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Editorial

Drug misuse in India: Where do we stand & where to go from here?

The first International Day against Drug Abuse and Illicit Trafficking was observed by the UN General Assembly on June 26, 1987. Since then, every year, this day marks the coherent and seamless global cooperation to achieve a drug-free society. So far, the UN has organized three international conventions in 1961, 1971 and 1988. The first one sought to eliminate the illicit production and non-medical use of opioids, cannabis and cocaine. The meeting held in 1971 extended the scope to the psychotropic medications or synthetic drugs (*e.g.*, amphetamines, barbiturates and LSD). The third convention against illicit trafficking was targeted at the suppression of the illegal global market, and the restriction was also extended to the precursor chemicals[1,2].

During the last five decades, the United Nations has also convened two special sessions to discuss the world drug problems, in 1998 and 2016. In the first session, the UN envisioned to reduce the illicit supply and demand for narcotics and synthetic drugs by 2008. However, the World Drug Reports rather showed an increase in the use of the illicit drugs[3,4]. A gross disparity in the access to narcotic drugs (especially opioid analgesics for pain conditions) among various nations across the globe also became apparent[5]. Taking note of the failure on both the fronts - curbing misuse and ensuring access for medicinal and scientific purposes - the UN convened the second special session in 2016. The report has acknowledged that the Sustainable Development Goal (SDG) 3.5 is 'complementary and mutually reinforcing' with the UN's commitment to curbing the world drug problem[6]. In addition, SDG 3.3 has also emphasized on the importance of the treatment of substance use to end the epidemics of HIV and hepatitis. The resolutions of the outcome document are likely to be reviewed this year.

India: The existing three-pronged strategies to address the drug problem

As enshrined in its constitution (Article 47) and being one of the signatories of the United Nation's International Conventions, India had the onus act to eliminate the use of illicit drugs, to develop measures to prevent drug use and to ensure availability of treatment for people with drug use disorders. India has adopted the three-pronged strategies - supply, demand and harm reduction.

Following the 1971's UN Convention on Psychotropic Substances, the Ministry of Health and Family Welfare, Government of India, established an Expert Committee to look into the issue of drug and alcohol use in India. The Committee's report was submitted in 1977, and after approval from the Planning Commission, Drug De-addiction Programme (DDAP) was rolled out in 1985-1986[7]. The primary aim of the DDAP was drug demand reduction. During the same time, India had enacted the Narcotic Drugs and Psychotropic Substances (NDPS) Act in 1985, which was amended thrice, latest in 2014[7]. The primary aim of the NDPS was 'to prevent and combat drug abuse and illicit trafficking', an apparent emphasis on the supply reduction. The consultative committee (an advisory committee formed by the NDPS Act), which was constituted in 1988, formulated a national-level policy to control drug abuse. The committee created a fund, National Fund for Control of Drug Abuse and involved a couple of other major stakeholders - the Ministry of Health (and Family Welfare) and the Ministry of Welfare (currently Social Justice and Empowerment). The Ministry of Health was entrusted with the job of prevention and treatment of drug dependence, whereas the Ministry of Welfare was assigned with the responsibility of the rehabilitation and social integration of people with drug dependence[7]. The Ministry of

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Health established seven treatment centres during the first phase (in 1988). The aims of these centres were treatment, drafting of educational material and training of medical and paramedical staff to generate the future workforce to deal with the problem of drug abuse. In addition to these centres, under the DDAP, one-time grant was provided to 122 De-Addiction Centres (DACs) of various psychiatry departments of government medical colleges and district hospitals. The Ministry of Welfare funded several non-governmental organizations (NGOs) across the country to establish counselling and DACs with the objectives of awareness building and treatment rehabilitation at the community level and human resource development[8]. The Ministry subsequently identified 10 Regional Resource and Training Centres (RRTCs) to mentor, train and provide technical inputs to various other NGOs[8]. RRTCs work under direct supervision of the National Institute of Social Defence (NISD).

Over the last three decades, there has been a substantial expansion of services in all dimensions. The Ministry of Social Justice and Empowerment published the draft policy of the drug demand reduction, the National Drug Demand Reduction Draft Policy in 2013[9]. To scale up the existing services, the Ministry has rolled out the 'Central Sector Scheme of Assistance for Prevention of Alcoholism and Substance Abuse and Social Defence Services[9].' The Ministry of Social Justice has also published its five-year plan, 'National Action Plan for Drug Demand Reduction' in 2018[10]. Till date, there are more than four hundred NGOs, spread across the country and are functioning as the Integrated Rehabilitation Centre for Addicts. The DDAP has also extended its scope from the previous DACs to the newly formed Drug Treatment Centres (DTC). These are parts of general hospitals, where a dedicated service with dedicated staff delivers outpatient-based care for substance use disorders, and medications are dispensed free of cost[9].

