

# Drug Demand Reduction Programme in India: Recommendations for the Future

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## Abstract

*India is a welfare-based nation; therefore, it has an embedded responsibility to protect the marginalized communities. However, drug dependency has always been a hidden phenomenon. Focusing on the Indian scenario, this research critically analyses the implementation of the demand reduction programme, i.e. the National Scheme of Assistance for Prevention of Alcoholism and Substance Abuse which emerged from Section 71 of Narcotic Drugs and Psychotropic Substances (NDPS) Act. Although the NDPS Act is prohibitionist in its approach and has criminalized the use of drugs, it has inculcated Section 71 of NDPS Act that stated the government can establish sufficient de-addiction centres for treatment and rehabilitation of drug dependents. In order to gain a broad understanding of the implementation the study covered a national perspective by including Chennai, Mumbai, New Delhi and Mizoram representing Southern, Western, Northern and North East regions of the country respectively. The treatment and rehabilitation services were analyzed categorically and thematically by posing specific standards such as availability, accessibility, quality and Protection of Human Rights.*

*It was learnt that at the regional and community level, no autonomous body was set up for implementation of treatment and rehabilitation, treatment was envisaged through correctional angle, huge gaps in extension of financial support to existing de-addiction centres, weak preventive measures, ineffective training of staff, restricted admission for high risk drug dependents, diverse cases of human rights violation, mismanagement of withdrawal symptoms and prevalence of minimal harm reduction measures. However, on the positive side, the best practices are also being recorded with ongoing study such as positive impact of meditation, yoga therapy, life coaching based on emotional intelligence among other indigenous practices. The focus of this article is to provide a knowledge framework to enhance the quality of policy formulation and disseminate recommendations of the study with the hope that policy makers and practitioners and other concerned stakeholders are better informed of the situation so as to make a positive change in the lives of the users and the society at large.*

**Keywords: Drug dependents, drug policy, indigenous practices, decriminalization, NDPS Act, de-addiction centres, human rights, harm reduction.**

## Introduction

Human behaviour cannot be isolated from the social, cultural and environmental reality surrounding it. Drug using behaviour is a dynamic, multifaceted phenomenon which is constantly changing and hence must be understood in the socio-cultural and political context in which it occurs. The customary use of stimulants, sedative and euphoric drugs were rampant in India long before any other country. Traditional uses of Cannabis and Opium Psychoactive substances especially cannabis and opium have been in the pharmacopeia of Indian medicine for a very long time. Although there is little knowledge of the medical practices of ancient times, historical evidence shows that cannabis and opium had esteemed medical history in India. Most of them are mentioned in the Atharvaveda (1400 BC), as a medicinal and magical plant.

Both Ayurvedic and Unani Tibbi systems in India have used cannabis in their medical documents as a therapeutic agent for many centuries. The 18th Century Ayurvedic work on Materia Medica, the 'Dhanawantari Nighantu', summarizes its properties, actions and indications.

Although the Unani Tibbi system did not arrive in India until the 9th Century, the use of cannabis in the system antedated that time. The Quranic laws on intoxicants were more tolerant towards the use of drugs such as opium and cannabis because of the paucity of means of relieving in the medieval world<sup>1</sup>.

Basu et al<sup>2</sup> state that the information collected as a routine procedure in a treatment centre can provide a relatively inexpensive method of monitoring changing trends of drug use in a community. It is important to compare these retrospective data from a single treatment against the national trend, if available. In 1824, Dr. W.B.O'Shaughnessy, Professor of Chemistry in the Kolkatta Medical College, used Cannabis in the treatment of patients suffering from such diverse ailments as Rabies, Rheumatism and Epilepsy. He also found that tincture of hemp was an effective analgesic and anti-convulsant and muscle relaxant properties<sup>3</sup>. Cannabis continues to be used in both Ayurveda and Tibbi systems of medicine, as an anodyne, hypnotic, an analgesic and antispasmodic. It is used extensively in the rural areas in the treatment of enteritis, dysentery, dyspepsia, gonorrhoea and cholera, neuritis, rheumatism and neuralgia as well as being used as a hypnotic and antispasmodic.

