable to the mental constitution of the individual concerned. For example, cannabis and cocaine produce negligible physical dependence, but we still find a large
percentage of persons dependent upon these drugs, as they cannot resist the desire or craving to use the drug for experiencing its pleasurable effect although no significant withdrawal symptoms or discomfort will result, even if such a person stopped taking these drugs.

The drugs which produce physical dependence do cause psychological dependence also to some degree. Therefore, even if a person gets rid of physical dependence on a drug due to medical treatment, he may relapse to his drug-taking behaviour unless he learns to get over the psychological dependence also. Glatt illustrates the relative importance of psychological and physical dependence by taking the example of compulsive gambling. He explains: "Here of course there is no physical and merely psychological dependence. Nevertheless, compulsive gambling shows most of the characteristic features of compulsive drug-taking and drinking." 

**TYPES OF DRUGS**

On the basis of their effect on the central nervous system of the human body, drugs may be broadly classified into: Depressants, Stimulants and Hallucinogens.

**Depressants**

Depressants are drugs which dull the consciousness, induce sleep or stupor, and relieve anxiety or pain. The movements of a person, who consumes any of these drugs, become slower, speech gets slurred, and the pupils appear dilated. These drugs can be further categorized into: Opium and its derivatives, barbiturate, and non-barbiturate sedatives and tranquillizers.
Opium is a dark brown coagulated milk of an unripe opium poppy which grows in temperate and subtropical climates. It is either eaten as it is or smoked through a long stemmed pipe.

The opium derivatives i.e. morphine, heroin, and codiene are abused in abundance. Morphine is a light brown or white crystalline powder which can be extracted either from opium (10% morphine content) or directly from the poppy straw. Morphine is medically used orally or by injection for relief of pain. Addicts prefer heroin to morphine as the former is more potent. Heroin is available in powder or tablet form, and is of white crystalline appearance. It is first dissolved in water and then injected intravenously by an addict into his or her body. Some addicts put small quantity of heroin on a tin foil, heat it and inhale its fumes - a process known as 'chasing'. It is also used by sniffing or smoking as the drug gets absorbed through the membranes of the nasopharynx and respiratory tract. 'Brown Sugar' or 'Smack' is a form of heroin in raw stage before final purification, and is also obtained by adulterating pure heroin with glucose, talcum powder or other adulterants. Heroin is said to be the most seductive drug due to its ability to cause tremendous physical and psychological dependence, and thereby enslaving the user. The United Nations considers heroin to be the greatest public health hazard as it can be easily manufactured clandestinely and transported conveniently in its pure form. Since the same syringe and needle is often used many times
without sterilizing by more than one person, a large number of addicts get infected with HIV. A high percentage of heroin addicts are estimated to die before attaining the age of forty.89

Codiene, another opium derivative, is used in most of the cough syrups and headache tablets which are freely available in the market. These codiene-containing medicines are often abused by some addicts when they are not able to get their regular supply of heroin or morphine.90

Amongst the non-opiate depressants, the barbiturates are most frequently abused drugs. These synthetic drugs are derived from barbituric acid, and have the sedative and sleep-producing effect. Medically, these drugs are used for relief from anxiety and tension. Most common of the barbiturates used by addicts are: phenobarbital, amobarbital, butabarbital and secobarbital.91

Barbiturates are available in the form of powders, elixirs, syrups, capsules and tablets, and can be taken orally or intravenously. These drugs produce physical and psychological dependence to such an extent that sudden withdrawal of such a drug from an addict can be highly dangerous, and may even lead to respiratory failure.92 Therefore, withdrawal should take place under close medical supervision.93 As barbiturates have the effect of distorting a person's sense of the passage of time as well as his memory, there have been numerous instances of deaths due to overdose as the addict often forgets that he has already taken a dose earlier, and keeps on taking additional doses till he gets into a heavy sleep or coma.94
The third category of depressants i.e. non-barbiturates, sedatives and tranquillizers find their target in all age-groups and classes of the society. These drugs reduce anxiety and tension, and promote sleep. Doriden and methaqualone tablets have been popular sedatives in use by adolescents and students. Tranquillizers like Valium, Diazepam and Equanil, commonly known as 'sleeping pills', are drugs which are often abused by middle-aged or old people. An overdose of any of these drugs can be fatal, and deaths due to this are not uncommon. Withdrawal of the non-barbiturate drugs from an addict, except under close medical supervision, can entail dangerous consequences similar to those resulting from sudden and unsupervised withdrawal from barbiturates.

Stimulants

Stimulants are the drugs which stimulate the central nervous system, and thus allay the feelings of fatigue, hunger or sleep.

Coca leaf and a coca derivative called cocaine, are the two natural stimulants. The other category of stimulants consists of amphetamines which are synthetic in nature.

