

DRUGS ABUSE IN THE UNITED ARAB EMIRATES

by

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Abstract

Many aspects of life have changed rapidly since the independence of the United Arab Emirates (U.A.E.) in 1971. The economic and social changes have catapulted people from a nomadic and isolated life into a relatively luxurious lifestyle. Many of the traditional values of the indigenous people have changed and come to be influenced by the values and attitudes of those who came to work in the U.A.E. The rapid social change has been an important factor behind the appearance of many types of anti-social behaviour, of which drug use is one.

As in most countries throughout the world, illicit drug use behaviour in the U.A.E. is thriving, in terms of a rapid increase in the number of users, in the amount used and in the choice by users of more dangerous substances. Drug use behaviour has moved from a small number of isolated people in some ethnic groups to many people in many different ethnic and age groups in the U.A.E.. Consequently this study examines the nature of drug abuse problems in the U.A.E.. It covers many aspects of drug abuse problem and the social climate in which it flourishes. These include: the prevalence rate of drug abuse; socio-economic changes in the U.A.E. and their effects on the increase of drug abuse; the effects of society's efforts and policies in attempting to reduce drug-related problems; and the effects of drug abuse on individuals, family and society.

It is found that the illegal drugs trade has become a means by which some people amass their fortune, exploiting the situation of social and security gaps in the U.A.E. The open market trade policy, a fundamental cornerstone of economic in the U.A.E., offers a fertile environment for abuses such as illegal immigration, drug trafficking, and other laws violation.

The findings show that rapid social change in the U.A.E. has reduced the influence of some of the social control measures such as the effect of the family, customs and tradition. The support role of the family in the new society has changed, and has been replaced by an expatriate work force. The research findings show that the large number of expatriate workers has influenced the spread of drug abuse among people in the U.A.E. Most of the expatriate workers come from drug producing countries such as Pakistan, Afghanistan, Iran, and India. In addition to the drug producing countries, there is public acceptance for some drug use in these countries. The cheapness of drugs in the above mentioned countries in contrast to the high prices and demand for illicit drugs in the U.A.E. encouraged some of the expatriate workers and some illegal immigrants to become involved in illicit drug activities.

The findings and results of the study show that the rate of drug abuse among young men is high, especially the use of heroin which is increasing. Drug abusers who are U.A.E. citizens are more likely to be involved in drug abuse problems. Most of them are multi-drug abusers and they spend a lot of money on their drug use. Substances such as hashish, heroin, opium and barbiturates are most common types of drugs which are on the increase in U.A.E. society.

The lack of a comprehensive and unambiguous policy to combat drugs in U.A.E. society is a significant factor behind the increase in problems of drug abuse in the U.A.E.. Drug policy in the U.A.E. depends mainly on individual efforts and the commitment of some government organizations. These efforts are mainly concentrated in the law enforcement agencies in the Emirates and federal legislation is not always effective or welcomed in the Emirates.

Table of Contents

List of Figures	v
List of Tables	vii
Declaration and Copyright	ix
Dedications	xi
Acknowledgements	xii
Chapter 1	
Introduction	1
Introduction	1
The significance of the study	3
Aims of the research	5
Methodological Issues	7
<i>Field study design and procedures</i>	8
<i>Questionnaire</i>	10
<i>The constituents of the questionnaire</i>	10
<i>Sampling</i>	12
<i>Geographical distribution of the sample</i>	14
<i>Pilot Study</i>	15
<i>Preparations for the interviews</i>	16
<i>The preparation of the interviewees</i>	17
<i>Preparation of each interviewee</i>	18
<i>Problems encountered</i>	19
Data analysis statistical procedures	22
Definitions of Drugs and Drug Abuse	22
Classification of Drugs	24
Chapter 2	
The Study of Drug Abuse	26
Introduction	26
The Study of Drug Abuse in the U.A.E.	26
The Explanations of Drug Abuse	31
Summary	42
Chapter 3	
A Background to the United Arab Emirates (U.A.E.)	45
Introduction	45
Geographical Location	45
The Area	47
Climate	51
Population	51
Political Institutions	62
Economic Aspects	66
Social Structure	73
<i>Life in rural communities</i>	75
<i>Life in urban communities</i>	77
<i>Social Change</i>	79
Summary	82

Chapter 4

Historical Background on Drugs	84
Introduction	84
The History of Drug Use	85
<i>The New Derivatives</i>	91
<i>Appearance of Drugs In Muslim Societies</i>	92
<i>The Period of The Four Islamic Schools</i>	96
<i>Sufism and Hashish</i>	97
<i>Drugs and The Moguls and Tartars</i>	98
<i>Drugs and the Mamluk Rule</i>	99
<i>The Classification of Drugs by Muslim Scholars</i>	99
<i>The Prohibitionist Opinions</i>	100
Background on Drugs in The U.A.E.	102
<i>Before The 16th Century</i>	103
<i>The 16th Century and After</i>	105
<i>The Situation in the 1980s</i>	110
Summary	114

Chapter 5

Drug Types and their Influences	116
Introduction	116
Opium	117
<i>Methods of Administration</i>	117
Morphine	119
<i>Methods of Administration</i>	123
Heroin	123
<i>Methods of Administration</i>	126
Codeine	129
<i>Effects of Opiates</i>	129
Barbiturates	130
<i>Effects of Barbiturates</i>	131
Benzodiazepines	131
<i>Effects of Benzodiazepines</i>	131
Cocaine	132
<i>Methods of Administration</i>	132
<i>Effects of Cocaine</i>	134
Amphetamines	134
Qat	135
LSD-25, Lysergic Acid Diethylamide	137
<i>The Effects of LSD</i>	139
Cannabis sativa and its Derivatives	139
<i>Hashish</i>	139
<i>Marijuana</i>	143
<i>Hashish Oil</i>	143
<i>Methods of Administration</i>	145
<i>The Effects of Cannabis Sativa Derivatives</i>	147
Solvents	147
<i>Methods of Administration</i>	148
<i>Solvents Effects</i>	149
Summary	149

Chapter 6

Patterns of Drug Abuse Behaviour: Demographic Characteristics and Drug Use	152
Introduction:	152
<i>Nationality and Drug Abuse Behaviour</i>	152
<i>Age and Drug Abuse Behaviour</i>	156
<i>Education and Drug Abuse Behaviour</i>	166
<i>Marital Status and Drug Abuse</i>	170
<i>Job Situation and Drug Abuse</i>	175
<i>Residence Situation</i>	179
<i>Financing Drug use</i>	183
<i>Summary</i>	195

Chapter 7

Patterns of Drug Abuse Behaviour	196
Introduction	196
<i>Initiation Into Drug Use</i>	197
<i>Types of Drugs Used</i>	208
<i>The Availability of Drugs</i>	213
<i>Methods of Administration</i>	235
Consequences of drug use	251
<i>Psychological and physical experiences</i>	251
<i>Drug use and other anti-social behaviour</i>	258
<i>Treatment of drug use</i>	261
<i>Summary</i>	264

Chapter 8

Drug Abuse Problems in the U.A.E.: Interpretation of the Main Findings	266
Introduction	266
Demographic Profile	267
<i>Patterns of Drug Using Behaviour</i>	270
Initiation of drug use	272
<i>Peer pressure</i>	275
<i>Seeking intoxication and euphoria</i>	276
<i>The availability of drugs</i>	278
<i>The expatriate workforce</i>	279
The risks of drug abuse behaviour	281
<i>Drug abuse and crime</i>	283
Seeking Medication	286
<i>Attempts to stop drug use</i>	287
<i>Continuation of drug use</i>	289
<i>Medication in the Clinics</i>	290
<i>Medication in prisons</i>	292
The Drug user - future prospects	294
<i>Drug-related relationships</i>	294
<i>Relationship with family</i>	295
<i>Work after release</i>	297
<i>Social life</i>	299
Summary	301

Chapter 9

Drug Combating Policies in the UAE	302
Introduction	302
Drug Control	302
<i>Trade in Drugs</i>	305
<i>Control of pharmaceutical activities</i>	306
<i>The storage of drugs</i>	308
<i>Offences Relating to Pharmaceutical and Medical Activities</i>	309
<i>The manufacture of controlled substances</i>	310
Regulation of designated psychotropic plants	312
<i>The Use of Controlled Substances</i>	312
Drug Offences and Punishments	313
<i>Import and export restrictions on drugs</i>	313
<i>Offences and penalties governing the use of controlled drugs</i>	315
The Additional Penalties	320
Enforcement of Drug Legislation	322
<i>The General Administration of Narcotics Control</i>	322
<i>The General Administration of Border and Coastal Guards</i>	322
<i>Trafficker's Infiltration</i>	325
<i>Methods of illegal entry for drug trafficking</i>	326
<i>The Departments of Narcotics in The Emirates</i>	330
<i>Customs</i>	336
<i>The National Committee for Combating the Illegal Use of Drugs and Alcohol</i>	338
Preventive Measures	340
<i>The Ministry of Education</i>	341
<i>The Ministry of Information</i>	344
Medication and Rehabilitation	345
Summary	352

Chapter 10

Conclusion and Recommendations	353
<i>Drug use and the impact of the rapid social change in the UAE</i> ...	353
<i>The population structure</i>	354
<i>The impact of the geographical location on the availability of drugs in the UAE</i>	355
<i>Drug combating efforts</i>	356
<i>The characteristics of drug use problem in the UAE</i>	356
Recommendations concerning drug problems in the UAE	359
<i>Law enforcement</i>	359
<i>Prevention</i>	361
<i>Treatment</i>	364
<i>Drug use reporting system</i>	365
<i>Further studies</i>	367
Bibliography	3698
Appendices	381
Appendix 1	381
Appendix 2	416
Appendix 3	428
Appendix 4	442

List of Figures

Figure 1.1:	Places where samples were taken	9
Figure 3.1:	United Arab Emirates	46
Figure 3.2:	The main villages in the U.A.E.	48
Figure 3.3:	Illegal immigrants captured by the U.A.E. Coastal Guards according to nationality, 1979-1989	56
Figure 3.4:	Permissions issued by the U.A.E. for expatriate workforce and type of permission 1980-1989.	58
Figure 4.1:	Opium trade routes in the Persian Gulf in the early 19th century	104
Figure 4.2:	The Persian Opium Trade Routes of the Late 19th and Early 20th centuries	106
Figure 5.1:	Opium poppy.	118
Figure 5.2a:	Opium smoking tools	120
Figure 5.2b:	Opium and hashish smoking tools	121
Figure 5.2c:	Two types of water pipe used by opium and hashish users in the U.A.E.	122
Figure 5.3:	Morphine injection tools and methods	124
Figure 5.4a:	Adulterated heroin types	125
Figure 5.4b:	Adulterated heroin and poppy seeds seized by the U.A.E. Drug Squad.	125
Figure 5.5a:	Heroin use tools	127
Figure 5.5b:	'Chasing the Dragon' The method of smoking heroin used in the U.A.E.	127
Figure 5.5c:	Coins put under the heroin user's tongue to avoid the bitterness of the drug vapours	128
Figure 5.6a:	Coca plant, coca processing and cocaine	133
Figure 5.6b:	One of the cocaine sniffing methods used by cocaine users in the U.A.E.	133
Figure 5.7:	Qā't leaves	136
Figure 5.8:	LSD	138
Figure 5.9:	Cannabis	140
Figure 5.10a:	Hashish resin	141
Figure 5.10b:	Bundle of Thai sticks	141
Figure 5.10c:	Hashish Oil	141
Figure 5.11:	Hashish types seized by the U.A.E. Drug Squad	142
Figure 5.12:	Hashish smoking	144
Figure 5.13:	Marijuana smoking	146
Figure 6.1	Respondents' nationalities.	153

Figure 6.2	Age of initiation	157
Figure 6.3	The distribution of the respondents' age group	162
Figure 6.4	Respondents' educational levels	168
Figure 6.5	Respondents' marital status	172
Figure 6.6	Respondents' job situation	177
Figure 6.7	Residence situation	181
Figure 6.8	Financial resources for drug use.	186
Figure 6.9a	Cost of drug use in a month	188
Figure 6.9b	Respondents spending more than 4,000 dirhams (£660) a month	189
Figure 7.1	Factors behind drug use	199
Figure 7.2	Type of the first drug	206
Figure 7.3	The prevalent types of drugs used among respondents.	209
Figure 7.4	Factors behind the availability of drugs	214
Figure 7.5	Drug sources	219
Figure 7.6	Drug sources in the UAE	226
Figure 7.7	Obtaining drugs from outside the UAE	228
Figure 7.8	Nationalities of drug dealers	231
Figure 7.9	Dealers' country of origin.	233
Figure 7.10	Methods of Administration	237
Figure 7.11	Frequency of drug use	242
Figure 7.12	Suitable time for drug use.	244
Figure 7.13	Places where drugs are taken.	247
Figure 7.14	Drug use and other anti-social behaviour	259

List of Tables

Table 1.1	Sample distribution among different jails and psychiatric clinics	14
Table 1.2	The distribution of drug users sample in relation to each Emirate	15
Table 1.3	The distribution of target population and the selected sample according to the place of interview	16
Table 3.1	The estimate of the Trucial States population at the beginning of twentieth century	51
Table 3.2	The estimate of the Trucial States population in the middle of the twentieth century	52
Table 3.3	The UAE population, 1962-1985	54
Table 3.4	The UAE population, 1988, 1989, 1990	59
Table 3.5	Vital statistics, 1987-1989	60
Table 3.6	Number of persons who took part in crimes in the UAE, 1980-1989	62
Table 3.7	The Trucial States income, 1964	69
Table 3.8	The distribution of the labour force in the UAE	71
Table 4.1	Quantities of opium imported into China in the 19th century	91
Table 6.1	The age of initiation of drug use and nationality	159
Table 6.2	Drug users' age and nationality	163
Table 6.3	Drug users' age and drug types	164
Table 6.4	Education level and drug type	169
Table 6.5	Marital status and nationality	173
Table 6.6	Marital status and drug type	174
Table 6.7	Job sector and drug type	178
Table 6.8	Place of residence and drug type	182
Table 6.9	Cost of drug use and nationality	190
Table 7.1	Factors behind drug use and nationality	202
Table 7.2	First drug type and nationality	207
Table 7.3	Types of drugs and nationality	210
Table 7.4	Factors behind the spreading of drug use and nationality	216
Table 7.5	Drug sources and nationality	222
Table 7.6	Dealers' nationality and users' nationality	234
Table 7.7	Places of using drugs and nationality	246
Table 7.8	Anti-social behaviour and nationality	260
Table 9.1	Drug trafficking into the UAE and routs of entry	325
Table 9.2	Nationality of illegal immigrants who tried to enter into the UAE, 1991and 1992	326

Table 9.3	Number of trafficking boats which have entered into the UAE, 1989, 1990, 1991	328
Table 9.4	Number of drug cases recorded by drug combating departments, 1974-1992.	332
Table 9.5	Accused persons arrested by drug combating departments, 1974-1992.	334
Table 9.6	Quantities of drugs seized by drug combating departments, 1974-1992.	335
Table 9.7	Arrests by drug combating departments in accordance to the type of drug-related crimes	335
Table 9.8	The proposed budget of the National Committee for 1988 in UAE dirham	340
Table 9.9	Number of addicts who had medication at Abu Dhabi and al- Amal addiction units, 1987-1992	348
Table 9.10	Number of addicts who had medication at Abu Dhabi and al- Amal addiction units in accordance to the type of drug, 1986-1992	349
Table 9.11	Number of addicts who had medication at Abu Dhabi addiction unit and the percentage of the relapsed cases	350

Declaration

No material in this thesis has been submitted for a degree in the University of Newcastle upon Tyne, or at any other university.

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Chapter 1

Introduction

The problem of drug abuse is one of the most complicated and difficult social problems facing modern society. In recent years, especially the 1980s and 1990s, drug abuse has increased rapidly in most countries in the world (United Nations' annual report, 1990). Many studies (Mendis, 1985; Glassner et al., 1987) have focused on the consequences of the abuse of drugs on individuals, their families and society in general. Some studies have concentrated on specific aspects of drug abuse such as drug control, medication, rehabilitation, aftercare and prevention. Many international and national policies, measures and efforts to combat the problems of drug abuse exist today, and are applied in many countries in the world. In spite of these efforts, the problem of drug abuse can be said to be of epidemic proportions amongst some sectors of society in many different parts of the world.

Many young people and even children are involved in drug abuse and it has been found that most users started taking drugs relatively early in life (Segal, 1990). After starting to take drugs, many people experiment with different types of drugs, many of which are dangerous. This behaviour is destructive to the individual affecting everyday performance, the undertaking of responsibility, decision-making, etc. (Drug abuse council, Washington, 1980). Eventually, the destructive behaviour also impinges on the community in which the individual drug abuser lives, affecting the performance and development of the community in general. Moreover, undesirable phenomena such as violence, robbery, and other antisocial behaviour, as well as some very dangerous health conditions, are often directly attributable to addiction (Clutterbuck, 1990; Suwanwela, 1978). The consequence for many addicts, even if they avoid violence and crime, is an isolated lifestyle and an early death.

Many drug users associate their drug abuse with the social, psychological and economic problems which exist in modern society (Suwanwela, 1978). The dissociation of the family's customary relationships and norms, negative elements of modernisation, industrialisation, and the present social structure are given as reasons for the phenomena of drug abuse and its rapid spread in many countries in the world especially developing countries (Bailey et al, 1992). The U.A.E. is one of the developing countries in which drug abuse is on the increase, and could become a serious problem in the future.

This thesis consists of nine chapters. Chapter 1 is an introduction to, and a résumé of, the contents of the thesis. The aim of this introductory chapter is to define the purpose and goals of this study, to explain the methodologies used and problems which occurred in researching this study, and to outline the areas of study in the U.A.E.. Chapter 2 is a literature review of drug abuse in general and in the U.A.E. in particular. Chapter 3 gives a background to the United Arab Emirates. This includes a brief examination of the geographical, demographic, political, social and economic characteristics from the pre-oil period to the present day.

Chapter 4 gives an historical background to drugs, and examines how the use of drugs was practised by various groups of people and for various reasons in the past and present. The chapter is divided into three sections: the first section gives an historical background to drugs in general, and how drug abuse has become widespread among people. The second section examines the appearance of drug abuse in Muslim societies, and how some Muslims have tried to deal with the problems of drug abuse. The third section examines the appearance of drugs in the U.A.E., and how drug use exists among its people.

Chapter 5 examines various types of drugs which are in use among drug abusers, and which are controlled by U.A.E.'s Drug Law of 1986. Information concerning methods of administration of drugs in the U.A.E. and the type and range of effects which are caused by drugs are also investigated.

Chapters 6 and 7 offer an analysis of the nature of the drug abuse problem in the U.A.E.. They explore the prevalence and patterns of drug abuse in the U.A.E.. These chapters are the result of the main field investigation. Chapter 6 explores the relationship between demographic characteristics and drug abuse. This chapter also examines drug abuse-related activities and behaviours such as the causes of drug abuse, and the age of initiation into drug use. Chapter 7 analyses the prevalence rates for drug abuse in the U.A.E.. This includes drug types, availability of drugs, drug sources, cost of being a drug user, methods of administration, frequency of drug use, locales for drug use, patterns of drug usage, drug use sessions, drug-related crimes and other consequences of drug abuse.

Chapter 8 contains interpretation and implications of the main findings of the field investigation. This chapter investigates the nature of drug abuse problems in the U.A.E., concentrating especially on the incidence level and trends of drug abuse problems.

Chapter 9 is based on field investigation and examines drug combating policies in the U.A.E.. This includes a study of drug control legislation, drug enforcement, preventive measures, medication and rehabilitation of drug addicts.

Finally chapter 10 offers conclusions and recommendations.

In this thesis Arabic words (unless incorporated into the Oxford English Dictionary) have been transliterated with diacritical marks.

Some respondents responses have been translated into english and written in quotation forms. They are distributed in chapters 6, 7, 8 and 9.

The significance of the study

The habit of taking drugs for other than strictly medical purposes has always existed in the U.A.E. among some ethnic groups especially Iranians, Pakistanis and Indians and among a few older U.A.E. nationals (Yousif, 1991). This habit was limited to a few

people and to drugs which were, on the whole, not life-threatening. Consequently, the state did not have any drug-related problems as a result of this phenomenon; but since the 1980s, the habit of taking drugs in the U.A.E. has come to represent a problem, in terms of a rapid increase in the number of users, in the amount used, and in the choice by users of more dangerous drugs (Ministry of Social Affairs, 1990). Drug abuse has spread from a few isolated examples in some ethnic groups to many people across a broad range of age and ethnic groups. Drug abuse is spreading among U.A.E. citizens as well as among people of other nationalities who are living and working in the U.A.E. (Ministry of social Affairs, 1990). It is spreading amongst the wealthy, poor, educated and uneducated alike. This makes the problem more complicated to examine. The U.A.E. is host to people of many different nationalities, most of whom are expatriate workers who have come to the U.A.E. to participate in the development of the state.

The presence of large numbers of expatriate workers leaves U.A.E. citizens in a minority in their own country. Many expatriate workers originate from drug producing countries such as Pakistan, Iran, and Afghanistan. Each nationality has its own norms, values, customs, traditions, etc., which makes the study of the subject of drug abuse and its problem more complicated and difficult.

In spite of the relatively small number of U.A.E. citizens in the state, drug abuse is spreading faster among this sector of the population than among other nationalities, and is causing problems not only to the individuals but also to their families and the social and economic life of the state. The extent of the problems caused by drug abuse has impelled some government and non-government organisations in the U.A.E. to exert more effort to tackle the problems.

In spite of the spread of drug abuse in the U.A.E., studies conducted in this field are rare. It is because drug abuse and its associated problems are developing and changing with time and events, and also because of the complex nature of the problem in the

U.A.E. generally, that evaluation and follow-up studies are needed from time to time in order to develop and modify prevention, treatment and combating policies to suit whatever situation exists at the time. It is also because the drug abuse problem is a sensitive problem or field of study to deal with, particularly in Arab/Muslim communities. They do not like to admit the existence of this problem.

This study examines the nature of the drug abuse problems in the U.A.E.. It highlights the prevalence rate of drug use behaviour in the U.A.E.; the socio-economic changes in the U.A.E. and their effects on the increase of drug abuse problems; the drug combating policies and their effects on the reduction of drug-related problems in the U.A.E.; and the effects of drug abuse on individuals, family and society, as well as the effect on the laws, customs, traditions, norms and morals of U.A.E. communities.

The U.A.E. is a suitable place for this type of study because social change has been rapid in many aspects of life and in the structure of the state. The state is made up of seven Emirates, all differing to some extent socially, economically and demographically, with a large number of different ethnic groups. There are also differences between the Emirates with regard to legislation, local laws, regulations, policies, etc.. There are also differences between the oil- rich Emirates and non-oil Emirates. It can be confidently asserted that this diversity also plays a part in the nature of drug abuse problems in the U.A.E., and a study such as this shows how the different aspects of life in the U.A.E. affect the nature of drug abuse problems.

Aims of the research

My aims in this research are to investigate and analyze the relationship between the nature of the drug use problems and the social, economic and political change in the U.A.E. occurring before the federation of the U.A.E. in 1971 and up to recent times; the proximity of the U.A.E. to drug producing countries such as Iran and Pakistan; and the structural nature of the U.A.E.'s population and the large number of expatriate workers

who make up the majority of the population, with particular reference to non-nationals from drug producing countries.

My study attempts to answer the following questions:

1. Are drug abuse problems in the U.A.E. limited to a small number of individuals or a small sector of the population, or is drug abuse spreading and, if so, amongst whom?
2. How are U.A.E. communities affected from an increase in drug abuse problems?
3. What are the causes of the increase of drug abuse in the U.A.E.? Are they social, psychological, economic or political?
4. What are the health, social and economic consequences of drug abuse?
5. What are the special characteristics of drug users, and how do these characteristics affect the user's relationship with society, family, friends, job, the law, etc.?
6. What is the effect of the ready availability of drugs in the U.A.E. and the existence of a thriving drug trade on the prevalence rate of drug abuse?
7. Does the proximity of the U.A.E. to drug producing countries affect the spread of drug abuse?
8. To what extent does the large number of expatriate workers affect the prevalence of drug abuse among people in the U.A.E.?
9. What is the relationship between demographic characteristics such as: age, ethnic group, marital status, education, living situation, job, age of initiation, etc. and the use of drugs?
10. To what extent do the U.A.E. drug combating policies succeed in combating the problems of drug abuse?

Methodological Issues

In order to define and discuss the components of this research, both qualitative and quantitative methods were used. Data were collected from various sources:

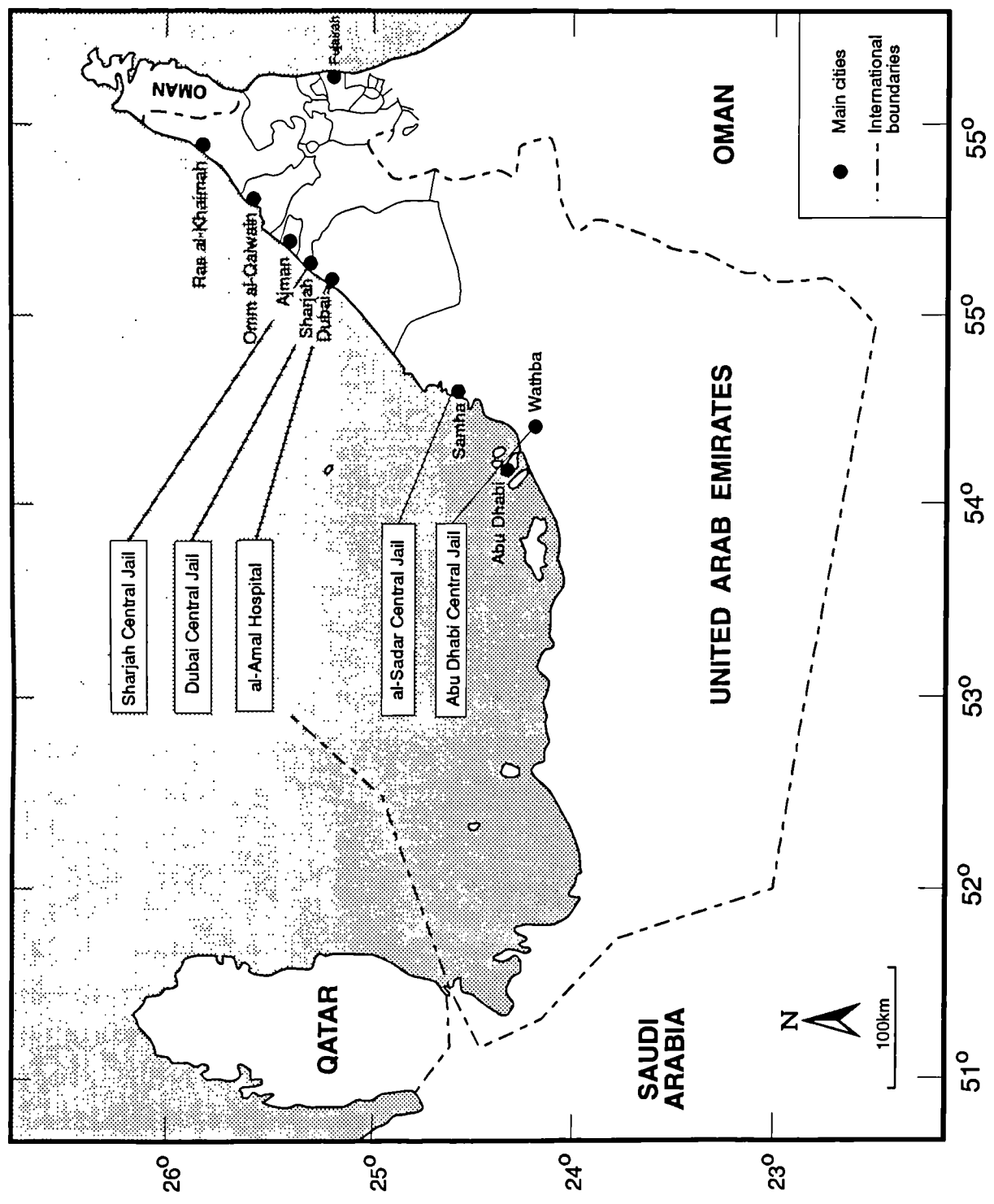
1. Books and articles relating to the study of drug abuse problems in general, in Muslim societies, Arab societies and U.A.E. society were consulted. These sources offer important information relating to drug abuse problems in the world generally, and in U.A.E. society in particular.
2. Abstracts of official reports, documents and statistics published by federal and local government and non-government organisations were significant sources of information. These secondary sources were collected from the following bodies: the Ministry of the Interior, General Administration for Combating Narcotics, Drug Combating Departments in the Emirates, General Administration of Border and Coastal Guards, customs departments of various Emirates, the Ministry of Health, Drug Addiction Units, Psychotherapy Departments in hospitals, the Ministry of Education, the Ministry of Social Affairs, the Ministry of Islamic Affairs, the Ministry of Youth, the Ministry of Information, Juvenile Custody Departments, women's associations, the Ministry of Justice, Police Departments, Courts, the office of the Attorney General, etc.. The government and non-government bodies mentioned above were unable to provide all the official information required for this research. For this reason, and also due to the confidentiality of some of the data relating to drug abuse problems, direct field investigation was necessary to achieve the main objectives of the research.
3. A number of fieldwork trips in the U.A.E. were carried out by me, some longer than others. Most of the fieldwork was carried out between November 1992 and March 1993.

4. I have the following relevant background experience: I was a police officer for 12 years; I was awarded an M.A. in criminology and a B.A. in mass media and politics; I headed the illicit drug combating section of Fujairah Police Administration; I was involved in drug abuse-related investigations; I lectured at the Police Academy in Abu Dhabi on the subjects of criminal investigation and drug problems in the U.A.E.; and I headed the police academy instruction department.

Field study design and procedures

The nature of drug abuse is complicated and changeable, and therefore, its evaluation must be wide-ranging and encompass most aspects of the subject, especially an examination of its characteristics (Al-Maghrabi, 1984). It is because of the lack of written, up-to-date information in the U.A.E. on the subject that fieldwork was conducted during 1992/93 and was designed to obtain information about the nature of drug abuse in the U.A.E.. As De Vaus (1990) has suggested, that the choice of the probability sample is preferable in social research. This is because the probability sample is more likely to give representative and accurate data. But the choice of the probability sample depends on the nature of the research problem, the method by which data are to be collected, money and the availability of good sampling frames. As a result of difficulties in obtaining information relating to drug abuse from the population of the U.A.E. generally, and in accordance to the limitations of the sample which will be described later, the fieldwork concentrated mainly on drug users who had been convicted and were serving jail sentences, and those who were being treated at psychiatric clinics. The fieldwork was conducted with the collaboration of prison and psychiatric hospital administrators. The sample was drawn from jails and hospitals from whom I had obtained administrative consent, and of course, that of the individuals who participated in the field study (see Figure 1.1). The number of agencies and individuals who refused to participate was too small to affect the procedures or the results of the study. The fieldwork procedures

Figure 1.1 PLACES WHERE SAMPLES WERE TAKEN



employed are detailed below, along with the method of sample selection, design of questionnaire and structure and application of procedures involved in the research. Further, an explanation is offered for the difficulties encountered in carrying out the fieldwork.

Questionnaire

The preparation of the structured questionnaire with limited qualitative component was undertaken, taking into account the following:

1. Questionnaires which have been used in previous studies, such as that used in the study of the use of hashish in Egypt (Al-Magrabi, 1984), a questionnaire used by the Ministry of Social Affairs to examine drug abuse in the U.A.E. (Ministry of Social Affairs, 1990), a questionnaire used in the study of the use of solvents among children in the U.A.E. (Thabit, 1984), a questionnaire used in the study of social change and drug abuse in Egypt (Salim, 1989), a study of the evaluation of the campaign about misuse of heroin prepared by RBL Research International, 1988, a sample survey of youth clubs in the London Borough of Croydon (Keith, 1991), a handbook of research design and social measurement (Miller, 1991), another book on research design (Hakim, 1987), and a book about fieldwork (Burgess, 1984).
2. Consultations with officials and experts in the field of drug abuse in the U.A.E.. These included personnel involved in law enforcement, social services and policy, medication, education, etc.
3. The findings of the pilot study.

The constituents of the questionnaire

The questionnaire was comprised of pertinent questions relating to the areas being studied, and included those:

1. Eliciting basic information of the interviewee's situation, such as nationality, age, place of birth, domicile, education, marital status, employment, and living situation.
2. Relating to the nature of drug abuse, such as the age of the drug user when he began taking drugs, the type of drugs he first tried, the person who offered him his first drugs, the different types of drugs he has used, methods of obtaining drugs, the places where drugs were taken, the user's relationship with other users and non-users friends, his relationship with his drug-taking companions, frequency of taking drugs, the cost of his habit, the best time for using drugs, methods of taking drugs, his relationship with drug dealers and others offering drugs, the amount of drugs used and sources of money for drug use.
3. Aimed at identifying the reasons behind drug abuse and the dissemination of drug use in the U.A.E..
4. Aimed at examining the physical, psychological, familial and social effects of the abuse of drugs.
5. Relating to the leisure activities of users.
6. Aimed at identifying the relationship between drug abuse and deviant behaviour.
7. Aiming to discover the accessibility, suitability and effectiveness of medical services available in clinics and prisons for drug-abusers.
8. Aimed at assessing the degree of an abuser's satisfaction about life, work, health, opportunities for recreation, religious life, freedom, family life, prospects for the future, etc..

The questionnaire was translated and printed in Arabic, and bound in a presentable form, in order for it to be easily understood by drug abusers (see Appendix 2).

Sampling

The selection of the sample is one of the most important stages in social research (Miller, 1991). It is usually considered that results obtained by the random sample method are the most accurate. In this research it was not possible to select the sample from the whole population of society because firstly, there is no accurate information about the number of drug abusers in the U.A.E.. Secondly, there is a lack of basic demographic information about drug abusers, such as their ages, nationalities, the type of drugs they use, geographical distribution, etc. Finally, it is difficult to get accurate information from drug abusers who are not in prison but living in society, because of the sensitivity of the illicit drug use issue in societies such as the U.A.E., and for social, family and security reasons. The drug abuser usually does not like to be identified as a user to other non-users in his social circle. Also what is considered anti-social behaviour by the public is seen as positive behaviour by drug users. For the above reasons, I decided to select the sample from drug abusers serving sentences in jails or to those being treated in psychiatric departments in hospitals. However, the decision to take the sample from such institutions also had certain merits. Firstly, drug abusers who have already been prosecuted and found guilty do not worry about exposure as this has already happened. Consequently, they were able to be more cooperative than abusers living in society. Secondly, there were no problems about locating respondents as they were all in prisons and psychiatric clinics. Finally, as with addicts seeking treatment in psychiatric clinics have already been exposed as abusers and have no further worries regarding exposure, and its associated social problems. Some had come to the clinics to try to kick the habit, and after suffering from the use of drugs they could appreciate and sympathise with the aims of the research. Others had been brought by the police or sent by the courts after prosecution and again were not inhibited by the risk of social exposure.

Because the Ministry of the Interior in the U.A.E. is responsible for drug abusers who are in prisons or being treated at clinics, the first step I made was to arrange a meeting with the Under Secretary of State of the Ministry to explain the purposes of my fieldwork and its

importance to U.A.E.. The Under Secretary of the Ministry of Interior approved the plan of my fieldwork and I am indebted to his efforts. He helped me by sending official letters to the police headquarters of each Emirate and in addition a letter to the Minister of Health. In these letters the Under Secretary explained the importance of the study and its purposes and asked these organisations to help me.

Meanwhile, and according to my request, the Federal Drug Enforcement Administration sent official letters to the following institutions in order to enable me to assess the number of drug abusers/addicts in each jail/clinic: Abu Dhabi Central Jail, Dubai Central Jail, Sharjah Central Jail, Ras al-Khaimah Central Jail, Ajman Central Jail, Umm al-Qaiwain Central Jail, Fujairah Central Jail, Al- Sader Federal Central Jail, Al-Ain Central Jail, Mukhairiz Jail in Abu Dhabi, The Psychiatry Department of Abu Dhabi Central Hospital, Al-Amal Psychiatry Hospital in Dubai, The Psychiatry Department of Rashid Hospital in Dubai, The Psychiatry Department of al-Jimi Hospital in the city of al-Ain, The Psychiatry Department of Zayed Military Hospital in Abu Dhabi and The Juvenile Custody Unit of the Ministry of Social Affairs.

Letters included the following questions: how many drug abusers/addicts are prosecuted and how many of them are still awaiting trial? (i.e. how many are available in jails?), what is their gender?, how long have they been in jail?, for how long have they been treated?, what is their nationality? and what language (or languages) do they speak?

Thirteen of these institutions answered my inquiries and only three ignored them. Reasons for non-co-operation can only be surmised. I suspect that one reason may be because the drug problem in the U.A.E. is a highly sensitive issue. Other possible reasons are that the administrative procedures would have made it difficult to participate, and because some high-ranking officials put restrictions on information regarding drug abuse problems.

However, only five institutions responded to my request and furnished me with the information I needed regarding numbers and distribution of abusers/addicts for the research. The selection of location was then made and is shown in Table 1.1.

Table 1.1: Sample distribution among different jails and the Psychiatry Clinic

The Place	The Number of Abuser/Addicts
Abu Dhabi Central Jail	189
Dubai Central Jail	118
Sharjah Central Jail	83
Al-Sader Federal Central Jail	58
Al-Amal Hospital	19
Total	467

After collating all the information from the letters received in response to my request, I decided to take my entire sample from the places listed in the table above, and I did not incorporate other places for the following reasons: some hospitals such as those at Rashid Hospital, al-Jimi and Abu Dhabi replied that they had no drug abusers/addicts being treated at the time of the fieldwork; Zayed Military Hospital and the Juvenile Custody Units in Abu Dhabi and Sharjah did not respond to my enquiries; Fujairah, Ajman, Ras al- Khaimah, and Umm al-Qaiwain jails had no drug users/addicts who fulfilled the research criteria at the time of the study. Some drug users/addicts had been transferred to the al-Sader Federal Central Jail because of the lack of places in the above jails at this time; and the location of the Mukhairiz Jail was too inaccessible. It lies in the desert near the Abu Dhabi - Saudi Arabian borders (about 300 miles from Abu Dhabi) (Figure: 1.1).

Geographical distribution of the sample

Most of the selected samples were from the Emirate of Abu Dhabi, which is the most densely populated Emirate in the U.A.E. (42.9%). The second most densely populated emirate at 25.6% was Dubai, and the third at 24.4% was Sharjah. The percentage of respondents in the sample is roughly in direct relation to the percentage of abusers in

prison at the time of the fieldwork from each Emirate. The rest of the sample was distributed among other Emirates (Table: 1.2).

Table 1.2: The distribution of drug users sample in relation to each Emirate

Emirate	Frequency	Valid Percent
Abu Dhabi	67	42.9
Dubai	40	25.6
Sharjah	38	24.4
Ras Al-Khaimah	3	1.9
Ajman	5	3.2
Umm Al-Qaiwain	1	0.6
Fujairah	2	1.3
Total	156	100.0

Pilot Study

Before I started the interviews I ran a pilot study in which I applied my questionnaire to 10 drug abusers from Sharjah Central Jail (about 60 miles from my residence, and the nearest jail). In this pilot study the following points were tested: the optimum length for an interview, the reaction of the interviewees to the questions, the degree of understanding of the questions by the interviewees, the optimum method of presentation of the questions, the length of time taken to listen to respondents' answers and to write them down, and the efficacy of using a translator who would help me to translate my questions to those drug abusers who did not speak Arabic or English.

Taking into account the result of the pilot study, the final sample was selected in accordance with the following conditions: that the interviewee should speak or understand Arabic or English; that he/she should have been living in the U.A.E. for not less than 6 months; that he/she should be using any kind of drugs except alcohol; that any interviewee in jail should have been prosecuted and be serving his/her sentence; that the addict being treated in hospital should be in a good physical and mental condition in order to be interviewed; and that he/she should agree to be interviewed without any external pressure.

In accordance with the above conditions, the final selected sample was as shown in Table 1.3. The selected sample was about 33.4% of the target population.

Table 1.3: The distribution of the target population and the selected sample according to the place of the interview.

Place of interview	The target population		The selected sample	
	Count	%	Count	%
Abu Dhabi Central Jail	189	40.4	70	44.8
Dubai Central Jail	118	25.2	12	7.7
Sharjah Central Jail	83	18.0	43	27.6
Al-Sader Federal Central Jail	58	12.4	16	10.3
Al-Amal Hospital	19	4.0	15	9.6
Total	467	100.0	156	100.0

Preparations for the interviews

I used interviewing as a method for collecting data because it offered particular advantages: it gives a high percentage of returns; establishes relationship between the interviewer and the interviewee; everyone in the selected sample can be reached; the interviewer can clear up inaccurate answers; information obtained by interview is more secured; helps the interviewer to get additional information from the interviewee such as previous experience; it can be used to obtain information from poorly-educated people; etc. (Miller, 1991). The selected sample included a number of drug abusers who had only a little education which meant they were not able to understand or to answer some questions without assistance. In such situations an interviewer can adapt an explanation of the meaning of questions to the educational level of the interviewee. The face-to-face interview gives rise to a direct interaction between the interviewer and the interviewee; the interviewee can ask the interviewer about anything he finds confusing in the questions and the interviewer can clear up and/or check for any misunderstandings, and the interviewer can observe the reaction of the interviewee about sensitive issues and he can change the subject or explain the purpose of such matters to the interviewee. There are

also some disadvantages of the interview such as: it takes longer than other methods; it costs a lot of money; unless the interviewer is trained and supervised, data may be inaccurate or incomplete; personal interviews may not facilitate the interviewee to reveal information accurately, especially in response to sensitive questions; because the free time of interviewees may be limited, because they are working people and the process of interviewing may require a large staff (Hakim,1987; Miller, 1991).

Before I started the interviews I met the director of each jail/clinic chosen. At these meetings I explained to them the aims of my study, its importance, what kind of help I needed and co-ordinated the following with them: the starting date of the interviews and the duration they would take, the number of interviewees and the approximate time of each interview; preparing a place for the interview; assigning a person to prepare the interviewee for the interview and accompany him back to his room after finishing the interview; and security procedures during the interview in case of any abusive behaviour by the interviewee towards me.

The preparation of the interviewees

Before I started the interviews I gathered all the drug user/addict respondents together in one place and the following took place: I introduced myself to them as a researcher doing a project on the drug problems in the U.A.E.; I explained to them the aims and the importance of my study to U.A.E. society, to their families and to their future; I explained to them that any information which they gave me would be treated as confidential; and I told them that the interview was entirely voluntary, and thanked them for agreeing to be interviewed. I also informed them that the interview would not be recorded on tape; I assured them that the information collected would not be seen by drug enforcement officers or by the staff of the jail/clinic and I told them that I did not know their names or addresses and I did not need them.

Preparation of each interviewee

Before I started the interview there were some measures to be taken in order to prepare the interviewee. When the interviewee entered the interviewing room I stood up and invited him to be seated on the chair facing me. I asked the person who brought him in to leave the room and close the door. I introduced myself to the interviewee again as a researcher and told him my name, nationality and the name of the university at which I am studying (if the interviewee understood English, I showed him my University ID card). Then I asked him if he needed anything, such as cigarettes, tea/coffee, or if he had an enquiry relating to the interview. If he was educated I gave him a copy of the questionnaire and let him have a look at its content and asked him to tell me if he had any query. If he was not educated, then I verbally explained the contents of the questionnaire.

Once the interview was finished, the interviewee's answers were checked by returning to his file and by asking the responsible officer about anything I could not get from his file. In spite of the fact that I am a police officer authorised by law to access their files, I required their permission to do so. The jailed drug user's file contained the following information: name, age, nationality, marital status, residence place, job situation, address, a résumé of previous convictions, a résumé of the offence (date, place and type of offence, his accomplices, the type of drug, whether he was a user or a dealer, etc.), the verdict of the court, his behaviour in jail, the names of his visitors, the expected date of his release and his medical report. The file of the drug user being treated in the addiction unit included name, age, nationality, marital status, address, a history of the case, (the type of drug he used to take, how long he had been using the drug, the type of effects which he had experienced, other diseases and previous medication), present medication, who brought him to the clinic (parents, police, court, etc.), the names of his visitors, and a projected discharge date.

The second field study was conducted acting on the findings and results of the analysis of data collected in the first field study. This second field study took two months and concentrated on drug combating policies in the U.A.E.. More than 37 officials involved in drug combating policies were interviewed. The officials interviewed were working for the following government and non-government organisations: The General Administration for Combating Narcotics, Drug Combating Departments in the Emirates, The General Administration of Border and Coastal Guards, Customs Services Departments, Ministry of Information, Ministry of Education, Ministry of Islamic Affairs, Ministry of Health, Ministry of Social Affairs, Television Broadcasting Stations, Addiction Treatment Units, Juvenile Custody Departments and Women's Affairs Associations (See Appendix 3).

The interview questions were aimed to elicit the following: how would officials describe the drug problems in the U.A.E.?; what do they think are the causes?; to what extent do they participate in drug combating policies?; what is the relationship between drug combating organisations in the U.A.E.?; what sort of difficulties do they face?; what do they think are the best ways of dealing with drug problems in the U.A.E.? and which agencies do they think should take the main responsibility for dealing with drug problems in the U.A.E.?

Problems encountered

It is axiomatic that there is no research without some difficulties being encountered, but some difficulties can be solved and others cannot. The U.A.E. being a relatively new state, there is a paucity of documentation; and because of the sensitivity of drug abuse problems in the U.A.E., there are restrictions on access to, and confidentiality regarding, many official reports and studies. Access to this data often required special permission from a Minister of State or the head of the relevant authority.

Some organisations did not answer the official letters. Others answered more than a month after receiving these letters and some of them asked to meet me or to show them a copy of my questionnaire before they allowed me to conduct the interviews. During the fieldwork project on the nature of drug use problems in the U.A.E. many problems occurred. Some officials did not understand the importance of social research or the fieldwork because of their lack of education and knowledge. In such cases I tried to encourage them by explaining to them the aims of my study and its benefits to U.A.E. society. This can be difficult to deal with. Because of the length of the interview, some interviewees got bored. In such cases I stopped the interview and took a ten minute break. Some interviewees did not know Arabic or English well enough, which made it difficult for them to understand some questions. Some interviewees hesitated to answer some questions, either because they did not understand the meaning of the question or because they felt that the information revealed might be used as evidence in court against them. In these cases I explained to them the confidentiality of the information and the purpose of the question and encouraged them to answer. Some interviews were interrupted by some interviewees who cried when they talked about their hard experiences in life. When this happened I stopped the interview and changed the subject for a while, and tried to cheer them up before returning to the same subject. Of 467 drug abusers, 9 were female, distributed around a variety of jails and psychiatric clinics during the period of the fieldwork: 4 in Abu Dhabi Central Jail, 3 in Dubai Central Jail, and 2 in Sharjah Central Jail. All refused to be interviewed. I tried to circumvent their reluctance to participate in the survey by employing a female assistant to interview them but they still refused, giving social and family reasons.

The length of each interview (two hours and fifteen minutes) in relation to the daily programmes of jails/clinics was such that 4 interviews per day was the maximum achievable, and sometimes it was impossible to adhere even to this schedule. For instance, the official working day in jails/clinics starts at 7.30 in the morning and ends at 1.30 in the afternoon.

Each jail/clinic has its own timetable including such activities as breakfast, treatment, taking prisoners to court or to the hospital, sports activities, etc. These timetables meant that I could not start my daily schedule before 9.30 in the morning.

To overcome the problem of the shortness of the respondent's time available to me, I asked the directors of jails/clinics to allow me to continue my work in the evening. All of them agreed except the director of Abu Dhabi Central Jail. He told me that he could not provide security for me during the evening because the majority of the jail staff leave the work place at 1.30 p.m..

In some jails the distance from the interview room to the drug abusers' wards was too long. There were also difficulties encountered with procedures of some jails which meant sometimes the interviewee took about 25 minutes on his way from a ward to the interview room because he was handed over from one member of staff to another until he reached the last person who brought him to the interview room.

Some staff at the jails/clinics entered the interview room during my work which interrupted me and the interviewee. If this happened I stopped the interview and took a break. Some of them would enter the room and sit down to listen. They obviously wanted to know what I was doing and sometimes asked me to give him/her a copy of the questionnaire or asked me about the interviewee, being especially interested in whether the interviewee was telling me the truth or not. Some jailed drug abusers thought that the interview was a criminal investigation which could be used as evidence against them. I explained to them that a person who has committed a crime cannot be prosecuted more than once for the same crime, and that I was an independent interviewer and they could refuse to be interviewed. In the pilot study I interviewed some drug abusers who were in jail but not yet prosecuted, but after I checked their answers I found that they did not always tell me the truth. Consequently I found it easier to interview prosecuted drug users serving their sentences because they had nothing further to worry about regarding prosecution.

I tried to interview some drug abusers who did not speak Arabic or English but the translators I used were not able to explain the questions sufficiently and each interview took a very long time. In the end I found it too difficult to use translators and had to abandon this.

The illicit nature of drugs makes any evaluation of the drug problems difficult. This is because data on the problems are not always reliable and available.

I fail to include some HIV positive drug users in my research. This is because in accordance to the law it is illegal to identify HIV positive people to the public.

Data analysis statistical procedures

After the collection of the data, each item in each questionnaire was coded and scored. A computer programme was used for analysing the data. The Statistical Package of Social Sciences (SPSS) was used for most of the analysis. Frequency tables to describe the data were used. Cross-tabulation was used to show the number of cases that had particular combinations of responses to two or more questions. For testing the relationship between variables, testing independence, calculating the observed significance level for the null hypothesis the chi-square test was used. The chi-square value, degrees of freedom, number of cases, and the probability value were shown in each cross- tabulation table. Fisher's exact test was applied to correct the chi-square distribution in cases where the expected frequencies in a table were less than 5. The probability values shown in each table are as follows: significant beyond level 0.001, significant beyond level 0.01, and significant beyond level 0.05.

Definitions of Drugs and Drug Abuse

Definitions of drugs differ not only between countries, but also between professions. Psychologists, sociologists, lawyers and medical practitioners, for instance, use different definitions for drugs in order to suit the functions such a definition has within their

profession. For example some experts and authors include alcohol, tobacco, coffee and tea as drugs (Salim, 1989). These substances are drugs to psychologists and medical practitioners (because they may bear on a patient's psychology or physiology), but are not drugs to lawyers, prosecutors or the police (because there is minimal legislative control over them). A prescribed drug is not necessarily a drug to police or customs officers (because its use is likely to be under medical supervision), but undoubtedly is a drug to medical practitioners. Some countries, such as the U.A.E., consider solvent abuse an offence, whereas other countries, such as Britain, do not. Two international conventions on drugs control deal with the issue of drugs. However, neither the 1961 Single Convention of Drugs Control nor the 1971 Convention on Psychotropic Substances offer a specific definition for narcotic drugs (The International Single Convention of Narcotic Drugs, 1961), (Abbas, 1989), (The International Convention of Psychotropic Substances, 1971). These two conventions list types of substances, categorising them under four headings according to their effects on a human being. Both conventions allow countries to add to the list substances not already included, such as *qāt* which is available in some countries but not in others, and to remove from the list substances which the country considers has minimal effect on human health, such as marihuana in some countries, e.g. the Netherlands. The U.A.E. 1986 Drugs Law, also, offers no specific definition of narcotic drugs, but lists the types of drugs under two categories. The first category includes any intoxicating substance. The law subdivides this category into four sections according to their effects. The second category includes plants which have an intoxicating effect on human beings, such as *qāt* leaves, cannabis, some types of mushrooms, etc.. (U.A.E. Drugs Law, 1986).

The World Health Organisation (WHO) defines a drug as a substance which reacts with living beings and may cause psychological or physical dependence or both, and also substances used for medical treatment or for recreational purposes which do not create dependence. A general definition of a drug is that it is a substance which affects the (human) central nervous system and psychological attitudes. Such effects may be

stimulating, depressing or hallucinogenic (Al-Bar, 1988). It becomes more precise to restrict definition to within a class of drug. There are two definitions for narcotic drugs in common use. The 'scientific definition' of narcotic drugs is that they are chemical substances which cause drowsiness, sleep and unconsciousness (This definition therefore encompasses neither stimulants nor hallucinogenic substances). The 'legal definition' of narcotic drugs is that they are a group of substances which poison the central nervous system and cause addiction. The drugs control laws of most countries in the world prohibit general handling of such substances except by people with official authorization to do so, such as medical practitioners and their patients.

Classification of Drugs

Drugs can be classified using one of several systems. They can be categorised into two broad groups according to colour: white drugs, such as cocaine and heroin; and black drugs, such as opium and cannabis (Safwat, 1957). This classification is used among drug users. A second system also groups drugs broadly into major drugs which have a dangerous effect on users such as opium, morphine, heroin and cocaine; and minor drugs which have a less dangerous effect on users, such as *qāt*, hypnotics and tranquillisers (Juwaidi, 1978).

A third and more sophisticated system classifies drugs according their physical and psychological effects on the central nervous system. Firstly, pain killing substances (narcotics), which include opium, morphine, codeine, heroin, hydromorphone, meperidine, methadone and other similar narcotics. Narcotics have long been used in medical practice (U.S.A. Drug Enforcement. Drugs of Abuse. 1980). They are now considered primarily to be useful painkilling substances, but are also used as cough suppressants, as well as a centuries old remedy for diarrhoea. They cause pupil dilation, vision attenuation, drowsiness, apathy, reduction in physical activity, and constipation. Secondly, depressants, which include barbiturates and other hypnosedatives, benzodiazepines, solvents and gases, alkyl nitrites and other similar substances. These substances have

a high potential for abuse associated with both physical and psychological dependence (ISDD. Drug Abuse, London, 1991). Taken as prescribed by a physician, depressants may be beneficial for the relief of anxiety, irritability and tension, and for the symptomatic treatment of insomnia. Thirdly, stimulants which include coca leaves, cocaine, amphetamines, anti-anxiety substances and other similar substances. The user of these substances tends to feel stronger, more decisive and self-possessed. Because of the cumulative effects of the drugs, chronic users often follow a pattern to taking 'uppers' in the morning and 'downers', such as alcohol or sleeping pills, at night. Young people who resort to stimulants for their euphoric effects consume large doses sporadically, over weekends or at night, often going on to experiment with other drugs of abuse. The consumption of stimulants may result in a temporary sense of exhilaration, superabundant energy, hyperactivity, extended wakefulness and a loss of appetite. It may also induce irritability, anxiety and apprehension (United Nation. Bulletin on Narcotics. Vol. xxxv no.2, 1983). Fourthly, hallucinogens which include LSD, (lysergic acid diethylamide), mescal buttons, cannabis, amanita muscaria mushroom, psilocybin, mescaline, morning glory seeds, dimethyltryptamine (D.M.T.) and other similar substances. These substances whether natural, such as hallucinogenic mushrooms, or manufactured, such as LSD, distort perception of objective reality. They excite the central nervous system and cause alterations of mood, euphoria and sometimes depression. The physiological effects of hallucinogens include the elevation of the body temperature and dilation of the pupils. Psychological effects include an inability to control the sense of direction, distance and time. High dosage of hallucinogens creates delusions and visual hallucinations (Abu Dhikra, W. 1989). The user may undergo depersonalisation and depression and may make rash decisions which can involve committing suicide or involvement in acts of danger which result in accidents. Hallucinogens can cause acute anxiety, restlessness, and sleeplessness (United Nations. Bulletin on Narcotics. Vol. 42, No.1, 1990).

The next chapter will examine the literature review of drug abuse in general and in the U.A.E. in particular.

Chapter 2

The Study of Drug Abuse

Introduction

The following literature review is not exhaustive but it highlights some of the pertinent issues about drug abuse problems in some countries in the world in general and in the United Arab Emirates in particular. The purpose of the literature review is to show that my research is not in isolation, but is part of a well-established field of past and on-going research. My aim is to show the related studies that have been done, the current status of knowledge about drug abuse problems, and to identify the gaps in knowledge which my study specifically sets out to fill. Drug abuse is a problem which has socio-economic, cultural and environmental roots and causes. Accordingly, different methodological approaches are used in the study of drug abuse problems, such as the psychological approach, which examines the relationship between the stages of an individual's development and drug abuse; the medical and pharmacological approaches, which examine the impact of drugs on the individual's health; and the economic, social and cultural, approaches which examine the relationship between the individual and the economic, social, cultural, etc. circumstances in the society. The theoretical explanations discussed in this chapter take anti-social behaviour as a general framework, i.e. drug abuse and addiction are viewed as anti-social behaviour. Social explanations of drug abuse and addiction will be emphasised, with a brief examination of other explanations.

The Study of Drug Abuse in the U.A.E.

There are few studies examining drug abuse problems in the United Arab Emirates. Whilst most of the studies which have been carried out are useful for my study, they were not comprehensive, nor did they examine most drug use-related aspects. Most

studies have concentrated on drug use problems among U.A.E. citizens alone, and ignored other ethnic groups who make up the majority of the U.A.E. population. In spite of the differences in many aspects of the oil-rich Emirates and non-oil Emirates, most studies have taken their samples from only one Emirate, usually one of the oil-rich Emirates. Most studies have not examined drug combating policies in the U.A.E. and their effects on the drug use problems, such as law enforcement, treatment, rehabilitation, prevention, etc.. Therefore, in the next pages I am going to make a critical review of the various studies made on drug abuse in the U.A.E..

Thabit (1984) in his study *Ḍāhirat Istinshāq al-Ghāzā t* (The Phenomena of Solvent Sniffing), concentrated on the use of solvents among adolescents. This was the first study, written in Arabic, to examine the prevalence of the use of solvents in the U.A.E.. A self-administrated questionnaire was conducted with 425 juvenile glue sniffers. The findings of his study show that most glue sniffers are students with primary and intermediate levels of education (78 %). I believe that the educational level of glue sniffers is the same in most other countries and therefore this feature is not peculiar to the U.A.E.. This is because solvent sniffing occure among young people (O'Connor, 1986). Although the monthly family income of most glue sniffers in this study was reasonable (c. £1,000/month), Thabit suggested that most glue sniffers are from poorer families (75 %). Taking into account the high cost of living in the U.A.E., and according to the monthly income of the sniffer's families, I cannot consider that glue sniffers are from poorer families, but would say that they are from low income families. Therefore, I do not believe that the economic factor is the most important factor behind the solvent abuse in the U.A.E.. Despite the fact that most (76 %) of the respondents in Thabit's study were living in the oil-rich Emirates (Abu Dhabi, Dubai and Sharjah), Thabit concluded that most glue sniffers live in areas which lack of leisure facilities and health services. I believe leisure facilities and health services to be more easily available in the oil-rich

Emirates than in the non-oil Emirates. Any impact of the lack of leisure facilities and health services on drug abuse was not examined in details in Thabit's study. Therefore, the impact of this provision will be examined in my study.

Amna Ahmed (1987), in her study *Dāhirat Ta'āṭī al-Mukhadarāt, Asbābiha, Athāra wa-Dawr al-Tarbiyah Fī Muwājahatiha* (The Phenomena of Drug Use, Its Consequences and the Role of Education in Combating It), investigated the role of education in combating drug use problems among young people. Ahmed's study, written in Arabic, depended on an analysis of documents associated with drug combating policies, and interviewing 14 people who were interested in drug combating policies in the U.A.E.. Ahmed's was the first study to attempt to evaluate drug prevention efforts in the U.A.E.. The findings of Ahmed's study show that U.A.E. drugs policies lack preventive measures to enlighten people and make them aware of the dangers of drug abuse. The findings also reveal a total lack of collaboration and coordination between agencies involved in drug combating efforts in the U.A.E.. Ahmed's study did not examine the efforts of some government and non-government organizations which are involved in drug combating policies in the U.A.E. such as the efforts of Drug Enforcement Departments, Custom Departments, National Committee for Drug Combating, Health Departments, etc.. In order to evaluate drug combating policies, especially prevention programmes, it is important to investigate those social problems arising from drug abuse which Ahmed's study failed to cover. Ahmed suggests that rapid social change in the U.A.E., after the discovery of oil, is an important factor behind the use of drugs. I believe that it is difficult to understand or to identify the factors behind drug abuse without carrying out field investigations which rely on information from a sample of drug abusers in society. Findings from studies which depend solely on official documents do not usually offer accurate indications related to drug abuse.

Al-Maftul (1989) in his study *Mushkilat Ta'āṭā al- Mukhadarāt Fī al-Emārāt, Derāsah Maydaniyah Li al-'Awāmil al-Ejtimā'iyah* (The Drug Use Problem in the U.A.E., A Study of the Social Factors Behind Drug Use), has investigated the social factors behind the spreading of drug abuse among people in the U.A.E. and the social characteristics of drug abusers. A self-administrated questionnaire was conducted with 90 drug abusers, dealers and traffickers who were jailed or being treated in jails/clinics. The sample was drawn only from U.A.E. nationals and did not include people of other nationalities. The findings of Al-Maftul's study, written in Arabic, show that many drug users are educated to intermediate level (33%) and most of them are in the age group 18 to 23 (64%), and that many are unmarried (35.56%). The findings also show that drug use behaviour is more likely to be associated with those who are employees and merchants (70%). I believe that the findings of Al-Maftul's study are not generally applicable to U.A.E. society. This is because the population of the U.A.E. is a mixture of different nationalities, and foreign nationals make up the majority of the population. The different foreign nationals each have their own values, customs, beliefs, etc.. Living alongside U.A.E. nationals, there is communication between them and an exchange of values, beliefs and traditions. Therefore, in order to study the factors behind drug abuse problems in the U.A.E., it is important not to ignore foreign nationalities. This means that drug prevention for U.A.E. nationals is difficult without providing drug prevention for other nationalities as well.

A study carried out by the Ministry of Social Affairs (1990), *Al-Mukhadarāt Fī Dawlat Al-Emārāt* (Drugs in the U.A.E.), gave valuable information about the prevalence for the use of some types of drugs, the characteristics of drug users, and methods of drug administration. This study, written in Arabic, depended on a questionnaire used by the Egyptian National Institute for the Study of Hashish use Among People in Egypt. The

study of hashish use differs from the study of drug use problems generally. This is because the consequences of the use of other types of drugs, especially heroin, are more serious than the immediate consequences of the use of hashish. Moreover, the structure of Egyptian society is different from that of U.A.E. society. The differences include the size of the population and its structure, socio-economic aspects, tribal impact, etc.. This official study failed to investigate drug combating policies in the U.A.E. such as prevention, treatment, rehabilitation, drug control, etc..

Shahdad (1991) in his study *Al-Twafīq al- ām Li Mut'atī al-Heroin* (The General Adjustment of the Heroin User) used the psychological approach to examine the impact of heroin use on the user's general adjustment, and looked at the emotional, social, health and family adjustment of the user. Shahdad applied five psychological scales: the family adjustment scale, the health adjustment scale, the social problems adjustment scale, the emotional adjustment scale and the general adjustment scale. The psychological scales were applied to 25 drug users who were jailed in Sharjah Central Jail. The findings show that most drug users are not socially well-adjusted. This study, written in Arabic, depended only on a sample drawn from U.A.E. nationals and did not include other nationalities. The findings of Shahdad's study show that heroin abusers have families, health and emotional problems but the study did not specify the types of these problems and the factors behind these problems. The findings also did not show causality: whether these problems were a consequence of heroin use or were in evidence before heroin users were initiated into drug abuse.

Sultana Yousif (1991) carried out a study of *al- Mukhadarāt Wa al-Shabāb* (Drugs and Youths). In this study, written in Arabic, she examined the prevalence of drug use among youths in the U.A.E.. The researcher mainly concentrated on the investigation of the social and psychological consequences of drug abuse among young people. A self-ad-

ministrated questionnaire was applied to 65 drug users and 29 non-drug users in Dubai Emirate. The findings of Yousif's study show that non-drug users are socially better adjusted than drug users. The findings also show that drug use behaviour is more likely to spread among people who lack information about the dangers of drug use. Peer pressure, a wealth of spare time and travelling abroad were, for young people, the most important factors behind the use of drugs in the U.A.E.. In drawing her sample only from the oil-rich Emirate of Dubai, and ignoring non-U.A.E. drug abusers, I believe that this study fails to describe adequately drug abuse problems in U.A.E. society, and is not more generally applicable.

The explanations of drug abuse

Glatt (1977) has argued that human life needs some organizational procedures to define and specify the types of social relationship between individuals. As each society has its own social organization, this affects the types of relationship between the individuals. For instance, where the social organization was on a small scale and simple, the relationship between people was strong, and the individual could satisfy their needs easily. At present, many human communities are very large with massive populations. Production and other developmental activities have increased, jobs have become more specialised and more difficult to obtain, and new and complex organizational procedures have been adopted. Formerly, social organization in the U.A.E. society was on a small scale and simple, social and economic solidarity were strong; the tribal spirit was widespread among people. In some villages the population was of one tribe or clan, and all members were bound by kinship. They would share each others' joys and sorrows, supporting and being supported during times of sadness. Nowadays, the relationship between the individuals is much more complex, and there is competition between local employees, local workers and expatriates. This situation creates many problems, as well as a feeling of frustration and indifference to national interests. Westermeyer (1987)

stated that urbanization has exacerbated the spread of drug abuse. This is because it has transformed the extended family into a nuclear family, and has had a negative impact on tradition, customs, religious and social norms. This social change has affected the lives of individuals and complicated the organizational procedures in the fields of economics, politics, social relationships, kinship and education. Some of the above mentioned arguments are applicable to the U.A.E. community. This is because the social change in the U.A.E has affected some aspects of life and has not affected others. For instance, social change has affected the economic situation, as a result of which most people now evaluate each other according to the amount of money they earn, not in accordance with their moral or their educational qualifications. This has led to weaknesses of the social relationships between people and even between family members.

Rubington et al. (1989) suggested that people create their abilities, experiences, skills, beliefs and behaviour through their communication with each other and through their relationship with the environment or social organizational procedures. Those with little chance to adapt to the organization of their society because of poor abilities or limited experiences become deviants from the point of view of that society. People who adapt to the norms of social organization are considered normal people, and are rewarded with high social status and a good social position. The individual who loses the ability to adapt may turn to committing crimes, and may become an alcohol or drug user. I believe that drug abuse and other anti-social behaviour appear when a society becomes swamped too quickly with a welter of differing and unassimilated values, customs, beliefs, tradition and goals. Since 1971, life in the U.A.E. has changed rapidly. This change, which jolted many people from isolation into the open-living situation of today, negatively affected the behaviour of some people, especially those unable to adapt effectively to the new situation. Regarding this situation, Rubington et al. suggested that anti-social behaviour, from the sociological point of view, accrues as a result of the individual's failure to adapt

to the institutional procedures in society. This means that studies should look for the reasons or factors which caused the indaptability such as personality or family, school, job, etc..

Durkheim (1951) believed that anti-social behaviour is related to social organization and the rapid pace of change of the economic and social situation which causes the inadaptability of the individuals. He explained that social organization can be considered a control unit for individual behaviour in society. If this system is beset by problems and becomes unable to control behaviour in society, individuals will try to attain their goals using illegitimate means (the massive growth in Mafia activities in the former Soviet Union is a case in point). As a result, control of the behaviour of individuals becomes problematic, and the degree of success in satisfying needs will depend on the abilities of the individuals to use illegitimate means and to adapt to the new situation. Thus forms of anti-social behaviour will appear. This situation could happen during an economic crisis, during swift changes in economic welfare, or during periods of rapid technological change. Economic crises test the abilities of an individual to adapt to the new situation by locating shortages of their abilities. Periods of rapid change in economic welfare and technology encourage people to overdraw their abilities, which makes some people try to use their limited abilities to reach unlimited goals. The failure of people to use their limited abilities to attain unlimited goals causes pressure and depression, which lead some people to commit suicide or other anti-social behaviour. I believe that it is not only economic downturns and catastrophes that create anti-social behaviour, but also a higher frequency of sudden increases in the wealth of a society: both are crises in their way, in which people try to use their limited abilities to attain unlimited goals. Most people in the U.A.E., U.A.E. nationals in particular, have a good standard of living compared with people in many other countries in the world. Moreover, the U.A.E. is not burdened with the yoke of high unemployment or the problems of grinding poverty, common in

other countries, especially in some developing countries. However, there are still drug abuse problems, especially among U.A.E. nationals, some of whom are wealthy. Wealth permits people who consider drug use a part of the luxurious life to obtain drugs more easily, and to use expensive types of drugs (heroin, cocaine, etc.). It also encourages dealers to supply drugs to wealthy people. This issue will be investigated throughout my study.

Merton (1959) suggested that the complexity of social structure creates many types of anti-social behaviour such as alcoholism, juvenile delinquency, mental disorder, crime, etc.. He also said that anti-social behaviour appears not only because of unlimited and unregulated goals of the individuals but because of a clash between an individual's goals and the legitimate means to access them. Differentials in racial and ethnic status, and particularly social class may mean that modern societies fail to provide adequate means for all individuals to attain their goals legitimately, and emphasize such status goals of competitive success as material gain and higher education.

In his explanations, Merton tried to establish why the frequency of anti-social behaviour varies between different socio-economic class in the society, and why people of a lower socio-economic classes are more likely to be involved in such behaviour. If we apply Merton's explanations for behaviour to drug abuse we can conclude that a drug abuser is a person who fails to achieve his goals by using legitimate and illegitimate means and in order to retreat from competitive struggle in the society he uses drugs.

Merton's suggestions could be applicable to the U.A.E. with regard to the issue of differential in social influence and tribal status. People who are members of particular tribes, and have more social influence, have a greater chance of achieving their goals legitimately. People in oil-rich Emirates in the U.A.E. have more chance of attaining their goals legitimately than people in the non-oil-rich Emirates. However, Merton (1959) also suggested that people who are members of lower socio-economic groups are more

likely to be involved in anti-social behaviour because the opportunities to satisfy their needs are fewer with lower levels of education. As a result, drug abuse may arise when such a person attempts to reach his goals but finds the way to those goals closed, and cannot use illegitimate means to get his goals because he has inhibitions against them. This also could be applicable to the expatriate workers, especially Asians who are living in the U.A.E.. Most of them are uneducated and unskilled, and opportunities to attain their goals are fewer than those open to U.A.E. nationals. Therefore, many of them are involved in anti-social behaviour such as illicit drug-related activities, trafficking in particular. I believe that the differentiation in drug abuse between socio-economic classes is less pronounced than with other forms of anti-social behaviour such as theft, delinquency, etc.. Drug abuse is not confined to specific groups, such as non-nationals or people of lower socio-economic class; indeed, wealthy people and middle-class people are more involved in drug abuse than people of lower socio-economic class. Suchman (1968) concluded that marijuana use is more prevalent among people from high-income families than others. Moreover, Blum et al. (1974) in their study "Drugs and Attitude Change" noted that drug use is higher among middle-class high school students than among working-class high school students. Increased wealth in U.A.E. society means that Suchman and Blum's conclusion could also be more widely applicable to U.A.E. nationals, with high purchasing power facilitating easy access to drugs sources and the acquisition of large quantities of expensive drugs.

According to Merton's explanations there are some likelihoods of anti-social behaviour arising as a result of individual adaptations such as conformity, innovation, retreatism, etc.. He believes that the likely emergence of anti-social behaviour patterns depends only on the environmental circumstances facing individuals, not on the individual's personality. The first likelihood is innovation. In this process, the individual creates illegitimate means to achieve legitimate goals. For instance, some people use drugs to avoid

problems. It is a legitimate goal to avoid problems, but it is illegitimate to use drugs as a means to achieve goals. The second likelihood creating anti-social behaviour is conformity. People who are brought up in a poor environment full of many types of anti-social behaviour have little opportunity to avoid the negative effects of this environment. In this environment there is no choice for the individuals but to adapt to the bad circumstances, and in order to achieve their goals they are forced to use illegitimate means. Chein et al (1964), in his study to examine narcotics use among juveniles in New York City, specified the characteristics of environments in which drug abuse takes place. He associated drug abuse with living in situations which are poor, overcrowded, and suffer declining education and family disorganization. This picture does not really coincide with living conditions in the U.A.E.. This is because the population of the U.A.E. is about two million, and its gross domestic product is high. Therefore, circumstances such as poverty and overcrowding are unlikely to exist in the U.A.E.. Poor educational attainment and family disorganization have a higher incidence in U.A.E. society than poverty and overcrowding. The third likelihood of anti-social behaviour is called retreatism. This happens when an individual fails to achieve legitimate goals in life, and having failed to adapt to circumstances by legitimate means, he/she then withdraws from these circumstances, through abusing drugs in some cases (Merton, 1959). According to Merton's explanations, retreatists are those who lack productive abilities, are frustrated and handicapped, do not share values in common with other people in society, and always escape from competitive conflict. This interpretation can be applied to some drug abusers and addicts, especially those who use hard types of drugs such as heroin. Heroin addicts, especially long-term users, find it difficult to stop using drugs, and prefer to continue using drugs than to seek medication. This is because they have low self-esteem and low self-confidence (Bilsen and Emst, 1989).

Anti-social behaviour such as drug abuse can be learned through imitation or learning process. Akers (1977) has stated that anti-social behaviour is learned, and it can be learned by communication and through interaction between individuals. Learning of an anti-social behaviour tends to occur within the membership of one group of people such as friends, relatives, students, youth, etc.. The techniques of learning of the anti-social behaviour are sometimes very complicated and sometimes very simple. Anti-social behaviour transfers from the highest social status groups to the lowest. Whilst I do not think this is always the case, some people do tend to imitate their role models, such as parents, film stars, sport stars, etc., and therefore the use of drugs and alcohol among parents may increase the likelihood that children will experiment with drugs. Akers also stated that through communication between individuals in the communities, the anti-social behaviour shifts from the deviant person to the normal person. For instance, the habit of drinking alcohol in Europe arises first among the highest social class, and then transfers through the social classes to the lowest (Akers, 1977).

Akers's explanation which I have mentioned above may be applicable to drug abuse because the drug abuse habit can be learned from others. But this theory could be applicable to some individuals who are prepared to learn and who have internal and external motivations. The internal motivations depend on individual psychological situations. However, the external motivations depend on the type of the individual's reaction to the institutional procedures in the society and the degree of relationship strength between the individuals in the society. Akers also suggested that before experimenting with drugs, the experimental user must learn how to define drug use in positive terms such as: drug use is exciting, is desirable, is not really dangerous, is justified, etc.. New drug abusers must also learn from experienced abusers how to obtain drugs safely, and how to use these drugs. Akers described the learning process of drug abuse as follows:

The use of drugs is associated with the availability of drugs in society and how to obtain them. The addict will be quite ingenious in ferreting out a supply, whereas the drug must be more readily available for the beginner. The beginner must learn and apply appropriate definitions to drug use which define it either in positive terms - that is, as a cool, exciting, or desirable experience to undergo, or in rationalizing or neutralizing terms - that is, not really dangerous, necessary to gain other ends, justified, or excusable. These steps will bring the person to the point of trying or experimenting with drugs, but the user will not continue use long enough to develop tolerance and dependence until he learns to administer the drug properly for optimal effect, and he must find the effects intrinsically rewarding or learn to define the effects, whatever they are, as desirable and obtain other social rewards upon taking the drug so that aversive consequences are offset. (Akers, 1977. p.105)

Becker (1955) described how some individuals become drug abusers. He concluded that the initiation into the use happens through individual communication with friends who are drug abusers and who initially provide the drug and positive information about its use to the experimental abuser. After that, if the experimental abuser has learnt how to overcome the initial negative effects of the drug, and learnt how to enjoy its effects, he then becomes willing to try it. The experimental abuser learns how to obtain and recognize the 'high' effects of the drug through the imitation of experienced abusers. I believe that the initiation of drug abuse behaviour occurs through imitation, but imitation does not motivate the continuation of the drug abuse. Continuation of drug abuse is motivated by a strong desire for the drug's effects. The 1990 study by the Ministry of Social Affairs in the U.A.E. concluded that the main factors behind drug use are peer pressure and the desire to escape from problems and to copy what their relatives are doing. About 50% of users used drugs under the pressure of friends, 20.3% for recreational purposes and 5.1% for sexual enhancement (Ministry of Social Affairs, 1990).

Goodstadt (1986) tried to explain the effects of peer pressure on drug initiation and drug abuse continuation. He found out that peer pressure encourages the individual to experiment with drug use but does not affect the continuation of drug abuse. The

continuation of drug abuse is associated with the desire to obtain psychological effects such as calming down or feeling good more than associated with peer pressure. This is also the situation for users of opiates, who are forced to continue using drugs in order to avoid withdrawal symptoms (Dupont, 1984).

Blum et al. (1974) have suggested that individuals who were influenced by peer pressure and who believe that drug use has a personal and social benefit are more likely to use drugs than others. People with a weakly developed personality, poor self confidence and low self-esteem are more likely to be influenced by peer pressure than others.

A study carried out in the U.S.A. by Siegel (1985), was able to categorise a number of patterns of drug abuse by young people. *Empirical use* is short-term, not exceeding ten times a year. Curiosity to experience the effects of the drug is the main reason given for this trend of drug use. This type of use can occur occasionally in closed groups of friends. *Social-recreational use* takes place in the social environment and among friends or relatives who consider the use of drugs to be acceptable and interesting, and they like to join other friends in using drugs. The factors behind this type of use are social, and whilst this type of use does not tend to increase, it could happen as frequently as once or twice a fortnight. *Circumstantial-occasional use* has a limited aim, and happens when unpleasant circumstances press the individual to use drugs in order to escape from the problem. This type of use might occur 4 or 5 times a week. *Intensive use* is long-term, and may happen each day. The reason behind this type of use is that the user tends to be imagining a relief of tension, depression or maintaining a level of ability. *Forced use* is a long-term and intensive drug use which may lead to addiction and make the drug into the main life aim of the user. The user creates a new behaviour which focuses on drug use activities. The reason for continued use is to avoid the drug's withdrawal symptoms. The user increases the use of drug in order to intensify its effects (UN, *Bulletin on Narcotics*, Vol. XXXVII, Nos. 2&3, 1985).

A wide variety of personality factors have been associated with drug abuse such as low self-esteem, strong need for independence, resistance to traditional authority, high tolerance of deviance, non-conformity to traditional values, high levels of sensation seeking and rebelliousness (Kandel et al. 1978). Every individual has a different character which is made up of physical, mental, moral, social and temperamental characteristics. These characteristics work together as a system which characterizes each individual, and distinguishes him from others. The development of each of the elements of the personality should be in some respect equivalent in order to create the normal behaviour to the individual. An equivalence in the development of the personality elements allows the individual to adapt to his external environment (Jessor, 1977). Hawkins et al., (1975) concluded that the characteristics of people who initiate into drug abuse before adolescence differ from the characteristics of people who begin drug use later. Compared with people initiated into drug use later, those who use drug before adolescence are more likely to be involved in anti-social behaviour, and may be aggressive and difficult to discipline. I doubt that the anti-social behaviour of people using drugs before adolescence is associated with psychological distress such as depression, aggressiveness, etc. of pre-adolescence. Indeed, psychological distress is more likely to be linked with factors relating to, and consequences of, the drug use itself on the user such as long-term use, types of drug, addiction, withdrawal symptoms etc..

Anti-social behaviour could occur as a result of the disjunction of personality elements, the degree of anti-social behaviour depending on the degree of the disjunction of the personality elements. This disjunction in the personality elements could create different disorders such as neurosis, psychosomatic illness and psychosis. The neurosis may create many types of disease such as hysteria, obsession, anxiety, phobias and traumatic neurosis which happen as a result of psychological shock (Al-Doory, 1976). In a study carried out by the Institute of Social and Criminal Studies in Egypt on the use of cannabis among

people in Cairo, it was shown that some users used drugs after they were shocked by the death of their parents (U.A.E. Ministry of Social affairs, 1990). Psychologists attribute drug use and addiction to psychological factors such as depression, anxiety, psychological shock etc..

Cancrini et al., (1985) classified patterns of addiction into four types. First, shock addiction, which could happen if the individual faced a strong psychological shock such as the death of a parent, or the discovery that he/she has a serious disease such as cancer. The individual in this situation may use drugs in order to deny the shock. Individuals who indulge in this type of addiction are characterized as introverted or unsociable and without good social relationships in their environment. The addict uses the drug not to get its "high" but to be intoxicated, and the addict of this type is characterized by a repeated increase in the drug dosage. This type of addiction is widespread among juveniles (Cancrini et al., 1985). The second type is transitional addiction, which is characterized by different types of neuropathy and psychopathy such as hypomania with depression and forced addictive behaviour. The addict increases the dosage not to get the "high" effect of the drug but to be intoxicated for a longer time. It is difficult to treat this type of addiction without involving the addict's family in the treatment programme. The third type is addiction related to social disorder, characterized by social psychological struggle. The addict may have behaved abnormally throughout his life, and is characterized as being indifferent, cool and inflexible. He/she is unlikely to be able to express his emotions or feelings to other people or to establish good relationships. The addict of this type has no self-confidence and has no social and psychological maturity, and he/she may experience difficulties with the law and social behaviour. This type of addiction can afflict individuals who are homeless, or whose families are disorganized. The fourth type is actual addiction. This type is characterized by the struggle between the individual and his/her social environment, which causes depression and dissatisfaction with life. They

use the drug only to be intoxicated, not to enjoy its effect (Cancrini et al., 1985). The addict challenges the people responsible for him/her. The families of addicts of this type are characterized by the weakness of the relationship between the parents, and one of the parents is more dominant in the family than the other. (UN. *Bulletin on Narcotics*, Vol. XXXVII, Nos. 2&3, 1985).

Anti-social behaviour personalities can be divided into schizophrenia personality, paranoia personality, changeable temper personality, sexual personality, alcoholic personality and the personality which relates to drug addiction (Al-Doory, 1976). The psychopathic personality is characterized by continuous failure in life, such as marital failure, failure at work, and in relationships with other people, etc.. The study of Calafat et al. (1985) examined the differences between the drug user personality and the non-drug user personality, Calafat et al., concluded that the drug user differs from the non-user. The drug users are characterized by a feeling of mutiny, and a weak relationship with others, especially with the authorities. They are also characterized by their failure in life and they have no tendency for religious practice (UN. *Bulletin on Narcotics*, Vol. XXXVII, Nos. 2&3, 1985). Individuals may develop many ways to cope with problems they face and with themselves, and drug use, alcohol, social withdrawal and isolation are some of these ways.

Summary

Whilst most of the western studies have highlighted certain aspects of drug abuse in many parts of the world, the studies which have been carried out in the U.A.E. have been lacking in the investigation of certain aspects related to drug abuse in U.A.E. society. This is because of the slow development of social studies in the U.A.E. and the lack of qualified people in the research field. U.A.E drug abuse-related studies have paid scant attention to some important aspects related to drug abuse in U.A.E. society such as increased wealth, immigration, social change, etc.. I believe that increased wealth in the

U.A.E. has influenced the prevalence of drug abuse in the U.A.E.. I think that the purchasing power of U.A.E. nationals has enabled them to use many types of drugs, including expensive types, and has encouraged drug dealers to supply drugs to U.A.E. nationals. Moreover, the impact of the population structure of U.A.E. society on drug abuse has not been examined. I think that examination of this matter is important, especially knowing that a majority of the U.A.E. population are expatriate workers whose countries of origin are drug producing countries such as Pakistan, Afghanistan, Iran, India, etc.. Therefore, my study will examine the above mentioned drug abuse related aspects. As none of the U.A.E drug-related studies have examined the impact of drug combating policies on drug abuse in the U.A.E., my study will examine such aspects related to drug combating policies in the U.A.E. as drug treatment, rehabilitation, prevention, drug enforcement, drug control etc..

Western studies have associated the study of drug abuse with other aspects of the individual's life such as physical and mental health, social welfare, juvenility, population infrastructure, education, rehabilitation etc.. The term 'environment' encompasses the psychological, social and economic aspects of the individual's life. The physical, mental, social and economic ways of the individual's life are connected to their needs and their goals. The occurrence of poor circumstances in the environment, such as poverty, economic recession, social conflict, social competition etc. encourage some individuals towards anti-social behaviour such as the abuse of drugs. The causes of anti-social behaviour in general, and the causes of drug abuse in particular, are variable and one factor cannot be preferred over another. However, the main factors behind drug abuse discussed in the above-mentioned studies include environmental, physical, psychological and genetic factors. It is important to review western literature related to anti-social behaviour in general and drug abuse in particular. However, I believe that it is not possible simply to generalize the findings of western studies to apply to U.A.E. society,

the nature of which is fundamentally tribal and conservative. Moreover, some social factors which have been associated with drug abuse in western literature, such as unemployment, poor environment, slum areas, economic crisis, poverty etc. are not associated with drug abuse in U.A.E. society. Therefore, different socio-economic factors behind drug abuse in the U.A.E. will be examined in my study. The next chapter will examine the impact of rapid social change on drug abuse, the impact of people's changing lifestyles from an isolated life to rapid communication with other parts of the world, and the impact of economic development on anti-social behaviour in the U.A.E..

Chapter 3

Background to the United Arab Emirates

Introduction

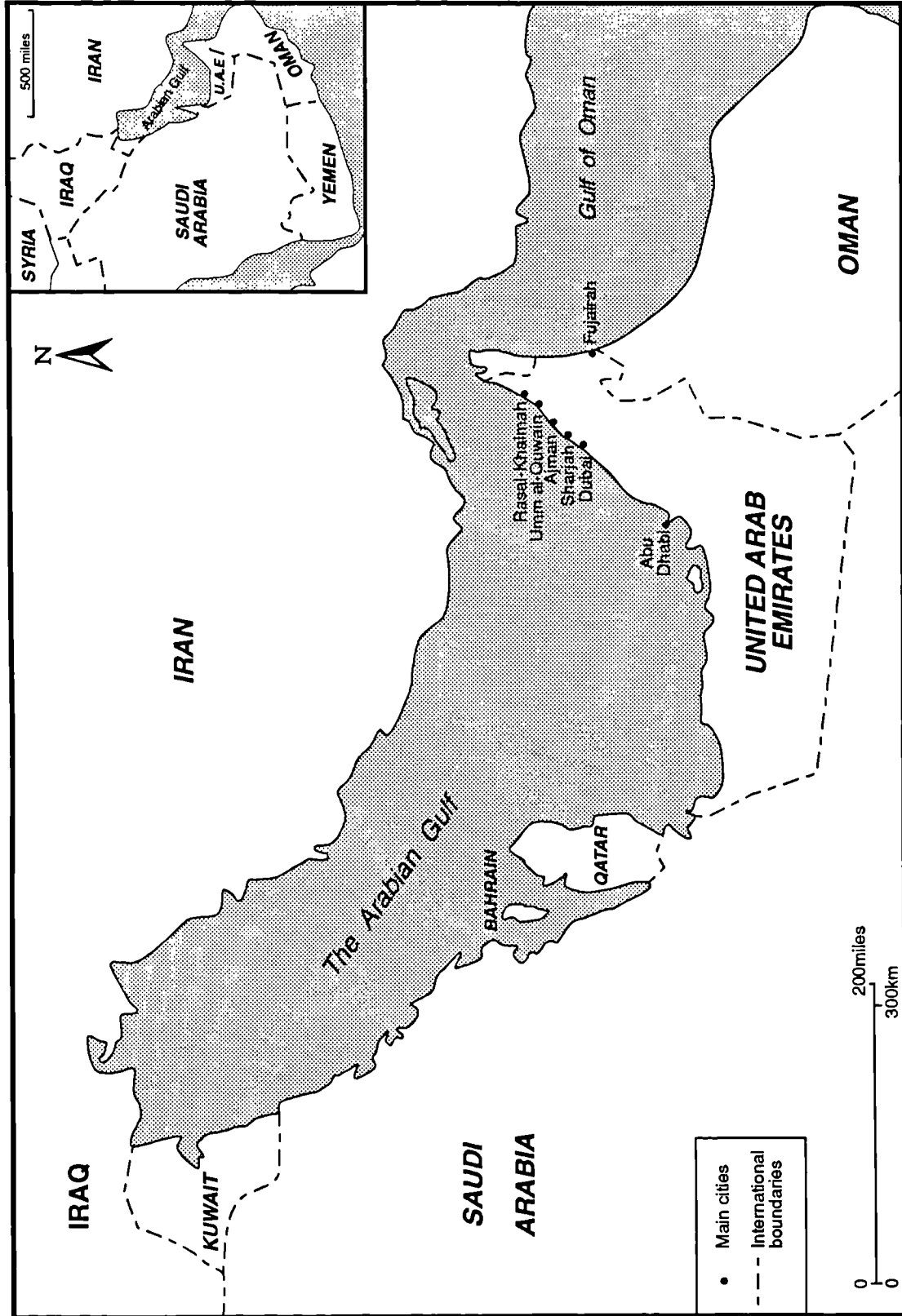
The study of any social phenomenon in a society should concern itself both with the structure of the society and the nature of the people who are living in the society. Social problems arise from the interaction between the people and the society. Some people are able to adapt through social change to social, political and economic problems in society, whereas others are not. Durkheim (1951) states that social organization in society is a control system for the behaviour of the people, and when the system does not work, the individuals will go without control to get their goals by using the available ways, whether legal or illegal.

Environmental conditions such as poor housing, social conflict, economic and social strife, ghettoisation, emigration and other social upheavals bear a measured responsibility for creating social problems. An example of such a social problem is that of drug abuse. Before examining the drugs problem in the United Arab Emirates, it is necessary first to examine the society under study: its social structure and political system, its geographical, economic and topographical aspects, the effects of social change on social behaviour and social cohesion, and the effects of these aspects on the quality and quantity of crimes in general and on the drugs problem in particular.

Geographical Location

The U.A.E. lies in the southeast of the Arabian Peninsula. Its borders to the north and north west are with the Arabian Gulf and Gulf of Oman. In the south it borders Oman; in the southwest and west Saudi Arabia; and in the west Qatar (Figure: 3.1). The Emirates have been in existence as a network of shaikhdoms for centuries. Only their international boundaries are of recent introduction.

Figure 3.1 UNITED ARAB EMIRATES



The U.A.E.'s location makes for easy communication and significance as a world transit area for commerce between East and West. Transport and communication services are seen as the lifeblood of the country, and there are thirteen sea ports, many oil and fishing sea ports, five international air ports, three Free Trade Zones and four satellite earth stations. There are two national flight carriers: Emirate Airlines, and the regional carrier Gulf Air which is owned by Abu Dhabi, Oman, Qatar and Bahrain. This plethora of services effectively 'decreases the distance' between the U.A.E. and rest of the world. It also goes some way to explaining the breadth of exchange of social customs, tradition and values between countries, and the degree of social change in the U.A.E..

