Please share your comments/suggestions on this task force separately on an individual page by 20th June 2024 on email Id: umeshkapil@gmail.com.

सत्यमेव जयते

DRAFT

NATIONAL ACADEMY OF MEDICAL SCIENCES (INDIA)

DIRECTORATE GENERAL OF HEALTH SERVICES

MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

REPORT OF TASK FORCE

ON

ALCOHOL, SUBSTANCE USE DISORDERS AND BEHAVIOURAL ADDICTIONS IN INDIA

2023

NAMS – DGHS – Govt. of India – Task Force Series No. 04

REPORT OF TASK FORCE

ON

ALCOHOL, SUBSTANCE USE DISORDERS AND BEHAVIOURAL ADDICTIONS IN INDIA

Acknowledgement

The contributions from various domain experts in the field of substance use disorders and behavioral addictions and the Ministry of Health and Family Welfare are acknowledged. The support from National Academy of Medical Sciences (India) is also acknowledged. Acknowledgements are also due to the various stakeholders working in the field of substance use disorders and behavioral addictions in India.

Task Force Members

1. **Dr. Rakesh K Chadda,** Professor and Head, Department of Psychiatry, Chief, National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences, New Delhi-110029 : Chairperson, Task force
2. **Dr. Shiv Gautam,** 1, Jacob Rd, near Water Tank, Madrampur, Civil Lines, Jaipur, Rajasthan 302006
3. **Dr. SC Tewari,** H.No. 2/38, Shwetank, Near Study Hall School, Vipul Khand, Gomti Nagar, Lucknow- 226010
4. **Dr. Pratima Murthy,** Director, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru– 560029, India
5. **Dr. Debasish Basu,** Head, Department of Psychiatry, PGIMER, Chandigarh - 160012
6. **Dr. Rakesh Lal,** Professor of Psychiatry, Department of Psychiatry and National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences, New Delhi-110029
7. **Dr. Shekhar Saxena**, Professor of the Practice of Global Mental Health, Harvard T H Chan School of Public Health, Boston, USA, Former Director, Department of Mental Health and Substance Abuse, WHO Headquarters, Geneva
8. **Dr. Siddharth Sarkar,** Additional Professor of Psychiatry, Department of Psychiatry and National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences, New Delhi - Co-opted member
9. **Dr. Ravindra Rao,** Additional Professor of Psychiatry, Department of Psychiatry and National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences, New Delhi– Representative of the DGHS
10. **Dr. Sajjadur Rehman,** Specialist (Psychiatry), Department of Psychiatry, Lady Harding Medical College, New Delhi 110001, Representative of the DGHS

Preface

Substance use disorders and behavioral addictions are now recognized as an important public health issue. Many psychoactive substances are being used in India, including alcohol, tobacco, opioids, cannabis, sedative-hypnotics, volatile solvents, etc. These are associated with multiple health problems, diseases and disability, which can progress on to an early death. Use of psychoactive substances additionally results in burden on the family members and also has social costs. In recent times, behavioral addictions have emerged as an another related problem needing initiatives on part of the health professionals and policy makers. Subjects with substance use disorders as well as behavioral addictions need help and treatment. In India, a range of services are available for helping patients with substance use disorders and behavioral addictions. However, more concerted efforts are required to improve the outcome of patients with these illnesses. The report of the Task Force on Alcohol, Substance Use Disorders, and Behavioral Addictions of the National Academy of Medical Sciences (India) provides a roadmap and recommendations to improve upon the availability and delivery of treatment for substance use disorders and behavioral addictions in India.

List of Abbreviations

AIIMS – All India Institute of Medical Sciences

ATF – Addiction Treatment Facility

CIP – Central Institute of Psychiatry

DTC – Drug Treatment Clinic

GOI – Government of India

IRCA – Integrated Rehabilitation Centres for Addicts

MoHFW – Ministry of Health and Family Welfare

MoSJE – Ministry of Social Justice and Empowerment

NAPDDR – National Action Plan for Drug Demand Reduction

NGO – Non-Governmental Organization

NIMHANS – National Institute of Mental Health and Neurosciences

ODIC – Outreach and Drop in Centres

PGIMER – Post Graduate Institute of Medical Education and Research

SUD – Substance Use Disorder

Operational definitions of the terms used in the report

Behavioral addiction – Syndromes related to repetitive rewarding behaviors that cause distress or interference with functioning.

Demand Reduction – Demand reduction means trying to prevent people from wanting to and taking illicit drugs

Harm reduction – An approach to reduce the harmful consequences of drug use without necessarily reducing drug consumption.

Prevention (in context of substance use disorder) – Process that attempts to prevent the onset of substance use or limit the development of problems associated with using psychoactive substances.

Substance use disorder – Involves patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects.

Supply reduction –Supply reduction means using various strategies to disrupt the production and supply of illicit drugs.

Executive Summary

Substance use disorders are a growing concern in India. In the last one decade, behavioral addictions have also emerged as a key mental health challenge. Community-based surveys have suggested that substance use disorders affect a significant proportion of the population. These disorders cause impairment of physical, psychological, social, and financial health. The burden attributable to the use of substances at the population level is considerable.

The high magnitude of substance use disorders and behavioral addictions calls for a multipronged and multifaceted action. The approaches to addressing substance use disorders can generally be categorized into supply reduction (reduction of availability of substances), demand reduction (effective treatment of substance use disorders and awareness to reduce initiation of substance use), harm reduction (reducing the harms associated with substance use, without necessarily targeting cessation of substance use). Acute treatment phase of detoxification is followed by a maintenance treatment and rehabilitation. All of these interventions and approaches have their role. From a public health perspective, substance use disorders and behavioral addictions are commonly observed in the primary care clinical setting (outpatient, inpatient and emergency), and empowering a range of medical professionals for screening and providing treatment for addictive disorders can be an important step in improving the availability of services. There is a distinct role of prevention, whereby preventive measures can be instituted at schools, colleges, workplaces and communities. There is a need for a convergence to jointly address the problem of substance abuse under a coordinating body.

Medical professionals can play an important role in mitigating the effect of substance use disorders and behavioural addictions in general population. The National Academy of Medical Sciences (NAMS), India can play a key role by offering considered views for addressing substance use disorders and behavioral addictions in the Indian population. In pursuance of the meeting of NAMS held on 21st April, 2022, a Task Force was constituted on Alcohol and Substance Use Disorders and Behavioural Addictions. The Task Force has the mandate to develop white paper to be submitted to Government of India for improving the health intervention activities in the area of alcohol and substance abuse disorders and behavioural addictions. The Task Force reviewed the current reports and data pertaining to alcohol and substance use disorders and behavioral addictions in India. It then developed a

consensus on the key observations and key recommendations, taking into consideration the healthcare services and the varied social-cultural-economic contexts across the Indian landscape.

The key takeaways and recommendations are as follows:

Policy

- A national alcohol policy is required in India in line with the WHO Global Strategy to Reduce the Harmful Use of Alcohol.
- Relocation of all health-related activities for alcohol, drugs and behavioural addictions within the Ministry of Health and Family Welfare.
- Legislative policies to divert patients with substance use disorders with small quantities of recovered substances towards medical care in lieu of criminal proceedings and incarceration; Sensitising important stakeholders including law enforcement authorities and judiciary on the need to distinguish users from drug dealers.
- Telemedicine rules and guidelines should facilitate the treatment of substance use disorders and behavioural addictions.