The leaves of the coca bush, which is an evergreen shrub grown primarily in South America, are consumed by chewing by the Andean Indians in Peru, Bolivia, Columbia and Argentina for protection against cold, fatigue and hunger.
Cocaine, which is an alkaloid extracted from the coca leaf, is used generally by the affluent class only as it is quite expensive. It is an odourless white crystalline fluffy powder, and is sniffed or injected intravenously by the addicts. Cocaine is a potent nervous system stimulant and creates a feeling of muscular strength, excitement, elation and euphoria. The euphoria is, however, short-lived and gets replaced by feelings of depression, delusions and hallucinations. Therefore, some addicts use it in combination with heroin. The combination, known as 'Speedball', extends the length of the euphoria.

Cocaine does not cause physical dependence but makes the user psychologically dependent on the drug. Hence, there are no significant withdrawal symptoms even if it is suddenly withdrawn from an addict.

'Crack', a more potent form of cocaine, is becoming highly popular in some countries at present as it is cheaper than cocaine in the illicit markets.

The other category of stimulants consists of amphetamines which are synthetic in nature, and were first developed in 1925. Common amphetamines are: Benzedrine, Dexedrine and Preludin. These drugs are available in the form of tablets, capsules and injections. Amphetamines act as strong stimulants of the central nervous system. These drugs have also been used as 'slimming pills' in the recent past. Due to their effect of causing increased wakefulness and reversal of fatigue, these drugs are commonly abused by students for
The effects are studying up to late hours at night. The effects are excitement, agitated restlessness and insomnia, and the user tends to be very talkative and euphoric. The pulse rate goes up, pupils get dilated and the body trembles. Another interesting effect of severe amphetamine intoxication is that the addict indulges in repeating tasks such as dismantling and re-assembling a radio set or clock without any purpose, and generally remains awake late at night.

Amphetamines have been widely abused by professional athletes in the recent past under the false impression that these drugs reduce fatigue and thus result in improved performance. Researches have shown that amphetamines only produce a hyperoptimism that does not allow the athlete to realistically assess his stamina, and thus he tends to over-strain himself.

Like cocaine, amphetamines also create great psychological dependence with insignificant physical dependence. It is, therefore, easier to de-addict a cocaine dependent person, but the relapse rate is generally very high.

Hallucinogens

Hallucinogens are drugs which produce radical mental changes such as vivid visual and auditory hallucinations, euphoria, delusions, paranoid reactions and distortions of the user's awareness of reality and his own identity.

Marijuana, known as 'ganja' in India, consists of flowering or fruiting tops of the cannabis plant, and is one
of the most popular hallucinogenic drugs used by the addicts throughout the world. 'Hashish' or 'charas' - a resin obtained from cannabis plant - is another natural hallucinogen. LSD, Mescaline, and Psilocybin are some of the other hallucinogens which are abused in a few countries.116

Marijuana is mixed with tobacco and smoked through a cigarette or a pipe. The effect of this drug is that the user's pupils get dilated, and he indulges in loud-talking and bursts of laughter without reason.117 He will also have hallucination and distortion of perception. 'Hashish' or 'charas', which is also smoked by mixing it with tobacco, produces similar results. The cannabis products do not cause any physical dependence, and are considered to be less dangerous as compared to other drugs.118 However, regular and prolonged use can seriously impair the cognitive and endocrine functions and immune system of the body.119

L-Serycic Acid Diethylamide, LSD for short, a synthetic hallucinogen, is available in the form of a white powder or colourless liquid. It is generally taken orally. Discovered accidently in 1943, it had been in use for treatment of neurotic illness.120 It produces hallucinations and striking changes in the user's perceptions; and therefore, it is often labelled as 'mind-bender' or 'psychedelic drug'.121 The user gets into a trance-like state but experiences depression and irritability as soon as effect of the drug starts wearing off.122 LSD has dangerous side-effects which persist for long, and may make the user almost appear to be a schizophrenic.123 The drug does not cause physical dependence.124 However, the
psychological dependence may leave a profound impact on the user's personality.\textsuperscript{125}

Mescaline is an alkaloid found in the peyote cactus, and causes visual hallucinations.\textsuperscript{126} Psilocybin was discovered in 1958 as an hallucinogenic agent present in a variety of small mushrooms belonging to species 'Psilocybe mexicana'.\textsuperscript{127} Its effect is similar to that of mescaline.\textsuperscript{128} Both mescaline and psilocybin have not been able to gain much popularity among addicts, and are of little consequence at present.

**Designer Drugs**

Designer drugs are the analogues which are produced in the laboratory by performing small alterations in the molecular structure of a controlled drug.\textsuperscript{129} These drugs have properties similar to the parent drug but can be thousands of times more potent.\textsuperscript{130} Common amongst such drugs are the analogues of Fentanyl, Meperidine and Amphetamines.\textsuperscript{131}

The great advantage to the producers and dealers of these drugs is that as these newly synthesized drugs take a long time before getting identified and listed on the drug statutes, their production, sale and use remain legal for sometime. However, since these drugs have extremely high potency, a person trying the drug may die simply due to overdose, and that is precisely the reason that these drugs have not gained any popularity so far among the potential drug abusers as even its experimental use is considered to be too dangerous.
Inhalants

Apart from the commonly known drugs, other simple substances like chloroform, gasoline, glue, ether, kerosene, lighter fluid and paint thinner are also abused by sniffing the vapours of such substances for getting hallucinogenic experience. As these substances have to be used in industry, construction and house-holds, it is almost impossible to prevent their abuse. The inhalation of the vapours of such substances disturbs vision, impairs judgement, and reduces muscle and reflex control. While many abusers die from the overdose of the fumes, others meet their death due to suffocation as they cover their heads and faces with plastic bags to concentrate the fumes for inhalation.

