INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 5 AND ISSUE 1 OF 2025

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

INDIA'S WAR ON DRUGS: A HISTORICAL AND LEGAL EXAMINATION OF NATIONAL AND INTERNATIONAL STRATEGIES FOR PREVENTION AND REHABILITATION

AUTHOR - RANJANA RAJASRI R, ADVOCATE AND INDEPENDENT AUTHOR. Email - ranjanarajasri22@gmail.com

BEST CITATION - RANJANA RAJASRI R, INDIA'S WAR ON DRUGS: A HISTORICAL AND LEGAL EXAMINATION OF NATIONAL AND INTERNATIONAL STRATEGIES FOR PREVENTION AND REHABILITATION, *INDIAN JOURNAL OF LEGAL REVIEW (IJLR)*, 5 (1) OF 2025, PG. 765-780, APIS – 3920 – 0001 & ISSN - 2583-2344.

SYNOPSIS:

The study provides a historical perspective on narcotic drugs and psychotropic substances in India, highlighting the impact of substance overuse and the introduction of drug regulation during British colonization. It covers the objectives and provisions of International Drug Control Conventions and the Sustainable Development Goals aimed at preventing substance misuse and protecting public health. The study also focuses on the development of drug laws in India, the current legal framework, and the role of the Narcotics Control Bureau in drug awareness and prevention. Additionally, it examines the judiciary's role in combating drug abuse and trafficking, detailing severe penalties under the law. Finally, the study addresses the state's obligation to protect drug victims and outlines rehabilitation measures, focusing on the National Action Plan for Drug Demand Reduction (NAPDDR) and initiatives by the government and NGOs.

Keywords: Narcotic drugs- Psychotropic substance -Drug regulation- Prevention and Rehabilitation.

INTRODUCTION:

Paul Gahlinger in his book "Illegal Drugs" remarks that drugs used by the Neanderthal people ages back the modern human evolvement is accepted by archaeological remains discovered in the Shanidar cave in Iraq dated to 50,000 years ago.[1352] Therefore, it is believed that human civilization has roots to drug usage before 50,000 years. This can be the result of exquisiteness and exploring attitude of humans that there was an interphase of humans and drugs. They can also be the outcome of the experimental deeds by the humans for survival which leads them to consuming of mind altering substances in the form of herbs and plants, being unaware of the hallucinating effects these create on human minds. Experiencing the happiness, increased stamina, relaxing and enjoyable effects of taking the intoxicants increased the portion and frequency of the intake of these substances, which eventually produced strange sensations, uncontrollable energy and terrifying visions. The open access to these intoxicants created a hick in the usage and consumption of drugs in the older human civilization. Furthermore, the herbs or drugs that were capable of curing disease were taken as sacred herbs or plants and the herbs or drugs created illness or were poisonous, were considered as devils. Eventually this belief prohibited the usage of those poisonous herbs or drugs in public occasions or ceremonies. Thus, it was a way of protection against drug abuse in the ancient human civilization. The usage of drug is found in almost all the ancient civilizations including China, Greece, Mayan, Egypt and Mesopotamia. India also carries the evidence for the existence of the intoxicants in the ancient civilization. Vedas and Purans document the usage of liquor among the Devas and the Asuras.

Drugs, intoxicants or substances are entities which are hazardous to human mind and

[1352] Gahlinger, P. (2004). Illegal drugs: a complete guide to their history, chemistry, use and abuse. Plume.

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]
VOLUME 5 AND ISSUE 1 OF 2025
APIS – 3920 - 0001 *(and)* ISSN - 2583-2344
Published by
Institute of Legal Education
https://iledu.in

body.[1353] These include illicit drugs and alcohol. Any natural drug or pharmaceutical substances used without proper medical care or supervision and that changes the way of natural thinking, behaviour and action of an individual is considered as illicit consumption of drugs.[1354] Consuming these kind of substances are capable of altering the behaviour and personal acts of the individual. Along with the mental health, the physical health condition of the substance consumer is also at risk.

Usage or consumption of drugs against the set norms of the society was looked upon as sin the ancient times. In modern society this sin is known as "drug abuse". Drug usage also leads path to criminal activities, inappropriate involvement of the drug users in illicit activities and using children as medium of drug peddling. Though the correlation between drug consumption and criminal activities is obvious and evident, its impact has not been conclusively built on criminal grounds.[1355] Whereas, the connection between the juveniles criminal involvements and adolescent drug usage is well observed and established. Substance use and crime share common risk factors thus, "drug-crime" cycle is evident of this mutual offence.[1356] The primary National data provides accounts of 55 % of male and 39% of female being admitted under the program of substance use treatment.[1357] Thus, it can be taken as a measure to reduce the consumption of drugs. Drug users sometimes happen to continue drug usage along with criminal activities in future.

Substance use offenders is linked with other health risk behaviours. In one sample of detained youth with substance use disorders, 63 percent engaged in five or more sexual risk behaviours, producing heightened vulnerability to HIV and other sexually transmitted diseases. Substance use is also associated with violence and accidents and, among pregnant women, with harm to fetal development. Among adolescents in the general population, substance users, particularly heavy substance users, tend to have less positive educational, occupational, and psychological outcomes.[1358]

HISTORICAL PERSPECTIVE OF NARCOTIC DRUGS AND PSYCHOTROPHIC SUBSTANCES

ANCIENT PERIOD:

In ancient India, intoxicants such as Soma, Cannabis, and Sura were present and referenced in religious texts like the Vedas, Ramayana, and Mahabharata. Soma, celebrated for its mind-altering properties, was linked with divinity and health, while Cannabis was associated with Lord Shiva[1359]. The use of Soma was viewed positively, enhancing memory and strength, whereas Sura, a potentially harmful substance, was considered a sin. The Manusmriti outlined that consuming Sura was as serious as committing severe crimes. The consumption of intoxicants was regulated based on caste, with certain liquors allowed for specific groups but prohibited for others, especially Brahmins[1360]. The Mauryan Empire, under rulers like Chandragupta and Ashoka, introduced systematic regulation and taxation of liquor to control its consumption, leading to both legal and illegal trade issues.

The role of intoxicants in ancient Indian society evolved over time. Initially, substances like Soma were used for religious and recreational purposes, but their misuse led to societal disruptions. During the Mauryan Empire, the government sought to control liquor through regulation and taxation, with liquor becoming a

[1353] WHO. Substance abuse [accessed on 27.03.2024] Available at: http://www.who.int/topics/substance_abuse/en.
[1354] Child line India Foundation, [accessed on 27.03 2024] Available at: http://www.childlineindia.org.in/cr- drug-abuse.htm.
[1355] H. Naci Mocan and Erdal Tekin, Drugs and juvenile crime: Evidence from a panel of siblings and twins, http://bus.Isu.edu/mocan/Juvenile%20Drug.pdf
[1356] Curtis Vander Waal and others, Breaking the Juvenile Drug-Crime Cycle: A Guide for Practitioners and Policy-Makers, US. Department of Justice, Office of Justice Programs, National Institute of Justice www.ajp.usdoj.gov/nij (May, 2001)
[1357] "Dennis Young, Richard Dembo, and Craig Henderson, A National Survey of Substance Abuse Treatment for Juvenile Offenders, Journal of Substance Abuse Treatment, 255-66 (2007)
[1358] "National Institute on Alcohol Abuse and Alcoholism, Underage Drinking: A Major Public Health Chal- lenge, Alcohol Alert 59 (2003).
[1359] Griffith, R.T.H. (tr.) (1896). Rigveda (Book 8). Retrieved on April 05, 2024 from https://www.sacred-texts.com/hin/rigveda/rv08048.htm
[1360] The Laws of Manu XI.07. Retrieved from https://www.sacredtexts.com/hin/manu/manu11.htm

