Drug Abuse: *News-n-Views*

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EDITORIAL

Dear readers,

In this issue of our newsletter, Drug Abuse: *News-n-Views,* we are exploring the theme "Policy and Legal Aspects of drug abuse."

Psychoactive substances have always had a controversial position in the human civilisation. While use of these substances has always been a part of the human history, such use was always regulated and controlled by formal and informal means by the society.

In modern times the control on psychotropic substances at the international level started in the early decades of the 20th century. Gradually, these international efforts paved the way for what we see today as international drug control mechanism, of which most of the countries around the globe are a part. These international mechanisms have catalysed the formation of national level policy and regulatory frameworks, so that there is now a certain degree of uniformity around the globe regarding how various nations look at the problems related to psychoactive substances. Certain substances are uniformly banned around the world, while certain others are controlled and regulated. Professor Ray and colleagues have provided an overview of the international drug control mechanisms and their relevance to India in their article.

On the face of it, the international drug control mechanism appears to be working in a robust manner. Or at least the proclamations by those at the helm of affairs lead us to believe so. However, there is now growing evidence that the picture may not be so perfect. The statistics may be pointing that the drug problems are being controlled but the so called 'war-on-drugs' may

have – inadvertently – led to more harms than the drugs themselves.

In one of our previous issues (April 2008, 'Harm Reduction') we did raise the issue that a stringent drug-control regime may end up enhancing the harms caused by drugs. Indeed, it has been pointed out that the so called 'anti-opium policy' has led to an increase in usage of heroin smoking (by making opium dearer) and the 'anti-heroin policy' may be leading to an increase in injecting drug use (for the same reasons). The amount of resources spent by the international community in drug supply-control may not be cost-effective. In other words, as a result of narrow interpretations of international drug control conventions and laws, on one hand we are not making enough gains in terms of reducing the negative health, social and economic consequences of drugs. On the other hand the societal cost of drug abuse may actually be increasing. Indeed, UNODC, in a recent review has discussed the unintended adverse consequences the international drug control mechanism may have brought about:

1. *Creation of a criminal black market:* Making certain drugs illegal enhances the prices and makes black-marketing of these, a lucrative business
2. *Policy displacement*: allocating more resources to law enforcement at the cost of public health
3. *Geographical displacement*: tighter controls in one place produce an increase in drug market in another place
4. *Substance displacement:* tighter controls on one drug leads to an increased consumption of other similar drugs. There are indications that tighter control over street heroin in India may have forced some drug users to switch to using injecting pharmaceuticals (with far more adverse health consequences)
5. *Marginalization of drug users*: drug users are often criminalized, leading to a stigma, and difficulty in accessing treatment.

The implications for our country are even graver. India's national drug regulatory mechanism has been succinctly described by Mr. Rajiv Walia in this issue of newsletter. However, there remain many shortcomings in the Indian law related to drugs – the Narcotic Drugs and Psychotropic Substances (NDPS) Act – as argued by Ms. Tripti Tandon in her article. It is noteworthy that at this moment in India, we do not have a National Policy on drug abuse and its treatment. In the light of the facts that (a) we have been a country with long-standing, culturally-ingrained practices of using plant-based psychoactive substances (like opium and cannabis products), (b) we are the single largest producers of *licit* opium in the world, (c) we are surrounded by the regions with the large *illicit* production of opium and (d) we face an ever-increasing problem of drug use and related consequences, absence of a national policy stares us in the face like a huge gap.

Through this editorial we urge the authorities to take necessary steps. While details of how to go about formulating a national policy are beyond the scope of this newsletter, at least a few key points are worth mentioning. Such a policy should adequately address not just the supply side of drugs but the demand side as well. At present the drug treatment in India is poorly regulated and confusion abounds regarding what constitutes treatment; who should deliver it and how; who should monitor it and so on. Dr Rajesh Kumar has described the plight of NGOs supported by the Ministry of Social Justice and Empowerment in his article. Clearly, we need to enhance the number and quality of treatment services within a regulatory framework which is acceptable to all. Another issue pertaining to drug policy of India is that such a policy should be clearly directed at reducing the harmful consequences of drug use. It must be noted that the Constitution of India also calls for the "state to take measures for prohibition of intoxicating substances which are *injurious to health*" (italics added). In other words, discussing (and implementing) the principle of harm reduction is well within the ambit of the Constitution of India.

Yet another aspect is the involvement of stakeholders in the policy-formulation process. Very often people responsible for implementation or people directly affected by the policies are totally excluded from the policy formulation process.

We hope that we have succeeded in bringing some important issues forward for discussion. As usual, we look forward to your feedback, suggestions and comments.

B. M. Tripathi ***Atul Ambekar***

International Policy and Legal Framework: An Overview

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Historical Overview

The use of psychoactive substances has been occurring since ancient times and has been fairly well documented. Cannabis was used as early as 4000 B.C. in Central Asia and north-western and opium was used in Mesopotamia (today's Iraq) even earlier than 3000 B.C, and in ancient Greece, starting around 1,500 B.C.

In traditional societies, these drugs were used for both recreational and medicinal purposes (notably opium) and/ or as part of religious rites (cannabis). However, many cultures/religions denounced opium use and thus the consumption was mainly limited to medical use to treat pain in the form of *laudanum*, an alcoholic tincture of opium. In India, cannabis was used to treat various health conditions like rheumatism, migraine, malaria and cholera; facilitate surgical operations; relax nerves; restore appetite and for general well-being.

By the beginning of the 19th century, India was by far the world's largest opium producer. The British East India Company however, exported most of opium to China, the chief user of opium in the world. With opium use growing rampant, China's social and economic woes increased with each passing year. The Chinese authorities attempted to react to this by issuing ever stricter laws banning opium imports. This led to many Anglo-Chinese hostilities and China was finally forced to fully legalize the importation of opium. As a result, Opium imports from India further rose.

The legalization of opium imports proved devastating for China's economy. Finally, the Chinese authorities started allowing domestic farmers to grow opium poppy around 1880. This led to a huge Opium epidemic, so much so that at the beginning of the 20th century China was consuming 85 to 95% of the global opium supply.

The main impetus for the creation of an international drug control system arose from this large-scale trade of opium from India to China, rising domestic production in China and the emergence in China of the world's largest drug abuse problem.

The Emergence of an International Drug Control Consensus

The introduction of controls over the opium trade in the early twentieth century occurred due to an exceptional confluence of interests of three important nations at that time: China, Great Britain and the United States of America. The strongest voice against the rising tide of addiction came from nationalist circles in mainland China itself, which saw the opium trade as directly threatening China's ability to resist foreign influence. In Great Britain, the newly elected Liberal Government, strongly backed by the church-inspired anti-opium movement, began to reverse the pro-opium trade policies of previous Governments.

The USA was worried about spread of opium use within USA on one hand and also had a strong geo-political interest in improving relations with China on the other. Joining efforts with China to curb opium exports actually represented an opportunity to improve strained relations for the USA.

The Shanghai Opium Commission, 1909:
The first international conference to discuss the world's narcotics problem was convened in 1909 in Shanghai. The Commission provided an evidence base on the opiates trade for delegations and collected a large amount of data on cultivation, production and consumption. The conference revealed that China was the world's largest opium producer at the beginning of the 20th century (second largest being India). India was also the largest opium exporter at the time,

***(Editors 'note: Professor Ray is the member-elect of International Narcotics Control Board (2010-2013))**

exporting 82% of its total production, primarily to China.

