_MH_2_A_SUDHA

MH-2.A.

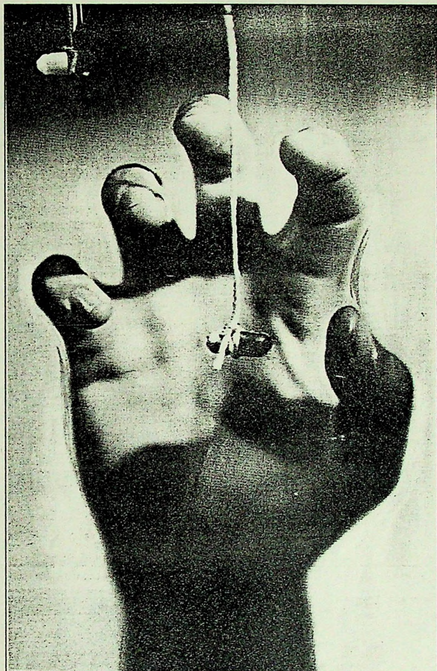
By Naveen Kumar

For thousands of years man has been using substances that have psycho-active effects. In some regions and countries the use of such substances was closely linked to the rituals and prevailing socio-cultural practices. For example, opium, coca-leaf, khat and alcohol have been regularly used in different regions of the world in a variety of ways. The apparent social acceptance of the use of such substances stemmed largely from the fact there was no abuse. Where there was, it was severely ostracized. Society had very clearly drawn the line and there was no question of condoning any abuse. Unfortunately, what we are witnessing today on a global scale is a virtual epidemic of drug abuse. According to the United Nations estimate, there are 15 million drug abusers world-wide.

About 2.27 lakh drug addicts were registered with various de-addiction, counselling and after-care centres during 1990-91.

As no census of drug addicts has been undertaken, exact number of drug addicts in the country cannot be

Smoking life away!



Clutching onto the fatal support

DRUG-DEPENDENCE

The Blind Alley

The probability of an adolescent succumbing to the temptation of drug is not necessarily related to his knowledge about it

ascertained. This figure is considered to be a conservative estimate or just the tip of the proverbial ice-berg. Adding a new and disturbing dimension to the problem is the fact that more and more young people are being affected by what can only be described as the sinister network of global drug cartels. In view of the vulnerability of intravenous drug users to AIDS, drug abuse has now assumed even more dangerous proportions.

Besides, for the people seeking a

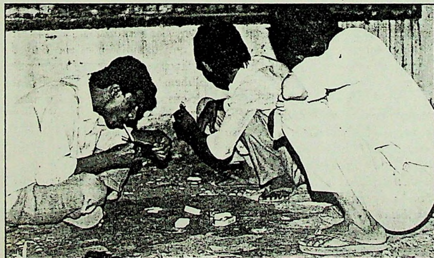
Drug addicts doing yoga exercises as part of their rehabilitation programme

euphoric state of existence, away from the maddening crowd around, the deadly consequences of substance abuse and dependence seem to be less important, if not an illusion. The dark future is washed away, at least for a moment, by the glaring "flash". Hence the rush for a "kuck" of a different life!

The phenomenon of substance abuse is the product of a complex interaction among the individual, substance and the environment.

"Drug-pleasure of a moment, debacle of a life-time", so goes a graffiti on the wall along one of the main thoroughfare of Delhi. Another hoarding exhorts, "say no to drugs the first time, every time". Looking at these hoardings one could sense that the problem of drug-abuse and dependence in our country is not an illusion but a reality that takes a heavy toll of human life.

It has been convincingly argued that people take to drugs because they are offered. It is very rare, at least for illicit drugs, that first drug contacts happen on the initiative of the user. The offer comes normally in circumstances where it is difficult to resist, in a situation which tends to be described not very aptly as social pressure or curiosity. More often, it is in a situation which is conducive to impetuous or precipitous behaviour, a mixture of peer-modelling, risk-taking and going for challenges. Or, it will simply be an offer of the opportunity to join with others in what appears to be the method of extending pleasurable aspects of a conventional recreational situation. So, in spite of being 'anti-drug' he or she evaluates the offer not in terms of the drug-education but in terms of the current situation and the normal rules of behaviour (sociability, enjoyment, reciprocity, keeping one's cool, etc) appropriate in such recreational situations. This is true both for early offers of legal drugs (cigarettes, alcohol) and for later offers of illegal drugs.

