



DRAFT POLICY DOCUMENT FOR DRUG DE-ADDICTION
FOR
THE STATE OF JAMMU AND KASHMIR

DRAFTED BY:

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In collaboration with:

- **DEPARTMENT OF PSYCHIATRY, SKIMS MEDICAL COLLEGE, SRINAGAR.**
- **J & K STATE AIDS CONTROL SOCIETY.**

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CHAPTER 1

INTRODUCTION:

Definition, Magnitude and Impact of the Problem

DEFINITIONS

1. Addiction:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these leads to characteristic, biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically, pursuing reward and / or relief by substance use and other behaviours.

2. Substance abuse:

A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by recurrent use in physically hazardous situations, recurrent use resulting in a failure to fulfill major role obligations and continued use despite substance-related legal problems, or persistent/recurrent social or interpersonal problems caused by the use of substance.

3. Acute intoxication:

A transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behavior, or other psychophysiological functions and responses.

4. Harmful use:

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical or mental.

5. Dependence syndrome:

A cluster of physiological, behavioural and cognitive phenomenon in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.

6. Withdrawal state:

A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a substance after repeated, and usually prolonged and/or high dose use of that substance.

7. Tolerance:

A need for markedly increased amounts of the substance to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount of the substance.

8. Over-dose:

A state in which a person uses a drug in quantities enough to produce a life-threatening reaction or death.

9. Prescription drug misuse:

The use of a medication in ways or amounts other than intended by a doctor, by someone other than for whom the medication is prescribed, or for the experience or feeling that the medication causes.

10. De-addiction Centre:

A de-addiction centre is an in-patient centre for detoxification and early maintenance, preferentially in hospital settings.

11. Rehabilitation:

Rehabilitation is the process of integration of substance abuse patients who have achieved remission into the community.

PROBLEM STATEMENT:

Jammu and Kashmir scenario

Jammu and Kashmir, despite being in the transit route of 'Golden crescent' remained devoid from the problem of addiction for long. However, we can no longer share this optimism as the state has seen a steep rise in the burden of physical, mental and substance-use disorders over the past two decades. Studies conducted in recent years have shown an alarming shift in

the pattern of substance use in terms of rise in the number of female users, decreasing age at first-use, increasing use of solvents, injectable opiates as well as increasing drug related deaths (over-dose and accidents). When it comes to mortality and morbidity from substance use, a regular and ever-increasing contribution comes from the legal substances, i.e. alcohol and tobacco. The menace of drug addiction is widely spread, fast rising and is quickly taking the form of an epidemic. It has been said that places where a bus cannot go, the deadly drugs reach! Scientific data based on community surveys on drug related problems in Jammu and Kashmir show that deaths have started occurring directly (due to over dosages, convulsions, and cardiac arrests) and indirectly (road traffic accidents). No wonder, drug over-dose is quickly becoming a common emergency in our hospitals. Drug addiction, unfortunately, does not come alone. It brings with it shame, violence, crime, destruction of individuals and families, accidents and death. It is rendering our youth unproductive causing slow and painful death of a nation. The problem we are dealing with is complex because it affects all the facets of one's personality and renders the person dysfunctional and a burden for the family and community.

Drug addiction usually also leads to drug peddling and the menace perpetuates. The enormity of the problem can be gauged from the fact that those seeking help themselves or because of their families only represent the tip of the iceberg and we have a huge hidden population of substance users in the community who do not come to fore for myriad reasons. If a proper policy is not followed to curb this menace, we might lament the loss of a generation!

MAGNITUDE OF THE PROBLEM

A recent study conducted by Rather et al. from IMHANS, in a Drug De-addiction centre in Srinagar, found that over two-third of patients in the

study had started substance abuse in the age group of 11-20 years. The most common substances of abuse identified included nicotine {94.4%}, medicinal opioids (65.7%), cannabis (63.6%), benzodiazepines {45.5%}, other prescription medications {43.4%}, alcohol (32.5%), inhalants {11.1%}, and cocaine (7.5%). Poly-substance abuse was found in 91.9% of the studied patients. Inhalant use was seen pre-dominantly among adolescents {54.5%} whereas nicotine {50.2%}, cannabis {49.2%}, alcohol {51.1%}, opioids {58.4%}, and benzodiazepines {53.48%} were more pre-dominant in the age group of 21 to 30 years.