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]
VOLUME 5 AND ISSUE 1 OF 2025
APIS – 3920 - 0001 *(and)* ISSN - 2583-2344
Published by
Institute of Legal Education
https://iledu.in

revenue source. King Ashoka, influenced by Buddhism, later banned alcohol after the Kalinga War, continuing the push for prohibition[1361]. However, after the Mauryan dynasty's decline, restrictions on intoxicants were lifted[1362]. The rise of illegal liquor trade and its damaging effects on society prompted strict actions by rulers to re-establish order, showcasing the balance between regulating substances for economic benefit and protecting public welfare.

MEDIEVAL INDIA:

During the medieval period in India, drug use and abuse became a significant societal issue, leading to strict regulations by various rulers. This era saw the introduction of medicinal uses for substances like cannabis and opium, the latter being brought by Arab physicians. Opium was valued for its pain-relieving properties, and cannabis was commonly consumed. The Sultanate period witnessed rampant alcoholism, gambling, and animal fights, leading rulers like Alauddin Khilji to enforce liquor prohibition, allowing only nobles to drink privately. However, these efforts were not entirely successful, though the higher taxation on intoxicants served as a form of prevention by making them less accessible to the lower classes[1363].

In the Mughal period, rulers like Babur and Humayun had personal affinities for alcohol and opium, while Akbar's reign saw the removal of excise duties on liquor. The arrival of tobacco, introduced by the Portuguese, was another contributing factor to the rise in drug use, though it was banned under Jahangir due to its growing popularity. During Aurangzeb's reign, public consumption of liquor was completely banned, with severe punishments for trafficking. Following the Mughal decline, Shivaji allowed limited alcohol consumption during public ceremonies, but illegal involvement in alcohol production was heavily penalized[1364]. Despite these efforts, the legacy of substance use continued, with even rulers like Shivaji's son succumbing to alcohol abuse.

BRITISH INDIA PERIOD:

The systemic excise duty on manufacturing of liquor was made in India by the Britishers during the British colonisation. Excise duty was also thrust upon import of the drugs, licensing of wholesale liquor trade and license fees[1365]. Though these steps helped in increasing revenues, the amount and number of substance use also increased. Apart from liquor and opium, the use of tobacco and hetel also increased during the British colonising period. The improved economic conditions of the lower class before the British colonisation was another reason for the increment in the rate of drug usage in the British India. To control the trafficking of liquor harsh rules and severe punishments were given. Liquors like malt beer, wine, fermented palm juice were produced and consumed by the Indians during this period. In 1901, there were huge number of liquor shops opened in India, approximately one shop per two thousand five hundred[1366]. In terms of excise revenue, country-made spirits and palm juice topped the list.

Excise Revenue from Intoxicated Liquor during the year 1902–2003 (approximately)[1367]

Type of Intoxicant Liquor	Excise Reve
Country Spirit	Rs.3,25,00,0
Palm Juice (Tadi, Toddy)	Rs. 1,11,00,00
Grain Beer	Rs. 17,00,000
Country Rum & C.	Rs. 12,00,000
Malt Beer	Rs. 4,00,000

[1361] Bhatta, K. (1910). The tantra varttika. (Jha, G., Trans.) Calcutta: Asiatic Society of Bengal. (Original work published 700 A.D.) Retrieved from https://archive.org/details/in.ernet.dli.2015.19900
[1362] Goswami, S.M. (2016). Prohibition during the period of Gandhi era - A study (Chapter 2).23-24.Retrieved from http://hdl.handle.net/10603/122035
[1363] Chaturvedi, G.N., Tiwari, S.K., & Rai, N.P. (1981). Medicinal use of opium and cannabis in medieval India. Indian Journal of History and Science, 16 (1), #31-35#. Retrieved from https://pubmed.ncbi.nlm.nih.gov/11611267/
[1364] Parikh, P. (2017). Cultural history of India. University Granth Nirman Board.23, 144
[1365] GBIO. (2017). The Indian empire; Administrative (Vol. 4). Forgotten Books. 254
[1366] Ibid.
[1367] Ibid

Foreign Liquor	Rs. 18,00,000(approx)

In a roughly estimated count, Bombay was the state with the largest number of liquor consumers and Madras (Chennai) was the largest in consumption. During this period all the classes in the society were in the position to have access to liquor abuse and the lower class was even more prone to it. Bengal was the largest in producing opium in India under British ruling. Among the other places producing noticeable amount of opium were Bhopal, Mewar, Indore and Gwalior. The Britishers colonising India started earning more and more revenue from exporting opium to China and to the West. During this period in British, there were two types of opium produced, provisional which was for the export purpose and excise opium which was produced for the local use[1368].

Opium was in high demand among the substance users in British India. It was taken as pills or dissolved in water and the Britishers claimed that the use of opium was for medicinal purposes alone as a pain reliever. Hence, intake of opium in the form of pills or dissolving in water was not under prevention. Though taking opium on medicinal grounds was acceptable, practise thus, it was fairly under control. Assam was on the highest in consuming opium, followed by Bombay/Mumbai. Bengal was the third on the list of consumption of opium and Madras was the fourth. Substances like Charas, Ganja and Bhang were prepared from the plants of cannabis. They were both used and misused.

Under the British rule in India cultivation of cannabis was in demand and it was licensed as well. The Britishers named cannabis as "Indian Hemp Drug"[1369]. Reference to the use of the hemp in the Indian culture can be traced back to 1000BC wherein hemp is used on the social and religious grounds. Till today the usage of hemp in the form of bhang is shown on religious purposes. Bhang is also used for its medicinal properties. It is believed that bhang helps to resolve health issues related to gastro-intestine and certain people carry bhang during their long distance journey to avoid and solve these gastro intestinal problems.

Ganja, Charas, and Bhang were made from the cannabis plant for consumption or abuse. During British rule, Ganja was primarily grown in Bengal province, including Solapur, Ahmednagar, and Khandeish (Maharashtra), Vizagapatam, Salem, Tanjore, Madura, Nellore, Arcot, Coimbatore, Kurnool, Bellary (Tamil Nadu and Andhra Pradesh), Bareilly, Gorakhpur, and Moradabad (Uttar Pradesh) for local trade and export to London and beyond[1370]. In 1892-93, Ganja Mahal, Bengal had 3540 bighas (1180 acres) of agricultural land. The crop yield was assessed at 7575 maunds, compared to an average of 7317 maunds per year between 1888 and 1892[1371].In 1893, 2002 maunds of cannabis were shipped to Assam, Nepal, London, British Indian Ports, Foreign Ports, and other destinations, while 5573 maunds were left for domestic consumption [1372]. Charas was mostly used in the North Western Provinces, imported from Nepal, Eastern Turkestan, and Bokhara[1373]. It was made to some amount in the Kumaon and Garhwal regions of the Himalayas (present-day Uttarakhand) from fibre crops[1374]. The Excise Commissioner assessed the entire import of Charas in 1893 at 5000 maunds[1375]. Bengal, Punjab, the Central Provinces, and the Bundelkhand States were the top exporters of Bhang. In 1893, the domestic import and export of bhang were 1644 and 1263 maunds, respectively[1376].

