ALLIANCE TO PROTECT DRUG USERS

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Recommendation from Alliance to Protect Drug Users (APDU) to Reform India's Drug Policies including the NDPS Act, 1985.

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Alliance to Protect Drug Users (APDU) recognizes a dire need to change the legal framework of addressing drug use/addiction in India. In comparison to the recent wave of progressive changes in drug policies across the world, India's policies appear regressive and dated including its NDPS Act, 1985 which is our primary piece of parliamentary legislation around drug use and pertains to the possession, sale, purchase, production and use of narcotic drugs and psychotropic substances. The government has initiated reforms to the NDPS Act but it has not published any data that clearly indicates that prosecution or incarceration has directly impacted either the demand or supply of psychoactive substances.

Since the government has stipulated a deadline for recommendations to the existing law, we advocate for the following changes in India's drug policies, while giving special attention to the protection, care and rehabilitation of drug addicts. These changes, some of which are fundamental, structural, as well as policy-specific, would help in nurturing a society where drug policies are grounded in a scientific spirit, compassion, health, human rights, and are independent of any prejudice or moral standpoint.

1. Decriminalize all Drug Use

Decriminalize the consumption (and possession for consumption) of all psychoactive substances (all drugs mentioned or categorised as 'drugs/psychotropic substances' in the NDPS Act [1]). Decriminalization does not mean legalization. In 2018, SADA (Sikkim Anti-Drugs Act) was amended by discarding criminal or administrative penalties for drug use. According to the officials of Sikkim Central Jail and the Police, the number of undertrial cases reduced from 200 to 66 after this amendment[2]. Detaining, arresting or prosecuting people simply for using drugs unreasonably penalizes the vulnerable sections of the society. It diverts attention from the care of addicts/co-addicts and aggravates social stigma. Therefore, the role of the criminal justice system in drug control should be reduced and be made a public health priority.

The term 'addiction' does not appear in the NDPS Act or the Mental Healthcare Act, but the registration certificates provided to Drug De-Addiction and Rehabilitation Centres in India are issued by the Directorate of Health Services under conditions laid down in the Mental Healthcare Act, 2017[3]. This indicates

that drug abuse and addiction are somewhat recognised as a mental health problem by the Indian legislative framework, but without much conviction or real impact. Therefore, the government should direct its resources and energy towards the care and protection of addicts instead of punishing them.

No research or data supports the idea that incarceration and prosecution can wean away drug addicts/users from drugs. According to the 1987 report of the National Crime Record Bureau (Ministry of Home Affairs, GOI), 9442 cases were registered under the NDPS Act, and in 2019 the number rose to 72779 [4], indicating a growth of almost 8 times vis-a-vis the population growth which has not even doubled[5]. This data indicates the inefficiency of criminalising drug use/trafficking as a deterrent to drug use/abuse in society. In 2019, 14,158 cases were registered in Maharashtra under the NDPS Act, of which 13,199 cases were for the possession of drugs for personal use/consumption while only 959 cases were for the possession of drugs for trafficking. This means 93.2% of the cases were registered against drug users/addicts. The country-wide percentage of cases registered for possession of drugs for personal use/consumption is 62.5%.

According to an RTI reply received from the Central Bureau of Narcotics in 2012-13, 899 registered opium addicts in India receive regular opium supply from the government. It also listed the constitution of opium addicts across India: Delhi (18), Punjab (68), Odisha (486), Maharashtra (186), West Bengal (12), Tamil Nadu (100), Himachal Pradesh (14), Uttarakhand (1), Haryana (2), Nagaland (1), and Gujarat (4)[6]. But as per a report published by the Ministry of Social Justice and Empowerment in 2019, about "2.1% of the country's population (2.26 crore individuals) use opioids which includes Opium (or its variants like poppy husk known as doda/phukki), Heroin (or its impure form – smack or brown sugar) and a variety of pharmaceutical opioids. Nationally, the most common opioid used is Heroin (1.14%) followed by pharmaceutical opioids (0.96%) and Opium (0.52%)[7]." The same report also says, "About 0.70% of Indians (approximately 77 lakh individuals) are estimated to need help for their opioid use problems." This number is specific to the use of opioids, among many other kinds of substances detailed in the report. But if the government has identified such a massive population who need help and care, then the first reform should begin with decriminalising all drug use and encouraging drug dependents to come forward and seek help without fearing persecution, incarceration, or social stigma.

