Verily all things move within your being in constant half embrace, the desired and the dreaded, the repugnant and the cherished, the pursued and that which you would escape.

These things move within you as lights and shadows in pairs that cling.

And when the shadow fades and is no more, the light that lingers becomes a shadow to another light.

And thus your freedom when it loses its fetters becomes itself the fetter of a greater freedom.

Khalil Gibran

Drug Culture in India

A Street Ethnographic Study of Heroin Addiction in Bombay

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Foreword

Drug Culture in India: A Street Ethnographic Study of Heroin Addiction in Bombay takes its place in an expanding repertoire of research and intervention projects in Asian settings. In fact, this publication is concurrent to, and fits in with the research and community services carried out in various cities (Bangalore, Madras, Bombay, Bangkok, Jakarta, Karachi, Manila) through the partnership of the International Federation of Catholic Universities and the European Union.

Using the tools of scientific empirical enterprise, Molly Charles and her cohort of peer colleagues lead us into the nuances and subtleties of drug use and abuse patterns within cultures and marginalized lifestyles. As a focused attempt to improve the quality of lives, the discussion gets beyond the ostensible quantitative orientation and statistics into delineating flesh and blood cases which bring the problems related to drugs closer to our doorsteps.

An additional feature of the work is the inclusion of illustrations that satirize for the most part, and sometimes laugh at

social foibles in dealing with intense concerns. Indeed, such sketching occasionally points to suggestive lessons: *by laughing at shortcomings we rectify them* (Castigat ridendo mores).

The analyses and projections of the study are courageous in that they question the social responses and interpretations of the customary treatments and marginalisation of drug users. The results presented seek to address future actions to be taken more in an indicative rather than prescriptive manner. In this respect, credit should be given to the larger debates that arise for further explorations.

Having been associated with Molly Charles and the team, I must observe that the commitment and driving force of this work has come through a sense of cohesiveness in social concerns. Apart from that, a striking rarity of the group's performance has been Molly's discrete and stimulating direction in the research and field activities of this project.

In sharing these findings for the benefit of the scientific and social community, this book merits attention and due respect. Congratulations should be given with the expectation that more of such reflexive collaborations be undertaken in guiding our steps in drug abuse management.

Pro Dr. Guy-Real Thivierge
Director for Research (IFCU)
Paris

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Preface

This research is the result of the contradictions that kept confronting us throughout our involvement in the field of drug abuse and personal encounters with functional and dysfunctional users. Our professional involvement emerged out of an intense desire to assert the views of the users against those of the professionals, politicians and international experts and bodies. For, the latter groups, have to a large extent, obliterated several perceptions about this human behaviour.

Probably, by mere accident, we were offered the opportunity to look into the presence or absence of linkages between culture and drug use. The thoughts of others in print revealed various paths. The bibliography provided in Chopra's (1990) book, *Drug Addiction with a Special Reference to India*, is almost a comprehensive listing of research done up to the 1960s. The National Institute of Public Cooperation and Child Development (NIPCCD) has compiled an annotated bibliography of Indian drug abuse literature from 1960 to 1985. Subsequent outputs have been compiled by National Addiction Research Centre (see NARC, 1995).

In India, research in the late seventies, undertaken in drug abuse after the introduction of brown sugar, has been quantitative in nature. Prior to this, a few anthropologists who studied tribal communities and their culture focused on drug use only in passing. Thus, in spite of their academic inclination towards the subtleties of social reality, their inquiries were not beneficial for drug abuse management. This lacuna was responsible for the implementation of centrally controlled uniform intervention strategies that were poor imitations of institutional models from the developed countries.

These limitations strengthened our decision to highlight the differences in drug use and their implication for policy planning. This exploratory study took shape through the use of street ethnography, indepth case studies and field observation. As an action research project, another purpose was to gain insights into the dynamics of drug abuse for the evolution of appropriate programmes in prevention, treatment and rehabilitation for various target groups.

This study would have been impossible but for the user population who were willing to accommodate inquisitive researchers. We admire their support and willingness to share their lives without expectations, though they live on the fringes of society struggling for survival. We may not have been able to do the same, had our roles been reversed. In their midst, we saw sparks of humanity—a rare experience in modern society.

We express our thanks to our colleagues, without whose valuable inputs this would have been an incomplete venture. They worked round the clock facilitating us to deal with medical complications which included carrying patients infected with lice, suffering from tuberculosis and having infected gangrene. We place on record our gratitude to A.A. Das, J. Mathew, P. Shirley, V. Jawlekhar, D. Pinto, B. Palande and P. Choudhury.

Built into the research was an ethical condition that we would offer free treatment to all our research subjects— the drug users. Many of them had several co-morbidities and some had serious medical complications. Being emotional beings, though our paths have separated, it was the presence of Dr. Dayal Mirchandani that gave us strength and confidence to bring complicated cases to the centre. We thank him for his concern for life.

The support of treatment staff was crucial to the project. We thank Dr. S. Amin, Dr. H. Shetty, Dr. P. Brahmachari, Dr. Kalpana Bhende, Dr. Isha Amin, Leena Joseph, Sosamma Varghese, Esther Sumithra, Ammini Koshy, Jayshree Punjabi, Manisha Dhurpate, Dilip Talekar, Maruti Pawar, Anthony Pandit, Avinash Rane, Panderi, Dondu and Gopal. Any project requires an administrative backing and in this context, we would like to thank K.X. Roy, Naresh Puthran and Zuleika D'Gama.

We thank Raju Patel, Mahadev Nakti, Sunitha Ethuskar and R. Anajali. Noorbi, a caring woman who was perennially smiling, as she attended to patients' needs deserves special mention here. While she was with us during the study, she passed away due to cancer before the book could be published. We miss her.

Any communication has to be trimmed for it to be acceptable to others. This final touch was given by the editors, Rajiv Wagh, Sanjay Wagh, Vijayakumar, Ashok Row Kavi, Tony Miller, Roger Silverman and Sudha Raghvandran before the publishers took it up. Roger's professional skills were crucial for relieving us from the trauma of being accused of slaughtering the language. Sudha Raghvandran gave the last strokes to this finished product. Baby Varghese, Usha Narayan, Shrinivas Macha and S. Thangsuanmung helped in data entry and the lay out of the present volume. We also thank K.V. Anuradha for providing the note on critical analysis of certain aspects of

NDPS Act.

We take this opportunity to thank Dr. Thivierge, IFCU-GRITO and CEC for their valuable contribution towards making this project possible. It is Dr. Thivierge who initiated this inquiry. Dr. Philip Roux and Dr. Christian Brule facilitated us to crystallize our inquiry.

We place on record the gratitude to Mr. A.S. Sabu who illustrated the thoughts with empathy and shaded it with humour to facilitate further analysis.

We thank Molly's parents and brother for supporting her to undertake the task of principal investigator and accepting her long absence during the period of research. Our gratitude to Dr. Adolph Furtado for supporting NARC.

We are indebted to HIVOS, Bangalore, for facilitating NARC to bring out its publications on drug abuse management.

NARC places on record the technical assistance provided by Rawat Publishers in bringing out this publication and for its distribution.

Molly Charles
K. Sadanandan Nair
Gabriel Britto

1

Introduction

On one occasion, the drug users of a street in Bombay were disturbed from their blissful highs by a group of social workers. They were armed with posters aimed at discouraging drug use, the messages illustrated with skulls, bones, cobras and chains. These well meaning people asked some of the users to help put up the posters in different localities. They obliged and were paid for it. After the social workers left, they used the money to purchase more drugs and consumed it, right under the posters they had put up. A user narrated this incident and it clearly reflects the limitations of universal programmes against substance abuse in attaining their specific goals.

Human behaviour in its present form is often moulded by years of evolution, and our interaction with mind-altering substances (MAS) cannot be different. Thus, historical analysis became a part of this action research project on culture and drug use in Bombay. Five other studies were undertaken simultaneously to explore the link between drug abuse and culture. The reports of Masihi (1998), Rao (1998) and Siddiqui (1998) on the

use of traditional drugs (opium and cannabis) provide vivid illustrations of the cultural basis of drug use in contemporary India. This initiated an inquiry into available historical data on mankind's varied associations with mind-altering substances. Tracing these historical changes clarified the relationship between brown sugar (crude heroin) and its users in Mumbai. Brown sugar has neither historical nor cultural roots in India. Field observation and case studies threw light on the changing associations with MAS. This study seeks answers to the following queries:

- What are the past and present cultural linkages with these substances?
- What is the present pattern of use and its impact on consumers?
- What are the factors that led to initiation into drug use?
- What is society's reaction to the individual's use of these substances?
- What are the factors that led to our present dilemma in our association with them?

Historical information indicates that on certain occasions, cultural sanction was given to drug use in different parts of the country. This persists even to this day and can be seen in Orissa, Gujarat, Karnataka, Rajasthan and Himachal Pradesh. The provision was applicable to male adults and not to the younger age group. However, the official machinery has criminalised drug use by a draconian legislation in 1985.

While this law is hardly known or even enforced vis-à-vis users and use of drugs in some areas, it is not the case in north-eastern India and in all major cities. In these parts, massive publicity campaigns have fed collective hysteria resulting in police action. Subsequently, drug use has become stigmatised and the decision to participate in this criminalised and 'deviant' act in

Bombay has placed drug users in a marginal position. The present study has identified factors that led to initiation into drug use, be it an accidental event or a conscious decision.

This process of marginalisation and the role of culture in facilitating or hindering it were looked into. It was observed that strong family ties, an important part of Indian culture, prevents the total marginalisation of the users. Isolation occurred when the user's financial requirement completely disrupted his/her family ties. Under withdrawal spells, some users not only sold family property, but also indulged in domestic violence to obtain money for the drug of their choice.

Even in the absence of total marginalisation, drug use leads to frequent friction at home, till the MAS user stands out like a sore thumb either in the family or the wider community. Hence, the study looks at the ways and means in which the user adapts to changes in his/her status within the family and society. Did the users accept and adapt to the marginal position, or did they try to change it? The study seeks to answer this query.

Different users opt for different types of associations with their family and society. While some struggle hard to limit their drug use and retain their family links, others alienate themselves from home and society and turn into street-users. Depending on their choice, drug use brought about many changes in their occupation, hygiene, health and social interaction. Yet, none of these choices were static. Personal experiences could either change a functional user to a street-level user or turn a marginalised user into a drug-free person. It was also seen that the level of social support a user enjoyed was critical in the process of becoming drug-free or functional.

The presence of varied reactions to life on the marginal fringe made us inquire into the universal characteristics of users. This led to the identification of probable categories of users in Bombay. Since users changed their association with MAS, their

adherence to any category was fluid as well.

The present and future dynamics of any social issue are influenced by the policies governing it. Drug abuse policies in India would, in many ways, have an impact on its dynamics.

An attempt to draw upon the experiences and insights gained through this study for rethinking the present dynamics of drug abuse management forms the last part of this publication.

Basically this work, though exploratory, is a loud call for evolving alternate paradigms for the management of drug abuse.

Locale

The study was conducted in Bombay, an important metropolitan city on the mid-western coast of India and the capital of the state of Maharashtra. The city has a history of interaction with MAS. Organised trade in MAS can be traced back to the British rule in India, when Bombay port played an important role in the transportation of opium from India to China, during the opium wars between China and Britain. Additionally, like many other parts of India, the Thane district too at one time cultivated opium (Gazetteer of Bombay Presidency, 1904).

Today, Bombay is industrially developed and a number of communities from different parts of the country live together. In this densely populated city, people function under constant pressure. A considerable part of the daily life is spent commuting to work. This harried lifestyle creates a feeling of alienation to many, especially to new entrants and visitors from rural areas and other cities.

Bombay is a replica of any other metropolitan city, where enslavement of human beings to technology is reflected in every facet of life. One of the first differences that strikes a new entrant to the city is the fleet-footedness of its inhabitants at every

moment of their lives. People in this metropolis become enmeshed in a time frame and rush through the day in a fight for survival. Their sensitivity to others is considerably reduced. This change in Bombay is slow but noticeable. The initial victims of that human condition would be the "deviant population" of the city. Interaction with its scapegoats, the drug users on the streets, indicated this phenomenon as well.

Selection of Sites

The selection of areas for undertaking the research was based on the existing data at the treatment centre of the National Addiction Research Centre (NARC). Our research team analysed the available patient data at NARC for identifying the major origins of users, after which a few selected drug dens or *addas* (locations in the city where the drug is sold and addicts sit and consume drugs) were visited.

Another source used for selection of the sites was NARC's survey of 830 community based organisations (CBOs) in the slums, which inquired into the availability of brown sugar in these slums (Britto, 1995). Twenty-five drug dens were identified. Of these, four were visited for pilot exploration and two of them were selected for in-depth observation and interviews. The selection was purposive, taking into consideration the number of addicts who can be more or less constantly found.

Site A is on the eastern side of an industrial area in south Bombay, and site B is in a slum in the suburbs. In site A, there are a few families who depend on the brown sugar (crude heroin) trade for their livelihood or the sale of paraphernalia related to drug use. This place is close to one of the major godowns of Bombay, and is busy throughout the day. One can find regular outstation vehicles parked on the street. In Bombay, while alcohol, cannabis and opium continue to be used, brown sugar and certain pharmaceutical products such as ni-

travet, mandrax are becoming drugs of choice especially for those seeking treatment. Though there is a small group of about 200 injectors in a few pockets, most brown sugar users 'chase' the drug. The vehicles parked on the roads offer a cover from wind and rain for users to sit and 'chase'. Another favourite place is below a bridge, between two sets of railway lines. Here, they are able to hide from the public eye whenever necessary. This place serves as an open toilet for members of the community. They also use the nearby 'pay and use' government toilet. The open space is used during bouts of diarrhoea and by those who avoid the public toilets.

An abandoned cabin in the same locality is another spot for the consumption of brown sugar. This dark dingy room, where stains of smoke have merged with dirt to form a coat of a uniformly dull colour, hides the users from prying eyes and provides shelter from the strong breeze while chasing the drug. This isolated environment provides adequate cover for functional users to smoke in comfort. The tell-tale signs are the strips of thick paper, such as cigarette covers, scattered around the room. The users find them handy and economical to heat the drug. A broken staircase without handrails is the only entrance to this cabin. The cabin's wooden floor has a wide hole in the middle through which a garbage bin below is visible. There have been accidents in this cabin; when users chased by the police rush down and fall.

The other site, B, is also located near a railway station. Here, users consume drugs at the entrance to a government building and are left in peace till the workers stream in for duty. Since most of them work outdoors, they intrude on the privacy of the users for few hours during the day. Unlike the other site, the peddlers here try to keep a safe distance from the users. They use young kids, often their own, to sell the product. Being part of the family their business interest is safeguarded. In a poverty stricken situation children are socialised into a different system where secrecy is an accepted way of life. Details of the drug scene in these sites are presented in another chapter.

Gaining Acceptance

Though NARC has been providing free detoxification facilities for users in this area from 1990 and field workers had been frequenting this locality to speak to their families, our interaction with peddlers was not devoid of initial hiccups. Our visits were facilitated by the rapport established earlier in the selected areas by NARC community workers. Our presence aroused curiosity, suspicion, irritation and resentment among the peddlers. Diffidence and even practical jokes masked their responses, especially towards the female investigator. To narrate one incident, on the first day, when the principal investigator was the only female member on the field visit, the reaction of small-time traders to her makes an interesting narrative. After our community worker had introduced her to the locality's main leader and his cronies, they offered her a seat on their cot placed beside the narrow lane close to the over-bridge leading to the railway platform. Their gestures and postures reflected power. Unable to provoke her, the peddler ordered a bottle of beer which the assistant opened and spilt some on to her dress. This was repeated on various other occasions but they just met her blank stare. The peddler's assistant kept asking her questions about NARC, while staring at her in an intimate manner. After tolerating their pranks for some time she turned her attention towards the users, who were sitting at various spots along the lane.

A few visits later, seeing that we meant business, the attitude of the peddler and his cronies changed. A specific reason for this change was our involvement with medically ill and neglected users. Once rapport was established with the peddlers, talking to them anytime of the day or night was not difficult.

The police were puzzled and unhappy at our extended presence in the locality and tried to harass and browbeat us occasionally. To handle these situations, researchers had to show tact and persistence.

Tenacity of purpose, indifference to rude and sometimes even livid provocation, suffering the filthy surroundings, tact, patience and persistence paid off. The users opened up and described their lifestyles.

While spending time with users, we had to deal with the filth of open toilets and garbage bins. The unhealthy surroundings and lifestyle of the users placed the investigators in difficult and delicate situations. For instance, they gave us drinking water that was often unhygienic. Yet, it was impossible to refuse when they had taken the trouble to find cold water for us. Besides, if we refused, they collected money to buy us beverages, a gesture we knew they could not afford. Under these circumstances, some of us fell sick and had to be treated. Other factors that created concern were hair lice and being infected by tape worms and round worms.

Being mute spectators to the death of street users was traumatic. Our initial efforts to provide care for medically difficult patients were resisted even by professionals from the NARC detoxification centre. The process of change was slow and difficult.

The health workers from the government hospital did not want to cater to compliant patients, especially those who did not have family members to take on the responsibility. The private hospitals were reluctant to take on cases that had any medico-legal connotations, out of fear of friction with the system. Experience also taught us that health professionals were more considerate to educated users than to illiterate and dirty persons.

Subsequently, a crisis intervention programme at NARC

was started, which helped a number of users to deal with their medical complications. Apart from our own direct intervention, users themselves brought difficult cases to NARC for medical care. Some of the users whose lives had been saved through crisis intervention put us on a pedestal.

Another perturbing experience was the passive inhalation of brown sugar fumes in such settings. The principal investigator found that this helped her to ignore the filthy surroundings and avoid the unease caused by her conditioned reactions to muck. On a few occasions, she even found herself involuntarily moving closer to the user as he was chasing, so that she could inhale a good portion of the fumes. The investigator was prevented from making field visits for the next few days by the Director.

Since we came from a treatment centre, we had to write slips for admission, blood tests and X-rays for twenty-five to thirty-five persons at a time. We explained to them the route to the treatment centre. We had to give personal attention to each individual for at that moment in time, the user believed or claimed that he wanted to be drug-free. Through experience, however, we knew that for every thirty slips we handed out only three or four would come for treatment. Others kept the slips with them along with other drug paraphernalia till they decided to approach the treatment centre.

Field work for the study was undertaken by a team of seven researchers for a period of six months. Data were collected from users in the field and from the treatment centre. Key informants of the areas were another source for data collection. All members of the research team maintained observation journals and personal diaries. Data thus collected were subsequently organized into case studies.

Gathering the Threads

This study has drawn on several measures of street ethnogra-

phy. Agar (1977) has provided a brief review of street ethnographic methods used in drug abuse studies. Agar looked at the anthropological studies in the field from two settings: joint (institutional) and street (community). There are studies that adopt an intermediate style. This exploratory study also falls within the same premise.

The key informants in the selected localities were identified and an in-depth, unstructured, informal, free-flowing interview technique was used to gather data from them. Interviews were also held with family members and friends of drug users. Group discussions with users both at the treatment centre and in the field were held to augment the data. The relationship with drug users was of a symmetrical nature, where no one party had more control over the conversations. Besides, as Weppner (1977) indicated, our study was facilitated by avoiding use of gadgets in street settings, letting the drug users understand our professional and personal lives and retaining the faith and trust shown by users by maintaining strict confidentiality. Secondary data were additional sources for historical association of man with MAS.

Researchers also collected information based on an interview guide from users in the locale itself and also from those who came to the treatment centre. Interview of users varied from one hour to sixteen hours per person in different settings and at various timings. At times, a single session went on for four to five hours and the researcher had to completely depend on her/his capacity for recollection. It was inadvisable to use tape recorders or make concurrent detailed notes on paper. Many street users were disclosing their personal histories for the first time. If their case histories had been written down in their presence they would have felt very uncomfortable, since several broke down while narrating their traumatic life stories. At times, two or three researchers collected data from the same person on different aspects. This was particularly important in the

case of sexual history, as male users felt uncomfortable discussing these details with female researchers, and women researchers could document the sexual history of female users better than those of male users.

Besides free flowing interviews and field observations, we spent time with users in the treatment centre at different hours of the day. Group discussions were held with three to six individuals at a time. One had only to start talking to a user and slowly, the others would join the conversation. The rapport with the users was facilitated by the fact that the principal investigator lived at the treatment centre itself.

The selection of informants or case studies was based on the frequency of contacts and their participation in the detoxification programme of NARC and other treatment centres. This was important, as it was not possible to fix formal timings and venues, given their lifestyles. It was with those who expressed a desire for detoxification or who came to the centre after the initial meeting that it was possible to get detailed data.

The secondary sources of our data consisted of studies conducted by NARC, data from detoxification centres, reviews of international literature and data on the different aspects of drug abuse published by government departments.

Issues

While cultural mechanisms, evolved through years of association with particular drugs, have exercised some constraints over drug abuse, recent policy changes have undermined this by removing drug use from the ambit of cultural control. The changes were to an extent justifiable in developed countries as cannabis and opium use were alien to the dominant western culture. This was not the case with some developing countries. Therefore emphasis on a universal approach and the political pressure which was applied to this end should be questioned.

The dilemma of these developing countries was that while some drugs were classified as illicit, cultural practices and norms supportive of numerous drugs persisted. This contradiction had an impact on the use of traditional drugs. In the present market economy, the yield on investment has the final say. When illegal commodities vie with each other, the winner is determined by many factors. To list a few:

- The **pharmacological properties** of the drug. Substances that can enable the user to experience altered states of consciousness (ASC) faster and more intensely are more likely to replace the others. Thus, heroin has an edge over opium and *ganja*.
- **Transportability**. Those which occupy smaller volume and are therefore easier to transport are more likely to be marketed than those that are bulky and heavy. Substances which can avoid detection are more likely to thrive than the others. Thus, synthetic drugs that can be more successfully transported than cannabis are preferred. Besides being bulky, cannabis has a strong and distinctive odour.
- **Facility in cultivation.** Plants which can grow in any climatic condition, without much input, have a greater chance of success than those which need care and a specific climate and soil. These constraints curtail the cultivation of poppy in many parts of the world. In this respect, cannabis has an advantage, and this ensures its cultivation. At the same time, it is its disadvantage as the consumers can grow their own plant for consumption, control over trade and sale can be difficult.
- **The profit margin**. Drugs with higher rates of return will be traded in preference to those with smaller returns. Here, opium loses out to heroin.

Existing empirical norms alienate both the traditional and the brown sugar users. But it is the brown sugar users who are

far more alienated due to the lack of any cultural norms and the deviant sub-culture in which they are forced to operate. This study explores the process of marginalisation and its impact on users by looking at:

- the circumstances under which a person is initiated into the use of brown sugar;
- the subsequent motives that sustain his/her habit; and
- the changes that occur in his/her lifestyle and the relationships he/she develops with society at different levels.

This exploration provided insights for the analysis of existing drug abuse management programmes stipulated for a given region. The specific questions for this research are grouped in four categories.

Research Queries

1. On the dynamic relationship between human beings and drugs

- Did existing cultures assign any role for the use of psychoactive substances in various traditional societies?
- Did society support the individual use of drugs for altered states of consciousness?
- Is the problem of indulgence a function of the availability of MAS, or is it a reflection of mankind's immature association with psychoactive plants?
- What are the reasons for our chaotic relationship with MAS?

2. Present drug use and marginalisation

- What were the circumstances under which individuals in Bombay city were initiated into brown sugar use?
- Did their lives change with the use of the drug?

- Did the pursuit of ASC play a role in the alienation of users from society?
- Did the initial reason for use change and new motives develop for continuing drug use?
- What was the community's reaction to drug users?
- Does drug use lead to marginalisation? Is there an inverse relationship?

3. Drug user population

- Are there common/universal characteristics among the marginalised individuals?
- Is it possible to categorise brown sugar users?
- Is criminalisation of drug use a solution to drug abuse management?
- Is it the cause for marginalisation and the sustained alienation from society?
- Does criminalisation hinder the process of recovery?
- Did users try to return to the society they rejected after being a part of the marginalised population? What were the strategies adopted by the users to do so?
- Under what circumstances did these changes occur?

4. Intervention programmes and policy implications

- What are the existing policies for drug abuse management?
- Are they culturally relevant?
- Can programmes for intervention be universal?
- Are the goals of intervention programmes also the goals of users?
- Are professionals sensitive to the problems of the users?
- Do the goals of intervention programmes include specific cultural factors, or are these derived only from international policies?
- What are the possible suggestions that can be made for a relevant drug abuse programme based on this study?
- What are the areas for further inquiry?

Conceptualisation

By 1950, social scientists had provided 300-odd definitions of 'culture'. These did not necessarily imply any qualitative improvement in the first definition put forward by Tylor:

> Culture or civilisation... is that complex whole which includes knowledge, belief, art, law, morals, custom and any other capabilities and habits acquired by man as a member of society (Tylor, 1874: p.1).

But, over the years, many new views and characteristics were brought to light (Vermeersch, 1977). According to Kluckhohn and Kelly, culture means:

> All those historically created designs for living, explicit and implicit, rational, irrational and non-rational, which exist at any given time as potential guides for the behaviour of men and women (1945).

Here, 'guides' are considered to be bits of information which make one type of behaviour more probable than its opposite and these guides map routes for human life. Human behaviour may or may not act consistently with their cultural guides. As Frelich states:

> Humans are proud of their culture, yet often they avoid its dictate. Stranger yet, non-proper behaviour generally escapes negative sanction and is generally predictable by other members

of the actor's community (1971: p.91).

It is possible to have two types of relationship between culture and behaviour, according to varied semantic interpretations (Siddiqui, 1998). Guidelines that map human behaviour can be functional or non-functional and abstract. When they have a history within a given system, they are called logical standards. The guidelines that are less abstract and without a history are called empirical standards. The standards in this study specifically, pertain to the Narcotics Drugs and Psychotropic Substances (NDPS) Act, 1985. These 'standards' led to unsaid norms that emerged within the elite and middle class society in India, especially in metropolitan cities.

Logical standards are also sometimes referred to as 'cultural' standards or 'normative' standards. For example, the use of cannabis has been indicated during religious meets and festivals such as *Holi, Mahashivaratri* and *Janmashtami*. It had to be consumed in groups after the performance of certain rituals. In religious places or in private households, a *ganja* pipe is passed around during the chants of the prayers (*bhajans*).

Cannabis has been associated with social and medical purposes for which cultural norms had been set. The present-day use of cannabis is considered to be a reflection of that cultural heritage. At times, this relationship has only a nominal linkage to the logical standards of the past. Contemporary group use of cannabis in urban and rural settings may or may not retain much of the cultural functions of yesteryears (Siddiqui, 1998). Thus, norms governing drug use needed to be explored.

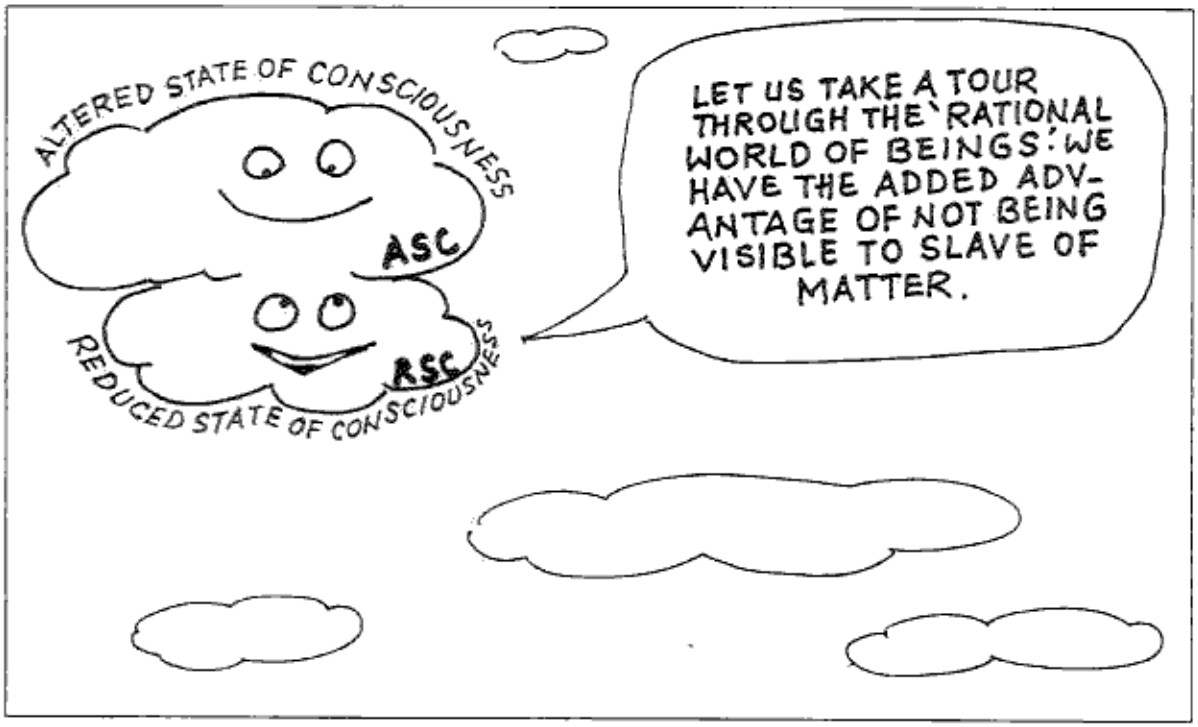
The more practical so-called 'empirical' standards are generalisations regarding the working of the system. There are two types of empirical standards: those set by the dominant caste or ruling elite, and those that operate at the subaltern strata. The former may be termed administrative standards and the latter may simply be called empirical standards. For example, drug use

in our country is prohibited by the NDPS Act (1985). This law is an administrative standard of our contemporary culture. However, there are millions of people who consume *ganja* (marijuana). It is described as a "poor man's liquor".

The level of social acceptance of different drugs also depends on the socio-economic class and cultural variation in the city and country. The use of *bhang* conforms to the empirical standards of some communities because it plays a practical role in everyday life. Among the upper classes, the use of alcohol is accepted behaviour, whereas the use of ganja is frowned upon. However, there appears to be social acceptance for money gained through any source. The peddler who piles up profit and lives well in a slum commands the respect of his neighbours, and there is no sign of any stigma attached to his work. These and other such not-so-explicit guidelines constitute the empirical standards that govern the drug field.

Duality in Relationship with Drugs

The duality of our relationship with MAS is reflected in the double standards of contemporary society vis-à-vis drug use, with its logical standards and its empirical ones. Historical norms can be considered as the logical category. Many philosophers and others have focused on our duality at different levels— Plato looked at the conflict between reason and sensuality, Descartes at time versus matter. Thanatos (death wish) has been an area of inquiry for psychoanalysts as a dimension of our dual nature. Use of MAS can also be seen as a reflection of duality. And at another level, all drugs seek to alter the level of awareness to a greater or lesser extent, Ironically, MAS can be a hindrance to survival because survival depends on living at a reduced state of awareness. At the same time, they also give pleasures by enhancing awareness. Use of MAS can also give relief from suffering which is a consequence of living at a reduced


ALTERED STATE OF CONSCIOUSNESS
ASC
RSC
REDUCED STATE OF CONSCIOUSNESS
LET US TAKE A TOUR THROUGH THE 'RATIONAL WORLD OF BEINGS': WE HAVE THE ADDED ADVANTAGE OF NOT BEING VISIBLE TO SLAVE OF MATTER.


ASC
RSC
YOU UNDERSTAND THEM BETTER THAN I DO, SO PLEASE DO ENLIGHTEN ME ABOUT THEIR BEHAVIOUR
THEY'RE TRYING TO DESTROY YOU.

state of awareness. This in turn sustains survival, avoiding thanatos. Hence, the relationship with drugs is dual at two levels with regard to use:

(a) they can threaten survival or enhance awareness; and

(b) they can facilitate survival by relieving suffering due to a reduced state of awareness.

It is also clear that duality in our association with drugs can be studied at two broad levels: at the level of their use and due to norms at the empirical and logical level relating to use.

Duality in History

Duality in mankind's associations with MAS has been reflected in history and it is evident from the studies by social scientists (Blum, 1969; Rubin, 1975). While in traditional societies the norms of consumption, group cohesion with the rituals associated with drug use to experience the 'high' created hurdles for secular use, nevertheless, secular use existed, as is seen from the study undertaken among certain hunting and gathering cultures (Blum, 1969). Though culture reduces secular use, it still persists. Such use can be seen as an expression of the duality of our association with drugs with regard to use. Another expression of this duality is its use for experiences relating to magico-religious experience within the framework given by the specific culture, as against use for medicinal purposes. Thus, duality in this aspect is not a recent one. The difference might be only in magnitude of drug use and impact. In the Indian context too, duality in our relationship with MAS has existed.

Marginalisation

When attempts were made by scientists to use MAS to enhance their understanding of existence, they did not receive much sup-

port from society (Weil, 1983,1972; Leary, 1970). In order to understand the negative responses, it is necessary to look at our reaction to any change that deviates from the 'normal'.

Drug use can be either a rational act or an irrational act, depending on its function. When used to attain philosophical insights into existence, it may be considered by the majority at a given point in time to be an irrational or non-rational choice. It is possible that, with time, the desire for such insights will become integrated into the normal stream of life. In that case it would be considered a rational act.

Human existence depends on the sharpening of survival skills through interaction with the environment. But our pursuits often go beyond sustaining life. All the advances in human history that subsequently increased man's survival skills resulted from his journeys to unknown frontiers and his desires to grapple with them. Changes in thinking patterns were brought about by those who took time to dream and challenge the accepted realm of thought. Our present understanding of the universe is also a reflection of such pioneers. The actions of these extraordinary individuals probably fell under the non-rational or irrational design of living in their times. Such avant-garde efforts later changed the rational designs for living of the common man!

Similarly, the efforts of a few individuals, like A. Huxley, T. Leary and A. Weil, who in their time in history were the marginal ones, influenced and will change our association with MAS and our understanding of Altered State of Consciousness (ASC), which Ludwig (1990) defined:

> Any mental state(s) induced by various physiological, psychological, or pharmacological manoeuvres or agents, which can be recognised subjectively by the individual himself (or by an objective observer of the individual) as representing a sufficient deviation in subjective experience or psychological functioning

from certain general norms for that individual during alert, waking consciousness (Ludwig, 1990: p.18).

Certain characteristics pertaining to ASC are: alteration in thinking, disturbed time sense, loss of control, perceptual distortion, change in emotional expression, change in meaning or significance of subjective experience, depersonalisation, a schism between body and mind, feelings of de-realisation, a dissolution of boundaries between self and others, the world or universe, sense of the ineffable, feeling of rejuvenation and hyper-suggestiblility (Tart,1990).

Society influences us to focus on certain aspects of life that are perceived to be relevant for survival and to ignore the others. Social scientists have termed this state as a "normal state of consciousness or reduced awareness" (Tart, 1990).

In this context, it is relevant to explain the theory put forward by Bergson in connection with memory and sense perception. According to him, the function of the brain, nervous system and sense organs is to be eliminative and not productive. The normal functioning of the brain and nervous system protects us from being bombarded by a mass of useless and irrelevant knowledge and prevents confusion. What we actually relate to on a daily basis is a narrow specially selected reality related to pragmatism. While we all have a 'Mind at Large', our emphasis is on survival or 'reduced awareness'. This state of awareness is expressed by languages and cultural symbols. These in turn mould the growth of individuals to a large extent. In the Christian framework, the reduced state of awareness really means 'the affairs of this world' and the altered state a case of the next one.

Depending on the geographical location and culture, these limitations are set, and it is within these limitations that one experiences ASC for fleeting moments. These temporary insights are achieved by only a few spontaneously! Others seek it

through yoga or spiritual exercises, hypnosis or MAS. These exercises help one to go beyond the carefully selected utilitarian material, which the narrow mind of everyday existence accepts as the complete and sufficient picture of reality (Huxley, 1977). The pursuit of ASC is basically an attempt to transcend this state of "reduced awareness" (Weil, 1972, 1983). Psychoactive substances have been used for this purpose too (Tart, 1990).

To a great extent Musgrove's (1977) concepts of marginalisation process and marginalised groups provide insights into our inquiry. When a group's position is ambiguous, not fully institutionalised and distant from what most people would see as society's central institutions and values, it is considered to be a marginal group. In this perspective, users of synthetic and designer drugs can be considered to be in a marginal position.

According to Musgrove (1977), there are four different types of marginalised groups: the convergers, the quietists, the separatists and the utopians. Convergers are those who play down, hide or deny any real difference between their position and the centre. Quietists accept the definition of deviation given by society and try to live in accordance with this definition. Separatists come out and assert their distinctiveness from others in terms of values and lifestyle. Utopians are people who emphasise their difference from normal society. Standing outside society, they express their desire to change the values and consciousness within society. Noticeably, not all persons in a marginal position are necessarily at the same level of interaction with the system. Our study explores this aspect among users of crude heroin or synthetic drugs, in order to understand the levels of interaction they have with the system. For this, Musgrove's classification of marginalised populations was adopted.

The process of marginalisation, which includes initiation into drug use, being in marginal position and adapting or changing the level of marginalisation and existence of varied

associations with society, have far-reaching implications for the management of drug abuse. The general tendency is to portray drug users as dysfunctional, disruptive and filthy personalities, incapable of modifying their behaviour in any way.

Cultural Contacts

There were changes in the cultural norms relating to specific drugs through interaction between various cultures. For example, when the Eskimos were exposed to alcohol after contact with western culture they developed a taste for it. In India, the use of opium by Rajputs, the use of alcohol for celebrating *Holi* by Gonds, consumption of alcohol or opium instead of home brewed rice beer among the tribes in the north-eastern part of India, are all changes brought about through cultural contacts.

Such a dynamic relationship is not the product of cultural change alone. It also occurs at the individual user level or from the action of a few individuals who breakaway from the mainstream. At the individual level, differences lie in motives for drug use. Cultural use gives a framework for initial use and subsequent association in the case of group consumption. Later, even in a group situation, individuals may add their own motives to the earlier defined ones. This phenomenon has been documented in the use of peyote among the certain tribes of American Indians. This will at times lead to secular use. The secular use of a drug in the initial period often revolves around the circumstances during its first use, and motives for it may vary from each individual.

Later, the individual may add further motives to his/her earlier premise for consumption, or may completely replace his/her initial motives with entirely different reasons for continuing its usage. It involves a learning process, and decision to continue the use revolves round various factors that are defined by the individual, the social context and the pharmacological

properties of the drug, or a combination of all three.

In the absence of cultural norms, it is left to the individual to define the relationship. Since synthetic and derivative drugs do not have and cultural moorings, the relationship users develop with a drug and their reasons for initiation into the habit and its continuation may not have a common premise as in the case of cultural use. These insights will be important for developing relevant programmes for drug use/abuse management.

Through the years, human beings' relationships with MAS exist within a cultural context may change. In India, the social sanction given to MAS has been through various ups and downs. Differential sanctions operate in different parts of India for various drugs. At present, only alcohol enjoys a comparatively global sanction. Even in Islamic countries, alcohol is said to have carved out a clientele among the elite. The impact of different drugs on consciousness varies. This difference could be the reason for the acceptance of a particular drug in preference to other drugs, apart from the global and national politics that currently govern the use of MAS. History shows many incidents of a drug transformed into an enemy, but the status for the banned drug changes. In the 1890s, in the British Isles, ether was seen as a problem and prohibited. Besides, most of the present illicit drugs at one time or the other were blamed for causing human misery.

Conclusion

Finally, this report was given shape based on seventy-five case studies, of which seven were not used because of certain deficiencies. Thirty-five of them were detailed cases and the rest were issue-specific case studies. The need for issue-specific case studies emerged during the process of inquiry. Issues dealt with were coping strategies of users, sexual history and daily life. In addition to case studies, field observation data were utilised for

highlighting subtleties.

The research team also conducted interviews with the families and friends of users, maintained observational journals and personal diaries. The team went through all the data collected and pooled together information to illustrate various insights emanating from the study.

The study addressed issues such as the history of cultural linkages with MAS, the existence of marginalisation, the process of marginalisation and types of users. It examined the implications of our study's findings for drug abuse management, and the policies and laws governing it in India.

The dynamics of life in any marginalised position begins with the process of initiation. Acceptance of deviation from the main stream does not occur on the spot. It calls for a departure from an earlier set of norms and the creation and adherence to another set of norms. Once a marginalised group comes into existence, it will also create its own forms of interaction with society. Besides, life on the margins of society itself calls for learning new skills. This study therefore explores the lives of brown sugar users within this context.

Marginalisation is related to existing society's norms or empirical and logical standards and cannot exist in isolation. In the case of drug use, administrative standards criminalised the habit and forced its practitioners underground into isolation. Therefore, the present source of human misery was explored to identify those factors that led to making the drug trade a viable operation along with those that increased the demand for drugs from consumers. Another aspect dealt with was society's responses to drug users, irrespective of whether these were based on false assumptions or actual facts regarding drug users and the drug use habit. The impact of society's responses to drug abuse management was also examined. The study ascertains whether there are certain universal characteristics for drug users.

Further, the criminalisation of drug use has also been studied. Earlier studies have shown that alienation can lead to an increase in risk behaviour, and consequently cause exposure to HIV. In the case of alcohol, it is well documented that whenever it was made illegal, certain associated evils arise which go far beyond the actual harm caused by the drug in question (Nadelman, 1972). In India, Britto et al (1994) have chronicled the numerous deaths caused by illicit hooch. HIV infection among injecting drug users is a result of their marginalised position, and not due to injection of drugs per se. There is an analogous situation in the case of users of brown sugar, which the study has addressed. This inquiry is important as it highlights the areas for change in the formulation of strategies and programmes for drug abuse management.

For example, the prevalence of tuberculosis (TB) among marginalised drug users, as recorded at NARC's de-addiction unit, calls for changes in the present management of resources for medical care. Preventive measures are required for the better control of infectious diseases. In Bombay, while users themselves have limited places for detoxification, and the poor among them have far less, the condition of users who have addiction complications is pathetic. Users who have TB are usually kept out of most centres, except the government-run TB Hospital, whose medical staff, lacking experience in detoxification, prefer each addiction centre to detoxify the patient first and then transfer the patient to them. Such a referral arrangement was established between NARC's treatment centre and the government TB hospital as a result of the present research project. Subsequently, the TB hospital began to give direct admission to drug users with TB co-morbidity. But many users admitted there ended up on the street, because they were unwilling to take the institutional framework of a public hospital. There is also an added belief and fear among the users that anybody who goes to the TB hospital never returns alive. This fear has some

actual basis, because the poor in India go to public hospitals only as a last resort, when their condition has deteriorated considerably. This is one main reason for the deaths in the TB hospitals.

The presence of HIV cases among users has also increased the extent of their marginalisation. There is as yet no process by which patients are given clarifications on the differences between HIV and AIDS. Drug users are routinely sent for HIV testing in some hospitals. After getting the results, the doctors inform the patient that he/she suffers from a certain form of blood complication and actual details are written in English in their report. This results in their being shunted around and instils the fear of death in them. Not surprisingly, when they feel that they are going to die, they see no reason to give up drugs.

Limitations

As professionals in the field of drug abuse management for a decade and a half, we were unable to sacrifice our empathy for the population which sustained our work. Besides, as an action research project in a marginalised population, researchers had to spend time on their intervention. This was both a problem and an asset to the study.

Our selected drug users were often high, detailed data on their life histories were often taken from those willing to take a short respite from drug use.

Since our study gained clarity through the process of search and interventions, the areas inquired into need further exploration. Our findings should be treated as hypotheses for further testing in the interest of developing a sound theoretical framework. Besides, the aspects touched upon are limited due to constraints of time and resources.

Unable to take on the role of detached observers, we did not

emphasise the need to establish a perceived objectivity, as in quantitative research. As the first street ethnographic study to have been conducted among this population in India, our methodology necessarily has its limitations.

In Bombay, the percentage of female users are far less than male users and our centre has infrastructure only for male addicts. Hence, the representation of female users in the study is limited.

2

The Dynamic Relationship Between Mind-Altering Substances (MAS) and Mankind

Yesterday's Images and Today's Reality

Drug use existed in most cultures, except in the land of the Eskimos. This has been extensively studied by many social scientists (Blum, 1969; Gossop, 1987; Rubin, 1975). Human association with drugs has always fluctuated with intermittent periods of stability. Changes either in a subtle or overt fashion highlighted the dynamic nature of our association with drugs. This in turn is related to whether:

- the status of the drug has changed;
- new drugs have been introduced;
- extent of any deviations from accepted patterns of use; and
- whether dual norms exist with regard to the same substance.

Associations with MAS in the Past

Mind-altering substances were integrated into society through

cultural sanctions. In traditional societies, the use of drugs was a group phenomenon. It occurred in different realms: medical, social and religious. The roles played by MAS were neither universal nor static. They varied depending on the culture, geography and period in human history. This is evident from studies undertaken in Latin America and Asia in anthropology, ethnohistory, psychiatry and sociology.

Medical Use

India has a vast repertoire of home remedies and folk medical practices, which use opium and cannabis extensively. Traditional systems of medicine (TSM), such as *Ayurveda, Siddha, Unani* or *Tibbi*, also use these MAS. While the medical use of some of the traditional MAS has shifted to synthetic and derivative drugs, the earlier usage, either within TSM or as home remedies persists in certain parts of the world. The medicinal value of *Cannabis sativa* in the treatment of tetanus, hydrophobia, delirium tremors, infantile convulsions, asthma, protracted labour and numerous other ailments has been documented by writers (Herer, 1990; Rubin, 1975; Chopra,1965).

Cannabis sativa was used for therapeutic and prophylactic purposes in Jamaica, Brazil, Canada and India. In Jamaica, it was consumed as a tonic or tea for general and specific ailments.

Medicinal tonics were made by blending rum or wine with *Ganja*. *Ganja* poultices were used for relief from pain or open wounds. These applications were not restricted to any particular class or stratum. Cannabis was also given for ailments among infants and children (Comitas, 1975). In Brazil, it was taken for rheumatism, menstrual troubles, colic diseases, dental problems and other common complaints. The process of preparation and intake differed from that in Jamaica. Brazilians make a tea by mixing marijuana leaves in hot water (Hutchinson, 1975).

Until 1939, cannabis had a place in Canadian medical prac-

tice for the treatment of a variety of ailments. Several over-the-counter remedies, such as cough syrups, sleeping potions and corn removers contained cannabis. Subsequently, these medicines were sold under prescription. This prescription practice disappeared later (Green and Miller, 1975).

In India, cannabis has a place in *Ayurvedic Materia Medica* and also in *Tibbi* medicine. According to the Indian Pharmacopoea of 1954, the uses of two preparations of cannabis, a liquid extract and a tincture, were officially sanctioned. Cannabis was used as a hypnotic, analgesic and antispasmodic agent. In rural areas, it was used as a prophylactic and in the treatment of dyspepsia, pain, rheumatism, dysentery and diarrhoea, hysteria, gonorrhoea and cholera. The difference between its medical use and its use as MAS was in the mode of consumption. Its intake was oral for medicinal purpose and the form of the product often *bhang* rather than *ganja* or *charas*.

Similarly, it was used in Nepal, besides the already mentioned ailments, for cholera, tetanus, insomnia, cough, digestive problems, lack of appetite, malaria, and also as a sophoric and an aphrodisiac. Cannabis was used in combination with other herbs or ingredients. For example, the compound used for diarrhoea and cholera contained cannabis and fifteen different ingredients including dried ginger, black pepper, nut grass, sea salt, black salt, opium, and the ashes of a clam shell. Cannabis used in these preparations was washed seven times with water in a cloth for removing impurities. It was also used to relieve fatigue and strain and to deal with general ailments due to ageing. Despite its medicinal value, *Ayurvedic* practitioners believed that, as with alcohol, overindulgence in cannabis could be hazardous (Fisher, 1975).

Opium was used by *Ayurvedic* physicians in the fifteenth century. It was used extensively in *Tibbi* medicine. The *Tibbi* physicians used it for relief from pain, drying of catarrh, for coughs, asthma, hiccups, treatment of manic delirium and in-

flammatory conditions of the brain, diarrhoea, dysentery, facial paralysis, epilepsy and similar nervous conditions. It was considered a stimulant which could give pleasure, physical vigour and a feeling of warmth. The medical need decided its form: it was used as paste, in pills or as a liquid. A paste of opium was applied for headaches, toothaches, inflammation and swollen joints. While it was used locally as a liniment for pain, it is not clear whether opium could be absorbed through an unbroken cuticle. The relief, in such instances might have resulted from the application of warmth, as the process involved fermentation with a decoction of poppy heads and other opium preparations. As a household remedy, it was useful for various inflammatory conditions, haemorrhage and erysipelas. Opium in liquid form was used for conjunctivitis, earache and toothache. For dental problems like a hollow tooth, a pellet of opium was kept inside the cavity. Suppositories of opium were used for disorders of the pelvic region. When oral intake was not possible, it was given through the rectum. Besides these functions, opium reduced sensibility during the advanced stages of smallpox prevented relapse of malaria fever and controlled diabetes.

New derivatives of MAS have replaced the earlier forms to an extent, but these products have been patented resulting in high costs, and are alien to traditional society. As a result, in many places, people still depend on the earlier forms of medicine. In such circumstances, it is unreasonable to classify opium as an illicit drug, especially when many developing countries cannot afford to depend only on modern allopathic medicine.

The present socially sanctioned recreational drug—tobacco—was used as a remedy for general chills, colds, and snake bites among the Jivaro,the South American Indians of Ecuador. Home brewed liquor at one time was used both as nutrition and medicine among different tribes. The usage of a particular drug for a specific reason remains static.

Religious Use

In traditional societies cannabis, nicotine, opium and mushrooms were used for religious and magico-religious rites. Our associations have changed since religions especially tribal religions have not remained isolated from scientific innovations. At present only alcohol has retained its religious and social status. With regard to the other drugs, since they are illicit, the cultural sanctions around them have slowly eroded or changed. In certain cases, magico-religious effects, which focused on enhancing existence according to the user's understanding of supernatural powers and to deal with the loss of life of dear ones through altering consciousness, were achieved through scientific innovations. Here, our interaction with MAS has changed far more than its use in the realm of medicinal use.

One of the earliest recorded mentions of cannabis was among the Synthians in Atai in mid-Asia. They used it to go into trances during the funeral rites of the king. Cannabis seeds were thrown into a hot cauldron and water was splashed to generate cannabis fumes (Emoden,1972).

Cannabis played a different function in Jamaica among the poor. They used it to attain the great "vision", which had cultural relevance for them. This also legitimised its consumption. Based on their experience of the vision, their role as smoker and their transition to the *ganja* subculture was confirmed (Rubin, 1975).

Tribal Indians in small communities near the Gulf of Mexico also used cannabis for religious purposes. Cannabis (*la santa rosa*) was given the central position during their religious ceremonies. It was considered a sacred plant with divine origin which helped people to verbalise extensively. In contrast, in the urbanised part of Mexico, cannabis consumption took on a secular hue among those who were exposed to western culture (Garcia, 1975).