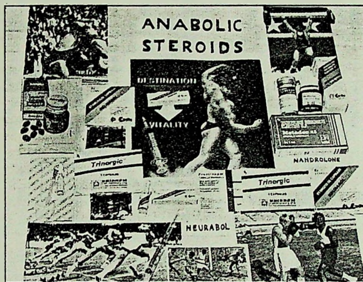

Seeking refuge in smack

Hardly any studies have been undertaken to elicit the circumstantial and emotional details of such situations of drug initiation. It is difficult to see how programmes of 'preventive education' can be effective if so little is known about the behaviour which is to be prevented. "Just say no" is certainly not the full answer. This lack of knowledge on the initiation into drugs has led to the generalisation of the medical model of dependence to drug use in general. We are asking for "cause" of using drugs. There is an evidence to suggest that dependence has a certain medical connotation in that there exists a genetic predisposition towards it.

However, the behaviour of taking a drug or accepting the offer of a drug does seem to resemble a medical condition about as closely as do other behaviours which imply a definite risk to health like skiing or mountaineering. All these behaviours are pleasurable. And in all of them risk-taking is one component of the pleasure. The fact that 'people do things which they enjoy doing' does not need further explanation.

However, it is important to keep in mind that the risk-taking can be fun, and especially so during adolescence. The physiological reactions to fear and fun are very similar. From merely observing hormonal and some other physiological changes we are normally not able to say whether a person is living through a frightening experience, is enjoying a good joke or is experiencing an orgasm. The smooth and virtually timeless undulations between fright and fun can well be observed on the faces of people on a roller coaster. It is therefore not surprising that the probability of an adolescent accepting the offer of a drug is not correlated to his knowledge about drugs. The component of pleasure experienced in the process of drug initiation in many instances often neutralises the unpleasant experience of the drug effect itself. This excitement permits, for example, adolescents to become smokers inspite of the initial unpleasant bitterness and cough provocation by cigarettes. They often have to literally work themselves into regular use. Like skiers, mountaineers or car drivers, drug users are convinced that they can overcome the risk. The facts, however tell a different story. The situation is so alarming in the N-E states that in Imphal there is rarely a home that has not been invaded by the drug menace.

The most widely used drug in these states is the most refined form of heroin, popularly known as *Number 4* among the locals. This brand of heroin is called Number 4 because it is fourth stage of refinement containing as high as 90 to 95 per cent heroin. From where do these drugs come? Immediately the query leads to the fact that National Highway No 39 connects India and Myanmar, a constituent country of the notorious "Golden Triangle" (Myanmar, Laos, Thailand) where opium is "grown like rice". Besides, Manipur shares a 352-km border with Myanmar which is sparsely guarded and it plays a crucial role in the availability of drugs in these areas. Apart from this, people in the districts of Rajasthan, (Barmer, Jodhpur) sharing its border with vicious 'Golden Crescent' (Afghanistan, Pakistan and Iran) hold opium offering in high esteem. Chippa and Sinhhis communities attach a lot of importance to opium. The high frequency (22 per cent) of opium intake may be attributed to their frequent handling of opium in their professional life.



A sportman's 'weakness'

Famous psychiatrist (AIIMS), Dr Mohan has found in his study of school boys and girls in Delhi, that they use painkillers (49 per cent) followed by alcohol (12.7 per cent), tobacco (6.4 per cent), tranquilizers (3.4 per cent) and less than 5 per cent other drugs like *cannabis amphetamines, barbiturates*, LSD and opium.

School of Social Work reported that drug users are marked by features like insecurity, dependence, frustration and anxiety. Besides, more than three fourth of the respondents were dissatisfied with their family and social situation.

In a study conducted by Malhotra and Murty at the National Institute of Mental Health and Neuro-Sciences, Bangalore, it was found that drug addicts manifest neurotic traits and anti-social behaviour patterns.

Drug peddlers befriend before they offer drug for the first time to their victims, at the pockets in city slums and, in the face of gross apathy from administrative, medical and related agencies, their business flourishes smoothly.

One may well ask what role government could play in the control of drug abuse. Supply reduction is the job of the police and narcotics bureau. Demand reduction is the job of doctors in their treatment centres. To the extent that these administrative agencies can't stop the availability of drugs, let the health care service cure those who become drug addicts, in spite of all supply control efforts.

We have ample evidence in India and abroad that these traditional strategies alone do not work. Law enforcement will at times drastically reduce the availability of illicit drugs by spectacular seizures, or a vigilant narcotics police may prevent the establishment of a criminal distribution network. But such successes do not sustain. Clinics and drug de-addiction centres may cure large numbers of them but the rate of relapse of this vicious cycle has acquired menacing proportions.

Drug abuse is thus closely linked to health care, with health services rendering necessary support. But for successful prevention and care of the disabled and chronically ill, community involvement is necessary. Only people, friends, teachers, media and above all a commoner can prevent others to stay drug free. ■