Following the 'war on drugs' rhetoric, the NDPS Act went through a series of amendments in 1989 to formulate stricter laws against drug abuse and trafficking. This included mandatory 10 years of imprisonment, seizing of property, trial by special courts, and even death sentence for repeat offenders. As legal commentators have pointed out, India's NDPS Act adopts more severe measures for drug control than those provided by the UN Drug Control Conventions in 1961 (article 19) and 1988 (article 12.10.b)[8].

Proper decriminalisation process would downgrade personal/recreational drug use and ensure that "using drugs is not a crime or is a lesser one."[9] Therefore, it is not the same as legalizing drugs. According to the World Health Organisation, "efforts to reduce stigma and discrimination at a national level, such as promoting antidiscrimination and protective policies for all key populations, can foster a supportive environment, particularly within the health-care and justice systems...Policies are most effective when they simultaneously address individual, organizational and public policy factors that enable or allow stigma and discrimination." [10]

Portugal was the first country to decriminalise the possession of all drugs for personal use in 2001. According to the United Nations, "Portugal's policy has reportedly not led to an increase in drug tourism. It also appears that a number of drug-related problems have decreased."[11] Similarly, the World Health Organization suggests that "Countries should work toward developing policies and laws that decriminalize injection and other use of drugs and, thereby, reduce incarceration. Countries should work toward developing policies and laws that decriminalize the use of clean needles and syringes... Countries should ban compulsory treatment for people who use and/or inject drugs."[12]

As recent as in November 2020 in the USA, "Oregon decriminalized hard drugs like heroin and methamphetamine and legalized therapeutic use of psilocybin mushrooms."[13] It became the first state in the USA to decriminalize the personal use and possession of all drugs while expanding access to addiction and other health services. New Jersey and Arizona legalized marijuana for adult use and Mississippi and South Dakota legalized medical marijuana. Drug Policy Alliance remarked that "the time has come to stop criminalizing people for drug use. It shifts the focus where it belongs – on people and public health – and removes one of the most common justifications for law enforcement to harass, arrest, prosecute, incarcerate, and deport people. As we saw with the domino effect of marijuana legalization, we expect this victory to inspire other states to follow suit and enact their own decriminalization policies that prioritize health over punishment. This is a monumental step away from criminalization toward a humane and health-based approach. It's time to stop arresting and incarcerating people who use drugs and begin to repair the harm that drug law enforcement has caused to our communities." [14]

According to a 2019 report published by the Ministry of Social Justice and Empowerment, GOI, "(the) criminalization of people using substances, further enhances the stigma, isolation and hinders access to treatment. In the line of recommendations by International Narcotics Control Board (INCB) and many other international agencies, we recommend the State to take necessary steps to minimize the stigma and discrimination around drug addiction and provide health and welfare services to people affected by substance use (rather than subjecting them to the criminal justice system)."[15]

2. Abolishing Death Penalty in NDPS

In 2011, the Indian judiaciary became the first in the world to overturn mandatory death penalty for drug-offences. The Bombay High Court's division bench of Justices A.M Khanwilkar and A.P Bhangale labelled Section 31A of NDPS as "unconstitutional" and violative of Article 21 (Right to Life) in the Indian Constitution. However, the court preferred to read it down instead of abolishing the law. [16]

On the other hand, in 2018, the Government of Punjab proposed the central government to initiate mandatory death penalty for those convicted of drug peddling or smuggling, even for first time offenders. The above-mentioned section in the NDPS Act clearly suggests "enhanced punishment for offences after previous conviction."[17] In fact, it makes provisions for death penalty after an amendment was introduced in 2001.