The use of hallucinogens for religious reasons has been well documented, the analysis of the process showing a clear link between culture and the hallucinatory experiences of the user. These hallucinogens ranged from fly agaric (mushrooms), *datura*, *ayahuasca* (cactus), mandrake and peyote. Mushrooms were used for experiencing vision in Taoist (third century BC) Chinese texts. Among the Koryak in Siberia, *shamans* used fly *agaric* during divination ceremonies and funeral rituals with spirits, as well as for euphoric purposes in gatherings. *Datura* was also considered to be a sacred plant by the Aztecs (Blum, 1969).

The Mestizo, an agricultural group on the north coast, and the transitional Indian group in the Peruvian Amazon city of Iquitos, both use hallucinogenic plants for important divine revelations. The coastal and rain forest healers use mescaline and harmine substances to diagnose the causes of illness, set within a magical framework of disease etiology. The coastal healers use the hallucinogenic drink made from cactus to obtain visions of the remedies, herbs, or pharmaceutical medicines they should prescribe for their patients. These healers claim that during the ritual, polished stones present on their healing table (*mesca*) can assume the form of plants and animals familiar to them and do their bidding in retribution against the evil agents responsible for their client's illness.

In the rain forests, the plants are used mainly to reveal the agent or person responsible for bewitching the patient before any therapeutic action is taken. The visions reported by people who consume *ayahuasca* include images of wild animals, rivers, boa constrictors and poisonous snakes. The image of the person responsible for bewitching the patient also appears. These patterned visions were interpreted by an experienced shaman healer, who would then lay the blame for illness on some evildoer or malfeasant spirit. The healer has to clearly identify the party responsible before taking any course of action.

According to Dobkin de Rois (1975), Indians use the *ayahuasca* plant for culturally specified goals, namely, to obtain an insight into the habits and peculiarities of the animals they hunt, to facilitate inter-group relations and as a tool to achieve political harmony. Among the Koryak, another use of hallucinogens has been to produce visions of their dead kinsmen instructing the *shaman* how to solve a problem. In certain tribes, consumption of hallucinogens produced visionary effects such as macropsia or micropsia, which entails perceiving objects very large or very small.

In the African continent, *Datura fatuosa* is used to attain religious experiences during initiation rites of females at puberty. Here the user experiences visual and auditory stimuli and also hears the voices of ancestors assuring procreation. In traditional society, the impact of hallucinogens depends on the antecedent-consequent variables.

Nicotine also played the role of a magico-religious drug among the South America Indians. Priests and doctors smoked it in rituals to produce dream visions and consult with their semi-deities to cure the sick. Tobacco is sometimes mixed with other MAS (Coca, *Datura*, *Bansiteriopsis caapi*, (*ayahuasca)* and other psychotropic cacti) for supernatural purification and as a revitalising agent during life crisis ceremonies, especially in initiating the training of neophyte *shamans*. In one of these tribes, the priest, after achieving an ecstatic state, negotiates with spirit forces to obtain health and sustenance for his kinsmen and to retrieve souls that might have strayed away. The priest under a trance can diagnose his patient's illness, and treats the patient by anointing him with tobacco concentrate and by blowing on the affected area. Among this population, tobacco was used not only for sanity but also for sanctity. It was considered to be the proper nourishment for supernatural beings by South Americans (Wilbert, 1975).

From the above examples it is clear that drugs also have a

magico-religious role to play in numerous societies. Here the emphasis was on magical healing and to deal with demons. The entire community need not be involved, it may be private occasions undertaken by the healer in consensus with the concerned families. The focus was on individual needs, whether materialistic or interpersonal witchcraft (Blum, 1969).

In India and Nepal, cannabis was linked to Lord Shiva, who is associated in mythology with the Himalayas. In Nepal consumption was not restricted to the Saivite sect. Cannabis was used among *yogis* for meditation purposes. Certain conditions surrounded this use, such as the general austerity of asceticism, coupled with the unusually rigorous climate and certain religious beliefs. It was a disinhibiting agent during esoteric tantric rituals. Thus, these rites in Hinduism allowed freedom in certain areas of human behaviour.

Another culturally sanctioned use was among male devotees who sang *bhajans* (religious hymns). *Bhajans* were usually sung in auspicious places, such as temples and *satals* (pilgrimage shelters) and at times in private houses. Such devotional meetings were often associated with the *Bhakti* cult and not necessarily linked to Lord Shiva. During the sessions, *ganja* is passed around in a *chillum* (pipe) among the singers and musicians. There are no hard and fast rules regarding consumption but it is almost like breaking bread together. In Kathmandu (capital of Nepal), there are about half a dozen such places where public *bhajans* occur on a daily basis at night. The participants are farmers and traders. The hymns are often sung in Hindi (India's national language), even though their language is Newari (Tibeto-Burma language) or Nepali in the case of Brahmins of Chhetris. Cannabis is consumed during festivals like *Shivaratri* and *Janmashtami*. During the latter, even children consume cannabis in the form of *bhang* (Fisher, 1975).

Cannabis appears to have been introduced in India in BC 800, but Dwarakanath (1965) stated that the earliest date for the

presence of cannabis was circa BC 400. The use of *soma*, a mind-altering substance, has been cited from the *Rg Veda*. Some writers have stated *soma* to be cannabis. Though the Brahmins and *Bhagats* abhorred alcoholic drinks, they did not abstain from using cannabis due to its religious associations. However, analysis of numerous verses from the *Rg Veda*, ethno-historical and ethno-botanical data tend to equate *soma* with the mushroom fly agaric and not cannabis (Wasson, 1971). *Soma* is the God who "represents and animates the juice of the *soma* plant". Some consider the *soma* plant of the *Rg Veda* to be the *Asclepias acide* of Roxburgh. It is a creeping plant, almost destitute of leaves. It has small white fragrant flowers collected round the extremities of the branches. It yields a milky juice which is mild and acidic in nature. McKeena (1993) considers *soma* to be *Strophoria cubensis* based on the climatic requirements for the plant and the psychoactive properties.

It was only in the twelfth century that cannabis became a part of the traditional system of medicine (Blum, 1969). Subsequent detailed studies by the Indian Hemp Commission (1893-1894) and Chopra and Chopra (1965) showed that cannabis was consumed in Hindu and Sikh temples and at Mohammedan shrines. Mohammedan *fakirs* (religious persons) used to congregate near their shrines and consume cannabis; on such occasions other users also joined them. Among *fakirs*, *bhang* is viewed as the giver of long life and means of communion with divine spirit.

The Prophet Mohammed (AD 570-632) did not prohibit explicitly the use of cannabis, but alcohol was prohibited. However, Morocco outlawed cannabis on Islamic grounds. Cannabis use was not prohibited in other Muslim countries (Blum, 1969). It was in the nineteenth and twentieth centuries that restraints were brought in through laws enacted by political authority.

Among the high-caste Hindus, alcohol use was prohibited

but cannabis use for festivals and ceremonies was sanctioned. This does not mean that alcohol was not used among the Hindus. It only indicates a difference in cultural and religious orientation towards these two drugs. Consumption of alcohol in villages in India is confined to the use of *daru* or *sharaab* (wine), *tharra* (country-made liquor), *tari* (toddy—the juice of the fan palm, date palm and coconut trees), *madhu* (rice beer), *mahua* and denatured spirits.

Alcohol in any form is absolutely prohibited for the Brahmin, the highest *varna* in the Hindu caste system. The prohibition of alcohol goes back to the Vedic period. Among the twice-born castes, the Kshatriyas are known to use alcohol and meat (Carstairs, 1954). The Kayasthas of North India also use alcoholic beverages. However, even among these castes, individuals who drink alcohol try to give up wine and meat with the onset of old age and turn to religion to die "pure" and pious (Hasan, 1975). Thus, use or non-use of a particular drug was dependent on the individual's membership of a *varna* and caste, or other groupings, such as the "holy" as against the "ordinary".

Cannabis use is sanctioned during certain festivals like *Holi* and *Shivaratri*. It also depends on the nature of the interaction between members within a kinship group. *Bhagats* (devotees) and holy men are free to use these drugs, while they are forbidden to take alcohol (Hasan, 1975). Since Brahmins are accorded the highest status in Hindu society, their practices (fasting, vegetarianism) and abstinence (teetotalism) are valued and respected. *Bhagats* of other castes adopt many of these practices. Many low-caste individuals, generally those above forty years, become *Bhagats* and must abstain from alcohol although they can continue to use hemp (cannabis) drugs.

The use of *ganja*, *bhang* and *charas* is associated with religious and social ceremonies among the Hindus. It is believed that Lord Shiva was very fond of hemp drugs; these drugs are still offered to Shiva in temples on the night of *Shivaratri* as the "food

of the god". The *Shivaratri* festival is observed on the fourteenth day of the dark half of the month, Phalgun (February to March). People celebrate it to express joy, as it is believed that Shiva was married on that day. Another festival during which cannabis is used is *Holi*. On this day both males and females have a drink made of cannabis leaves, milk and dry fruits.

Cannabis use by *fakirs* has been socially accepted as a means to relate to the supernatural realms of consciousness. The use of opium by *fakirs* has also been cited in the District Gazetteer reports and Indian Hemp Commission report (1893-94), and it was through socialising with them that others started using opium. The general belief among the *sadhus* was that these drugs help to free the mind from worldly distractions and concentrate on the worship of God. This may be the reason why in places of pilgrimage like Kasi, Mathura and Puri enormous quantities of these drugs are consumed.

A study undertaken in Lucknow (a city situated in northern India) showed that despite the visibly high consumption of alcohol by the people there, the consumption of hemp drugs was more. Among the Harijans, the use of alcohol is not prohibited. It is in this group that alcoholic beverages are commonly used. In this study (1959-1960) it was found that 87.1 per cent of the respondents did not object to the use of *ganja* as against 75 per cent for wine and country liquor.

Religious sanctions played a role in the differential association. For example, a person who wants to become a *bhagat* must pledge before his *guru* (religious preceptor) that he will not consume liquor, meat, onion or garlic and will not have sexual relationships (even with his wife) after becoming a devotee. It is important to note here that hemp drugs were not forbidden.

This is analogous to the process of sanskritisation, wherein the lower caste groups imitated the practices of higher or dominant caste groups. It was natural that *Bhagats* adopted Brahmin

practices to bring themselves closer to the Brahmins or other dominant castes in their area. Individuals from lower castes, over forty years, who became *Bhagats* moved up the social hierarchy in this manner.

Opium also played a role in religious functions. In western Rajasthan (a desert region in India) opium was distributed during funeral rites for facilitating catharsis. It was used in Assam during semi-religious ceremonies to avert sickness and natural calamities (Allen, 1903,1904 and 1905).

The increase in scientific knowledge over a period of time changed the religious outlook in most communities. This naturally transformed the faith concepts of the people, which included the use of MAS for enhancing supernatural perception. A rational approach to existence has not totally wiped out interest in magico-religious ceremonies or supernatural ideas; many of these customs are still prevalent in many parts, both in developing countries and developed countries. Probably it is society's extreme prejudice towards groups striving for non-rational domains that led to the emergence of groups that took recourse to rebellious and destructive attitude towards society.

Social and Functional Uses

In many present-day cultures, western influences dominate the choice of MAS. Accordingly, alcohol enjoys a higher social acceptance than any other drug. In earlier societies, various psychoactive substances were used in important social functions such as marriage, for sealing an important business deal, to facilitate catharsis after the death of an immediate family member, for longevity and for enhancing sexual pleasure. The Rajputs used opium for these purposes. They also used opium before engaging in battle and for sealing peace treaties. To cope with the desert sun before a long journey, camels or horses were also given opium. Another use was for female infanticide, especially

in Rajasthan. Even today, an opium drink plays an important role in our culture. A guest is offered opium to drink in the cupped palm of the hand by the host as a mark of respect. Alcohol is the social drug in the westernised segments of India. It is therefore not surprising that alcohol companies finance anti-drug campaigns in India. Today we can see alcohol outlets dotting the villages of Rajasthan which was never the case before.

Opium has been used for a long period to deal with critical situations like battles and wrestling. In the 1670s John Fryer observed that wrestlers who took opium performed feats ordinarily beyond their strength. It was also taken by warriors to face hurdles with a resolution to do or die (Brian, 1975). These practices persisted, until fifty years ago, among army personnel to help them manage their daily hardships and in battle. At present, in many regions, alcohol has taken over this function.

Opium was also used as a sedative for children. It was mixed with sweets and given to children to help them sleep or to keep them docile for a while. Mothers working in the fields dosed their children. In industrial areas such as Bombay, Calcutta and parts of Uttar Pradesh women working in factories administered opium to their children (Andrew, 1926; Chopra, 1969).

Cannabis was consumed in the form of a drink called *thandai* during the hot summer in central, eastern and north-western parts of India. Besides being cool, *thandai* is also nutritious, as it contains protein (almond) and fats with a high calorie value. Thus, it serves as a supplement to the poor who have little access to proteins and mineral salts. Between March and October, people perspire heavily; the consequent loss of salt is compensated by the intake of food and decoctions like *thandai*, which also helps in dehydration.

The preparation process of *thandai* during social functions

is ritualised. Members of the same family, caste or a group of friends from the village or the neighbourhood gather at the host's parlour. The preparatory phase takes an hour and stimulates close interaction among the participant. Members of the Shudra and untouchable castes have their own parties and do not join the *thandai* parties of the "twice-born" castes. Unlike *thandai* parties, the use of *ganja* in certain instances facilitates interaction between castes, as ordinary men and *Bhagats* sit together and smoke. Besides these functions, cannabis was cultivated for processing oil in the Dolpa district of Nepal (Fisher, 1975).

Fluctuations in Our Past Association

While cultural mechanisms, evolved through years of association with particular drugs, have exerted some constraints over drug abuse, recent policy changes have undermined most constraints by removing drug use from the ambit of cultural control. This has left the developing countries in a dilemma because, while many drugs have been reclassified as illicit, the cultural practices and norms supportive of drug use have persisted. This contradiction has had an impact on the use of traditional drugs. The shift from culturally controlled drug use has probably occurred not only as a result of legislation but also due to various general factors such as social mobility, enculturation, urbanisation, scientific advancement, economic change, globalisation, and the creation of universal policies and concepts of drug use and abuse. This study does not focus on any of these aspects, but concentrates on the dynamic nature of a human being's relationship with drugs.

This can be viewed from two levels:

- Development of new associations, and
- Strengthening of earlier associations.

Development of New Associations

The absence of a static relationship has been partly a result of exposure to other cultures. There have been changes in the cultural norms relating to specific drugs through interaction between various cultures. The best illustration of this is the consumption of alcohol by the Eskimos, who never had any history of association with any kind of MAS. They developed a liking for alcohol after their exposure to western culture (Gossop, 1987).

In the Indian context, the use of opium by the Rajputs and alcohol consumption during *Holi* by the Gonds have undergone changes, and are examples of the way in which a foreign culture can influence the local one. Among the Rengma Nagas of north-east India, the consumption of rice beer was part of their culture. Its daily use did not cause any change in their active life styles. Rice beer was extremely nourishing, so much so that old men used to live only on rice beer and little or no solid food. In another group, the Ao Nagas, rice beer was consumed regularly. The invasion by Christian missionaries changed the pattern, as missionaries discouraged its use and encouraged the use of unfermented grape juice from America and tea. The neo-Christians began to identify themselves as those who abstained from rice beer or *madhu* and it became a hallmark of their new faith. This was not the only change, for excessive use of opium was later documented. For example, Molugyimen village, founded by the missionaries, was inhabited only by newly converted Christians. In this village, after a few years, there was hardly any house that did not use opium. They mixed opium with betel (pan) leaves, dried the mixture over the fire and smoked it in a pipe. Travellers used to keep the ball in their mouth until it dissolved. Another shift noticed was from rice beer to synthetic alcohol in many parts of the north-east, during the British Raj. The British encouraged licensed shops for synthetic liquor, but banned home brewed liquor (Mills, 1973 and Imperial Gazet-

teer, 1907).

Environmental change can also alter attitudes towards drug or alcohol usage. An important example is that of Jews in Morocco, where cannabis use was common. Despite their exposure to cannabis, they never consumed the drug, although there was no restriction on its use in the country nor in their religion. Subsequently, when the French colonised Morocco, Jews began to migrate to Israel. Dislocated from their natural habitat, they could not relocate themselves either socially or economically in the mainstream of modern Israeli life. Thus began their use of hashish (Palgi, 1975).

The reindeer herdsmen of Siberia used fly agaric mushrooms to experience visions. After their contact with the Russians in 1954, consumption of mushrooms fell and they turned to vodka, a cheaper drug (Blum, 1969). Exposure to a different culture modified drug use pattern in Reunion Islands. Here cannabis was locally known as *zamal*. It had ritual and medicinal use. This changed to clandestine secular use among some ethnic communities. Their contact with metropolitan France brought about a new social structure and led to the use of *Zamal* as a MAS among literary circles and youth (Benoist, 1975).

In Jamaica, the elite class abstained from cannabis use as it was associated with the lower classes. It was discovered that even the poor who aspired for better living standards also abstained from the drug. There were instances of smokers who improved on their economic standing gave up cannabis to better their social status (Schaffer, 1975).

Strengthening of Earlier Associations

Change can occur when new motives are added to sustain an earlier association thereby strengthening it. As mentioned above, in Jamaica, the elite and those who planned to improve

their standard of living avoided cannabis. Another form of resistance has been already mentioned regarding avoidance of cannabis by Jews when they were in Morocco. Here the Jewish resistance was seen as a product of their desire to maintain their cultural identity. As a minority group in Morocco they had an inferior position but enjoyed the protection of the Sultan. They wore distinctive clothes, paid special taxes, and could not give evidence against a Muslim. Jews were given legal recognition as "People of the Book". The attitude of the Muslims reinforced their sense of self worth and of their own identity. When confronted by a dominant culture, they did everything to preserve their identity (Palgi, 1975). But upon their entry into Israel, they took on the Moroccan habit of consuming hashish.

This was also observed among many tribes in India, where despite high availability, there was hardly any use of certain drugs in numerous communities. Two tribes, (the Gonds and Bhumia) in Madhya Pradesh, who used home brewed liquor, were exposed to other cultures that used cannabis and opium drinks. While Gonds began to use cannabis and opium extensively, the Bhumia's continued their earlier practices. Through their exposure to other cultures, the Gonds began to celebrate Holi, but used alcohol during the celebration instead of the usual cannabis. Among the north-eastern tribes, the Khasis avoided the use of opium but consumed alcohol.

Our Present Association with MAS

Among all the other traditional drugs, it is only alcohol that has managed to retain its social place and also cross new frontiers. Most of the other drugs have been replaced by their derivatives or synthetic drugs or alcohol. Those which have managed to retain their earlier position are slowly losing out, as their traditional cultural use is eroded and new individual motives or group motives are being added on (Siddiqui, 1998).

The variations in the drug scene across cultures is becoming limited to the popularity of a particular synthetic drug as against another; for example, spread of cocaine, instead of heroin or inhalants. While this slow trend towards homogeneity is occurring, there are subtle variations in association with the same drug too. This has been partially due to cultural norms governing the use of MAS.

The shifts in the drug use is considered in the following paragraphs. When the MAS gets commercialised and is traded, a shift is created. It was observed in the case of alcohol during prohibition in India and other countries (Blum, 1969).

Earlier, landlords made part payment of wages for labour in opium, as was done in the case of coca in the Latin American countries. Under the Moghul regime, opium had been an important article of trade with China and eastern countries. It became a state monopoly under the rule of the Emperor Akbar in the latter part of the sixteenth century. With the decline of the Moghul empire, the monopoly of poppy cultivation passed on to a group of merchants from Patna. But in 1757, the East India Company took over. Between 1710 and 1759, Britain paid China 26,833,614 pounds sterling in silver and gold for tea, and only 9,248,306 pounds in goods. The British experimented with various commodities to balance the trade from ginseng to seal skins. But nothing worked and the situation called for immediate action to safeguard the fast emptying coffers, thanks to the British predilection for Chinese tea. The Chinese permitted only a limited amount of opium to be introduced into China via the British and other foreign warehouses in Canton. Unable to break the Chinese resistance to a more balanced trading agreement and in the face of a tightening of controls on opium imports, the British trader and smuggler Jardine attacked the Chinese navy and started the opium wars, which led to the opening up of opium trading with China (Husain, 1983; Scoot, 1969; Goldsmith, 1930; Chopra, 1965; Beeching, 1975) and accession of Hong Kong.

To facilitate the British trafficking in opium they sought a monopoly over all cultivation, processing and sale. This involved pressurising local princes to control or eradicate poppy cultivation in their own kingdoms. This was important, as in certain areas not under the British, the quality of poppy was superior to that produced in the British provinces (Brian, 1975). The whole process changed the relationship of human beings with opium in this part of the world. Until then, the relationship fell under the realm of 'logical standards' (historically based cultural guides for the behaviour of men; for example, the required use of opium in western Rajasthan and in Gujarat). The emphasis on monetary gain and the forced curtailment of cultivation in certain provinces slowly shifted relationship from the cultural context to that of 'administrative standards' (practical guides set by the dominant caste or ruling elite; for example, through legislation).

The cultural influence on opium underwent further modification with the invention of morphine and, subsequently, heroin. Initially, these were labelled 'wonder drugs', but this was limited to developed countries and did not have any impact on countries associated with a traditional use of opium. In India, then and even now, the percentage of people who use allopathic drugs for ailments is small. The majority of people depend on traditional systems of medicine such as *Siddha*, *Ayurveda* and *Tibbi/Unani*, tribal and folk medicine, and home remedies. Thus, the use of morphine and heroin in India, even for medicinal purposes, was limited. Traditional society did not have a utilitarian place for them. This is also reflected in the case studies and field observation notes in Bombay. Users, even those who know it is a derivative of opium, call 'brown sugar', a foreign drug.

The accepted need for opium began to narrow down to its

medicinal properties with the end of the opium wars. Countries began to compete for the international market for derivatives of opium. The international control bodies treated both traditional growers of opium and those who began cultivating poppy using far more cost effective methods on par with each other. For example, in India, farmers used to collect the gum of the poppy plant by slitting the pod with a star-shaped blade. This method of collection, known as the gum method, is very labour intensive and hence not viable in western countries. In Hungary, Janas Kabay discovered a less labour intensive way of collecting opium from the poppy plant. This method was called the poppy straw method. An added advantage was the synthesis of a higher quality of morphine. With this discovery Australia, France and Spain went into poppy cultivation. Earlier, poppy was grown in these countries because their climates were conducive to it. However, there was no systematic large scale cultivation for commercial purpose as the cost of labour required made it non-viable. All these aspects reduced the marketability of opium from traditional poppy growing countries (Annexure-C).

This resulted in a surplus of opium supposedly for the medical needs of the world. Unable to find markets and faced with the need to curb cultivation, countries like India attempted to reduce the area under poppy cultivation by administrative fiats, sought to lower procurement by reducing the purchase price and commission payable to *lambardars* who were collection agents. After the enactment to the NDPS Act and the subsequent creation of the Narcotics Control Bureau in different parts of the country, many control measures have been tried out. Nevertheless, the problems have been compounded with the rapid spread of crude heroin addiction in India. The profits from the drug trade now has become too tempting for anyone to want to stop cultivation.

Factors Responsible for Changes in Association

Our association with drug use has not been static. The factors that contributed toward shifts in our association can be broadly categorised as: globalisation of drug use and its control, changes in national norms, changes in motives associated with MAS use, pursuit of altered states without philosophical understanding, and group consumption versus individual consumption.

Globalisation of Drug Use and Its Control

In the late nineteenth and early twentieth centuries, the need for regulation and intervention at a glob-l level gained momentum. This was conceptualised and directed by western countries and adopted by the rest. At the International Conference held at the Hague in 1912 and 1913, the American representative was far more vocal and convinced about the need for prohibition and not regulation. But the other countries were not willing to oblige immediately. The United States passed the Harrison Narcotics Act of 1914 a year later.

Along with the Harrison Narcotics Act, the punitive model came into existence and over the years it became a favourite tool for many countries to deal with issues at the national and international levels. The model perceives users as deviants or criminals, thus justifying the use of power strategies to reform them. It assumes that law is the solution but it has been unable to deal with increasing poppy cultivation and the global opium pile up, which far exceeded the global requirement. Another approach that became popular in certain parts of the world was the disease model. This too widens the gap between drug users and the general population.

Interestingly, in the same period, the Americans, the most vocal propagators of the punitive model, prohibited alcohol, but it was later legalised as its use spread across all classes. Rich-

mond P. Hobson and Harry. J. Anslinger, tried their best to support the temperance movement and enforce an equally harsh approach towards opiates. Since alcohol was legalised in due course, they targeted foreign drugs, cannabis and opium. Their publicised personal opinions in course of time became factual statements for the public (Brian, 1975).

The punitive model resulted in the creation of a market force in drugs transaction which deviated from society's norms. Illicit drugs were imported on a large scale. The medical profession tried to look at public health as the basis for intervention, but it did not receive political support. The government went ahead to evolve the Comprehensive Drug Abuse Prevention and Control Act, which placed prevention and treatment also under the Federal law. In later years, America saw an upsurge of heroin imports, the formation of a subculture and cults, antisocial groups involved in trade, and crimes. A vast majority of drug related crimes result from the illegal status of drugs, for example arrest for possession of drug for consumption or involvement in petty theft for purchasing drugs.

The growth of the commercial market or "drug trade" was facilitated by the illicit status of the drug and the punitive measures undertaken to enforce the law. The control was at the international and local levels, the latter focusing on usage along with trade. The efforts at the international level (through a combination of crop substitution, aerial spraying of herbicides, armed intervention, and international pressure through threats to terminate aid for development, led to shifts in the source countries and trading routes, and the induction of new regions into the drug trade. For example, south-west Asian producers who played no role in the American market until 1976, began to meet half of the total American needs in the 1980s after the Afghan imbroglio.

Other factors that brought about changes were synthetic drugs and the emergence of new modes of consumption, such as

the use of hypodermic needles. The new illicit status and other factors already mentioned led to the development of secular, criminalised associations with drug use. The punitive approach, which became the set pattern for dealing with the problem, also created a situation which enabled the drug trade to survive and flourish.

With the setting up of international bodies, the need for caution while trading in drugs became crucial. This led to the development of a mafia who found it more profitable to deal with the fine, powerful and expensive heroin or cocaine rather than liquor, gold and silver. Several groups were involved in the business. They ranged from direct couriers, political supporters, establishments that laundered drug money, law enforcement officials who looked the other way, cultivators who sold to the illicit market for survival, farmers who directly cultivated for the drug lords, down to petty peddlers on the streets.

Subsequently, with cocaine and heroin being abused in many countries, cultivation increased and they were grown as cash crops. This affected the economy of these countries and the social impact was significant. The drug traders often invested their profits in the developed countries, while the cultivators continued to live in dire poverty. The tycoons of the drug world systematically milked their countries for personal gain. When drug lords were arrested, their assets were never repatriated to their native countries but retained in those developed countries where they were invested. Ironically those parties that cry out for change do benefit from the confiscated investments of the drug barons.

The constant shifts in nerve centres of drug trafficking often resulted in political upheavals. It is borne out by the history of the Mexican involvement, the French connection, the Dutch initiatives, the Italian Mafia and Chinese competitors (Kruger, 1980; Executive Intelligence Review, 1977: Mills, 1987).

The hippie movement was the first globally publicised subculture of users. It was a protest against the industrial corporate culture and the resultant materialist values. Their emphasis was on an existential approach to life, where drugs and music were simply catalysts (Weakland, 1969). Many members of this group went to the East to attain further insight into a non-capitalist lifestyle. Some of the local youth began using cannabis, not for traditional cultural reasons but to imitate the hippies (Rubin, 1975). By attacking their use of cannabis, the establishment managed to side-track other fundamental issues raised by the hippie movement (Weakland, 1969). *Ganja* users, aware of the government's or society's views on drugs, saw drug use as an expression of anti-establishment views. Largely as a result of the hippie movement, and the negativism which grew towards opium use by Chinese immigrants in the United States, public feeling was channelled into a ban on psychoactive plants like *Cannabis sativa* and poppy. Such a mobilised negativism towards opium users still persists.

It needs to be remembered that, at times, stressing one aspect could create wrong associations in a man's mind. The users' group philosophy was aptly expressed by Timothy Leary who said, "Tune in - tune on - drop out". In this movement, they fought against the establishment, but often people associated them only with cannabis or other drug use, psychedelic music and art. The basic philosophy of the movement was distorted through narrow media hype. The members of the movement were also responsible for this distortion, as they did not correct the impression created by superficial articles about them. They also did not offer alternatives less dominating and rigid than the ones they fought.

With the passage of years, their queries about rational existence in an industrial society were forgotten both by society and even by themselves. A majority of their members rejoined the culture which they had rejected. Society systematically destroyed the movement by absorbing some of its superficial features, like psychedelic art and music. This reduced their popularity and discouraged new recruits. Just like those anthropologists who seek a distant culture for enlightenment but bring about very little change in their own lives and culture, the members of this group also returned to society after their "trips". The process ended up as a trip of curiosity and nothing more (Weakland, 1969).

Changes in National Norms

The cultural context for psychoactive substances was disturbed through the efforts of international bodies, global policies, political changes in nearby countries which encouraged the growth of new trade routes, exposure to western culture, formulation of narcotics laws in line with international conventions, urbanisation, and competition between sale of natural forms of drugs and derivative/synthetic drugs within the recent legal framework. All these elements were active in disturbing the roles prescribed by culture for drug use.

A clear example of this impact of international norms and exposure to another culture was seen in Nepal, as the social structure in various parts of the country changed drastically. With the influx of 'flower children' from the West, there was a sudden increase in demand for cannabis. This provided an opportunity for some to make a quick buck, with the escalation of the market price of *charas* from $15 per kilogram (retail) to about $70 per kilogram in 1973. Initially, in Nepal, the government began to take regulative measures, but they were abandoned due to international pressure to enforce punitive approaches. This led to criminalisation of the use, cultivation and processing of various drugs. The profile of a cannabis user altered. Youngsters began to use it for a change and deemed it as a novel and pleasurable experience imitating a distant culture.

The factors that prompted the adoption of punitive measures in Nepal were the alarm within the middle-class families as their own youth turned into hippies, the pressure from United States government as part of its world-wide effort to control so-called 'narcotic' drugs and the pressure from the United Nations to outlaw cannabis. Being a small country, the opinion of these international bodies and countries was important, as the threat for disobedience was withdrawal of developmental aid (Fisher, 1975).

To control both the use and abuse of drugs, international pressure forced the developing countries to subscribe to uniform global norms. The universality of this approach had its own drawbacks. Policy changes in developed countries towards the cultivation and use of cannabis and opium, which were alien to the predominant Christian culture, may have been reasonable; but this was not so in some developing countries. Nevertheless, the Indian government duly enacted the Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act), which did not take into account the Indian situation and its plural cultures.

In India, for centuries, *Cannabis sativa* has been used for various social, religious and medicinal purposes. The NDPS Act placed cannabis among illicit drugs. When the Government of India signed the Single Convention of 1964, it accepted the international decision to phase out cultural and non-medical use of cannabis in twenty-five years. But did nothing about it. There was neither public debate nor research nor education. Technically we were obliged to bring cannabis under control only in 1989. However, on account of pressure from the United States, the NDPS Act was passed without any debate or study in 1985 itself. The Youth Congress was activated to launch a signature campaign and a memorandum was submitted to the Prime Minister as a modality of legitimisation. Apart from a study of addiction among college students in 1978 (Mohan, et al) and the

Gopalan Committee (1979), nothing significant was done as a follow-up to the ratification of the Single Convention.

Politicians wished even to eradicate the leaves, which continue to have far more social sanction than the resin of the same plant. It was the use of cannabis by the upper and middle class youth which was not acceptable to those in authority; but the reaction to this was not as extreme as in western culture.

The abuse of MAS has led to serious health and social problems in most countries. Nevertheless, the punitive measures which have been adopted to control their use have become a greater problem. It should not be forgotten that alcoholism has had a larger detrimental effect on health and social relationships world-wide than any other drug, legal or illegal. The extensive punitive laws which have been passed to eliminate drug cultivation and consumption have not only failed to do so, they have probably made matters worse.

The points that have been missed by the legislators are that prohibition only drives the practice underground and cannot be enforced, except in a totalitarian regime; and that complete liberalisation also leads to problems if the substance is in high demand and is physically addictive (for some, at least). Therefore, a balance has to be found somewhere between the two extremes as far as physically addictive substances are concerned. Ignorance and over-simplification have led to enormous energy being wasted on minor issues, such as cannabis use.

The dilemma of drug abuse management planners arises from the assumption that a dominant culture of the developed countries, which in itself is diverse, can dictate relevant programmes for India's 960 million people, with diverse races, languages, climates and geography. The irony is that the governments of the past drug-trading nations are today's policy planners for drug abuse management of the planet.

The legislative changes in India also created shifts in the trade and use of drugs. Early sellers of traditional drugs either had to switch over to selling synthetic/derivative drugs or give up trading altogether or go to jail. While some traders left for safer pastures, others shifted to selling synthetic or derivative drugs. Among the traders, a few continued to sell cannabis and opium on a very small scale and refused to deal with derivative drugs. The emergence of local entrepreneurs for marketing crude heroin (brown sugar) was inevitable under these circumstances. The local clientele paved the way for new marketing strategies: selling at low cost but poor quality drugs in small quarter-gram vials and sachets and gradually escalating the price. A sequel to the marketing of a new product and the criminalisation of traders in traditional drugs was that the cost of traditional products also increased drastically. Hashish, which had been available for Rs.2 per ball, is now Rs.10-15. A quarter-gram of brown sugar also costs only Rs.15. This also prompted a shift from traditional drug use to synthetic drugs.

The discovery of synthetic and derivative drugs brought into focus a practice known as the 'secular' use of drugs, that is, drug use without ritual or ceremonial significance (Blum, 1969). Earlier the secular use was absent or limited. The discord in society's present relationship with brown sugar may be an outcome of extensive secular use. Experiencing altered states of consciousness is as much contingent on the substance as the user's dispositions and the cultural setting (Rubin, 1975). Previous studies have illustrated norms for the use of traditional drugs, but similar information on derivative and synthetic drugs is lacking. This is explored in the present study.

Changes in Motives Associated with MAS Use

Besides the mentioned factors certain changes within the country also had an impact. Mahatma Gandhi and his followers

wanted to declare many states, if not the whole country, dry. This gave an incentive for illicit distillation, smuggling and restoration of denatured spirits (Hasan, 1975). It was around this period that the elite, exposed to western culture, adopted alcohol consumption as a status symbol, especially foreign liquor. Later, alcohol became a source of revenue in most states and led to bootlegging in dry ones. The government also tried to curb the sale of cannabis and opium through licensed retail sellers, which in turn led to an increase in the consumption of alcohol (Chopra, 1965).

State governments promote alcohol for the purpose of meeting ever-increasing need for revenue. The state of Maharashtra, for instance, adopted many pernicious policies and raised the alcohol revenue from a mere Rs.78 crores to over Rs.1000 crores in the period 1978-1996 (Britto, 1996).

The government issued a large number of licences in 1979 to tea stalls and eating houses to sell liquor from 6 p.m. to 11 p.m. In 1981, to capture the industrial night shift workers, the bars were permitted to operate from 11 a.m. In 1982, permitting young girls to serve in bars helped to attract young workers and college students, as most colleges function from 7 a.m. to 12 noon in cities.

In the 1960s, cultural norms relating to drug use changed further with the visit of the flower children to various tourist spots. These members of the hippie movement came from various developed countries. They also had a history of association with cannabis and opium use. Thus, they came with their own presumptions about drugs and associations with it, which were alien to the cultural sanctions of developing countries. The traditional associations with drug use were transformed within these cultures. The favourite tourist spots in India were Kulu-Manali in Himachal Pradesh, Puri in Orissa, Goa, Mumbai, Pune, Kashmir and Kerala. Here the tourists' passed on their approach to life to the local elite and educated youth. Cannabis,

which never received much attention from Indian youngsters, became a sought-after substance in certain strata of society. Thus, exposure to another culture and its associations with a drug created changes in the existing cultural context. The use of cannabis by the youth, initially was limited to certain classes and tourist spots. When the profit margin of the drug increased, it became an incentive for trading in it. This resulted far more from the criminalisation of the drug than any other factor.

Search for Altered States of Consciousness

In the initial stages of human history and subsequently till the opium wars, each society had its own control mechanisms to curtail drug use. The search for altered states of consciousness was available to individuals under the guidance of others, and this included philosophical input. According to the documents available, even during the British period in India, there was reference to the use of drugs for altered states by religious persons, who initiated other adults. It did not mention its use by youngsters. Most of the brown sugar users who were interviewed mentioned taking it 'by chance'. They had been taking cannabis and had never had any problem with it. During the 1980s they came across this 'foreign' powder which they decided to try on the suggestion of others, or because they did not get *madak* (drink made by soaking opium pod in water) or because they wanted a 'better high'.

The street user's description of a 'high' does not encompass the poetic description or the philosophical insights of writers like Aldous Huxley, Allan Watts, Julian Huxley and others.

Unlike these profound individuals, who could differentiate between various levels of consciousness, the brown sugar users speak about relief from pain that results from physical, intrapsychic, interpersonal or other mundane problems. Individuals, caught in the realm of enhanced consciousness without the insight for personal growth, perceived this as a means of evading the pain of mere survival bounded by the concept of time and space. The users from the upper and middle classes spoke about trying it because it was "hep" and one of the street users spoke about using it because rich college students were also consuming the powder.

While earlier society offered some links with altered states, present society, especially in urban areas, tends to give more acceptance to alcohol-induced states rather than others. It is important to remember that drugs offer different types of altered states, and those experienced by consuming psychoactive plants cannot be attained through alcohol. As alcohol has become a status symbol, it is natural that those who value that position will try to imitate that drug use and exclude others. This may explain the acceptance of alcohol but not cannabis by middle and upper class society in Mumbai. Among the lower strata, acceptance of cannabis and opium persists. The association formed with different drugs in a city like Mumbai is not reflected in rural India (Masihi, 1998; Rao, 1998).

Group Consumption versus Individual Consumption

In the case of cannabis or the products of opium, the pattern was to consume in groups. There were places called *Chandu Khanas* (opium dens) where one could consume various opium products. This was because some of these products required a special apparatus for consumption. In the case of cannabis, people used to sit in group and consume the drug. Heroin was sold in some of the *Chandu Khanas*, but as prices soared after the passing of the NDPS Act and subsequent police action, each person started buying his own quota. Users in group settings, where brown sugar was mixed with cannabis, subsequently became secular users (Britto, 1988).

The experience of consuming cannabis in a group setting

often involves singing or group discussion; this group behaviour is absent in brown sugar use even in a group setting. Brown sugar use exists in a group setting for economic reasons. In the secular use of brown sugar, people share their drugs if someone else is experiencing a withdrawal. This is done with the hope that whenever they face a similar situation there will be reciprocal help from another user.

Conclusion

Though the patterns of drug use were determined earlier by the given socio-cultural norms, opium wars and subsequent impact at the global level created a need for global control. One of the outcomes was to evolve United Nation's Control System. It is responsible for the creation of international treatise and laws, which in turn determine international policies. These policies create national laws based on which national policies in each country evolve. These policies affect the programmes and intervention strategies at the local level. These processes changed the drug abuse situation in different parts of the globe, including India. Yet, there are many parts in India, where earlier associations still persist and they need to be utilised constructively to prevent a shift to secular synthetic drug use. There is minimal effort to channelise micro realities back to international forum towards creating relevant and culturally sensitive norms. For a culturally sensitive and viable policy can evolve only when the foundation of the present global drug policy is addressed: The Single Convention. This can be done only by the member states and not even the United Nations, for it is just a tool functioning based on the dictates of the Single Convention.

3

Ethnography of Bombay City's Drug Dens

Illicit Drugs in Bombay City

The early morning light reveals the stark contrast in human existence, which is an integral part of life in the metropolis, where luxurious apartments and crowded shanty-towns stand next to each other. As a specific area becomes yuppified, the shanty gives way to 'development'. Since the process is slow, there are numerous pockets where the haves and have-nots still co-exist. In certain pockets, slums co-exist with factories and godowns where the buildings are gloomy and coated with soot and dust. The poor find such spots ideal as they offer an opportunity for daily wage work, or at least to make ends meet by recycling discarded goods or even by stealing food grains and other survival goods. Mal Mandi (a pseudonym) is situated in one such area of Mumbai city.

Mal Mandi takes on an anonymity amidst the milling crowds till darkness descends. Heavy transport rumbles by, as there is a major godown in the locality. The privacy explains

the presence of users who come to purchase their drugs. A few of them sit along the sides of various lanes to chase brown sugar. The scene remains the same except for the coming and going of users. This pattern of behaviour is seen in different parts of the city, but the constant presence of chasers is confined to certain pockets. In Mal Mandi however there are a number of pockets where people consume drugs in groups. There are three or four such spots near the station.

One such haunt is Chase Street, a favourite locale for purchasing the drug. This place has a railway station on its west, a building which stores goods for transport on the east, an overbridge reaching the platform on the south, and a small tunnel made of rocks which is part of another overbridge for road transport. Despite being a public area, it has certain factors that afford a degree of privacy. It is not on the main road, and other than long distance trucks, there is hardly any traffic here. The daily commuters just rush past, and any person who is new or who lingers for more than ten minutes is the focus of attention from the locals, unless he/she is a user.

The road to Chase Street is towards the west of the railway overbridge. It has shops on one side and houses on the other. The early morning silence is broken only by the voices of the customers at the tea shop. Further down the lane, there is a brick wall which separates the lane from the last railway track for long-distance trains. It has an opening large enough for users to cross over and sit under the overbridge in the empty space between the tracks. Often, there are thirty to forty users sitting and consuming drugs in small groups. This place acts as a natural garbage dump and site for excretion.

This is an accident-prone spot for users who are not well oriented to external stimuli after the consumption of drugs, and especially of Nitravet tablets. In this spot, between the wall and the last track, there is a round pipe two feet in diameter. The pipe is extremely smooth and a careless person can slip and fall

on the railway track. In their drugged state, users are often accident prone.

On one occasion, one of the researchers narrowly escaped an accident as she was conversing with a user. She did not notice a fast train approaching and nearly tripped on the pipe. Another researcher held her back. This incident brought to our minds the sad stories narrated by users who had lost their limbs in similar situations, and some had even lost their lives. Another factor that indirectly triggered these situations is the vigilance by the local railway police who chase the users. The users in their desperate bid to escape the police hardly notice where they are running. After chasing, it is difficult to be alert. We witnessed one incident when a user almost fell under a train trying to escape from a policeman.

If caught, the users get thrashed and end up with swollen limbs. A female user corroborated: "The sudden death of users is common. They either have an accident or die as they sit and smoke." To a peddler, a sign of a user's impending death is swollen limbs that do not respond to ordinary medication. The researchers took one such user to the NARC detoxification centre, where he fortunately responded to treatment.

The other haunts besides those near the railway tracks are rarely disturbed by the police. Open places are inconvenient for chasing drugs during the rainy season. Both rain and strong wind can be troublesome for a person attempting to chase precious brown sugar fumes. During the rains, users also use the stairways leading to the last platform as these tracks are not used much due to flooding. In the curved structure offering shelter above the stairs, the stillness of the air, along with the strong fumes escaping from the foils of the crowd of users, make passers-by giddy by merely inhaling the air.

Another favourite haunt of the users is the cabin in the port area. This is a small room on the first floor. The ground floor

has only a wall on one side, and the other sides are supported by pillars. The space on the ground floor is used to dump garbage. A stairway leads to the top floor, with broken handrails on one side. The first floor also has an opening through which the garbage on the ground floor is clearly visible. There are security guards stationed close to the cabin, as godowns are situated nearby.

There are two types of users in this area, the transit users (those who come to purchase the drug), and the local/visible users (those who sit and use the drug in the same locality or nearby localities). The local users are often from the economically deprived classes, or are impoverished through the drug habit. They wear tattered clothes and are generally dirty. Some of the street users have long hair, infested with lice, while others shave their heads to avoid hair lice besides saving the cost of frequent haircuts. They have baths and wear clean clothes only on special occasions. They look under-nourished, and their food is often limited to sweet tea and *maska pav* (local bread with butter). Most of them claim to have no appetite, while some others pointed out that they couldn't eat well because of their poverty. It is not uncommon to find street users scrounging around garbage bins at night for food.

The users claim that they come to this area as the drug available here is less adulterated than in other parts of the city. The researchers met two users who were reluctant to buy drugs from certain spots where purer stuff was available at almost the same price. They said: "If we take pure stuff, then we have greater problems with withdrawals when we do not have sufficient money."

The visible users depend on rag picking, petty theft or small time peddling for their livelihood. There are some who purchase the stuff for other users who have enough money. In return, they get a *pudi* of brown sugar, or the left-overs in the foil, or a few butts of cigarettes filled with brown sugar that

their patrons had smoked. One of the methods used to raise money is to steal things and sell them very cheap. In one incident, two large stolen bottles of soft drinks that cost Rs. 30 each were sold for two *pudis*, which costs Rs. 30. In another case, a user who had stolen a large music system and an imported organ sold them for a mere Rs. 900. It is also common for shoppers in Bombay to come across people who seem desperate to sell the few wares that they possess. Ordinary people feel very happy at their own bargaining skills, without realising that the seller is just desperate to sell stolen goods to buy a few *pudis*. One *pudi* in Bombay costs around Rs. 10-15.

Unlike the visible users, the users from the upper classes try to hide their habit. When they come to buy drugs they take extreme care to hide their identities. They come in cars and roll down the windows. Then a small child hands over the required quantity of drug and collects the money in exchange. At times cars with darkened glasses are used, so that the users can sit in the car and chase without anyone seeing them. There is a saying among those who reach the street that "brown sugar makes the richest man come down into the streets". This need not necessarily be true.

Use of Drugs

The basic 'works' they use to chase the drug are: a chaser, a silver foil, matches or a candle. Among the street users, a piece of cloth or gunny bag is added to the above list of paraphernalia. Brown sugar is placed on a silver foil that is rectangular in shape. This is heated from below with the help of matchsticks or a lit candle. As the flame is held under the foil, a certain quantity of the drug slowly vaporises while the rest of the drug liquefies and flows to the other side the foil. In order to smoothen the flow, the foil is always is bent to make a depression at the centre. The fumes of brown sugar are inhaled with

the help of the chaser. The chaser is a cylindrical pipe, narrow at one end. It is tied with a thread at the narrow end which is used to inhale the brown sugar fumes. In the initial period, the chaser was made of silver foil. Today, it is also made of cigarette covers, with a piece of silver foil attached to the inner portion of the narrow end.

A sack or a blanket is usually thrown over the head while chasing, in order to prevent the breeze from blowing the fumes away. As the brown sugar is heated, the chaser is moved up and down to enable the user to inhale the fumes. This back and forth movement some users call "*Mazgaon-Girgaon*", the names of two inner city regions. A nine year old daughter of one user told us: "My mother and her friend (male) keep doing *Mazgaon-Girgaon* throughout the day." This child was familiar with drugs and methods of consumption due to long exposure.

In the initial period, users utilised silver foil from cigarette packets. This was replaced by aluminium foils used for packing food sold to long-distance train travellers. When purchased in bulk, this foil is very cheap and is sold close to the peddler's joint for 50 paise per foil or Rs. 2 per set, which contains the chaser and the foil. One informant stated that some users collect the foil discarded by passengers after they have eaten their food, from the railway tracks. In the case of the chaser foil, the rough side is used as the inner part as it helps some of the stuff to stick onto the paper, and this is used when they run out of stock and are desperate. Users sometimes attach a small piece of silver foil to the tip of the chaser to collect the fumes that deposit on the foil, and use them during dire times.

It is not necessary that the user will only stick to this type of material. The choice is totally dependent on availability. On one occasion in a treatment centre, the aluminium cover of a toothpaste tube was used as a foil and a *beedi* cover as the chaser.

Users also keep a Nitravet tablet in their mouths, and let it melt while chasing the drug, for they feel that this gives them a better 'high'. The tablet disorients them to time and space and this often leads to accidents while crossing the tracks or getting down from the station. A female drug user's child said with a sparkle in her eyes: "After taking brown sugar and tablets, my mother tries to jump out of running train, thinking it has already come to a halt".

An elderly user recollected the eighties era when the drug began to garner a few customers. As he sat on the side of the lane in Chase Street, a begging bowl in one hand and a stick in the other, his lost expression reflected his journey to the past. In the early eighties, the drug was more pure and cheap. It was available Rs. 4 a vial or Rs. 2 a *pudi*. The vials were made of plastic, conical in shape, the bottom being very narrow. He could see through the vial and judge the quantity of drugs. Earlier, peddlers used to reduce the quantity by spreading it, but users became aware of their tricks and shook the vial to assess the exact quantity and picked an argument if the quantity was too small.

Subsequently, the peddlers became smart and decided to sell the drug only in *pudis*. The paper used for making *pudis* is butter paper. The colour of the heroin is not visible to the client because of the opaque wrapper. Colour is an identification of purity. The peddlers profited with this kind of packaging. In today's situation, it would be impossible for a user to check the drug, for fear of being caught by the law enforcement agencies. The users confide that their fears increased with the formation of the Narcotics Control Bureau (NCB). Invariably, a user just hands over the money, counts the numbers of *pudis* (if possible) and rushes away. Thus, he is often cheated in terms of quantity as well as purity.

Users say that in the eighties they started smoking the drug mixed with tobacco in cigarettes. They found this mode expen-

sive and they started chasing. The cost of consuming the drug in cigarettes is high because of the cost of cigarettes. The quantity of the drug required is also larger, because the cigarette continues to burn while the puff is held in the lungs, thus wasting some heroin fumes. Another method is to smoke it in a *chillum*. This requires far more of the drug than when it is chased. Besides, other users can easily steal a *chillum*, as it is expensive and more durable than the other paraphernalia needed for chasing and retains a larger residue of brown sugar for further use.

In the early eighties, users placed a ten paise coin between the lips and the teeth, to filter the drug as it was inhaled. The coin also helped during the days when they were desperate. The users could scrape the sediment and reuse it. According to one informant, this practice may have stopped as some of the users swallowed the coin while they were high.

Another shift noticed for economic reasons and for lack of space was the use of matchboxes instead of candles. As smoking in open spaces has become common, the user cannot depend on candles. Hence, there has been a shift towards the use of matchboxes. A user may require ten to twelve matchboxes every day. To make ends meet, users identify secluded places, where they store strips of cigarette covers to heat the drug.

Brown sugar has a bitter taste when chased. Street users smoke *beedis* immediately after chasing a line of brown sugar apparently to hide this bitter taste. The users also stated, "the kick is better after taking a puff of the *beedi*". It feels better along with *beedis*; it helps to reduce the bitter taste of brown sugar.

