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RAPID INCREASE OF HEROIN DEPENDENCE IN DELHI : SOME INITIAL OBSERVATIONS

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SUMMARY

The present paper documents and discusses the rapid increase in the problem of heroin dependence in the city of Delhi in the recent years. Initial observations on patients with heroin dependence attending the Deaddiction Clinic of a large general hospital are described with difficulties encountered in the clinical management of these patients. It is suggested that sustained efforts be made to control this problem because heroin is likely to give rise to medical and social consequences of serious nature in the near future.

Heroin is one of the most potent pain-relieving as well as addicting substances known to the medical science. Dependence on heroin ranks amongst the most malignant forms of drug dependence for the society. For many decades it has been a major public health concern of a large number of countries, including several from the developing world. However, till a few years ago India was one of the countries where heroin problem did not exist to any significant degree. This fortunate situation has come to an end and heroin dependence is now being seen increasingly in at least in the metropolitan cities of India. This recent development, hitherto not described in the scientific literature of our country, is of paramount importance to the drug dependence scene, with potentialities of posing a serious challenge to whatever meagre treatment and rehabilitative services exist in this field. Its socially disruptive consequences are likely to be equally dangerous for law and order as well as family organization.

The present paper summarises some of the initial observations in the area of heroin dependence based on our experience in managing patients with this problem in the Deaddiction Services of the A. I. I. M. S. Hospital, New Delhi.

BACKGROUND INFORMATION

India has traditionally been a major grower of the opium poppy plant. It is cultivated over large areas under official licence. Illicit cultivation of this highly valued crop of course, must be much higher, in spite of official claims to the contrary. Crude opium has been a common household remedy used for a variety of minor ailments besides being a constituent of several medicinal preparations in the indigenous systems of medicine. Opium has also been used and abused by large segments of population for its mind-altering as well as effort-sustaining effects. One investigation for example revealed that 5.8 per cent of adult males in rural Punjab consumed opium at least for a part of the year (Mohan *et al.*, 1979).

However, in spite of this extensive and prolonged exposure of the Indian population to crude opium, heroin-most refined and potent derivative, did not make its appearance in India till a few years ago. Several surveys done on general and specified populations in various regions of the country in Nineteen Seven-

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ties had not revealed any significant dependence on heroin (Dube, 1972; Mohan and Arora, 1976. Dube *et al.*, 1977, 1978; Varma *et al.*, 1977; Mohan *et al.*, 1978, 1979; Sethi and Manchanda, 1978; Singh and Lal, 1979). Similarly reports from deaddiction clinics demonstrated a conspicuous lack of patients with heroin dependence (Dube, *et al.* 1975; Trivedi and Sethi, 1978; Venkoba Rao *et al.*, 1979). It is indeed surprising that heroin did not become a common 'street drug' in India earlier, considering the abundance of heroin in many South-East Asian countries and almost all the West-European countries and presence of a significant tourist traffic from these places.

THE RAPID INCREASE IN AVAILABILITY

Evidences from a number of sources including clinic patients, law-enforcement agencies and newspaper investigations have revealed that the availability of heroin in Delhi has increased very rapidly in the last few years. Previous to that heroin was consumed by very small groups of people, predominantly foreigners who had brought supplies for personal use from foreign countries. About four years ago a white powder became available relatively freely, which in fact was a highly purified form of heroin. Its cost was rather high, ranging from Rs. 200 to 400 per gram. Later a somewhat impure preparation known as 'smack' or 'brown sugar' came to the market. It was initially priced at Rs. 80 to 120 per gram, however recently it is reported to be available at even Rs. 40 per gram. The declining prices have put heroin within the reach of even middle and lower income groups. It is believed that much of the 'brown sugar' is being smuggled into the country from across the borders, although a part may be manufactured in small, illicit local factories.

Certain specific localities of the Old-Delhi city are well known for relatively free availability of heroin. Apart from these, certain posh New-Delhi markets, industrial areas and even educational institutes are getting increasingly involved in heroin peddling. Heroin distribution outlets are generally in the form of cigarette shops, hotels and restaurants.

Some of the National daily newspapers have been perceptive enough to investigate and warn about the social consequences of these recent developments. For example one newspaper has published detailed reports (The Times of India, 3rd June 1983 and 12th June 1983) and has discussed the problem of heroin in two editorials with the appropriate titles of 'A Deadly Epidemic' (3rd June 1983) and 'Imperative for Action' (19th October 1983).

THE HELP SEEKERS

The Deaddiction Clinic of the A. I. I. M. S. Hospital, New Delhi did not have any patients with definite heroin dependence prior to 1981, except an occasional foreigner once in a few years. However beginning 1981, more than sixty patients have been seen who were dependent on heroin at the time of seeking help.

Table I gives the distribution of these patients according to the year of initial attendance.

TABLE I. *Yearwise distribution of patients*

Year	Total No. of pateints in Deaddiction clinic	Patients with heroin dependence	
		N	%
1980	41	0	0
1981	75	9	12.0
1982	104	20	19.2
1983 (upto Sept. end)	122	31	25.4

As can be seen from the table, the total number of patients in the clinic has shown an increase over these years. However, patients with heroin dependence have increased even more rapidly during the same time. The percentage of heroin dependents out of total patients has increased from zero to about 25 per cent in these four years which is the largest for any single drug, excluding alcohol. When it is remembered that the clinic patients may represent, just a fraction of the total dependent population in the community, the gravity of the problem facing us becomes obvious.