Ganja was produced and consumed in the Bombay Presidency as well. In 1893, the state

[1368] GBIO. (2017). The Indian empire; Administrative (Vol. 4). Forgotten Books. 254
[1369] Mills, H.J. (2005). Cannabis Britannica: Empire, trade and prohibition. OUP Oxford. 59
[1370] Mills, H.J. (2005). Cannabis Britannica: Empire, trade and prohibition. OUP Oxford. 59
[1371] IHDC. (1894). *Report of the Indian hemp drugs commission 1893-94.* The Government Central Printing Office, Simla
[1372] Ibid
[1373] Ibid
[1374] Ibid
[1375] Ibid
[1376] Ibid

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]
VOLUME 5 AND ISSUE 1 OF 2025
APIS – 3920 - 0001 *(and)* ISSN - 2583-2344
Published by
Institute of Legal Education
https://iledu.in

produced 7150 maunds of ganja, which were allocated as shown below[1377]:

Consumed in British districts maunds	3000
Consumed in Native States maunds	2000
Exported by Sea maunds	1500
Unaccounted for maunds	650

Charas was imported to Bombay from Amritsar and Hoshiarpur, and the annual use was limited to 7 to 8 maunds[1378]. Charas usage was only reported in Bombay and Pune in 1893. Bhang was mostly consumed in the Northern Division and Khandesh of Bombay Presidency, with production in Baroda, Surat, and Palanpur[1379].

Revenue from Excise Duty and License Fees from Cannabis Cultivation and Sell[1380]:

Year	Total Revenue (Rs.)	Yearly Average (Rs.)
1873 – 1878	1,02,44,324	20,48,864
1878 – 1883	1,27,69,578	25,53,915
1883 – 1888	1,73,53,155	34,70,631
1888-89 - 1892-93	2,01,43,851	40,28,770

The excise administration of cannabis medications in Bengal was so methodical that the figures of registered sales by retail vendors could be recognised as accurate.

The excise administration of cannabis medications in Bengal was so methodical that the figures of registered sales by retail vendors could be recognised as accurate. Except for the Bengal province, consumption data was inappropriate and could not be considered. Bengal province alone had 3,76,880 ganja users, accounting for 0.53% of the province's entire population. In 1892-93, users used 5452 maunds of ganja, or around 2475 kgs. In British India, moderate ganja and charas use was ½ tola per day, while severe use ranged from 1 to 5 tolas per day. Approximately 15% of users were considered excessive[1381]. Retail ganja prices varied from Rs. 7.5 to Rs. 25 per seer, depending on quality and province[1382]. The rate of charas was nearly twice in all provinces where it was sold retail. Using ganja costs 1-2 annas and charas costs 2-4 annas each day. Bhang is less expensive than both and can be purchased for 3-4 annas in retail. The table below displays ganja consumption in India's three major cities. Data regarding charas and bhang were not available.

Consumption of Ganja in the Three Big Cities (Presidencies) during the year 1893[1383]

City (Presidency)	Population (37.324 kg)
Calcutta	1400
Bombay	2300
Madras	4900

Excise Revenue from all Intoxicated Drugs, 1860 to 1903 (Figures in Lakhs)[1384]

Drugs / Year	1860-01	1870-01	1880-01
Liquor	91	156	212
Opium	16	36	74
Cannabis (Ganja/Charas/Bhang)	11	22	30

According to the table, intoxicating spirits generated the most excise income of any inebriated drug. Excise revenue from the manufacture and sale of all inebriated drugs had increased on average sixfold, indicating an

[1377] Ibid
[1378] Ibid
[1379] IHDC. (1894). *Report of the Indian hemp drugs commission 1893-94*. The Government Central Printing Office, Simla. 119
[1380] IHDC. (1894). *Report of the Indian hemp drugs commission 1893-94*. The Government Central Printing Office, Simla.
[1381] Ibid
[1382] Ibid
[1383] Ibid
[1384] GBIO. (2017). *The Indian empire; Administrative (Vol. 4)*. Forgotten Books

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 5 AND ISSUE 1 OF 2025

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

increase in demand for the medications throughout the period, as well as an efficient administration system under British authority. In 1903, money from inebriated medications accounted for approximately 25.21% of total land revenue collected in 1901. During Akbar's reign in 1605, the land revenue was Rs.17,45,00,000/- (from ⅗ area of the entire land), whereas during Shahjahan's reign in 1648 it was Rs. 21,15,00,000/- (from ⅗ area of the total land), and in 1901 it was Rs. 26,25,45,459/- (from the total land area) (GBIO, 2017). Thus, Britishers gained enormous cash selling inebriated drugs, and as a result, drug misuse, particularly spirits consumption, developed dramatically in a relatively short period of time, causing serious public and social health problems. Seeing drug usage as a severe societal problem, leaders of the Indian National campaign, particularly Mahatma Gandhi, incorporated a prohibition programme into their political campaign about 1920, sowing the seeds of prohibition for Independent India.

The uses of alcohol have also been mentioned in the play named Macbeth written by William Shakespeare, an extract of which reads as below: -

"Porter: . . . and drink, sir, is a great provoker of three things.

Macduff: What three things does drink especially provoke?

Porter: Marry, sir, nose-painting [cutaneous vasodilation], sleep [CNS depression], and urine [a consequence of the inhibition of antidiuretic hormone (vasopressin) secretion, exacerbated by volume loading]. Lechery, sir, it provokes and unprovokes: it provokes the desire but it takes away the performance. Therefore much drink may be said to be an equivocator with lechery: it makes him and it mars him; it sets him on and it takes him off; it persuades him and disheartens him, makes him stand to and not stand to [the imagination desires what the corpus cavernosum cannot deliver]; in conclusion, equivocates him in a sleep, and, giving him the lie, leaves him."

Hemp was in USA from the ancient time the English writer Homer had referred to opium and has writing same time hippocrats referred opium as a medical herb. Considering the literatures from the ancient India, is considered as a holy plant. The Indian in the older Times believe that the guardian of the family passed away resided in the Bhang leaf. They also carried the belief if they take Bhang in the morning it helps in cleansing sin and helps them to get salvation out of the act of consuming Bhang which is equal to sacrificing thousand horses. The Hindu's in the ancient India believe that was the lucky charm which day used to carry auspicious and important occasion. In the state of Gujarat people used to distribute Bhang among they are relatives during the time of marriage as a custom from the side of the bride's family[1385]. During the reign of the Britishers in India, the British government established a Commission named the Indian Hemp Drugs Commission which was active from 1893. This Commission had exclusive research on him found in India and traced the history Indian him literatures and mythologist available during that time. This can be taken as one of the most extensive research works done under the British India government.

The research done by Mr.G.A.Grierson, the magistrate and collector of Howrah, talks about the various names used to address Hemp in the ancient India such as Vijaya, Indiracana and Bhang. In his research, Mr.G.A.Grierson about the existence of Bhang 12th century. Sushruta in his writing 18th century a day about Bhang as a medicine which help gastritis issues. Components present in Cannabis consider as medicine for various diseases Chinese emperor Shon Nung. Cannabis was used by a Chinese physician named Hoa-Gho which was mixed with wine and given as surgical anaesthesia. The use of Cannabis in medical surgery was also found in India around 1000 BC. It was also as a religious component to create and experience hallucinogen. Though the

[1385] M. Charles, E.J. Masihi, et al Cultural and Drug – Use and Abuse in Asian settings. Bulletins on Narcotics 1994 Issue.

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 5 AND ISSUE 1 OF 2025

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

consumption of alcohol and opium unacceptable on the religious ground in India, Bhang was accepted and used during festival Times such as Shivaratri and Holi. The intake of Bhang was also believed why a certain group of Indians as a method to attain spiritual enlighten.

During the 19th century Cannabis and opium were widely used in India. Cannabis was also in use Ayurvedic treatment and Unani as medical aid. Bhang was taken as a component to experience religious hallucination by religious monks. It is also been documented that the tribals in ancient India used Ganja or marijuana while performing rituals during festivals and ceremonies. The Mughal period can we taken as the period which witnessed wide opium in India. The cultivation of opium poppy had a vast increment during the East India Company which extended the export of opium from India to China in 1767[1386].
Hemp was consider as a medicinal drug. 1840, Dr WB O'Shaughnessy who was the professor in medical college in Calcutta, conducted a scientific test to observe the effects of using Hemp. The first trial to testify Hemp was on dogs. Eventually, it was tried on patience who suffered from rheumatism, conversion, cholera etc. The report provided after the investigation in 1870 suggested that the usage of Hemp was less dangerous then it was expected to have. Thus, any kind of prohibition on using hemp unnecessary and partially impractical. Even after the publication of this report the British government established a new Commission for enquiry. In the year 1893 Mr WS Caine, President and anti-drug campaigner and the Member of Parliament for Bradford East, demanded foreign enquiry on hemp as a drug in India.

PROHIBITION OF DRUGS UNDER LEGAL INSTRUMENTS

DRUG ADDICTION: A UNIVERSAL PHENOMENON[1387]:

Drug misuse and addiction are well recognised as a global epidemic. The drug trafficking trade has spread to practically every country in the world, and its impact may be felt in both the health sector and human development. The global medicine business is estimated to be $500 billion annually and is expanding due to rising demand for both natural and synthetic drugs[1388].

According to the 2016 UNODC substance Report[1389], almost one-quarter of a billion people aged 15 to 64 abused at least one substance during the year. According to the UNODC data, approximately 207,400 people died as a result of drug usage in 2014[1390], which stayed consistent with previous research statistics. However, this ratio is unacceptable, and no effective measures were taken to prevent it[1391].

In terms of drug trade in India, the country is located between the Golden Triangle and the Golden Crescent, making it the continent's global drug trafficking powerhouse.

DRUG ABUSERS AS VICTIMS OF THE CRIMINAL JUSTICE SYSTEM[1392]:

According to NCRB figures from 2014, the police charge over 50,000 cases each year, with a 31.7 percent pending by the end of the year.6 In 2015, 7227 people were convicted in NDPS cases across India, while another 15959 were awaiting trial. These figures indicate the congestion in jails of NDPS cases and the volume of cases handled by the police. In India, the NDPS Act of 1985 continues to criminalise drug abusers, making a victimless crime an act against oneself. The NDPS Act of 1985 was enacted to

[1386] Alfred W. Mc. Coy – "Historical review of Opium/Heroin Production" DRC Net Library

[1387] Ms. Donita Quadros and Mr. Rajiv Yadav, "Victims of Drug Abuse and the Law Enforcement: A Field Intervention" 2017.

[1388] Jenner, Matthew S., "International Drug Trafficking: A Global Problem with a Domestic Solution" *18 Indiana Journal of Global Legal Studies 901 (2011)* (2017).

[1389] United Nations Office on Drugs and Crime, *UNODC World Drug Report 2016* (June 23, 2016).

[1390] United Nations Office on Drugs and Crime, *UNODC World Drug Report 2016* (June 23, 2016).

[1391] United Nations Office on Drugs and Crime, *UNODC World Drug Report 2016* (June 23, 2016).

[1392] Ms. Donita Quadros and Mr. Rajiv Yadav, "Victims of Drug Abuse and the Law Enforcement: A Field Intervention" 2017.

prevent the illegal production, manufacture, storage, supply, and consumption of chemicals prohibited by law. The NDPS (1985) prohibits the use of narcotics and psychotropic substances for non-medical purposes.

According to the authors' field experience, when an individual is booked under an NDPS case, brought to the police station, and later produced in court, the subject is forced to plead guilty and then pay Rs500 in bail charges before being released on bond. When the individual returns to the community, he or she nearly always resumes drug use. This also leads to an increase in recidivism rates for NDPS. This cycle imposes stress on the drug abuser's family, the community, and the police in terms of case load, as well as stigmatisation or secondary victimisation of the individual and the group to which he or she belongs. The implementation of any law is dependent on law enforcement, specifically the police. The police are also responsible for protecting the rights of the people in society, hence the drug abuse prevention model requires a shift in the police's position to perceive them as victims rather than perpetrators.

INTERNATIONAL DRUG CONTROL CONVENTIONS (1961, 1971, 1988):

Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drug, 1961; The Convention on Psychotrophic Substances, 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotrophic Substances, 1988 are the three conventions under the United Nations which is the framework for control of narcotic drugs, psychotrophic substances and precursor chemicals. These three conventions are together referred as the International Drug Control Conventions. These conventions allows the internationally controlled substances such as industrial use, medical use and scientific use for the border transit, at the same time these conventions ensuring that there shouldn't be a diversion of these substances to illicit track. This chapter provides an overview of the International Drug Control Conventions and how the international conventions prohibits the drugs and protects the drug victims. Additionally, this chapter provides other treaty bodies which helps the states for the implementation of International Drug control treaties.

SINGLE CONVENTION ON NARCOTIC DRUGS, 1961 (1961 Convention):

On 28 July 1958, the United Nations Economic and Social Council voted to hold a plenipotentiary conference to create a single convention on narcotic substances, which would replace the existing multilateral accords in the subject with a single instrument. The United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs convened at United Nations Headquarters from January 24 to March 25, 1961, and adopted the Single Convention on Narcotic Drugs. It was altered by the 1972 Protocol Amending the Single Convention on Narcotic Drugs.

This Convention seeks to address drug misuse through coordinated international action. There are two types of intervention and control that function together. First, it tries to confine drug possession, use, trading, distribution, import, export, manufacture, and production to medical and scientific uses alone. Second, it prevents drug trafficking by promoting international cooperation in order to deter and discourage distributors.

Earlier treaties only addressed opium, coca, and derivatives like morphine, heroin, and cocaine. The Single Convention, enacted in 1961, unified those conventions and expanded their scope to encompass cannabis and medicines with effects similar to the drugs listed. The Commission on Narcotic Drugs and the World Health Organisation were given the authority to add, remove, and transfer drugs from the treaty's four Schedules of Controlled Substances. The worldwide Narcotics Control Board was charged with overseeing drug manufacturing, worldwide commerce, and

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 5 AND ISSUE 1 OF 2025

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

distribution. The United Nations Office on Drugs and Crime (UNODC) was tasked with monitoring the situation in each country and working with national authorities to guarantee compliance with the Single Convention.

THE CONVENTION ON THE PSYCHOTROPHIC SUBSTANCES, 1971[1393]:

The Convention provides an international regulatory framework for psychoactive substances. It responded to the diversity and broadening of the drug misuse spectrum by imposing controls on a number of synthetic pharmaceuticals based on their abuse potential and therapeutic value, respectively. The Convention contains four Schedules of banned substances, numbered from I (most stringent) to IV (least restrictive). The 1971 pact included a list of psychotropic drugs and their respective schedules. A 2002 European Parliament report[1394] and a report on amphetamine-type stimulants (ATS) 1996 by UNODC[1395] explains the Schedules as follows:

Schedule I comprises supposedly harmful medications that are said to pose a substantial risk to public health but have no therapeutic value. It covers both synthetic and natural hallucinogens, such as LSD and DMT. Cannabis is the most contentious medicine in this category, despite the fact that many doctors believe it has significant medicinal potential.

Schedule II includes amphetamine-type stimulants with modest therapeutic use, as well as analgesics like phencyclidine.

Schedule III comprises barbiturate drugs with fast or moderate effects, which have been subjected to substantial abuse despite their medicinal value, as well as certain analgesics such as buprenorphine.

Schedule IV comprises hypnotics, tranquillizers (benzodiazepines), and analgesics, which cause significant dependence but are mostly used in therapy.

NATIONAL INSTRUMENTS:

Article 47 of the Indian Constitution stipulates that "The state shall make rules to prohibit the consumption of intoxicating drinks and drugs that are harmful to health, except for medicinal purposes." Alcohol is a State Subject under the Indian Constitution's seventh schedule.

The primary guidelines include the prohibition of harmful medicines and alcohol. Encouraging healthy lifestyles among citizens - Improving nutrition and living standards. Article 47 emphasises the importance of adopting a better lifestyle by forbidding intoxicating drugs and alcohol. However, this piece has received a great deal of criticism and is disputed among inhabitants of the country. These ideals are not hollow pledges; the government must take action to put them into practice. The courts can also intervene if they believe the government is not doing enough to protect the Directive Principles. However, Directive Principles are not legally enforceable.

NARCOTIC DRUGS AND PSYCHOTROPHIC SUBSTANCES ACT, 1985 (NDPS):

The NDPS Act was the outcome of a global push to regulate drug supply, known as the 'War on Drugs'. The movement rose to popularity during the First Opium War (1839–1842). The International Opium Convention, held in Shanghai in 1909, served as a stepping stone because it brought together delegates from all around the world. The Convention issued a declaration regulating licit drugs and prohibiting criminal drug smuggling. The international drug control framework was enhanced and reshaped by a series of treaties and legislation that were eventually consolidated into a single document known as the 1961 Convention. In 1971, the Convention on Psychotropic Substances was reformed, followed by the United Nations Convention

[1393] Convention on psychotropic substances , 1971(available at: https://www.unodc.org/pdf/convention_1971_en.pdf)

43. Rapporteur: Kathalijne Maria Buitenweg, "Working Document on the UN Conventions on Drugs by EUROPEAN PARLIAMENT - Committee on Citizens' Freedoms and Rights, Justice and Home Affairs" (2002)

[1395] Security Council, Amphetamine-Type STIMULANTS a GLOBAL REVIEW Prepared by UNDCP at the Request of the Commission on Narcotic Drugs (Mar. 05, 2016).

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]
VOLUME 5 AND ISSUE 1 OF 2025
APIS – 3920 - 0001 *(and)* ISSN - 2583-2344
Published by
Institute of Legal Education
https://iledu.in

against Illicit Traffic in Narcotic Drugs and Psychotropic Substances in 1988. This expanded the scope of international drug prohibitions to regulate the use of psychotropic substances and control drug trafficking[1396]

SIGNIFICANT AMENDMENTS:

The NDPS Act was first amended in 1988 to address the growing concerns of drug trafficking and abuse. Key updates included the introduction of property seizures related to illegal trafficking, the establishment of a national fund to combat drug misuse, and the creation of special courts for related offenses. The amendment also detailed penalties for trafficking and harboring offenders, and prohibited suspension or remission of sentences. The 2001 amendment expanded the act's scope to include Indian citizens abroad and introduced terms like "addict" and "commercial quantity." It also added stricter penalties, clarified possession and trafficking laws, and improved the government's efforts to fund drug treatment and prevention.

The 2014 amendment focused on making essential narcotics more accessible for medical purposes, such as morphine for pain management, and strengthened regulations on property forfeiture for drug traffickers. It also removed the death penalty for recurrent offenses, replacing it with longer prison sentences. The 2021 amendment further tightened punishments for sponsoring illegal drug activities, with harsher penalties for those involved in financing or harboring drug traffickers. It established minimum sentences of 10 years, extendable up to 20 years, along with fines for individuals found guilty of these offenses.

PREVENTION OF ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES ACT, 1988

Illicit traffic in narcotic narcotics and psychotropic substances endangers people's health and wellbeing, and the activities of those involved harm the national economy. Parliament deemed it necessary to prevent and detain individuals involved in clandestine drug and psychotropic substance trafficking, particularly in areas prone to such activity. Along with these goals, the Narcotics Drugs and Psychotropic Substances Act of 1988 prohibited illicit trafficking[1397].

DRUGS AND COSMETIC ACT, 1940 AND RULE, 1945

Label medications for specific performance if they contain substances listed in Schedule H and fall under the Narcotics drugs and Psychotropic Substances Act of 1985. The key features of the 1940 Act, as revised in 2008, are summarised here.

The first chapter discusses the Act's short title, scope, and commencement, as well as pharmacological and cosmetic classifications. Chapter two of this Act establishes the Drugs Technical Advisory Board, Central Drugs Laboratory, and Drugs Consultancy Committee. The Technical Advisory Board may advise the Central and State Governments on technical issues arising from the administration of the Act. Since the Board's Constitution has been provided[1398], it would not be for the Court to require any alteration in the legislative provisions relating to the Board's Constitution, as it is the function of Parliament solely, as ruled in judgement. Shri Krishna Homoeo Pharmacy vs. Union of India[1399].

THE PREVENTION OF MONEY LAUNDERING ACT, 2002

The Prevention of Money Laundering Act, 2002, came into effect in July 2005 to address money laundering and illicit financial activities in India. Enacted in response to a global initiative by the

[1396] Sanyal, K., Mitra, A., & Singhal, N. From addict to convict. The working of the NDPS act in Punjab,1. Vidhi Legal Policy (23 August 2018) https://vidhilegalpolicy.im/research/2018-8-23-from- addict-to-convict-the-working-of-the-ndps-act-1985-in-punjab/

[1397] Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988 (Act No. 46 of 1988), s. PREAMBLE

[1398] The Drugs and Cosmetics Act, 1940. (Act No. 23 of 1940), s. 5(2)

[1399] Shri Krishna Homoeo Pharmacy v. Union of India, (2006) 1 MAH.L.J., P.325

United Nations, the Act allows for the attachment and seizure of property related to money laundering, with penalties including imprisonment for up to 10 years and fines up to Rs. 5 lakh. The Act aims to prohibit money laundering, recover illicit assets, and strengthen the legal framework to combat money laundering, terrorist financing, and cross-border economic crimes. The 2009 amendment expanded the scope of the law to include financial intermediaries such as money changers and credit card operators, requiring them to report transactions. It also sought to prevent the misuse of funds from illegal activities, like drug trafficking, and allowed India to join the Financial Action Task Force (FATF) in 2009.

THE JUSTICE (CARE AND PROTECTION OF CHILDREN) ACT, 2015

The Justice (Care and Protection of Children) Act, 2015, which replaced the Juvenile Justice (Care and Protection of Children) Act, 2000, came into effect on January 15, 2016. This legislation allows adolescents aged 16-18 who commit heinous crimes to be tried as adults. It was introduced to curb the illegal supply of narcotics to individuals under 18. The amendment to Section 77 imposes severe penalties, including up to seven years of imprisonment and fines up to one lakh rupees, for providing children with intoxicating substances, narcotic drugs, or tobacco without a medical professional's approval. India is unique in its strict penalties for providing such substances to minors. Section 78 also states that anyone involving a minor in the trafficking or selling of these substances can face similar penalties. Despite these stringent laws, juvenile delinquency remains a persistent issue in public areas like railway stations and bus stops.

NATIONAL PROGRAMS RELATED TO DRUG:

1. **National Mental Health Program (NMHP) 1982:**

The NMHP was established in 1982 to provide accessible mental healthcare services, promote community engagement, and apply current knowledge for social development. The District Mental Health Programme (DMHP) since 1996 serves as the program's main operational component. The World Health Organisation (WHO) supports increasing resources for SUDs through the mhGAP action programme, and SUDs have always been an important aspect of NMHP[1400]. The NMHP has been criticised for failing to address substance use disorders during implementation[1401]. Currently, only lorazepam is available for treating SUDs on the list of pharmaceuticals recommended for Primary Health Centres (PHC)[1402]. The GoI's most recent Health and Wellness Clinics (HWCs) project, launched in 2018, aims to integrate SUD management into primary care. The operational guidelines address the fundamental management of SUDs, including drugs such as naltrexone, naloxone, and thiamine[1403]. Only time will tell how much of this SUD management integration in PHCs can be implemented in the near and long term. In implementing NMHP, rather of treating the entire spectrum of mental diseases as a single entity, splitting it into smaller entities such as psychotic spectrum disorders and substance use disorders will enable equitable resource distribution and service delivery[1404].

2. **Central Sector Scheme for Prevention of Alcoholism and Substance (Drug) Abuse 1985:**

Since 1985-1986, the MoSJE has implemented a Central Sector Scheme of Assistance for the Prevention of Alcoholism and Substance Abuse.

[1400] Arpit Parmar, Venkata Lakshmi Narasimha, et.al., "National Drug Laws, Policies, and Programs in India: A Narrative Review" 46 Indian Journal of Psychological Medicine 8 (2024).
[1401] Snehil Gupta and Rajesh Sagar, "National Mental Health Programme-Optimism and Caution: A Narrative Review" Indian Journal of Psychological Medicine (2018).
[1402] Arpit Parmar, Venkata Lakshmi Narasimha, et.al., "National Drug Laws, Policies, and Programs in India: A Narrative Review" 46 Indian Journal of Psychological Medicine 8 (2024).
[1403] Ministry of Health and Family Welfare, Government of India. Mental, Neurological and Substance use (MNS) disorders care at Health and Wellness Centre. Operational Guidelines. https://nhsrcindia.org/sites/default/files/2021-12/MNS%20Care%20Training%20Manual%20for%20CHO.pdf (accessed April 09, 2024).
[1404] Math SB, Thippaiah SM, and Nanjappa MS. Lessons learnt from the National Mental Health Programme (NMHP): A guide to success for the National health programme for non-communicable diseases. Indian J Med Res 2021; 154: 416.

This programme identifies, counsels, treats, and rehabilitates individuals with addiction through volunteer and other eligible organisations. In 2008, it combined with the social services system to form a single umbrella scheme. This project provides financial help to volunteer organisations and eligible agencies to run and manage Integrated Rehabilitation Centres for Addicts (IRCA). The plan now falls under the National Action Plan for Drug Demand Reduction (NAPDDR) 2018.

3. Drug De-Addiction Program of India 1988:

India's Drug De-Addiction Programme (DDAP) is another major programme established by the Ministry of Health and Family Welfare in 1988. It operates in designated government medical facilities, giving grants for SUD treatments. The programme aimed to establish 30-bed "De-addiction Centres" (DACs) in six top hospitals/institutions to offer high-quality inpatient care to individuals with substance use disorders. The programme grew over the next 4-5 years, bringing state medical colleges and district hospitals under the ambit of the DDAP.

The DDAP works in partnership with state governments. The central government will provide one-time funding for infrastructure, while the state governments will handle ongoing funding for workforce and supplies. The north-eastern Indian states will receive an additional 0.2 million per year in recurring assistance. As a result of DDAP, 122 DACs were established (as of 2017). Except for funding to north-eastern states, only a few medical institutions receive complete financial support, including recurring costs. The All India Institute of Medical Science0s in New Delhi was designated as the "National Drug Dependence Treatment Centre" (NDDTC) in 2002, while the Post-Graduate Institute of Medical Education and Research in Chandigarh and the National Institute of Mental Health and Neuro-sciences, Bengaluru, and the Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry. Under the DDAP, GOI, the NDDTC, New Delhi is the nodal centre[1405].

Recent developments in DDAP:

The DDAP and the National Programme for Tobacco Control (NPTC) were recently renamed "National Programme for Tobacco Control and Drug Addiction Treatment" (NPTCDAT). NPTCDAT is one of eight tertiary care programmes focused on non-communicable diseases (NCDs) and e-health.16 In addition, services were extended to three more tertiary care centres: AIIMS in Bhubaneswar, Ram Manohar Lohia Hospital in New Delhi, and the Central Institute of Psychiatry in Ranchi. Between 2019 and 2021, DDAP allocated an average budget of '45-51 crores to the aforementioned institutes.

4. National AIDS Control Program And PWID:

Harm reduction is seen as a critical method for reducing the risk of HIV among PWID and their sexual partners. The primary harm reduction strategies used by NACO are the Needle Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST). NACP II prioritised NSEP and other activities, while NACP III introduced OST as an HIV prevention method for injecting drug users (IDUs) in 2007 using an NGO model. Prior to this merger, various non-governmental organisations offered OST for this purpose. Since 2010, government hospitals have collaborated to deliver OST services under the public health approach. Government hospital psychiatry departments serve as OST centres in close partnership with non-governmental organisations (NGOs).

Under NACP, OST (mainly buprenorphine) is given in clinics known as OST centres, or "Directly Observed Treatment." Take-home dosing and doorstep delivery were also introduced during the COVID-19 pandemic. According to HIV sentinel monitoring 2017, the prevalence of HIV among PWID is 6.26% countrywide (the highest among all high-risk

[1405] Arpit Parmar, Venkata Lakshmi Narasimha, et.al., "National Drug Laws, Policies, and Programs in India: A Narrative Review" 46 Indian Journal of Psychological Medicine 8 (2024).

groups covered by NACP). According to recent estimates, 204 intervention locations target 0.168 million PWID, whereas 232 OST centres serve 28% (n = 41,215).17 However, given the present level of PWID in India, according to the National Survey 2019, there is an urgent need to expand the harm reduction arm of drug control.

5. National Viral Hepatitis Control Program (NVHCP) and PWID:

The NVHCP was created in 2018 to combat hepatitis and eliminate hepatitis C across the country by 2030, as well as reduce the prevalence, morbidity, and mortality associated with hepatitis B and C. PWID have an increased chance of developing hepatitis B and C. They are also more susceptible to all-cause mortality and morbidity, necessitating specific care. To prevent and manage hepatitis B and C, NVHCP collaborates with NACP through the National Viral Hepatitis Management Unit and the State Viral Hepatitis Management Unit. This includes key populations such as PWID. PWID are eligible for initial focused HCV screening as part of a comprehensive harm reduction programme.

6. National Action Plan For Drug Demand Reduction (NAPDDR) 2018:

According to Section 71 of the NDPS Act, 1985, the government has the authority to establish centres for identifying and treating addicts, as well as supplying NDPS, subject to prescribed conditions and procedures. NAPDDR was created to ensure that the objectives of the legislation and the NDPS Policy 2012 are effectively implemented. A multipronged approach is the most effective strategy for reducing drug use in the country. The MoSJE gives financial assistance to create "District De-Addiction Centres" in disadvantaged districts.

7. Nasha Mukt Bharat Abhiyan (Drug free society campaign)

This campaign was launched as part of NAPDDR, under the auspices of MoSJE. The campaign maintains an intensive outreach programme. It offers a website where users can access discussion forums, information, education, and communication materials, as well as a live dashboard. Furthermore, major players such as IRCAs are conducting awareness campaigns through social media platforms and at the grassroots level. Internship programmes are offered to adolescents and young adults to raise awareness in the community.

8. Ayushman Bharat Pradhan Mantri Jan Arogya Yojna 2018:

The Government of India just launched the Ayushman Bharat Pradhan Mantri Jan Arogya Yojna (AB PM-JAY) in 2018, with the goal of achieving universal health coverage[1406]. The strategy is based on two pillars: delivering universal primary healthcare and health insurance to roughly 500 million Indians to cut healthcare expenditures, and establishing Health and Wellness Centres (HWCs)[1407]. This initiative aims to address the diverse health needs of India's 1.3 billion people, despite the country's low health-care spending. This initiative creates 0.15 million HWCs across India and offers cashless care up to '0.5 million per family per year, covering around 1,350 medical and surgical procedures[1408].

Until recently, mental illness treatment was excluded from health insurance coverage in India. According to the MHCA 2017, individuals with mental illnesses must be treated equally with those with physical illnesses while receiving healthcare services. Along the lines of "Every insurer needs to make provisions for mental illness on the same basis as is available for the treatment of physical illness[1409]." This system covers 17 different mental health problems,

[1406] Angell BJ, Prinja S, Gupt A, et al. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance. PLoS Med 2019; 16: e1002759.

[1407] Ayushman Bharat Yojana | National Health Portal of India, https://www. nhp.gov.in/ayushman-bharat-yojana_pg (accessed April 09, 2024).

[1408] About Pradhan Mantri Jan Arogya Yojana (PM-JAY) | Official Website Ayushman Bharat Pradhan Mantri Jan Arogya Yojana | National Health Authority. https://www. pmjay.gov.in./about/pmjay (accessed April 09, 2024).

[1409] The Gazette of India. The Mental Healthcare Act, 2017. New Delhi: Ministry of Law and Justice; 2017. https://egazette.nic.in/ Indian Journal of Psychological Medicine | Volume 46 | Issue 1 | January 2024 13 Review Article WriteReadData/2017/175248.pdf (accessed April 09, 2024)

including those caused by psychoactive drugs. Despite this, health insurance companies excluded mental illnesses and substance use disorders from their list of covered conditions. Following extensive advocacy and activity by relevant stakeholders in mental health in this country, mental illnesses have just been added to the list of insured ailments[1410]. The inclusion of mental illness and substance use disorders (SUDs) in the AB PM-JAY scheme demonstrates the Government of India's commitment to improving mental healthcare for its citizens and reducing stigma associated with SUDs.

The deployment of this unique health insurance programme was recently evaluated. Sriee et al. (2021) examined the coverage, impact, and utilisation of the AB PM-JAY scheme in a rural catchment area near a medical college and hospital in Chennai, Tamil Nadu, and discovered that 77.33% of 300 households were aware of the insurance scheme. Only 42.33% of families were covered, while 47.24% received healthcare services through this system the previous year[1411]. According to a survey conducted by the National Health Authority, the Ayushman Bharat initiative has widespread coverage across Indian states. In Tamil Nadu, 80% of the populace was aware of the initiative, but just about 20% in northern states like Bihar and Haryana[1412]. Periodic evaluations of the scheme's awareness and implementation are necessary to determine its efficacy in reducing healthcare costs in India. This scheme's coverage of mental illness and substance use disorders requires immediate assessment.

9. Non-communicable disease (NCD) control programs:

NCDs account for around 62% of all deaths in India, the majority of which are preventable[1413]. SUDs are classified as NCDs and are one of the leading causes of other NCDs[1414]. The GoI's NCD-related Sustainable Development Goal aim is to reduce premature death from NCDs by one-third by 2030 through prevention and treatment, as well as increase mental health and well-being[1415]. This requires understanding the epidemiology, enhancing the infrastructure and staff, health promotion, and early detection and treatment of NCDs. The Government of India's "National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)" recognises the link between tobacco and alcohol use and various NCDs. The programme aims to identify and manage those at risk of these SUDs. NCD cells are established to meet strategic needs for NPCDCS at the state and district levels[1416]. Since then, other stakeholders have expressed interest in implementing this new programme. A research agenda for NCDs is needed to inform policy-making and healthcare delivery nationwide[1417]. This programme focuses on substance use disorders (SUDs), particularly alcohol and tobacco use disorders, as a key risk factor for NCDs. The MoHFW and GoI collaborated with leading institutes to provide instructional materials on identifying and managing risk factors for NCDs[1418]. The operational requirements include screenings and interventions for alcohol and tobacco use.

[1410] Dhawan A, Rao R, Ambekar A, et al. Treatment of substance use disorders through the government health facilities: Developments in the "Drug De-addiction Programme" of Ministry of Health and Family Welfare, Government of India. Indian J Psychiatry 2017; 59: 380.

[1411] Sriee GVVP and Maiya GR. Coverage, utilization, and impact of Ayushman Bharat scheme among the rural field practice area of Saveetha Medical College and Hospital, Chennai. J Fam Med Prim Care 2021; 10: 1171–1176.

[1412] Sharma N. Ayushman Bharat awareness 80% in TN, barely 20% in Bihar and Haryana. The Economic Times, 3 September 2019. https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/ayushman-bharat-awareness-80- in-tn-barely-20-in-bihar-and-haryana/ articleshow/70953467.cms (accessed April 09, 2024)

[1413] Dandona L, Dandona R, Kumar GA, et al. Nations within a nation: Variations in epidemiological transition across the states of India, 1990–2016 in the Global Burden of Disease Study. The Lancet 2017; 390: 2437–2460.

[1414] Sinha R and Pati S. Addressing the escalating burden of chronic diseases in India: Need for strengthening primary care. J Fam Med Prim Care 2017; 6: 701–708.

[1415] SDG 3: Good Health and Well-being. https://in.one.un.org/page/sustainabledevelopment-goals/sdg-3-2/ (accessed April 09, 2024).

[1416] Volutary National Review Report. On the Implementation of Sustainable Development Goals. New Delhi: United Nations High Level Political Forum; 2017. https:// sustainabledevelopment.un.org/content/ documents/15836India.pdf (accessed April 09, 2024).

[1417] Kataria I, Siddiqui M, Gillespie T, et al. A research agenda for non-communicable disease prevention and control in India. Health Res Policy Syst 2020; 18: 126.

[1418] Training Manual for Medical Officers. Reducing Risk Factors for Non-Communicable Diseases in Primary Care. Bangalore: National Institute of Mental Health and Neuro Sciences; 2016. https:// main.mohfw.gov.in/sites/default/ files/Training%20Manual%20for%20 Medical%20Officers%20on%20 Reducing%20Risk%20Factors% 20of%20NCDs_1.pdf (accessed April 09, 2024).

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 5 AND ISSUE 1 OF 2025

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

Health promotion programmes aim to raise community knowledge of the negative effects of tobacco and alcohol use. These initiatives may help to close the treatment gap for SUDs.

10. National Telemental Health Program (NTMHP) 2022

The NTMHP was announced by the Government of India in the most recent Union Budget (2022-2023). The goal of NTMHP is to improve access to mental health care. NIMHANS, Bengaluru, will coordinate with 23 Tele-Mental Health Centres of Excellence around the country, with technical help from the International Institute of Information Technology (IIIT), Bengaluru[1419]. Following the announcement, NIMHANS launched the Tele-Mental Health Assistance and Networking Across States (Tele-MANAS) initiative under the MTMHP. The effort offers free tele-counseling services (toll-free number 14416) across the country, mostly in underserved and distant areas[1420].Tele-MANAS aims to collaborate with local mental health providers, including medical colleges, hospitals, district hospitals, and state or central governments. According to a recent estimate, Tele-MANAS got more than 20,000 calls in two months.

The NTMHP intends to collaborate with government-provided health services. This comprises the Ayushman Bharat Digital Mission, which is the foundation of the country's digital health infrastructure, as well as the e-Sanjeevani platform (the national tele-consultation service)[1421]. The NTMHP, as a recent addition to the Government of India's mental health policy arsenal, has yet to be fully implemented. While Tele-MANAS will cover SUD services, the implementation is not yet certain.

"Telemedicine Practice Guidelines" and "Tele-psychiatry Operational Guidelines" of India:

The GoI produced "Telemedicine Practice Guidelines 2020" during the COVID-19 first wave in India, followed by Telepsychiatry Operational Guidelines[1422]. This patient-centered programme improved access to both mental healthcare and substance use disorder treatment[1423]. However, there are a few major flaws in this approach. These include the exclusion of pharmaceuticals used for SUDs (namely, Baclofen, Acamprosate, Naltrexone, Topiramate, Bupropion, and Varenicline) from List A of drugs, as stated in the telepsychiatry guideline. List A contains generally safe drugs with limited misuse potential that can be safely prescribed in the initial teleconsultation. Benzodiazepines and opioids are classified as Schedule X under the NDPS Act, and cannot be prescribed via teleconsultation[1424]. The latter is a serious issue because banning some benzodiazepines (e.g., Lorazepam, Diazepam, and Chlordiazepoxide) from tele-prescription makes managing patients with alcohol withdrawal syndrome difficult if they arrive in a tele-consultation seeking assistance. The inability to prescribe anti-craving drugs during the initial tele-consultation may discourage remote patients with SUDs from seeking care due to a lack of long-term pharmacological maintenance therapy.

There are a few limits to this new programme. However, it should be noted that because only mental health (and no other medical or surgical specialty) has a separate telemedicine guideline in India, it remains to be seen whether the recommendations will expand to include more comprehensive management of SUDs in the future. This may reduce the treatment gap for SUD in India.

CONCLUSION:

[1419] Budget 2022: Sitharaman announces 24x7 free tele counselling for mental health. Hindustan Times. https://www. hindustantimes.com/india-news/ union-budget-2022-sitharaman-announces-24x7-free-counselling-for-mentalhealth-101643741447764.html (accessed April 09, 2024).

[1420] T-MANAS to function as 24×7 tele mental health facility in states, UTs. The Indian Express. https://indianexpress.com/article/ cities/bangalore/t-manas-to-functionas-24x7-tele-mental-health-facility-instates-uts-7757141/ (2022, accessed April 09, 2024).

[1421] Sagar R and Singh S. National TeleMental Health Program in India: A step towards mental health care for all? Indian J Psychiatry 2022; 64: 117–119.

[1422] Telemedicine Practice Guidelines. Enabling Registered Medical Practitioners to Provide Healthcare Using Telemedicine. Medical Council of India; 2020. https://www.mohfw.gov.in/pdf/ Telemedicine.pdf (accessed April 09, 2024).

[1423] Nath S, Mishra BR, Padhy SK, et al. Meeting the unmet mental health needs during COVID-19: Where does telemedicine stands during these times in India? Psychiatr Danub 2020; 32: 594–595.

[1424] Arpit Parmar, Venkata Lakshmi Narasimha, et.al., "National Drug Laws, Policies, and Programs in India: A Narrative Review" 46 Indian Journal of Psychological Medicine 8 (2024).

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 5 AND ISSUE 1 OF 2025

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

Drug addiction treatment faces numerous challenges, with treatment centres often failing due to a lack of cooperation from patients, families, and staff, along with the ongoing availability of drugs in society. Despite government investments in rehabilitation programs and efforts to address drug addiction, the legal framework, such as the Narcotic Drugs and Psychotropic Substances (NDPS) Act, has flaws. The Act's penalties are ineffective and hinder drug users from seeking treatment, while law enforcement struggles due to insufficient education and motivation. Drug trafficking continues to thrive despite these regulations.

The issue of addiction is compounded by underlying societal problems such as anxiety, family issues, and lack of entertainment, leading individuals to drugs. Both medical and psychological care are crucial for rehabilitation, yet the current system fails to fully address the needs of addicts. The government's de-addiction programs, although present, are insufficient, requiring more focused efforts on prevention, education, and the establishment of additional rehabilitation facilities. Awareness campaigns should target schools and communities to better equip the younger generation to resist drug use.

Additionally, data reveals a rise in drug-related crimes, with arrests increasing over time, especially among men. The NDPS Act's limitations contribute to this rise, and many individuals re-offend due to lack of continuous support after rehabilitation. To improve drug addiction treatment, there is a pressing need for better funding, enhanced cooperation, and ongoing monitoring of drug availability. Establishing research centres and improving rehabilitation frameworks in each state would be key to addressing these challenges and ensuring more effective drug addiction management.