The harm reduction dimension was added in 2005 by the provision of low threshold, community-based opioid substitution therapy (OST). It was initially funded by the Department for International Development till 2007 when the Ministry of Health and Family Welfare took over the responsibility. The National AIDS Control Organization (NACO) continued the OST and Needle Syringe Exchange Programmes (NSEPs) under the targeted interventions. Adult HIV incidence has been brought down from 0.41 per cent in 2001 to 0.35 per cent in 2006 to 0.27 per cent in 2011[11]. However, the pace of decline of the new HIV infection was said to have levelled off, and the infection among the people with injection drug use (IDU) was implicated for the same. Under the National AIDS Control Programme-IV, special emphasis was placed on increasing the availability and accessibility of treatment of the people with IDU. The data published in 2012 suggested that there were 150 OST centres and >15,000 people with IDU, registered in those centres[12]. The National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi, has built-up a new model of OST service delivery - the GO-NGO model, to scale up the services. Under this model, the psychiatry departments of the government hospitals functioned as OST centres and worked in close collaboration with the NGOs. The NGOs acted as the bridge between the patients with IDU and the OST centres[13]. The latest amendment of the NDPS Act (in 2014) has included methadone as an essential narcotic drug and permitted use of methadone for OST, by licensed users[14]. This amendment has expanded the scope of OST in India.

The Mental Health Care Act (2017) has included alcohol and drug use disorders under its ambit. This measure is likely to increase the adherence to the human rights, to ensure non-discrimination, the respect to the right to autonomy and confidentiality, to increase the availability and access to the minimum standard of care and rehabilitation for people with substance use disorders[15]. The NISD and the RRTCs have formulated a minimum standard of care to be followed by the NGOs, whereas the NDDTC, AIIMS drafted the same for the government DACs[16,17].

Drug abuse in India: Current and future challenges

In the last three decades (following the inception of the NDPS), the Ministry of Social Justice and Empowerment has conducted two nation-wide drug surveys, published in 2004 and 2019[18,19]. The results of these surveys suggest that drug use in India continues to grow unabated. Opioid use has increased from 0.7 per cent in the previous report to a little >2 per cent in the present one - in terms of magnitude from two million to more than 22 million. More disturbingly, heroin has replaced the natural opioids (opium and poppy husk) as the most commonly abused opioids. A large scale epidemiological study from Punjab also concurred with this finding[20]. The uses of other synthetic drugs and cocaine have also increased significantly. The survey results suggest a need to strengthen our existing system, to have a more concerted effort and a need to

fix the loopholes. In the years to come, the government might like to concentrate on the following:

(*i*) The National Mental Health Survey (2015-2016) showed a treatment gap of >70 per cent for drug use disorders[21]. The recent nation-wide survey on substance use disorders has replicated the result, with nearly 75 per cent treatment gap for drug use disorders. Added to that misery, merely five per cent of people with illicit drug use disorders received inpatient care[19]. This large treatment gap indicates poor accessibility, utilization and quality of health care. To meet this unmet need, one should expand the treatment and rehabilitation facilities for substance use disorders. The DTC scheme by the Ministry of Health and Family Welfare could be the starting point, but it is not enough. At present, the scheme is implemented by the NDDTC, AIIMS. Other centres may also be involved. As drug demand reduction falls under the direct purview of both the ministries of Health as well as Social Justice, a coordinated and concerted effort is required to fill the treatment gap with a minimum standard of care. Nation-wide drug surveys are to be conducted on regular intervals to discover the undercurrents of substance use in India and to encourage the government to make informed decisions.

(*ii*) The harm reduction arm of the three-pronged approach needs to be strengthened further. Despite the progress made by the NACO and the GO-NGO model, the coverage of the OST among the IDUs is only seven per cent[12]. It calls for the scaling up of the OST, safely and effectively[22]. The NDPS policy prohibits the NSEP, whereas it is one of the cornerstones of harm reduction, practiced by the NACO. The NDPS policy also advocates a time-limited OST, which does not have any scientific evidence base and might cause more harm (than good). Recovery-oriented OST could potentially replace this time-limited OST policy[23]. These discrepancies and loopholes in the policies need to be fixed.

(*iii*) Current and future challenges in the supply reduction arm lie in the early detection and scheduling of the new psychoactive substances. The recently published report of the International Narcotic Control Board (INCB) revealed India's threat to mephedrone and captagon (a derivative of amphetamine and theophylline)[24]. The Report also discussed the country's potential problem with the precursor chemicals. Moreover, it has noted with caution the rapid proliferation of internet-based pharmacies and bitcoin-based transactions for the illicit drug use in India[24]. Misuse of the over-the-counter medications with definite (*e.g.*, benzodiazepines, tramadol and codeine) or with possible addictive potential (*e.g.*, pregabalin) is another concern, voiced by the international forum.

In summary, India has taken early and decisive steps to address drug problems. Though the government has an over-encompassing blueprint, committed workforce and several dedicated programmes and policies at its disposal, there is a need to improve the current programmes (to address the unmet needs), to have a coordinated effort between Ministries, incurring uniformity at the policy level, to make scientifically informed choices and to strengthen the supply reduction chains.

***Conflicts of Interest*:** None.

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