Beedis come in handy when the users wish to evade the strict treatment centre rules at NARC against smuggling brown sugar into the ward. One user told a social worker, after being in the centre for four days, that he had brought a quota of the drug along with him. By replacing tobacco with brown sugar in two *beedis*, he had evaded detection in the ward. In accordance with

the norms of the centre, users are allowed to bring ten bundles of *beedis* for their personal consumption. The user gave the bundles of *beedis* to the wardboy concerned but kept back the two *beedis* containing brown sugar. While the wardboy checked him, he saw the beedis but did not suspect anything else. In the night, after everyone was asleep, the user used the lantern kept in the ward to light the paper and chase the drug. On inquiring as to how the opportunities for a chase could be reduced, he said that if fixed electric lighters like those in cigarette shops were kept, it could be reduced. This was not adopted because it can lead to accidents, as some patients are disoriented during early stage of detoxification. It would be useful not to allow patients to bring their own *beedis*. Apparently for this reason, one centre, collects a sum of money to supply *beedis*, oil, toothpaste and other essentials to its inmates. NARC centre where the smuggling actually occurred, has not adopted this discipline, because, it does not have cash transactions with its patients.

Injecting is another mode of intake that some of the transit and visible users said they had tried at ne time or another. For this mode, they need a syringe, spoon, lime, water, cigarette butts and fire. After heating the water mixed with lime in the spoon, they dissolve brown sugar in it. Then, using the cigarette butt as a strainer, they syringe out the liquid from the butt. People subsequently inject this in turns. According to an informant, the users first check whether the needle is in the vein by withdrawing some blood, and then inject the stuff. After injecting, they do not immediately pull out the needle. They take a few puffs from the *beedi* and only then do they withdraw the needle. They feel that if the needle was withdrawn immediately they might vomit. In the case of heavy users, they keep cigarettes filled with brown sugar ready for a smoke before injecting. They smoke the cigarette before removing the needle and after injection. In case there is too much blood, the second person using the needle and syringe at times cleans it with a wooden stick.

While injecting brown sugar is not a common method for visible users in the sites A and B, transit users use it. A few users, who injected, later shifted to chasing, because they faced medical complications while injecting themselves. Others found it to be just as expensive as chasing, as the quantity required per day did not decrease and the withdrawals were far more severe than when they chased the drug.

Although much noise has been made about injecting drug use being one of the four major modes of HIV transmission, it is not a popular mode in India except in the three north-eastern Indian states of Manipur, Mizoram and Nagaland where the purity of street white heroin is around 90 per cent (Britto, 1993). In certain cities there are few pockets that have injectors: Bhubaneshwar, Delhi, Calcutta and Madras. Prevention campaigns showing needle use in Bombay in early eighties was certainly a mistake. Equally foolhardy was a needle exchange program reported to have been implemented for a while in Bombay.

Posture

Users who chase adopt a peculiar posture. They often sit huddled together while taking the drug. The usual tendency is to sit on their haunches. It is a wonder that they are able to maintain this strenuous position, along with periodic bending over to inhale the fumes. This could be because of the need to avoid losing precious fumes to the wind if chasing in the open. There are only a few who sit flat on the ground as people sit for meditation with their legs crossed. They do this only when they have some sort of protection from the breeze, for example a parked vehicle or an enclosed room. Some continue to maintain a crouching posture even in protected areas out of sheer habit. Another reason for this might be because they want to have least contact with the filthy surroundings, the garbage bins

amidst copious spread of human excreta. This position is also useful in case it is necessary to run away when the police make periodic rounds to chase them.

Often when chasing in a public place, users cover their heads with a thick rag in order to prevent the smoke from escaping. Usually this is done in the company of another user. Even in a group of thirty or more users, one can find small groups of two or three individuals smoking the drug together. However, isolated individual users also exist.

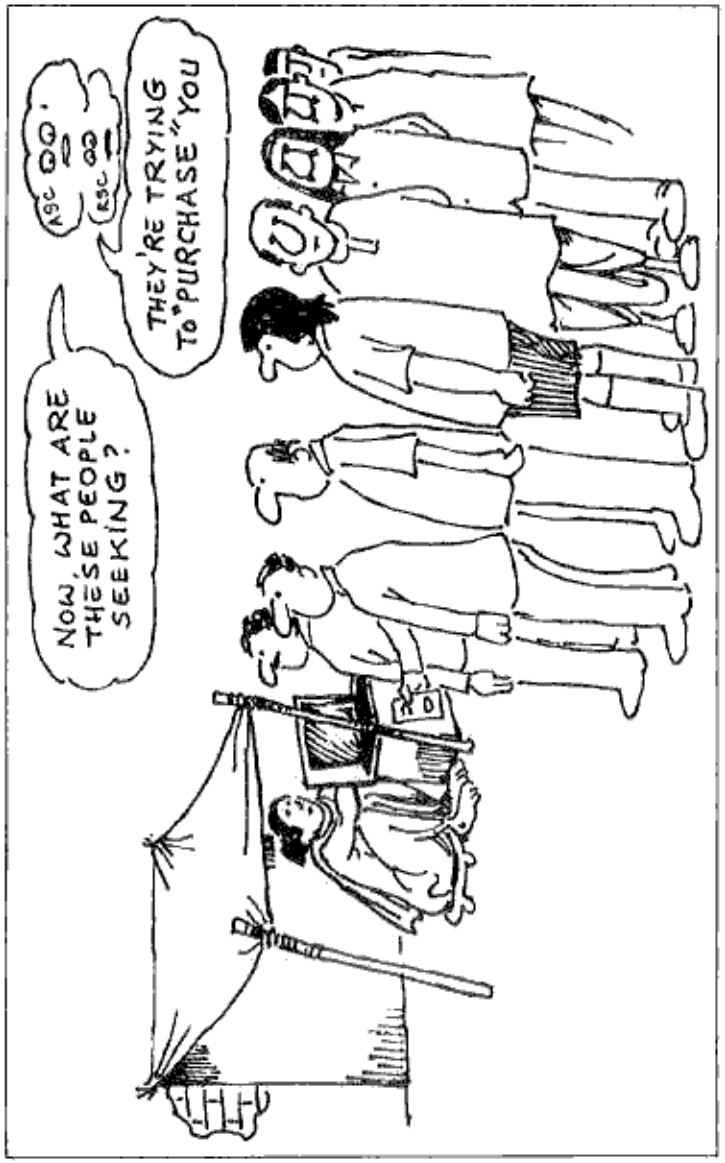
Drug users can hardly sit peacefully in a public place. They are always on their guard. It is only those users who are assistants to peddlers or friends of assistants who manage to sit for a long time next to peddlers' joint and smoke. Others have to quit the scene as soon as they buy the drug. At times they sit and take a few puffs right there out of desperation. But they are ordered out within five minutes or so. As we sat in Chase Street, two purchasers sat outside a peddler's shack in a corner. After they had settled down, they held their sack to keep out the breeze. One of the users started inhaling the fumes when the peddler noticed them and shooed them away immediately.

Groups of drug users always have the tendency to form circles, seek corners and huddle together. After a few hours, some users might get up either to organise the next dose or go home. But others replace them. An onlooker hardly will notice much of a difference from afar.

Cannabis users, who use a *chillum* (also known as a gun) while smoking in the open, form a circle and sit huddled together. Some of them prefer to sit on the ground to avoid the risk of breaking the *chillum* during their high.

Main Activity of the Users in *Addas*

The lives of visible users revolve more exclusively around the



drug than those who have not yet reached that state. The scenario for a specific site is different in the mornings, afternoon or at night. In the case of Mal Mandi, the place is extremely busy by 10 o'clock. Users do not have a place to sit and smoke, as lorries keep coming to off-load goods or move out on their return journey. The people in charge of the godown start driving out the users when it is time for the lorries to roll in. Otherwise, the users sit under the protection of the lorries and chase their drug, safe from the breeze. It is a common sight to find people in charge call users names and drive them away with a stick. Throughout this altercation, the users remain quiet without any protest. At times, they prolong the communication by ignoring the comments of others and continue to chase. After the sun sets, users return to the protection of the parked lorries to chase.

In the case of the cabin, users get a protected enclosure where they can chase throughout the day. One of the users said that the cabin is a very active place at night, as the users conspire to loot the *godhi* (port godowns). After they snatch the booty and sell it, they purchase their drug and chase into early morning hours.

Interactions

Users with Other Users

The interaction between users illustrates how enmeshed they are in their addiction. Their conversation revolves around different aspects of drug use, its marketing and involvement in crime for satisfying the urge for drugs. Though this is not applicable to those who continue to be a part of the system and are functional, it plays a prominent role in the lives of marginalised street users. Newspapers, magazines or other publications are scanned for information regarding the drug trade. Their intense preoccupation with one aspect of life to the exclusion of others

clearly reflects the extent to which they have deviated from the system.

While users sit in groups, their limited interaction revolves around the dismal aspect of their lives or the drug itself and places where 'good drug' is available, problems with the police or with the people at home or the activities of known peddlers. It is interesting to note that the user on his way to purchasing his drug, finds out from his friends about the quality of the substance and the possibility of facing trouble from sudden police action. A prospective buyer is willing to cover a distance if he believes that he can procure a better quality of drug. One of the methods used by the user to identify quality is to count the number of lines obtained from each *pudi*.

It is interesting to note that even when users come for treatment, their favourite topic for discussion is drugs, perhaps because it brings down the barriers and differences between them. This is an important issue to be dealt with when focusing on change in lifestyle.

Users with Peddlers

An undernourished elderly person with an unkempt appearance hesitantly approached a peddler. With pleading eyes he requested a *pudi* of brown sugar for Rs.8.50, compared to its actual price of Rs.15. The peddler, irritated with his demand, shouted at him and the user was humiliated and chased away.

"At the street level, there is no credit", said one user, as he narrated his experience. He had been purchasing from the drug peddlers in this locality for a decade, but could never dream of getting any drug on credit even when suffering from withdrawals. As he often picked pockets, he was flush with money. On certain occasions, when business was bad, he pleaded with a female peddler for drugs on credit. Though he had worked for her earlier, he was chased away with foul language. The reaction is

entirely different when a user with money tries to give up drugs. The peddler cajoles him to try the stuff, as "it is pure", and even gives it away free so that he continues using it.

Brown sugar is a commodity that does not need much canvassing to market. One can also rely on a smaller number of customers to market it. The usual interaction is limited to handing over the money and getting the brown sugar from the peddler. Otherwise money is given to his assistants (who are young kids) and to users who act as assistants to the peddler.

Unlike other aspects of day-to-day existence, where the rights of the customers are respected, there is not even a pretence of it here. It depends entirely on the client's economic background. If the transaction is large, the going is smooth. Otherwise, there is indifference. If a user has no money, he begs the peddler for brown sugar only if he cannot borrow some from his user friends immediately. Such an experience is demeaning.

Peddlers

It is interesting to study how people start trading in brown sugar. For instance, in one particular area in south Bombay, the families who started marketing drugs had earlier been involved in selling or stealing smuggled goods. It was when this organised theft was disturbed that some of them began to sell brown sugar. There are also instances of people who had lost everything due to one reason or another, and then turned to brown sugar as a source of livelihood. To narrate one instance, a person who was involved in various criminal activities was crippled in an accident and began to beg at tourist spots to eke out a living. Around this period, a user told him about brown sugar and the profit margin involved, and thus he became a seller.

Peddlers continue their trade by bribing the authorities concerned. But such understanding and smooth operations can be

disturbed when a new set of officials are posted or when another wing of the enforcement agencies enters the area. There are five distinct bodies for narcotics control: The Directorate of Revenue Intelligence (DRI), the Narcotics Control Bureau (NCB), Customs and Excise, the Narcotics Cell of the Police Department and the Intelligence Bureau.

An illustration of this is provided by the problems allegedly faced by a female peddler, Veena. Customers would stand in a queue in front of her shack to purchase drugs. For the police to turn a blind eye, she reportedly paid a *hafta* of Rs.10,000 per month since the mid-eighties. On one occasion, another set of officials questioned her about the long queue. Veena, who by now had learnt to have scant respect for the police answered back insultingly. This irritated the officials and they questioned the users. One of the users informed them that a Nepali was selling the commodity a little distance away. They caught the Nepali boy but found only Rs.10,000 in cash on him and no drugs. The official came back to question Veena who replied abusively. By then, some of Veena's relatives came to her rescue and thrashed the officials. This led to further violence between the police and Veena's supporters. Later, the police caught hold of Veena by her hair and dragged her to the main road. The police from the local station came and apparently questioned the officials about the interference in their territory. A case was registered against Veena; she subsequently came out on bail.

While peddlers make some money, there are very few instances of people actually becoming rich enough to raise income sufficiently to change their standard of living. Often, the money they save is spent on getting bail after the sporadic raids by various enforcement officials.

There was another case of two brothers who were users of brown sugar. Their aunt sold brown sugar. They made a lot of money and had managed to invest it in a flat in another district. Later, they were arrested and had to sell everything to get out on bail.

The shift from vials to *pudis* (butter paper packets) created an employment avenue for women and children. Women are often involved in making *pudis* and they face the occupational hazard of inhaling the powder. As a safety measure, they cover their faces with the *pallus* of their *saris* (the Indian dress—six yards of material wrapped around the body with one portion thrown over the shoulder, that is from the waist to the shoulder. The loose end, which is placed over the shoulder, is the *pallu*). Women are employed, as they are skilled in performing this repetitious job that requires constant alertness to prevent mishaps that can lead to financial loss. Often the papers are placed in a row on a platform. One of them spoons the exact quantity of powder onto each paper while others pack it. This activity takes place in closed shacks, with the door locked from the outside, to keep out busy-bodies and also deter any malpractice. Another added advantage is that women can hide the *pudis*/packets between their breasts. Young children are used to pass the required number of *pudis* to customers after collecting the money. There are also children who carry the *pudis* or Nitravet tablets in small packets and walk among the users calling out casually: "Ten rupees for a *pudi*. It is good quality from Chinnar (a false name)". The style of selling the stuff is similar to the manner adopted by roadside hawkers. The nickname for nitravet tablets in *vattana* (peas).

Another source of income for some families is to sell the paraphernalia required to consume drugs. This includes foils and chasers. They sell the set together for Rs.2 or the foil alone for fifty paise (half a rupee). They buy the foil paper in bulk and cut it to the required size for sale. Some of them make nearly Rs.250 per day in very busy sales centres. Often the paraphernalia are available near sites where the brown sugar is sold.

Besides drugs and their paraphernalia, the meeting place of users is also a market to sell tea, biscuits, matchboxes and ciga-

rettes or *beedis*. While users need matchboxes to vaporise the brown sugar, they also need to light their *beedis* frequently. This is because unless one puffs the *beedi* continuously it tends to go out.

A Glimpse into Marginalised Lifestyle in Bombay

Heroin came to Bombay in the late sixties along with the hippies. It remained within the isolated pockets of the rich since the cost was high. Since 1979, lower grade crude heroin, brown sugar, began to be marketed. Initially brown sugar was sold along with other natural drugs (opium and cannabis) in the *Chandu Khanas* of the city. Yet consumers of these derivative drugs were small in numbers.

Bombay, being a metropolitan city, had developed dynamics similar to any other city. Its lifestyle was consumerist in nature. However, in many pockets of Bombay, there were people from the same community who came together to express a feeling of solidarity. As in other regions of India, Bombay also retained a part of its early culture. This aspect of Indian culture has been traced to the lack of initiative by colonial rulers to take on the massive task of attempting to change the cultural compositions of micro-communities. Thus, the presence of a consumerist outlook on life, the plurality of cultures and a partial adherence to previous cultural norms, all played a role in changing our relationship with drugs.

It is not surprising that under these circumstances brown sugar entered not only Bombay city, but also other cities and tourist spots. In the 1960s, the drug trade was a result of the flower children or hippies travelling to the east looking for solace. Later years saw a gradual shift from the non-cultural use of natural traditional drugs to synthetic derivatives. The process of marketing was facilitated by the politics and power games that rule the world of drugs. The availability of a new drug and the

criminalisation of socially accepted drugs as per international norms created a situation where entrepreneurs promoted brown sugar. These aspects are dealt with in detail in the next chapter.

In Bombay, during the early eighties, users were unaware of the implications of brown sugar use. They opted for it accidentally. This is not the case for individuals who began to use brown sugar in the nineties. These aspects have been identified through our case studies and field observations. Similarly, the shift in the sale of this product was not an operation planned out at the street level.

The lives of the marginalised, especially of the visible users, revolve around the drug more than in the case of other users. This is because the criminalisation of drugs led to an increase in price. Users retreated to private spots to chase and also avoid the stigma. It was difficult for them to continue with their occupation once their daily quota increased beyond their financial capacity, making it difficult for them to be a part of the system.

Many of the identifiable users are involved in self-employed activities like rag picking, begging or manual labour. Begging has been included as self-employment, which at times requires several skills like portraying the appropriate emotions, twisting the limbs to create sympathy, or singing songs to catch attention. Another means of earning a living is by stealing, which includes stealing personal and government property. There are users who steal government goods but do not consider it as theft, for they maintain that it is public property and that they are not harassing any specific person through their act.

Another source of income for some users is "petty peddling" errands. There are different types of peddling that a user may undertake. He may collect money from a group of users on a regular basis to purchase the drug for them from some other locality. In return he gets an amount of brown sugar. At times,

he may chase the drugs he purchased for others and lie lost in his own world, while others wait for his arrival. Another way is to buy drugs for one specific rich person or someone involved in peddling and in return he gets paid in drugs and money or the chance to chase the leftovers in the foil.

Petty peddling can also include selling one drug to purchase another. One female peddler's brother was addicted to multiple drugs. His sister gave him a certain amount of brown sugar on a daily basis. He and his two assistants sold brown sugar to purchase liquor and nitravet tablets. As multiple drug use has affected his health, he became totally dependent on his assistants. They were happy with this arrangement, as in return for their services, they got their day's quota of drugs and food.

Some become regular assistants to peddlers, and often received drugs, food and a place to sleep in return. They may in the end discontinue the habit as a result of friction between the police and the petty peddlers under whom they work.

While some specialise in dealing with stolen public goods, others sell their family assets. Far more than the users who sell the product, the purchasers or the middlemen who arrange the sale of stolen products make a better deal. The middlemen are aware of the desperation of the users for the drug and they cash in on it.

To illustrate the point further, one group of people went shopping where goods were sold on the footpath. One person approached this group with a pair of spectacles. He asked for Rs.75 for them, but the group knew that the actual price was at least Rs.200. Nobody was interested in buying these spectacles. He repeatedly offered the spectacles to one member of the group reducing his price from Rs.50 to Rs.25 and finally to Rs.10. At that point, the prospective buyer realised that the seller just wanted money for brown sugar, so he gave him the money and took the spectacles.

In this context, one user explained that it is difficult for users to pretend to be ordinary vendors and sell their goods, because they do this when they are in urgent need of money for drugs, and seldom wait for a good bargain. Besides, they are scared of being noticed by the police or any other person in authority, as they have the tell-tale sign of their habit: black marks their hands. The sale of stolen goods can occur on a very small scale, but on a continuous basis and it can be a financially viable proposition for the buyer.

While poor users face problems when they become part of the marginalised segment of users, the process of marginalisation can be extremely painful for a person from the richer strata of society. They find it difficult to adjust to the basic realities of street life, using open spaces as a toilet which in the long run can lead to health problems. Again, a person who has been used to defecating in the open may find it difficult to change his habit, especially if he is high. In this context, it is interesting to recount the reaction of a psychotherapist to the normal behaviour of a street user. This therapist came from the upper strata of society. She found it difficult to let the patients use the toilet which she used. One day, a drug user was given permission to use the toilet. He did not close the door nor did he flush with sufficient water. The therapist, who commuted by train to work and was used to seeing numerous people defecating in public every day, but she found it unbearable and lost her temper. The toilet was banned for drug users thereafter for sometime.

To counter the notion that drugs by themselves make people into petty criminals, it is necessary to describe a way of earning a living adopted by some families, who do not necessarily fall under the category of addicts or users. These are families who had earlier depended on their male members to steal goods from the godown for survival. When the management became strict with a small group of 'thieves', who were not part of the

organised gang, certain changes took place. Instead of the man, his wife and other female members began to take up this activity. Initially, the police did not harass the female members. Later, this changed, and the police began to hit the women with sticks for stealing. Thus came in a new type of breadwinner, small children who would be woken up in the early morning by their parents to go in groups and collect as many items as possible. The police find it difficult to deal harshly with children. After her mother, a user, fell sick, Sharmila learnt the art well in order to provide food and drugs for her mother. Following her mother's death, Sharmila was sought by adults wanting to adopt her.

Among this new group of 'thieves', one can find some of the present-day users. They manage to deal with the police because they are brown sugar users. No police officer wants to take the trouble of keeping users in lock-up for long, for there have been instances in which the users, experiencing withdrawals, have broken bulbs and swallowed them or eaten lizards. After such incidents, the police have to rush them to hospital for immediate medical attention. There have been deaths of addicts in the lock-up. Another method used by some of the users is to slash themselves with a blade, usually on their chest or hands. They use a new blade each time for this purpose. Police cannot accept this behaviour and hence avoid them. There are others who apply human faeces or filth from the gutter onto their bodies to avoid the police. While many policy makers look to the law for solutions, few have bothered to understand the extent to which lives are wrecked through the criminalisation of drug use.

Conclusion

The presence of cultural use and the norms for control that evolved through the years had created a harmony in itself,

though there were cases of deviation. This situation changed drastically when new norms based on the legal sanctions were enforced. It created a different profile of users and petty peddlers. Depending on the extent of use and marginalisation, the users resorted to antisocial activities to satisfy their craving for drugs. As marginalisation is a process the drug programmes have to consider different stages of intervention. The change towards a drug-free existence also will be a long-term process depending on the users and cannot be attained through enforcement.

4

Drug Use and Marginality

In one of our field visits, on the side of a railway platform in broad daylight we found brown sugar users sitting huddled in a corner chasing the drug. Their torn clothes and unkempt appearance merged with the litter strewn near the garbage bin. They were completely lost to the world inhaling the precious fumes without letting any escape to avoid wastage. Suddenly there were sniggers and catcalls from the passengers in a passing train. "Hey *Gardulla*" (Addicts!). They did not respond or react to the catcalls or sniggering.

On another occasion we were speaking to users who were sitting between tracks to smoke their drug. Suddenly there was a commotion and users started running away. When questioned one of them answered: "The railway police will cane us." Why should a large group of users fear a single police official? Why did they not fight back, we asked. A few of them stood their ground and one said: Why do we keep running away in fear? Why should we deserve this treatment? Hearing this, some of

the users refused to budge and held their ground. The police official surprised by this unexpected turn of events came and threatened a user with his baton. At that precise moment we intervened saying: We would like to continue our discussion. We do not think any of the users would create a law and order problem. His hesitation gave us room to explain our presence and he was willing to accommodate us.

International and national norms based on the Single Convention created different images of drug users in the eyes of the public. The Single Convention was subsequently modified through various protocol after consultation with professional managers of drug management experts. The various approaches that arose were based on moral, criminal, deviant and disease models. Later, all of them were confronted by another model which focused on decriminalising drug use, regulated supply to medically certified addicts and some even proposed legalising all drugs. The Ministry of Health, after a series of consultation in different parts in India, has recommended that cannabis should be taken out of the purview of the NDPS Act. The debate that emerged from these approaches, in combination with identification of Human Immunodeficiency Virus (HIV) infection among Injecting Drug Users (IDUs), led to a new emphasis on harm minimisation strategies.

While the recent trend in numerous countries is not to classify users as criminals or deviant people there are a few countries, (for example, Singapore and United Arab Emirates) which retain some of the earlier perceptions. Even in countries where a more rational and humane approach has been propagated, the earlier image lingers as an unseen wall separating users from non-users. This, in turn, reflects the hurdles that a user will face in society.

It was the rational approach to drug abuse management in Holland (along with research finding substantiating the need for harm minimisation strategies for control of HIV among IDUs)

that initiated a debate in other countries. But, even in Holland, enforcement officials began to impose punitive measures to control drug use in their cities. At present certain European countries are putting forth the need for a rational and humane approach as against punitive measures. Since the Single Convention is a historical product of consensus between seven member states, in which United States is a major actor, the chances of its revision depends on the United States government's ability to see reality and accept the limitations illustrated through experience.

Harsh images of a future where HIV positive users can infect or spread associated infectious diseases to others, have made us look into the condition of users in Mumbai city. HIV infection among injecting drug users has been shown to be a result of their marginalised position and not only due to injection of drugs per se. Research shows that marginalisation leads to involvement in high-risk behaviour.

As in many other cities in India, patients in public hospitals in Bombay are not sufficiently informed about the differences between HIV and AIDS. Drug users are routinely sent for testing by hospitals. After the results, doctors tell them that they have some problem with their blood. They are illiterate and their reports are written in English and incomprehensible to them. Hence, while they themselves are ignorant about their health status all those who glance at their reports have access to this confidential information. They are shunted around and it creates a fear psychosis in them regarding their health. It results in hopelessness and they avoid further attempts to give up drugs. At times, doctors also tell them confidentially that their life span is limited to six or seven years.

Drug use marginalises a person as his act is unacceptable to the central values of the dominant social elite. Often drug users themselves internalise the fallacy that they are 'sick' or 'criminals'. The spread of HIV infection to drug users and their

potential to infect others has strengthened the stigma.

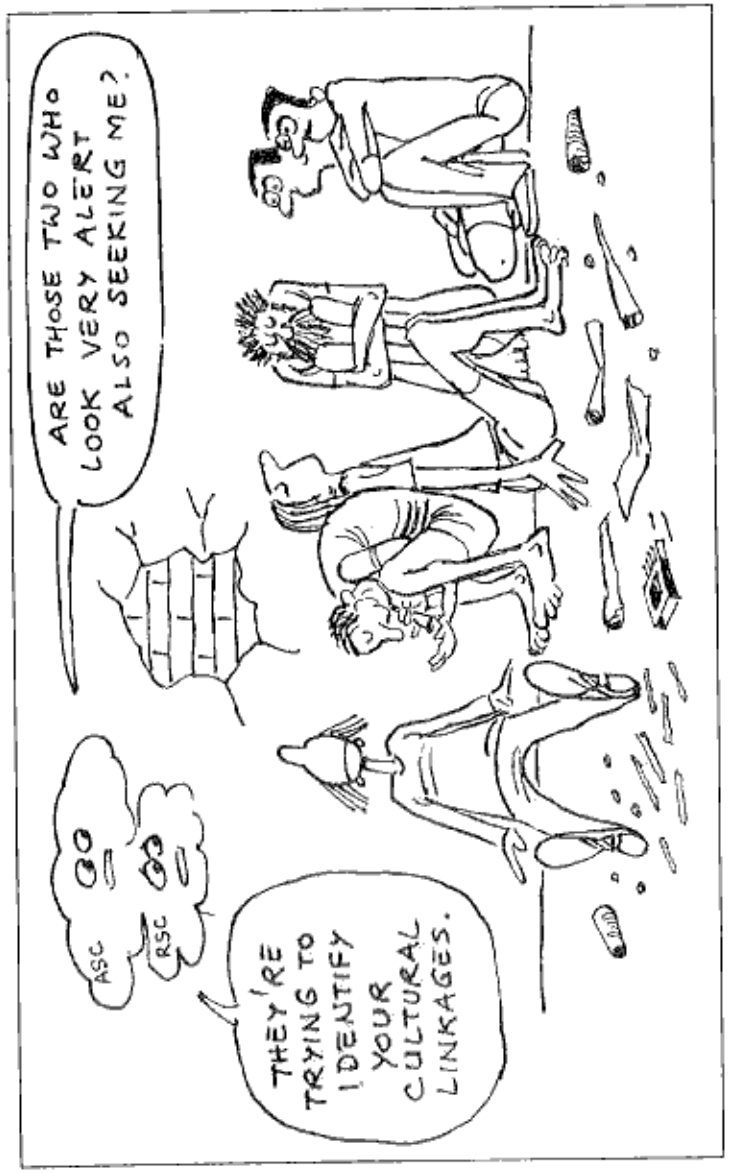
At present, in India, all users of psychoactive substances other than alcohol, nicotine and *bhang* are marginalised by the existing administrative norms. Moderate users of cannabis products and to some extent opium, are protected from marginalisation by the persistence of cultural norms. This is a boon as marginalisation of traditional drug use can create a shift towards synthetic/derivative drugs. Individuals who have excessive quantity of traditional drugs or who consume synthetic or derivative drugs, especially brown sugar, are marginalised both by empirical and cultural standards.

In this context, the study inquired into the following areas utilising Musgrove's framework on marginalisation already described in the first chapter:

1. Initiation into drug use,
2. Being in a marginal position,
3. Process of marginalisation,
4. Adapting to marginality,
5. Reducing marginality, and
6. Re-establishing relationships with society.

Initiation into Drug Use

An individual does not get marginalised instantaneously except as the result of a physical accident. Different situations in which people began to use drugs have been identified and categorised as either accidental events or conscious decisions. The categorisation depends on the period of first use of the drugs, the mode of consumption and knowledge of the drug. In the eighties, the usual mode of consumption was to mix brown sugar with *ganja* or *charas* and tobacco and smoke it in a *chillum* (pipe) or in a cigarette.



As cannabis smoking is often a group phenomenon, mixing in a little bit of powder like heroin/brown sugar could be done surreptitiously. When consumed in a group, usually one member will fill the *chillum* with *ganja* or *charas* and tobacco and pass it around. When the group meets in *Chandu Khanas* or other such places, the seller prepares the pipe. Heroin could be mixed either by the person who starts the process or by any one of the members as the pipe is passed around. Moreover, when brown sugar was introduced many assumed it was a new product akin to *ganja*. here have been cases where people smoked 'filled-in' (*barela*) cigarettes offered by a friend. Unlike cannabis users, opium users did not accuse others of duping them into brown sugar use. A few of them started using brown sugar to deal with withdrawal symptoms from opium. This could be related to the difference between smoking cannabis and opium, the latter making it difficult to entice others who are unaware. Opium users enjoy watching others preparing the pipe, smoking it and being observed by others. It is almost a ritual.

Accidental usage became difficult later since the price of brown sugar made it necessary for many users to chase the drug alone. While accidental use may still be applicable for the middle and upper classes, users from the poorer strata are aware of the drug. To illustrate this difference, case studies and field observation notes have been used here below:

From the total of forty-two detailed cases, it was found that in twenty-three cases the initiation process was out of choice and it was accidental in the other nineteen. This difference may be due to the limited sample: hence it is not considered important. The cases are documented to present the contrast.

Accidental Event

A case of accidental consumption could be related to seeking a high, avoiding pain of any form and non-availability of tradi-

tional drugs. These cases give insights into the ways in which brown sugar was integrated into the system and may indicate how other synthetic drugs are introduced in the same way. The individual factors that facilitate synthetic use are also illustrated.

Seeking a High

Accidental drug use can result from the desire to experience a high as traditional drugs are no longer satisfactory. When synthetic drugs were introduced, users did not have the information to understand their pharmacological differences between them and the traditional drugs. This could have been one of the factors that contributed to their uncontrolled use in the absence of norms. The consumption of brown sugar was a search for altered states of consciousness by users who had been consuming other substances like cannabis or opium. The case study below illustrates this aspect.

Case 4.1

Sharma Velar left his hometown in Tamil Nadu (a southern state in India), to seek a better future in Bombay. His family back home consisted of his parents, sisters and brothers. His dreams were shattered when he had to struggle for survival in the streets of Bombay at the age of seven. Twenty years of his life in the city was filled with painful and disturbing experiences.

From his early days in Bombay till his teens, he cleaned the gutters for a living. At first on seeing filth and dead human beings, he threw up. His most dreadful experience was to find dead infants in the gutter. He could not understand why small innocent kids were not wanted by the society. He found it difficult to accept such stark realities of life. His childhood memories left painful scars and made him cry even years later.

Soon experimentation with drugs became a part of his life. Though on one occasion, back home he had slyly taken few puffs of *ganja* that belonged to his father, he was not habituated to it. He started taking *charas* (the resinous part of *Cannabis sativa*, which is more potent than *ganja*/marijuana) to escape the reality of a lost life. He enjoyed the 'high' (*nasha*) as it helped him to deal with reality. Besides using *charas*, he also began to sell *charas*. Later, though he increased his consumption of *charas*, he could not experience a high. To blank out reality, he consumed nearly two *tolas* of opium along with *charas*. Unable to experience a high, he asked his friend for a stronger substance.

After his frequent requests, the seller gave him some powder to be smoked along with *charas*. He felt good after smoking the mixture. Thus, he was introduced to brown sugar without being aware of its pharmacological properties. His daily consumption increased to two or three *pudis* and later, to six to ten. Along with this, he occasionally took a strip of nitravet tablets. He tried cocaine on a few occasions but never on a regular basis.

Along with trafficking *charas* he soon began to deal in brown sugar. He sold it to clients from all walks of life. He set up business in the centre of the city behind a trading company. The business depended on the quality of the product.

According to him, a user experienced a high only with good quality of brown sugar and not with adulterated substance. When a user's expenditure on drugs exceeds his income, he tries to cut corners in the end he starts rummaging in the garbage bins for food. This is one process of marginalisation.

There is often rivalry between peddlers which is heightened as they buy from different sources. The source of supply is a trade secret. Sharma's narration of his modus operandi may raise eyebrows: he earned around Rs.4 lakhs to Rs.5 lakhs, but lost it all when he was arrested. He had to cough up his savings

to the police to avoid being imprisoned under the NDPS Act, 1985. On many occasions he bribed the police to continue drug peddling. If the police officers were satisfied, they took away his drugs and sold them to another peddler for half the price. The bribes varied depending on the position of the officials and the branch in which they worked. Another strategy Sharma employed was to send boys under ten as the alleged peddlers with the police to the station and they were invariably set free because they were underage.

The pain of survival on the streets of Bombay is summed up in Sharma's life. Over the years, the number of street kids in Mumbai has only increased. All of them come to the city with little or no money but with a dream. It does not take long for the dream to die. The city is a cold place for the young searching for means of survival. While young boys need not fear being trapped in a brothel, they have to learn to eke out a living. When the door is shut, they seek a livelihood in the underworld.

Survival makes a man out of a child. The process is more traumatic when children have no support structure. Seeking employment without skills drives them to daily drudgery for a pittance. They often work with older colleagues which makes them mature far beyond their years. They find it difficult to communicate their inner thoughts to adults who accept the sordid social reality.

These children avoid returning home till they reach their dream of a better life. They want to be known as a "success story". Living in the city gives them a chance to rub shoulders with the elite and they dream of becoming a part of the elite some day. The city offers outlets for their frustration by providing cheap fakes for those who cannot afford designer labels.

While learning the ropes, one way of relaxing or feeling good is seeing movies, drinking alcohol or smoking cannabis.

Since the use of cannabis is traditional in many parts of India, individuals are aware of its cultural and social role at an early age. In the city too cannabis consumption is not frowned upon. Sharma's association with drugs is a way of forgetting his immediate reality. His association with drugs started only after coming to the city. Even while he underwent detoxification in a treatment centre, he managed to chase the drug he had smuggled in. He found it difficult to give up the peaceful *nasha*. Was his problem related to drug use or was it an existential dilemma?

Non-availability of Traditional Drugs

Unlike cannabis which does not lead to physical addiction, excessive use of opium does (Chopra, 1990). While there are logical rational standards for controlling the use of traditional drugs these can be disrupted when exposed to another culture and lead to a change in the pattern of use. Added to this, secular use already existed even in traditional society. When opium was not available, individuals shifted to other drugs because they had not heard of medical detoxification. Besides, it is difficult for street users in the cities to resort to the traditional rural detoxification method, which involves soaking the outer shell of the opium pod (*doda*) in water for hours and drinking it for several days and gradually reducing the quantity.

Case 4.2

Anandan's childhood was far from pleasant. He had an alcoholic father, who abused him and his mother physically on one pretext or another. At the age of five, he came to Bombay along with his uncle, to live with his grandmother. As his uncle was occupied otherwise, he began to while away time with his friends. He got into trouble when he disappeared for days with his friends without informing his family. After that he had to return to his native place.

He was sent to work in a farm for a daily wage of Rs.1.50 by his father. The owner used the stick to get more work out of him. All his earnings were spent by his father on liquor and food. Stifled by the situation he ran away to his uncle who was kind to him. But, his father forcefully took him back home.

As a result, he returned to Bombay at fifteen and stayed at his grandmother's place. He earned money by doing odd jobs and later worked at a *madka* (gambling) den. He learnt the ropes of the business and earned Rs.50 per day, part of which he sent home to his mother.

Later his mother passed away and he held his father morally responsible for her death. His father was living with another woman and did not care about his family. Soon his contacts with his family reduced and he spent more time in Bombay.

When Anandan was nineteen, he got married to a person from a well-to-do family. His marital life was filled with upheavals, as his wife was mentally disturbed and sickly. They had two children and all of them lived in Bombay. His wife could not adjust to the city life and on one occasion tried to jump from the rooftop. He got scared and decided to return to his native place and make a living there. Unable to make ends meet he returned once again to Bombay and sent his wife and daughter to his in-laws' place. His aunt who was childless took care of his son. He visited his wife and children once or twice a year.

Meantime, in Bombay he was exposed to a *Chandu Khana* in the locality where he worked. He found people sitting here and having *afim* (opium) which was semi-solid. His daily intake increased and soon, he became addicted. Around this time, because of political disturbances, both the *Madka Den* and *Chandu Khana* were shut down by the police. Unable to deal with withdrawal pains, he tried to consume a large quantity of alcohol, which he had started to drink at home when he was fourteen, but it did not help. So he asked the owner to give him something to deal with the pain and was given some powder instead of opium. The shopkeeper said it was difficult to sell opium under police scrutiny but easier to sell the powder. He had seen others using brown sugar earlier in *Chandu Khana* but had never been curious enough to try it. The powder was mixed in a cigarette and given to him free of charge. He felt good after smoking it and continued to buy this powder and thus got hooked on brown sugar. In the beginning the price of brown sugar was cheap and the quality was very good almost white in colour. When the drug was later adulterated and the price increased he began to chase the drug because it was cost effective.

This case also throws light on the dark side of the family structure in India and the increasing number of street children in the cities. The family structure which can be constructive can be just as destructive. As in the previous case, Anandan too tried to eke out a living by working in 'anti-social' grey areas. He began to use opium through socialisation with others in a *Chandu Khana*. Later he shifted to synthetic derivatives because of the non-availability of the natural product. He needed a substitute to deal with opium.

Conclusion

No human act can be viewed in isolation from social reality. This is applicable to the use of mind-altering substances as well. The above cases illustrate two occasions when efforts to alter consciousness and the absence of a drug of one's choice led to a shift.

The search for an altered consciousness can occur in different groups and depending on their social reality the specific reasons may vary. The above case studies illustrate the trauma of street children who seek the anonymity of city life as an alternative to disturbed domestic circumstances in the hope of seeing a better tomorrow.

The user may become part of an alienated or marginalised group through consumption of brown sugar either unwittingly or out of choice. The former case was more common among those initiated into use in the early eighties as was also found in field data. Some of them observed white powder being mixed with cannabis and assumed it to be something similar to cannabis that had just arrived in the market.

These users also expressed confusion over the more recent users' decisions to consume brown sugar after seeing what it had done to others. There were also attempts to test the prospective market for the drug. It was given to users of cannabis for distribution among their friends. In one such case, the person who was given the drug never consumed it. Later, when he was very depressed he decided to try it, felt better and it became a habit. When the substance was over he began to experience withdrawal symptoms and he could not understand what was happening to him. It was only when his relative who gave him the drug came to meet him that he understood the reason for his physical discomfort. Then he restarted the drug to avoid withdrawal symptoms. Later, he went to a hospital for treatment but was immediately referred to a mental hospital. This frustrated him and he screamed at the professionals: "I do take drugs but I am not mad!" He avoided treatment until recently. By then he had been using drugs for a decade, and his lifestyle had undergone changes.

Users consume brown sugar to deal with their physical pain or psychological stress. The initial use of the drug is a source of temporary relief from pain and this is not surprising for psychoactive substances have been used for his purpose for decades (Chopra, 1990). The difference in association was an outcome of the pharmacological properties of the drug, lack of guidance for controlled use or lack of awareness of the drug's impact and of course, an absence of norms regarding its use.

Those who began consuming it in the early 1980s continued

to use it without any control and ended up on the streets as marginalised drug users. Years of use and continued changes in lifestyle made it difficult to envisage any drastic change, unless the person had an adequate support structure or a source of hope within.

Shift from Accidental Use to Choice

While initial use may be an accidental event, the user may consciously decide to start using brown sugar even after knowing the problems associated with the drug. This was seen in the case of two individuals in the study.

Case 4.3

Shiva's childhood dreams turned sour after his father's death. His mother, who was a housewife had to struggle for their survival. To make matters worse, they lost their home as it was forcefully taken away by his father's relative. Shiva and his mother shifted to another locality and his mother did odd jobs for a living. Their new locality was known for drug peddling and other criminal activities. During this period his mother started another relationship and the man moved in with them. Shiva was unable to accept the person as his father.

Though mischievous he was a good student and attended school regularly. His education was disturbed when he was wrongly arrested for theft and sent to a remand home. A few days, later, his parents got him out but he decided to discontinue his education. After this unfortunate incident, he was scared to face his schoolmates and teacher. Out of school, with time in hand, he slowly made friends with older individuals who were *goondas* (anti-social elements) in the locality. Shiva had a way with words and was soon given an important role in their main activity, that is extortion.

His first encounter with brown sugar occurred when he was in jail. He had been wrongly arrested by the police and was physically abused to make him divulge information on a notorious criminal. As the police refused to believe his ignorance on the issue, he was detained in jail. On one occasion he dragged himself to the toilet and saw a group of prisoners chasing brown sugar. He felt curious and asked them about the substance and was told that it gave relief from pain. Immediately he decided to consume brown sugar and continued to do so till he left the jail. Once outside, he discontinued the habit without experiencing any withdrawals.

Shiva was a good dancer and was invited to dance at a function, where he met an old friend who kept requesting for some money to purchase drugs. Because of his persistence, Shiva gave him some money. Later, he found this person sitting and chasing brown sugar and Shiva joined him.

During this period his mother began to sell drugs against severe protest from Shiva. He believed that in every peddler's house, one of the close family members died from addiction and he felt his destiny would not be any different. He went through programs to change his life, but relapsed. After his fourth stint at detoxification, he left for Madras for a change of scene.

His initial interaction with brown sugar was to deal with the pain of police wrath. Later, he took the same drug and experienced pleasure and also learnt that it induced withdrawal symptoms if stopped.

Case 4.4

Fahran Khan, aged 35, lived with his family, wife and four children at Jogeshwari, in Bombay. From birth he has been in Bombay. He worked as a *zari* worker for a daily wage of Rs.60. Some of his colleagues left the job to become taxi drivers for better remuneration. They parked their vehicles at the Gateway

of India next to the five star hotel. While waiting for their passengers, they passed their time playing cards and smoking cigarettes filled with brown sugar. Fahran used to spend time with them learning to drive and during that time he smoked their cigarettes unaware of its contents. Gradually he became addicted and left his *zari* job to become a driver.

Fahran worked as a taxi driver for two and a half years before going back to *zari* work. Though he earned more as a driver, he found the work too strenuous.

One day, as a result of police action and seizure, drugs become scarce. Fahran hunted every nook and corner in vain, disheartened he decided to stay away from drugs. He went home and handed over all the money to his wife. For the next eight days he went through severe withdrawals. Seeing his pathetic condition, his wife suggested he take some drugs, but he refused to change his decision. Thus, he became drug-free. Earlier, he had tried to get detoxified on an outpatient basis at a private hospital, but did not succeed.

After self-detoxification he continued as a *zari* worker in another company with a better salary. Four years later, he and another friend started their own *zari* business. His friend was an ex-user with psychological problems. They both consumed alcohol after a day's work. His friend visited their earlier drug haunt and restarted drug use.

When Fahran knew about the incident, he beseeched his friend to give up drugs. When he refused, in frustration, Fahran took the drug as well. His friend had another mental breakdown and was taken back to his home-town. Fahran continued to use drugs and worked as a daily wage earner.

Through his association with users, he had begun to consume drugs but desperation at the prospect of being addicted to it made him stop. After a break, his inability to prevent his friend from using the drug made him revert to addiction.

Conclusion

Drug use career will have intermittent periods of drug-free living. This can occur as a result of his own or his close ones' involvement in the drug trade. This has been illustrated in the case above. The second case reflects a very common scenario for restarting drugs. Often the user who gives up drugs is faced with two alternatives: either to be lonely or to interact with user friends. This may lead to their restarting drugs either through the subtle suggestions of others or out of their own choice.

Out of Choice

Not all drug users are victims of ignorance; there are those who consciously choose to have drugs even though they see marginalised users being chased away by the community. The study shows that in 23 instances users had decided to consume brown sugar on their own, even though they were aware of its adverse effects.

Case 4.5

Life had not been kind to Ramamurthy throughout his twenty-five years of existence. He lost his parents in his teens and had to take care of his eight-month old younger brother. His father expired from excessive drug use and his mother due to alcoholism. Ramamurthy took support from his uncle and aunt to take care of his brother. His uncle consumed brown sugar and his aunt peddled drugs.

Ramamurthy was employed as a loader at the port and he earned Rs.30 per day. He consumed alcohol and cannabis on a daily basis. While at work, under the influence of alcohol he misbehaved and lost his job. His wife walked away, but returned on his request only to walk away once again. Their young son was hospitalised, and his wife did not have money

for the treatment. At that time, Ramamurthy was behind bars for stealing from the Port Trust. His son passed away in hospital and his wife left him.

His younger brother, Ganesh was a brown sugar user, but Ramamurthy did not consume it. Ganesh started using drugs when he was sixteen and he stole from the Port Trust for supporting himself and his brother's family when necessary. Ganesh was arrested twice but he managed to bribe his way to freedom.

Ramamurthy began to use brown sugar after his child passed away and his wife left him. According to him, he consumed drugs to 'avoid the pain that existed within'. Along with chasing brown sugar, he sucks Nitravet tablets to get a better high. Soon, the brothers worked as team to steal from the port. To avoid the police they applied dirt from the gutter to their bodies and at times they slashed their chest, tongues and wrists with a clean blade. The officials could not understand such behaviour and often considered such acts as expressions of insanity.

Unable to accept his dependence on his younger brother and his wife's taunts, he decided to join his brother's shady activity to support his family. The death of his son and his inability to prevent it disheartened him. All this may explain his self- destructive behaviour.

Case 4.6

Shakti lost his father because of alcoholism and tuberculosis in his childhood, after which his mother took up work as a housemaid to support the family, consisting of himself and his two sisters. She went to Dubai for a short period to make money for her daughter's marriage.

Prior to drug use, Shakti enjoyed playing with his friends in

the locality. Later, he began to interact with individuals from a close-by sector who were involved in anti-social activities. In the company of new friends, he consumed *ganja* and *charas*. He started using drugs for fun; as he enjoyed the feeling he continued the habit. In 1991, one of the group members began to consume brown sugar and Shakti soon followed his footsteps. He and his friend had put up a temporary shed for them to smoke in isolation.

In the meantime, a peddler, Ravi, shifted back to his earlier residence in their locality. Ravi was an injector and he told Shakti and his friends that with intravenous use the high lasted for a longer period. To facilitate the process and remove their fear of injections, Ravi gave a live demonstration of intravenous drug use. It had its effect and Shakti along with his friend began to inject drugs.

The new mode of consumption was not a pleasant experience for one of his friends, who injected himself at a wrong place and had to be hospitalised. His father found him at home in bed with high temperature and swollen hands. After he that incident he never injected drugs again.

Shakti realised that the assumption that injecting reduced the daily quota of drugs was false. During this period he was hospitalised at a detoxification centre and was given information on HIV and modes of transmission. He relapsed again but chased the drug instead of injecting. He was detoxified the second time after which he went to his native place to be away from Bombay.

According to him, the major problem faced by an ex-user is that of social isolation. They can neither go to their drug using friends nor the earlier circle of non-users, for it created the wrong impression about their friends. Being seen in the company of ex-users, they were accused of consuming drug on the

sly by their families.

He came back to Bombay and started using again. Around this time, his mother left for Dubai for the second time and to support his habit he began to pick pockets.

Despite the fact that it happened a long time ago, he was unable to accept the death of his father and whenever he spoke about it his eyes would fill with tears. He sought the company of cannabis users and when some of them shifted to brown sugar, so did he. His decision to inject drugs emerged partly from the desire to experiment and partly to reduce his expenditure on drugs.

Case 4.7

Mathew, a law graduate works as a researcher for the past two years. He lives with his father and youngest brother, while two other brothers, who are married, live separately. He lost his mother due to mental illness and his youngest brother had periodic breakdown and required regular treatment.

As a student Mathew was exposed to a variety of drugs. He shared alcohol with his friends from the lower middle class and cannabis with those from the affluent class. He heard about brown sugar from a student studying for engineering and also from friends working in the docks. He did not try the substance till after his mother's death. Later, when prompted by his friends, he felt curious and consumed it along with his friends from the dock.

As very little was known about the drug, his family and friends were not too aware of his habit. This changed when he became a hard-case addict and indulged in petty theft. During this period he shifted from his residence, to his friend's home. There he had a mental breakdown and was hospitalised by his family. As part of the psychiatric treatment he was given ECT

(electro-convulsive therapy) and after that he withdrew into a shell.

Later, he was employed with an agency that worked in the area of child care. He started consuming cannabis again and subsequently, brown sugar. The community that supported him during his drug-free life was disappointed and isolated him from their midst. He went again for detoxification and become a member of Narcotic Anonymous. This helped him to remain drug-free for the last two years. He affirms that he will deal with life one day at a time, for once an addict always an addict.

His emotional ties with his mother, her ill health and subsequent demise, were a source of immense trauma. To deal with this painful reality, he indulged in mind-altering substances of varied kinds. While drug use may be the obvious problem, it was his difficulty to come to terms with life that led him to seek solace in drugs.

Case 4.8

Raghu Rao started his encounter with law at a very young age, when he was arrested for theft and put in a correctional home for children. His father visited him there and requested the authorities to detain him in the institute. His family lived in Nagpur and consisted of his parents, a married sister and two younger sisters.

Raghu became the leader of a group of boys in the home. He and another group member decided to run away from the home. They gave the security the slip and reached the railway station, where Raghu boarded a train that brought him to Bombay. He spent a few days in the city and then decided to go back to Nagpur as he could not adjust to city life.

In Nagpur, Raghu took up the job of cleaner and earned Rs.600 per month. While working there, he met a boy from

Mahim in Bombay, and was invited to visit the city. Raghu took Rs.60 from his owner and came to Bombay with his friend. In Bombay, he did odd jobs for a living and spent most of his money on movies and cannabis.

Once while walking through the streets, a boy, Parekh, (smaller in size than him), tried to pick a fight with him. Parekh caught hold of Raghu's shirt. Raghu being stronger insulted Parekh and boxed him. Immediately, a friend of Parekh who was hanging around joined the fight. All three of them had a good fight, and later became friends.

Parekh became the group leader and the size of group grew, at times with new members being recruited after a good tussle. They pooled in the money and shared it. The activities they indulged in included chain snatching, pick pocketing and theft. Occasionally they were caught and thrashed by the public. Once Raghu was caught by his victim and taken to the police station. The police slapped him and put him in the lock-up. But the magistrate let him off the following day.