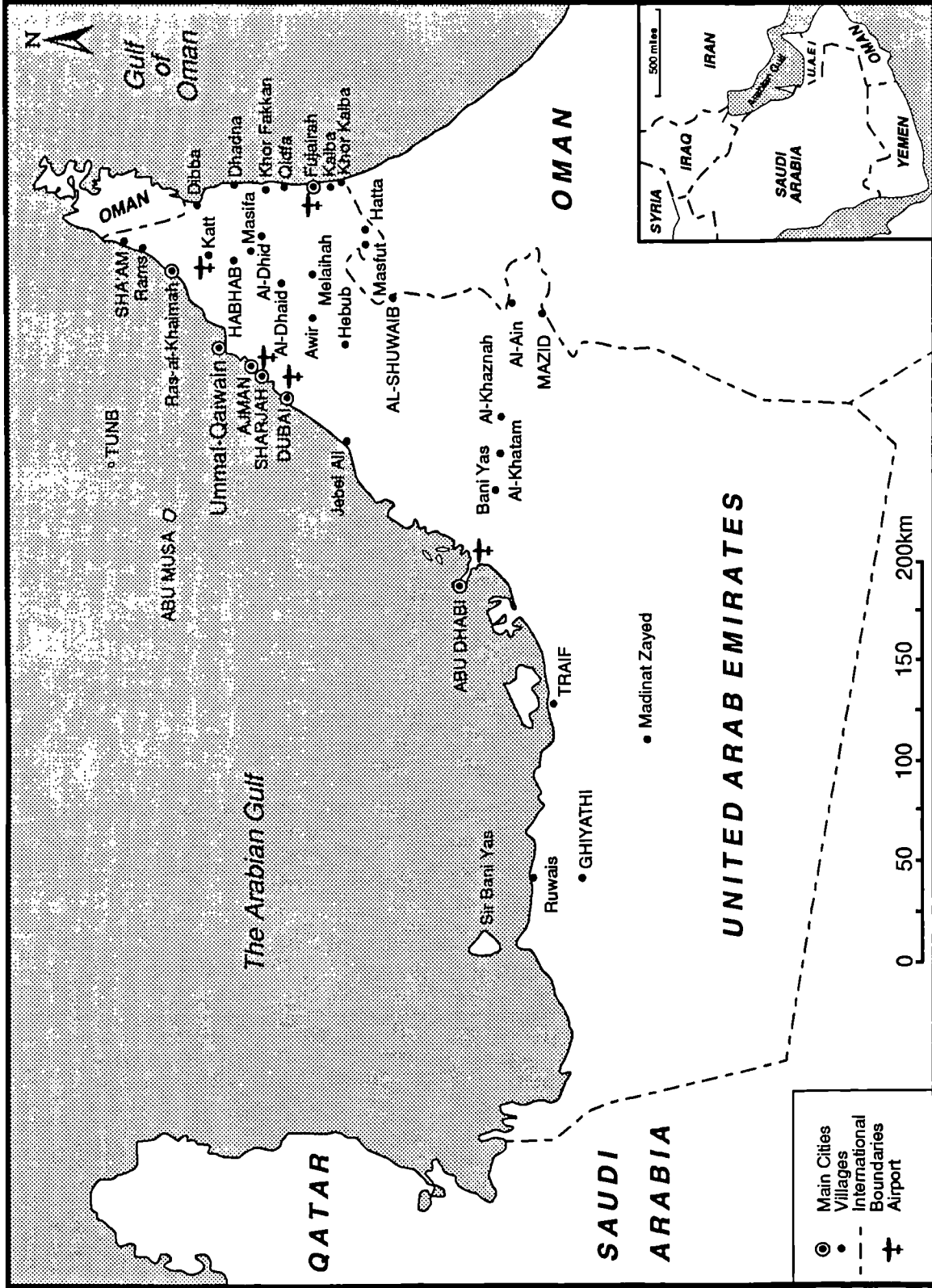
The Area

The land surface area of the U.A.E. is about 30,000 square miles, stretching from Abu Dhabi in the west to Fujairah on the Gulf of Oman. Much of the country is desert, although there are some oases, such as Liwa and al-Ain in Abu Dhabi. The rugged and largely barren Hajar Mountain range runs north through the country from Oman to the south of the Musandam Peninsula at the mouth of the Arabian Gulf (Al-Matrushi, 1988. p.6). The plains to either side of this range are broader to the west but only a few miles wide on the Gulf of Oman side. Seasonal rainfall and subterranean water supplies are slightly higher than elsewhere, permitting some agriculture.

The Eastern Coastal Plain of the U.A.E. stretches along the Gulf of Oman, from Dibba in the north to Kitmat Mulaha where Oman borders the U.A.E. in the south. The length of this coastal plain is about 55 km (Ghunaim, 1985.). The people have traditionally engaged in agricultural and fishing activities, but recently they abandoned these activities to take government jobs, or else to receive social security. In their place, they have employed Asian farmers and fishermen to manage their agricultural and fishing activities. The population is distributed among 29 small settlements, most being concentrated in Fujairah, Khour Fakan and Kalba. Some villages, however, have become part of cities or other larger villages as a result of construction and development in the area (Figure: 3.2).

Figure 3.2

THE MAIN VILLAGES IN THE U.A.E.



Mountainous areas lie in the east of the U.A.E., stretching from Shaam village in Ras al-Khaimah Emirate in the north, bordering Oman, to Hatta village in Dubai in the south, which also borders Oman. The length of the mountainous areas is about 155 km from north to south, and the breadth of the range varies from 8 km in the northern parts to 37 km in the middle and southern parts (Ghunaim, 1985).

These mountains are characterised by an abundance of valleys which allowed people to settle in the area. The people, distributed amongst 45 or so settlements, have traditionally practised agriculture on the slopes of the mountains. Nowadays, however, most of them are employees in local or federal government, or else receive social security. Like the farmers of the coastal plain, they employ Asian farmers, especially from Pakistan, to tend their farms. In addition, their sons have abandoned the practice of agriculture in the villages, and have instead settled in the cities because of the ready availability of jobs, especially in the Army and Police which offer high salaries and status.

Gravelly plains stretch from Ras al-Khaimah Emirate, past the village of al-Dhaid, and extend to the border with Oman. Other parts of these plains start from al-Hayir village in al-Ain city and cover most parts of al-Ain city to the borders with Oman. Most of the population of these plains is concentrated in al-Ain city because its location connects Abu Dhabi and Dubai Emirates on the west coast of the Arabian Gulf with Muscat and Suhar in Oman on the east coast of Gulf of Oman. This link has long aided and encouraged trade between the people of the U.A.E. and those of Oman. The remainder of the population is distributed amongst 63 or so settlements. People traditionally practised agricultural activities, such as cattle grazing and camel breeding. Nowadays, however, most people have abandoned this work, especially those in al-Ain, and have taken government jobs or else jobs in private business in the large cities such as Abu Dhabi. They still practise agriculture alongside their paid jobs, but they employ Asian and Egyptian farmers. The area around al-Ain, being both fertile and watered with an oasis, is one of the best agricultural areas in the U.A.E..

Desert covers most of the U.A.E.. Some parts of desert are significantly inhabited, whereas the rest is not. The most inhabited area of the desert is that which lies north of the main road connecting al-Ain city with Abu Dhabi. Most of its people are concentrated in al-Awir, Falaj al-Muala, al-Khuwanij and al-Sajaah. A second area is that which contains al-Dhafrah, Baynunah, Mati, and al-Majin areas. Inhabitants of this area are fewer because of the moving sands and brackish water (Tomkinson, 1975). The discovery of oil in the al-Dhafrah area led to it becoming inhabited. A third inhabited area of desert is the area which lies between the northern desert area and al-Dhafrah area. In this area, known as al-Khatim, there is camel breeding. A fourth area is that which lies south of the al-Dhafrah area, and is known as Liwa oasis. All these desert areas were inhabited by nomads who used to move from one area to another looking for water and grass. Nowadays, however, the U.A.E. government has settled most of the nomads in modern villages and shackled them to luxury living. In particular the Abu Dhabi government has established thousands of farms with modern farming equipment and given them to the nomads without charge. The Abu Dhabi government also built many buildings in Abu Dhabi and al-Ain, again distributing them to influential tribal people in order to settle them. By settling the nomads, they aimed to provide education, health, social, etc. services, and to employ some of them in government jobs.

The western coastal plain stretches from Shaam village in Ras al-Khaimah to al-Sela in the south. Most of the U.A.E.'s population is concentrated on this coast because it contains the Emirates of Abu Dhabi, Dubai, Sharjah, Ajman, Umm al-Qaiwain and Ras al-Khaimah. The population is distributed amongst 34 or so settlements, the largest being Dubai City where most of the population are emigrants. They work at the oil industry, manufacturing, trade, fishing, construction, services and other business (Mursi, 1978).

There are more than 200 islands belonging to the U.A.E.. These islands are of different sizes, and some of them are inhabited. Most of the population is concentrated on Dass and Zarkuh islands, which host oil industry activities. Some islands, such as al-Sadiyat and Dalma, have some agriculture and fishing.

Climate

The climate in the U.A.E. is generally hot, especially from May to September, with temperatures reaching 45°C. In the winter months there is occasional rainfall. The high temperature accompanied by high humidity affects the lifestyle of the people. In the pre-oil period, because of the high humidity, people in summer used to move from the coastal areas to the plains and mountains. Nowadays people spend their summer holidays in Europe and in other Asian countries. Another reason why the bulk of the population of the U.A.E. is distributed in the coastal areas is because of the sandstorms in the deserts. Further, the climate affects the style of housing, which differs between summer and winter residences.

Population

There are no accurate records of the size of the U.A.E. population before the advent of the oil industry, although there are some estimates. One of these estimates, mentioned by Lorimer (1908) at the beginning of the twentieth century, put the population of the Trucial States at 72,000, and he added about 8,000 for migrant nomads (Table: 3.1).

Table 3.1: The estimate of the Trucial States population at the beginning of twentieth century.

	The Trucial States*	Population
(a)	Abu Dhabi	11000
(b)	Dubai	10250
(c)	Sharjah	19000
(d)	Ras al-Khaimah	26000
(e)	Umm al-Qaiwain	5000
(f)	Ajman	750
	Total	72000
* Fujairah Emirate belonged to Sharjah Emirate at that time.		
Source: Khasbak, S., <i>The U.A.E.: A Study in Sociological Geography</i> , Baghdad: Matbaat al-Ershad, 1977, p.118.		

Dr. Novil, in his book *The Arabian Gulf* (1969), estimated the population in the middle of this century at 90,600, excluding the population of the Emirate of Sharjah (Khasbak, 1977).

The two estimates may be close to reality at that time, but examining more closely the first estimate, the Emirate given the highest population at the time was Ras al-Khaimah, perhaps because its agricultural land was able to support a greater number of people. The Emirate of Dubai, long considered the commercial centre of the area and the principal focus for foreign traders (especially from Iran and India, some of whom became Dubai citizens) had a population of only 10,250. There is a big difference between the first and second estimates of the population (Table: 3.2).

Table 3.2: *The estimate of the Trucial States population in the middle of the twentieth century.*

	The Trucial States	Population
(a)	Abu Dhabi	15000
(b)	Dubai	55000
(c)	Sharjah	not available
(d)	Ajman	5600
(e)	Umm al-Qaiwain	5000
(f)	Ras al-Khaimah	5000
(g)	Fujairah	5000
	Total	90600
Source: Khasbak, S., <i>The U.A.E.: A Study in Sociological Geography</i> , Baghdad: Matbaat al-Ershad, p.119 (in Arabic).		

The second estimate shows that there was a growth in the population of some Emirates, especially Dubai, and there was a decline in others, such as Ras al-Khaimah. The commercial development of Dubai made it attractive for immigration, and the population rose from 10,250 at the beginning of this century to 55,000 by the middle of the century. Over the same period, the population of Ras al-Khaimah fell from 26,000 to 5,000. Some

authors, such as Dr. Novil, attribute this fall to a failure of the Emirate's economy, and in particular the agricultural sector. This led to mass emigration of the people in search of a better life in nearby countries such as Qatar, Bahrain, Kuwait and Saudi Arabia. The decline of pearl fishing in the 1920s led to mass emigration from Abu Dhabi to countries such as Kuwait and Bahrain in search of jobs. Despite the largest land area in the region, Abu Dhabi's population became very small, because of the decline of pearl fishing and the brackishness of the drinking water.

Immigration to the Trucial States, especially from Iran, Pakistan and India, took place from earliest times because of pearl fishing and trade activities in the area. Many of the immigrants came to the Trucial States to work in the pearl industry, in pearl commerce or in trade, but even so, numbers remained small.

During the middle of the twentieth century immigration was low. However, at the beginning of the 1960s, when oil was discovered in the U.A.E., the number of immigrants in the Trucial States was estimated at 50,000 Pakistanis and Indians, and 5,000 Afghans, with the exception of Dubai for which the numbers are estimated at 30,000 Iranians and the same number of Pakistanis and Indians. The number of Iranian immigrants in the Trucial States is estimated at that time to be 65,000, making up about 60% of the Sharjah population, others living in Ajman, Umm al-Qaiwain, Fujairah and Ras al-Khaimah. In Dubai, local citizens are estimated at that time to have been about 15,000 people; Arab immigrants comprised 6,000 Lebanese and Palestinians, with a handful of Egyptians and Syrians. The relative poverty of Fujairah and Umm al-Qaiwain Emirates, and the difficulty of the transportation within Fujairah, resulted in the small number of emigrants in these Emirates. When oil started to be exported in 1962, first from Abu Dhabi and then from Dubai, Sharjah and Ras al-Khaimah, the population of the Trucial States rose rapidly (Table: 3.3).

Table 3.3 The U.A.E. Population Growth, 1962-1985

The Year	Population	The Year	Population
1962	136500	1978	877340
1968	180226	1979	891590
1974	325000	1980	1043000
1975	558000	1981	1122000
1976	656939	1982	1175000
1977	862000	1985	1622464

Source: al-Alkim, H., *The Foreign Policy of the U.A.E.*, London: Saqi Books, 1989, p.XX

From 1962, when the oil started to flow, there were three sources of immigration into the Trucial States. People from elsewhere in the Trucial States (moving between Emirates) and from neighbouring countries, such as Qatar and Saudi Arabia; from other countries in the Arab world (such as Syria and Palestine); and people from non-Arab countries. This immigration increased the population in the oil producing Emirates of Abu Dhabi, Dubai and Sharjah. There are many reasons for the immigration:

Firstly, Foreign oil companies prefer to employ expatriate workers rather than local workers, because it is easier for the companies to control the former, terminating their employment whenever the company wishes (local workers can petition for government support), and paying them lower salaries/wages than would be paid to local citizens. Secondly, some of the neighbouring countries, such as Iran, encourage their people to emigrate to other Gulf states for political and economic purposes. An example of this was Iran's claim in the 1960s to the annexation of Bahrain due to the great number of Iranian emigrants living there. In 1971, Iran occupied three U.A.E. islands claiming the need for trade protection. There are many Iranian organisations in the U.A.E., such as Iranian hospitals, schools, social associations and religious associations, especially in Dubai. These organisations help Iranian immigrants to find jobs and accommodation (Al-Tabtabayi, 1978. pp. 35-58).

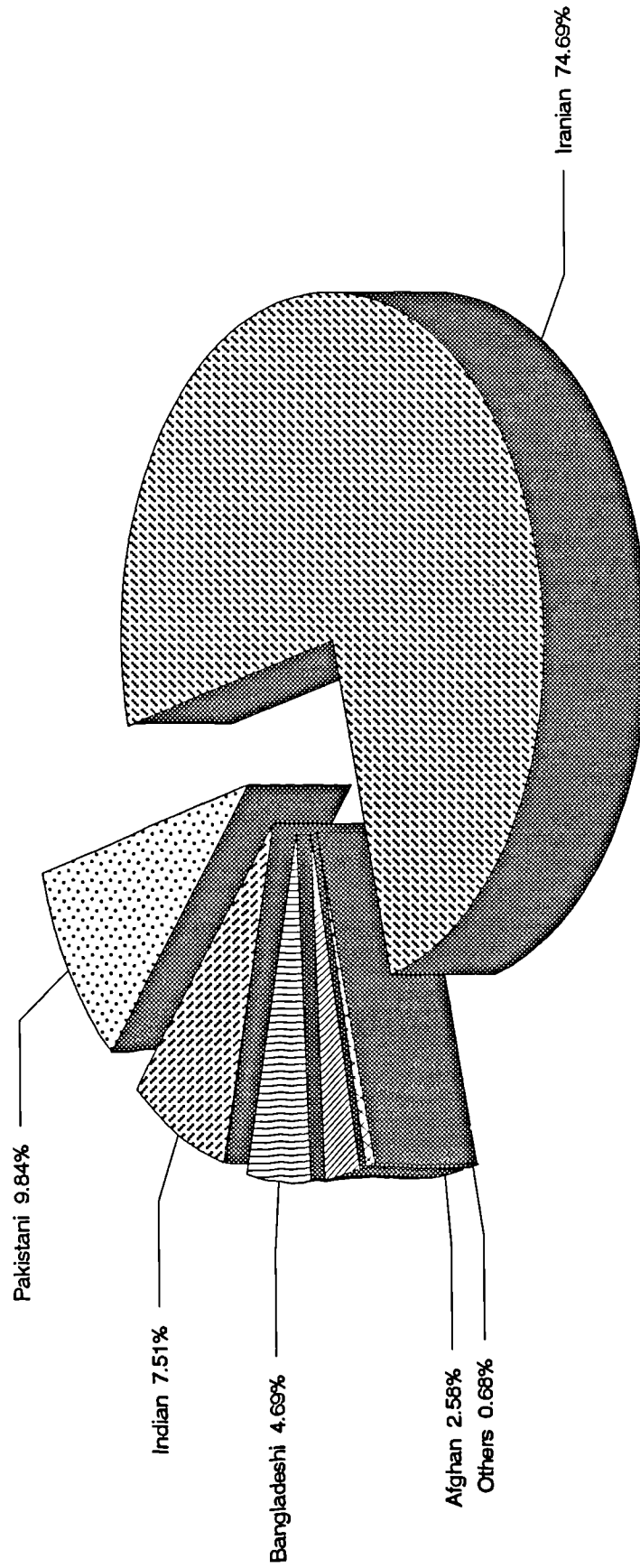
Thirdly, The availability of jobs and the high standard of living encourages many people to emigrate to the U.A.E., especially from countries with a high population density and slim employment prospects.

Fourthly, Illegal immigration into the U.A.E. was the one main causes of rapid population growth. Until 1976 there was no security control on the country's land and coastal frontiers, except in some areas such as the oil producing states of Abu Dhabi and Dubai. Thousands of illegal immigrants arrived in the U.A.E. by sea (90% of illegal immigration) particularly from Iran, Pakistan, India, Afghanistan and Bangladesh (Figure: 3.3). Some of them used to be deported from the U.A.E. for criminal reasons and they came back by illegal means. Some used illegal entry in order to smuggle drugs and to avoid security procedures at the air and sea ports.

The greatest number of immigrants has been from Iran, particularly during the Iran - Iraq war (Gubash, 1990). A few were captured by coast guards, but most quietly entered the country. The illegal Iranian immigrants travelled to the U.A.E. using new boats. They started their journey travelling from Bander Linjah in Iran to Bander Abbas and then to Abu Mousa Island (which was taken by Iran from the U.A.E. in 1971). The new boats took only an hour and a half to arrive from Bander Linjah, and here they would rest briefly. From Abu Mousa they would cross to the nearest Emirates: Sharjah and Dubai.

Illegal Indian and Pakistani immigration takes about seven days before arrival in the U.A.E.. The immigrants usually use large, old dhows (a type of boat). They would enter the country along the long coast which stretches from Kalba City to Dibba City, and also along the other Emirates coasts (Gubash, 1990). The large number of foreign immigrants in the country makes it easy for illegal immigrants to find a house and work, and to be almost invisible to the security forces. However, on 12 July 1976, the Supreme Council of the U.A.E. agreed to establish the Federal Coastal Guards to control the coasts of the

Figure 3.3 illegal emigrants captured by the U.A.E. Coastal Guards according to nationality, 1979-1989



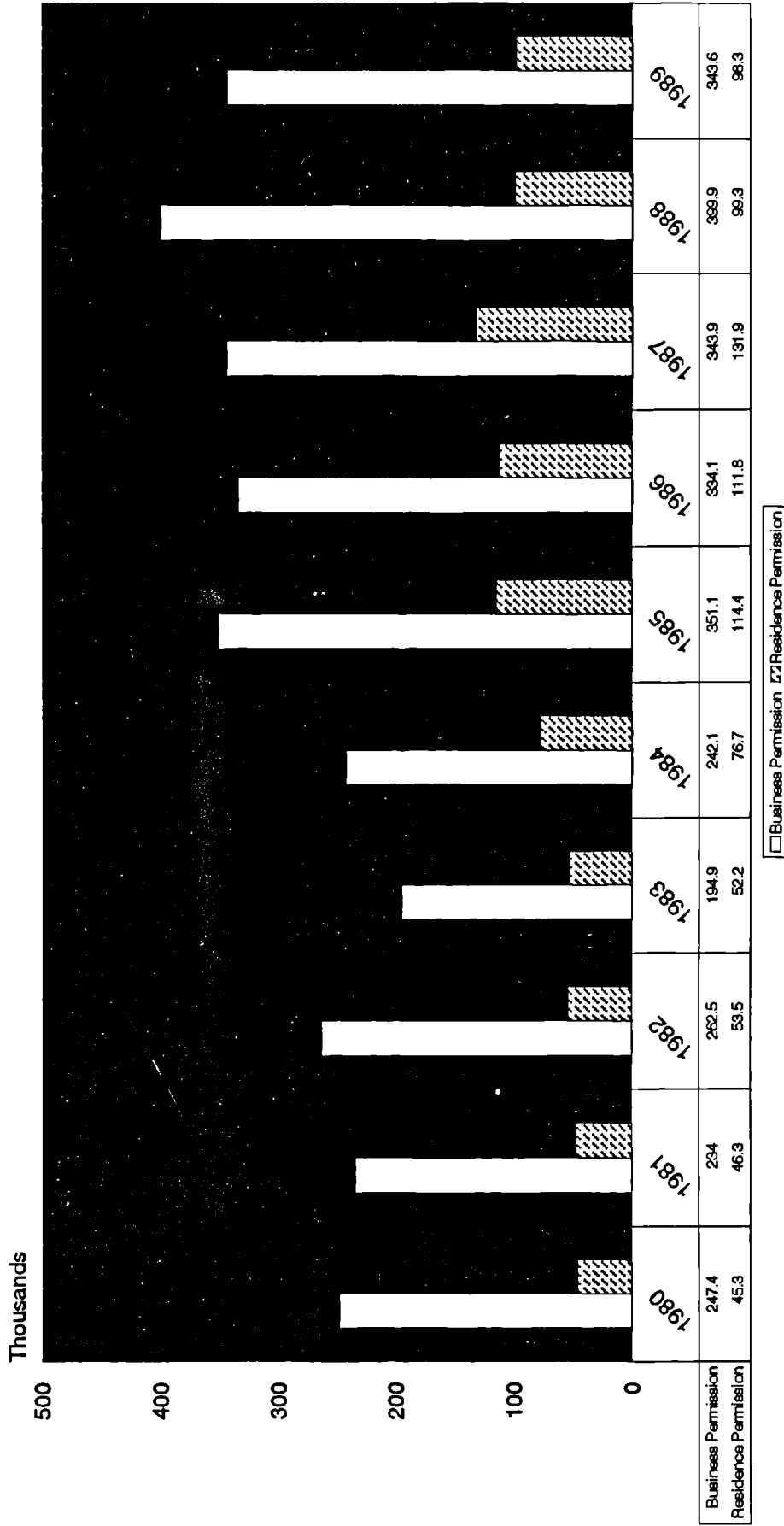
Ministry of Interior. (Annual Statistical Abstracts). Abu Dhabi, 1979-1989.

U.A.E.. They were responding to the report of a Saudi security delegation, commissioned by the U.A.E. authorities, which evaluated the security situation in the country (U.A.E. Official Gazette, 1976).

Another reason for the level of immigration was that the size of the U.A.E.'s population was inadequate to meet the needs of the development programmes. In response, the country opened its doors to an expatriate labour force, especially from Asia, but without control and without consideration for the proportion of local citizens in the population (Figure: 3.4). The government also failed to take into account the quality and quantity of the labour force required by the country for its development programmes.

The final reason for the level of immigration concerned the change of lifestyle enjoyed by the U.A.E.'s people as a result of an increase in wealth. Some local people employed Indian chauffeurs, Pakistani house guards, Philippino baby sitters, Sri Lankan housemaids, Thai office boys, Bangladeshi cars valets, etc.. In 1968 the proportion of local citizens was 63.3% of the population. By 1975 this proportion had declined to 36.1%, and by 1980 to 27.9%. Between 1975 to 1980 the annual growth rate of the local population was 7.3%. On the one hand the number of local citizens rose from 114,033 in 1968 to 201,544 in 1975. On the other hand, the number of the immigrants rose from 66,193 to 356,343 over the same period (Series of Books of the Journal of Social Affairs. Vol. 1., No.1, 1990). In 1980 non-Arab emigrants comprised more than half the U.A.E. population, and in the ensuing years their numbers continued to rise. The population of the U.A.E. rose from 180,226 in 1968 to 558,000 in 1975, and from 1,043,000 in 1980 to 1,622,464 in 1985. In 1990 the population was estimated to be about 1,844,000, which implies an increase of about 221,536 in five years (Table: 3.4).

Figure 3.4 permissions issued by the U.A.E. for expatriate workforce and type of permission
1980-1989.



Ministry of Interior. Annual Statistical Abstracts. Abu Dhabi, 1980-1989

Table 3.4: The U.A.E. population, 1988, 1989, 1990

		1990	1989	1988
Population		1844000	1739000	1640000
Male		1115000	1068000	1022000
Female		729000	671000	618000
Population by Emirate	Area Sq. Miles*			
Abu Dhabi	26000	772000	725000	682000
Dubai	1500	484000	459000	435000
Sharjah	1000	302000	286000	270000
Ajman	100	74000	69000	65000
Umm al-Qaiwain	300	26000	24000	23000
Ras al-Khaimah	650	125000	119000	112000
Fujairah	450	61000	56000	53000
Population by Age Groups				
0-4		269000	252000	235000
5-9		229000	212000	196000
10-19		238000	222000	208000
20-29		347000	341000	336000
30-49		666000	622000	580000
50-64		73000	69000	65000
65+		22000	21000	20000
* Excluding Islands				
Source: Ministry of Information and Culture, The United Arab Emirates 1991, Abu Dhabi: Department of Information, 1991, p.185.				

Oil production and commercial activities mean that about 1,558,000 people live in Abu Dhabi, Dubai, and Sharjah. These Emirates are the largest in area, together covering about 28,500 square miles. About 286,000 people are distributed amongst the other Emirates. Most of them are local citizens. The U.A.E. population is characterised by the high number of males, especially between age 20 and 49. It is estimated that in 1990 this age group made up about 1,013,000 of the population. The reason for the high number of males is that most males are expatriate workers. The high cost of living, and

the low rate of wages of the expatriate labour force, especially for Indians and Pakistanis, means that they are unable to afford to bring their families. The increase in population size has arisen from an expansion in the size of the expatriate labour force, and not from the natural population growth. In 1988, the population was about 1,739,000 and births for the same year were 50,836, of which 32,119 of were non-citizens (Table: 3.5).

Table 3.5: Vital Statistics, 1987-1989

The Year	1989	1988	1987
Total Births	51903	50836	47703
Births by Emirate			
Abu Dhabi	21686	22113	20667
Dubai	14461	13557	12208
Sharjah	7213	6780	6817
Ras al-Khaimah	3472	3528	3419
Ajman	1596	1555	1470
Umm al-Qaiwain	756	695	662
Fujairah	2719	2608	2460
By Nationality			
Citizens	18952	18717	18305
Non Citizens	32951	32119	29398
Registered Deaths			
Citizens	1550	1528	1402
Non Citizens	2090	1919	1829
Total	3640	3447	3231
Source: Ministry of Information & Culture, <i>The United Arab Emirates 1991</i> , Abu Dhabi: Department of Information, 1991, p.185.			

In the same year the number of registered deaths was 3,447, most of whom were non-citizens. The number of deaths increased to 3,640 in 1989, meanwhile the number of births increased to 51,903 from 1988 to 1989. The increase in the population from 1988 to 1989 was about 99,000, of which 47,097 was not from natural population growth.

The increasing number of immigrants raised in part both the number of crimes and the number of people involved in crimes known to the police. In addition, there are many crimes, probably a majority, about which the police are never notified.

Most of the people involved in crimes from 1980 to 1989 were immigrants, particularly from Pakistan, Iran and India. There were many types of crimes which appeared in the U.A.E. only after the advent of the oil era, such as disturbance of public security, crimes against public servants, forgery, currency counterfeiting, rape, organised crime, and drugs crimes.

According to the annual statistics of the Ministry of Interior, 8,531 crimes were recorded in 1988 (Ministry of interior, Annual Statistical Abstracts. 1980-1990). In 1989 this number had risen to 18,824, an increase of 10,293 crimes. In 1990 the number of crimes had risen to 20,268, an increase of 1,444 crimes. Most of the people involved in the crimes were foreigners. Between 1980 and 1986 (the time of the development boom) the number of people involved in recorded crime was 151,929, the number of foreigners was about 117,705, and the number of local citizens was about 34,224 (Table: 3.6). There are special crimes committed only by foreigners, such as forgery of passports, business and residence visas, and counterfeiting of currency. However other crimes are committed by local citizens and foreigners alike.

Table 3.6: Numbers of persons who took part in crimes in the U.A.E., 1980-1989

Year	Non Citizens	Citizens	Total
1980	10905	2678	13583
1981	16926	3182	20108
1982	22713	3805	26518
1983	19529	4636	24165
1984	16110	4419	20529
1985	14503	4521	19024
1986	17019	5033	22052
1987	unknown*	unknown	20447
1988	unknown	unknown	25795
1989	unknown	unknown	29209
* Unknown, numbers not available in the annual statistics.			
Source: Ministry of Interior, Abu Dhabi.			

Political Institutions

The federation of the United Arab Emirates consists of seven states, formerly known as the Trucial States. These states decided to come together after the withdrawal of British rule from the East of Suez in December 1971. From 1820 Britain controlled the region and created many treaties with the Sheikhdoms of the Arabian Peninsula. By means of these treaties Britain controlled the foreign affairs and external defence of the Sheikhdoms, although in other respects the Sheikhs were able maintain autonomy and sovereignty (Ministry of Information, U.A.E. 1991). From 1971 the U.A.E. became a member of such international organisations as the United Nations and its specialised agencies; the League of Arab States; the Non-aligned Movement; the Organisation of the Islamic Conference; and in 1981 became member in the Gulf Co-operation Council, launched that year.

The U.A.E. constitution is a temporary constitution created without referendum in 1971 by the rulers of the seven Emirates when they decided to come together as a federation.

This constitution concentrated federal authority in the Supreme Council. Legislative and executive powers are under the control of the Supreme Council, as is the Council of Ministers. At the beginning of the federation, the rulers of the seven Emirates decided to start with a temporary constitution because the Emirates had no experience of political federation. The idea was that after five years a formal constitution would be ratified. However, because of political differences between the seven Emirates about the distribution of power between the federation on the one hand, and the governments of the seven Emirates on the other, the approval of the final constitution was delayed. It could be suggested that the temporary constitution has proved too attractive in that it granted each Emirate individual rights, such as the use of its own flag on its own territory, the retention of each Emirate's sources of wealth, the creation of limited treaties with other countries, and the organisation and control of the local political system and rule (Tabtabayi, 1978). However, the constitution also gave citizens of each Emirate the right to live and to work in any of the Emirates, and banned discrimination against citizens according to their origins, home, etc.. This temporary constitution also lifted restrictions on trade, customs and tax between the Emirates.

Article 120 of the U.A.E. constitution gives the federal government legislative and executive authority in the following: control over foreign affairs; the federal army; protection of the U.A.E.'s internal and external security; security aspects of, and the ruling system in, the capital of the federation; the federal personnel department; federal justice; the federal budget, loans and income; postal and telephone services; the federal information, education, health services; nationality and passports; currency; electricity services; federal possessions; and the collection of statistics and census data (The Provisional Constitution of the U.A.E., 1971).

The temporary constitution allows the federal government legislative authority only, without executive authority. It gives the individual Emirates the right of execution in the

following aspects: labour laws; social security; property possession and the expropriation of it; criminal extradition; banking and insurance services; the protection of agriculture and fishing; law relating to criminals, criminal procedure, civil procedure, the personal (personal law), companies, commerce, copyright, patents, and the press; the importation of arms; the delimitation of territorial waters and air navigation services.

The legislative authority in the federal system should be divided into two councils, one to represent the people and the other to represent the States. However, the legislative authority of the U.A.E. is controlled by the executive authority, which is the President of the U.A.E., the Supreme Council and the Council of the Ministers. The Federal National Council (Parliament) has no legislative power. Nevertheless the National Council has the right to debate and to vote on the laws being passed. The National Council consist of 40 members appointed by the ruler of each Emirate as follows: Abu Dhabi and Dubai have eight members each, Sharjah and Ras al-Khaimah have six members each and Umm al-Qaiwain, Ajman and Fujairah have four members each. The President of the Federation has the right to refuse the proposed modifications of the laws by the National Council. Should the National Council refuse a proposed law, the President of the U.A.E. has a right of veto, and can pass the law after approval from the Supreme Council (The Provisional Constitution of the U.A.E, 1971). The issue of laws is related to the approval of the President, and the promulgation of laws is the right of the President of the U.A.E.. The Supreme Council has the right to object to proposed laws, to sanction laws, and to refuse to sanction laws. The constitution gives the Council of Ministers the right to propose laws, albeit under control of the Supreme Council.

Executive authority in the U.A.E. lies in three bodies: the President and the Vice President of the Federation, the Supreme Council and the Council of Ministers. The Supreme Council selects the President and the Vice President of the Federation from members of the Supreme Council. The term of office is five years, but they can be

selected for a further term. The authority of the President includes representing the Federation before other countries; calling joint meetings between the Supreme Council and the Council of Ministers; chairman the Supreme Council; chairman the Supreme Council of Defence; signing laws, decrees and decisions; and the control over the execution of U.A.E. policies. The President also exercises authority through, and after the approval of, the Supreme Council. These duties include the declaration of war, the declaration of martial law proposing the appointment of the prime minister and the dissolution of the Federal National Council. The President also exercises authority through the Council of Ministers. These duties include the appointment and dismissal of diplomats, the appointment and dismissal of high ranking employees according to the proposals of the Council of Ministers, the right to sanction and remit capital punishment, and the presentation of honourable decorations and medals.

The Vice-President exercises authority only during an absence of the President.

The Supreme Council comprises the rulers of the seven Emirates and it enjoys two types of executive authority: authority which it exercises alone; and authority which it exercises with the President or with the Council of Ministers.

Duties relating to the sole executive authority of the Supreme Council include: the appointment of the President and Vice-President; admission of new members into the federation; the planning of the general policies of the U.A.E.; the protection of security and the system of rule of the federation; a right to object to treaties between the individual Emirates and other countries; the authorization of issuance of decrees; and control over federal affairs.

Duties relating to the executive authority of the Supreme Council shared with the Council of Ministers include: the appointment and dismissal of the chief and the judges of the Federal Supreme Court according to the Council of Ministers proposals, and ratification of treaties with other countries.

The Council of Ministers is made up of the Prime Minister, the deputy Prime Minister and the ministers. Whilst according to the constitution the Prime Minister has the right to choose the ministers, what actually happens in the U.A.E. is somewhat different, for each Emirate chooses ministers from its ruling family or from influential families in each Emirate. The Council exercises its authority through the control of the Supreme Council. The current Council of Ministers, which was sworn in on 20 November 1990, comprises 27 Ministers in addition to the Prime Minister and his deputy. The Prime Minister and his deputy are drawn from a ruling family, as are the ministers of defence, finance and industry, higher education, youth and sports, and planning, and the ministers of state for foreign affairs and for Supreme Council Affairs. The remainder of the ministers are drawn from influential families in the Emirates.

The constitution divides judicial authority into two bodies. Federal courts judge issues between the federal authorities and the local authorities in each Emirate, or between the federal authorities and individuals, and also issues which arise in the capital of the federation. These courts are graded from court of first instance, to court of appeal, to federal Supreme Court. There is also, in each Emirate, a system of local courts. This type of court is administered by the respective Emirate. It judges issues arising in the Emirate. There are two types of local court: courts competent in Islamic law, and courts competent in 'positive law' on issues such as banking and insurance problems, and on other issues which fall beyond Islamic law. In terms of effectiveness, efficiency and consistency, the legal and courts system in the Emirates would benefit from being re-established under the supervision and control of the Ministry of Justice in the U.A.E..

Economic Aspects

Before oil began to be exported in 1962, the Trucial States suffered from a dearth of economic resources, which influenced the lifestyle of the people. The economy had traditionally depended on pearl fishing, accompanied by some agriculture and some

fishing. Pearl diving had been the principal source of wealth. In 1830, of the estimated 3,000 dhows involved in pearl diving, most of them were from Abu Dhabi, Sharjah, Ras al-Khaimah and Dubai. About 20,000 men from the Omani coast were involved (Tabtabayi, 1978. p.394).

Pearl fishing depended on two types of financial arrangements: the first known as *Khumumis*, which meant that the divers received in proportion one fifth of the income. This type of arrangement had positive and negative consequences. On the positive side, this arrangement encouraged a diver to work hard to increase his own income, as well as the profits of the dhow owner and the financier. Sometimes, however, the returns from a trip were meagre. Then the dhow owner or the financier would employ devious means to cut their losses, giving over only a small part of the profit to the divers who had just suffered four months or so at sea. The second type of financial arrangement was the loan. This entailed the dhow owner giving the diver's family a loan for foodstuffs to cover the period of the diver's absence, and the owner would then deduct the loan from the diver's wages. Most divers were unable to clear their loans in any one season, and therefore had to continue to work for the same dhow owner the next season (Lorimer, 1908). Pearl fishing collapsed with the appearance of manufactured Japanese pearls. This collapse seriously affected pearl diving and the pearl-related activities such as the chartering of dhows and ship manufacture. From pearl fishing activities, some people such as the pearl merchants, financiers, and dhow owners became wealthy and built good relationships with members of ruling families, but most people suffered from a hard existence and shortage of food.

Apart from pearl fishing there were other, secondary, economic activities such as agriculture and trade. At the beginning of the nineteenth century there was some trade with countries such as Iran, Iraq, Bahrain, Muscat, India and countries in Africa. Trust and faithfulness were the basis of trade, but the meagreness of the returns led many

traders to switch to smuggling activities such as in gold, slaves, arms and opium. Dubai was the main port in the region for smuggling activities, especially in gold (*Ma'had al-Buhūth wa al-Dirāsāt al-'Arabiyah*, The Institute of Arab Studies and Research, 1978).

Agricultural activities were practised by some people in some parts of the Trucial States such as Ras al-Khaimah, on the east coast, at al-Ain oasis, Liwa and Dhaid, but the profits of this activity were limited. The farmers would plant cereals such as barley, corn and wheat, vegetables such as onions and sweet potatoes, and fruit such as mangoes, lemons, guavas and dates. Some people had their own farms. Others, without a farm, would labour for farmers. The crops grown were usually for subsistence. There were often shortages because of the dependence on infrequent and unreliable rainfall. Live-stock, such as cattle, equally depended on there being water in the wells. There was also some fishing, and some limited manufacturing, such as nails, earthenware, and tools for fishing and agriculture.

The main source of revenue for the Trucial States treasury was the Islamic tax, *Zakāt*, which was collected from the people by the local authorities of each Emirate. It was about 20% of each product, the local authorities used to take from people a proportion of the products of fishing, agriculture, etc.. The income of all the Emirates was similar: in 1964 the Trucial States' income is estimated to have been about 6,735,000 pounds, distributed between the Emirates (Table: 3.7).

Table 3.7: The Trucial States Income, 1964

	Trucial States	Income (Thousands Pounds)
(a)	Abu Dhabi	5000000
(b)	Dubai	1500000
(c)	Sharjah	110000
(d)	Ras al-Khaimah	44000
(e)	Umm al-Qaiwain	32000
(f)	Ajman	24000
(g)	Fujairah	25000
	Total	6735000

Source: al-Tabtabai, A., *The Federal System in the U.A.E.*, Cairo: Matba'at al-Qahira al-Jadida, 1978, p.396 (in Arabic).

Since 1971 the economic situation has changed and the national income has increased rapidly, changing the social infrastructure and lifestyle. The standard of living soared with the spread of social, health and educational services to all parts of the U.A.E.. In 1971 the number of students was about 28,000 throughout the U.A.E. but in the 1990-1991 academic year the number of students had risen to about 300,000. There are 458 government schools and over 2,000 private schools. In the same academic year the number of U.A.E. University and Higher Colleges of Technology students reached about 9,000. State hospitals and clinics spread throughout the U.A.E., from cities to desert villages and remote mountain settlements, and there is now one doctor for every 933 people. There are about 28 government hospitals offering about 4,050 beds. Most of these hospitals are located in the oil-rich Emirates: Abu Dhabi, Dubai and Sharjah (Ministry of Information. U.A.E., 1991). The hospitals in these cities are funded by the local government of each Emirate, and the federal government can therefore offer a high standard of medical care. By way of contrast, the rest of the hospitals are located in the non-oil Emirates and funded only by the federal government. These hospitals offer a lower standard of medical care.

The U.A.E. government invested some oil income to change the housing system. In the 1970s the government built thousands of houses which it then gave away free. The decline in the price of oil in the 1980s led the federal government to abandon house building. In addition, only the Emirates of Abu Dhabi and Dubai had been supporting the federal budget. The governments of Abu Dhabi and Dubai therefore switched to building houses in their own cities, distributing them free to their own people. People in the other Emirates had to build their own houses through taking out bank loans.

The U.A.E. government is interested in information systems, and in 1991 there were three television stations, four radio stations, one news agency, five Arabic newspapers, three English language newspapers, and many specialised magazines and periodicals (Al-Hamdani, 1986). Most of the newspapers and magazines are only semi-official and do not belong to the government. The government also encouraged industrial activities such as gas and oil industry through the building of oil refineries like the Umm al-Nar and al-Ruwais refineries, gas liquefaction plants and other associated facilities. There are also other industrial activities such as the cable manufacturer and lube oil blending plants, ready-made garments, tourist industry, medicine industry, cement industry, furniture, and manufacturing. The oil income and the social change have motivated people to leave their farming, fishing and animal husbandry activities, and to take up jobs in trade and government public services and institutions. The federal government and some of the Emirates, such as Abu Dhabi, have tried to protect agriculture, livestock and fishing activities by giving people who practice these activities grants and equipment, and buying their produce. The farms used to be a principal source of income for many people, but nowadays most people who have farms use them as places in which to spend leisure time. Camels have changed their function, too, from a means of travel and a source of food and clothing to animals for the sport of racing. Racing camels have become lucrative, and the price of the best camels can be more than £600,000.

After the establishment of the Federation and construction of a new social infrastructure, many new economic sectors (such as irrigated agriculture, industrial activities, international trade) were developed and the labour force became more distributed throughout the economic activities (Table: 3.8).

Table 3.8: The distribution of the labour force in the U.A.E. 1987-1989

Sector	1989	1988	1987
Agriculture, livestock & Fishing	40120	39535	39113
Mining & Quarrying	9450	9140	8900
Manufacturing	61770	61065	59820
Electricity & Water	20058	19760	19953
Construction	113000	110000	104000
Trade, Restaurants & Hotel	97950	96240	95850
Transports, Storage & Communication	68300	68000	67000
Financing, Insurance & Real Estate	18056	17414	16858
Services	225807	220424	213252
Total	654511	641578	624746
Source: Ministry of Information,, <i>The United Arab Emirates</i> , Abu Dhabi, September 1991, p.158.			

During the period between 1975 and 1980, oil income rocketed. This was partly because of the high price commanded and the increasing demands for oil from the U.S.A. and from Europe. The timing was affected by the end of the Israeli - Arab war of 1973, when Gulf countries curtailed their export of oil to the U.S.A. and to Europe. This acceleration in oil revenues further boosted the standard of living and individual incomes, which matched the highest in the world, making consumption dependent on conspicuousness and not on need. More than half the GDP (gross domestic product) depended on the oil sector. The vulnerability of this sector, however, has left the U.A.E. exposed to economic problems such as a decrease in the price of oil or affected by international struggles such as the Gulf War and the Iran - Iraq War. The dominance of the oil sector in GDP declined from 62.3% in 1980 to 32% in 1986 because of the Iran - Iraq War. This decline had a

bad effect on GDP, the value dropping from 111.5 billion dirhams (£17 billion) in 1980 to 81.8 billion dirhams (£12.5 billion) in 1986 because oil prices plummeted. In 1990, however, GDP had risen again to 127.8 billion dirhams (£19.6 billion) (Ministry of Information, U.A.E. 1991). The U.A.E. government encouraged the non-oil sector in order to help the oil sector in GDP. Consequently, the non-oil industrial share in GDP reached 7.3% in 1990. The finance and insurance sector increased from 1.9% of GDP in 1980 to 4.8% in 1990. The wholesale and retail trade, restaurants and hotels sector increased from 8.2% of GDP in 1980 to 9.2% in 1990.

Trade in the U.A.E. depends on import and re-export activities. Exports from the U.A.E., on the other hand, depend predominantly on oil products. In 1980 imports reached 33 billion dirhams (£5 billion). This figure decreased due to the Iran - Iraq War, and increased again to reach 37 billion dirhams (£6.7 billion) in 1989. Imports included equipment, manufactured goods, mineral fuel, lubricants, foodstuff and livestock. From 1980 to 1984, the leading exporting region to the U.A.E. was the European Economic Community, but from 1985 Asian countries took the lead, achieving 44.3% of U.A.E. imports in 1989. American countries ranked third. The re-export activities increased rapidly from 3.8 billion dirhams (£0.6 billion) in 1980 to 9.4 billion dirhams (£1.4 billion) in 1989. The Gulf Co-operation Council countries ranked first for re-exports, and Asian countries, especially Iran, India and Pakistan, ranked second. The communication, transport and storage sector increased from 3.4% of GDP to 4.5% in 1990. The electricity and water sectors grew from 1.2% of GDP in 1980 to 1.8% in 1990. The real estate sector increased from 3.6% of GDP in 1980 to 5.6% in 1990.

The U.A.E. has six international airports, located in Abu Dhabi, Dubai, Sharjah, Ras al-Khaimah, Fujairah, and al-Ain. The country has thirteen sea ports (Ministry of Information, U.A.E. 1991). These sea ports and airports are used by hundreds of ships and air planes, with thousands of containers and passengers monthly arriving in the

country or passing through in transit. About 90% of the workers who work at these ports are expatriate workers, particularly from Asian countries such as Iran, India, Pakistan, the Philippines, Sri Lanka, Bangladesh and Korea. All of these activities make it difficult for the authorities of the U.A.E. to control the country's security in general, and drug smuggling in particular. The economic boom and the increased income had an effect on some individuals.

The economic boom may have encouraged some drug dealers to import drugs into the UAE, and the increased income makes it easier for some individuals to buy drugs.

Social Structure

The social structure in pre-oil U.A.E. can be divided in two: rural and city communities. Each has its own distinct characteristics. Before examining the social structure it is appropriate to give some information about the tribal structure of the U.A.E. society and the distribution of tribes. U.A.E. society is made up of many tribes distributed throughout the country. Tribes in the Trucial States could be divided into three types: the travelling nomadic tribes, which used to wander from one area of desert to another in search of grazing for their cattle and camels; the transhumance tribes, which would seasonally drive their cattle and goats from summer grazing in the mountains to winter grazing on the plains; and seasonally travelling tribes which farmed and grazed their livestock on the plains and at the oases during the winter, and in summer move to the coast because of the shortage of water, where they would fish and trade. Most U.A.E. citizens are affiliated to the latter type of tribe.

In the pre-oil period, tribal life was widespread in the Trucial States. Two principal tribes controlled and led most of the Trucial State tribes: the Bani Yass and the al-Qwasim. The Bani Yass tribe was considered the largest and strongest of tribes in the Trucial States. Its estimated population at the beginning of this century was about 15,000 (*Ma'had*

al-Buḥūth wa al-Dirāsat al-‘Arabiyah, The Institute of Arab Studies and Researches 1978). The Bani Yass tribe was made up of many clans, led by the al-bu-Falah clan. People of this tribe practised many jobs such as grazing, arable farming, fishing and pearl trade. Some of them practised more than one job, such as fishing alongside arable farming, and grazing alongside arable farming. Many tribes and clans were led by the Bani Yass tribe, such as al-bu-Falah (the Abu Dhabi Emirate ruling family, al-Nahyan, related to this part), al-bu-Flasa (the Dubai Emirate ruling family, al-Maktum, related to this part), al-Sudan, al-Qubaisat, al-Marar, al-Huwamil, al-Muharbah, al-bu-Muhair al-Rimaithat, al-Mizari, al-Qumzan, al-Sibayis, al-bu-Humyir, al-Rawashid and al-Mishagin.

The other important tribe was the al-Qwasim (the Sharjah and Ras al-Khaimah Emirates ruling families, al-Qasimy, related to this tribe), which was considered the strongest tribe controlling the coasts of the Trucial States (Mursi, 1978). This tribe controlled and led many tribes and clans, and its estimated population at the end of last century was about 20,000, distributed between Dubai and Khor Fakkan. People of this tribe would engage in trade, fishing and farming, and most of them used to be settled. Many tribes and clans were allied and led by the al-Qwasim tribe, such as al-Ali (the Umm al-Qaiwain Emirate ruling family is related to this tribe), al-Ebadlah, al-Za‘āb, al-Naqbyin, Bani Qitab, al-Mizaria, al-Tinaig, al-Khuwatir, al-Hubus, al-Shuhuh, al-Mitarish, al-shiwaiyin, al-Marar, al-Huwalah, etc..

There are also other tribes such as al-Manasir, al-Dhwahir and al-Owamir, where most of their people lived in the Emirate of Abu Dhabi, al-Nuaimi (which is a tribe of the Ajman Emirate ruling family), and al-Sharqiyin (which is a tribe of the Fujairah Emirate ruling family), etc. Most of these tribes consist of many clans.

Life in the rural communities

Rural communities were widespread throughout most parts of the Trucial States from Abu Dhabi to Fujairah. This type of life was founded on two main factors: economic co-operation, and social symbiosis among the people. Each village depended on its own resources and had its own social and economic characteristics. Villages of the Trucial States were barely aware of each other's existence because of topographic features such as the mountainous areas, especially in Fujairah, Ras al-Khaimah, and some parts of Sharjah (such as Kalba and Khour Fakkan). The absence of roads and the ruggedness of the terrain sometimes made communication between them impossible. Most people lived in poor circumstances. The scarcity of food led people to plant cereals such as barley and wheat, as well as tending palm trees, and growing mangoes, lemons, onions and sweet potatoes. Animal husbandry was practised, and people would breed cattle, goats, donkeys and camels. They would import some foodstuffs from cities such as Dubai, using camels and donkeys as pack animals. Economic cooperation between people of the same village was a key feature of village life. The people of agricultural villages helped each other to harvest dates and other fruits. Some villages produced agricultural tools. The people of fishing villages depended on fish for their food. Only when they had a guest would they prepare meat or chicken to honour their guest. Animals were bred, especially cows, camels and donkeys, and these were useful to them in their agricultural activities which they practised alongside the fishing. They used cows to plough their fields and to draw water from wells. Self-sufficiency was just about achievable by these communities. For instance, it was local craftsmen who built the fishing boats, sewed the nets, and made the tools. Direct co-operation between the fishing villagers and the city dwellers was rare. Nomads who travelled from one area to another would have dealings with both the village and city people. They bartered their products such as cooking oil, cheese, firewood, etc. for tobacco, sweet potatoes, dates, malt, dried fish and construction materials.

Social solidarity was strong alongside economic solidarity because the tribal spirit was widespread among people. In some villages the population was of one tribe or clan and all members are bound by kinship relationship. They would share each others' joys and sorrows, supporting and being supported during times of sadness. The village leader was a member of an influential family, who was appointed by the ruler of the Emirate. Otherwise the ruler sometimes sent a member of the Sheikh's family to be village leader (The Institute of Arab Studies and Research, 1978 - in Arabic).

The ruler of the Emirate at the end of each agricultural or fishing season sent his men to the villages to collect the *zakā't* tax from the farmers and fishermen. Under Islam, *zakā't* must be distributed among the poor people, but rulers collected it for themselves. Life was uncertain and dangerous. Conflicts and wars took place between tribes, especially over water resources and tribal boundaries between communities. These conflicts and wars created hate and spite between tribes and each tribe tried to control the others. Because of the shortage of food in the desert, and the everyday harshness of life, some people, particularly the nomads, specialised in kidnapping in order to secure their own livelihood. They would attack villages or tribes to kidnap some people and sell them to other tribes outside the U.A.E. as slaves. Those kidnappers used to be known as *al-Qawm* (highway robbers).

In the light of this, housing in the villages served as a defensive function. The houses used to be built as blockhouses, the back of the house facing out. A narrow path led between the houses. Building materials depended on geographical region; tribes in the mountains, such as the al-Shuhuh tribes, would build their houses of stone, mud and parts of palm trees. The people who lived in the oases and on the plains used to build their houses out of palm tree trunks, leaves and branches, with mud to cement the structure. This type of house consisted of one or two rooms joined together. The house would be surrounded by a further wall made from palm tree trunks, branches and leaves.

About 40% of the houses in the Emirates were of this kind. Some fishermen and farmers lived in a type of house known as *arī sh*. This was also built out of palm trees branches, trunks and leaves.

Coastal people changed their house-type according to season. In the winter, the fishing season, they used to live near the coast and build a type of house known as *Kā rī n*. Its back was built from mud, and other parts were built, predictably, from palm trees branches and leaves. In the summer, the farming season, the people moved from the coast to the farms. During this period they used to live in the *arī sh* houses mentioned above. These two types of house were appropriate for the weather, which is very hot in summer and cold in winter. As a result of economic and social change, the style of housing in the rural communities has changed and there is contact with urban centres in most parts of the U.A.E..

Life in the city communities

City society differed fundamentally from village society. It made up about 80% of the Trucial States population. City society was open and culturally heterogeneous, many nationalities mixing together. This contrasted with village society, which was isolated from foreigners. The location of the Emirates, connecting West and East and lying on international trade routes, resulted in the population of the main cities of the Emirates being a mix of nationalities, such as Iranian, Baluches, Indians and Africans, as well as local citizens. Lorimer (1908) mentioned that at the beginning of this century, there were about 500 Iranians and 635 people of other nationalities living in Abu Dhabi, in addition to the local citizens. There were also about 1,400 people from Baluch (an Iranian tribe) living in Dubai and Ras al-Khaimah; 194 Indians living in Abu Dhabi, Dubai, Sharjah, and Umm al-Qaiwain; and 213 Europeans living in Sharjah, Dubai, Abu Dhabi and Khour Fakkan. Many Africans were also living on the coasts.

The diversity of the population gave the city society special characteristics which did not apply to village society. Social solidarity was rare, and then only among kindred families. Each nationality had its own district in which to live, and had its own work, culture and customs. Each district was named after the nationality of the people who lived there, such as the district of Baluch, the district of Ajam (non Arab), etc.. Sometimes the district was known by the name of its people's occupation, or else by the name of the tribe. Communication between local citizens and the foreigners was rare, because of the differences in language, customs and religion. Even if their religion was Islam, each nationality had a different ideology such as Shia'h, Sunna, etc.. contact with others was mainly concentrated on the trade activities. Despite the fact that the local citizens consisted of tribes, the tribal spirit was weak among them, and the relationship between the joint families was the strongest. Abu Dhabi was the exception, for there the tribal spirit remains still strong even today. This is because the Abu Dhabi government protected the tribes and established the State Consultative Council, made up of the leaders of the Abu Dhabi tribes, each leader representing his tribe (Khasbak, 1977).

A problem facing city society was how to win the loyalty of the other nationalities. This problem remains, as the loyalty of most expatriates is to their country of origin. The problem was created by the British colonisers, who encouraged immigration and created confessional, national and tribal feuds between the immigrants and the local citizens, and between the local citizens themselves. In order to control the colony, the British colonisers created social divisions. They drew boundaries between the seven emirates using a bizarre system such that, for instance, some villages belonging to Sharjah and Ras al-Khaimah would be on Fujairah's land, and some villages belonging to Oman were on U.A.E. land, such as Wadi Madha, al-Yiradiya and Diba al-Biah. This strange means of division has been the cause of many long-standing and ongoing border disputes between the seven Emirates. The relationship between the Emirates sometimes depended more on distrust and fear of each other. This feud appears today, albeit in a different guise:

discrimination between U.A.E. people applying for local governments jobs. Some Emirates prefer to employ in high and sensitive positions people from the most influential tribe in the Emirate, and also prefer to employ their own citizens rather than citizens of other Emirates. As a result, many citizens of non-oil Emirates experience difficulty in securing a job commensurate with their education and experience.

City society population was divided into two social groups. The influential group which consisted of members of the royal families, merchants (pearl traders) and ships owners. This group controlled the wealth of the country. The second group consisted of craftsmen, ships captains, pearl divers, farmers and fishermen. Power among the first social group varies in accordance with the degree of influence each sub-group has. The merchants and the people who were closest to the royal families were able to exercise social and political influence. Wealth was concentrated in the hands of merchants and the royal families. Some members of the royal families, however, were not wealthy, especially those who were not involved in trade. In the small cities, the situation of merchants was different. The big merchants remained in the larger cities, and apart from some of the owners of fishing boats and big farms, a member of the royal family controlled much of the wealth in the small cities. Religious men tended to have social and political influence in the small cities, but in the big cities their influence was more social than political.

Social Change

After oil started to be exported from the U.A.E., society changed rapidly. This change affected the lifestyle of everyone. Life became more luxurious for many. The type of family changed from the extended to the nuclear family, and the authority of the father declined. Customs and traditions which prevented women from being independent have been weakened, and women attained social rights such as education and work alongside men. The system of marriage changed. The cost of marriage escalated, and many men went abroad to India and Egypt to find a wife. This situation has affected society as most

of the married men were old and their wives were young. Sometimes the men had more than one wife (one perhaps a citizen of the U.A.E., another Indian, and another Egyptian); this type of marital behaviour had an effect on the behaviour of children. Night life appeared in the U.A.E., and people started going to bars, night clubs, dancing places and social clubs. Moreover, in the summer many people now take a holiday away from the Gulf, in Europe, U.S.A., Bombay, Morocco and Cairo, and Far East cities such as Bangkok. This open living and communication with other peoples has had positive and negative effects. Whilst it has the potential to develop the people to their best, it could also destroy the society, particularly if this open living is associated with vices such as drug taking, prostitution, violence, etc..

As a result of these changes, the impact of the tribe in society has substantially weakened and no longer affects social life in most Emirates. Instead, the oil income has created a new group of people with substantial wealth, and a large group with very limited wealth. The wealthy group consists of members of some of the ruling families, the owners of real estate, traders, brokers, etc.. This group exerts a major influence on society in general by virtue of its control of the key aspects of society, in particular economic, cultural and social activities, occupying or determining key positions in information and cultural departments in each Emirate, newspapers, sport clubs, women's associations, etc.. They have used these positions in order to gain more influence, and to attain their ambitions. Some traders have used 'unusual' methods, such as illegal drug dealing, to amass their wealth. The activities of this wealthy group have an effect on people who are less well off. Wealth has become so desirable that 'short cut' methods, with their risks and penalties, are more commonplace, such as the trade in acquiring visas for the expatriate work force and the illegal drugs trade. A new social grouping has appeared: employees. This group can be divided into two. One subgroup is that of high-ranking employees and those who command the highest salaries. Most members of this group are not educated, but are given their position by using their influence in society, and their

proximity to the ruling families. The other subgroup is that of lower-ranking employees who tend to be educated and with valuable experience, but cannot progress to higher positions because they are without social influence. There is also competition between local employees, local workers and expatriates, especially in private sector functions. Arab expatriates occupy positions in most government departments and services, such as education, justice, health services, information, private sector administration, consultants, experts, etc.. Asian expatriates work in investment, banking, trade, construction, industry, oil production, personal services, etc..

This situation creates many problems, such as frustration, and indifference to the national interest. There are many problems for the expatriate work force, such as the high cost of living and the difficulty they experience in assimilating themselves into society. Accommodation in the U.A.E. is expensive, being under the control of the private sector. Most expatriate workers receive low wages and so cannot afford even half decent accommodation. Three types of accommodation in the U.A.E. are used by expatriates: flats used by Arab, European and Asian expatriates working for the government or the private sector, and whose salaries exceed £1,000 sterling per month; old houses, many in bad condition, which used to be inhabited by local citizens who have since left them to live in new houses, and which are now used by migrant workers, especially Asians; and 'unmarried groups housing', which are basically shanties, used by Asian migrant workers. These latter offer very poor living conditions. For example, in al-Ain City there is a district known as Batan district in which the shanties are made from tinsplate. The population of this district numbers 29,285, most of whom are labourers, taxi drivers, and chauffeurs. This district has about 1,800 tinsplate shanties, each giving shelter to around 16 people, perhaps nine to a room (The Administration of the Towns Planning, Department of Research and Studies, al-Ain, 1991).

Summary

In order to examine drug abuse problems in the U.A.E., it was important to study the social, economic, political aspects of the U.A.E. society. This is because drug abuse is a social problem arising from the interaction between the individuals and the social, economic, political, etc. aspects in the society. The lack of social organisational procedures in U.A.E. society results in disorganisation, and sometimes in maladaptation, disharmony, conflict, absence of consensus, social turmoil and uneven cultural development. One of the main problems currently facing U.A.E. society is the degree of application of laws, bylaws and legal procedures which controls people's activities in the country, and particularly those organisational features related to the structure of the population, immigration and other society structures. There is the added complication of an overlap in the laws which are applied, because of the availability of two types of laws, bylaws and legal procedures. The first type is federal law, which should be applied in all Emirates. The second type is the local (Emirate) government laws, some of which are incompatible with federal laws, bylaws and legal procedures. Some federal laws do not apply in each Emirate, and in the meantime each Emirate can choose to apply whichever laws best suit its interests. Inadaptability is a principal reason for crime and abnormal/antisocial behaviour. Crimes and other antisocial behaviour appear when a society becomes swamped too quickly with a welter of differing and unassimilated values, customs, traditions, ideologies and goals. People the world over find it difficult to adapt to rapid social change, and the U.A.E. is no exception. Since 1971, life has changed more or less rapidly in the U.A.E.. This change, which jolted many people from isolation into the open-living situation of today, negatively affected the behaviour of some people, especially those unable to adapt effectively to the new situation. Because the temporary federal constitution gives each Emirate considerable authority to manage its system, federal authority has spread its control over the U.A.E. only weakly, particularly in matters relating to internal security. As a result of this situation, the Abu Dhabi and

Dubai police forces are independent, and federal authority has no control over them. Security in any society is strengthened if controlled and applied under one system and one authority, for the division of security allows gaps and loopholes. This is what is taking place in the U.A.E. today. The illegal drugs trade has become a means by which some people amass their fortune, exploiting the situation of social and security gaps in U.A.E. society. The open market trade policy, a fundamental cornerstone of economic development in the U.A.E., offers a fertile environment for abuses such as illegal immigration, drugs trafficking, and economic crime such as forgery, theft, burglary, etc.. Rapid social change in the U.A.E. has reduced the influence of some social control measures such as the effect of the family, customs and traditions. The support role of the family in the new society has changed, and has been replaced by an expatriate work force. A study undertaken by the University of the U.A.E. found that some families employ many more Asian servants than they actually need, and in some families of four people there are eight servants (al-Itihad newspaper, 6 February 1992). Servants who are required to look after children between the ages of one and ten years are replacing a principal function of motherhood in the U.A.E. which is the socialisation of the children: the process of socialisation has become the servants' function. The aim of socialisation should be to build an individuals personality and help to build an individuals behaviour. Crime and abnormal/antisocial behaviour may arise from differential association through the learning of different values and behaviours. The next chapter will examine the historical background of drugs, and how various groups of people used drugs. The chapter will examine three aspects of drug use: the historical background of drug use in general, and how drug use became widespread among people; the appearance of drugs in Muslim societies; and the appearance of drugs in the United Arab Emirates and how drug use came to be considered a problem.

Chapter 4

Historical Background on Drugs

Introduction

The study of any social problem should begin with an examination of its historical origins, in order to collect detailed information about it and in order to scrutinise different aspects of the problem as it has changed through time. Use of the historical background to a problem permits tracking the steps through which the problem passed, and helps to identify when this issue became a social problem, and why.

The types of drugs used by people are multinominal, multicolour and various. Some of these substances are produced by legal laboratories and under international control and used for medical and research purposes (United Nations. Bulletin on Narcotics. Vol. 42, No. 1, 1990). At the same time, huge quantities of drugs are produced illicitly by clandestine laboratories and are used for 'recreational' purposes. The profits to be made from the sale of illicit drugs are so large that the illicit drugs industry has become widespread throughout the world. The trade supports a massive use of illicit drugs and has created a huge number of addicts and many 'drug barons'. This chapter examines the historical background of drugs, and how various groups of people used drugs, and for what purposes. The chapter is divided into three sections. The first section examines the historical background of drugs in general, and how drug use became widespread. The second section examines the appearance of drug use in Muslim societies, and how some Muslims dealt with drugs. The third section examines the appearance of drugs in the United Arab Emirates, and how they became widespread among people until their use came to be considered a problem.

The History of Drug Use

Using drugs is an ancient activity. From at least the time of mankind's emergence as a species many types of plant have been used in religious ceremonies and for medical treatment (Nafi, 1989). Some drug-related plants have been known for thousands of years, such as opium, cannabis, cohoba, coca, peyote, many types of mushroom, jimsonweed, etc.

Sumerian writing tablets record that, more than six thousand years ago, the juice of the oriental poppy (*papaver somniferum*) was used as a medicine for pain and for sleeping. Remains of its seed have been found in the late Stone Age in Switzerland. Called 'the plant of joy', it was known as a medicine in Assyria nine thousand years ago (Whitaker, 1987). Assyrian medical inscriptions from six thousand years ago describe the collection of opium from poppy juice: from the early morning girls, boys and women would scrape the poppy heads and collect the juice in earthenware pots. The same process is used today in the poppy fields of Asia (Whitaker, 1987). Opium was known by the Egyptians more than three and a half thousand years ago (Ministry of Interior. Riyadh, 1985. p. 68). They used opium as a medicine and to calm crying babies. The chronicler Sabra Jabra in his books mentions that medicinal cream containing an opium substance was discovered in the tomb of one of the pharaohs of the eighteenth family (1361-1352 B.C.) (Nafi, 1989). Egyptian archaeologists, during their work in the Valley of the Kings, discovered two earrings shaped in the form of a poppy plant. Poppy flowers were discovered around the mummified remains of one of the Pharaohs in the tombs of family twenty one. Sabra Jabra said that the Egyptian Pharaohs called opium "Shepen", and opium is mentioned twenty two times in the leaves of papyrus which named it "Chassincit" (Nafi, 1989). Egyptians used opium as a treatment for eye diseases, and as a pain killer. It was used by Hippocrates and Aristotle as a treatment for hay fever, headache and colic (Nafi, 1989). They also recommended poppy juice for their patients as a medicine to resist poison and venomous bites, and to cure deafness and epilepsy. Chinese writings from

the year 100 A.D. describe opium, and mentioned that Arabs brought opium into China during their travels looking for trade (Whitaker, 1987).

Cannabis sativa has also long been known in many societies around the world: China, Egypt, Greece, Persia, Mesopotamia and India. It initially appeared in Asia Minor, and then spread throughout the world (Al-Bar, 1988). Whilst hemp (cannabis) was known to early civilisations as a material from which to make cloth and rope from its fibres, people in many parts of the world, especially in India, China and in the South Sea Islands used the plant in their religious ceremonies, concocting of it a drink known as *kava*, 'food of the gods, a guide to heaven, and a means of communication with the supernatural: it was a favourite of Shiva in the Hindu Pantheon (Whitaker, 1987).

The use of drugs to create hallucinations or visions was widespread among people in many parts of the world. The Aztecs would eat peyote cactus as a divine messenger to put them in touch with their gods (Whitaker, 1987). Prior to the start of a major sacred ceremony, the Aztecs would eat hallucinogenic plants, in the belief that communication with the gods was impossible unless they became intoxicated. Most early societies had priests or shamans, sorcerers or doctors, who were able to cure sick people through communication with visions and spirits. They would ingest hallucinogenic plants in order to stimulate visions before they began treatment of their patient. Hallucinogenic plants were also given to patients as medicine. These included certain mushrooms (fly agaric, an *Amanita*, used in North America and Siberia, and *Cylocybe* in Europe), and a range of Solanaceous plants: thornapple (*Datura stramonium*), deadly nightshade (*Atropa belladonna*), [both of which contain atropine, a powerful alkaloid], mandrake (*Mandragora*) and henbane (*Hyoscyamus niger*). Medieval midwives in North America would prescribe these plants for childbirth; pregnant women anointing their bodies with preparations of these plants in order to create hallucinations which would help them in delivery (Whitaker, 1987). Aldous Huxley, the English novelist, before taking mescaline wrote:

from poppy to curare, from Andean coca to Indian hemp and Siberian agaric, every plant or bush or fungus capable when ingested of stupefying or exciting or evoking vision has long since been discovered and systematically employed. The fact is strangely significant; for it seems to prove that always and everywhere human beings have felt the radical inadequacy of their personal existence, the mystery of being insulated selves and not something else, something wider (Whitaker, 1987. p. 5).

Drugs were also useful to early societies in other ways. In South America, coca leaves were chewed to quell hunger pangs and to give a psychological boost, allowing long hours to be worked, great distances to be travelled, or long battles to be fought without need of food, drink or sleep (Inglis, 1975). Bolivian tin miners even today chew coca leaves to help them to work underground without feeling the effects of exhaustion. The indigenous peoples of America would use coca leaves for a variety of purposes: to boost their physical strength and stamina, and to stave off hunger and fatigue. Living at high altitude, chewing coca leaves helped them to breath more easily in the thin oxygen (Inglis, 1975). They believed that coca leaves were a gift from heaven to people on earth to help them through life. They could not guess that coca might wreak havoc in the lives of people elsewhere. Drugs were used by the indigenous peoples of America in the same way that alcoholic drinks were used by the indigenous peoples of Europe. Intoxicating substances were smoked until the smoker became sufficiently intoxicated that he was largely unaware of his surroundings, but strongly aware of visions and hallucinations. On returning to everyday reality, many a tale would be told of attending the council of the gods, and other visions. These stories were taken seriously by the ancient American tribes. Many people believed that a person who creates visions is inhabited by spirits and is therefore a fount of wisdom (Inglis, 1975). Smoking drugs is an ancient habit. People in some parts of the world such as Cuba have long been smoking tobacco and other dried plants. Columbus, in his travels to these countries in 1492, discovered people smoking tobacco. Columbus' followers also discovered, during their travel to the Americas, that about eighty different hallucinogenic and narcotic plants were used by people there. The

plants were either eaten, smoked, or both. Some of the plants discovered in America were unknown in other parts of the world (e.g. *Datura stramonium*, morning glory, coca and the peyote cactus), but others could be found growing in Asia and Africa. Even solvent sniffing has a long history in some parts of the world. The practice of inhaling chemical fumes for recreation or for purposes of intoxication is not new. What is new is the range of (synthetic) substances which are available and are inhaled. In ancient Greece, priests inhaled the vapour of burning henbane (*Hyoscyamus niger*) seed to induce visions (Inglis, 1975). The smoke from burning incense is used in several religions to create hallucinogenic behaviour. In some European countries, such as Britain, and in the United States, taking snuff was a fashionable activity. In eighteenth century England, taking snuff of either chloroform or nitrous oxide became a habit for some people.

In nineteenth century England, the use of many types of intoxicating substances such as laudanum, poppy-head tea, and paregoric were widely used amongst mothers, obtaining these substances from pubs or ordering them by post (Inglis, 1975). They were used to treat babies for diarrhoea, to deaden toothache, and to quieten crying. Many other types of drug were also used by English people for medicinal or recreational purposes, especially opium. The use of opium was justified on the grounds that doctors were expensive, and sometimes unavailable. As a recreational substance, opium was preferred to gin or beer, because it was cheaper.

Before the Harrison Act for drugs was passed in 1914, many types of drugs were widely and licitly consumed in the United States for medicinal and recreational purposes. The patient was able to obtain opium on a doctor's prescription. Cocaine was recommended as a medicine for hay fever, and was the official medicine of the Hay Fever Association. Cocaine was also used as a treatment for opium, morphine and alcohol addiction. Heroin was initially used in the United States as a cough medicine. However, cocaine was sold from door to door, and in 'dry states' cocaine was used as a substitute for hard liquor.

Also at that time some bars used to serve alcoholic drinks laced with cocaine. Even some soft drinks, until 1903, included cocaine, most notably Coca Cola (De Grazia, 1991). In 1900 the number of addicts in the United States was estimated at 250,000. Some of these were middle-class and middle-aged women whose opium was prescribed without restriction as a medicine, especially for those from rural areas or small towns. Some authors such as De Grazia (1991) claim that the spreading of drugs in the United States was associated with Chinese emigrant labourers and also with the widespread antipathy towards black Americans. In fact, opium was spread by the American traders who joined the European and Japanese powers to control the Chinese opium market.

From ancient times, intoxicating substances such as cannabis and opium were welcomed as commodities of trade. Sometimes they were used as a weapon with which to threaten people, or as an excuse to invade their country. The first people to use drugs for trade were the Portuguese, when they controlled the Indian Ocean coasts in the seventeenth century (Al-Bar, 1988). They exported opium to China's ports. The French followed the Portuguese and brought opium poppies into Laos, Kampuchea and Vietnam. They planted poppy fields in these areas. From the eighteenth century Britain controlled the opium trade through its East India Company (Al-Bar, 1988). The East India Company controlled the Bengal area, which had poppy fields. In 1773 the East India Company was reaping rich rewards from the opium trade, and it used these profits to support the export of silk, tea and spices from China for sale in Europe. In 1800 opium use increased in China, and opium became a threat to society. The Emperor of China prohibited the importing of opium. Britain ignored this law, and instead increased the quantities of opium being imported into China because it was so profitable. The Emperor of China sent one of his assistants to Canton to try to put an end to this disaster, and to ban the import of opium into China. The British Representative in Canton turned down the Chinese proposal. The East India Company controlled the Chinese ports and developed the opium trade. In 1729 the quantities of opium imported into China amounted to two hundred boxes (Table 4.1).

In 1767 this increased to one thousand boxes of opium, which rapidly increased to ten thousand boxes in 1820. By early 1838 this number had become forty thousand boxes per year, and in 1860 reached eighty five thousand boxes (Al-Bar, 1988. p. 94). The related opium trade negotiations between China and Britain stopped without any progress. Britain decided to continue to import opium into China and in 1839 the first 'opium war' between China and Britain broke out. This war ended in 1842 after the defeat of China, and the Emperor of China allowed Britain to import opium into China, but through five ports only: Canton, Amoy, Foochow, Ningpo and Shanghai. According to this treaty, China paid about four and a half million pounds to Britain which included a sum for the destroyed opium. By the end of the first opium war, smugglers from Britain, France and the United States had become active in smuggling opium into China. As a consequence of this attitude, the second opium war started between the two empires in 1856 until China suffered a second defeat in 1858. This defeat allowed European traders to spread their dealings in the opium trade into Chinese territories, and the import of opium into China by the East India Company became legal. Whilst the quantity of opium imported into China in 1827 reached sixty thousand boxes, the number had decreased by 1906 as a result of a campaign against smoking and drug use launched by the Chinese Emperor. In 1907 China signed a new treaty with Britain which included a ban on the cultivation and import of opium into China within ten years. After this, the East India Company increased the cultivation of opium in the Bengal region of India as a substitute for China (Jeudwing, 1923).

Table 4.1: Opium quantities imported into China in the 19th Century, 1700-1880

Year	The Quantity of Opium in Metric Tons
1700	12.095
1770	60.478
1790	245.181
1800	302.394
1817	217.724
1818	249.657
1819	325.800
1820	483.831
1822	303.060
1826	486.432
1830	1,209.579
1838	1,711.978
1840	2,419.159
The First Opium War	
1842	1,995.806
1850	3,144.907
The Second Opium War	
1860	5,140.713
1880	5,896.700
Total	24,423.246
Source: Aune, B., 'The Maritime Trade in Illicit Drugs, Ph.D. thesis, London: School of Economic and Political Science, University of London, 1989, p.40.	

The New Derivatives

Until the end of the nineteenth century, drug use was considered largely acceptable throughout the world. New technologies in the twentieth century have produced and synthesised new and more powerful types of drugs, which have a greater effect than natural drugs on human beings. Using modern techniques, a variety of alkaloids can be derived which can be used for medicinal or recreation purposes. Rapid development in transport and communications effectively reduces the geographical distances which

separate countries, and facilitates travel between countries. On the one hand these developments have improved the conditions of many people, but on the other they have also facilitated the export of misery. A drugs disaster has rapidly spread among people in many parts of the world, and has caused untold suffering for many individuals, families and even whole societies, creating many social, health, and economic problems. Twentieth century youth has become fixated on the pleasures offered by narcotic drugs and psychoactive substances. Until recently, drug use was associated with minorities who were suffering problems such as deprivation. Now, however, drug use is widespread and without regard for social and economic status. Some drug addicts require special care unavailable in some countries, which exacerbates their problems, as well as those of the society in which they live. The number of drug users amongst young people and women increases daily, and this also demands special care and help. Crime, violence, serious disease, suicide and death have become widespread as a result of illicit drug use. The addict's goal in life is the 'fix', and he is careless about his family and society. He tries to get his 'fix' by changing his lifestyle to one of crime (United Nations, Report on Drug Situations in The World. Division of Drug Control. 1982). Violence, prostitution, theft, murder, as well as drug trafficking or dealing, are all typical of the trade in drugs today.

Appearance of Drugs In Muslim Societies

This section examines the availability of drugs in Muslim societies from the coming of Islam in the seventh century until today. In categorising drugs, alcohol is included in those with which Muslims were initially involved. Alcohol, hashish, opium, and *qāṭ* can be termed 'natural' drugs. The synthetic drugs available today were unavailable during the period of the inception of Islam.

When Islam began, drinking alcohol was a widespread activity among the people of Mecca and Madina. They considered drinking alcohol to be part of their lifestyle and a mark of their social status (Salim, 1989). From its inception, Islam attempted to stamp out drinking alcohol because of its corrupting and degrading effect on society. Islam permits those activities which are good for the health and forbids those which are not. Step by step, the Koran and Sunna (traditions of the Prophet) have forbade the practice of drinking alcohol. The Holy Koran says:

O ye who believe! eat of the good things that we have provided for you and be grateful to God, if it is him ye worship. He hath only forbidden you death meat and blood and of the swine, and that on which any other name hath been invoked besides that of God. But if one is forced by necessity, without wilful disobedience, nor transgressing due limits, then is he guiltless. For God is oft forgiving and most merciful (Yusuf, 1946. p. 67).

Islamic law, Shari'a, was used to build a society founded on morals and justice. It was used to protect people and to help the individual to be a good member of society. Preserving human health is a goal of Islam, because human beings need their abilities to distinguish between good and evil. Accordingly, from the time of the Prophet Muhammad onwards, Islam forbade the use of any substances, including alcohol, which could adversely affect performance of religious duties or human thinking and health. In the Holy Koran God says:

O you who believe! strong drink and games of chance and idols and divining arrows are an infamy of Satan's handiwork. Leave them aside in order that you may succeed. Satan seek only to cast among you enmity and hatred by means of strong drink and games of chance, and turn you from remembering God and from prayer. Will you not then desist? (Yusuf, 1946. pp. 2701).

Drinking alcohol being a widespread activity among people at the inception of Islam, alcohol-related problems were rife, and alcohol- aggravated crimes were recognised, especially violence and murder (Salim, 1989). These crimes are still known today as aggravated by taking drugs and drinking alcohol (Ministry of Islamic Affairs, Cairo.

1991). Many types of alcoholic drink were brewed during the time of the Prophet Muhammad. For example, in Yemen two alcoholic drinks were produced: *tabiq*, honey wine; and *al-mazir*, corn and malt wine. Other alcoholic drinks were produced in Mecca and Madina, derived from raisins, wheat and dates. These were all termed *al-Khamur*, alcohol.

The Holy Koran does not mention other types of drug available nowadays, such as hashish, opium, coca or *qāt*. Neither did the Prophet Muhammad mention any of these in the Ḥadīth, Prophet's traditions. It is useful to consider why other drugs were not mentioned. Some reasonable suggestions for this can be offered: plants from which drugs such as hashish, opium, and *qāt* are derived were not known, and their derivatives were unavailable in Mecca and Madina, and therefore the only available intoxicating substances were alcoholic drinks, which went under a variety of names. Plants from which drugs such as hashish, opium and *qāt* are derived were available, but there was no desire to derive intoxicating drugs from them. Hashish, opium and *qāt* were available, either as a result of local production or through trade, but under names of alcoholic drinks, *al-Khamur*, because the only method of using intoxicating substances was drinking, so any plants or other substances were made into wine or some other drink. The Islamic Jurist Ibn-Abbas (the Prophets companion 619-687 A.D.) said:

The prophet Muhammad prohibited alcoholic drinks before it was called al-Badhaq (by saying) any drink that intoxicates is unlawful. I said, what about good lawful drinks? He said, apart from what is lawful and good, all other things are unlawful and not good. (Khan, 1985. p. 350).

The Prophet Muhammad is reported to have said:

All of the intoxications are alcohol, al-Khamur, and all of the intoxications are forbidden (Abbas, 1989. p.188).

The Prophet Muhammad did not discriminate between types of drugs. Neither did he make differences between eating, smoking or drinking drugs, but he did prohibit all alcohol-related activities. In his Ḥadīth, quoted by Abdallah Ibn Omar, he said:

God has cursed al-Khamur (alcohol) and cursed the one who brews it and the one for whom it is brewed, the one who carries it and the one for whom it is carried, the one who buys and the one who eats the profits from its sale.
(Badri, 1976. p.5).

As there is no awareness in the Holy Koran of opium, there may simply have been no abuse of the opium poppy in the region. However, in 1986, Syrian archaeologists discovered traces of opium in a Cypriot vase from the late Bronze Age. The vase was shaped like a poppy head. This implies that opium could have been available in Syria at that time, but maybe under a different name (Whitaker, 1987).

In Yemen, a famous drug named *qāt* has long been available, but it is not classified as an intoxicating substance. Even today it is used as a refreshment, and it is not abused. There is no evidence to confirm or refute whether these or other drugs were available after the period of the Prophet and at the beginning of period of the four Caliphs, from 632 to 661 A.D. There are in fact many references to drugs in Islam, but some authors fail to support their opinions with historical evidence. Rosenthal, in his book *The Herb*, suggests that the Prophet mentioned the drug hashish in his Ḥadīth quoted by Hudhayfah Ibn al-Yaman:

I went together with the Prophet into the countryside. He saw a tree and shook his head. I asked him why he was shaking his head, and he replied: A time will come upon my nation when they will eat from the leaves of this tree and get intoxicated, and they will pray while intoxicated. They are the worst of the worst. They are the bira (exempted) of my nation, as God has nothing to do with them (Rosenthal, 1971, p. 46.).

This story is not supported by evidence that by this tree the Prophet meant hashish. Islam became widespread and reached many countries in the world. People in Mecca and Madina communicated with people in other countries of Asia and Asia Minor where drugs were available. However, because early Muslims were forbidden to use any type of drug, they were not interested in knowing any type of drug, hashish or opium included.

The Period of The Four Islamic Schools

During the period of the four Islamic Schools Abu-Hanifah (699-767 A.D.), Malik Ibn-Anas (715-795 A.D.), al-Shafi'i (767-820 A.D.), and Ibn-Hanbal (780-855 A.D.), drugs such as hashish, *qāt* and opium were not mentioned. This could imply that there is no evidence concerning the availability of drugs under these names during their time. In their doctrinal opinions they mentioned only the name of *al-Khamur* (alcohol), and said that any substance that has the same effect as alcohol was forbidden. In the eighth century A.D., as stated by Abbas (1989), the earliest physician in Islam, Jabir Ibn-Hayyan, used hashish as a narcotic for treatment. He mentioned the word *banj* (which means anaesthetic as a synonym for hashish) in his book *al-Samūm* (The Poisons). This could be the first that Muslims knew of the effects of hashish and its use as a treatment. In the ninth century A.D. the Ismaili sect, which lived in Persia and Syria, became addicted to hashish and opium which were available in these areas (Juwaidi, 1978). The word *hashāshīn* in Arabic means the people who use hashish, and is related to the name used to describe the Ismaili sect which occupied the Syrian mountains during the Crusade Wars in the eleventh century A.D.. They are also named *Hashāshiyya*, particularly the followers of the Nizari branch of the Ismaili sect, and this name was carried from the Middle East to Europe by the Crusaders (Al-Bar, 1988). At first, some Muslim physicians tried to use these drugs as a medicine, having discovered their effects on human health. Avicenna, the Muslim physician who died in 1037 A.D., used opium for treatment

purposes mainly as pain killer. Some European authors said that Avicenna also used drugs for recreational purposes, and that he died as a result of an overdose of opium (Whitaker, 1989). At the beginning of 1230 A.D. drugs were widespread in Iraq. Some authors said that the people of Iraq were unaware of drug abuse until the ruler of Hurmuz (Saifaddin Abu Nadir) came to them and showed the people how to use drugs for recreational purposes (Rosenthal, 1971). This evidence is potentially objective, as Hurmuz at that time was a trade centre for Persian opium, and it was the communication hub between India, Persia, the Middle East, Africa and Europe.

Sufism and Hashish

From as early as 550 A.H. (1155 A.D.) some Muslim sects, such as some of the Sufis, used drugs, in particular hashish. They used hashish as part of their religious life to create visions to help them to communicate with God. It has been said that cannabis first appeared in Muslim society in 550 A.H. (1155 A.D.) as an intoxicant substance when Sheikh Hayder, the Sufi master, discovered it by chance:

The Master Hayder practised much mystical exercise and used little food, excelling in asceticism and pious worship. He was born in Nishawur in Khurasan, (which lies in the former Soviet Union) and he lived on a mountain between Nishawur and Zawah where he had acquired a small monastery. A number of Sufis were in his company. One day he went up into the countryside alone by himself. During the middle of the day, the heat became oppressive, but when he returned, his face radiated energy and joy, which was a marked contrast to his usual appearance as he was from before. He let his companions come close and he talked to them: In my isolation, I suddenly got an urge to go out into the countryside all by myself. When I came out, I noticed that every plant was completely still and showed not the slightest motion because there was no wind and the summer was oppressive. But then, I passed by a plant with leaves and noticed that in this weather it was gently swaying and moving without any force like someone who is inebriated. I started to pick a few of the leaves and eat them. Thus it happened that I was filled with this restful joy you have observed in me. He went out in the countryside and he showed his companions the plant. When they saw it, they said that it was the plant known as Qinnab, hemp. He told them to take a leaf and eat it, which they did. Then they returned to the monastery, finding in their hearts an

irrepressible joy and gladness. When the Sheikh saw his companions in this condition, he told them: That God has granted you the privilege of knowing the secret of these leaves. Thus, when you eat it, your dense worries may disappear and your exalted minds may become polished. Therefore, keep their trust and guard their secret. He told them to plant hemp in the monastery and around his tomb after his death. After the death of Sheikh Hayder a big cupola was built over his tomb. Many votive gifts were offered to it by the Khurasanians. They venerated his power, visited his grave, and showed great respect to his companions. At the time of his death, he exhorted them to show this drug and its secret to the refined and the great among the Khurasanians, and they used it. Hashish continued to spread in Khurasan and Fars. (Rosenthal, 1971. pp. 51-3).

Sufis used to take hashish as a rule for their religious community to help them to distance themselves from the temptations of food and sexual activity (Rosenthal, 1971). It has been said that in the tenth century A.D. drugs such as hashish were used as an intoxicating substance among the Arabs and Muslims in the Mediterranean. Its use permeated Islamic culture so thoroughly because alcohol is forbidden to the Muslim, and probably the expansionist Muslims introduced their preferred drug into all of North Africa from Egypt to Morocco during the ensuing centuries (*Encyclopaedia of Islam*, 1971)

Drugs and The Moguls and Tartars

The Egyptian Physician Ibn al-Baytar, who died in 1248 A.D., described the narcotic effect of drugs such as cannabis. He added that drugs such as cannabis were grown in Egypt and that the use of hashish was widespread among poor people. Some Muslim authors said that the drugs hashish and opium were brought to Islamic lands by the Moguls and Tartars who invaded the Islamic lands at the beginning of the seventh century of the Hijra (1400 A.D.). They used hashish and opium as a weapon to threaten the Muslim countries. They used Sufis addicted to hashish and opium, especially the branch of the Haydariyya Sufis who held religious opinions which were acceptable among some Islamic groups, to spread the drugs into

Muslim countries. From this time the abuse of drugs such as hashish and opium spread throughout the Islamic world and became a habit for some Muslims. The plants and/or their intoxicating derivatives were probably available before the Tartar invasion. Some authors said that the cannabis eating habit was introduced to the Egyptian and Syrian middle-class people by the emigrants who escaped from Iraq during the Tamerlane authority (Mogul military leader 1336-1405 A.D.) and invaded several Mediterranean countries. However, drugs such as opium and hashish were probably available to the ancient Egyptians, particularly during the reign of the Pharaohs who used drugs as means of communicating with their gods (Nafi, 1989).

Drugs and The Mamluk Rule

During the Mamluk rule in Egypt from 1250-1798 A.D., drug use, particularly with regard to hashish and opium, was widespread among poor people. Permitted by a Mamluk, a person was employed to sell hashish for the Government treasury. However, when the drugs caused a threat, one of the Mamluk leaders prohibited hashish taking: Prince al-Shikhuni fought with the hashish users, and punished them by taking out their teeth. The Muslim author Al-Maqrizi mentioned that hashish, or as he termed it 'the evil plant', became widespread in Egypt during the Mamluk rule and hence anti-social behaviour has increased with the increase in crimes (Salim, 1989). There is no accurate information relating to the spread of drug use among people in other Arab countries at the time of its spreading in Egypt. This is may be because of the paucity of Arabic literature in this field.

The Classification of Drugs by Muslim Scholars

After the appearance of drugs in the Islamic world, Muslim scholars tried to classify drugs according to their effect on human health. The Muslim scholar al-Qurafi, as cited by Abbas (1989), classified drugs into three types. Firstly, those substances which affect the thinking, do not stop feelings, and make the user feel happy and intoxicated. There

are many varieties of this type, the most well-known being *al-Khamur* (alcohol). Secondly, those corrupting substances which affect the health and thinking and do not stop feelings, and which do not make the user feel intoxicated. This type has many varieties such as the Blather Honey (kind of manufactured honey contains hashish, opium, and honey). Finally, there are sleeping substances which affect the health and feelings and the user becomes unconscious. There are many varieties, such as the plant Henbane (*Hyoscyamus*). He went on to say that the intoxicating substances are unclean or poisonous (filthy), but the corruptive types and the sleeping types are clean and not poisonous (Abbas, 1989). At least some of these plants are indigenous to the Islamic world, but before the inception of Islam people either did not know their effects as intoxicating substances or else were prepared to term them along with alcoholic drinks because they might be used as drinks. This latter opinion is supported by the fact that early Muslims knew the intoxicant plants by many nicknames. For instance, *Datura stramonium* (known as thornapple in Britain and as jimsonweed in North America) has several Arabic names including *al-Datura* and *al-Qubaisi* (named after the al-Qubaisi Mountain in Mecca). The Egyptians call henbane by various nicknames such as the *banj* (anaesthetic), and *samm al-firākh* (chicken poison). These plants are still used in folk medicine (Al-Bar, 1988).

The Prohibitionist Opinions

When drugs became widespread in Muslim society, especially during the Moguls, Tartars and Mamluk rule, the opinions of the legislators were divided into two groups. One group forbade both the medical and recreational use of drugs, pointing out that all types of drugs are unclean and bad, and that the user should stay away from prayer while under the influence of these drugs (Salim, 1989). The other group of the legislators, who knew the effects such drugs had on their users permitted the medical use of drugs such as opium, but forbade other uses. Some of the legislators from this group differentiated between the liquid drug and solid, they permitted the use of solid type for treatment and forbade the liquid (Salim, 1989).

They said that the liquid type is unsafe (poisonous), but the solid is not, such as the dried poppy straw. Scholars of the second group also said that opium has a bad effect on health: decreasing the appetite for sex and food, causing addiction if taken continuously for four days and causing death if any more than two *dirhams* were taken (*dirham*: ancient Greek measure of weight equal to 4.3g). Those scholars permitted the addicted person the continued use of the drug provided that he reduced the dosage progressively until returned to health. Drug addiction and the effect of drugs have been known to Muslims from medieval times. Addicts would be treated by the progressive reduction of the quantity of drug taken. This method of treatment is still used today in addiction clinics in some countries around the world (Salim, 1989).

According to Abdul-Majid Salim, the former head of the mosque of al-Azhar, the highest competent religious authority in Egypt:

Opium is stronger than hashish, and has an effect which could detrimentally affect the structure of society. Islam forbade anything that would detrimentally affect society. The planting, cultivating and producing of drugs for illegal trading or use are all forbidden because the producer is in effect supporting those who deal in drugs. Therefore he has agreed to help them to be guilty, and this in Islam is 'guilt' and drugs are forbidden by analogy with alcohol which has been forbidden by God. (Ministry of Islamic Affairs, Cairo. 1991. p. 282).