Services and training

- Sensitization and education of primary health care providers about detection of substance use disorders and behavioural addictions and their treatment. Screening, brief intervention and referral to treatment can be more frequently used in primary care.
- Optimum utilization of online training mechanisms for training of medical professionals about substance use disorders and behavioural addictions. As a long-term goal, there is a need to incorporate the Ministry of Health and Family Welfare approved addiction psychiatry curriculum at the MBBS level.
- Expanding the healthcare services available and making a basket of services available to cater to different needs of the population.

Education and awareness

- Enhancing the awareness about substances of use and the harms associated with them, especially in the younger population and educational institutions.
- Health promotion measures to enhance prosocial behaviours to reduce substance use experimentation among the younger population.

Contents

1. Introduction

Substance use disorders and behavioral addictions area growing public health problem all over the world including India. Substances that are commonly used in India include tobacco (both smoked and smokeless forms), alcohol (beer, wines, spirits, toddy, etc.), cannabis (bhang, ganja, charas, etc.), and opioids (heroin, raw opium, *doda,* pharmaceutical opioids, etc.). While many people use substances, some of them suffer adverse health consequences, develop dependence, and/or require help and treatment. Sometimes, certain rewarding behaviors like playing video games and gambling may become excessive and can lead to serious social, financial and legal consequences. These excessive behaviors are amanifestation of behavioral addictions, as the person finds it difficult to stop indulging in these behaviours despite acknowledging the harms caused by the behaviors.

Community based surveys have suggested that substance use disorders and behavioural addictions affect a substantial proportion of the population. Among the substance users, some become regular users, exhibit problematic patterns of use and a minority also develops substance dependence (as depicted in figure 1). Similarly, behavioral addictions may also

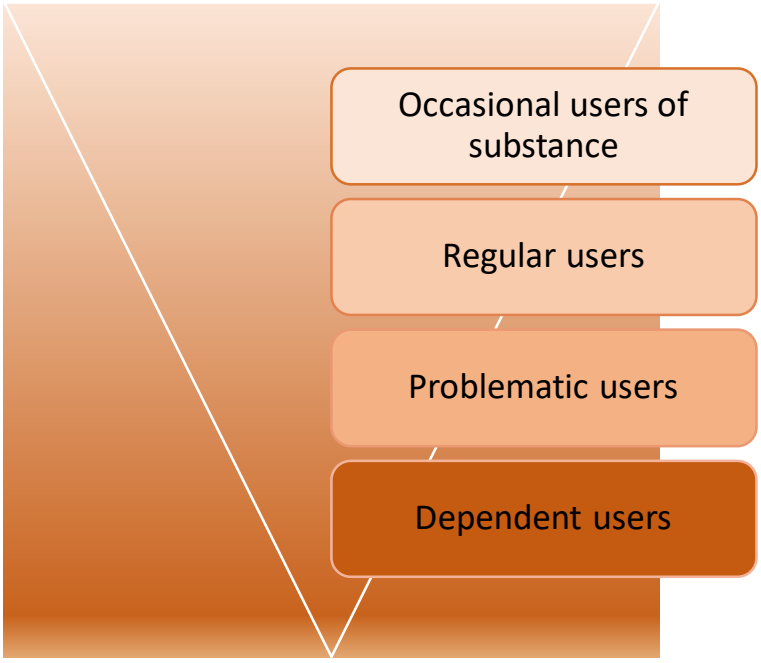

Figure 1: Continuum of substance related issues

affect a considerable proportion of the population, though a larger proportion may indulge in the behaviors in a non-addictive manner. Many factors play a role in development of problematic substance use among users. It is seen that the onset of substance use generally starts in adolescence, and multiple biological, psychological and social factors play a role in the genesis of substance use disorders.

Substance use disorders and behavioral addictions can cause impairment of physical, psychological, social and financial health at both, individual and societal levels. The profile of substances being used has changed over time, as evidenced by the changing profile of patients. There has also been an increase in the behavioral addictions, reflected by an increase in the number of adolescents presenting with addiction to internet/gaming disorders.

Substance use is a risk factor for many Non-Communicable Diseases (NCDs) like hypertension, mental health problems, and malignancies. Thus, substance use and substance use disorders are likely to be encountered by a range of healthcare professionals, and in various settings like routine outpatient, inpatient, wellness clinics and emergencies. Injection drug use (IDU) is associated with increased rates of transmission of human immunodeficiency virus (HIV), Hepatitis B and Hepatitis C. Substance use disorders and behavioral addictions are found to be more commonly present along with other mental health conditions than expected by chance, and substance use disorders can worsen the course and outcomes of psychiatric disorders.

The high magnitude of substance use disorders and behavioral addictions calls for a multipronged and multifaceted action. The approaches to address substance use disorders can generally be categorized into **supply reduction** (reduction of availability of substances), **demand reduction** (effective treatment of substance use disorders and awareness to reduce initiation of substance use), **harm reduction** (reducing the harms associated with substance use, without necessarily effecting cessation of substance use) and **rehabilitation** of individuals who have quit substance use to ensure they return to the main stream of society. Services can be provided at the primary, secondary and tertiary levels of care. Apart from therapeutic efforts, preventive efforts also have a major role in reducing the burden of substance use disorders and behavioral addictions. However, different organizations and entities are involved in addressing different aspects of addictive disorders. Hence, there is a

need for convergence to jointly address the problem of substance abuse under a coordinating body.

Despite preventive approaches and availability of services, substance use disorders and behavioral addictions remain a serious problem in the community level in India. There is a need to further plan about means and measures to address the issue more coherently and effectively. Medical professionals have the expertise and responsibility to chalk out the manner in which addictive disorders can be better addressed in India. Thus, the present white paper, under the auspices of National Academy of Medical Sciences discusses the manner in which substance use disorders and behavioural addictions can be tackled better.

2. Background

Medical professionals can play an important role in mitigating the effect of substance use disorders and behaviour addictions in general population. The National Academy of Medical Sciences (NAMS), India has taken initiative in constituting a task force in this area to develop guidelines for various stakeholders for addressing the problem of substance use disorders and behavioral addictions in Indian population. In pursuance of the meeting of NAMS held on 21st April, 2022 and the constitution of a Task Force on Alcohol and Substance Abuse to develop a white paper to be submitted to the Government of India for improving the health intervention activities in the area of Alcohol and Substance Abuse, the objectives of the task force were laid out.

This white paper document discusses the extent of substance use disorders and behavioral addictions in India and offers a roadmap for policymakers to address these more effectively with the help of medically oriented interventions.

3. Terms of Reference (TORs) for the Task Force

The main objectives of Task Force are:

1. To identify the current status in the area of alcohol and substance use disorders and behavioural addictions
2. To identify the deficiencies which need to be addressed

3. To recommend prevention of alcohol and substance use disorder and behavioural addictions and to make improvements in this field.

4. Methodology

The task force reviewed the current reports and data pertaining to substance use disorders and behavioral addictions in India. It then developed a consensus on the key observations and recommendations, taking into consideration the healthcare services and the varied social-cultural-economic contexts across the Indian landscape. The initial working draft was circulated among the task force members, and comments were sought. The working draft was modified based on the suggestions. Subsequently, an online meeting was held on 21st Sept 2022, in which the experts deliberated on the various aspects of the document. Further modifications were made to the document based on the inputs received from the experts.