As a medicine it is administered orally by the mouth and hardly ever by smoking. Use of cannabis to relieve fatigue and anxiety is also found to be acceptable. The number of persons who use bhang as a medicine is greater than those who use ganja. Bhang has a milder action and is used as an antispasmodic more frequently than ganja and charas<sup>4</sup>. Cannabis with sweets, as tranquilizer for children, to help them sleep or keep them quiet while the mother works in the field was a common practice. It is used by the elderly to ease their aches and pains. Older persons also use it as a recreational practice to spend time.

1 Dwarakanath, C. (1965). Use of Opium and Cannabis in the traditional systems of medicine in India. *Bulletin on Narcotics*, 17, 15-19.

2 Basu D, Aggarwal M, Das PP, Mattoo SK, Kulhara P, Varma VK. Changing pattern of substance abuse in patients attending a de-addiction centre in north India (1978-2008) *Indian J Med Res*. 2012;135:830-6..

3 Chopra R. N., and Chopra I. C., *Drug Addiction: With Special Reference to India.*, Council of Scientific and Industrial Research, Delhi Press, 1965.

4 Ibid 3.

The ancient books on Hindu medicine make no reference either to the poppy or its products. Similarly, the classic works of Chakradatta, Susruta and Vaghabatta, have made no mention of opium. Even the 11th century Chakradatta does not mention opium. Hence the exact time at which opium was introduced into ayurvedic medicine is open to speculation. However, a reference to opium is made as an antidote for rat poison; in the 862 AD work on toxicology, written by Narayan of Malabar. In the later works such as SharangadharaSamhit (14th & 15th centuries) and Bhavaprakash (16th Century) opium is freely mentioned in the material medica section as being used in medical preparations. Hence, it is probable that opium came to be used in Ayurvedic medicine after the Mohammedan conquest<sup>5</sup>. Opium was used in as many as eight preparations by the Ayurvedic physicians in the last two centuries. They are Karpura Rasa, Ahithenasava, Rihhat Gangadhar Churna, MakadeyaChurna, DugdhaVati, GrahaniKapata Rasa (Rasendra Sara Sangraha) AkrakaravadiChurnaSharangadhara) and Dambhunath rasa (Bhaishajya tantra)<sup>6</sup>.

In 1911, the British Government issued a policy note that stipulated that prohibition of opium eating in India is impossible. The British were clear that the drug (opium) habit was not a vice in India and that the drug is used for non-medical purposes were actually beneficial to the people and that it was not possible to make a difference between use and abuse.<sup>7</sup>

Earlier, society was self-regulating and did not need precise rules for effective drug control. Drug consumption was carried out openly, legitimized by cultural norms and restricted by traditional demand. With International intervention however, indigenous controls have been displaced by a single model, developed primarily for the West. In the Indian context, the imposition of this model has resulted in the replacement of culturally sanctioned use by secular use and of traditional suppliers by criminal networks. Furthermore, adherence to the United Nations Drug Control Conventions ensures that most nation states adopt a similar prohibition-oriented approach when formulating their national drug

5 Ibid 3.

6 Ibid 3.

7 Ibid 3.

controllegislation. With India's position between the Golden triangle and the Golden crescent, it was becoming a transit country for routing drugs to different countries through India. New drugs were also being manufactured synthetically in other countries which were falling off on the Indian soil during transit. The Government thereby brought in the Narcotic Drugs and Psychotropic Substances (NDPS) Act in 1985 with more stringency and concrete prohibition over usage of drugs. The NDPS Act 1985 was the only drug law for dealing with the drug problem in India. It came into force due to the pressure of International Conventions which India was a signatory. Cannabis and opium lost its traditional and indigenous value and became drugs of abuse. The Act did not in any way bring down the rate of drug trafficking but was only causing the drug mafias to improve and update their technology for safe and highly networked trafficking. It was only the small-scale drug peddlers and drug users who were falling prey to the extremely rigorous provisions of the NDPS Act.

