Indian Journal of Psychiatry, January 1987, **29**(1), pp. 81-83

Brief Communications

HEROIN ADDICTION: EXPERIENCES FROM GENERAL PSYCHIATRY OUT PATIENTS DEPARTMENT

A. K. GUPTA[1]
B. K. JHA[2]
SATYAWATI DEVI[3]

Introduction

A rapid increase in the number of heroin addicts has been observed in de-addiction clinics of Delhi within last six years (Saxena and Mohan 1984, Munjal and Jiloha 1986). A similar phenomenon was observed in the general psychiatry out patient department of Dr. Ram Manohar Lohia Hospital, New Delhi. This is said to be due to easy availability of a comparatively cheaper form of heroin commonly known as "Smack" or "Brown Sugar" which contains small amount of heroin adulterated with various substances.

In the literature available till date workers have not differentiated between abusers of pure heroin and smack. Since this recent spurt in heroin addiction has been due to a specific class of heroin, i.e., smack, it may be more useful from preventive aspect to know in detail about addicts of this compound only. The present paper describes the drug related clinical profile of patients who contacted us for de-addiction from smack.

Material and Methods

The study was conducted at Department of Psychiatry, Dr. Ram Manohar Lohia Hospital, New Delhi. All new patients registered in OPD between June 1st 1985 to September 30, 1985 were screened for presence of smack addiction. Diagnosis was made in accordance with ICD-9 (definition for heroin addiction). Patients' identification data, socio-demographic variables and clinical data pertaining to smack addiction were noted on a record sheet. The data were later tabulated and analysed.

Results

A total of 1756 new cases were registered during the period of study. There were 193 (10.99%) cases presenting with smack addiction. Socio-demographic variables are given in Table.

Out of 193 only 12 were graduates, 2 Post-graduates and 2 professionally qualified. 88.2% of the sample was represented by auto-rickshaw drivers, technicians, lab assistants, sweepers, peons, clerks and hawkers. 9.8% were school dropouts and unemployed and 2% were students. Almost half of the cases were those who were consuming smack for a year and a half or so approximately. There were 4 cases with addiction for more than 4 years, maximum duration being 8 years. There were 13% who consumed ¼ gm. of smack. Almost 75% consumed between ½ to 1 gm of smack either in the form of smoking in cigarettes or chasing on a silver foil and inhaling or both. There

1. Psychiatrist.
2. Senior Psychiatrist & Head.
3. Psychiatrist.

Department of Psychiatry, Dr. Ram Manohar Lohia Hospital, New Delhi – 110001.

Table
Socio-demographic variables of smack addicts

	No (N = 193)	%
Sex		
Male	192	99.5
Female	1	0.5
Age (Years)		
below 15	0	0.0
16-25	128	66.3
26-35	59	30.6
36-45	6	3.1
Above 46	0	0.0
Marital Status		
Married	101	52.4
Single	91	47.1
Widower	1	0.5
Educational Status		
Illiterate	25	13.0
Below Vth Standard	11	5.7
Vth – Xth Standard	137	71.0
Above Xth Standard	20	10.3
Occupation		
Auto rickshaw drivers	41	21.2
Rickshaw puller	12	6.2
Clerk/Typist	16	8.3
Small businessmen	37	19.2
Semi-Skilled workers (mechanic/technician/tailor/painter/carpenter)	31	16.1
Helper/Labourer	13	6.7
Peon	12	6.2
Sweeper	8	4.1
Students	4	2.0
Unemployed	19	9.8