Raghu saw some individuals chasing brown sugar. Being curious, Raghu snatched brown sugar from a user and chased a few lines. He enjoyed the high. His friend Salim was upset with the incident and warned him that their friendship was at stake, if he continued to chase brown sugar. Salim did not find use of *charas*, *ganja* or alcohol objectionable, but felt brown sugar was 'poison'.

During the riots in Bombay in 1992, the group was scattered and the leader, murdered. After that both Raghu and Salim began to chase brown sugar. Other gang members who were there did not take brown sugar and one them got married and settled down. In their group there was no affiliation to any specific religion, they visited both temples and *dargahs*. Some of them had two names, one Muslim and the other, Hindu; for example Salim's real name was Deepak. During the riots, though

Hindus and Muslims were at each other's throats, the boys stuck together.

The communal riots and death of his close friend, made Raghu realise the fragility of life. The riots eroded the security that sustained him. This reflects on the influence of the social environment in moulding an individual's life.

The decision to use brown sugar despite awareness of its impact can arise from a number of situations, some of which are reflected in the case studies: personal trauma caused by the loss of dear ones, as a member of a marginalised group, difficulty in making ends meet and being a street child in the city.

While belonging to a marginal group for socio-economic reasons, a person may use alcohol to alter his consciousness. When faced with difficulty in meeting one's bare needs on the one hand and the possibility of making an easy buck by antisocial activities on the other, the person may opt for the latter. As involvement in the brown sugar trade is also an option, he may become a part of this underground network. Another option is to steal heavy metal products from government godowns, and in such instances, there is an assumption among users that brown sugar helps them to carry heavy loads without much difficulty. This may make an individual take brown sugar.

While personal trauma can create a need to use mind-altering substances, the possibility of medical malpractices can further make the person dysfunctional. In India, there are few psychiatrists, and only a handful focus on psychotherapy to facilitate a change. The common method of treatment is to provide psychoactive substances and ECT. As the rights of mentally ill patients has not been an important area, the indiscriminate use of the latter occurs on a frequent basis. Initially, users were considered to be schizophrenics who needed ECT for any change to be possible. This in turn, hampers the users' recovery process.

Raghu's case illustrates how communal violence can destroy the limited security that street children build through years of survival on the streets. Such events can have an adverse effect on children with no effective social support system, which in turn can make them choose drugs to escape their social condition.

Conclusion

Initiation into drug use can be accidental or by choice but the first response to both is usually negative. When a person consumes brown sugar, he experiences nausea and itching all over the body. It is only after this negative reaction that people experience a high. Those who smoked it with cannabis in a *chillum* did not feel this nauseating experience. This difference may be due to the mode of consumption. Perhaps this mode prevents such responses, or perhaps the user does not relate the reaction to brown sugar use. Those who chased the drug or smoked it in a cigarette often cited negative reactions. The itching reaction is a result of adulteration of the drug. To avoid these reactions, newcomers are trained by others in smoking, how to inhale the fumes and hide the bitter taste, using *beedis* or sweet tea. There were users who gave up drug use after the first negative reaction, but later started again out of curiosity and the desire for a high.

In the case of use by choice, there is an additional initiating factor, the driving force because of the marginalised position. Drug users, being in an ambiguous and deviant position, wield a certain amount of power over society. Non-users can find this attractive and seek to be a part of this population. The power that users wield over others is seen in jails and treatment centres as well. They threaten to commit suicide by eating tube lights or lizards, knowing full well that a few users have done this on earlier occasions and struck fear among non-users. Depending on the environment, they either hope to be discharged or be provided with drugs within the jail.

A threat of suicide from a non-user is alarming enough, but when it comes from individuals who apparently show scant respect for life the authorities are shaken up. Even among these users, there will be those who use it as a survival strategy and others who are genuinely psychologically disturbed; hence there is a need to distinguish between the two. At another level, it creates excitement in a drug-free situation and shoots up the adrenalin in the participants and spectators. In an already marginalised population involved in antisocial activities, drug use leads to further marginalisation. Here a habit is a means of survival; consequently to become drug-free without a change in the degree of their marginalisation is difficult.

Whatever the circumstances for initial use, the person continues because of the pleasure he derives from it. This can be related directly to pleasurable sensations like sensuality, or to the avoidance of pain associated with reality. Writers have looked at drug use as an orgasmic experience (Hardin and Jones, 1977). The user may get addicted and keep chasing without accepting the limitations of the inactive substance. Often, individuals attach negative and positive reasons for using a drug while negating the role of their association with it. Individuals add their own motives for using drugs depending on their ability for controlled use or drug-free status.

The above case studies illustrate that brown sugar use can either be an accidental or a conscious decision. Even in the case of accidental occurrences, the person may make a conscious decision to take the drug again under different circumstances. The reason for initiation can offer guidelines for the formulation of prevention programmes.

In the case of accidental or conscious initiation and sustenance, use was found to be related to the presence of both logical and empirical standards. The logical standards for cannabis and opium differed and in both cases they varied with the territorial location of traditional communities. Standards

changed with migration to cities, where empirical values were far more important. In traditional societies some secular use of MAS disrupted the smooth relationship between human beings and drugs. However, people had various options of sustaining a functional relationship with cannabis or opium.

Before the early eighties, the secular use of traditional drugs did not create any concern within society or in an individual, even though the norms controlling their use were not replicas of the logical standards in rural areas. It is the subsequent changes in the political scenario and the introduction of empirical standards that opposed the logical standards that brought about change. This led to the emphasis on a market economy which created a clientele for brown sugar instead of opium or cannabis. In an urban setting there was little room for a faithful adherence to cultural norms. This probably led to the spread of the secular use and also to group use. Urban group use of a drug was not a reflection of its traditional use; it has its own dynamics where the drug especially cannabis and opium becomes a poor man's liquor.

Other factors that facilitated accidental consumption were the mode of intake, group consumption and an ignorance of physical addiction. In the case of opium, the enforcement of empirical standards and the flourishing expansion of the market economy for synthetic drugs led to the sale of brown sugar instead of opium, either for a high or to deal with the problems of withdrawal from opium.

After substitution during the initial period, users did not face many problems, but later the pharmaceutical properties of brown sugar ensured its continuity. Another sharp contrast was the age of the users. In a traditional setting, the average age of opium and cannabis users is far above the average age of the brown sugar users in the cities (Chopra and Chopra, 1990). Even today, the profiles of opium users in Saurashtra are different from those of brown sugar users (Masihi, 1998). The users of

cannabis and opium in Bombay are also different from the brown sugar users. This itself points to a change in the situation that is related to the period between adolescence and adulthood. If this is so then prevention programmes should focus on the circumstances in this period that led them to seek drugs and also make provision for the young to deal with problems in primary or secondary socialisation.

The reasons for taking brown sugar and the initiation process vary. It has been seen that stress or pain can be an important factor in the conscious use of the drug and its continuation. In a study conducted by NARC among users in nine cities, including Bombay, the occurrence of several stressful events before and after addiction were identified (NARC, 1985). This highlights the need for strategies in prevention which will consider these realities.

Users might have sought a high or been introduced to a different world by accident but, whatever the reasons, brown sugar does disturb their lives. To what extent the disturbance occurs depends on the person and life circumstances. Seeking altered states of consciousness can be the best reflection of man's inability to deal with reality. Along with man's capacity for ASC, addictive properties and additional interpersonal or intrafamilial factors can sustain drug use.

Being in a Marginal Position

The scene was typical at the Site B: a few users sat chasing in a corner. One user expressed his difficulty in discontinuing his drug consumption. Later, a well-dressed person, conspicuous because of his clean attire, entered the cabin. He was familiar with the users and they shared a few lines of brown sugar with him. He approached us and there was an outpouring. He had seen us talk to other users and had heard about the treatment centre.

He said he worked in a government factory nearby and during the lunch break he came to the cabin to smoke brown sugar. He said he did not identify himself with other users and maintained a distance from them. While chasing the drug, he often sat on his haunches so that his attire was not spoilt by the dirty floor.

Being a member of a marginalised group involves changes in lifestyle after initiation into this position. It may call for changes in three basic ingredients of reality; time, topicality and preconstituted knowledge (Musgrove, 1977). The extent of variation and its impact on the individual may differ from person to person.

This section is addressed to aspects such as the impact of drug use on daily life and its implication on the user's interaction with his family and society: whether there is a change in the user's situational reactions and his allocation of time and whether it necessitates the learning of new skills, which changes the relevance of his earlier preconstituted knowledge.

To illustrate this, case studies on users' daily life are given below. Theses were selected to show the difference in the impact of the drug on the users' daily life and the existence of various shades of interaction with the family and community.

Daily Life

Case 4.9

Rajesh, who belongs to a Gujarati family, lives with his wife and two kids in Kandivali. He worked at his uncle's cloth shop in Crawford Market prior to his excessive use of brown sugar. He began to consume brown sugar accidentally, when he shared his friends' cigarettes unaware of its contents.

Later, to earn a livelihood he and another user friend man-

aged a card player's club. They made a daily profit of Rs.300 to Rs.400, but wound up the business when his friend expired. For a year, he worked as a courier to Dubai. After which, he and a group of friends, started collecting money from traders on false claims of festival celebration or *pooja*. There was no room for verification and contributions were made on a voluntary basis. They made around Rs.125 to Rs.160 on a daily basis.

Rajesh and his friend consumed brown sugar behind the post office away from the eye of the public. After which they went around collecting money from others and were proud of the fact that they did not steal but took what was given voluntarily. They pooled in the daily collection and gave a part of it for purchasing brown sugar. At times, Rajesh reached home late in the night, and sometimes he stayed away for the night which led to fights with his wife. His father took care of his family, when he abandoned himself to drugs.

Now he has decided to give up drugs, as he does not wish his lifestyle to influence his children. Hence, after detoxification he intends to go to his native place because drugs are not available there.

This user's life has changed. He changed his occupation and got involved in antisocial activities in order to maintain his habit. Though his family members do not accept his dependence on drugs, they have not alienated him. The family support system has prevented him from becoming a street user.

Case 4.10

Niyaz is a part of a joint family residing at Byculla in Mumbai. He was a tailor by profession before he became a driver. He is married and has two daughters.

After a day's work Niyaz enjoyed having a drink. He had on many occasions seen drug users chasing brown sugar on the

staircase of his building. On many occasions, he tried to drive the users away but they claimed their relatives lived there and that he had no right to harass them. One night, when he returned home at night, he saw the group of users and in his drunken state snatched the drug and chased it. He was adamant, as he wanted to taste the substance that they refused to share willingly. After this incident, he became a regular user. Initially he chased the drug, but later shifted to smoking it in cigarettes as it gave less opportunity for suspicion. But, the mode of consumption became too expensive and he reverted to chasing. His daily consumption was around ten to twelve *pudis* per day.

He consumed his drug early in the morning at the family tailoring shop before going for work. Drug use did not affect his appetite or his daily routine. Usually, he took drugs twice a day, but when he got a ride towards Byculla he managed to have an extra dose.

He did not contribute much towards family expenditure except occasionally for his children's education. Being a part of a joint family, his family's needs were taken care of by others. At times his brothers gave him money for drugs as they were aware of the withdrawal pains.

Niyaz got himself detoxified, but relapsed after ten days. During his short drug-free life, he felt very lethargic and stayed at home. The sight of users on the staircase drew him back to drugs. He began to chase four *pudis* per day. He had a lurking fear that his quantity of intake would increase and decided to seek treatment the second time.

Though drug use has eroded his family responsibilities, the existence of the joint family has softened the impact of drug use on his immediate family, which in many cases, often leads to alienation. It is this family support that gives him the urge to take on his responsibility as a father and discontinue drug use. The

lethargy he faced after detoxification has been described by other users who worked as drivers or manual labourers. Often, taking drugs is an excuse for allegedly regaining their strength.

Case 4.11

Khanna was a welder prior to his entry into the drug world. He lived with his parents and brothers before becoming a petty peddler on the streets of Bombay.

He sells around 100 to 500 *pudis* per day and gets 20 *pudis* as his daily wage. At times, some of his customers are in a hurry and request for some place to chase the drug in privacy. In return, they share their drug with him.

His appetite or his alertness have not been affected by drug use. He bathes once in ten days or a week, for he has warm water bath and it is expensive. He has his bath at a public toilet, where for extra charge he is given warm water and soap. During festivals or celebration, he wears clear clothes and joins the festivities.

He never chases near his house as he is scared of his father and does not want his brothers to be influenced by him. His father blames his mother for his habit, and to avoid friction, Khanna stays away from his home. He does not want to lose his friends' respect. They are aware of his habit, but he avoids using it in front of them.

Alienated from his family, he has lost a support system. The city with its crowds can offer seclusion and anonymity. Like Khanna, many users opt for public places some distance away from their homes to chase their drugs. Their unkempt appearance and huddled posture and the public's desire to avoid them reduces the possibility of any identification.

Case 4.12

Ramamurthy's case has been described in the earlier section. He sustains himself through theft and has been arrested twice.

He is not particular about hygiene or nutrition. When he is high he has a bath once a month in a nearby gutter. He wears old discarded clothes or rags and lives on the street. He has friends who are both users and non-users, those from the latter keep urging him to give up drugs. The community members dislike him and chase him away. Ramamurthy feels a sense of hopelessness and isolation that only drugs can numb. He enjoys the blissful state of drugs and dislikes being disturbed then.

In this case, the user Ramamurthy has been alienated from his family, except for his interaction with his brother, who is also a user. The hopelessness and pain of his existence made him a street user.

Conclusions

While the drug user is alienated as a result of his habit, segregation is dependent on the extent that his habit is known to others. When it is limited only to the immediate family members and other close associates, deviation may not condemn the user to a marginal position. Family protection is taken away when the extent of the use becomes unaffordable, and drastically affects the user's responsibility towards his family and himself. When threats by the family members to disown him do not lead to viable lifestyle, then the user may be left to fend for himself.

In the case of a user who has no family support and who depends on other users or peddlers for emotional relationships, it is far more difficult to accept societal values. Probably, prior to becoming drug-free, they need to reduce consumption and detach themselves from their immediate environment. While drug

use can numb the user's emotional attachments, being drug-free and alone can be too threatening to deal with. If the user enters into a vicious circle of being detoxified and then re-enters his old marginalised environment for solace, then he may lose faith in his ability to deal with the drug. Hence, it is important for the person first to reduce his marginalisation or understand the impact it has on his lifestyle.

The present association man has formed with MAS can marginalise a user which in turn can change his lifestyle. Marginalisation can only occur when knowledge of consumption is available to individuals other than the immediate family. The existence of users who maintain a functional relationship with MAS has been identified. The contrast we observed between a functional user and an extremely marginalised individual led us to inquire into the process of marginalisation.

Process of Marginalisation

An undernourished user with torn dirty clothes came limping towards us. He balanced the weight of a large sack half full of rags thrown across his shoulder. He had covered a portion of his left leg below the knee with a piece of cloth. As he came nearer, he said in English, "I would like to seek medical care". We looked at him in surprise for knowledge of English is rare among street level users, though a few may learn to have a working knowledge of the language through their interaction with foreigners. He continued, "I have been on the streets for over a year. My family has disowned me and I am now unable to survive, I have opted to be a rag picker. An occupation where my earlier skills and education have no significance. Since I am on the streets, I would like to avail myself of the free service for street users". After a moment of hesitation we explained that we had a peculiar norm of not admitting English-speaking drug users since they probably still had the support of their families.

Since there are other centres dealing with them, we requested him to go to one such centre. Then the user said, "I need immediate medical attention, otherwise I will die on the streets". Another user butted in: "He was bitten by a dog and his wound has not healed." The user removed the piece of cloth form his knee and showed us the pus-filled swollen wound. We were in an awkward position for, we did not have any facility for crisis intervention and our doctor refused to take the case for fear of rabies and the limited infrastructure at our centre. We tried to convince him to avail of treatment from the government hospital nearby. He rejected our suggestion on the grounds that the government hospital would not treat him. Later, we explained our dilemma to another doctor at our centre, who asked us to bring the patient over. But we were unable to trace the user. After a few days, a priest working among users came seeking help for the same patient and we made arrangements for him. It was too late for the day before he had died on the streets of Bombay. It was this incident and the condition of other users that motivated us to start a crisis intervention programme. This incident and subsequent events prompted us to inquire into the process of marginalisation.

Criminalisation of the use and sale of drugs, initiation into drug use and continuation of the habit calls for integration into a different scenario. For the need to hide the habit from others itself calls for changes in lifestyle and personal priorities. The extent of the impact of brown sugar use depends on the degree to which the user's life revolves around it. No matter what option he takes, his life changes to a certain degree. This process is reflected in various aspects of life which the user modifies so as to be a part of the drug using group.

While society has certain norms that it expects everyone to adhere to, users are willing to change their goals for a one-point agenda. Some of the changes that took place in the lives of our

respondents are given below and reflect deviations from the system.

In some areas, changes occur in the lives of most drug users, such as expenditure on food, personal needs and the family. The impact differs from individual to individual and on the extent of marginalisation. Drug use does not influence a person's working life immediately; it is only after a period of continuous and uncontrolled use that a person either loses or changes his occupation. An individual may also modify his drug habit and retain his occupation. When the livelihood is disturbed, there is direct impact on family responsibility which in turn leads to alienation from the family. Family support helps the user to hide his habit from others but when it is disrupted he/she also faces alienation and rejection within the community.

Changes in Expenditure on Personal Needs

To sustain any habit that needs large amounts of money, the user has to divert expenses on other items of consumption such as food, clothes and social activities. The food habits of users are affected because their drug use also leads to a loss of appetite. Moreover, the user's high consumption of tea to counteract the bitter taste of the drug also suppresses his appetite. Another favourite item among those who smoked in public was *khari* biscuits. Users who have a support system continue to eat food at home, but eat small quantities. Among marginalised users there are some who spend Rs.40 to 100 a day on drugs, but scrounge the garbage bins for food at the end of the day.

Changes in Occupation

As drug use affected their work, twenty-two users had to give up their jobs and move into other appropriate employment. The choices they made reflected their decision to shift from being "convergers to separatists". Our case studies showed that many people shifted from government salaried jobs or daily manual labour to rag picking. The main factor that influenced this choice, besides instant cash benefits is that work schedules are no longer fixed. There is no accountability to a higher authority. For a person who experiences ASC, there is often no sense of time. Another example of convergers becoming separatists is when users decide to work as assistants to peddlers to sustain their habit. In one instance, a person lost his job as an assistant to a peddler and had to shift to helping in a *matka* (gambling) den. He found this job difficult as he was in charge of gambling, which involved standing in one place and being alert. He used to feel sleepy, so he left the job and started stealing metal from railway yards and later, shifted to rag picking.

The case study given below helps to identify whether drug use has an impact on the occupation of the individual.

Case 4.13

This case has been dealt with in detail in the next chapter. Rajan lived with his family in Madhya Pradesh before reaching the streets of Bombay. His eldest brother owned a jewellery shop and took care of his family expenses; and while the second brother, a graduate, was the moral and emotional support for the family. Rajan reached Bombay after a fight with his sister-in-law.

On reaching Bombay he went straight to Grant Road where his friends, two brothers, from his hometown lived. Both brothers were brown sugar users and the eldest brother sold the drug to sustain their habit. Rajan had adequate money and some amount of opium for consumption. The brothers lived on the streets and were very dirty. Rajan was unable to deal with their condition and spent money on them for clothes and their drugs. When he ran out of opium, he was forced to shift to brown sugar.

Rajan did not continue his relationship with the two brothers, as he wanted to be independent. He did construction work for a contractor and received Rs.70 per day. After his assignment was over, he stood at the *naka* for being hired as a casual labourer for the day. With increase in drug consumption, he found the work too strenuous and the returns inadequate.

A drug using friend explained how ragpicking brought in quick money, anything between Rs.20 to Rs.150 a day. Rajan urged him to teach him how to pick rags for a payment. They pooled in their collections and his friend received sixty per cent of Rajan's share in addition to his share. The arrangement continued till Rajan learnt the ropes and branched off on his own. He found that a clean rag picker received undue attention from the police and so the rule of the game was to be dirty and stinking.

He travelled to distant places to collect rags as the competition was very stiff in the inner city. He earned around Rs.100-150 per day. While at work, he cut short expenses and travelled without tickets. He was never caught for he carried the rag picker's bag on his shoulder. His day began at 4 a.m. and ended at 10 a.m. On certain days, he took a second round later in the day.

As he belonged to a *pundit* (Brahmin) family, he was particular about personal hygiene. Being a casual labourer, he did not have a place of his own and had to go to a *hajam* (a barber's shop) for his bath. Here for a price a person got soap, towel and warm water. Unlike non-users, drug users found it extremely difficult to use cold water and in the process avoided a bath and spent the saved money on drugs. Rajan never washed his clothes, but replaced them when the pair became torn and dirty.

Rajan had tea and *khari* or bun *maska* in the morning and *dal* and *chappattis* at noon. At times in order to sleep in a clean environment, he bought tickets for the most unpopular show in

a cheap theatre and slept through the movie. According to him, drugs made him do many things he had never done before in his life. Rajan preferred the rural areas for the space it offered for one to sit and smoke.

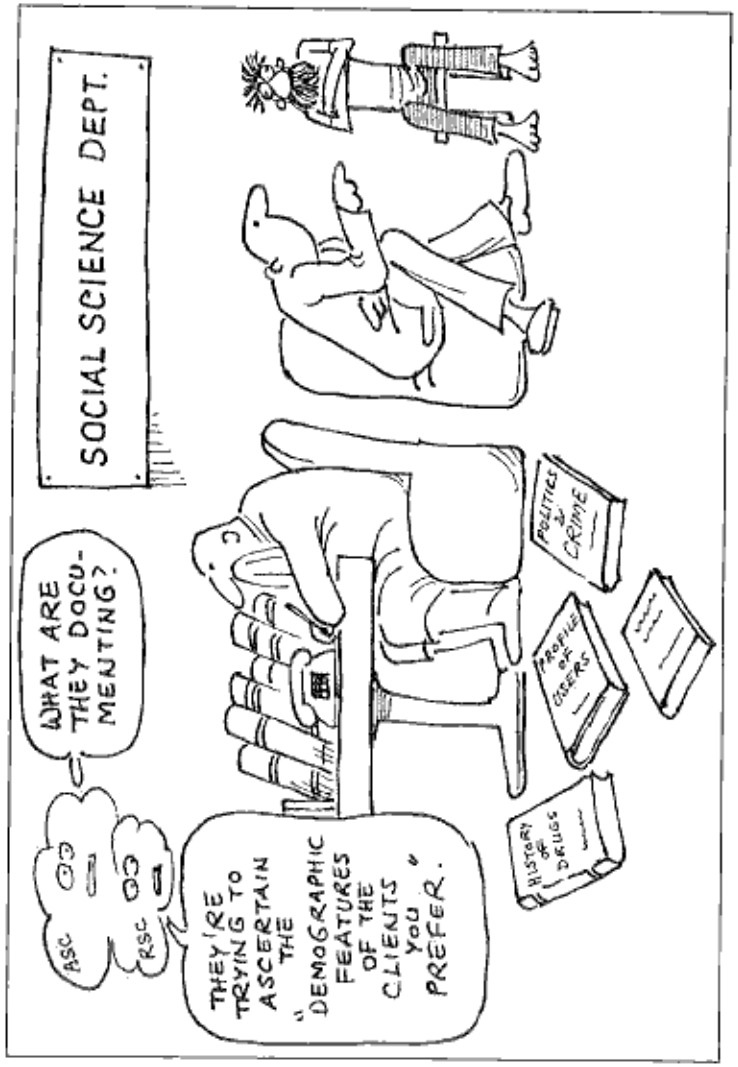
Rajan's case is an example of the drastic changes that the drug habit can bring about for a member of the Brahmin caste. While retaining his innate sense of cleanliness and personal hygiene, he paid to sustain his habit by turning into a rag picker.

No Change in Work Pattern

While the above cases illustrate a shift in occupation, there are people who continue their previous occupation. In this category fall taxi drivers, clerks and *zari* workers according to the data collected. A self-employed person who maintains himself through his skills may change the scale of operation but continue the same work. For example, he may reduce his business in carpentry or *zari* work and when it becomes too difficult he may work under another person. It would be interesting to examine the implications of drug use among drivers. Studies have examined the implications of drunken driving, but, in India, no one has probed into the effects of drug use on safety while driving. Another factor that would be of interest to addiction professionals is that, in two cases, drivers said they had relapsed because they could not continue to drive without drugs after detoxification. Apart from individual factors like physical health, there is also the fact that drivers in India, have to work long hours to keep their jobs. This underlines the need to formulate rules regarding working hours for drivers, which must be related to the human capacity for remaining alert for a long period.

Conclusion

In the present study, brown sugar did have an impact on occu-



pation, and especially so in the case of people who worked for specified hours. There was a difference in the case of drivers and those involved in *zari* work. Where there is little impact on work, this can also be the result of a person's decision to be a converger in relationship to society.

The shifts in occupation are inevitable - a user who is a salaried worker can turn to rag-picking and later revert to his former job. And the decision to seek treatment might come from a desire to change his occupation rather than to be drug-free.

In cases where the goal of the person is to be a functional drug user this is to be respected. Otherwise, the chances are very high that the drug professional will lose touch with the person. This probably requires a change in the policies of drug abuse treatment centre. In the final analysis, it is the individual who matters.

Interaction with the Family

All users spoke of alienation from their family after taking to drugs. Families are disturbed by the user's petty crime (this includes stealing from the house, borrowing from friends, stealing public property, etc.), irregular behaviour, the stigma attached to drugs, and so on. According to the sister of one person we interviewed, she had prevented a number of accidents. The user would sit on his bed, chasing his drug, using a bed sheet to cover himself so that the fumes would not escape. Sometimes he would falls asleep with his sheet over him, where it could catch fire, but she has always saved him in the nick of time.

In another case, two brothers lived in adjacent shacks. The partition was very thin with gaps in between and at the top. The elder brother was married and had a child who was only a few months old. The father and younger brother lived in the other shack. The father started consuming brown sugar and sub-

sequently the younger son also started. The son argued that he started smoking because, anyway, he was inhaling the brown sugar fumes all day long. One day, the elder brother's child fell very ill with a severe cough. They took her to the hospital, where she was admitted. The doctor asked them whether anyone at home smoked, as the child's chest was congested. It was then that they realised that their room was often full of suffocating brown sugar fumes. This led to an argument between the two brothers and the father. The daughter-in-law and the elder son told them that they could no longer sit inside the house and smoke. After that, they found another isolated shack to smoke in.

While these persons might have found an isolated shack, there are many who have no option and end up in garbage bins. And yet, at another level, when husbands are users and the sole earning members, few wives will protest at their sitting at home and smoking. The stigma attached to addiction makes the couple want to hide the fact from as many persons as possible. Besides, they might not be aware of the problem of their children inhaling the fumes. Here, the need is to educate both husbands and wives, as otherwise it might easily lead to additional marital problems. If the users become alienated from the family, they end up spending more time with other users.

Before taking to brown sugar, Prakash had a standing in society. He was an active worker with a political party and arranged many programmes. Once addicted he lost his credibility in the community. Most of his friends and others pretended to respect him in his presence, but behind his back they remarked, "After all, he is a drug addict". In his *mandal* (association), no one has any respect for him. This is not the case with his family. Since he is the earning member of the family and is responsible, they do not alienate him. But he feels he cannot gain back the respect of the community and thus feels lost.

Changes in Sexual Life

Almost all users speak of enjoying sex in the initial period of consumption but later some faced the problem of premature ejaculation. On one of our field visits, a user stated: "I would prefer to die of drugs than face the tension of being unable to be a man with a woman."

He said that on three occasions he had given up drugs and had got interested in having affairs. Each time he attempted to have sex, he faced the same problem, and then decided that he would never give up drugs. On another occasion, an alcoholic kept taunting the users that they were victims of *rath ki bimari* (premature ejaculation and wet dreams) because of which they never gave up drugs. There is general fear among common people that wet dreams weaken a person, and that one becomes anaemic. They assume that semen loss is blood loss. This calls for sex education programmes so that those myths that sustain drug use can be eliminated.

It is also essential to differentiate between users who associate brown sugar or opium with sexuality and consume it for sexual enhancement, as against those who continue to consume brown sugar to retain their manhood. While a few continued using it out of fear, others lost interest in sex after continuous use.

According to an informant, his friend Raghu (a user), faced marital problems because he was no longer able to satisfy his wife sexually. She started having an affair with his younger brother behind his back. Raghu was not aware of this fact, and on one occasion he decided to give up drugs and go to his native place to stay clean. On that day everyone had come to see him off his parents, wife, two children, brother and others. The train, which was to leave late in the evening, was delayed until the next morning, so in the end all of them slept on the plat-

form. During the night he went out to have his fix as usual. When he returned he found his wife and his brother sleeping in a very intimate position. He was very upset and said to his friend, "If this is how they behave when I am here, what will happen when I am absent?" He then left a message through his friends "I am going back home so ask everyone come there in the morning; I have a surprise for all of you". When they arrived there they found that he had hanged himself. Before his death, it seems he had told this informant, "What am I to do? I can't even keep my wife happy. What is the point in living?

Case 4.14

Arvind was first exposed to brown sugar at the age of sixteen and since then continued to use the substance. One day, he was invited by his friends to visit a brothel in Bombay (Kamathipura). There each person spent Rs.15 per shot and gave an additional Rs.5 to the women who entered the act.

Arvind was too shy to select his partner, as it was his first visit. A woman in her mid-twenties pulled him inside. He enjoyed the experience and kept visiting the place but after consuming his daily quota. Once as there was financial crisis, he went to the brothel without having drugs and had premature ejaculation. Thereafter, he decided to visit the place after consuming drugs, and he continued the practice for a long time.

He associates drug use with sexual potency and feels that it is the only way to avoid premature ejaculation. Some users experience this in their sexual relationship and assume this to be a permanent phenomenon which can counteracted only through drug consumption.

Case 4.15

(This case has been dealt with earlier in the section dealing with

initiation to drug). Prakash, aged 32, a taxi driver, lives with his wife, three children, his aunt and uncle. He finds it difficult to drive without drugs. He attempted to stay away from drugs and managed to do so with family support and change of environment. During this period he experienced difficulty in having sex with his wife; that disturbed him and he went back to drugs.

In this case, as in the previous case, the user believes that the only way to maintain his manhood is through brown sugar.

Case 4.16

Anandan's case study has been dealt with in detail earlier. His first visit to a brothel was at the age of fifteen. Then, he was unable to ejaculate though he spent a long time with a woman in her mid-twenties. After a few days, he returned and spent time with another person and as he enjoyed the experience he became a regular visitor. He took either opium or brown sugar before visiting. He too believed in the association between drug use and sex. According to him, one not only felt humiliated because of lack of performance but also had to deal with snide remarks from the partner. In 1977, he was sterilised along with others as part of a government drive, and since then he has had no interest in sex.

Brown sugar use and sexual performance are linked together in the mind of this person as well.

Conclusion

Opium has been associated with sexual desire and emotions, as documented by Chopra and Chopra (1990). In India, small quantities of opium were used as an aphrodisiac and to deal with cases of impotence in young adults. The traditional indigenous practitioners often used the drug in the treatment of sexual neurasthenia, premature ejaculation and spermatorrhea, due to

hyper-excitability. Opium acts as a general depressant on the nervous system and is said to prolong the sexual act and prevent premature ejaculation. Hence, opium has been used, along with cannabis and alcohol by some, as an aphrodisiac. But excessive use is said to cause loss of sexual desire and sexual emotions. Some of the males complained of a complete absence of sexual desire. On withdrawal from the drug, they experienced an exaggerated sexual desire. Brown sugar, as an adulterated derivative of opium, continues to play a role in the lives of users, either by curtailing desire or enhancing it.

Users take brown sugar to remain sexually active. In some cases, even years after brown sugar use they visit brothels. In others, it has led to loss of sexual interest. A person's mind-set influences the impact of the drug on his sexuality. Besides, the general myths associated with sex and sexuality among the people become accentuated when the user experiences wet dreams or premature ejaculation after staying drug-free. This in turn can be a hurdle in the way of change in the lives of users.

It is important to conduct indepth studies of sexuality and drug use in the Indian context. Since, the human mind plays an important role this aspect need to be focused upon. Such information can facilitate to evolve appropriate strategies for intervention. It is possible that drug use lowers inhibitions which in turn may liberate sexual libido.

Changes in Personal Hygiene

When users decide to change their lives totally for the drug, they try to stay filthy. While some do it out of lack of interest and others for economic reasons, there are many who use it as a strategy for survival as seen from the earlier cases. Even among visibly marginalised users, the reasons for their appearance and relationship they have established with the drug will vary. Extreme lack of personal hygiene is a clear characteristic of being a

"separatist".

Changes in Place of Consumption

Prior to the introduction of the NDPS Act, the use of cannabis and opium enjoyed acceptance in many parts of the country. Rao (1998), Siddiqui, (1998) and Masihi, (1998) have documented this in different areas of the country as a part of this study on "culture and drug use". This has been dealt with in detail in the chapters dealing with historical data and types of uses. One of the clear expressions of the social sanction of drug use was the presence of *Chandu Khanas* or opium dens where group of users would come to enjoy their smoke. These places have either disappeared or have been driven underground. As one user recounted, "There are places run in isolation in certain parts of the city where users of cannabis and opium can relax and have their drug. These place are catering to the elite or middle class and not to the poor. Here, *chillums* decorated in various styles can be purchased but the use of synthetic drugs in not entertained.

Another person, Rajan, whose case has been dealt with in detail in the chapter on typology, narrated his experience both in his native town and Bombay city. Back home there was a place where *madak*, *bhang* and *ganja* were sold, and consumers could use it there as well. There, often, the sale of *bhang*, *madak* and *ganja* is a family business, with father, mother, and daughter-in-law, all playing a part in its running.

His favourite haunt was above the place of purchase a loft connected to the floor by a small staircase where customers would consume their drug. He enjoyed his smoke in this place, especially since at night, during the full moon, the view was spectacular. While enjoying their opium the newcomers were educated by experienced users on various aspects of the drug including methods of self-detoxification. There were a lot of other

places including open spaces near river banks, where users enjoyed their drugs. After their smoke, they would float in the water, as it enhanced their high.

Cannabis is grown in many parts of Rajan's native place. Now, people grow it secretly as it is illegal. *Pandits* have *ganja* near their place of worship and people who come there take a few drags from him and go away. Only very few sit and smoke on a continuous basis. Later, after being addicted to brown sugar in Bombay city, Rajan began to use the drug in filthy surroundings where the stink of defecation fills the air.

Through the imposition of empirical norms, cultural sanctions and norms have been eroded, and users are left to fend for themselves to find a place to consume drugs. In the case of the elite and middle class, users can find privacy up to the point where they become totally dysfunctional. The poor in the city struggle to find a niche for themselves, a site where they can smoke brown sugar. Under such circumstances, they become identifiable as users in a short span of time which in turn leads to alienation within the community.

Reaction of the Community to Users

Users of cannabis, opium and alcohol are not seen in a negative light by people in the community, nor were brown sugar users stigmatised in the early eighties. However, brown sugar is not like a natural form of drug, where people are still capable of being functional. The NDPS Act of 1985 was responsible for an increase in the price of the drug and as a result users began to adopt any method to sustain their habit. This led to people avoiding them and chasing them away. The usual descriptions of users are "They lie in the dirt" and "They are irresponsible". The users accept these comments as well. They express their appreciation when we go and sit with them in the garbage dens and filth: "You come and sit with us here, even though you are from good families."

Another clear illustration of the community's ambivalent behaviour is evident from the following case study. Shahid from Masjid Bunder has been taking brown sugar for the past twelve years. As a drug peddler he earned a lot of money and was respected by others in the community. All the people in the area knew him well. Later, he began to consume brown sugar. His wife used to advise him against it. Finally, she left him and went to the Gulf to work and said she would return to him only if he gave up his habit. He had been detoxified three years ago but has relapsed. At present he does not sell drugs any more but helps other sellers by keeping a watch to warn them about the presence of the police.

He functions as a watchdog for the peddlers in return for which, they give him two *pudis* in the morning. He stays on the streets, roams about here and there, but generally hangs around near the peddler's house. He used to go home to sleep at night, but after a fight with his mother-in-law, he does not want to go home. He keeps himself clean as he believes that it is only his cleanliness that helps him avoid discrimination.

The interaction of users with others in the community depends on the extent of the addiction, the impact of drug use on the lives of the users, especially with regard to whether or not they are functional, the users' involvement in antisocial activities, the extent of support available to the users, the skills they have and the presence of other medical problems associated with the use of brown sugar.

The users who depend on begging or rag picking do not get any sympathy from the community. If a user is able to sustain his habit, be it even by working as an assistant to a peddler, the chances of being chased away by others in the community is far less. In the area of our study where there were a number of families who depended on brown sugar as their means of liveli-

hood, the chances of a person being stigmatised for selling is far less than in other communities. The people in the locality generally comment to us: "Unless this business stops, these users will continue to take drugs. What is the point in your wasting your time with them? They go to the treatment centre and get cured only to come back and consume drugs again." It is noticeable that, although only a few persons from the locality might have come for treatment, whenever one person reverts to using drugs, the general conclusion about users "never being able to change" is strengthened. At the same time there are users who give up on their own, without any treatment. But these cases are seldom highlighted. Seeking treatment is not often encouraged, except when the person is medically unfit.

Passers-by on these routes were curious to find us talking to users and spending time with them. They seem puzzled by our presence as they felt that the users would never change. They keep taunting them with a monotonous repetition of catcalls *Gardulla*! *Gardulla*! The term has a negative connotation both in the minds of the public and for users as well. Often users react very negatively to being called a *Gardulla*. On the other hand they comment, "What can we say? After all, we are just *Gardullas*".

Lady commuters on the local trains are scared of the users and immediately quicken their pace when they have to pass them. Media hype, along with the risk of petty theft, might be the reason for this. On many occasions users have warned the researcher against keeping her handbag open, and keeping money in the book which she uses. But they have never actually taken anything. On one occasion, a user came and gave the researchers a passport that he claimed to have found on the road, but it seemed more likely that he had stolen a handbag from some lady and wanted to return the passport. Another user, who is also a street kid and shoeshine boy, said that there are groups of users who come to Church Gate to pick pockets. He

identified a few of the users from the study area as part of the gang.

People who live in the locality, and are not involved in the trade in any way, but whose family life has been affected by drug use, express their anger to the peddlers, and say, "Allah will punish them." Their feelings towards users are those of contempt: "They will never improve and it is a waste of time to try and treat them." If one of the family members of such a group gets involved with peddlers in any way, they tend to sever their relationship with him. For example, a user from one such family got married to a female who was an assistant to a peddler and that led to family friction. On the other hand, people who had been peddlers prior to becoming users remark how they commanded respect when they were peddlers and had money.

At the community level, people react more often to the status of a street user, rather than to his drug intake. A person who consumes a controlled quantity will not be harassed in the same way as one who cannot control his intake, and is involved in crime or is physically dirty. At times, community members do advise the users to shift to cannabis instead of brown sugar. This feeling is also acceptable to the users, who state, "*ganja* is all right, it even gives you a nice appetite, and one can do without it if it is not available".

Conclusion

After the initiation process, continuation of drug use leads to changes in the lifestyles of the users in areas like work pattern, family interaction, sexuality, personal hygiene and food consumption. Their drug use also leads to the formation of new social networks. The extent to which these become a substitute for earlier support systems also indicates the extent to which the user has deviated from society. As a result of the changes in the lifestyles of the users, their communities alienated them; the re-

action being focused on their lack of responsibility and their unhygienic lifestyles.

Thus, after the person is initiated into drugs, the world of drug use creates its own dynamics. This integration into a different circle might alienate one from whatever congruence one has with the centre, and after treatment this alienation might become the reason for return into the world of drugs.

This point was expressed by one user when he stated:

> When I go back home, I do not know what to do with my time and the only friends I have are users, I do not want to go near non-users who were my friends before I started drugs as their parents will wrongly think that they have also become drug users instead of the other way around. The problem is that most people identify me as a drug user and nothing else.

The users felt that the world of drugs is a totally different one from that of everyday life. The time factor becomes insignificant, and with regard to space it is only when they take "*vattana*" (Nitravet) that they face a problem in misjudging space. This can lead to accidents and even death. There are many users who claim that other users who have been using these tablets have met with accident and in the process lost limbs or suffered severe injury. This has been illustrated earlier. Brown sugar, they feel, does not lead to accidents that result from misjudgement of time and space. It only stops one from considering time as the focal point. Time exists and yet it does not. If one were to look at various altered states in all their totality, time is not a major point of reference.

In sharp contrast, time has played a major role in the lives of people in India, be it for marriage ceremonies, business ventures, birth charts or for any important event. For religious events especially, it plays a crucial role. In a metropolitan city, daily life revolves around the time factor. This is reflected both

in routine and mundane things. A user is either lost in his world, which reflects life or is intensely involved in identifying, sharpening and integrating his coping skills with the aim of obtaining another high. This sharp deviation will bring out a crisis in his interaction with society, unless and until his need for an altered state of consciousness is dealt with through the functional use of drugs or by other means, as was done earlier within the ambit of traditional culture.

The earlier space sanctioned for drug use have been eroded with drugs falling under the purview of empirical norms. This has led to making previously legal acts illegal, and driving the drug scene into a different ambit of control. This naturally led either to the isolation of such an infrastructure from the public eye, or the discontinuation of such practices. This change also led to marginalisation, as the poor do not in any case have any privacy, and their only option in the end may be to smoke in public.

Nevertheless, it is not sufficient for users to change; it is also necessary for society at large to understand altered states of consciousness, the existence of other forms of altered states and the impact of change on consciousness produced through drugs. This may enable the community to begin to understand the problems faced by users.

The unknown has always been viewed as something threatening, and people have either refused to acknowledge it or avoided it. When people are equipped with some understanding of the dynamics of addiction, probably they will go beyond the existing role of being self-righteous and instead attempt to deal with this issue rather than seeing it in an "ethical" perspective with preconceived notions.

Adapting to Marginality

Marginalised individuals will either try to reduce the cues that

can lead to their identification or adapt their lives to their marginal position. The shift can be either towards marginalisation or away from it. Even when marginalised, individuals do not exist in isolation; they try to create their own network to deal with the void created by isolation from society.

Musgrove (1977) has looked at the phenomenon of people in marginal positions moving in and out of society. This is also seen in the case of users. Many users try to pass themselves off as members of the centre once in a while and, depending on the distance from the centre, their attempts to identify themselves with it vary. Some try to cope with their brown sugar use without disclosing it to the public. This phenomenon is far more noticeable in the case of brown sugar than in the case of other drugs, like cannabis or alcohol.

The shift towards the centre is very dramatic in the case of those who have alienated themselves from social norms in many areas. On special occasions they have a bath, change their rags, get into newly laundered clothes and join the public for a festival or any other social function. This behaviour is seen on a regular basis among other marginalised street people. This phenomenon can be limited to a few days or longer. At times, besides passing themselves off as someone else, individuals will try to modify their behaviour so that they will be able to be a part of the centre.

Based on the data available, this study has looked at the process of moving towards the centre.

Our study has looked into the means adopted by users to deal with marginalisation at two levels: their efforts to create their own social environment and their efforts to merge back into society. The latter is dealt with under 'reducing marginality'. These steps can emerge for reasons within the individual, family or community. Identification of these and communication of the impact of drug career on their lives may facilitate a

synthesis of the individual's relationship with MAS.

Evolving a New Social Environment

Alienated from the family circle and friends who are non-users, users try to strengthen their links with other users and peddlers in their network in order to deal with their sense of isolation. Depending on the extent of use and the time spent on it, the type of relationship established with the marginal group varies. This can be illustrated through the experience of one addict, Raja. He says many people in the community beat him and chase him away. He took drugs because he wanted to be in his own world by himself, and enjoy the calm and serene feeling. He disliked being disturbed by others at that time. Others in the community never understood the problems faced by users and he felt that their reaction would probably be different if they did.

The interaction that exists between users and peddlers in *addas* helps us to understand the dynamics of an alternative lifestyle. According to one informant, while users sit in groups, their interaction is very limited and often revolves around negative aspects of their lives, or around the drugs itself. Users also say that outside *addas* their conversation revolves around brown sugar. The basic interest of a user is to find good quality stuff at an affordable price. They ask each group of users they see on the road for information about these two aspects. In order to get a few lines extra from one *pudi*, they do not mind going further than their usual haunt. After the person chases his first few lines, he might talk about the quality of the drug, about users who face problems and want to give up the drug, and about the availability of various treatment centres and the kind of facilities there.

While users say that they will never share their drug with another user, they often share a few lines. This was observed

during our field observation in all three *addas*. At times there is a clear understanding between users who sit and smoke together that if one shares his *mall* (stuff) today, then others users will reciprocate whenever he is short of drugs. Users do not help other users when they are going though withdrawal symptoms or any other illness, except to share a few lines of brown sugar. They express their inability to do anything, even if they see a user in a very critical situation. In the case of a group of regular users who are known to one another, they do help. They feel, "If we don't help another user in trouble who else will?"

The users who are known to one another share their problems. Their world always revolves around obtaining the drug, problems in the family, individual problems and stories about peddlers and their assistants. One user who knew how to read Marathi said that he always read the newspaper whenever he got a chance. He read only about traffickers, gang wars and robberies. A hard-core user's world revolves around making money for his daily dose, finding a safe place to use it, dealing with police, peddlers and users who might want at times to steal his stuff, avoiding the public and their insulting remarks. At times he consumes more drugs to deal with pain or discomfort arising from medical problems.

Since many areas of life and money begin to revolve around the drug, the user's interest naturally focuses on peddlers, trafficking, petty peddling and the politics that surround it. The degree of his interest depends on the level of marginalisation of the user. The relationship also depends on the status of the user at any specific time. Among the users from the upper strata or those with minimum marginalisation, interaction with the peddler is limited to handing over the money in return for the stuff, or giving money to his assistants, who are young kids, and to users, who act as assistant to the peddler. Often, peddlers also use their own young children for peddling. These kids are initiated into the business at a very young age, and their education is ignored as it interferes with the family business. The peddlers usually do not feel uncomfortable bringing their tiny tots to places where users sit and smoke. A common trend at present is to use either women or children for marketing the stuff.

Since some users perceive the peddler as a powerful person, they tend to take a meticulous interest in his life. The peddler usually has the last word about users sitting and smoking in the place because some shacks belong to him. They often harbour the desire to see him suffer, for they can always recollect the innumerable times they have been chased away with insults for asking for a *pudi* at a lower price. A recent incident in our treatment centre will illustrate this feeling. A peddler was brought to the centre as he was ill. This person had started using brown sugar and within a few months his consumption kept increasing till it reached 30 to 40 *pudis* per day. Along with his habit he had other medical complications. After this person was admitted, because of his deteriorating critical condition he was shifted to another hospital. The other patients in the centre helped the ward boys to shift him. Later these patients told the treatment staff, "That person is a big time peddler, you should not help him". He should suffer for the number of times he has kicked a user for asking for a *pudi* for Rs.9.50 or less, when the actual price was Rs.10. The user often believes that anyone who sells drugs will one day suffer or at least a member of his/her family will. They also cite a number of peddlers whose brothers, husbands, or children are addicted to brown sugar. This is not far from reality.

There are instances of kids expressing their care for a relative who is a user by giving him drugs free of charge, stolen from their parent's stock. Among peddlers, it is not uncommon to find at least one user in the family. This was explained clearly by one user who said that his best friend started taking drugs "as the whole family is immersed in this business he decided to join them".

Another reason for the negative attitude towards peddlers could be their cordial relationship with officials, who chase away users. Often those feelings are a bit misplaced, for the peddler in the streets is the visible culprit and lowest in the hierarchy of the political economy of drugs.

Users feel that peddlers maintain a relationship with different branches of the police as this is beneficial to them. They said in the initial period that the "narcotic people" were very rigorous but that only led to the death of the officials concerned. After that this branch also started taking a cut, they said. The only difference was that they received more than the others did. We have no way to verify these views of our respondents. There are peddlers who feel uncomfortable with the whole process. According to one user who was earlier a peddler, he used to go to the mortuary and identify his regular customers who had died of illness or accidents and arrange for their proper cremation.

According to the users, big time drug dealers are so powerful that they harass or kill police officials and journalists who come in their way. One journalist, they say, who wrote strongly against drug peddling, was thrashed by thugs and then, thrown on the railway tracks in an unconscious state. Later, the death of the journalist was reported as an accident. Again, we have no documentary or even circumstantial evidence to verify the veracity of these statements of our respondents.

Despite their involvement in various antisocial activities, peddlers do not find it difficult to arrange suitable marriages for their children. In one case, even though the daughter of a peddler was arrested for dealing in drugs, the father was able to find a person from a good family for her to marry. They say there are many occasions in which peddlers are set free after being detained for three years. A user who was also a peddler said he had made about six lakhs (Rs.6,00,000) through his business, but had to spend all the money when he was arrested in order to avoid

imprisonment.

At times a peddler, whose business has been disturbed, only changes his mode of activity. Instead of selling *pudis*, he begins to sell in grams or kilos. This makes the transaction very smooth. He gets customers who come from Pune and other places to buy his stuff. This also helps business people to maintain their status in society and obtain more profit. The peddler's house is used for business transactions. After some trouble from the police, some of the peddlers, for whom it is a family business, just break up and choose different locations for their business. There are also those who shift to the deep suburbs and other parts of Maharashtra for their business. This might explain the fact that during difficult times some users go to Ambarnath to get their drug.

Unlike other instances in day-to-day existence, where the rights of clients are respected here there is not even a pretension of this. Of course, it depends entirely on the client's financial resources. If the amount transacted is large, then the relationship is as smooth as it is indifferent. If the user has totally run out of resources, then he asks the peddler for some stuff only if he cannot obtain it from his user friends immediately. According to one user, he was suffering withdrawal symptoms when he went and requested a female peddler to give him some stuff but she refused and chased him away. He was very upset, as he had helped this lady initially in her business. He said he had been reluctant to ask her, but his physical condition forced him to approach her. Usually he had friends who share their drugs with him, as he also gave them brown sugar. An older person, was chased away by the peddler with a string of bad words, as he had only Rs.8.40 instead of Rs.10 for a *pudi*. At times, the users come and accuse the peddler of peddling substandard or bad stuff and praise the competitor's drug.

The relationship of the peddler and user can shift once the down-and-out user agrees to assist the peddler in marketing his

goods. In the case of Arti mentioned earlier, a female user, whose husband disappeared and she was unable to trace his whereabouts. After her husband deserted her she used to help in the housework of the peddler and in return got a meal a day and two *pudis*. The peddler harassed her emotionally whenever he felt like it. She also purchased drinks for the peddler. Despite all the accusations she had made against the peddler, in the end she was willing to forget everything and become his assistant. This sudden change might be very difficult for a normal person to accept even at a superficial level. As Arti put it: "It is on his *daya* that I survive now."

One hardly ever hears of a peddler encouraging a user to undergo treatment. He only says: "These people will never improve, and it is a waste of time to take them for treatment." According to users, when one comes back from the detoxification centre, the peddlers who would refuse to give them any stuff earlier, would change their stand and offer to give them drugs free of charge. Given below is case study which shows the difference between the community's relationship with a user on the one hand, and a peddler on the other.