According to a UNODC Report<sup>8</sup>, that presents a statistical approach to assessing supply and demand for illicit drugs, the office reported that one million heroin dependents were registered in India, and unofficially there were as many as five million. Abuse of inhalants and pharmaceuticals are the prevalent patterns of drug use which is in keeping with observation in India including north India<sup>9</sup>. Substance use is ubiquitous with a range of substances being abused the world over. Their abuse and associated harm have been of international concern since early 1980s and the WHO highlighted the importance of monitoring the drug abuse situation and trends<sup>10</sup>. According to a report titled, "The Extent, Pattern and Trends of Drug Abuse in India: National Survey" by the Ministry of Social Justice and Empowerment and the United Nations Office on Drugs and Crime

(UNODC) published in 2004, apart from alcohol (62.46 million users), Cannabis (8.75 million users), opiates such as Heroin, opium, buprenorphine and propoxyphene (2.04 million users) and sedatives (0.29 million users) were the drugs most abused.

The availability of drugs in a neighbourhood raises the curiosity of youngsters and they become prone to making use of the drug that is available. Young people want to experiment and see for themselves whatever comes on their way. Drugs are no exception to this character of youngsters. There are some drugs that are common among males and there are certain drugs that are common among females. To identify themselves with their own groups, young people take drugs<sup>11</sup>.

For the welfare of the drug using population, the National Demand Reduction Programme which has its roots from Section 71 of the Narcotic Drugs and Psychotropic Substances Act, 1985 was formulated. Accordingly, from Section 71, the National Scheme of Assistance for Prevention of Alcoholism and Substance Abuse emerged. As the NDPS Act deals with drug use both from the enforcement and treatment angles, the responsibility of treating drug dependents in the country did not completely fall in the hands of Ministry of Health. Thereby the Ministry of Social Justice and Empowerment approached it as a correctional issue and envisaged a wide range of services for treating addiction. However, the Ministry of Social Justice did not become a direct provider for services, it limited its responsibility by training and providing financial assistance for the NGOs in the field of de-addiction. Mohan et al state that the viability of a Drug Abuse Monitoring System in the country was examined for the first time through a Task force project (ICMR) conducted at Delhi, Jodhpur and Lucknow in 1990 and provided one-year data among 10,321 persons<sup>12</sup>.

Legalization of specific drugs could pave a way for decrease in users involved in drug crimes as they are usually the soft targets of drug mafias. The funds

11 Sen, K. Arun & Anis Ahmad. (1999). Drug Abuse and Youth- A psychological study. New Delhi: Gyan Publishing House.

12 Mohan D, Sitholey P, Purohit DR. Collaborative study on narcotics drugs and psychotropic substances, subcomponent-Drug abuse monitoring system. New Delhi: ICMR; 1993. Task Force project. Report submitted to Indian Council of Medical Research.

8 United Nations Office on Drugs and Crime. UNODC Report 1999, Global Illicit Drug Trends, [https://www.unodc.org/unodc/en/data-and-analysis/global\\_illicit\\_drug\\_drug\\_trends.html](https://www.unodc.org/unodc/en/data-and-analysis/global_illicit_drug_drug_trends.html)

9 United Nations Office on Drugs and Crime. UNODC, Illicit use of prescription drugs in South Asia. Regional report. UNDOC; 2010

10 (Rootman I, Hughes P.) Drug abuse reporting system. Geneva: WHO; 1980. WHO Offset Publication No. 53

which Government spends for enforcement activities for dealing with drug offences may also decrease. Therefore, the funds could be effectively utilized for treatment, rehabilitation, preventive education and awareness generation. India should soon be adapting the decriminalization approach simultaneously strengthening harm reduction mechanisms and promote preventive education. The Ministry of Social Justice and Empowerment, Government of India, recently drafted the National Action Plan for Drug Demand Reduction (2018-2023) for further addressing the issue of drug use. This new action plan includes a multi-pronged strategy that includes education, de-addiction and rehabilitation of affected individuals and their families to address the problem using collaborative efforts of Government and NGOs and a stringent monitoring by the Cyber cell has been proposed. It further calls for an increase in community participation and public cooperation which was not the focus in the earlier policy. Some initiatives like increase in financial assistance for Narcotic control, rewards for seizure, signing agreements with foreign countries and combating illicit trafficking do not look into the human rights violations in deaddiction centres. The need to look into these areas are important and therefore the reiteration of the recommendations made in this study is paramount<sup>13</sup>.