5. Observation /Critical review

5.1. Current situation in the country

Alcohol and other substance use, and behavioural addictions constitute an important public health issue all round the world including India. Several research endeavours have estimated the prevalence of substance use and substance use disorders in India. In this section, we present the magnitude of the problem based upon reports from India.

The National Survey on Magnitude of Substance Use in India (2019), conducted by the NDDTC, AIIMS, New Delhi, has estimated the national and state-wise prevalence of substance use in the country. The survey has reported that alcohol is the most common psychoactive substance used by the Indian population. Nearly 15% of the population aged between 10 and 75 years consume alcohol. Converting these to absolute numbers, about 16 crore persons consume alcohol in India. The prevalence rate of alcohol use is much higher among men (about 27.3%) as compared to women (1.6%). The states with the highest prevalence of alcohol use as per this survey are Chhattisgarh, Tripura, Punjab, Arunachal Pradesh and Goa. The types of alcohol commonly consumed in India includes both country liquor and Indian made foreign liquor. Among the 16 crore alcohol users, about 5.7 crore individuals were found to be problem users (i.e., experiencing some problems with the use of

substances), and about 2.9 crore individuals were identified as dependent users (Figure 2 and 3). This suggests that there are a large number of individuals with alcohol use disorders.

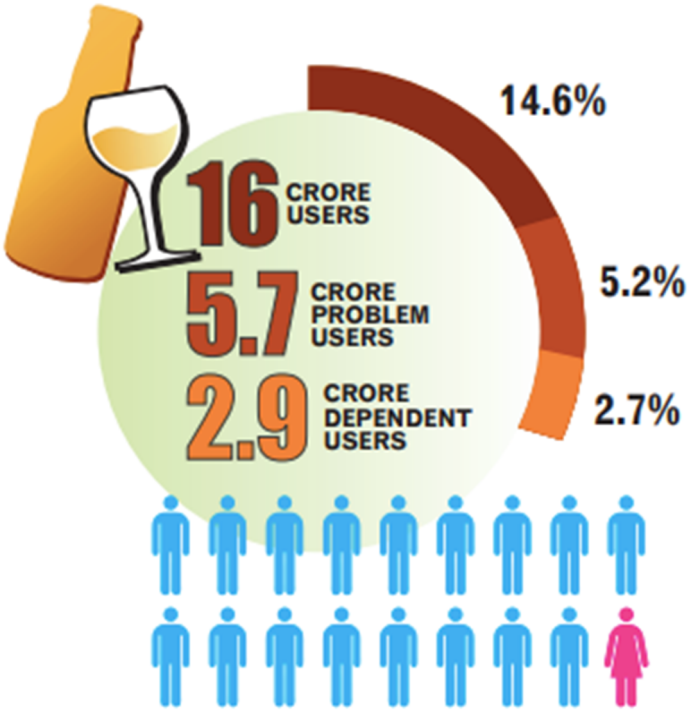

Figure 2: Alcohol use in India

(Source: Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India. 2019.)

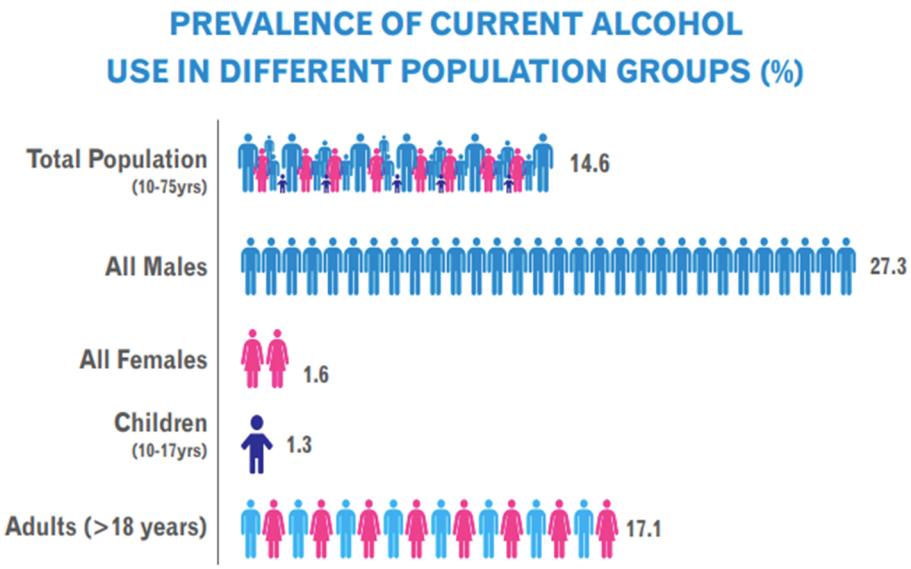

Figure 3: Alcohol use in different population sub-groups

(Source: Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India. 2019.)

Cannabis use was reported by about 2.8% of the population. This translates to about 3.1 crore individuals reporting cannabis use in India. Different forms of cannabis used have also been assessed in this survey. About 2% of the population uses *bhang* (translating to about 2.2 crore individuals), and 1.2% of the population uses *ganja* and *charas* (translating to about 1.3 crore individuals). The states with the highest reported prevalence of cannabis use were Uttar Pradesh, Punjab, Sikkim, Chhattisgarh and Delhi. There were about 72 lakh problem users and 25 lakh dependent users of cannabis across the country (figure 4).

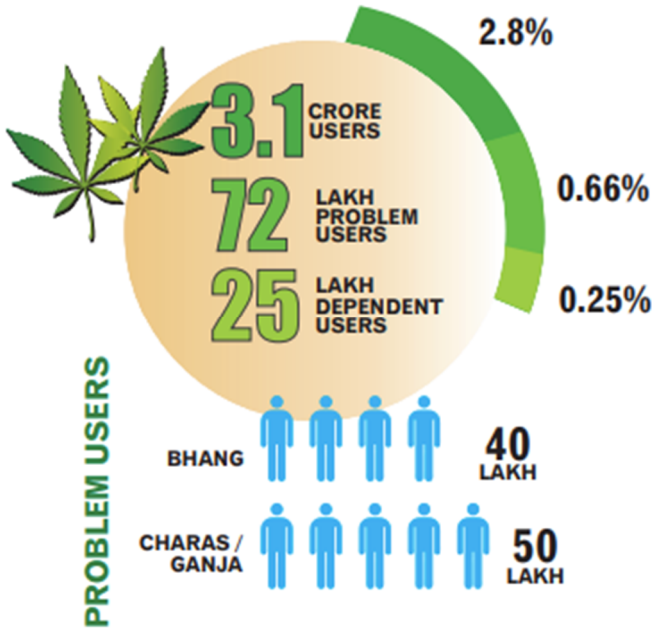

Figure 4: Cannabis use in India

(Source: Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India. 2019.)

Opioids were the next common substance of use. About 2.26 crore individuals, translating to about 2.1% of the country's population consume opioids. Heroin (1.14%) followed by pharmaceutical opioids (0.96%) and raw opium (0.52%) were the commonest opioids being used in India. The states with the highest prevalence of opioid use were Sikkim, Arunachal Pradesh, Nagaland, Manipur and Mizoram (prevalence of use in the general population more than 10%). It was estimated that there were 77 lakh problem users of opioids, and about 28 lakh dependent users (Figure 5).