Case 4.17

Shahul Hamid lives with his wife, three children, his mother-in-law and brother-in-law. He started taking brown sugar from his mid-twenties, prior to which he used to be a petty peddler. He had earned a lot of money and was respected till he started excessive use of drugs. At present, he works as an assistant for peddlers, especially to warn them about any disturbance from officials.

He has lost interest in food and is bothered only about his daily consumption. He went home every night, until he had a fight with his wife and decided to live on the streets. He is particular about remaining clean and wearing good clothes, as he

wants to be respected by the community and not treated like the normal street user.

Since he is a Muslim, he celebrates only Muslim festivals, and during those days he washes himself and wears new clothes. But even on non-festival days he takes care to keep himself clean.

Survival Slang

Users try to adapt to their environment by evolving slang that can camouflage their topic of interest. Often while upper class habitues use words like "gun" for *chillum*, poor users try to use common words for most illicit items. For example *vattana* (peas) for Nitravet tablets, *goda* (horse) for pistol, etc. An interesting episode occurred in our treatment centre. One night a user went and made a complaint to the nurse: "You are giving everyone *vattana* (tablets). Why aren't you giving some to me as well?" The confused sister could not understand why the patient was accusing her of distributing *vattana* (peas), which she never did. Totally harassed by the incident, she contacted the person in charge and then it was explained to her that the patient was talking about Nitravet tablets.

Engaging in Petty Crime and Peddling

After beginning to use brown sugar many users found it difficult to sustain their habit and this led them to sell brown sugar or to assist in peddling the stuff or engaging in other anti-social activities. The relationship between drug use and antisocial activities is not inevitable nor is it static. It varies according to the person's life situation. Even in the case of the same individual, it is not permanent.

Being an assistant to a peddler is economically sound for the users. Some of the users stated that they got Re.1 per *pudi* as

commission and that helped their income to rise from Rs.150 to about Rs.800 per day. In the case of another user he got free *pudis* to smoke, a place to sleep and food. This person said he was part of the peddler's family; he did not feel like asking them for money as all his needs were met. In another instance, a person got Rs.20 and two *pudis* to smoke.

Case studies are presented below to illustrate the impact of drug use on the initiation of antisocial activities.

Case 4.18

Arvind, who is in his late twenties, lost his father in his teens. He discontinued his studies in order to take care of his mother and two siblings. Close to their residence in Bombay, he started work as a cleaner for trucks. He earns Rs.600 per month out of which he keeps Rs.100 for himself and gives the rest for household expenses.

Arvind was introduced to brown sugar accidentally when his friend mixed white powder along with the *charas* they smoked. He enjoyed the high, but suffered severe bodyache the next day. He tried in vain to deal with the pain by consuming triple the quantity of his usual intake of *charas*. His friend came over to his place and told him to consume the white powder along with *charas* and he has continued to do so ever since.

With time, he shifted to chasing brown sugar as it gave a better high. Drug use made it difficult for him to continue his regular routine at work and so he shifted to theft. He stole oil from empty trucks that came for refilling their load. He managed to get ten to twenty litres of oil per truck and he sold the oil at Rs.1 per litre. At other times, he stole gas cylinders, metal valves and any other item he managed to lay his hands on.

He was arrested for the sale of stolen goods and was put in jail for six months. He often managed to escape the law by his

presence of mind. For example, once the police chased him and his friend when they were carrying stolen goods. The police, who saw only Arvind arrested him along with the goods. Later, in the court Arvind pointed out that he was not involved in the incident as the goods were too heavy for him to carry alone. The magistrate verified the fact, found his argument to be true and set him free.

He was never caught while chasing. Even if the police saw him chasing they would turn the other way and ignore him. They are scared of the effects of brown sugar withdrawal and knew they might have to provide the drug inside the lock-up. Many times when he was in the lock-up, the police provided him with brown sugar to overcome his withdrawal symptoms. He used to refuse to tell the whole story unless they gave him the drug. So in order to build up a proper case against him and procure a confession, the police would give him brown sugar. He would never give all the details at once, but spin it out over a period of days in order to ensure his supply of brown sugar. The police never beat him unnecessarily, he says, they did so only when they felt that he was not cooperating with them and was withholding information.

Later, the company posted uniformed guards armed with machine guns around the premises so he could not break in. Since then he has relied on oil tankers to make enough money to buy brown sugar.

He left his job as a cleaner and started stealing in order to maintain his habit and to support his family.

Case 4.19

John lives with his parents and two siblings, one of whom is married. He discontinued school at the secondary level because his father gave in the application after the last date of submission. Since then he began to work at a bag manufacturing unit.

John comes from a very religious family, belonging to the Pentecostal denomination of Christians. He went regularly to church prior to starting work, after that he gradually stopped going to church. At his workplace he began to interact with a group of friends who dealt with brown sugar and he helped them to make *pudis* as well. In the course of time, he began to use brown sugar and when his drug expenditure increased, he stopped giving money for household expenses.

John felt he could not serve two masters at the same time. As he was involved with drugs, he could not be a follower Christ. Though he does not go to church, he believes that God can make anything possible and the reason he cannot give up drugs is because he does not have adequate faith. His parents live in the hope that he will give up drugs one day.

As his drug consumption increased his work got affected and he took frequent breaks away from work. In the end he left his job at the bag manufacturing shop. He became an apprentice in a watch repair shop for a year. Here, in addition to his daily wages he could pawn the watches whenever he was in need of money for drugs.

It was his involvement in the sale of brown sugar that initiated him into drug use. Later he took up a job but found it difficult to keep it. His new job of repairing watches helped him.

Case 4.20

Haseena Bi lives on the streets with her second husband and youngest daughter. She also has two daughters from her first marriage, of whom one was married and the other worked as a prostitute.

Her first husband was a smuggler and gave her all the luxuries money could buy. But he was a womaniser and did not

think twice about bringing his partner home. Haseena had to stay in the balcony, while her husband shared the bed with someone else. In order to deal with the situation, she began to take alcohol. Later, her husband died from tuberculosis, but others claim that the police killed him.

Her second husband was younger to her by many years and his family was against their marriage. She and her husband worked at a factory that made pins and each of them earned Rs.20-30 per day. Her husband earned more but he spent all his money on drugs. Prior to drug consumption, he had helped Hassena arrange for her first daughter's wedding. After the marriage, the daughter had problems with her in-laws and was found dead with burn injuries.

Her second husband exposed her to drugs. She always pestered him to give up drugs. She fell ill with typhoid and also had menstrual pains at that time her husband asked her to take brown sugar to deal with pain. Since then, she became addicted to drugs. In the end both of them sold their house and household possessions for drugs and reached the streets. For survival, they began to steal from the *Godi*.

When Haseena came for treatment she was suffering from severe liver infection and was hospitalised at NARC. She returned to her earlier environment and relapsed. The doctors had warned her that the chances of survival were slim if she took drugs again.

She survived for a few months. During that period her daughter took care of their expenses and her drug needs. At that time her husband who had been detoxified went to his hometown and before leaving he asked them to go with him but they declined his invitation. He tried his best to persuade his daughter for he knew his wife would not come because of her drug needs, but neither mother nor daughter could deal with the separation.

Unable to sustain her habit through antisocial activities, due to her ill health, she trained her child to steal. After her death, this child had many adults interested in adopting her, as she was good at her job. Her father was unable to remove her from her social network to become independent.

Conclusion

The relationship between drug use and marginalisation can be seen in two types of population—those who are already marginalised prior to use and those who become marginalised through their habit. In the case of the former, drugs can play a role in helping the victim of marginalisation to survive, whether by selling the drug or by consuming it. Drug use can embolden them to steal heavy metal and also to bear a thrashing, if caught.

Such individuals may have already been involved in antisocial activities and drug use may just underline their deviation from society. At times, drug usage can lead to alienation even from a circle that engages in antisocial activities as a means of survival. Thus, a peddler who gets into the habit of uncontrolled drug use may become alienated from a family which had depended on him earlier and thus, he becomes a street-user with no support. These users find it very difficult to enlist support, even from people accustomed to dealing with the drug-using population. This can be illustrated through an event that happened in our treatment centre. A peddler's wife brought in a colleague in a medically critical condition. This person, Salim, was kept at the centre for one day but then his condition worsened, he was shifted to a private nursing home. After this incident, the users in the centre expressed strong feelings against Salim. Apparently Salim used to chase them away if they offered even 50 paise. less than the actual price for one *pudi* of brown sugar.

When drug use has an adverse effect on most areas of an individual's life, he is far more alienated than functional users or convergers. When a person becomes marginalised because of his habit, he will try either to reduce the marginality or to adapt to his new social environment. The latter course may include becoming an assistant to a peddler or an errand-person for a group of users, in return for his daily quota of drugs. For a person who is alienated from his family and other non-users, and at the same time entrenched in his interaction with users and others in the drug circle, he will find it difficult to establish an alternative network even if he becomes drug-free. If someone who has adapted to an alternative network receives detoxification and returns to the old environment, unless his decision to give up or control his consumption of drugs is strongly motivated, he will relapse back to drug consumption. Hence, when formulating programmes for relapse prevention, it is important to consider the extent of marginalisation and the individual's interaction with the alternative network.

Reducing Marginality

Like other marginalised groups, users will tend to try and reduce their alienation from society. Not all users will do so, however, there are users who do not accept institutional support even though they have been using drugs for years, and their lifestyles has been totally affected by drugs. Some of the users in our study had been consuming drugs since the eighties, and some of them also suffered from medical complications. These users had never sought any detoxification facility unless they were in a state of medical crisis. Otherwise they had kept the admission forms we had given them in their plastic covers along with their drug paraphernalia and took great pride in showing them to us every time we met them. The worst aspect of this is that, since they were able to ignore their physical problems with brown sugar, their decision to seek treatment would often come too late. A few of them died on the streets crying for

help but it was too late.

Often, users do not get support from anyone else in their locality even in an emergency. Most users express a desire to give up drugs immediately or at some time in the future. Others decide not to try to give up drugs until they are sure that they will not want to return to drugs afterwards. The expression of a desire to give up can either be an articulation of their own genuine wish or to appease society and show that the goals of the 'centre' are not disputed. The decision to give up drugs and look for alternatives is far easier for those who have some sort of support system. This does not refute the fact that some street users who have hardly any support structure have nevertheless given up drugs on their own.

This study has looked into users' motives in seeking change, and the methods they have adopted to bring about this change. The latter were termed the "coping strategies" of the users in dealing with their marginal position. Coping strategies were divided into two broad types:

- individually based interventions
- institutional interventions

The hope for change is also reflected in attempts made by users to hide their habit from others or to curtail the impact of drugs or their habit from others or to curtail the impact of drugs on their lives, or to seek the support of programmes that give them a place in society. At times they do this at the cost of their individuality.

Circumstances for Seeking a Change

The circumstances for seeking a change can be brought about by the extent of marginalisation, which in turn affects the user's health and capacity to earn money for the next dose. This is reflected in the kind of help the user seeks. In the case of medical

complications, an institutional setting is the natural preference.

This is the main reason for seeking change among street users who have no support system. Other factors that motivate users to seek change are the impact of drug use on their relationships and work and their hope for a better future. Another reason could be boredom.

Relationships

Relationships have an important bearing on whether people give up drugs, or relapse after treatment or self-management. In the case of Hussain Hasan, who tried to give up his drugs only once on his own, it was his children who mattered most. In 1990 he went to his in-laws' place in Pune where, even though drugs were available, he kept away from them for two and a half months.

During this period he used to drink alcohol. He said that while he was free of drugs physically, he was attracted to them mentally. He stayed away from drugs only because his children were with him. Later, he quarrelled and fought with his wife, and that caused him to relapse.

In another case, Varma had been admitted to various centres for detoxification. He had always picked a fight and walked away, because he did not actually want to give up drugs. A few months ago, he came again to our centre. He had decided to give up the habit because his wife was six months pregnant. A Muslim *mausi*, who is a close family friend, kept telling him how the children of alcoholics say, "My father did nothing for me; he only blew his money on drinks." This disturbed him, and he decided to give up drugs, because he did not want his child to say later, "My father was a *gardulla* who never did anything for me." However, after a few months Varma relapsed.

Hope for a Better Future

Vinod has been taking drugs for the past eight years. Eight months ago he tried to give up drugs. He did not consume any drugs for a week when he was working as a watchman in a factory. He had decided to give up drugs because his elder brother had promised him a job at a salary of Rs.900.

He went to work and though he did experience problems due to withdrawal symptoms, he managed to tolerate them. After being marginalised, users often end up with a number of problems besides addiction resulting from their involvement in petty crime. These acts also marginalise them from their immediate support structure. In a drug-free state these hurdles (which could include financial problems, physical weakness and alienation from society) have to be tackled. When someone feels confident that he can make a fresh start, he might decide to deal with his drug problem. The user will need support not only at this stage but also when he begins to renew his interaction with society.

For Health Reasons

Drug use at one level can be seen as destructive behaviour; users often speak casually of dying. They are aware that many users have died in the streets through drug use, or complication arising from it. This may not have made them give up drugs, but when they themselves fall sick they are very vocal about the need for change.

There are users who have destroyed their health completely because hospitals have refused them admission under one pretext or another. They meet their end in the streets of Bombay. In one case, a person had a large abscess on his leg, on which he had tied a piece of cloth in order to save himself from the street dogs.

Some users, aware of these attitudes never even bother to approach a treatment centre. After their deaths, the bodies of these people lie on the sidewalks for a day or two before they are taken away. A social worker who works with street kids has in the last six months arranged for the burial of some kids who died of road accidents, cerebral malaria, tuberculosis, etc.

The naked bodies are thrown any how on the firewood pile. Bodies lie criss-cross. Protruding hands and legs are hammered with fire wood. To ensure even a modicum of dignity, he has to part with Rs.800 (give Rs.100 to Rs.200 to each person there) so that they allow him and the street kids to lay out the body of their colleague, put a clean sheet on him, do some *puja* and place the body on the pyre. Getting the body of a street kid who may have died on the road or in a hospital for burial/cremation itself can be a nightmarish experience and costs a lot of money.

Users who have witnessed these events feel very disturbed, and often decide to seek treatment. In the Indian setting, death is often associated with various rites, and few people can actually accept the idea that after death nothing matters. This feeling can be an occasion for bringing about a change in people's lives. In this context, as already mentioned, one peddler who learnt of the deaths of some of the users whom he knew, would go to the general mortuary and make arrangements for their proper cremation.

Another expression of this dilemma is when one user advises another to seek treatment, but does not volunteer for it himself. There are users who bring friends who are very ill for treatment, but will tell the professionals that they themselves have not decided whether they want to give up drugs.

Case 4.21

Rajan's case has been described in detail earlier. He began to

long for home, when he saw the dead body of David lying on the streets unattended too.

It disturbed him and he was very ill, so he decided to seek a change. Even when he did not have money the peddlers in his area were willing to give him drugs free, as he was their regular customer. Later, he was very sick and sought treatment in two government hospitals but was thrown out. The research team found him lying alongside a railway track and he was treated in NARC.

Coping Strategies

Here, coping strategies are examined as skills that the user develops in order to sustain an existence that does not totally shatter his own perception of himself. Many users on the street learn skills that will help them to become functional. This is an important area for further inquiry in the field of addiction since institutional care cannot be sustained as a means of controlling drug abuse and its eradication is a distant dream.

In the twenty cases where attempts to control drug abuse were documented, all the users had attempted in various ways, either through individual efforts or through institutional support, to give up drugs. Change can also occur through forced detoxification, that is, treatment imposed without the individual's consent as in the jails.

Given that the users wanted to change their lifestyles, an attempt was made to look at the duration of their use of drugs, change in occupation and family relationships, the presence of medical complications, the availability of drugs, their quantity of consumption, the period for which they had stayed clean, their reason for desiring a change, and the help received in the process.

Self-based Efforts

(a) *Seeking alternatives*: Many users seek alternative ways of altering their mind in order to give up brown sugar. They opt for other drugs such as alcohol, *ganja* and *charas*. The community is not averse to such substitutions. Users state that often those who are close to them in the community request them to shift to these drugs, instead of continuing to take brown sugar.

(b) *Change of Place*: Another means of dealing with one's addiction is to leave Bombay and go to distant native places in the interior where brown sugar is not available. This method has been used by many. While not all of them have managed to stay clean through this process, some do. If it were possible to document the process systematically, one could enable people to deal with their problems outside the treatment centre. However, the infrastructure is insufficient to deal with the number of addicts in Bombay.

Institutional Support

Seeking medical help whether in nursing homes, hospitals or de-addiction centres, is a prominent means of dealing with addiction. Depending on the structure from which they seek support, the facilities and time available for making the change will vary. Users who seek certain programmes will also learn to integrate the philosophies of the specific approaches concerned and make changes not only in the area of drugs but also in their general outlook on life.

Case 4.22

Ahmed lives with his mother and five siblings. Prior to excessive drug use, he worked in a laundry shop, but later shifted to ragpicking to sustain himself. He had relationships with a few

women and drug use did not hamper his sexual life.

He was using brown sugar for a decade, prior to which he smoked *charas*. Earlier, he had brown sugar in the *chillum* and then shifted to chasing. Subsequently, he took alcohol along with brown sugar. Twice he tried to keep away from drugs. Once he went to his village with the intention of never returning to Bombay, but was back after four months. While in the village he dealt with withdrawals by consuming *ganja*, alcohol and having frequent baths. He came back to Bombay with the intention of going abroad, but at that time the war broke out in Iraq and this put an end to his plans for change. Disappointed, he went back to drugs. The second time he got detoxified at NARC, he went to his native place for two weeks. Back in Bombay he started using drugs because of friction at home, and fight with his brother.

He was able to give up drugs on his own, though only for a short time by substituting drugs with frequent baths. He remained drug-free on this occasion for a longer period than when he had medical detoxification. On both occasions, personal trauma made him start consuming brown sugar once again.

Case 4.23

Prakash's case has been dealt with earlier in this chapter. He had made frequent attempts to give up drugs, but relapsed back after twenty or thirty days. He made fifteen attempts by going to his native place. To deal with withdrawal he took alcohol and sudinol. The moment he returned to Bombay, he went back to drugs.

Case 4.24

Nitin's family consists of his parents and two siblings, both of

whom are employed. Prior to drug use, Nitin had a secure job as a waiter, but later he worked on casual basis for a lower payment. He began taking *charas* and *ganja* as an adolescent and shifted to brown sugar in his mid-twenties. Later, he began to take liquor as well.

He tried to give up drugs on his own on three occasions, but failed each time. Five years ago he went to stay with his uncle in Gujarat to give up drugs. As he could not procure either drugs nor medicines, he had to suffer withdrawals. He stayed there for six months, before returning to Bombay because of ill health. On reaching Bombay, he immediately went back to drugs for seven to eight months.

On the second occasion he was sent to Arthur Jail for a year for theft. During that period, he was unable to take any drugs and had severe withdrawal symptoms such as loose motions, pain in the joints and bodyache. Immediately after being released from jail, he consumed brown sugar.

The last time, he went again to Gujarat for being drug-free. He took ten *pudis* with him, which he smoked on his journey. He was in Gujarat for eight months without drugs. He was able to deal with his withdrawals as it was winter. After eight months, he returned to Bombay and started taking brown sugar again.

He managed to restrain himself from drug use on three occasions, twice out of choice and once because of situational reasons beyond his control. His return to Bombay caused him to start taking brown sugar again.

Case 4.25

Ramesh, a teenager, came to Bombay in his adolescence and lives on the streets of the city. His family lives in Nagpur. He started using brown sugar and made four attempts to become

drug-free. Once he went to Nagpur to be drug-free, only to find drug outlets there. Then he went to Ahmedabad with his friend to give up drugs. They managed to stay there for three days, after which they came back to Bombay because of withdrawal pain. He tried to give up drugs but failed each time as he could not deal with withdrawals.

Case 4.26

Kishore worked in the naval dockyard before becoming a rag picker. His family consists of his parents, four brothers and a sister.

He began using brown sugar in his early twenties and often tried to become drug-free. His main method was to leave Bombay and stay in his native place. To deal with withdrawals he took *ganja* and a large quantity of alcohol. He managed to be drug-free for a year, but relapsed on his return to Bombay. On the first day itself he took fifteen to twenty *pudis* along with tablets. After a few months of stay in Bombay, he again went back again to his native place and became drug-free. Again on his return, he started to use drugs and decided to seek medical attention.

Case 4.27

Navaz became a beggar because of drug use, prior to which he was a vegetable vendor. His family consists of two brothers and two sisters. All of them were married, but Navaz's wife left him because of addiction.

He took drugs for seven to eight years and made frequent attempts to be drug-free. He went to his native place and consumed alcohol to deal with withdrawals and became drug-free for two years. As his relatives brewed alcohol it was easily available to him. On his return to Bombay, he consumed brown sugar.

His voluntary break from brown sugar was facilitated by consumption of alcohol and relocation in a distant region away from Bombay. When he returned to the city he went back to drugs.

Case 4.28

Chavan lives alone in Bombay, while his wife, two daughters and two sons live with his brother and mother in Uttar Pradesh.

Chavan has been taking drugs for over a decade and attempted to give up drugs. A doctor at his workplace referred him to a hospital for treatment. On the third attempt unable to deal with the withdrawals, he went out and purchased the drug and consumed it inside the hospital. Though he had been admitted to a hospital, he manipulated the situation to satisfy his urge for drugs. As the quantity of consumption increased, he again tried to give up drugs by going to his native place. He stayed there for a month and took *ganja* to deal with withdrawals. On his return to Bombay he went back to drugs.

In this case his withdrawal was brief and his voluntary decision to stay away from brown sugar was facilitated by the use of cannabis. On return from his native place to Bombay, he relapsed.

Case 4.29

Arvind made many unsuccessful attempts to give up drugs. Once he was admitted to a government hospital for ten days, but on return he relapsed to drug use. The second time, the doctor he consulted asked him to reduce the consumption

gradually. On the third attempt, he was on IV fluid and given an injection, after which he became very violent and ran away from hospital. Later, he was admitted in NARC twice; after the first admission, he relapsed. He stated that the presence of others users made him relapse.

On the second occasion, he was taken to his sister's house and as he was not familiar with the place he remained clean for a few days. He found it difficult to sleep at night and took money from his sister to buy *ganja*. But the moment he laid hands on the money, his mind switched to brown sugar and he managed to procure it.

At last Arvind's brother-in-law gave him an ultimatum that he could stay with him only if he was clean. If he became drug-free, his brother-in-law promised to find him a job or to set up a business. Arvind did not want to become a street user and decided to give up drugs and got admitted for detoxification. His mother has decided to sell the house and purchase a place close to her daughter's house.

All Arvind's his efforts to give up drugs have led to immediate relapse. The presence of other users in his locality reinforced his urge to consume drugs. He tried to move to another locality to avoid this obstacle, but failed. It was family pressure and the threat of alienation that have made him seek treatment again.

Enforced Change

Another circumstance by which users get detoxified is non-availability of drugs. Users might end up in a lock-up for petty crime, or be hospitalised due to an accident or other medical reasons. Sometimes they are forcibly kept in hospital or at home by their families. Users state that when they are forced to stay clean, the only thought in their mind is to dream of their next chase.

While under treatment, a user can take advantage of medical help for withdrawal symptoms and other problems. That is not the case for those who are in jail except in Manipur and Delhi. In the case of Rajan, he was detoxified in jail by the police. He was dipped in water for hours, or tied to the cot and given minimum painkillers.

Dinesh tried to give up drugs on two occasions. On the first occasion, he was detoxified while undergoing treatment for an accident, and on the second, he was admitted to NARC. He had an accident while dealing with goods train coaches at a port in Bombay. His job was to make sure that the connection between the coaches were securely fitted, but this time for some reason, the connecting links broke off and the coach hit him. After being admitted to hospital, Dinesh told the doctor about his drug consumption and asked for medical help for detoxification as well. On both occasions, it was family problems that made him go back to drugs.

Self-Help Groups

There are users who successfully complete long-term programmes as ex-addicts, but identify themselves only along the lines as prescribed by the group. These people remind themselves daily about their addiction, even though they are no longer addicted. They end up becoming addicted to the idea of being an "ex-addict". They have a tendency to strip themselves naked in front of others and dwell on their negative aspects time and again. This can be a problem as usually one expresses one's problems either to people who are close, or to a religious person or to therapists. Such relationships have certain mechanisms, whether at the professional or emotional level, that safeguard the person from abuse of his rights. This is not the case when one discloses one's problems in a group. The dynamics of this procedure are further disturbed when the group is an open one. In addition to all this, there is also the stigma associated with being an addict.

Often, when a member begins to associate with these groups, there is a tendency for older members of the group, subtly or otherwise, to "take charge" of a new member. In the guise of preventing relapse, they can invade his privacy, and as they are the only visible support, he cannot protest. Assertion of his individuality can be regarded by others as being "troublesome" or hassling those who care for him. Thus, the group slowly stifles the individual, and at one level destroys any chance of his being integrated back into the system. Unlike the hippie movement, leading to the formation of a cult, this process makes one feel indebted for life to a movement, outside of which its members feel that they cannot exist. This approach will be unacceptable to street persons, who are unwilling to give up their freedom. These aspects have to be considered, and self-help groups with different dynamics should be evolved. This may be useful in the process of social integration.

Conclusion

The circumstances for seeking change depend on the adverse impact of drugs on the individual's life, and degree of hope for the future. Even those who are in an extremely marginalised position will often wish for social acceptance and becoming good. At times, they express the attitudes of the community, especially when asked why they do not protest about society's reaction to them. They do not expect others to go to their place of consumption and sit and chat with them. This feeling was expressed by a nine-year-old whose mother is an addict and whose father is in jail for petty crime. "*Didi*, what is a person from a good family doing here in this filth?" The separatists absorb the attitudes of the community towards their dirty habits and petty crime.

Any marginalised population has certain links with the cen-

tre which can be strengthened. Identification of these links can help to reduce sense of alienation it can be a major factor in relapse prevention. Analysis of these aspects will also enable us to develop new approaches or modify existing ones so that the option is not limited to being an addict to drugs or to the idea of being an ex-user. This can also reduce the demand made on the treatment centre for intervention. These case studies illustrate the role of the family in reducing marginality and initiating steps towards drug-free status or functional use.

While users may fail in their attempt to be free of drugs, recent studies have shown short term treatment/drug-free status is as useful as long-term residential care. Under these circumstances it is necessary to strengthen indigenous efforts, which may include substitution with traditional drugs, an association with frequent baths with the reduction of withdrawal pains, and the mitigation of associational cues for drug use. Besides, the absence of a support structure and a network with members of the same age group who are non-users can motivate a drug-free ex-user to seek the company of users, and start consuming drugs again. The person's association with users can be interpreted as a sign of relapse by his family and community members, in spite of his denials. This may in turn alienate him from others and strengthen his interaction with users. It is here that marginalisation leads to maintenance of the habit it is intended to stop.

Attempts to gain social acceptance can be made either before a condition of extreme marginalisation has been reached or after. The user may decide to change because of the impending adverse effects of continued drug use on his family and personal relationship, or on his livelihood, or to avoid the tendency to get involved in antisocial activities to sustain the habit. If the person has never before been involved in such antisocial activities, then the chances of his getting caught are high, if he starts such activities in a desperate desire to avoid withdrawal pains.

Sheikh, a *zari* worker, had never been involved in antisocial

activities, he always obtained an income from his occupation or his immediate family members. Alienated by his family, he tried stealing clothes from the neighbourhood. He was caught red handed and thrashed by the owners. According to another user, the marks from chasing brown sugar on the thumb and first finger are cues for non-users to identify drug users, and conclude that any goods they are selling must be stolen.

In the case of conscious 'separatists', it is often the need to get medical help that plays a major role in their desire to change. Incidents such as dog bites and high fever or onset of tuberculosis can motivate them to seek help. Another trigger for seeking help is the sight of other users dying or of the contempt shown to dead bodies of drug addicts. This may motivate them to give up drugs and start a new life.

A 'separatist' may seek medical help after a long period of illness. Thus, it may be difficult for him to regain his earlier health. In such instances, if he does not have any support or institutional care, he may return to drugs to continue his work and live on his own. This may not happen in the case of skilled users. The outcome of such steps depends on their support system, the impact of marginalisation in their outlook, the skills available to them for making a livelihood and their hope for the future.

Though marginalised populations exist at a distance from the centre, they are still very much a part or of it. There are distinct contrasts between them but there are certain concepts of values and power that are shared. The chances of users overcoming the differences can be determined to some extent by studying the level to which the user has retained any shared values with the centre. Analysis of these aspects can be useful in formulating intervention programmes.

Re-establishing Relationships with Society

The goal of re-establishing relationships with society can arise at

different levels of marginalisation. As seen earlier, it is the individual's immediate environment and his perception of the future that motivate and sustain the process. At times the process can be dramatic, as when a 'separatist' changes his lifestyle and conforms to society's norms once again.

The following case study is used to illustrate the movement of a 'separatist' to the centre after a single medical detoxification. On an earlier occasion, he had given up drugs on his own by going home to his native place.

Zakir, aged 30, is a native of Uttar Pradesh. His father is still in Uttar Pradesh but his mother died years ago from tuberculosis. He came to Bombay because he had committed a petty crime in his native place. After he came to Bombay, he was working in a company that makes clips to fix into plastic ropes. He used to make Rs.80 per day. He met his wife (Hassena Bi) there. (The case of Hassena Bi has been mentioned earlier).

Zakir said his family was not happy about his involvement with this lady, as she was at least ten years older than him. His family told him that it would have been more appropriate to get involved with her daughter. Against his parents' wishes he decided to go ahead with the marriage. His wife had previously been married to a smuggler. This person died of tuberculosis. His wife had two daughters from her previous marriage and one through him. Zakir took care of his wife's other children.

He got involved with drugs in 1983, when he was working as a cleaner of trucks. During the riots in Punjab he was employed in a lorry driven by a *sardarji* (Sikh). There was widespread violence against Sikhs in certain parts of India. Feeling under threat, the driver discontinued the tour and asked him find his own way home.

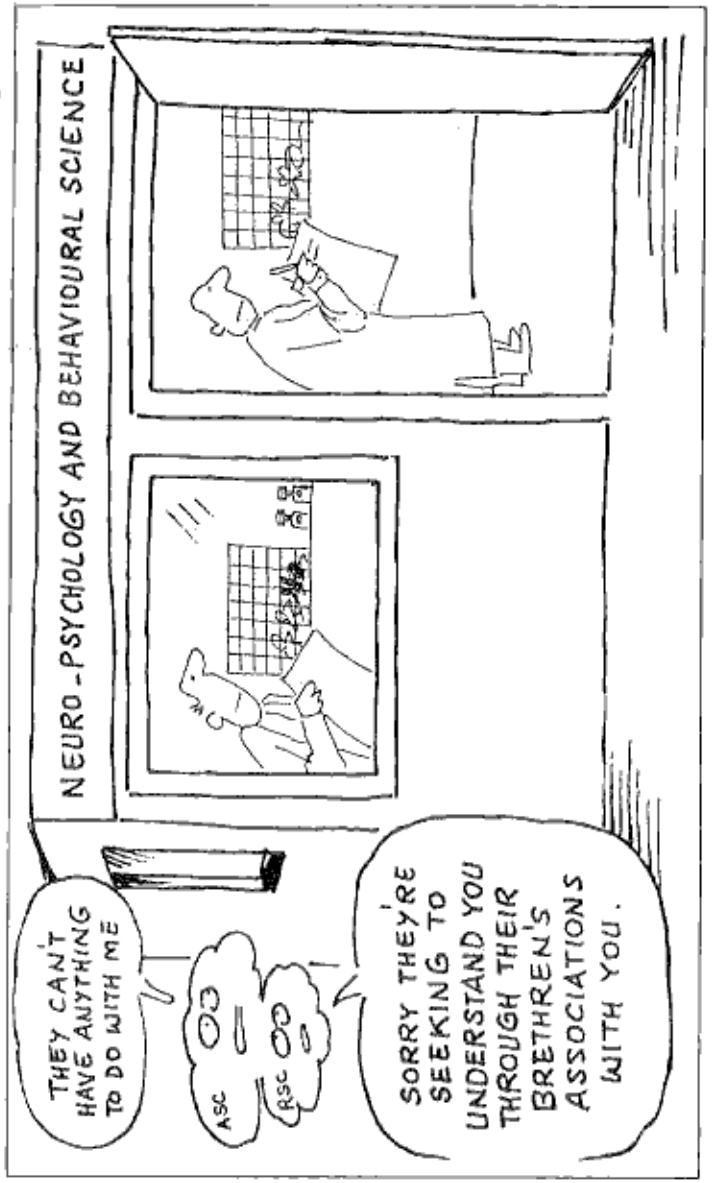
At that period, out of fear of police brutality, local people met at a particular place, and there he started smoking brown sugar. Previously, he had only smoked tobacco. His friend of-

fered him a *barela* cigarette (mixed with brown sugar) to relieve tension, after which he vomited and felt very sick. He continued taking these cigarettes from his friend. Later on, he experienced withdrawal symptoms and when he approached his friend for another cigarette he was shown how to chase brown sugar. The drug subsequently destroyed him and his whole family. He began to sell everything that he had, including his wife's house and her jewellery, for the drug. On one occasion, he gave the drug to his wife to relieve her of pain during menstruation. His brothers had wanted to put up a cigarette shop for him, but gave up the idea once he was addicted.

Later on, his brothers began to chase him away. The community had little respect for a drug addict and would spit on him. Because he did not get along with his brothers and had sold his house, he had to leave Govandi in Bombay. He and his family were forced to live on the streets. He began to steal from the *Godi* to maintain his habit.

He tried to give up drugs by going to a distant place along with his wife, but they could not manage there and came back to Bombay. On another occasion, he tried to give up drugs by moving to Uttar Pradesh. He managed to stay clean for three months. He used to take frequent baths in hot and cold water to deal with the 'cold turkey'. His father also arranged some medical help for him. After three months he wanted to see what was happening in Bombay to his wife and child. When he reached the city, he found that his wife was still chasing. When he met her he asked her why she had not given up drugs. She later invited him to take a line from her chaser, and he did.

His wife became very ill with liver problems and was hospitalised for a long period, but relapsed again. She continued her habit by forcing her daughter to steal from the *Godi*. When his wife was being treated, he too was detoxified, after which he stopped taking brown sugar, but used to go to the cabin every day to meet his wife and kid. He used cannabis for some time af-



ter detoxification, but gave it up as he felt it was causing him chest congestion. He took alcohol instead of brown sugar. After treatment he began to work in the *Godi* as a painter. Before he got the job, our treatment centre supported him whenever he came in by giving him a small weekly allowance and food. He was able to stay away from brown sugar on his own, but restarted his habit on returning to Bombay. Later, the personal trauma of watching his wife deteriorate in front of his eyes made him determined to give up brown sugar use. He succeeded, though his wife died and his child became estranged from him. At present he works as an assistant to a lorry driver and has been clean for over a year.

Conclusion

Change may be less pronounced where a 'separatist' becomes a 'converger', or a 'converger' or a 'quietist' becomes a non-user. All but the 'separatists' try to maintain their personal hygiene, health and family contacts.

The process of re-entry into society can be facilitated by reducing the impact of drugs on a person's lifestyle through controlled use. Awareness of the situational cues (that can lead to drug use) helps the person to make rational decisions and regain strength to deal with inner conflicts.

Discussing the process of marginalisation with the user can strengthen his/her analytical understanding of himself/herself, and thus make the user seek alternatives, when faced with the prospect of extreme marginalisation. It could also help the user to deal with drug use within the larger concept of ASC and marginalisation to understand the habit better, and enable the user to attain his/her goal, whether to be drug-free, functional or just be dysfunctional.

5

The World of the User

Contemporary drug policies marginalise the drug user because of his/her actions. Marginality in turn influences a drug user's life at numerous levels. (This was explained in the previous chapter). Apart from drug users, many groups are marginalised in society. Not all groups have the same relationship with society, the variation depending directly upon the extent and type of their deviation. Persons who are mentally ill, those suffering from Hansen's disease, (leprosy) AIDS patients, homosexuals and other groups interrelate differently with society. For any specific group, its marginalisation depends upon the culture and history of a given society. In any such group, there are also individual differences in the members' relationship to society.

Users are labelled as "addicts" by addiction professionals, in accordance with international definitions. While this universal definition might help us to understand the phenomenon of drug use, it obliterates those subtle differences that can play a major

role in the lives of individuals. To highlight these differences, Musgrove's classification is used to create a typology of the user and the emphasis here is on marginalisation.

Three studies conducted by Kaplan, Diaz and Merlo (1994) among cocaine users in Rotterdam, Barcelona and Turin, classified types of users through qualitative and quantitative data. The Barcelona and Rotterdam studies linked cocaine use to the broader concept of lifestyles (Diaz, 1993).

Based on a comparison between these studies, four types of cocaine lifestyles were defined: the leisure type, the instrumental type, the cocainist type and the poly-drug type.

(a) The Leisure Type

Cocaine plays a peripheral role in the lives of this type of users. The consumption of cocaine is linked with leisure activities. It is used in company with friends and not when the user is alone. The ambience of use can be described in terms of pleasure, affection, enjoyment and celebration. Usage outside the leisure context is valued negatively. The lifestyle of these users is integrated with society. Cocaine is used alongside with other drugs like alcohol and cannabis and compared with these drugs, cocaine is given minor importance. The only mode of consumption is sniffing. These users earn their money legally.

This group is further sub-divided into two types: one that uses the drug sporadically on special occasions such as Christmas, New Year's Eve, and the second group where use is more habitual and not limited to special occasions. There are periods when consumption increase, and the user faces minor problems. This is followed by a reduction in intake.

(b) The Instrumental Type

Among these users, cocaine plays a major role and is not limited

to leisure-type activities. It is used to gain benefits as in work or sexual relationship, and to emphasise social distinction from other groups. The location of use of is important, often being home or workplace. The users consume the drug with or without friends. The modes of consumption include sniffing and basing (cocaine is mixed with oil and heated to form a base, which is smoked). Injecting is ruled out.

These users experience physical, psychological and financial problems with drug use, immediately after which there is a reduction in the quantity used. They may also break away from friends who continue to use the drug. These people need help and do not know whom to turn to. The drug assistance centres are associated with junkies and are therefore out.

The lifestyle of these users is considered to be generally integrated with society but to a lesser degree than the leisure type user.

(c) The Cocainist Type

This user's lifestyle is centred around cocaine. They consume cocaine on a daily basis and in large quantities. Several routes of consumption occur, including sniffing and basing, though injecting is not rejected. The use of cocaine is linked to almost all aspects of their lives.

Its use is linked to all possible occasions and situations. The reasons for use are multiple including disrupted childhood and alcohol addiction. Use takes place in all possible locations, at home, in the workplace, in bars, and so on.

The pattern of use is dysfunctional, and often creates physical, psychological, social and financial problems. When these problems occur there is no decrease in use, and they are unable to reduce intake without help. Many of them have contacts with drug agencies or health services, which are often enforced by family, parents or police/justice authorities. State-supported

agencies for poly-drug users are avoided, as they do not want to be associated with junkies.

The income of the cocainst type of users often comes from illegal means and sometimes they get involved in criminal activities to obtain cocaine. The drug here has no social relevance, but is an addiction.

(d) The Poly-Drug Type

These users consume various drugs on a compulsive basis. Poly-drug consumption is the pivot of their daily lives. They consume drugs either with other poly-drug users or alone. The common location are their own homes, those of other poly-drug users, the street, or dealers' premises. They are part of the hard drug (heroin) culture. Their high consumption is due to the fact that they cannot do without it. The common methods of consumption are basing, injecting and "chasing the dragon".

Their lifestyles cannot be considered as integrated with society. They often have no jobs and have an illegal source of income. Delinquency related to the use of drugs is more or less common among them. This group has been further divided into two, depending on the role of cocaine in their lives. In one group, cocaine plays only a minor role with heroin or methadone being the central substance consumed. They use cocaine whenever they can, and do not go into criminal activities to obtain cocaine. In the second group, heroin and other drugs are also used, they are of secondary importance. They have more severe problems with regard to cocaine use and consider cocaine to be worse than heroin. This category would be called 'separatists' in our typology.

Types of Marginalised Groups

The areas we chose for differentiation were: the impact of drug use on working life, health, hygiene, relationships with family and community, drug use in public, continuous and excessive use of drugs, involvement in petty crime to obtain the drug and adherence to society's definition of an "addict". The impact of drugs on the lifestyle of the user determined the extent to which he/she could be integrated into the system.

Musgrove (1977) describes four different types of marginalised groups: the convergers, the quietists, the separatists and the utopians. Convergers are who "play down, hide or deny any real difference between their position and the centre". Quietists accept the definition of deviation given by society. Separatists assert their distinctiveness from others in terms of their values and lifestyles. Utopians emphasise their difference from normal society. Standing outside society, they express their desire to change the values and consciousness within society.

In the past, all users were categorised as deviant or diseased people incapable of being functional. However, recent studies have questioned the concept of a drug abuser as a "never-do-well" fellow incapable of coping with the real world. Others have focused on occasional, casual, experimental or controlled users as differing from the classical definition of a "drug addict" (Kaplan et al, 1994).

The accepted definition of a drug addict may not be applicable to all users. Despite the extent of its deviation, the drug habit does not necessarily obliterate the individuality of the person or the distinctive character of his/her immediate social environment.

According to Musgrove (1977), not all marginalised persons are necessarily at the same level of interaction with the system. Musgrove's classification of marginalised population provides the basis for understanding the levels of interaction which users of synthetic drugs have with the system. This understanding is an important prerequisite for enabling change in the user's life;

hence it is of fundamental importance for addiction professionals and policy makers.

Convergers

Convergers deny any difference between their position and society. When behaviour or thought is labelled as deviant, the converger will try to hide it from others, or at least limit the number of people knowing about it.

They try to merge with society and disclose their drug habit only to those who can help them hide their deviation. They do not identify themselves with visible or street users who make their presence very conspicuous. They refer to street users as *avara log* (loafers). It is very difficult to find convergers chasing drugs where the public can identify them. They go to remote places to buy their drugs convergers use drugs in the privacy of their homes. As long as they are responsible towards their families, their partners may not protest, even though they may lack the resources to buy drugs on a regular basis. They try to avoid continuous and excessive use of drugs, and thus maintain a semblance of balance in their lives.

There are various mechanisms that convergers develop to retain their role in society. Those coming from the upper classes have certain advantages. We observed a few coming in their cars; having established their first contact, they roll down their car windows for the peddler's assistants to bring them their regular quota of drugs. Another means of hiding is to use tinted car windows.

Some of them have assistants who will buy drugs for them in return for a certain amount of brown sugar. These assistants do this errand for more than one person and in the process attain sufficient quantity of drugs for their own use. There are cases of users having personal assistants who take care of drug related needs. These users also try to hide their habit by smoking the drug in cigarettes. This is a reliable strategy, since the fumes of brown sugar are odourless. The only setback of this method of consumption is that the quantity of drug required is large, and thus the habit becomes expensive.

In our field experience, we also saw two well-dressed individuals walking towards a bridge. The users sitting in the *adda* called them over where we were also present. Once they had come towards us, one of the users suggested they seek treatment from us. They looked totally blank and one of them asked what the treatment was for. The users explained that we were from a treatment centre for brown sugar addiction. Both of them got irritated, and said that they did not consume brown sugar and were simply being harassed. With this, they turned and walked away. The other users greeted them with cat calls saying "Don't you know anything about gard (brown sugar)? Who are you kidding?"

The problems faced by convergers is illustrated by a mechanic who boasted that as long as no one knew about his habit, his skills were appreciated by his boss and his customers. Only one of his friends was aware of his habit. One day this friend divulged his habit to the boss who made it a point to tell all his customers how a good mechanic had become a brown sugar addict. Customers who earlier gave him tips turned away saying, "If we give you money you will only throw it away." As he could not manage on his monthly salary, he left his job to became an assistant to a fruit seller.

Three case studies of convergers among brown sugar users in Bombay are as follows:

Case 5.1

Sitting on the metal chair at NARC detoxification centre, Ram Naresh, reflected on his nineteen years of existence. He had come to Bombay seven years ago, from his home town in Uttar

Pradesh in North India. After his parents expired, his family was limited to a married elder sister and a younger brother who worked in a *Bhangar* (dealing in scrap) shop.

On reaching Bombay, he slowly found his way to the Don Bosco Shelter Home for street children. Being inclined to mechanical work, he started working in a garage and was soon skilled enough to handle two and four wheelers. This institution offers residential facility for street kids. Here they have space to sleep, bathe and store their personal goods. There are no structured events, except for a monthly festival. But it is clearly laid down that no drugs may be consumed or stored on the premises. They have trained barefoot doctors (paramedics) from among the participants of the programme. Drug users, once identified, are asked to go in for treatment or to leave the premises.

After five years in Bombay, Ram Naresh longed to meet his brother and went to his hometown. There he stayed with his grandfather, who owned a sugarcane juice shop. Having met the family, he decided to return to Bombay. But on the day of his journey, a curfew was declared in his locality and he had to change his plans. So he stayed on and began working in a garage and he also helped his grandfather in his shop. He continued taking *charas* and also shared a bottle with his grandfather on certain days.

Ram Naresh was often drawn to the court complex nearby where many people got together after office hours, to smoke *charas* and *ganja*. He watched them daily, till he could not control his urge and decided to join them. He enjoyed smoking *charas* in the company of others.

One day, his usual request for a puff from a *chillum* was refused, for he was told that it contained brown sugar along with *charas*. Ram became insistent and persisted till the user gave in and shared his drug. After few puffs, Ram felt nauseated and

threw up. This did not deter Ram for he continued smoking, but on an empty stomach. Initially he continued to smoke brown sugar with *charas* in a *chillum*. Slowly he began to chase brown sugar and his daily quantity reached two *pudis*.

As his grandfather looked after the temple complex close by, they spent their nights there. Every morning he woke up at six, cleaned the shop and kept things in order. Then he went to the court complex to smoke brown sugar. He took special care to maintain his personal hygiene as he did not want his grandfather to notice anything amiss. Everyday, he had a bath in the morning and had a wash in the night. He had snacks whenever he was hungry for brown sugar destroyed his appetite.

During working hours, he never consumed more than one *pudi*, for he did not want to be negligent while at work. He consumed brown sugar when his boss left him in charge of the garage and in the evening while working at the juice shop. He was extremely careful about the quantity of consumption as had two minor mishaps earlier—once while taking a vehicle on a trial run and another time, while operating the juice maker.

Besides the money from his work, he managed to earn a little more from the juice shop. He charged some customers extra per glass of juice. He managed to get away with it as he was very selective in this and none complained.

After some days, he decided to come back to Bombay and went to stay at the Don Bosco Shelter Home. He continued to chase brown sugar at night for a few days. Till one day a young boy saw him and reported the incident to the priest in charge. The patient was directed to NARC for treatment.

This user took care to control his intake, to avoid the dysfunctionality resulting from high consumption. He was particular about his personal hygiene as he wanted to hide his habit from others.

Case 5.2

The grateful look in his friend's eyes on being offered a job in a cement manufacturing company made Sunil recollect his past. Though only in his early twenties, he had seen many setbacks in his life. His family came from Haryana and at present, they live in Malad. Since his father passed way, he lives with his mother and younger brother. His mother works in a hospital and earns around Rs. 850 per month.

He worked as a sweeper in a private agency. Every day before leaving for work, he chased brown sugar either at home or in the nearby public garden along with his friends. His association with brown sugar began in 1989 in the company of his friends. His daily consumption was three to four *pudis*. He did not feel that his habit hampered his work. One day, on his way to the office he experienced withdrawal symptoms and reported late for work. His boss got angry and they had an argument following which he walked out and never returned. For almost a year he continued to smoke brown sugar and did odd jobs to support his habit like cleaning the drains or clearing away mud. He also borrowed money from his mother.

He opted for detoxification in 1990 and stayed clean for almost three years. During this period, he was employed in a company which made cement blocks for buildings. Later, his mother arranged his marriage. In their community, marriages are arranged by the couple's parents, and the bride and bridegroom do not see each other until four days after the wedding. This relationship did not last, as his wife was unhappy with the marriage from the beginning. She deserted him and went back to her parents. When his wife's parents asked for a divorce, he asked them to repay the expenses he had incurred for the wedding, after which the divorce was arranged. Around this time, he started chasing again. When his habit began hampering his output, he decided to ask his friend to replace him at work.

Despite these stressful events and changes, he has continued to hide his habit from everyone except his family. He knows several non-users, but he has no deep or meaningful relationship with them. He relates to them, only when he has some work with them.

He is concerned about social discrimination so he has kept his habit a secret except for his family. He has changed occupation to cover up any dysfunctionality arising from drug use.

Case 5.3

As Nagesh took the loaded cart for his long trip for the day, his employer gave Rs. 20-30 for daily quota of drug. At twenty-eight, having discontinued his education in Standard VII, he made a living as a manual labourer. He lived with his family, his two brothers, a sister and mother, in the suburbs of Bombay. But he went home only twice or thrice a month, for he often stayed back in the city.

He was employed in the textile industry, but when it was reorganised he lost his job like many others. He became a handcart puller in Masjid. He and his colleagues load iron bars and sheets (*pathar*) and transport it 20 kilometres away. They earn around Rs. 100 per day. Their work begins after midnight to avoid the traffic. After consuming two *pudis* of brown sugar, he sets out with the other two workers to deliver the goods. They reach their destination around ten o'clock in the morning. For their return, they board lorries paying Rs. 25 for transporting their cart as well.

Sometimes they are dropped off on the way and return with their empty carts by about twelve noon. Besides this, he does loading and unloading work at Masjid market or occasionally does *wadi* (cleaning vessels and helping in cooking) work.

His meals often consist of *vada pav/maska pav* (bread and butter) and tea. Though he roams around on the street, he has a bath daily before retiring for the night.

He is functional and manages to control his consumption. His inability to undertake strenuous work without brown sugar is acceptable to his employer, who provides him with money for his morning fix. He is particular about personal hygiene.

Conclusion

In the Indian context, unlike in developed countries, the family is a strong support system within every community and people leave their family structures relatively very late in life. Even with those who start working early, there are strong familial ties. Some Western treatment models encourage families to break their relationship with users, on the assumption that only when the user is 'down and out', will he reformulate his life and proceed to become free of drugs. This is not the case in India except perhaps in the case of middle class or rich families who have slowly adopted this alien approach.

Avoidance of social alienation in spite of drug use has been possible with family support. Unlike street users, these users are able to maintain their personal hygiene, and continue to be functional and integrated in society. As a result, there are probably far more convergers in Bombay than is realised because they can survive undetected within the privacy of the family circle. This is an important aspect that epidemiologists need to take into account while estimating the rate of drug use incidence.

Though the study was conducted in *addas*, consisting mostly of separatists, there were also convergers present. This clearly illustrates the need to document and support such functional associations.

Quietists

These are individuals who accept the definition forced on them by society and they try to live accordingly. A clear example of this, described by Musgrove, were the inmates of the Cheshire homes (Musgrove,1986). Institutionalisation as a means of controlling anything considered deviant by society is also practised in other areas of marginalisation such as mental illness.