The accelerated pace of social and institutional changes, especially after Independence, have distorted the balance of traditional Indian social system. The extent of change has been so great that every social institution, whether family, community or religion which had hitherto exercised tremendous control over the conduct and behaviour of an individual member, by prescribing role models, over a period of time has lost the ability to devise an alternate and generally acceptable behavioral set. The society and community have ceased to be central to the requirements of an individual in the highly impersonal, mechanical and individualistic industrial and urban society of today. The disintegration of the informal social control mechanisms exercised by the family, community and the neighbourhood, has resulted in a kind of social vacuum. The rise of

western style individualism and value system has eroded the traditional value system but has not fully replaced it with an alternatively acceptable value system. In this transitional phase it appears that more has been lost than gained<sup>14</sup>. A survey carried out by the Ministry of Social Justice and Empowerment in India in 2004 revealed that 21 percent adolescents below 18 years use alcohol, 3% use cannabis, 0.1% use opiates.<sup>15</sup>

### **Rationale of the Study**

A study of this nature is pertinent in the sense that it seeks to understand the cause and effect of the present phenomena with regard to drug policies in India. It looks at the sociological impact of such policies and identifies its success levels in implementation. It is hoped that India should soon be adapting the same decriminalization approach as it is the need of the hour. It is vital to develop essential humanism in adopting an analytic rather than a moral stance toward dealing with drug dependents. Further, there is a need to alter the current policy and existing practices in India of seeing rehabilitation in the purely medical context and merely as an annex to treatment. Treatment is an early step in a much longer process and treatment programmes must be linked from the outset to broader rehabilitation and social reintegration measures by safeguarding the rights of the drug dependent in the Indian society.

Yet another concept to understand in this context is the theory of marginalization of drug dependent persons that should be considered because it gives an understanding about how the society has contributed to the problem of addiction. European researchers use the word exclusion, which means the way individuals get 'cut off from full involvement in the wider society'. Exclusion implies that addicted persons individuals or groups do not get opportunities, which are available to majority of the population. Exclusion may be seen in economic, political and social terms<sup>16</sup>.

International and national norms based on the Single Convention created different images of drug

14 Mohan and Saxena, 1984; Singh 1975; Singh and Khan 1981.

15 Arunachalam, DuraiPandi. (2005). Adolescent Anxiety and Substance Abuse. Journal of School Social Work, Vol II, Issue 02, July. 8-12

16 Giddens Antony. (Anthony Giddens, 2001)

13 Ministry of Social Justice and Empowerment, GoI, 2018

users in the eyes of the public. The various approaches that arose were based on moral, criminal, deviant and disease models. Later, all of them were confronted by another model, which focused on decriminalizing drug use, regulated supply to medically certified addicts and some even proposed legalizing all drugs. At present certain European countries are putting forth the need for a rational and humane approach as against punitive measures. Research shows that marginalization leads to involvement in high –risk behavior. Drug use marginalizes a person, as his act is unacceptable to the central values of the dominant social elite. Often drug users themselves internalize the fallacy that they are ‘sick’ or ‘criminals’. At present, in India, all users of psychoactive substances other than alcohol, nicotine and bhang are marginalized by the existing administrative norms.<sup>17</sup>

The pressing need to research in areas of hunger, poverty and unemployment have overtaken the need to research in areas of addiction. The hidden manifestation of addiction and all related issues need to be given more priority in areas of research and development. According to Saroj Prashant, existing studies in India do not cover all the different state or regions to obtain a reliable index of drug addiction/abuse in the country. Even the few studies available in India, are mostly cross-sectional and not representative of the population. Methodology used by different researchers are different and thus most studies are not comparable<sup>18</sup>. This major gap in the field of drug use/abuse has prompted this attempt to contribute towards building up the knowledge. Therefore, a study of this nature highlights the need and propounds the urgency to be conscious of the issue at hand and commit towards the enhancement of research in the field of drug abuse.

### Methodological Approaches

The study titled ‘Policies and Practices of Drug Use in India: A Situational Analysis - The University in Dialogue with Political and Social Actors’, was concerned with studying Drug policies and its implementation processes in India. It looks at the

<sup>17</sup> Molly, Charles., K.S.Nair., & Gabriel Britto. (1999). Drug Culture In India. Mumbai: National Addiction Research Center, Rawat Publications.