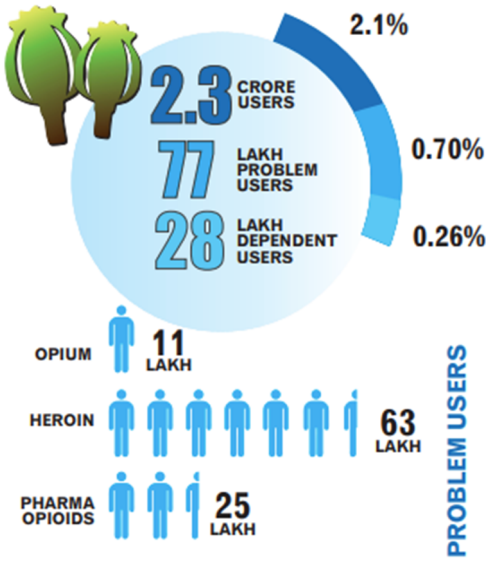

Figure 5: Opioid use in India

(Source: Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India. 2019.)

The survey estimated 1.08% of the population (translating to about 1.18 crore people) are as current users of non-medical and non-prescription sedatives. Sikkim, Nagaland, Manipur and Mizoram have the highest prevalence of such sedative usage. Inhalant use was more common among children and adolescents (1.17%) than adults (0.58%). Other categories of drugs, such as, cocaine (0.10%), amphetamine-type stimulants (0.18%) and hallucinogens (0.12%) were reported to be used by a smaller proportion of the population.

The National Mental Health Survey of India conducted in the years 2015-16 has also presented the data on harmful and dependent use of alcohol and other substances. The prevalence of alcohol use disorders was found to be 4.7% and prevalence of other substance use disorders (apart from tobacco) was found to be 0.6%. The prevalence of tobacco use disorders was 20.9%. These findings also suggest a high prevalence of substance use disorders in the country.

The rates of tobacco use according to National Family Health Survey- 5 was found to be 38.0% among men and 8.9% among women, though this survey did not present the prevalence of tobacco use disorders per se. Similarly, the prevalence rate of alcohol use among men and women was reported to be 18.3% and 1.3% respectively.

Of late, behavioural addictions have emerged as an important consideration in India as well. (Balhara et al, 2017). Among them, internet addiction has drawn research attention across the different states of India (Joseph et al., 2021). It has been estimated that about 20% to 40% of college students in India are at risk of internet addiction. Similarly, gambling related problems have been studied in the Indian context and there is evidence to suggest that 7.4% of college students indulged in problem gambling (George et al., 2016). Thus, behavioural addictions also need to be addressed from a policy and healthcare perspective in India. However, the literature on behavioural addiction has been limited, and representative national surveys are yet to be conducted on behavioural addictions.

Substance use disorders and behavioural addictions cause adverse health consequences, which result in disability and deaths. Ramalingam et al, (2022) showed that alcoholic liver disease led to more than 8000 deaths in the National Capital Territory of Delhi in a single year starting March 2017. The health-related expenditure due to alcohol was estimated to be about two times the revenue generated due to the sale of alcohol. Similarly, the Bangalore study suggests that alcohol use was associated with several familial and social adverse consequences, and the costs incurred due to alcohol use exceeded the revenue generated from alcohol (World Health Organization, 2006; Gururaj et al, 2011).

Taken together, there seems to be a high prevalence of substance use and substance use disorders in the country. Problematic substance use not only affects the person from a health perspective, but also causes a burden to the family and society. Substance use can cause both direct and indirect harm to individuals and communities.

5.2. Current infrastructure, facilities, technologies, policies, programs etc. in the country in context of the problem/health issue

Care of people with substance use disorders can be at various levels, including primary, secondary and tertiary care (Figure 6). Primary care has the widest approach and is most easily accessible to individuals with substance use disorders.

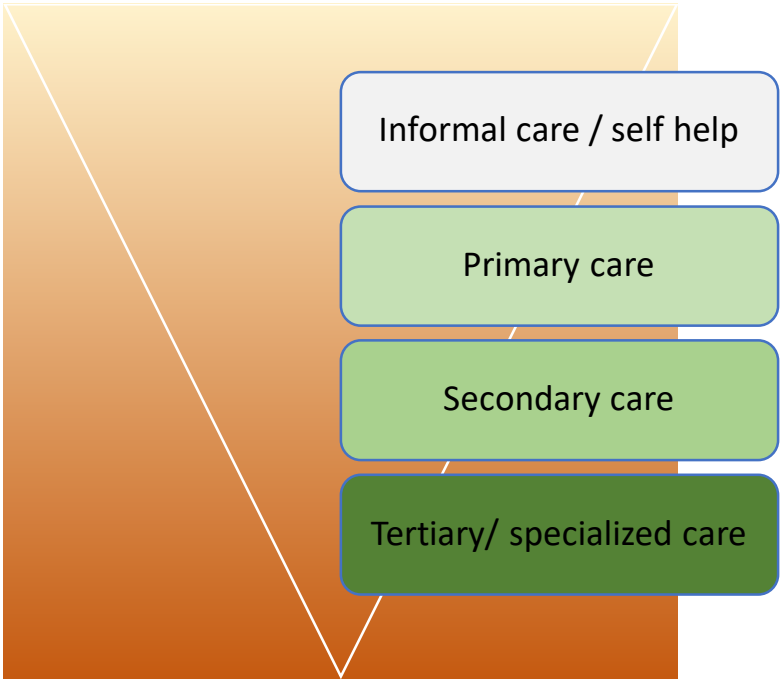

Figure 6: Care levels for people with substance use and behavioural problems.

(Source: Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India. 2019.)

A larger number of individuals can be helped at a lower level of care. As severity of problems increase, the individual may need to be referred to a higher level of care.

Brief interventions at primary care level can be of much use to elicit problematic substance use, and use the medical/ clinical encounter for suggesting behavioural change and discussing methods of reducing or ceasing substance use (Sarkar et al, 2020). For example, a clinical encounter in the medicine/ emergency department with medical health problem can provide an opportunity to discuss cessation of alcohol use which has led to gastritis/ accident. Screening, brief intervention and referral to treatment (SBIRT) can be utilized to screen and refer patients with more severe substance use disorders to the secondary level of care, and patients with complex needs can be referred to the tertiary levels of care.

Provisions of care can be through various approaches and settings:

- **Public institutions** – There is a wide array of medical and mental health services at primary, secondary and tertiary care. Generally, patients with substance use disorders and behavioural addictions would have closer access to primary care. Much of the

treatment of patients with substance use disorders especially screening and identification can be conducted in primary care.

There are also specialized centres and psychiatry departments in medical colleges for helping people with substance use disorders and behavioural addictions. NDDTC Ghaziabad, PGIMER, Chandigarh; NIMHANS, Bengaluru; RML Hospital, New Delhi; AIIMS, Bhubaneswar; and CIP, Ranchi, are among the centrally supported institutions. Apart from that, there are several Drug Treatment Clinics (DTCs) and Addiction Treatment Facilities (ATFs) across the country. Medical colleges (centrally supported or supported through state governments) also provide care.

- **Private medical facilities** – Many private medical facilities (both inpatient and outpatient) provide care for patients with substance use disorders. These facilities may be dedicated mental health facilities, or general medical facilities. Counselling is also provided by independent practitioners from across the country. Alcohol, tobacco and other substance related harms may make individuals visit general healthcare facilities, and this can be an opportune moment to discuss cessation/ reduction of substance use.

