NATIONAL POLICIES TO MEET THE CHALLENGE OF SUBSTANCE ABUSE: PROGRAMMES AND IMPLEMENTATION

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ABSTRACT

Drug abuse has become a growing issue of concern to humanity. India has a large consumer base of drug and alcohol abusers. This has serious repercussions in terms of morbidity & mortality. Hence the need for a national policy. In India, the Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS) provides the framework for drug abuse control in the country. A large number of measures have been undertaken as part of demand reduction activities. These include framing policies and programmes, setting up of centres, developing pilot projects, etc. However, the implementation still needs a lot to be desired. The efforts have not yet been streamlined and no revision of policies has taken place based on experience. This paper critically reviews the initiatives taken thus far to control drug abuse in our country.

Key words: Substance abuse, control, programmes, policies

Drug abuse has become a universal and growing issue of concern to humanity. The illicit drugs have multiple consequences to health, society and economy. The issue is complex and multifaceted requiring both health measures and efforts to control trafficking/smuggling and manufacture of illicit drugs. A reduction in the demand of drugs of addiction both legal and illegal, which lead to numerous health, family and societal consequences, is required. The purpose of the review is to inform about the various initiatives and activities that are taking place in this important public health area. All data have been updated as far as possible. The effectiveness and the impact of the various initiatives will not be dealt with as this is the work of the various administrative agencies. The purpose of the review is also not to ascertain the reasons for success and/or failure of the various administrative agencies and NGO's as this would constitute a separate paper by itself. Magnitude of the problem: Without going into too much detail, according to estimates made by the Ministry of Health and Family Welfare (MOH & FW), at least 40 million people throughout the world regularly abuse drugs. In India too, the problem is increasing and it is estimated that 3 million people are alcohol and drug abusers of which 5-6 lakhs are dependent, requiring medical treatment and rehabilitation. Need for national policy: India has a fairly large reservoir of raw opium, cannabis, alcohol and now synthetic opioid users, both in urban and rural areas, with a large number of them being young and adolescent population. The social, health and economic consequences of substance dependence are well known and include health: mortality, morbidity, psychiatric and physical disorders; social: accidents, absenteeism, family disintegration, prostitution, organized crime etc; and economic: finances spent on developing services, drain on national resources, loss of productivity, etc. (Malhotra et al., 1997b). Hence the need for a national policy to deal with this major problem.

The U.N. General Assembly adopted a
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A resolution called ‘A Political Declaration and Global Programme of Action’ setting forth its objective and outlining measures related to drugs. The Assembly also proclaimed the period from 1991-2000 as the UN Decade against Drug Abuse to be devoted to effective and sustained action to promote the implementation of the global programme for action.

India is a signatory of the following conventions:
1. Single Convention of Narcotic Drugs 1961 as amended by the 1972 protocol.
2. Convention on Psychotropic Substances 1971.
3. UN Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1988.

India is a party to all three UN Conventions and also has ratified all of them. In India, the Narcotic Drugs and Psychotropic Substances Act (NDPS), 1985 provides the current framework for drug abuse control in country.

Essentially, the Act deals with supply reduction activities. However, certain provisions for health care for drug dependent individuals exist. It authorizes the central government to take necessary measures for identification, treatment, after care rehabilitation of addicts and preventive education. It gives the central government the power to establish, maintain and regulate treatment centres. The Act permits supply of ‘drugs’ to registered addicts, and use of these substances for medicinal and scientific purposes. It would be important to note that ‘bhang’ does not come within the purview of the Act. The law provides light penalty for possession of small quantity (defined for various drugs) or for personal consumption. In such a situation, the person may be recognized and directed to seek treatment in centres (Kaker, 1989). The focal points for demand reduction activities are the Ministry of Health and Family Welfare (MOH & FW) and the Ministry of Welfare (MOW). Demand reduction is not just concerned with the individual abuser, but also with the family. Although concern is focussed on individuals, it is within specific cultural and economic contexts. Demand reduction activities include education, treatment, rehabilitation and community empowerment.