Presently, the sentencing Court possesses the option, if not an obligation, to impose capital punishment on a person convicted a second time for drugs in quantities specified under Section 31A . [18]

In 2019, when the Sri Lankan Government imposed death penalty on four individuals convicted in drug-related offences, the United Nations Office on Drugs and Crime (UNODC) came up with a clear statement against the use of death penalty for drug abuse and trafficking. [19]

The Calcutta High Court recently commuted a death sentence granted by a trial court under the NDPS Act. The two-judge bench of Justices Joymalya Bagchi and Surva Ghosh dismissed the death sentence stating, "Imposition of death penalty on the appellant may or may not deter others from committing similar crimes in future. However, no statistical data or empirical study has been placed before me on behalf of the prosecution to conclusively establish that imposition of death penalty would definitely lead to reduction of crime committed by others in society"[20]

In June 2019, the Malayasian government proposed decriminalising drug use, putting "science and public health before punishment and incarceration."[21] In a statement, the health minister said "certainly putting them (addicts) in prison is not going to change that. It is not just a matter of someone having weak will power... an addict shall be treated as a patient (not as a criminal), whose addiction is a disease we would like to cure."[22]

The International Narcotics Control Board (INCB) in its 2019 report also urges all governments to review and abolish the death sentence for drug-related offences. [23] India can seize this opportunity to decriminalise all drug use and entirely remove the provision for death sentence in the NDPS Act, taking a leading position among all governments in South Asia and across the world to do so.

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3. Differentiating between Peddlers and Consumers

A fundamental distinction between drug users, addicts, traders and peddlers should be constituted in the NDPS Act to recognize the intent for the possession. In India, the category of "possession of small quantity intended for personal consumption" was discarded in 2001 and presently, possession of small amounts attracts uniform punishment, irrespective of intent. It is also difficult to decisively discern whether enforcement is targeted at 'users' or 'traffickers'. [24]

In 2017, the Sikkim state legislature amended SADA (Sikkim Anti-Drugs Act) to recognise the distinction between 'peddlers' and 'consumers'.[25] The recognition of this distinction enabled Sikkim to channelise its healthcare services to the most vulnerable drug users. However, despite the well-intended amendment, there are certain methodological flaws in recognizing such distinctions, thereby, becoming a stumbling block in realising its primary objectives. As per SADA, anybody caught with small quantities of drugs was now categorised as a 'consumer' while those caught with larger quantities were categorised as 'peddlers'. But differentiating between 'consumers' and 'peddlers' merely on the basis of the quantity of substance often leads to users being arrested as peddlers. Also, as legal advisors have pointed out, "Quantity based distinction between 'consumers' and 'peddlers' does not consider the possibility of drug users and addicts turning to peddling to support their addiction and that such categorization might subject them to harsher punishments."[26]

In some countries that have decriminalised drug use the amount defined for non-criminalised individual use is so low that possession is effectively a crime.[27] Moreover, in terms of peddling, where large quantities are seized, people who get arrested are often involved in merely carrying or transporting the substance instead of those who actively control or manage the trade.[28] Official crime statistics also do not reveal what proportion of drug law arrests and convictions are conducted against users or low-level offenders (involving small quantity offences) as opposed to 'traffickers' (involving larger quantities of drugs).[29]

On the issue of detecting drug quantity, in 2009, the government declared that the total weight of seized drugs (impure or "cut") should be considered instead of the pure content, thereby refuting the Supreme Court's earlier suggestion of considering the pure content only. In the current situation, low-level offenders are more prone to being sentenced for commercial quantity offences because most of the street drugs are heavily "cut" or impure.[30] Such confusion, controversies, and inconsistent interpretations in ascertaining the total weight and purity of the contraband substances should also be resolved once and for all.

Therefore, in many aspects, quantity is often an imperfect criteria for determining the classification between drug users and peddlers. As suggested earlier, following the decriminalization of all drug use, India should have a robust mechanism with which law enforcement, prosecutors and the judiciary can identify and distinguish

between a person who is compelled to sell drugs to support their addiction from a person selling/distributing drugs for extensive financial gain. The government should also consider eliminating mandatory minimum sentences and have a concrete rehabilitation and employment plan for people leaving prison for drug-related offences.

4. Towards a Clinical Understanding of Drug Addiction

Assign an internationally-accepted definition of drug addiction in the law as an illness and distinguish between drug users and those who are addicted to drugs. These definitions must be kept airtight, so that moral bias or ignorance may not creep into the investigation, prosecution or judicial decision. There should also be a pronounced difference in defining drug use by social/recreational users from that of an addict. Once addiction is acknowledged as illness/disease in the NDPS Act, the health sector will have a greater share in battling drug abuse from a clinical and biopsychosocial perspective. Hence, addiction, which is a compulsive disorder, can be effectively de-stigmatised by positing it as a public health concern.

Drugs and addiction are fundamentally intertwined, but the word 'addiction' is omitted from the NDPS Act and the Mental Healthcare Act (2017) which provides certificates to Drug De-Addiction and Rehabilitation Centres in India. There is no rationale behind such omission though the law has been amended several times over the last three decades.

Drug use/abuse does not necessarily imply drug addiction. An 'addict' in the NDPS Act is defined as a "person who has dependence on any narcotic drug or psychotropic substance."[31] This is a gross oversimplification because a person who is chemically dependent on a certain substance at a given point, may not necessarily be an addict. However, an addict who might be in sobriety for several years could relapse into substance abuse. This is the reason recovering addicts regularly meet in numerous self-help groups all across the country (and the world) to stay away from drugs. For example, in New Delhi alone there are 44 recovery meetings every week for those who identify themselves as suffering from the disease of addiction.[32] There are meetings in other metro cities and smaller urban centres too. The complexity of the behavioural pattern, which is characteristic of addiction, and addictive personality, is entirely lost in such a simplistic set of definitions and are ultimately self-defeating. Binge or occasional/social users may be using or addicted to substances temporarily, and quit on their own without medical or other interventions, whereas addicts have an inherent pathological relationship with psychoactive substances and an obsessive-compulsive behaviour pattern which constitutionally prevents them from exercising self-will to stop using a given substance. This is a fundamental difference between the two.

In 2004, the World Health Organisation published a detailed report on psychoactive substance and dependence where it said, "This neuroscience report is the first attempt by WHO to provide a comprehensive overview of the biological factors related to substance use and dependence by summarizing the vast amount of knowledge gained in the last 20-30 years. The report highlights the current state of knowledge of the mechanisms of action of different types of psychoactive substances, and explains how the use of these substances can lead to the development of dependence syndrome." It further said, "substance dependence has not previously been recognized as a disorder of the brain, in the same way that psychiatric and mental illnesses were previously not viewed as such. However, with recent advances in neuroscience, it is clear that substance dependence is as much a disorder of the brain as any other neurological or psychiatric illness."[33]

Governments across the world have enacted specific laws to define addiction in detailed and elaborate ways. This helps to successfully identify and treat addiction, and create access to treatment for and give rights to those that suffer; it also creates awareness among the public. In the US, there are several laws that address drug addiction, for instance, the treatment of opioid dependence with opioid medication is governed by federal regulations, under the Substance Abuse and Mental Health Services Administration, which acknowledges that "addiction is a medical disorder that may require differing treatment protocols for different patients." [34] The Supreme Court of Canada recognizes the following definition of addiction: 'a primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour.' This definition was developed by the Canadian Society of Addiction Medicine and duly accepted by the Supreme Court of Canada. The medical literature differentiates between substance abuse and substance dependence. Substance dependence is recognized as generally more severe, as the criteria involve tolerance, withdrawal or a pattern of compulsive or uncontrolled use."[35]

The World Health Organisation (WHO) mentions withdrawal and defines substance abuse as "the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state." They have further mentioned, "Policies which influence the levels and patterns of substance use and related harm can significantly reduce the public health problems attributable to substance use, and interventions at the health care system level can work towards the restoration of health in affected individuals."[36] The WHO has detailed guidelines on managing withdrawals inside prisons in their "Prison and Health" report of 2014.[37]

The physical symptoms suffered by addicts – like the state of withdrawal, for instance – are not even mentioned in the NDPS Act. This makes it almost impossible for lawyers and judges to effectively argue cases or produce judgements. For any amendments in the NDPS, we strongly urge the government to define withdrawal symptoms in the law as a biological phenomenon which the addicts have to suffer while in custody. It must be recognised and remedies should be clearly outlined in the law so that the accused doesn't suffer or die in prison. In Switzerland, for example, the government has used Heroin Assisted Treatment (HAT) inside prisons and elsewhere to counter withdrawals of heroin addicts. Since the 1990s, this process of using medical heroin has been adopted by several countries such as the UK, Germany, Netherlands, and Canada and is deemed widely successful. This is different from Opioid Substitution Treatment (OST) which is typically reserved for opioid addicts who have proven unresponsive to other forms of treatment. [38]

We strongly recommend that the government should form a high-level committee including all stakeholders to define drug addiction as an illness in the law and further elaborate the distinctions between drug users, addicts, and withdrawals from a clinical and biopsychosocial perspective. This will encourage corporate stakeholders and entrepreneurs to invest in the health sector to treat addiction/substance abuse. The pharmaceutical industry in India will also work towards updated medicinal drug-related treatments as per International standards. This will entirely change the currently unregulated, informal, and largely unscientific industry of de-addiction and rehabilitation centres for drug abuse across the country. Consequently, this will create employment and entrepreneurial opportunities.

5. Cover the Expenses of Addiction Treatment with Government and Private Health Insurance

Following the clear recognition and definition of addiction as an illness in the Indian legislature, we urge the government to launch an insurance scheme to cover the cost of treatment, de-addiction, and rehabilitation for drug addicts. This will also encourage private insurance companies to include it in their various health insurance policies. In most European countries, funding for residential treatment is provided by governments, typically in the context of a joint funding arrangement either between different levels of the government or in tandem with health insurance.

In Germany, for example, addiction was recognised as a disease in 1968 and costs for treatment were covered by public insurance funds. In Austria in 1971, the need for health and social interventions for drug addicts was clearly defined in an amendment to its drugs law. In 1970, France opened the door to state funding for various new and experimental treatment initiatives, including therapeutic apartments, foster families and facilities in rural environments. It was effectively targeted to offer 'a way back to healthy living' to drug users.[39]

6. Treatment of juvenile addicts, women, and LGBTIQ+ community

The 2019 report "Magnitude of Substance Use in India" by the Ministry of Social Justice and Family Welfare, GOI, details the alarming state of drug abuse among children and adolescents in India.[42] The present rehabilitation and treatment system is totally incapable of providing care and support to this age group.[43] Besides, the bureaucratic delays in the current functioning of the Juvenile Justice Board across the country also becomes a hindrance in issuing relevant clearances for admitting children in different rehabilitation centres. This is a pertinent reason why most of these centres do not admit patients of this age group. In most of the cases, these centres cannot prove to the Juvenile Justice Board that they are capable of taking care of these children. These technicalities must be outrightly resolved to ensure quick and efficient delivery of juvenile treatment and rehabilitation.

There are only a handful of rehabilitation centres specifically tailor-made for women in India. Women are more subject to stigmatization than men for drug-abuse. The identification of women drug addicts by health care professionals can, therefore, be an obstacle because of stereotypic views of women and of addicts.[44] Hence, it is the responsibility of the government to create necessary supportive infrastructure and provide care for them. In 2015, the Indian Drug Users Forum also emphasized that women drug users need alternate strategies and treatment centres.[45] Despite the lack of infrastructure for providing support to women addicts, several self-help groups across India have managed to have separate recovery meetings and support systems entirely run by women. The government must learn from these citizen-led initiatives and proactively intervene with relevant systemic changes.

The LGBTIQ+ community in India already faces stigmatisation based on their sexual orientation; drug abuse by anyone from this community further fuels hate crime, public humiliation, emotional abuse, threat, and ridicule. As a result, they are exclusively ostracised from the already limited availability of treatment facilities in India. LGBTIQ+ individuals also face health issues such as HIV-related anxiety and the constant threat of sexual abuse/assault.[46] "Lesbian, gay, bisexual, transgender and intersex persons who use drugs are disproportionately impacted by drug policies in many countries and experience a range of harms flowing from drug use and drug-induced mental trauma. Lesbian, gay, bisexual, transgender and intersex persons who use drugs may not seek support or treatment from health-care providers because of previous or anticipated experiences of discrimination."[47] The government must create a mechanism by which special rehabilitation centres can be created for the LGBTIQ+ community or train/equip the established rehabilitation centres licensed under the Mental Health Care Act, 2017 to make special arrangements and accommodate people from this community. This would ensure their safety and adequate care of one of the most vulnerable sections of society.

7. Administrative Reforms and Model Treatment Centres

After decriminalizing all drug use, defining addiction as an illness, and including it in the NDPS Act and the Mental Health Care Act, the Indian government must ensure that all drug addicts are treated equally before the law as any other physically or mentally ill patient.

The most essential move towards an all-round change would be to introduce a single nodal government department for its drug policy regime and relax authority from the Ministry of Finance, GOI (Department of Revenue), which looks at drugs from the colonial perspective of revenue loss/gain; its enforcement agency the Narcotics Control Bureau whose mandate is to arrest, investigate and prosecute for penalisation under the NDPS law; and the Ministry of Social Justice and Empowerment which does not look at Drug use/addiction as an illness, but concerns itself only with the "rehabilitation of victims of alcoholism, substance abuse, and their families."[48] Such a simplistic goal and objective of MoSJE is a deterrent for a holistic understanding and treatment of drug addiction. Like any other physical and mental health issue, the treatment of drug addiction/alcoholism including rehabilitation, institutional support to using/recovering addicts/alcoholics and their family members should come under the purview of the Ministry of Health and Family Welfare. This will not only enable a well-coordinated function in treating and rehabilitating addicts/alcoholics, but will also pave new ground for the conceptual reorientation of drug addiction, alcoholism, and its treatment.

It is important to constitute a high-level committee, including all stakeholders, to form the basic foundation of a model drug de-addiction/rehabilitation center which can be followed nationwide. According to the April 2018 guidelines by the MoSJE, they have claimed to be supporting 400 Integrated Rehabilitation Centres for Addicts (IRCA) which, according to them, cater to persons dependent on alcohol and drugs.[49] We must understand that rehabilitation is a long process and these IRCAs hardly make any difference in making recovery from active addiction possible. Notably, the MoSJE guidelines mention the term "therapeutic community model" under Integrated Rehabilitation Centres for Addicts.[50] This term is casually used because none of the government guidelines mention that this "therapeutic community" originates from the 'Minnesota Model'. Also known as the 'abstinence model' (first initiated by a psychologist and a psychiatrist in the 1950s), it is loosely built around the Alcoholics Anonymous (AA) 12-step programme model, where individuals suffering from alcoholism/addiction provide support to each other. This model proliferates in most rehabilitation centres in India. The treatment creates a humane 'therapeutic community' where one addict helps another. Treatment centres based on this model are primarily run by 'recovering drug addicts' or people who have quit using drugs. They work as counsellors in these rehabilitation centres to form a fulcrum of this "therapeutic community".

This 'Minnesota Model' was introduced in India by Kripa Foundation (Kripa) in the early 1980s and tailored to suit rehabilitation needs in Indian society which has colloquially come to be known as the 'Kripa Model'. A publication of the United Nations International Drug Control Programme says, "Kripa conducts its programme in three phases; 5 to 10 days are required for detoxification, following which coping strategies are suggested and the individuals are helped to understand their addiction. The third phase, i.e. rehabilitation, involves returning to normal life while taking into account the self-acknowledged problems of addiction."[51] Today, literally all the rehabilitation centers in India knowingly or unknowingly follow this model. By the end of 80s and 90s, when illicit chemical substances flooded Indian streets, new rehabilitation centres had to come up. Many of these were founded by people who had once been patients at Kripa and had managed to stay clean after treatment. It helped other suffering addicts recover from active addiction through a robust system on one hand, and on the other gave employment to people who were stigmatised by the society for their history of addiction. It must be noted that this was happening in a time when treatment for drug addiction and alcoholism also involved Electro-Convulsive Therapy (electric shocks) in mental asylums, duly prescribed by psychiatrists. For the first time in South Asia, recovery was finally available in a more humane and dignified manner facilitated by these unrecognised and unregulated rehabilitation centers. Hence, in India and South Asia, this is popularly known as the Kripa model. This model also follows the 12-Step programme which believes that "the therapeutic value of one addict helping another is without parallel."[52]

If this treatment model is officially acknowledged and adopted by the Government of India then the entire discourse of drug addiction treatment will hugely benefit from it. This will inevitably formalise the current system in place with maximum impact not only in India but in all of South Asia where the Kripa model treatment centers have mushroomed in the last decade. The government must form a high-level committee to gather information from the experience of recovering addicts/councillors working in these rehabilitation centres and empower them to expand their reach in the country. This will help the suffering addict to recover and reintegrate in the society and will also provide employment opportunities to the recovering addicts by hiring them as counsellors in these centers, encouraging others to integrate into mainstream society through social acceptability of recovering addicts. It is an undocumented reality in India that recovering drug addicts themselves have created a successful model of rehabilitation, much like some of the formally recognised ones in different parts of Europe.

"During the 1970s and 80s, self-help groups such as Release (UK) and ex-addicts took the lead in developing treatment programmes and centres in several countries. For example, in 1978, Marek Kotanski established the first Monar therapeutic community (TC) in Poland. It became the nucleus of the Monar youth association, which set up another 10 Monar TCs under a funding agreement with the Ministry of Health" " said the The European Monitoring Center for Drugs and

and Drug Addiction (EMCDDA), who have defined 'residential treatment' as "a range of treatment delivery models or programmes of therapeutic and other activities for drug users, including the 12-step/Minnesota model, therapeutic community and cognitive– behavioural (or other) therapy-based interventions, within the context of residential accommodation in the community or hospital setting."[53]

As outlined by EMCDDA, the main therapeutic approaches found in residential treatment programmes in Europe are based on:

- Therapeutic community principles — in a programme using therapeutic community principles, the pillars of the therapeutic process are self-help and mutual self-help; clients and staff live together in an organised and structured way that promotes change and makes possible a drug-free life in society;
- 12-step/Minnesota model — in a programme with a 12-step orientation, group sessions focus primarily on encouraging clients to accept that drug dependence is a disease;
- Psychotherapy, using:
  - cognitive–behavioural therapy (CBT) — in a programme with a CBT orientation, group sessions emphasise helping residents to identify situations in which there is a risk of relapse and to learn appropriate coping responses; or
  - other psychotherapeutic models, for example psychodynamic, gestalt, family-oriented.[54]

The efficacy of the 12-Steps Model, on which the Minnesota/KRIPA model is based, has been widely deemed successful by the MATCH project, an eight-years long project undertaken by the National Institute on Alcohol Abuse and Alcoholism and supported by the U.S. Department of Health and Human Services Public Health Service National Institutes of Health.[55]

The World Health Organisation reaffirms, "perhaps the best known description of a strategy for the treatment of alcohol problems is the 12 steps of Alcoholics Anonymous (AA). The steps outline in a detailed but succinct and sequential manner the way in which an individual AA member should attempt to achieve the goal of sobriety. It is not too much to say that the carefully crafted account of its strategy is one of the principal attractions of AA and it is not surprising that it has been widely imitated by other mutual help organizations."[56] The presence of A.A can be found in approximately 180 nations worldwide, with membership estimated at over two million. A.A. literature is translated into more than 100 languages and there are more than 118,000 A.A. groups around the world.[57]

Narcotics Anonymous, which was founded on the same principles as those of A.A, holds nearly 67,000 weekly meetings in 139 countries. Narcotics Anonymous World Services states, "NA's approach makes no distinction between drugs including alcohol. Membership is free, and we have no affiliation with any organizations outside of NA including governments, religions, law enforcement groups, or medical and psychiatric associations." [58]While treatment centres help addicts to

quit drugs and embrace a life without drug use, NA meetings––through its 12-step programme and the therapeutic support of recovering addicts––help a newcomer in recovery to integrate into mainstream society. This helps them collectively to stay away from active drug use and become acceptable and productive members of society. In the US, the judiciary in certain cases also mandates NA/AA meeting attendance for addicts/alcoholics as a part of their probation programme. Such measures fall under the ambit of Therapeutic Jurisprudence (TJ) which was first framed in terms of mental health laws in drugs courts in the US.[59]

The concept of therapeutic jurisprudence "focuses on the law's impact on emotional life and on psychological well-being."[60] The goal of TJ is to produce therapeutic outcomes by "taking a non-adversarial approach to the administration of justice". Judges with TJ practices communicate directly with defendants in a problem-solving court setting; this compassionate communication gives voice, motivation, validation, and social encouragement to the person in trial.[61] At the outset, the judge should always treat the individual with dignity and respect. Treatment is a collaborative process between the individual and the treatment team, including the judge, and the conditions necessary to forge a genuine treatment alliance include reciprocal understanding, mutual affirmation, emotional attachment, and respect. Therefore, the judge and treatment personnel must act so as to give the individual the perception that they are empathic, accepting, warm, and willing to permit self-expression.

In the Gurjit Singh v/s State of Punjab judgement in 2012, the Punjab-Haryana High Court encouraged that the petitioner "be sent to Rehabilitation Centre set up by the State Government for treatment on experimental basis." The court further directed, "the State of Punjab to identify the addicts involved under the NDPS cases and make arrangements for their treatment and consequential rehabilitation." Referring to the "rise of therapeutic culture" in the US where drug offenders are treated as victims of a "biopsychosocial disease-drug abuse", the court suggested that "State(s) should be directed to provide treatment as alternative to prisons, separate youth-detention facilities in jails and probation homes."[62] While such directives are encouraging and signal positive changes, the concept of Therapeutic Jurisprudence should be imbibed as one of the principal legal philosophies in guiding India's drug laws.

The NDPS Act allows the formation of a 20-member NDPS Consultative Committee to review the NDPS Act and Rules, to advise the government on policy changes, etc. The committee holds the power to distribute specific tasks to sub-committees dealing with policy check, treatment, rehabilitation, social reintegration.[63] But none of these provisions have been effectively realised by the administration. The NDSP Act also permits the committee to draw experts and civil society representatives to review and recommend changes in drug policy. Therefore, it should be ascertained that the committee engages with the survivors of drug abuse and their family members to build informed conversations around drug addiction and invoke changes on a more practical ground.

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In the NDPS Act, there is a provisional fund under the scheme of National Fund for Control of Drug Abuse. Since the purpose and application of this expense is vague and unspecified, the government must deploy these funds to create public awareness campaigns and de-stigmatise drug use/addiction. The same fund, or a new one, can be utilised by the government to support and regulate the model treatment centres across the country that may be based on the Minnesota/Kripa model. This will strengthen and empower the massive network of recovering addicts, therapeutic communities, self-help groups, and the most important person among all, the still-suffering addict.

Recommendations:

- Decriminalise all Drug Consumption.
- Abolish death penalty from the NDPS Act, 1985.
- Remove mandatory minimum sentences for people involved in drug trade at low-level.
- Redirect state funds on treatment and care rather than punishment and incarceration.
- Define addiction as an illness in the NDPS Act, 1985 and the Mental Healthcare Act, 2017.
- Define and further distinguish between drug user, addict, peddler in the NDPS Act, 1985.
- Drug addicts should be treated equally before the law as any other physically or mentally-ill patient.
- Therapeutic Jurisprudence should become the core legal philosophy in India's drug laws.
- Include government and private health insurance cover for drug de-addiction and rehabilitation.
- Formalise the unregulated drug de-addiction and rehabilitation industry and encourage its complete inclusion in the healthcare sector.
- Special de-addiction and rehabilitation centres for juveniles, women, and the LGBTIQ+ community.
- Allocate national funds for a model rehabilitation centre based on the Minnesota/KRIPA model.
- Public awareness campaigns to de-stigmatise drug use/addiction in society and move beyond stereotypes and unjust, zero-tolerance policies.

Take Action

To reform India's Narcotic Drugs and Psychotropic Substances Act, 1985, the Government of India has tasked a committee to suggest changes to the law. They are inviting suggestions, opinions, and views from the public.

If you agree with our recommendations, please send them before the 16th of November, 2020 to: https://criminallawreforms.in/open-consultation/

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