- **Non-governmental organization (NGO) and not-for-profit sector** – This sector also aims to reach out to patients with substance use disorders and provide care for them. There are a range of models of providing care, and these services tend to provide low-threshold services in the community. NGO and not-for-profit sectors provide a wide range of services varying from outpatient counselling services to long-term residential rehabilitation services. Additionally, Alcoholics Anonymous and Narcotics Anonymous also provide mutual self-help twelve-step facilitation among substance users.

- **Traditional and alternative systems of medicine –** Many patients with substance use disorders approach traditional and alternative systems of medicine as well. Several interventions like yoga have demonstrated efficacy for patients with substance use disorders.

- **Digital and tele services** – In the recent past, telephone and digital platforms have expanded in India. These offer an opportunity of reducing costs and make care more

easily and immediately available. mHealth based applications can be used through smartphones and can help in the reduction of substance use. Similarly, quit lines can provide counselling for cessation of tobacco.

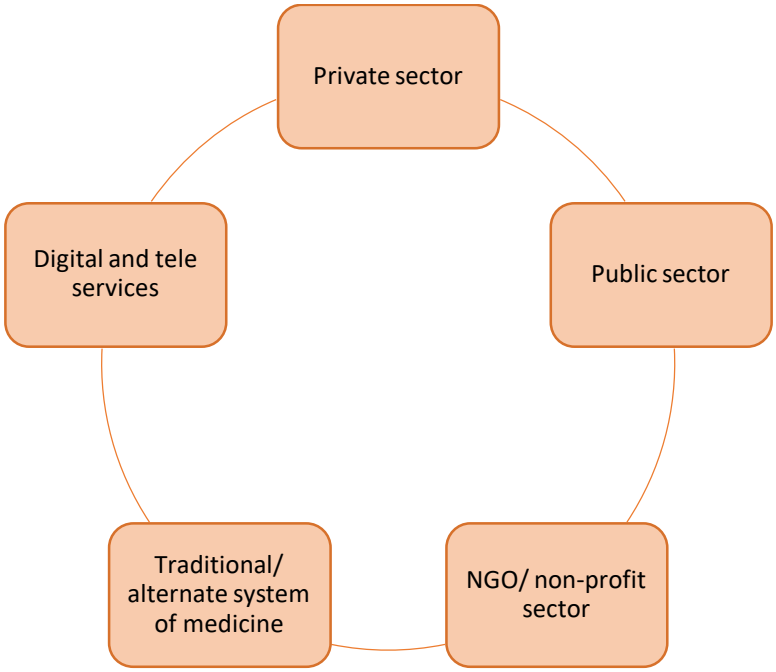

Figure 7: Treatment service provisions

Figure 7 summarises the range of services available for substance use disorders and behavioural addictions.

Apart from services, prevention forms an important component of approach to substance use and substance use disorders at the community level. Prevention aims at both educating the younger population about harms associated with substance use, and emphasizing the measures available for addressing substance use. Other approaches for prevention rely on improving prosocial behaviours in the school setting which has shown to reduce substance use initiation. Workplace-based interventions have also shown promise for reducing substance use. Prevention measures can be universal, selective or indicated, though universal approaches may have a wider reach and show greater impact. Prevention approaches that have shown a reduction in substance use among adolescents and young adults include increasing taxes on alcohol, brief alcohol screening and intervention for college students, and workplace interventions.

Supply control measures may also have an impact on the use of substances like alcohol. Restrictions on the sale below a certain age, prohibition of the sale of alcohol in a particular area, control on the number of outlets, and taxation may also limit the consumption of alcohol, and hence the consequent harms.

Current policies:

National Policy on Narcotic Drugs and Psychotropic Substances

Current programs:

- Drug De-Addiction Program under Ministry of Health and Family Welfare, Government of India.
- National Action Plan for Drug Demand Reduction under the Ministry of Social Justice and Empowerment, Government of India.
- Nasha Mukt Bharat Abhiyaan under the Ministry of Social Justice and Empowerment, Government of India.

5.3. Current Budget

Ministry of Health & Family Welfare is running a National 'Drug De-Addiction Programme (DDAP)' with the objectives to provide affordable, easily accessible and evidence-based treatment for all substance use disorders through the government health care facilities and to build the capacities of health care staff in recognition and management of substance use disorders. The programme is implemented through the health institutions under the MoH&FW viz. AIIMS, New Delhi; PGIMER, Chandigarh; NIMHANS, Bengaluru; RML Hospital, New Delhi; AIIMS, Bhubaneswar; and CIP, Ranchi. Out of these six, the centre at AIIMS, New Delhi (NDDTC) is functioning as the National / Nodal centre. MoHFW has released the "Standard Treatment Guidelines for the Management of Substance Use Disorders and Behavioural Addictions". The average annual budget of Rs. 45 to 53 crores has been allotted in for DDAP Programme for these above cited DDAP Institutes in last 3 years.

Ministry of Social Justice and Empowerment (MoSJE) implements National Action Plan for Drug Demand Reduction (NAPDDR), which is an umbrella scheme under which financial assistance is provided to

(i) ‘State Governments/Union Territory (UT) Administrations for Preventive Education and Awareness Generation, Capacity Building, Skill development, vocational training and livelihood support of ex-drug addicts, Programmes for Drug Demand Reduction by States/UT etc.

(ii) ‘Non-Government-Organizations/Voluntary Organizations for running and maintenance of Integrated Rehabilitation Centres for Addicts (IRCAs), Community based peer Led Intervention (CPLI) for early Drug Use Prevention among Adolescents and Outreach and Drop In Centres (ODIC) and Addiction treatment facilities (ATFs) in Government Hospitals’.

6. Recommendations

6.1. Key issues/ gaps identified in the current situation in the country in context of the problem/health issue

Despite having a considerable substance using population, there is a large unmet treatment need pertaining to substance use disorders in India. The National Survey on Magnitude of Substance Use in India suggests that only one in four persons with dependence on illicit substances receive treatment. For alcohol dependence, the rates were even abysmal, with only one in thirty-eight individuals with alcohol dependence ever receiving treatment. **The National Mental Health Survey of India found the treatment gap to be 86.3% for alcohol use disorders, 91.8% for tobacco use disorders and about 73% for other drug use disorders (overall 90%).** This emphasizes the fact that there are much larger number of individuals with substance use disorders than who seek treatment.

Additionally, among those who seek treatment, many drop out of treatment due to various reasons. There could be many causes of drop-out from treatment including inaccessibility of treatment, lack of motivation, logistical difficulties, peer pressure for discontinuation, and other reasons. Drop-out from treatment may be associated with relapse to substance use and recurrence of the problems associated with substance use. Thus, unplanned treatment cessations need to be focussed upon so that the duration of abstinence from substances can be prolonged.

Treatment facilities of substance use disorders need to be expanded. Treatment for substance use disorders is provided through dedicated services, through various channels. There is a need to expand the services so that it is accessible to individuals who need it. Providing such treatment at subsidized costs or free of cost or bringing it under the ambit of insurance cover may make the care affordable to the patients.

There is also a **need to expand the training and teaching in addiction psychiatry among the medical graduates.** Since alcohol dependence and substance use disorders are a common presentation in the clinical medical setting, clinicians need to be empowered to deal with these disorders. However, as of present, the attention to substance use disorders in the medical curriculum is limited. This forces medical graduates to ‘learn on the go’ when they

practice. A greater training of the medical graduates about substance use disorders and behavioural addictions is warranted.