The details of the socio-demographic and dependence characteristics of the clinic patients are being reported elsewhere, however to summarise-most of them were educated young males between 20 and 30 years of age. Majority of them were unmarried and were either unemployed or involved in some business, generally of hotel/restaurant or travel agencies. Some of the patients were students or salaried employees. Majority of patients were consuming heroin for less than two years and the quantity consumed every day was usually less than one gram. The route of administration was smoking in cigarettes for the majority, although a significant minority administered it parenterally. Another significant finding was that about one third of the patients had not consumed any other drug or even alcohol on a regular basis before starting on heroin, indicating a significant proportion of 'fresh' addicts in this group.

PROBLEMS IN MANAGEMENT

Management of patients with heroin dependence posed an unusually large number of complex problems. Overall motivation to give-up the drug was very poor for many patients. Most of the patients had experienced severe withdrawal symptoms in the past during their own attempts to leave the drug and they dreaded recurrence of severe physical distress. Frequently, poorly motivated patients were brought forcibly by family members. Many others came due to financial crisis. transient non-availability of the drug or because of pressure from the employer. However if the inner motivation to give-up the drug was not present, the drop-out rate was high.

We experimented with several approaches of management including gradual withdrawal on heroin brought by the patient. However, sudden complete withdrawal from the drug appears to be most successful in spite of presence of severe withdrawal symptoms. Most of the patients require initial hospitalization although lately we are trying an outpatient withdrawal regime. The initial withdrawal period of these patients is often turbulent, with severe physical symptoms, fluctuating motivation and marked craving especially in the terminal stage. We use relatively massive doses of anxiolytics, phenothiazines, non-narcotic analgesics and other drugs for symptomatic relief. Chlorpromazine proves to be very useful for decreasing restlessness and sleeplessness in the initial 48 hours, however sometimes it gives rise to transient periods of disorientation and confusion, specially at nights. This effect disappears completely on stopping phenothiazines.

A close, sympathetic but responsible family member is required to stay with the patient continuously during the withdrawal period whether in the inpatient or outpatient setting. This is essential for close surveillance as well as for psychological support. Absence of a close and reliable family member was a handicap in the management of many patients.

ATTITUDE TOWARDS HEROIN

Heroin being a new substances for our population, the extent of harmful

effects associated with its regular use are not obvious to the patients and their family members. Frequently a person switches over from cannabis preparations to heroin without realising that the latter is a different class of drug altogether. He understands the gravity of the situation only when marked withdrawal symptoms appear on missing even a single dose. Intense craving further prevents him from keeping away from the drug for any length of time. Simultaneously economic pressures mount up and borrowing money, cheating and even small thefts become essential. Family members generally become aware of the problem at this stage and they react either with denial of the severity of the problem followed by protection of the patient or by outright condemnation and rejecting attitude. Both these reactions lead to a less than optimum participation by the family members in the management programme. These factors make it necessary to arrange sessions with the immediate family members of the patient for imparting correct information about the process of heroin dependence and to define their role in the future management plan.

COMMENTS

Drug Addiction Committee Report, submitted to the Government of India in 1977 (*Drug Abuse in India, 1977*) mentioned that drug abuse among the general population was limited except for tobacco and alcohol. However the same report noted that there were disturbing signs which showed that the situation in India is likely to worsen and get out of hand if adequate measures were not adopted to curb this evil. Recent developments in this area eminently justify the value of this warning by the Committee. Addition of heroin to the street drugs in India is one such development, which cannot be taken lightly. Experience from all over the world indicates that it is almost impossible to eradicate hard drugs like heroin from any area where they have become firmly established. Viewed this way, heroin has not only arrived in India but it is here to stay.

The reasons for the sudden and rapid increase of heroin in India can only be guessed. Larger geo-political developments in the countries around India may be important in this regard. Iran, which earlier provided an easy route for drugs out of this region has come down heavily on smuggling. Political instability in Afghanistan has further cut-off routes to the Western countries. It is believed that with the large-scale influx of Afghan refugees to the metropolitan cities of India, a number of addicts have also come with huge supplies of drugs. They dispose of these over a period of time for economic gains and on exhausting the drugs even make a revisit to the border areas for further supplies. Pakistan also, with its new Islamic regulations and stiff laws cannot continue as the prominent port for west-bound heroin. In context of all these developments, India with its lax drug laws and inefficient controls has become the obvious choice as the centre for illicit drugs. A sudden spurt in reports of seizures involving massive quantities of narcotics including heroin worth crores of ruppes, in transit from Delhi and Bombay tends to corroborate these assumptions.

Response of the society to sudden arrival of a new hard drug is another interesting area of study. All societies have their traditional substances of abuse like alcohol in Western countries and opium and cannabis in India. These are occasionally or even regularly used by large proportion of population, but the number of hard-core addicts is relatively

small. This is at least partly because of adequate knowledge and well established safeguards about these traditional substances of abuse. However whenever a new substance of abuse is introduced in the society, lack of information about the substance leads to widespread experimental use by the people who are exposed, and this use is qualitatively different from the socially sanctioned use of traditional substances. This phenomenon has been earlier with the large-scale introduction of cannabis in the Western countries and now we are seeing this with heroin in India. The latter is especially dangerous because heroin being extremely potent for physical dependence, even experimental users are exposed to the risk of becoming regular addicts. In this context it becomes vital to make the population aware of large-term hazards of heroin abuse.

NEED FOR ACTION

A series of steps need to be taken to counter the serious threat posed by the recent increase of heroin problem. Vigilance by the law-enforcement agencies needs to be increased to curb the illicit production and transport of hard drugs in the country. Penalities for drug smuggling also need to be enhanced to make them really deterrent as has been done by many South-East Asian countries. Heroin dependence should be made a notifiable condition and registers of these patients be kept with a central agency. Awareness of the medical professionals as well as of general population needs to be increased about the problems associated with heroin consumption. Lastly, treatment and rehabilitative facilities need to be expanded and stregthened to cope with the increasing number of patients with heroin dependence.

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