Sniffing of solvents and other volatile substances has become increasingly widespread in recent years in many developed and developing countries.

CURRENT INTERNATIONAL SCENARIO

Drug abuse is increasing at an alarming rate throughout the world. A brief analysis of the situation prevailing in various regions is given below:

Africa

According to the report of the International Narcotics Control Board for 1992, drug abuse and trafficking is on the increase in African countries. The political, economic and social upheavals and unrest in the region in recent years have adversely affected drug control measures.
Cannabis is the main drug produced and consumed throughout Africa. Egypt has particularly serious problem of abuse of cannabis with an estimated number of 20,000,000 addicts in 1992. Morocco is one of the largest producers of cannabis meant for trafficking to Europe as 'Hashish', and had between 30,000 - 40,000 hectares of land under illicit cultivation in 1991. Opium cultivation is also taking place on a small scale in Kenya, Egypt, Morocco and Sudan.

The abuse of heroin was virtually unknown in Africa till the early 1980s. However, there is evidence of an abundant use of this drug now in Mauritius and Nigeria as these countries serve as transit points for heroin coming from Asia for being smuggled into Europe and the Americas. Nigeria is known worldwide as the 'source of an seemingly endless stream of heroin couriers operating in all the five continents.' In 1990, Nigerian nationals accounted for over 40 percent of U.S. Customs seizures. Nigeria is at present the focal point for most West African heroin trafficking organizations, according to the United States government sources.

While heroin addiction is within manageable limits in Africa, methaqualone, a synthetic addictive drug illicitly produced mainly in India, is becoming popular. According to the recent report of the International Narcotics Control Board, cocaine abuse too is on the increase in several countries in the region.
South Asia

Drug abuse is on the increase in South Asian countries. According to a late-1992 estimate, Nepal has about 50,000 heroin addicts. Sri Lanka has become a potential consuming market for heroin, and also an important transit route for smuggling of drugs from India to North America and Europe. According to the International Narcotics Control Board, Sri Lanka had about 47,000 heroin users and 2,00,000 cannabis users in 1992.

Bangladesh is fast emerging as a transit country for narcotics traffic from India to Europe and United States. According to the estimate of local experts, Bangladesh had between two million to five million addicts in 1992. India has shifted its role from a major transit country to a major consumer country for illicit drugs, with over 25,00,000 addicts. India is also the world's largest producer and exporter of licit opium meant for extraction of opiates for medical purposes.

East and South-East Asia

About 2,500 metric tonnes of illicit opium is produced in 'Golden Triangle' comprising of Myanmar, Thailand and Laos. Nearly 90 percent of this quantity is produced in the northeast area of Myanmar, which is under the control of the Burmese Communist Party and the Shan United Army. According to the U.S. State Department, Myanmar's annual output of opium was about 2250 tons in 1991. The opium
and heroin trade is largely at the hands of one Khun Sa who heads the Shan United Army, an insurgent group of about 6,000 men. According to the U.S. Government sources, the Myanmar government has reached accommodations with this insurgent group on illicit drug trafficking front in exchange for an end to their anti-government insurgencies. Khun Sa has repeatedly made offers to the United States government to buy out his illicit drug trade for 42 million dollars, but U.S. authorities have been declining such offers for obvious reasons.

The opium extracted from illicit poppy in Myanmar is first taken to the refineries in Laos along the Thai-Myanmar border, and the heroin produced is brought to Thailand for onward transport to USA by concealing it in export cargo and routing it through relatively drug-free countries to create deception about the place of origin and avoid scrutiny of cargo to which the goods originating from 'Golden Triangle' countries are subjected to. During the last three years or so, a new drug route from Myanmar to Yunan province in China, and then to USA via Hongkong has come into operation. A part of the heroin of Myanmar origin enters India also through border states of Manipur and Mizoram. Heroin trade entails its usual consequences, and Myanmar had about 1,50,000 addicts in 1992.

Thailand is a comparatively minor producer of heroin in the 'Golden Triangle' region but acts as a major transit area for heroin of Myanmar origin. Heroin addiction is reported to be on the rise, and the estimated number of
addicts in 1992 was about 1,00,000. The local authorities estimate that 50 percent of intravenous drug abusers carry the deadly HIV infection, and predict that by the year 2000, from 5 percent to 10 percent of the total population will suffer from AIDS. 162

Laos produced an estimated amount of 265 metric tons of illicit opium in 1991.163 United States government sources report that illicit cultivation is on the decline due to the crop substitution programmes undertaken by the Laos government. According to the latest report of the International Narcotics Control Board, there are about 30,000 to 50,000 drug-dependent persons in the country.165