There is a need to empower primary care physicians and other health professionals through trainings to enable them to screen substance use disorders and treat them. This might be done by providing clinical experience through case discussions, and handholding in the initial period so that they become more attuned to care of patients with substance use disorders in a routine manner.

Apart from training medical graduates, there is a need to train specialists in the field of addiction to provide care for patients with complex needs. Specialized training is also needed to develop a workforce of those who are able to train personnel for the treatment of addictive disorders.

Services of clinical psychologists, professionals from psychiatric social work and professionals from psychiatric nursing can be utilized for the purpose of awareness, identification, counselling of persons with substance use disorders.

Short-term courses (for example, under IGNOU) can be designed to increase human resources for counselling services and work at community level. This would enable services to be provided at a larger scale to those who use substances, or have issues related to behavioural addiction.

Furthermore, there need to be **efforts to enhance knowledge about substance use disorders in the general population**. More awareness about these disorders, putting in the context of harms associated with them and the help available for treatment would be helpful. Coupled with this, stigma reduction measures would help to de-stigmatize the substance use disorders and enable greater acceptability of treatment.

While drawing and implementing policies, one has to consider the social needs and expectations. The perceptions of the community and their expectations should be factored in while framing programs and implementation. Social marketing and social engagement need to be implemented to improve the outcomes of policies. The experience from previous programs has suggested that corrective measures may be required to improve community engagement and delivery of services.

6.2. Key issues/ gaps identified in the current infrastructure, facilities, technologies, policies, programs etc. in the country in context of the problem/health issue

Key gaps in current infrastructure, facilities, technologies, policies, programs include:

1. Lack of adequate facilities and evidence-based treatment available to provide treatment for substance use disorder.
2. Lack of knowledge and skills in medical personnel to address substance use disorder
3. Different agencies to deal with different aspects of substance use disorders
4. Non-uniform policies on alcohol
5. Lack of awareness regarding available treatment for substance use disorders and behavioural addiction
6. Lack of community support for treatment, support and aftercare for people with substance use disorders
7. Lack of regulation of some centres that cater to people with substance use disorders resulting in the mistreatment of people with substance use disorders
8. Lack of due emphasis/focus on substance use disorders at the state level (which is responsible for health) in the midst of competing priorities.

6.3 Key issues/ gaps identified in current financial inputs etc. in the country in context of the problem/health issue

While financial inputs are being provided for the treatment of substance use disorders, there needs to be a greater emphasis. Some of the further measures could be:

- Dedicated outlays for evidence-based preventive measures
- Greater government expenditure for sustaining services in the government sector
- Dedicated budget for substance use disorders through telemedicine
- Financial incentive for provision of care to patients with substance use disorder in the NGO sector
- Dedicated funds for incentivizing capacity development – trained primary care physicians, medical professionals, counsellors, nurses, and other health professionals.

- Funds for research need to be earmarked to find contextual solutions to the problems of substance use and behavioural addictions in India

7. Way forward

The way forward should include both preventive and curative aspects to address the problems of substance use and behavioral addictions. There is a need for clearly demonstrated efficacious measures, especially which have been shown to be implementable in the country. Due to cultural and linguistic differences across the country, a multiple set of approaches might be useful to address the concerns of substance use disorders and behavioral addictions (Figure 8).

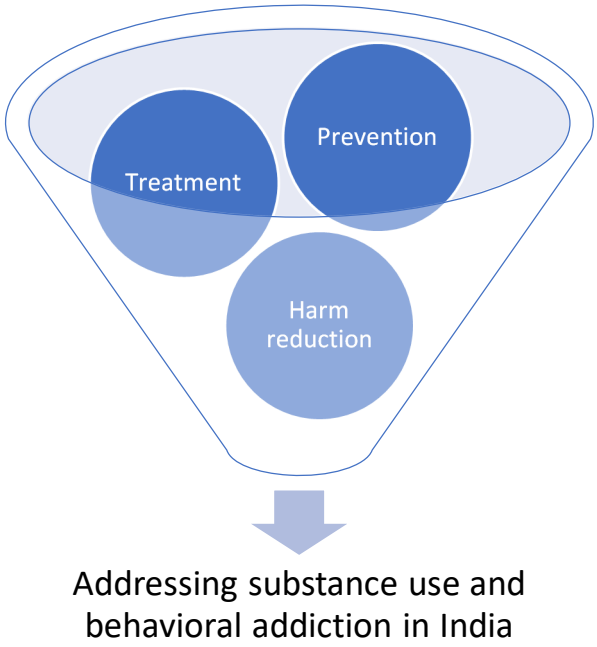

Figure 8: Addressing substance use disorders and behavioral addictions in India

7.1. Suggested Policy activities and advocacy for policy makers

- Working further towards a national alcohol policy in line with the WHO Global Strategy to Reduce the Harmful Use of Alcohol.

- Relocation of all health-related activities for tobacco, alcohol, drugs and behavioural addictions within the Ministry of Health and Family Welfare.
- Framing policies to divert patients with substance use disorders with small quantities of recovered substances towards medical care in lieu of criminal proceedings and incarceration.
- Sensitising important stakeholders including law enforcement authorities, judiciary, on the need to distinguish drug users from drug dealers.
- Telemedicine rules and guidelines should also facilitate the treatment of substance use disorders.
- Enabling provisions to ensure the physical safety of healthcare providers at workplace.
- Advocating with policy makers on the need to ease the availability of medicines that are otherwise regulated under the Narcotic Drugs and Psychotropic Substances (NDPS) Act of 1985 and need to protect medical fraternity from inadvertent lapses in following processes/procedures in prescribing and dispensing medicines. This includes benzodiazepines that are needed for patients with mental illnesses.
- Fund policy related research activities on existing policies on substance use disorders and behavioural addiction, for example, the impact of banning alcohol in some regions/states, whether criminalisation/decriminalisation of some substances is the way forward, etc.

7.2. Recommendations for health/medical professionals

- Training medical professionals and other healthcare providers about substance use disorders to enable screening and detection of substance use disorders and behavioural addictions at primary/ emergency care level.
- Every patient who visits any health centre or tertiary care centre and has any of the above listed addiction habit should be counselled by the doctor at first instance and necessary referral from a psychiatrist in case need arise.
- Greater utilization of brief intervention and referral to treatment of patients encountered in the medical setting who have problematic substance use at the primary level of care.
- Optimum utilization of online training mechanisms for the training of medical professionals about substance use disorders and behavioural addictions. As a long-

term goal, incorporate the Ministry of Health and Family Welfare approved addiction psychiatry curriculum at the MBBS level.

- Enable provision of basic treatment of substance use disorders and behavioural addictions at the primary care level.
- Making a basket of services available to cater to the different needs of the population.
- Greater access to treatment services like opioid substitution treatment for those who need such treatment.
- Integrate psychosocial rehabilitation with medical treatment of patients with substance use disorders.
- Training about addictive disorders at postgraduate levels in mental health and allied disciplines.

7.3. Suggestions to create awareness among general public, NGOs, Community stake holders

- Enhancing the awareness about substances of use and the harms associated with them at the school and college levels. This includes not only medical harms and health deterioration, but also mental health concerns and social consequences of substance use disorders.
- Strengthening, implementation and monitoring of "Nasha Mukt Bharat Abhiyaan" could hold promise in preventive aspects.
- Initiate workplace interventions for substance use problems in the work force.
- Sensitising teachers in educational institutions about substance use for early identification, and referral
- Target school and college students towards enhancing prosocial behaviours, to reduce substance use experimentation.