In the context of addiction, a quietist is a user who accepts the concept: "Once an addict, always an addict", and whose health is not ruined primarily because his family supports him.

Quietists accept that drug use is a disease over which they have no control. This concept of addiction was introduced by treatment professionals who wanted to promote a sympathetic understanding of users among non-users and especially to cushion the negative reactions associated with relapse. While drug abuse in itself stigmatises the individual, its definition as a disease creates a forum where concerned people can express the helplessness/limitation in bringing change.

Rehabilitation centres and addiction professionals highlight through media campaigns, the control that drugs exercise over the user. They seldom show the other side. To enable the user to deal with a powerful drug, they initiate him into a twelve-step life-style programme. Power is again taken away from the individual. He is expected to remind himself on a daily basis about his identity as a drug user, or someone perennially vulnerable to relapse. Even after years of abstinence he is labelled a recovering addict. He has to live a drug-free life on a day-to-day basis (Narcotics Anonymous (NA), 1988).'

The concept of addiction as a disease has been aptly termed by Peele (1989) as "the addiction treatment industry". It expanded from alcoholism, to drug abuse, to gambling and to the children of drug abusers. He points out that the problems of users especially in ghettos have their source and their solution not

in the availability of drugs but in other social realities. He further points out the evolution of three types of disease models:

- first-generation diseases: physical ailment
- second-generation diseases: mental disorders
- third-generation diseases: addiction

Mental disorders are apparent because of the feelings, thoughts and behaviour they produce in people. The third generation of diseases, addictions is even more nebulous, because addictive disorders are known by the behaviour they describe.

When a substance abuser gives up his habit, he ceases to be addicted. This is the fundamental argument against using addiction as a disease model which defines addiction as a lifelong process and would categorise alcoholics as alcoholics even if they have not drunk a drop for fifteen years. The other difference is that addiction involves appetites and behaviours which differ in different cultural contexts. Even in the same culture what is described as addiction does not remain consistent over a long period of time. Despite claims by the medical profession that they hope to inevitably find organic causes of second-and now third-generation diseases, the hunt is still on, while definitions and re-definitions of these keep changing according to different social and situational contexts.

Those who promote the "third-generation of diseases" typically define them as follows:

That the disease is marked by a loss of control over behaviour: that the sufferer himself cannot recognise the disease in the absence of education by disease experts; that the disease will progress inexorably, no matter what efforts sufferers make for lifestyle changes unless they receive treatment aimed at containing or eliminating the behaviour that defines the disease; and that it is a permanent trait to which sufferers must adjust to for

the rest of their lives.

The disease responds to two diverse and different types of treatment:

- a support group organised by and for those who share the disease; and
- treatment according to a medical model under the supervision of a physician or other trained specialist.
  This involves private consultation and a medical type of regimen preferably in hospital settings and established therapeutic communities.

The indirect and implicit message is that sufferers should not be judged by ordinary moral standards or held down to codes of community conduct with relation to behaviour attributable to their disease; and that despite the inherent tendency for sufferers and for society in general to deny the presence of the disease, it is remarkably prevalent yet frequently. This calls for more innovative methods for identification and treatment for the sufferers. It also takes away the responsibility of the government to deal with the political and economic issues related to the drug situation and place the onus on the individual.

Both users and the lay public accept the concept of addiction and perception of it as a disease. This has created a group of users who keep seeking detoxification in numerous places on a rotational basis. Such individuals willingly accept the fact that they are victims of a disease called "addiction". They prefer to conform to the social definitions of the disease. They do not express a need to change the values and goals of such a system. They receive financial and other support from a social structure that helps them to be healthy, to avoid continuous excessive use and to maintain personal hygiene.

After entering treatment programmes, many addicts willingly agree to get groomed into models of existing treatment

philosophies. Through their continuous interaction with various treatment approaches they become familiar with the outlook of the treatment centres they approach and at times are willing to accept any kind of accusations, however demeaning they are. Subtly or otherwise, quietists learn to express guilt at relapsing, as though their goal is to satisfy society's need to see them clean, rather than to fulfil any objectives of their own. By accepting the norms and standards set by society or their families or the treatment centre in an unquestioning manner, the quietists allow their guardians to control not only their drug intake but also their whole personalities. After a period of being moulded, they are then willing to groom the next group of addicts. Thus the wheel keeps rolling. When a quietist moulds another person according to the set philosophy of a centre, he integrates these norms internally to a greater extent than when he himself was being treated. At a radical level, such individuals become mouthpieces for the others therapeutic centres and produce clones who look and behave like them. While some of them reach a drug-free status through these programmes, they lose the most valuable asset that a person can have—individualism. Not all users are willing to go through this process. As some street users say: "We are not mad, one wonders why they treat use the way they do." These street users are unwilling to allow someone else to have power over them. They are people who have been used to a pragmatic outlook and find it very difficult to accept the rules and activities formulated by detoxification centres that tend to impinge upon their personalities.

These quietist users, by integrating the philosophy of various treatment approaches into their own lives, also begin to believe that overconfidence in being able to deal with their drug habit is related to relapse. Thus, unlike separatists or convergers, they associate negative feelings with self-confidence. They reject the notion that a person can deal with drug use on his own; that

they should be masters of their own lives, with or without the intake of drugs. They associate their success in being drug-free with their treatment programmes.

There will be some individuals among quietists who manage to remain drug-free by asserting their superiority over their weaker brethren. At the same time they accept their classification as "recovering addicts" by the rehabilitation centre. Some of these become part of the rehabilitation centre. Those who question the basic philosophy of the rehabilitation centre are discarded as "trouble-makers", or as people who are not yet ready for reform. While such quietists remain free from drugs, they become prisoners to the twelve-step approach to life. There are studies that show that such individuals have in effect shifted from one form of addiction to another. Here, a particular cult philosophy takes over their lives, instead of the drug. In addition to sustaining their new lifestyle, their personal lives and their circle of friends are also controlled.

This approach denies the existence of coping strategies within the individual and assumes that users have no resources beyond institutional, professional or self-help group interventions. In the process, they make the term "self-help group" a misnomer. A poor street user develops a range of survival skills to stay alive, obtain drugs and even deal with the police. It is difficult for him to even accept the concept of powerlessness in relation to the brown sugar user.

Often, convergers and separatists find it difficult to adjust to these programmes. Moreover, the rigorous behaviour modification approach antagonises street users who have never adhered to rigid rules. To them the enclosed environment is another jail from which they need to escape. This problem may never be faced by a middle class person who does not believe in the disease model as he can afford treatment at private clinics or avail of the facility of home-based detoxification. Thus, we find few quietists among drug using street kids, and there is also a group

of middle class habitues who are not quietists, particularly if they have become pauperised, have lived on the roads for a while, and have braved the cops, dogs and street hooligans. These are hardly likely candidates for the traditional therapeutic communities. Few of the therapeutic communities and other rehabilitation centres report on how many users either came or were brought to them; how many they screened through different techniques and policies at various stages prior to admission; how many dropped out after detoxification; how many enter their rehabilitation programme, how many 'complete' the course, how many drop out in between and which are the periods of high drop out rates.

It is theoretically possible that it is quietists who are specifically recruited into the therapeutic communities and rehabilitation centres. Is it this category of habitues who succeed through therapeutic communities and rehabilitation centres? Further research is called for in this regard. Unfortunately, while the therapeutic and rehabilitation centres are well endowed financially and can therefore employ professionals, most of them employ ex-addicts, who have not been trained for research. The cult-like nature of these movements and their moorings in punitive, repressive deviancy control philosophies make the rehabilitation and therapeutic centres follow closed door policies and thus they resemble jails. Therapeutic communities have little to boast of in the way of a therapeutic environment. Such a group of addicts, by any stretch of the imagination can hardly be called a community in the sociological sense.

Case 5.4

Dinesh, a lawyer by profession, aged 26, has been taking brown sugar for the last ten years. In between, he was clean for a year and a half, but later relapsed. His parents and brother are aware

of his habit and accept it as a disease that is beyond his control.

He smokes brown sugar at night and wakes up late in the morning. After having his morning coffee prepared by his mother, he has a wash. Each day after ensuring his daily quota is with him, he spends the day reading. His mother provides him with good food.

In the evening he meets his drug using friends who also supply him with drugs. In return he shares his drugs with them. He also spends time with a group of rickshaw pullers who take *charas* but not brown sugar.

Dinesh is not particular about his personal hygiene, but his mother ensures that he takes a bath and changes his clothes every day. She also gives him money for purchasing his drug. He has gets additional money by forging his brother's signature.

He has been living off his parents who have accepted the disease concept of addiction and do not attempt to question his dysfunctionality. He exploits his parents' attitude to the full.

Case 5.5

Narendra was born in Kuwait and came to Bombay with his parents at the age of three. He has four brothers and three sisters. Narendra, aged 30, is a mechanic who deals with air-conditioners. He is the second last child and his immediate sibling is fifteen years older.

He began to smoke *charas* to avoid being caught, as unlike his first love alcohol, it did not have tell-tale signs. Once he became a regular smoker he was scared of detection, as his family began to notice his red eyes.

On one occasion after heavy use of *charas*, his nose started bleeding and he was scared. He stopped regular consumption for a long period and switched to alcohol. While smoking hash,

he and his friend were introduced to a new drug. They rolled it in their cigarette and smoked it. They enjoyed a pleasant feeling and Narendra wanted to consume more, but he was not able to get it.

The urge to smoke brown sugar kept playing on his mind, and in the end he found someone who sold brown sugar in his locality. He purchased the drug with the help of another person and smoked it regularly for one week till he ran out of money.

He began to crave for the drug, became restless and suffered from severe bodyache. He went home and experienced severe withdrawals at night. Earlier, he never purchased his drug with stolen money, but now, for the first time, he stole.

He realised that he needed brown sugar on a daily basis. As his resources were insufficient, he lied, cheated and stole on a regular basis. But guilt drove him away from home.

After leaving home, he began selling drugs and became known in the community as a drug addict. His father pleaded with him to return home, which he did, but continued to sell drugs. Though was caught and sent to jail for four days, he continued selling immediately after being relased.

His family faced social ostracism because of his habit. This motivated him to give up drugs and he got himself detoxified at home. Later, he began to use pharmaceutical drugs before going back to brown sugar. For detoxification, he admitted himself in a mental hospital that had a ward for addicts. He stayed there for a month, but his father's ill health prompted him to leave it.

Unable to deal with the situation, he relapsed, and began stealing again. His father passed away and on the day of his funeral, Narendra was wrongly accused of stealing his sister's earrings.

He lost interest in life and began to rob houses and joined a group of pickpockets as well. Under the pretext of being employed, he contributed towards his family expenditure. It gave him a sense of pleasure.

In this period, his younger sister got married and he was the "best man". He could not get through the formal function without a dose of the drug and thus faced rejection by his family. After this he went through a series of detoxification and rehabilitation programmes, but relapsed. Later, through self-determination and self-medication he gave up drugs for a period of five years.

In his drug-free period he experienced intense desire for sex, and led to a relationship with his sister's housemaid. His sense of guilt made him avoid his sister's house, especially when he realised that his sister falsely assumed that her maid was having a relationship with her husband.

Witnessing the friction in his sister's family he began to desire for drugs. The chance came when he was entrusted to deliver some money to an individual. Instead of carrying out the task, he decided to pick up a prostitute. Prior to that he got drunk on beer. The next morning he went straight back to drugs. According to him:

> I had been waiting for an opportunity. I did not know how cunning and powerful this addiction is. I only needed an excuse. Directly or indirectly, I went back to the drug.

Journey back to drug life was lonely and traumatic. He attempted suicide on three occasions, especially when he could not sustain his drug habit.

He had friction with the law on different occasions and the reasons were sale of drugs, theft and unlawful entry. While on the run, he entered his locked home through the back door. The neighbours informed the police and he was arrested. With the help of his family, he was granted bail after fourteen days.

Back on drugs, he felt he had reached the rock bottom and he decided to seek professional help. At present he lives "one day at a time" and has been clean for about a year and a half. He is able to cope with life with the help of Narcotics Anonymous. Today, he works in a rehabilitation centre which emphasises the disease model of addiction. Now, he is dependent on one thing, Narcotic Anonymous.

He had been able to stay away from drugs for five years but he did not consider this of any significance, as he relapsed again. He has accepted the concept that he is "diseased" and is actively involved in propagating the idea that users have no control over their drug consumption.

Conclusion

Though it emerged in Britain, the perception of drug use as a disease has been integrated in many long-term programmes in America. While initially these movements gained support, the resource crunch has affected this area too. There are hardly any research studies which show the validity of such an expensive approach against any other medical or indigenous intervention (Peele, 1989). In the Indian context, the concept of the use of MAS as a disease is questionable because of historical realities. Even today there are regions where traditional drug use continues to exist within a cultural milieu. Hence, acceptance of the disease concept can create problems in future for the following reasons:

- If addiction is a disease, the users of any substance are diseased for life. The natural conclusion would be to ban all drugs. This would leave the field open for market forces to set the trend in drug use without being influenced by cultural norms. We note, for example, the spread of heroin within traditional opium-using areas, for example in Rajasthan. Besides, the abuse of pharmaceutical drugs may increase and the pharmaceutical industry will rake in money without sullying their reputation as drug traffickers.
- Violation of the human rights of users will intensify, since as 'diseased persons' their rationality will be under a cloud. This might even continue years after giving up drugs.
- Limited resources will be concentrated on a few users who are sufficiently empowered to access the multiplying but insufficient health centres.
- Drug agencies may consider the imposition of fees as a deterrent to avoid the use of health-care facility. This would mean that a large number of poor users would be unable to afford treatment.
- The presence of the existing cultural foundations for MAS will view drug use as a disease unacceptable except among a few professionals and a small group of ex-users. As in the West, this will gain momentum with the development of elite cults striving for total "cleanliness". For example, the offshoots of the temperance movements in Europe will become stronger. These institutions will be cornered by the few who can adhere to this philosophy and funds sanctioned for the user population as a whole will be squandered on this minority.

Separatists

Separatists assert their own lifestyles, as distinct from the accepted norms of society. Their personal hygiene is poor and health is badly affected and they have a history of continuous excessive use of drugs. The separatists are alienated from family and community and their occupational status is looked down upon by society. As a sequel to continued alienation and excessive use, they may take up antisocial activities. Some may already have been undertaking antisocial activities prior to drug

use. Often they have no regular eating habits and it is not unusual to come across users in this category who take a bath only twice a year. Their marginalisation is reflected in their very existence, and its ambiguity becomes a source of power. Similar behaviour can be seen in the case of artists and homosexuals (Musgrove, 1986). Rag pickers in Indian cities are another group of separatists. Another clearly identifiable separatist group in Bombay is that of the eunuchs. The separatism of drug addicts can encourage drug use among the poor or lower middle classes and deter its use by the middle or upper classes mainly because of the separatists' filthy appearance. Initiation into drug use out of curiosity might occur, but it is limited.

Separatists are identifiable to the public as users and look conspicuously different from the "normal" population. At present they are labelled and stigmatised without much threat. They do not accept social norms, especially those regarding cleanliness and reach this stage as they get impoverished because of continued drug use. At times, separatists are encouraged by various social mechanisms to perpetuate their role.

Drug using rag pickers are a distinct group of separatists. They insist on their dirty appearance deliberately to avoid being harassed by the police. Some of them keep a few good clothes in a laundry which they wear whenever they decide to return to the "normal" world. Some of them have their own families, and yet they wear these rags for functional reasons. For instance, they also apply filth to their bodies to avoid arrest.

In a crowded city where the lack of privacy and space is the main factor affecting the poor compared to the rich, it is natural that separatists are marginalised sooner than the rest. A person in government employment can maintain a functional life better than somebody involved in manual work or rag picking.

Case 5.6

Mahesh's parents came from Calcutta fourteen years ago to live

in Bombay. After his father, a porter, expired, his mother began to work as a domestic worker. Now, she has a small fruit shop and her youngest daughter lives with her.

Mahesh is 22 years old and lives on the street, for it helps him to sustain his drug habit. His entire life revolves around drug use. He stays close to the railway yard steals iron at night and sells it in the morning to a shopkeeper nearby. Iron from the railway yard is less lucrative than those from the 'docks', and it fetches only half the price.

Other than expenditure on drugs his personal needs are minimal. He ignores his personal hygiene and changes his clothes only when he is infested with lice. His only intake is *maska pav* with tea.

Mahesh's association with drugs began with *charas* and *ganja* in the company of his friends. When his friends shifted to brown sugar, he did not, for he had heard of the adverse effects of brown sugar. But, one day, after a fight with his mother, he went over to his friends and smoked a couple of doses of brown sugar. Though he threw up and felt nauseated, he continued the habit. At present he consumes ten *pudis* a day and also consumes two or three nitravet tablets every week. While chasing brown sugar, he keep a one rupee coin to filter the fumes he inhales, under the illusion that it will reduce the harmful effects of the drug.

He was arrested twice, but was let off free by the magistrate, on grounds of insufficient evidence.

He consciously took brown sugar for situational reasons and sustained his addiction through criminal activities. In the process of adopting a new lifestyle, he changed his attitude about hygiene as well.

Case 5.7

Gopal has been in Bombay throughout his life, for the last 25

years. His father is a Keralite and mother, a Maharashtrian. Gopal has separated from his wife. He has close ties with his younger brother who is also a user.

After his parents passed away, Gopal began to consume alcohol and *ganja*, in his teens he began taking brown sugar and it affected his health. He consumes ten to fifteen *pudis* of brown sugar daily and takes Mandrax tablets occasionally.

Earlier, he worked as a loader at the port and earned Rs.30 per day, but was sacked for being drunk at work. He began to steal from the port to sustain his habit and meet other needs. As a result, he was arrested twice and jailed for fourteen days.

It was when he was in jail that his wife left him. Earlier, she had walked out on him twice for his drunken behaviour, but came back on his request. On the last occasion, when he was in jail, his son fell very ill and passed away, as his wife could not afford to give him medical care.

Now, he lives on the street and his life revolves around his habit. He ignores his personal hygiene and has a bath once a month in the nearby gutter. His clothes are the rags he picks up from the street. His expenditure on food is minimal.

Recently, he began to avoid arrest for theft by hurting himself. He slashes his tongue and chest, and pretends to be mad at times. This behaviour makes the police uncomfortable and they leave him alone.

He has been chased and beaten up by the community. For him, brown sugar is the only source of escape and peace. He finds people are insensitive to the problems of users. His only hope is that his younger brother manages to be drug free.

His personal inability to deal with reality has caused him to seek solace in drugs. His excessive use made him physically ill within a short span of drug use. All this made him defy societal norms and give up any pretence of adhering to them.

Conclusion

Separatists are clear products of the marginalisation and criminalisation arising from drug use. The progress of a drug user to this stage has to be arrested for fear of sliding into an alternative lifestyle where involvement in antisocial activities and at risk behaviour may be a part of the change.

Utopians

Among the marginalised, some actively stress their separate identity from 'normal society'. Standing outside it they proclaim their wish to change the values and consciousness of society. Cults such as Hare Krishna and the Sufis fall under this category, according to Musgrove(1977). Because of the criminalisation of drug use, it is difficult for such cult formation of brown sugar users to emerge. This is so in other countries too since national drug laws everywhere are broadly derived from the Single Convention. But, in rural Rajasthan, Saurashtra in Gujarat, and rural Karnataka (Rao, 1995), we have evidence that people praise the merits of opium and cannabis and are proud of their habit. Some of their quotes are interesting:

> "*Ganja* smoking is necessary to increase one's appetite."

> "When the bride and bridegroom assemble for the marriage ceremony, the bride's family are expected to distribute *ganja* to all the invitees; it is a well known custom."

> "Chewing *ganja* helps us to get over anxiety and weariness during working hours."

> "*Ganja* smoking is a part of our everyday life."

Among the opium users who are often from an older age group there is little evidence of any desire to seek medical help

(Masihi,1995). In the west, the hippie movement expressed similar sentiments along with "generalised" protest against a regimented existence. In recent times, injecting drug users in Britain have formed associations. Their ideas also fit into this category.

Today, in many regions in our country with an established cultural tradition of MAS, empirical norms place the users in a marginal position, by considering them as 'deviants'. But this population may not accept society's definition and thus behaviour that had earlier been sanctioned becomes a platform for the creation of utopians. As a result of these norms, some may shift from traditional drugs to alcohol, the legal drug of today. Others may become convergers and slowly shift towards a separatist status. This leads to a shift from drugs like opium to their derivatives, as empirical norms also create a market for the latter. This can be far more threatening than the present association with traditional MAS.

A brown sugar user's deviation from society is related to the extent that his life revolves around the drug and his capacity to mobilise resources without emphasising his deviance. For example, a user with an adequate support structure might be able to sustain his drug habit without its having a drastic effect on his lifestyle. Another option for the user would be to control his drug use, so that his deviation from the centre goes no further than is acceptable to him. In the following pages, an attempt is made to look at various types of users and the interlinkages between these types, as well as the insights that can be drawn from these cases for intervention programmes.

There are also cases of people from well-to-do families, who have a professional occupation and live a very functional and productive life. They take brown sugar for specific periods in a year. Their lives, unlike those of street users, do not revolve round drug use and its related dynamics alone.

These individuals question the image society has of users as filthy criminal incapable of managing their own lives. They contest the idea that users have to be continually prompted, confronted and be treated for life as slaves, either to drugs or to the concept of being clean "one day at a time".

In this study of the *addas*, it was very difficult to locate individuals from these categories. Most of the users we met there had separated themselves from the system. The illustrations for this category are based on personal experience and on data collected from key informants such as psychiatrists in private practice.

There are some professionals from different fields who have been using brown sugar, morphine, tranquillisers, speed and other drugs for an altered state in a sporadic manner. Interestingly, some of them use drugs only after reading about the clinical effect of each of the drugs in the body. Some of them purchase drugs or get themselves injected far away from their own locality so that they will not be tempted to frequent these haunts again.

There have been cases of people converging into a particular state from other states of India to take part in moonlight parties. At these parties different types of drugs are displayed on the table, so that it is something like a cafeteria at which you can pick and choose.

There are drug users whose views on drugs differ drastically from those of professionals in the field. Take the case of Ramu. He is a Maharashtrian Brahmin, an engineer by profession. He takes brown sugar for three or four months a year and for the rest of the year he keeps away from brown sugar and takes alcohol. Brown sugar consumption only takes place when he has extra money in his pocket through sources other than his regular income. He says there is no such things as addiction and that the concept has been invented by the treatment industry to sus-

tain its own mafia. He chases brown sugar in his own house. He continues to fulfil his family responsibilities and has therefore not been alienated.

Shifts in Association

The association a user forms with a drug need not be static and the shift can occur in either direction. A converger can become a quietist or separatist, and vice versa. The process that leads to these shifts should be extensively documented for this can provide guidelines for harm minimisation strategies which can be viable and effective as they are sensitive to the ground realities of the users' existence.

Often the first association formed with brown sugar or traditional illegal drugs will be that of a converger. This may be maintained for a lifetime or may shift to other forms of association. Treatment programmes at present are not designed to cater to convergers, as clients who come to treatment centres are usually quietists or separatists. It is in this context that an attempt has been made to look at the shift toward separatism and its policy implications.

The utopians may decide to change their lives, settle down and become convergers. This was seen in the case of another drug, cannabis, among the 'flower children'. Unable to deal with the systematic bombardment of negative stimuli, they either merged completely with society or hid their subtle deviations. This process was facilitated by the commercialisation of the group's symbols which worked against the original goals of the group. Today, in the case of utopians, it may be difficult to obtain information unlike in the case of traditional drug users. Hence, shifts can be difficult to document unless they reach the stage of separatism.

Acceptance of different types of users implies the need to alter the present forms of treatment and other intervention

modalities. In this context, given the reality of the dynamic nature of human associations with MAS, the need for outreach programmes attains far greater importance.

Converger to Separatist

Users feel that brown sugar is a great equaliser in the lives of people. They say: "A man from a bungalow who uses brown sugar will one day come to the streets; that is the way this drug works." While this might be true in some cases, it cannot be generalised, otherwise there would be far more drug-related crimes and visible users than is the case now. This is clear when one looks at the number of people who buy the drug from drug dens.

It is possible once they get involved in petty crime, convergers might alienate themselves from their families and in the process end up as separatists on the streets. It is not uncommon to find convergers who have lost everything and in the end, resorted to rag picking to support their drug habit.

Convergers from any class of society need some sort of support structure to retain their lifestyles. In the long run, they must either control their quantity of consumption or organise their financial resources to support it. When they fail, they either become separatists or indulge in petty crime.

When a user is confronted with the fact that he has to change his behaviour to continue as a converger he might decide to control his drug use. Then he tries out various mechanisms to deal with it. These include seeking detoxification, going out of town, and systematically reducing the quantity consumed, substituting other drugs like cannabis, opium, alcohol or pharmaceutical drugs. All these are economically more viable than continuing to consume brown sugar.

Another option is to use the financial resources of the family, either under duress or without their knowledge. It is at this stage that the relationship with the family undergoes dramatic changes. During the friction with the family the user may leave home or is asked to leave. Then they may become either assistants to peddlers or end up stealing expensive goods and selling them off for a few *pudis* of brown sugar. The latter actively helps the peddlers and others involved in the racket to make a fast buck. As they sell at rock bottom prices, there are many customers interested in cutting a deal. This can sometimes backfire as in the case of one peddler who got hold of some gold and was arrested. During our field visits we have also noted the disappearance of one assistant of the peddler and it was alleged that he was arrested for possession of drugs. It is a known practice in Bombay that drug peddlers' assistants are willing to get arrested instead of the peddler when the pressure is too much. These arrests are often 'fixed' and end in short-term imprisonment and subsequent bail due to inadequate evidence. As part of the deal the person arrested and his near ones are taken care of by the peddler.

Among those who steal, people from the lower strata are far more likely than the better-off to shift from being convergers to other categories. They may have to be seperatists to stay out of reach of the law. Mukesh, a doctor by profession, managed to remain a converger though he had taken to stealing. He could not remain a converger without changing his lifestyle. He is from a rich family from South India. He started stealing from Maruti cars parked near a railway station. The articles he robbed included cars stereos, money and other valuables. He mastered the art of tampering with the locks of car doors effortlessly. No one suspects him since he does not fit the classical image of a thief. His friend, a separatist, occasionally supplies him drugs. The case of Rajan, on the other hand, shows a long-

term converger sliding to the level of a separatist.

Case 5.8

This case has been focused on in the previous chapter. Rajan's second brother was highly respected by his community and family members. When his brother refused to work in Bombay as it was bad city, Rajan became curious about Bombay and wanted to visit the place.

Rajan did not get along with his sister-in-law. After a quarrel, his eldest brother's wife insulted him for being dependent on his brother. This irritated him and he ran away to Bombay at eighteen. When he returned from Bombay, he casually told his family about this argument. This led to his brother's separation from his wife. Their marriage had been difficult as they did not have children. Rajan's parents blamed the wife and wanted their son to get a divorce. Rajan's eldest brother got divorced and married again. The second wife was very docile and got along well with the family.

Rajan's Village

Cannabis was surreptitiously grown in his village and people consumed it in the shrine along with the priest. Most of the people had a few drags from the *chillum* and walk away. A few of them sat and smoked on a continuous basis. Here people associated cannabis with Lord Shiva. The festival of Holi is celebrated by all, and *bhang* is an important part of the festivities.

Rajan's Drug Use

Rajan began smoking with friends at school and then shifted to *bhang* and *madak* use along with his close friend. According to him, *madak is* opium mixed in water and then strained through a cotton mesh and purified. The purified product, when heated and mixed with *babul* leaves becomes thick. If it is kept in the

open, it crumbles into powder. A *chillum* is used to smoke *madak*.

At first, he took one or two tablets of *madak*, but it increased to 20-30 tablets. He began to take the drug throughout the day and took money from his brother under one pretext or another. Sometimes, they smoked *madak* near the riverbanks and then went for a swim in the river. He enjoyed the feeling of water splashing all over him when he was high. In his native place, there was privacy for people to consume drugs.

Rajan Gives up Madak

In his hometown, the place where *madak* was sold had space for use as well. He often smoked it on the terrace as it had a good view. Here he overheard instances about *madak* withdrawal and methods to deal with it. *Doda* a drink made of powdered poppy pods was supposed to be good. Poppy pods are soaked in water for ten hours and then filtered.

On his brother's insistence, Rajan decided to give up drugs. Rajan took *doda pani* for dealing with withdrawals and slowly reduced the consumption of the liquid as well. His sister gave him an oil massage for his bodyache. He stopped *madak* for sometime, but smoked *charas/ganja* occasionally.

Once on seeing his reddened eyes and influenced by the comments of others in the community, his brother accused him of smoking *madak* again. Upset at being suspected, Rajan reverted to drug use.

Rajan Goes to Mumbai Again

With his brother's money (Rs. 7,000) meant for purchasing goods, Rajan left for Bombay. He went straight to Grant Road and met his old friends who were then on the streets. When his

opium got over Rajan was unable to get *doda* to deal with *madak* withdrawals and hence shifted to brown sugar as per his friend's suggestion. His friends helped him to obtain drugs, in return he gave them food, clothing and drugs. This did not last for long, as Rajan soon ran short of money.

Becoming a Separatist

After he had run through his money, he had to find an alternate source of income. He became a casual labourer and then a rag picker for better returns and more freedom in work timings. Being a rag picker he bought a new pair of clothes only after the old pair become torn and dirty. Having a bath was a rare.

Once Rajesh was caught chasing near Chinchpokali Railway station. He was locked up in the morning but released later the same evening as he threatened to smash light bulbs and eat them. Apart from this incident he has never had any trouble with the police.

Health Problems

One day Rajan lay on Grant Road running high temperature, when a pavement dweller gave him tea and a blanket. He did not even have the strength to chase the drug with him. In the end he dragged himself to the government hospital and forced his way through to the doctor's room. The doctor gave him a prescription but even after taking the medicine he felt very ill. He went back to the doctor in the evening and lied that he was passing blood in his urine. That night they checked his urine found it was normal and threw him out. He went to another doctor the next day who gave him a reference letter to a government hospital, which had a deaddiction centre. He just rolled it into a ball and threw it at her. She patiently gave it back to him. He left the hospital and tore it up. Later he reached Chase

Street, and a local peddler gave him two *pudis* out of pity. We saw him lying close to the railway tracks and directed him to NARC.

Rajan says that it was his ill health and the sight of a dead body lying in the street that made him reflect on his life. He did not want to end up as an unidentified body on the city's streets and wanted to see his nephew once more.

Rajan's life on the streets of Mumbai was in stark contrast to life in his hometown. Though he found it difficult to adapt to his environment he had learned to be a rag picker.

Conclusions

While earlier cultural norms did not stigmatise the use of mind-altering substances such as cannabis, *charas*, *bhang* and opium, the current empirical attitude places users of all drugs—cannabis, opium and synthetic drugs alike in a marginal position. This created room for a more differential association with a spectrum of substances depending on the traditions in each region and on individual choice. Studies conducted in different regions illustrate the existence of various drug cultures within India (Masihi, 1998; Rao, 1998; Siddiqui, 1998).

In the case of synthetic drugs such as brown sugar, it is evident that the associations formed vary, depending on the individual. Earlier generalised attempts to find causal factors were abandoned, for they led to the enumeration of a long list of psychological and social factors. The 'disease' school, on the other hand, by its definition of addiction, clubbed all excessive users of any substance together and classified them as diseased personalities throughout their lives. The studies that showed existence of functional users were ignored. While the disease concept was publicised and its programme implemented throughout the country. This gained political support, for it

took away responsibility from the government and society, and placed it on the individual and the family.

It is in this context that the existence of various associations with the same drug attains importance.

While studies in other countries have looked at occasional and functional users, this area has been neglected in India. Hence these case studies are relevant for they bring to light varied associations with derivative drugs, shifts away from traditional drug and their implications for drug abuse management.

As in the case of other marginalised groups, drug users as a group also have different kind of relationships with society, depending on their level of marginalisation. For drug use or abuse does not obliterate the individuality of the consumers and these varied relationships are reflected in their lifestyles.

Though this study was conducted in the drug dens of Mumbai, it succeeded in identifying a number of convergers. This highlights the need for a rational approach to support systems that maintain a functional existence, before they reach the separatist stage. This stage incurs many hidden costs for the individual, his family and society. Besides, such a trend would only contribute to a shift to the injectable mode of drug use. Since the goal is to integrate the user within the system, intervention programmes must take account these shifts, for approaches to facilitate re-entry into society will vary accordingly. The integration of indigenous approaches can strengthen this process and make it more practical and reliable.

6

Management of Drug Use in India

With the passing of the Narcotics Drugs and Psychotropic Substances Act, 1985, drug abuse control was no longer within the purview of the cultural standard of different communities in the country. Drug use came under the control of legislation, based on which policies and intervention programmes were conceptualised and implemented. In this context, to understand the dynamics of drug abuse management in India, it is important to focus on the following issues:

- International policies and their influence on India
- The existing dynamics of drug abuse and trafficking
- The national response

International Policies and their Influence on India

Based on the international policy that emerged from the Single

Convention in 1960 and the general consensus arrived at by the member states, India opted to criminalise drug use of any form other than alcohol use. It ignored the cultural norms of control that evolved through the years for cannabis and opium, except in the case of *bhang*. Even this was to be eradicated in the long run, as cannabis plant cultivation was to end by 1989. India, like other developing countries, had to pass narcotics laws of control, ignoring its history and culture, because of the pressure from the United Nations and United States in particular.

Prior to going into the details of the national perspective, a glimpse into the international policies of drug control may be useful. The philosophical basis for these policies can be traced back to the drug laws that evolved in America and Britain. While the American approach was to criminalise the social issue through punitive measures, Britain chose to create mechanisms of control within the medical perspective.

The vocal assertion of punitive measures by the Americans gained support in Britain to some extent, as a result, the drug issue control measures were removed from the domain of medical practitioners for a short period. As a result, the behaviour did attain a criminal perspective in Britain too.

Tracing the evolution of narcotics policies in America and Britain, Rousse (1992) puts forward the factors of public health, vice regulation, prohibition, criminalisation and rehabilitation. During the period of opium wars, it was commercial morality that shaped the attitude of many countries, Britain, Holland, France, Portugal, Spain and America towards poppy, coca and cannabis plants.

The situation changed when because of political disturbance and industrialisation, cheap labour force was imported to United States, Europe and Canada. The Chinese labour force brought along with them, the opium for their own consumption. The presence of opium dens led to interaction between

white and other races, this created concern in these countries. As a result, opium use and opium dens were banned, as the law had far more to do with prevention of interracial fraternisation than use of drugs per se. Soon there was a change in the attitude towards "foreign" psychoactive plants and western powers began to feel the need for a different morality.

In the late 19th century and early 20th centuries, the need for regulation and intervention on a global scale gained momentum. This was initiated by western countries and accepted by the rest. At the international conferences held at the Hague in 1912 and 1913, the American delegate was far more insistent on the need for prohibition rather than regulation. But other countries were not willing to oblige. A year after the International Conference of 1913, the Harrison Narcotics Act was passed by the United States of America (USA).

In USA, the emphasis has been on prohibition and criminalisation. Initially, doctors were prescribing opiates for users as a means of controlling their intake; but this led to an ethical conflict between the medical profession and the law enforcement bodies. The former felt they had the right to dispense opiates to needy clients; and the latter decided that this was illegal. The judiciary ruled in favour of the enforcement agencies. But in 1925 the Court overruled itself, and decided that the Harrison Narcotics Act was a revenue measure and nothing to do with criminal law. However by that time, the medical profession's right to dispense opiates had been undermined.

It was during the 1920s that prohibition of alcohol was enforced. But as its clientele cut across all classes, its use was subsequently reinstated. There were two individuals, Richmond P. Hobson and Harry J. Anslinger, who tried to uphold the temperance movement, and resist any sufferance of opiates. Since alcohol was legalised in due course, they targeted all their energies onto foreign drugs such as cannabis and opium. Their well publicised personal views were accepted as facts in the long

run (Brian, 1987).

As a part of this approach, the enforcement agencies used punitive measures leading to the creation of underground commercial market forces outside official policy. An underworld of organised trade developed in America alongside illegal hooch during prohibition and became a sophisticated racket by the 1950s. Illicit drugs began to be imported on a large scale. Around this time, the medical profession tried to look at public health institutions as the basis for intervention, but this did not receive political support. The government went ahead with the Comprehensive Drug Abuse Prevention and Control Act, which placed prevention and treatment under Federal law. Soon, the USA saw an upsurge in heroin smuggling, the formation of a drug sub-culture with associated cults and antisocial groups involved in the trade. Crimes related to the illegal status of the drug rather than with the use of the drug per se.

To deal with users, USA was willing to accept the rehabilitation philosophy which focused on "repentance" by deviant members of society and a subsequent willingness on the part of Americans to "forgive" them. It led to the creation of various therapeutic communities that thought it right to break down the personality of the users and reconstruct them to fit social norms. Another approach was a substitution programme which included maintenance on methadone. However, in the USA, the process was not independent of government intervention whereas in Britain the medical profession had an important say.

The growth in the commercial market in the USA was facilitated by the illicit status of the drug, and the punitive measures further increased the price. Control was to be ensured at international and local levels. At the international level, crop substitution, aerial spraying, armed intervention, and economic pressure through the threat of termination of development aid, led to shifts in source countries, trading routes, and the induction of new regions to the business. For example, south-west

Asian producers who had played no role in the American market before 1976, began to meet half the total American need for heroin in the 1980s.

In Britain, drug was considered a disease and the medical profession was co-opted in curtailing consumption, rather than emphasis on prohibition as in the USA. Other areas of "deviant" behaviour like homosexuality and pornography, were also tackled on the basis of an approach aimed at vice regulation. It was stated that only in the case of behaviour that promoted corruption, exploitation and public indecency was the law equipped to deal with moral issues; in all other cases, questions of morality were beyond the domain of the law.

In recent times, the identification of HIV and its presence among drug users, led to the creation of a different perspective of harm minimisation. This perspective has gained much support in certain European countries and as a result they have been able to control the rate of HIV transmission among injecting drug users. This perspective focuses on safer methods of consumption through distribution of disposable needles and syringes and through maintenance programmes. The approach has been replicated in some parts of India, without adequate critical analysis. For example, though it is of some use in certain pockets of the north-eastern region, in other parts of the country harm minimisation cannot be restricted to such efforts. It should consider the following issues as well:

- Need to differentiate between hard drugs and soft drugs. To hinder the shift from cannabis or opium to synthetic or derivative products through socio-cultural control strategies.
- The need to facilitate brown sugar injectors to shift to chasing as a strategy. It is possible to implement this in most states except in the case of north-east, where the chasing habit has almost disappeared. Professionals need to pay attention to this aspect, instead of blindly imitating international projects to satisfy short-term needs.
- Inappropriate implementation of the present harm minimisation strategies can do more harm than good. It can lead to adoption of a more harmful mode of consumption or use of poly-drugs.
- Harm minimisation programmes have to consider the historical, cultural and social reality of the specific region.

Existing Dynamics of Drug Abuse and Trafficking

To understand the dynamics of drug abuse in India, it may be useful to look at

- existing pattern of use,
- cultivation, trade and marketing of drugs, and
- geopolitical changes.

Existing Pattern of Use

India with it vast and varied culture has evolved different associations with cannabis and opium. In recent times, associations have evolved with synthetic/derivative/pharmaceutical drugs outside the purview of cultural norms. Among the new drugs are heroin, brown sugar, morphine, codeine, Tidigesic, tranquillisers, stimulants and hypnotics and hallucinogens.

Use of Cannabis and Opium

Ganja is the poor man's liquor throughout the subcontinent, along with other cannabis compounds such as *charas* and *bhang*. Their use is widespread especially in Orissa and is very popular in Tamil Nadu, Andhra Pradesh and parts of Kerala. It needs little tending and grows wild in the mountainous regions (Himachal Pradesh and Sikkim). The mode of consumption of

these products and their medical use has been dealt with in earlier chapters. In recent times cannabis has been used even in allopathy for the treatment of cancer and for wasting syndrome in AIDS. Although this is now being curtailed, the debate is wide open.

The products of the poppy plant are used in different forms, opium is smoked, eaten or drunk. Consumption of liquid opium is widespread in desert areas of western Rajasthan and northern Gujarat. In these regions, opium has a cultural significance and its role is analogous to that of liquor in Western society. It used to be mandated by caste panchayats to mark festive occasions, mourning, etc. It was also used to cope with harsh desert conditions such as heat, dust and unemployment.

The eating of opium is widespread in Punjab since the Sikh religion prohibits smoking. Here, the habit is associated with its analgesic (pain killing) properties, and is used by truck drivers and agricultural labourers (mostly migrant Biharis). The situation is similar in Haryana. Both these states have an equally high incidence of alcohol consumption. In the aftermath of the NDPS Act, alcohol consumption is on the rise in Rajasthan. Despite the fact that alcohol has been consistently prohibited in Gujarat since the formation of that state, over 58 per cent of all patients admitted for treatment in 13 de-addiction centres were alcoholics (Masihi, 1996).

Derivatives of Opium

The common derivatives of opium that are used for non-medical purposes are morphine, heroin, brown sugar or adulterated heroin and codeine. White heroin, which is smuggled from Burma, is injected in three states of north-eastern India. This drug is locally known as 'number four'. As the pure form of heroin is available, intravenous drug use is the regular mode of consumption. This is the main region in India with an incidence

of HIV infection among drug users. Another common drug is codeine, which is obtained through certain cough syrups. A user can consume several bottles a day.

In many parts of the region, there is resistance to the abuse of alcohol. It was under the British regime that licensed shops selling liquor were promoted in preference to home-brewed rice or flower/fruit beer. In some parts of North-east India, there is a strong movement against alcohol use. Having brewed liquor from rice, flower or fruit has been a part of the culture of different tribes, but use of opium or cannabis occured only among a very few commuities. It was during the British regime that this pattern was disturbed. The abundance of alcohol along with minimal development of the region, alcohol became the only solace for many.

The large extent of unemployment, underdevelopment, alienation and presence of military and other factors have contributed to abuse of alcohol. There was a strong movement by the local women against alcohol. It was also partly to safeguard their menfolk who could be easily picked up by the army and harassed. Even today, it is difficult to move around after 5.30 pm. without being stopped by the armed forces on one pretext or another. The easy availability of pure heroin prompted the youth to shift to drug use to deal with their pathetic existence. The situation is worsened by the fact that the minimal age of users is nine years at the time of initiation to drugs. Another substance abused in these parts is cough syrup for its codeine content. The shift to the use of cough syrup probably came after parents, voluntary agencies and society in general began to condemn the use of heroin and the periodic crack-down on heroin made it difficult to obtain.

Crude heroin was introduced to the cities in India during the early eighties. Studies conducted by NARC (1985-87), first highlighted this problem in Kashmir, Bhubaneshwar, Madras,

Coimbatore, Pune, Hyderabad, Goa and Mumbai. The 1978 multicentered study among college and school students had not listed brown sugar in the interview schedule, since it had not yet entered the market. The repeat study by the same authors (Mohan, 1987) indicated that students were by now consuming brown sugar/heroin, among other drugs. The Ministry of Welfare subsequently commissioned a study in 33 cities and brown sugar was significantly present in almost all of them (Singh,1992). Thus, a phenomenon which began in the metropolitan cities and tourist spots soon spread to district capitals and towns along the major train/bus routes as well. This can be seen from the rapid appraisals made by Hope in 18 towns of Karnataka (1991), in 21 towns of Kerala (1992), in 14 towns of Maharashtra (1993) and 11 towns of Tamil Nadu (1994). Border villages lying on trafficking routes were also affected. For instance, there were patients coming to Madras from the fishing communities of coastal Tamil Nadu.

Focus on Iatrogenic Addictions

A large number of pharmaceutical products (stimulants, hallucinogens, tranquillisers, hypnotics) have addictive potential. The NPDS Act lists a number of substances. The case studies in psychiatric practice (SPARC, 1989) indicate a few cases of Iatrogenic addictions.

The lack of proper procedures in the treatment of drug abuse has brought about a situation where addicts buy prescription drugs over the counter for self-medication and self-detoxification, without proper guidance. This leads to different kind of addiction (Sahai Trust,1995). The availability of pharmaceutical drugs that can be purchased under the guise of legitimate reasons from pharmacies creates a space for them to be the drug of future. This condition is also apt for women to indulge in abuse or excessive use, without involving the attention of others. Under such circumstances the pharmaceutical

companies can market a product for a short span of time (two to three years) and subsequently ban the production when adverse effects become popularised. In the process, they are able to market drug and yet be clean in the eye of the law (Shetty, 1997).

Cultivation and Marketing of Mind-Altering Substances

The cultivation of the poppy crop that was systematised under the British regime continued as a cash crop after independence. While India was one of the traditional growing countries which satisfied global pharmaceutical requirements, the situation changed after the Second World War. Enhanced efforts by international bodies led to pressure on India to reduce its area under cultivation. This did not necessarily imply that the administrative directives were implemented.

With the introduction of the labour-saving 'poppy straw' method of extracting opium, many developing countries started cultivating the poppy and extracting opium for their own medical requirements. Indian opium thereby lost its place in the world market. Brown sugar entered the market in 1979. Many other geopolitical changes in South and West Asia occurred along the way, which contributed to the spread of both drug trafficking and drug abuse in India. By an arrangement mediated by the United Nations Drug Control Programme, the US government agreed to buy 80 per cent of its medicinal requirement from India and the other 20 per cent from Turkey. India soon ran out of official surplus and the government has decided to expand cultivation to around 35,000 hectares. However, there are a couple of intriguing aspects here. Only a fraction of the brown sugar in the country originated from Pakistan or Afghansitan. Where has the raw material to make the illicit drugs in the mar ket come from?

No one seems to compute the requirements of thousands of

practitioners of traditional systems of medicines who use opium and cannabis as part of their treatment of both animal and human ailments. One of the most perverted outcomes of the NDPS Act will be to undercut the practice of traditional systems of medicine (TSM) practice in India. Though the rules under the NDPS Act provide for disbursal of opium and cannabis for medicinal purposes, no outlet has been established at district or block level.

Some Agronomic Policy Problems

With mountains of unsold stocks of opium piling up, the government had to employ armed security men to guard the opium, thereby increasing the unit cost of opium. Further, there was a decrease in the floor purchase price of opium from Rs. 280 to Rs. 270 per kilo, thus inducing the farmers to divert sales to private parties instead.

There was a reduction in the commission payable to the lambardars (agents who buy opium from the farmers and sell it to the government depots), from 3.5 per cent to 0.75 per cent. Administrative fiats first restricted every poppy farmer from cultivating more than 25 hectares of land, on the assumption that the total acreage under poppy cultivation would in practice be reduced as a result of these dictates by bureaucrats. In subsequent years, a 10 per cent cut was similarly ordered. But high-yielding varieties had been introduced, producing over 42 kilos of opium per hectare, whereas the official computation of productivity remains at 28 kilos per hectare.

Traditional Retail Outlets for Ganja/Charas/Opium

Since the consumption of these raw drugs had been widespread, there was already a network of retail petty vendors all over the country. With the introduction of brown sugar, some of these retailers switched over to it or added it to their merchandise, to

make a quick buck. The NPDS Act enacted in 1985 aided this process.

In India, brown sugar was initially available (in the early eighties) in the metropolitan cities and the areas bordering Burma. At that time, the impact of international policies and their incompatibility with existing cultural tradition was not of major concern either to the user or the seller.

Neither users nor sellers gave any special preferential treatment to brown sugar, labelled as the foreign drug. The trade in psychoactive substances was not a major concern for law enforcement agencies. It was political changes and the introduction of the NPDS Act under pressure from the United States that introduced contradictory messages into drug use and trade.

Geopolitical Changes

In addition to the factors described above, the diversion of opium to the illegal market was facilitated by certain geopolitical changes in Asia that occurred during this period, which contributed to the spread of drug trafficking and drug abuse in India.

It was the political disturbances that occurred in 1978 which initiated a shift. Political changes in neighbouring countries (the fall of the Shah of Iran, the Soviet invasion of Afghanistan, the reinstallation of the military regime in Pakistan under Zia-ul-Huq) disturbed the close knit links in the trafficking of heroin. This led to the routes being redrawn through cities in India (Britto,1987). The industrialisation of Bombay created an influx of rural migrants from all over. For sheer survival some of them entered the underworld.

The Underworld

The origins of criminal gang formation in Bombay curiously

goes back to the day India became a party to the economic boycott of South Africa because of apartheid. Since Bombay, Surat and other parts of Gujarat had a fairly large diamond trade with South Africa, business had to continue. An unofficial channel was needed even though a moral position prevented official trade links. The underworld emerged to fill this void. The low price of silver in India for a period prompted its export by the same underworld.

With the passing of the Gold Control Act, the price of gold in India remained high. At that time, the same underworld imported gold clandestinely. The presence of different trade-off opportunities, gave space for varied services. There emerged distinct groups of transporters, landing specialists, couriers, money holders, etc. With rigid import controls, 300 per cent duty on imports electronic goods and an expanding middle class with a taste for 'foreign' consumer goods, such as watches, computer parts, colour televisions and calculators from Taiwan, Japan and Singapore, the underworld geared itself to cater to these needs. When brown sugar emerged, it had a readymade infrastructure to enter India. It was exported through the same pipelines.

It was natural that some of them also moved into the brown sugar trade for higher returns. In addition to these factors, political disturbances within the nation led to police harassment of sellers of MAS in the city. As the police vigil made it difficult to deal with bulky opium and cannabis, the sellers shifted to less voluminous fine heroin powder. The massive profit margin also prompted this decision. An indirect factor was the police nexus in the illegal trade. This made it imperative that sellers set aside a part of their income to buy legal protection.

National Response

Until 1985 the Government of India denied that there was any drug addiction in the country. It maintained that Pakistan and

other countries were trafficking in drugs to the west, using India as a conduit. The government also denied any illicit cultivation of opium or its diversion from official stocks and its link with the problem of drug use.

In 1985, the United Nations Drug Control Program offered to provide financial and technical assistance to India to enable it to solve the 'problem'. The USA and other Western countries pressurised India into passing stringent laws on drugs. Further, there was a furore from social institutions, and people of influence whose children were into drug abuse. By 1964, the Government of India had already signed the United Nations Protocol on the Control of Drugs. This had allowed a grace period of 25 years to countries where the use of opium and cannabis was traditional, to reduce it through mass education and other means. The protocol should have come into effect by December 1989. However, the government has done nothing about it.

Yielding to pressure, in September 1985, the government hurriedly passed the Narcotics Drugs and Psychotropic Substances (NPDS) Act. No discussion took place, no studies were commissioned on the harmful effects of these substances, nor on their medicinal properties (almost 800 allopathic medicines which have life saving properties are linked with opium; further, it has been extensively used for centuries by traditional medical practitioners in India, for instance, as an analgesic and in the treatment of malaria, diarrhoea). The consequences of banning these drugs were never analysed. Would alcohol consumption replace drug abuse, leading to wife-beating and violence against children?