The Hague Convention, 1912:
In the follow-up of the non-binding Shanghai Commission, the first legally binding convention took place in The Hague in 1912.

Parties to this 1912 Convention agreed to "control the production and distribution of opium and to impose limits on the manufacture and distribution of drugs; cooperate in order to restrict use and to enforce restriction efficiently; close opium dens; penalize possession; and prohibit selling to unauthorized persons."Additionally, the principle of drug use only for medical and scientific purposes was enshrined in international law for the first time.

However, there were limits to how far the Hague Convention actually went. Most producer countries objected to proposals to reduce cultivation. Thus, the convention only obliged the contracting powers to 'control' opium production, not to reduce it to medical and scientific use.

Drug control under the League of Nations, 1920-1945:
The peace treaties of 1919 (after the First World War) also laid the foundation for the League of Nations. By a resolution of the League of Nations, in 1920, the Opium Advisory Committee (OAC) was established to oversee the implementation of the Hague Opium Convention.

In 1925, two further international drug control agreements were concluded that gradually enforced a reduction (rather than control) of the opium cultivation. The first agreement stated that the signatory nations were, "fully determined to bring about the gradual and effective suppression of the manufacture of, internal trade in and use of prepared opium." The second agreement, the new International Opium Convention, or "1925 Convention," detailed the content of the Hague Convention, institutionalized the international control system and extended the scope of control to cannabis.

The 1925 Convention also established the Permanent Central Opium Board, the forerunner of the International Narcotics Control Board (INCB). The Permanent Central Opium Board was set up as an impartial body, whose members were experts who did not hold any office which would put them in a position of direct dependence on their Governments. The main task of this Board was to administer the statistical information sent by member states to Geneva and to "watch the course of the international trade."

Since the 1920s schedules have played a central role in drug control regulation and schedules have served as a key tool for negotiating the political, economic, medical, administrative, moral and bureaucratic interests and suffuse all determinations about licit availability of drugs.

Scheduling first appeared on the international stage as a result of negotiating that led to the 1931 Manufacturing Convention (League of Nations, 1931a, 1937). That treaty, in conjunction with the 1925 International Opium Convention (League of National 1925), created the basic structure for global drug control efforts. The regulatory system devised by the framers stipulated that supplies of potentially addicting but medicinally useful substances, such as morphine and codeine, should be limited to the amount necessary for medicinal and scientific/research purposes.
Amidst these economic, political, administrative, moral, and professional considerations, efforts to enact the delicate balance between limiting manufacture and ensuring adequate medicinal supplies at a reasonable price proved problematic. Delegates reached a compromise by creating a straightforward two-tiered regulatory structure (League of National 1931a, Article 1):

Group I
- Morphine and its salts
- Heroin and their salts
- Derivatives of morphine and heroin possessing the same essential chemical structure
- Cocaine and its salts
- Esthers of morphine (ecgonine, thebaine, and their salts, etc.) except codeine, ethylmorphine and their salts.

Group II
- Methylmorphine (codeine), ethylmorphine and their salts.

The creation of schedules introduced new incentives into calculations about the national/international commerce in drugs. Representatives of the manufacturers soon attempted to influence the scheduling recommendations of medical authorities. During 1930s and thereafter schedules became a key element in determining international control measures.

With regard to schedules and psychotropic drugs, most of these compounds were seen as addictive drugs that resembled opiates or cocoa. Because the definition of addiction was so closely tied to the opiate model, it took international medical and treatment communities many years to deal with the conceptual issues produced by newer drugs (psychotropic substances). In the latter half of 1960s international treaties were signed to regulate global flow of psychotropic.

Unfortunately, progress made on the licit side prompted the emergence of illicit activities and illicit trafficking and trade flourished. Concerns over the expansion of drug markets led to the 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs. This was the first treaty to explicitly focus on drug trafficking and the first to make certain drug offenses international crimes.

International Drug Control under the United Nations:

At the end of World War II, in 1946, the United Nations assumed the drug control functions and responsibilities formerly carried out by the League of Nations. The functions of the League's Advisory Committee were transferred to the United Nations' Commission on Narcotic Drugs (CND), established in 1946. The CND remains the central policy-making body within the United Nations system for dealing in depth with all questions related to drug control. The main control body, the International Narcotics Control Board (INCB), was established by the 1961 Convention on Narcotic Drugs.

In the years surrounding World War II a number of new synthetic narcotics were developed, including methadone, and pethidine which were in great demand. The newly formed CND soon concluded that there was a real danger that a large trade in these new dependence producing substances could develop if manufacture and trade remained unchecked. Thus the CND drafted a separate agreement (The 1948 Synthetic Narcotics Protocol) that required states to submit estimates of the new substances in the same way as for opium-based narcotics. The application of this Protocol allowed 20 new substances to come under the international control.

Another protocol – the 1953 Opium Protocol – was intended to limit opium production and use to medical and scientific needs. According to this Protocol, only seven countries Bulgaria, Greece, India, Iran, Turkey, the USSR and Yugoslavia – were authorized to produce opium for export. The Protocol also asked countries to implement comprehensive control systems at the national level.

These historical developments in the first half of the 20th century paved the way for the current international framework for drug control (Bayer, 2009)

Single Convention of 1961:

The complexity and number of the legal agreements on narcotic drugs (which with the 1953 Protocol had reached nine) created the need for unification and simplification. In an attempt to correct this, the 'Single' Convention was adopted in 1961. It superseded all previous protocols and conventions. With this convention, there was a historical turn in the philosophy of international drug control: it was decided that the traditional cannabis smoking, coca leaf chewing and opium eating should be considered as drug abuse, and these habits must be gradually eliminated. The selection of drugs for control was determined by this decision. As a consequence of that decision, drugs on the schedules of the 1961 Convention are primarily natural drugs in relationship with the following three plants: opium poppy *(Papaver somniferum)*, coca bush *(Erytroxylon coca)* and hemp *(Cannabis sativa)*. The cultivation of these plants is also subject to (at least partial) control.

Drugs under the control regime of the 1961 Convention can be divided into five categories:

- *Herbal products*: for ex. opium, coca leaf, cannabis resin

- *Active ingredients of plants (natural compounds)*: for ex. morphine, codeine, cocaine
- *Semi-synthetic compounds*: for ex. Heroin
- *Precursors**: for ex. thebaine (opiate precursor), ecgonine (cocaine precursor)-compounds that are convertible into compounds that can be used as medicines and/or recreational drugs (attention: compounds and not raw materials!)
- Synthetic Opioids: for ex. pethidine, methadone, fentanyl, which are analogues of natural and
- Semi-synthetic Opioids (opiates)

The Commentary to the 1961 Convention points out that the term 'for medical purposes' was not uniformly interpreted by governments. Some prohibited the consumption of narcotic drugs by all addicts, while others permitted consumption by persons whose addiction proved to be incurable to prevent painful withdrawal symptoms.

During the 1950s, concerns began to emerge about amphetamine and barbiturate abuse and the over-prescription of sedatives and hallucinogens. These issues were discussed by the World Health Organization (WHO) and by the Commission on Narcotic Drugs starting in the early 1960s. While there was agreement over the need to bring those substances under greater control, there was disagreement over whether to place them under the control of the 1961 Convention or create a new treaty. Ultimately, the **Convention on Psychotropic Substances of 1971** dealt with these heterogeneous drugs and called for a more stringent control.