China and Hong Kong are acting as major transit countries for heroin originating from the 'Golden Triangle'. According to the official reports in China, the number of known drug addicts in the country in June, 1992 was 1,48,000 which was twice the figure reported in 1990.166 The Chinese government, however, gives a high priority to narcotic control. On October 26, 1991, 35 drug traffickers were publicly sentenced to death and later executed.167 In October, 1992, twenty four persons convicted for drug trafficking had been executed in the southern province of Guangxi before a crowd of 10,000 people.168

Hong Kong was estimated to have 41,000 addicts as of 30th June, 1991.169 In Malaysia, the number of identified addicts increased from 711 in 1970, 12,484 in 1975, and 1,20,332 in 1986 to 1,45,684 by the end of 1989.170
In 1992, the number of addicts in the country was estimated to be 1,57,000. Japan continues to be affected by the abuse of methamphetamine, a psychotropic substance, smuggled into the country primarily from Taiwan. In Korea too, there has been a sharp increase in the abuse of methamphetamine in the 1980s. Philippines and Singapore are reported to be not significantly affected by drug abuse.

Near and Middle East

The 'Golden Crescent' region comprising of Afghanistan, Pakistan and Iran, is the major source of illicit opium and its derivatives.

Opium poppy has been the traditional crop of Afghanistan for centuries. During the Soviet occupation, the Mujahideen guerrillas fighting the Soviet army were relying on drug trafficking to finance their activities. Even after the Soviet withdrawal, the Mujahideen groups continue to depend on drug money as they have been involved in internecine wars. Various estimates put the quantity of opium produced in Afghanistan from 400 tonnes to 3000 tonnes annually.

Pakistan had banned opium cultivation in 1979. However, about 200 tonnes of opium poppy is still grown illicitly in the tribal areas of NWFP region as these areas are governed by the local tribal laws, and the writ of the federal government extends only to the maintenance of communication links. According to the recent estimates of the International Narcotics Control Board, the illicit
production of heroin in Pakistan exceeds 70 tonnes annually at present. The latest estimates put the number of addicts in Pakistan at 3 million, of whom about 1.2 to 1.7 million are addicted to heroin. Addiction is increasing in this country at a fast pace as evidenced by the facts that the national survey on drug abuse conducted in 1982 had reported the number of addicts to be 1.3 million, out of whom 3,00,000 were heroin abusers, while the survey in 1986 had put the number of addicts at 1.9 million, of whom 6,57,000 were addicted to heroin.

Iran is a major transit country for heroin produced in Afghanistan and Pakistan, and smuggled through Turkey and other Middle East countries to North America and Europe. The official estimates had put the number of addicts in Iran in 1991 at 6,00,000. Drug abuse and trafficking continue in spite of the fact that traffickers in possession of more than 30 gms of heroin or 5 Kg. of opium are liable to death penalty and confiscation of their property.

Turkey is a traditional grower of opium poppy. It is also one of the few countries allowed by the United Nations to produce opium to meet the medicinal requirements of the world. Turkey faces a serious drug trafficking problem at present. In the first ten months of 1991 alone, 1480 Kg. of heroin/morphine base was seized and five illicit heroin processing laboratories destroyed. According to the International Narcotics Control Board, Turkey continues to be the principal transit country for South-West Asian heroin destined for Western markets.
Lebanon is currently facing the problem of trafficking in cocaine which enters the country from Brazil. In Saudi Arabia, cannabis and psychotropic substances continue to be widely abused.

North America

The United States of America has been the country worst-affected by the drug menace. However, it has achieved some success in the recent years in containing drug abuse. The estimated number of users of illicit drugs was 23 million in 1985, 14.5 million in 1988, 12.9 million in 1990, and 12.6 million in 1991. In spite of the decline in drug abuse in general, the number of hard-core heroin and cocaine abusers is on the increase, and was estimated to have reached 3 million in 1991. The heroin consumed in the United States is smuggled mostly from Mexico, Afghanistan, Pakistan and the 'Golden Triangle' countries, while cocaine comes from the Andes region. Marijuana is illegally cultivated locally as well as smuggled from Mexico, Columbia and the Caribbean.

In Canada, surveys conducted in the recent years indicate that there is an overall decline in abuse of cannabis products. However, the availability and abuse of cocaine continues to remain at a high level.

Mexico has been a major source of heroin supply to the United States. Opium is illegally grown extensively in
Mexico, and refined heroin pushed through the 2,000 miles border with the United States. According to the latest nation-wide surveys in Mexico, there has been no significant increase in the abuse of drugs, with the exception of cocaine, during the last five years. More than 100 tonnes of cocaine was seized and over 9,000 hectares each of poppy and cannabis cultivation destroyed, from 1st December, 1988 to 1st March, 1992.

South and Central America and the Caribbean

In this region, Peru is the world's largest producer of coca leaf while Columbia is the world's largest producer of refined cocaine. Bolivia is the second largest producer of both coca and cocaine. Brazil does not have any significant coca plantation but acts as a transhipment country for cocaine originating from Peru, Columbia and Bolivia, and destined for the United States and Europe.