While addicts were punished, most of the traders and big-time operators succeeded in evading the law. Further amendments were made in 1988, and another law was enacted to confiscate the property of drug smugglers, thereby giving more teeth to the existing law. Preventive detention came into

force. Today, the law punishes both addicts and traffickers with ten years' imprisonment and a fine of Rs.1,00,000 (for a detailed critique of this law see NARC, 1992).

Treatment Response

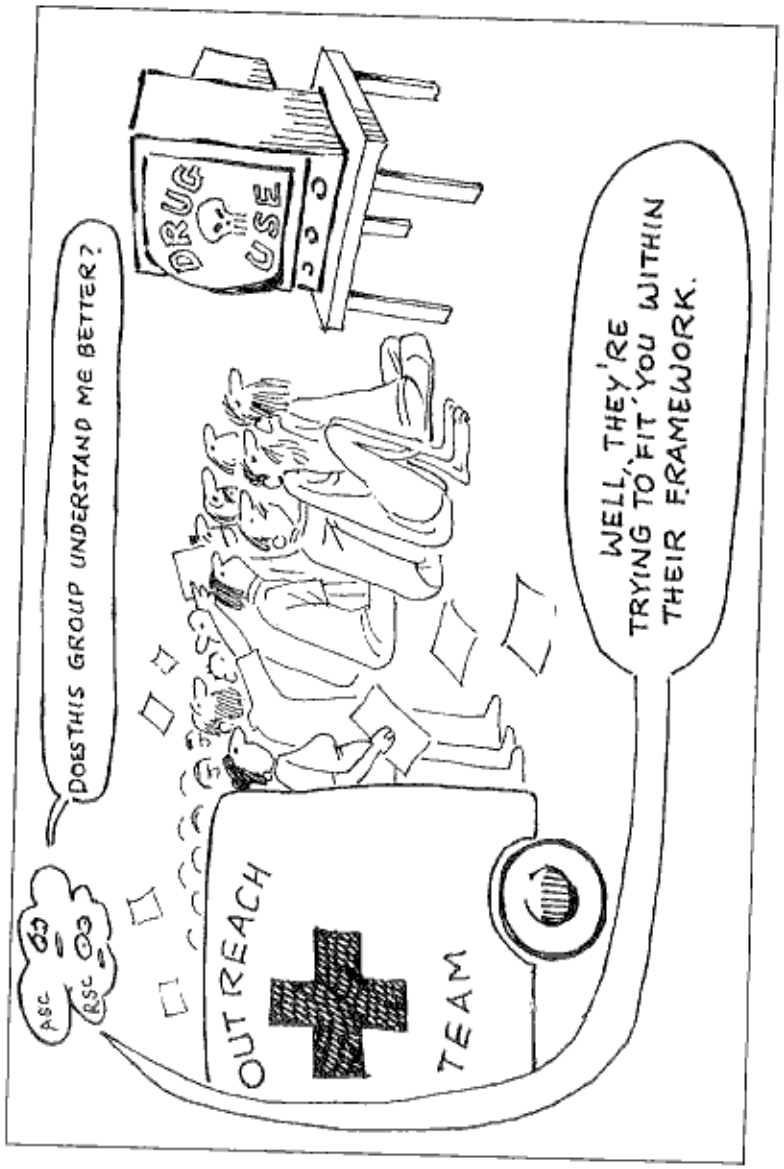
The pattern of drug abuse varies all over the country. The Ministry of Welfare has not taken into account these variations. With no consultation whatsoever, the Ministry of Welfare devised three schemes: counselling centres, de-addiction centres, and after-care centres.

As of March 1998, there were over 172 counselling centres, 111 de-addiction centres and 33 awareness centres (MOW,1998). Recognising the limitations of the government in outreach work with addicts, all these centres were given to NGOs right from 1986 when these schemes came into operation. The Ministry of Health played a limited role. Its research wing, the Indian Council of Medical Research (ICMR) started developing a Drug Abuse monitoring system, established an intervention project at Manipur with injecting drug users to prevent HIV, set up four centres of excellence in Delhi, Bombay, Calcutta and Madras of which the first two function efficiently. The most deplorable outcome of these motions is that the entire public health system in almost all states have excluded treatment of addiction from their purview. This creates several problems. Most of the NGO de-addiction centres are not equipped to treat tuberculosis, asthma, bronchitis, liver dysfunctions, accidents which are all common ailments among drug user. Well-established district hospitals and city hospitals have specialists, equipment and they cannot abdicate their responsibility towards addicts. NGO de-addiction centres wish to avoid additional responsibility and costs of referrals of such patients and therefore deny them admission. Several preventable deaths have occurred on account of these policies. Even patients with venereal diseases are turned away. This practice of admitting only 'clean', addicts must end. In the liberalised context, publicly funded institutions constitute the safety net for the poor. Government funded de-addiction centres should not charges fees in any guise and should cater to the poor. Since October 1995, the government has scrapped the scheme of after-care centres and stipulated an admission period of six weeks.

The strategy adopted was to set up separate vertical structures, wholly controlled from Delhi. There was no linkage with existing health and human service institutions either in the government or in the voluntary sector. Whether a problem of this magnitude, in such a vast country, could be handled by inadequately staffed NGO de-addiction centres each with just 15-bed facilities, was never debated. As a result, the large health-care structures in the urban areas have abdicated their responsibility in the field of drug abuse management. Neither community development agencies nor youth organisations have placed a premium on solving the problem of drug abuse. Even the existing NGOs set up separate outfits when they entered the field, and their total structure only accommodated the new drug unit. This concern did not embrace other resources, including human resources. Since these centres were virtually set up overnight, they had to willy-nilly learn on the job. These remedial measures were far from adequate when compared to the magnitude of the problem.

Religious Response

With its vast resources of land and money, the church responded with the age old 'leprosaria' approach: It set up long-term rehabilitation centres, which essentially isolated the addict for periods lasting from two to five years. It imported the Minnesota model from the USA, without assessing or considering its cultural suitability, its financial viability and its



affordability for the poor. The long-term care did not stand the test of time even in the USA. The widespread extent of the problem, led to the proliferation of a number of centres, but no one seems to have given any thought as to its impact on other human rights considerations. Some of these centres by and large manned by ex-addicts or 'recovering patients' can cause immense harm, since the methodology involves bringing the new patient to his knees through strong confrontation techniques. It is almost a case of 'break him down' and 're-build' him. The use of confrontation techniques calls for trained professionals attuned to the dangers it can cause.

Prevention Response

As can be seen from the diagram shown below, the origins of drug abuse involve a complex set of factors. Most of the prevention work focuses on the intra-psychic level. It is based on the following assumptions:

- Need for training in assertiveness: The assumption being that peer pressure is the cause of drug abuse, hence if the youth are trained to say 'No', then the problem of drug abuse can be eradicated. This is the basis for 'Just Say No' programmes. Some of the drug agencies have used movie stars to convey the messages, without giving due attention to the pros and cons of the process. Others have imported packages from the west and without any cultural adaptation implemented prevention programmes based on them.
- Lower self-esteem can lead to drug use.
- Knowledge can be the key to bring changes in attitude and behaviour. It has been seen that increase in knowledge does not lead to change in attitude or behaviour. Besides, in India, instead of providing unbiased information, fear techniques have been utilised towards changing attitude and behaviour without taking into account research studies that

have documented adverse effects of such intervention.

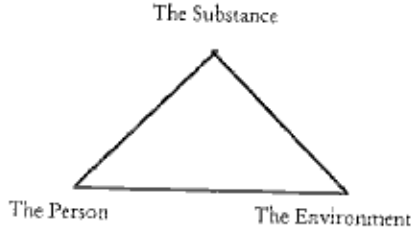
The field of drug abuse is replete with sweeping assumptions based on little scrutiny or scientific justification. This field requires studies that evolve appropriate strategies that considers drug abuse as part of the development dynamics of the region and not an isolated human behaviour.

The approach to prevention is to depict the drug user as a filthy, criminalised, fraudulent, self-indulgent, immoral person whom society has to marginalise. The hope is that if the youth know that by taking drugs, they will be cut off from all social intercourse, they will avoid it. Likewise, if drug use is made a criminal offence, the majority of youth would prefer to avoid brutal police force and hence avoid drugs.

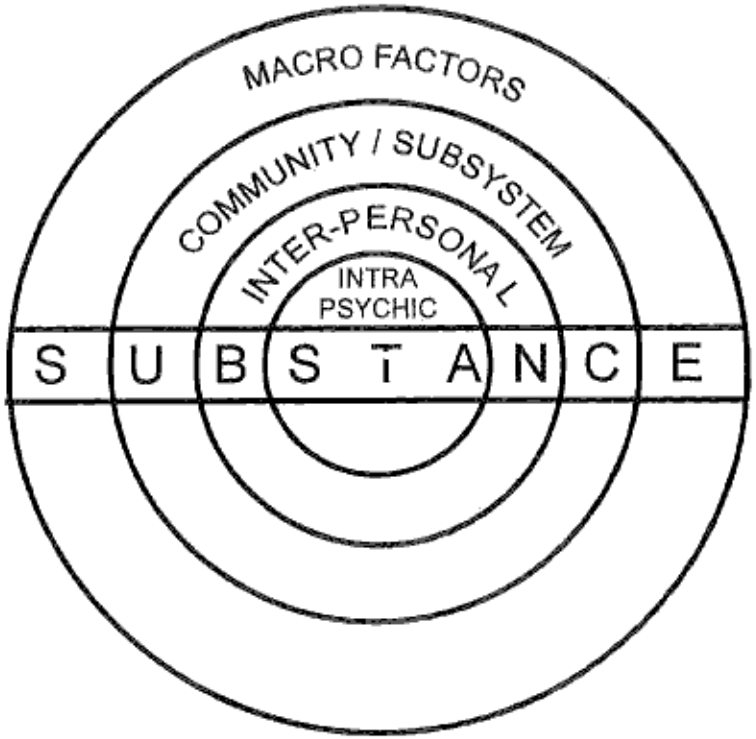
These two basic strategies emanating from the west need discussion for their applicability in India.

Notes on the Diagram

The standard depiction of the aetiology of drug abuse has been presented by many as follows:



Layer (1): Geopolitics has always been associated with the spread of drugs cultivated in other countries. The availability of a drug is obviously a logical precondition for its abuse. Agronomic factors too are subsumed in the first layer.



Layer (2): The country is so vast and varied, with innumerable cultural sub-systems and indigenous communities with their distinct norms and customs. Hence, we have introduced this as a separate set of factors in our schema: Community or sub-system factors.

Layer (3) & (4): Within the two broad categories of interpersonal and intra-psychic factors, we have numerous schools of psychology, psychoanalysis, group-theorists and sociologists offering different explanations for drug abuse.

Base Layer: Some drugs are addictive in themselves, while others are not. Cannabis is not physically addictive; cessation of its intake does not cause physical pain, nausea or other symptoms associated with other addictive substances such as pethedine, Fortwin, Tidigesic, opium, heroin, brown sugar, etc.

Note: This is a homespun schema prepared for presentation and we invite readers to criticise and improve on it. No claim is made so far as to its tenability. Our schema also explicitly incorporates supply side factors, elaborating on the 'environmental' factor in the traditional triangular presentation (Britto, 1992).

7

Impact of Drug Policies at the Micro-Level Intervention

Programmes: The Wall of Separation Between Users and Professionals

Institutional Intervention

This section has borrowed the insights of Erving Goffman (1961) on the social situation of mental patients and other inmates. In his writing, Goffman points out that the first and most important feature of a mental institution is the barrier to social intercourse with the outside world, and this is symbolised by high walls, barbed wires and heavy locks.

He divided institutions into five different categories:

(a) those established for people who are incapable yet harmless;

(b) those established for people who are incapable and are a threat to society;

(c) those built to safeguard the society against what is felt to be

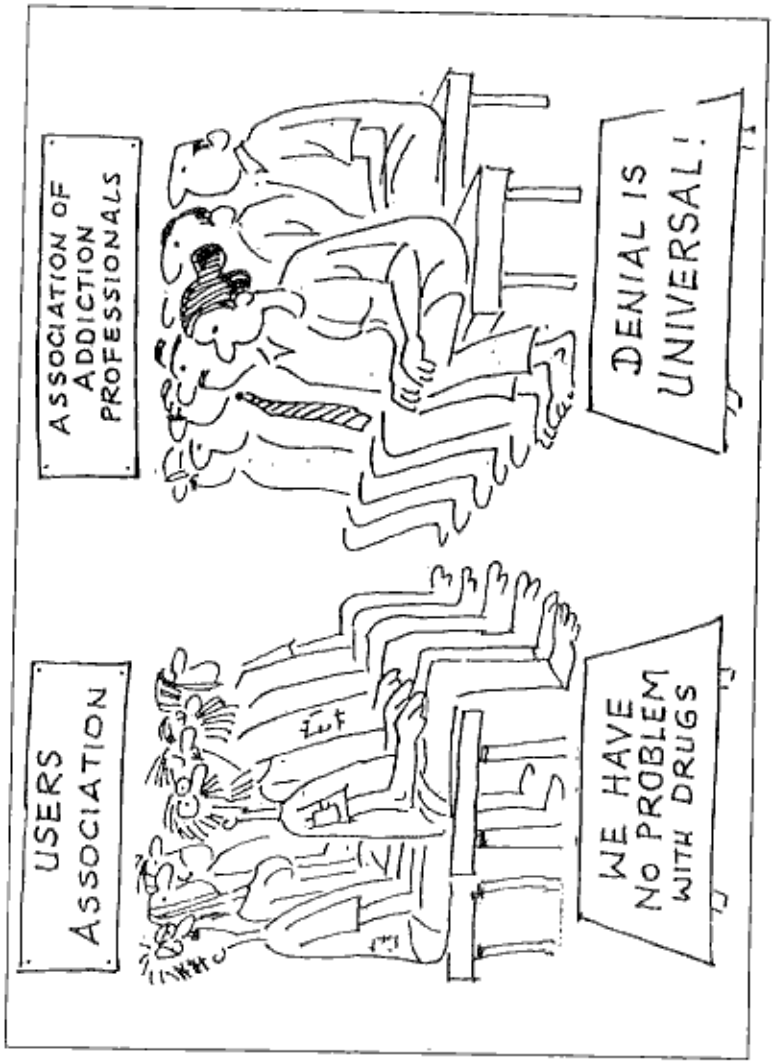
an explicit danger (here the welfare of the inmates is not the prime consideration such as prisons);

(d) those established for pursuing tasks such as factories; and

(e) those designed to provide a retreat from the world—usually training centre for religion, for example abbeys and monasteries.

Detoxification centres and rehabilitation centres can be counted as institutions, since the normal routine of sleeping, playing, and working in different places within different frameworks is disturbed in this setting. Here, the inmates face problems of adjustment, since unlike other institutions these have operated beyond the constraints of space and time for years; and yet they are not so physically or mentally disturbed as to surrender to the medical professionals' total control over their individuality. Having expressed a desire to give up drugs, these people have to adjust immediately to a routine of space and time, along with the social niceties which they had forgotten as drug users. A street-level drug user faces further problems as he is accustomed to a marginal existence, where a daily income had been scraped together through activities at ungodly hours, and where eating routines, habits of hygiene had become chaotic or had been abandoned.

There are some specific aspects of an institutional setting that were identified by Goffman as the reason for acculturation. All activities are carried out under one roof and by a single authority; each phase of activity is conducted in the company of large groups, of whom all are treated alike and expected to act uniformly; all daily activities follow one other sequentially in accordance with explicitly formal rules and under the supervision of a body of officials; all the activities imposed are formulated in accordance with the policies of the institution.



Two Worlds in One: Staff and Inmates

In such an institution, the focus of the staff is not one of guidance or periodic inspection but surveillance of the inmates in order to enforce law and order. Under these circumstances, any infraction by a person is likely to stand out in sharp contrast with the visible, constantly monitored compliance of the rest.

Staff and inmates are clearly separated into two different categories, and each group conceives the other in narrow, hostile stereotypes. The staff views the inmates as bitter, secretive and untrustworthy; and inmates regard the staff as condescending, high-handed and mean. While the staff feels superior and self-righteous, the inmates tend to feel inferior, weak, blameworthy and guilty.

While the dynamics of most institutions fit into this category, in the case of brown sugar users they are further complicated by the fact that the staff does not understand the role of mind alteration, the likelihood of frequent relapses, and the tendency for inmates to be "unlike normal patients". This is best illustrated when the staff expresses irritation at the patients' demand for specific medicines (nitravet tablets, calmpose injection, etc.) and inability to fool the patients by giving them B-complex or other tablets as panacea instead of sedatives. The typical answer of the staff is: "Are you a doctor?". Doctors often cannot contain their anger when patients demand to see their case-sheets.

Mobility Between the Two Worlds

Social intercourse between the two groups is very restricted: the time is restricted to a set pattern for specific tasks related to the implementation of the institution's goals. In the field of drug abuse management, the tacit goal of most organisations is a drug-free lifestyle. Some organisations go to extremes. This can

create undercurrents of friction resulting from a clash of interests. Users may have opted for treatment for many different reasons: to reduce their consumption; for medical reasons, as a result of temporary non-availability; to save money for a family event or a religious function.

Since contact between staff and inmates is highly programmed, there are specific officials whom the inmates relate to for different aspects such as medical requirements, empathic support, daily nourishment and so on. The patient is not encouraged to choose his confidante; the organisation makes the choice. This pattern is never disturbed as this would hinder the smooth functioning of the organisation. The flow of information is in one direction and the inmates are not encouraged to question the organisation or its policies. Decisions regarding patients are taken in line with organisational policies and not in consultation with them.

According to Goffman (1961), these restrictions reinforce the stereotypes and do not encourage a sympathetic synthesis. Two different worlds are further perpetuated within this structure. In the case of drug use, this problem is further accentuated as health professionals working in this field do not understand the need for altered states of consciousness and the tendency especially of street-level users to take drugs at whatever it may cost them.

As responsible health professionals often come from the upper or middle class, their stereotyped 'high' moral codes stand in sharp contrast in the relationship with the patients. Professionals find it difficult to understand the dynamics of poor people resorting to antisocial activities to sustain their habit. Inmates very rarely give an honest account of their lives, as they are afraid of the judgmental responses they invoke. A user is invariably bombarded with judgmental homilies every day.

The movement of nurses, doctors and other professionals in

the wards is very restricted. Every effort is made to establish the distinction. Anyone who deviates from this pattern is seen as a trouble-maker. Often the organisation's policies are modified to suit the requirements of the staff and soon enough inmates identify the policies of the centre as the goals of the staff. Those who formulate policy often take on executive responsibilities for administrative reasons. This further identifies staff with institutional policy. Here we have dealt with some of the dynamics of drug de-addiction centres based on personal observation and interaction with professionals and inmates of NARC detoxification centre and other centres.

The World of the Users

(a) Curtailment of Self

This process starts as soon as somebody enters the institution. Whatever stable social arrangements he had in his natural environment are disturbed as soon as he enters the treatment centre. Whatever support he had received in his personal relations with the outside world is terminated. Drug users have developed their own mechanisms within marginalised populations to deal with society: now they have to drop their old strategies and take on a strange role, neither as part of a marginalised community, nor as a functioning member of society. These people are put through an artificial set of procedures which create debasement, degradation, humiliation and profaning of the self. While users might accept society's general stigmatisation as *Gardullas* while they are on drugs, they find it difficult to tolerate degradation once they have decided to consent to societal norms. People who had used coercion to manipulate society find it hard to submit to control.

Another way of destroying the self is to insist that they wear uniforms. The selection of uniforms is usually based on

practical and economic considerations and this dissolves the patients, individuality. The staff may have also been users wearing the rags they came in, they are often unaware of the fact that street users often have clean clothes tucked away in some laundry shop to wear when they decide to give up their marginal position and return to society. They are expected to suddenly imbibe the etiquette of the middle class, such as sitting at the dining table, using hair oil everyday, and being neat and clean. But who will help them sustain these habits on the streets?

As it becomes difficult to remember their names, patients are often reduced to 'numbers', a further reduction of their individuality. Their names and life histories are taken down, and they are given a code for further reference. After this initiation procedure, they are shaved and given haircuts not because they want to, but to fit into the organisation's programme. All these processes characterise the institutionalisation programme, which has been termed as 'trimming' or 'programming' by Goffman.

(b) Sustaining the Trimming Process

The initial face-to-face meeting gives the staff a chance to assess the patient. If he is "nice", they label him acceptable and are willing to make concessions and overlook his frequent relapses under one pretext or another. This is not so when he takes discharge against medical advice (DAMA). Here the staff never gives up an opportunity to pass a snide remark. If any patient dares to question the treatment or living conditions, the staff unite to crush him instead of encouraging this questioning attitude. They can reprimand him so subtly that they can always claim it is a case of 'patient understanding' or sympathetic treatment of a trouble-maker.

(c) Centre: An Entry Point to the Outside World

A street-level user, especially a separatist, is a person who has ig-

nored the norms of society. Everybody develops a number of defensive manoeuvres, to be exercised at his own discretion, to cope with conflicts, discredit and failure. This process helps him to retain a tolerable sense of self worth. In most institutions, there exists a tension between the home world and the institutional world, and this is utilised by professionals as a strategic lever to manage the inmates.

Entry into an institution, even as a result of structural separation, erodes temporally what had earlier been learned through experience. Unlike many others, heroin users generally tend to be 'lost' in their own world and few of them retain social skills. Suddenly they are thrust into a situation where their activities are proscribed by someone in authority and they all have to move in uniformly regimented blocks. These routines become familiar to re-admission cases, and they manage to develop their own means of disrupting them. Hence the frequent comments of the staff: 'Re-admissions are the problem cases'.

In a long-term programme, acculturation can occur and this is undertaken zealously by the rehabilitation centres. These centres firmly believe in the modification of individuals' personalities into a set pattern of thinking. The procedure will vary depending on the policies of the institution. In cases of detoxification, the period of institutionalisation is limited, and inmates know that the adjustments they make are temporary for the convenience of the centre. Those who no longer have a family know that soon they will be back on the streets, fending for themselves and none of the social routines imposed can be continued outside. For many, the detoxification centre may represent not just a means of drug management, but also a first opening to re-enter the normal world of time and space as understood by humanity at large. There are many who might be unable to deal with this transition, and probably that accounts for DAMA. The DAMA cases are viewed by professionals as a reflection on their intervention programmes, or as cases of 'law

and order'. This ends with patients being tied down with a total violation of their human rights. In other instances, the professionals might express the view that DAMA cases represent a reality which is part of drug abuse management. But the hollowness of these statements becomes obvious when you see their irritation with re-admission of DAMA cases. A DAMA case is always subtly or otherwise instructed that he is not supposed to repeat his behaviour. Drug abuse management has a long way to go before the goals of the patient and professionals meet.

(d) Time Management

Another area of conflict arises from the inmates' difficulty in utilising their spare time. This applies especially to drug users who suddenly find themselves with a lot of time on their hands. This is not a problem when they are suffering withdrawal symptoms. Heroin users are the easiest to manage in this respect. If they do not have medical complications, withdrawal symptoms usually disappear within three or four days.

After this period, keeping them for longer periods calls for planning so as to structure their time use and prevent unnecessary consequences developing in the ward, which can be detrimental to the smooth functioning of the organisation.

One way of killing their boredom, according to institutional policies, is to let the inmates watch television or play games or take part in work therapy. These activities are selected by professionals who establish procedures in accordance with their perceptions. If someone is interested in reading, the question of boredom does not arise. Irrespective of the activities chosen there are set timings for all the inmates. They are never encouraged to do anything after 10 p.m. People who have been on brown sugar for years (and very few users come to the centre in the early stages) are not used to the normal routines of society. The prescribed 'lights out' is far more convenient for the night staff than for the patients.

(e) Contact with the Outside World

Visitors are allowed to meet inmates only within the strict rules laid down by the centre. During visiting time there is always staff member present to keep an eye on the patient and see if he makes an effort to procure drugs through visitors. The emphasis once again is on the smooth functioning of the centre rather than on easing the relationship between patients and their relatives or friends.

An inmate in a rehabilitation centre has to give up his freedom for a longer period, ranging from eight months to even five years. He is forced to give up all normal intercourse with the outside world. It is only when the long-term rehabilitation period is complete that they are allowed to interact in anyway with the outside world. This whole procedure is not recognised as a hindrance to the healthy development of the individual. In fact, if a former inmate goes back to drugs after re-entering society he is given another chance (after testing his motivation level) to return to the institutional setting. If necessary, he will continue in this setting: the only difference is that he will shift from the role of patient to that of a staff member. Those who violate these two stereotypes are discouraged from participation in the group. Having a former inmate on the staff is beneficial, as he understands the perception of the user and can manipulate the situation to the advantage of the institution. The institution does not question why, after years of a drug-free life, the person concerned is addicted to the centre, or to the process of curing other users. Often, a major reason for this continuing attachment is that long-term rehabilitation destroys an inmate's social skills.

(f) Ceremonies Perceived as Demeaning

Inmates are deprived of various things, and are forced to beg for small mercies. In treatment centres, the use of the telephone is

barred to the patient. It is only under extraordinary circumstances that the patient is allowed to make a phone call. Permission is granted only after a long procedure of pleading, and the patient is constantly reminded what a great favour has been bestowed.

Another example is the supply of *beedis*. Brown sugar users are accustomed to smoking *beedis* after every intake of brown sugar fumes or brown sugar shots. It is very difficult for them to give up *beedis* and brown sugar at the same time, especially when this is a rule enforced by the centre. Staff tries to clamp control by rationing *beedis* that the patient has bought. It is a fact that poor people do not think of tomorrow for very practical reasons. This is especially true of addicts, all the more so for those from the streets. Invariably, the *beedis* brought by the patient run out within one or two days and then the friction between the ward boys and the patient starts. The ward boys or nurses assert their superiority instantly, making it clear what great favours they are bestowing on the inmates.

Another point of friction is in the distribution of medicines. If the staff cannot see any medical problems with patients, the question of distributing medicines to the patients never occurs to them. Patients are supposed to stand in a queue and put out their palms to collect the medicines across a grilled partition. It is a common sight to find the nurses harshly refusing patients' pleading for more medicines. Users have learned how to achieve sleep with sedatives and tranquillisers and experiencing a high. They begin to use numerous strategies to manipulate the situation.

The provision of meals has become an event with its own dynamics in most hospitals. This also applies to the treatment centres. Here no patient is allowed to eat as per his own body clock a right most humans exercise without a second thought. Inmates are given food by the ward boys, on the assumption that they will eat too much of one dish and waste another. This

also becomes a method of asserting their authority over the patients.

(g) Dynamics of Record-Keeping

Detailed case histories are taken from the patient as a first step in selection criteria. These records are always referred to during the next admission. It is also common practice to keep a record of any friction that has taken place between the patient and the doctors or other staff. This goes into the files as a permanent black mark. A former patient's previous records are always checked before he is readmitted. It is assumed that experience has not changed the individuals concerned and that the staff has not matured in learning how to deal with the situation. While records can be useful in identifying trends, the necessary modifications should also be made so that prejudices on the part of the staff are not permitted to obstruct further dialogue with the patient.

(h) Searching the Patient

On entering any institution for the first time, the new inmate is coerced into parting with his belongings which are entrusted for safe-keeping. This is the first step towards depersonalisation and conditioning an inmate's life. In the case of drug users, this takes on additional dimensions. The staff feel justified in making a thorough search, including a body search, to eliminate the smuggling of drugs. Thus users are exposed to the new balance of power between the staff and themselves at the very outset. Anyone who manages to evade the ubiquitous eyes of the staff, is caught and thrown out of the centre. His record will forever carry this black mark.

The World of the Staff

Unlike other institutions, such as factories, where people work

with inanimate objects, here the personnel are expected to obtain the desired output from humans. Besides, these individuals belong to a marginalised population unlike other occupations involving interaction with human beings such as personnel management or service relationship. These institutions tend to become mere dumping-grounds for individuals perceived to be threatening, either by the family or society. Unlike inmates in mental hospital, drug users may start treatment for reasons other than the goals set by society: for example, to find a hiding place, to pacify the family, to reduce consumption, or to merely change one's lifestyle. Here two sets of goals operate—those of the inmates and those of the institution. Professionals are conscious of these discrepancies, and they may respond in three ways: they may accept the goals set by the individual; they may use the applicant's entry into their domain as an opportunity for behaviour modification, to instil in him the objectives of society; or they may deny admission on the grounds of the discrepancy, or postpone admission until the user becomes totally helpless or "hits rock bottom", and thus becomes more manageable.

Often, the staff may feel that they are working with dangerous antisocial elements, who at any moment may turn violent. At present, identification of HIV infection among drug users has made the prospective patients seem more threatening for personnel who are still unaware of the modes of transmission of HIV. Unlike other countries, the health professionals in India very rarely use gloves as a precautionary measure. Another alarming factor is the presence of tuberculosis in some prospective patients.

Institutions try to maintain certain humane standards. In most cases, set goals are respected merely out of fear of public watch dog agencies who are looking for shortcomings in order to create an uproar. In any case, in most institutions, the organisation's philosophy does not reach the menial staff who has to

translate ideal goals into practical responsibilities. This may lead to the staff taking an easy way out. For example, the requirement for keeping inmates clean can lead to their heads being shaven if their long hair is unmanageable. A suicidal patient may be tied up, to prevent him from doing himself any harm. Patients who want to leave may be tied up or detained by force because the organisation has taken a non-refundable advance payment for the full course of rehabilitation and would find it difficult to explain why the patient discontinued treatment and why they cannot subsequently refund the money received.

In the interest of the smooth running of the organisation, inmates can be taught to behave. But their relatives can also make trouble. And they cannot be trained to behave! Hence they can become a source of worry for the staff. The involvement of relatives is therefore discouraged and often opportunity for dialogue is used to condition them to official concepts of 'addicts' and their 'disease'. After such training, relatives can be used as an additional lever to break down the inmates' resistance to institutional rules.

To carry out their responsibilities, the staff uses various methods which sustain the social distance between themselves and the inmates.

(a) Record Keeping

One way in which responsibility can be distributed and maintained is by keeping proper records. At each and every stage, a record is kept of what was done with the patient and who was responsible. Thus, in moments of friction, a staff member can be held personally accountable.

(b) Keeping them in Line

For effective management, it is necessary to avoid conflict. This

is achieved by the use of threats, rewards and punishments, to attain the required behaviour modification. Unlike inanimate objects, people can thwart the goals of any institution. So they have to be kept under constant observation.

One way is to make inmates conduct themselves in a manageable way. Both 'good' and 'bad' behaviour must be defined as springing from the personal will and character of the individual. They must be made to realise that they exercise self-control. In any institution we can observe the micro exercise of the development of something akin to a functionalist version of moral life.

The inmates' behaviour is translated into moral terms which suit the institution's avowed perspective. This implies some broad presuppositions as to human character. The staff in charge of inmates who must be processed in a particular way tend to evolve what may be called 'theories of human nature'. Such theories rationalise institutional activities and provide a subtle means of maintaining a social distance from inmates. This perpetuates a stereotyped view of them and justifies the treatment accorded to them. These theories cover the full range of possible inmate conduct, value of privileges and punishments and the essential difference between staff and inmates.

(c) Maintaining a Distance

Entry into an institution is considered to be enough reason to classify the inmate as 'sick' or 'deviant'. Once this definition has been accepted, the staff members try to maintain a social distance from the inmates they interact with. This process is reinforced when dialogue is restricted to request from inmates and justification of the rules by the staff.

One flaw in this controlled interaction arises when a staff member develops affection for any inmate. When the patient behaves exactly as he pleases, and the staff member concerned

feels hurt and betrayed. Any affection between inmates and staff members is also seen as a threat by other personnel determined to maintain a social distance. Often, the outcome of such a case is that the concerned staff member tries to shift to a different level of interaction, perhaps moving to an intellectual level from an emotional level. These shifts can be cyclic and a means to deal with the burn-out syndrome that is common while working with drug addicts or in mental health.

(d) Redefinition of Terms

One important concept that is redefined is work within the institutional context. Work is ordinarily done for pay, profit or prestige. When these motives are withdrawn, a new interpretation of work is called for. One of the means of rehabilitating a person in an institution is through work therapy. For this, patients are given typically menial tasks, such as raking leaves, waiting at tables, sweeping and washing floors. The choice of these tasks depends on the institution's work needs, but the claim presented to the patient is that these tasks will help him to relearn how to cope with society, and that his capacity and willingness to handle them will be taken as diagnostic evidence of improvement. The inmates themselves may or may not go through a similar process of redefining work. For behaviour modification work therapy is sometimes imposed as punishment, where the staff may mix tea leaves with sugar and tell an inmate to separate them to spite the inmate. In the case of an ex-addict continuing as a counsellor, it is termed as a favour to enable him to remain sober, while in fact the institution gets cheap labour.

(e) Giving a Face Lift

Professionals from various fields such as yoga, psychotherapy or transcendental meditation are sometimes employed to

heighten the institute's image. These techniques need not be properly evaluated to assess their effectiveness for future modification. These professionals may be enlisted to impress visitors. Other staff members, who have to deal with patients on a regular basis may face the contradiction that while they use coercive methods to impose obedience, an impression is created that humane standards are being maintained and rational goals realised.

8

Implications of the Study for Drug Abuse Management in India

While certain similarities in the global trends of drug use can be seen, socio-cultural distinctiveness which play a role in drug use, abuse and its management have not been obliterated. There are cultural as well as individual differences between users of the same or different drugs. This calls for a rethink about uniform strategies in the field of prevention, treatment or rehabilitation. From the earlier chapters and other studies, it is evident that drug use is a complicated phenomenon and requires varied and multifaceted responses.

Limitations of the Prevention Responses

The drawbacks of an intervention programme in the field of prevention can be viewed from the conceptual and implementation levels. A few of the dominant tenets will be discussed here.

1. Drug use is a new social evil

Since the identification of excessive use of psychoactive substance and definition of substance use as a disease, the image communicated has been that drug addiction is a new phenomenon which erodes culture. This has been refuted by historical data and case studies of individuals who have used mind-altering substances for years prior to the enactment of the NDPS act. The cultural role assigned to various drugs has been documented here and elsewhere (Chopra, 1990; Rubin, 1975; Herer, 1990). These realities are negated and history has been forgotten by contemporary slogans. As a result, negative messages clubbing all mind-altering substances together are utilised. Hence, the effectiveness of anti-drug campaigns is limited. Take the case of Rajan, who came from a region where cannabis use was sanctioned for specific occasions. It would be difficult for him to perceive cannabis as a social evil. Even in the case of brown sugar, the perception of it as social evil is not universal. For example, drug users show the total ambivalence when they use the earnings, from pasting up prevention posters to chase a few more *pudis* of brown sugar. The case of users who indulge in controlled use is contrary to contemporary preventive messages.

2. Negation of the nexus between the drug industry and politics

Prevention programmes often ignore this factor which determines the availability of different mind-altering substances. While macro factors determine the dynamics of this social issue, the entire responsibility is often heaped on the user and his immediate social network. Research studies which tried to enumerate the causes of excessive drug use arrived at a dead end, or created a maze of interlinking factors which cannot be isolated from the user's environment. Yet prevention programmes under taken arbitrarily isolate one particular variable in the intrapsychic factor on the basic assumption that the individual is personally responsible.

This leads to programmes such as assertive training, 'Just say No', programmes on self-esteem building exercises as corner-stones of the drug abuse prevention programme. The initiation into drug use is either an accidental event or a conscious decision. In either case, the premise for the 'Just Say No' approach to drugs is debatable. In the former case, the person concerned may not be aware of the consequences of consuming a particular drug; he may not even know that he is consuming it or he may assume it to be like other drugs he has used earlier. In the case of the latter, he has information about the drug and may also know about its ill effects on the lives of other abusers, nevertheless he decides to consume the drug. Here the inputs required for prevention may be those related to access to alternative options within his environment.

Most of these programmes are based on the premise that greater awareness will lead to modifications in attitude and behaviour. The Knowledge-Attitude-Performance (KAP) Model of diffusion of innovation has helped marketing industrial products, new agrarian practices and so on but has little to show in controlling human behaviour, in pursuit of pleasure such as sexuality or drug use, etc. While such approaches may lead to greater awareness, the desired improvement effect in terms of attitude and behaviour does not necessarily follow. Besides, in those areas where over the years a particular attitude towards mind-altering substances has already evolved, information alone (which is often biased), cannot bring about the desired results.

The case studies of Sharma Vellar and Ramamurthy indicate that the social reality of the individual has a major role to play in the use of mind-altering substances. While Vellar used it to deal with isolation and the trauma of growing up as a street child, Ramamurthy opted for drugs to evade the guilt of his child's death and his own irresponsible behaviour.

Besides, the cultural use of opium in Saurashtra, Rajasthan or cannabis in Orissa, Gulbarga and other parts of India emphasise the need to consider the role of culture in drug use. The positive impact of culture in preventing a shift from natural to derivative or synthetic products has been documented in our study. These cultural norms can be used to prevent shifts in trade for higher profits which in turn creates a new breed of users, traders and manufacturers. In the case of Anand, he saw brown sugar being used but did not start using it till social disturbance made it difficult for him to obtain his regular substance, opium. Here factors other than individual choice led to a shift in the choice of the drug.

3. Placing the responsibility on the user

The traumatic lives of people at a marginal level with the accompanying poverty and lack of social support can be difficult to deal with. This state of existence itself could motivate someone to opt for drugs. The dilemma might not be fully understood by professionals who come so often from the richer classes. Though they emphasise the responsibility of individuals to society, they never talk of social responsibility to the individuals. This creates a wall of separation between these groups from the very onset which already makes any realistic change difficult. The case study of Raghu Rao illustrates isolation and alienation of a life lived on the street. While Raju's emotional attachment to friends had prevented his continued abuse of brown sugar, the destruction of emotional ties led to the reuse of brown sugar.

The previous chapter focuses on the dynamics of the relationship between professionals and users and its limitations. The goals being varied leads to subtle or overt interpersonal conflicts which often highlight the discrepancy between the two groups. Drug abuse control policies have emanated from the US and other western countries. The international organisations (the UN, for example) have transferred these global metropolitan definitions of the problem to the urban elite, policy makers

through international structures such as Churches, Rotary Clubs, Lions Clubs, the Red Cross, the Salvation Army and YMCAs. Annual international conferences are a mechanism by which policy ideas get transferred. The master plans prepared by the UN bodies and through other international consultations are some of the mechanisms. In a country where 80 per cent of the population lives in villages, and 50 per cent of the urban people have numerous health problems such as tuberculosis and malaria, and where millions die of diarrhoea, it is a microminuscule of articulate elite who contribute to making policy and priority decisions. Thus, there is a need to provide accurate information to the people who have the capacity to make or influence policy on the nature, typology of drug use, harmful use and addiction.

4. Need to differentiate between initiation and continuation of drug use

The factors that sustain drug use are not the same as the motives for initial consumption. This calls for changes in prevention and intervention programmes that exaggerate the negative aspects of drug use.

While the initial reasons for drug use can be accidental or out of choice; the decision to continue use has its own dynamics. This is clearly illustrated in the case of a relapse, where the users resume drug use because of their inability to deal with withdrawal symptoms, social isolation or to deal with users associated with earlier life that creates a need for the drug. For example, there are intervention programmes to facilitate users to understand the cues which elicit this response in them and methods of dealing with it. Besides, this can be the first step towards making the user seek a change by identifying the differential factors that sustain his habit before getting entrenched in an alternate lifestyle.

5. Differentiation between natural forms of drugs and derivative or synthetic drugs is not considered

The presence of varied patterns in the use of mind-altering substances requires different types of intervention programmes. For example, in places where there is traditional use of opium, the adoption of intervention programmes that call for a drug-free lifestyle ignoring the cultural norms developed over centuries can lead to individual non-cultural use of synthetic drugs, according to their availability. This drug substitution can be far more harmful to the individual and to society. In the case of opium, those who seek treatment due to excessive use are often older. The profile of users may change with a younger age group. This shift may not be noticeable immediately as their drug use may not take place within any cultural or social context.

The non-availability of traditional drugs like opium leads to the use of brown sugar. This has been reflected in the case of Anand and also that of Rajan. When Anand was unable to obtain his regular quota of opium and the seller found it easier to sell him sleek, well-packed brown sugar, Anand shifted to it. Rajan wanted to deal with opium withdrawal pains with *doda* water. When he was unable to procure it, he began using brown sugar. The clubbing of all drugs together without considering their historical and cultural realities is detrimental to society. In the case of cannabis, its use may not be limited to mind-altering but production of varied fibre products and classification of the plant as illegal will disturb many aspects of development in various regions of India. Measures such as legalisation of cannabis and maintenance programme of opium can go a long way in preventing a large proportion of cannabis and opium users from switching over to brown sugar. This should be the basis of harm minimisation programme in India.

6. The concept that drug users are 'never-do-wells' and can change only through drastic measures is faulty

The extensive use of cannabis in Bombay city, the belief that cannabis is harmless and the acceptance of cannabis users by the community, is not taken into account by the Narcotics and Psycho-tropic Substances Act, 1985. This is shown by the response of the community to brown sugar users. Even families of users themselves give similar opinions.

The families and the immediate network around brown sugar users usually accept them as long as they remain functional and do not drop to the nadir of marginality. This calls into question the premise of the 'disease model' of certain therapeutic communities, which claims that habituated users cannot be helped until they reach 'rock-bottom'. It even insists that the family precipitates their decline. These approaches postulate that until drug users become utterly helpless, no help should be extended to them. It must be stated here emphatically that more families are concerned about dysfunctionality than about drug use per se. The absence of alienation and tolerance towards brown sugar users was reflected in the life of Rajesh. Even when drug use affected his responsibility towards his family, Niyaz was able to cushion its impact because of a strong family support system. Besides, the alienation from the family pushes the users into an alternate lifestyle and makes the process of rehabilitation far more difficult, as seen from the case of Khan.

7. Marginalisation hinders the integration process

The portrayal of users, especially street users as unhygienic and irresponsible, or as people involved in antisocial activities, further widens the gap between users and the community. This, in turn, makes the user avoid non-user social network and become more deeply entrenched in a separate users' culture. Slowly the

options for change diminish. There may be cases where even after detoxification, the only option available for a former user depends not on his own personal choice, but on his old habituated routine. Feeling isolated he may go back to the company of users.

In any case, marginalisation increases the chances of involvement in high-risk behaviour, unprotected sex, injecting drug use and antisocial activities which may change the user's entire lifestyle and also expose him to HIV infection. The life of Shakthi reflects the trauma of an ex-user. He avoids interaction with non-users as they might be reprimanded by their parents for associating with a former drug user. Unable to deal with the isolation he ends up spending time with users and returns to drugs. During our study, users often requested for permission to stay back at the centre after detoxification in order to deal with alienation. Earlier, druguse helped them to avoid negative feelings. Thus, intervention programmes have to be sensitive to subtle factors in a user's life in order to be effectively appropriate.

Prevention Strategies and Their Limitations

Prevention strategies for change can be broadly classified as:

- informational/educational strategies,
- persuasive strategies,
- facilitative strategies, and
- power strategies.

In the field of drug abuse prevention, power strategies have been more or less integrated with other strategies with more emphasis on punitive philosophy for intervention. Unlike other social issues, even today the principal strategy of intervention in drug abuse management is punitive. Alienation, marginalisation

and enforcement of change is ingrained in almost all interventions.

Informational, educational strategies form a large percentage of prevention programmes in India. These strategies include the fear approach; educational programmes to increase knowledge about drugs; their uses, mode of intake and impact on body and mind, narratives by ex-drug users on the adverse impact of drugs on their lives and opting for a healthier way of life.

The limitations of these efforts in India are:

- They assume that individuals who use drugs are unaware of the long-term and short-them consequences. Hence, information dissemination will prevent drug use. It does not differentiate between initiation and continuation of use.
- They do not emphasise the difference between slip, lapse and relapse.
- Prevention efforts utilise symbols and phrases used in other countries and do not consider the cultural and historical reality of India.
- When emphasis is on written information and the percentage of illiteracy is high, coupled with a multiplicity of languages, then people focus more on symbols. Yet, very few prevention programmes have looked at the cultural significance of symbols used in communication.
- They disregard the rich oral tradition in the transfer of information which has been the most effective medium in oriental culture.
- They ignore regional variations.
- They view any drug use as a moral issue which may be contradictory to the views held for years with regard to certain drugs.

- They assume that attitude and behaviour can be changed through information.
- Large-scale information dissemination does not take into consideration variations in social and economic status, educational level, gender, religious beliefs, culture and its distortion through industrialisation. It ignores the persistence of tradition in modernity.
- The efforts are never the outcome of participatory inquiry with the concerned target population but based instead on assumptions and the insights of the middle and upper class professionals exposed to western literature.
- Adolescents are more concerned with psychological and social well-being than with health concerns, especially those with long-term effect.
- There has been only a sporadic application of approaches such as affective education, alternative activities, social assertiveness-skills training, cognitive behavioural skill training, life skills training and social inoculation training.

These approaches too have their limitations. They are:

- Segmentation and specialisation of drug addiction discipline by experts from different fields and their search for independent solutions to manage the problem.
- Isolation of drug use from other social issues and seeking solutions outside the developmental perspective.
- They assume that there are no rational reasons for drug use. They emphasise the negative role of peer pressure in consuming drugs. But, social inoculation training based on persuasive communication theory focuses on imparting knowledge through individuals in the same age group.
- It ignores the constructive role played by peer pressure. For example, brown sugar users shifting to cannabis due to peer

pressure (CYSD, 1987).

- There is an assumption that assertive training can be limited to countering the negative influence of peers but ignores the dynamics of utilising the same skills in other situations. This is especially true in a country like India, where an authoritarian family system still exists. The same is the case with the education system even at the advanced levels. It is equally a characteristic of schools of social work which are to produce agents of social change with participatory approaches. Institution also often perpetuate the gender bias that exists, which restricts even creative outlets for girls.

Suggestions for Preventive Measures

- The need to document assumptions regarding the role of drug use within different segments of the population based on which prevention measures can be evolved.
- Before suggesting alternative activities for preventing drug use, the needs of youth and realistic options available for them should be documented.
- To evaluate the educational system and identify ways of integrating various skills for development as part of the curriculum for enhancing growth. They should not be perceived merely as being isolated areas in the prevention of drug use.

Limitations of Treatment and Rehabilitation Programmes

Current government programmes in the field of drug abuse management are uniform throughout the country. As they do not consider the varied patterns of drug use, funds are being wasted on inappropriate options. The hurdles in evolving appropriate and realistic intervention programmes emerge from

the conceptual confusion and lack of understanding about the process of drug use careers and de-addiction. In the case of conceptual clarity the drawbacks can be looked at from the following levels:

1. Treating drug use as an individual problem

Drug use treatment programmes are targeted at the individual and his family. The emphasis is on the act of drug use and not on the socio-cultural reality or the developmental dynamics of the region. For example, the circumstances that sustain the use of opium in Rajasthan are different from the realities that sustain injecting heroin use in north-east India. While an individual user's reaction to social reality is an important factor, it is not the only responsibility.

2. Considering drug use as a medical problem with a difference

At one level, most intervention programmes assume that drug use is a disease, incapacitating the user for life. But unlike other diseases, there does not exist any valid physiological agent or vulnerability or scientifically proved emotional weakness correlating drug use. Most of the genetic studies are based on rats, dogs and monkeys.

Thus, the individual has to accept whatever addiction professionals have to say about his progress. Besides, unlike other diseases it has a moralistic dimension, which degrades the user as a 'sinner' and promotes professionals as 'saviours'. These dynamics are often used by professionals to their advantage for dealing with relapse or selecting cases to their advantage.

At the level of implementations, the setbacks arise from the following aspects:

1. Perception of drug use as a moral issue that requires repentance

The present approaches consider consumption of both traditional and synthetic drugs a moral issue. This comes into conflict with earlier associations. An addiction professional exposed to western literature or Indian literature and philosophy, will be in a dilemma if he communicates to an opium user in Rajasthan or a cannabis user in Orissa or Karnataka that drug use is a moral issue. Even brown sugar users may not accept being classified as 'amoral' individuals. When convergers or separatist enrol in such programmes, they feel alienated, as their need is to be helped to become functional users and not to be branded as 'amoral'. The perception of these people as amoral invokes guilt in them on re-admission to detoxification centres. It also gives the professionals the right to 'pardon' the 'repenting' user. The power given to professionals makes the relationship between the user and the professional an unequal one.

2. Absence of different types of treatment options

The requirements of functional users may be different from those of marginalised drug users. The latter are often ignored and die on the streets because of a total absence of treatment. This has been highlighted in our field study where we had to arrange for emergency care or surgery. The deaths of users prior to the launching of our crisis intervention programme also emphasised the need for differential treatment options. While drug agencies may be catering to marginalised users or to those who accept the definition of being an 'addict', they may not be perceived as a viable option by those who are functional and do not want to be identified as addicts. Hence, there is a need for alternatives for these functional users. Private clinics are available for

the rich, but they are beyond the reach of many users from the lower middle class. Even these private clinics have limited information on detoxification and this can lead to the use of merely symptomatic and trial-and-error methods. One of the myths created through their efforts is the belief that IV-fluids play a major role in detoxification. While in reality it is a ruse to extract extra fees from ignorant patients (Rs. 50 for a bottle which costs Rs.8 in the wholesale market).

Some users may seek health care so as to maintain a functional relationship with drugs. Thus, intervention programmes need to accept other goals in addition to curative ones. The ideology of the purist cannot be imposed on all users, since a number of them seek only to lead a functional life. It is also possible that a user's initial reason for seeking detoxification may arise out of medical complications or the non-availability of their drugs. Individuals who have been marginalised for years will have in tense negative emotions towards society. As they may have found it hard to express themselves clearly when they were admitted to the treatment centre, their reactions will differ. While some may be thankful for finding their 'saviours', others may take this opportunity to articulate their negative attitudes.

If a user acknowledges the treatment staff for their 'selfless' contribution towards the *Gardulla*, then the staff members are naturally pleased with the individual and show concern and positive feelings towards him. On the other hand, if he were to express negative reactions, this can provoke subtle or overt messages of rejection from the staff, which in turn contributes to further hostility on the part of the patient. This creates a vicious circle. On such occasions, there is a need to ventilate the issues and channellise negative emotions. It is also necessary to help an individual understand the process of marginalisation and its impact on him.

3. Dependence on institutional framework

Since a user can form varied associations with drugs, the resources required will differ. The dependence on institutions with uniform intervention programmes may be inadequate. As involvement in drug use is a process, intervention at different levels require varied strategies. For example, to prevent entry into a separatist lifestyle, the functional drug user may require periodic detoxification either as an outpatient or inpatient. Besides, there is a need for outreach programmes. The case studies of Raghu and Sharma clearly indicate the same.

The majority of brown sugar users are in a marginal position. Which leads to changes in their lifestyle and at times to involvement in other antisocial activities. It questions the dependence on detoxification and rehabilitation centres alone for change. The situation is worsened by the policies of treatment centres, which often emphasise assessing motivation, though there are no standardised tests for it. An institutional programme assumes that intervention stops after the patient is discharged. This is a fallacy. For the users, re-entry into the system will be a process where many factors may act as a hindrance. Hence, there is a need for outreach programmes. Separatists might require additional support within their environment if they are to become functional. Understanding the survival techniques of users outside the treatment centre will facilitate the development of appropriate outreach programmes. Most female drug users may resort to prostitution or crime to sustain their drug habit. At times, their children support their habit by theft, as was in the case of Sharmila who stole from the port.