A study conducted by Ismail et al. from IMHANS, in the year 2016-17, on phenomenology of inhalant use found that two-third of the study population were in the adolescent age group. About 99% of study population were males belonging to middle socio-economic class. 'Bagging' was found to be the predominant mode of inhalation followed by 'sniffing'. Associated psychiatric co-morbidities were found in 25% of the patients.

Margoob et al. in a study published in the Indian Journal of Psychiatry in 1993, reported that a total of 9726 cases of substance related disorders were reported to IMHANS in a period of eight years starting from January 1980. In contrast, we have been consistently seeing more than 6000 patients of substance related disorders per year since 2015 at IMHANS.

Ab Majid et al. in a study published in January 2005 reported that psychoactive substance use is an increasing public health concern. Although levels of illicit substance use in many developed countries had remained stable or even declined for a number of years, the patterns of use now appear to be changing. There is also increase in use of opioids, cocaine, and other psychotropic substances in developing countries. This trend is also worsening in Kashmir valley over the last few years. The present study compared the substance abuse in the years 1980-88 to the year 2002 in patients presenting to the Govt. Psychiatric Diseases Hospital. There has been an alarming increase in the use of opioid-based preparations along with

multiple substance use from the 80's to the year 2002. The Pattern of abuse has also changed in female patients. Among the various reasons for substance abuse significant number attributed it to the prevailing condition in the valley (11%). Other findings are discussed in the paper.

Nizaamet al. in a study published in 2010, reported increased use of medicinal opioids in the youth in Kashmir valley. They also reported increased use of multiple substances as modes of addiction.

According to the database of GMC, Srinagar and Associated Hospitals, the number of patients with substance use visiting OPD in the year 2016-2017 was 6157 and between Jan 2017 and Dec 2017 it was 6550.

At the Community Centre, SMHS Complex, the number of patients with drug dependence admitted in the year 2016-2017 was 535 and between 2017-2018 it was 710. The number of admitted patients from Srinagar were 185, followed by Budgam(43), Baramulla(40), Anantnag(39), Kupwara(25), Pulwama(24), Shopian(15), Bandipora(14), Kulgam(11) and Ganderbal(11).

A national survey being led by the National Drug De-addiction Center, AIIMS, in collaboration with SKIMS Medical College and IMHANS, Kashmir, will provide deeper insights into problem of substance use disorders in Kashmir. From the preliminary data (as communicated by SKIMS Medical College) during the course of the Household Survey (HHS), it was found that the most affected districts are Samba and Jammu, in the Jammu division. It was also found that in Jammu, apart from the use of alcohol and cannabis, sedative pharmacological agents like buprenorphine, Tramadol, Alprax, were also used. A few cases of intravenous use of heroin, brown sugar were also present. In Respondent Dependent Sampling Survey (RDSS), the sample districts, Anantanag and Srinagar, show higher use of Heroin and medicinal opioids, both injectables and orals, in addition to benzodiazepines, inhalants and other newer psychoactive substances.

IMPACT OF SUBSTANCE USE DISORDERS

Impact on Society

Over the years, drug addiction has become an area of gross concern. Our society had remained free of this menace for many centuries. However, times have changed and so have social benchmarks, moral values and economic avenues. The disintegration of family norms, strains of living a reasonable life in a rapacious world, struggle for existence in a competitive society have all destroyed the basic supportive framework of the society. Drug abuse in the last few years has increased manifold and is fast proving malicious to the society by causing physical, psychological, and intellectual decay. There has been increased morbidity and mortality, enhanced crime rates, decreased productivity and wastage of economic potential of young generation.

Impact on economy

Economic effects can be broadly measured by:

- The resources spent on law enforcement, drug policies and other efforts aimed at drug interdiction which are actually the resources not spent on education, health-care, employment etc.
- The cost of treatment and rehabilitation services including burden on acute emergency care.
- The cost of drug itself to the individuals and families that go into debts. The cost of lost human productivity from morbidity and premature mortality caused by substance use.

Impact on public safety

Driving in intoxicated state impairs perception, attention, cognition, co-ordination and increases reaction time that leads to accidents (risk to self and others). Drug addiction also leads to increase in crime rates and violence in the society.

Impact on specific population

Women

Gender differences have been identified as huge determinants in the onset of addictive behaviours, including drug abuse. Women are acutely affected by particular consequences of drug abuse, such as sexually transmitted diseases, domestic violence, in addition to being more likely to be affected by drug-facilitated crime.

Children

Parents who abuse drugs are more likely to live in homes in which relatives, friends, and strangers also use drugs, exposing children to possible emotional and physical harm. Additionally, children that have to be removed from such environments are more likely to engage in crime, drug use and delinquency.

CHAPTER 2

PRINCIPLES OF THE POLICY

The drug policy will be based on the preventive model of disease which involves prevention at primordial, primary, secondary and tertiary levels.

The focus will be on :

- A) Reducing behaviours in individuals that leads to substance use,
- B) Making early intervention and preventing complications in cases where substance use does occur,
- C) Preventing relapse of successfully treated cases and their rehabilitation into the community.

PRIMORDIAL PREVENTION.

The aim at this level would be to reduce the emergence of risky behaviours in the general population that are likely to result in addiction and related problems.

The main goals at this level would be :

1. To increase the knowledge base of the community about the potential risk factors and consequences of substance use and the means that can be adopted in order to avoid those factors.
2. To improve over-all living conditions in the community.
3. To promote healthy environment at schools and work-places.
4. To promote physical and mental health in the community.

PRIMARY PREVENTION

At the primary level, focus would be to enhance the specific protective factors and reduce the impact of existing risk factors.

The goals at this level would be:

1. To target 'at-risk' population and focus on decreasing their vulnerabilities.
2. To strengthen existing laws and to introduce new laws for increasing restrictions on the production and sale of illicit substances.
3. Effective treatment of mental health problems as untreated mental illnesses are known risk factors for substance use disorders.
4. To involve faith-based organizations and schools in teaching families of children with high-risk behaviours the role of parental monitoring and family support.
5. Teaching basic counseling skills to teachers, physicians, policemen, imams/pandiths etc.

SECONDARY PREVENTION

The aim at this level would be early identification of cases and their successful management.

The goals at this level would be :

1. Increasing awareness about symptoms of drug withdrawal and intoxication as well as educating families and school teachers about the pattern of behaviour associated with substance use disorders so that timely help may be sought.
2. Training of all health - care providers at primary, secondary and tertiary care levels to deliver basic de-addiction and counseling services.

3. Teaching how to use drug screening kits to staff at health centres and main hospitals.

TERTIARY PREVENTION

At this level, focus will be on treating complications, preventing relapse and ensuring successful rehabilitation of treated cases into the community.

The goals at this level will be:

1. Routine screening for common complications like hepatitis B, Hepatitis C, HIV, STDs and skin infections.
2. Making at-hand medical help available for management of acute emergencies e.g. Drug overdose, withdrawal complications as well as for management of concomitant medical co-morbidities.
3. Strategies of harm-reduction aimed at reducing physical complications in the person and criminality in the society that may arise due to substance use disorders.
4. Making religious efforts at successfully rehabilitating the treated cases back into the community.

KEY STRATEGIES:

Prime focus is on 4A's

1. Increasing **A**wareness:

- This will be done by programmes that target entire communities as well as by special programs targeting 'high risk' population.
- The programmes will focus on enhancing the protective factors and reducing the modifiable risk factors in the individuals and their environment.

- These will also include knowledge about the types of commonly abused substances, symptoms of intoxication/withdrawal, and consequences of substance use, both physical and mental.
- De-stigmatization of treatment process through awareness programmes.
- Knowledge will also be given about when and where to refer for treatment.
- Basic learning about substance use disorders can be included in the school curriculum and at higher level in the curriculum of undergraduate medical students.

Programs can be :

a. **School-based:**

Classroom programmes delivered by teachers or peer leaders focusing on life and social skills, self-control, emotional awareness, communication, drug-resistance skills, etc.

b. **Faith-based organization programmes:**

Religious beliefs are important protective factors. Involve religious and spiritual leaders by highlighting that promotion of substance use prevention activities is already in line with their preachings.

c. **Media-based:**

Public education campaigns on radio, TV, social-media, billboards etc. Anti- drug slogans and films. Media education about de-glamourizing cigarettes and alcohol use.

d. **Programmes based on educating prescribers and pharmacists:**

Knowledge about the abuse potential of various medications, about identifying drug-seeking and manipulative behaviours and also about the existing laws guiding sale of various medications.

2. Restrict **A**vailability to drugs :

- This can be achieved by enforcing the already existing laws vigorously and checking their compliance at regular intervals.
- Stringent laws are needed against the rampant misuse of prescription medications and reckless sale of medication with psychoactive properties at medical shops.
- Laws are needed for restriction of sale of solvent containing compounds especially to minors. There should be special directions to teachers and parents to supervise the use of solvent containing products by children and adolescents.
- More restriction is required on the sale and public use of the legal drugs, tobacco and alcohol, especially on its under-age sale.
- Heavy restriction and law measures are needed on the increasing production and trade of prohibited drugs across the states. This becomes essential in the current scenario of increasing influx of labour-class population into the state, as well as efflux of youth to outside of state in search of employment and educational opportunities.
- Non-compliance with policy should be dealt with strict punishment.

3. Increase **A**ffordability and **A**ccessibility to treatment programmes.

- Insurance benefits/Medical leave should cover de-addiction treatment just as any other general medical condition.
- Primary care physicians can provide treatment to local patients in uncomplicated drug intoxication/withdrawal conditions and hence should be trained for the same.

4. Promoting Activities that protect against substance abuse.

- Educational opportunities for children.
- Employment opportunities for youth.
- Improved, affordable and accessible health-care, both physical and mental.
- Rehabilitation of existing slum establishments and prevention of mushrooming of slums as the poor condition of living in these areas breeds addiction and related problems.
- Increasing opportunities for sports and scope for leisure activities eg health parks, amusement parks, zoos, museums etc.
- Incentives/awards that reinforce healthy behaviours e.g. bravery awards, awards for social work, awards to upcoming sportspersons, young entrepreneurs etc.

CHAPTER 3

RULES AND REGULATIONS FOR DE- ADDICTION CENTRE

1. SETTING

INTERGRATIVE MODEL

Drug-deaddiction centers should be integrated with the main hospitals to facilitate de-stigmatization of treatment process that occurs when centres are established in isolation.

From our past experiences with the process of treatment and our efforts towards eradication of previously stigmatized diseases like Tuberculosis and Leprosy, we have learnt the lesson that isolation leads to increased stigmatization and feelings of shame and exclusion, which impedes case finding and makes treatment difficult, let alone eradicating the disease. Therefore, we strongly recommend that the de-addiction centres be integrated with the hospitals not only functionally but also geographically.

Integration with main health services at whichever level that might be, village (PHC/CHC), district (sub-district/district hospitals) or state (tertiary care hospitals) also has other inherent advantages to it. Firstly the basic infrastructural facilities are already present in terms of building, laboratory facilities and staff which can be further advanced with time.

Secondly, with increasing use of hard drugs, emergencies like overdose, withdrawal complications and other medically co-morbid conditions become a frequent possibility. With the integrative model of de-addiction centres, consultations for co-morbid medical conditions and referrals for emergency conditions can be made / hence treating the patient in whole rather than in parts.

2. SERVICES

Services should be provided in controlled hospital settings with Out-patient clinics providing motivational therapies, basic detoxification treatment and treatment for co-morbid mental health conditions.

In-patient services should be available whenever admission is indicated which can be in view of complicated withdrawals, multiple relapses, patient preference or any other situation as the clinician sees fit. However, written informed consent duly signed by the patient and his care-giver should be obtained prior to commencing treatment, a copy of which should be given to the patient and the original can be retained for hospital records.

In-patient treatment should include detoxification, early maintenance and psychosocial interventions. After discharge from centre, follow-up services should be provided on out-patient basis.

List of services which should be available at model de-addiction centers:

- Registration and documentation
- Outpatient Treatment
- Inpatient Treatment
- Emergency services including ambulance services
- Dispensing of medications (pharmacotherapy)
- Psychosocial interventions
- Laboratory services
- Referral/Consultation/Linkages (with RNTCP and NACO)
- Record maintenance and Service audit systems.
- Training of other medical staff from primary and secondary care levels
- De-addiction Centres at the Medical College level should provide harm reduction services wherever indicated.

REHABILITATION

Rehabilitative care should be based on the community rehabilitation model where patients once successfully detoxified are motivated to maintain abstinence by linking them with social schemes for skills development and vocational rehabilitation. This works on the concept of token economy where, for example, specific behaviours like maintaining abstinence, regular follow-up, improved social relations, can be used for earning a slot in the skills development scheme and vocational rehabilitation. Other tokens like help with procuring a loan for setting up a small business, subsidized housing facility, etc. can be earned by positive behaviours and maintaining the 'staying clean' pact. Token may be withdrawn if the pact is not maintained.

3. STAFF

At minimum, a De-addiction centre should have the following manpower:

1. A Psychiatrist, M.D in psychiatry from an MCI recognized institution, who will lead the team.
2. A clinical Psychologist with RCI recognized degree.
3. A Social worker.
4. A Nurse.
5. A Pharmacist.
6. A Medical Officer either pooled from main hospital staff or specific for de-addiction centre.

CHAPTER 4

EXISTING INFRASTRUCTURE

26th of June 2014, the international day against drug abuse, witnessed the inauguration of valley's first specialized Drug De-addiction Centre (DOC) at SMHS Srinagar, which is located in the heart of the city with good accessibility. Till this day, it remains one of the only two government-run de-addiction centers in the whole state of Jammu & Kashmir, second being functional at GMC hospital, Jammu.

- The centre which caters to the whole valley is receptive for patients of substance abuse 24 x 7, with a psychiatrist and a nurse available round the clock.
- A social worker exclusively for providing de-addiction related services is available from 10-4 pm from Monday through Saturday.
- In addition to OPD clinics that run from 10 am to 4pm on all days of the week, the centre has in-patient services as well, which includes the following facilities:
 - a. Separate wards for males and females, with a total bed capacity of 30 (including 10 for females). Wards are well lit and adequately ventilated.
 - b. Separate male and female toilet complexes.
 - c. Provision of free meals, adequate bedding and proper sanitation facilities to the in-patients and their attendants.
 - d. The building is centrally heated and also provides recreational services for in-patients in the form of gym equipment, indoor games and television with cable connection.

- e. This is the only centre in the valley with the facility of opioid substitution therapy.
 - f. All the patients are seen by a doctor and a social worker, with rooms provided for both, ensuring adequate privacy during the interview of the patient.
- De-addiction services are also available at Jammu Psychiatric Diseases Hospital with the following facilities :
 - a. OPD de-addiction services.
 - b. IPD de-addiction services.
 - c. Counseling/Psychotherapy services.
 - d. Oral Substitution Therapy.
 - Out-patient de-addiction services at SKIMS Medical College & Hospital, Bemina.
 - Out-patient de-addiction services in all district hospitals having a psychiatrist.
 - De-addiction facilities are also being provided by the JK Police in police control rooms of Srinagar, Anantnag, Baramulla and Jammu.
 - Besides, de-addiction services of varying degrees are also provided by various non-governmental organizations in Jammu and also in Kashmir.

However, there is lack of such facilities in Ladakh division.

CHAPTER 5

GAP ANALYSIS

1. **Gaps In Health Promotion And Prevention:-**

The health promoting activities which decrease substance use are on decline throughout the state of Jammu and Kashmir particularly the outdoor sports which not only help in dissipating the pent up energy in the young, but also promote healthy living and social bonding. It creates a counter peer group averse to the use of substance hence stops the spread of substance use disorders.

There seems to be a general lack of awareness in the adolescents and teens about the harm and addictive potential of various substances like solvent, cannabis, smoking etc.

2. **Gaps In Early Identification And Intervention:-**

The greatest impediment in early identification seems to be denial in families and in health care professionals about the presence of substance use disorders as a major health problem in young and youth. Health care institutions seem to be very insensitive to substance use disorders in terms of identification and treatment, thus impeding early identification and intervention.

3. **Gaps In Recovery And Support:-**

Substance use disorders create huge stigma in the lives of the affected individuals, thus preventing them from opportunities to re-integrate with the community and take the path of recovery. None of the social service schemes is linked to the recovery pathway, no social support groups exist in the state of J&K for helping substance users in remission, with rehabilitation in the community.

CHAPTER 6

ROLES AND RESPONSIBILITIES OF VARIOUS STAKE HOLDERS

1. INSTITUTE OF MENTAL HEALTH & NEUROSCIENCES KASHMIR (IMHANS)

(Associated Hospital Of Government Medical College, Srinagar)

AND

GOVERNMENT PSYHIATRIC DISEASES HOSPITAL, JAMMU

(Associated Hospital Of Government Medical College, Jammu)

The role of these Departments will be multi-faceted involving Information, Education & Communication (IEC) at one extreme and management of complicated cases at the other. These Centres will be involved in the following activities:

- a) Will serve as Nodal centres for all de addiction purposes, for Kashmir and Jammu divisions respectively.
- b) Coordination and linkage with all other involved agencies
- c) Research & training of man power
- d) Capacity building and human resources development by organizing different training programmes. This can be achieved by training of different medical professionals of Health Department by means of lectures, role plays etc. Different persons from education department including teachers and lecturers can be sensitized and trained in this context to affect this change.
- e) Development of treatment protocols based on latest guidelines.
- f) Sensitization of bureaucracy and judiciary regarding substance use.
- g) Utilization of Faculties from various institutes for training and human resource development.
- h) Providing of round the clock helpline with provision of manpower from the state government.
- i) Provision of mobile de-addiction units with provision of manpower

from the state government.

- j) Management of all complicated cases of patients having multiple medical or psychiatric co-morbidities.
- k) Continuous liaison with other medical specialties for the same.
- l) The department will create a data-base based on patient characteristics, patterns of drug abuse, presence of morbidity and new trends in drug abuse.
- m) This centre will look after the work of different sub-centres and different people working in the field.
- n) This centre will entertain all the referrals from different quarters including district hospitals, community hospitals and different NGOs.
- o) This centre will be in continuous two way communication with different stakeholders. It will communicate vertically to Government officials and different Government Departments and horizontally to different NGOs, Organizations.

2. DIRECTORATE OF HEALTH SERVICES, Jammu/Kashmir.

- a) Provision of indoor de-addiction services at the district hospitals where a trained psychiatrist is posted.
- b) Continuous information, education and communication regarding substance abuse.
- c) Two way communication with nodal centre as well as community.
- d) Integration of de-addiction services in national rural health mission as well as District Mental health programme in a gradual manner.
- e) Directorate can send different medical officers (working in field) as well as paramedical staff for proper training at nodal centre located at SMHS Hospital.
- f) Training of all Counselors posted with Directorate at the nodal centre so as to provide basic coping skills and other services to patients

- g) Mobilizing its field staff including ASHA workers, multi-purpose workers for the same.

3. SKIMS Medical College, Srinagar and Five New District Medical Colleges and Hospitals

- a) Drug de-addiction centres will be established.
- b) These de-addiction centres will have both out-patient and in-patient facilities
- c) They will work in co-ordination with Nodal centres in providing trainings.
- d) They will also conduct research and help in dissemination of that research to develop better de-addiction services.

4. JAMMU & KASHMIR POLICE, DRUG DE ADDICTION CENTRE

- a) The police drug de-addiction centre located at Police control room, Srinagar will continue to provide de-addiction services as it has been doing.
- b) The Police drug de-addiction centre will maintain a liaison with the nodal centres, and make referrals wherever and whenever applicable.

5. DEPARTMENT OF EDUCATION

- a) Consider making documentary as IEC material against drug abuse to be screened in all schools.
- b) The Department of Education can start awareness at the gross root level by different means like seminars, debates and symposia.
- c) The Department of Education can arrange a training program for teachers (ToTs) who would then train other teachers. Training will

be provided at the nodal centre.

- d) The Department of Education can invite experts from the Nodal Centre on the subject in their schools, colleges and universities for free interaction with students.
- e) Drug abuse and its ill effects can be started in the curriculum by the Department of Education.
- f) The Department should use services of trained counselors in schools who will counsel the students about the issues of substance use.

6. EXCISE & TAXATION DEPARTMENT, J& K.

- a) Enforcement of prohibition on cultivation of illicit crops, e.g poppy.
- b) Providing education to farmers on alternate crops in liaison with experts from departments of agriculture & horticulture.
- c) The department can execute different enactments of NDPS Act in letter and spirit.
- d) The department can stop the smuggling/illicit trafficking of prescription drugs across the borders of the state. In this case, checking at Lakahnpor and Banihal can be further enhanced.
- e) The department can maintain a strong information network with the nodal centre for gathering of information on this subject. This includes monthly feedback from all de-addiction centres about cultivation pattern and areas affected.
- f) The department can engage itself in sloganeering, advertising, mass awareness by using different media and initiate a strong campaign against drug addiction.

7. POLICE AND INTELLIGENCE DEPARTMENT.

- a) Need to have special cells dedicated to drug menace.
- b) Jammu and Kashmir Police, Security and Intelligence Wing and Crime branch need to work in tandem with Nodal Centre by deputing adequate personnel to this division for training.
- c) The different Station House Officers can be sensitized and trained in groups at Nodal Centre regarding this issue.
- d) The department can ensure a proper regulatory control on drug peddling issues.
- e) The Department can mobilize its intelligence wing to gather inputs and make proper decisions.

8. DEPARTMENT OF SOCIAL WELFARE.

- a) The department should have a mandate for rehabilitation and skill development.
- b) The department can introduce and execute different schemes for the same.
- c) The department should provide rehabilitation and skill development to the treated patients.
- d) The department can open-up new rehabilitation centers where patients can be taught basic life skills for a period of three months. This will include different courses like plumbing, electrician course basic computer training etc. Skill development initiatives will be implemented in coordination with the nodal centre.

9. J&K STATE AIDS CONTROL SOCIETY. (JKSACS)

- a) Can implement various schemes and projects for drug abusers linked with HIV/AIDS.
- b) Can establish more OST centres at community level which will work under the Nodal Centre.
- c) The programs/activities could be further intensified to cover maximum area possible with special focus on high risk areas.

10. YOUTH SERVICES AND SPORTS DEPARTMENT

- a) Awareness campaigns through different sports and recreational activities.
- b) Setting up more recreational centres for youth and encouraging youth to take up sports.
- c) Organize training programmes for physical teachers and lectures regarding this subject with the department of Psychiatry J&K Srinagar.
- d) Encouraging youth to take up sports and recreation. Mobilizing and involving youth in various social activities etc.

12. NGOs working in the field of de-addiction in Jammu and in Kashmir.

- a) Community social work including generating awareness among locals regarding substance use.
- b) Should provide rehabilitation and skill development to the treated patients.
- c) To work in close with local Imams, Panchayat heads and other Community leaders for awareness against drug abuse.

14. DIRECTORATE OF INFORMATION & PUBLIC RELATION.

This department could take the lead in publishing of IEC materials in all regional languages and making documentaries against use of drug which could be then screened in schools etc.

CHAPTER 7

MONITORING MECHANISMS

POLICY IMPLEMENTATION MONITORING COMMITTEE

- This will be a state level committee chaired by the Chief Secretary and will have Administrative Secretary of the Department of Health And Medical Education as the Vice-Chairman.
- Administrative Secretaries of Law, Education, Social Welfare, Youth Services And Sports as Members.
- Director SKIMS, IG Crime Branch and Excise Commissioner will also be members of the committee.
- The Principal, Medical College, Srinagar and Jammu will alternately, every two years, act as Member Secretaries of the committee.
- The Head of the Department, IMHANS, Kashmir and the Head of the Department, Govt. Psychiatric Diseases Hospital, Jammu, will be Technical Members in the committee.
- Government will also co-opt two members from the Civil Society, one each from Kashmir and Jammu to aid in the functioning of the committee.

FUNCTIONS OF THE COMMITTEE

- The committee will meet twice a year, once each in Jammu and Srinagar, to monitor the implementation of the policy on ground.
- The committee will also suggest changes in the policy from time to time as may be deemed necessary.
- The committee will also try to look for financial support for various de-addiction activities in the state.

DE-ADDICTION CENTERS MONITORING COMMITTEE

- The De-addiction Centres Monitoring Committees will be one each in Jammu and Kashmir divisions.
- They will have Administrative Secretary, Health and Medical Education Department as the Chair Person.
- The Head of Department, IMHANS, Kashmir and the Head of Department, Psychiatry, GMC, Jammu will be Member Secretaries for Kashmir and Jammu committees respectively.
- The Head of Department, Psychiatry, SKIMS Medical College, senior most psychiatrist from the Directorate of Health Services, Kashmir, and the Head of the Department, Psychiatry, Rajouri Medical College, senior most psychiatrist from the Directorate of Health Services, Jammu will be expert members of the respective committees of Kashmir and Jammu divisions.
- Principal SKIMS Medical College, Director Jammu And Kashmir and State AIDS Control Organization and Drug Controller will be Members.
- IG Crime Branch will nominate two members, one each from Jammu and Srinagar of the rank of DSPs, to be part of the committee.
- Law department will nominate two Law Officers one each for Jammu and Srinagar Committees.

FUNCTIONS OF THE DE-ADDICTION CENTERS MONITORING COMMITTEE

- To inspect the existing de-addiction facilities in the whole state of J & K and grant or cancel licenses, whatever applicable, after thorough and proper inspection of infrastructure, manpower and standards of care.
- All new de-addiction facilities will need to apply to the division level committee for grant of license for establishment of de-addiction facilities.
- This committee will also advise various stakeholders from time to time in order to implement de-addiction policy on ground.
- This committee will also look at monitoring of prescription drug abuse and suggest remedial measures to drug controller.

CHAPTER- 8

ACTION POLICY

- 1) Up-gradation of de-addiction centers of GMC, Srinagar and Jammu in terms of infrastructure and manpower to enhance the care level and provide linkage to the community.
- 2) Establishment of drug de-addiction centers in SKIMS MCH and all upcoming medical colleges in the state.
- 3) Enhancement of de-addiction treatment services in all district hospitals having a psychiatrist, and providing man power to the psychiatrist through District Mental Health Programme for running the de-addiction services efficiently.
- 4) Training of medical doctors, para-medical staff and other para-clinical staff in identification, intervention and referral of patients with substance use disorders.
- 5) Utilization of mass media in spreading awareness across schools by making and broadcasting movies and internet based informative videos.
- 6) Sensitization of community leaders including teachers, preachers, social activists about substance use.
- 7) Sensitization of para-social and para-health workers including village level workers, ASHAs, ANMs, para-legal field workers about substance use and their role in curbing it.
- 8) Implementation of NDPS Act in letter and spirit. Discussions and deliberations about its utility and any amendments needed in view of the changing trends of substance use, including solvents and synthetic drugs that are currently not covered in the NDPS Act.
- 9) Re-orientation of literacy-mission into an educational-mission,

focusing on overall development of children with special focus on out-door sports/playing and moral education, thus, contributing to society building.

- 10) Regulation of content on the internet and curbs on glamorizing the substances of abuse (smoking/alcohol/cannabis).
- 11) Extension of after-care in the form of rehabilitative care within the community, ensuring life of dignity and purposefulness by empowering them socially and economically.
- 12) With the changing modus operandi of creating availability of substances of abuse, the controlling agencies need to re-orient their modus operandi to counter balance the availability of substances.
- 13) The school health check-up camps, particularly in case of adolescents, should include screening for substances of abuse.
- 14) Introduction of self-help communities on the lines of Narcotics Anonymous and Alcoholics Anonymous in the state of Jammu and Kashmir.
- 15) Medical insurance and medical leave benefits should cover de-addiction treatment period just like any other medical condition.
- 16) Resources for data collection and research should be made available in the de-addiction centers as knowledge of the menace is key in its control and facilitates development of evidence based treatment protocols.