In Peru, the area under illicit coca cultivation increased from 2,50,000 hectares in 1990 to approximately 3,50,000 hectares in 1992. In 1988, 37 percent of the secondary-school students in the country were reported to be abusing drugs.

Columbia has about 1.2 million drug abusers, according to the recent estimates. Medellin and Cali cartels in Columbia alone control about 90 percent of world's illicit cocaine trade. About 200 judges, 25 journalists, hundreds of policemen, a Minister of Justice and an Attorney General
had been murdered by drug mafia during 1978-1988. In 1991 alone, 429 policemen were killed during action against drug traffickers. In December 1990, a judicial reform decree was issued under which the drug cases would be tried by 84 well-protected judges whose identity was to be kept a secret to reduce the chance of their being intimidated or killed by the drug mafia. In September 1992, a major multinational law enforcement operation, involving coordinated efforts of eight countries, was undertaken against the Columbian Cali cartel, and it led to the seizure of 44 million US dollars in assets and the arrest of a number of top financial managers of the cartel.

In Bolivia, 10,000 metric tons of coca leaf is consumed annually, according to the United States government sources. About 5 percent of the total population is engaged in earning its living directly or indirectly from illicit trafficking in drugs.

Panama has been an important transit point for the flow of drugs to the United States. In December, 1989, U.S. President sent 23,000 troops into Panama to oust the Panamanian dictator Manuel Noriega who had been engaged for long in supporting the drug-lords engaged in cocaine smuggling. Noriega was captured and taken to the United States for trial according to the American law. Later, he was convicted of eight drug-related felonies following the testimony of 78 witnesses and thousands of documents, and was sentenced to 40 years imprisonment on the 10th July, 1992.
Drug abuse is reported to be on the increase in Chile and Ecuador. Suriname, Venezuela, Guatemala and the Caribbean countries are important transit points for the flow of cocaine to North America and Europe.

Europe

Drug trafficking is increasing throughout Europe. In 1990, more than 6 tonnes of heroin, over 13 tonnes of cocaine, and 200 tonnes of cannabis were seized in this region. These seizures were almost double of the quantities seized in 1989.

In Western European countries, the number of users of cannabis and heroin is stable but cocaine abuse is on the increase. After years of its declining abuse, LSD is once again recapturing its popularity in some countries of Europe, as evidenced by the fourfold increase in seizure of this drug in this region in 1991.

In Austria, France, Germany, Italy, Poland, Spain, and the United Kingdom, fresh legislative measures have been taken in the recent years to check drug trafficking and combat money-laundering.

The Netherlands is the only country in the region which has adopted a policy of tolerating cannabis abuse and sale of up to 30 grams of cannabis in the coffee shops. At present, the number of such coffee shops is between 1,000 to 2,000, and the number of regular cannabis abusers ranges between 5,50,000 to 6,00,000. While the current drug policy finds approval
at various levels of Dutch society, the International Narcotics Control Board does not approve of it, and has highlighted, in its report for 1992, the dangerous consequences of such a policy for the Netherlands as well as for the rest of Europe.\textsuperscript{213}

The highest number of drug abusers is estimated to be in the CIS member States i.e. the former Soviet Union.\textsuperscript{214} Cannabis is illicitly cultivated in more than 3 million acres land, together with about 1,00,000 poppy fields, and the number of drug abusers was between 1 to 1.5 million in 1991, in this region.\textsuperscript{215} CIS member States are presently being used as transit points for drugs originating from Afghanistan or Pakistan and destined for Western Europe.\textsuperscript{216} The disintegration of the Soviet Union appears to have resulted in the breakdown of the unified drug control network, and the successor republics are unable to give priority to this problem due to their economic crisis and internal conflicts.\textsuperscript{217} Most CIS member States also suffer, according to the International Narcotics Control Board, from inadequate national drug legislation and drug control machinery.\textsuperscript{218}

\textbf{Conclusion}

There is no significant drug abuse in the countries of this region, except in Australia, New Zealand and Papua New Guinea where cannabis is the most widely produced and abused drug.
INTERNATIONAL EFFORTS AT DRUG ABUSE CONTROL

The first international conference on the subject of drug abuse, held in Shanghai in 1909, led to the signing of the International Opium Convention at the Hague in 1912. The Convention made it obligatory on the signatories to take effective and progressive measures to suppress the manufacture and use of opium prepared for smoking; and to prohibit the import and export of such prepared opium. The Convention also aimed at limiting the manufacture and use of morphine, cocaine and their respective salts to legitimate medical purposes.

The Hague Convention, 1912 was followed by the International Opium Convention which was signed at Geneva in 1925. The Geneva Convention established the Permanent Control Board to supervise control over production, manufacture, trade and distribution of narcotic drugs. The signatories to the Convention resolved to take further measures to suppress the contraband traffic in and abuse of dangerous drugs, especially those derived from opium, Indian hemp and coca leaf. The Geneva Convention had thus extended the range of controlled drugs to include coca leaves and cannabis also which had not been covered by the Hague Convention, 1912.

The Hague Convention, 1912 and Geneva Convention, 1925 could not prevent smuggling and over-production of narcotics as Turkey and Persia, both being large producers of these drugs, had not ratified either of the Conventions till 1930. It was estimated by the Health Committee of League of Nations...
that 256 tons of raw opium and 5 tons of cocaine were sufficient to meet the medical requirements of the whole world but Turkey alone had exported 2282 Kgs. of morphine and 4383 Kgs. of heroin in the first 6 months of 1930. Therefore, the Convention for Limiting and Regulating Distribution of Narcotic Drugs was signed at Geneva in 1931. This Convention aimed at limiting the manufacture of narcotic drugs to the quantities needed for medical and scientific purposes. A Drug Supervisory Body was installed under the Convention to estimate the annual drug requirements of various States. The Convention empowered the Drug Supervisory Body to initiate an embargo against the parties whose imports and exports exceeded these estimates, or who exceeded the prescribed limitation on manufacture.

The Convention for the Suppression of Illicit Traffic in Dangerous Drugs, 1936 was the fourth international convention on the subject. The Convention aimed at making illicit drug trafficking a crime of international character, strengthening the measures intended to penalise offences, and encouraging a similar approach to all drug offences in all the countries.

With the United Nations coming into existence in 1945, the Economic and Social Council constituted the United Nations Commission on Narcotic Drugs in 1946. The efforts of this organisation led to the adoption of the Single Convention on Narcotic Drugs at New York in 1961.
The adoption of this Convention was motivated by the desire of the nations to conclude a generally acceptable international convention which would replace the existing treaties on narcotic drugs, limit such drugs to medical and scientific use and provide for continuous international co-operation and control in this field. The Single Convention on Narcotic Drugs, 1961 is the most notable piece of international legislation on the subject. With a view to further increase the efforts to control illicit drug production, use and trafficking, and also to highlight the need to provide facilities for treatment, rehabilitation, after-care and social integration of the addicts, a conference of the Economic and Social Council of the United Nations was held at Geneva in 1972 to consider some amendments to the Single Convention, 1961, and a protocol amending the said convention was adopted on the 25th March, 1972.

Each Party to the Single Convention on Narcotic Drugs 1961, and also to the Protocol of 1972, which amended the said Convention, is required:

(a) To furnish the estimates of quantities of drugs to be consumed for medical and scientific use, to the International Narcotics Control Board.

(b) To prohibit cultivation of opium poppy, the coca bush and the cannabis plant whenever the prevailing conditions in the country render such prohibition the most suitable measure, in its opinion, for protecting the public health
and welfare, and preventing the diversion of drugs into illicit traffic;\textsuperscript{230}

(c) To subject the production of cannabis or production of cannabis resin, if the cultivation of cannabis plant is at all permitted, to same controls as are applicable to similar activity in relation to opium poppy;\textsuperscript{231}

(d) To require that the manufacture, trade and distribution of drugs shall be under licence and control of government except where such activity is undertaken by the government enterprises;\textsuperscript{232}

(e) To subject all imports and exports of drugs to licencing and controls by the government;\textsuperscript{233}

(f) To make arrangements at the national level for preventive and repressive action against illicit traffic and to co-operate with other signatories with a view to maintain a co-ordinated campaign against the illicit traffic;\textsuperscript{234}

(g) To ensure that all the serious drug-related offences are liable to adequate punishment particularly by way of imprisonment or other penalties of deprivation of liberty;\textsuperscript{235} and to enact laws, subject to constitutional limitation, to provide that intentional participation in, conspiracy to commit and attempts to commit any drug-related offence,
and preparatory acts and financial operations
in connection with such offences, shall
also be punishable offences.

The psychotropic substances also drew the attention
of the United Nations in 1971 when the Convention on
Psychotropic Substances was adopted in Vienna. The main
obligations imposed on the Contracting Parties to the
Convention are:

(a) To prohibit all use of psychotropic substances
as listed in Schedule I of the Convention,
except for scientific and very limited
medical use in scientific or medical
institutions under control of the government;

(b) To restrict manufacture, export, import,
possession or sale of all other psychotropic
substances only for medical and scientific
purposes, and subject the same to licensing
controls;

(c) To take all practicable measures for the
prevention of abuse of psychotropic substances
and for the early identification, treatment,
education, after-care, rehabilitation and
social reintegration of abusers of such
substances;

(d) To take steps for preventive and repressive
action against the illicit traffic, and to
co-operate with the other countries for
achieving this.
In 1988, the delegates of 106 States met in a United Nations Conference held under auspices of the Economic and Social Council, and expressed deep concern at the magnitude and rising trend in drug abuse and illicit trafficking, and also at the fact "that children are used in many parts of the world as an illicit consumer market." Consequently, the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 (hereinafter referred to as "1988 Convention") was adopted.

Under Article 3 of the 1988 Convention, it is mandatory for all the Parties to make the following activities to be criminal offences under their domestic law:

(a) Production, manufacture, possession, import and export etc. (including financing or organising of all such activities) of any narcotic drug or psychotropic substance contrary to the 1961 Convention or the 1971 Convention;

(b) Conversion, transfer or dealing in any manner whatsoever with drug-related property;

(c) Acquisition, possession or use of any property or materials with the knowledge that such property or materials are connected with the drugs.

Article 3 of the 1988 Convention further makes it mandatory for the Parties to ensure that their courts or other competent authorities bear in mind the seriousness
of offences and all relevant circumstances when considering the eventuality of early release or parole of persons convicted of such offences. Article 5 requires the Parties to take all steps for confiscation of proceeds, or the property of equivalent value, derived from drug-related offences. It is also mandatory for the signatories to adopt necessary measures to identify, trace and seize such proceeds or property. If the drug-related property is situated in the territory of another State, a request for ordering confiscation thereof can be made and it is mandatory for that other state to take appropriate action on such request.

The Convention further makes it mandatory that all drug related offences will be deemed to be included as extraditable offences under any existing extradition treaty. The Convention makes it obligatory on the member States to: (a) afford mutual legal assistance to one another in the matters of investigation, prosecutions and judicial proceedings in relation to drug crimes; (b) co-operate with one another in the matters of exchange of information and training of enforcement officials; (c) prevent illicit diversion of substances which are frequently used in manufacture of illicit drugs; and (d) take appropriate measures to prevent illicit cultivation of plants containing narcotic drugs or psychotropic substances.

The United Nations has played an important role in
the international efforts to control drug abuse, and has been instrumental in the adoption of various international conventions on the subject. In 1971, the United Nations Fund for Drug Abuse Control was set up with the objective of giving assistance to governments and international agencies in their effort to restrict the supply of drugs to medical and scientific requirements, improve administrative and technical capabilities of existing machinery dealing with drug trafficking, create public awareness against drug abuse, and provide due facilities for treatment and rehabilitation of addicts. On January 1, 1991, United Nations Drug Control Programme (UNDCP) was set up for reorganization of all the UN activities relating to drug control and illicit trafficking, and the United Nations Fund for Drug Abuse Control became a part of the new set-up.

The Economic and Social Council of the United Nations formulates the overall policies of the organization for drug abuse control, and makes suitable recommendations to the member States on the advice of the Commission on Narcotic Drugs. The Commission on Narcotic Drugs is one of the six functional commissions of the Council. It has been assigned a number of important functions under various international conventions on drug abuse. In general, the Commission assists the Council in supervising the application of these conventions.
The role of International Narcotics Control Board is also significant. It was established by Article 9 of the Single Convention, 1961, and has been given the responsibility of administering the control system envisaged by the Convention. The Board is authorised under Article 14 of the Convention to investigate all aspects of drug trade. It remains in touch with the member States and persuades them to strengthen their laws and enforcement for drug control. Similar functions have been assigned to the Board under the 1971 Convention and the 1988 Convention. It also conducts training programmes and seminars for the drug enforcement officials from the member States.

The various specialized agencies of the United Nations like the International Labour Organization, World Health Organization, UNESCO, and Food and Agriculture Organization have also played notable roles in the field of drug abuse control by taking appropriate steps in this regard in their respective spheres of activities.

International drug abuse control system has had a tremendous impact on legislations on the subject in various countries. Most of the anti-drug laws in a country can be linked directly to the signing or ratification of an international convention, treaty or agreement by that country. The passing of the Harrison Act, 1914 in USA, and the Dangerous Drugs Act, 1920 in Britain, was the result of the signing of the International Opium
A social problem such as drug abuse can not be effectively solved by laws alone, howsoever stringent these may be. The enforcement efforts can only temporarily stifle the drug supply as the drug traffickers will always be able to find new avenues and strategies to meet the demand of consumers. Making the availability of drugs harder will not by itself eliminate the demand for such drugs. Paul Fuqua rightly points out that "history too aptly demonstrates the folly of assuming that enforcement efforts directed only at shutting off supplies can be successful." Therefore, the only way to control the drug menace is to reduce the supply of drugs as well as the demand for drugs. Demand-reduction strategies are as important as the supply-reduction strategies.
The basic objective of the present study is to find out the most appropriate approach for supply-reduction through the instrument of law and enforcement. As the demand-reduction issue can better be thoroughly investigated by a sociologist or a psychologist rather than by a legal researcher, this aspect has been dealt with at appropriate places in this work only to highlight the importance of framing a suitable demand-reduction strategy.
NOTES


5. Id.


8. Einstien, op. cit., p. 36.


11. Id.


17. Id.

21. Id.
27. Ibid., p. 339.
30. Id.
31. Szasz, op. cit., 186.
34. Id.
37. Id.
38. Suwanwela and Poshyachinda, op. cit., p. 42.
40. Wells, op. cit., p. 17.
41. Id.


44. J.H. Willis, Drug Dependence, London: Faber and Faber, 1974, p. 27.

45. Steiner, op. cit., pp. 1052-1053.

46. Bean, op. cit., p. 18.

47. Dusek and Girdano, op. cit., p. 124.


49. Dusek and Girdano, op. cit., p. 124.


52. Einstien, op. cit., p. 37

53. Id.


55. Dusek and Girdano, op. cit., p. 3.


57. Discussed later in this Chapter, at pp. 38-47 infra.

58. See, Appendix 'A' to this work.


64. M.Z. Khan, Drug Use Amongst the College Youth, Bombay: Somaiya, 1985, p. 5.


66. See, Dusek and Girdano, op. cit., pp. 29-47.

67. Id.


70. Id.

71. Id.


73. Chopra and Chopra, op. cit., p. 58. See also, Willis, op. cit., pp. 15-29.

75. Fuqua, op. cit., p. 9.
76. Barrymore, op. cit., p. 22.
78. Chopra and Chopra, op. cit., pp. 54-57.
79. Fuqua, op. cit., p. 44.
80. Interviews were conducted at Imphal Central Jail, and also at Divine Light De-addiction and Rehabilitation Centre, Imphal, by the researcher himself on 26 June 1992.
82. Teasdale, op. cit., p. 52.
83. Rehabilitation, after-care and social re-integration of ex-addict are essential for overcoming psychological dependence. See Chapter IX of this work.
85. Id.
86. Fuqua, op. cit., pp. 43-44.
91. Imlah, op. cit., pp. 64-66. See also, Einstien, op. cit., pp. 42-43 for the popular street names of these as well as other barbiturates.
93. Id.
94. Einstein, op. cit., p. 44. See also, Barrymore, op. cit., pp. 40-42.
95. See, Dusek and Girdano, op. cit., pp. 166-170.
97. Fuqua, op. cit., p. 10.
99. Id.
100. Willis, op. cit., pp. 54-55.
101. Id.
103. Fuqua, op. cit., p. 10.
104. Einstein, op. cit., p. 50.
105. Anne Jamieson, Dealing with Drug Misuse, London: Tavistock, 1984, p. 205. For the street names of these drugs, see Einstein, op. cit., p. 51.
106. Id.
108. Willis, op. cit., p. 47 and p. 50.
109. Id.
110. Id.
112. Id.
113. Einstein, op. cit., pp. 53-54.
114. Willis, op. cit., p. 53.
116. See, Einstein, op. cit., at p. 56, for street names of these as well as other hallucinogens.
117. Willis, op. cit., p. 62.
118. Ibid., p. 64.
120. Willis, op. cit., p. 60.
121. Einstein, op. cit., p. 80, and Barrymore, op. cit., p. 46.
123. Id.
124. Imlah, op. cit., pp. 73-74.
125. Barrymore, op. cit., p. 50.
127. Id.
128. Id.
130. Id.
133. The United Nations and Drug Abuse Control, op. cit., p. 28.
139. United States, Department of State, Bureau of International


144. Id.

145. Id.


152. Chapter II of this work.


155. Louis Kraar, "The Drug Trade", *Fortune*, June 20, 1988, pp. 27-29. See also, Merchant and Dorkings, op. cit., p. 34


158. Id.
161. Id.
164. Id.
166. The Times of India, New Delhi, 30 October 1992.
173. Ibid., p. 23.


184. Ibid., p. 30.

185. Ibid., p. 31.


189. Id.


191. Id.

192. Ibid., p. 40.


205. Id.

206. Ibid., pp. 29-35.

207. Id.

208. Id.


210. Ibid., pp. 31-39.

211. Ibid., pp. 36-37.

212. Id.

213. Id.


215. Id.

216. INCB Report (1992), op. cit., p. 34.

217. Supra note 69.


220. The United Nations and Drug Abuse Control, op. cit., p. 64. See also, Bean, op. cit., pp. 20-23. For the text of the Convention, see Merchant and Dorkings, op. cit., pp. 13-24.
221. Chatterjee, op. cit., pp. 45-51. In India, the possession, transport, import or export, and sale of opium was already under government control by virtue of the Opium Act, 1878.


223. India was a signatory to the Convention, and hence the Dangerous Drugs Act, 1930 was enacted to give effect to the provisions of the Convention.


225. The United Nations and Drug Abuse Control, op. cit., p. 64.

226. For critical comments on the Convention, see Chatterjee, op. cit., pp. 194-197, and Bean, op. cit., pp. 43-44.


229. The Board was constituted under Art. 9 of the Convention.


231. Art. 28(1), ibid.

232. Art. 29 and Art 30, ibid.

233. Art 31, ibid.

234. Art. 35, ibid.

235. Art. 36(1), ibid.

236. Art. 36(2)(a)(ii), ibid.

237. For the list of psychotropic substances, see Narcotics Drugs and Psychotropic Substances Act, 1985(Appendix 'A' to this work).

239. Art. 5(2), ibid.
240. Art. 8, ibid.
241. Art. 20, ibid.
242. Art. 21, ibid.
244. Art. 5(4), ibid.
245. Art. 6(2), ibid.
246. Art. 7(1), ibid.
247. Art. 9, ibid.
248. Art. 12(1), ibid.
249. Art. 14, ibid.
253. For details on the role and working of these organization, see The United Nations and Drug Abuse Control, op. cit., pp. 91-96.
254. Fuqua, op. cit., p. 263.