The presence of a health care system by itself does not guarantee care for drug users. For example, the case of Rajan, a separatist, reflects the difficulties faced by users in accessing the existing health care infrastructure. Often the appearance of the

separatists make the professional seek referral options rather than direct intervention.

4. Excessive emphasis on long-term stay in institutions

The rehabilitation centres of today are nothing but relics of former asylums. Someone's entry into the centre involves an initial 'deprogramming' of earlier socialisation. The person is then programmed to meet the requirements of the institution. The dehumanising process is labelled as a humane intervention.

While users who have adequate structures which can support them while they are unproductive opt for long-term care, others have no such options. For example, some of the rehabilitation centres employ ex-users either as counsellors or in other capacities. This has two dimensions, it provides the centre with a source of cheap labour which can be justified as 'occupational therapy'. The fact that this process further hinders the chances of former users to integrate with society and restricts them within the community of ex-users and treatment professionals is not considered a limitation by the programme implementers. Thus they spend their lives 'repenting', unaware of other options in life.

At another level, (in the case of poor people), enrolment in such programmes destroys their livelihood. This applies to a large number of self-employed and other workers: door-to-door vegetable sellers, rag pickers, drivers and others.

5. Ignorance of indigenous mechanisms developed by users

Marginalised people try to develop strategies to reduce the extent of their marginalisation. Hence there is a need for non-institutional programmes which will build upon the efforts of the users, where the users would be managing their own lives; unlike in the 'disease models' which are based on the helplessness of the patients. Our field study shows that existing

institutional services are not sufficient to deal with the needs of the users and outreach programmes for them are non-existent. The users, especially marginalised persons try to evolve strategies to deal with drug use and their marginalised condition.

This has been documented in a number of cases where users have attempted to detoxify outside the institution. Hence, there is a need to document these ventures and identify ways in which they can be sustained and strengthened.

Suggestions for Intervention Programmes

- Need for outreach programmes to sustain indigenous efforts of the users for controlling drug use or being drug-free.
- Outreach programmes for restricting continuation of synthetic/derivative drugs consumption among new clients.
- Undertaking programmes for identifying and reducing high-risk behaviour leading to infectious diseases.
- To evolve outreach programmes by networking with existing health care systems to deal with crisis cases.
- Evolving outreach programmes for female users to reduce or stop drug use, to facilitate them to get involved in income generation activities which do not involve high risk behaviour that hampers their lives or that of their children and to use health facilities for medical care and to facilitate harm minimisation through behaviour modification. In the case of female users with children, it is important to have insights about the impact of their lifestyles on their children and provide opportunities to the mothers to socialise the child in an alternate lifestyle without institutionalising the child.
- To identify the factors that hinder drug use among street kids and utilises them to evolve preventive programmes.

- To facilitate utilisation of health care as a preventive measure and not cure alone. The tendency of many users to seek medical help for medical complications reflects the perception of a detoxification centres as a hospital among certain segments of the population.
- The need to understand how drugs influence sexual interaction and evolve preventive programmes targeted at HIV and Hepatitis B and C.
- Understanding myths about sexuality that promote drug use and contribute to a relapse after detoxification.
- Identify the influence of drugs on the sexual behaviour of HIV positive cases or their partners and evolve programmes for the same.
- Intervention programmes need to identify the perception of a target population's risk factors. For example, losing a friend who is an intravenous drug user may be seen as far more threatening than involvement in any high-risk behaviour. The fear of losing a daily wage through risk behaviour may be considered more fearful than the threat of HIV. Unless these relative perceptions are understood and dealt with, intervention programmes may be inappropriate.
- The type of drug could also influence appropriate safety measures. For example, prolonged penetration associated with delayed ejaculation through the use of stimulants can cause condoms (when not used properly or condoms are of poor quality) to tear and their subsequent avoidance.

Discussion

Today's debate revolves round harm minimisation, maintenance, decriminalisation, legalisation and punishment approaches. The respective foci are often on the negative impact or the ineffectiveness of the punitive approach, the fear of an

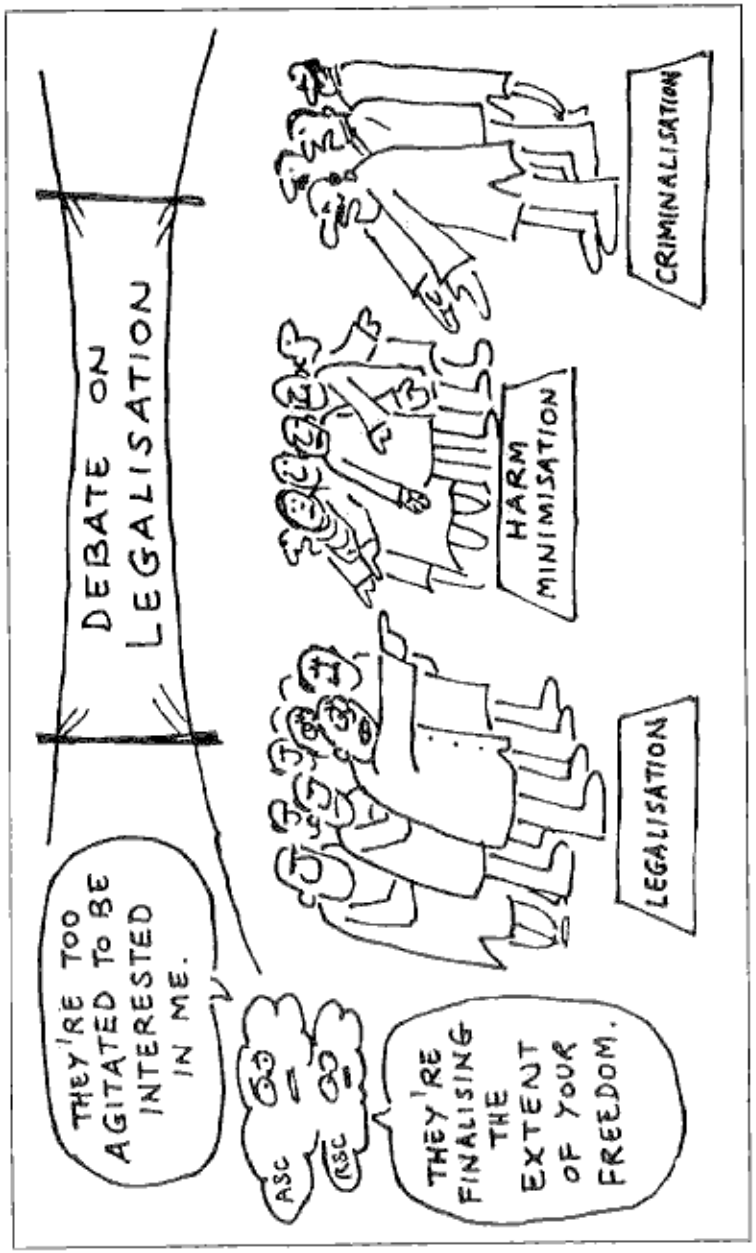
uncontrollable surge in drug use in the absence of punitive measures, and the impact of drug use on health.

At present, punitive measures have proved insufficient, and harm reduction measures have been adopted in many countries as a result of HIV infection among users. Harm reduction programmes cannot take away the stigma and marginalisation that results from use of an illicit drug. The feasibility of this approach even among professionals would depend on their commitment and capacity to differentiate between use and abuse. It would be very difficult to bring about social acceptance of users other than as repentant ex-users as long as criminalisation is the dominant dogma. In this context, issues related to drug abuse management in India are considered. Some of them are:

1. Presence of uniform national empirical norms

Both historical data and recent studies done in certain parts of India (Siddiqui, 1998; Rao, 1998; Masihi, 1998 and CYSD treatment data, 1995) show that cultural norms persist. In such situations, any emphasis on empirical norms lead to the encouragement of trafficking in synthetic drugs and the creation of an alternate culture. In Orissa, where cannabis use has a cultural sanction, those who gave up brown sugar shifted to cannabis. This constructive shift is difficult if the situation becomes akin to that in Bombay, where cannabis is highly adulterated, expensive and difficult to come by. *Charas* (hashish), which used to cost half a rupee a *goli* (ball), now costs Rs.8-10. This is sufficient for just one smoke, while the cost of one *pudi* of brown sugar is Rs.10-15, which unlike *charas* gives a high for hours.

The cultural norms that govern a particular drug use can be changed through exposure to another culture and industrialisation. This is seen in metropolitan centres like Bombay where cannabis and opium use is not limited to culturally sanctioned



occasions. For example, cannabis use is not limited to festive occasions or religious reasons, it has become a social drug which gives respite to people from daily drudgery. In the evenings, small groups of cannabis users get together to smoke it. Besides, it is quite common for youth to experiment with drugs in cities. These changes too contribute towards a shift to derivative or synthetic drugs as it creates a competitive market with the enforcement of empirical norms.

The protective blanket of plurality of cultures and languages in India has prevented the uniform implementation of the Narcotics and Psychotropic Substances Act of 1985. This has been a boon in disguise, as otherwise, the situation would have been unmanageable if synthetic or derivative drugs had taken the place of consumption of traditional drugs. This is probably the only explanation for the presence of cannabis fibre products such as slippers and bags in some parts of India. This status of natural drug use has to be safe-guarded if not encouraged for the cannabis plant can be used for variety of consumer goods including the manufacture of paper, ropes and so on.

2. *Uniform drug abuse intervention programmes*

Users are not a homogeneous population. Even in the particular territorial area of drug use, which is often the only common habitat that links them together, they differ. The category they fall under depends on the extent of use and the skills they have developed to curtail the impact of the drugs on their lives. It is only when their capacity to hide their habit gets disturbed that they shift to other categories.

Further analysis of the types of users can be useful in the formulation and implementation of relevant intervention programmes. It is also possible to enable users to retain the skills that help them to be functional and extend the transition period between being convergers and becoming separatists. Since the

present resources and programmes are incapable of offering long-term care to all users, and these rehabilitation models have a high rate of relapse, it is necessary for professionals in the field to rethink their strategy.

Continued drug use and marginalisation affect different aspects of life, such as livelihood, social relationships, personal hygiene and health, and push the user into antisocial activities. Currently a significant number of drug users are marginalised. Changes in the lifestyles they adopted alienate them further. The extent to which they have deviated from the centre will provide the basis for intervention programmes.

The first use of brown sugar was accidental in most cases. However, there were some cases of use by people already aware of the adverse impact of the drug. Traumatic early childhood experiences may have been a factor for such users; some could not control their habit and ended up in the present marginalised group, while some earlier users committed suicide. This is not the case now. In the early eighties, when the substance was pure and new, a few users intentionally lost their limbs, to enable them to earn money by begging for their drugs. Users can now manage their withdrawal symptoms to some extent. At present, death is far more likely to be related to the disorientation created by nitravet tablets and the resulting accidents, or due to medical negligence.

In the Indian context, family support prevents extreme marginalisation. While in the nuclear family, the extent of functionality determines the family dynamics, in the case of the joint family system this can be further cushioned as other members help out in the process. This was seen in the case of Niyaz. There was another case where the user's elderly mother did odd jobs to sustain the user's family and prevent extreme marginalisation. Though western approaches may propagate the need to facilitate isolation and allow the user to touch rock-bottom before seeking help in dealing with drug use, there is no scientific

evidence to show that they prevent relapse or are constructive. Besides, the family might want the brown sugar user to be functional and may suggest a shift to cannabis as an alternative.

Under such circumstances it would be useful to facilitate the users to be functional and slowly deal with their drug habit, than uphold a puritan approach.

Marginalised users make attempts to re-enter society and become a part of the system when they see some hope for a change. Despite all the flaws of a drug abuse programme, users have identified various coping strategies to deal with drug use. Though this change is not permanent in all cases, some manage to give it up on their own. Street users raise serious questions about the 'disease model' of addiction.

The initial visit to detoxification centres may be prompted by health problems, lack of availability of drugs, inability to obtain the drug without engaging in antisocial activities, pressure from estranged families and, last but not the least, the need for a change in their living environment. Relapse is related to lack of social support after detoxification, the need to experience a high and to forget the continuing miseries of life. The presence of different types of users and attempts by street users to be functional raises queries about the puritan and disease approach to addiction.

Altered states of consciousness are alternately encouraged and condoned in India. While profits from the sale of brown sugar encourage some peddlers to shift from selling cannabis to dealing in brown sugar, not all have taken this step. In spite of the widespread availability of brown sugar, there are a large number of users, especially among the poor, who still continue to use country liquor or cannabis. The importance given to being functional or responsible is evident from the degradation faced by the street users and respect given to successful petty sellers. In spite of the efforts of the law and the police, there ar

many people who are willing to take the risk of selling brown sugar for the sake of a better livelihood. The children of these people are being socialised into a different network, where drugs are seen as a commodity.

Yet big profits are often an illusion, because, from time to time they are arrested and have to give up all their savings to avoid imprisonment. The smart ones have learnt to divert money to legal businesses or to deal in bulk, which is safer if one has the right contacts. This was seen in the case of a peddler who started a food grain shop to support his family along with the income from peddling.

The stigma attached to street users is far more explicit than to sellers of the drug. A person who can be a functional user might never have to face the wrath of the public because his family will protect him. The process of marginalisation takes time. The period and extent varies, depending on the coping strategies of the users.

In spite of the uniformity of the term 'drug user', there are various kinds of relationships that users establish in order to be functional. The difference is in their relationship to the drug, their interaction with society, the extent to which they want to assert their difference and the support systems available to them for dealing with addiction.

3. Isolation of the drug use phenomenon from the development dynamics of the region

The dynamics of the specific geographical area plays a major role in drug use. For example, places where opium cultivation has been restricted without adequate preparation at the ground level will only encourage the interaction between cultivators and illicit traders. In Bombay, the crowded housing societies make it possible for sellers to become inconspicuous when necessary. The new emphasis on changing or displacing slum

structures to distant areas and converting the city into a clean area filled with skyscrapers will not reduce drug use per se but shift street users, now an eyesore to the elite, to distant suburbs. Thus in the interior suburban areas the population will be exposed far more to derivative and synthetic drugs than they were earlier. The prominent parts of Bombay will be cleared for pharmaceutical companies, the legal traders of MAS to have a field day. This shift to use of pharmaceutical drugs has been noticed in other countries too.

4. Need for region-specific drug abuse programme and policies

There is a need for region specific programmes which will consider the cultural realities, the existing cultural norms, the hazards of drug substitution especially to synthetic or derivative products, the existing social control mechanisms for preventing abuse and drug use by youth. Programmes and policies based on these insights will be far more useful for the region rather than uniform norms set as per international design.

List of Abbreviations

ASC	Altered States of Consciousness
DAMA	Discharge Against Medical Advice
ECT	Electro-Convulsive Therapy
HIV	Human Immunodeficiency Virus
IV	Intravenous
IDU	Intravenous Drug Users
KAP	Knowledge Attitude Performance
MAS	Mind-Altering Substance
NARC	National Addiction Research Centre
NDPS	Narcotic Drugs and Psychotropic Substances Act
NGO	Non-Governmental Organisations

SPARC	Society for the Promotion of Area Resource Centres
UNDCP	United Nations Drug Control Programme

Glossary

addas	drug dens
afim	opium
arrack	country liquor
avara log	vagabonds
barela	filled in
beedi	local cigarette
bhabi	sister-in-law
bhajans	religious hymns
bhang	cannabis drink
bhakti	religious movement
bhagats	priests
Chandu Khannas	opium dens
chappatis	Indian bread

charas	hashish
chillum	smoking pipe
daru	liquor
daya	pity
doda	drink made of opium pods
dal	pulse
darshan	audience
didi	elder sister
Dasara	a festival celebrated in West Bengal
fakirs	religious persons
godhi	port
ganja	cannabis
gard	brown sugar (crude heroin)
gardullas	brown sugar users
goondas	thugs
goli	ball-shaped
goda	horse
hafta	bribe
Holi	a festival of colours
idli	cake made of rice and pulses
khari	a local form of biscuit
jadi buti	herbal medicine
Janma-shtami	Lord Krishna's birthday
lambardars	agents who collect raw opium from farmers to supply to the government depots

madak	form of opium
madhu	rice beer
matka/ madka	gambling den
mahua	a drink brewed from mahua flower
mall	stuff
maska	butter
mandir	temple
naka	junction/street corner
nasha	high
nani	grandmother
Navratri	a Hindu festival
pallav	a part of saree---an Indian dress for women.
pandit	a learned man
parathas	dry bread
patra	tin
pav	bread
pudis	packets
puris	a form of dry bread
roti	dry bread
Rg Veda	Hindu classical religious text
sabji	vegetable dish
saree/sari	Indian traditional dress
shamans	religious person
sharab	wine
Shivaratri	A Hindu festival

tolas	a measurement of about 10 grams
tari	toddy-juice of the fan palm/date palm/coconut
tarra	country made liquor
Varna	a caste hierarchy
vattana	peas
wadi	cleaning work during festivals and celebrations
yogi	a person who has achieved a high order of spirituality
zari	embroidery

Annexures

Annexure-A

MAJOR CONVENTIONS IN DRUG ABUSE MANAGEMENT

United Nations Involvement in Drug Control

In 1946, the United Nations assumed the drug control functions and responsibilities formerly carried out by the League of Nations. The functions of the League's Advisory Committee were transferred to the United Nations Commission on Narcotic Drugs, established in 1946 as a functional commission of the Economic and Social Council.

1946 Protocol

One of the first acts of the newly formed world body, this Protocol is the instrument which legally transferred the drug control functions previously exercised by the League of Nations

to the United Nations. It entered into force on October 10, 1947. The treaties on drug control had remained in force to the extent possible throughout the period of the Second World War and, by the 1946 Protocol, the international community restated its firm intention to maintain control over addictive drugs.

1948 Protocol

In the pre-war years, the number of products considered to be a threat and subject to control were largely limited to those related to the opium poppy, the coca bush and the cannabis plant. Shortly after the end of the Second World War, many other compounds had been synthesised which had dependence-producing effects. This whole new are of man-made substances was brought under the mantle of international law and control by the 1948 Protocol which entered into force on 1 December, 1949, bringing under international control drugs outside the scope of the 1931 Convention.

1953 Opium Protocol

Responding to the need for greater regulation of the opium poppy, the 1953 Opium Protocol (Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in and Use of Opium, signed at New York), which entered into force on 8 March, 1963, dealt with limiting opium use and trade to medical and scientific needs. It eliminated legal over-production through control of the amount of opium that could be stocked by individual states. Only seven countries—Bulgaria, Greece, India, Iran, Turkey, the USSR and Yugoslavia—were authorised to produce opium for export.

The Opium Protocol empowered the Permanent Central Board (now the International Narcotics Control Board) with

specific supervisory and enforcement responsibilities. These measures could, however, only be used with the consent of the government concerned. The Board could also impose, in some cases, an embargo on the import or export of opium.

Single Convention on Narcotic Drugs, 1961

In the period following 1912, the narcotics control system grew rather haphazardly, and by 1960 had become overly complicated. This led to the 1961 Single Convention on Narcotic Drugs, which consolidated most of the earlier international instruments. The Convention, which entered into force on December 13, 1964, and was amended by the 1972 Protocol, is regarded as a major achievement in the history of international efforts to control narcotics.

The United Nations had three objectives in drafting the Single Convention, with the need to codify all existing multilateral treaty laws in this field as a primary goal. This was accomplished successfully.

The new treaty simplified and streamlined the control machinery, which was another important step in strengthening the impact of the international community's efforts. The Permanent Central Board and the Drug Supervisory Body became a single unified body, the International Narcotics Control Board (INCB). In addition, through the Single Convention other administrative duties were consolidated, simplified and amplified.

The third goal of the Convention was the extension of the existing control systems to include the cultivation of plants that were grown as the raw material of natural narcotic drugs. The 1961 treaty continues to keep a tight rein on the production of opium and includes the coca bush and cannabis in the list of plants whose production was placed under international control. The treaty established or maintained certain national

monopolies. It also provided for a special national administration to be designed to apply the Convention's provisions. A specific obligation was placed on states' parties to limit production of narcotic plants exclusively to the amount needed for medical and scientific purposes.

Some provisions of the Single Convention contained new obligations dealing with the medical treatment and rehabilitation of addicts. Some provisions, such as those on the estimates and statistics system established by the Conventions of 1925 and 1931, were working effectively and were therefore retained virtually without change. Other provisions of earlier treaties also remained in tact: those that dealt with the requirement that exports and imports be expressly authorised by government authorities from both sides of the transaction; and those requiring governments to submit reports on the working of the treaty and to exchange, through the United Nations Secretary-General, national laws and regulations enacted to implement the treaty. Provisions for controlling the manufacture of narcotic drugs and the trade in and distribution of narcotic substances were also continued and new synthetic drugs controlled under the 1948 Protocol were included.

The Single Convention prohibits the practices of opium smoking, opium eating, coca-leaf chewing, *hashish* (cannabis) smoking and the use of the cannabis plant for any non-medical purposes. A period of transition was established to allow the States concerned to overcome the difficulties that could arise from the abolition of these ancient practices in their countries. The Convention also obliges States parties to the treaty to take any special control measures deemed necessary in the case of particularly dangerous drugs, such as heroin and ketobemidone.

The Single Convention has been recognised as a flexible and effective instrument, and consequently it has been widely accepted.

Convention on Psychotropic Substances, 1971

Till 1971, only narcotic drugs were subject to international control. Growing concern over the harmful effects of psychotropic substances, amphetamine-type drugs, sedative-hypnotic agents and hallucinogens—all men-made and capable of altering behaviour and mood and of creating harmful dependency effects—led in 1971 to the adoption of the Convention on Psychotropic Substances. This Convention, adopted by a Plenipotentiary Conference held in Vienna in January and February 1971 under the auspices of the United Nations, placed those substances under the control of international law.

By this Convention, which entered into force on August 16, 1976, the international drug control system was considerably expanded to include hallucinogens, such as LSD (lysergic acid diethylamide) and mescaline; stimulants, such as amphetamines; and sedative-hypnotic, such as barbiturates.

The control system provided for by the Convention is based largely on the one in force since 1964 by virtue of the Single Convention on Narcotic Drugs. In view, however, of the wide variety of substances subject to control under the 1971 Convention, the differences in the risks arising from the abuse of these substances and their addictive properties, as well as their widely varying therapeutic values, the necessary control measures were categorised in four separate "schedules". These Schedules are annexed to the Convention and the parties to the Convention are obligated to abide by their restrictions.

Schedule 1 lists those substances, which are completely prohibited, except for scientific and very limited medical purposes, by duly authorised persons in medical or scientific establishments, directly under the control of or specifically approved by their governments. The very strict provisions of the Schedule make any other activity, such as manufacture, trade, distribution or possession, subject to special licence or to prior

authorisation, always under close government supervision. The export or import of these substances is prohibited, except through very specific procedures in which both exporter and importer must be authorised by the competent authorities.

Schedules 2, 3 and *4* of the Convention dictate that each of the parties must apply specific control measures established by the Convention, as well as such additional measures considered appropriate in order to limit manufacture, export, import, distribution, stockpiles, trade, use and possession to medical and scientific purposes. Substances listed in these schedules can be exported or imported, manufactured or distributed only through licences granted by the government or similar control organisations. In order to enable people to take advantage of the therapeutic effects of these substances, prescriptions may be written by physicians, subject to sound medical practices and regulations, particularly as to the number of times the prescriptions may be refilled, the duration of their validity, proper labelling and necessary warnings. This Convention also regulates inspection of stocks, records and laboratory premises. It bans advertising to the general public. States parties must maintain a system of strict control of the manufacturers, importers, exporters, wholesalers and retail distributors of the substances and the medical and scientific institutes, which use them. They must establish or maintain a special administration to oversee these functions, much like those set up under other treaties on narcotic drugs. Efficient methods of record-keeping must be established, differentiating between the types of psychotropic substances and activities concerned.

The Convention contains special provisions relating to the abuse of these substances aimed at ensuring early identification, treatment, education, after-care, rehabilitation and social reintegration of persons who have become addicted to any of the controlled substances. Other articles address illicit traffic control and penalties. The United Nations bodies already involved

in implementing and executing the narcotics control system have the added responsibility for the control of the drugs covered by this Convention. These are the Commission on Narcotic Drugs (CND) and International Narcotics Control Board (INCB).

Because of the nature of these substances, the World Health Organisation (WHO) was the agency designated to determine on a medical basis whether a new substance should be included in one of the schedules. The criteria are: (a) the substance must have the capacity to produce a state of dependence and it must stimulate or depress the central nervous system, resulting in hallucinations or disturbances in motor function, thinking, behaviour, perception or mood; and (b) the abuse of the substance must produce ill effects similar to those caused by a substance already included in one of the schedules. WHO must also establish that the substance is being or is likely to be abused so as to constitute a public health and social problem. After a medical determination has been made, the Commission on Narcotic Drugs considers such other factors as the extent of known abuse and trafficking and then decides whether or not to include the substance in one of the schedules.

1984 Declaration on Control of Drug Trafficking and Drug Abuse

Describing drug trafficking and abuse as "an international criminal activity demanding urgent attention and maximum priority", the General Assembly, on December 14, 1984, adopted the Declaration on the Control of Drug Trafficking and Drug Abuse. The Assembly thereby 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 peoples and should be combated by all moral, legal and institutional means, at the national, regional and international levels". Its eradication, the Assembly said, was the collective responsibility of all states.

The Declaration goes on to state that member-states "undertake to intensify efforts and to coordinate strategies aimed at the control and eradication of the complex problem of drug trafficking and drug abuse through programmes including economic, social and cultural alternatives".

1987 International Conference on Drug Abuse and Illicit Trafficking

Recognising the heightened international dimensions of the problem connected with illegal drugs, United Nations Secretary -General Javier Perez de Cuellar called for an international conference as an expression of the political will of nations to combat this menace on a global basis. The General Assembly subsequently called for an International Conference on Drug Abuse and Illicit Trafficking, the first United Nations conference at the ministerial level to deal with questions of drug abuse and the illicit traffic in drugs.

Convened in Vienna, Austria, from June 17 to 26, 1987, the Conference was attended by representatives of 138 States, about half of whom were Ministers of Cabinet rank. The Conference adopted by consensus recommendations for a board range of measures to address the entire drug abuse phenomenon. Guidelines for dealing with reduction of both supply and demand of illicit drugs, as well as the suppression of illicit trafficking, were adopted by the Conference under the title "Comprehensive Multidisciplinary Outline of Future Activities relevant to the problems of Drug Abuse and Illicit Trafficking".

The Comprehensive Multidisciplinary Outline (CMO) is divided into four chapters, containing 35 targets defining the problems and suggesting specific courses of action at national,

regional and international levels.

Chapter I, on prevention and reduction of illicit demand, calls for:

- further research and study of drug abuse,
- more systematic analysis of data,and
- development of national education programs aimed at preventing drug abuse, particularly among young people.

The dangers of drug abuse in the workplace and the need for joint employer-employee programs to discourage it are also highlighted. The crucial role of cultural and sports activities as an alternative to drug abuse is emphasised, as is the importance of broadcasting, film and other media coverage that discourages rather than glamorises the use of illicit drugs.

Chapter II, advocates the reinforcement and extension of measures for control of the supply of drugs instituted by the international drug control treaties, including the following:

- rational use of pharmaceuticals containing narcotic drugs or psychotropic substances;
- control of international movements of psychotropic substances;
- control of the commercial movement of precursors, specific chemicals and equipment;
- identification of illicit narcotic plant cultivation;
- elimination of illicit plantings;and
- redevelopment of areas formally under illicit drug crop cultivation.

Suppression of illicit trafficking is dealt with in *Chapter III*. National legislative bodies are urged to establish penalties for transport companies that do not correct misuse of their facilities by international trafficking networks and to improve reporting

of suspect activity by financial institutions that may by involved in laundering profits derived from drug sales. Several recommendations are made as to criminal justice procedures:

- greater use of the technique of controlled delivery, whereby drug shipments once detected are followed to their destination so as to discover criminal ringleaders;
- facilitation of extradition;
- mutual judicial and legal assistance between States in international trafficking cases;
- laws allowing the admissibility in evidence of samples of bulk seizures of drugs, thus reducing the opportunities for illicit diversion of these caches;
- adequacy of penal sanctions for convicted traffickers and greater international standardisation of sentencing procedures; and
- forfeiture of the instruments and proceeds of illicit drug trafficking.

The following possibilities for more efficient co-operation between states are also outlined:

- surveillance of approaches to frontiers, airports and seaport; and
- regulation of the mails and controls over ships on the high seas and aircraft in international airspace.

Greater efforts to treat and rehabilitate drug addicts are urged in *Chapter IV*, including:

- analysis of existing techniques for working with chronic drug users taking into account local social, cultural and environment factors;
- reintegration of former drug abusers into society on a permanently drug-free basis; and

- reduction of the incidence of diseases spread through drug use, such as hepatitis and AIDS.

The political declaration adopted unanimously at the 1987 Conference reaffirmed the political will of the participating states to take vigorous action against drug abuse and trafficking and sets a benchmark for progress towards the long-term goal of a society free from drug abuse. The concept of a balanced approach and the need for the international community to adopt measures to treat all aspects and causes of drug abuse was affirmed.

States participating in the Conference recognised the collective responsibility of governments to provide appropriate resource for the elimination of illicit production, trafficking and drug abuse.

1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

Throughout the world, millions of individuals are affected by drug abuse either directly or from the criminal activities of the traffickers, related violence and ever-increasing corruption.

Drug abuse and illicit trafficking not only destroy human lives but also jeopardise the structure of society and even threaten the stability of governments. Drug-related problems are increasingly affecting countries in most regions of the world, transcending national frontiers and social systems. Billions of dollars are involved. All nations are vulnerable regardless of geographical location, political orientation of stage of economic development. In view of its alarming dimensions, the drug abuse phenomenon is now increasingly seen as a growing global challenge requiring a global response. The need for intensified international co-operation in this field is abundantly clear.

Continuing its role in the international fight against this modern plague, the United Nations convened a Conference of

Plenipotentiaries in 1988 which led to the adoption of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances by 106 states. This Convention is designed to hit drug traffickers where it hurts them most: by depriving them of ill-gotten financial gains and freedom of movement.

One of the innovative provisions of the (Article 34) Convention concerns the tracing, freezing and confiscation of proceeds and property derived from drug trafficking. To that effect, courts are empowered to make available or to seize bank, financial or commercial records. Bank secrecy cannot be invoked in such cases.

In addition to providing for the criminalisation of drug trafficking offences, the 1988 Convention bars all havens to drug traffickers, particularly through its provisions for: extradition of major drug traffickers; mutual legal assistance between States on drug-related investigations; and the transfer of proceedings for criminal prosecution. Another significant and innovative landmark is the commitment of parties to eliminate or reduce illicit demand for narcotic drugs and psychotropic substances.

Over 60 states are now party to the 1988 Convention, which entered into force on November 11, 1990. Other states are invited, to the extent possible, to apply provisionally the measures contained in the Convention.

Note: This is an extract from the booklet, *The United Nations and Drug Abuse Control*, United Nations International Drug Control Programme,1992.

In 1998, the UN Special General Assembly has mooted introducing laws for the control of money laundering.

Annexure-B

The Narcotic Drugs and Psychotropic Substances Act, 1985

K.V. Anuradha

For controlling drug abuse in the Indian context and keeping in line with the requirement of the Single Convention, 1961, and the 1971 protocol convened under the aegis of United Nations the Narcotics Drugs and Psychotropic Substances Act was passed in India. The general theme of the Act has been to emphasize the sanctions against illicit use of the narcotics, namely poppy, cannabis and coca plant products though it does include other drugs and psychotropic substances.

The offences can be broadly considered to be of two categories : trafficking and consumption. The main focus is on trafficking. Under section 2 the meaning and scope of various terms used in the Act are explained. For example, 'illicit traffic', 'controlled substance', etc. In section 8 details are given on restrictions with regard to cultivation of opium, poppy, cannabis plant and coca plant and the production, manufacture, possession, selling, purchasing, transport, warehousing, consumption, import interstate or into India, export interstate or out of India of any narcotic drug or psychotropic substance except for medical and scientific purposes as specified by the government and under its control. Section 9 describes the powers vested with the central government to permit, control and regulate production.

The details about the punishment for each of the activities mentioned in Section 8 are given in Section 15 to 25. A person who indulges in cultivation, production, transporting, importing and exporting of any narcotic drug or psychotropic substance is liable to be punished with rigorous imprisonment for a term of not less than 10 years but which may extend to 20

years and also minimum fine of one lakh rupees which may extend to two lakh rupees. If the court records its reasons, it can exceed the fine of two lakh rupees. Similar punishment is applicable in case of financing illicit traffic, harbouring offenders, abetting or attempting to commit an offence under the Act (Section 27A to Section 29). In case of second offence under Section 31 provision is made for enhanced punishment of rigorous imprisonment not less than 15 years extendable up to 30 years and a minimum fine of one and a half lakhs extendable to three lakh rupees.

Ganja is the only exception to this rule, where production is punishable with a minimum sentence of five years and a fine which may extend to rupees fifty thousand (Section 20). In instance of repeat offence in case of Ganja, the punishment is double the first offence. Further, through the amendment in 1989 Section 31A was included laying down death penalty for second offences with regard to certain drugs if the quantity involved exceeded the limit set down by the Central Government against each item.

The Act attempts to make some provisions for drug addicts. As per Section 27, illegal possession of certain drugs in small quantities intended only for personal consumption carries a punishment only up to one year or fine or both. For each of the specified drugs small amount has been listed by the central government and in case of drugs not listed, the punishment is upto six months or fine or both. An addict convicted under this Section may be released for medical treatment subject to certain conditions, from any hospital or organization maintained or recognized by the central government in lieu of the sentence. This provision is made for once in a lifetime (Section 39A and 64A). Towards this purpose the government may establish and maintain any number of centres to identify, educate, provide

treatment, after-care and rehabilitation. It will lay down rules and 'the conditions and manner in which narcotic drugs and psychotropic substances shall be supplied for medical necessity to the addicts registered' at the centres (Section 71 and 78).

This part of the law pertaining to drug users is extremely weak and needs change. Addiction by definition is a relapsing condition. Thus, once in a life time reprieve is practically meaningless for addicts. Besides, the small quantity for heroin is a quarter gram. Any addict would buy as much as he can afford at any given time in order to avoid going through the troubles of avoiding the police, etc. The law as it stands now, does not distinguish an addict possessing one gram of heroin from a trafficker who has been caught with 100 kilos of heroin! The judge has no discretion to impose punishment less than ten years for 'traffickers' if one had in his possession more than a quarter gram ! To add to the problem of addicts, the court procedures are so tardy, that an addict can be held in custody for as long as five years before his case comes for disposal. As of now, only two jails have a wing for addicts (one in Manipur and one in Delhi) and only four centres have been notified for custodial treatment. Though the Ministry of Social Justice and Empowerment (formerly known as the Ministry of Welfare) finances over 350 treatment centres, these are not notified; these are for voluntary patients. Due to external pressures, the government has not opened any depot to supply opium or cannabis as provided for under the Act and the Rules of the NDPS law for maintenance purposes.

The procedures of investigation to be followed for the offences are given in Chapter V of the Act. This is particularly important since the court delivers its judgement after weighing the nature and accuracy of the evidence on these guidelines. The Section 51 states that 'the provisions of the Code of Criminal

Procedure' shall apply in so far as they are not inconsistent with the provisions of this Act, to all warrants issued and arrests, searches a warrant with the metropolitan magistrate, magistrate of the first class or any magistrate of the second class specially empowered by the State Government. It also invests any officer of gazetted rank of the departments of Central Excise, Narcotics, Customs, Revenue Intelligence or any other department of Central Government and the corresponding departments of the State Government as especially empowered on this behalf, the power to authorize any officer subordinate to him but above the rank of a sepoy, peon or constable for search, seizure and arrest of any person, article, conveyance or building.

Provision is made under Section 42, for any officer above the rank of peon or constable of the departments mentioned above from Central and State Government who are so empowered by order can from personal knowledge or information given by any person and taken down in writing in respect of any offence committed under the Act between sunrise and sunset, enter and search any building, conveyance or place, seize any material, object or article which he believes could be furnished as evidence of offence, detain, search and arrest any person whom he has reason to believe has committed an offence. In case, such officer has reason to believe that a search warrant of authorization cannot be obtained without affording opportunity for the concealment of evidence or facility for the escape of an offender, he may enter and search at any time between sunset and sunrise after recording the grounds of his belief. And any information or record of grounds of belief taken down in writing should be sent forthwith to his immediate superior officer. Section 43 enlarges the scope of search, seizures and arrest in any public place or in transit.

Section 50 lays down the conditions under which search of

persons shall be conducted, (1) when any officer duly authorized under section 42 is about to search any person under the provisions of Section 41, 42, or 43, he shall, if such person so requires, take such person without unnecessary delay to the nearest Gazetted Officer of any of the departments mentioned in Section 42 or to the nearest magistrate, (2) if such requisition is made, the officer may detain the person until he can bring the Gazetted Officer or the magistrate referred to in sub-section (1), (3) the Gazetted Officer or the magistrate before whom any such person is brought shall, if he sees no reasonable grounds for search, forthwith discharge the person but otherwise shall direct that search be made, (4) no female shall be searched by anyone excepting a female.

Section 52 states that the persons arrested and articles seized should be forwarded without delay to officer-in-charge of the nearest police station. Section 52A provides for the disposal of seized drugs. Section 53 speaks about the power to invest officers of certain departments with powers of an officer-in-charge of a police station for investigating offences of the Act. Section 55 empowers such officer to keep in safe custody the articles seized. The articles should have the seal of the officer who accompanies them and the seal of the officer-in-charge of the police station. Section 58 affords protection from vexatious (malicious) entry, search, seizure or arrest of any person, place or object by making such act a punishable offence.

Chapter VA, Section 68A-68Y on the forfeiture of property derived from or used in illicit traffic has been included by the amendment of 1989 subsequent to the United Nations International Convention against Illicit Traffic in narcotic drugs and psychotropic substances in 1988. This chapter details the procedure for identifying, freezing and forfeiture of illegally acquired assets, and subsequent legal action. The necessary preconditions

for forfeiture are that the person should have been convicted for a minimum sentence of five years by court under this Act, or should have been preventively detained under the 'Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988.' Furthermore, the order of detention should not have been revoked by the Advisory Board or set aside by a court of competent jurisdiction.

The Act is generally suspicious of the accused. According to Section 32A, no sentence awarded under this Act can be remitted, commuted or transferred, i.e., it cannot be suspended, adjusted or altered. And as per Section 35, the court presumes the culpable mental state of the accused with regard to the offence that is the accused had the intent, motive and knowledge of and for his actions, and it is upto the accused to prove that he had no such mental state. Section 54 goes a step ahead to add that until and unless the contrary is proved it shall be presumed that the accused was in possession of the illicit articles seized from him. Lastly, all the offences under the Act are cognizable and non-bailable offences. In rare cases bail is granted only after (a) the public prosecutor has had an opportunity to oppose the bail application, and (b) after which the court upon considering the evidence and circumstances of the offence is of the opinion that the accused is unlikely to commit any offence while to bail (Section 37).

There is a provision in the Act for the creation of a National Fund for Control of Drug Abuse (Section 7-A), which shall collect and control all funds towards implementing the provisions of this Act, to combat drug trafficking and for treatment of addicts. Till date this fund has not become operational.

Though the law clearly provides for supply of opium and cannabis to medical practitioners of any system both for the

treatment of animal and human beings, the problem of access and procedures have created a situation in which the practitioners systems of medicine are being forced to purchase these drugs in the black market or are unable to make their preparations. Thus, a systematic destruction of these systems of medicine has been instituted though not intended by the policy makers.

Annexure-C

Table 1.1

Total production of opium (in tonnes) in four major producing countries over years

Year	*India*	*Turkey*	*USSR*	*Yugoslavia*	*Total*
1964	501	85	188	7	781
1965	487	83	177	9	756
1966	340	130	201	3	674
1967	369	88	181	7	645
1968	585	125	116	1	827
1969	868	127	217	1	1213
1970	794	60	226	1	1081
1971	883	149	144	1	1177
1972	991	75	114	...	1180
1973	866	...	93	1	960
1974	887	...	...	...	887
1975	1033	...	...	...	1033
1976	1177	...	...	...	1177
1977	1174	...	...	...	1174
1978	1646	...	...	...	1646
1979	1413	..	...	...	1413
1980	1131	...	...	...	1131
1981	1126*	...	...	...	1126*

Source: INCB (1981), Table 8.

**Provisional*

Table 1.2

Production of poppy-straw (in tonnes) for alkaloid extraction in four major countries

Year	*Australia*	*France*	*Spain*	*Turkey*
1975	791	4711	5800	30
1976	1803	2817	14200	120
1977	4536	6660	36000	340
1978	4640	9129	28253	810
1979	7665	4776	12000	796
1980	1179	3739	13735	942
1981	2850	...	...	...

Source: INCB (1981), modified from Tables 10-13, pp 100-102.

Bibliography

Agar, M. H., 1977, "Ethnography in the street and in the joint: A comparison," in R. S. Weppner, (Ed), *Street Ethnography*, (143–155), London: Sage.

Allen, B. C., 1905, *Assam District Gazetteers*, Nagan Hills and Manipur, Volume IX, Calcutta: Baptist Mission Press.

Allen, B. C., 1903, *Assam District Gazetteers*, Nowgong, Volume VI, Calcutta: City Press.

Allen, B. C., 1903, *Assam District Gazetteers*, Goalpara, Volume III, Calcutta: City Press.

Andrew, C. F., 1926, *The Opium Evil In India: Britain's Responsibility*, London: Student Christian Movement.

Beeching, J., 1975, *The Chinese Opium Wars*, New York: Harvest Book.

Benoist, J., 1975, "Reunion: Cannabis in a Pluricultural and Polyethnic Society", V. Rubin, (ed), *Cannabis and Culture*, (227-234), The Hague: Mouton Publishers.

Blum, R. H., 1969, *Society and Drugs*, California, Jossey and Bass.

Blum, R. H., 1969, "A background history of drugs", Blum, R. H., (ed) *Society and Drugs*, (3-24), California: Jossey and Bass.

Brian, Inglis, 1975, *The Forbidden Game: A Social History of Drugs*, London: Hodder and Stoughton.

Britto, G., 1996, *Developing Social Capital: Building a Network of Community Based Organisations (CBOs) and their Capacities*, Mumbai: NARC (unpublished).

Britto, G. and Unnikrishnan, P. V., 1994, *Tragedies of Hooch*, Mumbai: NARC (unpublished).

Britto, G., 1993, *Injecting Drug Use and HIV Management in India*, Mumbai: NARC(unpublished).

Britto G., 1988, Policy Perspectives in the Management of Drug Abuse, Mumbai: NARC(unpublished).

Britto, G., 1992, Management of Drug Abuse in India, K., Thomas (ed), *Serving The Youth Today in India*, (288-296), Bangalore: Kristu Jyothi Publications.

Carstairs, G. M., 1954, Daru and Bhang: Cultural Factors in the Choice of interests, *Quarterly Journal on Alcohol* 15: 220 - 237.

Centre for Youth and Social Development (CYSD), 1987, Drug Abuse in Orissa, Bhubaneswar: CYSD.

Chopra, R. N. and Chopra, I. C., 1990, *Drug Addiction with special reference to India*, New Delhi: Council of Scientific and Industrial Research.

Comitas, L., 1975, "The Social Nexus of Ganja in Jamaica", Rubin, V., (ed), *Cannabis and Culture*, The Hague: Mouton Publishers.

Diaz, B., Mero, Kaplan, 1993, Lines Across Europe: Nature and Extent of Cocaine Use in Barcelona, Rotterdam, Turin, Amsterdam: Swets and Zeitlinger.

Dobkin de Rios, M., 1975, "Man, Culture and Hallucinogens: An Overview", V., Rubin(ed), *Cannabis and Culture*,(401-416),The Hague: Mouton Publishers.

Dwarakanath, S. C., 1965, "Use of Opium and Cannabis in Traditional Systems of Medicines in India", *Bulletin of Narcotics*, 17 (1), 15 - 19.

Executive Intelligence Review, 1977, Dope Inc Boston Bankers and Societ Commissars, New York: New Benjamin Franklin House.

Emoden, W., 1972, *Narcotic Plants*, New York: Macmillan.

Fisher, J., 1975, "Cannabis in Nepal: An Overview", Rubin, V.(ed), *Cannabis and Culture*, (247-255), The Hague: Mouton Publishers.

Frelich, M., 1977, *The Concept and Dynamics of Culture*, Paris: Mouton Publishers.

Garcia, R. W., 1975, "The Ritual use of Cannabis in Mexico",V. Rubin (ed), *Cannabis and Culture*, (133-146), The Hague: Mouton Publishers.

Gazetteer of Bombay Presidency, Volume XVII-B, Ahmadnagar, 1904, Bombay: Government Central Press.

Goldsmith, M., 1930, *The Trail of Opium*, London: Robert Hale Limited.

Gopalan, C., Adiseshiah, M., Anand, D. P., Gore, M.S., Mehrotra, R.C., Mohan, D., Naik, J.P., Puri, K.K., 1977, *Report on the National Committee on Drug Addiction*, Ministry of Health and Family Welfare, Delhi: Kapoor Art Press.

Gossop, M., 1987, *Living with Drugs*, England: Wildwood House.

Green, M., Miller, D. R., 1975, "Cannabis Use in Cannada", V. Rubin (ed), *Cannabis and Culture*, (497-520), The Hague: Mouton Publishers.

Hasan, K., 1975, "Social Aspects of the use of Cannabis and Culture", V. Rubin(ed),*Cannabis and Culture*,(235-246), The Hague: Mouton Publishers.

Herer, J., 1990, *The Emperor Wears No Clothes* USA, Business Alliance for Commerce in Hemp (Bach)/Library of Congress.

Husain, A., Sharma, J. K., 1983, *The Opium Poppy*, Lucknow: Central Institute of Medical and Aromatic Plants.

Hutchinson, H. W., 1975, "Patterns of Marijuana use in Brazil", V Rubin(ed), *Cannabis and Culture*, (173-184), The Hague, Mouton Publishers.

Huxley, A., 1977, *The Doors of Perception and Heaven and Hell*, London: Grafton.

Indian Hemp Commission Report, 1893-1894.

Kluckhohn, C. and W. H. Kelly, 1945, "The Concept of Culture", *The Science of Man in the World of Crises*, Ralph, 1, (ed), New York Colombia University.

Kruger, H., Medlon, J., 1980, *The Great Heroin Coup: Drugs, Intelligence and International Fascism*, Montreal: Black Rose Books.

Rao, J., 1998, *Culture and Drug Use in Karnataka*, Mumbai: NARC

Rubin Vera (ed), 1875, *Cannabis and Culture*, The Hague: Mouton

Publishers.
Leary, T, 1970, *The Polictics of Ecstasy*, London: Paladin.
Ludwig, A. M., 1990, *Altered States of Consciousness*, New York: Harper Collins.
Masihi, E. J., 1998, *Culture and Drug Use in Saurashtra*, Mumbai: NARC.
McKeena, T., 1993, *Food of the Gods*, United States, Bantam Books.
Mills, J. P., 1973, *The Ao Nagas*, Bombay, Oxford University Press.
Mills, J., 1987, *Underground Empire* New York: Dell Publishing, Co. Inc.
Ministry of Welfare, 1998, *Annual Report of Welfare*, Delhi: Government of India Press.
Mohan, 1987, *A Multicentred Study of Drug Abuse Among University Students*, New Delhi: Government of India, Ministry of Welfare.
Mohan, D., Thomas, M.G., Prabhu, G. G., 1978, "Prevalence of Drug Abuse in High School Population", *Indian Journal of Psychiatry*, (20), 20-24.
Mohan, D. Prabhakar, A. K., Mohan, M., 1978, "Factors Associated with the Prevalence of Drug Abuse Among Delhi University Students", *Indian Journal of Psychiatry*, (20), 332-338.
Mohan, D., Sundaram, K. R., Sharma, R. K., Darshan, S., Neki, J. S., 1978, "Prevalence of drug abuse in young rural males in Punjab", *Indian Journal of Medical Research*, (Oct 1978), 689-694.
Musgrove, F., 1977, *Margins of the Mind*, London: Mouton and Co. Ltd.
Nadelman, 1972, "Alternate to Drug Prohibition", *Daedalus*, Cambridge: Academy of Arts.
Palgi, P., 1975, "The Traditional Role and Symbolism of Hashish among Moroccan Jew in Isarel and the effect of Acculturation", Rubin, V.(ed) *Cannabis and Culture*, (207-216), The Hague: Mouton Publishers.
Peele, S., 1989, *Diseasing of America*, Cannada: Lexington Books.
Rubin, V., 1975, The Ganja Vision in Jamaica, V. Rubin(ed), *Cannabis and Culture*, (1-10), The Hague: Mouton Publishers.
Schaeffer, J., 1975, "The Significance of Marijuana in a Small Community in Jamaica", V. Rubin(ed), *Cannabis and Culture*, (355-388), The Hague: Mouton Publishers.

Scoot, J. M., 1969, *The White Poppy*, London: Cox and Wyman Ltd.
Shetty, H., 1997, *Addiction to Pharmaceutical Drugs: An Emerging Trend*, paper presented at Federation of Indian NGOs for Drug Abuse Prevention (FINGODAP), Pune: University of Pune.
Siddiqui, H. Y., 1998, *Culture and Drug Use in North India*, Mumbai: NARC.
Singh, H., 1992, *Drug Abuse: Summaries of Research Studies Sponsored by Ministry of Welfare*, New Delhi: National Institute of Social Defence.
Tart, C., 1990, *Altered States of Consciousness*, New York: Harper Collins Publishers.
Tylor, sir. E. B., 1871, *Primitive Culture*, London: Murray.
Vermeersch, E., " An Analysis of the Concept of Culture", in Bernado Benardi, *The Concept and Dynamics of Culture*, The Hague: Mouton Publishers, 1977
Wasson, R. G., 1971, *Soma: Divine Mushroom of Immorality*, New York: Harcourt Brace Jovanovich.
Weakland, J. H., 1969, Hippies: "What the Scene Means", Blum, H. (ed), *Society and Drugs*, California: Jossey and Bass.
Weil, A., 1972, *The Natural Mind: A New Way of Looking at Drugs and the Higher Conciousness*, Boston: Houghton Mifflin.
Weil, A., 1983, *Health and Healing: Understanding Conventional and Alternate Medicine*, Boston: Houghton Mifflin.
Weppner, R. S., 1977, "Street Ethnography Problems and Prospects", R. S. Weppner(ed), *Street Ethnography*, pg 21-47, London: Sage.
Wilbert, J., 1975, Magico - Religious Use of Tobacco among South American Industry, Rubin, V.(ed), *Cannabis and Culture*, (439-462), The Hague: Mouton Publishers.

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