Initiatives so far (Drug dependence Programme, 1996): Soon after this Act was passed, the MOH & FW appointed an Expert Committee in 1986 to suggest various activities. The committee observed that “the NDPS Act was the single most important piece of social legislation after independence”. The expert committee (1986) recommended several measures:
1. The development of a national network in the long-term perspective and in the immediate context, resource mobilization on a priority basis from within the existing system. The latter is elaborated in the action plan. Here the main policy decisions were to develop centres for manpower development and research at national and state levels; to develop treatment services facilities for drug and alcohol dependent individuals who voluntarily seek assistance, to establish a national drug abuse monitoring system.
2. Development of a national centre under MOW which is visualized as a centre for specialized care, consultancy and referral centre.
3. Equivalent centres in various states.
4. Development of these centres should take precedence over development of treatment centres (designated centres).
5. Human resource development should receive high priority.
6. Existing general hospitals should be strengthened to provide treatment.
7. Treatment of subjects with drug dependence should be the responsibility of the health ministry at the centre and state health departments.
8. Several treatment modalities: both short term and long term, were suggested.
9. Monitoring patients’ profiles from treatment centres was suggested through the development of a drug abuse monitoring system.
10. As regards policy, the committee suggested that drug and alcohol dependence should have a separate visibility in the National Health Policy.
11. It was also noted that abuse of psychotropics might increase soon. Thus in due course, prescription monitoring should be established. Rational use of psychotropics should be promoted.
through national/state level workshops.

12. For effective programme implementation, it was noted that intersectoral integration and linkage with other programmes should be promoted. Involvement of MOW, and social scientists besides the health workers, was considered crucial.

13. An Action Plan for service augmentation was proposed. Several measures were initiated following submission of this report.

Administrative mechanisms for implementation:

As a follow up to the act, the Government of India (GOI) created the Narcotics Control Bureau (NCB) in March 1986 and empowered it to coordinate all activities for administration and enforcement of the Act.

As regards assignment of roles, the responsibility for educational and social welfare aspects of drug abuse was assigned to MOW. For medical and health care, MOH & FW initiated several measures along with the MOW. Over the years, the MOH & FW became involved with treatment and the MOW with counselling and rehabilitation. Under the NDPS Act, An Advisory Committee called the Narcotic Drugs and Psychotropic Substances Consultative Committee (NDPSCC) was constituted in 1988 to formulate a national policy towards drug abuse control measures. A national fund for control of drug abuse was established. The central government constituted a cabinet subcommittee in April 1988 and in August 1993. Another high level committee with Members of Parliament, experts and senior level officers was also constituted. Further, in order to have effective coordination, a committee of secretaries (Narcotics Coordinator Committee of Secretaries) was constituted in 1994. On the basis of recommendations made by the expert committee (1986) and the cabinet subcommittee (1988), five centres were established. A 30 bedded Drug Deaddiction and Treatment Centre (DDTC) was started at the All India Institute of Medical Sciences (AIIMS) to serve as model centre. Other additional centres were also set up in Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh; Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Pondicherry; Lady Hardinge Medical College (LHMC) and Ram Manohar Lohia (RML) Hospitals in Delhi. In addition, Regional level centres were also setup with assistance from UNDCP at King Edwards Memorial (KEM) Hospitals, Bombay and Institute of Postgraduate Medical Education and Research (IPGMER), Calcutta. The above centres, besides providing treatment services also provide training to medical/paramedical personnel, prepare health education material, and render community out reach services.

AIIMS is serving as a national level apex centre and is actively involved in providing modules for medical care, development of training curriculum, development of health education material and programmes to increase the awareness of general public about adverse health consequences of drug abuse. In July 1988, specific programme documents were developed on drug demand reduction as a collaborative activity between UNFDAC and GOI. This project "Development of Drug Abuse Prevention, Treatment, Rehabilitation and Control Measures, for the years 1988-1993" had the subprojects on prevention, treatment, and rehabilitation. Programme A (drug abuse prevention) was to be implemented by UGC; programme B (drug dependence and treatment) by MOH & FW; Programme C (rehabilitation and social integration) by MOH & NGOs. A detailed workplan listing objectives, output, activities, budget and mechanisms of implementation was worked out jointly. There was rapid development of projects followed by a slow-down from 1990 and these were initiated again in 1992. In March 1994, a National Master Plan for the drug abuse control was submitted.

MOH and FW: On the basis of recommendation made by Expert Committee in 1986. 5 centres and 2 regional centres were established by 1988. In Oct 1989, the assistance from UNDCP stopped. An interim work plan for 1990 was implemented, pending approval of the revised plan of activities. By 1992-1994, the central government with assistance from UNDCP, started providing
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Construction grants to various state governments to establish treatment centres. By 1994, 27 centres in various states received assistance. Thus a total of 34 centres were established. 18 of these institutions carried out several training programmes for health personnel with assistance from UNDCP. During this period 32 courses were carried out and about 1000 doctors trained. It was a three-week training programme. The model was developed at AIIMS. In August 1994, a training master plan was formulated.

MOW: The ministry, under the scheme for prevention of alcoholism and substance abuse has provided assistance to 339 NGOs for running 193 Drug Awareness-Counselling and Assistance Centres and 228 Treatment-cum-Rehabilitation Centres till 1998-99. On the basis of feedback received by the implementing agencies the scheme titled as "Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse has been revised. The most important aspect is the involvement of the Panchayat institutions and local bodies in awareness generation programs and redesigned Treatment-cum-Rehabilitation Centres. For awareness building, the following activities were undertaken: audio visual publicity; development of print material; press advertisements; out-door publicity; distribution of materials; publicity through traditional media.

National Master Plan (1994): The team responsible for the development of the national master plan reviewed the current (1994) drug abuse situation: available facilities, existing legal and administrator arrangements and measures initiated. The team proposed a comprehensive plan, sector wise, for the years 1994-2000 for both demand and supply reduction activities.

Several recommendations were made: those included developing an appropriate administrative mechanism for the drug abuse control programme in the MOH and the creation of a coordinator for voluntary activities of drug abuse control in the MOW (Table).

It is obvious that there is some degree of overlap regarding the proposed roles and activities between the two ministries. Estimated expenditure and phasing the mechanism of monitoring and evaluation were also suggested (Drug dependence programme 1996, South Asia - Drug Demand Reduction Report, 1998).

Achievements (South Asia - Drug Demand Reduction Report 1998)

MOH:
- Establishment of national and state apex centres
- Establishment of drug abuse monitoring system
- Establishment of treatment centres
- Development of several levels of treatment modalities
- Establishment of maintenance programmes for opiate dependent subjects
- Human resources development (HRD)
- Establishment of laboratory services (screening)
- Development of health education materials
- Surveillance of supply and use of psychotropics

MOW:
- Establishment of national centre for drug abuse prevention
- Development of comprehensive awareness scheme
- Preventive education for several population subgroups
- Development of treatment centres in the NGO sector
- Providing treatment facilities in prisons
- Development of pilot projects on rehabilitation of drug abusers
- Training of personnel in drug abuse prevention

| TABLE |
|PROPOSED ROLES OF THE MINISTRY OF HEALTH (MOH) AND MINISTRY OF WELFARE (MOW) AS ENVISAGED IN THE NATIONAL MASTER PLAN, 1994|

**MOH**
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5. A suitable data system - Drug Abuse Monitoring System (DAMS) has been developed and pilot tested in three cities over 3 years. Efforts are now on to develop it as a national activity and use the National Information Centre (NIC) satellite network.

6. A number of research studies have been carried out on epidemiology, treatment, and outcome of substance abuse.

7. Several national and regional workshops have been held to strengthen delivery of service facilities. Special emphasis was laid for North Eastern states with strategies for harm reduction.

8. New initiatives
   a) Community based pilot projects have been initiated in three districts - Churachandpur (Manipur), Mandsaur (MP) and Barabanki (UP) which aim at providing comprehensive services at community level, involving government medical institutions, health infrastructure, NGO and local self government. The project is an integrated approach involving officials from both demand and supplies reduction. The AIIMS and MOW act as agencies for execution, advice and monitoring. District bodies do the actual implementation. Periodic reviews are carried out by field visits with formal mechanism. An interim evaluation report was prepared in July 1997.
   b) Another project is in progress in three districts of eastern and northeastern India with assistance of WHO. It has two components:
      i) Survey to assess magnitude of the problem.
      ii) Ethnographic observations by interviewing selected number of drug abusers.

MOW : During the 7th Plan (1987-92), the Ministry was promoting a community based approach towards drug abuse prevention. In the 8th plan, the deaddiction and after care centres were changed into deaddiction and rehabilitation centres, while counselling centres were converted into drug awareness, counselling and assistance centres.

1. A bureau of Drug Abuse Prevention was established. It is responsible for policy formation, programme development and human resources development. A training Master Plan (1994) has also been developed.
2. By March 1999 - the total number of centres established were 339. Of these, 193 were drug awareness, counselling and assistance centres and 228 were treatment cum rehabilitation centres.
3. Several radio and TV programmes were carried out. A number of films were produced and several NGOs were given grants to undertake preventive education among specific target populations.
4. National Institute of Social Defense conducted several training course of variable duration.
5. Under the 'Umbrella Equipment Project', the Ministry recommended the names of 95 counselling centres and 45 deaddiction centres for receiving various medical and other equipment.

Summarizing:
   a. There has been a significant upgradation in the capabilities of the concerned departments.
   b. The achievements were visible. Drug use control including demand reduction activities did receive higher priority and created greater awareness in the government.
   c. A number of institutions have come into existence both in the governmental & NGO sectors.
   d. HRD (training of several categories of staff) took place through established infrastructure of high quality.
   e. The policy and programmes for future development were clearly formulated and stated.
   f. The ministries had developed their own programmes with budgeting allocation from internal sources.

Thrust areas to strengthen the programme:
1. To develop a vast network of trained manpower in the country in the areas of detoxification and to prepare health and after care services. Training should cover professionals at all levels.
2. To set up DDTCs in specified areas where the problem is acute or has potential danger of spread such as N.E. states, industrial belts, international borders, tourist places etc.
3. To conduct epidemiological and research studies on various aspects of drug addiction.
4. To develop database on the basis of research
studies and also to establish DAMS at central and state levels.

5. To promote innovative approaches in providing comprehensive treatment and referral services. The concept of therapeutic community and halfway homes as a long-term therapy needs to be experimented in the Indian cultural context.

6. Special health education material containing information needs to be developed.

7. Keeping in view the growing menace of use of I/V drugs leading to AIDS, Linkage of National AIDS Control Programme (NACP) will be developed in areas of prevention, training and joint awareness campaigns.

8. Particular stress will be laid on developing services in forensic toxicology and upgrading those, which, already exist.

Critical issues:

1. The numbers of trained psychiatrists are inadequate to man existing programmes. This also relates to the specialist non-medical professionals namely, psychiatric social workers and clinical psychologists.

2. Immediate detoxification and after care programmes are relatively easy for general physicians to handle. Therefore training to such professionals should be provided.

3. Hardly any emphasis is laid on undergraduate medical training about drug dependence and management. This should be part of training from a long-term perspective.

4. No drug abuse monitoring system has developed even about 15 years after enacting NDPS and only a few specialized laboratories have been set up.

5. There is need for caution to avoid rapid expansion without adequate time for professional attitude change, infrastructure change, financial support and community education. It may be prudent to develop modest programmes and give adequate time for change and the system to integrate. The core components should be identified and made a focus of state policy and programmes.

6. To a limited extent, there has also been dependence to initiate programmes on international funding. This has been beneficial but also limited the extension beyond the initial stages. Many of the initiatives were with the WHO funds. Subsequent to the non-availability of this source, many of the activities will not to be taken up.

7. Administrative bottlenecks have its part to play in delaying implementation of the programmes. Isolated activities taken by individual ministries could have repercussions on functioning of other ministries. There is a substantial scope for improvement in roles and the integrated functioning of various ministries for development of dependence programmes. The roles of each ministry need to be clearly spelt out to prevent overlapping of functions.

8. There are various problem with NDPS too:

8.1 There is an inexplicable relaxation in the rules as well as punishment prescribed for offences connected with ganja.

8.2 There is no distinction made between a user and a pusher or trafficker. Both are considered as equal offenders.

8.3 In certain cases, the gravity of offence is not taken into consideration while prescribing punishment.

8.4 With regards to enforcement, there are more acquittals than convictions, thus evidencing loopholes. Offences seem bailable.

8.5 The Act says that the government may set up centres for identification and treatment of addicts but no targets or time frame have been given. This will lead to delays in implementation.

8.6 The Act does not take into consideration the role of NGOs in this field. This is unfortunate as most of the work is being done by the NGOs.

9. In spite of a large amount of money available, drug dependence services have not been streamlined. There has not been any systematic evaluation as well as modification based on experience. The funds for activities on drug dependence prevention and treatment in the health sector were generally underutilized. Postponement of funds due to various reasons led to delays or non-utilization.

10. One of the key factors in maintaining drug free state following detoxification is close follow
up of each individual in community i.e. surveillance. In this regard, role of voluntary associations and of primary care workers becomes self-evident. They can play vital role in fulfilling both objects of early identification and also follow up and treatment of such cases.

11. The activities under the project 'Prevention of Drug Abuse through Education' were not carried out.

12. The National Master Plan (1994), after all these years, is still just a document of various recommendations. Neither is it publicly available as a government document, nor is it known if the government has officially endorsed it and acting upon it. Most likely the answer will in the negative.

Alcohol policies in public health area: Alcohol has traditionally been used as a beverage for various purposes, in different parts of the world, with varying emphasis, depending on ecological climate factors (cold) and socio-cultural norms of a society. Concern about alcohol was incorporated in Article 47 of the Directive Principles where alcohol was passed on to the states. This position has been clarified in the recent Supreme Court decision. Hence no national policy can evolve, unless the issue is covered in the concurrent list (Mohan, 1997).

National policy: Policy on alcohol in India has never had a national consensus in implementation despite the statement in Article 47. The directive principles advocated a single policy, e.g. prohibition with no other option, both of alcohol of intoxicating drugs. Alcohol prohibition has been on the political agenda of governments both at the state and central levels, with ranging degrees of emphasis. By 1977, the central govt. was reasonably clear on three points:

(a) No multi-national companies to be allowed unless they were 100% Export Oriented Units.
(b) The federal and state governments did not enter into alcohol production.
(c) 20 points and 10 point programmes here suggested by Prohibition Advisory Committee to states.

Presently Gujarat, Nagaland, Mizoram and Manipur have enforced prohibition. Prohibition has been tried for ranging period from 1-5 years before repeal. In Gujarat, no systematic public health statistics have been collected in this regard. Further no data has been gathered in states where the availability of alcoholic beverages was always a norm. Thus insufficient database exists for making a case for or against prohibition. Between prohibition and unrestricted availability a lot of policy options are available:

These are as follows:

- State monopoly of alcohol: under this policy system, the state determined which alcohol beverage is to be made available when, where and how. Alcohol monopoly is in existence in Delhi. Non availability of spirits on national highway.
- Low content of beer (1%) in selected outlets.
- Exclusive outlets for beer, spirits and wine.
- Different tax policy to reduce consumption.
- Information and education campaigns.

Selective enforceable legal provisions e.g. blood alcohol levels if drinking blood levels at workplace excluding alcohol availability in, on and around workplace.

- Zoning laws, in which the local consumer population votes for or against alcohol, tends.

In the Indian context, the above need to be debated so that uniform standards can be applied nationally or differentially.

Revenue vs. availability consideration: Excise tax is considered a major revenue earner for the state, which in turn governs availability of sales outlets. The question which needs to be examined and answered -

Is that the only sources of revenue earning? If yes, in the Indian context, does it also aim to reduce consumption or promote it?

In various considerations, these issues need to be debated.

- Is the revenue and taxation limited to reduced consumption or are they independent?
- Is the revenue taxation linked to any index or it is ad-hoc and flexible?
- Is any of the revenue so generated spent on alcohol drug related issues or not?
- Is it desirable or not, who decides and strikes balances? An independent
alcohol boards, or is it purely bureaucratic, or do the excise and revenue departments decide. India having joined WTO is currently under pressure to reduce restrictions on important of duties on bottled alcoholic beverages from them. The local alcohol industry is pressing for easing of both quantity restrictions as well as import duties. The need for the developed countries to push spirits and other alcoholic beverages is obvious. In them, the capacities are full and sales are falling on health grounds. Alcohol is being promoted as a health lifestyle issue, and the industry constantly promotes safe or moderate drinking. Safe drinking is being advocated in a civilization/population groups with a long history of drinking. There is enough evidence of multiple systems irreversible health damage, the cost of which on public health is immense. There is no evidence to predict who among moderate drinkers will progress to harmful drinking and dependence syndrome. Safe drinking could be a smoke screen to promote alcohol, and delude the alcohol naive population to start alcohol use. It is hoped that national workshops shall promote rational public health responses to existing and future situation in the country (Mohan, 1997; Malhotra, 1997a)

To conclude, the last 15 years have seen rapid growth in the combat against drug dependence especially the areas of policy formulation and growth of infrastructure. This is commendable. What now remains to be seen is the effectiveness and impact of the various measures initiated. It is imperative to have evaluation and subsequent modifications of plans and policies based on effective research. Without any systematic evaluation, plans would be just that - plans.

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