Contemporary Muslim legislators from all Islamic schools of jurisprudence forbid all drug-related activities, apart from the medically-supervised and medically-prescribed use of drugs (with the exception of alcohol). Their opinion is based on reason: drugs are damaging to users, causing harmful physical, psychological, economic and social effects. The individual is part of society, and must be fit and healthy so that society can draw on his abilities; drug use is an attack on life and some of them are destructive for users. In this context God says:

Nor kill or destroy yourselves: for verily God hath been to you most merciful. If any do that in rancour and injustice, soon shall we cast them into the fire: and easy it is for God (The Holy Koran, Sura: al-Nisa,).

Further, there are drug-related and drug-aggravated crimes. At a simple level, drug use lowers inhibitions and allows people to behave badly. In this regard, God says:

Satan's plan is to excite enmity and hatred between you with intoxicants and gambling and hinder you from the remembrance of God, and from Prayer: will you not then abstain? (The Holy Koran, Sura: al-Ma'ida).

Background on Drugs in The U.A.E.

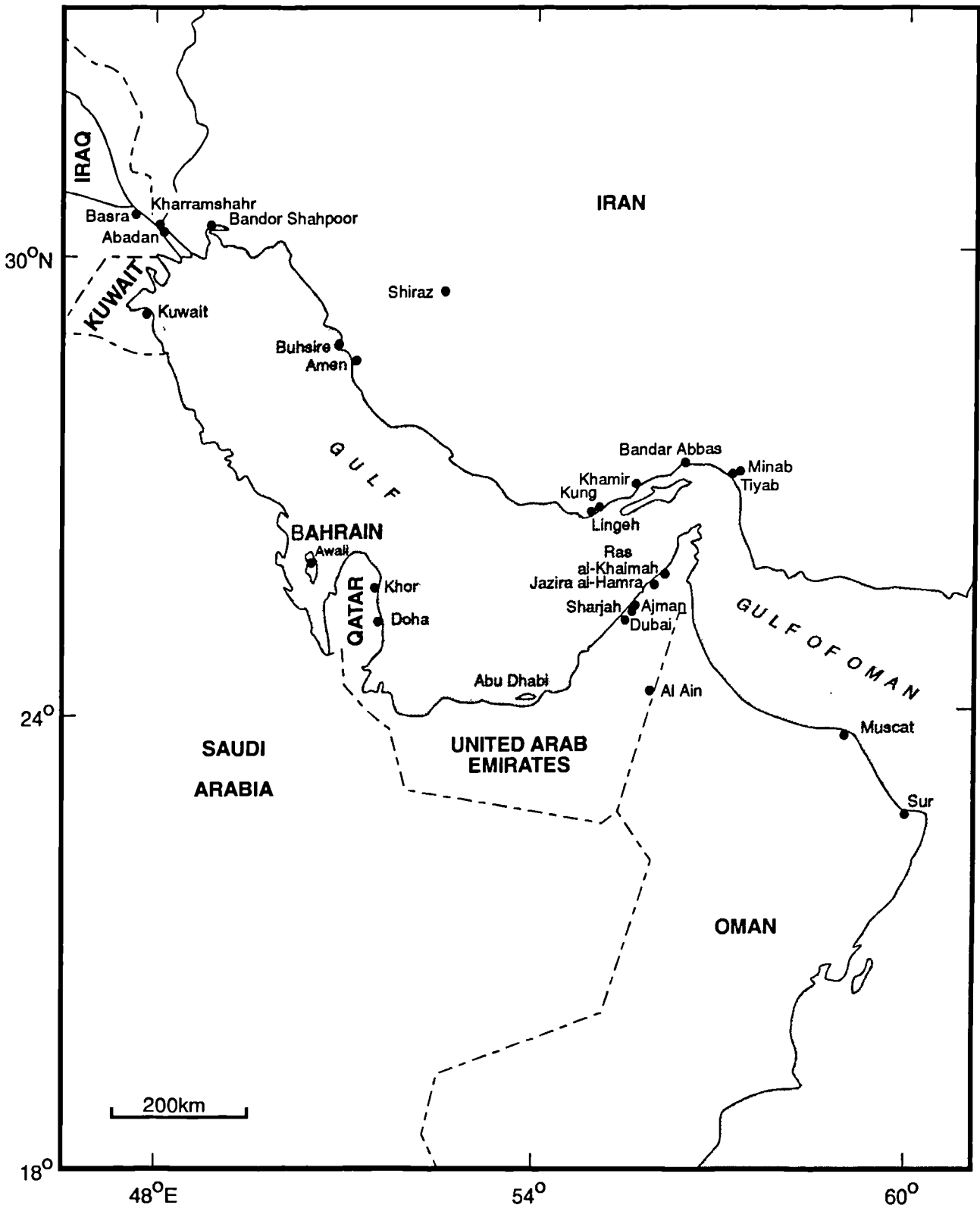
There is no accurate data on the early availability of drugs in the U.A.E.. Even studies on drugs problems did not mention any information about the availability of drugs before oil began to be exported from the U.A.E.. U.A.E. officials tend to attribute the availability of drugs to the appearance of the expatriate work force associated with oil exportation in the 1960s. Some official studies attributed the availability of drugs in the Trucial States to the British Army, which had a military base in Sharjah. A study undertaken by the Ministry of Social Affairs mentioned that drugs in the U.A.E. were brought by the British Army in the 1930s (Ministry of Social Affairs, 1990). A marijuana cigarette used to cost about one Indian Rupee and some of the British soldiers distributed hashish to some of the seamen and immigrants. The study claimed that drug use at that time was exclusive to foreign seamen and immigrants, but that U.A.E. citizens were aware of drugs. Colonel al-Mu'alla, the chief of Sharjah police said that the U.A.E. had no real contact with drugs until the 1960s. The first instance of a drugs offence was recorded by Dubai police on 16 June 1969, when Dubai police arrested a Pakistani national, Mr. Hasan Khan, with 25gm of hashish (Ministry of Social Affairs, 1990). The chief of Dubai police, Brigadier Dhahi Khilfan, said that, in the past (1950s, 1960s), U.A.E. society knew nothing about drugs, but that nowadays drugs have become a major problem in the U.A.E. (Security Issue. Dubai, No. 167, December, 1988). Moreover, in a seminar held by the Ministry of Interior, it was stated that neither the U.A.E. nor other Gulf countries people used or knew anything about drugs in the past, and that the problem has appeared only over the past few years. In a study undertaken by Ahmad

al-Hashimi, the Director of Dubai Medical Zone, it was concluded that drug use may be a new phenomenon in the U.A.E. because the people were previously unaware of drugs. The information above is the official position about the history of the availability of drugs in the U.A.E.; this information may not tell the whole story. There is clear historical evidence, as will be discussed below, that drugs have been available in the U.A.E. since ancient times, even as far back as when trade first began between Asia and Europe. Because of the lack of information and research related to drug use in the UAE before the 1970s, most officials state that UAE society was unaware of drug use behaviour.

Before The 16th Century

The Arabian Gulf (Persian Gulf) was and still is the link connecting trade between East and West. For more than two thousand years drugs, especially opium, were a principal commodity in the trade plied by dhows in the Indian Ocean and Arabian Gulf (Martin & Martin, 1978). Arab traders controlled trade activities in the Indian Ocean, their dhows sailing from Africa and Asia to Basra port in Iraq (Figure: 4.1). From there they transferred their cargo, which included opium, by pack animal as far as the Mediterranean, at which point the goods would be loaded back onto a ship and taken to one or more European countries. Arab traders also traded with China. They would bring opium from Persia and sell it to Chinese merchants in Sri Lanka, an island which was considered the meeting point for the Arabian Gulf traders and the Chinese (Mutawali, 1977). However, Chinese ships arrived in the Arabian Gulf at the end of the tenth century; the focus of their trade, which included opium, was Seraf, a port in Persia, to which place many goods were carried from Oman and Iraq. Many other Gulf ports were important opium trading ports, including al-Aylah, Basra, Awal, on the Arabian coast, and Mahroban, Seraf, Qais, and Hurmuz on the Persian coast. All of these ports have dwindled into history, except Basra in Iraq.

SEA PORTS USED FOR OPIUM TRADE ROUTES IN THE ARABIAN GULF IN THE EARLY 19TH CENTURY

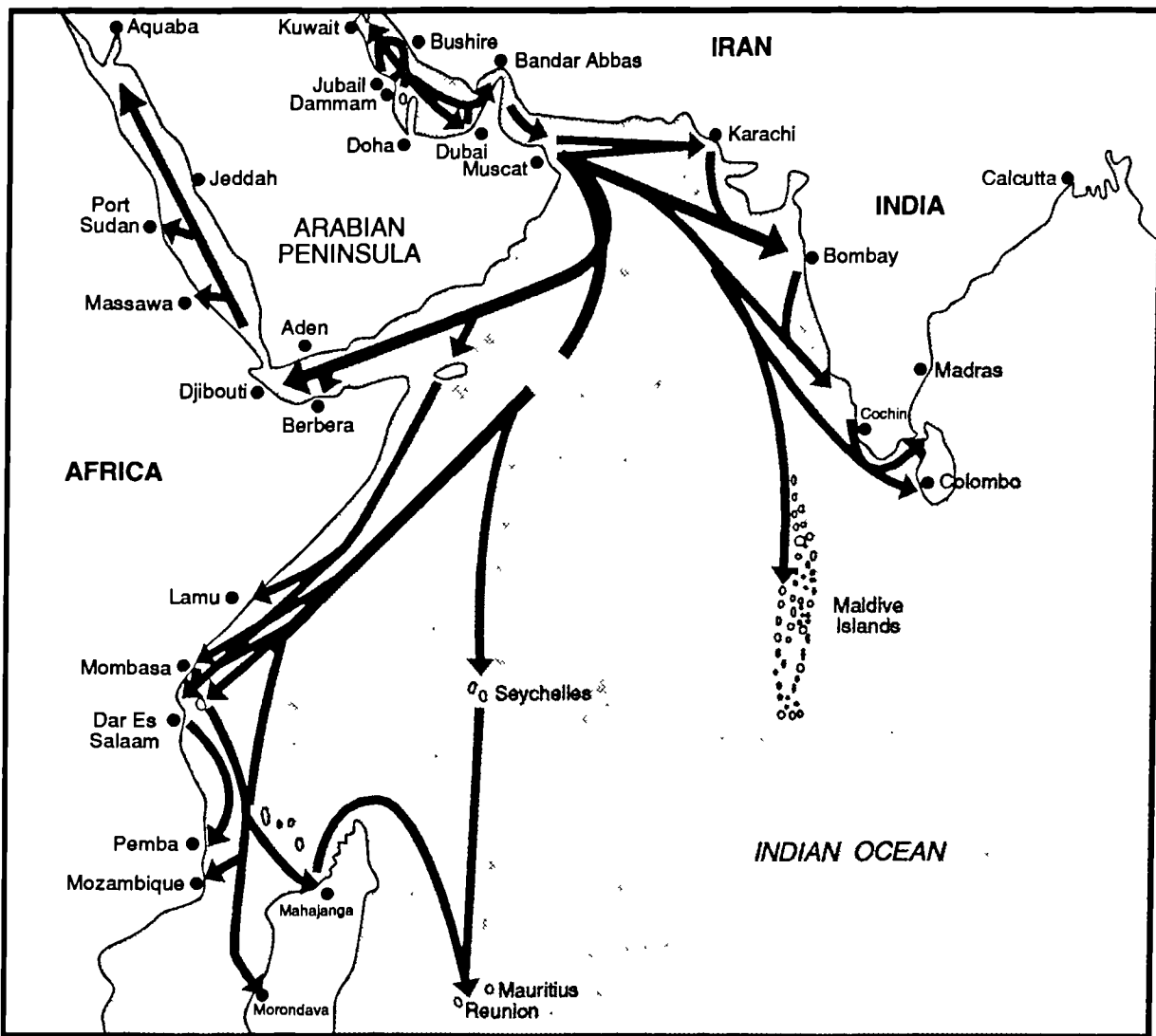


The 16th Century and After

European traders arrived in the Indian Ocean in the sixteenth century. The first to deal in the drugs trade in the Indian Ocean and through the Arabian Gulf were the Portuguese. They established many trading centres in the Indian Ocean, such as Kilwa, Mombasa, Muscat, Hurmuz and Goa. They dominated the opium trade and exported opium between their colonies of Dmam and Goa in India, and China (Aune, 1989). Controlling the opium trade in the Indian Ocean was no easy task, and the Portuguese faced major problems. This highly lucrative trade had been under the control of Arab traders who were, unsurprisingly, reluctant to relinquish their livelihood (Aune, 1989). The Portuguese attempted to prohibit the opium trade by Arab dhow traders, a regulation which the Arabs traders ignored. The Portuguese were permitted by their government to use their power to control the opium trade.

Since the eighteenth century, Britain, in the form of the East Indian Company, controlled the opium trade in the Indian Ocean through the Arabian Gulf ports. Iran was the main source of opium for Arab dhow traders. Opium was being produced in significant quantities and transported to a variety of Iranian ports, such as Bushire and Bander Abbas. The Arab dhow traders were exporting the opium through the Arabian Gulf to the west coast of India. In the nineteenth century, Hurmuz was the main centre for the opium trade. Opium travelled from Persia to Hurmuz and from there the opium was carried by ship to the Gulf, by Indian and European traders to other countries (Al-Shamsi, 1989). From the middle of the nineteenth century, the opium trade between Iran and Muscat in Oman developed, and Muscat became a major trading centre for the regional drugs trade. In the 1850s, more than 800 kgs of opium was exported from Iran to Muscat and then transported to other countries by Arab dhow (Martin & Martin, 1978). Opium was transported by ship from Iran to Muscat in Oman by Arab traders and then from Muscat exported either legally or illegally by dhow to India, Kenya, Pakistan and Zanzibar (Figure: 4.2).

THE PERSIAN OPIUM TRADE ROUTES OF THE LATE 19TH AND EARLY 20TH CENTURY



SOURCE: Aune, B. *The Maritime Trade in Illicit Drugs: Thesis Submitted for the Ph.D. Degree.* London: University of London, 1989. p.44

By the end of 1870s, Dubai (in the U.A.E.) had become an important Gulf trading port. The British Indian Company used Dubai as a main port for their ships, as did the Persia Steam Navigation Company. Goods including opium arriving from all round the Indian Ocean changed hands at Dubai port (Mutawali, 1977). In the 1930s, the dealers of opium and hashish in Dubai were mostly resident expatriates from Iran, Pakistan and India. A few local citizens were involved in the use of drugs, especially wealthy people such as merchants and the owners of pearl fishing dhows. The British Indian Company carried out trade activities with many ports on the Arabian coast of the Gulf, including Basra, Muhamara, Kuwait, Bahrain, Doha, and Dubai and on the Iranian coast with ports such as Bushire, Linjah and Bander Abbas (Mutawali, 1977). The most important exports from Iran to the Arab coast ports were opium, gums, carpets, cereal and wool. Moving the other way were dates, dried fish and leather goods. Most Arab ports were used for trans-shipment to other countries such as India, Pakistan, Britain, Germany, and France (Mutawali, 1977). In 1906, there were approximately 300 shops and 67 Hindu and Khojah traders in Dubai, 65 Hindus in Abu Dhabi, 51 Hindus in Sharjah, and 11 Hindus in Umm al-Qaiwain (Lorimer, 1908). From 1947, when the Indian government prohibited the import of gold, the Dubai government encouraged its merchants to smuggle gold to India. Dubai imported gold from Europe and re-exported it to Pakistan and India by dhow. At that time there were no restrictions in Dubai on the import and export of commodities, even opium. Most of the dhows which were used in smuggling were owned by Trucial States citizens, but their crews were from India and Iran. The voyage from Dubai to India took from five to seven days, the dhows covering a distance of about 1,200 miles (Martin & Martin, 1978). The gold trade between Dubai and other ports in India and Pakistan was connected with opium trade in two ways. Firstly, the dhow crews would carry opium and hashish from India on their return trips to Dubai. They could sell these drugs in Dubai markets legally because there were no drugs laws at that time. Secondly, the Indian merchants who used to buy gold from Dubai traders paid for their gold in

Indian Rupees (Martin & Martin, 1978). Until 1966, when the use of Indian Rupees in the Gulf was prohibited, there were four ways for Indian merchants to pay for their gold: to exchange Indian silver for Dubai gold by smuggling it from India to Dubai; the Indian and Pakistani merchants who used to work in Trucial States used to pay Dubai's gold merchants in foreign currency on behalf of Indian merchants in Bombay and Delhi, and in return they received payment in India or Pakistan in Indian Rupees in this way they could exchange their foreign currency at higher than official rates. Thirdly Indian Rupees could be exchanged illegally for hard currency with tourists travelling in India and Pakistan and fourthly, there was illegal drugs export, especially opium, from India and Pakistan to the Gulf. As well as smuggling opium, the Gulf dhow owners were also involved in smuggling arms, slaves and emigrants throughout the Indian Ocean. The smuggling of people from Pakistan, India, and Iran to the Gulf sheikhdoms was big business for Gulf dhow traders. This illegal trade was one of reasons for the increase in the number of expatriates in the U.A.E. (Martin & Martin, 1978). In the 1950s the drugs trade in the Trucial States expanded. In response, the British government issued a special Dangerous Drugs Regulation in 1955 (Public Record Office, Dangerous Drugs Legislation. File, F0371/114755). This regulation contained ten articles, some relating to drugs crimes, and the others to penalties.

Article One prohibited the sale or supply of any dangerous drug within the limits of the order except the al-Maktum Hospital in Dubai and the American Mission Hospital in Sharjah. Any person or body of people could be permitted from time to time to sell or to supply drugs under license from the Political Agent. Article Two allowed individuals access to prescribed drugs from medical practitioners approved by the Political Agent. Article Three prohibited the prescription of drugs without treatment. Article Four prohibited the import into and the export from the Trucial States of dangerous drugs without permission from the Political Agent. Article Five contained:

that any person who, within the Trucial States, aids, counsels, or procures the commission in any place outside the Trucial States of any offence punishable under the provisions of any law in force in such places and providing for the control or regulation of the manufacture, sale, possession, use, export or import of dangerous drugs shall be guilty of an offence against this regulation (Public Record Office, F0371/114755).

Article Six prohibited any attempt to do anything or aid any other person in doing anything against this regulation. Article Seven concerned penalties. These included imprisonment not exceeding three years, or a fine not exceeding 5,000 Indian rupees (£300), or both, and the forfeiture of anything related to the crime. Article Eight concerned the types of drugs prohibited by this regulation: raw opium with its derivatives, coca leaves with their preparations, and Indian hemp with its preparations. This regulation was not applied by the rulers of the Trucial States, neither did it demand that the Rulers of Trucial States should enact ordinances along the lines of the regulation. The Rulers preferred to apply Islamic Law rather than secular law. Together, the Political Agent in the Trucial States and the Rulers were satisfied that between them this regulation and Islamic Law were adequate for the purpose. In the 1960s, drugs such as opium, hashish and *qāt* were on sale, especially in Dubai and Sharjah, without restriction from the Rulers of Trucial States. Opium and hashish were the two drugs most used (as distinct from being traded) in the Trucial States. Small quantities of *qāt* were brought from Yemen and Africa by the dhow merchants. Two names were used for drug takers; the opium user was known as *teryāqī* (antidotal). The hashish user was known as *hashāsh*. The Iranian users were known as *Bāfūriyah* (sing. *Bāfūri*), as the name of one of the opium use method in Persian is *Bāfūr*. One drugs dealer was punished by the Ruler of Sharjah for importing opium and hashish from Iran to sell to users especially to the elderly, who believed that these drugs could increase sexual activity (Interview with an Iranian Opium User, 17 January, 1992). In 1970, the Abu Dhabi government issued the first Dangerous Drugs Act. This law encompassed most drugs which were available at that time with exception of

qāt, which was prohibited on 16 July 1973. This law included only two penalties, imprisonment for a maximum of five years, or a fine not exceeding 10,000 Bahraini Dinnars (£16,000) (Abu Dhabi Gazette. No.20, 1973). This law was applied only in Abu Dhabi. In 1971, Dubai issued its dangerous drugs law. The remaining Emirates had no drugs laws, but most of them applied the Dubai drugs law, which included the same penalties as Abu Dhabi's law. In the 1970s drugs smuggling into the U.A.E. expanded, especially after the birth of the federation of the U.A.E. with the increase in trade and communication with other countries.

The Situation in the 1980s

From the beginning of the 1980s, drugs appeared as a problem in the U.A.E.. The number of addicts increased and quantities of drugs were seized. There was an official blackout on the size of drugs problem. Even today no-one is able to give an accurate figure for the number of addicts or the number of U.A.E. nationals illegally involved with drugs. Whilst the number of people involved in drugs crimes is large, the number of people known or recorded is small. Were a member of an influential family in the U.A.E. involved in drugs crime, no-one would know how he/she would be dealt with by the authorities, and it would be impossible to find his/her name in the police or court records. The same applies to hospitals: the number of recorded addicts in the hospitals bears little relation to the real number. Some addicts go outside the U.A.E. for treatment, and others receive treatment at home. There are hospital records on only a small number of addicts, and then from families without influence. Many U.A.E. officials consider the drugs problem bizarre, shameful and a problem that foreigners have imported from elsewhere. They attempt to deal with the problem according to this perception. In contrast, a handful of officials involved in combating the illegal use of drugs have tried to address the drugs problem in the U.A.E. taking into account its real size. At the beginning of 1990, about 65% of drugs addicts were U.A.E. nationals, their ages ranging from 15 to 35 years; 20% expatriates; 8.7% are Arabs from other Gulf countries and 6.3% are Arab expatriates (*al-Khalij* Newspaper. 23 March 1990).

During the Iran - Iraq war, the economic situation in the U.A.E. declined, partly because of the steep rise in the cost of shipping insurance, and partly because of the delay in arrival of the goods due to the maritime blockade. As a result of this war many companies collapsed, and many businessmen faced financial difficulty. These difficulties led many businessmen into an involvement in drugs trafficking to cover their financial problem. Even so, few of their names were ever mentioned. In a similar vein, the former head of the Dubai drug squad, Colonel Hareb Bin Khalifa, said:

Dubai banks could be involved in drugs smuggling operations, by transferring cash for drugs operations in Asia. (Arab Time Magazine, 4 March 1990).

He added that Dubai businessmen facing financial problems may be involved in drugs trafficking. Moreover, the U.S. State Department reports on drugs production and trafficking in the Arab world cited the U.A.E. not only for drugs trafficking, but as a major financial haven for drug traffickers (*Arab Time Magazine*, 4 March 1990).

Colonel Hareb also said that Dubai has clamped down hard on drug smuggling recently, and that 300 of the 600 prisoners currently serving sentences in the Emirate's jail were involved in drugs-related offenses. The Dubai authorities estimate that drugs worth 200 million sterling are smuggled through Dubai every year. Colonel Hareb estimated that the drugs squad officers in Dubai manage to confiscate about 20% of this total (*Kuwaiti daily, al-Siyasa*, 9 October 1985). In the middle of the 1980s the drugs problem was still escalating, and officials were unable to hide the fact. Dr. al-Tayib Razuq (Psychiatric Consultant at al-Amal Hospital in Dubai) said:

The drug addiction phenomenon is here in the U.A.E.. It is dangerous and frightful. Many local citizens are addicted and there are many foreigners who are addicts and who refuse to go to the hospital because they might be punished or deported. Most drugs types which are known in the world are available in the U.A.E. but the most widespread type among addicts is heroin (al-Ittihad newspaper, 2 February 1986).

In 1986 the U.A.E. Federal National Council approved a federal law on fighting drugs. This law is made up of 65 articles, some listing names of drugs which are either banned or are allowed to be imported for medical reasons, and some advocating capital punishment to punish violators. A member of the National Council, Mr. Mohammed al-Amry, at a Council meeting, said that there are about 50,000 addicts in the U.A.E. about 20,000 of whom are U.A.E. citizens. The exact numbers are not recorded. Many officials rejected this number of addicts and objected to the member of the council speaking out (*al-Khalij* Newspaper, 29 April 1988). The National Council member's estimate gives an indication of the scale of increase in drug abuse problems in the U.A.E.. However, because his estimate depended on appraisal by using drug enforcement statistics and did not depend on the national household survey for the whole population of the U.A.E., his estimate cannot give a real picture of the number of drug addicts in the U.A.E.. In addition, many U.A.E. nationals are involved in drug-related crime, and 90% of these are under 25 years of age. There are many cases of death as a result of overdose.

Women, too, are now appearing charged with drug abuse (*al- Khalij* Newspaper, 16 October 1986). In 1987, the Council of Ministers agreed to organise a National Committee to deal with the drugs problem in the U.A.E.. The membership of this committee was drawn from government ministries such as the Ministries of the Interior, Justice, Education, Social Affairs, Health, Information and Defence. The aim of this committee was to evaluate the drugs problem and to co-ordinate the fight against drugs in the U.A.E.. This committee worked for only two years before being stopped because of funding problems. At the beginning, the committee was headed by the chief of Abu Dhabi police, General Hammad Saied. After many meetings had been held, the committee concluded that the U.A.E. has a drugs problem, and that it affects health, social and economic aspects of life. The number of drugs crimes continued to rise.

The fight against drugs in the Emirates is carried out by drugs squad officers alone. No other government or public organisation is involved in fighting drugs. There are many security gaps at the airports and sea ports. These gaps are a result of the lack of collaboration between federal government authorities and local government authorities. The committee also concluded that few people (workers or employers) working at the ports are foreigners, and therefore few had experience in fighting drugs. To make matters worse, the differences in funding arrangements between the police forces of different Emirates affects the drugs fighting capability of the different Emirates: the two most active police squads in the U.A.E. are those of Abu Dhabi and Dubai, because they receive a subsidy from their local government, whereas the other Emirates rarely receive a subsidy from the federal government. The committee gave no information about the drugs situation in the U.A.E., but gave a report only about the drugs situation in 1987 (The Report of the National Committee for Drugs Fighting, 1987-1988). In the meantime, the chief of Dubai police, Brigadier Dhahi Khalfan, in 1987 submitted a report to the Ministry of Interior about the drugs situation in the U.A.E. He considered that the drugs problem in the U.A.E. could be divided in two: the visible part and the invisible part. The visible part consists of statistics regarding quantities of drugs and numbers of drug addicts recorded at the Ministry of Interior and Ministry of Health. He also mentioned that between 1972 and 1985 the total quantity of drugs seized by the Emirates police reached about eleven tons of various types of drugs. This would imply that the police annually seize about 800 kg; about 45% of all drugs smuggled into the U.A.E.. The invisible part is the 55% of drugs annually smuggled into the U.A.E. and distributed amongst the users (Dubai Police Headquarters. Report on Drugs Problem in the U.A.E., 1987). This amounts to 13 tons of drugs being smuggled into the U.A.E. from 1972 to 1985. He also reported that over the same period the number of people who had been arrested totalled 3,536, of whom 489 were nationals, the remainder being expatriates, especially from Pakistan, Iran, India, and other Arab countries (Dubai Police Headquarters. Report on drugs problem in the U.A.E., 1987). According to these reports, the

Ministry of Interior in 1987 established a special department for combating drugs. The main department was established in the Ministry of Interior in Abu Dhabi. Divisions of the department were created in the other Emirates (except in Dubai) attached to local police departments in the Emirates (*al-Khalij* Newspaper, 17 May 1987). Nevertheless, collaboration between these divisions tended to be rare. The main department was unable to control these other divisions because each division followed the policy of its respective Emirate, rather than a federal police policy.

Summary

Plants such as hemp and the opium poppy, from which drugs can be derived, have been available throughout history, and were used for medical, recreational and religious purposes. Some of these plants were probably indigenous to what later became the wider Islamic world, but were known by various names such as *banj* and *al-Khamur*, or just as poisonous plants. Today the use of drugs for recreational purposes is widespread in some Arab/Muslim societies and addiction problems have appeared in some Muslim/Arab countries. Some Arab/Muslim countries have been involved in cultivating and producing drugs, and drugs became cheap and in common use. In Egypt, that the use of hashish produces greater sexual pleasure is a widespread belief, in particular among the poorer classes. This use is also common in other parts of Arab world, particularly in north-western Africa, from Tripoli to Morocco. (*Encyclopaedia of Islam*, New Edition. 1971, Vol. 3, HIRAM). Until the end of the First World War (1919) the only two types of drugs widely used in the Muslim/Arab world were opium and hashish. In 1919 new types of drug appeared in Arab countries: notably cocaine, which appeared in Egypt in 1919, and heroin, which initially appeared in Palestine among the Arab soldiers who used to work for the British Army in Palestine (Al-Bar, 1988). They used heroin as a pain killer for the army horses, and then transferred it to other Arab countries. These two types of drugs appeared in the U.A.E. in the 1970s, although opium and hashish have been known from early times.

This chapter has given an historical background to drugs, has examined how drug abuse has become widespread among people in Arab/Muslim communities in general, and how drug use existed among people in the U.A.E. in particular. It is important then, to examine the types of drugs which are used among people in the U.A.E., and to examine if they are different from those that are used among other people in other parts of the world, and what methods of administration are used by drug users in the U.A.E.. Therefore, the next chapter examines the types of drugs which are available in the U.A.E. illicit drugs market and the administration methods used by drug users in the U.A.E.. This will give an indication of whether these types of drugs and their methods of administration have been introduced to the U.A.E. drug users from outside, or have been generated from within the U.A.E.. The next chapter will also examine the effects on the human being of drug types which are used among drug users in the U.A.E.

Chapter 5

Some Drug Types and their Influences

Introduction

Drug abuse is considered a dangerous problem by most societies throughout the world because of the negative social and health effects of drugs. Some drugs which affect the central nervous system have attractions for many people, and many people have become users. There are many types of drugs, the origins of some are natural, whereas other types are manufactured; and each has many derivatives. Some types of drugs have only slight effects, whilst others are immensely powerful and may dominate the life of a user, causing psychological and physical effects including addiction, dependence, tolerance and withdrawal syndromes. Overdosage of some drugs may cause the death of the user. Some of these drugs were at one time prescribed as a medicine, and others are still used in appropriate medical treatment today. Hence, these drugs and their effects have attracted the interest of authors and experts who study drug types and their influence on human beings.

In order to examine any drug-related problem it is necessary to know which drugs are being referred to, their origin and sources, the type and range of effects they can produce, the manner in which they are used and for what purposes. This chapter gives information about various types of drugs which are in use among drug users in the U.A.E., and which are controlled by U.A.E.'s Drugs Law of 1986. Information concerning methods of administration of drugs in the U.A.E. and the type and range of effects which are caused by drugs will also be given. Moreover, I will discuss the topic of substances such as solvents, which produce effects similar to those produced by drugs, but which are not under legislative control (although their abuse is an offence in the U.A.E.).

Opium

Opium is the dried milk-like sap of the poppy plant *papaver somniferum*. The plants are cultivated in fields in various parts of the world, including Laos, Burma, Afghanistan, Pakistan, China, Turkey, Iran, Lebanon, Thailand, Mexico, Yugoslavia and Hungary (Figure 5.1). Poppies are annual plants, the height of which ranges from 70 to 110 cm. The flowers vary in colour from white to red, crimson and violet (Lane, 1981). The leaves are long, smooth and green. The 'milk' (sap) is gathered by scraping the unripe seed pods with a sharp tool such as a knife. After scraping, the farmer allows the 'milk' to coagulate naturally on the seed pods. The coagulant is collected from the fields and stored until it has dried to a gum, at which point it is cut into small pieces for longer term storage.

Opium contains at least 35 alkaloids, which make up about 25% of the weight of opium gum. Some of the most important alkaloids are:

Name	% of weight of opium gum
Morphine	815%
Narcotine	57%
Codeine	1%
Narceine	1.00.5%

Some of these alkaloids are used as medicines, such as the phenanthrene alkaloids, represented by morphine and codeine, which are used as analgesics and cough suppressants (ISDD, 1991). However, isoquinoline (represented by papaverine) is used as an intestinal relaxant, and noscapine is used as a cough suppressant.

Methods of Administration

Opium is usually taken orally, a piece being put on the tongue and sucked while drinking tea or coffee. This method is used in the U.A.E., Egypt, Iran and India (Abbas, 1989).



Poppy Incised Seedpod



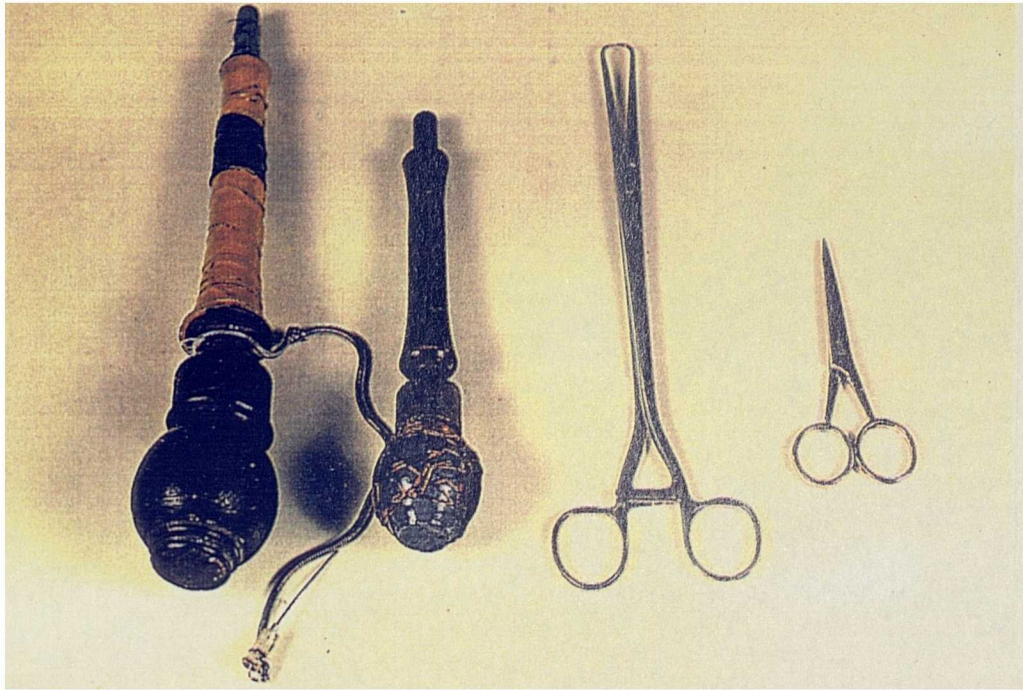
Scraping Raw Opium

Source: Abu Dhabi Police Administration

Oral administration used to be practised among older people in the U.A.E., especially those who believed that opium increases sexual activity. Some users in the U.A.E., and also in some Mediterranean countries, smoke opium. This method uses special tools, such as the *jouza*. This consists of three parts (Figure 5.2 a). The main part is a round wooden container. The wooden container is connected to a small metal container which holds a piece of coal and a piece of opium gum. A long pipe is connected to the wooden container, and it is through this pipe that the fumes are drawn (Abbas, 1989). Some users prefer to smoke opium using a *nargīla* (water pipe). Others prefer to mix opium with tobacco, and use a small pipe of the kind usually used for tobacco alone (Figure 5.2 b,c). This latter method is practised in the U.A.E.. In other countries, such as Europe and the United States, users inject an opium solution beneath the skin using a hypodermic needle and syringe. Sometimes opium in the form of powder can be swallowed.

Morphine

Morphine is the active substance in opium. The concentration of morphine in opium ranges between 8% and 15%. Concentration varies from one variety of opium to another (Abbas, 1989). For instance, the concentration of morphine in Turkish and Iranian opium is greater than in other types. Morphine is one of the most effective pain killing drugs in existence. Preparations of morphine are marketed in the form of white crystals, hypodermic tablets and injectable preparations. However, only a small proportion of the morphine derived from opium is used medically as morphine (United Nations, Drugs Types Guide for Drug Enforcement Officers, 1975). Most morphine is converted into codeine, and secondarily to hydromorphone. Morphine is odourless, tastes bitter, and darkens with age. The medical use of morphine was widespread throughout the world, especially as a pain killer for patients who suffered from broken bones, burns, injuries and cancer.



Types of opium smoking tools used among users in the U.A.E.



One of the opium smoking methods used among users in the U.A.E.

Source: Abu Dhabi Police Administration

Figure 5.2b

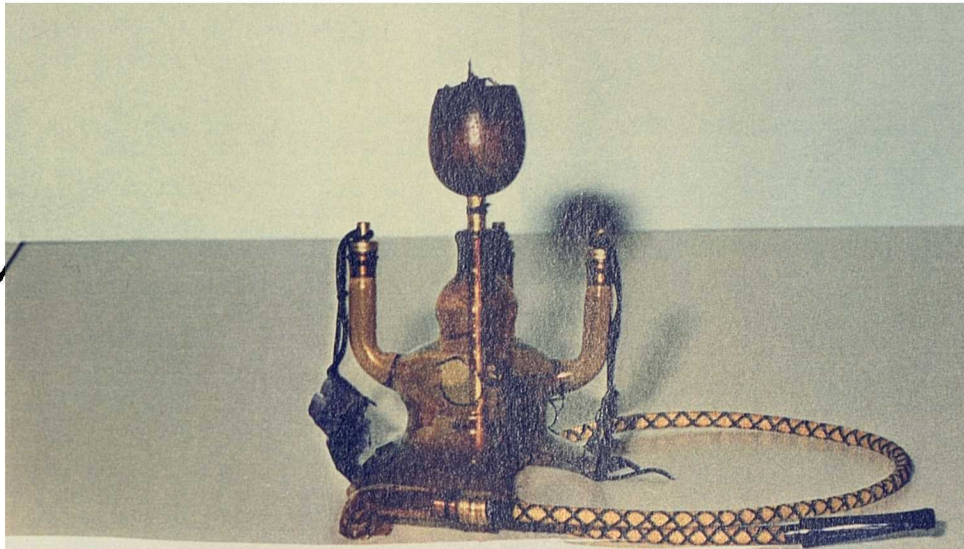


The water pipe, type of tools used among hashish and opium users



Types of hashish and opium smoking tools used among users in the U.A.E.

Source: Abu Dhabi Police Administration



Two types of water pipe used by opium and hashish users in the U.A.E. seized by the U.A.E. Drug Squad

Source: Abu Dhabi Police Administration

Methods of Administration

Morphine is taken by smoking, orally and by hypodermic intramuscular or intravenous injection. Hypodermic injection is the method most frequently adopted by addicts (Figure 5.3). Using this method it takes only two weeks, with one daily injection, to become an addict (Tyler, 1986). This method is common among morphine users in the U.A.E.. Users with little experience of hypodermic injection risk overdosing, and many die as a result. Administration of morphine orally or by smoking are rare in the U.A.E..

Heroin

Heroin was first derived from morphine in 1874 by the English physician Dr. Wright. It was not extensively used in medicine until the beginning of the twentieth century. In 1898 the Bayer Company in Germany began to market heroin as a new pain killer. This commercial production received widespread acceptance throughout the world. After years of using heroin as pain killer, however, medical experts discovered its addictive effects (United Nations, Drugs Types Guide for Drug Enforcement Officers, 1975).

Pure heroin is a white powder with a bitter taste. Heroin traded illegally comes in a variety of colours from white, to brown and dark brown (Gossop, 1987). The colour variation may be due to impurities which remain after the manufacturing process, or else indicate the presence of additives such as food colouring, cocoa, or brown sugar. Street heroin is usually impure, other substances having been added by dealers in order to increase their profits. To boost the physical bulk of the material sold as heroin, diluents are mixed with heroin in ranging from 9 to 1 to as much as 99 to 1 (U.S.A. Drug Enforcement. Drugs of Abuse. 1980). Sugars, starch, powdered milk and quinine are among the diluents used. There are many types of heroin available on the U.A.E. streets (Figure 5.4 a,b) . Examples include:



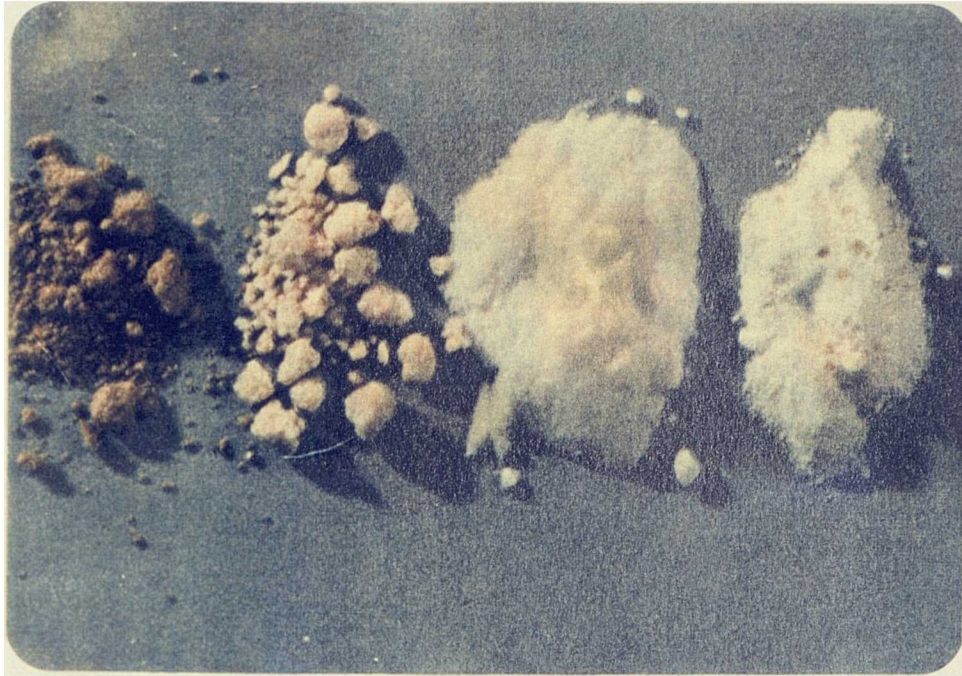
Morphine injecting tools



Morphine injection, a method used among morphine users in the U.A.E.

Source: Abu Dhabi Police Administration

Figure 5.4a



Adulterated heroin types

Source: al-Maftul, S. (Drug Abuse in the U.A.E.) p.197.

Figure 5.4b



Adulterated heroin and poppy seeds seized by the U.A.E. Drug Squad

Source: Abu Dhabi Police Administration

1. 'Heroin number one', 'black heroin', marketed in large chunks, it has a strong smell.
2. 'Heroin number two' is a solid which can be powdered simply by crumbling it in the hand. Its colour ranges from grey to dark grey and brown.
3. 'Heroin number three' is a mixture of heroin, quinine and other substances. The heroin concentration in this type ranges from 25% to 45%.
4. 'Heroin number four' is a white powder, and is sometimes mixed with other substances to increase its weight and bulk. This type of heroin is more expensive than others (Abbas, 1989).

The relative speed of action of heroin and the relative absence of undesirable side-effects associated with other opiates have made it the opiate preferred by many drug users. Its potency relative to other opiates makes smuggling of small amounts more profitable.

Methods of Administration

Heroin is rarely swallowed but can be 'snorted', like cocaine, or smoked. When smoked, heroin powder is heated and the fumes are inhaled, commonly through a small tube, a practice known as 'chasing the dragon' (Al-Bar, 1988). This method is more current among heroin users in the U.A.E. than other methods (Figure 5.5 a,b,c). Other methods of smoking heroin are 'organ playing', in which the heroin fumes are inhaled from a small empty match box; and 'antiaircraft gun launching', which involves placing the heroin powder along the top of a cigarette which is then smoked.

Heroin can also be administered by hypodermic injection. Users, particularly the less experienced, sometimes help to inject each other, although the experienced user is able to inject him/herself.

Figure 5.5a



Heroin use tools



Figure 5.5b

(Chasing the Dragon) The method of heroin smoking used in the U.A.E.

Source: Abu Dhabi Police Administration



Pieces of coins put under the heroin user's tongue to avoid the bitterness of the drug vapours. This method is used among heroin users in the U.A.E.

Source: Abu Dhabi Police Administration

Codeine

Codeine can be derived from raw opium gum. Its concentration in opium varies between 0.7% to 2.5%. Codeine was first isolated in 1832 as an impurity in a batch of morphine. Most codeine is produced from morphine but codeine produces less analgesia, sedation and respiratory suppression. It is marketed under names such as codeine, Empirin Compound with codeine and Robitussin AC (ISDD, 1991). Two general types of codeine preparation are marketed. The type used for moderate pain relief is marketed in tablet form, or mixed with other products such as aspirin or acetaminophen (Tylenol). The type used as a cough suppressant (anti-tussive) is marketed as a linctus. There is also a type of codeine used for pain relief marketed in injectable form. Codeine is widely used as a medical preparations in treatment (ISDD, 1991).

Effects of Opiates

The effects of opiates differ with dosage. In moderate doses, opiates have predominantly physical effects, depressing activity of the nervous system (The Blenheim Project, 1988). They reduce the heart- rate, dilate blood vessels and depress bowel activity. In long-term use, tolerance of the drug's effects develop. This means that in order to achieve the same level of euphoria, the user must either increase the dosage or else change the method of administration (The Blenheim Project, (1988). Intravenous injection of an opiate solution increases its effect over smoking or oral administration. The development of tolerance tends to prompt users to move from smoking opiates to their hypodermic injection. Tolerance can also wane. Fatal overdoses have been known to occur when opiate users take their usual dose after a break during which tolerance has faded. As a result of several weeks of frequent high doses, withdrawal symptoms can appear. The effects of withdrawal symptoms start 8 to 24 hours after the last dose and include sweating, watery eyes, runny nose, loss of appetite, irritability, aches, tremors, panic, chills, cramps and nausea. These symptoms disappear in seven to ten days, but the feeling of weakness and

loss of well-being may last for several months. The physiological effects include respiratory complaints, constipation and menstrual irregularity in women. Repeated opiate sniffing (heroin) may damage structures in the nose. The psychological effects of opiate use are rarely serious in long-term users. However, the consequences of injecting opiates and of a drug-using lifestyle can be serious. Among regular injectors, there is commonly physical damage associated with poor hygiene and the injection of adulterants. Adulterants contribute to respiratory disease, skin lesions, tetanus and other complications depending on the agent used and the individual's sensitivity (ISDD, 1991). Decreased appetite and a general apathy can contribute to disease caused by poor nutrition, self-neglect and bad housing.

Barbiturates

Barbiturates are the drug most frequently prescribed by physicians as a medicine to induce sedation and sleep. Barbiturate derivatives, of which there are about 2,500 are manufactured from barbituric acid (ISDD, 1991). Only about 15 types are used as medicine. They are divided into three groups. A first group is known as 'barbiturates of long term effect'. This group includes barbital (Veronal), phenobarbital (Luminal), mephobarbital (Mebaral) and metharbital (Gemonil) (Hassan, 1988). A second group is known as 'barbiturates of intermediate effect' (Hassan, 1988). This group includes butabarbital (Butisol), butalbital (Lotusate), allobarbital (Dial), aprobarbital (Alurate) and vinbarbital (Delvinal). A third group is known as 'barbiturates of short term effect'. This group includes pentobarbital (Nembutal), secobarbital (Seconal) and amobarbital (Amytal) (Hassan, 1988). There are also some types of drugs which have a chemical structure similar to barbiturates, and similar effects. These types included glutethimide, introduced as a medicine in 1954, and marketed in tablet form in 125, 250 and 500 mg (Abbas, 1989). The other type is methaqualone, which has many brand names, such as Quaalude, Parest, Optimal, Somniface and Sopor. Barbiturate preparations are widely used among

young people in the U.A.E.. Some are obtained from physicians, especially from private clinics, as medicine for psychological diseases; others are smuggled into the U.A.E., particularly from India. The barbiturate derivative most used by drug users in the U.A.E. is Seconal.

Effects of Barbiturates

Barbiturates affect the central nervous system, and have a calming effect if the dose is small. Large doses cause sleep lasting from 20 to 60 minutes after oral administration. The effects of large doses may progress from sedation to sleep, coma and death. Barbiturates of short effect produce anaesthesia within a minute after intravenous administration, the duration of action being up to 6 hours (ISDD, 1991) However, the duration of the action of the long-effect barbiturates ranges up to 16 hours. They are used medically as sedatives, hypnotics and anti-convulsants.

Benzodiazepines

Benzodiazepine derivatives are used as a medicine to relieve anxiety, tension and muscle spasms. They produce sedation and prevent convulsions. They are marketed as mild or minor tranquillisers, sedatives, hypnotics, and anti-convulsants (ISDD, 1991), under various names, such as chlordiazepoxide (Librium), clonazepam (Clonopin), clorazepate (Tranxene, Azene), diazepam (Valium), flurazepam (Dalmane), lorazepam (Ativan) (Petursson, et al., 1984). Librium, Ativan and Valium are among the drugs most widely used by drug users in the U.A.E..

Effects of Benzodiazepines

These substances are used as a medicine to relieve tension and anxiety. Their action is to depress the nervous system, and they have a number of effects: they promote relaxation, impair the efficiency of mental and physical functioning and decrease self-control (ISDD. Drug Notes, 7. 1991). High doses may result in drowsiness, stupor, sleep

or unconsciousness. Withdrawal symptoms appear after a week to 10 days of continual use of high doses. The delay in the appearance of the abstinence syndrome is due to the slow elimination of the drug from the body (Wolfson et al., 1986). The usual method of administration of these substances is oral. When these substances are used to obtain a 'high' they are usually taken in conjunction with another drug, such as marijuana.

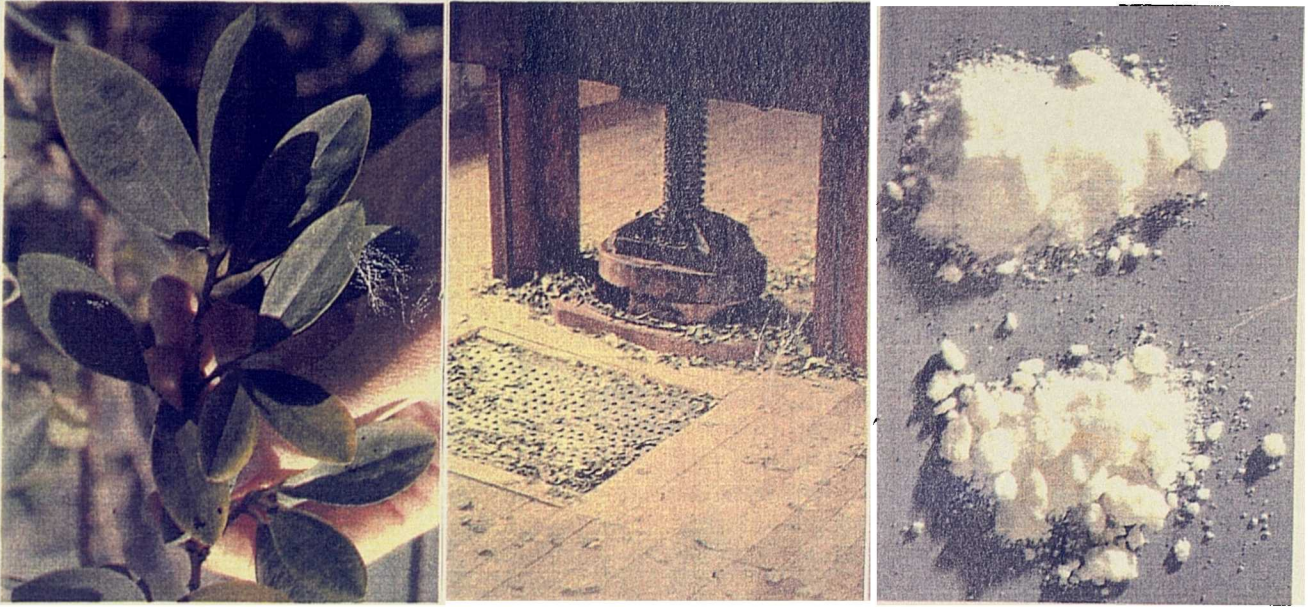
Cocaine

Cocaine is obtained from the leaves of the coca plant *Erythroxylon coca*, which is cultivated in some Latin American countries. It has been traditional amongst some people in these countries to chew coca leaves for refreshment and relief from fatigue. Pure cocaine was first produced in the 1880s (U.S.A.'s Drug Enforcement, 1980). It was used as an anaesthetic in eye, nose and throat surgery because of its ability to constrict blood vessels and thus limit bleeding. Cocaine is marketed medically as a white crystalline powder (Figure 5.6 a). On the illicit market, cocaine is distributed adulterated to about half its volume by a variety of other substances such as lactose sugar, inositol and mannitol. Because the enormous distance between sources of cocaine and the U.A.E., cocaine is rare on the U.A.E.'s illicit market (Cohen, 1984). It appeared in the U.A.E. during the 1980s, being used personally, rather than for trade, by travellers to North America. Nowadays, the use of cocaine among drug users in the U.A.E. is little in comparison with the use of other substances such as hashish, heroin, opium, etc..

Methods of Administration

Cocaine is usually 'snorted' through the nasal passages, a method which may cause nasal infections, and can damage the structures of the nose (Figure 4.6 b). Some users in search of a quick 'high' administer it by intravenous hypodermic injection (ISDD. Drug Notes, 5. 1991). Cocaine can also be smoked, through a process known as 'free-basing', whereby the cocaine base is freed from the acid hydrochloride. 'Crack' is free-based

Figure 5.6a

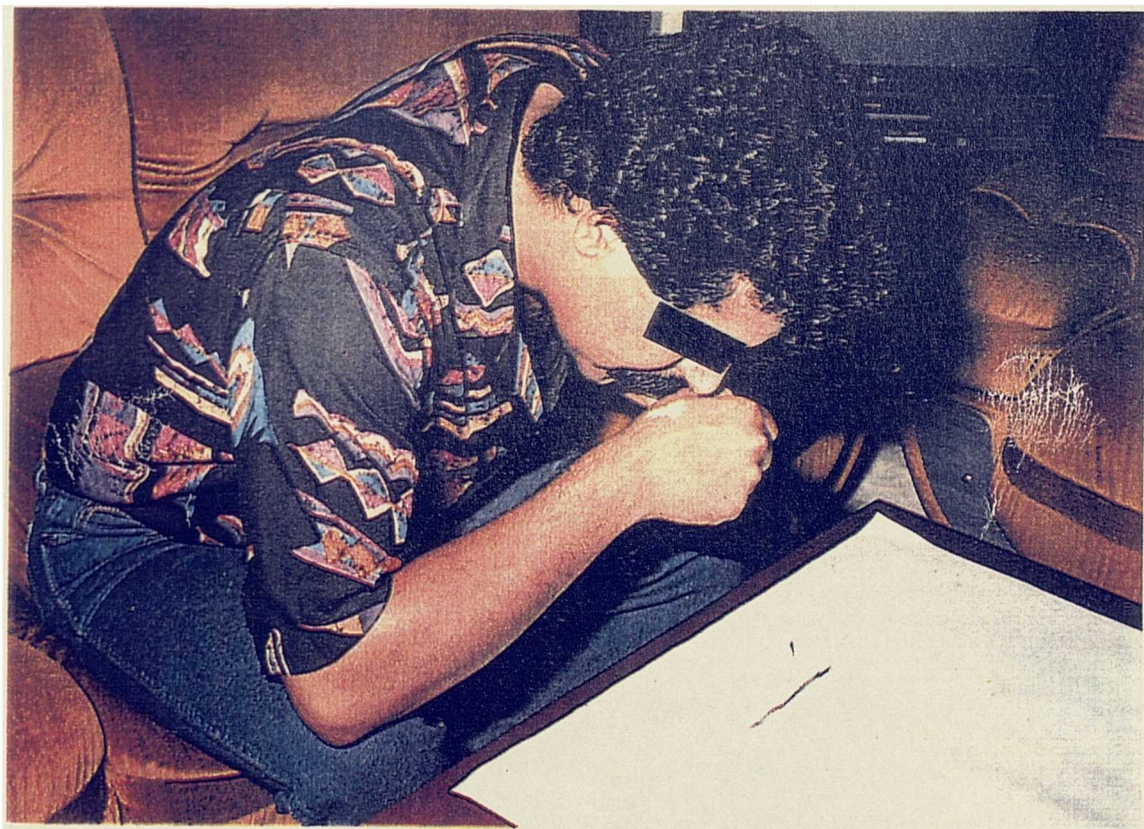


Coca plant

Coca processing

Cocaine

Figure 5.6b



One of the cocaine sniffing methods used by cocaine users in the U.A.E.

cocaine produced by a simpler method resulting in small rocks of cocaine (ISDD. Crack. 1989). Snorting and injection are the most common methods used amongst cocaine users in the U.A.E.

Effects of Cocaine

Cocaine causes physiological symptoms such as exhilaration, a feeling of well-being, decreased hunger, indifference to pain and fatigue, and feelings of great physical activeness. The psychological effects of cocaine appear after about 15 to 30 minutes of snorting the drug, and in order to maintain the effect the dose should be repeated every twenty minutes. Smoking crack produces effects which appear and disappear rapidly (ISDD. Drugs & Drug Using. 1988). Withdrawal symptoms from cocaine include apathy, long periods of sleep, irritability, depression and disorientation. These symptoms encourage users to repeat the dose.

With continued use, a state of mind may develop similar to paranoid psychosis.

Amphetamines

These substances have been used as a medicine since the mid- 1930s for hyperkinesis, narcolepsy and weight control. They are administered orally or by hypodermic injection. The effects of amphetamines are similar to those of dextroamphetamine and methamphetamine (Scottish Health Education Group. Drugs & Young People in Scotland. 1988). They are marketed illicitly under various names, such as sulphate, sulph, dexedrine and durophet. The number of amphetamine abusers, particularly teenagers, has increased with the use of amphetamine as a medicine. In the U.A.E. the use of amphetamines is widespread among students, especially before final examinations, the drug being used to maintain an effective level of attention. Long-distance truck drivers driving between the U.A.E. and countries such as Turkey, Syria and Lebanon used to take amphetamines in order to increase their physical activity. The normal prescribed dose is between 2.5

and 15 mg per day, but users who seek to get a high 'speed' effect inject hypodermically about 1,000 mg every two or three hours. Despite widespread recognition of the risks, clandestine laboratories produce vast quantities of amphetamines, particularly methamphetamine, for distribution on the illicit markets. High doses of amphetamine cause a variety of symptoms, including increased alertness, excitation, euphoria, elevated pulse rate and blood pressure, insomnia and loss of appetite. Overdoses may induce agitation, increased body temperature, hallucinations, convulsions and possibly death (Tyler, 1986).

Qāt

Catha edulis is a plant grown in the southern Arabian Peninsula (in most Yemen regions and in Saudi Arabia in the areas such as Fifa, Surat, Bani-Malik and Rayth), Somalia, Ethiopia and some other African countries (Figure 5.7). It contains the stimulant known as cathine (Al-Maqrimy, 1987). This substance affects the central nervous system and may cause psychological dependence. Its psychological effects appear after two to six weeks. Qāt leaves are administered by chewing. In the U.A.E. and in the most Arab countries, with exception of Yemen, the use of *qāt* is controlled under the drug laws. However, it is not under international control, and few countries around the world control it. Most *qāt* is grown in Yemen, where it is considered a part of the Yemen culture and customs, and where *qāt* use is widespread amongst poor and wealthy alike (Mansur, 1988). Its effects bear on the economy of Yemen. Some coffee growers have given up planting coffee and have planted *qāt* instead, because it is more profitable than coffee in the Yemen market (Juwaidi, 1978). Most of the Yemen-produced *qāt* is consumed by the local market, but part smuggled to other countries, especially to the U.A.E. and other Gulf countries, partly because there are many Yemeni people living in these countries.



Qat leaves

Source: al-Maftul, S. (Drug Abuse in the U.A.E.), p.197.

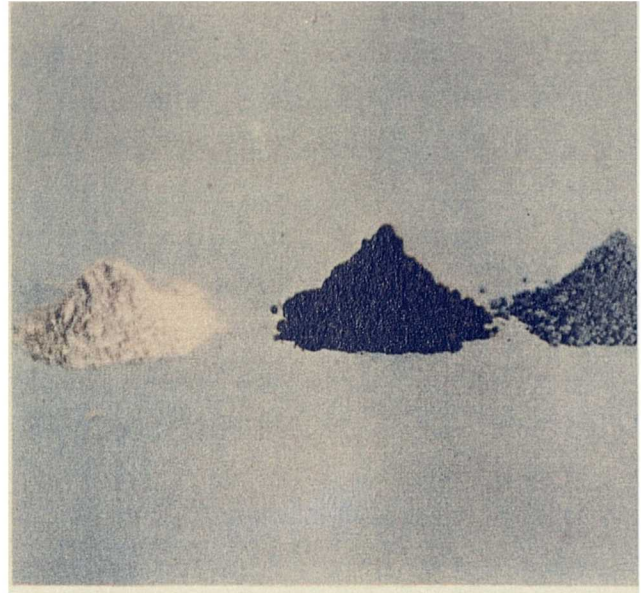
The Yemeni *qāt* user spends about 14% of his monthly income on his habit, and may spend about four hours a day in *qāt* chewing meetings. *Qāt* is marketed under varieties names such as *al-Rabt* or *al-Zarb* (a big bunch of *qāt* weight from 2 to 3 kilograms), *al-Kālāwt* (a bunch of *qāt* covered with banana leaves), *al-Brax* (a good bunch of *qāt* covered with banana leaves), *al-Manādīl* (a bunch of *qāt* wrapped with plastic), *al-Qulūb* (a small bunch of *qāt*; contains from 10 to 15 tender branches) and *al-Awāridh* (a small bunch of good quality of *qāt*; contains from 10 to 15 tender branches) (Al-Maqrimy, 1987). Most of these types are used among some drug users in the U.A.E.

LSD25, Lysergic Acid Diethylamide

Lysergic acid diethylamide was first synthesised by Dr. A Hophman in Germany in 1938. LSD is an abbreviation of the German expression of it. At the beginning of the 1970s, LSD became the principal drug used by 'hippy' groups. It is derived from ergot (*Claviceps purpurea*), a parasitic fungus which grows wild on rye and other plants (ISDD. Drug Notes, 2. 1988). Small amounts of LSD are sufficient to induce hallucinogenic behaviour and create visions. It is generally marketed after being mixed with other substances. It is formed into tablets and capsules, but may be a solution (Figure 5.8). It is usually marketed in the form of tablets, thin squares of gelatine ('window panes'), impregnated paper ('blotter acid') or on sugar cubes (ISDD. Drug Abuse. 1991) The effective dose is about 30 micrograms, and 30 gm (i.e. 1 oz.) is enough for about 300,000 doses. It is easy to smuggle because of the minuteness of the effective dose. LSD is generally administered orally, even in solution form. Some users prefer to administer it by hypodermic injection.

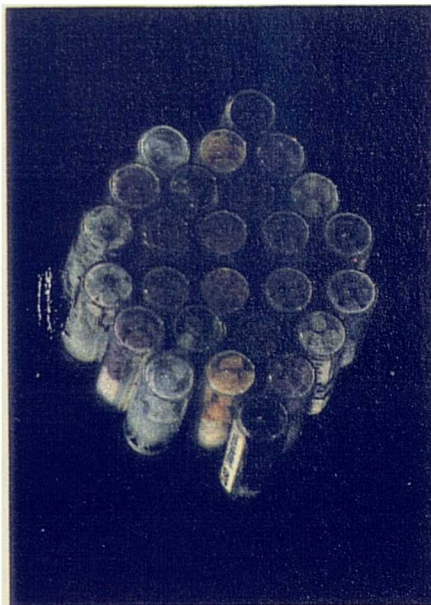


LSD Tablets



LSD Powder

Source: Abu Dhabi Police Administration



LSD Drops



Phencyclidine

Source: Drug Enforcement Administration, Issues of Drugs of Abuse. Washington, Department of Justice, 1980, Vol. 6, No. 2, p.31.

The Effects of LSD

The effects of LSD begin about 30 minutes to 1 hour after administration. These effects reach a peak after 2 to 6 hours, and decline after about 12 hours, depending on the dosage. LSD creates visions and visual effects such as intensified colours and distorted shapes and sizes (Dupont, 1984). It induces psychological and emotional effects, but its physical effects are slight. Its psychological effects include heightened appreciation of sensory experiences, perceptual distortions and feelings of dissociation. Some LSD forms, such as impregnated paper and tablets, are used among drug users in the U.A.E.

Cannabis sativa and its Derivatives

Hashish

Hashish or hemp is a plant that both grows wild and under cultivation throughout most of the tropical and temperate regions of the world (Figure 5.9). It is a single species, but of two types: male and female. The female plant has more flowers and its flowers are larger than the male. Its most effective psychoactive substance, tetrahydrocannabinol (THC), is more abundant in the female type than in the male. Its biologically active substances, such as cannabinol, cannabidiol, cannabinolic acids, cannabigerol and cannabichromene are most highly concentrated in the leaves and resinous flowering tops (Gossop, 1982). There are about 61 cannabinoids, which are unique chemicals found only in hashish. Delta-9-tetrahydrocannabinol is one of these active chemicals. On illicit drug markets, and among experienced drug users, hashish is the name given to the drug-rich resinous secretions of the cannabis plant. Resinous secretions are collected, dried, and then compressed into a variety of forms such as balls, cakes, or cookie-like sheets (Figure 5.10 a). Hashish is the drug most smuggled into the U.A.E., especially from Pakistan, Afghanistan, India and Lebanon. Lebanese hashish is the most famous and expensive type of hashish marketed on the U.A.E.'s illicit market, a kilogram costing about £5,000 (Figure 5.11).



Cannabis Seeds

Cannabis Leaves

Cannabis Plants



Cannabis Seeds

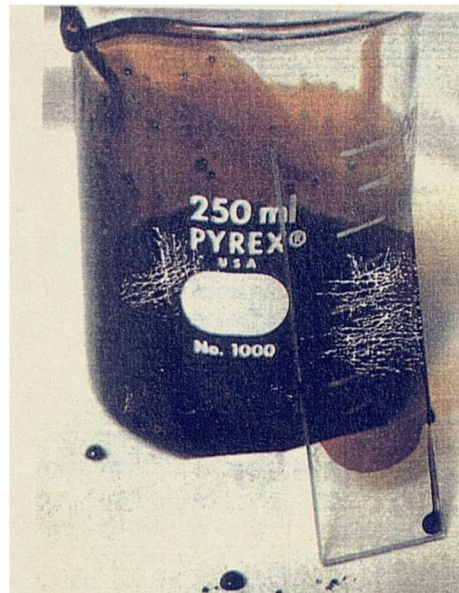
Source: Drug Enforcement Administration. *Issues of Drugs of Abuse*. Washington, Department of Justice, 1980, vo. 6, no. 2, pp.36-7 and Abu Dhabi Police Administration



(a) Hashish Resin



(b) Bundle of Thai sticks



(c) Hashish Oil

Source: Abu Dhabi Police Administration

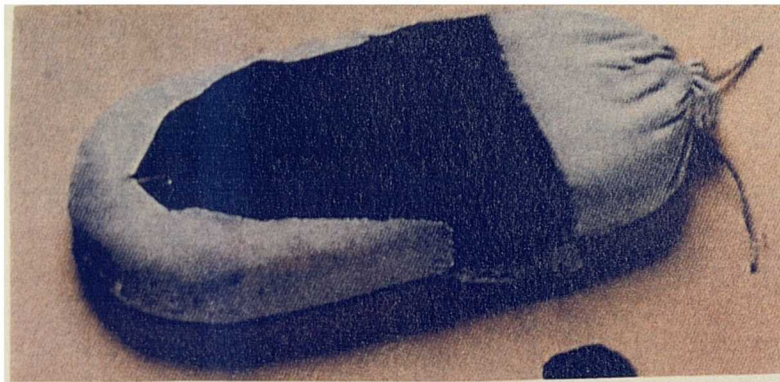
Figure 5.11



Indian Hashish



Pakistani Hashish



Lebanese Hashish



Turkish Hashish



Moroccan Hashish

Hashish types seized by the U.A.E. Drug Squad
Source: Abu Dhabi Police Administration

Marijuana

Marijuana or marihuana is the name used for cannabis and any part of it (particularly the dried flowering tops, leaves and small branches) that produces somatic or psychic changes in the user (Auld, 1981). Concentrations of the effective substance (THC) in marijuana ranges from 0.5% to 6% by weight (U.S.A.'s Drug Enforcement. Drugs of Abuse. 1980). The potency of marijuana depends on the source and selectivity of plant materials used. Spanish marijuana (Spanish: sinsemilla, meaning 'without seed') is about the best quality marijuana on the illicit drug market. It contains about 6% THC. Southeast Asian marijuana, known as 'Thai sticks', (Figure 5.10 b) contains about 6% THC and is highly considered world-wide (U.S.A.'s Drug Enforcement. Drugs of Abuse. 1980). Marijuana cigarettes are available on the U.A.E.'s illicit drug market; they are used by young people, especially students. Most of the marijuana in the U.A.E. comes from Pakistan, India, Lebanon, and Thailand. Marijuana may be smoked in the form of cigarettes. There are two types of marijuana cigarette. One type has pure marijuana and produces a strong effect. The second type has marijuana mixed with tobacco and produces a milder effect. Hashish oil is usually used by dripping a drop or two onto a tobacco or marijuana cigarette (Figure 5.11).

Hashish Oil

Hashish oil is a dark viscous liquid produced by a process of repeated extraction from hashish plant materials (Figure 5.12). The best type of hashish oil contains about 20% THC. The psychoactive effect of one or two drops of hashish oil on a tobacco cigarette is equal to effect of single cigarette of marijuana. Hashish oil is little used among drug users in the U.A.E. This is because other forms of hashish are available. Some drug users in the U.A.E. put hashish oil drops on a piece of hashish resin or on a marijuana cigarette to increase the euphoria or the effect of cannabis.



The shillem or head of the broken bottle used as a tool for hashish smoking. This method is used by hashish takers in the U.A.E.



Hashish taker from the U.A.E. smoking hashish by using the Shillem or head of broken bottle.
Source: Abu Dhabi Police Administration

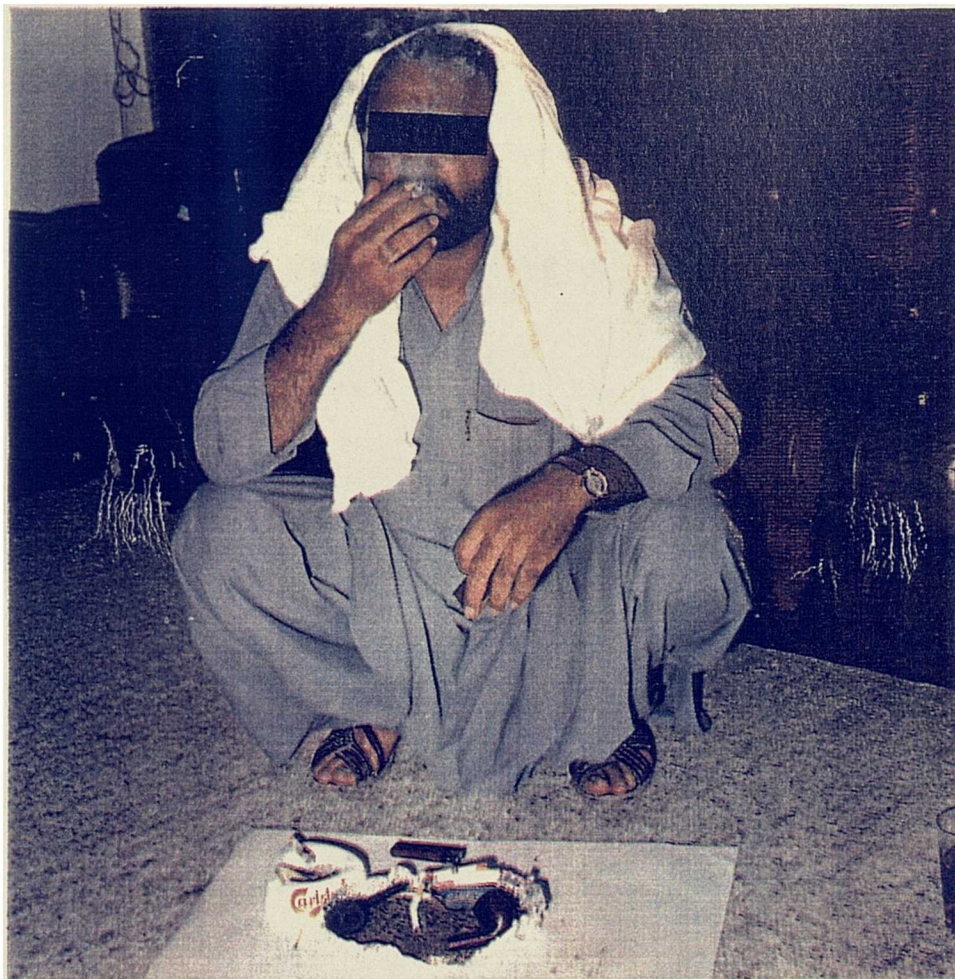
Methods of Administration

Cannabis derivatives are usually administered orally or by smoking. Some users in the U.A.E. particularly older or experienced users, who believe that hashish increases sexual activity used to eat it mixed with sugar or honey, nutmeg and saffron. This preparation, known as *al-manzūl* or *ma'jūn*, is also available in Sudan and Egypt. A cannabis solution can be drunk, the solution being prepared by one of three methods. In the first method, cannabis leaves are soaked in water for several hours, and then the solution is drunk. This method is used in cannabis-producing countries such as Pakistan, India and Egypt. The second method involves dissolving some hashish resins in alcohol, and then adding this to a sweet drink. This method is used by Turkish cannabis users, and is known as *asrīr* (secrets) (Juwaidi, 1978). The third method involves putting some hashish resin in a sugar solution and heating this until the resin dissolves. The drink is then served in small cups. This method is used in Egypt and known among users as *kanakah*.

A variety of methods are used to smoke cannabis. Hashish resin can be smoked using a water pipe known in Mediterranean countries as a *jouza* (described above) or by another type of water pipe known as a *nargīla*. Some users smoke cannabis using a tobacco pipe, or by sprinkling small pieces of hashish resin into tobacco cigarettes (Al-Maghrabi, 1984). In the U.A.E. users smoke hashish by using either a water pipe or a tobacco pipe. There is also a special tool used for hashish smoking, known as a *Shillem* (Figure 5.13). This is the head of a broken bottle filled up with tobacco and hashish. The method originated in Iran, and was brought by Iranians into U.A.E.. It is a method used by old and experienced users alike. In all of these methods of hashish smoking, the hashish is usually mixed with tobacco, and a group of users share one tool, passing it from mouth to mouth.



Marijuana mixed with tobacco



Smoking of marijuana mixed with tobacco is widely spread among drug users in the U.A.E., especially among workers.

Source: Abu Dhabi Police Administration

The Effects of Cannabis Sativa Derivatives

The effects of cannabis differ from one user to another. The mood, motivations and expectations of the user affect the range of cannabis' influences, as do the situation in which the cannabis is being used, the dosage, and its source. (Martin, 1987). The most common effects of cannabis are a state of relaxation, talkativeness, bouts of hilarity, and appreciation of sensory experiences such as colour, sound and taste. Inexperienced users can feel pangs of hunger and some anxiety. Large doses create effects such as perceptual distortion, forgetfulness, and confusion of thought processes. The effects of cannabis start a few minutes after smoking, and may last up to several hours for a large dose and about one hour for a small dose. Large doses may have more severe effects on the user, such as fatigue, paranoia, and possible psychosis. There is, however, no danger of fatal overdose (Goode, 1970). When cannabis is eaten or drunk, its effects take longer before manifesting themselves, and disappear more slowly. There is no accurate evidence that cannabis causes physical dependence, but it is probable that frequent inhalation of cannabis smoke over a period of year exacerbates respiratory disorders, and may cause bronchitis and even lung cancer (Nahas, 1985). Cannabis produces some withdrawal symptoms such as insomnia, hyperactivity, and decreased appetite.

Solvents

Solvent inhalation is a habit which is widespread in the U.A.E., especially among young people. Solvents are organic chemicals which contain carbon based compounds. These compounds induce effects similar to opiates and alcohol (Thabit, 1984). The most common solvents used among young people in the U.A.E. are glues, paints, cleaning fluids, shoe cleaners, nail varnish removers, degreasing compounds, vehicle fuels, etc.. These substances can be inhaled through the mouth or nose. Aerosol sprays which are abused by young people are available in many products such as cleaning agents, paint spray, hair lacquer, pain-relief spray, and fly & cockroach killer. Cleaning agents usually

contain one or more of a variety of solvents, such as trichloroethylene, trichloroethane, tetrachloroethylene and carbon tetrachloride (Tyler, 1986). These solvents have severe effects on human beings. Adhesive substances are amongst the most widespread among solvents users in the U.A.E. because they are cheap and easy to obtain. Rubber solutions and petrol contain some substances which have a deleterious effect on the human central nervous system. These substances include benzene and hexane, both hydrocarbon compounds, and chloroform (O'Connor, 1986), (Watson, 1986). Dyes may also contain some substances, such as acetone and the anaesthetic methylene chloride, which have a bad effect on sniffers. The solvents most commonly used by young people in the U.A.E. are adhesives and petrol. Some sniffers in the U.A.E. used to sniff strange substances, such as the vapours of burned insects, especially cockroaches and ants. This habit is common among young sniffers in the U.A.E.. Some solvent users would eat dates mixed with hair cream. (Thabit, 1984), (U.A.E. Ministry of Social Affairs, 1990).

Methods of Administration

Methods of administration depend on the type of substance; Cleaning fluids are usually inhaled straight from the container, or else a piece of cloth or cotton wool is soaked in the fluid and then placed over the nose and mouth. Rubber solution and petrol can be inhaled straight from container, and car or bike petrol tanks (Tyler, 1986). Some of these substances be poured into a can (such as a fizzy drink can) in order to hide the practice from parents or from other people, and inhaled from that. Aerosol products are used by spraying them onto a piece of cloth or cotton wool and then inhaling the fumes. Experienced sniffers sometimes spray the product into a balloon in order to avoid the effect of poisonous substances. They believe that the impurities and the concentrates of aerosol will stick to the sides of the balloon, allowing them to inhale the fumes (Richard, 1990). Users of adhesive substances put a dollop of the substance in the bottom of bag or empty can and then deeply inhale

the fumes between 6 and 20 times. This method is usually a group activity and the bag or can is passed between members of the group. Experienced sniffers seeking a more powerful effect place a plastic bag or blanket over their heads while they are sniffing adhesive.

Solvents' Effects

The most dangerous effect of inhaling solvents is their quick action on the brain. The vapours travel into the lungs and rapidly reach the brain. The effects of solvents depend on the quantity of oxygen to which the user has access. If oxygen is scarce, the effect will be significant and dangerous. Solvent inhalation depresses body functions such as breathing and heart-rate. As a result of the depressed effect, the user may feel disorientation, loss of control, dizziness, sickness, emotional behaviour, unreality or even loss of consciousness. Sniffing a solvent in a vaporous atmosphere may cause death or permanent injury, because the sniffer becomes intoxicated (Richard, 1990). Sniffing aerosols may cause kidney and liver damage. Experienced sniffers need to inhale several times more than they started with in order to get their high effect. In general, these substances cause psychological and probably physical dependence.

Summary

Drug definition depends on its effect on a human being. The definition depends on who is wanting to define it. To a physician or pharmacist, a drug is any type of medicine which may be used for the purposes of treatment. To a psychologist, a drug is any substance which may cause psychological dependence. These substances include all types of strong drugs, as well as alcohol, solvents, tobacco, coffee and tea. To police and customs officers, a drug is any substance prohibited and controlled

by customs and drugs laws. These substances do not include solvents, alcohol, tobacco, coffee or tea. The Drugs Committee of the United Nations defines a drug as follows:

any natural or manufactured substance containing depressant or stimulant substances and the non-medical using of these substances may cause psychological or physical dependence and these substances induce withdrawal syndromes for the user if he stops taking them (Abbas, 1989, p.16.).

Drugs are of different types and have different effects. The level of effect of these substances depends on the circumstances of their use, the purity of the drug, the method of administration, and its source. The abuse of these substances causes health, economic, and social problems for the individual and for society. In this study a drug is any substance which is under international drugs control and which is controlled under U.A.E. drugs law. This study also includes solvents, although these substances are not controlled under the drugs law, their abuse is considered an offence in the U.A.E..

The quantities of drugs seized by drug enforcement in the U.A.E. do not give a true picture of the prevalence of drug use behaviour in the U.A.E., and the type of drugs seized do not represent the full range of drug types available in the U.A.E.. This is because drug enforcement cannot arrest most drug users in the U.A.E.. Neither can they seize more than a fraction of the quantity of drugs imported into the U.A.E. or distributed by drug users in the U.A.E.. In spite of drug enforcement, statistics indicate that drugs are reasonably available in the U.A.E.. Hospital records in the U.A.E. indicate that the number of drug abusers is increasing. From the survey which I carried out, I found that most drugs which are used among drug users in the world are used among drug users in the U.A.E.; heroin, opium, morphine, hashish, marijuana, amphetamines, barbiturates, LSD, cocaine, tranquilisers, solvents and gases are the most common substances used. The findings of my survey indicate that many types of drugs are available on the illicit drug market in the U.A.E.. However, the increased wealth, the lucrative business, the availability of large numbers of

expatriate workers, the proximity of the U.A.E. to drug producing countries such as Iran, Pakistan, Afghanistan, etc., and young people travelling abroad without the supervision of their parents were the most important factors influencing the availability of drugs in the U.A.E.. In the next three chapters, the results of the survey which I have made will be discussed in detail.

Chapter 6

Patterns of Drug Abuse Behaviour: Demographic Characteristics and Drug Use

Introduction

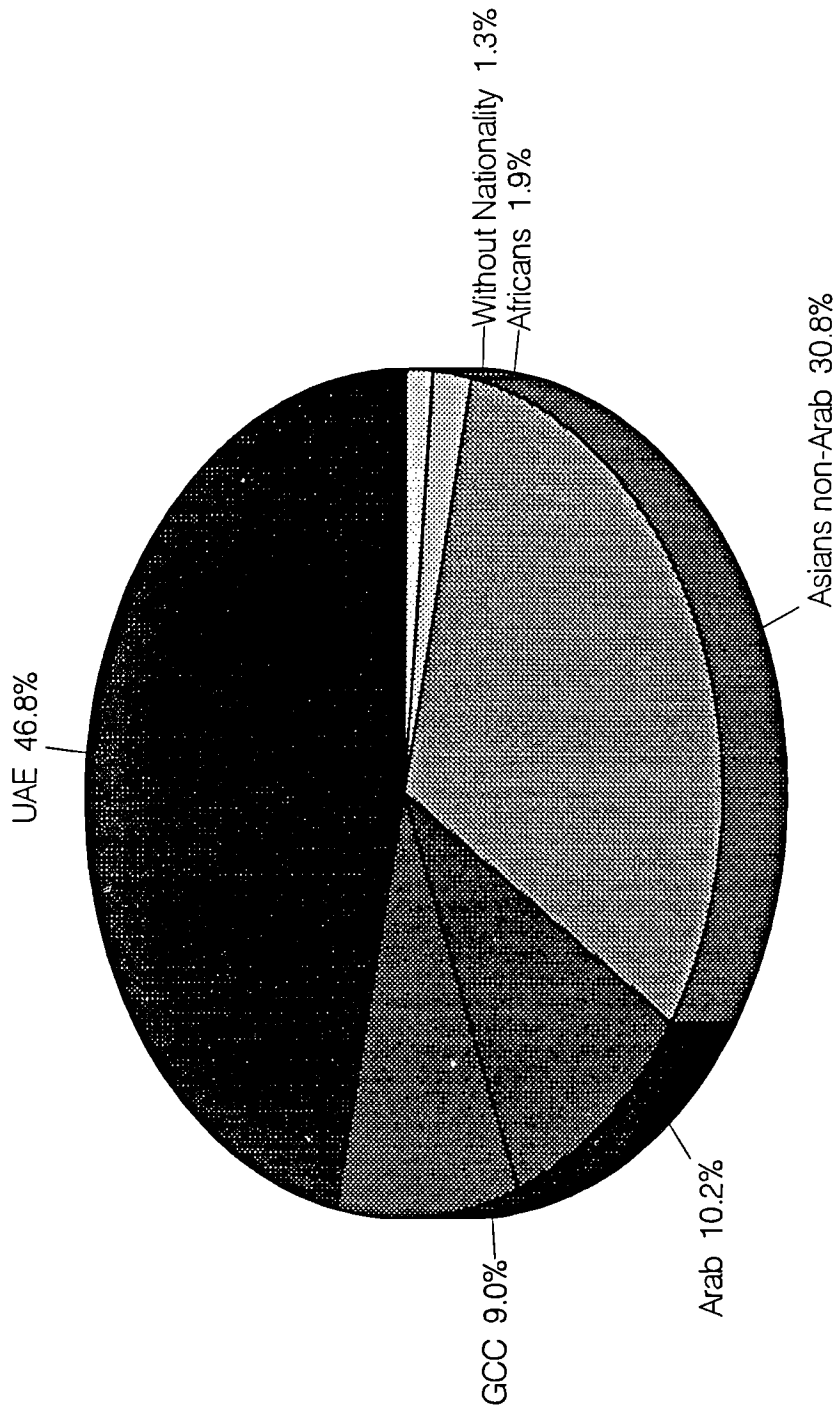
This and the following two chapters examine the findings compiled from 156 drug users through a structured questionnaire that was conducted by personal interviews. In particular this chapter examines the relationship between specific characteristics of drug users and patterns of drug use. In chapters 7 and 8, I will examine some correlates of drug use, describing factors that may be viewed as either causes or consequences of drug use. It is important for the study of the patterns of drug use to include the demographic characteristics that describe the relationship between patterns of drug use and specific characteristics of drug users, such as the relationship between drug use and age group, nationality of drug users, educational level, marital status, residence situation, and job situation. This understanding throws a light on the nature of drug abuse and the problems resulting from drug abuse, and helps drug policy makers to identify which groups of people in society may become drug abusers and thereby devise prevention programmes accordingly.

Nationality and drug use behaviour

The 17 different nationalities of drug users identified in the U.A.E. can be divided into six categories. U.A.E. citizens comprised the largest nationality of respondents (46.8%) followed by Asian non- Arab nationalities (30.8%). Respondents from Arab nationalities other than the Gulf Co-Operation Council countries were third largest in number (10.2%) followed by Arab nationals from GCC countries (Figure 6.1).

Figure 6.1

Respondents' Nationality



The distribution of these nationalities in the general population of the U.A.E. is as follows. Asian non-Arabs comprise the largest proportion of the population in the U.A.E. (50%) followed by U.A.E. citizens (27.9%). Non-U.A.E. Arabs form the third largest population group (21.1%) (Ministry of Social affairs, 1990). Asian respondents are of five nationalities, the largest number of Asian respondents being from Pakistan (56.3%), followed by Iranians (27.1%). These two nationalities make up most of the expatriate workforce in the U.A.E.. The number of respondents from India was a relatively small (10.4%), followed by 4.2% respondents from Sri Lanka and a very small number of respondents from Bangladesh (2.1%).

Arab respondents excepting those from the GCC were from eight countries: Respondents from the Sudan were the highest number of drug users (25%), followed by those from the Somali Republic (18.8%). Respondents from Egypt made up about 12.5% of the total, and Syrians and Jordanians 12.5% each. The smallest group of respondents came from the Lebanon, Palestine and Iraq 6.3% each.

Respondents from the GCC nationalities came mainly from four countries: 42.9% from Oman, followed by 35.7% from Bahrain. A small number of respondents were from Qatar 14.3%, and only 7.1% from Saudi Arabia.

There was also a small number of respondents from African Non- Arab nationalities, mainly Uganda and Tanzania, comprising 66.7% from Uganda and 33.3% from Tanzania out of the total of the African respondents.

In the category of respondents who were U.A.E. nationals, there was a large number of users from the oil-producing Emirates such as Abu Dhabi (30%), Dubai (30%) and Sharjah (31.5%). The number of respondents from other Emirates was comparatively small. The results of the distribution of the drug users' nationalities shows that U.A.E. nationals comprise the largest single nationality among drug users in the U.A.E. (46.8%);

the rest of nationalities made only (53.2%). This result differs from the popular belief that U.A.E. nationals are not the main drug users in the U.A.E.. Although non-Arabs comprise the largest proportion of the population in the U.A.E. (51%), the results indicate that the spread of drug use among Arabs is higher (58%) than among non-Arabs (42%). This is because U.A.E. nationals and other Arabs have more purchasing power and demand for drugs than Asian workers.

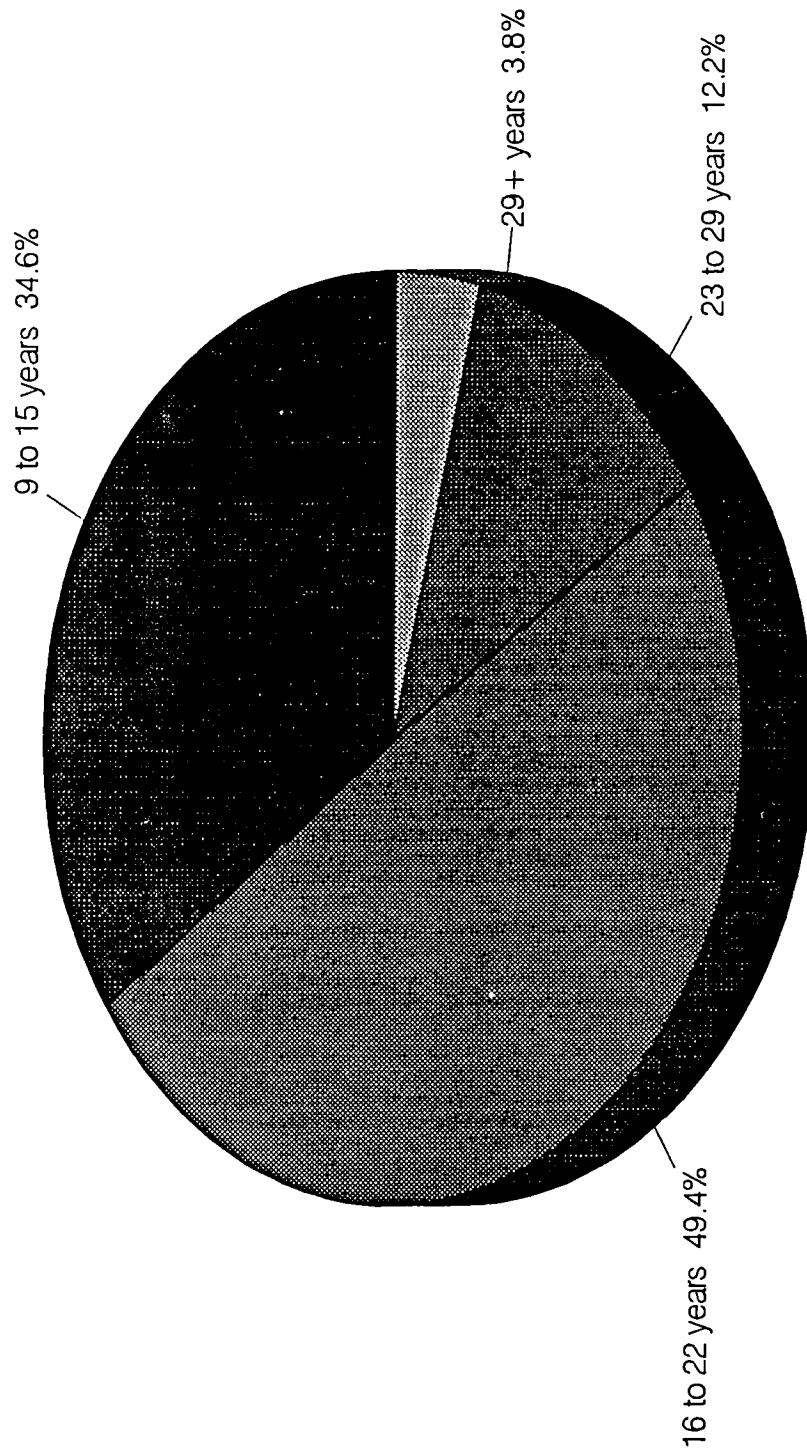
The findings show that drug use in the U.A.E. is not confined to specific groups of people or to individuals of specific nationality. Drug use is spreading among nationals as well as among the expatriate communities resident in the U.A.E.. The need for workers created by rapid economic development in the U.A.E. since the 1970s has drawn in expatriate workers, particularly from Asian countries and drug producing countries such as Pakistan, Afghanistan, Iran, India and Thailand. Each expatriate prefers to live in his/her own community rather than settling into a mixed community. Within their own community, each immigrant group shares certain common behaviour patterns, beliefs, values, tradition, norms. In the context of drug abuse, Iranian immigrants introduced into the U.A.E. the habit of using opium as a pain killer and as a sexual stimulant, whilst Indian and Pakistani immigrants introduced hashish and marijuana smoking. It is for this reason that U.A.E. nationals associate the use of drugs with immigrant groups. The majority of expatriate workers in the U.A.E. are immigrants from poor rural areas in Pakistan, Iran, Afghanistan, India, etc., where the production of drugs, drug dealing, drug trafficking, and drug use takes place. Some studies have suggested that drug abuse is more widespread among people of lower socio-economic class: people who are poor or working for low wages or doing work they consider to have little worth; people who are displaced from their home; and people living in unsuitable accommodation (Winick, 1968). Some of these factors apply to drug-using expatriate workers in the U.A.E., and therefore are associated with their drug use, and may be seen as a cause of it. Most of

the immigrant groups are made up of people of lower socio-economic class from a poor environments, and few have received much education or have skills applicable to a technologically-developing economy. When they immigrated to the U.A.E. they swapped their poor environment for a wealthy environment in order to find suitable means to reach their goals and to satisfy their needs; however, the complicated social and economic life in the new environment makes it difficult to find and use legitimate means to attain their goals in the U.A.E., as do the limited abilities and opportunities. In this kind of situation, people tend to look for alternative means to reach their goals, and for some the alternative means are illegal means. The results of this are clear in the drug enforcement statistics in the U.A.E., which suggest that expatriate workers (mainly from drug producing countries) are more involved in drug-related crimes such as trafficking, dealing, selling, etc. than others. Strengthening the temptation is the increased wealth, and consequently increased drug use of some U.A.E. nationals. This has served to encourage the involvement of some immigrants groups in drug-related crimes. Some of these expatriate workers who have failed to reach their goals by legitimate means on offer in the U.A.E. have found it easy to earn large amounts of money in a short time by drug dealing, trafficking, selling, supplying, etc.. U.A.E. nationals and some other Arabs have both the purchasing power and the demand for drugs, and the expatriate drug dealers have the drugs which they supply, immigrant nationalities and U.A.E. nationals complementing each other. Therefore, poverty and wealth are both affected by the increase of drug abuse in the U.A.E..

Age and drug abuse behaviour

The distribution of the age of initiation into drug use in Figure 6.2 shows that half of all respondents were initiated into drug use at between 16 and 22 years of age. A third of respondents were initiated into drug use between 9 and 15 years of age. Some of them were initiated into drug use between 23 and 29 years of age and only small number of respondents

Figure 6.2
Age of initiation



were initiated into drug use after the age of 29 years. Most respondents have started the use of drug at an early age, because in this age group young people start to create relationships with other people; thus sharing drugs is a form of creating relationships. Moreover, curiosity and imitation are two characteristics of adolescents (Glassner and Loughlin, 1987). The absence of preventive measures in U.A.E. society fails to discourage young people from early initiation into drug use.

Drug use is apparently initiated when some members of a group of young people find that by using drugs you can get "high" or feel happy (Donald, et al., 1968). When such a group of children, adolescents or adults become involved in drug use, one of the group members usually becomes the source of the drugs. This supplier may encourage others to try drugs (Donald, et al., 1968). My findings show that drug use is practised more among young people than older, and an early age of initiation into drug use is characteristic of the U.A.E.. One of the respondents said:

I have been a delinquent since I was child. I have used solvent, especially gasoline. Ever since I was at school I have been a troublemaker: fighting with other pupils; drinking alcohol; and using hallucinogenic and sleeping tablets. Afterwards I became experienced with other drug types.

The findings show that the effect of peer pressure motivates initiation into drug use. Peer pressure also sometimes acts to reinforce continuation of drug use, although continuation of drug use is more closely associated with the purposes of using drugs, such as wanting to feel good. The findings also show that the young age of initiation into drug use in the U.A.E. means that school children may be using drugs. Drug use among young people in the U.A.E. should be of greater social concern than drug use by older people, because compared to old people, young people are less likely to make well-informed decisions, and thus their behaviour is more vulnerable to manipulation by people with a vested interest in continued drug use as well as experiments with different types of drugs. As a result they may become physically and psychologically dependent on drugs, creating a

major social problem for themselves their families and U.A.E. society. Also, young people imitate older people, and therefore, both groups need to be looked at. Medical tests show that harmful drugs appear to have a more deleterious effect on the young, who are still in the process of development, than on the mature (Kleiman, 1989). Another reason why the spread of drug use among young people is of greater public concern than drug use by old people is that society depends for its development on the young, alongside the experiences of old people. This is especially true for the U.A.E., which is a developing country with a population shortage. For young people, particularly those at school, the financial cost of drug use can be important, because their income may be low. This may lead to committing crimes, such as theft or dealing in drugs, to finance their drug use. Young drug users constitute a major challenge to school, family, drug enforcement, health services, drug policies makers, etc.. This is alongside the damage they do to themselves, and the waste of the abandoned educational potential and lost productivity.

Table 6.1: The age of initiation of drug use and nationality

Nationality	U.A.E. Citizens		Arab Citizens		Asians & Others		Total	%
	Count	Col%	Count	Col%	Count	Col%		
9-15 years	27	37	9	30	18	34	54	34.6
16-22 years	40	54.8	14	46.7	23	43.4	77	49.4
23+ years	6	8.2	7	23.3	12	22.6	25	16
Total	73		30		53		156	100
D.F = 4	Chi-square = 6.39570			P.Value = < .715				
Keys :		D.F = Degrees of freedom			Col% = Column percentage			
		P.Value = Probability value						
Source : Fieldwork Study, 1993								

Table 6.1 shows no statistically significant differences between the age of the initiation into drug use and nationality. Most respondents from all nationalities were initiated early into drug use. This is because of the availability of the drug in the society, and because of the lack of preventive measures. The early anti-social behaviour could be a sign of

lack of control of children, or the failure of education to prevent young people from taking drugs, or because of early learning about drug use through friends or family members.

The findings show that there is little difference in the age of initiation into drug use between drug users in the U.A.E. and drug users in other part of the world. Moreover, despite the U.A.E. population being a mix of many nationalities, there is no difference in the age of initiation into drug use between these different nationalities. Most respondents who are not U.A.E. nationals were initiated early into drug use when they were living in their country of origin. As one of the respondents stated:

I have used hashish since I was child. I was brought up in an environment where drug use was normal. Members of my family used hashish and opium.

This suggests that early initiation into drug use is a part of life for young people expressing their maturity, seeking freedom, yearning for independence and craving for excitement. At this age, they begin to make relationships outside the family range. They communicate with new people, share exciting beliefs toward sex, drugs, habits, etc., create their own norms and deepen relationships with friends. Factors conducive to early initiation into drug use include availability of and access to drugs in society, lack of parental and school supervision of children, actual drug use or favourable beliefs toward drug use by family members, relationships with one or more drug users, etc.. Initial drug use is therefore associated with opportunity and availability, and drug prevention programmes should aim to prevent young people in childhood, adolescence and adulthood from drug use. Most drug users who are not U.A.E. nationals have come from drug producing countries such as Pakistan, Iran, Afghanistan, India, etc.. Their age of initiation into drug use was about the same as that of U.A.E. nationals. This suggests that motivation towards initiation into drug use among different nationalities may be the same. However, some young people stop using drugs soon after initiation, whereas others continue. This

difference may be attributable to the social settings of drug use, the availability of information about the deleterious effects of drug effects, and the subjective experience produced by some types of drugs. The findings also show that the period between initiation into drug use and arrest or commission to treatment in hospital may be short. Most respondents, the majority of whom were addicted to heroin, were arrested or treated after a short term of experience with drug use, because heroin is both expensive and causes physical and psychological dependence, thus forcing some users to seek medication to stop using heroin.

The distribution of the respondents age groups in figure 6.3 shows that over half of the respondents (51.9%) were in the age range 18 to 29 years. Drug use among this age group is global, not least because this is the age at which young people create relationships outside the family environment and try to express their maturity. They also are responding to peer pressure. Users from this age group are more likely to be multiple drugs users. Some of them use more than eight types of drugs in their lifetime and more than three methods of drug use. They also tend to use more expensive and hard drugs, especially heroin and barbiturates. The overall findings show that drug use is lower among older age groups. This is because some drug users abandon drug use after unpleasant experiences, and others after they realise the consequences of being a drug addict. Some respondents said that some users give up using drugs prior to marriage, because it is harder for addicts to find U.A.E. women who will accept them as husbands.

Figure 6.3

The distribution of the respondents' age groups

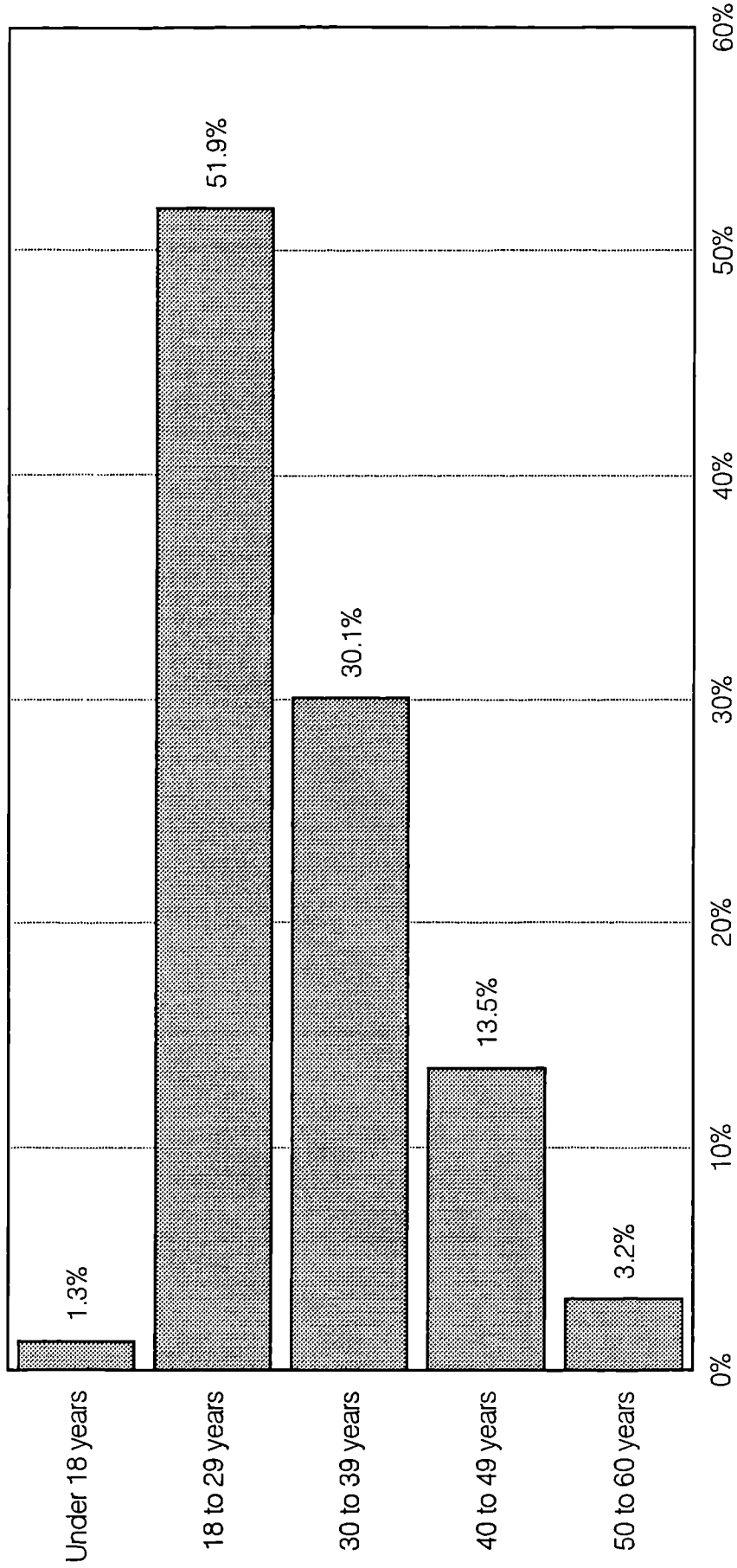


Table 6.2: Drug users' age and nationality

Nationality	U.A.E.		Arab		Asians & Others		Total	%
	Count	Col%	Count	Col%	Count	Col%		
18-29 years	59	80.8	8	26.7	16	30.2	83	53.2
30-39 years	13	17.8	12	40	22	41.5	47	30.1
40+ years	1	1.4	10	33.3	15	28.3	26	16.7
Total	73		30		53		156	100
D.F = 4	Chi-square = 46.19333			P.Value = < .0000				
Keys : D.F = Degrees of freedom Col% = Column percentage P.Value = Probability value								
Source : Fieldwork Study, 1993								

Table 6.2 shows the distribution of age groups in relation to respondents' nationalities. Whatever the nationality, the age group 18 to 29 years had the highest number of respondents. The table shows that there is a high statistically significant difference between age and nationality. Most respondents who were U.A.E. citizens were in the age group 18 to 29 years (80.8%). The largest age group of the other Arab respondents was that of 30 to 39 years (40%). The largest age group from Asian non-Arab and other nationalities was also the 30 to 39 years group (41.5%). Most respondents over 40 years were from Asian non-Arab nationalities, and there were a few from Arab nationalities. Respondents from the U.A.E. were the youngest, and respondents from Asian countries and others the oldest. These findings suggest that the age group 18-29 years is significant to drug use among U.A.E. nationals. At this age, some young people are studying at university, and others have recently started work. Drug users who are not U.A.E. nationals tend to be older, in the age group 30 to 39 years. This is not because they started to use drugs later, but because the labour market in the U.A.E. prefers this age group for work in the expatriate workforce because of their experience in their professions. The overall findings suggest that the age 18 to 29 years may be an important age for drug use in most nationalities.

Table 6.3: Drug users' age and drug types

Age	18-29 Years		30-39 Years		40 + Years		Total	%
	Count	Col%	Count	Col%	Count	Col%		
Marijuana								
Used	55	66.3	22	46.8	10	38.5	87	55.8
Never	28	33.7	25	53.2	16	61.5	69	44.2
Total	83		47		26		156	100
D.F = 2	Chi-square = 8.39407			P.Value = < .0150				
Heroin								
Used	60	72.3	28	59.6	8	30.8	96	61.5
Never	23	27.7	19	40.4	18	69.2	60	38.5
Total	83		47		26		156	100
D.F = 2	Chi-square = 14.52961			P.Value = < .0007				
Morphine								
Used	20	24.1	8	17	0	0	28	17.9
Never	63	75.9	39	83	26	100	128	82.1
Total	83		47		26		156	100
D.F = 2	Chi-square = 7.84495			P.Value = < .0198				
Barbiturates								
Used	53	63.9	23	48.9	3	11.5	79	50.6
Never	30	36.1	24	51.1	23	88.5	77	49.4
Total	83		47		26		156	100
D.F = 2	Chi-square = 21.75732			P.Value = < .0000				
Tranquillisers								
Used	35	42.2	23	48.9	3	11.5	61	39.1
Never	48	57.8	24	51.1	23	88.5	95	60.9
Total	83		47		26		156	100
D.F = 2	Chi-square = 10.53207			P.Value = < .0052				
Solvent								
Used	16	19.3	0	0	1	3.8	17	10.9
Never	67	80.7	47	100	25	96.2	139	89.1
Total	83		47		26		156	100
D.F = 2	Chi-square = 13.08186			P.Value = < .0014				
Keys:	D.F = Degrees of freedom			P.Value = Probability value				
	Col% = Column percentage							
Source : Fieldwork Study, 1993								

Table 6.3 shows the rates for drug abuse among respondents in relation to their ages. It also shows the prevalence of heroin, barbiturates, solvent, morphine, and marijuana use was highest amongst those aged between 18 to 29 years. There are also statistically

significant differences between the rate of heroin use and the respondents' ages. The prevalence of heroin use is higher among respondents between 18 to 29 years of age than in other age groups. Also, the rate for barbiturate use among the same age group is higher than that of other age groups. The rate for the use of marijuana, morphine, tranquillisers and solvents was higher among respondents aged between 18 to 29 years than other age groups. Some respondents have said that they use more than one type of drug and experiment with new types; this is because they want the maximum euphoria and intoxication achievable. Some respondents have said that being inexperienced in the effects of different drugs, they are more likely to try many types until they become experienced and are able to choose the most suitable type of drug for the effect they want. The pattern of use observed in the above table shows that the use of heroin and barbiturates is connected more with people in the age group 18 to 29 than with other users. This is because most drug users in this age group are U.A.E. nationals, who are younger than other users. Some of them have said that they are less wary of avoiding hard drugs, and they also enjoy a greater purchasing power than non-U.A.E. nationals, and can afford to buy hard and expensive drugs such as heroin (a gram of heroin costs between £80 and £100 on the U.A.E. drugs market). One of the respondents stated:

I was able to use drugs because I had plenty of money. I used to get 5000 dirhams (£800) a day as pocket money from my family.

In contrast, other nationalities are less involved in expensive drugs such as heroin. The findings also show that the use of barbiturates is connected with the use of heroin. Most heroin users use barbiturates as a substitute for heroin when it is unavailable on the drug market, or when they cannot afford heroin. They also use barbiturates to avoid or minimise the withdrawal symptoms of heroin. The findings show that there is a relationship between experimentation with new types of drugs and certain age groups. Most respondents who used more than one type of drug went on to try new types of drugs after having experienced the first type.

Education and drug abuse behaviour

The findings show a significant relationship between drug use and leaving school early. Most respondents failed to complete secondary school. This does not mean that drug use in the U.A.E is confined to people with little education; the situation is more complex. The majority of the U.A.E. population are expatriate workers, who are mostly unskilled and lack education. Most uneducated people in the U.A.E. are Asians, mainly from Pakistan, India and Iran. Their lack of education is due to a dearth of schools in their country of origin, especially in rural areas from where most originate. Some of them stated that even when there were schools in their areas, their parents and families preferred them to take up jobs in agriculture or fishing or to emigrate to neighbouring countries to work rather than to send them to school. The findings show that drug use among U.A.E. nationals is more associated with those who have only intermediate education. This is attributable to a school curriculum which fails to satisfy the students' needs because it depends on the dictation process and a poor relationship between home and school which encourages some students to quit school and take up employment at a relatively young age. As one of the respondents said:

I attended the first and second years of my elementary education in a private school in which I completed my fourth year. Because my parents and my teachers haven't been effective in my education, I failed three years continuously. Consequently, I became acquainted with some solvent sniffers who introduced me to drug use. I was spending one or two days away from home which made my father and my brothers keep me imprisoned in a room for a day or two, and they beat me aggressively. It was following this treatment that I changed from using drugs of the low effective types to hard drugs.

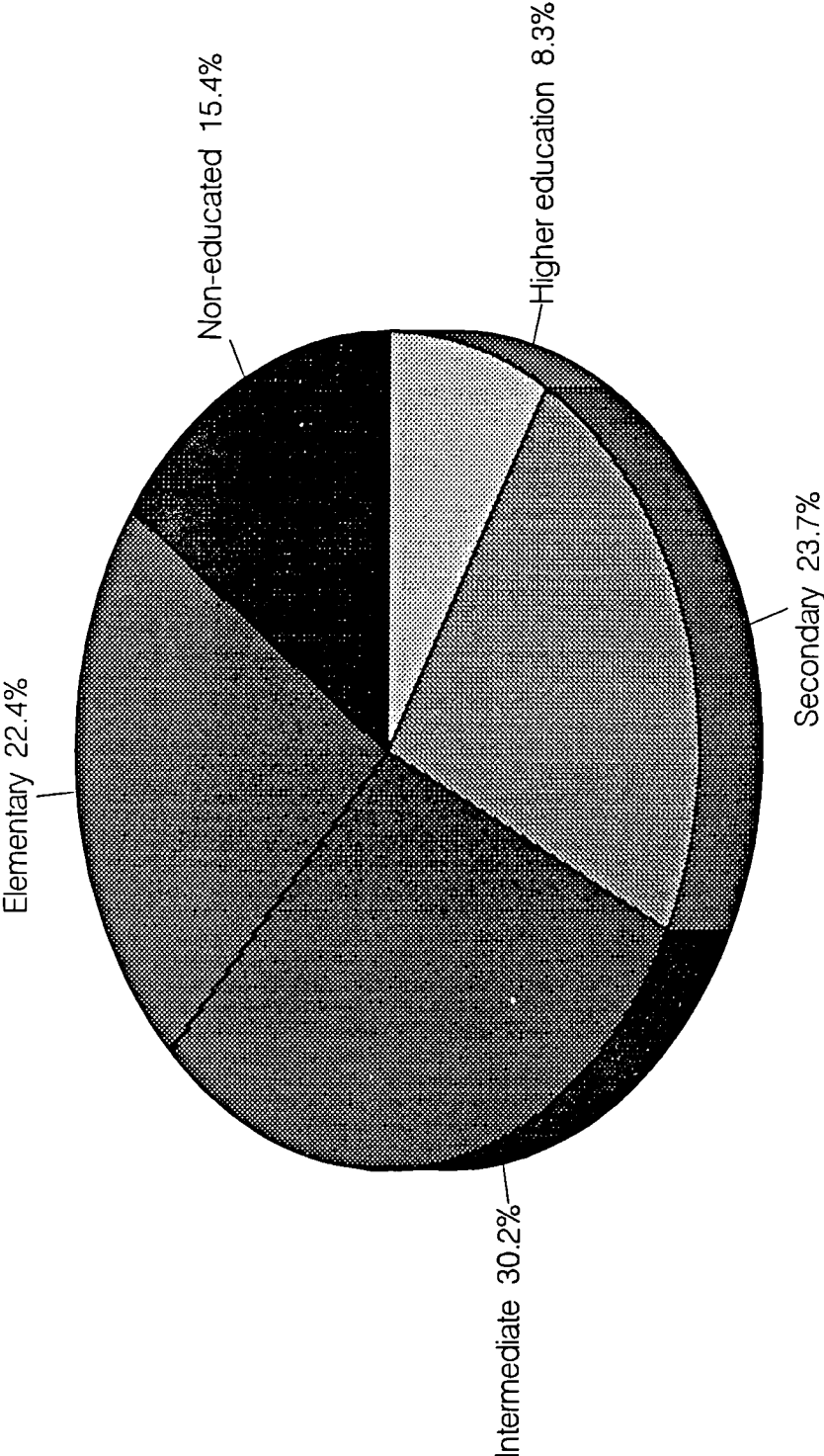
In the age group 15 to 59 years, people with an intermediate education make up to 11.4% of the U.A.E. population. In the same age group people who are uneducated make up 30.4% of the U.A.E. population. Only 7.3% of the U.A.E. population are university graduates. In many countries, it can be difficult for people with little education to obtain a good job that will satisfy their needs, and they have little hope of attaining their goals

by legitimate means. Lack of training and education results in many remaining unemployed, isolated and socially withdrawn. This situation is conducive to drug use and to involvement into drug-related crimes such as trafficking, dealing, selling, etc.. By way of contrast, in the U.A.E. society it is easy for those with little or intermediate education to get a well-paid job which will satisfy their needs; some public sector establishments, such as the army and the police force, pay well but do not require a high level of education. For these people, the use of drugs occurs not because they are unemployed or because they are dissatisfied with their salaries, but because they are well able to pay high prices to obtain drugs. Increased wealth among poorly educated people who do not realise the dangers of drugs may partly lead to the spread of drug use in the U.A.E..

Data in Figure 6.4 shows the educational establishments respondents have attended. Most respondents had intermediate education, followed by respondents with secondary education. Respondents with only elementary education made up about 22.4% of the total, followed by non-educated respondents. Only a small number of respondents were university graduates, followed by respondents who had attended colleges of higher education. The figure shows that most respondents had low educational attainment and very few had undergone higher education. The findings suggest that the spread of drug use among people with low levels of education is higher than amongst others. Some respondents said that they preferred to leave school early and to work for a public sector employer, such as the army and police, which does not require high levels of education but nevertheless pay high salaries. This results in young people being able to finance themselves from the age of 14 upwards. As one of the respondents reported:

I left intermediate education after the death of my father. I was in need of money and therefore I worked for the army. The army sent me on a training course in London and during my training period there I became friendly with some people from Brazil and one British girl. The girl was a drug user and used to get drugs from Brazilian people. She introduced me to heroin and encouraged me to become addicted to it.

Figure 6.4
Respondents' educational level



The purchasing power available to these young people encourages them to involve themselves in drug use. Moreover, most of the uneducated respondents are Asian non-Arabs. Their lack of education is due to the lack of schools in their original countries. Most of them are unskilled labourers from rural areas. The spread of drug use among those with a higher education is low. This is not because educated people avoid drug use, but may be because the number of people with a high education in the U.A.E. is low.

Table 6.4: Education level and drug type

Educational Establishment	None		Elementary		Intermediate		Secondary		College		Total	%
	Co	C%	Co	C%	Co	C%	Co	C%	Co	C%		
Opium												
Used	9	8.8	20	19.6	33	32.4	30	29.4	10	9.8	102	65.4
Never	15	27.8	15	27.8	14	25.9	7	13	3	5.6	54	34.6
Total	24	7	35		47		37		13		156	100
D.F = 4	Chi-square = 14.572		P.Value = < .0057									
Marijuana												
Used	1	1.1	19	21.8	31	35.6	26	29.9	10	11.5	87	55.8
Never	23	33.3	16	23.2	16	23.2	11	15.9	3	4.3	69	44.2
Total	24		35		47		37		13		156	100
D.F = 4	Chi-square = 33.429		P.Value = < .0000									
Heroin												
Used	8	8.3	17	17.7	34	35.4	30	31.3	7	7.3	96	61.5
Never	16	26.7	18	30	13	21.7	7	11.7	6	10	60	38.5
Total	24		35		47		37		13		156	100
D.F = 4	Chi-square = 19.165		P.Value = < .0007									
Cocaine												
Used	1	2	11	21.7	20	39.2	12	23.5	7	13.7	51	32.7
Never	23	21.9	24	22.9	27	25.7	25	23.8	6	5.7	105	67.3
Total	24		35		47		37		13		156	100
D.F = 4	Chi-square = 13.622		P.Value = < .0086									
Barbiturates												
Used	3	3.8	23	29.1	24	30.4	23	29.1	6	7.6	79	50.6
Never	21	27.3	12	15.6	23	29.9	14	18.2	7	9.1	77	49.4
Total	24		35		47		37		13		156	100
D.F = 4	Chi-square = 19.222		P.Value = < .0007									
Other												
Used	16	11.6	33	23.9	44	31.9	32	23.2	13	9.4	138	88.5
Never	8	44.4	2	11.1	3	16.7	5	27.8	0	0	18	11.5
Total	24		35		47		37		13		156	100
D.F =	Chi-square = 15.393		P.Value = < .0040									
Keys:	D.F = Degrees of freedom					CO = Count						
	C% = Column percentage					P = Probability value						
Source: Fieldwork Study, 1993												

Table 6.4 shows the relationship between the level of education and drug type used. There are statistically significant differences between the educational level of respondents and the prevalence of drug use. The table shows that the rate of marijuana, opium, heroin and barbiturates use is higher among respondents with secondary and intermediate education than other levels of education. The rate of cocaine use among respondents with higher education was higher than those other with levels of education. This is because most people who used cocaine were introduced to it when they were studying in the USA or in Europe. The results show that drug use is highest among drug users with low levels of education and lowest among users with high education. What these findings suggest is that people with intermediate and secondary education seem more likely to be involved in drug use than others. Most of them are multiple drugs users who use hard and expensive types, especially heroin. This may be because most of them are young, mainly in the age group 18 to 29 years; at this age the psychological and emotional problems are at a high level and individuals are more likely to exhibit abnormal behaviour such as drug abuse.

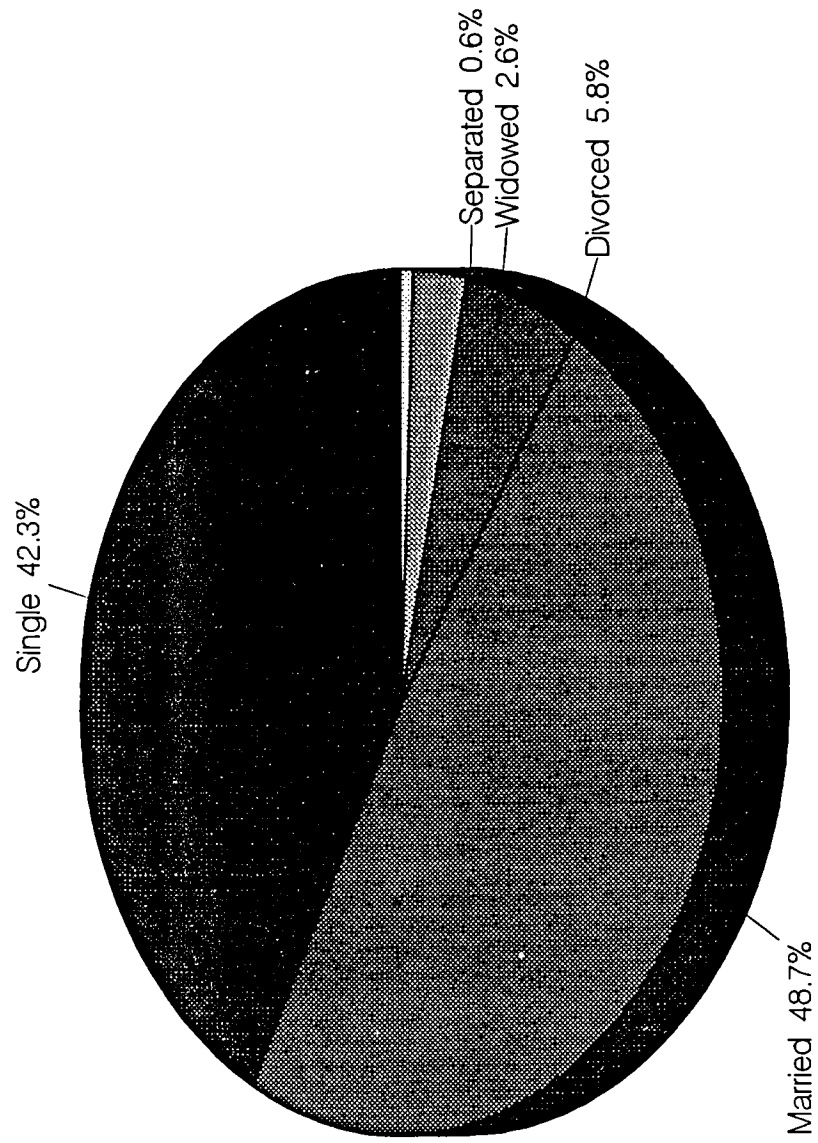
Marital Status and drug abuse

The findings suggest that drug use may occur as a result of conflicts and difficulties in the individual's relationships within the family and between stressful forces in society such as living difficulties; drug use is a method (albeit dysfunctional because it gives rise to more problems than it is likely to solve) to cope with frustrations and difficulties. Although the findings appear to show that drug use is more widespread among married people than among single people, this is not due to a relationship between drug use in the U.A.E. and marriage. Many of the respondents were expatriate workers, living in the U.A.E. because they were working in order to send money back to their families in their country of origin. In fact, despite living a single life in the U.A.E., most expatriate workers were married in their twenties, and had been initiated into drug use in their country of origin at around much the same age. When they emigrated to the U.A.E. they

continued to use drugs. This is because of the availability of drugs in the U.A.E., and the difficulties and frustrations they face because they are away from their families. In a time of difficulty the individual may turn to drugs or to social withdrawal and isolation. The findings show that divorce and separation cases among respondents did not cause the initiation into drug use but are a result of it. After getting married, some drug users who used to use light effective drugs such as hashish, marijuana, etc. may give up drug use, especially those who had been discovered using drugs by their relatives or police. But it is difficult for those who used hard drugs that cause physical dependence such as heroin or opium to give up drug use after getting married, and this would lead to the damage of the marriage, especially if there is not enough medication facilities for addiction in the society. Among U.A.E. nationals, drug use is associated more with single people than with married people. Single people in the U.A.E. tend to be young, and if they are in work are likely to have a high disposable income which is not committed to maintaining dependants.

Data in Figure 6.5 present the distribution of respondents in relation to their marital status. The findings show there were more married respondents in the sample. Most of these had one wife and only a few had more than one wife. The number of single respondents was also high, and only a small number of respondents were divorced, widowed or separated. Most married respondents had children (88.0%). The above findings have important implications; one is that the spread of drug use is slightly higher among married respondents than among single respondents. This result does not give an entirely accurate picture, whilst it does indicate that drug use is more widespread among married people in the U.A.E.. In fact this is because most Asians and other Arab respondents are married but live in the U.A.E. as single without their families. A second important implication is that single males comprise about 60% of the U.A.E. population. This is because of the increase of legal and illegal immigration, especially from Asia

Figure 6.5
Respondents' Marital Status



(*Al-Sharq Al-Awsat* Newspaper, 30 of July, 1993). The overall findings show that drug use is spreading among both single people and married people.

Table 6.5: Marital status and nationality

Nationality	U.A.E. Citizens		Arab Citizens		Asians & Others		
	Count	Col%	Count	Col%	Count	Col%	Total
Single	43	58.9	11	36.7	12	22.6	66
Married	22	30.1	16	53.3	38	71.7	76
Others	8	11	3	10	3	5.7	14
Total	73		30		53		156
%	46.8			19.2		34	
D.F = 4		chi-square = 21.87695			Significance = < .0002		
Keys : Col% = column percentage							
Source : Fieldwork, 1993							

Table 6.5 shows that there were statistically significant differences between the marital status and the nationality of the respondents. Most respondents who were from the U.A.E. were single (58.9%), whilst most respondents who were Asian non-Arabs were married (71.7%). Whilst most Asian respondents are married, they live in the U.A.E. without their families. This is because of the high cost of living in the U.A.E. and the low wages they are paid. Most respondents who are U.A.E. nationals are single; this is because most respondents from the U.A.E. were younger than drug users of other nationalities, the ages of most of them being between 18 and 29 years. Most Asian respondents were older than other nationalities and their ages fell into the 30 to 39 years group. Asians (especially those from Pakistan and Iran) tend to get married earlier than U.A.E. citizens because in their countries the cost of marriage is not high, whereas it is high in the U.A.E.. Most Arab respondents were married. They tend to get married later than U.A.E. nationals and Asians. This is because most of them prefer to earn and save some money from their jobs before they being married.

Table 6.6: Marital status and drug type

Marital Status		Single		Married		Other		Total	%
Drug type		Count	Col%	Count	Col%	Count	Col%		
Marijuana	Used	43	65.2	32	42.1	12	85.7	87	55.8
	Never	23	34.8	44	57.9	2	14.3	69	44.2
	Total	66		76		14		156	100
D.F = 2		Chi-square = 13.19698			P.Value = < .0014				
Heroin	Used	46	69.7	40	52.6	10	71.4	96	61.5
	Never	20	30.3	36	47.4	4	28.6	60	38.5
	Total	66		76		14		156	100
D.F = 2		Chi-square = 4.98200			P.Value = < .0828				
Barbiturates	Used	40	60.6	29	38.2	10	71.4	79	50.6
	Never	26	39.4	47	61.8	4	28.6	77	49.4
	Total	66		76		14		156	100
D.F = 2		Chi-square = 9.78025			P.Value = < .0075				
Solvent	Used	12	18.2	3	3.9	2	14.3	17	10.9
	Never	54	81.8	73	96.1	12	85.7	139	89.1
	Total	66		76		14		156	100
D.F = 2		Chi-square = 7.55301			P.Value = < .0229				
Keys:		D.F = Degrees of freedom							
		Col% = Column percentage							
		P.Value = Probability value							
Source : Fieldwork Study, 1993									

Table 6.6 shows that there are low statistically significant differences between the prevalence of the use of some types of drugs and marital status. The rates for marijuana, barbiturates, heroin, and solvent use are higher among single respondents than others. This may be because single people have no family to support, and therefore they can spend more money on drug use and afford many types of drugs. Single people are more likely to be multiple drug users using more than three type of drugs. This is because more single users were U.A.E. nationals, were young, and had greater purchasing power, enabling them to buy more drugs and more expensive types than other nationalities. Single people also have fewer family responsibilities and can afford to spend more on

drugs than married people. The high rate of drug use among single people is a global issue (Badir, 1987). In addition, psychological and emotional problems are more prevalent among single people than married ones. The effect of these problems in Arab/muslim countries may be different than in other countries. This may be because sexual and emotional relationships outside marriage are more restricted and prohibited in Arab/Muslim countries.

Job situation and drug abuse

Drug use is more likely among those whose jobs are of a low status than among those whose jobs are of a high status. Most respondents were workers in the private sector, or soldiers in the army. However, despite the low status of their jobs, the U.A.E. nationals were still paid well, particularly users who are U.A.E. soldiers. Drug use among U.A.E. nationals, therefore, can be correlated with high salaries, low educational attainment and young age. For users who are non-U.A.E. nationals, the picture looks very different; overwork, low income, and dissatisfaction with jobs as unskilled low class workers. An unsettled job history is characteristic of drug users in the U.A.E.. This is not because they are dissatisfied with their jobs or income, but because they cannot adjust their drug use to the requirements of their job. Most respondents have changed their jobs more than three times, and some of them, especially the U.A.E. nationals, have been dismissed, returned to their job, and after that fired for a second or even third time. Low productivity and frequent absence has resulted in many having changed their job more than three times. Most respondents lose interest in their job after being addicted to drugs and their interests change to their drug use circle. The findings show that long term drug use leads to a decline in the drug user's productive abilities and aspirations, and increased carelessness. Being dismissed from a job precipitates a drug user into a difficult situation: losing their means of access to drugs. The situation is especially acute for married drug users who also have family commitments to maintain. Under the pressure of these circumstances, many drug users get involved with crime; either in the drug trade directly, or by committing crimes such as theft, which gives them the money with which to buy

drugs. Some drug users in the U.A.E. prefer to deal with drug trade rather than involve themselves in other types of crime, because drug dealing is safer and easier than committing other crimes, and the income from drug dealing is greater, thus more easily satisfying their own needs and perhaps also the needs of their family.

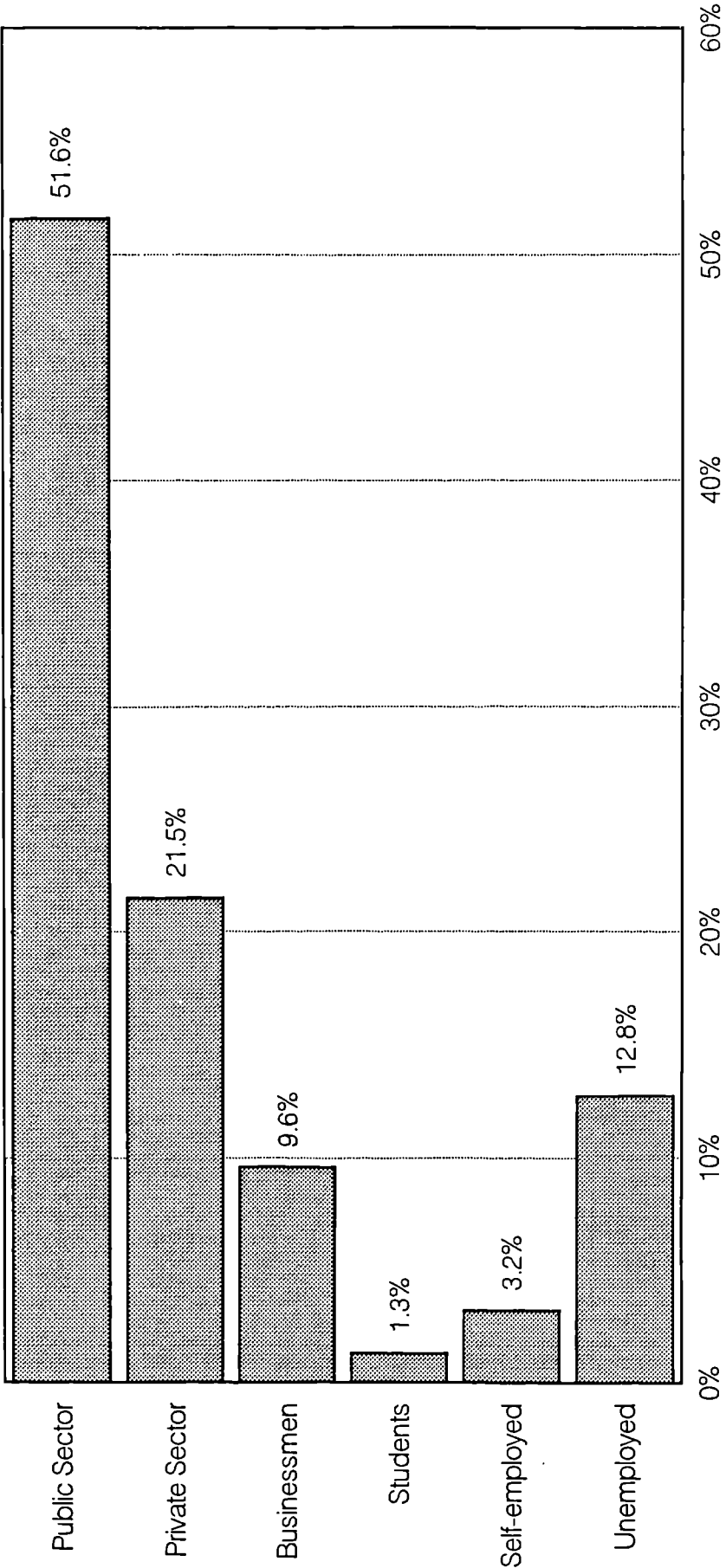
The distribution of job situation in Figure 6.6 shows that most respondents had jobs. More than half of them worked for the public sector, followed by respondents who worked in the private sector. Unemployed respondents were in third place, comprising 12.8% of the total, followed by respondents who were businessmen. Only small numbers of respondents were students, and the other small category of users were the self-employed.

Most respondents who worked for the public sector were soldiers in the army (57.5%), followed by respondents who were working in the police force (12.5%). This may be because army and police sectors employed young people and attracted them by giving them high salaries and not demanding high educational qualifications.

Most respondents who worked in the private sector worked as chauffeurs (25.0%), and most of them were Asians. This is because many people in the U.A.E. prefer to employ someone as a private chauffeur than to drive themselves.

The highest category of unemployed respondents had been out of work for more than five years (55.0%), followed by respondents who had been unemployed for a period between four to five years (20.0%). Unemployed respondents who had been out of work for between one and two years made up about 15% of the total, followed by unemployed respondents who had been unemployed for two to three years (5.0%) and those unemployed for three to four years (5.0%). Most respondents who are unemployed are dismissed from their previous jobs because of their addiction. The last job for most of the unemployed respondents was as a soldier in the army (60.0%), and the second highest previous occupation for unemployed respondents was studying at school or university (25.0%). A small number of them were workers who had been in short term employment in different places.

Figure 6.6
Respondents' Job Situation



Most respondents from the U.A.E. work for the public sector (67.1%). Most Arab respondents work for the public sector (50.0%). Most Asian respondents work for private sector (54.7%). These differences in the job situation related to the requirements of jobs. The public sector in the U.A.E. usually employs people who speak Arabic and prefers to employ people from the U.A.E. or who are Arab citizens, rather than to employ non-Arab Asians. This is because the official language of the public sector is Arabic, and because U.A.E. citizens take priority in employment in the public sector. The private sector deals with different languages and prefers to employ non-Arab Asians because they cost less than other nationalities. Most U.A.E. citizens prefer to work for the public sector because of the high salaries and good job security, which is unavailable in the private sector.

Table 6.7: Job sector and drug type

Job Sector		Public Sector		Private Sector		Other		Total	%
Drug type		Count	Col%	Count	Col%	Count	Col%		
Barbiturates	Used	42	52.5	18	34.6	19	79.2	79	50.6
	Never	38	47.5	34	65.4	5	20.8	77	49.4
	Total	80		52		24		156	100
D.F = 2		Chi-square = 13.26628		P.Value = < .0013					
Tranquillisers	Used	32	40	15	28.8	14	58.3	61	39.1
	Never	48	60	37	71.2	10	41.7	95	60.9
	Total	80		52		24		156	100
D.F = 2		Chi-square = 6.05156		P.Value = < .0485					
Solvent	Used	13	16.3	1	1.9	3	12.5	17	10.9
	Never	67	83.8	51	98.1	21	87.5	139	89.1
	Total	80		52		24		156	100
D.F = 2		Chi-square = 6.73711		P.Value = < .0344					
Other	Used	73	91.3	43	82.7	22	91.7	138	88.5
	Never	7	8.8	9	17.3	2	8.3	18	11.5
	Total	80		52		24		156	100
D.F = 2		Chi-square = 2.54662		P.Value = < .2799					
Keys:		D.F = Degrees of freedom Col% = Column percentage P.Value = Probability value							
Source : Fieldwork Study, 1993									

Table 6.7 shows statistically significant differences between the type of drugs and the job situation. The prevalence rate for barbiturate use was high among respondents working for the public sector. There is also a relationship between the prevalence rate for tranquilliser use and respondents who have other job situations, such as businessmen, students, the unemployed, and the self-employed. This may be because the nature of their work situation (or lack of it) sometimes exhausts them, and, suffering from insomnia, they turn to this type of drug in order to sleep. There is also a relationship between the prevalence rate for solvent use and respondents who work for the public sector. This may be because most respondents who work for the public sector are from the U.A.E., and most of them are younger than other respondents, and the use of solvents is usually associated with young people. The overall findings show that drug use is more widespread among working respondents than among unemployed respondents. This may be related to the fact that the U.A.E. unemployment rate is low (1.2% of the population), which differs from that in other countries in the world such as European countries (Ministry of Social Affairs, 1990). The table also shows that the spread of drug use is higher among those who are working in the public sector. This may be because most of them have a lower standard of education but receive high salaries, and most of them are young U.A.E. citizens.

Residence Situation

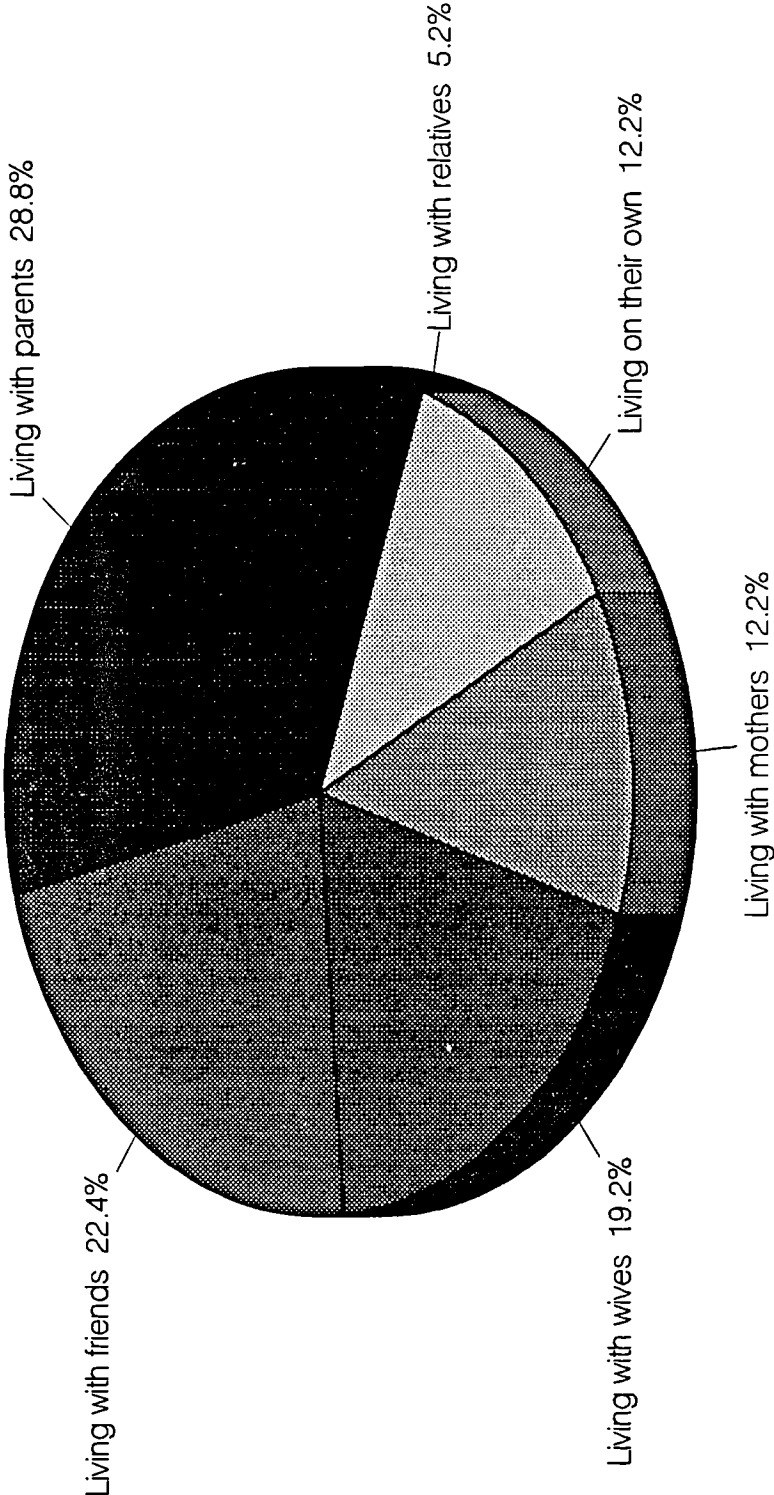
Some researchers have suggested that drug use is more likely to occur in depressed socio-economic areas of large cities (Winick, 1968). Such areas are also likely to have immigrant or minority groups who are relatively less likely to have access to opportunities in the larger community. Under these circumstances some people may turn to using drugs that offer them a fantasy way of making up for lack of opportunity and satisfaction in reality (Winick, 1968). The survey findings show that the residence situation is related to drug use in various ways. Drug use is more widespread amongst people who rent premises and live together with friends of whom some are drug users. Most of those are Asian immigrants earning a low income, living with friends because alone they cannot

afford the high rents. Under the pressure of their friends, frustration, low income, overwork, high rent cost, and living alone without their families, some of them started to use drugs or restarted to use after having given them up on emigration to the U.A.E.. Subsequently, some moved from drug use only to active involvement with the drug trade. Most Asian immigrants experience difficulty in finding somewhere to live in the U.A.E., especially in the large cities such as Abu Dhabi, Dubai, and Sharjah. Most accommodation occupied by Asian workers is characterized by overcrowding, some rooms having to be shared by more than five people of the same nationality. The collective houses in the U.A.E. are characterized by low health status, and the high rents prompt some immigrant workers to move from place to place seeking a lower rent. Most of the collective houses have been left behind by U.A.E. nationals who have moved to new houses. Most of these collective houses are in areas to which the authorities pay little attention. In contrast, U.A.E. national drug users are likely to be single, high earners, and pay no rent because they live free with their parents. Most of them have their own rooms within their parents' houses. They earn high salaries in contrast with non-U.A.E. nationals, and live in better circumstances. Therefore, drug use is not associated with poor living conditions; it is associated with the availability of drugs in the society and the availability of means to access them, especially the purchasing power of the U.A.E. nationals.

Figure 6.7 shows that most respondents are living with their parents, followed by respondents who are living with friends. Most of those who are living with their friends are Asians, and most of them are living in the U.A.E. without their families. They live together in order to minimise the high cost of living in the U.A.E.. Despite the fact that most respondents are married, only a small number of them are living with their wives, followed by respondents who are living with their separated or divorced mothers only, then the respondents who are living on their own. Only a small number of respondents are living with their relatives. Most of those who are living with their parents are U.A.E. citizens.

This may be because most of them are single and younger than respondents of other nationalities, and in these circumstances some U.A.E. citizens usually prefer to stay with

Figure 6.7
Respondents' Residence Situation



their parents in order to avoid the high cost of living in the U.A.E.. Most respondents who are living with their friends and relatives are non-Arab Asians (76.7%). Most of them are unskilled workers who earn low wages and live with friends and relatives in order to mitigate the high cost of living, and to save money to send to their families outside the U.A.E..

Table 6.8: Place of residence and drug type

		On their Own		With Parents		With Mother		With Wife/ Wives		With Friends & Relatives		Total
Drug Type		Count	Col%	Count	Col%	Count	Col%	Count	Col%	Count	Col%	
Opium	Used	12	63.2	35	77.8	14	73.7	22	73.3	19	44.2	102
	Never	7	36.8	10	22.2	5	26.3	8	26.7	24	55.8	54
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 13.04872						P.Value = < .0110				
Marijuana	Used	11	57.9	33	73.3	16	84.2	17	56.7	13	30.2	87
	Never	8	42.1	12	26.7	3	15.8	13	43.3	30	69.8	69
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 18.27326						P.Value = < .0011				
Heroin	Used	9	47.4	38	84.4	16	84.2	20	66.7	13	30.2	96
	Never	10	52.6	7	15.6	3	15.8	10	33.3	30	69.8	60
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 33.85228						P.Value = < .0000				
Morphine	Used	3	15.8	11	24.4	7	36.8	5	16.7	2	4.7	28
	Never	16	84.2	34	75.6	12	63.2	25	83.3	41	95.3	128
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 11.15108						P.Value = < .0249				
Cocaine	Used	6	31.6	20	44.4	7	36.8	14	46.7	4	9.3	51
	Never	13	68.4	25	55.6	12	63.2	16	53.3	39	90.7	105
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 16.33726						P.Value = < .0026				
LSD	Used	3	15.8	4	8.9	6	31.6	8	26.7	2	4.7	23
	Never	16	84.2	41	91.1	13	68.4	22	73.3	41	95.3	133
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 12.40513						P.Value = < .0146				
Barbiturates	Used	6	31.6	33	73.3	16	84.2	15	50	9	20.9	79
	Never	13	68.4	12	26.7	3	15.8	15	50	34	79.1	77
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 35.78881						P.Value = < .0000				
Tranquillisers	Used	7	36.8	25	55.6	11	57.9	10	33.3	8	18.6	61
	Never	12	63.2	20	44.4	8	42.1	20	66.7	35	81.4	95
	Total	19		45		19		30		43		156
D.F = 8		Chi-square = 15.98070						P.Value = < .0030				
Solvent	Used	1	5.3	9	20	5	26.3	0	0	2	4.7	17
	Never	18	94.7	36	80	14	73.7	30	100	41	95.3	139
	Total	19		45		19		30		43		156
D.F = 8		Chi-square = 14.50974						P.Value = < .0058				
Other	Used	14	73.7	43	95.6	19	100	30	100	32	74.4	138
	Never	5	26.3	2	4.4	0	0	0	0	11	25.6	18
	Total	19		45		19		30		43		156
D.F = 4		Chi-square = 20.98254						P.Value = < .0003				
Keys : D.F = Degrees of freedom Col% = Column percentage P.Value = Probability value												
Source : Fieldwork Study, 1993												

Table 6.8 shows statistically significant differences between the use of drugs and the living situation. The prevalence rates of heroin and barbiturate use are higher among respondents who are living with their parents and their mothers only than other respondents. This is because most of them are in their twenties and drug users in this age group usually use hard drugs in large quantities in order to achieve maximum intoxication and euphoria. This may be accompanied by low of education of their parents or few of their knowledge concerning the dangers of drug use. Uneducated people make up to 30% of the U.A.E. population. (Ministry of Social Affairs, 1990). As one of the respondents said:

I was brought up in a Bedouin family. My parents knew nothing about drugs. I have learned about alcohol, hashish, tablets, heroin, and opium from my friends and became addicted to heroin. My parents are uneducated and they do not know the dangers or the withdrawal symptoms of drug abuse. There have been times I have been suffering in front of them from withdrawal symptoms but they believed that I had some sickness or jinn.

The table shows that the prevalence rates of the use of most drug types are low among respondents who are living with their friends and relatives. This may be because not all of their friends are drug users, and therefore they try to avoid using drugs in front of their friends or relatives because some of them may be police informants. What these findings suggest is that drug use is seen to be more associated with those who are not living in their own houses. Most of those are U.A.E. nationals who are living with either both parents or mothers who were divorced, separated or widowed. This is because most of them are single people, and it is usual for single people in the U.A.E. to live with their parents until they get married.

Financing drug use

The findings show there is a relationship between financial resources and continuation of drug use, experimentation with new types, multiple drug use, extended drug use

sessions, and physical and psychological dependence on drugs. When a society has access to money, drugs become accessible from within or outside the society. Access to large amounts of money can maintain the availability of drugs. It can also reduce the risk of arrest; this is because drug users with more purchasing power tend to buy drugs in larger quantities, kilos instead of grammes, which reduces the contact with drugs dealers or suppliers and thereby the risk of arrest. For drug users, the financing of drug use is more important. When their income is low they may be reduced to committing crimes such as theft or drug dealing in order to finance their drug use. When U.A.E. drug users run short of money, they prefer to deal in drugs rather than to steal. Some of them explained that it is more shameful to steal than to deal in drugs. Alongside the money, drug dealing also supplies drug users with their drug needs. For non-U.A.E. drug users, the main source for financing drug use is their job. Once dismissed from their job, they move into drug dealing, not only to finance their drug use but also to continue sending money to their families outside the U.A.E.. As one of the respondents said:

I was living in Kuwait before I came to the U.A.E.. Because I was a drug user and needed to finance my drug abuse I became involved in the illicit drug trade. I dealt in the drug trade for some time in Kuwait. I used to bring drugs into Kuwait from India, Pakistan, Turkey, Iran, Lebanon and Syria. Because the illicit drug market in the U.A.E. was so profitable and because drug prices were higher than in Kuwait, I transferred my activities in illegal drug trade to the U.A.E..

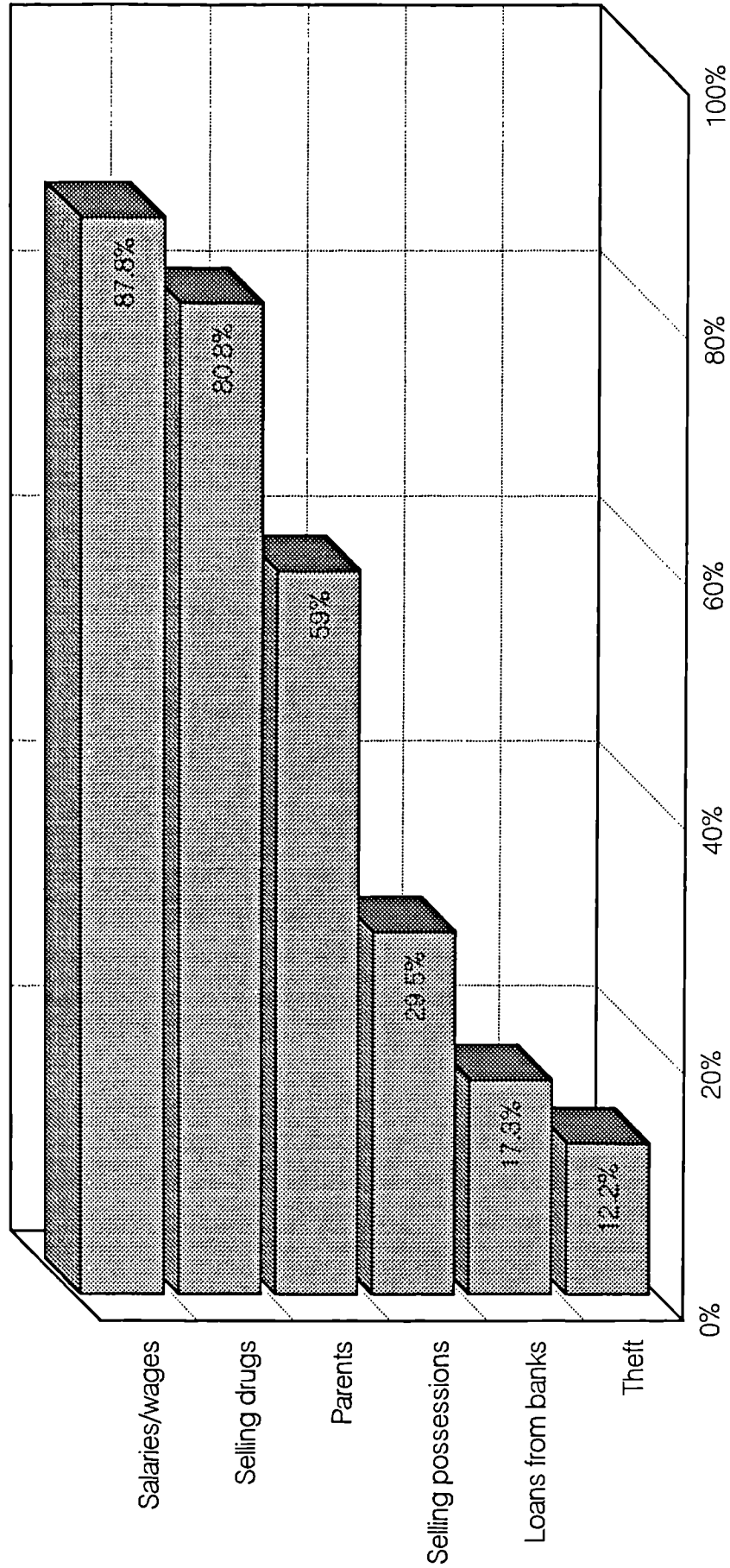
Most expatriate drug users being unskilled, uneducated and earning only a low income, they prefer to deal in drugs than to look for another job. This is because dealing in drugs is more profitable than working. The survey findings show that whenever the income is low the quantities of drug used falls, the types of drug used are cheap, and sometimes the low income even leads to discontinuation of drug use. Drug users in the U.A.E. who have a low income or limited financial resources tend to use only one type of drug, the cheapest; mainly cannabis or marijuana, and do not use expensive types such as heroin

or cocaine. For drug users who are U.A.E. nationals, sources of finance for drug use are many, especially from parents, relatives, business, jobs and drug dealing. When dismissed from their job, they face no difficulties in obtaining money for their drug use. Most of them depend on their parents and relatives to finance their habit. Access to excellent financial resources reduces their need to be involved in crimes such as theft and burglary to finance their drug use. Some of them have said that the main reason behind their dealing in drugs is not because it is a lucrative business but because it maintains the constant availability to them of the drugs they use. No doubt with every good intention, parents in the U.A.E. tend to give their children a lot of pocket money without realising the consequences of their act. Access to legitimate financial resources for drug users reduces involvement in crime to finance drug use. Drug use will continue until drugs become less available, and the long-term negative consequences for drug users, for their families, and for society will be significant.

Figure 6.8 shows that most respondents depended on their salaries and wages as a main financial resource for drug use. Selling drugs was the second financial resource for most respondents, followed by money from parents, family and relatives. Some respondents would sell their possessions in order to obtain money for drug use. Some respondents in work would get loans from banks in order to spend on drug use. Theft was also a financial resource for some respondents.

Most respondents used their salaries/wages at the start of their drug use. When dismissed from their job, they would try to obtain money by selling drugs. When selling drugs proved too difficult, they would turn to their parents, families and relatives. Those who found it difficult to obtain money from family or parents would progressively sell their possessions, especially expensive watches and cars. Findings show statistically significant differences between the financial resources available for drug use and the nationality of drug users. U.A.E. nationals are more dependent than other respondents on parents,

Figure 6.8
Financial resources for drug use (%)



families and relatives as a financial resource (79.5%). This is partly because most of the U.A.E. drug users are younger than other nationalities, and partly because their families can afford to spend a lot of money on them. As one of the respondents stated:

I used to get money for drug use from my family. I had my own bank account. This is because my family is very wealthy.

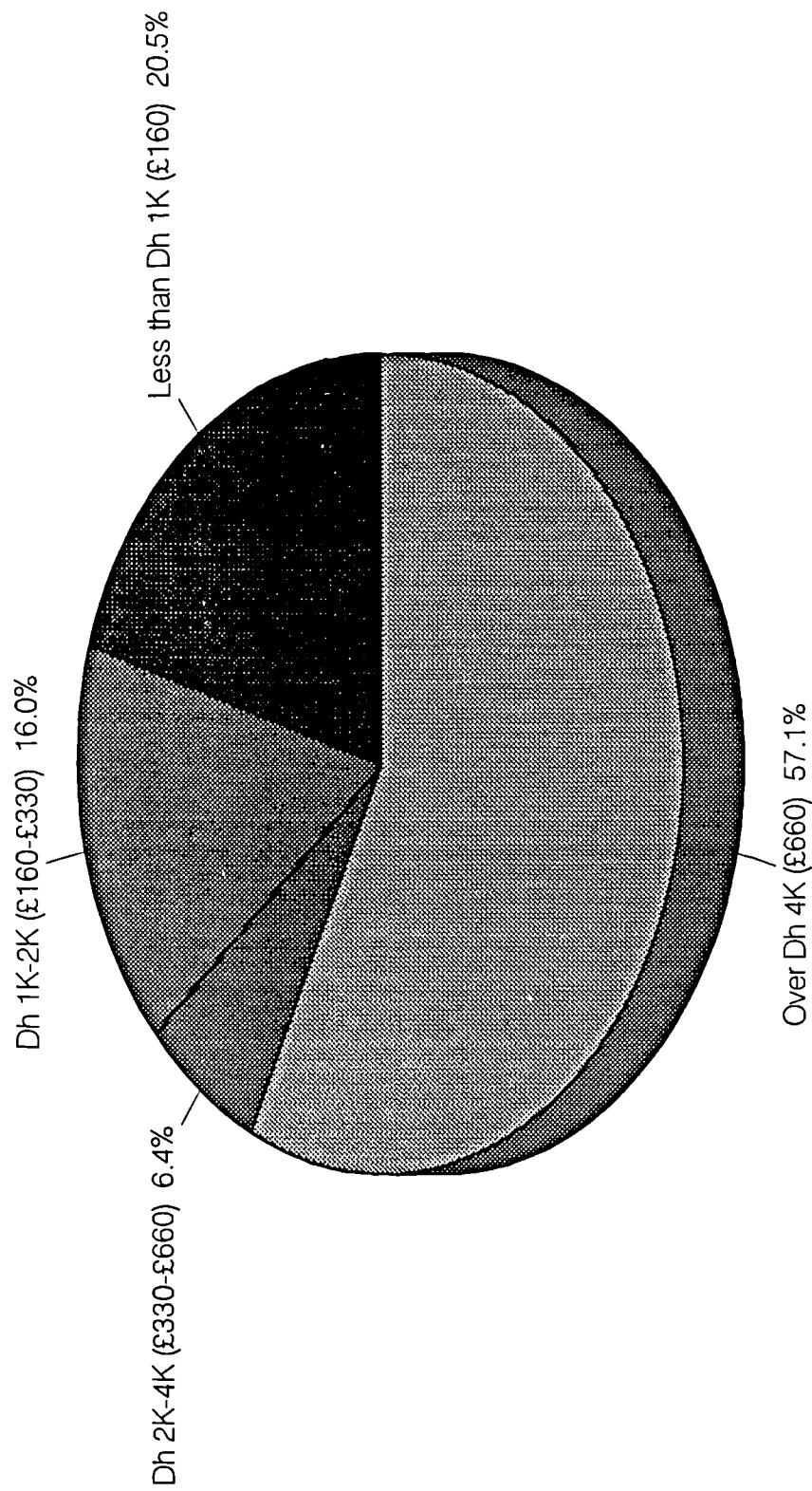
Users of other nationalities do not depend on their families/parents for obtaining money, because most of their families/parents are not living with them in the U.A.E. or else are not able to give them money. Most of them are older than the users from the U.A.E.. U.A.E. nationals depend more than respondents of other nationalities on selling their possessions to obtain money for drug use (42.5%). The most expensive things they sell are their expensive watches, cars and wife's jewellery. As one of the drug abusers said:

I began taking opium when I was young. I continued to use it until I became an addict and couldn't stop. Because I was in need of money to buy opium, I sold a lot of my property and possessions. Even my wife's jewellery has been sold. When I lost everything I became involved in the drug trade in order to finance my opium habit.

U.A.E. nationals are more likely than respondents of other nationalities to secure loans fraudulently from banks to obtain money for drug use (28.8%). U.A.E. nationals also depend more than respondents of other nationalities on theft as a financial resource for drug use (20.5%). This is because U.A.E. drug users use hard and expensive drug types; most of them are addicted to heroin which compels them to obtaining money by any means. They usually start by stealing from their parents, families, relatives and friends. Drug selling and theft are the two main sources of money for drug use for those who are using heavier drugs and addicted to heroin.

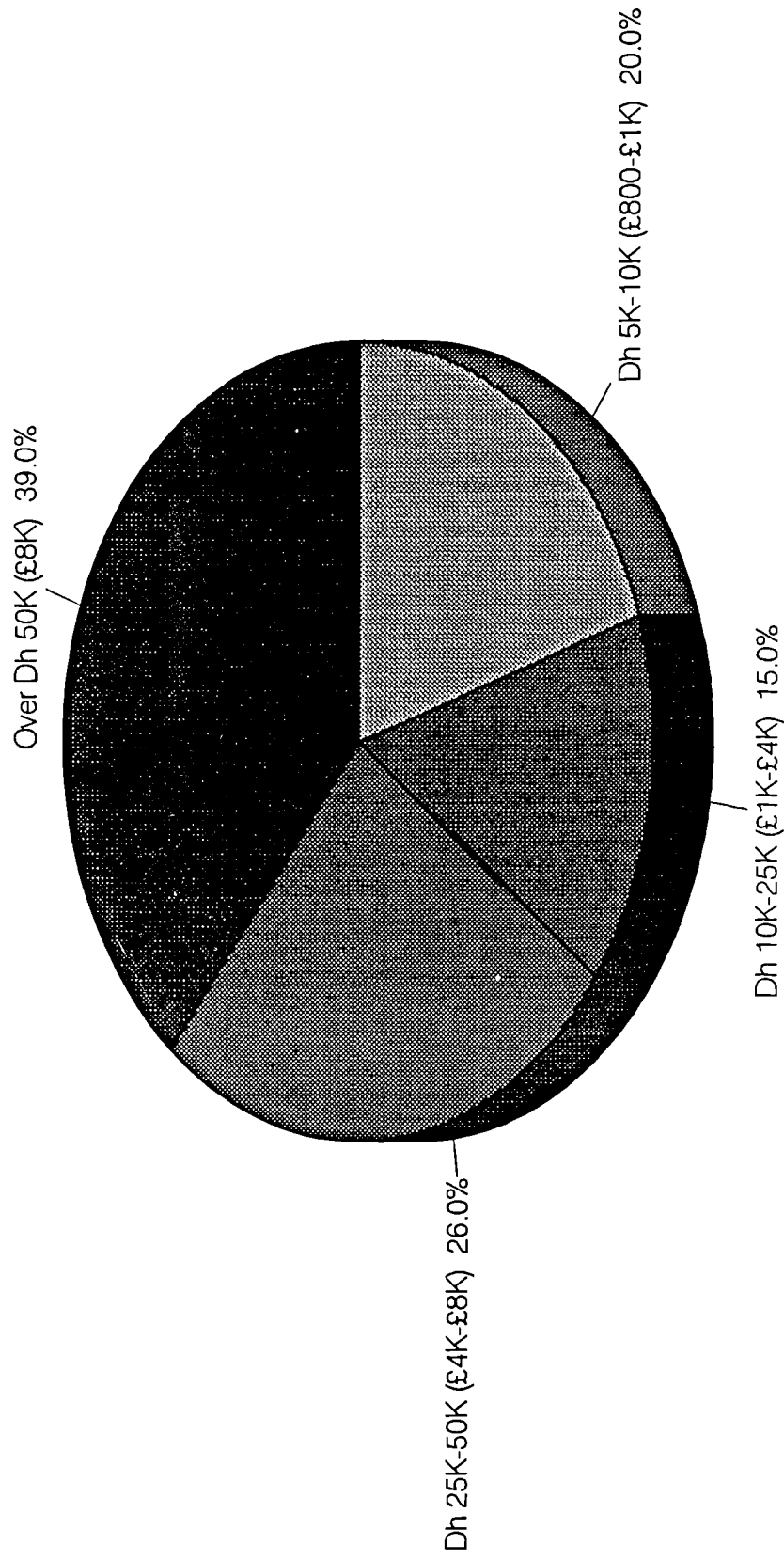
The cost of drug use depends on the type of drug, the quality, the user's experience, the availability of drugs in the market, whether they get their drug from the U.A.E. or from outside the U.A.E., the method of drug use and the availability of the money. Data in

Figure 6.9a
Cost of drug use in a month (in dirhams) with percentage of respondents



Dh = dirhams; K = 1,000 units (e.g. Dh 50K = 50,000 dirhams, £9K = £9,000)

Figure 6.9b
Respondents spending more than 4,000 dirhams a month (£660) as a percentage



Dh = dirhams; K = 1,000 units (e.g. Dh 50K = 50,000 dirhams, £8K = £8,000)

Figure 6.9a show that over half the respondents were spending monthly more than 4,000 dirhams (£650) on drugs. A fifth of respondents spent less than 1,000 dirhams (£160) a month. Respondents spending between 1,000 and 2,000 dirhams (£160 - £330) a month ranked third, followed by respondents spending between 2,000 and 4,000 dirhams (£330 - £660) a month.

Figure 6.9b shows that of respondents spending more than 4,000 dirhams a month, most of them were spending more than 50,000 dirhams (£8,000) a month, followed by those spending between 25,000 and 50,000 dirhams (£4,000 - £8,000) a month, those spending between 5,000 and 10,000 dirhams (£800 - £1,600) a month, and those spending between 10,000 and 25,000 dirhams (£1,600 - £4,000) a month. The monthly income which respondents earn from their job is between 1000 dirhams (£200) and 6000 dirhams (£1000). This low income does not cover the high cost of drug use. Therefore, in order to finance their drug use, most drug users become involved in the drug trade or crime.

Table 6.9: Cost of drug use and nationality

Nationality	U.A.E.		Arab		Asians & Others		Total	%
	Count	Col%	Count	Col%	Count	Col%		
Less than 1,000 Dirham *	6	8.2	4	13.3	22	41.5	32	20.5
1,000 -4,000 Dirham *	11	15.1	8	26.7	16	30.5	35	22.4
More than 4,000 Dirham *	56	76.7	18	60	15	28.3	89	57.1
Total	73		30		53		156	100
D.F = 4	Chi-square = 33.61852				P. value = < .0000			
Keys :	* Pound = 6 dirhams				Col% = Column percentage			
	P.value = Probability value				D.F = Degrees of freedom			
Source : Fieldwork Study, 1993								

Table 6.9 shows high statistically significant differences between a respondent's nationality and the monthly expenditure on drugs. Most respondents spending less than 1,000 dirhams (£160) a month on drugs were Asians (41.5%). Asians are also more likely than other nationalities to spend between 1,000 and 4,000 dirhams (£160 to £660) a month (30.2%). This is for a number of reasons. Most Asian drug users living in the U.A.E.

use light affective drugs, cheap drugs such as hashish and marijuana. Moreover, most earn low salaries/wages and cannot afford expensive drugs. Few are addicted physically to hard drugs such as heroin which may force an addict to buy. Asian respondents are employed in the private sector, working more than eight hours a day, and consequently have little time to spare on using drugs. Some of them supply themselves from their own countries where drug prices are significantly cheaper than in the U.A.E.. Asian drug dealers usually take into consideration the financial situation for Asian drug users, and consequently charge them less than they charge U.A.E. nationals. Some assist U.A.E. drug users by working for them as middleman in obtaining drugs from dealers. In return, they receive money and drugs. Asian drug users living in the U.A.E. rarely share their drugs with friends, in order to eke out what little they can afford.

Over three quarters (76.7%) of respondents who spend more than 4,000 dirhams a month on drugs are U.A.E. nationals. Most of them spend between 25,000 and 50,000 dirhams a month (£4,000 to £8,000). Ranking second are respondents from other Arab countries. Some respondents from other GCC countries spend the same as respondents from the U.A.E.. There are reasons for U.A.E. nationals spending these large sums on drugs. Most U.A.E. drug users are heavy users of heroin, which is expensive: a gram of heroin costs 500 dirhams (£80). Drug dealers of other nationalities ask more money from U.A.E. drug users than from other nationalities. The purchasing power of U.A.E. users is greater than that of other nationalities. The main source for U.A.E. drug users is the local drug market, which is more expensive than outside the U.A.E.. The U.A.E. drug user has better access to finance than other nationalities. Some U.A.E. nationals who are worried about their reputation can afford to employ other people to assist them in obtaining drugs. Some U.A.E. drug users can afford to rent flats or hotel rooms in order to use drugs in peace, and in order to evade the prying eyes of law enforcement agencies. U.A.E. drug users usually help each other out; if one is short of drugs and has no money, his friends can give him some. This help is self-interested, not altruistic. They help him not because

he is a friend, but because he is an addict. If he fails to get his fix, and starts to suffer from withdrawal symptoms, he might seek help from family or police, the price of which may be to report the names of his friends to his family or to the police.

The quality of the product also affects its prices. For instance, 100 grams of heroin from Afghanistan or Pakistan costs 10,000 dirhams (£1,600), whereas the same amount from Iran cost 6,000 dirhams (£1,000). There are discounts for buying in bulk; for example, 10 grams of heroin on the street costs about 5,000 dirhams (£800), but bought wholesale, the same amount works out at 1500 dirhams (£250). This price depends on the availability of money with the user and also on the need of the seller for money. The drug seller sometimes regulates the price of his product in accordance with the drug user's state. If the drug user is suffering from withdrawal symptoms and is desperate for a fix, the drug seller may raise the price in the knowledge that he can exact any price for his product. In this state the drug user has little choice other than to buy the drug.

Moreover, drug prices increase as the risks involved in trafficking increase. Drug prices increase both with distance from which the product is brought to the place of use, and also with the number of staging posts. For instance, the price of heroin produced in Pakistan rises when the product enters Iran, and then rises again between Iran and the U.A.E.. Because the U.A.E. is boarded by Iran, drug prices in the U.A.E. market are lower than in other GCC countries. A gram of heroin in the U.A.E. costs 500 dirhams (£80) but the same gram in Bahrain costs between 60 and 100 Bahraini Dinar (£60 - £160), and in Saudi Arabia more than 1,000 Riyal (£160). Some drug addicts who are able to travel abroad travel to countries where the price of drugs is low. Many young drug users who are U.A.E. citizens, especially those heavy users, travel to drug producing countries. They stay there for a while, using drugs, and when they return they bring some for their use, and maybe some to sell to friends. The price of drugs in such countries is low. A gram of heroin in Thailand costs US\$3, and in India costs US\$1.5.

Drugs are usually sold into different amounts in the U.A.E. drug market. Opium is usually sold in a plastic bag shaped like a pen and known among users as an 'opium pen'. Each pen contains between 25 and 50 milligrams of opium, and costs between 200 and 400 dirhams (£30 - £60) in the U.A.E. drug market. Hashish is sold by the tola (a tola is an Indian weight unit = 11.664 grams). Each tola costs between 350 and 500 dirhams (£60 - £80). For a short-term user, one tola of hashish can last more than a month, but for the long-term user, one tola may be used up in a week. The best hashish in the U.A.E. drug market is from Pakistan. There are three types: Shetrak, Triple Zero, and Habib Allah. Lebanese hashish, called al-Zahrah al-Lobnaniyah (Lebanon flower), ranks second. Most Pakistani hashish is first smuggled into Iran, and from there into the U.A.E.. A kilo of hashish in Iran costs between 30,000 and 45,000 Iranian Tomans (£150 - £300). The same product sells in the U.A.E. for between 7,000 and 35,000 dirhams (£1100 to £5800). Heroin is usually sold by the gram, and because it is expensive most users are unable to buy heroin by the kilo. The price of a gram of heroin in the U.A.E. drug market rarely exceeds 500 dirhams (£80). Heroin is also sold in containers. The 'al Kodak' (Kodak film can) contains about 25 grams of heroin, and costing between 4,000 and 5,000 dirhams (£650 to 800). There are also heroin bags, each bag containing between 25 and 50 grams, and costs between 4,000 and 10,000 dirhams (£650 - £1,600). The actual amount called a 'gram' is not precise, and may be inaccurate. Drug dealers and sellers divide the heroin into grams without using scales. The buyer rarely has the time or opportunity to rescale the amount sold. As a result, the weight sold as a 'gram' differs from one Emirate to another, and from one dealer to another. For instance, a gram of heroin bought in Sharjah will make between 3 and 4 doses, whereas a 'gram' bought in Dubai will make between 8 and 10 doses, and a 'gram' bought in Abu Dhabi will make between 10 and 12 doses. There are several reasons for these differences:

1. There is a difference in the purchasing power of drug users in each Emirate, drug dealers preferring to deal with users who will pay more.

2. The confidence and reputation of the dealer are important factors. The best dealers who are known among drug users to sell the best quality heroin which is perfectly scaled are the Baluchis. Those dealers concentrate their activities in Abu Dhabi and Dubai more than in other Emirates, because they prefer to sell their product in larger quantities, and users in Abu Dhabi and Dubai have a greater financial ability to buy in large amounts compared with users in other Emirates where purchasing power is weaker (see Chapter 3).
3. The drug dealer usually reduces the amount of the 'gram' in order to guarantee that the amount will be used for the user only, and not give any away to someone who might turn out to be a police informant who would use the amount of drugs as evidence against the dealer.
4. The relationship between the drug dealer and the user also affects the amount and the purity of the gram. The dealer attempts to keep customers who have been buying drugs from him for a long time by giving them more perfectly scaled and purer drugs.

The shortage of cocaine in the U.A.E. illicit drug market keeps its price high. A gram of cocaine costs about 1,500 dirhams (£250). A gram in Lebanon costs between £30 and £50. Cocaine in the U.A.E. is used only by the wealthy. The cocaine market is monopolised by Lebanese and Syrian drug dealers. Cocaine supplies enter the U.A.E. from Lebanon, which is used as a re-exportation zone for cocaine from the U.S.A. and Europe.

Qāt, used by Yemeni and Somali people, is also available in the U.A.E. illicit drug market. A kilo of *qāt* costs about 500 dirhams (£80). *Qāt* users spend a lot of money on *qāt*. The *qāt* user usually uses *qāt* with family members, relatives and friends, and so has to buy large quantities for each meeting, which may take anything from 3 to 6

hours. As a special favour to the guests, *qā't* is considered a good thing to give to your guests.

Summary

Drug use in the U.A.E. is not restricted to a specific nationality or ethnic group, but is to be found among most nationalities regardless of country of origin. The high number of drug users who are U.A.E. nationals is a dangerous indicator for U.A.E. society. This is because U.A.E. nationals comprise only about 27.1% of the U.A.E. total population and the immigrant nationalities make up about 72.1%, and therefore the rate of drug use among U.A.E. nationals is high. The findings showed that the age group 18 to 29 years is most likely to be involved in drug use in the U.A.E.. Most drug abusers are young, in their teens and twenties. The findings showed a significant correlation between drug use and leaving school early. This is not only because of the low educational attainment, but because early involvement in a job gives young people access to the high salaries provided by some employers such as army and police which in turn enable them to access drugs. To explore drug abuse patterns in the U.A.E. in greater depth, the next chapter will examine drug-related activities and behaviour, in particular causes and motivations behind drug abuse, especially the impact on drug abuse of the availability of drugs in society. Psychological and physical consequences of drug use will also be examined.

Chapter 7

Patterns of Drug Abuse Behaviour

Introduction

There are various pressures experienced by drugs users which motivate them towards using drugs. These pressures, whilst they vary from user to user, are similar the world over (Glassner & Loughlin, 1987). The restrictions on drugs use involve availability, both in the presence of a drug on the market, and also access to the money to pay for the drugs. Drug enforcement measures help to reduce overall levels of availability. Access to a wealthy, modern lifestyle in the U.A.E., however, aids access to drugs, especially when they can be imported from overseas. Drug use prevention depends on understanding the motivation and consequences of drug use. In this chapter I will examine drug-related activities and behaviours, in particular underlying causes and motivation towards drug use and the prevalence rate for drug use, including the drug types used by drug users in the U.A.E., how the availability of drugs entices new users into using drugs and encourages experienced users to continue to use drugs, drug sources and access to suitable drug sources, methods of administration, frequency of drug use, locales for drug use, patterns of drug usage sessions, and the consequences of drug use. Psychological and physical experiences will be examined, as will the relationship between drug use and anti-social behaviour. I will also examine drug treatment and factors behind the continuation and discontinuation of drug use, seeking medication, medication experiences, medication in psychiatric hospitals and in jails, and the satisfaction or otherwise of drug users who have undergone treatment. The information in this and the next chapter is based on my structured questionnaire conducted with drug abusers in the U.A.E..

Initiation Into Drugs Use

There are many explanative models of drug use which seek to account for factors influencing drug use (Rushing, 1975). Different models variously emphasise environmental, social, cultural, family, peer pressure and psychological factors. No single conceptual model is accepted globally or is even necessarily applicable globally. There is not even one model which is generally preferred over others. There are many reasons why people use drugs. Some people use drugs to have fun, to feel good, to go along with what their friends are doing, and because they are unrestrained by parental supervision. Some people have dysfunctional personality traits, poor communication skills, or faulty attitudes and beliefs. Drug use is not associated with the individual personality alone, but with the difficulties in personal relationships among family members and between stressful forces in community. As one of the respondents stated:

I was a famous football player and then I broke my leg and was in hospital for six months. After I was discharged from hospital I stayed in my house and was unable to play football which I love. Consequently, I became very depressed. Then I made some friends with whom I started to drink alcohol and use hashish and heroin. I did not pay attention to my parents' advice to avoid having friends who used drugs. This is because I was happy when I was with these friends.

Certain circumstances may predispose the individual toward drug use, especially when money and drugs are readily available. Drug use is an easy way to respond to frustration and difficulties. Historically, a wide variety of drugs have been used by individuals in their efforts to cope with life. Some people cope with difficulties in life by using drugs or by social withdrawal into isolation, whereas others manage without drugs or withdrawal. The difference between these two groups of people may be attributable to differences in personality traits between individuals, previous experiences of the individual in the family and the way in which he/she was brought up, the degree the social environment influences the individual, or the impact of social processes on the guidance of the individual activity to or from different types of behaviour.

Broader social motivations towards drug use include legal, economic, social and cultural circumstances.

A drugs user cannot use drugs that are unavailable, and is less likely to use drugs if they are difficult to obtain. Therefore, an individual who lacks access to drugs will not use them even though motivated to do so. My research findings suggest that the reasons behind drug use are global and there is little difference between the motivations of drug use in the U.A.E. and those elsewhere in the world (Glassner & Loughlin, 1987).

Findings in Figure 7.1 show that most respondents have reported that the reason they used drugs, in order of priority, was to make them feel better, to enjoy themselves with their friends, to escape from their problems, because they cannot stop it, and to increase sexual activity. One of the respondents said:

Taking hashish makes me think better; become more polite when I am talking with other people; and I feel very happy and hungry. Heroin use makes me very nervous and selfish. When I use opium I feel very comfortable and it enhances my sexual desire.

Some of them also have reported that they used drugs for other reasons such as a pain killer or a medicine for anxiety or insomnia. As one of the respondents said:

Opium use helps me to avoid the pain of a renal disorder. I had medical surgery but the problem recurred again. When I use opium I feel more comfortable.

A number of respondents also reported that they used drugs in order to go along with what their friends are doing. Most respondents have said that the positive effect of a drug is the main factor prompting the use of drugs. As one of the heroin users said:

In the beginning, taking heroin is very good and gives intense pleasure. Two weeks later the user has become addicted and he must continue to use heroin to avoid withdrawal symptoms. Before addiction, the positive effects of heroin last about 8 hours after use. But when a user becomes addicted to heroin, its effects last for only an hour.

Figure 7.1
Factors behind drug use (% of respondents)



They said that when the experimental user felt better as a result of using drugs, he would use the drug again if available. The heavier users especially those who are addicted to particular types of drugs feel better when they use drugs because they may have been suffering from withdrawal symptoms. Both of these explanations are connected with their happiness with the use of drugs because they cannot be happy under non-drug circumstances. Those who use drugs to enjoy themselves with their friends associated their enjoyment of time with their friends with the use of drugs.

There were other factors behind drug use among people in the U.A.E.. Some drug users stated that there is a lack of preventive measures in the society. The drug prevention policy in the U.A.E. depends solely on threats to drug users by government bodies to punish them with high penalties, even though this may not be effective in decreasing the drugs problem. As one of the respondents said:

The individual who knows the dangers of drug abuse should not accept the life of drug use. The individual needs to be guided towards the right path, and the mass media could play a worthwhile role in prevention. However, the preventive approach of some police - that of threatening the punitive consequences of abuse - in session with users is unlikely to have positive results.

The lack in the U.A.E. of youth welfare centres, social welfare and the absence of solutions for youth problems such as housing, high cost of marriage, etc. exacerbates the use of drugs among people. Problems which have been mentioned by users fall into several categories. First, educational failure and young people working without proper qualification and who face difficulties of adapting to a job: all these have affected their career life and their behaviour. Second, the effects of social change and difficulties in adapting to a society made up of many different nationalities. Third, the consequences of separation, divorce or death of parents, lack of parental love and care, and the lack of family control on children's behaviour. As one of the respondents stated:

After the divorce of my parents and re-married to other partners I went to live with my grandmother who was an old woman. I used to go out a lot and spent a lot of time with friends but there has been no-one to supervise me. Through my relationship with my friends I have learned drug abuse.

Fourth, there is the lack of the parents' education, child abuse and severe disciplining.

As one of the respondents said:

I experienced many difficulties in my childhood. My parents used to be too aggressive with me. They were worried I would become deviant, and so didn't allow me to go outside the house alone. I attended a public school but I did not feel free because my life was limited to school and home. Later I attended a military boarding school. At this school I met some friends and felt free and happy. It was there that I learned about alcohol, hashish and heroin.

Fifth, the early undertaking of responsibility for the family could be disastrous for a young person. Some families, in desperate need of money, send their children out to work rather than allow them to continue their studies. This applies especially to those who do not have U.A.E. nationality which means they have no right to state support.

Sixth, some young people who fail to continue their studies leave school early and are therefore young when they get involved in work and face the difficulties of getting a job.

Those who lack education may experience difficulties in obtaining needs such as houses, cars, and other social needs such as marriage. Seventh, as kinship ties become weaker and because parents in the U.A.E. increasingly are employed outside the home or the engagement of some parents in luxurious lifestyles, the socialization of young people is being left to other people, such as expatriate workers and friends. As one of the respondents said:

I did not complete my education. I left school early when I was in the intermediate school. I was living with my aunt and her blind husband. My aunt's husband was suffering from cancer and was using opium as a pain killer. When I was 14 years old I tried opium through my aunt's husband and after that I became experienced with many types of drugs.

Eighth, some people in the U.A.E. who need special care to cope with senility problems, use drugs as a medicine or solutions for their problems. Finally, there is a relationship between drinking alcohol and drug use. Some respondents have said that there is inability to imbibe alcohol without drugs such as hashish, marijuana, and pills. They believe that drug use with drinking alcohol makes them more intoxicated and is therefore more enjoyable.