<sup>18</sup> Prashant, Saroj., Drug Abuse and Society; Ashish Pub, N. Delhi, 1993. pp 47

nature and formulation of drug policies and their applications, their effects and impacts on concerned populations in India in a broad context.

The aim of this research was to draw up a situational analysis of the current drug policies and rehabilitation practices existing in India, its rationale, formulation, implementation and its relevance to the current reality of new drug use/abuse problem. It further aimed at strengthening and consolidating understandings of such policies and practices concerning the co-operation mechanisms between the Non-Governmental Organizations and the Governments. This study was primarily formulated keeping in line the initiative of the United Nations of the World Forum on « Beyond 2008 » on Drugs use/ Abuse and its policies.

### Objectives

1. Study policy implementation mechanisms ranging from the central to the community levels with reference to the National Demand Reduction Programme.
2. Analyse strengths and gaps in the demand reduction programme- its rationale, planning, implementation mechanisms, intervention processes, monitoring systems and outcomes.
3. Suggest a knowledge framework so as to enhance the quality of policy formulation and its overall implementation using the inclusive/ participatory approach.

### Research Design

The study design was qualitative study design. Interviews and focus group discussions were the qualitative techniques used in the research. The study design involved observing and describing the behavior of social and political actors in the field of drug use. It researches and analyzes complexity, sensitive areas, and areas in need of exploration, to discover associations and relations with regard to drug issue. Interviews, focus group discussions, content analysis were the qualitative methods used in the research.

### Sample Design

The study being qualitative in nature, in-depth interviews with key informants, focus group



discussion were used. Nonprobability sampling design was the broader design used for the study. Multistage sampling design was used to identify the geographical regions and for further selection of units of data collection in each region. Multi-stage sampling is a kind of complex sample design in which two or more levels of units are imbedded one in the other. Heterogeneity sampling design complemented with purposive sampling was used to identify the units of data collection. Heterogeneity sampling design is a design which is used to include all opinions or views, and not concerned about representing these views proportionately. Another term for this is sampling for diversity. This design helped in identifying different stakeholders in the field of drug abuse from outreach workers, recovering drug dependents, teenagers, practitioners, professionals, policy makers, government officials, and experts in the field. However heterogeneity sampling combined with purposive sampling design enabled the researcher to identify the units of information with maintaining both diversity and as well as sustaining an underlying purpose of seeking specific predefined groups. In effect, sampling was not people, but opinions, perceptions, and ideas in order to obtain the crux of the working of the scheme at the local level.

### **Tools and Techniques for Data Collection**

#### **Primary sources**

In-depth Interviews with Key informants: Key informants for interviewing were identified at different levels namely at the National level where the programme was formulated, at the regional levels where it was implemented, monitored and evaluated, and at the community level where the services were executed to the beneficiaries. Focus group discussions: Focus group discussion was adopted mainly at the community level with service providers at the IRCAs, among groups which comprised of counselors, an outreach worker, peer educator, medical practitioner and psychiatrist. Additionally, the data collected during focus group discussion enhanced the concurrence to the data collected during In-depth interviews. Secondary sources of information comprised documents of: Content Analysis was carried out on Policies, Acts, schemes, brochures, manuals, journals, books,

reports etc., from various agencies namely Narcotics control Bureau, UNODC, Directorate of Social Defence, Ministry of Health and Family Welfare, Ministry of Social Justice and Empowerment, academic institutions, RRTCs, NGOs, Govt. De-addiction centres and Private de-addiction centres etc. Content analysis was done to study all forms of documents the policies, laws and legislations which are available in connection to demand reduction.

#### **Period of Study**

The study was carried out in 2013 and data was subsequently analysed. The research was completed in 2014.

#### **Limitations of the Study**

The study was carried out only in deaddiction centres and experts in the field. Clinical aspects of addiction were not included as this would add a greater dimension to the study. However, this would require more time and personnel to carry out the study. Since the issue is highly stigmatized, respondents were hesitant to disclose more detailed information. This was a hindering factor in bringing out the human rights violations in the situation.

#### **Major Findings**

##### **NDPS Act and Specific Provisions of Demand Reduction**

The NDPS Act was enacted by Parliament in 1985 in keeping with International Drug Conventions, namely the Single Convention on Narcotic Drugs, 1961; the Protocol amending the Single Convention on Narcotic Drugs, 1972 and the Convention on Psychotropic Substances, 1971. The NDPS Bill, 1985 was passed hastily over four days, without much legislative debate. It received the President's assent on 16 September 1985 and came into force on 14 November 1985. The NDPS Act, 1985 replaced the Opium Act, 1857, the Opium Act, 1878 and the Dangerous Drugs Act, 1930.

According to the Statement of Objects and Reasons of the NDPS Act, 1985, India was becoming a transit for drug trafficking and the then legislation was ineffective in countering the problem. The following deficiencies were noted in the law prevailing at the time – (i) absence of stringent penalties against drug trafficking, ii) weak enforcement powers, iii)

development of a vast body of International law, which India was a signatory to, and, iv) lack of regulations over psychotropic substances.

Like other International treaties, the drug Conventions to which India was a signatory, were not self-executing. Their provisions were supposed to be incorporated into domestic law by legislative acts, in accordance with constitutional principles and the basic concepts of the legal system of that State. The NDPS Act, 1985 was introduced as a comprehensive legislation to tighten control over abuse on narcotic drugs and psychotropic substances, enhance penalties, especially for trafficking in drugs, strengthen regulations over psychotropic substances and provide for the implementation of International Conventions. Although the NDPS Act was prohibitionist in its approach and has criminalized the use of drugs, it has still inculcated a provision in the Act for treatment and rehabilitation of drug dependents. Section 71 of the NDPS Act has stated that the government can establish as many de-addiction centres as possible for the treatment and rehabilitation of drug dependents. Accordingly, from Section 71, the National Scheme of Assistance for Prevention of Alcoholism and Substance Abuse emerged which catered to provide financial assistance for NGOs to provide preventive, treatment and rehabilitation services to the drug using population. The Ministry of Social Justice and Empowerment was the nodal agency for demand reduction in the country.

**Key Findings on Treatment and Rehabilitation Measures**

**Major Findings on Treatment and Rehabilitation Measures**

The following table presents the availability of services and the corresponding access to the various beneficiaries.

Availability of services	Unavailability of services
Detoxification services	Admission for children and women drug dependents
Allopathic treatment	Siddha, Ayurvedha and other indigenous treatments
Voluntary admission and involuntary admission in some centres	Treatment for related psychiatric disorders
Individual counseling	Basic sanitation facilities
Group therapy	Nutritional food
Lecture sessions	Harm reduction measures/ substitute therapy
Family therapy	Yoga therapy classes
Basic follow-up services	Legal assistance for patients
Abstinence based model of treatment	Awareness cum de-addiction camps in communities (norm of scheme)
	Workplace prevention programmes

**Source:** Interpretation of Primary data from four regions

**Gaps in Accessibility**

- Integrated Rehabilitation Centre for addicts registered with the Ministry are minimal within interior districts of a State.
- Transport constraints faced by family members to travel to the centre
- Restricted admission for severely dependent patients on hard drugs like heroin, cocaine and synthetic drugs
- Restricted admission for HIV positive and TB patients
- Cost of food was high although treatment is free
- Stigmatization of use – Hesitance of family members to visit a de-addiction centre
- In-treatment duration is minimum one month which results in economical burden for the family as the dependent becomes unemployed

**Gaps in Quality of Services**

- The norms as specified in the Minimum standards of services were not followed in the centres properly
- Professional counselors and social workers were not appointed in the centres, which resulted in
- compromised outcome out of the counseling sessions.
- Awareness generation programmes were organized mostly for the motive of publicizing their centres. Lack of emphasis on preventive education and awareness in society.

- Space allotted for counseling, group therapy and family classes were not very spacious to accommodate all patients.
- Sixty percent of patients relapsed after undergoing treatment
- Simple replication of other centres' treatment model without any research and innovations
- Female counselors and male patients face difficulty in counseling sessions when sharing and dealing with sensitive issues during counseling sessions
- proved fatal.
- Lack of expertise among staff resulted in restricted admission of narcotic drug dependent patients
- Lack of care & management of withdrawals resulted in chaining the patients to their beds and assaulting them if they showed aggressive withdrawal symptoms instead of proper medications and timely care
- Drug dependents who were referred through police custody faced the most violations in the centres.
- Lack of provision of legal assistance for patients who needed it.

### **Gaps in Protection of Human Rights**

- Involuntary admission: Patients were forcefully admitted only with the consent of family members with rescue vans from their homes to the centres
- Certain centres jailed the patients and disallowed them to visit their family members. The staff at the centres assumed that only if they were disallowed to meet their family members, the patients will realize their presence and importance.
- The patients were forced to do all the odd chores at the centre and if they disobeyed, they were assaulted and physically abused
- Lack of space: 30 – 35 patients were lodged in the space which was fit only for 15- 20 patients.
- There were reports of escapism of patients and incidences of mysterious murder which had taken place in few centres.
- Certain centres believed in negative reinforcement as a technique for recovery of patients. They believed that through punishment and insult the patients will change for the better. Dignity of the individual was not upheld at all.
- Discrimination of HIV patients led to restricted admission and referral to other hospitals
- Certain patients underwent in-treatment for more than 2 months by paying expensive fees as the family members did not want them back home but were willing to pay. In such cases the patient without his will was jailed in the centre unwillingly.
- Misappropriate use of Anti-abuse tablets (Disulfiram) by patients after discharge resulted in emergencies and sometimes even

### **Recommendations**

#### **Policy Recommendations**

##### **a) Anti-death penalty law**

Section 31A was incorporated in 1989 after the Parliament passed the NDPS (Amendment) Bill, 1988. The issue of mandatory death penalty for drug offences is excessive, unscientific and inhumane. Poor drug users are soft targets for law enforcement, and they are unable to afford legal representation and plead guilty for crimes they have not committed. This section has to be removed from the Act through an amendment and it is in the hands of the judiciaries and parliamentarians of the country to take this giant leap and stand up for the right to life for drug dependents.

##### **b) Need for Convergence between Ministries**

The role of Ministry of Health and Family Welfare in the area of drug de-addiction is demand reduction by way of providing treatment services alone. The de-addiction programmes in India developed by the two ministries, Ministry of Social Justice and Empowerment and Ministry of Health and Family Welfare appear to run in parallel lines to each other with little or no cooperation between the two agencies. While Addiction is considered as a disease, it is not seen from the purview of health department but treated as a moral issue or a correctional disorder.

Demand reduction by way of treatment alone is the concern of Ministry of Health and Family Welfare. It does not provide after care and rehabilitation services. However, the activities of



the Govt. agencies overlap considerably in several ways. It is recommended that both the ministries' resources and expertise should be converged for the betterment of services provision to drug dependents. At the policy level amendments has to be made for coalition of ministries to work together.

**c) Replacement of imprisonment with rehabilitation**

The funds exhausted for maintaining the drug dependents in prisons can be utilized sensibly by the Government to set up more human resources and establish an independent commission for executing the demand reduction programme. Instead of receiving medical assistance, drug dependents are prosecuted and jailed, which worsens their condition. Those prisons are not conducive to treatment and rehabilitation, which the NDPS Act itself aims to secure. Therefore those persons who are under police custody and are proven to be drug dependents should strictly be referred to de-addiction centres and not jailed.

**d) Differentiation of alcoholism and substance addiction**

The Government of India conveniently included treatment for alcoholic patients along with treatment of patients dependent on hard drugs. The dynamics and needs of the drug dependents are way different from the dynamics of alcoholic dependents. The withdrawal symptom of substance dependents is very intense when compared to that of withdrawal symptoms of alcohol addiction. Treating different profiles of drug dependents in the same centre may not be advisable as low profile dependents may be exposed to different kinds of drugs from other patients. Group sessions and lectures can also not be given in a similar manner. Section 71 of the NDPS Act, states that de-addiction centres be established for voluntary treatment & rehabilitation of drug dependents. Such voluntary treatment was meant for persons who were dependents of narcotic drugs and psychotropic substances as per the NDPS Act. The main reason for the emergence of the section was to provide treatment instead of prosecution.

Thereby, the scheme of assistance for prevention of alcoholism and substance abuse emerged from the spirit of Section 71 of the NDPS Act. But inclusion of treatment for alcoholic patients in the

de-addiction centres cannot be justified as alcohol was not mentioned in the list of narcotic drugs or psychotropic substances in the NDPS Act.

**e) Diverse spread of voluntary organizations**

The presence of Voluntary organizations is not uniform throughout the nation. Similarly, there are certain spheres of activities that attract more voluntary organizations just as their concentration in some regions. This twin situation often results in disparate development of regions as well as of sectors. It is the intention of the Ministry to encourage the horizontal spread of development alongside sectoral growth in spheres that have received comparatively less attention or may need more attention. For example, the North eastern part of India needs more concentrated and even spread of voluntary organizations than the other regions as it has high rate of addiction.

**Recommendations for Social Integration**

**a) At school level**

There has not been any concrete effort taken by the Department of Education in inculcating modules in the curriculum for awareness on ill effects of drug use among school children. The new National Policy on Narcotic Drugs and Psychotropic substances which came about in 2012 has suggested inclusion of mandatory chapters of drug use and effects in the curriculum for Higher secondary students. Education on drug dependency should become a part of the curriculum. More focus should be given to the age group of 13 to 18 years who are more susceptible to drug abuse.

**b) Medical management of addiction to hard core drugs**

Drug dependents addicted to hard core drugs like heroin, cocaine and other opiates do not get admitted easily in de-addiction centres/voluntary organizations because of lack of expertise to manage the withdrawal symptoms posed by the patients. Training and capacity building of service providers is a must at the grass root level for treating and rehabilitating persons who are dependent on hard core drugs.

**c) Women and children**

The present demand reduction programme studied under the research project does not provide exclusive

services to women or children drug dependents. The de-addiction centres are not equipped with enough resources to cater to women or child drug dependents. Therefore the Ministry should undertake a study and look into the concentration of are women and children drug dependents region wise. For example the population of street children who are dependent on drugs are majority in Mumbai and the ratio of women drug dependents are relatively high in the North eastern regions. Accordingly, de-addiction centres should be established through NGOs exclusively in such regions.

#### **d) Inclusion of Harm Reduction Measures**

Harm reduction model helps in reducing the harms inflicted to and by the dependents. When drug dependents associated with criminal behaviour are introduced to abstinence model of treatment, it is not very effective in the rehabilitation process. Further, injecting drug users are high risk groups for contracting HIV, AIDS. They face many other health ailments and as a result they die at a very early age. Therefore in order to reduce the impact of addictive behaviour, harm reduction strategy acts as a very good alternative and effective process. Patients who are dependent on opiates can be given substitution therapy with buprenorphine and methadone under the demand reduction programme. Injecting users should be given needle exchange programme which will reduce the risk of contracting HIV and AIDS.

#### **e) Indigenous models of treatment**

In very few NGOs of the country, yoga techniques are profoundly inculcated in the de-addiction services. Ayurvedha, Siddha and Unani medicines are also used for de-addiction but in very few centres. The effectiveness of these services in no way can be underestimated when compared to the allopathic medicine. However Allopathic medicine is widely used for medical management of addiction across the country. The concerned ministry dealing with drug abuse in the nation should deploy more resources to research into the effect of indigenous medicines on addiction.

#### **Conclusion**

Drug policies around the world have proven to be largely ineffective in controlling the production of illegal narcotics. With very few exceptions, national

drug laws and policies seek primarily to punish illicit drug production, possession, use and even dependence. In the worst cases, drug users are made to be scapegoats for a wide range of social problems, and sanctions are vastly disproportionate to the supposed offenses. According to the 2010 World Drug Report there is currently more opium, more coca and more cannabis on the market than ever before. amphetamines are being produced on an alarming scale.

Not only have these policies been unsuccessful, they have had a broad range of destructive consequences for both individuals and society. Around the world, drug policy is characterized by heavy-handed and punitive law enforcement strategies absent of a public health or human rights framework. These policies have failed to reduce drug use and have exacerbated the spread of HIV and hepatitis C.

Legalization of drugs could pave a way for decrease in users involved in drug crimes as they are usually soft targets of drug mafias. The funds which Government spends for enforcement activities for dealing with drug offences will also decrease. Instead the funds can be used for treatment and rehabilitation of drug users and for preventive education and awareness for curbing initiation of new drug users. The Government of India should be able to curtail the criminalization approach towards drug users at the earliest.

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