1971 Convention

Among the drugs under the control regime of the 1971 Convention – diametrically opposed to the 1961 Convention – plant materials, herbal products or isolated plant ingredients cannot be found, and LSD is the only representative of semi-synthetic compounds. The majority of synthetic drugs on the schedules of the 1971 Convention are hallucinogens, amphetamine-type stimulants, hypno-sedatives or anxiolytics (first of all barbiturates and benzodiazepines). Surprisingly – following astonishing WHO recommendations – two synthetic Opioids (pentazocine and buprenorphine) have been put on the schedules of the 1971 Convention (instead of the 1961 Convention).

It can be concluded that the "drug list" of the 1971 Convention is the opposite of that of the 1961 Convention in three respects: 1) In the 1961 Convention, synthetic compounds are represented exclusively by synthetic Opioids, while natural compounds are practically missing from the 1971 Convention 2) In the 1961 Convention, plants and herbal products which contain narcotic drugs (for ex. morphine or cocaine) were put systematically under international control, in the 1971 Convention no plants or herbal materials were scheduled (despite the fact that magic mushrooms and cacti do contain psychotropic substances) 3) In the prevention oriented 1961 Convention - beside raw materials - precursors are under control, in the prevention hindering 1971 Convention the possibility of the scheduling of precursors is completely excluded.

1988 Convention

In the 1961 and 1971 Conventions substance control is the leading principle, in the case of the 1988 Convention this is just a complementary issue. The substances on the schedules of the 1988 Convention can be divided into two categories:

- Compounds that can be used as precursors of some psychotropic substances, and
- Reagents and solvents that can be used during the illicit production process of narcotic drugs and/or psychotropic substances

The omission committed in 1971 (neglect of the control of precursors of psychotropic substances) was corrected - with a delay of 17 years - in 1988. Unfortunately this was not achieved by the amendment of the 1971 Convention but by the insertion of these substances into a new convention (making the international drug control system even more complicated).

The 1981 International Drug Abuse Control Strategy:

Despite efforts made over the previous decades, sharp increases in drug abuse occurred in many countries towards the end of the 1970s. Taking this into consideration, the CND studied the possibilities of launching a comprehensive strategy to reduce international drug abuse. This resulted, in 1981, in the formulation of an International Drug Abuse Control Strategy.

The global influence of organized crime groups increased throughout the 1980s in-spite of all

international laws and so the "Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances" was called by UN in Vienna, in 1988. This convention was signed by almost all countries (99% of world population), and has proven to be a powerful instrument in the international fight against drug trafficking. The measures taken in compliance with the 1988 Convention were successful in dismantling some of the world's largest criminal networks in the first half of the 1990s.

At the same time, by the late 1990s the prospects for a drug free world appeared to be more distant than ever before. Although some of the large drug networks had been neutralized, drug trafficking was continuing at a high level, facilitated by a myriad of smaller, seemingly dispersed groups. The geo-political changes following the end of communism in Central and Eastern Europe also included increased drug consumption, notably among youth. Drug abuse also emerged as a serious social problem in many developing countries, notably in countries along the main transit routes. By the mid- 1990s, the international community felt that the levels of illicit drug production and consumption required an immediate and significant response. This response came in the form of the declaration of the **Special Session of the United Nations General Assembly (UNGASS) in 1998**.

One of the main achievements of the UNGASS process was the elaboration of a 'Declaration on the Guiding Principles of Drug Demand Reduction'. The main 'innovation' of these Guiding Principles was the recognition that demand reduction policies should not only aim at preventing the use of, but also at 'reducing the adverse consequences of' drug abuse. This has been interpreted by some experts as endorsement of the concept of "harm reduction." Indeed, the INCB also acknowledged in 1993 that harm reduction had a role to play as a tertiary prevention strategy.

Current International drug control mechanism

The three treaties: **The Single Convention on Narcotic Drugs, 1961; the 1971 Convention on Psychotropic Substances; and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances;** adopted under the aegis of the United Nations now govern the international drug control system, with the United Nations and its subsidiary bodies being the ultimate regulatory authority.

The Commission on Narcotic Drugs (CND) is the central policy-making body of the United Nations in drug related matters. The Commission enables Member States to analyse the global drug situation and to take measures at the global level within its scope of action. It also monitors the implementation of the three international drug control conventions and is empowered to consider all matters pertaining to the aim of the conventions, including the scheduling of substances to be brought under international control.

The International Narcotics Control Board (INCB) is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions. Broadly speaking, INCB deals with the following:

- As regards the licit manufacture of, trade in and use of drugs, INCB endeavours, in cooperation with Governments, to ensure that adequate supplies of drugs are available for medical and scientific uses and that the diversion of drugs from licit sources to illicit channels does not occur.
- INCB also monitors Governments' control over chemicals used in the illicit manufacture of drugs and assists them in preventing the diversion of these into the illicit traffic.
- As regards the illicit manufacture of, trafficking in and use of drugs, INCB identifies weaknesses in national and international control systems and contributes to correcting such situations.
- INCB is also responsible for assessing chemicals used in the illicit manufacture of drugs, in order to determine whether they should be placed under international control.

The control strategies are implemented worldwide by the UN under the United Nations Office on Drugs and Crime (UNODC). At the country level, the UNODC assists Governments in the preparation of national drug control master plans, that is, national agendas that address both illicit

demand and illicit supply reduction. The three major mandates of UNODC are:

- Technical cooperation to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism;
- Research and analytical work to increase knowledge and understanding of drugs and crime issues and expand the evidence base for policy and operational decisions;
- Normative work to assist member States in the ratification and implementation of the relevant international treaties, the development of domestic legislation on drugs, crime and terrorism, and the provision of secretariat and substantive services to the treaty-based and governing bodies.

Thus, the international drug control mechanism, despite a multitude of problems associated with an ever-changing world, continues to function in a robust manner. However, it is very difficult to say, what would have been the global drug situation, in the absence of this mechanism. Experts have analyzed the data and estimated that the combined prevalence rate for opiates, cocaine and ATS have *declined* by about 40% over the last century (UNODC 2009).

Drug Policy and India

National drug control legislation is in keeping with the requirements of the United Nations drug control conventions. This led to criminalization of drug use in certain instances, in the background of longstanding cultural sanctions for drug use; particularly those involving psychoactive plant products such as cannabis and opium. Such sanctioned cultural use, produces a situation wherein a drug's mind-altering properties are not the sole focus of drug use and related activities. Further, social sanction meant that there was no criminalisation of the drug or its use, thus drug use was not linked to illegal behaviour of its users. A similar situation is seen in present day alcohol users and heroin users where far more number of heroin user get drawn into illegal activities than alcohol users.

Finally, locally cultivated substances were cheap and hence economically sustainable, were of less potency and established modes of use caused less harm. For these reasons, the present drug control systems are often criticized for causing more harm than good.

The earliest voices of concern against prohibitive drug policy were raised as early as in 1893. In that year the British Government formed a Royal Commission on Opium to inquire whether poppy growing and the sale of opium should be prohibited in India. The Royal Commission concluded that prohibiting the non-medical use of opium was neither necessary nor wanted by Indians. Opium consumption in India did not constitute any dramatic abuse problem in India, nor did it cause, "extensive moral or physical degradation" as suggested by the clergy. The daily consumption for bulk of Indian opium users was less than one third of per capita opium consumption in china.

As a signatory to the UN 1961 Single Convention, Indian delegation at the UN had long objected to a proposed policy of international cannabis prohibition, but had made little headway against the massive, predominantly western and US-led, "anti-cannabis bloc." Fortunately, for widespread acceptance, the final draft of the Single Convention included so called grace periods for phasing out traditional drug use. This meant that the "quasi-medical use" of opium had to be abolished within 15 years of the Convention coming into force. Similarly, the non-medical or non-scientific use of cannabis was to be discontinued as soon as possible, "but in any case within 25 years" from the date the convention came into force.

Prior to the present drug control legislation, the focus of Indian drug policies was control of the drug trade and the collection of revenues through licensed sales. Due to India's international commitments, the Narcotics Drugs and Psychotropic Substances Act (NDPS) act was instituted 1985. In political terms, it was difficult for the government to tamper with popular religious and cultural feelings concerning the use of opium and cannabis. Mindful of international obligations regarding the UN grace period and the political sensitivity of the issue within the country, the NDPS Act was quietly put on to the statute books with little national debate (Charles et al, 1999).

As such, the legislation made many traditional forms of drug use a criminal act that could be punishable by imprisonment. The only provision for non-medical cultural use within the 1985 Act was that drinks made from cannabis leaves were to be sanctioned.

> One of the major gaps in the response of India to drug problems is absence of a single, coherent policy to deal with psychoactive drugs.

Strict enactment of NDPS Act, led to a significant increase in the arrests of low-level drug users over the subsequent years. In a study undertaken in 2001 in Tihar jail in Delhi, among 1,910 individuals arrested under the NDPS Act around 17 per cent were arrested under Section 27, i.e. for the possession of small quantities of drugs meant for personal consumption. While the law has provision for such arrestees to seek treatment instead of serving a sentence, the provision is rarely utilized in reality (Annuradha, 1999). Also due to the slow pace of the Indian judicial system, many of those arrested on drug charges spent years in jail before their cases came up for hearing (Annuradha, 2001; Charles et al, 1999). In some instances, it has meant that those caught with small quantities of drugs were eventually acquitted after spending years behind bars.

As a consequence of such criticisms, a reassessment of the Act in 2001 resulted in amendments relating to the length of imprisonment and the quantity and type of drug seized. This ensured that, where traditional drugs are concerned, only individuals with large quantities of cannabis can be arrested for drug trafficking and face imprisonment. Nonetheless, despite the efforts made to revise the Act, currently, any form of use remains a criminal offence, which can result in imprisonment for a period of six months

Over the last two decades the drug use pattern in India has changed significantly: A shift from the traditional drugs to use of high-potency drug use is being observed. Similarly urbanization resulted in increased drug use as urban communities. Abuse of pharmaceutical drugs (legal compounds) and through injectable route is of most change and worrisome. Children, who were hitherto unseen in the drug scenario, started using inhalants in large numbers. Over the later part of the last decade drug use has spread to rural areas of India as a secondary spread from the urban centres. These changes (like any other social change) are multi-factorial, but the question that begs asking is: whether some of our policies and laws inadvertently facilitated this shift to harder forms of drugs and riskier modes of consumption in Indian population?

Drug Policy and India: The future

There are different arms of the government which look at problems related to drugs with different perspectives: the control on illicit drug trafficking and its production, as well as coordination with international agencies is the responsibility of the Ministry of Home Affairs. Legal production of opium is looked-after by the Department of Revenue (Ministry of Finance). Rehabilitation and counselling of addicts is the responsibility of Ministry of Social Justice & Empowerment. Demand reduction by way of treatment and after care is the concern of Ministry of Health & Family Welfare. As it often happens coordination is often lacking.

Consequently, it is very important for the country to come up with a broad-based policy related to use of psychoactive substances. In order for the policy to be acceptable and implementable it would be extremely necessary to involve all possible stakeholders in the policy formulation process. Further the cultural and social scenario as well as the challenges posed by economic development and globalization should also be taken into account. (rayrajat2004@yahoo.co.in)

National Drug Regulatory Framework

Rajiv Walia, United Nations Office on Drugs and Crime, New Delhi

In India, the National policy on Narcotic Drugs and Psychotropic Substances is based on the directive principles contained in Article 47 of the Indian Constitution which directs that the "State shall endeavor to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drugs injurious to health." The government's policy flows from the above constitutional provision and is also guided by the three UN Conventions to which India is a signatory, namely,Single Convention in Narcotics drugs 1961 as amended by the 1972 Protocol, Convention on Psychotropic Substances, 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988

The broad legislative policy is contained in the three Central Acts, namely,

- Narcotic Drugs and Psychotropic Substances Act, 1985 as amended
- The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988
- Drugs and Cosmetics Act 1940 as amended

The Narcotic Drugs and Psychotropic Substances Act 1985 (NDPS Act) which came into effect from 14 November 1985, sets out the statutory framework for drug law enforcement in India. This Act consolidates the erstwhile principal Acts, viz. the Opium Act 1857, the Opium Act 1878 and the Dangerous Drugs Act, 1930. The NDPS Act also incorporates provisions designed to implement India's obligations under various International Conventions.

Certain significant amendments were made in the Act in 1989 to provide for the forfeiture of property derived from drug trafficking and for control over chemicals and substances used in the manufacture of narcotic drugs and psychotropic substances. In order to give effect to the statutory provisions relating to these substances, an order, namely the N.D.P.S. (Regulation of Controlled Substances) Order, was promulgated by the Government of India in 1993 to control, regulate and monitor the manufacture, distribution, import, export, transportation etc of any substance which the Government may declare to be a 'controlled substance' under the Act.

The statutory regime in India consequently covers drug trafficking, drug related assets as well as substances which can be used, in the manufacture of narcotic drugs and psychotropic substances.

Further amendments were incorporated in the NDPS Act in 2001, mainly to introduce a graded punishment structure.

The NDPS Act provided for constituting a Central authority for the purpose of exercising the powers and functions of the Central Government under the Act. In exercise of the powers, the **Narcotics Control Bureau** was constituted in the year 1986.

The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988 was earlier promulgated as an Ordinance on 4 July 1988 which subsequently became a law in August 1988. This is an Act to provide for detention in certain cases for the purpose of preventing illicit traffic in narcotic drugs and psychotropic substances and for matters connected therewith. While specific contraventions of the NDPS Act are dealt with by prosecutions in Court, some situations may arise where preventive detention may be found necessary to prevent the continued illegal activities of the persons concerned.

The Drugs and Cosmetic Act governs, inter alia, the licensing and regulation of medicines containing narcotic drugs and psychotropic substances which are specified under the Schedules of the NDPS Act.

The responsibility to administer these acts also resides with different ministries of the Government. The Department of Revenue under the Ministry of Finance administers the Narcotic Drugs and Psychotropic Substances Act, 1985 and The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988. The

Ministry of Health administers the Drugs and Cosmetic Act, 1940.

India is one of the largest licit producers and exporter of opium in the world. The Central Bureau of Narcotics (CBN) headed by the Narcotics Commissioner supervises the control system over licit cultivation of poppy and production of opium. It is also the licensing authority authorizing import/ export of narcotic drugs, psychotropic substances and controlled substances (precursor chemicals).

"Often major traffickers are not brought to the book and offenders escape from the clutches of the law."

The Narcotics Control Bureau (NCB), under the Ministry of Home Affairs, is the national nodal agency to coordinate drug law enforcement. Various central and state agencies have been empowered under the NDPS Act. These include the Central Bureau of Narcotics, Customs, Central Excise, Directorate of Revenue Intelligence (DRI), Border Security Force (BSF), Coast Guard, Sashastra Seema Bal (SSB), Central Bureau of Investigation (CBI) and State Police, Excise and Forest authorities etc.

A multi agency approach is therefore, adopted in India to combat drug trafficking. The role of various agencies is complimentary to each other. The primary counter narcotics focus areas in the country include:

- Surveillance and enforcement at import points and land borders
- Preventive and interdiction efforts along known drug routes
- Control measures at export points, such as air-passenger terminals, cargo terminals and foreign post offices
- Identification and eradication of illicit cultivation and the wild growth of cannabis and the opium poppy
- Improved co-ordination between the various drug law enforcement agencies
- Strengthening of the intelligence apparatus to improve the collection, collation, analysis and dissemination of operational intelligence
- Increased regional and international co-operation, both in operational and long term intelligence as well as in investigations and mutual legal assistance

"The NDPS Act needs to be strengthened to take care of illegal activities on the internet.."

Majority of the drug offence cases are booked by Police, while cases having regional and international ramifications are booked by the NCB and DRI.

Often major traffickers are not brought to the book and offenders escape from the clutches of the law on technical and procedural grounds. Uniformity in procedures adopted by agencies in implementing the provisions of the NDPS Act is the key to success in attaining conviction. Therefore, sensitization of drug law enforcement officers on the laws, rules and regulations is essential in improving the conviction rate in drug offence cases.

Among the new trends that need to be watched and monitored is the emergence of Online pharmacies that source drugs from countries like India. Online pharmacies are normally based outside the country. The modus operandi is for customers to log on to these internet pharmacies, place orders for drugs and make payment through credit cards. The drugs for which orders are normally placed usually are psychotropic substances or pharmaceutical preparations containing narcotic drugs or psychotropic substances. The managers of the Online pharmacies thereafter, procure these drugs and courier them to their customers.

The NDPS Act bars any narcotic or psychotropic drug from being dispatched by post. The sale of such drugs is also regulated under the Drugs and Cosmetics Act whose provisions are not complied with during the online transaction. All these and other factors are relevant when the sourcing of these drugs is from India. The NDPS Act needs to be strengthened to take care of illegal activities on the internet.

An emerging threat is the increased availability of synthetic drugs (ATS – Amphetamine Type

Stimulants). Of greater concern are the repeated attempts to set up clandestine facilities for illegal manufacture of these drugs in India. Over the last few years, the Narcotics Control Bureau has neutralized half a dozen such manufacturing facilities. A feature of these clandestine laboratories is the involvement of outsiders (non Indians) in almost all cases.

In this context, regional and international cooperation is important. Drugs do not recognize national borders. The fight against drugs is therefore, to be fought by all countries.
(*Rajiv.WALIA@unodc.org*)

Events and Announcements

Workshop to disseminate findings of PMS of Buprenorphine-Naloxone combination

A one-day workshop was recently organized at AIIMS, New Delhi to disseminate the findings of the study, 'Post-Marketing Surveillance of Buprenorphine-Naloxone combination.' The event was attended by over 100 professionals throughout the country; additionally drug-dependence treatment experts from USA also participated. The major finding of the study was that this combination has been found to be safe. Implications for making this treatment widely available in India (as an 'office-based practice') were discussed.

Doctors Training on drug-dependence treatment at Bilaspur

A training programme for doctors working in Government sector at District Bilaspur, Chattisgarh was organized in October 2009. This event was a part of the NDDTC, AIIMS project 'community based project to enhance substance use services' being implemented at four districts in the country in collaboration with the local administration and the Ministry of Health and Family Welfare.

Did you like this issue of **Drug Abuse: *News and Views*?** Do you have something to tell us? Your suggestions and feedback are valuable to us.

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Reclaiming drug treatment as a right

Tripti Tandon, Lawyers Collective HIV/AIDS Unit, Delhi

It is now well accepted that drug dependence is a medical condition, classified as a "*multi-factorial health disorder that often follows the course of a relapsing and remitting chronic disease*".[1] It is then imperative that health interests be central to the response to drug use. Although drug policy in India provides for treatment, it is not prioritised in enforcement. This article critically examines the legal framework for drug treatment and offers suggestions to "work" the same in order to make treatment *real and rightful.*

Drug control in India

The first legislations regulating narcotics in India were the **Opium Acts of 1857 and 1878**, which introduced licensing for cultivation and trading in poppy with a view to consolidate the British colonial government's commercial interests from the profitable opium trade. In keeping with social norms that allowed the use of cannabis and opium, the government allowed opium supply through legal outlets.[2] The practice, which finds mention in current legislation, bears semblance with present day agonist maintenance programmes where drug dependent persons are provided opiate substitutes under clinical supervision.

In 1930, the **Dangerous Drugs Act** was enacted to extend government controls to coca and cannabis besides opium. Notwithstanding proscriptions on drug related activities under the law, use and possession for personal consumption were exempt from penalties.

The **Narcotic Drugs and Psychotropic Substances Act** (hereinafter "NDPS Act") was introduced in 1985, overriding earlier legislations. It lays down a strict criminal regime around narcotic and psychotropic drugs including controls over cultivation, delivery and use. The clampdown on traditionally used substances, that is, cannabis and opium under the NDPS Act in the late 1980's is believed to have triggered a pattern of shifting to use of more dangerous drugs – such as chasing and injecting heroin.[3] The Act has been amended twice – in 1989 and 2001.

Legislative changes in 2001 rationalized sentencing for possession of drugs. Prior to 2001, a drug user could be sentenced to ten years and a hefty fine for possession of small amounts is s/he was unable to establish that the drug was for personal consumption. The Supreme Court's criticism of harsh and disproportionate penalties[4] against drug users led the legislature to fix penalty on the basis of the amount of drug in possession,[5] irrespective of intention to use or sell. Currently, (under the Sections 21 and 22, NDPS Act, 1985) the punishment for *possession* of small quantity of drugs is imprisonment for a maximum of six months imprisonment or a fine of Rs 10,000. *Consumption* is a separate offence, punishable with a maximum of six months to one year sentence, depending on the drug consumed (Section 27, NDPS Act 1985).

Despite the punitive mandate, concern for persons using drugs and treatment for drug dependence figured consistently in legislative debates on the NDPS Act, as seen in the statement by a member of parliament: "…. they [„addicts"] are victims and there is no law in the world *where I have heard that a victim* or patient is punished."[6]

[1] UNODC and WHO, Principles of Drug Dependence Treatment, Discussion Paper, March 2008.
[2] Molly Charles, Dave-Bewley-Taylor, Amanda Neidpath, Drug Policy in India: Compounding Harm? Briefing Paper Ten, The Beckley Foundation Drug Policy Programme, October 2005.
[3] UNAIDS and UNODCCP, Drug Use and HIV Vulnerability: Policy Research Study in Asia, Task force on drug use and HIV vulnerability, October 2000.
[4] See, Raju v. State of Kerala AIR 1999 SC 2139 where the appellant was sentenced to ten years imprisonment and fined Rs 1 lakh fine for possession of mere 100 mg heroin worth Rs 25. Lower courts' considered absence of withdrawal as evidence that the accused was not drug dependent and therefore held that the drug was not meant for own use. Reducing the sentence to possession for personal use, the Supreme Court held that such a small quantity of heroin could not have been meant for sale.
[5] Notification specifying small quantity and commercial quantity vide S.O 1055 (E) dated 19th October 2001.
[6] Lok Sabha, Legislative Debates, NDPS Amendment Bill, 1988

Drug control objectives are then interlaced with care and concern for those dependent on drugs.

Legal provisions related to treatment

With respect to health, the NDPS Act and Rules there under provide for: (1) use of narcotic and psychotropic substances for medical reasons, (2) treatment of persons dependent on such substances and, (3) administration of such substances in treating drug dependence.

The table below summarises provisions related to treatment for drug dependence under the NDPS Act and Rules:

Section	Summary
2 (a)	Defines "addict" as a person who has dependence on any narcotic drug or psychotropic substance
4 (2) (d)	Directs the Central Government to take measures for identification, treatment, education, after care, rehabilitation and social reintegration of persons dependent on drugs
4 (3)	Permits the Central Government to constitute authorities to undertake the above
7 A	Enables the Central Government to set up a national fund to meet expenditure towards identification, treatment and rehabilitation and provision of drugs to dependent persons where such supply is a medical necessity
10 (1) (vi)	Authorises State Governments to regulate possession of medically prescribed opium for personal use by registered "addicts"
39	Empowers Court to, in lieu of sentencing, divert "addicts", convicted for consumption or offence involving a small quantity of drugs, to a government recognized medical facility for detoxification
64 A	Entitles a drug dependent person, charged with consumption or offence involving a small quantity of drugs, to undergo treatment at centres maintained or recognised by government and be exempt from prosecution
71 (1)	Allows Government, to establish centres for identification, treatment and care of drug dependent persons and to ensure supply of any narcotic drug and psychotropic substance to "addicts" registered with government and to others, where provision of such drugs is a medical necessity
71 (2)	Authorizes Government to make rules providing for: - establishment, appointment, maintenance and superintendence of treatment centres - supply of narcotic drugs and psychotropic substances at treatment centres and, - for the appointment, training, powers, duties and persons employed in such centres
76 (2) (f)	Authorizes the Central Government to make rules for the establishment, appointment, maintenance, management and superintendence of centres established by it under Section 71(1) and for appointment, training, powers and duties of persons employed at such centres
78 (2)(a)	Authorizes State Governments to regulate the manner in which narcotic drugs and psychotropic substances shall be supplied to registered "addicts" and others in medical need
78 (2) (b)	Authorizes State Governments to frame rules for establishment, maintenance, management and superintendence of centres set up under Section 71(1) and appointment, training, powers and duties of persons employed at such centres
Rule 67 A (a) and (c) NDPS Rules	Allows use of narcotic drug and psychotropic substances: - by foreign nationals on medical advice - for "de-addiction" of drug dependent persons by Government or voluntary organization or other institution approved by the Central Government

Though guided by prohibition, the NDPS Act does provide room to accommodate use of drugs, in medical as well as non-medical contexts. Through their rule making powers, the Central and State Governments can prescribe conditions for supplying narcotic and psychotropic drugs to a select class of persons, which include patients, foreign nationals, registered "addicts" and persons undergoing treatment for drug dependence. In the latter category, the NDPS Act supports treatment both as an *alternative to*, and *independent of* penal measures. Arguably, for drug users, addiction treatment is part of the right to health, which the Supreme Court has recognized within the constitutional guarantee of life and liberty[7] and international

"The NDPS Act supports treatment both as an *alternative to*, and *independent of* penal measures."

[7] Paschim BanagKhet Samity v. State of West Bengal (1996) 4 SCC 37

human rights law.[8] Treatment provision must then be guided by principles of *non-discrimination, participation*, *quality* and *evidence informed standards* that characterize the right to health.[9]

Enforcement of drug treatment provisions

Treatment sections under the NDPS Act have been implemented in varying degrees of scale and scope.

National Fund:

A National Fund for Control of Drug Abuse was established in May 1989. Rules for its administration were notified almost twenty years later, in 2006.[10] The fund can receive contributions from the Central Government, individual donors and proceeds from the sale of property forfeited from drug trafficking. Both NGOs and government departments are eligible to make requests for grants for drug control activities including treatment. Till date, amounts, if any, disbursed from the fund for drug treatment, are not known.

TREATMENT CENTRES:

The mainstay of drug treatment delivery are ***"de-addiction"*** centres, which, according to the NDPS Act, may be set up by the Central or State governments or by voluntary organizations with government approval. Another legislation that regulates treatment is the **Mental Health Act, 1987**, which mandates the establishment of special institutions for persons addicted to alcohol and other drugs that cause behavioural changes.[11] This statute and rules framed under it set out an onerous system of licensing of private institutions that offer such treatment.[12]

> "Drug treatment in India largely remains unregulated, placing the health and safety of patients at risk."

Presently, services for drug dependence are offered through:

- Government hospitals that provide inpatient and outpatient care, mostly detoxification.
- NGOs, who receive grants from the Ministry of Social Justice and Empowerment (MOSJE) and their state counterparts – Departments of Social Welfare to run integrated rehabilitation centres for "addicts". There is greater emphasis on psycho-social interventions in order to make "*addicts drug free, crime free and gainfully employed*".[13]
- Psychiatric hospitals or nursing homes, operating privately, under license by the Mental Health Authority. These institutions offer a range of psychiatric services besides addiction treatment
- Private "de-addiction" centres that operate without registration or license and reportedly charge anything between Rs 3,000 to 7,000, from addicts' or their families.

Problems in the legal issues surrounding drug treatment centres in India

a) Silent on standards

Notwithstanding statutory provisions, drug treatment in India largely remains unregulated, placing the health and safety of patients at risk.[14] With the exception of some reputed institutions, most centres do not follow sound clinical practices; instead, utilize outmoded and unscientific methods. There is no standardized care; anything and everything is called treatment. In some parts of the country, many faith based centres run on the belief that God, not medicines will help "addicts". In Punjab, where drug dependence has reached enormous proportions, numerous "clinics" have opened up to cash in on the desperation of persons who use

[8] See International Covenant on Economic, Social and Cultural Rights, Article 12.
[9] See General Comment No. 14 to Article 12 of International Covenant on Economic, Social and Cultural Rights.
[10] Notification No. G.S.R. 177(E), New Delhi, 24th March 2006, Ministry of Finance (Department of Revenue) (Narcotics Control Division), Narcotic Drugs and Psychotropic Substances (National Fund for Control of Drug Abuse) Rules, 2006.
[11] Section 5 (1) (b), The Mental Health Act, 1987
[12] Rule 22, State Mental Health Rules, 1990

[13] Ministry of Social Justice and Empowerment, Government of India, Central Sector Scheme of Assistance for Prevention of Alcoholism and Substance (Drugs) Abuse and for Social Defence Services [Effective From 1st October 2008].
[14] EDITORS' NOTE: For a discussion on this, also see Drug Abuse: News-N-Views (Minimum Standards of Care), April 2007

drugs and their families.[15] Instead of medical care, "punishments" are meted out to rid patients of addiction.[16] Physical isolation, chaining, electric shocks, beatings, forced labour, denial of meals, other cruel and inhuman behaviour are commonly practiced at such unauthorized centres. Many drug users have reportedly died because of physical torture and/or lack of timely medical attention.[17]

b) No monitoring

Existing guidelines[18] are sketchy; they elaborate neither clinical nor human rights standards in managing drug dependence. Further still, they are operational codes and not statutorily binding on private centres. Legally, confusion prevails over whether drug dependence treatment is governed by the NDPS or the Mental Health Act[19]. Systems for review and oversight are non-existent; evaluation of NGO centres is limited in scope to grant and/or renewal of funding. The effectiveness of psychosocial interventions supported by MSJE has not been scientifically evaluated till date.

c) Absence of evidence based therapy

The world over, opioid dependence is effectively managed with medicines like Methadone and Buprenorphine – that are on the World Health Orgainsation's list of essential drugs. Barring premier centres like the National Drug Dependence Treatment Centre at the All India Institute of Medical Sciences, most government centres do not offer such treatment and stick to abstinence based models. Currently, a small number of injecting drug users receive sublingual Buprenorphine for a limited duration under the National AIDS Control Programme III. Withholding clinically proven medical therapy from millions of opiate users in the country is *indeed questionable.*

"Withholding clinically proven medical therapy from millions of opiate users in the country is indeed questionable."

As explained above, the NDPS Act allows the medical use of narcotic and psychotropic substances. It also supports the provision of opiates to drug dependent persons as part of medical care. Drug control agencies must abandon their restrictive understanding of treatment as "de-addiction." Instead, Governments must be encouraged to make use of flexibilities within the law to provide quality and evidence based treatment to discharge its Constitutional obligation to safeguard the right to health of all persons including persons dependent on drugs.

DIVERSION FROM PRISON TO TREATMENT:

The NDPS Act (Section 39) confers powers on the Court to direct "addicts" convicted for certain low-grade offences to treatment. Instead of sentencing a drug dependent offender to jail, the Court can, after assessing her/his background and health status and obtaining consent, remand her/him to a treatment facility maintained or recognized by the Government. Treatment access is contingent upon undertaking an oath not to commit drug related offences including use and submission of medical reports (The NDPS [Execution of Bond by Convicts or addicts] Rules, 1985). On completion of treatment, the Court may defer the sentence and release the offender on a bond.

Till date, few drug dependent persons, if any, have benefited from this provision. Neither the government nor judicial authorities have framed protocols, without which Magistrates are reluctant to transfer drug dependent offenders to medical care. Further still, Courts are not provided with a list of recognized drug treatment facilities and often, do not know where to refer the user. Unlike other jurisdictions, Courts in India do not elicit support of medical and social workers, who are critical to drug treatment. Given the relapsing nature of dependence, insistence on abstinence for a judicially determined period is both unsound and impractical.

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[15] Priya Yadav, Drug addicts open to fraud, Times News Network, 24 Feb 2008

[16] De-addiction centre inmates tortured, Tribune News Services, August 8, 2003.

[17] Mystery shrouds death of drug addict, The Hindu, August 25, 2008.

[18] Ministry of Social Justice and Empowerment, Government of India, Manual on Minimum Standards of Services for the Programmes under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse, March 2009.

[19] EDITORS' NOTE: See the article in this issue by Rajesh Kumar and Zeenat Naqati too

There is an urgent need for drug treatment and law authorities to collaborate and develop mechanisms to "work" this provision. Assistance may be sought from enforcement officials, lawyers and drug user groups whose practical insights can help create diversion programmes that are pragmatic and client friendly.

ENROLMENT IN TREATMENT AND PROTECTION FROM PROSECUTION:

Drug dependent persons who opt for medical treatment are entitled to relief from prosecution, provided the charge is that of consumption or involves a minor quantity of drugs (Section 64 A, NDPS Act, 1985). For people who use drugs, this provision depenalises personal use and possession of small amounts on the condition that they accept and complete treatment. Criminal proceedings may be reinstated if treatment is left halfway.

"There is an urgent need for drug treatment and law authorities to collaborate."

The application of this clause is, however, fraught with ambiguities. Unlike Section 64 which confers powers on the Central or State Government to tender immunity to accused persons who offer to assist the State in prosecuting drug offences, this provision does not specify which authority – the executive or judiciary, can waive criminal proceedings. Recent cases indicate that it is the latter.[20] In *Shaji vs. Kerala State*[21], the Kerala High Court ruled:

> "*whether a person is entitled to the immunity provided in Section 64A of the Act, being a person undergoing treatment for de-addiction, is a matter to be specifically urged and proved by production of sufficient evidence by the person concerned.*"

In holding that addiction be proved to the Court's satisfaction, the decision may be undermining the legislative intent of the section, which is to discourage criminalization of drug dependent persons and encourage treatment seeking. Being beneficent in nature, the provision ought to be construed *liberally* and *not strictly*.[22] Further, seeking Court's permission will only delay entry in treatment. Another drawback is the restricted application to "addicts"; first time users cannot be exempted from punishment, unless they falsely testify as being drug dependent. This flies in the face of reason and good practice, which demands that, naïve/experimental users be educated on drug use and related harms. By committing such persons to prison, the system is blighting more lives and futures than drugs themselves.

If access to drug treatment is constricted by Courts; poor users, who rarely have legal representation, will remain bereft of remedial measures. Once again, law enforcement and drug control agencies must work with drug users and health providers to ensure wider application and benefits of this provision.

Drug treatment must be given its due...

Being a criminal statute, welfare provisions of the NDPS Act have remained under-emphasized. Over the last two decades, drug law enforcement has relegated treatment to a mere paper provision. This must change. Statutory sections beneficial to persons who use drugs are as much a part of drug policy as those proscribing drugs. The vigour in enforcing penal procedures must also be seen in applying measures that support the health and rights of people who use drugs. The need of the hour is for concerned authorities to deliberate, together with people who use drugs, on mechanisms that affirm voluntary and effective treatment as an *important* and *legitimate* constituent of drug policy.

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[20] Fardeen Feroz Khan v. Union of India, (2007) 3 Mah LJ 782

[21] 2004 (3) KLT 270

[22] It is a settled principle of law that welfare provisions, which, in this case, imply access to drug treatment, be interpreted widely in favour of the class of persons for whose benefit the statute is enacted. Penal provisions, on the other hand, are to be construed strictly so as to keep the burden imposed within the letter of the law.

Mental Health Act is a hindrance to Drug Treatment

Rajesh Kumar, SPYM, New Delhi

Introduction

The scheme of Ministry of Social Justice and Empowerment (MSJE) to provide financial assistance to support NGOs to provide treatment of addiction was initiated in the year 1987. The scheme was based on the belief that the problem of addiction should be addressed in its totality. This includes prevention efforts, creating awareness, early identification, treatment and rehabilitation, sustained follow-up care, and also involving and mobilising the community. In the year 2001, 'Minimum Standards of Care' initiated and developed by FINGODAP with the approval of MSJE were implemented, to improve the quality of treatment delivery.

To date the MSJE has provided Rs 22 crore worth of grants to 480 centres across India, through the recently updated "**Central Sector Scheme of Assistance for Prevention of Alcoholism and Substance (Drug) Abuse and for Social Defense Services, Effective from 1st October 2008**". This Scheme encourages the voluntary sector to help rescue citizens from addiction to alcohol and drugs, through establishment of **Integrated Rehabilitation Centres for Addicts (IRCAs).**

Alcoholics and drug addicts are high risk group for HIV-AIDS. Hence, creating awareness, prevention and referral to other NGOs to tackle the issue of HIV-AIDS is another priority. To deal with multi faceted problems of alcohol and drug users, networking with other NGOs who are offering allied services is an important aspect of the scheme.

Integrated Rehabilitation Centres for Addicts

There are a number of de-addiction centres established and run by non-governmental organisations that work with alcoholics and drug addicts to treat them and try and cure them of this illness. These centres aim at helping the drug user to:

- Achieve total abstinence – a drug free life
- Whole person recovery (WPR) indicates improving the quality of their lives by helping them to
    - identify and deal with personality defects
    - strengthen inter-personal relationships
    - develop healthy work ethics and financial management
    - develop healthy recreational activities
    - establish a crime free life
- Become aware of risk factors for relapse and develop positive coping skills to sustain their recovery through follow-up services

Additionally, they also provide guidelines to family members to break out of the 'victim mould' and emerge as strong survivors, to deal with their problems and improve the quality of their lives.

Mental Health Act confines scope of drug treatment

Under the provisions of the Mental Health Act, 1987 a psychiatric hospital or nursing home means 'a hospital/nursing home including a convalescent home established or maintained by the government or any other person for the treatment and care of mentally ill persons'. This does not include a general hospital/nursing home established or maintained by the government and which also provides psychiatric services.

Section 2 (I) of the Act defines "mentally ill" persons as persons who is in need of treatment by reason of any mental disorder other than the mental retardation.

Chapter III of the Act deals with psychiatric hospitals and psychiatric nursing homes. In the **Section 5** of the chapter it is stated that the central or state government may, establish or maintain such hospitals or nursing home for the admission, treatment and care of mentally ill persons at such places it as it thinks fit. Separate

psychiatric hospitals and psychiatric nursing homes may be established or maintained for those who are under the age of sixteen years, those who are addicted to alcohol or other drugs which lead to *behavioral change* in a person, those who have been convicted of any offense and those belonging to such other class or category of persons as may be prescribed.

Section 6 of the chapter states that on and after commencement of this Act, no person shall establish or maintain a psychiatric hospital or psychiatric nursing home unless he holds a valid license granted to him under the Act.

Thus, it must be understood that the de-addiction centres functioning under MSJE, Govt., of India scheme **do not provide treatment services to "mentally ill" persons** as defined by the Act. Further, such de-addiction centres will not fall under the classification of Psychiatric hospitals or nursing homes as defined under the act for the following reasons:

- NGOs that run de-addiction centres treating drug addicts and alcoholics do not admit and treat patients that are mentally ill or patients that have primary psychiatric problems. These de-addiction centres refer such patients to psychiatric hospitals or nursing homes.
- The de-addiction centres focus on patients whose primary problem is alcoholism or drug addiction. Therefore, the focus of treatment is to deal with addiction.
- The nature of admission and treatment in case of mentally ill persons differs from that of alcoholics and drug addicts. Unlike "mentally ill" persons, drug addicts and alcoholics admit themselves voluntarily into the de-addiction centres.
- In these centres, the kinds of therapies involved are :
    a. Medical help/detoxification to deal with withdrawal symptoms and related medical problems
    b. Therapy focussed on helping the addict to give up alcohol/drugs completely and to make positive changes to improve the quality of life. These goals are achieved through providing individual counselling, group therapy, re-educative sessions and self-help programmes
    c. Family members are also given therapy to help them deal with their emotions (through counselling and group therapy
- Since 1987, more than 300 NGOs that run de-addiction centres have been functioning well and providing treatment to alcoholics and drug addicts. These centres are functioning under the MSJE instead of the Ministry of Health & Family Welfare.
- Only a small percentage of addicts may have psychiatric problems or dual-diagnosis disorders. So it is this small percentage of patients that may need custodial care. Such patients are referred to psychiatric nursing homes /hospitals and are not dealt by the de-addiction centres.
- Many Mentally ill people have no insight. But while the addicts may deny or minimize the problem, they do have an insight.
- In all NGO de-addiction centres, the focus is on helping the addicts give up drugs and alcohol as well as on improving the quality of their lives. This falls under the purview of rehabilitation. Hence, medical help is minimal and more support is given in the form of psychological therapy. In many centres, homeopathy, ayurveda and acupuncture are also practiced as part of therapy.

Problems faced by the Drug De-addiction and Rehabilitation Centres

It has been brought to our attention through FINGODAP network that many MSJE supported de-addiction centres have been facing difficulties since many authorities insist that such centres fall under the purview of the Mental Health Act. We present just two brief examples of such instances.

Example from Karnataka –

The Bangalore police have conducted raids on IRCAs, and closed down some centers for not having licenses under the MH Act. The Tehmina Sidhwa Trust's Self-Help Centre was similarly raided on 3.3.2009 and an FIR 16/2009 dt 3.3.09 was filed in the AMMC Court No 11 on 4.3.09. One of their paid counselors was arrested and subsequently released on bail. Two lady Founder-Trustees apprehend similar treatment.

Example from Punjab –
Kiran Foundation, an NGO established a de-addiction Centre in the name of Navjeevan Drug Couselling and Rehabilitation Centre (for brevity 'the Centre'), under the scheme of MSJE. The NGO has submitted a writ for issuance of a writ in the nature of certiorari/Mandamus for directing the Director, Health and Family Welfare, Punjab, Chandigarh, Sr Superintendent of Police, Punjab, Amritsar to provide protection to the society and its staff, so as to enable them to run the Navjeevan Drug Counseling and Rehabilitation Centre, Tehsil and District Amritsar

On 6.6.2007 an anonymous complaint was made against the Centre, which was investigated by Deputy Superintendent of Police, Sadar, Amritsar. In his report dated 16.7.2007 he has recorded a finding of fact that the Centre is a double storey building constructed in 450 square yards, which is comprised of three hall rooms, two rooms for residence purpose in which attached bathrooms and toilets have been constructed. For patients, even special air-coolers have been fitted with a special arrangement of generator also. The report further points out that for the treatment of patients, two doctors have also been employed. In the Centre, 60 patients were found admitted and on enquiry from them, it was also found that the drug addicted patients were properly treated as all the facilities are being provided. Even statements of admitted patients were recorded which were attached with the report. The complainant, Iqbal Singh, was sought to be associated with the enquiry but he had given wrong address resulting in his non-joining. The Police has concluded that false complaints have been made for harassing the owner of Kiran Foundation unnecessarily. He further recommended consigning the complaint to record.

Thus, these two examples go on to show that due to lack of clarity at different levels regarding the implications of the Mental Health Act, NGOs under the MSJE and patients who receive treatment from them are being harassed unnecessarily. This should stop. There certainly are many private centres who proclaim themselves to be 'de-addiction centres' but which have not been recognized by any authority. Such centres should certainly be brought under the purview of relevant laws. But the MSJE supported de-addiction centres clearly lay outside the purview of the Mental Health Act.

Conclusion

The most important principle of an effective drug treatment programme is to attend the multiple needs of the individual and not just his/her drug abuse. Medically assisted detoxification is only the first stage of addiction treatment and by itself does not do much to alter the long term drug abuse. We must not forget that addiction is a complex but treatable disease and therefore, the individual needs to remain in the treatment for an adequate period of time. Also since, drug use during treatment needs monitoring continuously so as to avoid relapses.

Clearly, the de-addiction centres established and run by NGOs under the aegis of Ministry of Social Justice & Empowerment do not fall under the purview of psychiatric hospitals or psychiatric nursing homes as defined under the Mental Health Act. Moreover, the patients being treated in these de-addiction centres are not "mentally ill" persons as per the definitions provided in the Act.

All this poses a great threat to the scope of treatment and rehabilitation to the drug/alcohol users who may or may not be falling in the category of "mentally ill" individuals. It is critical to understand the implications of the Act on MSJE's scheme so as to strengthen the strategies to address the issue.

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