The Key thrusts at policy, professional and awareness levels are given in Figure 9

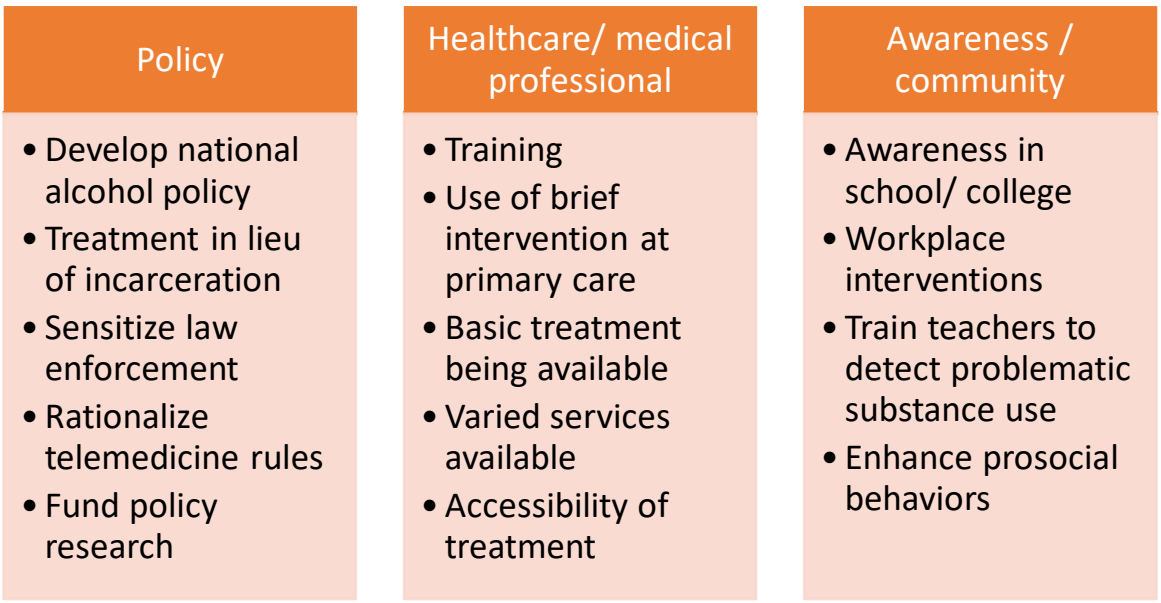

Figure 9: Key thrusts at policy, professional and awareness levels

The implementation plan would need more thorough deliberations with not only medical experts, but also a multi-stakeholder approach including individuals with substance use disorders, those with programmatic and administrative experience, financial experts, and others. The choice of strategies to be prioritized should be based upon the evidence base and also the unique cultural, social, economic and political landscape of the country. Social marketing should be considered while planning and implementing programs that address substance-related problems and behavioral addictions (Tiwari, 1998). The strategies selected should be linked to measurable outcome evaluated on a suitable time frame basis. The objectives being defined by being specific, measurable, achievable, reliable, and time-bound would help to know whether the strategies are having the intended effects. This would be beneficial in directing resources and better utilization of the inputs.

Further implementation plan is given below in Figure 10

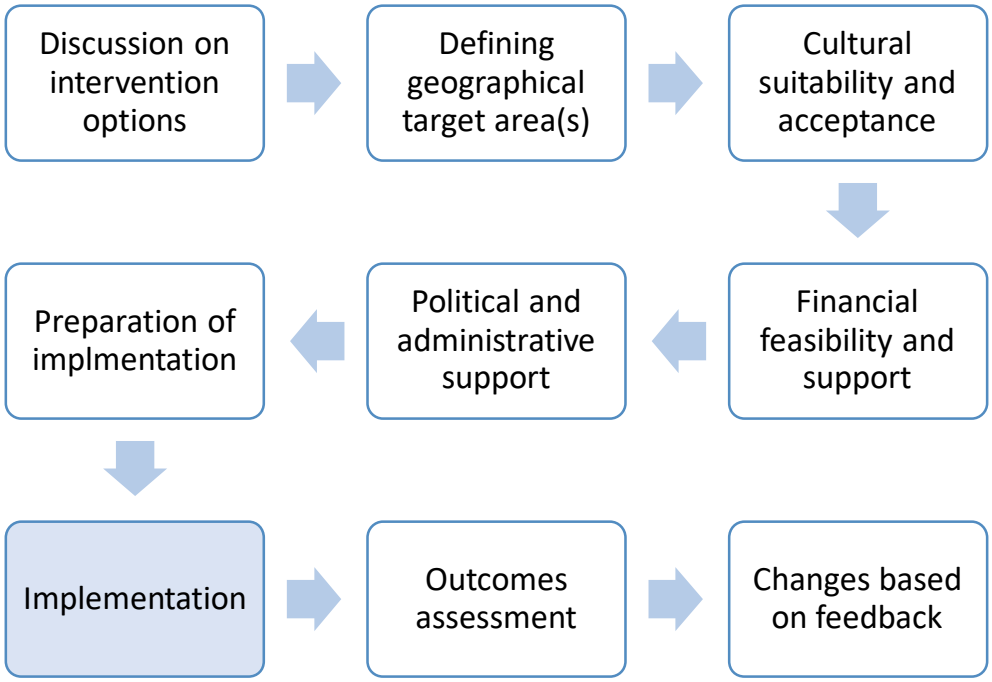

Figure 10: Further implementation plan

8. Documents referred by the task force

- Advisory on Alcohol Withdrawal during the lockdown, 2020. Available at http://socialjustice.nic.in/writereaddata/UploadFile/Advisory%20MoSJE_%20AIIMS%20 1.pdf (last accessed on 19.01.2021)
- Ambekar A, Agrawal A, Rao R, Mishra AK, Khandelwal SK, Chadda RK. Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India. 2019.
- Ambekar A, Rao R, Agrawal A. Contribution Towards National Policies and Programs Related to Addiction Treatment Services During COVID-19 Pandemic: An Experiential Account. In Rakesh K Chadda, Mamta Sood, Raman Deep. COVID 19 Pandemic and Mental Health: Experiences of Organizing Services at a Tertiary Care Healthcare Institution. Department of Psychiatry & National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), 2021; 70-74.
- Balhara, Y.P., Bhargava, R., Chadda, R. (2017). Service development for behavioural addictions: AIIMS experience. Annals of National Academy of Medical Sciences (India); 53:130-38
- Basu D, Aggarwal M, Das PP, Mattoo SK, Kulhara P, Varma VK. Changing pattern of substance abuse in patients attending a de-addiction centre in north India (1978-2008). The Indian journal of medical research. 2012;135(6):830.
- Chadda RK. Substance use disorders: Need for public health initiatives. Indian Journal of Social Psychiatry. 2019;35(1):13.
- Chadda RK, Chatterjee B. Need for psychosocial interventions: From resistance to therapeutic alliance. Indian Journal of Psychiatry. 2018;60 (Suppl 4):S440.
- Chadda RK, Lal R, Basu D, Gupta N, Balhara YPS, Bhargava R, Patra BN, Gupta S. Standard Treatment Guidelines. Management of Alcohol Dependence. Ministry of Health & Family Welfare Government of India, New Delhi, 2017.
- Dhawan A, Rao R, Ambekar A, Pusp A, Ray R. 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 Journal of Psychiatry. 2017;59(3):380.
- Gautham MS, Gururaj G, Varghese M, Benegal V, Rao GN, Kokane A, Chavan BS, Dalal PK, Ram D, Pathak K, Lenin Singh RK. The National Mental Health

Survey of India (2016): Prevalence, socio-demographic correlates and treatment gap of mental morbidity. International Journal of Social Psychiatry. 2020;66(4):361-72.