were two patients who consumed up to 5 gm. All the patients were also requested to tell the reasons why they wished to get de-addicted. Their answers pertained to either financial difficulties or health problems or social pressures or a combination of these. 33.7% had come because they were financially unable to afford and to purchase smack daily, and a total of 66.2% mentioned economic pressure as one of the reasons for seeking help for de-addiction. 7.5% patients came because they felt a decline in their health after smack addiction, though a total of 35.3% mentioned deterioration of health as one of the reasons. 44.6% patients accepted that they were compelled by their family or neighbours or other relatives to get rid of smack addiction. For as many as 11.9% family or social pressure was the only reason for seeking de-addiction because they were being condemned by their family for this habit. 87% of the patients came to the hospital along with either family members or friends. 13% came alone with a request for de-addiction. 25.4% accepted that they had tried to get rid of smack at least once in the past for more than 48 hours, but they later on restarted under the influence of peer group and due to severe withdrawal symptoms. 66.3% patients had not abused any other drug in past or at present other than tobacco. 16% had abused alcohol, 7.8% had abused cannabis and 9.8% were abusing all of these. Majority of these cases had stopped abusing these substances after they started abusing smack.

Discussion

In the present paper patients presenting for de-addiction from smack at a general psychiatry out patients clinic have been studied with regard to their socio-demographic variables and clinical profile. They constituted 11% of total new patients registered at OPD, thus revealing the magnitude of the problem. The present sample consisted largely of males, in the age group of 16 to 35 years. Exactly the same observations were also made at de-addiction clinics of All India Institute of Medical Science, New Delhi and G. B. Pant Hospital, Delhi (Adityanjee et al. 1984, Munjal and Jiloha, 1986). It confirms that smack addiction is prevalent largely amongst male youth, the

segment of population that would be responsible for the progress of our country in near future.

Commonly, it is believed by general public that heroin addiction is prevalent only in college students belonging to high socio-economic class. Contrary to this, these persons were neither illiterate nor professionally educated. Rather, they were educated between Vth to Xth standard. These are the ones who form a large working group among manual and semi-skilled class of workers. The analysis of occupation confirms this as we observed that 88.2% of them were either auto rickshaw drivers, sweepers, hawkers or class III and IV Government employees. 9.8% were unemployed school or college dropouts. Munjal and Jiloha (1986) at G. B. Pant Hospital, Delhi, have reported that approximately 25% of their sample consisted of college dropouts. We are not aware of any specific reasons for this difference. It is possible that people from higher socio-economic class of population are going to private practitioners for de-addiction. That is why we have not observed them in our hospital sample.

The duration of smack addiction in most of these persons was not more than two years. The dose of smack used was also usually less than or at the most equal to one gram.

25.4% had even tried to leave smack on their own prior to coming to the hospital. 33.6% of them also abused other drugs such as cannabis or alcohol or a combination of these, but they requested for de-addiction only from smack. The reasons they admitted to were mainly two –

(1) Financial burden due to smack.

(2) Social pressure or objection of society.

Probably the reason is that it produces physical dependence with severe painful withdrawal symptoms on missing even a single dose. As a result an addict is compelled to think all the time about managing next dose of smack. Their usual daily earnings are consumed in the form of smack. Over and above quite often smack is not available due to active surveillance of law enforcing agencies, and then its prices further escalate. The new Narcotic Drugs and Psychotropic Substances Act 1985 has provided for stringent punishment for persons found to be carrying heroin even if it is not for their personal use. This may be another reason for creating scare amongst heroin addicts and their thronging psychiatry out patients department with request for de-addiction.

To conclude we would like to mention that the addiction to 'smack' is most prevalent among young males in occupations such as auto-rickshaw drivers, sweepers, peons, semi-skilled workers and other Class III and IV Government employees. Our health education programmes regarding drug abuse should be addressed to this section of our population so that it reaches where it is most needed. It should be framed in accordance with their educational level.

References

ADITYANJEE., MOHAN, D. & SAXENA, S. (1984), Heroin Dependence, The New Delhi Experience, *Indian Journal of Psychiatry*, 26, 312-316.

MUNJAL, G. C. & JILOHA, R. C. (1986), Drug abuse in Delhi, Experiences of a de-addiction unit in a general hospital. *Indian Journal of Psychiatry*, 28, 87-88.

SAXENA, S. & MOHAN, D. (1984), Rapid increase of Heroin Dependence in Delhi, Some initial observations, *Indian Journal of Psychiatry*, 26, 41-45.

WORLD HEALTH ORGANISATION (1977), International Classification of Diseases, 9th Edition, W.H.O. Geneva.