Table 7.1: Factors behind drug use and nationality

Nationality		U.A.E.		Arab		Asians & Others		Total	%
The Reasons		Count	Col%	Count	Col%	Count	Col%		
The use of drug makes me feel better	Yes	56	76.7	21	70	50	94.3	127	81.4
	No	17	23.3	9	30	3	5.7	29	18.6
	Total	73		30		53		156	100
D.F = 2		Chi-square = 9.4996				P. value = < .0087			
To increase sexual activity	Yes	23	31.5	14	46.7	28	52.8	65	41.7
	No	50	68.5	16	53.3	25	47.2	91	58.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 6.12629				P. value = < .0467			
I cannot stop it	Yes	51	69.9	13	43.3	9	17	73	46.8
	No	22	30.1	17	56.7	44	83	83	53.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 34.66852				P. value = < .0000			
Keys :		D.F = Degrees of freedom				Col% = Column percentage			
		P.value = Probability value							
Source : Fieldwork Study, 1993									

As stated above, there is little difference between reasons behind drug use in the U.A.E. and in other communities in the world. Even among different groups of people in the same society the broad reasons which lead to drug use are similar. However, some reasons behind drug use encourage some people to use drugs more than others; for instance, peer pressure is more influential on young people than on old (Glassner & Loughlin, 1989). The effect of the reasons which lead to drug use depend on user age, lifestyle and the degree of the effectiveness of the environmental circumstances around the user. The findings in table 7.1 show statistically significant differences between

factors behind drug use and nationality. For respondents from the U.A.E., the most important factor for continuing to use drugs was because it was the only way to avoid withdrawal symptoms ($p < .0000$). Most of them are addicted to heroin and are suffering from withdrawal symptoms. Respondents from Asian citizens are more likely to use drugs for the purpose of making them feel better. Moreover, they are more likely to use drug especially, hashish because they want to forget about their problems. This may be because most of them live alone without their families and because some of them have to work very hard. Also because the general view of some dominant and influential groups in the U.A.E. especially the employers regard Asian workers as socially inferior, the socialization between the two groups is limited to the place of work. Asians also use drugs to increase sexual activity. They believe that some drugs, such as opium and hashish, motivate sexual activities. All nationalities stated that they have been using drugs to enjoy time with friends. Some people take drugs on their own. But the majority regard taking drugs with their friends as a social occasion. This means that drug use in the U.A.E., especially among young, is a group activity and therefore peer pressure is a very important factor behind initiation into drug use. Friends are the most important source of the first drugs; drugs cannot be used unless there is an opportunity to use them. As one of the respondents said:

I was living in an area near the sea where many Indian workers lived. Some of their children were glue sniffers who introduced me to solvent sniffing. After that I moved to another area where I became acquainted with some glue sniffers and started to buy sedative tablets from private pharmacies and to drink alcohol. My experiences with drugs developed from taking solvents, sedative tablets and alcohol on to using hashish and heroin. Since then I haven't been interested in doing anything except taking drugs.

It is less easy for the prospective or new drug user to obtain drugs than it is for an experienced user. The lack, therefore, of the means which gives experienced drug users access to drugs, tends to discourage prospective and new drug users. The source of the first drug is important for initiation into drug use, but is not necessarily the means by

which the new users continue their drug use. Friends, relatives, pushers, dealers, etc. are the most important sources that introduce drugs to the new user. The findings show that the first drug for most respondents was offered by a friend (78.8%), followed by those who were offered drugs by a relative (7.1%), even their fathers (1.9%). Those who were offered drugs by their relatives including fathers were Asians (mainly Iranians and Pakistanis) whom their fathers used to use drugs especially opium and hashish. Other sources of first drug use include prostitutes, taxi drivers, etc. (6.4%). Most of those who were offered drugs by prostitutes and taxi drivers were U.A.E. nationals who were offered drugs when they were travelling outside the U.A.E., especially in Thailand and India. They go on holiday to India and Thailand for the purposes getting drugs and seeking prostitutes as well as holidaying. As one of the respondents said:

The first drug I took was offered to me by a prostitute when I was visiting India.

Strangers also have been sources for the first drug for some respondents (5.8%). They meet their customers in luxury hotels and night clubs. Some respondents said that they trust their friends more than other people and in order to enjoy time with them they go along with what their friends are doing. As one of the respondents said:

I began using cocaine through my American girlfriend when I was studying in the USA. She explained to me that cocaine use would help me to understand my study and to be active for a longer time. I used cocaine for some time in the USA but when I came back to the U.A.E. I began to use hashish. Because of my work requirements, I was travelling abroad a lot and I obtained and used cocaine and hashish during my travels. In the U.A.E. I was not living with my wives but spending my time with my friends in my private apartment.

The type of the first drug used by the new user depends on several variables. Factors which favour one first-use drug over another include wider availability of the drug in the society, easier access to the drug, greater use among friends or relatives, lower cost, and that it can more easily induce the desired "high" and it is easier to use. Unless they are offered information related to the specific types of drugs, new drug users are unable to

choose their first-use drug type. This information usually has to include how to use the drug, how to enjoy it, and how to avoid its negative effects etc... Friends being the main source of first-use drug, they are most likely to be the people who direct the new user towards a specific type of drug, probably that which it is used among them. As one of the respondents said:

I became initiated into using drugs when I was student at school. I was happy to use hashish but one day I could not get any hashish and one of my friends offered me some heroin. I gave up heroin use for a long time. I worked for the army for some time and then I went to Greece to study. When I was in Greece I used hashish but when I returned to the U.A.E. I used heroin. This is because heroin was available in the U.A.E. especially among U.A.E. nationals. U.A.E. nationals prefer to buy expensive drug types. This is because they want to vie in boasting with one another.

The new user, having tried one type of drug, is then faced with two decisions: (a) whether to continue to use that drug; (b) whether to be introduced to new types of drugs through his/her friends. The findings in Figure 7.2 show that two thirds of respondents were initiated into use of drugs through hashish, followed by those who were initiated by using a solvent. Some drug users have reported that hashish has no bad effects on health nor does it cause physical or psychological dependence. It is cheap, commonly available, produces a feeling of happiness and intoxication, is easy to use, and is most popular drug among friends. Some respondents reported that solvents are the most common substances among young friends and are available in most shops. As one of the respondents said:

I have used solvents and alcohol since I was a child. Later I shifted to hashish and tablets, and then to heroin. During my study period in America I learned to use cocaine.

Respondents who were initiated by using opium were in third place, followed by those who were initiated by using psychotropic substances, heroin, marijuana, cough syrup containing codeine and *qāt*, and after that respondents who were initiated by using cocaine.

Figure 7.2

Type of first drug

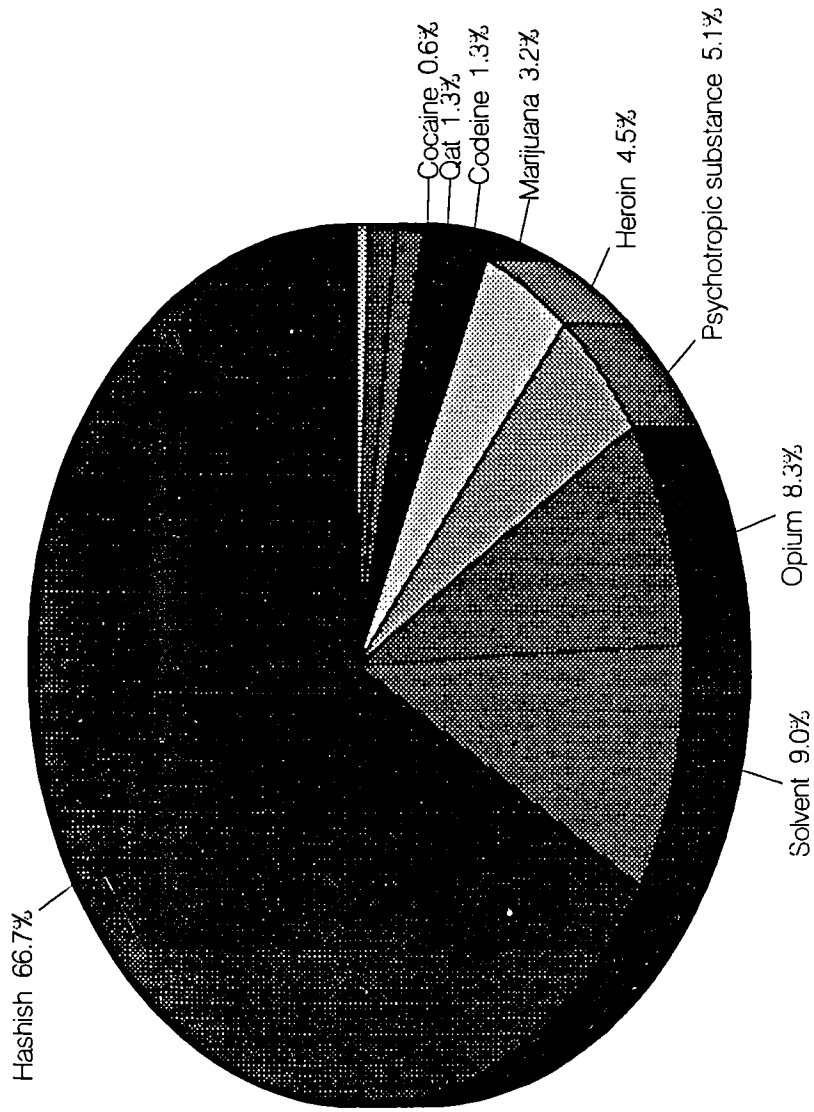


Table 7.2: First drug type and nationality

Nationality	U.A.E. Citizens		Arab Citizens		Asians & Others		Total	%
	Count	Col%	Count	Col%	Count	Col%		
Hashish	43	58.9	24	80	37	69.8	104	66.7
Opiate	8	11	3	10	9	17	20	12.8
Other	22	30.1	3	10	7	13.2	32	20.5
Total	73		30		53		156	100
D.F = 4	Chi-square = 8.92904					P.Value = < .0629		
Keys :	D.F = Degrees of freedom			Col% = Column percentage				
	P.Value = Probability value							
Source : Fieldwork Study, 1993								

It was stated above that the new user is more likely to be initiated into drug use by using the type of drug which is more available and easy to obtain. As one of the respondents said:

I was brought up in the mountainous area in Pakistan where there are hashish plantations. Hashish is sold openly in shops there and its use is spreading among people.

The opportunity to use a given drug depends, in part, on the availability of that drug in the community. For instance, in Yemen it is unlikely that the new user's first-use drug will be cocaine, which is less easy to obtain than the much more popular *qat*. In Latin America, on the other hand, the new drug user's first-use drug is much more likely to be cocaine or coca leaves than other types of drugs: coca leaves and their derivatives are more popular and available than other substances.

Table 7.2 shows low statistically significant differences between nationality and the first type of drug used ($p < .0629$). Arab citizens are more likely to have started with hashish than other nationalities. This may be because some Arab countries have been involved in planting and producing hashish such as Lebanon, Egypt, Morocco and Sudan. Hashish in some of these countries has been in common use among people for different purposes (see Chapter 3). Because the production of opiates in some Asian countries, such as Pakistan, Afghanistan, Iran, Laos and Burma, is more than in other countries, Asian citizens are more likely than other nationalities to have started the use of drugs by using opiates.

Types of drugs used

In the U.A.E. the new user, having been introduced to a specific drug, is faced with a decision about whether to continue its use. There are several alternatives: to stop using that drug and try no other; to stop using that drug but to try a different type; to continue using only that drug; to continue using that drug and to try a different type as well. The decision to continue using a specific drug depends on many variables. These variables include the opportunity to use specific types of drugs, availability of the drug, and the availability of the means to access to it. Drug users usually use drug types which are more popular, cheap, easy to use, induce fewer and less serious negative effects, and induce a pleasant feeling state such as euphoria and stimulation. Newer drug users may well experiment with a variety of drug types, but may be unable to continue the use of any one type of drug for long. After a period of time, drug users tend towards the use of those drugs which induce a pleasant feeling, are cheap, easy to obtain, etc..

Figure 7.3 shows that hashish use is the highest among most respondents, followed by respondents who used other substances such as cough syrup containing codeine, (Codipront, Phensedyl, Actifed, Benylin, Diction, Benafed, Rhinotossal, Romilar, Del-sanna), pain killer medicine (Lagaflex, M.S.T, D.F118, Distalgestic, DHC, Veganin, Pethidine), alcohol, methadone, substances for spasm treatment (Artane, Symmetril), etc. Psychotropic substances which are spreading amongst users in the U.A.E. are: Mogadon, Rhypnol, Mandrax, Surmontil, Valium, Librium, Ativan, Largactil, Ludiomil, Melleril, Tranaxen, Meprobamate, etc. The prevalence for opium use was in the third place, followed by heroin, marijuana, barbiturates, tranquillisers, cocaine, amphetamines, morphine, LSD, solvents and crack. The overall findings show that the types of drugs used in the U.A.E. are those which are increasing among users in the world generally (Salim, 1989).

Figure 7.3
The prevalent types of drug used among respondents (%)

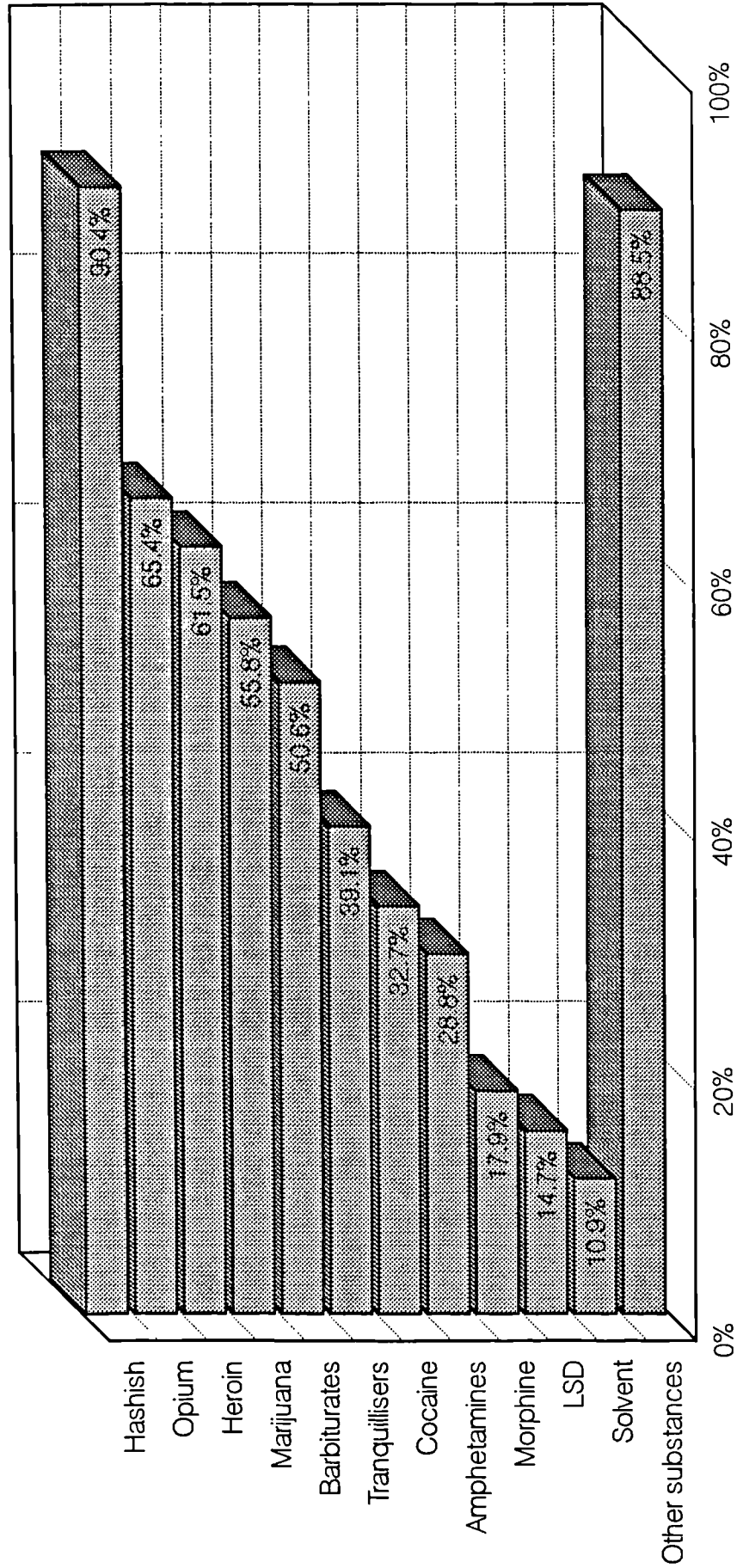


Table 7.3: Types of drugs and nationality

Drug Type		U.A.E. Citizens		Arab Citizens		Asians & Others		Total	%
		Count	Col%	Count	Col%	Count	Col%		
Opium	Used	57	78.1	18	60	27	50.9	102	65.4
	Never	16	21.9	12	40	26	49.1	54	34.6
	Total	73		30		53		156	100
D.F = 2		Chi-square = 10.46810				Probability value = < .0053			
Hashish	Used	70	95.9	27	90	44	83	141	90.4
	Never	3	4.1	3	10	9	17	15	9.6
	Total	73		30		53		156	100
D.F = 2		Chi-square = 5.85999				Probability value = < .0053			
Marijuana	Used	54	74	17	56.7	16	30.2	87	55.8
	Never	19	26	13	43.3	37	69.8	69	44.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 23.87586				Probability value = < .000			
Heroin	Used	59	80.8	19	63.3	18	34	96	61.5
	Never	14	19.2	11	36.7	35	66	60	38.5
	Total	73		30		53		156	100
D.F = 2		Chi-square = 28.53797				Probability value = < .0000			
Morphine	Used	20	27.4	6	20	2	3.8	28	17.9
	Never	53	72.6	24	80	51	96.2	128	82.1
	Total	73		30		53		156	100
D.F = 2		Chi-square = 11.74214				Probability value = < .0028			
Cocaine	Used	35	47.9	13	43.3	3	5.7	51	32.7
	Never	38	52.1	17	56.7	50	94.3	105	67.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 26.86226				Probability value = < .0000			
LSD	Used	18	24.7	5	16.7	0	0	23	14.7
	Never	55	75.3	25	83.3	53	100	133	85.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 14.96170				Probability value = < .0006			
Amphetamines	Used	28	38.4	9	30	8	15.1	45	28.8
	Never	45	61.6	21	70	45	84.9	111	71.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 8.11933				Probability value = < .0173			
Barbiturates	Used	56	76.7	14	46.7	9	17	79	50.6
	Never	17	23.3	16	53.3	44	83	77	49.4
	Total	73		30		53		156	100
D.F = 2		Chi-square = 44.06376				Probability value = < .000			
Tranquillisers	Used	39	53.4	12	40	10	18.9	61	39.1
	Never	34	46.6	18	60	43	81.1	96	60.9
	Total	73		30		53		156	100
D.F = 2		Chi-square = 15.41145				Probability value = < .0005			
Solvent	Used	14	19.2	2	6.7	1	1.9	17	10.9
	Never	59	80.8	28	93.3	52	98.1	139	89.1
	Total	73		30		53		156	100
D.F = 2		Chi-square = 10.13985				Probability value = < .0063			
Other drugs	Used	72	98.6	29	96.7	37	69.8	138	88.5
	Never	1	1.4	1	3.3	16	30.2	18	11.5
	Total	73		30		53		156	100
D.F = 2		Chi-square = 27.43480				Probability value = < .000			
Keys :	D.F = Degrees of freedom				Col% = Column Percentage				
Source : Field Work Study, 1993									

Some drug users who use drugs once or twice a month are considered occasional users, some who use drugs every week are considered regular users and other who use drugs every day are considered heavy users. Some drug users use only one or two types of drug in their lifetime experience, whereas others are considered to be multiple drug users. I think that there are many factors which determine into which category the drug user falls. The most important factor is the purchasing power of the drug user. Wealthy drug users are more likely to obtain many types of drug than are poor users. Compared to poor drug users, wealthy drug users are more likely to avoid the risk of being arrested. This is because wealthy drug users usually buy drugs in larger quantities, such as in kilogrammes, which means that they deal with drug dealers less often than poor users who, on account of their poverty usually buy drugs in grammes, and are therefore compelled to contact drug dealers more often. The purchasing power of wealthy drug users encourages them to use a wide variety of drug types, expensive types, pure and hard types. This also means that, compared to poor drug users, wealthy drug users are more likely to be physically and psychologically addicted to many types of drugs. As one of the respondents said:

In order to avoid the withdrawal symptoms I used to have 15 shots of heroin everyday.

It is possible for the long-term heroin user to use the above mentioned amount of the drug in a day. This is because street heroin is usually impure and in long-term use tolerance of the heroin's effects develop. This means that in order to achieve the same level of euphoria, the user must increase the dosage.

Table 7.3 shows high statistically significant differences between the prevalence rates for different types of drugs and respondent's nationality. U.A.E. citizens are more likely to use drug types which are widely known and used among users throughout the world. As one of the respondents stated:

I used to have every day 8 marijuana cigarettes, 4 grams heroin, 40 different sedative tablets and half a gram of opium.

These different types of drugs are more likely to be used by the long-term experienced drug user who has purchasing power and easy access to many types of drugs. However, the table shows a strong relationship between U.A.E. citizens and the prevalence rates for the use of some types of drugs: rates for the use of marijuana, heroin, cocaine, barbiturates and other substances among respondents were highest among those from the U.A.E. than among other respondents ($p < .0000$). The prevalence rates for the use of LSD ($p < .0006$), tranquillisers ($p < .0005$), opium ($p < .0053$), hashish ($p < .0053$), morphine ($p < .0028$), and solvent ($p < .0063$) were also the highest among respondents from the U.A.E. than among other respondents. The prevalence rates for some types of drugs such as opium, hashish, marijuana, and heroin are higher than other types of substances. The prevalence rate for heroin use among respondents who are from Arab countries but are not U.A.E. citizens is higher than that for other types of drugs, especially among those who are from the Gulf Cooperation Council countries. Because heroin use costs much money than the use of other types of drugs, its use is more likely to be common among those who are wealthy or have high purchasing power such as U.A.E. and the GCC nationals.

The prevalence rate for opium and hashish use was high among non-Arab Asian respondents compared with other types of drugs. This is because these substances are produced in Asia and they have been using them for a long time for many purposes (see Chapter 3). Moreover, these two substances are available and cheap in Asian countries. However, in spite of the availability of heroin in their countries, they are unlikely to use it; this because the age of the user and the street price of drugs has a controlling influence on the type of drug used. The U.A.E. respondents are younger and less experienced in drug use than respondents of other nationalities, and use different types of drug in order to obtain the best effect. Some drug users, without the experience of withdrawal symptoms from some types of drugs such as heroin, are incautious and do not try to

avoid using them. Access to the price of a fix also helped the U.A.E. respondents to obtain expensive drugs. On the other hand, Asians and other nationalities such as Africans are more experienced in using drugs and hence avoid using hard drugs, preferring to sell them to other users. Also, the income of Asians and other nationalities is less than the income of U.A.E. citizens, and therefore they tend to use less expensive drugs such as hashish unless it can be bought more cheaply outside the U.A.E.. Heroin is considered a strong drug by users. Once a drug user has used heroin, its effect is not replaceable by other types of drugs except opiates. If a drug user has been using other types of drugs and he wants to try heroin, it will be difficult for him to use it, especially at first.

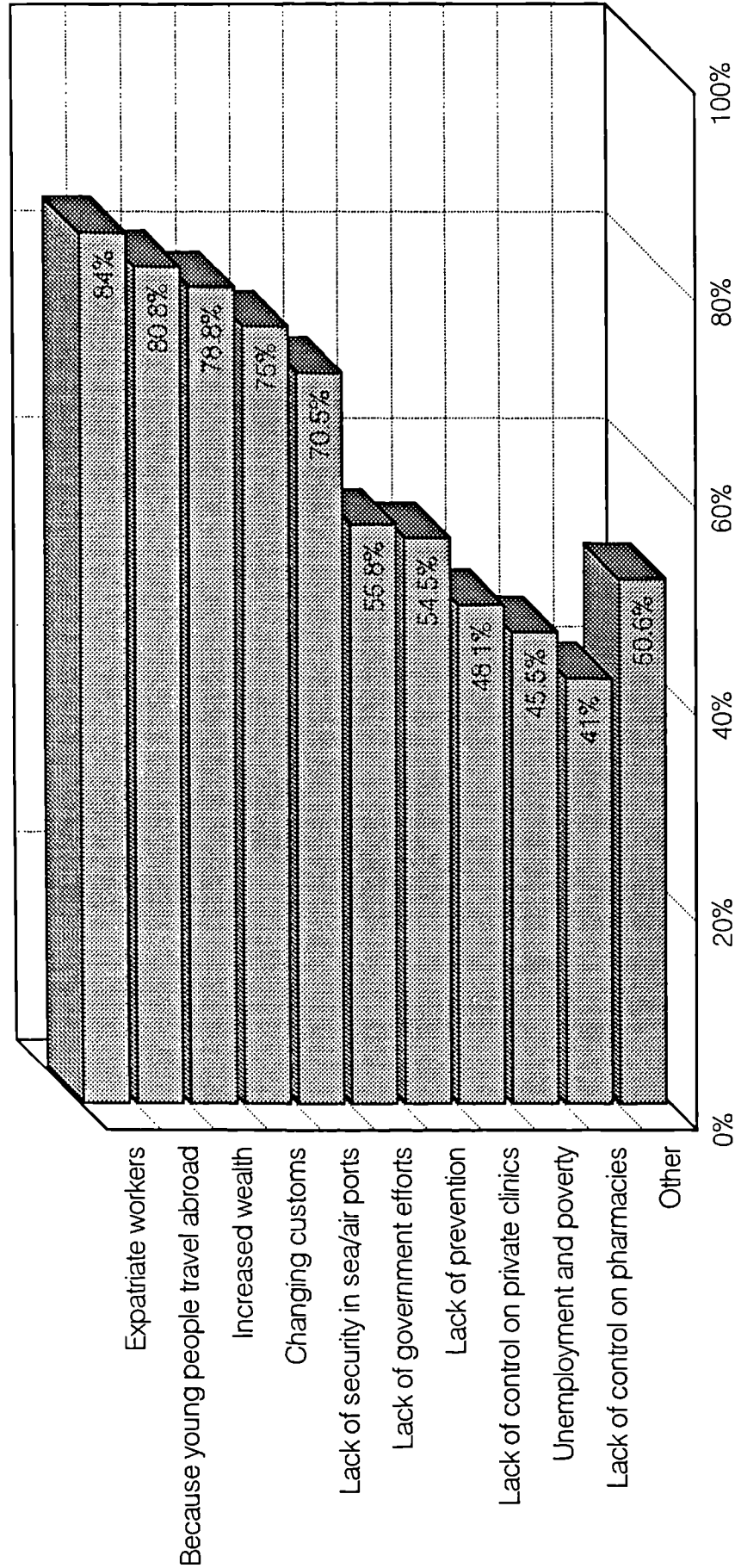
The availability of drugs

The availability of drugs is important for initiation into drug use and for the continuation of drug use. Greater availability of drugs is an enticement for new drug users to experiment with different drugs, and an encouragement for experienced users to use more than one type of drug. There is a relationship between the demand and the supply of drugs. When drug demand increases, the supply increases in response. In order to keep the illicit drug market lively, drug traffickers use a variety of tactics, including taking advantage of poor law enforcement and using more than one means to keep a drug available on the market. One of the reasons why it is difficult for law enforcement to eliminate drug use-related activities is because the drug traffickers, dealers and users all benefit from the availability of drugs in the market.

Data in Figure 7.4 show that most respondents reported that the large size of the expatriate workforce is the most important factor behind the wide availability of drugs in U.A.E. society. This is because expatriate workers make up the majority of the U.A.E. population, and most of them are Asians whose countries of origin are drug producing countries such as Pakistan, Afghanistan, India, Iran, etc.. As one of the respondents said:

In Pakistan, older people look upon the use of hashish as a bad thing, but among young people hashish is considered a means of enjoyment. Old people in Pakistan prefer to use opium as a pain killer and as a medicine for disease of senility. Opium and hashish are illegal in Pakistan but because we are a mountainous people, we can largely avoid contact with the police or with the

Figure 7.4
Factors behind the availability of drugs in the UAE (%)



authorities. Illicit drug trade in the U.A.E. is a lucrative business and brings in much money. We buy drugs from Pakistan at a very low price and sell them in the U.A.E. at very high prices.

Most of them are low paid workers, and their wages do not satisfy their needs. Drugs being relatively cheap and produced in their country of origin, some expatriate workers are involved in drugs trafficking into the U.A.E. in order to supply drug users in the U.A.E. who are willing to pay high prices. In this way, the expatriate worker can earn much more than is achievable by hard work. As one of the respondents said:

I came to the U.A.E. to work as a farmer and to earn good money. But because the work was so hard and the amount of money which I earned was so little I began taking hashish with some of my friends. I discovered that the U.A.E. has a prosperous illicit drug market which made me decide to become involved in the illicit drug trade alongside my work. I used to go to Pakistan in my holidays and on my return to the U.A.E. I used to bring quantities of drugs back, some of which I used and the rest I sold.

Young people travelling abroad alone without control from their parents was the second factor, followed by increased wealth, changing customs and traditions in society, lack of security control in sea/air ports for drug trafficking, lack of drug combat measures from government, lack of information about the dangers of drug use, social and financial problems, lack of parents knowledge about drug use, family problems, lack of control of private clinics in prescribing drugs and problems of unemployment and poverty especially among uneducated, unskilled and illegal immigrant workers in society who face difficulties in securing a job. This is because it is illegal in the U.A.E., to employ illegal immigrants. Therefore, when some of them fail to secure a job in the U.A.E. they work as drug traffickers, suppliers, pushers, etc. in order to satisfy their families needs in their country of origin. The lack of control on pharmacies in selling drugs was also a factor behind the availability of drugs in the society. The findings suggest that individuals use drugs when they are available in the society in which they live, alongside the existence of socio-economic factors which predispose individuals to use drugs. Most respondents believe that the large number of the expatriate workers has influenced the spread of drug use among people in the UAE.

Table 7.4: Factors behind the spreading of drug use and nationality

Nationality		U.A.E.		Arab		Asians & Others		Total	%
The Reasons		Count	Col%	Count	Col%	Count	Col%		
Government doesn't deal with illegal drug activities	Yes	47	64.4	19	63.3	21	39.6	87	55.8
	No	26	35.6	11	36.7	32	60.4	69	44.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 8.49360				P. value = < .143			
The changing of customs/tradition	Yes	60	82.2	24	80	33	62.3	117	75
	No	13	17.8	6	20	20	37.7	39	25
	Total	73		30		53		156	100
D.F = 2		Chi-square = 6.99860				P. value = < .0302			
There is a large number of the expatriate work force	Yes	67	91.8	27	90	37	69.8	131	84
	No	6	8.2	3	10	16	30.2	25	16
	Total	73		30		53		156	100
D.F = 2		Chi-square = 12.01514				P. value = < .0025			
Not enough security in sea/air ports for drug trafficking	Yes	59	80.8	21	70	30	56.6	110	70.5
	No	14	19.2	9	30	23	43.4	48	29.5
	Total	73		30		53		156	100
D.F = 2		Chi-square = 8.66651				P. value = < .0131			
The lack of control on pharmacies in selling drugs	Yes	44	60.3	13	43.3	7	13.2	64	41
	No	29	39.7	17	56.7	46	86.8	92	59
	Total	73		30		53		156	100
D.F = 2		Chi-square = 28.19636				P. value = < .0000			
The lack of control on private clinics in prescribing drugs	Yes	54	74	14	46.7	7	13.2	75	48.1
	No	19	26	16	53.3	46	86.8	81	51.9
	Total	73		30		53		156	100
D.F = 2		Chi-square = 45.44873				P. value = < .0000			
The lack of information about the dangers of drug use	Yes	54	74	19	63.3	12	22.6	85	54.5
	No	19	26	11	36.7	41	77.4	71	45.5
	Total	73		30		53		156	100
D.F = 2		Chi-square = 33.79787				P. value = < .0000			
Because young people travel abroad	Yes	64	87.7	28	93.3	34	64.2	126	80.8
	No	9	12.3	2	6.7	19	35.8	30	19.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 14.71113				P. value = < .0006			
Keys :		D.F = Degrees of freedom				Col% = Column percentage			
		P.value = Probability value							
Source : Fieldwork Study, 1993									

Table 7.4 shows statistically significant differences between the users nationality and factors contributing to the spread of drug use. Three factors are more common to

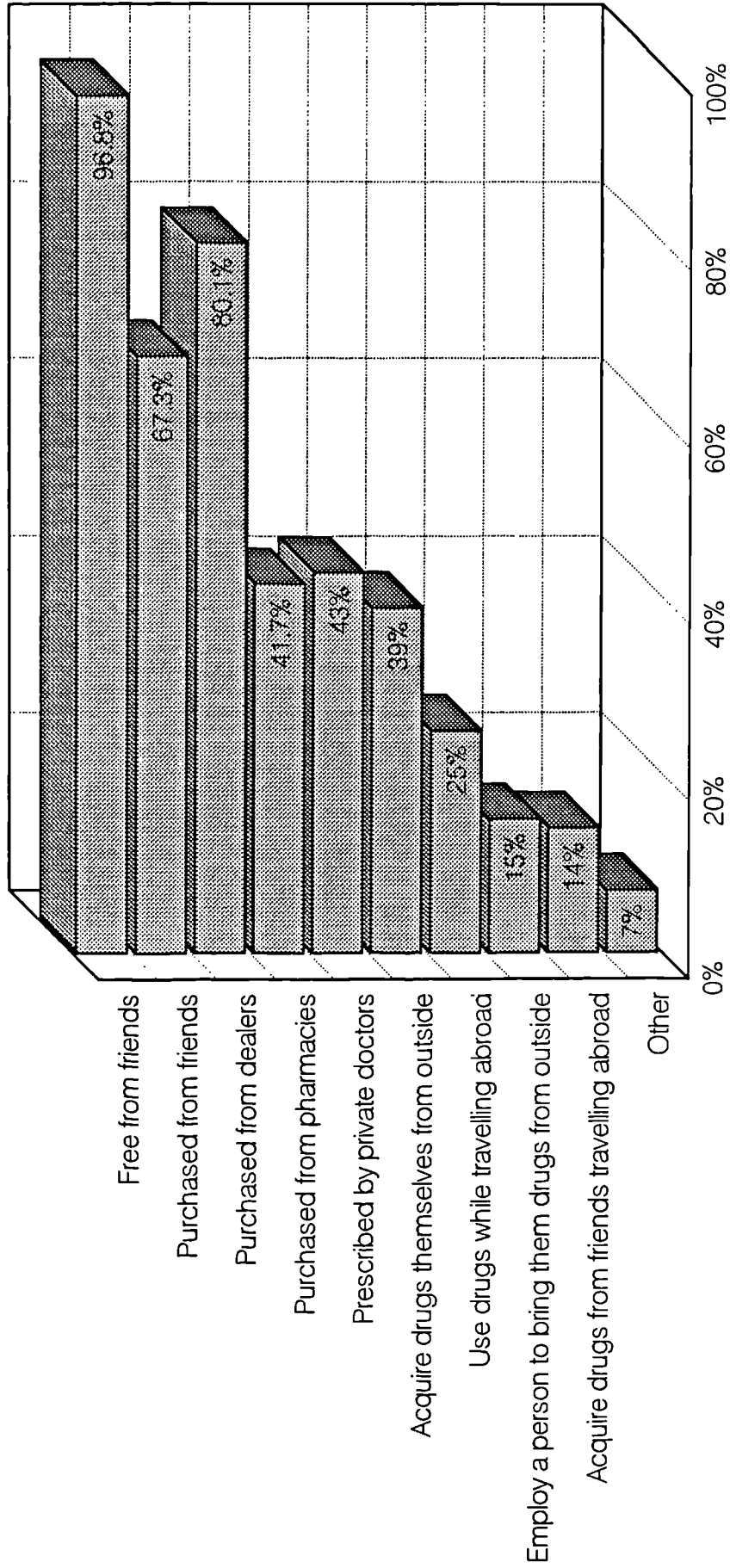
respondents of U.A.E. nationality than to other respondents. They think that the lack of control on pharmacies in selling drugs, the lack of control on private clinics in prescribing drugs and the lack of information about the dangers of drug use were the most important factors behind the spreading of drugs in society. Respondents from other Arab countries believe that young people travelling abroad and away from the authority of their parents was the important factor behind the spreading of drug use among people in the society. Respondents from the U.A.E. also believe that the changing of customs and traditions in the society have increased the spreading of drug use in the U.A.E. (see Chapter 3). They also believe that security measures at the sea/air ports are insufficient to prevent drug trafficking into the U.A.E. Some respondents also believe that publicity regarding the massive money that is earned by the illicit drug trade has encouraged some people to become involved, resulting in the increasing availability of drugs in society. Some users also mentioned other factors such as the paucity of facilities for the dissemination of information related to drug use, the fact that there is no equality in the application of laws to people and the lack of treatment facilities for drug addicts. Drugs laws in the U.A.E. are not applied equally across the socio-economic spectrum; influential groups within society tend to experience less rigour in the application of the law than groups with little influence. Compared to richer people, poorer people are more likely to come into conflict with the law because they have access to fewer resources to cope with social needs and with which to attain their life goals by legitimate means. Therefore, some poor people withdraw socially or use drugs as a crutch to help them cope with their problems. It is important for drug users, especially those who are psychologically or physically dependent, to maintain their access to drugs at all times. To achieve this, drug users use several sources. If one source is closed down by law enforcement, another source is used instead. The circle of friends is an important drug source for drug users, especially for new users. However, the circle of friends may not be a large enough source to provide

for all the drugs needs of an experienced drug user, especially long-term users and those who use large amounts or expensive types of drugs. Therefore, obtaining drugs through drug dealers is required to keep drugs available. However, it is difficult for some users to access drug dealers without making use of the circle of friends. Drug users usually depend on a friend who knows how to access drug dealers. However, drug users usually try to use a drugs source with the minimum of risk. Only in the case of the drug user who is suffering from physical dependence is it difficult to choose the right source at the right time to avoid the risk of being arrested.

Figure 7.5 shows that most respondents reported that they used to get drugs free from their friends. The second drug source for most respondents was the drug dealer, followed by purchasing drugs from dealers who are their friends. Few respondents used to get some prescribed drugs by some physicians in some private clinics in the U.A.E.. Therefore, some pharmacies were sources for some types of drugs for some respondents. However, three quarters of the respondents used other sources or methods to obtain their drugs. A number of respondents reported that they acquire drugs themselves from outside the U.A.E., or use drugs while travelling abroad or employ a person to bring them drugs from outside the U.A.E. in order that they themselves will not be caught by the authorities. Moreover, some respondents reported that they acquire drugs from friends travelling abroad, allow friends to take drugs in their house in order to get their drugs free, involve a wealthy friend in drug use in order to rely on them as drug source and to share drugs, acquire directly from traffickers, grow hashish in their countries (such as Pakistan), or otherwise get drugs from patients receiving psychotherapy or one of their family members.

Drugs become important in the life of the user. He uses drugs to induce states of "high", or to obtain some benefit such as money, or to exchange them for other goods. The first experience of drug use costs the user neither money nor time in looking for drugs (Segal,

Figure 7.5
Drug sources (% of respondents)



1990). The first use could happen by sharing drugs with friends. After this step the new user is expected to provide drugs for his friends to share. The new user is unable to offer drugs to his friends because he does not know the sources of drugs in society (Segal, 1990). Most drug dealers in society are anonymous and obtaining drugs from strangers is risky. If the new user wants to buy drugs he has to introduce himself to one of his friends who is more experienced in drug use and is a heavier drug user. The experienced drug user would get some money from the new user and he also keeps a small amount of drug to himself before giving the drug to the new user. The new user might then share some of the drug with an experienced user in order to test the quality and by way of thanks (Segal, 1990). This means that experienced and new users depend on each other in obtaining drugs. The new user is unlikely to be in a position to buy drugs in large amounts for low prices. The buyer must have good reputation and be a known person to the seller. The drug distribution network in the U.A.E. consist of dealers, sellers, middlemen, and users. The dealer is the person who gets his drugs direct from the suppliers. He buys in large quantities, and he stands to make the largest profit. Some dealers use drugs, but others do not. Most dealers who use drugs used to be drug users who turned to drug dealing in order to secure money and drugs for themselves. Most dealers who use drugs use only light drugs; their motive is profit from selling drugs. Dealers rarely sell drugs to strangers or to careless users, preferring to sell drugs to those of the same nationality.

Drug dealers prefer to sell drugs in large quantities so as to maximise their turnover, and they usually specialise in selling expensive drug types. Most U.A.E. drug users who deal with other drug-related activities can be classified as drug sellers (those who sell drugs in small quantities such as in grams), whilst Asians and non-U.A.E.-Arab citizens are classified as drug dealers (those who deal with high quantities of drugs such as in kilograms). This is perhaps because most U.A.E. drug users who deal with other drug-related activities are young and have no experience in dealing with drug trade. The

involvement of some of them in drug trafficking or selling is in order to finance their use of expensive drugs. People who deal with drugs for profit or for making a living tend not to use drugs, or to use cheap and light types such hashish. The drug seller, on the other hand, is a person who sells drugs in small amounts and is not looking for large profits. He is usually a heavier drug user. He obtains his drugs from dealers living in the U.A.E., and his connection with dealers outside the U.A.E. is rare. He usually sells his drugs to friends or to those who are introduced to him by his friends. He is less experienced than the drug dealer. He prefers to sell only one or two types of drugs, and mostly those types which he uses. His aim is to obtain large amounts for his own use and to resell small amounts to his friends. Some drug users in the U.A.E. turn to work as middleman between drug dealers and inexperienced drug users. The middleman is a drug user who is more experienced than his friends. He aims to help his friends to obtain drugs from drug dealers or sellers, and in return expects to share their drugs, or to be given either money or some of their drugs as thanks.

Drug users have many sources of drugs, whether from the U.A.E. or from outside the U.A.E.. Most of them started to use drugs by being given drugs free from their friends. At first, an experienced drug user will offer some types of drug free to his non-drug-using friends. After some time he will stop offering them free drugs. This is because the drug users motivation is to bring his friends into drug use in order to have a good time with them. At the same time he also wants to sell some drugs to them once they become hooked on drugs in order to obtain money to finance his own drug use. When the new user is no longer able to obtain drugs free from his friend, he might ask him to buy some drugs from him or to tell him about any source of drug he can buy from. Step by step, the new user will be in touch with an increasing number of sources. Multiple drug sources are important for drug users wherever they are, especially those who are addicted to hard types such as heroin. Once the drug user has many sources, he becomes a leader or boss

for other users. Users who have more sources of drugs are more likely to be involved in drug selling. This is because they sometimes become middleman for their friends in return for money, or become drug sellers by retail.

Table 7.5: Drug sources and nationality

Nationality		U.A.E.		Arab		Asians & Others		Total	%
Drug Source		Count	Col%	Count	Col%	Count	Col%		
Purchased from friend	Yes	59	80.8	24	80	22	41.5	105	67.3
	No	14	19.2	6	20	31	58.5	51	32.7
	Total	73		30		53		156	100
D.F = 2		Chi-square = 24.28569				P. value = < .0000			
Purchased from dealer	Yes	62	84.9	23	76.7	40	75.5	125	80.1
	No	11	15.1	7	23.3	13	24.5	31	19.9
	Total	73		30		53		156	100
D.F = 2		Chi-square = 2.00523				P. value = < .3669			
Purchased from Pharmacy	Yes	50	68.5	7	23.3	8	15.1	65	41.7
	No	23	31.5	23	76.7	45	84.9	91	58.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 41.15982				P. value = < .0000			
Prescribed by private Doctors	Yes	40	54.8	7	23.3	6	11.3	53	34
	No	33	45.2	23	76.7	47	88.7	103	66
	Total	73		30		53		156	100
D.F = 2		Chi-square = 27.74623				P. value = < .0000			
Other Methods	Yes	56	76.7	23	76.7	38	71.7	117	75
	No	17	23.3	7	23.3	15	28.3	39	25
	Total	73		30		53		156	100
D.F = 2		Chi-square = .46678				P. value = .7918			
Keys :		D.F = Degrees of freedom				Col% = Column percentage			
		P.value = Probability value							
Source : Fieldwork Study, 1993									

Two principal factors affect a drug user's choice of a suitable drug source, firstly, the intensity of addiction experienced by the drug user. Heavy users, long-term users and users who are physically addicted need drugs constantly available in order to maintain drug use and avoid withdrawal symptoms. In order to keep themselves adequately supplied, therefore, they need several drug sources. Secondly, the ability of the drug user to obtain drugs easily. This includes access to financial resources, and the reputation

of the drug user among drug dealers and suppliers. Drugs are available only when money is. Wealthy drug users are more likely to obtain drugs from different sources than other users. Experienced drug users are more able than new users to have access to drug sources.

Table 7.5 shows that there are high statistically significant differences between the sources of drug and the respondent's nationality. Respondents from the U.A.E. and Arab citizens are more likely to purchase drugs from friends than Asian and other respondents ($p < .0000$). This is because Asians usually get their drugs from outside the U.A.E., and most of them use light drugs such as hashish. If they do not get their drugs free from friends they will wait until they go on leave to their countries and bring some drugs on their return. Furthermore, light effective drugs do not compel the user to use them, in contrast to hard drugs such as heroin which always forces users to use them immediately. Because U.A.E. citizens are more likely to use hard drugs such as heroin than other nationalities, they are more likely to depend on their friends for buying drugs. When the heroin addict is short of drugs, the first thing he will do is phone his friends asking them about the availability of drugs in their possession.

Respondents from the U.A.E. are more dependent on dealers for obtaining drugs than other respondents (84.9%). This because they are able to spend more money on drugs than other nationalities and they are less worried about laws, police and justice than other nationalities who usually hesitate in dealing with drug dealers who might be informants. Moreover, as the U.A.E. is not a drug producing country, most drug users who are U.A.E. citizens depend on their relationship with Asians, especially those who are from drug producing countries, to obtain their drugs. Drug dealers usually look for users who can pay them the highest price.

In contrast with users of other nationalities, respondents who are U.A.E. citizens are more likely to purchase their drugs from pharmacies ($p < .0000$) or get them prescribed

by private doctors ($p < .0000$) than other respondents. This is because U.A.E. citizens are more likely to use those substances, such as amphetamines, barbiturates and tranquillisers, which could be prescribed by private doctors or purchased from pharmacies. Most private doctors and pharmacists are foreigners. Some pharmacists sell substances without prescription to local citizens who are drug users. The purchasing of these substances without prescription happens in one of two ways: by threatening them to commit an aggressive or a hostile act against them; or by enticing them with payment many times over the usual price. Until the end of 1989, control on pharmacies selling drugs was weak. Control was subsequently tightened. A drug user who is a U.A.E. citizen can obtain drugs from private doctors by introducing himself to a private doctor as a drug addict, although in fact he may not be. He then asks the private doctor to help him by giving him the same drug which he is addicted to or a similar drug. The user can ask the doctor to increase the quantity of the drug in return for more money than its real price. Moreover, private medication in the U.A.E. is developing rapidly as a business with an interest in money only, not paying enough attention to the public health. In the past it had a moral base and used to take interest in the development of public health alongside business. Lack of control from the Ministry of Health means that private doctors do not hesitate to prescribe the quantity of drug which the user needs.

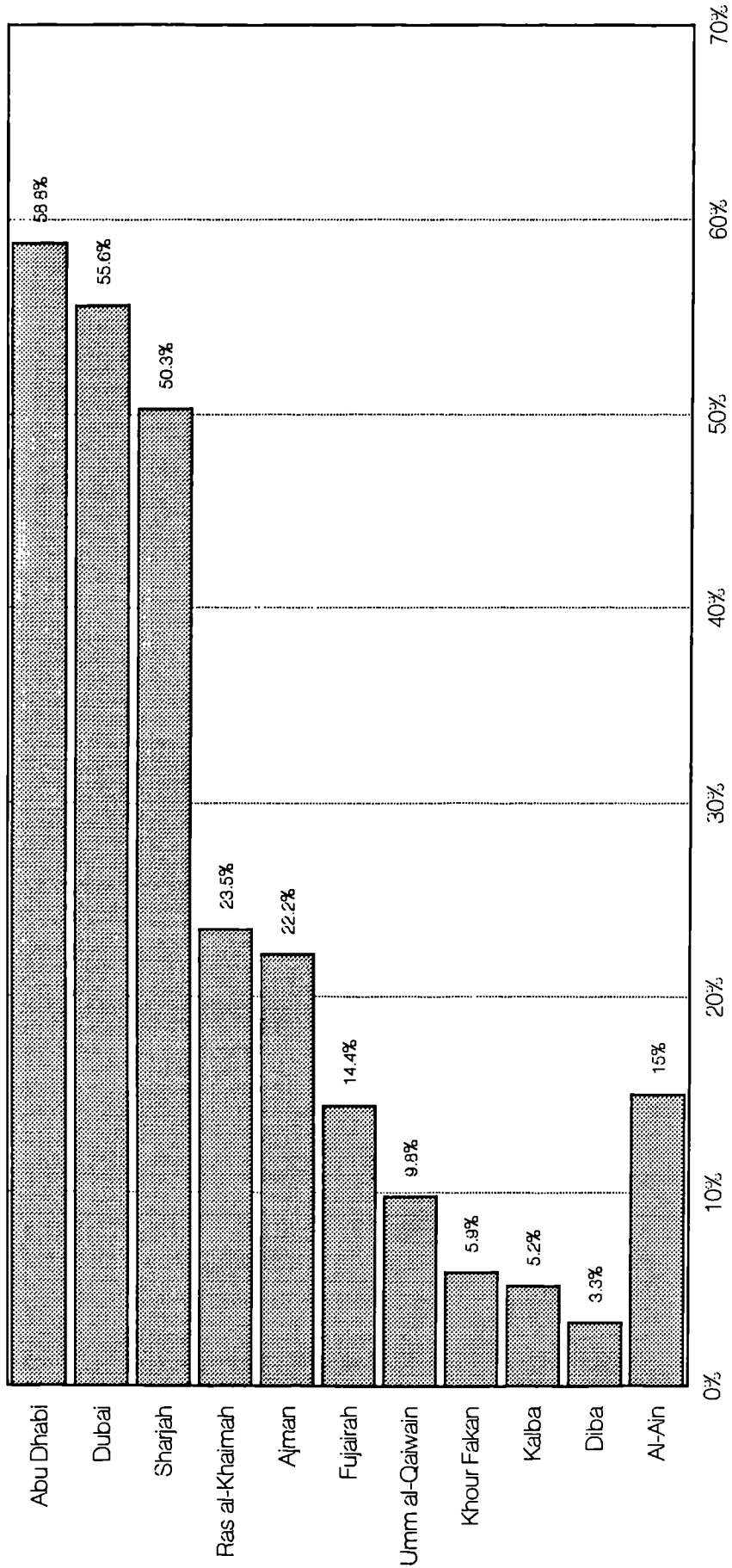
Drug users in the U.A.E. always supply themselves, at least in part, through the drug distribution network in the area. Some drug users, especially those who are more experienced, are able to utilize their transportation, communication and financial facilities to access drugs sources outside their area. The intensity of law enforcement activities affects the choice of drug source. Tight control on drug trafficking and drug supply resources in the society increases demand over supply, and drug prices increase. Under these circumstances, more drug users are willing to risk arrest. Wealthy drug users, on the other hand, can avoid the shortage of drugs in the society by obtaining

drugs from outside, especially direct from the main drug source countries. Consequently, it is difficult to eradicate drug abuse in a wealthy society.

Findings show statistically significant differences between the respondents' nationality and the obtaining of drugs from the U.A.E. ($p < .0026$). U.A.E. citizens feed their need for drugs from the U.A.E. more than other respondents. This is because drugs sources within the U.A.E. are more available to U.A.E. citizens than to other nationalities because they can easily contact other people by using transportation and communication facilities which are not available for most drug users from other nationalities. That some U.A.E. citizens deal in drugs in the U.A.E. means that it is easy for drug users who are U.A.E. citizens to get their drugs from them. Drug users from Arab countries are more likely to get their drug: from outside the U.A.E. than other nationalities. Asians and other drug users come second in getting drugs from outside the U.A.E..

The results in Figure 7.6 show that for more than half the respondents, the principal source of drugs in the U.A.E. was Abu Dhabi, followed by the Dubai Emirate, and the Sharjah Emirate. This is partly because between them, these three Emirates encompass most of the U.A.E. population, and partly because the majority of the expatriate work force lives in these three Emirates (see Chapter 3). The findings show that drug users do not depend in obtaining drugs on the area where they live but they contact with drug sources throughout the U.A.E.. In spite of the lack of control in most other non-oil Emirates, only small number of users obtained their drugs there. This is partly because these Emirates have only small populations, and partly because few of them are wealthy; drug dealers tend to look for large numbers of users willing to pay high prices for drugs. Citizens living in the oil-rich Emirates can afford to spend more on drugs than can other U.A.E. citizens. Smaller numbers of respondents, therefore, obtained drugs from the Ras al-Khaimah Emirate, the Ajman Emirate, the Fujairah Emirate and from the Umm al-Qaiwain Emirate. Some respondents obtained their drugs from other cities, such as Khour Fakkan, Kalba, and Diba. There is little control on drug trafficking in these cities.

Figure 7.6
Drug Sources in the U.A.E. (percentage)



This is because there are no custom services or drug enforcement offices in these cities. In addition, these cities are used as free sea ports for fishing and for small vessels which are working in small trade activities between the U.A.E. and Iran and Pakistan. Al-Ain city is reported as a main source of drugs for some users, because of the large number of expatriate workers, especially from Pakistan.

Most respondents told me that they do not depend on one source for their drugs, especially those who are heavy users. However, those who import drugs from outside the U.A.E. have reasons for doing so:

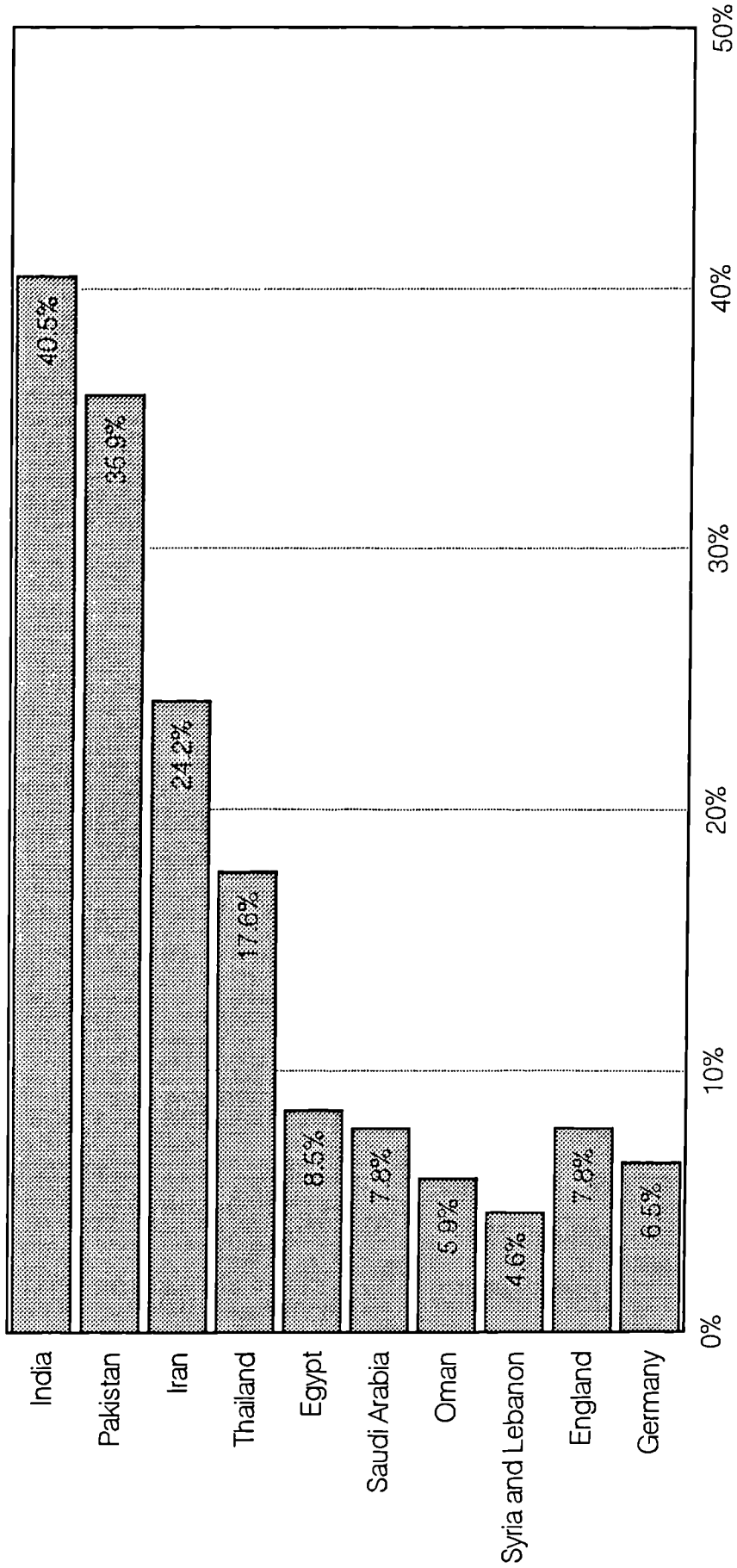
1. The quality of drugs

Some drug types which are available on U.A.E. drug market are adulterated. For instance, the best heroin on the U.A.E. market is from Afghanistan. A drug dealer or seller who buys a kilo of it will make it into three kilos by adding substances such as sleeping tablets or some other chemical to it, in order to increase his profit. For this reason, some drug users prefer to obtain their drugs from outside the U.A.E..

2. Drug prices

Drug users can buy drugs from abroad more cheaply than in the U.A.E.. Drug prices in the U.A.E. are high in comparison with those in Iran, Pakistan, India, Afghanistan, etc. This is because Pakistan, Afghanistan, Iran, India, etc. are considered drug producing countries where drugs are more available, pure, and sold in large amounts and at a low price. Asian Non-Arab countries were the main drug sources for most respondents: India, Pakistan, Iran, and Thailand. In addition to the low prices, drug users prefer to get their drugs from these countries for the following reasons: Thailand is attractive not only because drugs (especially heroin) are cheap, but also because of the extent of prostitution. Travel to Thailand increases in the spring and summer holidays.

Figure 7.7
Obtaining drugs from outside the UAE (percentage)



This is due in part to the U.A.E. school holidays, but also to the unpleasantly hot weather typical during the U.A.E. summer.

Some families from the U.A.E. prefer to spend their summer holiday in India because prices of drugs are cheaper than elsewhere. Drug users who accompany their families to India try to get drugs there. The low price of drugs in India is attractive, and their families can be used as innocent carriers, most family members having no idea about the drugs which they carry. Moreover, there is favourable treatment for U.A.E. families in U.A.E. airports which means lack of control on inspecting their possessions.

Some drug users visit Pakistan, Afghanistan and Iran to obtain their drugs in person. However, such visits can attract police attention because U.A.E. citizens rarely visit these countries. In order to avoid the risk of being arrested, most U.A.E. drug users employ a person (usually a national of the country from which they intend to obtain their drugs) to smuggle drugs from these countries. The national not only has the advantage of speaking the language, which means that he can more easily locate a good source of drugs, but is also more likely to be offered lower prices.

Some drug users acquire drugs from friends returned from travel abroad. The friends are usually drug users themselves. Money may change hands before the trip, or else the drugs are sold to his friends on his return. As one of the respondents said:

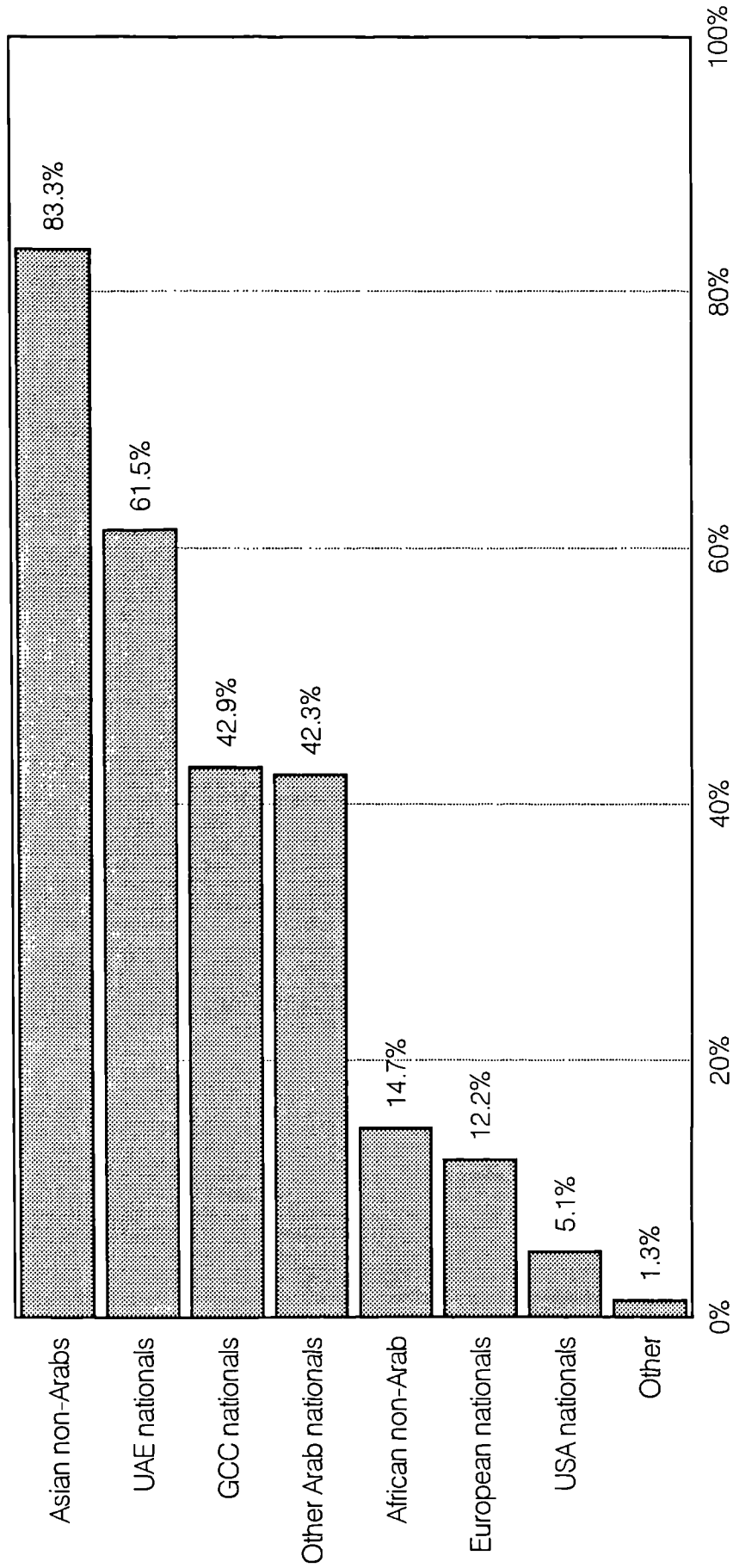
I was 19 years old when I came to the U.A.E. looking for work. I was a hashish user before I came to the U.A.E.; but after one year in the U.A.E. I could not get hashish. I went to Pakistan for my holidays and on my return to the U.A.E. I brought in a kilogram and a half of hashish. I used some of it, gave some to my friends and sold some of it to other users.

For some respondents, especially hashish users, three Arab countries stand out as principal sources: Egypt, Lebanon and Syria. This is because in these countries there is illicit drugs production, especially of hashish and heroin. Lebanon is also considered a base for the collection of cocaine smuggled from Latin America. Some respondents

reported that most drugs obtained from Saudi Arabia are in tablet form, and therefore include psychotropic substances. Smugglers (using the melee of the annual pilgrimage, during which a vast number of people from all over the world travel to Saudi Arabia, swamping the authorities' ability to monitor entry as carefully) are able to smuggle these substances into Saudi Arabia in large quantities because tablets are easy to hide. Oman is also mentioned by some respondents as a source of drugs. Located near both Iran and Pakistan, Oman has large number of expatriate immigrants from these countries. Iran and Pakistan both being drug producing countries, it is not surprising that some drugs are smuggled into Oman as well as directly into the U.A.E.. According to some respondents, Britain is the principal European source of drugs for some U.A.E. national drug users, followed by Germany. This is because some Arabs like to spend their summer holiday in these countries and use drugs while travelling abroad.

According to the distribution of drug dealers ethnic groups, figure 7.8 shows that respondents obtained their drugs mostly from drug dealers of Asian nationalities, in particular nationals of Pakistan, Iran, India, Thailand, Afghanistan, Sri Lanka and Bangladesh. U.A.E. nationals ranked second as drug dealers, followed by other Gulf Cooperation Council nationalities. nationals, nationals of other Arab countries, nationals of African non-Arab countries, European nationals, U.S. nationals, with other nationalities ranking last. The reasons why respondents depended more on Asian Non-Arab drug dealers than on other nationalities may be that Asian nationals make up the largest nationality grouping in the U.A.E. population. Iran, Pakistan, Afghanistan and India are all drug producing countries, and Asian nationals have greater access to the main drug suppliers than other nationals. From the point of view of Asian drug dealers, the U.A.E. is a desirable place to trade because U.A.E. currency gives a much better rate of return. This benefit also works to the advantage of the U.A.E. national buying drugs, for the Asian drug dealer usually sells better quality goods at a cheaper price. The Asian dealer

Figure 7.8
Nationalities of drug dealers (percentage)



is more trusted among drug users than other drug dealer nationalities. This is because they usually sell good quality drugs at a cheap price.

The cheap cost of drugs in Asian countries and the expensive street prices of illicit drugs in the U.A.E. mean that the trade is highly lucrative, and so some Asians are involved in the drug trade. Asians are less concerned about deportation if they are prosecuted and deported because they can always re-enter the U.A.E. illegally (see Chapter 3).

U.A.E. nationals involved in the drug trade also have some advantages. They have better access than people of other nationalities to facilities such as communication and transportation, and so are able to travel abroad more easily. Officials at air/sea ports are more considerate in their dealing with U.A.E. citizens than with others. They have money to help them solve difficulties or problems such as employing an assistant, carriers and traffickers. Some, particularly those with Iranian roots, have relatives in Iran who assist in drug trafficking into the U.A.E.. Drug dealers who are U.A.E. nationals tend to be more laid back than people of other countries about law enforcement because they may be released from being jailed after only a short time.

According to the distribution of drug dealers country of origin, figure 7.9 shows that most respondents obtained drugs from drug dealers who are U.A.E. nationals, followed by dealers from Pakistan, Iran, Egypt, Bahrain, Oman, Sudan, India, Qatar, Saudi Arabia, Syria, Lebanon, England, Tanzania, Kuwait, Thailand, and Palestine. Drug dealers from the U.A.E., Pakistan, Iran and Egypt control the drug market in the U.A.E.. There are many reasons for the greater involvement in the U.A.E. drug market of people of these nationalities than of others. Pakistan is a major source of drugs. Nationals of Pakistan and Iran are heavily represented in the U.A.E. population. Drug trafficking from Iran into the U.A.E. is easy because of the lack of control on the Iran - U.A.E. border. Egypt produces hashish and opium, and its nationals are the largest Arab nationality in the U.A.E..

Figure 7.9
Distribution of drug dealers according to country of origin (%)

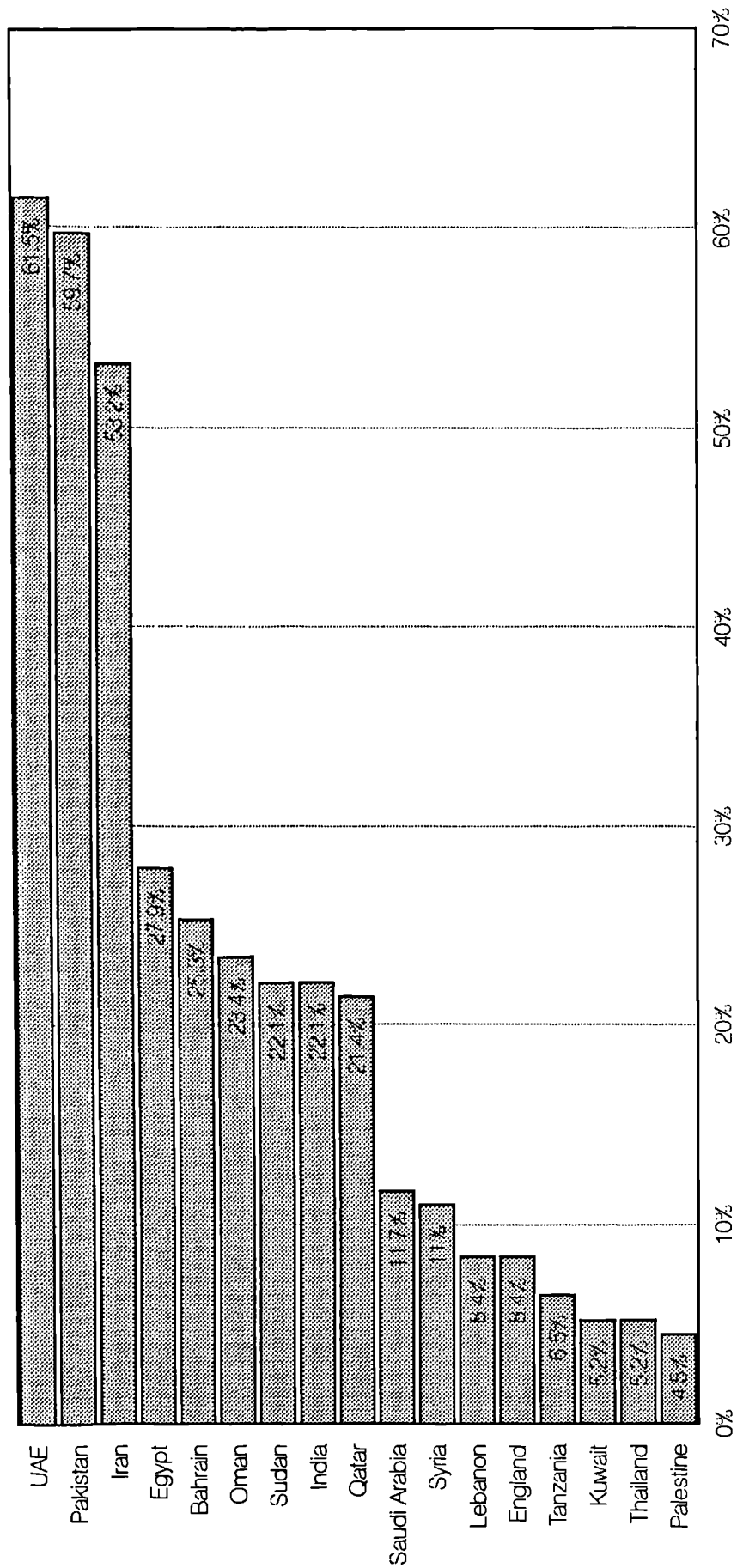


Table 7.6: Dealers' nationality and users' nationality

Users Nationality		U.A.E.		Arab		Asians & Others		Total	%
Dealers Nationality		Count	Col%	Count	Col%	Count	Col%		
Dealers from U.A.E.	Yes	66	90.4	16	53.3	14	26.4	96	61.5
	No	7	9.6	14	46.7	39	73.6	60	38.5
	Total	73		30		53		156	100
D.F = 2		Chi-square = 54.188				P. value = < .0000			
Dealers from Asia	Yes	67	91.8	14	46.7	49	92.5	130	83.3
	No	6	8.2	16	53.3	4	7.5	26	16.7
	Total	73		30		53		156	100
D.F = 2		Chi-square = 35.964				P. value = < .0000			
Dealers from Africa	Yes	19	26	3	10	1	1.9	23	14.7
	No	54	74	27	90	52	98.1	133	85.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 14.901				P. value = < .0006			
Dealers from Arab Countries	Yes	38	52.1	14	46.7	14	26.4	66	42.3
	No	35	47.9	16	53.3	39	73.6	90	57.7
	Total	73		30		53		156	100
D.F = 2		Chi-square = 8.5593				P. value = < .0138			
Dealers from GCC Countries	Yes	46	63	14	46.7	7	13.2	67	42.9
	No	27	37	16	53.3	46	86.8	89	57.1
	Total	73		30		53		156	100
D.F = 2		Chi-square = 31.29652				P. value = < .0000			
Keys :		D.F = Degrees of freedom				Col% = Column percentage			
		P.value = Probability value							
Source : Fieldwork Study, 1993									

Drug dealers are an important source of drugs because they are always looking for obvious drug users to whom to sell drugs. Drug dealers prefer to sell drugs in large quantities, and to sell to those users able to pay well. It is not always easy for drug users to deal with a drug dealer, or to purchase drugs in large quantities, or for a low price. This is because drug dealers cannot sell drugs to unknown persons unless they have a reputation as a trusted person. Therefore, a drug user must have a reputation and be known to the dealers. This is what makes new drug users initially purchase drugs from their circle of friends. Drug users obtain drugs from outside their circle of friends only after being introduced to a dealer by one of their friends already known to the drug dealer.

Table 7.6 shows high statistically significant differences between the drug dealers' nationality and respondents' nationality. U.A.E. nationals are more likely than those who are not U.A.E. nationals to obtain their drugs from dealers who are also U.A.E. nationals ($p < .0000$). Asian respondents are more likely than other respondents to deal with Asian Non-Arab dealers ($p < .0000$). U.A.E. nationals are more likely than those who are not U.A.E. nationals to deal with African dealers ($p < .0006$). U.A.E. nationals are more likely than those who are not U.A.E. nationals to obtain their drugs from dealers who from other Arab countries ($p < .0138$). U.A.E. nationals are more likely than those who are not U.A.E. nationals to obtain their drugs from dealers who are from other G.C.C. countries ($p < .0000$). From this table we can conclude that drug users prefer to have contact with a drug dealer who is of the same nationality and that U.A.E. nationals obtain drugs from most nationalities of drug dealer, not depending on one nationality.

From the above points we can conclude that U.A.E. users are more able to buy expensive types and pay more than other users. Therefore, most dealers deal with them. Most of the U.A.E. drug users are heavy users and consume large amounts. When they buy their drugs they buy large amounts, and the drug dealer prefers to sell large amounts than small amounts. Avoiding risk is an important reason for selling drugs to a person from the same nationality, especially where the dealer is known to the user. Drug users who are not U.A.E. nationals are more likely than those who are U.A.E. nationals to be employed as agents by law enforcement agencies because their country of origin is likely to be a drug producing country.

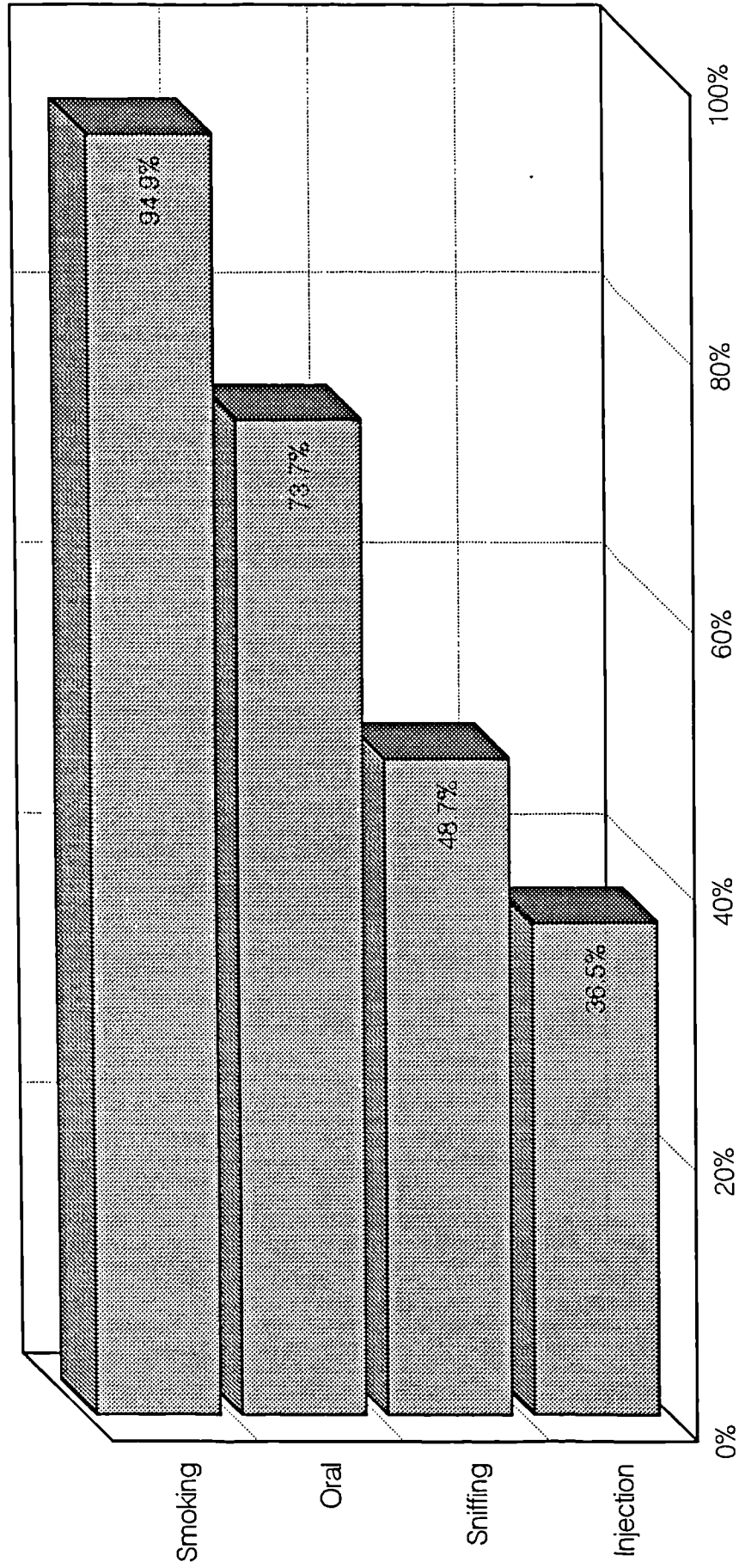
Methods of Administration

When a prospective drug user is introduced to drugs, the first thing he/she learns is the right beliefs regarding drug use (Winick, 1968). Before they are ready to try drugs they should learn how to use them properly, especially hard types such as heroin (Winick, 1968). Some respondents have reported that to use a drug properly means both to achieve

the desired "high" and to avoid "bad trips". Through the circle of friends new users learn how to use a drug. Drug use techniques differ from drug to drug, and are not necessarily transferable. Learning how to use marijuana does not confer an ability to use heroin until taught by an experienced heroin user. Methods of drug use in the U.A.E. are broadly the same as in other parts of the world: smoking, injecting, sniffing and oral. There are some differences in the methods, and in the tools which are used. Some drug use methods are group activities such as smoking marijuana and hashish or chewing *qāt*, whereas others are solitary activities. However, the choice of a suitable method depends on many factors.

As we can see in figure 7.10 the findings show that smoking was the most common method used among most respondents, followed by oral method, sniffing and injection. Each method depends on the type of drug, on the degree of the addiction, the withdrawal symptoms, the availability of drug use tools, place of using drugs, whether the user is alone or with friends, the amount of drug available and the degree of the user's hunger for the drug. Hashish, marijuana, heroin, and opium are taken by smoking. Opium sometimes can be injected by heating a piece of opium gum with small amount of water until the opium dissolves. It is then injected. This method is used by those who use heroin by injection. When they have no heroin, they inject opium instead. Asian drug users, especially Iranians, employ two methods to take opium. One method is to smoke it. This can be done in one of two ways. The first way is called in Persian *Seekh wa-Sank* (the stone and the iron stick). It means that a piece of opium is put on a small stone and then a heated iron rod put on the piece of the opium. The user inhales its smoke through a hollowed stick or by pipe. The second way is called *Bafour* or *Wafour*, in which the opium is smoked by using a long pipe called *Bafour* or *Wafour*. The second method of using opium among Asian users is the oral method. A piece of opium is placed under the tongue of the user and then dissolved by drinking a cup of tea. The origin of this method is Iran and most opium users in the U.A.E. are accustomed to it.

Figure 7.10
Methods of Administration (%)



Heroin is taken by smoking, injection and sniffing. The most common method among heroin users in the U.A.E. is to smoke heroin through a piece of foil. The most common types of foil used are kitchen foil, cigarette foil, and biscuit and chocolate wrappers. One or two lines of heroin are placed on the foil and this is held by one hand. With the other hand, the user heats underneath the foil by using a lighter or paper spill. Through a rolled up tube of paper, the user inhales the smoke of the burned heroin. Without learning this in the company of friends, it is difficult for new user to use the foil method, and therefore the new user cannot use heroin without assistance. This method also requires a larger amount of heroin than the injection method. This method is usually used when the user wants to share his heroin with his friends. This method also depends on the amount of heroin the user has available. In the injection method, heroin powder is dissolved in an acid such as lemon juice, or in lemon salt and then the solution of the heroin is injected. Solvent sniffing is also associated with respondents who are U.A.E drug users. They have many methods for taking solvents: firstly, they put some glue in a coca cola can and sniff it while watching television. To avoid their parents, relatives and police discovering them taking drugs, they also use this method of taking drugs while outdoors rather than at home. Secondly, sprinkling shoe polish on a piece of tissue paper and sniffing it. (again a method of taking drugs which is not readily discernible to parents.). Thirdly, sniffing burnt vehicle tyres. They get old tyres free from vehicle repairing shops, and after the tyres are burnt they inhale the smoke and gases through nose and mouth. Asian and Arab drug users are more likely to take drugs by smoking than by other methods, and Arab users are more likely than Asians to inject. This is because multiple drug users use multiple methods. The place where the drugs are taken influences the type of method used. For instance, the user who usually takes drugs by injection cannot use this method in front of his parents, but he can take drugs without being as readily discovered by smoking them in form of a cigarette. The age of the user also affects the method used. Young users usually try all methods available and take drugs when among

friends. The experienced user has already tried most methods of taking drugs, and has chosen the method he has found most suitable to him and which costs him the least to give him the desired effect.

Drug users usually like to take drugs in a session with friends. They choose one of their friends to be the organiser and the head of the drug taking session. This person must have many characteristics in order to be the organiser and the head of the session: he must have many sources of drugs, and should be able to obtain large amounts of drugs; he must have safe places for taking drugs, and be respected by the public and the police; he is usually from an influential family which is unlikely to be under suspicion for any misdemeanours. The acceptance of a new user to the session follows certain procedures. The new user should be introduced to other users by one of the session's members and he has to be the one to start taking drugs in front of the other session members before they take their drugs. There are some differences between drug use sessions. These differences depend on the type of drug which members use. Sessions involving the use of hashish and marijuana are usually larger than other sessions and most of those attending use the same types of drugs. Alcohol is often drunk at sessions. The main characteristic of this type of session is that most its members are close friends or relatives. Most respondents have reported that drug sessions are very important to drug users. Through them, drug users meet with friends, and their problems in obtaining drugs may be solved at sessions. They also can give them a feeling of security. The drug taking sessions may include users of different nationalities, vocational groups, ages, etc. The only characteristic which they have in common is the use of drugs.

The findings show that the number of drug users at a heroin session is usually fewer than other sessions and most of its members are heavier drug users. Some drug users divide their friends into groups such as: those they take drugs with, those with whom they drink alcohol, non-users for normal social occasions, and friends for travelling with. Most

respondents took drugs alone, followed by those who took drugs with friends. Some drug users take drugs with strangers, and others take drugs with a member of their family. Most drug users who took drugs alone were heroin users who believed that any disturbance decreases the amount of euphoria and 'high' feeling they experienced. Most hashish and marijuana users preferred to take drugs with their friends. They thought that taking hashish and marijuana was more enjoyable with friends than alone. Heroin users have less fear about taking drugs in the company of strangers than other types of drugs users. This happens while they are travelling abroad. Some drug users take drugs with their relatives or members of their families. These relatives are usually brothers or cousins. This is because of the social values in the U.A.E. where families are close and children seek their friends amongst their relatives rather than outside the family. Large numbers of relatives in the U.A.E. live together in the same house, and this promotes friendship between young relatives as they grow up together.

When a drug user has a physical or psychological need for drugs, he/she cannot control the occurrence of drug use. This user can be classified as a regular, heavy, experienced, or long-term user. However, a drug user who is not addicted to drugs and uses drugs when they are available can be classified as a recreational or occasional user. But dependence on drugs is not the only factor that controls the frequency of drug use. As I have mentioned above, the opportunity to use drugs is a very important factor behind initiation into drug use. It is also as important factor behind the continuation and occurrence of drug use. In addition to the physical or psychological dependence, the availability of drugs resources and financial resources are likely to be more important factors behind the occurrence of drug use.

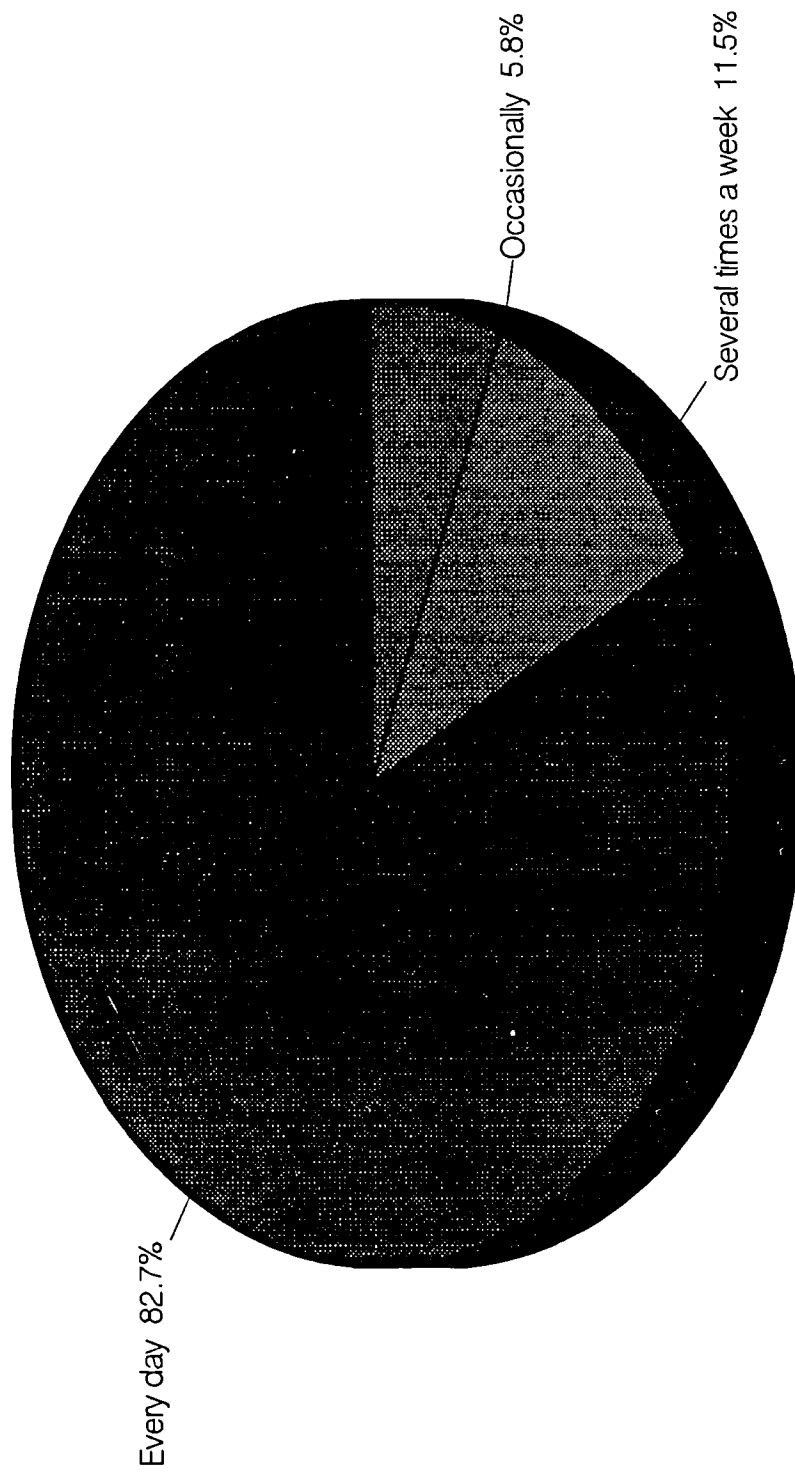
Figure 7.11 shows that most respondents used drugs every day, followed by those who used drugs several times a week. Only a small number of respondents used drugs occasionally. They mainly use light effective substances which do not induce physical

dependence such as hashish and marijuana. This meant that most respondents were heavy drug users who were able to obtain drugs every day. Most respondents who admitted using drugs every day took drugs more than five times a day. Some respondents have reported that the frequency of drug use depends on mood, the availability of drugs and money and the degree of tolerance of the withdrawal symptoms. For example, the user could take hashish to change his psychological state. Tranquillisers (especially valium) are also used by heroin users every day because they cannot sleep after the effects of heroin. Other drug users take tranquillisers several times a month or only occasionally. Because LSD and cocaine are rare in the U.A.E. illegal drug market, they are not used every day. Because hashish and marijuana are cheaper than other types of drug such as heroin, they are more likely to be used every day. Some drug users use high amounts of drugs for specific occasions such as friends' parties or when they go to nightclubs/discos, in order to be intoxicated for a long time.

The time that the user considers most suitable for taking drugs depends on many factors: the psychological and physical state of the user, his lifestyle, his job, his responsibility in the family, the availability of drugs, etc. But for drug users who have a physical and psychological need to use drugs, the choice of suitable time cannot be controlled especially when drugs are available. For recreational users the choice of suitable time for drug use sometimes cannot be controlled, especially if they have large amounts of drugs, have access to drug sources and use drugs with friends. But some recreational users who lack access to drugs sources from which they can buy large amount of drugs at low prices use drugs when drugs are available to them.

Figure 7.12 shows that the most frequent time for most respondents was in the evening, with the afternoon in second place, followed by using drugs at night. Using drugs in the morning was in fourth place, followed by the use of drugs as soon as the user wakes up. Evening is a good time for relaxation and recreation, and this is perhaps why drug dealers

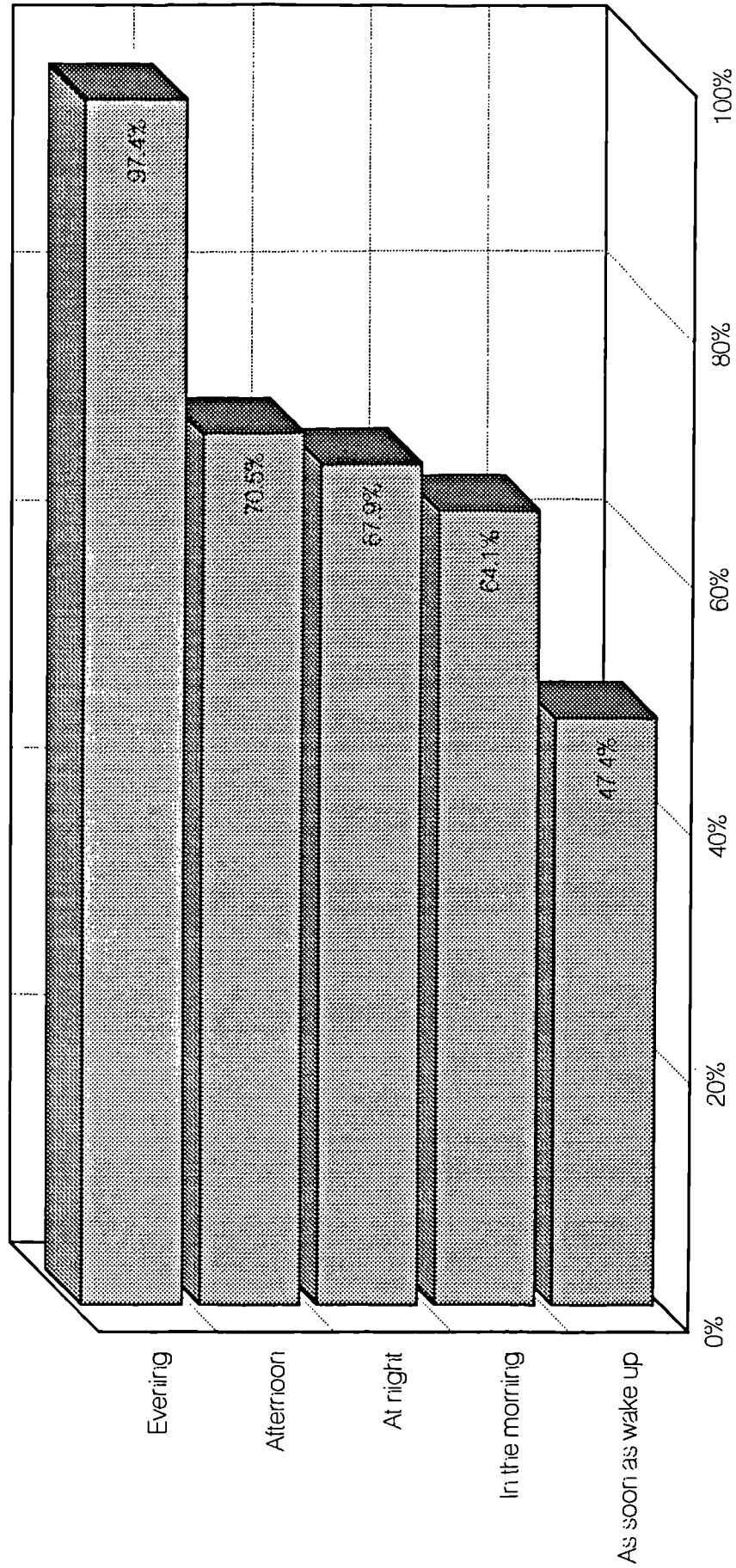
Figure 7.11
Frequency of drug use



usually practise their trade in the evening. Most of them have specific times and hours when they deal in drugs. Again, law enforcement is more active in the morning than in the evening. Most staff work in the mornings and only some of them have evening duty. Most social activities take place in the evening such as meeting friends, social events, etc.. The findings show that some drug users who are addicted to heroin cannot leave their bedrooms without taking an early morning dose. They usually store large amounts of heroin in their parents' or in their own rooms because of their addiction. Drug users who are U.A.E. nationals take drugs at all times of the day and evening, and therefore they cannot work or take any responsibility toward their families or society. Most Asian and some Arab drug users start work at 6.00 a.m and therefore some of them take drugs only between early evening and midnight. For working drug users, the use of drugs in the morning helps them to get through the working hours. In the morning, a drug user takes his dosage before he goes to work, usually after he has had his breakfast. Opiate addicts cannot eat any kind of food before they have had their morning dosage so they take their first dose when they are still in bed and the second dosage before they have their breakfast. The use of different types of drug in the morning is common among most respondents. The use of heroin and barbiturates in the morning is more prevalent than other types of drugs. This is because these types of drugs cause physical dependence and consequently because most respondents were heavy users, they were forced to take drugs often.

Hashish users are more likely to take hashish in the evening; some respondents have said that they find it uncomfortable in the heat of the day, and also because hashish tends to be a 'social' drug and they do not usually use hashish when they are alone but with friends, which is usually in the evening. They usually get together in the evening in a specific place such as the house of one of them, or hire a room in a hotel. But certainly, the hotels do not know about this. Respondents also used other types of drugs in the evening, such as marijuana, heroin, barbiturates and other substances. This is because most of the drug users of these drugs are from the U.A.E. and because most of them have been dismissed from their jobs. The

Figure 7.12
Suitable time for drug use



availability of drugs and money enables them to take drugs at all times. Marijuana cigarettes are usually used after heroin has been taken. Heroin users think that the use of marijuana and hashish after the taking of heroin increases the 'high' of the heroin. Opium, barbiturates, tranquillisers, amphetamines, and morphine are also often associated with the use of heroin as an alternative, or to mix with heroin, or sometimes are used to relieve the withdrawal symptoms of heroin.

Like the occurrence of drug use, it is sometimes difficult for drug users who have a physical or psychological need for drugs to choose a suitable place to use drugs. The withdrawal symptoms force drug users to use drugs any time in any place if drugs are available. However, drug users also take into account some considerations when deciding to use drugs. These considerations would include the avoidance of police enforcement, relatives, non-users friends, etc. These considerations may differ from one society to another. This depends on how people in the society view drug use; norms, traditions and customs affect people attitudes toward drug use. For instance, it is possible to see a drug user take drugs in a public garden in Switzerland or in a Coffee Shop in the Netherlands, but it would be impossible for such activities to take place in the same places in other countries, particularly the U.A.E.

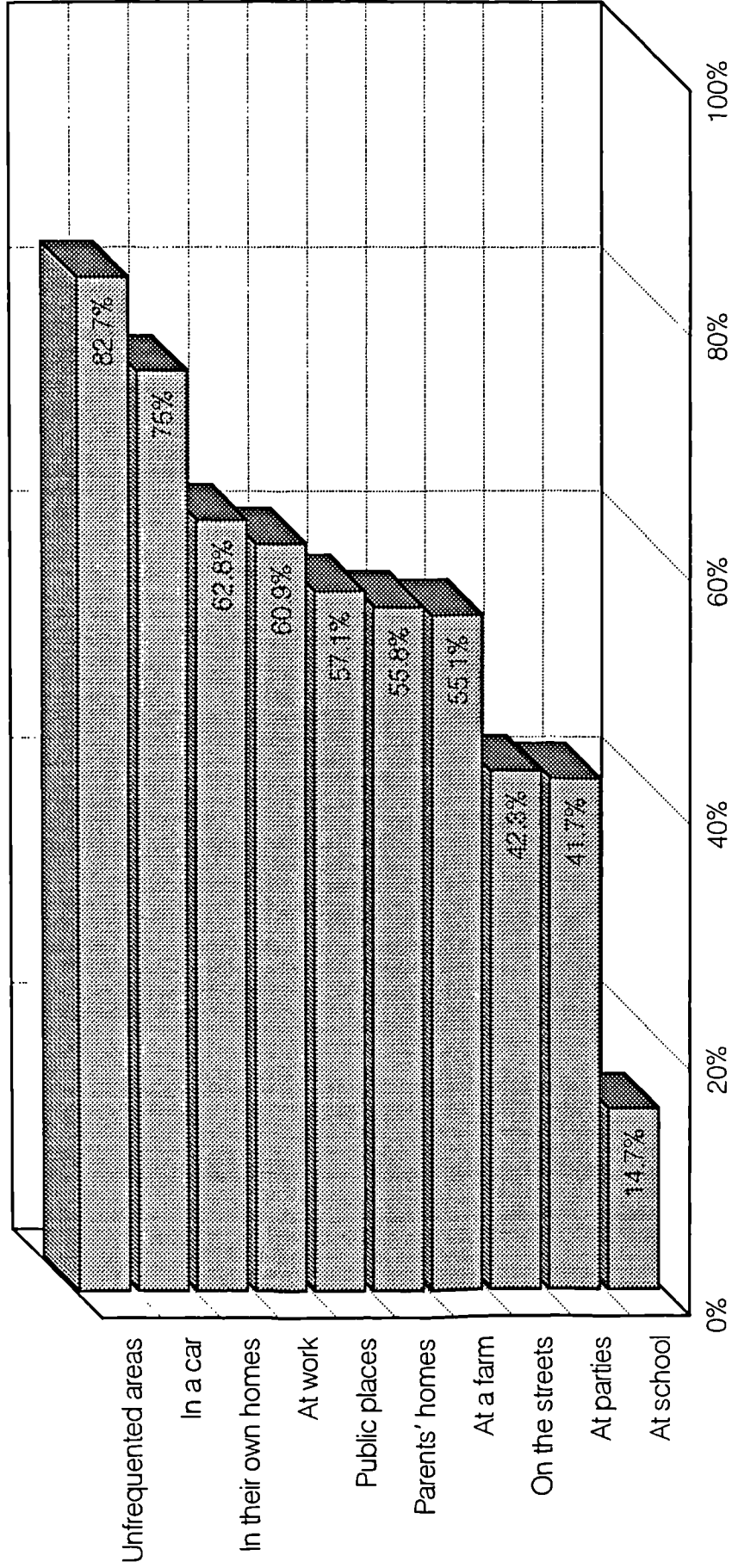
Figure 7.13 shows that most respondents prefer to take drugs in unfrequented areas, followed by taking drugs in a car, in their own houses, at work, in public places, in parents' houses, at farms, in the streets, at parties and other social venues, and at school. Most drug respondents prefer to take drugs in unfrequented areas because they feel more comfortable and far from law enforcement, family, relatives, and the public. Most drug users who take drugs in these areas do so with friends, and most of them have no secure place to take drugs in, such as a house, or they are worried about their reputation if they were to be discovered taking drugs in their usual haunts. Some respondents have reported that most new users prefer to take drugs in unfrequented areas because they have no experience in how to evade police, family, relatives, and the public while taking drugs.

Table 7.7: Places of using drugs and nationality

Drug Type		U.A.E. Citizens		Arab Citizens		Asians & Others		Total	%
		Count	Col%	Count	Col%	Count	Col%		
On street	Yes	39	53.4	12	40	15	28.3	66	42.3
	No	34	46.6	18	60	38	71.7	90	57.7
	Total	73		30		53		156	100
D.F = 2		Chi-square = 8.02114					Probability value = < .0181		
In a car	Yes	66	90.4	24	80	27	50.9	117	75
	No	7	9.6	6	20	26	49.1	39	25
	Total	73		30		53		156	100
D.F = 2		Chi-square = 26.00507					Probability value = < .0000		
In their parents house	Yes	54	74	12	40	21	39.6	87	55.8
	No	19	26	18	60	32	60.9	69	44.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 18.43232					Probability value = < .0001		
At work	Yes	50	68.5	19	63.3	26	49.1	95	60.9
	No	23	31.5	11	36.7	27	50.9	61	39.1
	Total	73		30		53		156	100
D.F = 2		Chi-square = 4.96405					Probability value = < .0836		
In their own homes	Yes	34	46.6	27	90	37	69.8	89	62.8
	No	39	53.4	3	10	16	30.2	67	37.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 11.74214					Probability value = < .0001		
In public places	Yes	50	68.5	19	63.3	20	37.7	89	57.1
	No	23	31.5	11	36.7	33	62.3	67	42.9
	Total	73		30		53		156	100
D.F = 2		Chi-square = 12.45343					Probability value = < .0020		
Unfrequented areas	Yes	70	95.9	23	76.7	36	67.9	129	82.7
	No	3	4.1	7	23.3	17	32.3	27	17.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 17.72185					Probability value = < .0001		
Outside the U.A.E.	Yes	60	82.2	29	96.7	48	90.6	137	87.8
	No	13	17	1	3.3	5	9.4	19	12.2
	Total	73		30		53		156	100
D.F = 2		Chi-square = 4.73068					Probability value = < .0939		
At a farm	Yes	53	72.6	16	53.3	17	32.1	86	55.1
	No	20	27.4	14	46.7	36	67.9	70	44.9
	Total	73		30		53		156	100
D.F = 2		Chi-square = 20.43641					Probability value = < .0000		
Keys :		D.F = Degrees of freedom			Col% = Column Percentage				
Source : Field Work Study, 1993									

Table 7.7 shows statistically significant differences between the location used for taking drugs and the nationality of the user. U.A.E. nationals are more likely to take drugs in different places than users of other nationalities. This is because most of them are addicted

Figure 7.13
Places where drugs are taken (% of respondents)



to heroin and they have to take their drug with them at all times because they may feel withdrawal symptoms at any time. Also the U.A.E. drug user is more likely to have a car than other nationalities. The user who takes drugs in a car usually covers the car windows with black plastic paper in order to be safe from observation. A permit is required for car window covers, and these are issued by the police and usually given to those U.A.E. citizens who do not want their families to be watched or to be bothered by curious people outside the car. However, a lot of people cover their car windows without permission and for other purposes such as drug use.

U.A.E. nationals are more likely than users of other nationalities to use drugs in their parents' houses ($p < .0001$). This is due to several factors, such as that most U.A.E. drug users are young and therefore are still living with their parents, and the lack of education of their parents about drugs use and their dangers. Even if their offspring use drugs in front of them they will not ask them about it, or if they do ask he can tell them that it is a medicine from hospital he is taking and they will not suspect otherwise. Some parents are too busy with their own interests to be aware of what their children are doing, and often it is the housemaid who looks after the children. Thus there is lack of parental control over children (Thabit, 1984). In particular, parents who have large houses often give each child his/her own room, and often each child in the house has his/her own telephone line, pager, television and video. The child is thus free to indulge in drug taking alone or with his friends in his room without any control from his parents, because he has a key to his room and can lock it when he is taking drugs to prevent parents and others discovering his drug habit or hoard.

Heroin users prefer to take their drugs in their parents' house in order to protect themselves from discovery by the police; also the heroin user prefers to take drugs when he is on his own because he does not like to be disturbed. Often when he is under the influence of heroin he is unconscious. He may sometimes stay in his room for more than two days without leaving it at all, and he would argue or fight with his parents if they

asked him to leave his room. U.A.E. nationals are more likely than users of other nationalities to use drugs at work ($p < .0836$). This is because they have more job security than other nationalities, and also because most of them are addicts and thus have to take their drugs at certain times and cannot wait till they leave work. Some of them who are unable to get permission to leave the work place for one or two hours take their drugs in the washroom or in their car in the car park. Those who are able to leave their workplace (with permission or without permission) use drugs at home or in the houses of friends. Heroin users prefer to use their cars or houses where they have the equipment they need to take the drugs.

However, other Arab and Asian drug users are more likely to take drugs in their own homes than the U.A.E. drug users ($p < .0001$). They may feel insecure outside their houses and sometimes they allow their friends to keep their drug supply in their houses in return for free drugs. Moreover, most drug users of other nationalities live alone away from their families or with friends, which gives them more freedom to use drugs in the home in order not to be caught by police or seen by the public.

U.A.E. nationals are more likely than users of other nationalities to use drugs in public places ($P < .0020$). Most of them prefer hotels to take drugs. This is because they are more likely than users of other nationalities to be able to afford to rent a room in a hotel in order to take drugs. They prefer to use hotels which are located outside the city centre, and also they prefer to rent beach cabins rather than rooms. Some users rent a beach cabin or a room in a hotel for a month or a year and use it as a place for drug taking. In addition to the cost of taking drugs, these facilities also cost a lot of money.

U.A.E. nationals are more likely than users of other nationalities to take drugs in unfrequented areas ($p < .0001$). However, other Arab and Asian drug users are likely to use more drugs when they travel outside the U.A.E. than U.A.E. nationals ($p < .0939$). This is because the use of some types of drugs such as hashish, marijuana, and *qāt* is legal or more socially acceptable among people in other countries such as Egypt, Lebanon, Yemen, Pakistan and India. As one of the respondents said:

The use of marijuana is spreading among people in Sri Lanka and most members of my family smoke marijuana.

They are also more worried about law enforcement in the U.A.E. than U.A.E. citizens.

Because many U.A.E. drug users have their own farms, they are more likely to take drugs at their own and their families' farms than other nationalities ($p < .0000$). Farms usually have a villa or a rest house, and farm owners usually spend the weekend at their farms but drug users use them all the time for their habit.

The choice of location for taking drugs depends on many factors; the strength of the desire to take drugs, the degree to which the user is worried by discovery by his parents, the degree of law enforcement and family and public control, and facilities which the user has available, such as transportation, houses, farms, money, etc.

The U.A.E. drug user usually tries to present himself as a normal person, impartial, who does not use drugs, straightforward in front of his family and work associates. This is done for social reasons, such as to preserve his reputation at work or to avoid being discovered by his parents. For these reasons he usually often changes the place where he takes drugs.

Arab and Asian drug users prefer to use drugs in their own houses, and they do not like to use many different places. They are more worried about law enforcement than are U.A.E. nationals, because they are more prone to be suspected by the police and members of the public than U.A.E. nationals. Some people in the U.A.E. may hesitate to report to the police another U.A.E. citizen

who has been breaking the law, but they will hesitate less about reporting a foreigner.

This may be because they believe that unless reported to the police, a foreigner who has broken the law will simply leave the U.A.E. and therefore escape U.A.E. jurisdiction.

Consequences of drug use

Psychological and physical experiences

One factor behind the concern about drug use is the belief that drugs can have physical and psychological consequences for drug users. As one of the respondents said:

Drug abuse destroys the life of an individual. It wastes money and time and both creates and increases family problems. I find myself isolated, with my only friends being other drug users. I have no interests other than how to obtain drugs.

The consequences of drug use vary with the type of drugs used and the amount. The findings show that some respondents who used heroin, opium, marijuana, morphine and barbiturates have reported that they have felt nauseous. Users of these types of drugs are more likely to experience this symptom than other users who use other types of drugs. Other types of drugs gave the same feeling for some respondents, such as cocaine, amphetamines, tranquillisers, and LSD. This feeling increases among those who use opiates regularly because most of them lose their appetite. It usually occurs in the withdrawal period. However, most respondents who used heroin, cocaine, barbiturates, opium and marijuana reported that they experienced nervousness and trembling (67.3%). Users of the above mentioned types of drug were more likely to experience nervousness than were users of other types of drugs. The relationship between this symptom and other types of drug is less marked, but nevertheless is experienced by users of hashish, morphine, LSD, amphetamines and other types of drugs. Neuropathic disorders such as mood swings and nervousness are prevalent among drug users, especially those who use heroin, opium and morphine. Under the influence of some types of drugs, emotional feelings decrease, with an escalation of paranoiac spells and fits of anger. Because of the increase of anxiety and depression, hallucinations and delusions increase, which leads to an escalation of nervousness and trembling (Medzerian, 1991).

Suicidal thoughts feeling was high among respondents who used heroin, barbiturates, and tranquillisers (51.3%). Some respondents who used other types of drugs also had the same feeling, but less so than the users of the above mentioned drugs. There is a low relationship between some types of drugs such as opium, marijuana, morphine, LSD, and amphetamines and suicidal thoughts. This feeling tends to increase because of the increase of anxiety and depression with these drugs, especially among heroin users. In 1991, about 32 suicidal attempt cases have been reported to Al-Amal Psychiatric Hospital in Dubai (Al-Amal Hospital Annual Report, 1992). As one of the respondents said:

Many of my friends with whom I used to take drugs have died through drug abuse and I intend only to keep company with my non-user friends in the future.

Hearing voices was also reported by some respondents who used tranquillisers than other types of drugs (48.1%). The relationship between these hallucinations and the use of other types of drugs was less marked than the relationship with tranquillisers. Respondents who use hashish, marijuana, morphine, amphetamines, barbiturate, and solvents have also experienced hearing voices.

Phobic feelings were higher among respondents who used drugs such as hashish, marijuana, and barbiturates than users of other types of drugs. The relationship between this feeling and the use of other types of drugs was less marked than the relationship with the above mentioned drugs. Some respondents who used opium, heroin and solvents also experienced the same feeling. Hashish users, more than users of other drugs, reported that they become scared when they are under the influence of drugs. This is because the feelings of hashish users are intensified under the influence of the drug (see Chapter 5). Heroin users become scared when experiencing withdrawal symptoms, and during periods of insomnia and overdose, which are both features of the addiction. The feeling of hopelessness about the future was higher among respondents who used heroin, LSD, and barbiturates than users of other types of drugs (55.1%). Users of morphine,

tranquillisers, opium, marijuana, cocaine and amphetamines also experienced the same feeling. Users of hallucinogenic drugs and opiates were more likely to experience this feeling than users of other types of drugs. This is because users of these types of drugs become more depressed and anxious under the influence of these drugs than other types. Most drug users feel that they are isolated from society and they feel that they are less worthy than other people, which results in a loss of self-confidence and self-esteem, and subsequent conviction in the hopelessness of their future. As one of the respondents said:

I have been trying to avoid being arrested by the police and not to become known as a drug user but now I have nothing to hide, everybody knows that I take drugs and I have lost my job. I feel I have no future except to take drugs.

Euphoria has been reported by some users, especially those who used cocaine, LSD, amphetamines, and tranquillisers. After using drugs, feeling of happiness start within a few minutes and can last for some time if high doses are taken. The short-lived happiness is followed by rebound after-effects, and leads to extreme mood swings. Respondents who used other types of drugs did not experience the same feeling. This may be because of the bad experience of withdrawal of other drugs, especially opiates and barbiturates; or sometimes the drug users know that the feeling of happiness produced by the drug is not real happiness, but a drug-induced imaginary feeling.

Only users of hashish and barbiturates have experienced the feeling of sexual enhancement (55.8%); users of other types of drug did not report the same feeling. Some drugs such as heroin, opium, barbiturates, etc. depressed the sexual glands, which causes impotence to the user (Al-Bar, 1988). Impotence was reported by most opiate users, especially the heavier users. They also reported that because of their impotence they had many problems with their wives, and they become worried about their sex life. In Arab societies sexual potency is considered an important part of manhood. Moreover, the feeling of working better was higher among heroin, barbiturate, opium, marijuana,

hashish, morphine, cocaine, amphetamines and tranquilliser users. Also users of some types of drugs which cause physical dependence, such as heroin, opium, barbiturates, etc., usually feel more active when under the influence of the drug. Users of hashish reported that they had good experiences from the use of hashish. They thought that when they were under the influence of hashish they were able to think more effectively and they were able to make their families happier than when they were not under the influence of hashish. Also they reported that under the influence of hashish they were more persuasive and they preferred to use hashish when they had meetings to attend. There is a low relationship between the use of heroin and barbiturates and the conviction that they have more self-control than users of other drug types. Most users of other types of drugs did not report this feeling. Users of drugs which cause physical and psychological dependence usually lose their self-control, especially during the absence of the drug or in cases of overdose. Also the prevalence of nervousness and trembling leads to the loss of self-control. The loss of self-control is also common among users of hallucinogenic drugs. Opiate users experienced withdrawal delirium, loss of consciousness and continuous spasm spells. The lack of awareness concerning the passing of time was also reported by drug users especially those who used hallucinogens and opiates. Meanwhile, some users who used opium, amphetamines, tranquillisers, barbiturates and solvents have experienced feeling of increased energy. This feeling is usually common among users of stimulant drugs such as cocaine and amphetamines but rarer among users of depressant drugs, which indicates that the feelings are drug-induced. Moreover there is weak relationship between the use of cocaine and the use of LSD and the feeling of self-confidence. This may be because cocaine is a stimulant which induces high euphoria and also because of the hallucinatory effects of LSD.

The findings show there is a strong relationship between the use of opium, marijuana, heroin, morphine, cocaine, amphetamines, barbiturates, tranquillisers and LSD and the experiencing of eye problems. There is some albeit weak relationship between eye

problems and other types of drugs such as hashish. Itching and watering are absent symptoms for some types of drugs. Double vision is usually associated with the use of hallucinogenic substances or as a result of overdose. Opiate users experienced these symptoms more than users of other drugs. Meanwhile, the findings show a strong relationship between the use of some types of drugs such as opium, marijuana, heroin, morphine, cocaine, LSD, amphetamines, barbiturates and tranquillisers and nasal problems such as congestion, a running nose, sneezing spells, etc. There is also a weak relationship between the use of hashish and these problems. Most of these symptoms occurred during the withdrawal period of some drugs. Sniffers of cocaine and heroin reported that they experienced troubles with nasal congestion. This is because these types of drugs cause infection in the nose, especially if the drug was adulterated. Most of the psychological and physical consequences of drug use which have been mentioned by some respondents have been found reported in their files. Moreover, the findings show a relationship between the use of barbiturates, heroin, morphine, LSD, tranquillisers, cocaine, and amphetamine and the experiencing of wheezing or gasping. These symptoms are more likely to happen to heavier drug users than to others, and also to those who take drugs by smoking or inhalation. These symptoms also occur during overdose or during the withdrawal period of some types of drugs, especially opiates. The use of heroin reduces the oxygen in the respiratory system and causes hypoxia, which leads to breathing difficulties (Al-Bar, 1988). Some respondents who used amphetamines, barbiturates, opium, hashish, heroin, cocaine and tranquillisers have experienced problems with the teeth, mouth or gums. The most common problem relating to the mouth is halitosis. Users of opium also have experienced damage to their teeth. Users of cocaine and hashish reported that they experienced dryness of the throat and in order to moisten their throat they drank too much alcohol.

The findings show that there is a relationship between the use of opium, heroin, marijuana, cocaine, barbiturates and tranquillisers and urinary problems. These problems also have been reported in most heroin users' files. There is also a relationship between

these problems and the use of other types of drugs such as morphine, amphetamines, other substances, LSD and hashish. Users of opiates have reported that they experience difficulties during urination when under the influence of the drug. To solve this problem, they usually drink juice or alcohol. Also during the withdrawal symptoms they experienced burning and cystitis and loss of control of urination. Opiates cause congestion of the urinary tract, which causes difficulties with urination (Al-Bar, 1988). There is a relationship between the use of some drugs such as amphetamines, marijuana, barbiturates, and other substances and the experience of heart-related problems. Amphetamines increase the blood pressure, damage the blood vessels and can cause heart failure. Some drug use causes infection of the pericardium and endocarditis (Al-Bar, 1988).

The findings of my study show that there is a relationship between the use of opium, heroin, barbiturates and tranquillisers and skin problems. There is also a relationship between skin problems and the use of other types of drugs, such as marijuana, morphine, cocaine, LSD, amphetamines and other substances. Heroin users experienced skin itching more than users of other drugs. The appearance of abscesses was reported more by those who were using opiates by injection, as was skin allergy. Itching is also associated with withdrawal symptoms of some types of drugs. Skin problems were also caused by using dirty needles and syringes and adulterated substances. Some respondents who used barbiturates, tranquillisers, marijuana, heroin, cocaine and amphetamines have reported experiencing of faintness or dizziness. These symptoms arise during the withdrawal period of some drugs or as a result of overdose (especially by injection) or the use of adulterated substances. My findings also show there is a relationship between the experiencing of shaking or trembling and the use of heroin, barbiturates and tranquillisers. Respondents who used these substances experienced this more than users of other types of drugs. There is also a relationship between shaking or trembling of limbs and the use of types of drugs such as opium, marijuana, morphine, cocaine, other substances, LSD, amphetamines and solvents. These symptoms were usually associated with withdrawal and overdose. Also, long-term users and heavier users were more likely to

experience these symptoms than other users. Shaking and trembling of the arms and legs is more common among heroin users than other types of drugs. This is because heroin users have less appetite for food than users who use other substances; therefore they suffer from maladministration and lack of body energy.

Headaches during work or daily activities have been reported by some respondents especially those who used opiates, barbiturates, hashish, solvent, LSD, amphetamines and tranquillisers. Pressure on the top of the head was also reported by some drug users, especially those who used opiates. They felt that a heavy object was put on their heads. Some users also reported that headaches could occur when they used more than one type of drug at the same time, or when using marijuana, or hashish with alcohol. Also, users of some adulterated substances reported that they suffered headaches. Headaches were also associated with withdrawal symptoms for some substances. Stomach problems have been reported by some respondents, especially those who used opiates. Users of opiates reported that they experienced indigestion, and solidification of stools when they were under the influence of the drug; they also experienced diarrhoea during the withdrawal phase. This is because these substances depress the stomach and the intestine, which causes a reduction of digestive substances in the stomach (Al-Bar, 1988). The findings show that there is a relationship between the use of opium, heroin, cocaine, barbiturates, tranquillisers, marijuana, amphetamines, LSD, solvents and morphine and loss of appetite. Users of heroin do not like to eat any kind of food except chocolate and fruit juice. Users of hashish reported that they ate a lot of food when they became intoxicated. Opiates cause stomach and intestine constipation and reduce the digestive substances in the stomach (Al-Bar, 1988). In corroboration of my interview data, much other research related to drug use and addiction confirms the symptoms mentioned above by respondents. The doctors I interviewed also confirmed most symptoms related to drug use reported by respondents (Medzerian, 1991; Ditzler & Haddon, 1986; Geller & Territo, 1991; Pita, 1992).

Drug use and other anti-social behaviour

It is possible that some drug users become involved in criminal activities. This is because some drugs allay tension and fear, which encourages the expression of anti-social tendencies. Some drug users reported that they found that they could only concentrate on looking for money and drugs, and suffered a lack of self-control. They also tended to become involved with anti-social behaviour, and grew careless about the consequences of their actions.

Figure 7.14 shows that most respondents reported that they were involved in other drug-related activities such as selling, dealing and trafficking with drugs. This is because for drug users, the availability of drugs and price of drug use are more important, especially for those who have physical dependence. They deal in drugs alongside drug use to finance their habit. Some respondents have reported that the need for money to satisfy their habit often pushes drug users to steal drugs from friends. This leads to stealing money and jewellery from parents, wives and relatives, and after that they become involved in stealing from other people. To finance their use of drugs, most users preferred to be involved in selling drugs rather than committing theft or burglary. They consider drug selling more acceptable behaviour than committing theft or burglary, and they also said that obtaining money from selling drugs was easier and guaranteed. As the use of hashish is more widespread among people than other types of drugs, most respondents have been involved in selling hashish. A heroin and opium are expensive and lucrative, some drug users became involved in selling them.

Some respondents had been jailed for committing crimes before their present imprisonment. Most of them have committed drug-related crimes (32.7%), crimes involving injury (14.7%), alcohol-related crimes (9.0%), and theft and burglary (8.3%). The others committed different crimes such as pederasty (3.2%), traffic offences (3.8%), adultery (1.9%), kidnapping (.6%), crimes against public servants (.6%), forgery (1.9%), violation of customary laws (1.3%) and other financial crimes (2.6%).

Figure 7.14
Drug use and other anti-social behaviour (% of respondents)

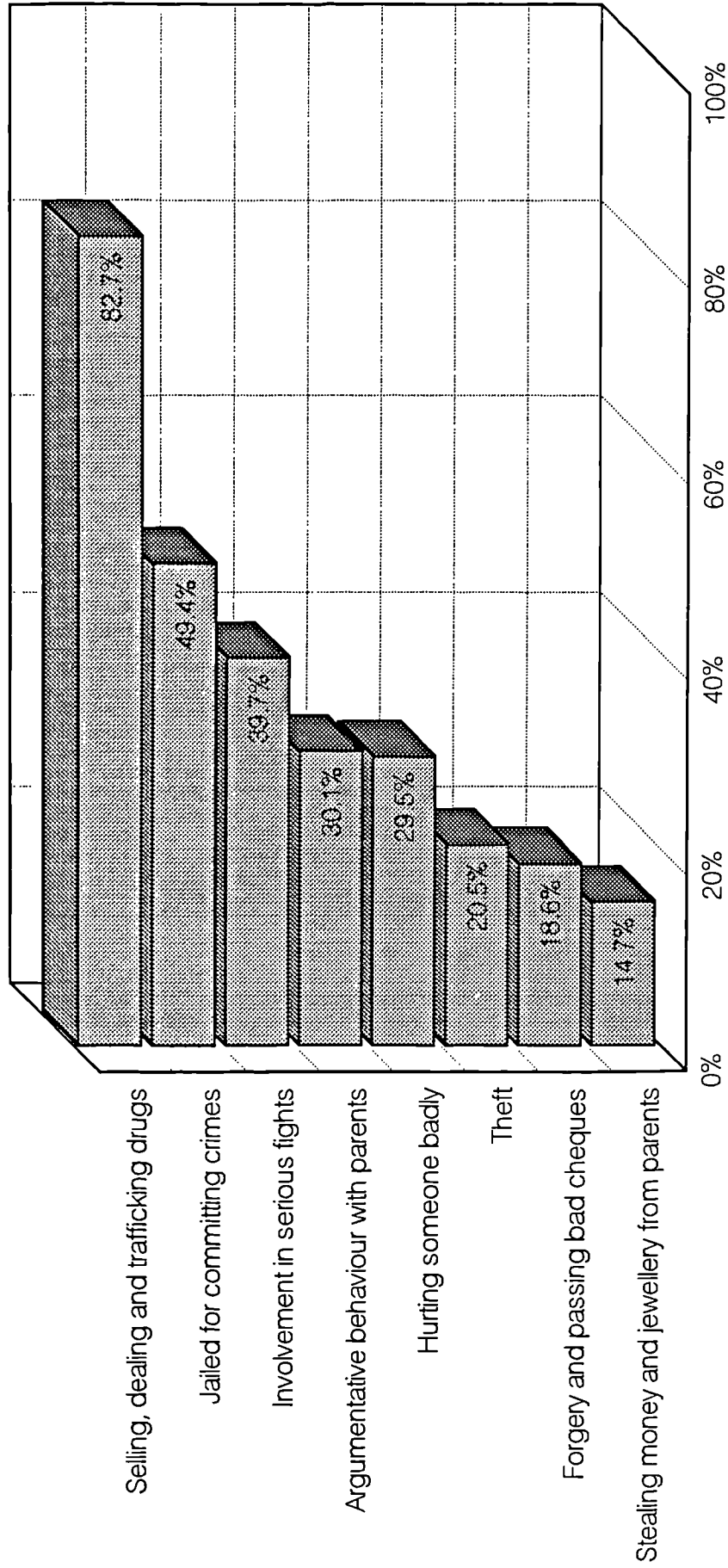


Table 7.8: Anti-social behaviour and nationality

Nationality		U.A.E.		Arab		Asians & Others		Total	%
		Count	Col%	Count	Col%	Count	Col%		
Been jailed for committing a crime	Yes	50	68.5	13	43.3	14	26.4	77	49.4
	No	23	31.5	17	56.7	39	73.6	79	50.6
	Total	73		30		53		156	100
D.F = 2		Chi-square = 22.29011				P. value = < .0000			
Argued or had a fight with either of your parents	Yes	34	46.8	5	16.7	8	15.1	47	30.1
	No	39	53.4	25	83.3	45	84.9	109	69.9
	Total	73		30		53		156	100
D.F = 2		Chi-square = 17.65341				P. value = < .0001			
Had a serious fight in school, at home, at work etc.	Yes	40	54.8	14	46.7	8	15.1	62	39.7
	No	33	45.2	16	53.3	45	84.9	94	60.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 20.95227				P. value = < .0000			
Forged or passed bad cheque(s)	Yes	19	26	8	26.7	2	3.8	29	18.6
	No	54	74	22	73.3	51	96.2	127	81.4
	Total	73		30		53		156	100
D.F = 2		Chi-square = 11.64920				P. value = < .0030			
Stolen money, jewellery from your parents etc.	Yes	22	30.1	3	10	2	3.8	23	
	No	51	69.9	27	90	51	96.2	133	85.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = 11.31916				P. value = < .0035			
Hurt someone badly	Yes	36	49.3	8	26.7	2	3.8	46	29.5
	No	37	50.7	22	73.3	51	96.2	110	70.5
	Total	73		30		53		156	100
D.F = 2		Chi-square = 30.77170				P. value = < .0000			
Sold drugs	Yes	60	82.2	25	83.3	44	83	129	82.7
	No	13	17.8	5	16.7	9	17	27	17.3
	Total	73		30		53		156	100
D.F = 2		Chi-square = .02534				P. value = .9874			
Stolen any thing from person, shop, car, etc.	Yes	22	30.1	7	23.3	3	5.7	32	20.5
	No	51	69.9	23	76.7	50	94.3	124	19.5
	Total	73		30		53		156	100
D.F = 2		Chi-square = 11.46380				P. value = < .0032			
Keys :		D.F = Degrees of freedom				Col% = Column percentage			
		P.value = Probability value							
Source : Fieldwork Study, 1993									

Table 7.8 shows the statistical differences between nationality and the anti-social behaviour of drug users. Drug users from the U.A.E. were more likely to commit crimes than those of other nationalities. They were also more likely to be involved in serious fights in school, at home, at work, etc. than other respondents. This is both because most drug users who are U.A.E. nationals are younger than drug users of other nationalities, and because most of them are using hard drugs such as heroin, which causes nervousness

and shakiness, especially during the withdrawal period. Respondents from the U.A.E. were more likely to injure someone badly than other respondents; this is because most of them are heroin users, and the findings show that heroin users have a greater tendency than other drugs users to cause serious injury or to act aggressively, especially during the withdrawal period. They were also more argumentative and aggressive with either of their parents than other respondents. There is also a relationship between respondents from the U.A.E. and the theft of money and jewellery from parents, family, relatives, etc.. This is because most who use multiple drugs and are addicted to expensive types such as heroin are younger. Arab respondents were more likely to be involved in forging or passing bad cheques than other respondents. There was also a relationship between stealing from people, shops, cars, etc. and respondents who are from the U.A.E., because most drug users who are U.A.E. nationals are physically and psychologically dependent, and are constrained by their continued drug use to finance their habit, which may result in committing crimes, especially theft.

Treatment of drug use

Most respondents reported that they had tried to stop using drugs (60.3%). They tended to do so after a bad experience, such as going through withdrawal symptoms. The rest have not tried to stop (39.7%). My findings show statistically significant differences between the discontinuance of drug use and drug type. Respondents who used drugs such as heroin and barbiturates had a greater desire to stop using drugs than users of other types of drugs. This is because the users of these drugs had suffered bad experiences from using them. These types of drugs induce severe withdrawal symptoms which usually make users want to save themselves from further suffering. As one of the respondents said:

I promised myself to give up drug use. Then I sought help by contacting a drug enforcement officer who asked me to come to his office, but one of my friends told me if I went I might be arrested by the police. After that I sought

medication from a private doctor who gave me some medicine, but one of my friends tempted me back to drug use by giving me heroin.

There is also a relationship between the discontinuation of drug use and some other types of drugs such as cocaine, marijuana, morphine, LSD, amphetamines, tranquillisers, other substances and opium. There is no relationship between respondents who used hashish and the discontinuation of drug use. This may be because most of them have not had bad experiences from hashish use.

My findings also show the relationship between the continuation of drug use and drug type. There is a relationship between the use of opium, heroin, morphine, cocaine, barbiturates, and tranquillisers and the respondents' desire to continue drug use. This is because most users of these types of drugs have experienced bad withdrawal symptoms from their use, and they continue to use these types of drugs as a medicine to relieve the painful effects. They associate their relief with continuing to use the drugs. A lack of medication means that they suffered greatly with withdrawal symptoms. Users of hashish were more able to stop using drugs than users of other substances. This is because most hashish users had not experienced adverse effects from hashish and they were able to stop using it at any time without experiencing adverse symptoms.

There is also a relationship between some types of drugs such as hashish, marijuana, LSD, amphetamines ($p < .0001$), other substances ($p < .0002$) and the desire for continuation of drug use. Users who used drugs which cause physical dependency are more likely to continue drug use, especially if they receive no medication for addiction.

Most respondents sought medication to enable them to stop using drugs (60.3%), but some users never sought medication (39.7%). Only some of those who had sought medication to stop drug use had received medication (43.6%). Most of those who sought medication were addicted to opiates, especially heroin, and most of those who did not seek medication for addiction were hashish and marijuana users.

Most of those who had medication for drug addiction were cured (55.9%). Most of them had received medication more than once, because they had been brought to the medication centre by police or their families after having refused to have medication voluntarily.

Most heroin users who had received medication stopped using of heroin but continued to use other substances, especially hashish. They were treated only physically, to release their bodies from the effects of heroin. Most received no psychiatric treatment or help with dealing with family or social problems, or rehabilitation, which meant that psychological problems connected with their addiction were still present. Most of those who said they were cured after they had medication were relieved only of the painful withdrawal symptoms of the drug.

The findings show that there is a relationship between the use of opium, heroin, marijuana, cocaine, amphetamines, barbiturates and tranquillisers and the seeking of medication. This is because most users of these types had experienced painful effects from using drugs at some time, especially those who used opiates and barbiturates, which result in physical dependency. There is also a relationship between seeking medication and the use of certain drugs such as hashish, morphine, LSD and other substances. Users who used hashish were less likely to seek treatment than users of other substances. This is because most hashish users were short-term users.

Only a small number of respondents were treated both in a clinic and in jail (22.4%). Most of them were treated in a clinic. Most users who were in prisons had received no medication or rehabilitation (77.6%); this is because lack of medication and rehabilitation services in prisons. Also, some of those who were in the Al-Amal Psychiatric Hospital said that they were not in need of medication because they were not addicts, but that their families had them committed there in order to avoid prosecution. In fact, some of those who were in jails were more in need of psychiatric treatment in the hospital than those who were being treated in the clinic.

Most of those who had been treated in clinics or in jails reported that they were cured (85.7%). They had received treatment such as screening, physical examinations, emergency care and other medical services. They felt physically better but they still suffered mentally and psychologically. Most of them still have the desire to use drugs.

The findings show that there is a relationship between the provision of medication and the Al-Amal Hospital. Most users who had received medication were treated at Al-Amal and Sharjah Central Jail provided more medication than other jails.

The findings also show statistically significant differences between the rehabilitation and treatment facilities and different prisons and clinics. Users were more satisfied with the rehabilitation and medication facilities provided in Dubai Central Jail than in other places, and the Al-Amal Hospital came second in provision of facilities. This is because Dubai Central Jail provides more recreational, vocational, and social assistance to drug users than other places, and this helps in the treatment of addiction.

Summary

The findings in this chapter show that the types of drugs used in the U.A.E. are those used by drug users the world over. Most respondents were multiple drugs users, frequently using more than ten types of drugs. The findings also showed that the rate of use of opiates such as opium and heroin was high, especially among users who are U.A.E. and G.C.C. nationals, and is increasing. This high rate is because these types of drugs are produced in neighbouring or nearby countries such as Iran and Pakistan, and because their prices are within reach of the U.A.E. and G.C.C. nationals' purchasing power. Most users who are from the U.A.E. and G.C.C. countries frequently use expensive and hard effective drugs such as heroin. Users of other nationalities use heroin only occasionally, and prefer to use only cheap drugs such as hashish and marijuana frequently. The findings show that peer pressure combined with the lack of parental

supervision on children, and the availability of drugs in the context of high purchasing power, were the principal factors behind young people starting to take drugs. The findings showed that individuals use drugs when they are available in the society in which they live. The life of a drug user becomes a continual struggle to obtain drugs and the money required to pay for them, and to avoid police, family, relatives and other people. Therefore, some of them may get involved in other anti-social behaviour, such as theft, to finance their habit. The findings show that the desire to stop drug use and seek medication was present among drug users, especially those who use hard drugs. Most of those who have tried to stop using drugs and have sought medication did so after bad experiences fear of social consequences and imprisonment and suffering from withdrawal symptoms. As a result of the lack of facilities for treating drug users in prisons and clinics, drug users have often tried to treat themselves. It was usually after experiencing bad effects that drug users have tried to fight their addiction.

The next chapter continues the exploration of the nature of the drug abuse problem in the U.A.E., focusing on the incidence level and trends of drug abuse. The findings and implications of my fieldwork are examined, and are compared with the findings of similar research carried out in other countries. The next chapter will examine the extent to which patterns of drug use in the U.A.E. differ and resemble patterns of drug use in other countries.

Chapter 8

Drug Abuse Problems in the U.A.E.: Interpretation of the Main Findings

Introduction

Since the 1980s, the problem of drug abuse has become one of the major problems in U.A.E. communities (Ministry of Social Affairs, 1990). This is because the behaviour of drug users has affected individuals, families and society. One very worrying element of the drug problem is that drug use is especially prevalent, and increasing, among adolescents and young adults. This situation is not only associated with the U.A.E., but also occurs in other countries in the world. In order to formulate a policy to combat the drug problem, an understanding and evaluation of drug use and its attendant problems is very important. One of the aims of this research is to understand the nature of drug use. This includes an understanding of the users' beliefs, values and attitudes toward drugs, and also to understand the patterns and trends of drug abuse. The understanding of patterns of drug abuse and drug-related problems should be the main objective of the U.A.E. government before the establishment of a new policy towards drug abuse.

Some officials in the U.A.E. maintain that because people of the U.A.E. retain their traditional customs and traditions, the country will not become prey to the problems of drug abuse which are on the increase in the world generally. But how long will the U.A.E. people be protected by their customs and traditions? Youths in the U.A.E. are following, if not exceeding, the patterns of drug abuse that are prevalent among youths in other countries in the world. It is essential that the U.A.E. has a reasonable estimate of the rate of drug abuse among the population in order to formulate solutions for the problem. Without an estimate of the prevalence of drug abuse, an inaccurate understanding of the extent of the problems is likely, and this could lead to an underestimation

of the problem which in turn could affect the degree of importance given to it by the government. This could result in effective measures not being applied until it is too late, which may increase and complicate the drug problems in the U.A.E..

This chapter, with the previous chapter, explores the nature of drug abuse problems in the U.A.E., especially the incidence level and trends of drug abuse, and interpretation and implications of the main findings.

Demographic Profile

Most abusers of whatever nationality in the U.A.E. use more than one type of drug. The incidence of use of more than two types of drug, however, is more prevalent among U.A.E. citizens than other nationalities. U.A.E. citizens are more likely to be multiple drugs users, closely followed by those from the G.C.C., with other Arab citizens ranked third and Asians fourth. Multiple drug users usually use hard and expensive types of drugs such as heroin and opium. The fieldwork findings have shown that the rate for users of heroin, opium and barbiturates is very high among drug users from the U.A.E. and from the G.C.C., and low among Asians and other nationalities. This difference may be related to the different attitudes to drug use of the different nationalities (Segal, 1990). The findings of this research are different from those of other research. Some researchers found that an increase in drug abuse is more prevalent among ethnic groups who come from other countries than among local citizens (Strasbourg, Council of Europe, 1987). In Amsterdam, studies have reported that drug abuse was brought into the country by immigrants from the old colonies and did not originate amongst the local citizens (Strasbourg, Council of Europe, 1987). The research findings show that U.A.E. citizens are more experienced in drug abuse than other nationalities. They use heroin, which is the most dangerous type of drug known among users. The immigrants, especially Asians, rarely use heroin. This result is the same as that found in England. The use of heroin is more prevalent among British people than other ethnic groups (Strasbourg, Council of

Europe, 1987). Findings have also shown that the prevalence of drug abuse is higher among wealthy people, who are from the U.A.E., and lowest among poor people, most of whom are Asians. This result differs from what has been found in some other countries. For example, in Ireland studies have shown that the prevalence of drug abuse is highest among local citizens who are unemployed and suffering from poverty (Strasbourg, Council of Europe, 1987). Despite the increase of drug abuse in their countries of origin, the prevalence of drug abuse among Asians in Ireland is low. In France, the prevalence rate of drug abuse is higher among ethnic groups who have come from North Africa, especially from Morocco where cannabis cultivation is widespread (Strasbourg, Council of Europe, 1987).

The high rate of drug abuse among U.A.E. citizens is a dangerous indicator for U.A.E. society and government. This is because U.A.E. nationals comprise only about 27.9% of the U.A.E. population, other nationalities making up about 72.1% (Ministry of Social Affairs, 1990). This means that in spite of the fact that the actual number of U.A.E. nationals is small, the rate of drug abuse among them is high. The behaviour of users who are U.A.E. nationals differs from that of other nationalities, especially in their preference of the use of specific types of drugs. Pakistani people prefer hashish to other types of drugs and Iranians prefer to use opium, whilst the U.A.E. citizen prefers to use heroin.

The different patterns of drug abuse among different ethnic groups in U.A.E. society could increase and complicate drug use problems. In order to solve these problems the government should not concentrate only on the drug abuse problems of U.A.E. nationals, ignoring the problems of the other ethnic groups. In order to create an effective policy to combat the spread of drug abuse, the cultural values and behaviour of each ethnic group must be studied and understood, together with an appreciation of the different factors behind the increase of drug abuse among each ethnic group. In my research, I did not examine the cultural values and social behaviour of each ethnic group. This is

because the examination of these aspects among different groups of people needs big efforts which cannot be provided by a researcher, such as fund resources, higher numbers of researchers, more time, the ability to speak different languages, etc..

Drugs and other related social problems must be tackled simultaneously, and solutions should be sought for drug users of all ethnic groups because there are grave social implications for increasing drug abuse among all nationalities in U.A.E. society, such as a higher living cost, housing problems, population structure, immigration problems, etc..

My research findings have shown that most drug users are young people in their teens and twenties. Some studies have also reported that the prevalence rate of drug abuse is high among young people, especially those in the 16 to 29 year age group (Mohan et al., 1985). In Mexico, the rate of drug abuse is highest among people in the 15 to 19 year age group. This age group makes up about 55.4% of drug users in Mexico (Ortiz et al, 1989). This is because the aim of young people is to obtain from drug use a feeling of euphoria, therefore they usually take drugs which induce high euphoria and intoxication. The rate of heroin use is highest among the age group 18 to 29 years. The increase of drug use among young people is a global phenomenon. In France the use of heroin is highest amongst the age group 18 to 24 years (Ingold et al, 1989). The rate of heroin use in Dublin is highest among adolescents and young people (Strasbourg, Council of Europe, 1987).

Research findings have shown that the highest rate for drug abuse was among respondents who had had an intermediate and secondary education (54%). Most of them are multiple drugs users who use hard and expensive types. They have a tendency to experiment with new types of drugs. This may be because most of them are young, mainly in the age group 18 to 29 years, and at this age psychological and emotional problems are at a high level and individuals are more likely to exhibit

behaviour such as drug abuse (Al-Bar, 1988). The rate of heroin use is higher among users with intermediate education. This finding is different from the results of some studies. In India the highest rate for heroin use is among people with a higher education (Mohan et al., 1985).

Patterns of Drug Using Behaviour

The types of drugs used in the U.A.E. are those which are increasing among users in the world generally. There are more than ten types of drugs used frequently, and most respondents were multiple drugs users.

The rate for hashish, opium, marijuana, barbiturates, tranquilisers, amphetamines, morphine and LSD use among respondents was the highest. Hashish was tried by most drug users, and was the type used most frequently. The use of hashish was considered by users as part of their lifestyle. Most of them considered using hashish as normal as smoking cigarettes. They believed that hashish does not cause physical or psychological dependence. For heroin users, the use of hashish is important. They smoke hashish cigarettes after using heroin, believing that the use of hashish increases the intoxication of heroin. Another reason for the common use of hashish is its low cost in contrast with other types of drugs. The amount of money which a heroin user spends in a day can keep the hashish user supplied for a week or more.

But for U.A.E. national drug users, heroin was the most commonly used drug. Barbiturate users used barbiturates in conjunction with heroin to reduce the suffering of the heroin withdrawal symptoms and heroin users used barbiturates when they could not get hold of heroin. Psychoactive substances were not taken in a social context, e.g. at parties, but were used as substitutes for other drugs such as heroin and opium. The use of these substances is spreading among respondents who use other types of drugs.

Because cocaine and crack are produced in countries such as those of Latin America, its use is low. Solvents are used by some drug abusers, although mostly by adolescents.

The main factors behind the increasing use of heroin in the U.A.E. is that it is produced in neighbouring countries such as Pakistan and Iran and that its prices are within reach of the U.A.E. and G.C.C. citizens' purchasing power.

The desire of the individual to earn money tempts him to become involved in the illicit drug trade. This is because drug users who are U.A.E. nationals are willing to pay a lot of money to drug dealers, thus fostering and encouraging the desire to earn money.

The purchasing power of the user was also one of the factors behind the spread of cocaine use in Canada in the 1970s when cocaine was spread only among wealthy adults and adolescents, then among the middle and low classes (Stamler & Fahlman, 1987). Because most cocaine in the world is produced in nearby countries in Latin America, most cocaine which is smuggled into Canada and the United States come from nearby countries such as Colombia and Bulivia (Stamler & Fahlman, 1987). The increase of the use of heroin among people in the U.A.E. is evident from the high quantities seized by the police.

Most heroin users do not like to continue using it. This is because of its painful side effects. Most users who are from U.A.E. and G.C.C. countries use heroin frequently; but users of other nationalities use heroin only occasionally. Heroin users consume from half to one gram of pure heroin and from one to three grams of adulterated heroin per day.

The rate for the use of other substances among respondents is high. They use many different types of substances. The rate for the use of cough syrup, for instance, is high; the most commonly known types (whose use is spreading among respondents) are Codipront, Phensedyl, Actifed, Benylin, Diction, Benafed, Rhinotossal and Romilar (which contains codeine). The rate for the use of pain killers among respondents is also high. The most famous

types used among respondents are Lagaflex, M.S.T, D.F 118, Distalgesic, DHC, Veganin and Pethidin. These substances are used more by heroin users than other substance users. They use cough syrup that contains codeine as a substitute of heroin.

The findings of this research which are related to patterns of drug use differ little from those of other research findings which have been carried out in other countries. Many studies (Madianou & Madianos, 1987; Dias & Polvora, 1983) have shown that hashish is the most commonly used drug among drug users. This is may be because of the availability, low price and slighter physical and psychological effects of hashish compared with other types of drugs. In Greece, among most drug users, the most frequently used drug is hashish (Madianou & Madianos, 1987). The use of opiates is also high among users in other countries. In Portugal, hashish is the most commonly used drug (33%), followed by opiates (24%) (Dias & Polvora, 1983). A multi- cities study carried out in 1987 by the Council of Europe showed that in European countries such as England, France and Italy, hashish was the most commonly used drug, followed by the use of other substances such as heroin and cocaine (Strasbourg, Council of Europe, 1987). In Nigeria, among most drug users, the most frequently used drug is hashish (Pela & Ebie., 1982). However, in Malaysia, the most frequently used drug among about 80% of drug users is heroin (Navaratnam et al., 1989).

Initiation of drug use

The research findings show that the commonest age of initiation of the drug use was between 16 and 22 years. But there were some respondents who started to use drugs in the age group 9 to 15 years. Most Asian respondents started the use of drugs in the age group 9 to 15 years. This may be related to the availability of drugs in their societies. Pakistani respondents started the use of drugs earlier than other Asians. This may be because Pakistan is a main source for hashish and opiates in the world. Most Pakistani respondents claimed that hashish is accepted among people in some parts of Pakistan,

especially in the mountainous areas, and the social reaction toward drug use is lenient. Some Pakistani respondents said that they used to get drugs such as hashish and opium from normal shops in some parts of Pakistan, and some of them used to plant cannabis and poppies on their own farms. Most respondents who became opium users were Iranians. This is because of the availability of opium in Iran. Also some respondents have said that in Iran opium is used as a medicine, especially for children's diseases and senility. Only a few respondents started with heroin. This may be because heroin is expensive and it is difficult for new users to find out where to buy it and also because of its hard effect.

Most respondents used to smoke cigarettes and drink alcohol before they started used other types of drugs. This seems to indicate that smoking and drinking alcohol may lead to the use of hard drugs. But this is not the case all the time and for all people. As one of the respondents reported:

Early on in my childhood I had some delinquent friends. We started to smoke cigarettes and then sniffed solvents. But when we grew up we felt that cigarettes and solvents were suitable only for children and not suitable for us as mature people. After that, we tried alcohol, then hashish. I travelled to India to bring some hashish to the U.A.E. for my own use, and when I was there I met a heroin dealer who encouraged me with the drug until I became addicted to it. Because I was in need of money to spend on my drug habit, I began dealing in the illegal drug trade.

Most respondents who are U.A.E. citizens smoke cigarettes and drink alcohol before they use other types of drugs. Some of them started with smoking cigarettes, then went on to use solvent or glue, and after that shifted on to the use of hashish and then experimented with many types of drugs. Some of them started with smoking, then used alcohol and after that moved on to hashish. Most of them experimented with many types of drugs until they settled on the use of one or two types of drugs mainly heroin and hashish or heroin and opium. The more a drug user experiences drugs, the more he experiments with new types of drugs. Some people in the U.A.E. distinguish between

the drug abuser and the drinker of alcohol. In spite of the fact that alcohol is forbidden by Islamic law and has a greater impact on health than marijuana, some people consider drinking alcohol to be more acceptable than the use of marijuana. This is because some of them consider alcohol a part of a fashionable lifestyle. Therefore it might be that stricter control of cigarette and alcohol consumption could prevent some people from later using other types of drugs.

Peer pressure combined with the lack of control of children was a principal factor behind young people starting to take drugs. Through their relationship with their friends they try to express their maturity, curiosity, courage, etc.. They are always trying to match their peers.

Anti-social behaviour of parents and relatives also seems to affect children's behaviour regarding drugs. The use of drugs and alcohol among members of the family raises the likelihood that the children will experiment with drugs. Drug use is lowest among children who have close relationships with parents (Friedman et al., 1985). About 9% of respondents said their first use of drugs was after being offered them by their parents or one of their relatives. Corrigan (1986), in his study of heroin abuse among young Irish people, found a higher prevalence among young people for whom one of their parents was experiencing alcohol-related problems or else had separated or died.

Most respondents claimed that they began using drugs by trying one type, mainly that which was most readily available, and that they saw the use of drugs as publicly acceptable. Drugs had been recommended by friends, and its use was increasing among their friends. If the individual experienced positive effects he continued using the same type of drug, sometimes all his life; but if he experienced negative effects, one of the following could occur:

1. He intends to stop using this substance, but because of the pressure and encouragement of his friends he eventually uses the same substance again. This often

happens to individuals who started drug abuse by using heroin. Individuals whose first experience of drug use is with heroin may experience violent reactions such as vomiting, dizziness, nausea, delirium, etc., but because of the pressure of their friends they may use heroin again until they become familiar with its use.

2. He stops using heroin forever, might use other substances, which are less effective, offered by his friends.

Initiation into drug use may be influenced by the social customs and traditions of the society of the drug user. The more public acceptance there is in a society of drug use, the earlier the age of initiation.

Peer pressure

Friedman et al., (1985) have suggested that the drug use of a young person's best friends is a more powerful determinant of the young person's behaviour than the behaviour of his parents. Drug use by one's best friend may more than outweigh the influence of a close relationship with a non-drug using parent. On the positive side, a non-drug using friend can overcome the effects of a poor relationship with parents or a parent who uses a more than average amount of mood-changing medicine.

The findings have shown that the use of drugs is closely connected with peer pressure. About 75% of respondents stated that they have been 'forced' by their friends to use drugs. One of the respondents said:

I had finished secondary school and travelled to Egypt to continue my studies. While I was living in Egypt I met a U.A.E. national who was studying there. I used to go to his flat and had sex with some girls there. He was addicted to cocaine and offered me some. He encouraged me to use drugs by telling me that to enjoy sex with girls I needed to use cocaine or hashish. Initially I used hashish and after that I used cocaine. At first he used to offer me free drugs but when I became addicted he stopped giving me drugs and started to ask me to give him money.

However, the effect of peer pressure differs from one age to another and from one individual to another. Some personalities are more likely to succumb to peer pressure than others, i.e., there is a tendency evident among some individuals to imitate their friends, and perhaps therefore there is the possibility that such a tendency can be identified among individuals, say at school, and therefore measures could be taken to prevent their initiation into drug abuse. Through peer pressure the individual starts using drugs and learns where to get drugs, what types to use and how to use them. Most users who use drugs in company show the same trends towards the use of drugs. They support and reinforce each other. Friends always provide important information and social support for initiation into drug use, and create opportunities for using or experimenting with new types of drugs (Hoffmann, 1981). The first experience of drug use usually depends on the individual's relationship with his/her friends. The first experience of drug use usually does not cost the new user any money or time looking for drugs or dealers. The first use may happen by sharing with friends in a drug using session (Glassner & Loughlin, 1987). New users do not usually know the sources of supply, and are therefore dependent on friends to obtain their drugs.

Seeking intoxication and euphoria

Some drug use may be related to social disorder, and characterized by social psychological struggle. The drug user may have behaved abnormally throughout his life, and is characterized as being indifferent, detached and inflexible. He/she is unlikely to be competent at expressing emotions or feelings to other people, or at establishing good relationships without being intoxicated or feeling "high". Drug use gives the drug user a sort of feeling that can be figuratively termed the "orgasm" of drug use (Nahas et al., 1986). This feeling occurs as a result of the interaction between the drug and the satisfaction and the enjoyment functions in the central nervous system (Nahas et al., 1986). The drug user may therefore have a tendency to continue to use the same type of

drug if he experienced the "orgasmic" feeling the first time he used drugs. Most respondents (81.4%) have said that one of the important factors behind the use of drugs was the pleasant sensation caused by the drugs. They stated that the euphoria which is induced by drug use is different from any other type of euphoria and happiness that individuals may experience without using drugs. As one of the heroin users stated:

When I use heroin I feel very happy and more physically alive. I become more courageous, but nervous and I do not feel comfortable when sleeping. Taking hashish makes me think better; it makes me convinced I am an acceptable person. When I am under the influence of hashish I feel that I am capable of making decisions better and can make better choices, eg in gifts or buying goods. Taking hashish strengthens the relationship between myself and my family.

When a drug user comes under the influence of drugs, he feels physical and psychological comfort. This feeling of comfort differs from one type of drug to another, but it is more intensified in the use of hashish and marijuana than in other types of drugs. The feeling of euphoria which is induced by the use of hashish may become increased if the user uses hashish in company with his friends (Al-Magrabi, 1984). As one of the respondents said:

Taking hashish gives me a sense of euphoria. Its effect can depend on the mood of the user. If the user is happy when he takes the drug, hashish increases his happiness; if he is sad, hashish increases his sadness. Heroin used to make me intoxicated but when I became an addict, its use increased my nervousness and made me tired. Heroin use also changes the personality and behaviour of the individual. Using cocaine gave me the ability to work for long time without feeling tired.

Most respondents who used to use hashish or marijuana claimed that when they are under the influence of hashish or marijuana they become more sensitive to words, see things more beautifully, and sounds are more beautiful. This feeling of euphoria may change to depression if the drug user becomes angry, or if he/she does not get the regular supply.

The availability of drugs

Individuals use drugs when they are available in the society in which they live. For instance, due to the security disorders in Lebanon in the 1970s and 1980s, the production and use of drugs was widespread. In 1984, 20,000 hectares of land was planted with cannabis, and about 4,000 workers worked in the cannabis plantations. As a result of the availability of high quantities of drugs in Lebanon the number of addicts increased from 10,000 in 1975 to 300,000 in 1990 (*al-Ittihad* Newspaper, 14 July, 1990). As one of the respondents said:

I did not give up hashish use, because it was available on our farm. I used to plant hashish in my family farm in Pakistan, and have used it since I was a child. Hashish did not harm me at all.

Most respondents said that they used drugs because they were available and they had easy access to many types. Also, experienced drug users who try new types of drugs or increase or reduce the dosage only do so when they have the opportunity to get drugs easily. Because cocaine and crack are rare and because they are more expensive than other types of drugs in the U.A.E., only a few users have tried them, and most of those have been using other substances beforehand. Because hashish and heroin are more readily available and cheaper than cocaine, they are more prevalent among users. However, some respondents have claimed that psychological or physical dependence does not encourage users to use drugs more than the ready availability of drugs in the society. One of the respondents said:

I do not intend to take drugs again unless they are readily available, especially if they are offered to me free by friends.

The availability of drugs and the low prices also encourage some users to offer some drugs free to their friends. Most respondents have said that they have used some drugs that have been offered free by their friends (96.8%). There is a link between the demand

for and supply of drugs, and their prevalence for any type of drug use. The increasing quantities of drugs in society leads to a decrease in prices, and this in turn may lead to the increasing prevalence of drug abuse. When one type of drug disappears from the drug market, other types may replace it and drug users switch to the use of other types which are more readily available in the market. The appearance of new types of drugs is also connected with the supply and demand of drugs in society. Between 1973 and 1974 the supply of hashish on the Italian drug scene dried up and heroin replaced it (Strasbourg, Council of Europe, 1987). The availability of drugs in society was the main factor behind the British heroin epidemics in the early to mid-1960s, the amphetamines epidemics in Japan after the second world war and the amphetamines epidemics in Sweden in the mid-1960s (Sagarin et al, 1974). There is a connection between drug markets in U.A.E. cities and also between the U.A.E. drug market and other Gulf states. The U.A.E. drug market is the main source for other Gulf states drug markets. An increase or decrease of the volume of drugs in one market affects the other drug markets. Some drug users from G.C.C. countries prefer to get their drugs from the U.A.E. drug market. Also there is a link between the drug market in the U.A.E. and those in Iran and Pakistan. When the quantities or prices of drugs increase or decrease in one of these markets, the other drug markets are affected directly or indirectly because all these drug markets reinforce each other.

The expatriate workforce

The research findings show that the large number of expatriate workers has influenced the spread of drug abuse among people in the U.A.E.. About 84% of respondents claimed that the expatriate workforce have increased drug problems in U.A.E. society. This is not because expatriate workers have more attendancy to commit crimes or to deal with drugs than the U.A.E. nationals, but it is may be because the population

of the U.A.E. is about 2.1 millions, of which only about 653,000 are U.A.E. nationals and the rest are expatriate workers and other foreigners (Al-sharq Al-Awsat, 30, July, 1993). Also it may be because most of the expatriate workforce comes from drug producing countries such as Pakistan, Afghanistan, Iran and India. In addition to the drug producing activities in these countries, some respondents have said that there is public acceptance of some drug use (especially the use of hashish and opium) among some people in these countries. As one of the respondents said:

I used drugs when I was child. At that time drugs were spreading in Pakistan. They used to be sold in shops, especially shops which sold medicine to the general public. When I came to the U.A.E. drugs were available. I used drugs for a long time, especially hashish. I used to bring quantities of drugs from Pakistan, and I buy some of them from the U.A.E.. Because of the high prices of drugs in the U.A.E., I decided to get involved in the illicit drug trade.

It seems clear that many legal and illegal immigrants are involved in illegal drug activities in the U.A.E., and that this has increased the problems of drug abuse. The association of some behaviour patterns with some immigrant groups has been reported in some parts of the world. In the United States, the general public associate the spread of some types of drugs with some immigrant groups. For instance, the Chinese introduced the habit of smoking opium into the United States, and the Mexicans brought marijuana smoking (Sagarin et al, 1974). The cheapness of drugs in some drug producing countries such as Pakistan, Afghanistan, India and Iran in contrast to the high prices and demand for illicit drugs in the U.A.E. encourages some of the expatriate workers, and some illegal immigrants, to become involved in illicit drugs activities.

Most of the expatriate workforce consists of unskilled labourers, and on low salaries some of them are not able to get work permits. Therefore, they look for other ways to obtain money. As one of the respondents said:

Drug abuse, especially the use of hashish and opium, is common in Pakistan, especially among young people. I used drugs when I was in Pakistan, and when I travelled to the U.A.E. I continued taking drugs. I had my own business in the U.A.E., but because the illicit drug market was so good I decided with some of my friends to deal with drugs alongside my own business.

The different exchange rate between the currency of the U.A.E. and the currencies of some drug producing countries has also encouraged some expatriate workers to become involved in illegal drug activities. However, some U.A.E. citizens involved in illegal drug activities employ expatriates, especially Asians, and pay them high salaries in order to use them as drug traffickers or carriers. Most employees and workers who work for sea/air ports are expatriate workers. Traffickers from certain nationalities would receive assistance from workers of their own nationality. As the U.A.E. is located near several drug producing countries, such as Iran, some U.A.E. nationals who are drug users acquire their drugs directly from traffickers, who are helped by expatriate workers living in the U.A.E.. This happens when the drug user asks one of them to help him to get drugs from outside the U.A.E. in return for money. When the other person accepts the offer, he contacts traffickers and dealers who are living in Iran or Pakistan and prepares the deal for the U.A.E. drug user. When the drugs are ready to be brought into the U.A.E., the expatriate tells the U.A.E. user the place and time of the drug's arrival. But in accordance with drug enforcement information this method of obtaining drugs does not happen all the time.

The risks of drug abuse behaviour

Most respondents stated that not all types of drugs were bad. They have said that using hashish does not develop into a physical or psychological dependency. This point of view has encouraged some people to involve themselves in drug abuse. The argument has been disputed by some researchers, who state that the heavy use of cannabis may develop physical dependency (Segal, 1990). Smoking hashish may cause a sore throat, coughing

and lung cancer. Hashish intoxication affects most mental functioning; driving, psychomotor functioning and learning (Segal, 1990). Some researchers also found that hashish causes blood vessel diseases and high blood pressure. Hashish also has an effect on the sex gland and decreases the production of semen (Khan, 1985).

Most drug users were found to dislike the norms, customs, and tradition of their society. They felt that the norms control their freedom and they felt they had to release themselves from this control by creating a different environment for themselves. This different environment has a culture and set of beliefs which differ from those of society at large. The result of this is that drug users often live in isolation and dislike their families, work and social obligations. They perceive drug use as an expression of their freedom from the norms of society. Because of these perceptions, drug users think that anyone who tries to stop them using drugs is their enemy. Their existence becomes a continual struggle to obtain drugs and the money required to pay for them, and to avoid police, family, relatives and other people.

Most drug users who are U.A.E. nationals are young, and most of them use hard drugs such as heroin. Most of them are multi-drug users. They use heroin by injection, especially into veins, which mean that they may become prey to disease. The sale of syringes to the general public is banned by the Ministry of Health, and consequently most drug users not only share syringes, but they use each syringe for a long time without cleaning it. They also use and share dirty needles. This makes them more prone to hepatitis infection and HIV (which causes AIDS). Hepatitis is more prevalent among heroin users than among other types of users (Al-Bar, 1988). Those who use heroin by injection use many different solutions to dissolve the heroin in preparation for injection, which means that they may become affected by disease via the solutions used.

Drug users who are U.A.E. nationals are more likely to be addicted to drugs than other nationalities. This is because most of them are heroin, opium and barbiturates users. If the use of these substances continues to increase amongst young U.A.E. nationals, drug addiction and drug-related diseases may spread throughout society until it reaches epidemic status.

Most drugs which are available in the U.A.E. drug market and used among drug users are adulterated by different substances such as glucose powder, chalk dust, caffeine, quinine, flour, talcum powder, bones powder, etc. in order to increase their weight. Some of these substances are poisonous if taken over a time, and may cause physical damage to drugs users (ISDD, 1991). Heroin users become uninterested in their food or health, which means that they may have little resistance against disease.

Smoking is common amongst drug users, and one of the characteristics of using cigarettes used with drugs is a higher tendency to diseases of the respiratory system and cancers. Heroin users also have a tendency to increase the drug dosage, which means that they more likely to die by an accidental drug overdose.

Drugs and Crime

The link between drug abuse and other criminal behaviour has frightened people in many communities that have of an increasing number of drug abusers (Quinney, 1970). Most people believe that the use of all types of drugs relaxes the discipline function of the central nervous system and precipitates violence and aggressive behaviour (Quinney, 1970). Some studies (Quinney, 1970) have found that in 1960 much violence and other anti-social behaviour in Europe and in the United States was connected with the spread of drug abuse, especially the abuse of LSD, marijuana and heroin, among young people. This attitude towards drug abuse is the same in U.A.E. society where the issue is more sensitive. This is because the impact of custom and traditions which encourage people to hold onto a rigid morality tends to be more powerful in countries such as the U.A.E.

My research findings showed that most respondents were not involved in serious crimes such as murder, rape, burglary, etc. which studies (Ingold, 1989) in other countries have found in association with drug abuse. This may be because drug users in the U.A.E. are wealthier than users in other countries and are hence more likely to have money to pay for their drugs or have many more ways of obtaining money to feed their drug dependency than drug users in other countries, who are often forced into crime to pay for their addiction. Most U.A.E. users depend on their parents, families, relatives, friends, etc. to obtain money, rather than turning to crime. The most common type of crime, which is increasing among drug users is that of selling drugs. Large numbers of respondents have been involved in drug selling (82.7%). They claimed that obtaining money from drug selling was easy, safe and guaranteed. The research results show that drug users who are U.A.E. citizens commit more crimes than other nationalities. Most crimes committed by respondents were drug related crimes. Most users who were U.A.E. citizens have been jailed for committing crimes more than once. This is because the U.A.E. drug users are less worried about justice and law enforcement than other nationalities. The police have been known to turn a blind eye to some drug users committing crimes, especially those who are from influential families. Often prosecutions are not made or brought before a court, and some who have been prosecuted do not complete their sentences and are released early. This intervention in justice and weakness of law enforcement for some U.A.E. citizens has encouraged some drug users to return to crime, and recidivism was characteristic of U.A.E. drug users.

The results show that drug users who are U.A.E. citizens are more aggressive and more frequently in conflict with their parents than other nationalities. This is because most respondents who were from the U.A.E. were younger than other nationalities and most of them were living with their parents. It is also partly due to lack of family discipline in some cases. As one of the respondents said:

In my childhood I suffered from many different things, amongst them my father's forcing me to attend religious school, which I hated. I failed three years continuously, then my father shifted me to an evening school which was for both young and old students. It was at this school that I was introduced to drugs through some of the other students. I started to use solvents and alcohol, and then progressed to other drugs. When my father discovered that I was taking drugs, he tied me up and trailed me behind his car and bated me. My father hasn't been fair in dealing with my brothers and I. He prefers my brothers to me. Because I was in need of money, I committed many thefts and burglaries.

Quarrelling with parents is a behaviour spreading among young people in the U.A.E. (Thabit, 1984). Drug users who were from the U.A.E. were also more likely to experience serious conflicts at home or at work than other nationalities. This is because most of them were using hard drugs such as heroin, which cause nervousness and shakiness, especially during the withdrawal period. In experiencing greater job security than other nationalities, they are often less worried about the consequences of quarrels at work than other nationalities. The results also showed that drug users who are U.A.E. citizens are more likely to forge or pass bad cheques than other nationalities. It was also found that drug users who were from other Arab countries, especially G.C.C. countries, have a greater tendency to forge or pass bad cheques than those of Asian nationality. This is because users who were from the U.A.E. and other Arab countries were on multiple drugs and more likely to use expensive drugs which cost them a lot.

Some researchers (Kleiman, 1989) have found that for young people the cost of drug use is more important. This is because their income is low, which may lead to the committing of crimes such as theft or dealing in drugs to finance their drug use. Stolen money and jewellery from parents was more likely to be associated with drug users who were U.A.E. citizens than other nationalities. This is because most of them were young and living with their parents. Some of them used to depend on their parents to obtain money for their drugs. The results also showed that drug users who were using heroin showed a greater tendency than other drug users to cause serious injury or to smash things. This is because of the nervousness, shakiness, and lack of self-control which the use of hard drugs such as heroin induces (Al-Bar, 1988).

Seeking Medication

Some respondents, especially those who use heroin, have stated that they have been using drugs as medicine for the painful feeling of the withdrawal symptoms. They get the feeling of euphoria at the beginning when they use heroin, but when psychological and physical dependence develops the feeling of euphoria becomes connected with the relief of withdrawal symptoms. They seek the high intoxication by increasing the amount of drug used or by mixing many types of drug together. The results have shown that heroin and barbiturates users had more desire than other users to stop using drugs. This shows that the desire to stop drug use is present among drug users, especially those who use hard drugs. Most of those who had tried to stop using drugs had done so after bad experiences and had been suffering from withdrawal symptoms. An important factor behind their trying to stop using drugs was that they had experienced the down side of drug abuse, and had seen how destructive it is to their future. Another important factor was that they had been worried about being arrested or jailed again, or even dying. These reasons particularly encouraged those drug users who had experienced one or more friends dying from drug use or having no chance of an early release from custody. Escalating problems with their families due to drug use also encouraged some users to try to stop using drugs, especially married users with children whose wives claimed divorce or separation because of the drug use.

The loss of job, friends, contact with relatives, and family also encouraged some users to try to stop using drugs. Most of these were married foreigners with children who were the only financial source for their families. The resultant loss of contact with family and relatives, and the isolated lifestyle of the drug user, also encouraged some drug users to stop using drugs. Some of them hated the lifestyle, which isolated them users from society, family and non-user friends. Family encouragement also proved a good motivation for some drug users to stop drug use. Some families, notably those who were

educated, were able to encourage some drug users to try to stop using drugs. However, most drug users refused to stop taking drugs just because of pressure from their families or from someone else. Loss of wealth and possessions has prompted some drug users to try to stop using drugs, especially those who are running good businesses. Also, the difficulties of getting drugs because of the high cost or the shortage of drugs in the market has encouraged some users to try to stop drug use. This only happens if law enforcement keeps pressure on drug dealers or sellers. Some drug users have tried to stop using drugs because they know that drug use is forbidden in Islam.

Attempts to stop drug use

As a result of the lack of facilities for treating drug users in the U.A.E., drug users have often tried to treat themselves. It is usually after experiencing a bad 'trip' that drug users have tried to fight their addiction.

Most drug users have tried, and have thus had periodic cessations of drug intake. Most heroin users who have tried this method have failed. Other users have tried to obtain medication without being seen by a doctor. For instance, heroin users use barbiturates and tranquillisers as a medicine to ameliorate the withdrawal symptoms when they cannot get hold of heroin, or when they are trying to give up the drug.

Another common method of self-medication is a reduction in the amount of drug used. Most heroin, opium and morphine users who have tried this method have failed because most of them were long-term drug users, which meant that from time to time they had to increase the amount of drugs taken to satisfy the addiction. Drinking alcohol or taking pills such as barbiturates, amphetamines and tranquillisers was also used as a method of self-medication. As one of the respondents said:

I stopped being a drug user for about a year and during this time I depended solely on alcohol; but then I returned to using drugs.

Some users believed that alcohol has fewer adverse effects than other types of drugs, and that by increasing the level of alcohol they take they could help themselves to relieve the painful effects of other drugs on their bodies.

Some drug users had sought medication from hospital. This method was mostly used by opiate users when they had a shortage of drugs. Most of them preferred to seek treatment from private hospitals and clinics than from public ones. As one of the respondents said:

I sought help from a private clinic. I did not stay in the clinic but received medication. Three days later I returned to drug abuse because the medication had not been useful.

Most public hospitals reported drug users who sought medication to the police. This was the reason given by most drug users for avoiding seeking help from public hospitals. Some drug users had also sought help from people in authority or those they saw as responsible persons. They sought help from officials involved in drug problems, especially those who work for drug enforcement or justice departments, and who can solve their legal problems at the same time as providing medication. Most of the users who sought help from officials had been disappointed because the officials also asked them to give them the names of their friends and dealers. This made them too scared to continue to seek help.

Some users also sought help from their families. Most of those who used this method were from influential families capable of putting pressure on justice and law enforcement agencies in order to avoid the prosecution of their relatives for drug abuse. Some users also sought some help from educated relatives who were able to deal with drug addicts and help them by persuading them to accept medication without the application of external pressure. Other users who had been using light drugs tried to treat themselves by playing sports in order to reduce their spare time and thus avoid thinking about drugs.

The final method which has been used by some drug users in order to treat themselves was to remove themselves from contact with friends who were also drug users. As one of the respondents said:

I gave up taking drugs for a month. I stayed in the house. But once I left the house I met my previous drug user friends again and began to take drugs again with them.

Most of them failed and eventually recontacted friends. This was the case especially of those who used opiates or those whose family economic situation was poor and there was lack of family control or concern.

Continuation of drug use

Some respondents have never tried to stop using drugs (39.7%). The results show that users of opium, heroin, morphine, cocaine and barbiturates are more likely to continue drug use than other users. There were many factors behind the wish to continue drug use. The most important factor was that most of them said they liked the results of drug use and that they had not been adversely affected by the use of drugs. Most of those who claim not to have experienced bad effects from drug use were users of hashish and marijuana. They reported that use of these drugs has no bad effects at all on them. As one of the respondents said:

I did not give up taking hashish because it did not harm me and it was available especially in my country, Pakistan, and easily accessible.

The availability of drugs in the market and the ease with which they can be acquired encouraged some drug users to continue using drugs. Unresolved family and financial problems also motivated some users to continue using drugs. Some users believe they can escape their problems through the use of drugs. Others believe that drug use especially hashish allows them to think more effectively and thus helps them solve their problems. Lack of personal self- control was also one of the factors behind the

continuation of drug use. Some users felt they were not strong enough to withstand the temptation of the ready availability of drugs; this was especially the case for those who had been using heroin. Some heroin users said that they could not stop using drugs because they suffered so badly from the withdrawal symptoms. The lack of help from family or society and the fear of telling anybody about their drug problems encouraged some users to continue using drugs. As one of the respondents said:

I gave up taking drugs for some time but I did not know where to go for medication to help me continue in my attempts to wean myself off the drugs and because there was no-one to counsel me, I started taking drugs again.

These users have claimed that there was no-one in their families who could provide help or advice because most members of their family were not well educated and consequently had no idea of the dangers of drug use. As one of the respondents said:

Drug abuse is spreading among young people. When the individual becomes involved in drug abuse he finds nobody to help him to give it up. This is especially the case in the use of heroin, which is very dangerous and destroy the individual.

Some respondents said that they did not try to stop using drugs because they had nothing of interest to do except take drugs. Most of these were unemployed or in danger of being discharged from their jobs because of the use of drugs. Some respondents said that they chose not to stop using drugs because they felt under pressure from their families to do so, and they refused to stop using drugs against their own wishes or because of external pressure.

Medication in the Clinics

The results show that a few respondents who had been treated in the psychiatric clinic were satisfied with the type of medical treatment received, but that most of them were not. Those who were satisfied claimed that they received good care and medication and were provided with recreational facilities such as television, volleyball, etc.. They were

also allowed telephone calls and visits which made them feel better. Most of the respondents who were satisfied with the clinic had a strong desire to stop their drug abuse. They also said that they liked the cleanliness of the clinic in comparison with that of prisons and also that the food was good in the clinic in comparison with prisons. Some of them also said that it is better to stay at the clinic where they did not have to suffer the problems they had outside than to be in society with all the social and family problems they had to face in the outside world; also that to stay in the clinic was better than to be in prison. All the respondents who were satisfied with the psychiatric clinic were necessarily U.A.E. citizens, because other nationalities (except nationals from other G.C.C. countries) are not allowed treatment in the Al-Amal psychiatric hospital. Despite the official ban on visiting in the clinic, the administration of the hospital allows relatives from influential families to visit drug users.

However, most drug users who were treated in the psychiatric clinic were dissatisfied with the medication, rehabilitation and vocational aspects of the psychiatric clinic. As one of the respondents said:

I had medication seven times, four of them in the Al-Amal Hospital and three times in the Rashid Hospital. The treatment was only through giving me sedatives and sleeping tablets. I need medication and I am going to try to get psychotherapy.

There were many reasons behind their dissatisfaction. Some of them said that the physicians and staff were always threatening to report them to the police or return them to the jail if they did not follow the procedures of the clinic. Some of them also said that the physicians did not spend enough time with them and prescribed medicine before talking to them. The lack of provision of social workers to provide help with the solving of problems between drug users and their families or jobs was also a disappointment to most drug users. They also said that there was a lack of society-based services, vocational assistance, vocational training, etc. in the clinic. They also said that the clinic admini-

stration banned visiting and did not provide recreational facilities to cater for their spare time. Respondents claimed that there was a lack of psychotherapy and counselling and that the only treatment available was medical care, rather than help to enable them to withstand drug use in future, a failing which resulted in most drug users discharged from the clinic relapsing into using drugs again.

Medication in prisons

The research results show that most drug users who were in prison were dissatisfied with the medicational, rehabilitation and vocational systems operating in prison. The absence of rehabilitation and vocational training caused greatest disappointment because it meant they had too much spare time and were always thinking about what they were going to do in the future when they got out of prison.

Some respondents felt that the vocational training provided in some jails was not appropriate to drug users. For instance, prisons such as the Dubai and Sharjah Central jails offered the production of bricks and gifts as vocational training. It was felt they provided these things not as vocational training but only to reduce the amount of time hanging heavy over the drug users. Most respondents said that they had too much time with nothing to do, and so thought even more about drugs than before. They also said that the visiting time, which was set down at ten minutes maximum, was too short and the prison administration's ban on sitting with their families during visiting times was unfair. Some drug users in prison have no visitors because of problems with their families, and they found there was nobody available to help them to solve these family problems. This made them feel depressed, and meant that they ended up thinking about drugs most of the time.

Most drug users in prison said that they learnt many types of anti-social behaviour whilst in prison. They claimed that there was no separation between prisoners according to their

offences, which meant that prisoners exchanged their criminal experiences. Some drug users, traffickers and dealers who were in jail were put in the same prison wing as other drug offenders, and continued to make drug deals both inside and outside the jail, depending on the assistance of some workers who work for prisons. Because of this proximity, users were able to make drug deals with dealers and traffickers sometimes before they were released. Drug dealers and traffickers exchanged telephone and pager numbers, and addresses, with drug users who wanted to buy drugs for their friends, or with those involved in illicit drug activities outside jail. Some drug dealers and traffickers also collaborated with other prisoners, such as forgers, who were jailed with them in the same wing.

Most drug users reported that they faced difficulties in dealing with prison staff. Most prison staff lack education and are not qualified to deal with drug users. They abused the treatment of drug users and discriminated between U.A.E. nationals who were drug users and foreigners. Prisoners were forbidden to read books or listen to the radio, and the prison officers punished any drug user who tried to seek medical assistance. This is because the prison officers think that prisoners are lying on them. There was a ban on having family photographs in the prison and on receiving or making telephone calls. Few prison staff did anything to encourage drug users to return to society as rehabilitated individuals, and drug users found that the prison staff tried to frustrate even ordinary activities. Because of the absence of physicians, psychiatrists and social workers in most jails, most jailed drug users suffered from physical and psychological problems. There was a lack of contact between them and their families, which increased their depression.

Most respondents felt that because of the lack of concern of prison administration about the users' problems, most jailed drug users failed to solve their family problems and suffered problems at the hands of the prison staff. Some drug users reported that they suffered from the lack of cleanliness in the prisons, and poor quality food, which caused

the spread of some diseases, especially skin and respiratory system diseases. They also said that the prison clothes were dirty and prison administrations banned the wearing of the prisoners' own clothes. Some drug users reported that the use of drugs was active in some jails which made some users return to their addiction.

The Drug users' future prospects

Drug-related relationships

The research findings show that just over half (51.2%) of drug users believe they are unable to give up or to change their relationships with the friends with whom they used drugs. This is because some of them were brought up together or have been studying together at the same school. Some respondents said that they would abandon friends, especially those they met during their drug use period, whom they have not known for long (36.5%). A small number of them said that they would continue their relationships with previous drug user friends but would advise them to give up drug abuse (6.4%). However, some drug users expected their friends to avoid them after release from prison, because they think they are going to be watched by law enforcement officers (3.8%). Only 1.9% of them said that they would end the relationship with their previous drug user friends and then only if their financial, social and family problems had been solved.

Some drug users preferred to make new relationships with drug users in jail, or who were having treatment in the same prison or clinic, especially those who have new information about drug related activities such as new drug sources, new types of drugs, new methods of administration or trafficking.

A number of drug users said that they intended giving up the use of drugs after being released (39.2%). Most of them were heroin users who have been suffering from withdrawal symptoms. As one of the respondents said:

I am going to stop my relationship with my previous drug user friends. This is because they introduced me to drug use. I am going to give up drug use. This is because I am going to look after my children, who are in need of me.

Some said that they would not give up, but expected to reduce the amount of drugs they used (24.3%). This is because they want to avoid obtaining drugs from dealers who might be police informants. Some said that they intended to give up only hard drugs, such as heroin and opium (15.4%). As one of the respondents said:

I am going to give up the use of hard effective drugs, but I am going to continue to use hashish. This is because I use hashish as a medicine for diabetes and asthma.

A number of respondents said they would give up drugs if they got jobs or if their problems with their families were solved (8.3%). Some (4.4%) said that they would try to give drugs up, but 2.6% would not give them up even if threatened with deportation (in case of non-U.A.E. residents). Only 1.3% of them would give drugs up if they could get good medical treatment, and 4.5% do not know.

Relationship with family

There is no doubt that the family is responsible for the creation of the personality type of the individual and thus how the individual interacts with his environment. From the family, the individual obtains his principal needs such as security, welfare, love, compassion..etc.. As one of the respondents said:

My childhood was spent away from my father who refused to accept me as a legitimate son. He believed that I was a love child. This is because my mother became pregnant when my father was travelling outside the country. When he came back he went to court and denied that I was his child and divorced my mother. Then I went to live with my grandfather; but I suffered from the lack of my father's love. My father re-married and I have always felt very sad because I was a love child.

However, the structure of the family in the U.A.E. has changed from the extended family to the nuclear family, and has lost many of its traditional roles. The family used to be

socially and economically intergrated, and its members collaborated. Poor quality family relationships may direct the individual in either two ways. Either isolation makes him live as a stranger in his family, or alternatively he may leave the family home and look for other options to replace his family life. Large numbers of drug users said that they expected their relationship with their families to be better when they returned home (51.3%). Most of these were Asians, especially from Pakistan and Iran, whose families accept the use of some types of drugs such as hashish and opium. As one of the respondents reported:

I have used hashish since I was child. I was brought up in an environment where drug use was normal. Members of my family used hashish and opium.

Some respondents said that the relationship with their families is too bad (17.9%). Most of these were U.A.E. citizens, and said that because they returned to drug use and were in jail more than once, their families felt too ashamed to accept them again, having interceded for their release too many times before. As one of the respondents stated:

I am not happy with my father's treatment of me. He is an aggressive person. He has not visited me since I have been jailed. I feel emotionally tired and this situation has resulted in me continuing to use drug.

Many felt isolated because no-one from their families ever visited them. They also felt that, because of the lack of social workers in jails, there was nobody to help re-establish normal relationships between the drug user and his family. Some of them did not know what would happen to them after their release, because their relationship with their families was too strained (17.3%). Some of the respondents' wives (9.0%) had divorced them or asked for a divorce or separation. As one of the drug abusers said:

My relationship with my family is strange and complicated. I was divorced from one of my wives after I had been jailed when she insisted on a divorce. I do not know how I am going to fare with my family after being released.

Another example:

I divorced my wife after she insisted on a divorce. She is British and she insisted on taking my children back to England with her. I am emotionally tired and I do not know what will happen for me after I am discharged from hospital.

Most of these were U.A.E. citizens, and their wives were under pressure from their families to divorce their husbands. This is because the use of drugs is still considered to shame the families of both the drug user and his wife. The shame is worse if the drug user is convicted and jailed. As one of the respondents stated:

Because of drug abuse, my wife has divorced me and my children are living with their grandfather. I am going to look after my children if I can get a job.

A few drug users intended to strengthen their relationship with their mothers only (3.2%). Most of these were U.A.E. citizens who had been abused by their fathers because they were drug users. Only 0.6% of them said they would not like to live with their families again, having been thrown out by their families or parents because of their use of drugs. The same number (0.6%) said that their relationship with their families depended on whether they could get a job or not. As one of the respondents said:

Unless my family members and society support me and give me the self-confidence which I need, I cannot give up taking drugs.

Work after release

Large numbers of convicted drug users will leave their jobs in the U.A.E. because they will be deported to their country of origin after release (48.1%). Many of them will face difficulties getting jobs in their countries because of the high unemployment rate or because they cannot get the same level of salaries or wages which they had been getting in the U.A.E..

Some drug users said they would not be able to work without getting a certificate of good conduct which is issued by police (31.4%). Without this certificate nobody can work in the public sector in the U.A.E.. Certificates are issued only to those who have no criminal record. Those with a criminal record must wait a minimum of one year after being released in order to get certificate.

This is a big problem facing most drug users who are U.A.E. citizens. After being released they are often unemployed for more than a year with no financial resources which creates a lot of problems for those drug users who want to give up drug use. They experience problems, especially with their parents, wives, children, etc., which often means that most of them return to drug use again. However, some users from influential families may get the certificate without difficulty. Dubai Police are also more indulgent in giving the certificate to former jailed drug users than police departments in other Emirates, but they only give it to those who are living in the Emirate of Dubai.

Some respondents (8.3%) have claimed that they could not get work because their passports were held by the police. Public and private sectors do not employ anyone without seeing their passport and police hold some U.A.E. nationals drug users' passports for some time after being released in order to prevent them travelling outside the U.A.E., especially to some drug producing countries. However laudable the reason for it, this makes difficulties for drug users who are seeking work, and the result is they are usually unemployed and return to drug use again.

A small number of respondents (7.1%) intended to try to return to their former job. However, the police and the courts usually report the names of drug users who have been convicted to their workplaces, and make their employers responsible for them which means they usually dismiss them or deprive them of their employment rights. It is difficult for convicted drug users to be accepted back at their previous workplace, especially those who work for the public sector. However, some convicted drug users do return to their previous jobs if their families have social influence.

Some respondents (6.5%) claimed that they would prefer to be unemployed. Most of these are used to depending on their families' wealth, and so do not need to work. A small number (4.5%) said that they would be unable to work for the public sector because of the difficulties of getting a certificate of good conduct, and because work for the private sector needs special qualifications and its salaries are low. A small number (4%) expected to experience difficulties in returning to their former job or in obtaining a new job because of police harassment. The police sometimes exert pressure, and place difficulties in the way of some released drug users, in order to persuade them to work as informants and not to work for others. As one of the respondents reported:

The drug enforcement squad sometimes arrests users in order to get them to collaborate with them and inform upon other drug users in return for police help for them in court.

Most drug users refused to work for the police because this makes them very unpopular with their friends. In fact, there has been complaints about the police on this issue.

Social life

Macdonald (1965) has stated that drug use is not an isolated problem of the individual drug user alone, but a result of conflicts and difficulties in personal relationships among family members, neighbours, the public and social/environmental circumstances. Certain developmental relationship influences may predispose toward drug use, especially so when the drugs are readily available as one of the easiest ways open to people of coping with frustrations (Harms, 1965).

Many drug users (38%) expect to face problems in dealing with people in their social life once they are released from prison. As one of the respondents said:

I fear that my social life and my relationship with other people in society will be difficult when I am released. This is due to the negative view of people towards drug abusers. I expect some people will ban their children from contacting me or having any relationship with me because of my history of drug abuse. I feel that I will be a social outcast and feel very isolated.

They expect they will not be accepted among people, friends, relatives and families because of their use of drugs and because they have been jailed. Most of their non-user friends, relatives and neighbours will avoid contact them which means that they could live in isolation. Most of these are U.A.E. citizens who consider that they have lost their dignity and reputation among the people they know because of their use of drugs and because they have been jailed. As one of the respondents said:

After being released, I expect to face some difficulties, especially with relatives and neighbours. My children will be affected by these difficulties. This is because people look upon drug users as criminals. I expect to feel isolated for some time, until I became adapted to the situation.

A number of drug users (36%) thought that they were going to live a normal life after release, and did not think that they would face problems in their relationships with other people in society. Most of these users were foreigners who will be deported to their own countries. They will change their living places from the U.A.E. to other societies, which means that they are going to make new relationships. They claimed that no one will know that they have been convicted for using drugs or that they have been jailed.

Some U.A.E. nationals (14%) who are drug users believe they will face problems in getting married. This is because most families in the U.A.E. refuse to marry their daughter to a drug user, especially if he has been convicted and jailed. Even if a woman wanted to marry a drug user, her family and relatives would prevent her from doing so. Reputation and dignity are important marriage issues in the U.A.E.. To avoid this problem, some drug users from the U.A.E. claimed that they would marry a relative.

Some respondents (12%) said that they intend to adapt to any new circumstances in their social life. They will ignore the public discomforts. Some of drug users intend to change their previous lifestyle (10%). Most of those are users who wanted to give up drug use after being released because they had suffered bad experiences from taking drugs, especially those who had been using heroin. Some drug users said that after release they

expect to be living in isolation because most their friends and relatives would avoid contact with them because they have been convicted of drug-related activities (6.5%). Only 4% do not know how or what their future social life will be. This is because most of them were given sentences of more than ten years imprisonment. However, 2% of drug users thought their social life would depend on whether they get a job, and 1.3% thought they would not be accepted by their families or relatives.

Summary

The findings and results of the study indicate that the rate of drug use among young people is high, especially the use of heroin (which is increasing). Drug users who are U.A.E. citizens are more likely to be involved in drug use problems. Most of them are multi-drug users who spend a lot of money on drug use. Hashish, heroin, opium, solvents and barbiturates are the most common types of drugs which are on the increase in U.A.E. society. The lack of preventive and medicational measures in society has increased the amount of and seriousness of drug problems in the U.A.E.. There is no doubt that the large numbers of expatriate workers has an effect on the quantity of drugs available in society. The absence of a comprehensive, unambiguous policy to combat drugs in U.A.E. society is a significant factor behind the increase in drug abuse problems in the U.A.E., therefore the next chapter examines and evaluates the U.A.E. drug policy, and in what ways the policy addresses these issues and positively and negatively impacts on the drug problem in the U.A.E..

Chapter 9

Drug Combating Policies in the U.A.E.

Introduction

The reduction of illegal drug supplies on the drugs market is an obvious part of any policy to combat drugs. An equally essential component of a successful policy for combating drugs is to reduce demand, i.e. to persuade those who may be tempted to take drugs not to take them, and help existing abusers to break their 'habit'. Most policies which have concentrated on the reduction of drug supplies alone have failed. In order to be effective, measures to reduce the demand for drugs should be given the same attention and priority as prevention of drug trafficking.

This chapter examines drug policy in the U.A.E.. This policy is made up of drug control laws, law enforcement regarding addicts, dealers and traffickers, preventive measures, medication and rehabilitation. Most of this chapter will be drawn from information gained from the interviews conducted with officials involved in the formulation and application of drug combating policies in the U.A.E.. It will also draw upon official statistics and reports. The efforts of the legislators, drug combating squads, border and coast guards, customs services, educational institutions, health services and mass media will also be examined.

Drug Control

In response to increases both in worldwide drugs production and drug demand in the U.A.E., law makers in the U.A.E. instituted legal measures designed to protect the health, welfare and finance of people from the effects of drug use. Law makers in the U.A.E. have recognized that illicit drug related activities are global activities and that these activities are associated with other criminal behaviour; therefore they have tried to honour the spirit of international conventions related to drug control.

The Federal Drug Act No 6 (1986) regulated the procedures regarding the trade of drugs in the U.A.E.. It forbade the import of drugs into, and export of drugs from, the U.A.E. without a permit issued by the Ministry of Health. The purpose is to maintain control over all people and organizations involved in drug trade, and to restrict the quantities of drugs available in the U.A.E. to the real need of the community, whether for treatment or research, and to ban the infiltration of drugs to the illicit drugs market. The Act also confined the granting of permits to government authorities and licensed academic institutes, licensed private hospitals and clinics, laboratories licensed for chemical analysis or for academic, medical and industrial research purposes, licensed drug stores and pharmacies and factories involved in the production of and/or sale of medical supplies. The Act stipulates that such bodies must have a licensed pharmacist to deal with drugs, and that middlemen and agents of licensed factories producing medical supplies themselves must also have a license. These firms or individual businessmen must also employ a licensed pharmacist to deal with the drugs they handle. Permits are issued only by the Ministry of Health and are in the name of the director of the firm or institute.

The following information must be incorporated into the permit. The name and address of the applicant, the name of the institute, firm or drug store which the applicant represents, and its registration number, the name and address of the exporter and the country of origin, the name of the drug to be imported, the pharmaceutical form of the drug, the strength and quantities of the preparation to be imported, details of previous imports of the same preparation and an up to date balance of the stock of the drug held, the exact amount of drugs to be imported and the expected date of delivery. In addition the Ministry of Health has the authority to reject any application for the import or export of drugs to any institution, commercial or otherwise, and also the right to reduce the quantity of drugs to be imported or exported (Article No. 11). Article No. 12 of the drug Act stipulates anyone who has committed any of the following must not be permitted to

import or export drugs: crimes which are classified as outraging the honesty and honour of the state for which the penalties comprised either a custodial sentence or whipping; anyone who has committed any drug-related crime listed in the Act, excepting crimes for which the penalties are imprisonment of less than a year, fines not exceeding 10,000 dirhams (£1,500) (or by one of previous two penalties) (Article 12 and Article 51, paragraphs a, b); and crimes against property, indecent assault or depravity. Also included is anyone who has been suspected of any of the above, or who is homeless, or who has unsuccessfully attempted any of the above crimes.

The Act forbids the issue of a permit to import or export drugs to anyone who has been discharged from their job because of dishonesty or dishonourable act within the previous three years.

The Act forbids the collection of drugs from customs offices without a written permit. The permit is a standard form prepared and issued by the Ministry of Health, and must include a signature from the of the import firm cocerned authorising collection. One copy of this permit must be sent to the Ministry of Health and another is kept by the customs office (Article 13).

In addition the Act forbids drugs to be imported, exported or transported with other substances or in the same load as other substances. The drugs must be insured before being imported or exported, and the full name and address of the importer must be given on leading documents together with the name and quantity of drugs and the full name and address of the exporter.

A register of every drug movement in and out of the U.A.E. is kept by the Ministry of Health, and the numbers of the import and export permits issued by the Ministry are recorded in this. Also included in the register is the following information: the name, official status (e.g. director), date of birth, nationality and address of the applicant; the

date and number of the permit; the types and quantities of drugs (written in their chemical terms and in words); and the name of the organisation which has ordered the drugs. The permit for drug import or export becomes invalid if not used within 60 days of its issue (Articles 14, 15 and 16).

Whilst the regulations mentioned above are designed to maintain tight control over the import of dangerous drugs, it may be that few of these conditions are applied.

Trade in Drugs

Dealing with drugs designated as dangerous and/or addictive is forbidden in the U.A.E. without a permit issued by the competent authority. The same conditions apply to any business manufacturing or dealing in drugs as to any business or institution importing or exporting them, i.e. a permit must be issued and the agency dealing in drugs must be licensed (conditions for which are mentioned in articles 11, 12, 13, 14, and 15). The authorised firm or institution must employ a licensed pharmacist to administer the drugs. If a licensed firm or institute ceases trading in drugs at any time, the owner of the firm must report this fact to the competent authority within 15 days from the date of cessation and the firm's licence must be returned to the competent authority (Articles 18 and 19).

Licensed firms which sell drugs are forbidden to sell or give any quantity of drugs on the list of the Control of Drugs Act 1986 (hereinafter called 'controlled' drugs) to anyone, with the following exceptions: directors of licensed drug stores, pharmacies and factories involved in the production of medical supplies; directors of licensed pharmacies and of the pharmacists of hospitals and clinics; physicians of licensed hospitals and clinics who have been authorised by the hospitals and clinics to buy or otherwise obtain drugs; directors of licensed laboratories involved in chemical analysis, medical, academic and industrial research; and representatives of government organisations and of licensed academic institutions (all is forbidden except that which is expressly permitted.). Article No. 23 gives the

Minister of Health the right to amend the current procedures for the sale of controlled drugs at any time should this prove necessary in the furtherance of drug control.

The director of a licensed firm or institution is required to record the quantities of drugs which are sold, the quantities which are bought, and the current stock. This record must be sent to the competent authority during the first week of each month. However, some firms violate the rules, especially those firms which have a good relationship with officials. Some officials who work for the competent authority do not require the monthly record mentioned above in its due time for some firms, especially those which have been dealing with licensed drugs for a long time.

Control of pharmaceutical activities

Pharmaceutical activities are controlled by the Control of Drugs Act 1986, and by the Act of Pharmaceutical Activities 1983, which regulate pharmaceutical activities in the U.A.E. The giving or selling of medicine to anyone without a medical prescription issued by a licensed physician or licensed veterinarian working in the U.A.E. is forbidden (The Control of Drugs Act, Article 24). The prescription must conform to the following conditions: it must have a serial number and must have the stamp of the Ministry of Health; it must not be written in an eradicable substance, e.g. a pencil; it must contain the quantity of the medicine written both numerically and in words, the method of administration of the medicine, and the name and address of the patient; prescriptions must be dated and are invalid two days after issue; and the quantity of drugs prescribed must not exceed the normal dosage which is known for the patient and must not exceed three days' supply.

Regulatory Decree No. 106 (1989) issued by the Ministry of Health regulates the amount of controlled drugs prescribed to patients in government and private hospitals as follows. A general practitioner has the right to prescribe controlled drugs to patients up to a maximum of three days' supply; a specialist has the right to prescribe controlled drugs

to a patient for a maximum of two weeks' supply; consultants have the right to prescribe controlled drugs to the patients for a maximum of four weeks' supply; psychotherapists have the right to prescribe controlled drugs to patients for a maximum of five weeks' supply; government controlled psychiatric clinics have the right to prescribe controlled drugs to patients for a maximum of four weeks' supply; and if the patient is a juvenile, the prescribed controlled drug must be handed over to his guardian rather than to the patient.

The same regulations prohibit medication containing cocaine to be used in treatment, and the use of barbiturate acid preparations is limited to government controlled hospitals and for inpatients of private hospitals. The prescribing of controlled drugs is limited to government controlled hospitals and inpatient departments in private hospitals (Ministry of Health, Regulatory Decree, No. 106, 7111989).

If a patient needs more than the usual quantity of a controlled drug, the prescribing physician must get permission from the competent authority (The Control of Drugs Act, Article 24).

Firms licensed to deal in controlled drugs have the right to sell drugs to the following bodies and individuals after permission is issued by the competent authority: licensed physicians and veterinarians; pharmacists of hospitals and clinics; and physicians of hospitals and clinics who have been authorised to deal with drugs in the place of licensed pharmacists (The Control of Drugs Act, Article 25).

The manager of the pharmacy must record the amount of drugs prescribed in accordance with the procedure set down in schedule 2 of the Control of Drugs Act. A government form is issued for the purposes of recording information, and contains the quantity of drugs purchased or sold and comprehensive details about the drug and the transaction. Each form is numbered, and must be stamped by the competent authority before being

used (The Control of Drugs Act, Article 26). Prescriptions of controlled drugs must be kept locked in a secure place in the pharmacy, and a report recording the purchases and outgoing and balance of drugs must be sent to the competent authority in the first two weeks of every January and July (the Control of Drugs Act, Article 28). The drugs listed in schedule 2 of the Control of Drugs Act which are available in the pharmacy must be stored in a locked cupboard or other receptacle, and the manager of the pharmacy is the only person authorised to open this storage receptacle (Controlled Drugs Act, Article 29).

Whilst some of the rules mentioned above are applied, there is also some violation of the rules by authorised persons, especially by physicians and pharmacists. The fieldwork findings show that some drug users, especially those who are U.A.E. nationals, manage to obtain drugs from private clinics and pharmacies. Not only can drug abusers buy drugs illicitly, but they can also obtain drugs from licensed institutions; thus it is difficult to control the supply of drugs if these institutions continue to supply drugs (see Chapter 6).

The storage of drugs

Article 3 of the 1983 Act controlling pharmaceutical activities specifies the conditions under which drugs must be stored. It forbids drug cupboards to be opened without permission, and only in accordance with the following conditions. The authorised person must be of U.A.E. nationality, and the storage facility must be managed by a licensed pharmacist and must satisfy the health legislation and any other legislations, conditions and requirements. The authorised person must not transfer his licence to anyone else, and if the ownership of the receptacle where drugs are stored is transferred to another person the license to store goods becomes invalid and the new owner must apply for, and receive, authorization before he can open the drug cupboard. Furthermore, authorization is valid for only a year. It can be renewed for periods of less than a year (Articles 34, 35, 36, 37 and 38, Pharmaceutical Activities Act, 1983).

The Pharmaceutical Activities Act also forbids anyone who has no licensed drug storage facilities to import drugs or pharmaceutical and chemical preparations. Moreover, if the owner of the drug storage facility is an agent for a drug producing company or manufacturer, he must be authorised by these agencies to import their products. The owner of the drug storage facility must keep two records, one recording normal drugs and the other recording controlled drugs. Both records must be filled in by the manager of the storage facility and he is held solely responsible for the veracity of the information recorded. The recorded information must contain the quantity of imported drugs, the quantity sold and the current balance of drugs in stock. The drugs which are stored must be sold only to pharmaceutical or medical firms or institutions, and chemical preparations used for agricultural or industrial purposes must be sold only to authorised individuals or firms. The owner of the drug storage facility must not sell more than the legally specified quantity of drugs or poisonous substances to anyone other than a licensed pharmacist who is responsible for a pharmacy or to a licensed physician or authorised persons who are legally entitled to use poisonous substances in their place of work (The Pharmaceutical Activities Act, Articles 39, 40, 41, 42, 43, 44, 45 and 46).

Offences Relating to Pharmaceutical and Medical Activities

Any physician who abuses the issuing of controlled drugs, for instance by prescribing drugs to non-patients, or by helping addicts to get drugs without permission is deemed to be guilty of a drug offence and is treated according to the Control of Drugs Act in the same way as an ordinary individual. Furthermore, physicians must observe the Control of Drugs Act as well as the regulations regarding professional conduct in relation to medicine, because the Control of Drugs Act is a general Act applying to all people whereas the rules regarding medicines are laid down by the professional body and are a form of private law applying to people involved in the medical professions. If a physician commits any indictable offence relating to the Act, either in the course of his job or in

private life, he is prosecuted by the Control of Drugs Act as well as by the medical body regulating his profession; thus, physicians and pharmacists are not exempt from observing the Control of Drugs Act and the Pharmaceutical Activities Act by virtue of their profession. In addition, the possession of regulated drugs without permission from the appropriate authority is forbidden even for physicians, and their standing as physicians does not exempt them from punishment as set out in the Control of Drugs Act.

The manufacture of controlled substances

The Control of Drugs Act forbids the production of substances designated under the Act without permission, and this permission is issued only for the following: government authorities and licensed academic institutions; government controlled and licensed private hospitals and clinics; laboratories of analytical chemistry; laboratories of medical, scientific and industrial research; the storage of medicine; and licensed pharmacies and manufacturers of medical preparations, all of whom must have at least one licensed pharmacist to be responsible for the drugs (The Control of Drugs Act, Article 30).

In addition the Act forbids manufacturers of pharmaceutical and medical preparations to produce any preparation which may contain any controlled substances without permission. Such firms must not use drugs falling under the Control of Drugs Act for any purpose other than for the production of medical or pharmaceutical preparations (The Control of Drugs Act, Article 31). The quantity of the controlled substance which the preparation contains must not exceed the quantities set out in schedule 4 of this Act and also as agreed acceptable in medical practice (The Control of Drugs Act, Article 32).

The Pharmaceutical Activities Act (1983) specifies the conditions and requirements which must be conformed with in the manufacture of drugs. The two Acts mentioned above forbid the production of drugs without a permit issued by the appropriate authority in the U.A.E.. In addition, the regulations contained in the Industrial Activities Act (No 1, 1979) must be complied with in the manufacture of drugs and preparations including

drugs. These are as follows: production must take place only in suitable and approved factory conditions or in chemical, sterilisation and germinal laboratories and must satisfy all health and technical requirements; the manufacture must be managed by a licensed, full-time pharmacist; and each laboratory must be managed by a licensed pharmacist who is a specialist in the medicine which is being produced by the manufacturing process.

The manager of the manufacturing plant is solely responsible for keeping the dangerous drugs secure and for keeping accurate and up to date records of these drugs at all times. If the manager is absent for any reason, she/he must be replaced by another licensed manager. If the manufacturer's licensed manager leaves his job he must be replaced by a new licensed manager within 15 days. The manufacturer must report to the Ministry of Health any absence or the ending of employment of the licensed manager. In addition, the names of all the employees engaged in the production and administration of any business involving drugs must be notified to the Ministry of Health, as must any changes in the jobs of employees. All forms recording information concerning drugs must be numbered and stamped by the Ministry of Health; the manager of the firm is solely responsible for these records. In addition, these records must be checked by an authorised government inspector from time to time. Records must contain the manufacturing process of the medicine or medical preparations and also details of expenditure, preparation, manufacture and distribution of any product involving drugs. The above rules and restrictions are created in order to avoid and ban dealing in drugs by illicit means.

Any licensed firm must have the following storage facilities: firstly, secure and appropriate storage containers for raw materials. Such storage must have appropriate temperature and humidity controls. Secondly, a secure storage for dangerous drugs, located away from the main building. Finally, there must be appropriate storage containers for the finished products. (The Pharmaceutical Activities Act, Article 55).

There are also regulations governing the buildings in which drugs are produced and/or processed. The manufacturing plants must be at a suitable safe distance from each other and comply with safety requirements. In order to prevent environmental pollution and health hazard the disposal of waste must be by strictly approved methods. Moreover, the manufacturing process and commercial activities must all comply with the appropriate health and safety requirements set down for employees of drug manufacturers (The Pharmaceutical Activities Act, Article 56).

Regulation of designated psychotropic plants

The Regulation of Drugs Act specifies those plants and their seeds which are forbidden to be grown, imported, exported, possessed and used and also prohibits any activities relating to these plants (Schedule 5 the Control of Drugs Act, Articles 35 and 36) These plants include male and female *Cannabis Sativa*, Coca, *Qāt*, Poppies, *Datura*, *Shakaran* and poisonous and hallucinogenic mushrooms. If a farmer discovers that any of the above are being cultivated on his farm, he must report this fact to the appropriate public authority (Article 37). However, the Minister of Agriculture has the right to grant permission for the cultivation of these plants to government agencies and licensed academic institutions (Article 38). This permission is issued only for the purposes of study and research. There have been many instances of the cultivation of psychotropic plants, especially cannabis, on farms and around houses. Most people convicted of cultivating psychotropic plants had done so for their own use only. The seizure of quantities of psychotropic plant seeds at sea/air ports in the U.A.E. indicates that cultivation of these plants probably takes place in the U.A.E..

The Use of Controlled Substances

The Act forbids the use of controlled drugs except for treatment purposes according to prescription issued by a licensed physician, except for the substances mentioned in schedule 6, which contain: fibres of the branches of cannabis sativa and toasted cannabis

and poppy seeds (i.e. the substance has been treated in such a way that it is not able to grow (the Control of Drugs Act, Article 34).

In addition, any prescription for drugs must only be issued by a licensed physician or veterinarian. A licensed physician or veterinarian must not prescribe a drug or drugs for a patient unless the drug or drugs is essential for his or her treatment and in quantities specified in schedule 4 of the Control of Drugs Act, Article 33).

Drug Offences and Punishments

Import and export restrictions on drugs

The offences and punishments described here are not related to Shari'ah Law because Shari'ah Law is not applied in cases of illicit drug-related activities. The Control of Drugs Act lays down conditions and requirements, which must be conformed with, for the import and export of controlled drugs. One requirement is that permission must be granted by the appropriate authority for any import, export, stocking, storage, transportation or other movement of controlled drugs. The Act also specifies which type of individuals and firms have the right to apply for permission. The Act also bars from the above any individuals who have committed specific crimes such as crimes against property, indecent assault, depravity, etc. (mentioned above). These restrictions were made in order to ban those convicted of specific crimes from dealing with the drug trade when they are not qualified to do so.

Legislation defines the importation of drugs as to bring in drugs into the territories of the state; drugs must not be transported beyond the custom line on land or water borders without the appropriate permission and licence, and this must be in accordance with the regulations laid down by international law (Al-Shazli, 1984).

The owner of any imported drug can be prosecuted for an importation offence regardless of whether he was the person who personally brought the drug into the country without

conforming to the above legislation or the drugs were brought in by someone else. The legislation distinguishes between the importation of drugs into the U.A.E. without permission on the one hand for the personal use of the person bringing the drugs into the state, and on the other hand for the purpose of distribution. The Control of Drugs Act discriminates in the punishment of those who import or export drugs for their own use and those who import drugs for financial gain. Article 49 (a) prescribes that an importer convicted of illegally importing drugs must be punished by a term of imprisonment not less than 3 years and not exceeding 5 years, with fines of not less than 30,000 dirhams (£4,000) and not exceeding 200,000 dirhams (£30,000). Penalties may be either or both of the above in the case of drugs being imported for the personal use of the importer. However, where drugs are imported for financial gain, the punishment is increased to a term of imprisonment not less than 5 years and not exceeding 10 years. In the case of a second or subsequent offence, the term of imprisonment is increased to not less than 10 years and not exceeding 15 years and the court is also able to impose the fines mentioned above in addition to the term of imprisonment.

In addition, the Act discriminates between individuals who commit an import or export offence with drugs and criminal organisations which commit the same offence, with heavier penalties for the latter. The Act states that the head of any criminal organisation (defined as a group of three or more people found guilty of drug import/export offences) must be punished by the following: the death penalty or life imprisonment if the imported drug was one listed in schedule 1 or 5; by life imprisonment or by a term of imprisonment of not less than 10 years and not exceeding 15 years if the imported drug is listed in schedule 2 or 3; and by the death penalty in case of a second offence (The Control of Drugs Act, Article 50 (a), (b)). To date, no-one in the U.A.E. convicted of a drug-related crime has received the death penalty. Most penalties in the Drug Act have lower and upper limits, and it is up to the judge to choose the appropriate penalty.

Legislation also stipulates that anyone illegally importing drugs should be prosecuted for the offence of illegal importation, and for any other drug-related offence such as possession, whether the drugs were for his own personal use or for someone else (Abu al- Russ, 1989). This in effect means that an offender may receive two sentences, one for illegally importing drugs and one for illegal possession.

Other than the distinction between drugs illegally imported for personal use and those for financial gain, i.e. trading purposes, the Act does not discriminate in drug-related import and export offences. Whatever the intent of the person or persons importing or exporting drugs illegally, the offences are theoretically punishable in the same way nevertheless. For instance, someone bringing in a quantity of drugs for his own use and that of a few friends, in theory, can be punished as severely as a drug dealer whose trade can be said to cause the suffering of many. However, in practice, in cases where the quantity of drugs illegally imported or exported is small, the court can decide that the drugs were intended solely for personal use and thus mitigate the length of sentence. Thus the degree of harmful intent of the offender is in practice taken into account in the degree of punishment meted out. The results of fieldwork research revealed, however, that most people convicted of drug import crime were given the same penalty was ten years imprisonment regardless of whether they imported drugs for their own use or for trade.

Offences and penalties governing the use of controlled drugs

Article 39 of the Control of Drugs Act stipulates that a person found guilty of using any substance or plant listed in schedules 1 or 5 must be punished by imprisonment of not less than 1 year and not exceeding 3 years. The use of substances and plants in the list attached with the Drug Act is forbidden, whether for treatment or recreational purposes and the quantity of drug makes no difference. An offence is considered to have been committed by its use, no matter how small the quantity involved. Moreover, Article 40

of the Control of Drugs Act states that the user of any substance listed in schedules 2 or 3 without prescription must be punished by imprisonment of not less than 6 months and not exceeding 3 years. If anyone uses such a substance without prescription but nevertheless for the purposes of medical treatment, and the type of substance was appropriate for such treatment, the punishment can be reduced to a fine of not less than 1,000 dirhams (£150) and not exceeding 10,000 dirhams (£1,500). The elevation of the penalty tariff for drug use does not mean that drug use will decline, nor even that its spread will slow. Despite the increasing severity of the penalties, drug enforcement statistics show a year on year increase in the number of drug users. I believe that increases in the penalties for drug use should be associated with prevention and rehabilitation programme. As one of the respondents said:

The first time I appeared in court no-one asked me why I became a drug user. No-one enquired what factors forced me to become a drug user, and no-one counselled me. I believe that the penalties which are applied to drug abusers are unjust in that because they are only applied to poor people.

The Act does not discriminate between the use of substances according to their effects on humans but it does discriminate between the use of substances according to their purposes. Article 39 of the Act stipulates that the punishment for someone found guilty of using opium or heroin (which can cause severe physical and mental damage to the user) and that for *qāt* or hashish (which only produces slight effects on humans) is equal. On the one hand, it can be argued that non-discrimination between types of drugs used is useful in that users have no plea to avoid penalties on the grounds of the slight effect of any given drug. On the other hand, it can also be argued that, were fines or imprisonment for the use of 'lighter' drugs such as *qāt* and hashish correspondingly lighter, some people may be discouraged from using heavier drugs, preferring to use lighter drugs. Under the present arrangements, given that the punishments are the same, there is little incentive for someone wanting to try drugs to avoid the harder drugs in

favour of 'lighter' drugs. An appropriate change in the legislation might thereby reduce the number of people being introduced to or using more addictive and destructive drugs such as opium and heroin.

This apparent lack of concern in the legislation for the physiological severity of a drug is illustrated by the fact that legislators in the U.A.E. on the one hand allow permitted persons who are non-Muslims to drink alcohol, which can cause serious physiological damage and is addictive, and on the other forbid the use of drugs such as *qāṭ* which causes less damage to the human body than alcohol.

The Control of Drugs Act forbids the use of any substance not listed in the schedules attached to the Act but which can produce intoxication or a state of narcosis (Article 41). By this means the court is able to prosecute any person who uses dangerous substances such as solvents which are not listed in the schedules of the Control of Drugs Act. article 41 providing that persons found guilty of using such substances must be punished by imprisonment of not less than 6 months and not exceeding 3 years.

Courts are allowed to 'exchange' the penalties for drug abuse for an order for the user to attend an addiction treatment clinic. An addiction treatment clinic was created in the 1980s to enable the Act to be enforced humanely after taking into consideration the recommendations of the Medical Committee, which now controls the treatment in the addiction clinic. The Medical Committee is required to present a progress report to the court every 6 months for every offender receiving treatment at the clinic. If the report is positive, the court has the right to release him before the end of his custodial term after taking into consideration the opinion of the Public Prosecutor. At the request of the offender, the court can release the offender from the treatment clinic after taking into consideration the opinion of the Medical Committee and that of the Public Prosecutor. If the court turns down the addict's request, he cannot reapply for 6 months from the

date of the first request. According to the Act, the minimum period of residence in the addiction treatment clinic for an offender is not less than 6 months and not more than 3 years. In fact, and according to the results of the fieldwork, most drug addicts are discharged after less than a month in the addiction treatment units. This may happen under the pressure of their families or police. One of drug abusers stated:

Sometimes when the police arrest a drug abuser they send him to jail rather than to hospital. At other times the police select some users they have arrested and send them to the hospital, without consulting the physicians.

Article 43 offers a drug offender immunity from prosecution and punishment if he gives himself up to treatment at the addiction clinic or to the recommendations for treatment of the public prosecution which usually involves treatment either at the clinic or other medical institution. An offender's request for this alternative to fines and/or imprisonment can be accepted only if the Medical Committee is satisfied that he is in need of treatment and will benefit from it. The Medical Committee is the only body which can decide how long the offender must undergo treatment in the clinic, and it has the right to release him after the treatment is considered to be complete. This may, in effect, mean a remission of the remainder of the term of the sentence. Remission, however, does not apply if the user is found to have any drug (in however small a quantity) which he did not hand over to the clinic or to the Public Prosecution.

The acceptance of medical treatment by the offender and his subsequent immunity from prosecution and punishment are solely within the jurisdiction of the Medical Committee, and from what I saw of the activities of the Committee during my fieldwork, the Committee did not accept any drug user for treatment unless he genuinely was able to benefit from treatment. This means that if an offender is refused by the Medical Committee for treatment, the police may arrest him for an offence against the Control of Drugs Act. If he is refused by the Medical Committee he might be accepted for treatment were a permit obtained from the police or a court.

In my view the above is beneficial for the drug addict who is in need of treatment. Not all users become addicts, and this is taken into account. The prosecution must specify the type of drug which is used by the defendant. The defendant must be released if the substance which it is proved he used is not in the Control of Drugs Act list, even though the substance which was used by the charged person is capable of causing addiction. The assessment of whether the substance used by the defendant is addictive must be undertaken by an expert in drugs. Whereas the Act does not specify whether the quantity of drugs should be taken into account in the severity of the sentence, it does specify the percentages allowed in medical preparations which contain substances on the 'controlled' list.

The penalties which are laid down for the use of drugs differ according to the type of drug. Legislators have assessed penalties in accordance with the effects of different drugs. The following are some offences relating to drug abuse for which the Act lays down the degree of punishment: The person who facilitates or encourages or invites another person to use drugs should be punished by a term of imprisonment of not less than a year and not exceeding three years or by a fine which should not be less than 10,000 dirhams (£1,500) and not more than 30,000 dirhams (£4,500). What are termed 'aggravating circumstances' can be added to the penalties of these offences, for instance if the person encouraged or invited to take drugs was either female, a juvenile, an intoxicated person, or insane, the penalties are more severe. (The Act perceives a female as being easily persuaded or coerced by a male.) Also, if someone encourages another person to take drugs in order to hurt them or to cause them to suffer harmful effects, terms of imprisonment are increased to not less than five years and not exceeding ten years. If the effect of the drug was known to be harmful to the person who encouraged the other person to take it, the term of imprisonment is increased to not less than ten years and not exceeding fifteen years. If someone dies due to the effects of drugs the person who encouraged or invited them to take the drugs, can be sentenced to death.

A person commits an offence if, being the occupier or concerned in the management of any premises, he has permitted drug-related activities to take place there. The punishment is imprisonment of not less than ten years and not exceeding fifteen years if the drug involved was listed in schedule 1 or 5, and by imprisonment of not less than five years and not exceeding ten years if the drug was from schedule 2 or 3. The courts can impose a sentence of life imprisonment for subsequent offences.

The Act does not discriminate between situations where the occupier who permits drug-related activities to take place on his premises in return for money situation where and where no financial gain is made. It can be argued that the Act should not punish the person upon whose premises drug-related activities took place if he was unaware of the fact, and also that the person who takes no money for allowing a drug-related activity to take place on his premises should be less severely punished than the one who benefits financially from allowing his premises to be used for the taking of drugs.

However, any person who allows his premises to be used for drug-related activities knowingly is liable to be punished by a term of imprisonment of not less than six months and not more than one year, or by a fine of not less than 5,000 dirhams (£750) and not exceeding 10,000 dirhams (£1,500) (except if that person is the mother, father, wife, forbear or descendant of the occupier of the premises). Those people according to the Act, should be punished by a fine of not less than 1,000 dirhams (£150) and not more than 10,000 dirhams (£1,500), or else by a caution.

The additional Penalties

The additional penalty is a term for a penalty which follows and is in addition to the principal penalty. This penalty does not apply if it is not mentioned in the final judgement. Junior penalties consist of the following:

Firstly, article 56 of the Control of Drugs Act states that all narcotic substances, intoxicant plants, tools, equipment and means of transportation involved in drug-related crimes

must be confiscated. However, the Act does not provide for the confiscation of the financial benefits which are gained from drug-related crimes. The Act would undoubtedly be more effective were the confiscation of profits gained from drug-related crimes included.

Secondly, article 57 of the Control of Drugs Act provides that any premises in which drug-related activities have been allowed to take place must be closed. However the Act does not specify the length of time for which the premises must be closed, and neither does it discriminate between premises which belong to the person or persons who took part in the drug-related crime and premises which belong to someone else. The premises cannot be reopened without permission from the Public Prosecutor.

Thirdly, in addition to the main penalty, it is the court's right to make the abstract of the final judgement public by any media it chooses and the convicted person must pay for the cost of the publicity. This is in order to discourage other people in society from violating the controlled drugs act.

In addition to the above, the court has the right to restrict or specify the domicile of the prosecuted person. He can also be banned from frequenting certain places. Anyone who has been accused of drug abuse more than once may also be banned from driving. This ban ceases one year after the end of his principal penalty. Convicted drug users may also be banned from getting a job in the public sector. Meanwhile, the convicted drug user can open a bank account. Convicted foreigners might be deported after completing the sentence, or otherwise released to re-start a normal life in society.

A new proposal currently under consideration recommends increasing some penalties, especially those of trafficking and trading. Some offenders such as traffickers and dealers could be sentenced to the death penalty and the drug use penalty will be raised to four years imprisonment if the new recommendations are adopted. The new recommendations will be applied in order to combat the import of illicit drugs into the U.A.E.. (Al-Khalij Newspaper, April 25, 1995).

Enforcement of Drug Legislation

The General Administration of Narcotics Control

The General Administration of Narcotics Control (GANC) is the federal government organisation which deals with drug control. It is part of the Ministry of the Interior and is located in Abu Dhabi. The original intention was that branches of the GANC would be set up in every Emirate and cities throughout the U.A.E.. Since it was established in 1986, the Minister of the Interior has been trying to achieve this, but without success. Most local governments refuse to allow drug control to pass into the jurisdiction of the federal government. The reasons appear to be that local governments do not want to give a federal organisation more authority than local organisations and that most federal organisations are financially and administratively weaker than local organisations, especially those in the oil-rich Emirates. Thus the General Administration of Narcotics Control has no effective authority or role in drug combating activities in the U.A.E., and its officers are not allowed to work in the territory of any Emirate other than Abu Dhabi.

To offset its lack of authority, the GANC collaborates with other drug combating agencies in the Emirates which are run by local governments. They exchange reports and information about traffickers, dealers and users. The GANC also supports drug combating agencies in the Emirates by contributing in the technical and training spheres, and sometimes, financially. They also collaborate and co-ordinate with international drug control organisations.

The General Administration of Borders and Coast Guards

In accordance with the Saudi Arabia Security Experts Report (1976) the Supreme Council in the U.A.E. agreed to create the General Administration of Borders and Coast Guards. (Official Gazette, No. 40, 1976.). The General Administration of Borders and Coast

Guards has five departments distributed throughout the Emirates. The aim of the border and coast guards is to secure protection on the borders and coasts of the U.A.E.. It also aims to combat illegal infiltration and the smuggling of narcotics, to ensure that ships and people enter only through official outlets, to protect fishing grounds and aquatics, oil installations, sea ports, bays and islands, and to discover and fight sea pollution (General Administration of Border and Coast Guards).

The activities of the borders and coast guards covers more than 680 km of the U.A.E. coast along the Arabian Gulf, and about 90 km of coast on the Gulf of Oman. On these coasts there are more than 18 commercial sea ports and more than 31 fishing and pleasure sea ports, in addition to many natural bays and harbours.

Some of the more recently created sea ports were established without consulting the coast guards, and consequently most of them lack adequate security facilities. In spite of the responsibility of the Ministry of the Interior for control of security for sea ports and coasts, the authorities of sea ports in the Emirates do not as a matter of course consult the Ministry of the Interior on security issues at sea ports, because most of them belong to local governments whose main concern is to encourage trading activities in these ports. Considerations of security which may deter commerce are given minimal attention. In addition, competition for trade between the Emirates has led to a lack of control and security in most of the sea ports. Methods that have been used by local governments to encourage trading activities include abandoning customs in sea ports, allowing ship crews to leave port without being checked and allowing ships to stay for a long time in port. The lack of modern equipment such as fast boats, surveillance aircraft and radar, and the lack of suitably trained personnel, coupled with the reluctance of the Emirates to exchange information relating to drug trafficking activities seriously hampers the government organisation's efforts to combat the illegal entry of drugs into the country. Another major contributory factor to the problem of lack of control over entry at seaports is that there are more than 11,000 Asians working in the fishing industry in the U.A.E., and many

thousands of foreigners working in and around the sea ports. This makes it easy for some of them to be involved in drug-related activities or to help smugglers enter the country.

A report from the Minister of the Interior was submitted to the Supreme Council of the U.A.E. on 28 October 1991, setting out in detail the lack of control on most coasts, sea ports, harbours and borders and asking the Supreme Council to assist the General Administration of the Coasts and Borders Guards by giving it authority to control sea ports and coasts.

It also requested that the influence of local governments be reduced in matters of entry and inspection of people and goods as regards ports coasts and borders. In the same report, the Minister of the Interior asked the Supreme Council to re-evaluate the reason behind the availability of the large number of sea ports in the Emirates and that this evaluation should be undertaken with a view to maximising both commerce and security. The Minister of the Interior also requested that security activities in all sea ports be increased.

As a result of the problems outlined above, the participation of the Borders and Coasts Guards in drug prevention is minimal and the willingness of local government authorities to collaborate with federal departments involved in drug control is often grudging. Many laws which have been passed to control the country's security, such as immigration laws, are not applied in all Emirates and some Emirates prefer to create and use their own by-laws rather than federal laws.

Few coast guards have any training in combating illegal drug activities. Many of them are unskilled, and have little idea about the types of drugs that are on the controlled list, or even how to recognise dangerous drugs. The majority of illegal drugs which entered the U.A.E. between 1989 and 1992 were smuggled through sea ports, coasts and frontiers (43%) (Table 9.1).

Table 9.1: Drug trafficking in the U.A.E. and routes of entry

The Route	Air ports		Frontiers		Maritime		Unknown		Total
	Count	%	Count	%	Count	%	Count	%	
1989	80	24	149	51	40	14	23	8	292
1990	76	23	113	35	52	16	83	26	323
1991	38	11.5	74	18	66	16	233	57	412
1992	137	41.2	221	21	194	18	516	48	1068
Total	331	16	557	27	352	17	855	40	2095

Source: The General Administration of Narcotics Control, Abu Dhabi.

In 1989 about 65 % of drug trafficking offences were through frontiers and coasts, about 27% of illicit drugs were brought into the U.A.E. through the airports and for about 8% the entry point was unknown. In 1990 51% of the illicit drugs seized were being smuggled into the U.A.E. through frontiers and coasts, 23% through airports and the rest (26%) through unknown entry points. In 1991 activities to combat illegal drugs entering the U.A.E. were stepped up, resulting in 411 cases being recorded. The point of entry for most of the illegal drugs discovered was unknown (57%). Of the rest, it is estimated about 34% were smuggled through frontiers and via the sea and only 9% through airports. In 1992 there were 1068 cases of attempted drug trafficking recorded, and for most of them entry points are not known (48%). About 39% of illicit drugs were brought into the U.A.E. via frontiers and the sea, and only about 13% through airports. Entry by unknown means accounts for 40% of cases, the smuggled drugs being seized after entry into the country and sold to people who did not know the entry route of the drugs.

Trafficker’s Infiltration

One of the main problems facing the General Administration of Borders and Coasts Guards is that of illegal immigration. Hundreds of illegal immigrants enter the U.A.E. every year, some bringing quantities of drugs with them. Most illegal immigrants come from Iran, Pakistan, Afghanistan, India and Bangladesh. They use speedboats, mostly from Iran, with engines more powerful than those of Coast Guards’ vessels.

According to the General Administration of Borders and Coasts Guards reports, in 1990 more than 1,591 persons tried to enter the U.A.E. illegally by sea (Table 9.2), most of them from Iran (61%). This is because Iran shares maritime borders with the U.A.E. and there is a lack of control on these borders. The next largest group of smugglers and illegal immigrants were Bangladeshi (14%), followed by those from India (8%), Afghanistan (7%), Pakistan (6%) and other nationalities (4%).

According to Coasts Guard reports, it is estimated that about 80% of illegal immigrants who entered the U.A.E. by sea were arrested and only about 20% were able to evade the Coasts Guards and enter the country (Annual report, General Administration of Borders and Coasts Guards, Abu Dhabi, 1990-1991).

In 1991 the number of smugglers and illegal immigrants who tried to enter the U.A.E. by sea numbered about 1,459 persons, most of them from Iran (48%), with 15% from Afghanistan, 11% from Bangladesh, 5% from Pakistan, 5% from India, and immigrants and smugglers from other countries such as Sri Lanka and Somalia comprising 16% of the total. The above shows that most illegal immigrants and smugglers came from drug producing countries such as Iran, Pakistan, Afghanistan and India.

Table 9.2: The nationality of illegal immigrants who tried to enter into the U.A.E., for the years 1990 and 1991.

Nationality	1990		1991	
	Count	%	Count	%
Iran	970	61	702	48
Pakistan	87	6	73	5
Afghanistan	116	7	218	15
Bangladesh	228	14	162	11
India	125	8	73	5
Other	64	4	231	16
Total	1590	100.0	1459	100.0

Source: General Administration of Boarder and Coastal Guards, Abu Dhabi

Methods of illegal entry for drug trafficking

Most traffickers and illegal immigrants who tried to enter the U.A.E. came by speedboat. In 1989, 186 boats were apprehended by the coast guard, of which 83 boats were seized while trying to enter illegally, 40 boats found on the shore after being left by traffickers who had managed to enter the country illegally (Table 9.3), and 63 boats fled after landing their complement of illegal immigrants and traffickers. In 1990, 261 boats were found trying to enter the U.A.E. with illegal drugs. Coast guards apprehended 125

boats, 83 escaped after putting ashore drug traffickers and illegal immigrants, and 53 were found on the shore after being abandoned by traffickers who had entered the country. In 1991 coastguards took possession of 271 boats believed to be involved in bringing into the U.A.E. illegal drugs and immigrants; 144 boats were seized by coast guards, 59 boats had to flee after landing their passengers, and 68 boats were found abandoned on the shore after being left by traffickers who had entered the country. It has been estimated that in 1989, about 55% of boats trafficking in illegal drugs or carrying immigrants succeeded in entering the U.A.E. with their loads, only 45% being apprehended by coast guards. In 1990, the coast guards seized the loads of about 48% of boats trafficking in illegal drugs and carrying immigrants and about 52% of boats managed to put their loads ashore in the U.A.E.. In 1991, the loads of 53% were seized by coast guards and about 47% managed to enter into the country illegally.

Table 9.3: Number of trafficking boats which have entered into the U.A.E. for the years 1989, 1990, and 1991.

	1989		1990		1991	
	Count	%	Count	%	Count	%
Arrested	83	45	125	48	144	53
Found empty on seashore	40	21	53	20	68	25
Escaped after put shore their load	63	34	83	32	59	22
Total	186	100.0	261	100.0	271	100.0

Source: The General Administration of Boarder and Coastal Guards

There are many reasons behind the increasing of trafficking activities:

1. Geographical factors, such as the mountainous areas along the east coast, especially from Khour Fakkan to Diba and the border between Oman and the Emirate of Rass al-Khaimah. Some of these mountains are very close to the shore (only 50 metres away in some areas), which means traffickers can hide quickly from coast guards once they have landed. Some of these areas, particularly the coasts, are unfrequented or even uninhabited.
2. There is a lack of customs/emigration control in some countries, such as Iran and Pakistan.
3. There is a thriving industry in forged passports and identity cards in countries such as Iran, Pakistan, Afghanistan, India and Bangladesh. The crew of boats apprehended by the coast guards are often found to have forged passports and identity cards.
4. The unsettled political situations of countries such as Afghanistan and Pakistan encourage some people to emigrate to other countries.
5. Some illegal immigrants and traffickers receive help from Asians already living in the U.A.E.. Some crews of illegal boats procure identity cards in the names of other people legitimately living in the U.A.E. in order to enable them to enter the

country. Also some Asians, especially those who work as fishermen or who are living along the coast, assist illegal immigrants by hiding them in their houses or in their boats.

6. Boats used for illegal traffic in drugs and for carrying immigrants are similar in size and appearance to those used by U.A.E. fishermen, which means it is difficult for the coast guards to distinguish between boats illegally trafficking in U.A.E. waters and fishing boats going about their legitimate business. The situation is made more difficult in that most fishermen in the U.A.E. are Asians, as are many drug traffickers.
7. Some trafficking boats put their load ashore on the border between Oman and the U.A.E. at places such as Diba al-Biah, which is part of Oman and Rass al-Darah which is also in Omani territory. Both the above are close to Sham, which is part of the Emirate of Rass al-Khaimah. These areas have little control from either the U.A.E. or Omani authorities, and they are mountainous areas with the shore very close to the mountains, i.e. perfect for smuggling and illegal entry.
8. The proximity of the U.A.E. coasts to Iran means that boats take two to three hours to travel from the Iranian coast to the U.A.E..
9. Most boats engaged in trafficking are small, and the coast guards sometimes fail to pick them up on their radar, especially during bad weather and poor visibility.
10. The lightness of penalties for breaking immigration laws encourages some traffickers and illegal immigrants to enter the country many times. The highest penalty is imprisonment for 1-2 months (The General Administration of Border and Coastal Guards, Annual report, 1990).

Most borders guards and coast guards are inexperienced in dealing with drug trafficking. They also lack modern drug detecting equipment and this makes it difficult for them to

prevent infiltration of drugs through the borders and coasts of the country. The coast guards also have no authority to search for drugs in ships which are anchored at sea ports. Any ship suspected by coast guards which is near a sea port comes under the jurisdiction of the port authority and must be handed over to them for the search of its cargo. However, most ports have no satisfactory searching procedure because they do not want to discourage ships returning to the same port. Coast guards have no authority to search suspected ships in port or as they patrol along the coast, and it is difficult for the guards to search ships out at sea in deeper waters, especially in bad weather. Most sea ports do not 'frisk' ships' crews which means that it is easy for crews to bring in drugs illegally.

As a result of the above difficulties, the Minister of the Interior has established a new department in the General Administration of Borders and Coasts Guards whose objective is to combat drug trafficking at sea. The supervision of this department comes under the General Administration of Narcotics Bureau (Ministerial Decrees no. 222, 1993).

The Departments of Narcotics in The Emirates

Narcotics departments are controlled by the local police in each Emirate. There are seven departments - one for each Emirate - and each department has several branches in each Emirate in the major ports and cities. Their aim is to reduce the availability of illegal drugs in society, and the number of drug traffickers and abusers. Their activities include receiving reports, follow-ups, surveillance, arrest and investigation. They also collaborate with other government and non-government organisations in drug prevention activities. All departments depend financially, for both training and technical support on the Ministry of the Interior, except for the Abu Dhabi and Dubai police departments, which are supported entirely by their local governments. The drug prevention department in the Emirate of Sharjah receives some financial support from the local government as well as federal support. Federal support gives the departments the authority to pursue drug combating activities in the U.A.E..

Between 1974 and 1992 drug combating agencies made 4,462 separate confiscations of illegal drugs (Table 9.4). These figures indicate that drug problems in the U.A.E. are on the increase and that the activities of the drug prevention agencies are having to be stepped up accordingly. Most of these confiscations were made by drug prevention agencies in the oil-rich Emirates (82%), the remainder - 18% - occurred in the non-oil-Emirates. The drug prevention agency in Dubai seized 41% of the total, followed by that of Abu Dhabi (26%), Sharjah (15%), Ras al-Khaimah (9%), Ajman (5%), Umm al-Qaiwain (2%) and Fujairah (2%).

Between 1974 and 1992 (with the exception of 1981, for which figures are unknown) 6,599 people were arrested on drugs related-crimes (Table 8.5). Most of the arrests were made by drug combating agencies in the oil-rich Emirates (84%), with those in the non-oil Emirates making 16% of the total arrests. About 39% were arrested by the Dubai drug combating agency, 28% by that of Abu Dhabi, Sharjah making 17% of arrests, followed by Ras al-Khaimah (7%), Ajman 5%, Umm al-Qaiwain (2%), and finally Fujairah (2%).

Table 9.4: Number of drug cases recorded by drug combating departments, 1974-1992

Year	Abu Dhabi		Dubai		Sharjah		Ajman		Ras al-Khaimah		Umm al-Qaiwain		Fujairah		Total
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	
1974	63	48	45	34	17	13	0	0	7	5	0	0	0	0	132
1975	38	37	40	39	23	22	0	0	2	2	0	0	0	0	103
1976	41	42	30	31	24	24	0	0	1	1	1	1	1	1	98
1977	29	18	41	25	9	5	5	3	81	49	0	0	0	0	165
1978	25	24	54	52	11	11	11	11	3	3	0	0	0	0	104
1979	17	12	103	70	23	16	1	0.6	2	1	1	0.6	0	0	147
1980	62	37	82	49	18	11	2	1	2	1	0	0	2	1	168
1981	38	24	88	55	26	16	3	2	1	0.6	1	0.6	2	1	159
1982	49	29	82	48	27	16	4	2.3	7	4.1	0	0	1	0.6	170
1983	77	28	154	55	26	9	6	2	8	3	2	1	5	2	278
1984	75	33	92	40	40	18	4	2	9	4	0	0	8	4	228
1985	80	31	107	42	39	15	6	2	18	7	3	1	3	1	256
1986	73	29	106	42	41	16	12	5	11	4	2	1	7	3	252
1987	137	28	223	46	58	12	29	6	21	4	4	1	10	2	482
1988	49	20	125	50	28	11	19	8	15	6	3	1	14	6	253
1989	69	24	119	41	29	10	10	3	25	8	10	3	17	6	279
1990	95	28	115	33	53	15	10	3	32	9	13	4	25	7	343
1991	70	17	112	27	95	23	29	7	63	15	27	7	15	4	411
1992	76	16	124	26	95	20	51	10	79	16	24	5	35	7	484
Total	1163	26	1842	41	682	15	202	5	387	9	91	2	95	2	4462

Source: Ministry of Interior, Abu Dhabi

Drug hoards seized by drug combating agencies in the Emirates for the same period of time (1989 is unknown) totalled about 16,722 kilograms of different substances excluding tablets (Table 9.6). About 50% of the total was seized by the Dubai drug combating agency, 33% by that of Sharjah, 10% by Abu Dhabi, 3% by Umm al-Qaiwain, 2% by Fujairah, and 1% each by Ajman and Ras al-Khaimah.

The extent and effectiveness of the activities of drug combating agencies in the individual Emirates varies greatly. This variance may be related to population density in Emirates such as Abu Dhabi and Dubai (see Chapter 4), but there are other factors affecting the drug combating success levels in the Emirates. For example, with the exception of the Abu Dhabi, Dubai and Sharjah drug combating agencies, agencies are totally dependent

on the financial support of the federal government. Allocation of funds is poor in comparison with that of local governments in the Emirates of Abu Dhabi, Dubai and Sharjah. Moreover, with the exception of Dubai, there is an absence of motivation in most drug combating departments. Dubai has its own legal system which allows its law enforcement agencies more freedom to apply laws effectively. The lack of specialised technical equipment, qualified personnel, sniffer dogs, vehicles, etc., in most drug combating agencies is another factor. The majority of courses and training activities in most agencies are for high ranking officers, and thus the rest of the staff are ignored in this respect. Proficiency in techniques such as surveillance, recruiting and use of informants, undercover operations, etc. differs from agency to agency. Most agencies lack these techniques, and most depend too heavily on informants. Finally, there are problems relating to the territorial range of each drug combating agency. Each agency tends to work only within its own Emirate, and where there is liaison and/or collaboration between agencies of Emirates it tends to depend only on the relationship between the individual drug combating agencies rather than on legislation insisting that liaison and collaboration are to take place when drug-related offences stray over from one Emirate to another.

Table 9.5: Accused persons arrested by drug combating departments, 1974-1992

Year	Abu Dhabi		Dubai		Sharjah		Ajman		Ras al-Khaimah		Umm al-Qaiwain		Fujairah		Total
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	
1974	64	39	63	38	28	17	0	0	10	6	0	0	0	0	165
1975	71	43	61	37	30	18	0	0	2	1	0	0	0	0	164
1976	85	52	37	22	35	21.4	0	0	1	0.6	2	1	3	2	163
1977	74	37.3	59	29.7	34	17	5	3	26	13	0	0	0	0	198
1978	51	30	80	47	17	10	15	9	8	4	0	0	0	0	171
1979	30	13	153	65.6	44	19	1	0.4	3	1.2	2	0.8	0	0	233
1980	85	36	119	51	23	10	3	1	2	1	0	0	2	1	234
1982	55	24	107	46	45	19	7	3	15	6	0	0	2	1	231
1983	123	29	233	54	31	7	9	2	18	4	2	0.4	11	2	427
1984	141	41	105	31	70	20	6	2	15	4	0	0	4	1	341
1985	151	36	166	39	59	14	10	2	30	7	3	1	4	1	423
1986	99	24	198	48	72	17	21	5	13	3	2	0.4	9	2	414
1987	137	28	223	46	58	12	29	6	21	4	4	1	10	2	482
1988	91	23	193	48	60	15	23	6	15	4	4	1	14	3	400
1989	138	29	188	39	64	13	15	3	15	3	32	7	23	5	475
1990	167	29	201	35	92	16	16	3	55	10	7	1	34	6	572
1991	156	22	175	25	176	25	43	6	100	14	30	4	18	3	698
1992	153	18	216	25	214	25	103	12	135	15	24	3	21	2	866
Total	1844	28	2577	39	1152	17	306	5	484	7	120	2	116	2	6599

Source: Ministry of Interior, Abu Dhabi. Note: (191 unknown)

Most agencies have no division of work enabling personnel to specialise in specific areas of drug combating, e.g. trafficking, possession, dealing, certain types of drugs, etc.. This means that personnel cannot build up a corpus of information, informants, expertise, etc., in any one field. In each agency all staff work together on whatever project is current at the time and all staff deal with everything. Most drug combating agencies concentrate on arresting drug abusers.

Table 9.6: Quantities of drugs in kilogram seized by drug combating departments, 1974-1992.

Year	Abu Dhabi		Dubai		Sharjah		Ras al-Khaimah		Ajman		Umm al-Qaiwain		Fujairah		Total
	kg	%	kg	%	kg	%	kg	%	kg	%	kg	%	kg	%	
1974	90	53	69	41	10	6	0	0	0	0	0	0	0	0	169
1975	218	97.3	3	1.3	3	1.3	0	0	0	0	0	0	0	0	224
1976	84	29	202	70	4	1	0	0	0	0	0	0	0	0	290
1977	85	24	96	27	147	42	22	6	4	1	0	0	0	0	354
1978	87	18	358	75	2	0.4	21	4.3	11	2.3	0	0	0	0	479
1979	22	6	352	89	18	4	0	0	1	0	0	0	0	0	393
1980	289	46	169	27	170	27	0	0	0	0	0	0	0	0	628
1981	58	26	87	40	22	10	2	1	17	8	0	0	33	15	219
1982	34	29	45	39	32	28	3	3	1	1	0	0	0	0	115
1983	120	28	322	69	21	4	2	0	3	0	0	0	0	0	468
1984	126	13	815	81	18	2	0	0	36	4	0	0	4	0	999
1985	73	6	1181	93	8	1	1	0	4	0	0	0	5	0	1272
1986	169	5	2775	84	352	11	0	0	4	0	0	0	0	0	3300
1987	63	3	1083	56	765	40	2	0	7	0	0	0	0	0	1920
1988	26	4	161	24	5	1	0	0	4	1	478	70	0	0	674
1990	127	25	96	19	5	1	2	0	0	0	0	0	274	54	504
1991	31	1	106	3	3235	94	30	1	8	0	8	0	10	0	3428
1992	107	8	417	33	663	52	19	1	19	1	0	0	50	4	1275
Total	1809	10	8337	50	5480	33	104	1	130	1	486	3	376	2	16722

Source: Ministry of Interior, Abu Dhabi. Note: (1989 unknown)

This made up about 45% of the workload of drug agencies. Dealing with drug dealers and carriers made up about 28% of their activity, and 16% of their workload is concerned with pushers and possessors (Table 9.7).

Table 9.7: Arrests by drug combating departments in accordance with the type of crime 1988-1992

Year	Carrier & Dealer		Possessor & Pusher		User		Total
	Count	%	Count	%	Count	%	
1988	129	32	90	23	181	45	400
1989	91	19	171	36	213	45	475
1990	144	25	141	25	287	50	572
1991	191	27.4	45	6.5	462	66.1	698
1992	283	33	43	5	540	62	866
Total	838	28	490	16	1683	56	3011

Source: Ministry of Interior, Abu Dhabi

Customs

In most countries in the world, one of the main functions of customs is to prevent the illegal entry of drugs into the country through sea ports and airports and across road borders. In the U.A.E. this function is weak in the customs departments of some Emirates and absent in others. In the U.A.E. there is no federal customs administration; each local government administers its own customs department. Many perceive their main function as collecting customs tax and encouraging commerce by providing facilities and flexibility of entry to goods and people rather than preventing the entry of illegal drugs.

Customs departments in the Emirates can be divided into two groups. In the first group are those of the oil-rich Emirates of Abu Dhabi, Dubai and Sharjah. These departments have good financial backing, training, and technical support from local government. In the second group are those of the non-oil Emirates which suffer from a lack of money, training, and technical support. The majority of customs departments do not have sufficient authority and resources to combat the entry and trafficking of illicit drugs effectively. One reason is that most drug combating activities are controlled by the drug combating agency in each Emirate, and these are controlled in turn by police headquarters in each Emirate. For example, in Dubai the customs department has no authority in drug combating activities; its function is limited to commercial activities. Most customs departments in the Emirates face many difficulties in pursuance of their drug prevention role, the main ones being:

1. The main priority of most customs departments in the Emirates is to provide more facilities to attract commercial activities. The prevention of entry of illegal drugs is not one of their main aims.
2. Most customs officers are not experienced in detecting drugs.
3. Most customs officers have had no training - in-house or on courses elsewhere - relating to combating drugs, and some of them have never even been shown the

different types of drugs so that they can recognise them if and when they encounter them in their work.

4. The absence of co-operation between police and customs departments. This is because customs want to encourage merchants to use their sea/air ports without being bothered by police detectives.
5. There are many sea ports in the country, and competition for trade is fierce. In order to encourage merchants to use their sea ports, customs departments in the various emirates try to avoid saddling their customers with searches and checks.
6. Some influential merchants in some Emirates are exempt from customs checks, and some may ask customs officers to do their checks at the merchants' houses or commercial properties rather than at the port.
7. There is no regular exchange of information between the police and customs departments in the Emirates regarding drug trafficking activities.
8. The absence of federal government control on customs departments. The main reason for this is that the local government wants customs revenue for its own treasury and discourages the federal government from interfering in what it claims is its jurisdiction.
9. Most customs officers start their jobs without the benefit of courses or other training facilities.
10. Customs checks are not usually carried out for goods to be re-exported, and these goods move from port to port without restriction or control.
11. The low salaries in the customs departments of non-oil Emirates discourages the recruitment of high calibre staff, and deter people with ability from choosing such jobs as careers.

The National Committee for Combating the Illegal Use of Drugs and Alcohol

The National Committee for Combating the Illegal Use of Drugs and Alcohol was established in accordance with the Decree of the Council of Ministers in 1987. It is headed by an Under Secretary of the Ministry of the Interior and representatives of the following the Ministry of Defence, the Ministry of Information and Culture, the Ministry of Education, the Ministry of Social Affairs, the Ministry of Islamic Affairs, the Ministry of Health, the Ministry of Justice, the Ministry of Economic Affairs, the Ministry of Youth and Athletics, the Secretariat of the Customs Services and the University of the U.A.E.. The Committee aims to enlighten people about the dangers of drug use. The main committee has three subcommittees:

1. The Prevention Sub-Committee aims to reduce the availability of drugs in the U.A.E. by supporting drug combating agencies, customs departments and law enforcement agencies. Representatives from the Ministry of the Interior, the Ministry of Justice and the Ministry of Economic Affairs are represented on this subcommittee.
2. The Enlightenment and Guidance Sub-Committee aims to make people aware of drug use problems and educate them about the dangers of drug abuse. Officials from the Ministry of Information, the Ministry of Education, the Ministry of Islamic Affairs, the Ministry of Defence, the University of the U.A.E. and the Ministry of the Interior are represented on this subcommittee.
3. The Medication and Rehabilitation Sub-Committee aims to provide medical treatment and rehabilitation for drug addicts. Officials from the Ministry of Health, the Ministry of Social Services and the Ministry of the Interior are represented on this subcommittee.

After many meetings and field visits to the organisations involved in combating the use of illicit drugs, the National Committee for Combating Drug and Alcohol Abuse

submitted a report to the Council of Ministers. Important comments included the following:

1. There is a lack of control in most sea and airports in the country, and an absence of drug detection equipment and sniffer dogs.
2. There should be more control over diplomatic bags at airports.
3. It is suspected that crews of some civil and military aeroplanes may be involved in drug trafficking, and more control is required over their movement.
4. There is a lack of control on ships, boats and other vessels in territorial waters.
5. The purchase of drugs by private pharmacies must be more closely supervised.
6. There is a lack of control on mail, especially parcels, in most post offices around the country.
7. Most drug combating agencies suffer from a lack of modern equipment and materials.
8. There is a lack of information regarding illicit drug activities and a lack of informants in most drug combating agencies in the country.
9. There is a lack of co-operation between drug combating organisations in the U.A.E. and other countries.
10. Some travellers and students who are studying outside the U.A.E. are involved in drug abuse, and they need to be more rigorously searched on re-entry into the country.
11. There is a lack of training courses for those working for drug combating agencies.
12. There is a lack of preventive measures for drug abuse.
13. There is a lack of medical treatment facilities in the country.

In order to create an effective drug combating policy, the National Committee asked the Council of Ministers to set aside a special budget every year for the activities of the National Committee (Table 9.8). The suggested budget, however, was more than the federal government budget could afford, and consequently the Council of Ministers rejected the proposal.

Table 9.8: The proposed budget of the National Committee in 1988 in U.A.E. dirham.

Item	Ministry of Interior	Ministry of Health	Ministry of Information	Total
Salaries & Wages	22754160 (£3,792,360)	2508496 (£410,802)		25262656 (£4,210,442)
Current Expenditures	14902436 (£2,483,739)	1030560 (£171,760)	200000 (£33,333)	16132996 (£2,688,832)
Capital Expenditures	29496400 (£4,916,066)	1735500 (£289,250)		31231900 (£5,205,316)
Total	67152996 (£11,192,166)	5274006 (£879,001)	200000 (£33,333)	72627552 (£12,104,592)

Source: Ministry of Interior, Abu Dhabi.

After the proposed budget had been rejected, the activities of the National Committee ceased and discussions and research towards supporting drug combating activities then had to depend on the efforts of some determined individual committee members committed to combating the problem, especially the Minister of the Interior. In the 1990s the Minister of the Interior restored the National Committee for Combating Drug and Alcohol Abuse, and since then many meetings have been held. It is evident, however, that an insufficient budget severely hampers the work of the Committee.

Preventive Measures

In spite of the lack of an effective drug combating policy in the U.A.E., some governmental organisations are trying to combat drug abuse behaviour. These include:

Prevention Through the Ministry of Education

Within the Ministry of Education there are three departments with responsibilities which include health education and the prevention of drug abuse among students and school-children. These departments are the Department of Social Work, the Department of Curricula and the Department of Educational Media.

Officials working for the Ministry of Education are aware of the drug problem in the U.A.E., and are also aware of its extent and the fact that it is a complex problem to deal with. They admit that one of the factors exacerbating the problem of drug abuse is the failure of the educational system in the U.A.E. to cope with drug abuse.

There is a lack of qualified social workers and psychologists able to deal with drug-related problems in schools in the U.A.E., and the education system depends entirely on the teaching process and the educational role of the teacher. Of the few social workers and psychologists who are dealing with drug problems in schools, most have no experience in the field, and most are more involved with administrative activities than with drug abuse. The lack of facilities for the student's spare time is considered to be a major factor in drug abuse.

The department of Social Work in the Ministry of Education is responsible for dealing with social, family and educational problems which may face students. The department has no established policy for drug preventive measures, but they do apply some programmes which are intended to help students to resist drugs, namely posters and murals in the form of magazine stories, created by the students themselves and concentrating on spelling out the dangers of taking drugs, and seminars relating to the dangers of drug abuse which are held from time to time. Experts in religion, legal affairs, law enforcement and health education participate in these seminars; leaflets, pamphlets and posters are published. These publications try to dissuade students from taking drugs by showing the effects of taking drugs on users' health, on society, etc.. Research relating to antisocial behaviour generally is encouraged by students, teachers and social workers.

One of the department of Educational Media's aims is to make students aware of the dangers of anti-social behaviour generally and to prevent students from using drugs in particular, as a part of its health education programme. Since 1989 this department has produced preventive programmes which are broadcast in the media. For instance, one of the programmes produced was called 'Educational Horizons' and part of it concentrated on drug prevention. However, in 1991 this programme was banned by the Minister of the Interior because the programme had been created by unqualified people.

This department has no annual programme for drug prevention, but promotes individual preventive activities such as student work fairs and camping trips.

The Department of Curricula is responsible for the creation and modernisation of the educational curricula in public education in the U.A.E.. In order to participate in the drug prevention campaign, some subjects include information relating to health education in general, and this includes drug prevention. In biology for first years at secondary schools, some mention is made about the dangers of drugs. Under the title of 'Some dangerous plants which affect human health', some information is given to the students about the dangers of plants such as *Nicotiana Tobacum*, *Cannabis*, *Poppies* and *qā t*, and the effect of the above on human beings is touched upon (Biology for first year of secondary schools, 1992/93). The subject of drugs is also mentioned in the 'Introduction to Sociology' for second year students at secondary schools. The teaching material concentrates on drug-related social problems. However, the information given does include the factors behind the spread of drug abuse among people and its damaging effects on society, the family and the individual. Sociology lessons also contain some information about prevention and medical treatment (Sociology for the second year of secondary schools, 1992/93).

The subject of psychology, which is taught to third year secondary school students, contains some information about addiction and the psychological factors behind the spread of drug abuse among young people. The subject also gives information about the psychological effects of addiction and the characteristics of addicts, prevention and medication etc. (Psychology, third year of secondary schools, 1992/93).

The subject of Arabic reading for third year intermediate level students gives some information about the dangers of drug abuse. The subject includes a story called 'My Story With the White Poison'. This story concentrates on drug addiction, its factors and how people can avoid drug abuse (Arabic Reading for third year intermediate level, 1992/93).

Most of the programmes mentioned above are aimed at secondary school students. This is because students in these grades are at a vulnerable age as regards drug abuse and thus need more attention and counselling on drug issues. On the whole, teachers who are using these programmes are not qualified to deal with drug problems and have never attended training courses in drug abuse and prevention. Therefore they have no guidelines to draw upon when they teach students about drug problems. Often the parents of students are unaware of drug prevention programmes.

Most schools suffer from a lack of collaboration between schools and parents of students as regards drug prevention. Many parents of students refuse to take their share of responsibility for their children's behaviour vis-a-vis drug abuse. This may be because many of them have little education and/or are always busy with their own affairs.

Health education programmes in most schools are rare, and most of them concentrate on such matters as dental care, etc.. Programmes of health education are usually created by the Ministry of Health in collaboration with the Ministry of Education. There is no evaluation of these programmes, and consequently nobody knows if their effect on students is negative or positive.

Prevention Through the Ministry of Information

The role of the mass media in drug prevention and in educating people of the dangers of drugs is an important one in most countries. This is because the media's ability to affect public opinion and trends is very strong (Ahmad, 1986). On the whole, the media in the U.A.E. makes a responsible contribution to combating drugs. Television and radio stations, magazines and newspapers are all involved in enlightening, educating and warning people about the dangers of drug abuse. They spread awareness among people and teach them how to avoid drug abuse. They interview experts who deal with addiction, law, law enforcement and Islamic affairs in order to alert people about the dangers of drugs and to prevent drug abuse. Radio, newspaper, magazine and television interviews have been conducted face to face with drug addicts, psychiatrists and sociologists. Most mass media programmes about drug abuse are conducted on seminar or interview lines. These programmes aim to educate people, but they concentrate heavily on theoretical issues which makes it difficult for many people to understand them. Most of these programmes are created by well-meaning but unqualified people who are trying to fill the gap evident in the U.A.E. of a structured drug prevention programme via the media. Thus programmes may have negative effects on people, especially the uneducated. In the mass media in the U.A.E. there is no-one suitably qualified to organise, supervise and evaluate the drug preventive programmes. Most programmes are 'one-offs', transmitted any time and intended for all ages. They do not, on the whole, follow an effective method of persuasion, e.g. informative or warning.

Most programmes concentrate on the legal aspects of drug abuse, patterns of drug use behaviour, social and physical characteristics of drug users, how drug users can be identified, and methods of seeking help for addicts, parents, etc.. All this is useful, but not necessarily effective in that it does not target or focus on the specific sectors of society who will benefit from their message and information. Most of the media involved in drug prevention do not study the characteristics of their audience before they broadcast their

programmes, nor do they evaluate their programmes after broadcast. This means that they do not know the reaction of the groups in society who are in most need of information on drug abuse and thus cannot learn from feedback how to make their programmes more effective.

Most drug prevention programmes are aimed at people who speak Arabic; there are no programmes for non-Arabs on drug abuse and prevention. The makers of programmes on drug prevention are not really qualified to deal with the topics they are portraying in these programmes, and they suffer from a lack of information relating to drug problems in the U.A.E..

Medication and Rehabilitation

The Psychotherapy Department in Abu Dhabi Central Hospital started to accept addicts in 1987 and has continued to do so ever since. It only has 24 beds. The department was not established for the purpose of treating addiction, but because of the absence of addiction clinics in the country the department has tried to help some addicts who have sought medication. The personnel in the department possess no special qualifications regarding drug addiction. The department has two psychiatric consultants, two medical psychiatrists, four general practitioners, one social worker and one psychologist. Nursing care comprises 6 nurses working 8 hour shifts, 2 nurses on duty at all times. This department provides medical treatment mainly to local citizens. The department also has three medication units alongside the addiction unit. The first unit is for less severe psychological cases, such as slight mental disorders (such as depression), alcohol addiction, neuroses, etc.. The second unit is for those who are suffering from acute mental illness, and the third unit is for those suffering from chronic mental disorders. The same staff deal with all the cases, of whatever severity, and with the addicts. The department provides some recreational facilities such as a television and video room and some sporting activities such as exercise and table tennis. There are two addicts per room

and only in the case of an important addict may a room be allocated for the sole use of one person. The addiction unit does not provide for female addicts. Female addicts receive medication in the psychological disease unit.

The addiction unit is supervised by the Committee of the Addiction Treatment Unit. This committee is made up of representatives of the following: the Director of the hospital, the Head of the Psychotherapy Department, the Head of the Addiction Unit, the Head of Nursing Staff, a social worker and a representative of the Attorney General. It is responsible for the medical practice and procedures of the unit, for admission and discharge of addicts, and for problem solving. Security facilities are provided around the clock for convicted addicts.

The Al-Amal Psychiatric Hospital is located in Dubai. It provides psychotherapy to people who live in the northern Emirates. The hospital provides only 29 beds for drug addicts. It consists of three departments: the Female Psychological Department, the Male Psychological Department and the Addiction Department. The hospital suffers from a lack of qualified staff able to deal with addicts. There are five social workers, nine psychiatrists, a consultant in psychotherapy, three psychologists and two general practitioners. The staff work in all hospital departments. The drug department is also under the supervision of the Addiction Unit Committee.

All drug addicts who seek medical treatment in addiction units must abide by the following procedures:

1. The addict should not be accepted before completion of the admission form, which must be signed by the members of the Addiction Committee. This form contains personal information such as the addict's name, nationality, age, occupation, etc. and also the mode of admission to the addiction unit whether voluntary or compulsory (by police, court or the Attorney General). It also contains the addict's undertaking to abide by the addiction units rules.

2. In the case of voluntary admission, the signature of an Addiction Committee member is sufficient for acceptance of the addict into the addiction unit, but if the addict's admission to the unit was compulsory by order of police or court, the signature of a representative of the Attorney General is necessary for the acceptance of the addict to the addiction unit.
3. Discharge of the addict depends on the approval of members of the committee and the recommendations of a doctor's report.
4. The Control of Drugs Act 1986 must be explained to the addict and his family by a social worker before the addict enters the addiction unit.

The patient is first seen in the outpatient clinic where information about his addiction is recorded. This information includes addiction period, type of drugs, psychological and physical symptoms, and the last dose the addict took. Then the addict is transferred to the addiction unit where physical and psychiatric examinations are made before treatment can begin. Methadone treatment is the usual treatment given to all addicts; it usually lasts from seven to eight days. The quantity of methadone is reduced every day. In case of acute withdrawal symptoms other medicines such as painkillers, sleeping tablets, vitamins, tranquillisers and glucose are prescribed. Once four days have passed since the last dose of methadone, the only medicines given to the addict are tranquillisers and painkillers.

During the treatment period, the psychiatrist and social worker examine the social, family and other aspects of the life of the addict. The social worker may hold a meeting with the family of the addict in order to encourage them to assist their relative in his treatment. Individual and group psychotherapy and counselling sessions are provided in the addiction unit.

From 1987 to 1992, about 1,648 drug addicts underwent medical treatment for drug addiction in the Abu Dhabi and Al-Amal addiction units, about 49% of them at Abu Dhabi Addiction Unit and about 51% at Al-Amal Hospital in Dubai (Table 9.9).

Table 9.9 *Number of addicts who had medication at the Abu Dhabi and Al-Amal Addiction Units, 1987-1992.*

Year	Abu Dhabi Addiction Unit		Al-Amal Addiction Unit		Total
	Count	%	Count	%	
1987	201	59	139	41	340
1988	128	55	106	45	234
1989	121	48	130	52	251
1990	83	31	182	69	265
1991	150	52	138	48	288
1992	129	48	141	52	270
Total	812	49	836	51	1648

Source: Abu Dhabi Central Hospital & Al-Amal Hospital in Dubai.

About 45% of those who received medication between 1986 and 1987 were addicted to opiates and hashish and 55% being addicted to other substances such as psychotropic substances, alcohol and solvents (Table 9.10). In 1990 a slight majority of addicts who were treated were addicted to opiates (55%), and the rest were addicted to other substances (45%). Similarly, in 1991 most addicts treated were addicted to opiates (52%) but in 1992 only about 28% of those who had medication were addicted to opiates, with the remaining 72% being addicted to other substances (72%).

Table 9.10: Number of addicts who had medication at the Abu Dhabi and Al-Amal Addiction Units in accordance to drug types, 1986- 1992.

Year	Opiates and Hashish		Psychotropic Substances, alcohol and solvents		Total
	Count	%	Count	%	
1986	165	50	168	50	333
1987	172	51	168	49	340
1988	72	31	163	69	235
1989	128	51	123	49	251
1990	146	55	119	45	265
1991	149	52	139	48	288
1992	105	28	265	72	370
Total	937	45	1145	55	2082

Source: Abu Dhabi & Dubai Addiction Units

Many of those who received medical treatment at the Abu Dhabi Addiction unit in the period 1985 to 1992 have relapsed (46%) (Table 9.11). In 1985 the incidence of relapse was 47%, but in 1986 this decreased to 35%. In 1987 the relapse rate was 39%, increasing in 1988 to 48%. The other years also recorded high percentages of relapse amongst addicts treated. In 1990 the percentage of relapsed addicts was 60%. This percentage decreased slightly in 1991 to 55% and in 1992 to 53%. The continuing high rate of relapse is disturbing, as it comprises over half of all the addicts who received medication and questions the effectiveness of the treatment.

Table 9.11 *The number of addicts receiving medication at Abu Dhabi Addiction Unit and the percentage of relapsed addicts, 1985- 1992.*

Year	Number of Addicts who had Medication	Percent of Relapse	
		Count	%
1985	126	59	47
1986	185	64	35
1987	201	78	39
1988	128	61	48
1989	121	53	44
1990	83	50	60
1991	150	83	55
1992	129	68	53
Total	1123	516	46
Source: Abu Dhabi Central Hospital			

Treatment for addiction in the U.A.E. depends mostly on medicine and does not provide enough psychological and social intervention. This imbalance hinders addicts from making a full recovery. There is also a lack of policy in prescribing psychotropic substances in hospital. This is because most doctors and clinical psychiatrists prefer to prescribe these substances to their patients rather than give psychotherapy which takes longer. Most drug addicts who are treated at addiction units are brought into the units compulsorily by police, court order, by the order of the Attorney General, or by their family, which means they have been forced into undergoing medication, which in itself affects the recovery success rate. A case could easily be made out that, given these circumstances and the limited resources available, a re-evaluation of the treatments used in the addiction units would be of some use.

The research found that most addicts who sought medical treatment at the units have been addicts for a long time and had complicated social and family problems which made it difficult for them to accept medical treatment in the addiction unit.

Rehabilitation is not part of the treatment programme at addiction clinics in the U.A.E.. The addict is discharged after having recovered from the withdrawal symptoms and must then fend for himself in the outside world. Rehabilitation and other supporting services such as education, legal aid, provision of a job, vocational rehabilitation, family care, aftercare, etc., and community-based services (outreach, alternatives, information, early intervention, employee assistance, etc.) are virtually non-existent. Thus it is more likely that the one time addict may not be able to cope with the outside world and may, once again, seek the familiar world and companionship he has previously known and thereby re-enter the society of drug abusers and addicts.

When drug addiction units devise their treatment programmes they do not take into account the prevalence rate for drug abuse among people in the U.A.E.. This is partly because of the lack of research which is urgently required to help them plan their programmes. As a result of the absence of studies and planning relating to drug abuse treatment, most drug addicts who live in the northern Emirates (Sharjah, Ajman, Ras al-Khaimah, Umm al-Qaiwain and Fujairah) suffer from the lack of drug addiction treatment in their Emirates. Most of them face difficulties when they seek medical treatment at the Al-Amal drug addiction medication unit in Dubai which is the nearest place for them to get help. This is because the unit has few beds and limited facilities and priority is given to local addicts. Any addict from the northern Emirates wanting medical treatment in Dubai must have an official letter from the Dubai Police in order to be accepted in the Al-Amal drug addiction unit. Thus the difficulties involved in being accepted for treatment discourages some addicts from seeking medication in Dubai.

The drug addiction medication units do not encourage drug addicts in society to seek medication in the units as, given its limited facilities, it can hardly cope with its referrals from court. This is because of the lack of beds, medication, and other facilities necessary to provide treatment for addicts. Even those who seek emergency care in their homes do not get any help from drug addiction units.

Summary

Drugs policy in the U.A.E. depends mainly on individual efforts and the commitment of some government organisations. These efforts are mainly concentrated in the law enforcement agencies in the Emirates, and federal legislation is not always effective or welcomed in the Emirates. An effective drug policy co-ordinating planning research, co-operation, and co-ordination between government and non-government organisations does not exist in the U.A.E.. Most of the efforts which are being made are concentrated on trying to reduce the availability of illegal drugs in the U.A.E.. The Ministry of the Interior is the only organisation which is trying to reduce the availability of drugs in society. The role of customs departments in combating drugs is either virtually absent or ineffective. Little effort is made in the sphere of drug use prevention. Most government organisations which should be involved in this issue, such as the Ministry of Health, the Ministry of Social Affairs, the Ministry of Information, the Ministry of Youth, etc., are not participating to any noticeable extent in a drug prevention policy. There is also a dearth of addiction treatment clinics and medical treatment for addiction generally. The present system concentrates too much on the provision of medical treatment and largely ignores social and other aspects integral to the addict's problem and his struggle to stop taking drugs. The relationship between the addict and the medical centre ceases when the addict is discharged from the hospital. Rehabilitation, follow-up care and social-based support are not part of the treatment of addicts. This is because of a dearth of qualified people and facilities in addiction clinics in the U.A.E..

Chapter 10

Conclusion and Recommendations

Historically, it seems, drug use is not confined to specific people, to specific communities, to specific religions or to specific places: it has been widespread throughout the world during most historical periods. The prevalence rate of drug use has differed between communities. Until the end of the first world war (1919), opium and hashish were the only two types of drugs widely used among some people in some Muslim and Arab countries. Since 1919 new types of drugs appeared in some Arab countries, such as cocaine, which appeared in Egypt in 1919, and heroin which initially appeared in Palestine. These types of drugs appeared in the U.A.E. in the 1970s (see Chapter 4).

Drug use and the impact of the rapid social change in the U.A.E.

Since 1971, the revenue from oil production has made great changes and affected many aspects of life in the U.A.E.. These changes jolted the U.A.E. people from isolation into the open living of today. The jolt has negatively affected the behaviour of some people, especially those who are unable to adapt effectively to the new situation. The change and development of economic, political and other physical aspects of the U.A.E. was not accompanied with positive change and the development of social, family and individuals-related aspects, leaving a vacuum in society. As a result of this vacuum, the rapid social change in the U.A.E. has reduced the influence of some of the social control measures, such as the effect of the family, customs, norms and traditions. This has created a lack of social control on the behaviour of individuals, and precipitated many social problems for U.A.E. society:

Rapid social change in U.A.E. society led to a rising cost of living, which has created some housing, job and marriage difficulties. These difficulties have caused psychological and moral conflict, to which some people have responded by resorting to anti-social

means such as drug use and drug dealing. Even today people deal with each other in accordance to the influence in society of their respective tribes or families, or else in accordance with their wealth. This social discrimination is the cause of psychological difficulties such as continued anxiety about living, worry about the future, lack of psychological stability and poor job security. There is a social distance between the citizens of the oil-rich Emirates of Abu Dhabi and Dubai and the citizens of non-oil Emirates. This social distance makes for a lack of interaction and familiarity, and has created a disparity in their thoughts, values, norms and beliefs.

Family life and structures in the U.A.E. have been affected by the great and rapid social change. This change has brought about a reduction in the traditional functions of the family. The result of this change has led both to the involvement of the mother in work outside the home and to the weakening of kinship ties among family members. These in turn mean that young people spend less time with members of their family, and spend long periods of time outside the home with friends. The support role of the family in this brave new society has changed, particularly in the socialization process of young children, and has been replaced by an expatriate workforce. There is a wide gap between the beliefs and values of new generation and those of their families.

The population structure

U.A.E. nationals have become a minority in their homeland. The sheer numbers of expatriate workers of different nationalities, with their different cultures, values, beliefs, etc., has made it difficult for some U.A.E. nationals, especially youths, to adapt to this situation. Most social roles formerly occupied by U.A.E. nationals are now performed by an expatriate workforce. U.A.E. nationals are participating less and less in the building of their own country and society. This situation has made some people feel that they are no longer important, that they no longer have a social role in society; therefore they withdraw from social reality to an unreal life, such as the subcultural life in which drug

use is one of its values. The socialisation process in the U.A.E. needs to concentrate on building and developing an individual's personality behaviour. A U.A.E. government review of the policies of the utilisation of an expatriate workforce is overdue. There also needs to be a re-evaluation of the structure of the population, with more social responsibilities and roles being given to U.A.E. nationals.

The impact of geographical location on the availability of drugs in the U.A.E.

A confluence of geographical and social factors permit drug traffickers to use the U.A.E.: the geostrategic location of the U.A.E.; the maritime borders with Iran, the physical and demographic geography of some coastal areas which are both mountainous and uninhabited, with little state security; the large number of sea/air ports few of which have much state security; and the open trade policy and the huge annual tonnage of goods imported into the U.A.E.. Drug traffickers use the U.A.E. as a transit zone to re-export drug production from its sources in Afghanistan, Pakistan, Iran, etc., to the more lucrative drug markets in other countries in the world. The quantities of drugs which have been seized by law enforcement indicates that there are large quantities of drugs smuggled into the U.A.E. especially, across the maritime borders between the U.A.E. and Iran. The combination of an active drug demand, purchasing power and a suitable retail drug market means that drugs infiltrate into the illicit drug market in the U.A.E.. Whilst official reports detail many cases of drug addicts, including some cases of death as a result of addiction, these numbers do not offer a picture of the real prevalence of drug use problems in the U.A.E.. It is difficult to estimate the real prevalence rate of drug use in the society. Collecting data to give more accurate figures would require a larger sample of the population, different techniques to collect data from different groups of the population, a large number of researchers, and much more time and money.

Drug combating efforts

As a result of escalating drug use problems in the society, especially among local citizens, some governmental authorities put effort into combating drug problems. Most of these efforts were provided by the Ministries of Interior, Justice and Health, and concentrated on combating the illicit drug market and providing some medication for some drug addicts. Drug policies which depend on planning, research, and co-operation between governmental and non-governmental organisations do not exist in the U.A.E.. The illicit drug market and drug use problems have affected U.A.E. society, and these problems will continue causing damage to the society for long time unless the government of the U.A.E. consider drug use control and prevention programmes a priority.

The characteristics of the drug use problem in the U.A.E.

It was an intention of this research to identify and study the characteristics of drug use problems in the U.A.E.. These characteristics are summarised in the following points:

1. The prevalence of drug use is concentrated among those who are 18 to 29 years old. Most users in this age group are heavy users, use hard drugs, use more than one type of drug and experiment with new types of drugs.
2. The use of drugs is more widespread among those with an intermediate and secondary education than among people with a higher education.
3. Drug use is more widespread among single than among married people. Most single users who are U.A.E. nationals are heavy users.
4. The prevalence of drug use is more widespread among working people than among the unemployed. It is also more widespread among those working for the public sector than for the private sector.
5. Drug users in the U.A.E. can be classified into three categories:

- (I). Most of the experimental users, who take (light drugs such as hashish, *qāt* and amphetamines) once or twice a month.
 - (II). Most regular or frequent users, who use drugs such as (hashish, amphetamines, *qāt*, cocaine, solvent and barbiturates) two to four times a week some of these are suffering from psychological and physical problems.
 - (III). Most of the heavy users, who use drugs such as heroin, opium, morphine, cocaine, barbiturates and other hard substances every day. Most of them are addicted to these substances, and suffering psychologically and physically.
6. The likelihood of drug use is greater among those who have some social problems such as educational failure and early exit from school; working without qualification; early involvement in work and difficulties of adapting to a job (especially those young people who are working for the army); the separation, divorce or death of parents, lack of parental love and care; the lack of parents education child abuse; severe disciplining; family disorders; the engagement of some parents in a luxurious lifestyle while forgetting their principal duties toward their children; and those who have lack of family control on their behaviour.
 7. The age of initiation into drug use is between 15 and 22 years, and most users were initiated with the use of hashish. They believe that the use of hashish has no bad effects on health and gives a feeling of happiness intoxication and it is the most used drug among most friends. The first drug is usually offered free by friends especially those who are close friends. It also could be offered by relatives.
 8. Peer pressure is a principal factor behind drug use among people in the U.A.E., especially among those who are young U.A.E. citizens. Friends can provide free drugs and drug sources, and help the experimental users to be involved in drug

use. Therefore, drug programmes which aim to prevent young people from drug addiction could usefully concentrate on how to minimise peer pressure.

9. The prevalence rate for hashish use is the highest among most drug users in the U.A.E., but the use of heroin is higher among users who are U.A.E. nationals than among other users. Most drug users who are U.A.E. nationals are addicted physically and psychologically to opiates. Most of them use heroin by injection and share syringes with friends. Asian users use hashish and opium more than other substances, and users from other G.C.C. countries use the same types of drug as those used by users who are U.A.E. nationals. Hashish and *qāt* are more used among other Arab citizens than other substances.
10. There is an illicit drug market in the U.A.E., especially in the oil-rich Emirates of Abu Dhabi, Dubai and Sharjah. Most drug users get their drugs from the U.A.E., although some of them acquire drugs from outside the U.A.E., especially from Iran, Pakistan and India. There are more than 38 nationalities of drug dealers working in the U.A.E. drug market. Most drug dealers who are working in the illicit drug market in the U.A.E. are Asians. Among Asian drug dealers, Pakistani dealers rank first, followed by Iranians and then Indians. Drug dealers who are U.A.E. nationals are in the second place in illicit drug market, followed by dealers who are G.C.C. citizens, and then other Arab citizens.
11. The increased wealth of some U.A.E. nationals enables most drug users who are U.A.E. nationals to spend a great deal of money on drug use. This increased wealth enables users to buy expensive types of drug such as heroin and cocaine, buy and use large amounts, experiment with new types and acquire drugs from outside the U.A.E.. Their high purchasing power enables them to buy drugs in bulk. At this stage most of them become addicts of hard types of drugs, especially opiates, and then they run short of money. This situation leads them first to sell their possessions,

especially cars and expensive watches. When they become bankrupt, they shift to committing crimes, especially theft and other drug-related crimes such as selling and trafficking drugs. With the exception of drug-related crimes, the involvement of drug users in other crimes is rare in comparison with other societies such as the U.S.A. and in Europe. This is because the wealth of parents, family and relatives may give users unintentional financial support.

Most drug users who are U.A.E. nationals are more likely to be involved in addiction problems. This is because most of them are young, using heroin and are multi-drug users. Hashish, heroin, opium and barbiturates are the most common types of drugs which are on the increase in U.A.E. society. There is no doubt that the lack of preventive and medication measures in society have increased the amount and seriousness of drug problems in the U.A.E..

Recommendations concerning drug problems in the U.A.E.

In the following pages I would like to suggest some recommendations which might help governmental and non-governmental organisations to create appropriate policies and strategies for the combating of drug use problems in the U.A.E..

Law enforcement

There is no doubt that an increase in drug law enforcement efforts toward illicit drug-related activities may frustrate attempts to obtain drugs, and therefore increase the street price of drugs (Fuqua, 1978). Higher drug prices might push some drug addicts towards seeking medication, especially those who are addicted to opiates and suffering from physical and psychological problems (Polich et al, 1984). However, the drug enforcement agencies should recognise that the drug supply cannot be turned off completely because it is far too lucrative a business for many people, and dealers and users learn to adapt to law enforcement strategies and tactics (Fuqua, 1978). The present

law enforcement strategy concentrates on arresting drug users and low-level retail dealers. This policy has no hope of diminishing the drug supply, or of raising street prices, because low-level dealers who are arrested are immediately replaced by others (Fuqua, 1978). The aims of any law enforcement strategy should concentrate on the following points: aiming at seizure of the larger quantities of drugs; increasing the risks of importing and distributing drugs by arresting and punishing high-level dealers, as well as low-level dealers, carriers and users; and confiscating of revenue and assets from illicit drug-related activities (Dorn et al, 1992).

Most drug trafficking comes through the maritime outlets and many sea/air ports lack security and customs control. Therefore, the Federal Narcotic Combating Administration, the General Administration of Border and Coast Guards and Customs should accept the priority of combating drug importing activities into the U.A.E.. This includes trafficking, seizing drugs, carriers, high level possession and high level dealers. This could be done by giving more authority to the Ministry of the Interior to control all sea/air ports and coasts in all Emirates. Customs services departments in the Emirates should integrate under the supervision of the federal government and work in accordance with its procedures and

laws. Local drug departments should be responsible for the arrest and seizure of medium and low-level retail dealers, drug users and investigating drug related crimes such as simple possession, small scale supply, etc.. A new drug intelligence-gathering system should be established in the Ministry of Interior to collect, exchange and co-ordinate drug intelligence information between all law enforcement agencies in the U.A.E.. Most drug law enforcement agencies, especially those which are working in the non-oil Emirates, should be equipped with modern drug detecting equipment in order to increase the effects of law enforcement activities, and adopt new tactics for dealing with drug dealers, traffickers, etc.

The results of this research have shown that many drug users who are U.A.E. nationals have been involved in drug related activities while travelling abroad. Therefore, I recommend that a control on young people travelling abroad without the supervision of their families should be made by the government.

The legal issues between the federal government and local governments concerning security should be solved in accordance with the constitution of the U.A.E.. In addition, more power and authorities should be given to the federal government in order to control security in the Emirates.

Prevention

It is important for the U.A.E. to create new policies for combating illicit drug use. This is because most drug users are young, experience early initiation into drug use and are multi-drug users who experiment with new types of drug, and spend much money on drug use. Most of them are involved in drug trade activities, and their number is increasing. Preventive measures are important for the combating of drug use.

Since social factors are important to the spread of drug use problems, preventive programmes should concentrate on these factors, e.g. peer pressure, and such incorrect beliefs about drug use as that some drugs (hashish and marijuana) have no bad effects on health and that the use of drugs is a sign of maturity (Polich et al., 1984). Most drug users begin using drugs as a result of pressure from their friends. It is important, therefore, for any preventive programme to aim at how young people can resist these peer pressures (National Research Council, 1993). This may include the reinforcement and strengthening of social norms against drug use. Most drug users are young and lack knowledge about health, social issues, family life, the economy, and the consequences of drug use; they think that their use of drugs is simply a part of their lifestyle and friendship. Therefore, drug preventive programmes should aim to dissuade young people from their falsely positive beliefs about drug use, such as that the use of drugs expresses the maturity of young person (Polich et al., 1984).

Preventive programmes should be focused on targetable groups within society, such as non-users, experimental, regular and heavy users. To reduce positive beliefs about drug use, these programmes should include: information about the dangers of drug use; the legal situation; and the effects of short- and long-term use (Bennett et al., 1990). These programmes should aim to change the environment of the individuals and to prevent the development of drug user-related problems for those who are non-users (Bennett et al., 1989). Programmes should aim to prevent experimental and regular users from experiencing physical and psychological problems, and dissuade them from involvement in crime. Special preventive programmes should be created for those already involved in drug use and experiencing physical and psychological problems, especially those who use opiates.

Special programmes should be created to protect families from drug use problems, and from other social, economic and health problems. The family is one of the best environments in which to apply preventive programmes (U.S. Department of Health and Human Services, 1989). The family drug preventive programmes should include: the dangers of drug use in the family; how parents can recognise that one of their children is a drug user; the dangers of the approval of drug use, alcohol and smoking among family members; antisocial behaviour; how to prevent children from educational failure, how to keep interested in their education, and to prevent early exit from schools; and early involvement in work (Polich et al., 1984).

Drug policy in the U.A.E. should prioritise the protection of school students from the dangers of drug use. Preventive programmes in schools should concentrate on overall health and how students can improve their health. Programmes should also include information about the social, mental, physical, psychological, etc. effects of drug use. These programmes should also aim to increase the knowledge of the student concerning antisocial behaviour, and try to relate their studies with their present and future

expectations (U.S. Department of Health and Human Services, 1989). Drug prevention programmes at schools should aim to strengthen the relationship between the local society, the family and the school. This may happen through encouragement by parents and agencies within the local society, participating in the creation and the application of school preventive programmes and other school activities (Hanson, 1980).

The educational media and the social work departments in the Ministry of Education should increase their efforts to create school-based programmes to alert students to the dangers of drug use and other anti-social behaviour. These programmes should aim to change students attitudes, beliefs, values, etc. about drug use, and to increase the students self-esteem, self-image, self-satisfaction, their ability at decision-making, their communication skills, self-confidence and how they can avoid peer and social pressures (U.S. Department of Health and Human Services, 1989). All teachers and social workers should have courses related to drug preventive measures, and they should know the factors behind drug use among students, how students may be involved in drug use, and the effects of drug use on the social life, health and the financial position of individuals and families.

Drug use prevention policies should enable people to recognise that drug use problems are social problems which need the efforts and collaboration of governmental and non-governmental agencies as well as the efforts of individuals. Each local government in the U.A.E. should create and support long and short-term comprehensive drug preventive programmes.

The government should utilise the mass media to enlighten and guide people about the dangers of drug use on the individuals, family and society. Before the preparation of media-oriented drug preventive programmes involving pamphlets, brochures, articles and television interviews with experts, the programme makers should take into consideration the attributes of the target audience, their educational level, age, interests, etc., and they should ensure that these programmes will not affect people negatively (National Research Council, 1993).

Treatment

One of the drug use problems in the U.A.E. is the lack of the medication for drug addicts. The addiction medication systems available in the Abu Dhabi Central Hospital and the Al-Amal Hospital do not provide an integral medication system customised to the individual's addiction, to the individual's need, or to factors behind an individual's drug addiction, such as personality, biological, interpersonal and socio-cultural explanations (Ellickson et al., 1984). Therefore, I think that a number of drug addiction clinics should be established in different places in the U.A.E. in accordance with the geographical distribution of the population. The medication system at these clinics should include detoxification, counselling and psychological therapy, social assistance, job placement, therapeutic communities (a method of psychological therapy in which drug addicts attend groups in which each addict encourages the other addicts to accept the medication and to avoid thinking of hard drug-related experiences), individual and family therapy, etc. (Polich et al., 1984).

The addiction medication in the two addiction clinics in the U.A.E. depends on chemotherapy as a principal method in the addiction treatment, and they mainly depend on methadone maintenance with only slight psychological intervention. Drug addiction treatment needs to involve counselling and psychological and social therapy as a principal method for treating drug addiction. Methadone maintenance is useful for some acute cases, particularly those who are addicted opiates, especially to heroin (Bennett et al., 1990).

The staff dealing with drug addicts should be qualified for dealing with them. Most drug users who are U.A.E. nationals are addicted to heroin. It would be appropriate, therefore, were the Ministry of Health to appoint people in addiction clinics who are qualified for dealing with opiates and heroin addicts. An annual plan should be put forward by the Ministry of Health to provide training courses for staff in addiction clinics and department

of psychology. These training courses should include the designing of medication treatment systems, modern methods of addiction medication, heroin addiction medication, and the evaluation and development of treatment systems (Polich et al., 1984).

Most drug addicts who are being treated at drug addiction clinics arrived involuntarily, being brought by police or sent by the court. Some were brought by their parents or relatives. Compulsory treatment is less likely to give good results because the desire of addicts to have medication is an important part of treatment (Bennett et al., 1990). Therefore, the Ministry of Health should encourage and persuade drug addicts to seek medication. It should publish and distribute information concerning the medication facilities which are provided for drug addicts in hospitals and clinics, along with telephone help-lines which should be established in some hospitals and clinics for those seeking consultation. Courts and the police should withdraw from intervening in the medication of drug addicts, and should leave both the treatment, and the encouragement for seeking treatment, of addicts to psychiatrists and the social workers.

Most prisons in the U.A.E. lack the facilities for treatment and rehabilitation for prisoners especially those who are jailed for committing drug-related crimes. It is important for each jail to have its own medication and rehabilitation systems, which may include psychiatrists, psychologists, social workers, physicians, rehabilitation staff, etc.

Drug use reporting system

Evaluation of the prevalence of drug use in society is important for the creation and evaluation of drug combating policies. The availability of information related to the prevalence of drug use should contain the geographical distribution of drug use, demographic information, the consequences of drug use, the types of drugs used, the classification of drug users, etc.. It is important for the Ministry of Interior or the Ministry of Health to establish a reporting system for the evaluation of the nature of drug use in

the U.A.E.. These reporting systems should depend on the collection, preparation, analysis, publication and distribution of the results to people who are involved in drug combating policies. Information related to the prevalence rate of drug use problems may be collected from public and private hospitals and clinics, public and private schools, prisons, courts, police, juvenile and custody centres. In accordance with the annual results of the collected information, the drug control agencies may renew, evaluate and establish drug combating policies (Navaratnam et al., 1989).

The success of drug combating policies in the U.A.E. depends on the nature and the degree of co-ordination of combating efforts among all agencies. In order to use all sources in society and to avoid duplication in combating efforts, drug combating efforts should be co-ordinated between all governmental and non-governmental agencies in the Emirates through the National Committee for Drug Combating. The Committee should have a secretariat office for the co-ordination of the combating efforts. This secretariat office should appoint co-ordinators in each Emirate, cities and local communities. The National Committee should have representatives from local governments alongside the representatives of the federal government agencies. The National Committee should study and propose the different efforts which aim to combat drug use problems in society, propose any changes in drug control laws, and co-ordinate the efforts of drug use combating, such as illicit drug combating, medication, rehabilitation and prevention. It should evaluate all combating efforts. In order to ensure the participation of most local and federal government organisations in drug combating efforts, a law or regulation should be promulgated requiring their participation and resources in drug combating efforts, and also giving the National Committee the power to apply its policies in every part of the U.A.E..

Further studies

This research has indicated that there is a dearth of research in the field of drug-related problems in the U.A.E.. Therefore, further studies should be carried out on drug use problems in the U.A.E.. These studies may include the examination of HIV disease among injecting heroin users, the characteristics of female drug users (the authorities should allow such study for the sake of data collection, analysis, comparison and treatment), the impact of the availability of the large number of the expatriate workforce in the prevalence of crime in the U.A.E., the impact of the spread of prostitution activities on the prevalence of drug use, the impact of the political and economic structure of the U.A.E. on the rate of drug trafficking, and future patterns of drug use.

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Appendix 1

Appendix 1 contains some of the research findings which were not incorporated into the thesis and which might be useful to the readers.

Table 1: Drug use in the get up time and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Used	65	63.7	9	16.7	74	47.4
	Never	37	36.3	45	83.3	82	52.6
	Total	102		54		156	100
D.F = 1		Chi-square = 31.35849				Probability value = .0000	
Hashish	Used	71	50.4	3	20	74	47.4
	Never	70	49.6	12	80	82	52.6
	Total	141		15		156	100
D.F = 1		Chi-square = 5.01001				Probability value = .0252	
Marijuana	Used	58	66.7	16	23.2	74	47.4
	Never	29	33.3	53	76.8	82	52.6
	Total	87		69		156	100
D.F = 1		Chi-square = 29.17372				Probability value = .0000	
Heroin	Used	66	68.8	8	13.3	74	47.4
	Never	30	31.3	52	86.7	82	52.6
	Total	96		60		156	100
D.F = 1		Chi-square = 45.47601				Probability value = .0000	
Morphine	Used	23	82.1	51	39.8	74	47.4
	Never	5	17.9	77	60.2	82	52.6
	Total	28		128		156	100
D.F = 1		Chi-square = 16.48578				Probability value = .0000	
Cocaine	Used	37	72.5	37	35.2	74	47.4
	Never	14	27.5	68	64.8	82	52.6
	Total	51		105		156	100
D.F = 1		Chi-square = 19.16507				Probability value = .0000	
LSD	Used	21	91.3	53	39.8	74	47.4
	Never	2	8.7	80	60.2	82	52.6
	Total	23		133		156	100
D.F = 1		Chi-square = 20.82136				Probability value = .0000	
Amphetamines	Used	34	75.6	40	36	74	47.4
	Never	11	24.4	71	64	82	52.6
	Total	45		111		156	100
D.F = 1		Chi-square = 20.05570				Probability value = .0000	
Barbiturates	Used	60	75.9	14	18.2	74	47.4
	Never	19	24.1	63	81.8	82	52.6
	Total	79		77		156	100
D.F = 1		Chi-square = 52.18729				Probability value = .0000	
Tranquillisers	Used	44	72.1	30	31.6	74	47.4
	Never	17	27.9	65	68.4	82	52.6
	Total	61		95		156	100
D.F = 1		Chi-square = 24.49973				Probability value = .0000	
Other drugs	Used	73	52.9	1	5.6	74	47.4
	Never	65	47.1	17	94.4	82	52.6
	Total	138		18		156	100
D.F = 1		Chi-square = 15.19515				Probability value = .0001	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 2: Drug use in the afternoon and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Used	81	79.4	29	53.7	110	70.5
	Never	21	20.6	25	46.3	46	29.5
	Total	102		54		156	100
D.F = 1		Chi-square = 11.22294				Probability value = .0008	
Marijuana	Used	68	78.2	42	60.9	110	70.5
	Never	19	21.8	27	39.1	46	29.5
	Total	87		69		156	100
D.F = 1		Chi-square = 5.53351				Probability value = .0187	
Heroin	Used	81	84.4	29	48.3	110	70.5
	Never	15	15.6	31	51.7	46	29.5
	Total	96		60		156	100
D.F = 1		Chi-square = 23.06781				Probability value = .0000	
Morphine	Used	25	89.3	85	66.4	110	70.5
	Never	3	10.7	43	33.6	46	29.5
	Total	28		128		156	100
D.F = 1		Chi-square = 5.78407				Probability value = .0162	
Cocaine	Used	44	86.3	66	62.9	110	70.5
	Never	7	13.7	39	37.1	46	29.5
	Total	51		105		156	100
D.F = 1		Chi-square = 9.05336				Probability value = .0026	
Amphetamines	Used	39	86.7	71	64	110	70.5
	Never	6	13.3	40	36	46	29.5
	Total	45		111		156	100
D.F = 1		Chi-square = 7.93715				Probability value = .0048	
Barbiturates	Used	69	87.3	41	53.2	110	70.5
	Never	10	12.7	36	46.8	46	29.5
	Total	79		77		156	100
D.F = 1		Chi-square = 21.80087				Probability value = .0000	
Tranquillisers	Used	50	82	60	63.2	110	70.5
	Never	11	18	35	36.8	46	29.5
	Total	61		95		156	100
D.F = 1		Chi-square = 6.32082				Probability value = .0119	
Solvent	Used	16	94.1	94	67.6	110	70.5
	Never	1	5.9	45	32.4	46	29.5
	Total	17		139		156	100
D.F = 1		Chi-square = 5.11280				Probability value = .0238	
Other drugs	Used	106	76.8	4	22.2	110	70.5
	Never	32	23.2	14	77.8	46	29.5
	Total	138		18		156	100
D.F = 1		Chi-square = 8.37168				Probability value = .0038	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 3 Drug use during the morning and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Used	76	74.5	24	44.4	100	64.1
	Never	26	25.5	30	55.6	56	35.9
	Total	102		54		156	100
D.F = 1		Chi-square = 13.86958				Probability value = .0002	
Hashish	Used	96	68.1	4	26.7	100	64.1
	Never	45	31.9	11	73.3	56	35.9
	Total	141		15		156	100
D.F = 1		Chi-square = 10.10728				Probability value = .0057	
Marijuana	Used	64	73.6	36	52.2	100	64.1
	Never	23	26.4	33	47.8	56	35.9
	Total	87		69		156	100
D.F = 1		Chi-square = 7.65065				Probability value = .0057	
Heroin	Used	76	79.2	24	40	100	64.1
	Never	20	20.8	36	60	56	35.9
	Total	96		60		156	100
D.F = 1		Chi-square = 24.61457				Probability value = .0000	
Morphine	Used	23	82.1	77	60.2	100	64.1
	Never	5	17.9	51	39.8	56	35.9
	Total	28		128		156	100
D.F = 1		Chi-square = 4.82637				Probability value = .0280	
Cocaine	Used	44	86.3	56	53.3	100	64.1
	Never	7	13.7	49	46.7	56	35.9
	Total	51		105		156	100
D.F = 1		Chi-square = 16.18730				Probability value = .0001	
Amphetamines	Used	36	80	64	57.7	100	64.1
	Never	9	20	47	42.3	56	35.9
	Total	45		111		156	100
D.F = 1		Chi-square = 6.94592				Probability value = .0084	
Barbiturates	Used	63	79.7	37	48.1	100	64.1
	Never	16	20.3	40	51.9	56	35.9
	Total	79		77		156	100
D.F = 1		Chi-square = 17.02287				Probability value = .0000	
Tranquillisers	Used	47	77	53	55.8	100	64.1
	Never	14	23	42	44.2	56	35.9
	Total	61		95		156	100
D.F = 1		Chi-square = 7.29633				Probability value = .0069	
Other drugs	Used	94	68.1	6	33.3	100	64.1
	Never	44	31.9	12	66.7	56	35.9
	Total	138		18		156	100
D.F = 1		Chi-square = 8.37168				Probability value = .0038	
Keys : D.F = Degrees of freedom							
Source : Field Work Study, 1993							

Table 4: Drug use in the evening and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Hashish	Used	140	99.3	52	96.3	152	97.4
	Never	1	0.7	2	3.7	4	2.6
	Total	141		54		156	100
D.F = 1		Chi-square = 20.19440			Probability value = .0000		
Marijuana	Used	87	1000	12	80	152	97.4
	Never	0	0	3	20	4	2.6
	Total	87		15		156	100
D.F = 1		Chi-square = 5.17620			Probability value = .0229		
Heroin	Used	96	100	56	93.3	152	97.4
	Never	0	0	4	6.7	4	2.6
	Total	96		60		156	100
D.F = 1		Chi-square = 6.56842			Probability value = .0104		
Barbiturates	Used	79	100	73	94.8	152	97.4
	Never	0	0	4	5.2	4	2.6
	Total	79		77		156	100
D.F = 1		Chi-square = 4.21189			Probability value = .0401		
Other drugs	Used	136	98.6	16	88.9	152	97.4
	Never	2	1.4	2	11.1	4	2.6
	Total	138		18		156	100
D.F = 1		Chi-square = 5.94966			Probability value = .0147		
Keys : D.F = Degrees of freedom							
Source : Field Work Study, 1993							

Table 5: Drug use at night and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Used	86	84.3	20	37	106	67.9
	Never	16	15.7	34	63	40	32.1
	Total	102		54		156	100
D.F = 1		Chi-square = 36.23571				Probability value = .0000	
Hashish	Used	99	70.2	7	46.7	106	67.9
	Never	42	29.8	8	53.3	50	32.1
	Total	141		15		156	100
D.F = 1		Chi-square = 3.45141				Probability value = .0632	
Marijuana	Used	72	82.8	34	49.3	106	67.9
	Never	15	17.2	35	50.7	50	32.1
	Total	87		69		156	100
D.F = 1		Chi-square = 19.80945				Probability value = .0000	
Heroin	Used	83	86.5	23	38.3	106	67.9
	Never	13	13.5	37	61.7	50	32.1
	Total	96		60		156	100
D.F = 1		Chi-square = 39.26564				Probability value = .0000	
Morphine	Used	26	92.9	80	62.5	106	67.9
	Never	2	7.1	48	37.5	50	32.1
	Total	28		128		156	100
D.F = 1		Chi-square = 9.72162				Probability value = .0018	
Cocaine	Used	46	90.2	80	62.5	106	67.9
	Never	5	9.8	48	37.5	50	32.1
	Total	51		105		156	100
D.F = 1		Chi-square = 17.22010				Probability value = .0000	
LSD	Used	22	95.7	84	63.2	106	67.9
	Never	1	4.3	49	36.8	50	32.1
	Total	23		133		156	100
D.F = 1		Chi-square = 9.50697				Probability value = .0020	
Amphetamines	Used	36	80	70	63.1	106	67.9
	Never	9	20	41	36.9	50	32.1
	Total	45		111		156	100
D.F = 1		Chi-square = 4.21749				Probability value = .0400	
Barbiturates	Used	68	86.1	38	49.4	106	67.9
	Never	11	13.9	39	50.6	50	32.1
	Total	79		77		156	100
D.F = 1		Chi-square = 24.14890				Probability value = .0000	
Tranquillisers	Used	51	83.6	55	57.9	106	67.9
	Never	10	16.4	40	42.1	50	32.1
	Total	61		95		156	100
D.F = 1		Chi-square = 11.27633				Probability value = .0008	
Other drugs	Used	99	71.7	7	38.9	106	67.9
	Never	39	28.3	11	61.1	50	32.1
	Total	138		18		156	100
D.F = 1		Chi-square = 7.89001				Probability value = .0050	
Keys : D.F = Degrees of freedom							
Source : Field Work Study, 1993							

Table 6: Feeling physically sick or ill and drug type

The effect/drug type		Used		Never Used		Total	%
I feel physically sick or ill		Count	Col%	Count	Col%		
Opium	Yes	79	77.5	16	29.6	95	60.9
	No	23	22.5	38	70.4	61	39.1
	Total	102		54		156	100
D.F = 1		Chi-square = 333.90852			Probability value = .0000		
Marijuana	Yes	67	77	28	40.6	95	60.9
	No	20	23	41	59.4	61	39.1
	Total	87		69		156	100
D.F = 1		Chi-square = 21.44867			Probability value = .0000		
Heroin	Yes	79	82.3	16	40.6	95	60.9
	No	17	17.7	44	59.4	61	39.1
	Total	96		60		156	100
D.F = 1		Chi-square = 47.97706			Probability value = .0000		
Morphine	Yes	27	96.4	68	53.1	95	60.9
	No	1	3.6	60	46.9	61	39.1
	Total	28		128		156	100
D.F = 1		Chi-square = 18.09200			Probability value = .0000		
Cocaine	Yes	42	82.4	53	50.5	95	60.9
	No	9	17.6	52	49.5	61	39.1
	Total	51		105		156	100
D.F = 1		Chi-square = 14.64801			Probability value = .0001		
Amphetamines	Yes	38	84.4	57	51.4	95	60.9
	No	7	15.6	54	48.6	61	39.1
	Total	45		111		156	100
D.F = 1		Chi-square = 14.72588			Probability value = .0001		
Barbiturates	Used	67	84.8	28	36.4	95	60.9
	Never	12	15.2	49	63.6	61	39.1
	Total		79		77	156	100
D.F = 1		Chi-square = 38.43383			Probability value = .0000		
Tranquillisers	Used	49	80.3	46	48.4	95	60.9
	Never	12	19.7	49	51.6	61	39.1
	Total	61		95		156	100
D.F = 1		Chi-square = 15.88150			Probability value = .0001		
LSD	Used	22	95.7	73	54.9	95	60.9
	Never	1	4.3	60	45.1	61	39.1
	Total	23		133		156	100
D.F = 1		Chi-square = 13.68436			Probability value = .0002		
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 7: Experiences of nervousness and trembling

The effect/drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	84	82.4	21	38.9	105	67.3
	No	18	17.6	33	61.1	51	32.7
	Total	102		54		156	100
D.F = 1		Chi-square = 30.31234			Probability value = .0000		
Hashish	Yes	99	70.2	6	40.0	105	67.3
	No	42	29.8	9	60.0	51	32.7
	Total	141		15		156	100
D.F = 1		Chi-square = 5.62414			Probability value = .0177		
Marijuana	Yes	72	82.8	33	47.8	105	67.3
	No	15	17.2	36	52.2	51	32.7
	Total	87		69		156	100
D.F = 1		Chi-square = 21.33996			Probability value = .0000		
Heroin	Yes	87	90.6	18	30.0	105	67.3
	No	9	9.4	42	70.0	51	32.7
	Total	96		60		156	100
D.F = 1		Chi-square = 61.67243			Probability value = .0000		
Morphine	Yes	25	89.3	80	62.5	105	67.3
	No	3	10.7	48	37.5	51	32.7
	Total	28		128		156	100
D.F = 1		Chi-square = 7.49100			Probability value = .0062		
Cocaine	Yes	47	92.2	58	55.2	105	67.3
	No	4	7.8	47	44.8	51	32.7
	Total	51		105		156	100
D.F = 1		Chi-square = 21.26273			Probability value = .0000		
LSD	Yes	22	95.7	83	62.4	105	67.3
	No	1	4.3	50	37.6	51	32.7
	Total	23		133		156	100
D.F = 1		Chi-square = 9.84980			Probability value = .0017		
Amphetamines	Yes	38	84.4	67	60.4	105	67.3
	No	7	15.6	44	39.6	51	32.7
	Total	45		111		156	100
D.F = 1		Chi-square = 14.72588			Probability value = .0001		
Barbiturates	Used	71	89.9	34	44.2	105	67.3
	Never	8	10.1	43	55.8	51	32.7
	Total	79		77		156	100
D.F = 1		Chi-square = 37.03815			Probability value = .0000		
Tranquillisers	Used	53	86.9	52	54.7	105	67.3
	Never	8	13.1	43	45.3	51	32.7
	Total	61		95		156	100
D.F = 1		Chi-square = 17.44767			Probability value = .0001		
Solvent	Used	13	76.5	92	66.2	105	67.3
	Never	4	23.5	47	33.8	51	32.7
	Total	17		139		156	100
D.F = 1		Chi-square = .72797			Probability value = .3935		
Other	Used	100	72.5	5	27.8	105	67.3
	Never	38	27.5	13	72.2	51	32.7
	Total	138		18		156	100
D.F = 1		Chi-square = 13.68436			Probability value = .0002		
Keys :		D.F = Degrees of freedom					
Source :		Field Work Study, 1993					

Table 8: Experiences of thoughts of ending life and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Used	63	61.8	20	37	83	53.2
	Never	39	38.2	34	63	73	46.8
	Total	102		54		156	100
D.F = 1		Chi-square = 8.67130				Probability value = .0032	
Marijuana	Used	54	62.1	29	42	83	53.2
	Never	33	37.9	40	58	73	46.8
	Total	87		69		156	100
D.F = 1		Chi-square = 6.20707				Probability value = .0127	
Heroin	Used	64	66.7	19	31.7	83	53.2
	Never	32	33.3	41	68.3	73	46.8
	Total	96		60		156	100
D.F = 1		Chi-square = 18.16696				Probability value = .0000	
Morphine	Used	19	67.9	64	50	83	53.2
	Never	9	32.1	64	50	73	46.8
	Total	28		128		156	100
D.F = 1		Chi-square = 2.94249				Probability value = .0863	
LSD	Used	16	69.6	67	50.4	83	53.2
	Never	7	30.4	66	49.6	73	46.8
	Total	23		133		156	100
D.F = 1		Chi-square = 2.90015				Probability value = .0886	
Amphetamines	Used	29	64.4	54	48.6	83	53.2
	Never	16	35.6	57	51.4	73	46.8
	Total	45		111		156	100
D.F = 1		Chi-square = 3.20880				Probability value = .0732	
Barbiturates	Used	55	69.6	28	36.4	83	53.2
	Never	24	30.4	49	63.6	73	46.8
	Total	79		77		156	100
D.F = 1		Chi-square = 17.32198				Probability value = .0000	
Tranquillisers	Used	45	73.8	38	40	83	53.2
	Never	16	26.2	57	60	73	46.8
	Total	61		95		156	100
D.F = 1		Chi-square = 17.01578				Probability value = .0000	
Keys : D.F = Degrees of freedom							
Source : Field Work Study, 1993							

Table 9: Experiences of hearing voices and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Hashish	Yes	71	50.4	4	26.7	75	48.1
	No	70	49.6	11	73.3	81	51.9
	Total	141		15		156	100
D.F = 1		Chi-square = 3.04750				Probability value = .0809	
Marijuana	Yes	49	56.3	26	37.7	75	48.1
	No	38	43.7	43	62.3	81	51.9
	Total	87		69		156	100
D.F = 1		Chi-square = 5.35636				Probability value = .0206	
Morphine	Yes	19	67.9	56	43.8	75	48.1
	No	9	32.1	72	56.3	81	51.9
	Total	28		128		156	100
D.F = 1		Chi-square = 5.34857				Probability value = .02027	
Amphetamines	Yes	28	62.2	47	42.3	75	48.1
	No	17	37.8	64	57.7	81	51.9
	Total	45		111		156	100
D.F = 1		Chi-square = 5.06922				Probability value = .0244	
Barbiturates	Yes	48	60.8	27	35.1	75	48.1
	No	31	39.2	50	64.9	81	51.9
	Total	79		77		156	100
D.F = 1		Chi-square = 10.31284				Probability value = .0013	
Tranquillisers	Yes	40	65.6	35	36.8	75	48.1
	No	21	34.4	60	63.2	81	51.9
	Total	61		95		156	100
D.F = 1		Chi-square = 12.28438				Probability value = .0005	
Solvent	Yes	13	76.5	62	44.6	75	48.1
	No	4	23.5	77	55.4	81	51.9
	Total	17		139		156	100
D.F = 1		Chi-square = 6.16176				Probability value = .0131	
Keys : D.F = Degrees of freedom							
Source : Field Work Study, 1993							

Table 10: Experiences of being scared and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	72	70.6	31	57.4	103	66
	No	30	29.4	23	42.6	53	34
	Total	102		54		156	100
D.F = 1		Chi-square = 2.73458				Probability value = .0982	
Hashish	Yes	98	69.5	5	33.3	103	66
	No	43	30.5	10	66.7	53	34
	Total	141		15		156	100
D.F = 1		Chi-square = 7.90722				Probability value = .0049	
Marijuana	Yes	67	77	36	52.2	103	66
	No	20	23	33	47.8	53	34
	Total	87		69		156	100
D.F = 1		Chi-square = 10.58275				Probability value = .0011	
Heroin	Yes	70	72.9	33	55	103	66
	No	26	27.1	27	45	53	34
	Total	96		60		156	100
D.F = 1		Chi-square = 5.28382				Probability value = .0215	
Barbiturates	Yes	61	77.2	42	54.5	103	66
	No	18	22.8	35	45.5	53	34
	Total	79		77		156	100
D.F = 1		Chi-square = 8.93351				Probability value = .0028	
Solvent	Yes	15	88.2	88	63.3	103	66
	No	2	11.8	51	36.7	53	34
	Total	17		139		156	100
D.F = 1		Chi-square = 4.19545				Probability value = .0405	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 11: Experiences of being hated and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	53	52	13	24.1	66	42.3
	No	49	48	41	75.9	90	57.7
	Total	102		54		156	100
D.F = 1		Chi-square = 11.24933			Probability value = .0008		
Marijuana	Yes	43	49.4	23	33.3	66	42.3
	No	44	50.6	46	39.8	90	57.7
	Total	87		69		156	100
D.F = 1		Chi-square = 7.80066			Probability value = .0052		
Heroin	Yes	49	72.9	17	28.3	66	42.3
	No	47	49	43	71.7	90	57.7
	Total	96		60		156	100
D.F = 1		Chi-square = 7.80066			Probability value = .0052		
Barbiturates	Yes	47	59.5	19	24.7	66	42.3
	No	32	40.5	58	75.3	90	57.7
	Total	79		77		156	100
D.F = 1		Chi-square = 19.36744			Probability value = .0000		
Solvent	Yes	12	70.6	54	38.8	66	42.3
	No	5	29.4	85	61.2	90	57.7
	Total	17		139		156	100
D.F = 1		Chi-square = 6.25168			Probability value = .0124		
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 12: Experiences of decision making difficulties and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	72	70.6	29	53.7	101	64.7
	No	30	29.4	25	46.3	55	35.3
	Total	102		54		156	100
D.F = 1		Chi-square = 4.40974				Probability value = .0357	
Marijuana	Yes	63	72.4	38	55.1	101	64.7
	No	24	27.6	31	44.9	55	35.3
	Total	87		69		156	100
D.F = 1		Chi-square = 5.06960				Probability value = .0243	
Heroin	Yes	69	71.9	32	53.3	101	64.7
	No	27	28.1	28	46.7	55	35.3
	Total	96		60		156	100
D.F = 1		Chi-square = 5.56110				Probability value = .0184	
Barbiturates	Yes	63	79.7	38	49.4	101	64.7
	No	16	20.3	39	50.6	55	35.3
	Total	79		77		156	100
D.F = 1		Chi-square = 15.78325				Probability value = .0001	
Tranquillisers	Yes	45	73.8	56	58.9	101	64.7
	No	16	26.2	39	41.1	55	35.3
	Total	61		95		156	100
D.F = 1		Chi-square = 3.57580				Probability value = .0586	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 13: Experiences of hopelessness and drug type

Drug Type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	64	62.7	22	40.7	86	55.1
	No	38	37.3	32	59.3	70	44.9
	Total	102		54		156	100
D.F = 1		Chi-square = 6.91097				Probability value = .0086	
Marijuana	Yes	58	66.7	28	40.6	86	55.1
	No	29	33.3	41	59.4	70	44.9
	Total	87		69		156	100
D.F = 1		Chi-square = 10.58628				Probability value = .0011	
Heroin	Yes	68	70.8	18	30	86	55.1
	No	28	29.2	42	70	70	44.9
	Total	96		60		156	100
D.F = 1		Chi-square = 24.88744				Probability value = .0000	
Morphine	Yes	24	85.7	62	48.4	86	55.1
	No	4	14.3	66	51.6	70	44.9
	Total	28		128		156	100
D.F = 1		Chi-square = 12.90545				Probability value = .0003	
Cocaine	Yes	35	68.6	51	48.6	86	55.1
	No	16	31.4	54	51.4	70	44.9
	Total	51		105		156	100
D.F = 1		Chi-square = 5.58184				Probability value = .0181	
LSD	Yes	22	95.7	64	48.1	86	55.1
	No	1	4.3	69	51.9	70	44.9
	Total	23		133		156	100
D.F = 1		Chi-square = 17.90925				Probability value = .0000	
Amphetamines	Yes	32	71.1	54	48.6	86	55.1
	No	13	28.9	57	51.4	70	44.9
	Total	45		111		156	100
D.F = 1		Chi-square = 6.53098				Probability value = .0106	
Barbiturates	Yes	62	78.5	24	31.2	86	55.1
	No	17	21.5	53	68.8	70	44.9
	Total	79		77		156	100
D.F = 1		Chi-square = 14.07285				Probability value = .0002	
Tranquillisers	Yes	45	73.8	41	43.2	86	55.1
	No	16	26.2	54	56.8	70	44.9
	Total	61		95		156	100
D.F = 1		Chi-square = 14.07285				Probability value = .0002	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 14: Experiences urges to beat, injure people or smash things

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	67	65.7	13	24.1	80	51.3
	No	35	34.3	41	75.9	76	48.7
	Total	102		54		156	100
D.F = 1		Chi-square = 24.47126				Probability value = .0000	
Marijuana	Yes	56	64.4	24	34.8	80	51.3
	No	31	35.6	45	65.2	76	48.7
	Total	87		69		156	100
D.F = 1		Chi-square = 13.48152				Probability value = .0002	
Heroin	Yes	67	69.8	13	21.7	80	51.3
	No	29	30.2	47	78.3	76	48.7
	Total	96		60		156	100
D.F = 1		Chi-square = 34.22827				Probability value = .0000	
Morphine	Yes	21	75	59	46.1	80	51.3
	No	7	25	69	53.9	76	48.7
	Total	28		128		156	100
D.F = 1		Chi-square = 7.68374				Probability value = .0056	
Cocaine	Yes	36	70.6	44	41.9	80	51.3
	No	15	29.4	61	58.1	76	48.7
	Total	51		105		156	100
D.F = 1		Chi-square = 11.30431				Probability value = .0008	
LSD	Yes	17	73.9	63	47.4	80	51.3
	No	6	26.1	70	52.6	76	48.7
	Total	23		133		156	100
D.F = 1		Chi-square = 5.53036				Probability value = .0187	
Amphetamines	Yes	30	66.7	50	45	80	51.3
	No	15	33.3	61	55	76	48.7
	Total	45		111		156	100
D.F = 1		Chi-square = 5.99146				Probability value = .0144	
Barbiturates	Used	57	72.2	23	29.9	80	51.3
	Never	22	27.8	54	70.1	76	48.7
	Total	79		77		156	100
D.F = 1		Chi-square = 27.90263				Probability value = .0000	
Tranquillisers	Used	44	72.1	36	48.4	80	51.3
	Never	17	27.9	59	62.1	76	48.7
	Total	61		95		156	100
D.F = 1		Chi-square = 17.42814				Probability value = .0000	
Solvent	Used	12	70.6	68	48.9	80	51.3
	Never	5	29.4	71	51.1	76	48.7
	Total	17		139		156	100
D.F = 1		Chi-square = 2.84641				Probability value = .0916	
Other	Used	76	55.1	4	22.2	80	51.3
	Never	62	44.9	14	77.8	76	48.7
	Total	138		18		156	100
D.F = 1		Chi-square = 6.87780				Probability value = .0087	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 15: Experiences of happiness and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Cocaine	Yes	40	78.4	99	94.3	139	89.1
	No	11	21.6	6	5.7	17	10.9
	Total	51		105		156	100
D.F = 1		Chi-square = 8.88621			Probability value = .0029		
LSD	Yes	17	73.9	122	91.7	139	89.1
	No	6	26.1	11	8.3	17	10.9
	Total	23		133		156	100
D.F = 1		Chi-square = 6.41024			Probability value = .0113		
Amphetamines	Yes	36	80	103	92.8	139	89.1
	No	9	20	8	7.2	17	10.9
	Total	45		111		156	100
D.F = 1		Chi-square = 5.39669			Probability value = .0202		
Tranquillisers	Used	51	83.6	88	92.6	139	89.1
	Never	10	6.6	7	7.4	17	10.9
	Total	61		95		156	100
D.F = 1		Chi-square = 3.11610			Probability value = .0775		
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 16: Experiences urges to kill themselves and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	23	22.5	5	9.3	28	17.9
	No	79	77.5	49	90.7	128	82.1
	Total	102		54		156	100
D.F = 1		Chi-square = 4.23433				Probability value = .0396	
Marijuana	Yes	22	25.3	9	8.7	28	17.9
	No	65	74.7	63	91.3	128	82.1
	Total	87		69		156	100
D.F = 1		Chi-square = 7.19295				Probability value = .0073	
Heroin	Yes	23	24	5	8.3	28	17.9
	No	73	76	55	91.7	128	82.1
	Total	96		60		156	100
D.F = 1		Chi-square = 6.12095				Probability value = .0134	
Morphine	Yes	13	46.4	15	11.7	28	17.9
	No	15	53.6	113	88.3	128	82.1
	Total	28		128		156	100
D.F = 1		Chi-square = 18.79444				Probability value = .0000	
LSD	Yes	7	30.4	21	15.8	28	17.9
	No	16	69.6	112	84.2	128	82.1
	Total	23		133		156	100
D.F = 1		Chi-square = 2.85584				Probability value = .0910	
Amphetamines	Yes	13	28.9	15	13.5	28	17.9
	No	32	36.9	96	86.5	128	82.1
	Total	45		111		156	100
D.F = 1		Chi-square = 5.13977				Probability value = .0234	
Barbiturates	Used	24	30.4	4	5.2	28	17.9
	Never	55	69.6	73	94.8	128	82.1
	Total	79		77		156	100
D.F = 1		Chi-square = 16.79408				Probability value = .0000	
Tranquillisers	Used	16	26.2	12	12.6	28	17.9
	Never	45	73.8	83	87.4	128	82.1
	Total	61		95		156	100
D.F = 1		Chi-square = 4.66397				Probability value = .0308	
Solvent	Used	6	35.3	22	15.8	28	17.9
	Never	11	64.7	117	84.2	128	82.1
	Total	17		139		156	100
D.F = 1		Chi-square = 3.89770				Probability value = .0484	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 17: Experience sexual enhancement and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Hashish	Yes	82	59.8	26	48.1	87	55.8
	No	59	41.8	28	51.9	69	44.2
	Total	141		54		156	100
D.F = 1		Chi-square = 3.386			Probability value = .0657		
Barbiturates	Used	38	48.1	49	63.6	87	55.8
	Never	41	51.9	28	36.4	69	44.2
	Total	79		77		156	100
D.F = 1		Chi-square = 3.815			Probability value = .0508		
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 18: Working activity and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	32	31.4	30	55.6	62	39.7
	No	70	68.6	24	44.4	94	60.3
	Total	102		54		156	100
D.F = 1		Chi-square = 8.622				Probability value = .0033	
Marijuana	Yes	27	31	35	50.7	62	39.7
	No	60	69	34	49.3	94	60.3
	Total	87		69		156	100
D.F = 1		Chi-square = 6.229				Probability value = .0126	
Heroin	Yes	20	20.8	42	70	62	39.7
	No	76	79.2	18	30	94	60.3
	Total	96		60		156	100
D.F = 1		Chi-square = 37.270				Probability value = .0000	
Morphine	Yes	6	21.4	56	43.8	62	39.7
	No	22	78.6	72	56.3	94	60.3
	Total	28		128		156	100
D.F = 1		Chi-square = 4.779				Probability value = .0288	
Cocaine	Yes	13	25.5	49	46.7	62	39.7
	No	38	74.5	56	53.3	94	60.3
	Total	51		105		156	100
D.F = 1		Chi-square = 6.427				Probability value = .0112	
Amphetamines	Yes	11	24.4	51	45.9	62	39.7
	No	34	75.6	60	54.1	94	60.3
	Total	45		111		156	100
D.F = 1		Chi-square = 6.181				Probability value = .0129	
Barbiturates	Used	14	17.7	48	62.3	62	39.7
	Never	65	82.3	29	37.7	94	60.3
	Total	79		77		156	100
D.F = 1		Chi-square = 32.412				Probability value = .0000	
Tranquillisers	Used	14	23	48	50.5	62	39.7
	Never	65	77	47	49.5	94	60.3
	Total	61		95		156	100
D.F = 1		Chi-square = 11.795				Probability value = .0006	
Other	Used	48	34.8	14	77.8	62	39.7
	Never	90	62.2	4	22.2	94	60.3
	Total	138		18		156	100
D.F = 1		Chi-square = 12.291				Probability value = .0005	
Keys : D.F = Degrees of freedom							
Source : Field Work Study, 1993							

Table 19: More self-control and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Heroin	Yes	56	58.3	46	76.7	102	65.4
	No	40	41.7	14	23.3	54	34.6
	Total	96		60		156	100
D.F = 1		Chi-square = 5.4832			Probability value = .0192		
Barbiturates	Used	46	58.2	56	72.7	102	65.4
	Never	33	41.8	21	27.3	54	34.6
	Total	79		77		156	100
D.F = 1		Chi-square = 3.6220			Probability value = .0570		
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 20: Experiences increased energy and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	42	41.2	12	22.2	54	34.6
	No	60	58.8	42	77.8	102	65.4
	Total	102		54		156	100
D.F = 1		Chi-square = 5.6045				Probability value = .0179	
Amphetamines	Yes	21	46.7	33	29.7	54	34.6
	No	24	53.3	78	70.3	102	65.4
	Total	45		111		156	100
D.F = 1		Chi-square = 4.0582				Probability value = .0440	
Barbiturates	Used	33	41.8	21	27.3	54	34.6
	Never	46	58.2	56	72.7	102	65.4
	Total	79		77		156	100
D.F = 1		Chi-square = 3.6220				Probability value = .0570	
Tranquillisers	Used	27	44.3	27	28.4	54	34.6
	Never	34	55.7	68	71.6	102	65.4
	Total	61		95		156	100
D.F = 1		Chi-square = 4.1187				Probability value = .0424	
Solvent	Used	2	11.8	52	37.4	54	34.6
	Never	15	88.2	87	62.6	102	65.4
	Total	17		139		156	100
D.F = 1		Chi-square = 4.4016				Probability value = .0359	
Other	Used	51	37	3	16.7	54	34.6
	Never	87	63	15	83.3	102	65.4
	Total	138		18		156	100
D.F = 1		Chi-square = 2.8962				Probability value = .0888	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 21: Experiences self-confidence and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Cocaine	Yes	42	82.1	72	68.6	114	73.1
	No	9	17.6	33	31.4	42	26.9
	Total	51		105		156	100
D.F = 1		Chi-square = 3.31.7				Probability value = .0687	
LSD	Yes	22	95.7	92	69.2	114	73.1
	No	1	4.3	41	30.8	42	26.9
	Total	23		133		156	100
D.F = 1		Chi-square = 6.9881				Probability value = .0082	
Amphetamines	Yes	35	77.8	79	71.2	114	73.1
	No	10	22.2	32	28.8	42	26.9
	Total	45		111		156	100
D.F = 1		Chi-square = .71033				Probability value = .3993	
Barbiturates	Used	62	78.5	52	67.5	114	73.1
	Never	17	21.5	25	32.5	42	26.9
	Total	79		77		156	100
D.F = 1		Chi-square = 2.3757				Probability value = .1232	
Tranquillisers	Used	48	78.7	66	69.5	114	73.1
	Never	13	21.3	29	30.5	42	26.9
	Total	61		95		156	100
D.F = 1		Chi-square = 1.6032				Probability value = .2054	
Solvent	Used	13	76.5	101	72.7	114	73.1
	Never	4	23.5	38	27.3	42	26.9
	Total	17		139		156	100
D.F = 1		Chi-square = .11168				Probability value = .7382	
Other	Used	101	73.2	13	72.7	114	73.1
	Never	37	26.8	5	27.8	42	26.9
	Total	138		18		156	100
D.F = 1		Chi-square = .0075				Probability value = .9307	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 22 Experiences trouble with eyes and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	75	73.5	20	37	95	60.9
	No	27	26.2	34	63	61	39.1
	Total	102		54		156	100
D.F = 1		Chi-square = 8.622				Probability value = .0033	
Hashish	Yes	90	63.8	5	33.3	95	60.9
	No	51	36.2	10	66.7	61	39.1
	Total	141		15		156	100
D.F = 1		Chi-square = 5.29517				Probability value = .0214	
Marijuana	Yes	67	77	28	40.6	95	60.9
	No	20	23	41	59.4	61	39.1
	Total	87		69		156	100
D.F = 1		Chi-square = 21.44867				Probability value = .0000	
Heroin	Yes	82	85.4	13	21.7	95	60.9
	No	14	14.6	47	78.3	61	39.1
	Total	96		60		156	100
D.F = 1		Chi-square = 63.01646				Probability value = .0000	
Morphine	Yes	27	96.4	68	53.1	95	60.9
	No	1	3.6	60	46.9	61	39.1
	Total	28		128		156	100
D.F = 1		Chi-square = 18.09200				Probability value = .0000	
Cocaine	Yes	43	84.3	52	49.5	95	60.9
	No	8	15.7	53	50.5	61	39.1
	Total	51		105		156	100
D.F = 1		Chi-square = 17.44767				Probability value = .0000	
LSD	Yes	22	95.7	73	54.9	95	60.9
	No	1	4.3	60	45.1	61	39.1
	Total	23		133		156	100
D.F = 1		Chi-square = 13.68436				Probability value = .0002	
Amphetamines	Yes	39	86.7	56	50.5	95	60.9
	No	6	13.3	55	49.5	61	39.1
	Total	45		111		156	100
D.F = 1		Chi-square = 17.63651				Probability value = .0000	
Barbiturates	Used	68	86.1	27	35.1	95	60.9
	Never	11	13.9	50	64.9	61	39.1
	Total	79		77		156	100
D.F = 1		Chi-square = 42.61053				Probability value = .0000	
Tranquillisers	Used	54	88.5	41	43.2	95	60.9
	Never	7	11.5	54	56.8	61	39.1
	Total	61		95		156	100
D.F = 1		Chi-square = 32.10694				Probability value = .0000	
Other	Used	92	66.7	3	16.7	95	60.9
	Never	46	33.3	15	83.3	61	39.1
	Total	138		18		156	100
D.F = 1		Chi-square = 16.71717				Probability value = .0000	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 23: Experiences trouble with nose and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	77	75.5	13	24.1	90	57.7
	No	25	24.5	41	75.9	66	42.3
	Total	102		54		156	100
D.F = 1		Chi-square = 38.24113				Probability value = .0000	
Hashish	Yes	67	77	23	33.3	90	57.7
	No	20	23	46	66.7	66	42.3
	Total	87		69		156	100
D.F = 1		Chi-square = 6.54487				Probability value = .0105	
Marijuana	Yes	67	77	23	33.3	90	57.7
	No	20	23	46	66.7	66	42.3
	Total	87		69		156	100
D.F = 1		Chi-square = 30.07705				Probability value = .0000	
Heroin	Yes	80	83.3	10	16.7	90	57.7
	No	16	16.7	50	83.3	66	42.3
	Total	96		60		156	100
D.F = 1		Chi-square = 67.23232				Probability value = .0000	
Morphine	Yes	27	96.4	63	49.2	90	57.7
	No	1	3.6	65	50.8	66	42.3
	Total	28		128		156	100
D.F = 1		Chi-square = 20.97833				Probability value = .0000	
Cocaine	Yes	47	92.2	43	41	90	57.7
	No	4	7.8	62	59	66	42.3
	Total	51		105		156	100
D.F = 1		Chi-square = 36.87343				Probability value = .0000	
LSD	Yes	23	100	67	50.4	90	57.7
	No	0	0	66	49.6	66	42.3
	Total	23		133		156	100
D.F = 1		Chi-square = 19.78346				Probability value = .0002	
Amphetamines	Yes	39	86.7	51	45.9	90	57.7
	No	6	13.3	60	54.1	66	42.3
	Total	45		111		156	100
D.F = 1		Chi-square = 21.75227				Probability value = .0000	
Barbiturates	Used	68	86.1	22	28.6	90	57.7
	Never	11	13.9	55	71.4	66	42.3
	Total	79		77		156	100
D.F = 1		Chi-square = 52.82749				Probability value = .0000	
Tranquillisers	Used	52	85.2	38	40	90	57.7
	Never	9	14.8	57	60	66	42.3
	Total	61		95		156	100
D.F = 1		Chi-square = 31.15660				Probability value = .0000	
Other	Used	87	63	3	16.7	90	57.7
	Never	51	37	15	83.3	66	42.3
	Total	138		18		156	100
D.F = 1		Chi-square = 14.03109				Probability value = .0002	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 24: Experiences of wheezing or gasping and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	57	55.9	19	35.2	76	48.7
	No	45	44.1	35	64.8	80	51.3
	Total	102		54		156	100
D.F = 1		Chi-square = 6.05392				Probability value = .0139	
Marijuana	Yes	48	55.2	28	40.6	76	48.7
	No	39	44.8	41	59.4	80	51.3
	Total	87		69		156	100
D.F = 1		Chi-square = 3.27990				Probability value = .0701	
Heroin	Yes	59	61.5	17	28.3	76	48.7
	No	37	38.5	43	71.7	80	51.3
	Total	96		60		156	100
D.F = 1		Chi-square = 16.21643				Probability value = .0001	
Morphine	Yes	23	82.1	53	41.4	76	48.7
	No	5	17.9	75	58.6	80	51.3
	Total	28		128		156	100
D.F = 1		Chi-square = 15.26015				Probability value = .0001	
Cocaine	Yes	33	64.7	43	41	76	48.7
	No	18	35.3	62	59	80	51.3
	Total	51		105		156	100
D.F = 1		Chi-square = 7.75239				Probability value = .0054	
LSD	Yes	19	82.6	57	42.9	76	48.7
	No	4	17.4	76	57.1	80	51.3
	Total	23		133		156	100
D.F = 1		Chi-square = 12.40248				Probability value = .0004	
Amphetamines	Yes	30	66.7	46	41.4	76	48.7
	No	15	33.3	65	58.6	80	51.3
	Total	45		111		156	100
D.F = 1		Chi-square = 8.15505				Probability value = .0043	
Barbiturates	Used	56	70.9	20	26	76	48.7
	Never	23	29.1	57	74	80	51.3
	Total	79		77		156	100
D.F = 1		Chi-square = 31.48317				Probability value = .0000	
Tranquillisers	Used	41	67.2	35	36.8	76	48.7
	Never	20	32.8	60	63.2	80	51.3
	Total	61		95		156	100
D.F = 1		Chi-square = 13.71491				Probability value = .0002	
Other	Used	73	52.9	3	16.7	76	48.7
	Never	65	47.1	15	83.3	80	51.3
	Total	138		18		156	100
D.F = 1		Chi-square = 8.36671				Probability value = .0038	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 25: Experiences with teethrelated problems and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	52	51	11	20.4	63	40.4
	No	50	49	43	79.6	93	59.6
	Total	102		54		156	100
D.F = 1		Chi-square = 13.74113				Probability value = .0002	
Hashish	Yes	60	42.6	3	20	63	40.4
	No	81	57.4	12	80	93	59.6
	Total	142		15		156	100
D.F = 1		Chi-square = 2.86436				Probability value = .0906	
Marijuana	Yes	43	49.4	20	29	63	40.4
	No	44	50.6	49	71	93	59.6
	Total	87		69		156	100
D.F = 1		Chi-square = 6.67762				Probability value = .0098	
Heroin	Yes	48	50	15	25	63	40.4
	No	48	50	45	75	93	59.6
	Total	96		60		156	100
D.F = 1		Chi-square = 9.58526				Probability value = .0020	
Cocaine	Yes	28	54.9	35	33.3	63	40.4
	No	23	45.1	70	66.7	93	59.6
	Total	51		105		156	100
D.F = 1		Chi-square = 6.63293				Probability value = .0100	
Amphetamines	Yes	30	66.7	33	29.7	63	40.4
	No	15	33.3	78	70.3	93	59.6
	Total	45		111		156	100
D.F = 1		Chi-square = 18.14506				Probability value = .0000	
Barbiturates	Used	46	58.2	17	22.1	63	40.4
	Never	33	41.8	60	77.9	93	59.6
	Total	79		77		156	100
D.F = 1		Chi-square = 221.16575				Probability value = .0000	
Tranquillisers	Used	35	57.4	28	29.5	63	40.4
	Never	26	42.6	67	70.5	93	59.6
	Total	61		95		156	100
D.F = 1		Chi-square = 12.01345				Probability value = .0005	
Other	Used	60	43.5	3	16.7	63	40.4
	Never	78	56.5	15	83.3	93	59.6
	Total	138		18		156	100
D.F = 1		Chi-square = 4.75442				Probability value = .0292	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 26: Experiences with urine-related problems and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	4	72.5	14	25.9	88	56.4
	No	28	27.5	40	74.1	68	43.6
	Total	102		54		156	100
D.F = 1		Chi-square = 31.21254				Probability value = .0000	
Hashish	Yes	83	58.9	5	33.3	88	56.4
	No	58	41.1	10	66.7	68	43.6
	Total	141		15		156	100
D.F = 1		Chi-square = 3.59427				Probability value = .0580	
Marijuana	Yes	65	74.7	23	33.3	88	56.4
	No	22	25.3	46	66.7	68	43.6
	Total	87		69		156	100
D.F = 1		Chi-square = 26.79587				Probability value = .0000	
Heroin	Yes	79	82.3	9	15	88	56.4
	No	17	17.7	51	85	68	43.6
	Total	96		60		156	100
D.F = 1		Chi-square = 67.99517				Probability value = .0000	
Cocaine	Yes	42	82.4	46	43.8	88	56.4
	No	9	17.6	59	56.2	68	43.6
	Total	51		105		156	100
D.F = 1		Chi-square = 20.73925				Probability value = .0000	
LSD	Yes	19	82.6	69	51.9	88	56.4
	No	4	17.4	64	48.1	68	43.6
	Total	23		133		156	100
D.F = 1		Chi-square = 7.53025				Probability value = .0061	
Amphetamines	Yes	36	80	52	46.8	88	56.4
	No	9	20	59	53.2	68	43.6
	Total	45		111		156	100
D.F = 1		Chi-square = 14.31259				Probability value = .0002	
Barbiturates	Used	64	81	24	31.2	88	56.4
	Never	15	19	53	68.8	68	43.6
	Total	79		77		156	100
D.F = 1		Chi-square = 39.39795				Probability value = .0000	
Tranquillisers	Used	49	80.3	39	41.1	88	56.4
	Never	12	19.7	56	58.9	68	43.6
	Total	61		95		156	100
D.F = 1		Chi-square = 23.30366				Probability value = .0000	
Other	Used	85	61.6	3	16.7	88	56.4
	Never	53	38.4	15	83.3	68	43.6
	Total	138		18		156	100
D.F = 1		Chi-square = 13.07103				Probability value = .0003	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 27: Experiences heart-related problems and drug type,

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Marijuana	Yes	17	19.5	6	8.7	23	14.7
	No	70	80.5	63	91.3	133	85.3
	Total	87		69		156	100
D.F = 1		Chi-square = 3.60030				Probability value = .0578	
Amphetamines	Yes	13	28.9	10	9	23	14.7
	No	32	71.1	101	91	133	85.3
	Total	45		111		156	100
D.F = 1		Chi-square = 10.06719				Probability value = .0015	
Barbiturates	Used	17	21.5	6	7.8	23	14.7
	Never	62	78.5	71	92.2	133	85.3
	Total	79		77		156	100
D.F = 1		Chi-square = 5.84521				Probability value = .0156	
Other	Used	23	16.7	0	0	23	14.7
	Never	115	83.2	18	100	133	85.3
	Total	138		18		156	100
D.F = 1		Chi-square = 3.51880				Probability value = .0607	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 28: Experiences with skin problems and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	71	69.6	16	29.6	87	55.8
	No	31	30.4	38	70.4	69	44.2
	Total	102		54		156	100
D.F = 1		Chi-square = 22.87689			Probability value = .0000		
Marijuana	Yes	61	70.1	26	37.7	87	55.8
	No	26	29.9	43	62.3	69	44.2
	Total	87		69		156	100
D.F = 1		Chi-square = 16.41043			Probability value = .0001		
Heroin	Yes	77	80.2	10	16.7	87	55.8
	No	19	19.8	50	83.3	69	44.2
	Total	96		60		156	100
D.F = 1		Chi-square = 60.43604			Probability value = .0000		
Morphine	Yes	23	82.1	64	50	87	55.8
	No	5	17.9	64	50	69	44.2
	Total	28		128		156	100
D.F = 1		Chi-square = 9.62262			Probability value = .0019		
Cocaine	Yes	40	28.4	47	44.8	87	55.8
	No	11	21.6	58	55.2	69	44.2
	Total	51		105		156	100
D.F = 1		Chi-square = 15.7569			Probability value = .0001		
LSD	Yes	18	78.3	69	51.9	87	55.8
	No	5	21.7	64	48.1	69	44.2
	Total	23		133		156	100
D.F = 1		Chi-square = 5.53253			Probability value = .0187		
Amphetamines	Yes	35	77.8	52	46.8	87	55.8
	No	10	22.2	59	53.2	69	44.2
	Total		45		111	156	100
D.F = 1		Chi-square = 12.41875			Probability value = .0004		
Barbiturates	Used	66	83.5	21	27.3	87	55.8
	Never	13	16.5	56	72.7	69	44.2
	Total	79		77		156	100
D.F = 1		Chi-square = 50.05554			Probability value = .0000		
Tranquillisers	Used	49	80.3	38	40	87	55.8
	Never	12	19.7	57	60	69	44.2
	Total	61		95		156	100
D.F = 1		Chi-square = 24.49178			Probability value = .0000		
Other	Used	85	61.6	2	11.1	87	55.8
	Never	53	38.4	16	88.9	69	44.2
	Total	138		18		156	100
D.F = 1		Chi-square = 16.45128			Probability value = .0001		
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 29: Experiences fainting or passing out / dizziness and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Marijuana	Yes	53	60.9	26	37.7	79	50.6
	No	34	39.1	43	62.3	77	49.4
	Total	87		69		156	100
D.F = 1		Chi-square = 8.31355				Probability value = .0039	
Heroin	Yes	60	62.5	19	31.7	79	50.6
	No	36	37.5	41	68.3	77	49.4
	Total	96		60		156	100
D.F = 1		Chi-square = 14.04333				Probability value = .0002	
Cocaine	Yes	32	62.7	47	44.8	79	50.6
	No	19	37.3	58	55.2	77	49.4
	Total	51		105		156	100
D.F = 1		Chi-square = 4.44119				Probability value = .0351	
Amphetamines	Yes	30	66.7	49	44.1	79	50.6
	No	15	33.3	62	55.9	77	49.4
	Total	45		111		156	100
D.F = 1		Chi-square = 6.49795				Probability value = .0108	
Barbiturates	Used	56	70.9	23	29.9	79	50.6
	Never	23	29.1	54	70.1	77	49.4
	Total	79		77		156	100
D.F = 1		Chi-square = 26.24401				Probability value = .0000	
Tranquillisers	Used	45	73.8	34	35.8	79	50.6
	Never	16	26.2	61	64.2	77	49.4
	Total	61		95		156	100
D.F = 1		Chi-square = 21.43845				Probability value = .0000	
Other	Used	76	55.1	3	16.7	79	50.6
	Never	62	44.9	15	83.3	77	49.4
	Total	138		18		156	100
D.F = 1		Chi-square = 9.39620				Probability value = .0022	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 30: Experiences shaking arms or legs and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	68	66.7	21	38.9	89	57.1
	No	34	33.3	33	61.1	67	42.9
	Total	102		54		156	100
D.F = 1		Chi-square = 11.11856				Probability value = .0009	
Marijuana	Yes	60	69	29	42	89	57.1
	No	27	31	40	58	67	42.9
	Total	87		69		156	100
D.F = 1		Chi-square = 11.39492				Probability value = .0007	
Heroin	Yes	71	74	18	30	89	57.1
	No	25	26	42	70	67	42.9
	Total	96		60		156	100
D.F = 1		Chi-square = 29.11822				Probability value = .0000	
Morphine	Yes	24	85.7	65	50.8	89	57.1
	No	4	14.3	63	49.2	67	42.9
	Total	28		128		156	100
D.F = 1		Chi-square = 11.66158				Probability value = .0007	
Cocaine	Yes	39	76.5	50	47.6	89	57.1
	No	12	23.5	55	52.4	67	42.9
	Total	51		105		156	100
D.F = 1		Chi-square = 11.66158				Probability value = .0006	
LSD	Yes	20	87	69	51.9	89	57.1
	No	3	13	64	48.1	67	42.9
	Total	23		133		156	100
D.F = 1		Chi-square = 9.84645				Probability value = .0017	
Amphetamines	Yes	34	75.6	55	49.5	89	57.1
	No	11	24.4	56	50.5	67	42.9
	Total	45		111		156	100
D.F = 1		Chi-square = 8.83777				Probability value = .0030	
Barbiturates	Used	61	77.2	28	36.4	89	57.1
	Never	18	22.8	49	63.6	67	42.9
	Total	79		77		156	100
D.F = 1		Chi-square = 26.55796				Probability value = .0000	
Tranquillisers	Used	48	78.7	41	43.2	89	57.1
	Never	13	21.3	54	56.8	67	42.9
	Total	61		95		156	100
D.F = 1		Chi-square = 19.13899				Probability value = .0000	
Solvent	Used	13	76.5	76	54.7	89	57.1
	Never	4	23.5	63	45.3	67	42.9
	Total	17		139		156	100
D.F = 1		Chi-square = 2.93637				Probability value = .0866	
Other	Used	86	62.3	3	16.7	89	57.1
	Never	52	37.7	15	83.3	67	42.9
	Total	138		18		156	100
D.F = 1		Chi-square = 13.54361				Probability value = .0002	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 31: Experiences headaches and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	67	65.7	23	42.6	90	57.7
	No	35	34.3	31	57.4	66	42.3
	Total	102		54		156	100
D.F = 1		Chi-square = 7.71469				Probability value = .0055	
Hashish	Yes	85	60.3	5	33.3	90	57.7
	No	56	39.7	10	66.7	66	42.3
	Total	141		15		156	100
D.F = 1		Chi-square = 11.11856				Probability value = .0009	
Marijuana	Yes	60	69	29	42	90	57.7
	No	27	31	40	58	66	42.3
	Total	87		69		156	100
D.F = 1		Chi-square = 11.39492				Probability value = .0007	
Heroin	Yes	71	74	18	30	90	57.7
	No	25	26	42	70	66	42.3
	Total	96		60		156	100
D.F = 1		Chi-square = 29.11822				Probability value = .0000	
Morphine	Yes	24	85.7	65	50.8	90	57.7
	No	4	14.3	63	49.2	66	42.3
	Total	28		128		156	100
D.F = 1		Chi-square = 11.66158				Probability value = .0007	
Cocaine	Yes	39	76.5	50	47.6	90	57.7
	No	12	23.5	55	52.4	66	42.3
	Total	51		105		156	100
D.F = 1		Chi-square = 11.66158				Probability value = .0006	
LSD	Yes	20	87	69	51.9	90	57.7
	No	3	13	64	48.1	66	42.3
	Total	23		133		156	100
D.F = 1		Chi-square = 9.84645				Probability value = .0017	
Amphetamines	Yes	37	82.2	53	47.7	90	57.7
	No	8	17.8	58	52.3	66	42.3
	Total	45		111		156	100
D.F = 1		Chi-square = 15.59082				Probability value = .0001	
Barbiturates	Used	65	82.3	25	32.5	90	57.7
	Never	14	17.7	52	67.5	66	42.3
	Total	79		77		156	100
D.F = 1		Chi-square = 39.63744				Probability value = .0000	
Tranquillisers	Used	52	76.5	77	55.4	90	57.7
	Never	9	23.5	62	44.6	66	42.3
	Total	61		139		156	100
D.F = 1		Chi-square = 31.15660				Probability value = .0000	
Solvent	Used	13	76.5	77	55.4	90	57.7
	Never	4	23.5	62	44.6	66	42.3
	Total	17		139		156	100
D.F = 1		Chi-square = 2.75634				Probability value = .0969	
Other	Used	87	63	3	16.7	90	57.7
	Never	51	37	15	83.3	66	42.3
	Total	138		18		156	100
D.F = 1		Chi-square = 14.03109				Probability value = .0002	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 32: Experiences heartburn and drug type

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	79	77.5	17	31.5	96	61.5
	No	23	22.5	37	68.5	60	38.5
	Total	102		54		156	100
D.F = 1		Chi-square = 31.52359				Probability value = .0000	
Hashish	Yes	90	63.8	6	40	96	61.5
	No	51	38.2	9	60	60	38.5
	Total	141		15		156	100
D.F = 1		Chi-square = 3.25277				Probability value = .0713	
Marijuana	Yes	69	79.3	27	39.1	96	61.5
	No	18	20.7	42	60.9	60	38.5
	Total	87		69		156	100
D.F = 1		Chi-square = 26.24753				Probability value = .0000	
Heroin	Yes	8	86.5	13	21.7	96	61.5
	No	13	13.5	47	78.3	60	38.5
	Total	96		60		156	100
D.F = 1		Chi-square = 65.48818				Probability value = .0000	
Morphine	Yes	25	89.3	71	55.5	96	61.5
	No	3	10.7	57	44.5	60	38.5
	Total	28		128		156	100
D.F = 1		Chi-square = 11.10042				Probability value = .0009	
Cocaine	Yes	45	88.2	51	48.6	96	61.5
	No	6	11.8	54	51.4	60	38.5
	Total	51		105		156	100
D.F = 1		Chi-square = 22.81664				Probability value = .0000	
LSD	Yes	21	91.3	75	56.4	96	61.5
	No	2	8.7	58	43.6	60	38.5
	Total	23		133		156	100
D.F = 1		Chi-square = 10.09869				Probability value = .0015	
Amphetamines	Yes	38	84.4	58	52.3	96	61.5
	No	7	15.6	53	47.7	60	38.5
	Total	45		111		156	100
D.F = 1		Chi-square = 14.01970				Probability value = .0002	
Barbiturates	Used	70	88.6	26	33.8	96	61.5
	Never	9	11.4	51	66.2	60	38.5
	Total	79		77		156	100
D.F = 1		Chi-square = 49.54917				Probability value = .0000	
Tranquillisers	Used	53	86.9	43	45.3	96	61.5
	Never	8	13.1	52	54.7	60	38.5
	Total	61		95		156	100
D.F = 1		Chi-square = 27.18963				Probability value = .0000	
Other	Used	92	66.7	4	22.2	96	61.5
	Never	46	33.3	14	77.8	60	38.5
	Total	138		18		156	100
D.F = 1		Chi-square = 13.28889				Probability value = .0003	
Keys :		D.F = Degrees of freedom					
Source : Field Work Study, 1993							

Table 33: Experiences loss of appetite and drug type,

The drug type		Used		Never Used		Total	%
		Count	Col%	Count	Col%		
Opium	Yes	75	73.5	21	38.9	96	61.5
	No	27	26.5	33	61.1	60	38.5
	Total	102		54		156	100
D.F = 1		Chi-square = 17.90049				Probability value = .0000	
Marijuana	Yes	65	74.7	31	44.9	96	61.5
	No	22	25.3	38	55.1	60	38.5
	Total	87		69		156	100
D.F = 1		Chi-square = 14.42344				Probability value = .0001	
Heroin	Yes	80	83.3	16	26.7	96	61.5
	No	16	16.7	44	73.3	60	38.5
	Total	96		60		156	100
D.F = 1		Chi-square = 50.09333				Probability value = .0000	
Morphine	Yes	23	82.1	72	57	96	61.5
	No	5	17.9	55	43	60	38.5
	Total	28		128		156	100
D.F = 1		Chi-square = 6.12095				Probability value = .0134	
Cocaine	Yes	43	84.3	53	50.5	96	61.5
	No	8	15.7	52	49.5	60	38.5
	Total	51		105		156	100
D.F = 1		Chi-square = 16.60577				Probability value = .0000	
LSD	Yes	20	87	76	57.1	96	61.5
	No	3	13	57	42.9	60	38.5
	Total	23		133		156	100
D.F = 1		Chi-square = 7.36398				Probability value = .0067	
Amphetamines	Yes	38	84.4	58	52.3	96	61.5
	No	7	15.6	53	47.7	60	38.5
	Total	45		111		156	100
D.F = 1		Chi-square = 14.01970				Probability value = .0002	
Barbiturates	Used	68	86.1	28	36.4	96	61.5
	Never	11	13.4	49	63.6	60	38.5
	Total	79		77		156	100
D.F = 1		Chi-square = 40.71439				Probability value = .0000	
Tranquillisers	Used	51	83.6	45	47.4	96	61.5
	Never	10	16.4	50	52.6	60	38.5
	Total	61		95		156	100
D.F = 1		Chi-square = 20.61044				Probability value = .0000	
Solvent	Used	14	82.4	82	59	96	61.5
	Never	3	17.6	57	41	60	38.5
	Total	17		139		156	100
		Chi-square = 3.49234				Probability value = .0617	
Other	Used	93	67.4	3	16.7	96	61.5
	Never	45	32.6	15	83.3	60	38.5
	Total	138		18		156	100
D.F = 1		Chi-square = 17.30978				Probability value = .0000	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 34: Obtainment of medication and drug type

The drug type		Yes		No		Total	%
		Count	Col%	Count	Col%		
Opium	Used	58	85.3	44	50	102	65.4
	Never	10	14.7	44	50	54	34.6
	Total	68		88		156	100
D.F = 1		Chi-square = 21.11188				Probability value = .0000	
Hashish	Used	65	95.6	76	86.4	141	90.4
	Never	3	4.4	12	13.6	15	9.6
	Total	68		88		156	100
D.F = 1		Chi-square = 3.75579				Probability value = .0526	
Marijuana	Used	55	80.9	32	36.4	87	55.8
	Never	13	19.1	56	63.6	69	44.2
	Total	68		88		156	100
D.F = 1		Chi-square = 30.82003				Probability value = .0000	
Heroin	Used	63	92.6	33	37.5	96	61.5
	Never	5	7.4	55	62.5	60	38.5
	Total	68		88		156	100
D.F = 1		Chi-square = 49.28769				Probability value = .0000	
Morphine	Used	19	27.9	9	10.2	28	17.9
	Never	49	72.1	79	89.8	128	82.1
	Total	68		88		156	100
D.F = 1		Chi-square = 8.17291				Probability value = .0043	
Cocaine	Used	35	51.5	16	18.2	51	32.7
	Never	33	48.5	72	81.8	105	67.3
	Total	68		88		156	100
D.F = 1		Chi-square = 19.31755				Probability value = .0000	
LSD	Used	18	26.5	5	5.7	23	14.7
	Never	50	73.5	83	94.3	133	85.3
	Total	68		88		156	100
D.F = 1		Chi-square = 13.18846				Probability value = .0003	
Amphetamines	Used	33	48.5	12	13.6	45	28.8
	Never	35	51.5	76	86.4	111	71.2
	Total	68		88		156	100
D.F = 1		Chi-square = 22.75404				Probability value = .0000	
Barbiturates	Used	57	83.8	22	25	79	50.6
	Never	11	16.2	66	75	77	49.4
	Total	68		88		156	100
D.F = 1		Chi-square = 53.10073				Probability value = .0000	
Tranquillisers	Used	43	63.2	18	20.5	61	39.1
	Never	25	36.8	70	79.5	95	60.9
	Total	68		88		156	100
D.F = 1		Chi-square = 29.48217				Probability value = .0000	
Other	Used	67	98.5	71	80.7	138	88.5
	Never	1	1.5	17	19.3	18	11.5
	Total	68		88		156	100
D.F = 1		Chi-square = 11.97082				Probability value = .0005	
Keys :	D.F = Degrees of freedom						
Source : Field Work Study, 1993							

Table 35: Seeking medication: Treatment in Jail

	Abu Dhabi Central Jail		Dubai Central Jail		Sharjah Central Jail		Al-Sader Central Jail		Al-Amal Hospital		Total	%
	Count	Col%	Count	Col %	Count	Col%	Count	Col%	Count	Col%		
Yes	5	7.1	3	25.0	11	25.6	1	6.3	15	100.0	35	22.4
No	65	92.9	9	75.0	32	74.4	13	93.7	0	0.0	121	77.6
Total	70		12		43		16		15		156	100
DF = 4		Chi square = 63.96335							Probability value = .0000			
Keys: Col% = Column percentage; D.F. = Degrees of Freedom												

Appendix 2

Interview for Drug Users

The questionnaire was written in English and then translated into Arabic, as the majority of respondents did not know English. The translation is as close as it could be to the English.

Place of Interview

Identifying NO.

Date of Interview

/ /199

1. What is your age?
2. Place of birth
3. Where do you live?
 - Abu Dhabi 1
 - Dubai 2
 - Sharjah 3
 - Ajman 4
 - Umm al-Qaiwain 5
 - Ras al-Khaimah 6
 - Fujairah 7
4. What is your nationality?
 - UAE citizen 1
 - GCC citizen (give country) 2
 - Arab (give country) 3
 - Asian (give country) 4
 - African (give country) 5
 - European (give country) 6
 - American 7
 - Other 8
5. Which the highest educational establishment(s) have you attended?
 - None 1
 - Elementary 2
 - Intermediate 3
 - Secondary 4
 - Higher College of Technology 5
 - The Islamic Scientific Institute 6
 - University 7

6. Are you
- | | |
|-------------------------------|---|
| Single | 1 |
| Married to one wife | 2 |
| Married to more than one wife | 3 |
| Separated | 4 |
| Divorced | 5 |
| Widowed | 6 |
7. Do you have children?
- | | |
|-----------------|---|
| Yes | 1 |
| No | 2 |
| If yes how many | |
8. Do you live
- | | |
|---------------------------|---|
| On your own | 1 |
| With parents | 2 |
| With father | 3 |
| With mother | 4 |
| With wife/wives | 5 |
| With friend(s) | 6 |
| With relatives (identify) | 7 |
9. Are you
- | | |
|--|---|
| Student | 1 |
| Government employee (what do you do) | 2 |
| Business man (what do you do) | 3 |
| Private sector employee (what do you do) | 4 |
| Self-employed (what do you do) | 5 |
| Unemployed | 6 |
| Other (specify) | 7 |
10. If you are unemployed how long have you been unemployed?

11. If you are unemployed what was your last job?

12. If you are unemployed do you get the state support?
- | | |
|---------------------------------------|---|
| Yes | 1 |
| No | 2 |
| If yes how much do you get per month? | |

13. Have you travelled outside the UAE?

- Yes 1
 No 2

If yes have you visited the following countries?

Countries Names	Yes	No	Q.13
(a) Lebanon, Syria, Morocco and Egypt	1	2	
(b) Indian, Pakistan and Afghanistan	1	2	
(c) Laos, Burma and Thailand	1	2	
(d) Latin America and the United States	1	2	
(e) Iran and Turkey	1	2	
(f) Netherlands and Spain	1	2	

14. How old were you when you first used drugs?

..... years

15. What was the first drug you took?

.....

16. Who offered you the first drug?

- Friend 1
 Relative (specify) 2
 Father 3
 Mother 4
 Stranger 5
 Other (specify) 6

17. Have you used the following?

	Used	Never used	Q.17
(a) Opium	1	2	
(b) Hashish	1	2	
(c) Marihuana	1	2	
(d) Heroin	1	2	
(e) Morphine	1	2	
(f) Cocaine	1	2	
(g) Crack	1	2	
(h) LSD	1	2	
(i) Amphetamines (specify)	1	2	
(j) Barbiturates (specify)	1	2	
(k) Tranquilizers (specify)	1	2	
(l) Solvent (specify)	1	2	
(m) Other (specify)	1	2	

18. How did you get your drugs?

	Yes	No	Q.18
(a) Free from friends	1	2	
(b) Purchased from friends	1	2	
(c) Purchased from dealers	1	2	
(d) Purchased from Pharmacy	1	2	
(e) Prescribed by private doctors	1	2	
(f) Other (specify)	1	2	

19. Where did you get your drugs?

	Yes	No	Q.19
(a) From the UAE (specify)	1	2	
(b) Outside the UAE (specify)	1	2	

20. Where do you take drugs?

	Yes	No	Q.20
(a) On street	1	2	
(b) In a car	1	2	
(c) In your parents house	1	2	
(d) At school	1	2	
(e) At work	1	2	
(f) In your own house	1	2	
(g) In public places (hotel, gardens, beaches, etc.)	1	2	
(h) Unfrequented areas	1	2	
(i) Outside UAE	1	2	
(j) At parties or social activities	1	2	
(k) At a farm	1	2	

21. How many of your friends are using drugs?

None	1
Some	2
All	3

22. Do you take drugs,

	Yes	No	Q.22
(a) With strangers	1	2	
(b) With friends	1	2	
(c) With member of your family (specify)	1	2	
(d) Alone	1	2	

23. Did either of your parents or brothers/sisters or relatives know that you were using drugs?

Yes 1

No 2

If yes specify who?

(a) Father

(b) Mother

(c) Brother/Sister

(d) Relative

24. When did you use drugs?

	Yes	No	Q.24
(a) When you get up	1	2	
(b) In the morning	1	2	
(c) In the afternoon	1	2	
(d) In the evening	1	2	
(e) At night	1	2	

25. How did you take your drug?

	Yes	No	Q.25
(a) Smoking	1	2	
(b) Injection	1	2	
(c) Oral	1	2	
(d) Sniffing	1	2	

26. Do you know the nationalities of the drug dealers who supply you drugs?

	Yes	No	Q.26
(a) Don't know	1	2	
(b) UAE citizens	1	2	
(c) Asian (specify)	1	2	
(d) African (specify)	1	2	
(e) European (specify)	1	2	
(f) Arab (specify)	1	2	
(g) American	1	2	
(h) GCC citizens (specify)	1	2	
(i) Other (specify)	1	2	

27. How often do you use drugs?

Every day	1
Several times a week	2
Several times a month	3
Occasionally	4

28. How much does taking drugs cost you in a month?

Less than 1 thousand dirhams	1
From 1 thousand to 2 thousands	2
From 2 thousands to 4 thousands	3
More than 4 thousands	4

29. How many grams/tablets/cigarette/can of drugs do you usually use each time?

Drug type	Amount

30. Where do you get the money for your drugs?

	Yes	No	Q.30
(a) From salary/wages	1	2	
(b) Loans from banks	1	2	
(c) From parents/family/relatives	1	2	
(d) From selling possessions	1	2	
(e) From selling drugs	1	2	
(f) From theft	1	2	

31. Why do you use drugs?

	Yes	No	Q.31
(a) Make me feel better	1	2	
(b) To get away from my problems	1	2	
(c) To enjoy time with my friend(s)	1	2	
(d) To increase sexual activity	1	2	
(e) To go along with what my friend(s) is/are doing	1	2	
(f) I cannot stop drug use	1	2	
(g) Other (specify)	1	2	

32. What does taking drugs do to you?

.....

33. Why do you think that drug use is spreading in the UAE?

	Yes	No	Q.33
(a) Unemployment/poverty	1	2	
(b) Government doesn't deal with illegal drug activities	1	2	
(c) The changing of customs/tradition	1	2	
(d) There is a large number of the expatriate work force	1	2	
(e) Increased wealth	1	2	
(f) Not enough security in sea/air ports for drug trafficking	1	2	
(g) The lack of control on pharmacies in selling drugs	1	2	
(h) The lack of control on private clinics in prescribing drugs	1	2	
(i) The lack of information about the dangers of drug use	1	2	
(j) Because young people travel abroad	1	2	
(k) Other (specify)	1	2	

34. What do you do in your spare time?

	Yes	No	Q.34
(a) Play any kind of sport	1	2	
(b) Watch video tapes	1	2	
(c) Go to the cinema	1	2	
(d) Play music tapes/records	1	2	
(e) Go to watch sport	1	2	
(f) Go to nightclubs/discos	1	2	
(g) Go to lectures/events	1	2	
(h) Read books, Newspapers, Magazines, etc.	1	2	
(i) Ride around in a car for fun	1	2	
(j) Visiting friends, families, etc.	1	2	
(k) Other (specify)	1	2	

35. Do you agree or disagree with the following things?

	Agree	Disagree	Q.35
(a) There is not enough leisure facilities in the UAE	1	2	
(b) I find that I don't know what to do with my spare time	1	2	
(c) I feel that I waste my spare time	1	2	

36. I would like to know whether any of the following things happened to you when used drugs.

	Yes	No	Q.36
(a) I feel physically sick, ill	1	2	
(b) I feel I could handle with any serious problems	1	2	
(c) Experience nervousness and shakiness inside	1	2	
(d) I have thoughts of ending my life	1	2	
(e) I hear voices	1	2	
(f) I become scared	1	2	
(g) I feel that people around me are unfriendly or dislike me	1	2	
(h) I find it difficult to make decisions	1	2	
(i) I feel hopeless about the future	1	2	
(j) I have urges to beat, injure people or smash things	1	2	
(k) I feel really happy	1	2	
(l) Trying to kill myself	1	2	
(m) Sexual enhancement	1	2	
(n) I work/study better	1	2	
(o) I feel I have more self-control and can stay out of trouble	1	2	
(p) increased energy	1	2	
(q) I eat more food	1	2	
(r) I am more self-confident	1	2	
(s) Other (specify)	1	2	

37. I would like to know if any of the following physical symptoms have happened to you when you used drugs?

	Yes	No	Q.37
(a) Trouble with your eyes such as itching, watering, seeing double, etc.	1	2	
(b) Trouble with nasal congestion, running nose, sneezing spells, etc.	1	2	
(c) Experienced wheezing or gasping	1	2	
(d) Problem with your teeth, mouth, or gums	1	2	
(e) Urine related problems such as infection, burn, etc.	1	2	
(f) Heart related problems	1	2	
(g) Skin problems	1	2	
(h) Felt faint or passed out/dizzy	1	2	
(i) Your arms or legs have a tendency to shake or tremble	1	2	
(j) Headaches during work or daily activities	1	2	
(k) Heartburn or other stomach pain	1	2	
(l) Loss of appetite	1	2	

38. Have you ever been worried about:

	Yes	No	Q.38
(a) Your way of life	1	2	
(b) Job security	1	2	
(c) Your overall health	1	2	
(d) Opportunities for recreation and relaxation	1	2	
(e) Your religious life	1	2	
(f) Your independence and freedom	1	2	
(g) Your family life	1	2	
(h) Your relationship with your parents, relatives, etc.	1	2	
(i) Your prospects for the future	1	2	

39. Have you done any of the following things?

	Yes	No	Q.39
(a) Been jailed for committing a crime (specify)	1	2	
(b) Argued or had a fight with either of your parents (give reasons)	1	2	
(c) Had a serious fight in school, at home, at work, etc. (give reasons)	1	2	
(d) Forged or passed bad cheque(s)	1	2	
(e) Stolen money, jewelry from your parents etc.	1	2	
(f) Hurt someone badly (give reasons)	1	2	
(g) Sold drugs (give types)	1	2	
(h) Stolen any thing from person, shop, car, etc (give reasons)	1	2	

40. Did you try to stop using drug?

Yes 1

No 2

If yes how?

If no why not?

41. Do you want to stop taking drugs?

Yes 1

No 2

If yes why?

If no why not?

42. Have you ever had medication for drug addiction?

Yes 1

No 2

(a) If yes what have you had?

(b) Did you get better?

Yes 1

No 2

43. Do you get medication in the clinic/prison?
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |
- (a) If yes what do you get?
- (b) Did you get better?
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |
44. Do you get vocational training in the clinic/prison?
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |
- If yes what do you get?
45. Do you like the medication system of the clinic/prison?
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |
- If yes why?
- If no why not?
46. What will happen for the following things when you go home?
- (a) Your family
 - (b) Your work
 - (c) Your friends
 - (d) Your drugs
 - (e) Your Medication
 - (f) Your social life
47. Is there any thing else you want to tell me about your life, drugs, etc?
-
-

Appendix 3

Interview Questionnaire for Government Officials

Ministry of Education

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. Do you have educational programmes for prevention of drug abuse? If yes, specify them.
- Q4. How long have they been running?
- Q5. At what age is your programmes aimed?
- Q6. How do people get on these programmes?
- Q7. Who teach these programmes?
- Q8. Do you give students written text about the prevention of drug abuse?
- Q9. Do you have a guidelines for teachers who are going to teach these programmes? If yes, what are they?
- Q10. Do you have special programmes for teachers who are going to teach drug-related programmes? If yes, what are they?
- Q11. Do you have specialized people in each school who can manage these programmes? If yes, who are they? What nationalities do they have?
- Q12. Do you have special programs addressed to students parents? If yes, what are they?
- Q13. Do you have educational workshops which involve students, parents, and teachers? If yes, describe them?
- Q14. Do you have special programmes for health prevention in general?
- Q15. In your programmes, do you concentrate on drugs or on the drug user?
- Q16. Do you aim in your programmes to improve the social relationship among students and their parents/families?
- Q17. Do you aim to improve students self-confidence? If yes, how?
- Q18. Do you aim to improve the decision making among students? If yes, how?
- Q19. Do you improve the relationship between students and other people, especially their parents? If yes, how?

- Q20. Do you teach students how to spend their spare time? If yes, what do you teach them?
- Q21. Do you have a regulation which bans smoking among students at schools? If yes, is it enforced?
- Q22. What do you do if you find that students are taking drugs?
- Q23. What do you think are the best ways of dealing with drug problem in the UAE?
- Q24. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Communication Media

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. Do you have special programmes for prevention of drug abuse? If yes, what are they?
- Q4. What method do you follow in your programmes? (informative or warning method).
- Q5. To what type of people are your programmes aimed? (educated, non- educated, parents, youth, etc.).
- Q6. Do you believe that knowledge about the social and personal drug use dangers will lead to the prevention of drug abuse?
- Q7. Do you connect your programmes with:
- Legal status for drug use.
 - The patterns of drug use behaviours.
 - Social and physical characteristics of drug users.
 - How drug users can be identified.
 - Methods of seeking help for addicts, parents, etc.
- Q8. Do you study the characteristics of your targeted people before you broadcast/telecast your programmes?
- Q9. Are you facing financial, administrative, or technical problems which may make it difficult to execute your Preventive programmes?
- Q10. Who controls the preventive programmes in your organization?
- Q11. Do you have preventive programmes which depend on the face-to-face meeting with drug addicts? if yes, what are they?
- Q12. Do you have special preventive programmes aimed at foreigners? If yes what are they?
- Q13. When you broadcast/telecast your programmes, how do you know that the targeted people will understand your message?
- Q14. Do you coordinate the drug preventive programmes with other programmes in order to avoid negative results? If yes, how?
- Q15. Do you evaluate your drug preventive programs after they have been broadcast/telecast? If yes, how?
- Q16. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q17. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Ministry of Health

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. How do you participate in drug combating policy?
- Q4. How do you evaluate drug problems in the UAE?
- Q5. How do you prevent people from becoming drug addicts?
- Q6. How big problems of drug use are?
- Q7. Do you think that your health programmes can reduce the spreading of drug problems in the society?
- Q8. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q9. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Addiction Clinics and Psychotherapy Departments

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. Do you provide the following treatment facilities in your Clinic/department?
- a. Medical services
 - Intake and screening
 - Physical examinations
 - Emergency care
 - Other medical services
 - b. Psychotherapy and counseling
 - Individual
 - Group
 - Family
 - Psychological testing
 - Other
 - c. Social assistance
 - Education
 - Legal aid
 - Job counseling, placement
 - Vocational rehabilitation
 - Family care
 - Aftercare
 - d. Community-based services
 - Outreach
 - Alternatives
 - Information
 - Early intervention
 - Employee assistance
 - Other

- Q4. When you create your medication programmes do you put in your account the prevalence rate for drug use behaviours among people in the UAE?
- Q5. Do you encourage drug addicts in the society to get medication? if yes how?
- Q6. Do you assist drug addicts in their homes if they seek help?
- Q7. Do you think that your official procedures to get medication are easy for drug addicts?
- Q8. Do you think there is a coordination between hospitals/clinics which are involved in drug addiction treatment in the UAE?
- Q9. Do you apply the compulsory or optional medication system?
- Q10. What are the factors behind applying the compulsory medication on drug addicts in the UAE?
- Q11. Do your treatment systems work? If yes, would you give some evidences?
- Q12. What type of difficulties do you face?
- Q13. Do you report drug addicts who seek treatment to the police or court?
- Q14. Are all your treatment staff qualified enough to deal with addiction problems?
- Q15. Do you evaluate your medication system?
- Q16. Do you thing there is any collaboration between governmental organizations who are involved in drug combating policy?
- Q17. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q18. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Ministry of Social Affairs

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. To what extent are you involved in drug use combating policies?
- Q4. Do you have vocational and social rehabilitation systems for drug addicts?
- Q5. What sort of difficulties are you facing in order to apply your drug combat-related programmes?
- Q6. Do you give financial support for unemployed people? If yes, what level of support?
- Q7. Do you collaborate with other governmental and non-governmental organizations in drug combating policy? If yes, how? In what ways?
- Q8. What do you think are the best ways of dealing with drug problem in the UAE?
- Q9. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Women's Associations

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. How do you participate in drug preventive policy?
- Q4. Do you apply special programmes which aim to prevent the women, parents, family, etc. from drug addiction? If yes, what are they?
- Q5. What sort of difficulties are you facing in applying your programmes?
- Q6. Do you collaborate with other governmental or non-governmental organizations which are involved in drug combating policy? If yes, how?
- Q7. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q8. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Ministry of Youth

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. To what extent are you involved in drug combating policy?
- Q4. Do you have a policy which aims to prevent youth from using drugs? If yes, what is it?
- Q5. What sort of difficulties do you have?
- Q6. Do you collaborate with other governmental and non-governmental organizations?
- Q7. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q8. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Federal Drug Combating Administration

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. Do you have a drug combating policy? If yes, what is it?
- Q4. To what extent do you participate in the illegal drug combating?
- Q5. Do you have a relationship with other drug combating departments in each Emirate? If yes, describe the type of the relationship.
- Q6. What sort of difficulties do you have?
- Q7. How do you collaborate with other governmental and non-governmental organizations?
- Q8. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q9. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Drug combating departments in the Emirates

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. To what extent do you participate in the illicit drug combating?
- Q4. What is the relationship between your department and other drug combating departments in each Emirate?
- Q5. What is the relationship between your department and the federal drug combating administration?
- Q6. What sort of difficulties are you facing?
- Q7. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q8. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Coastal Guards

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How would you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. To what extent do you participate in drug combating policy?
- Q4. Do you manage to control all coasts and islands in the UAE? If yes, how?
- Q5. Do you collaborate with other governmental organizations who are involved in drug combating policy? If yes, how?
- Q6. What sort of difficulties are you facing?
- Q7. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q8. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Ministry of Justice

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

.....

- Q1. How do you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. How do you participate in drug combating policy? If yes, give evidence?
- Q4. Do you think that courts in the UAE have enough rights to apply the laws on anybody?
- Q5. Do you think that courts apply penalties to match the size of offences? If yes, give evidence?
- Q6. How do you evaluate the illicit drug laws in the UAE?
- Q7. What sort of difficulties are you facing?
- Q8. What penalties are the most effective?
- Q9. What do you think the best ways of dealing with drug problem in the UAE? Why?
- Q10. Which agencies should take priority responsibility for drug problem in the UAE? Why?

Custom services

Date of the interview

.....

Place of the interview

.....

Name of the interviewee

.....

Position of the interviewee

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- Q1. How do you describe the drug problem in the UAE?
- Q2. What do you think are the causes?
- Q3. How do you participate in drug combating policy?
- Q4. How do you collaborate with other governmental organizations?
- Q5. What sort of difficulties are you facing?
- Q6. How do you evaluate the drug combating policy in the UAE?
- Q7. What do you think are the best ways of dealing with drug problem in the UAE? Why?
- Q8. Which agencies should take priority responsibility for drug problem in the UAE? Why?