- George S, Ts J, Nair S, Rani A, Menon P, Madhavan R, Rajan JC, Radhakrishnan KS, Jose V, Benegal V, Thennarasu K, Petry NM. A cross-sectional study of problem gambling and its correlates among college students in South India. BJPsych Open. 2016;2(3):199-203.
- Gururaj G, Murthy P, Girish N, Benegal V. Alcoholrelatedharm : Implications for public health and policy in India, Publication No. 73, NIMHANS, Bangalore, India, 2011.
- Indian Psychiatric Society. Interim Guidelines for Opioid Substitution Therapy (OST) during COVID-19 outbreak, 6 April 2020. Available at https://indianpsychiatricsociety.org/ips-interim-guidelines-for-opioid-substitutiontherapy-ost-during-covid-19-outbreak/ (last accessed on 19.01.2021)
- Joseph J, Varghese A, Vijay VR, Dhandapani M, Grover S, Sharma S, Khakha D, Mann S, Varkey BP. Prevalence of internet addiction among college students in the Indian setting: a systematic review and meta-analysis. General Psychiatry. 2021;34(4).e100496
- Kaur J, Jain DC. Tobacco control policies in India: implementation and challenges. Indian Journal of Public Health. 2011;55(3):220.
- Ministry of Health & Family Welfare, Government of India, 2020. 'Managing Drugs/Substances Withdrawal in the context of Lock down as a response to COVID19 Pandemic'. Advisory issued by DDAP, MOH&FW to Principal Secretaries of Health, all states and UTs, dated 14 May 2020.
- Murthy P, Manjunatha N, Subodh BN, Chand PK, Benegal V. Substance use and addiction research in India. Indian journal of psychiatry. 2010;52(Suppl1):S189.
- National Drug Dependence Treatment Centre (NDDTC), AIIMS, 2020. Lockdown and Alcohol Withdrawal. Available at https://covid.aiims.edu/lockdown-and-alcoholwithdrawal/ (last accessed on 19.01.2021)
- National Family Health Survey – 5. 2019-21. India Fact Sheet. International Institute for Population Sciences. 2022. Available at http://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf

- National Policy on Narcotic Drugs and Psychotropic Substances (2012). Retrieved from http://dor.gov.in/sites/upload files/revenue/files/NationalPolicyonNDPS.pdf
- Ramalingam A, Pasupuleti SS, Nagappa B, Sarin SK. Health and economic burden due to alcohol-associated liver diseases in the Union Territory of Delhi: A Markov probabilistic model approach. Indian Journal of Gastroenterology. 2022;41(1):84-95.
- Sarkar S, Nebhinani N, Gupta S, Parakh P, Basu D. Self-reported medical co-morbidity among 400 substance using patients at an addiction unit in India. Journal of Substance Use. 2016;21(1):41-7.
- Sarkar S, Pakhre A, Murthy P, Bhuyan D. Brief interventions for substance use disorders. Indian Journal of Psychiatry. 2020;62(Suppl 2):S290 – 298.
- Standard Treatment Guidelines for the Management of Substance Use Disorders and Behavioural Addictions. Murthy P, Dhawan A, Basu, D, Gupta M, Chandra M, Chand PK, Mahadevan J, Bhatia G, Nirwan H, Sharma N, Singh S, Singh VV (Eds). New Delhi: Tobacco Control & Drug De-Addiction Programme Ministry of Health and Family Welfare, Government of India, 2020.
- Substance Abuse and Mental Health Services Administration: Substance Misuse Prevention for Young Adults. Publication No. PEP19-PL-Guide-1 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.
- Tiwari SC. Social marketing: A new approach in mental health research. Indian Journal of Psychiatry. 1998;40(4):311-321.
- World Health Organization. Global Strategy to Reduce the Harmful Use of Alcohol. World Health Organisation: Geneva, 2010.
- World Health Organization. Regional Office for the Eastern Mediterranean. (2021). Summary report on the regional technical consultation on the working document for development of the action plan (2022-2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority, virtual meeting, 23 February 2021. World Health Organization. Regional Office for the Eastern Mediterranean. https://apps.who.int/iris/handle/10665/351532.
- World Health Organization. Burden and Socio-Economic Impact of Alcohol — The Bangalore study. World Health Organization, Regional Office for South-East Asia, 2006

- World Health Organization. International Standards for the Treatment of Drug Use Disorders: Revised edition incorporating results of field-testing. World Health Organization and United Nations Office on Drugs and Crime, 2020

9 Annexure

9.1 Details of Task force members

S No	Name of the Expert	E mail
1	**Dr. Rakesh K Chadda-**Chairman Professor and Head, Department of Psychiatry, Chief, National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences, New Delhi-110029	drrakeshchadda@gmail.com
2	**Dr. Shiv Gautam**, 1, Jacob Rd, near Water Tank, Madrampur, Civil Lines, Jaipur, Rajasthan 302006	dr_shivgautam@yahoo.com
3	**Dr. SC Tewari**, H.No. 2/38, Shwetank, Near Study Hall School, Vipul Khand, Gomti Nagar, Lucknow- 226010	sarvada1953@gmail.com
4	**Dr. Pratima Murthy** Director, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru– 560029, India	dirstaff@nimhans.ac.in pratimamurthy@gmail.com
5	**Dr. Debasish Basu** Head of Department, Department of Psychiatry, PGIMER, Chandigarh - 160012	db_sm2002@yahoo.com
6	**Dr. Rakesh Lal** Prof. of Psychiatry, National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences, New Delhi-110029	drrakeshlall@gmail.com
7	**Dr. Shekhar Saxena** Professor of the Practice of Global Mental Health, Harvard T H Chan School of Public Health, Boston, USA; Former Director, Department of Mental Health and Substance Abuse, WHO Headquarters, Geneva	ssaxena@hsph.harvard.edu
8	**Dr. Siddharth Sarkar** Additional Professor, Department of Psychiatry and NDDTC, AIIMS, New Delhi - Co-opted member	Sidsarkar22@gmail.com
9.	**Dr. Ravindra Rao** Additional Professor, Department of Psychiatry and NDDTC, AIIMS, New Delhi– Representative of the DGHS	dr.rvrao@gmail.com
10	**Dr. SajjadurRehman** Specialist (Psychiatry), Department of Psychiatry, Lady Harding Medical College, New Delhi 110001 – Representative of the DGHS	sajjadur25@gmail.com

9.2. Important data, statistics related to the issue.

Relevant data available from:

- Ambekar A, Agrawal A, Rao R, Mishra AK, Khandelwal SK, Chadda RK. Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India. 2019.
- Murthy P, Manjunatha N, Subodh BN, Chand PK, Benegal V. Substance use and addiction research in India. Indian journal of psychiatry. 2010;52(Suppl1):S189.
- National Family Health Survey – 5. 2019-21. India Fact Sheet. International Institute for Population Sciences. 2022. Available at http://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf